Social Health across the Channel:
Evaluating Four Years of the Interreg-funded *Social Prescribing Plus* and Connected Communities Project

Final Evaluation Report

Final version: 14 July 2023

This report has been prepared by the University of Essex with materials and evidence supplied via the cooperation of the Councils of East Suffolk, Kent, Medway, and Suffolk, and the Department of L'Eure. We thank these partners for their participation and collaboration in compiling and sharing information for this report, as well as in the Connected Communities Project in general. The report satisfies the following bid deliverables: T3.1.1; T3.1.2; T3.1.3

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1 Key Findings

Referrals to Connected Communities were made from across a wide sector of voluntary and community organisations, social care, family members, neighbours, media, leaflets and other sources. Individuals who received Connected Communities services over 12-week period (based on Kent and Medway data), were primarily referred through leaflets, voluntary and community sector, social services, professionals such as Kent Community Wardens, self-referral, family and friends and many other sources. In contrast, only a small number of the beneficiaries were referred via GP services (6% in Kent; 1% in Medway which was deemed inadequate and referral was made to other services). Despite the NHS design of social prescribing as an approach to healthcare to be implemented by GPs around the country, Connected Communities data suggests that GPs have not thoroughly adjusted to the paradigm. The findings regarding GP services' referral in Medway and Kent point to a greater need for engagement of social prescribing within GP services.

Based on Medway's data, Connectors primarily linked service beneficiaries with local neighbourhood groups (60%). This finding shows the role that the community sector plays in delivering social prescribing, people's need to be involved with their communities and the desire to be involved given the opportunity to do so.

Connected Communities received a large number of referrals, with a number of cases deemed not eligible to receive the service (see more in **Referrals made directly to other services** section). For those who did not receive the service Connectors invested significant time and effort to find more adequate services for their needs.

Data numbers (data shared for the purpose of evaluation) were substantially lower than the expected number of cases that the partnership estimated at the start of the programme. This was due to a variety of contextual (for example, COVID-19) and programme specific factors (lack of partner-level coordination during the development stage).

- ***Gender.*** A majority report identifying as female.
- ***Age*** ranges from 64-96.
- ***Ethnicity.*** A majority report to identify as White.
- ***Marital status.*** A majority report being widowed.
- ***Education.*** A majority report having secondary education.
- ***Income.*** A majority report that their current income just about covers their living expenses.
- ***Living status.*** A majority report living alone.
- ***Housing status.*** A majority report owning a house.
- ***Critical life event.*** A majority report experiencing such event in recent times, including one of the following: accident, death of a loved one, health event, covid experience, relationship breakdown.
- ***Long-term health conditions*** are experienced by a third or more of the beneficiaries across the partner locations.
- ***Physical activity*** beneficiaries in L'Eure seem to be least physically active in comparison to those in Medway and Suffolk. Medway was the only partner to provide physical activity data for the first and last visit, and the results show that

Medway beneficiaries report being more physically active during their last visit in comparison to first visit.

- ***Habits such as smoking and drinking*** were low across all of the partner locations, and exhibit no change over time.

Interactions before COVID-19, a sense of loneliness and connectedness. For Medway, the only partner that provided data on these measures, we find:

- a statistically significant reduction in loneliness levels when comparing last to first visit scores (with the time before COVID-19 pandemic emergence being a benchmark);
- a statistically significant improvements in connectedness levels when comparing last to first visit scores (with the time before COVID-19 pandemic emergence being a benchmark)

Loneliness. We find a statistically significant reduction in loneliness for Medway, Suffolk, and Kent, with beneficiaries reporting that they feel less lonely during the last visit in comparison to their first visit (No evidence of change in L'Eure - not statistically significant).

Social isolation. We find statistically significant reductions in 4 aspects of social isolation***:***

- beneficiaries report that they feel that they have more people that they are close to and can depend on during the last visit in comparison to their first visit (No evidence of change in Suffolk - not statistically significant).
- beneficiaries report that they are spending more time with someone who does not live with them (socialise) during the last visit in comparison to their first visit (No evidence of change in Suffolk - not statistically significant).
- beneficiaries report that they talking more on the phone with someone who does not live with them during the last visit in comparison to their first visit (No evidence of change in L'Eure and Suffolk - not statistically significant).
- beneficiaries report that they are going more often to the club meetings, religions meetings and other group events during the last visit in comparison to their first visit (No evidence of change in Suffolk - not statistically significant).

Wellbeing. We find statistically significant improvements in 4 aspects of wellbeing***:***

- beneficiaries report that they feel more satisfied with their life nowadays during the last visit in comparison to their first visit.
- beneficiaries report that they feel things they do in their life being more worthwhile during the last visit in comparison to their first visit.
- beneficiaries report that they feel happier during the last visit in comparison to their first visit.
- report that they feel less anxious during the last visit in comparison to their first visit (No evidence of change in Kent - not statistically significant).
- beneficiaries report greater overall wellbeing during the last visit in comparison to their first visit.

Trust. We find a statistically significant improvements in trust:

- beneficiaries report that they trust people more during the last visit in comparison to their first visit.
- Kent beneficiaries report that they trust officials more during the last visit in comparison to their first visit (No evidence of change in Suffolk and Medway - not statistically significant).

Satisfaction with Connected Communities Programme. We find a statistically significant improvement in satisfaction with the programme in both Kent and Medway.

Health care usage*.* A majority report not visiting the GP (with the exception of L'Eure), the A&E, or the hospital in the month prior to being asked by their Connector about their health care usage.

Social care usage. A majority report not using social services or social care in the month prior to being asked by their Connector about their social care usage.

APA autonomy payments. In L'Eure, 29% of beneficiaries report receiving autonomy payments (APA).

Community-level analyses Given the number of individual-level data received from each individual partner for evaluation, analyses for the community-level impact were limited to descriptive discussion of community-level data trends. The results show an increase in the costs of residential care costs across Kent, Medway and Suffolk over the last 2-3 year period, and an increase in the number of requests for home care services.

A potential link between an increase in residential care costs and an increase in the number of home care service requests, should be further investigated as it is possible that as more people start to rely on home care services, care sector could likely experience more pressure in the near future. This can have wide reaching repercussions for the care sector as well as for the field of social prescribing.

We advise local authorities to further test and explore the potential link between increases in the costs of residential care and its impact on other social care services such as home care. If the link exists, reliance on home care puts additional pressures on carers and care agencies, with more resources and staff time needed in this sector. A better understanding of the trends in social care would also enable social prescribing services to tailor their social prescribing programmes to help mitigate increases in social care usage. The impact of social prescribing on social care usage is the least explored area of social prescribing.

Impact of Delivery has been noted in the way in which programme was delivered, managed and evaluated. All partners noted the need for greater partner-level engagement (ex. more project steering group meetings-PSG), clearer implementation and leadership guidance and a need for more co-productive work across all deliverables. Data collection is an important and essential aspect of programme delivery as it provides a mechanism through which beneficiaries' progress and programme impact is captured, so time should be devoted to discussing, understanding, and reaching a consensus regarding data collection protocols.

Impact of Partnership and Contextual Factors was primarily observed in relation to COVID-19 related complexities (delays with programme start, services closed), Brexit (loss of French partners), partner interactions (desire for more interactive and collaborative engagement), and partnership management by the Joint Secretariat.

What worked?

- Extensive and positive interactions with Voluntary, Community and Enterprise Sector organisations helped to:
    - Promote Connected Communities
    - Collaborate to avoid service duplication & better serve community—*a whole system approach.*
- Partners were devoted to fostering an increase in awareness of loneliness and isolation among community members and local authority.
- Kent's Communications approach was useful and informative.
- Building the Directory of Services in Kent and Medway was effective and useful.
- Utilising La Poste workers in L'Eure and Community Wardens in Kent capitalised on already established trusting relationships with community.

What did not work?

- No unified Client Record Management System (CRMS) was detrimental to:
    - data management, collection and monitoring
    - impact evaluation
    - coordination across partners.
- Knowledge exchange via workshops and collaborative meetings was low:
    - The partners would have appreciated more opportunities to come together to solve problems, discuss programme progress, utilise each other's competencies, facilitate collaborative working time, and build rapport.

We recommend that programme designers, deliverers, and evaluators take the experience of Connected Communities as an opportunity to:

- Recognise the power of a shared vision and how to create it through communication, goal setting, and active action planning.
- Understand that co-production is only possible when there are clear leadership roles, a clear vision, and a long-term commitment to collaboration.
- Regularly update risk-management plans for all aspects of design, delivery, and evaluation.
- Allocate adequate time to work with stakeholders and partners to find the balance between data collection and analysis requirements on the one hand and the needs of delivery professionals and beneficiaries on the other.

2 Connected Communities Data

The Connected Communities data was collected between June 2020 and December 2022, with services being disrupted during the COVID-19 lockdown restrictions. Frequent and prolonged periods of social distancing impacted programme participation and as a result reduced the number and the quality of the data that we aimed to capture.

Social prescribers (Connectors) who worked on delivering Connected Communities services in the areas of Kent, L'Eure, Medway and Suffolk interacted with beneficiaries over a 12-week period and recorded the data during the first and last visit, and in some cases during the follow-up visits in between. In a few of the cases, Suffolk Connectors recorded evaluation question responses for 3 or more visits.

The evaluation logic model[1,2] proposed by the University of Essex Evaluation Team (UoE Evaluation Team) sought to capture the impact of Connected Communities at the individual, system and community levels.

Individual-level data: changes in loneliness, social isolation and wellbeing

All delivering partners agreed to record pre- and post- programme participation information on beneficiaries' levels of loneliness (1 item), social isolation/interaction (4 items), wellbeing (4 items - ONS4 questionnaire), trust (2 items) and overall satisfaction with the Connected Communities programme (1 item). The partners also collected basic demographics and health-related questions during the duration of the programme. Some partners recorded additional information on individual's habits, civic engagement, and social connectedness. The data is incomplete for many beneficiaries and inconsistent across partners. Individual-level cross-partner comparisons and project-wide analysis will therefore only be possible for loneliness, social isolation, two wellbeing questions and satisfaction with the service. For all remaining beneficiary responses, we provide descriptive analysis without any evidence of change over time.

System-level data: changes in demand for health and social care

The data for system-level change was meant to come from questions to beneficiaries regarding their own usage of these services. Pre and post programme participation information on health and social care usage was collected only by Medway. L'Eure collected information on health and social care usage during the first (pre) assessment. Suffolk provided only information for general practitioner (GP) visits for 4 individuals and accident and emergency (A&E) visits for 1 individual. Thus, analyses of the impact of Connected Communities on system will be only possible for Medway.

Community-level data: changes in productivity and connectedness

When it comes to community-level data, some partners have shared with the UoE Evaluation Team monthly-level data for various usage of short and long-term care services. While some partners were able to provide us with the number of individuals receiving various short and long-term services, others were able to provide us with costs. Some of the partners were only able to share yearly level data on taxes, revenue and social care expenditure for an entire region. Others have shared MOSAIC[3] data classifying households based on demographics, behaviours, lifestyle and attitudes.

Cross-county comparisons for the community-level data will not be possible given the various categories and the types of the data that were provided. Instead, community-level data analyses will be presented for each individual local authority.

Data quality

In previous reports, we have detailed numerous issues related to data quality. As we will present findings based on this data below, we take this opportunity to highlight a few of the concerns and complications that have arisen. Due to issues with the data recording system development, oversight, and standardisation, the quality and presence of data across partners is inconsistent. Any conclusions we can draw about the effectiveness of the Connected Communities Project should therefore be interpreted cautiously and with clear knowledge of all limitations.

Unified versus separate CRMS

Initially, when the programme was proposed, all partners agreed to co-develop a common Client Record Management System (CRMS) and a protocol for its use. As partners started implementing Connected Communities a few months after the award was granted, they encountered various complexities that come with creating a joint CRMS while being subject to their own data protection rules and regulations. Most partners were eager to develop their own preferred system which could align with other projects within their local authority. Ultimately the partners considered and voted on 3 basic options:

1) Acquire, jointly purchase, and implement a single unified CRMS among all 8 local authority partners (later reduced to 5 local authority partners, including East Suffolk, L'Eure, Kent, Medway, and Suffolk);
2) Separated into groups by language, acquire, jointly purchase, and implement a total of two CRMS systems – one for English partners (4 local authorities), and one for French partners (4 local authorities, later reduced to 1);
3) Separately and individually acquire, fund, and implement one CRMS system for each partner. Allow each partner to set the specifications and needs of the CRMS it chooses.

Despite objections from the Evaluation Team, partners voted and chose Option 3. While the reasoning behind the decision was merited, it resulted in multiple complications with data quality and subsequent analysis. The partnership agreed on the questions to be asked and overall data recording structure in July 2020. However, each partner implemented the data recording structure in a slightly different way, varying elements such as question order, question availability, response options, and spelling. These differences only became clear once partners shared their first data in 2022. At that point, no partner was willing or able to change their data collection system. The lack of partner-level management and oversight thus meant data was not compatible or standardised, and consolidating the information resulted in increased workloads across the partnership.

Once the decision was made that each partner would acquire its own CRMS system, there was no partner responsible for the oversight or management of the 4 different recording systems. There was therefore no one with the authority or remit to ensure compatibility across systems. A software company called Simply Connect was contracted to develop CRMS system for Suffolk and Medway. Suffolk choose to utilise

an “off the shelf” format that Simply Connect was already contracted to deliver for other County services, and to make small edits to this system by adding questions to be asked beneficiaries. Medway chose to use Simply Connect as well, but to pay extra money for additional development of the format which would match more closely the needs of Connected Communities and the previously-agreed structure.

In an attempt to ensure standardisation, the Evaluation Team evaluated the CRMS for L’Eure, Kent, and Suffolk once each, and sent audit reports to the appropriate CRMS managers and partner. In each case, these involved an assessment of the ease of use for Connectors, the reliability in terms of accurately collecting the needed information (that which had been agreed by all partners), and a list of any outstanding modifications needed to question wording, data collection flow, or other elements. Reviews of the CRMSs for Kent and L’Eure did not reveal the need for any modifications. UoE Team evaluated Suffolk’s Simply Connect platform and provided an audit report highlighting concerns due to functionality, clarity and content in mid-2020. Suffolk needed multiple modifications, which the Evaluation Team were never allowed to verify had been made. UoE Team was never given access to review the Simply Connect platform developed for Medway.

Data recording

The aim of the CRMS audit was to ensure that the system would be easy for Connectors to use and adequately capture the data. UoE Team determined that the Simply Connect system in Suffolk was not fit for purpose, and proposed a number of changes to the layout, presentation, sequencing of questions, and location of key items.[4] Some of the proposed changes included: adjusting the flow and appearance of the questions and sections to clearly indicate which questions should be asked at least 2 times versus those that could be recorded as and when they came up in discussion, clarifying instructions for the Connectors regarding how questions should be asked, and adding options “not discussed” and “participant refuses to discuss/answer” for each question.[4]

Initially, Suffolk considered the report and decided that, other than typographical errors and the addition of COVID-related questions, Simply Connect would not be asked to modify the CRMS. UoE cautioned against this decision, asserting that difficulties in recording the data might compromise the data quality. If so, any inconclusive results of the programme might then be based on poor data, rather than on programme design or delivery, with no way of knowing the actual cause for the results. After discussion with the UoE team, Suffolk opted to provide the full audit report to Simply Connect and request all of the corrections.[1] Suffolk reported to UoE that Simply Connect had reported that they had implemented these corrections. Unfortunately, despite this assurance, the data that UoE received from Suffolk in February and May 2022 was not usable (below).

Data extraction

The fact that each partner utilised a different data recording system led to partners providing data to the UoE Evaluation Team with conflicting identifiers and content. The Evaluation Team raised the issue of data quality as soon as partners began to deliver data, and provided feedback for each partner regarding their data recording practices. The breadth of challenges prompted a joint post-implementation effort to standardise data collection. Partners agreed in September 2022 to create a newly unified data

reporting format using Excel spreadsheets and a codebook. Three of the partners were able to provide the data in formats close to the agreed standardisation. L'Eure was unable to provide data in the format developed in September 2022 due to programme time limitations.

Suffolk was not able to extract the data from the Simply Connect System effectively. Staff members of Suffolk Family Carers (SFC), who delivered *social prescribing plus* in Suffolk, who recorded and shared the data with UoE, had to manually copy and paste the content into a new spreadsheet to create a shareable and readable form of the data. We therefore conclude that Suffolk's capacity to record the data during delivery and to extract the data to share with the UoE Team was negatively affected by the quality of the Simply Connect platform.

Medway worked with the same provider, Simply Connect, and were eventually successful in aligning the needs of the Connected Communities programme with the Simply Connect platform abilities. Nonetheless, Medway staff also invested considerable time in manually entering the data into a shareable format.

Kent developed their own CRMS platform in-house. UoE evaluated the platform and found that it met functionality, clarity and content criteria needed for recording high quality data.[1] However, Kent staff also spent their time manually copying and pasting information as some of the evaluation questions that the UoE proposed were not directly linked to the platform, but were recorded in a separate section, which made data extraction less efficient. Kent also made the manual adjustments agreed by partners in September 2022.

Data processing

Collating, cleaning, merging, and analysing the self-reported individual and system level-data took hundreds of UoE person-hours. None of this time would have been necessary under the originally planned unified CRMS, because in the unified plans, the UoE would have overseen structuring the data platform, and would have had direct, authorised, and secure access to the data. The lack of standardisation and access caused inefficiencies and the reallocation of workloads that led to severe delays in delivery.

Inconsistencies in data recording have also resulted in a lack of insight into missing data. Based on what some partners recorded during their interaction with a beneficiary, it is not clear whether incomplete data is missing because it was not recorded, because a beneficiary refused to answer a question, because a Connector did not ask a question, or because a particular topic was not discussed. We therefore have only anecdotal evidence to inform future decisions regarding measurement selection and validity.

3 Individual and System-Level Analyses (T3.1.1 Deliverable: CRMS Report)

In this section, we investigate Connected Communities service delivery and outcomes using both quantitative and qualitative data. First, we present beneficiaries' referral pathways, demographic characteristics, life circumstances, and overall health.

We then explore whether there are observed changes in beneficiaries' levels of loneliness, social isolation and wellbeing over time. We compare beneficiaries' reported levels of these individual attributes from before they participated in the programme to those when they were at or near the end of their participation. We also present beneficiaries' satisfaction with the Connected Communities service, and their levels of trust over time, when those attributes are available in the data.

We also present analyses comparing self-reported pre-programme to post-programme usage of general practitioner services (GP), accidents and emergency services (A&E), and hospital and social care services for beneficiaries within Medway, the partner that recorded and provided this data. For beneficiaries within L'Eure, we describe health and social care usage as self-reported at one point in time.

When available, we also report information on beneficiaries' participation in other social prescribing programmes, levels of civic engagement, and perceived changes in their sense of connectedness, habits, and loneliness levels with respect to the COVID-19 pandemic.

Basic Descriptive Statistics

Referral sources – How do beneficiaries find the Connected Communities Project?

Partners report receiving referrals from numerous sources and across a wide sector of VCSE, social care, health care, family members, friends, neighbours, media, leaflets and others. Referred cases are categorised into two groups:

- hard cases – individuals who received social prescribing via the Connected Communities Project
- soft cases – individuals who were referred to Connected Communities, whose needs were deemed better addressed by other services, and who were therefore signposted to other providers.

Some partners have provided UoE Evaluation Team with the raw data regarding referral pathways to and from Connected Communities. Kent provided a graph aggregating referrals for both hard and soft cases, and provided raw data for soft case referrals. Medway provided raw data for both hard and soft cases.

To compare referral sources across Kent (Figure 1, graphic shared by Kent) and Medway (Figure 2, UoE-produced graphic based on raw data), hard and soft cases for Medway are combined in Figure 2. This section also provides an overview of the hard referral cases from Medway. This section requires a greater attention on hard cases given that the evaluation analyses are can only be conducted on hard cases – individuals who received Connected Communities service. For more information on Medway and Kent soft cases, see **Referrals made directly to other services**.

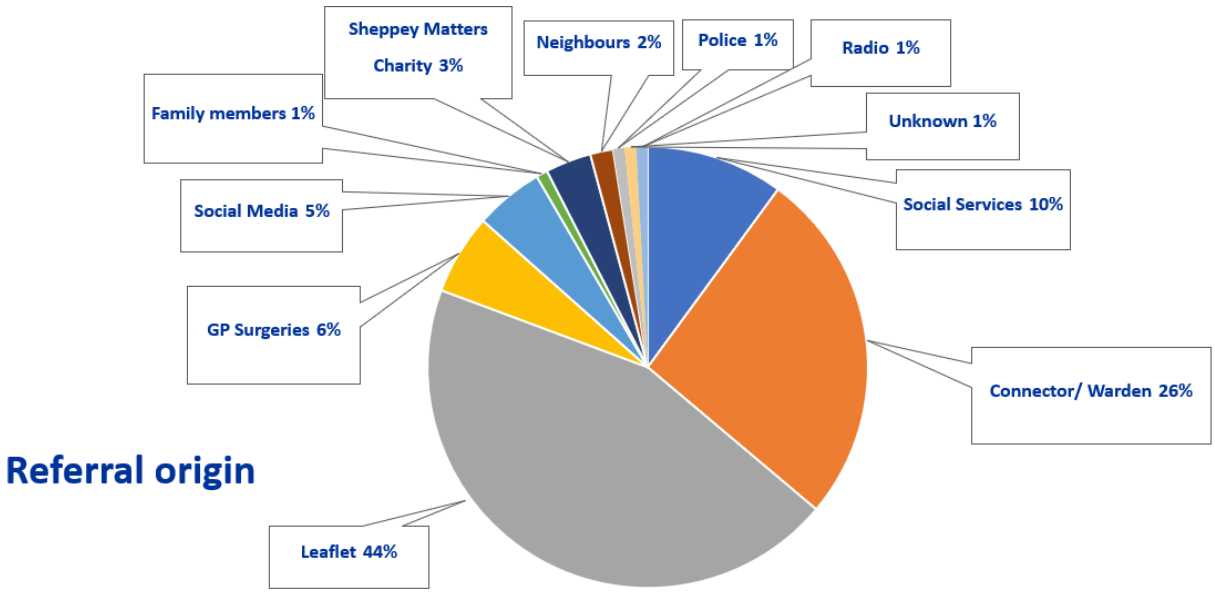


Figure 1. Referral sources – Kent

(graphic shared by Kent, includes both hard and soft case referrals)

Figure 1 shows that in Kent the most commonly identified referral source was leaflets (44%), followed by referrals from Connectors who also have been serving as Community Wardens in Kent (26%).

In the UK, social prescribing has been greatly promoted as a part of the NHS Long Term plan[5], meaning each GP is now resourced to have a social prescriber as a part of their service. This level of support has not been equally afforded to the social care sector. Still, social services outpaces GP services in making referrals to Kent's Connected Communities programme. The number of referrals from social services was 10%, while the referrals from general practitioner (GP) services was 6%.

Figure 2 shows that in Medway, the most commonly identified referral source is the COVID welfare hub (72%), followed by family and friends (5%), voluntary and community services (6%), self-referral (3%), adult social care (3%), care agencies (2%), housing association (1%), council tax leaflet (1%) self-referral – Medway Matters Magazine (1%), care navigation services (1%) and primary care (1%). Similarly to Kent, small numbers of referrals were made through GP services (1%) in comparison to voluntary and community services, adult social care and family and friends.

The majority of the referrals in Medway were received through the COVID welfare hub, which illustrates the extent of needs in Medway and the pressures under which local authorities had to operate during the COVID-19 pandemic. Furthermore, when comparing Medway referral sources in Figure 2 (hard and soft cases) with Figure 3 (hard cases only), it is evident that not all the referrals from the COVID welfare hub could be served by the 12-week social prescribing service. Nonetheless, Connectors in Medway ensured that anyone who reached out to Connected Communities was referred to services which could most appropriately address their needs.

Medway's work demonstrates the contribution of Connected Communities to people in need during one of the most unprecedented public health events in recent history, the COVID-19 pandemic. It also points to a need to develop a greater understanding of what a social prescribing framework can offer to communities in need.

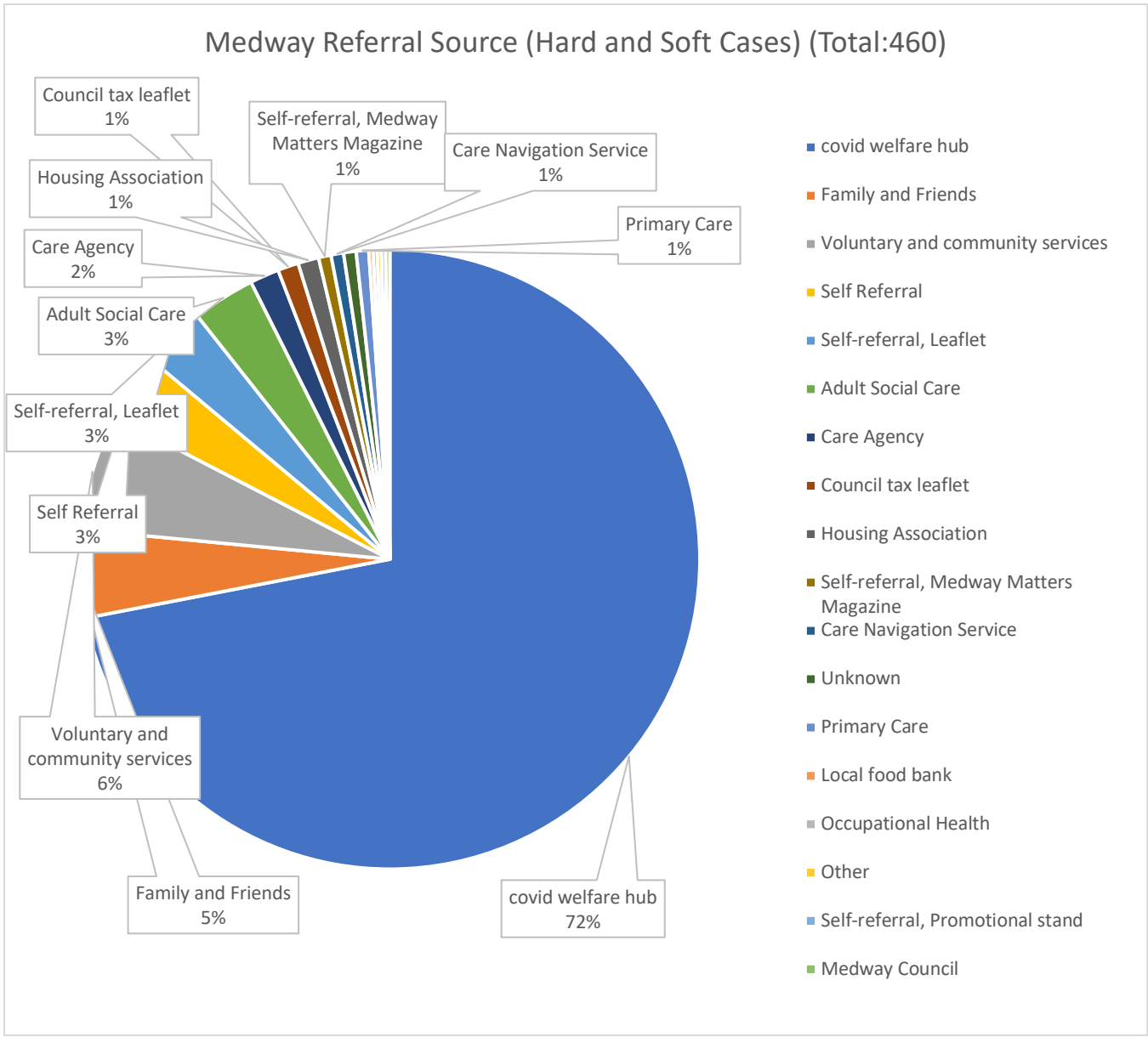


Figure 2. Referral sources – Medway hard and soft cases

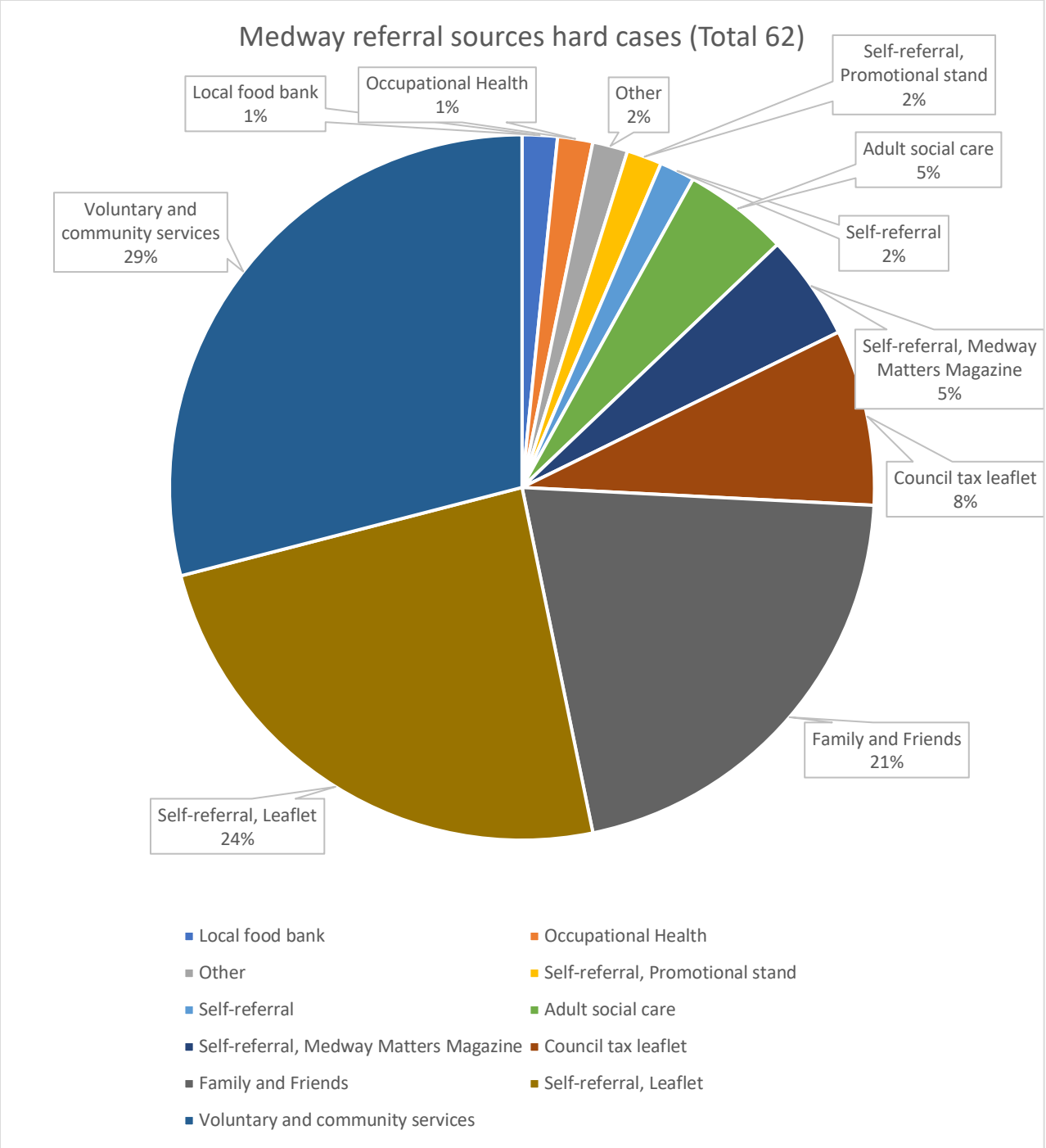


Figure 3. Referral sources – Medway hard cases

Figure 3 includes only Medway's hard case referrals, individuals who received the service over 12-week period. It shows that most beneficiaries came to Connected Communities (called Better Connected in Medway) via voluntary and community services (29%), leaflets that prompted self-referrals (24%), family and friends (21%), leaflets in council tax letters (8%), Adult Social Care (5%), Medway Matters Magazine (5%), promotional stands placed at events (2%), occupational health services (1%), and the local food bank (1%). There were no adequate hard referrals made through GP practices.

Medway invested concerted effort and attention to engagement with the voluntary, community and social enterprise (VCSE) sector, the largest referral source (*see Toolkit* for more information). Medway engaged with numerous VCSE sector organisations and employed a variety of tools to inform individuals and organisations in their communities about Connected Communities and the programme's potential to improve health and wellbeing.

The findings regarding GP services' referral in Medway and Kent point to a greater need for engagement of social prescribing within GP services. Despite the NHS design of social prescribing as an approach to healthcare to be implemented by GPs around the country, Connected Communities data suggests that GPs have not thoroughly adjusted to the paradigm.

Onward referrals – Where did beneficiaries go to connect with others?

Medway has recorded information about onward referrals for beneficiaries of the 12-week social prescribing service, indicating to which VCSE services people were recommended and actions taken to support beneficiaries. Figure 4 shows that the majority of beneficiaries were referred to local neighbourhood groups (60%), illustrating the importance of the community sector in delivering social prescribing as well as people's need to be involved with their communities and eagerness to engage given the opportunity. Neighbourhood groups are followed by befriending services (13%), practical support (6%), mental health support (5%), physical activity support (5%), and arts-based groups (1%). Interestingly, 8% of beneficiaries were not referred to any other services due to complex health conditions and difficulty finding an onward service suitable for their needs.

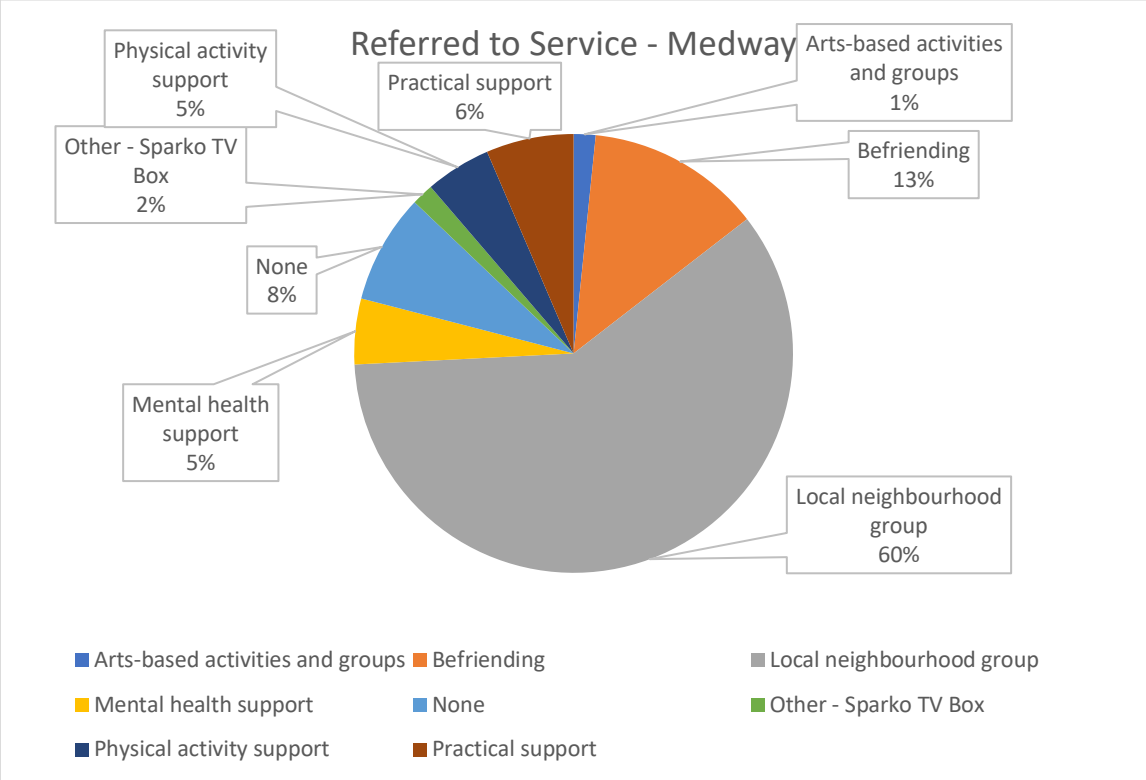


Figure 4. Referred to Services – Medway hard cases

Figure 5 shows that Connectors supported beneficiaries in a variety of ways during their participation in Connected Communities programme, with 41% of beneficiaries being accompanied, 43% assisted in connecting, and 8% given information to connect with other services.

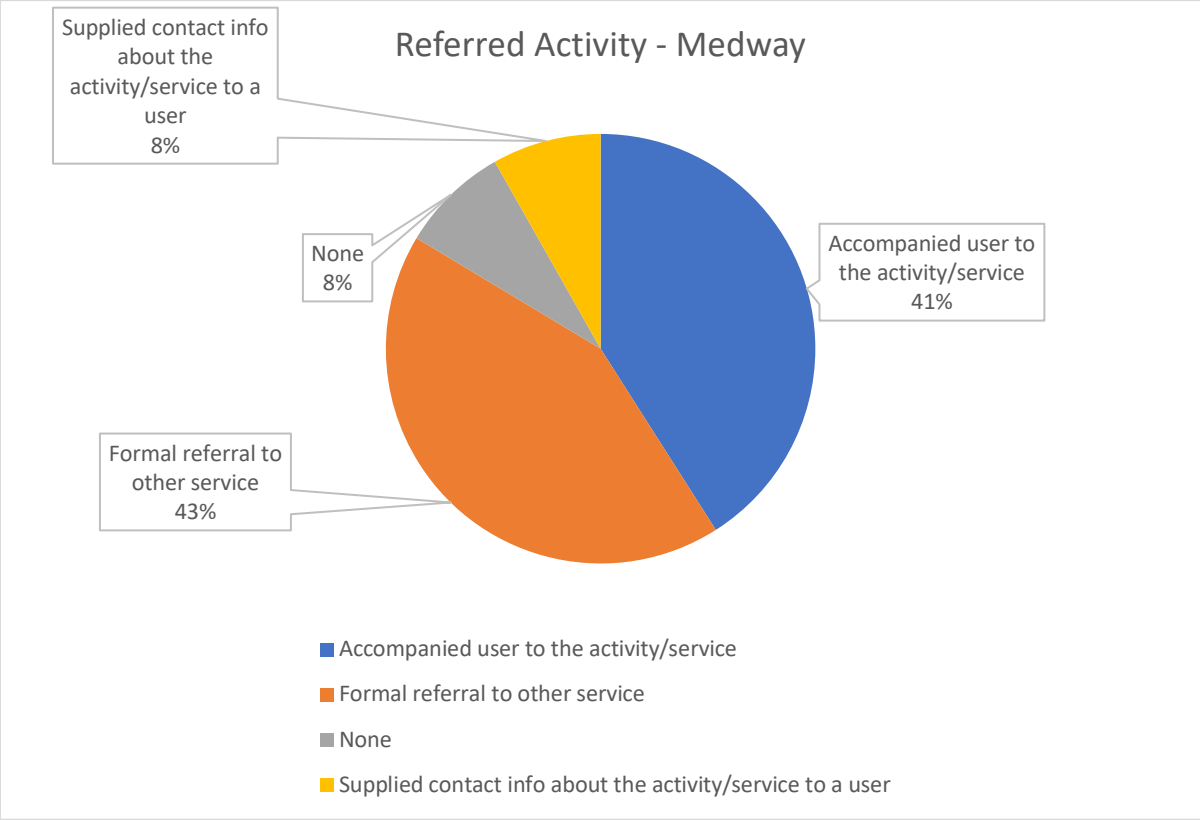


Figure 5. Referral activity – Medway hard cases

How many beneficiaries were there?

The total number of beneficiaries that received Connected Communities services (hard cases) differs across partner locations. What also differs is the number of responses during the first and final visit, so there is a limited number of cases that have both pre- and post-participation answers to compare (third column, Table 1). Partners' hard cases are as demonstrated in Table 1 and depicted in Figure 6.

Partner	Hard cases with data recorded and shared at least one point in time	Hard cases with data recorded and shared at least two points in time
Kent	101	73
L'Eure	202	102
Medway	62	56
Suffolk	19	9

Table 1. Count of hard and soft cases, by Partner

Some beneficiaries lack data from a second visit, which is either due to a lack of continuation with the programme or due to a change in the beneficiary's personal circumstances, such as an illness that prevented the Connector from asking questions.

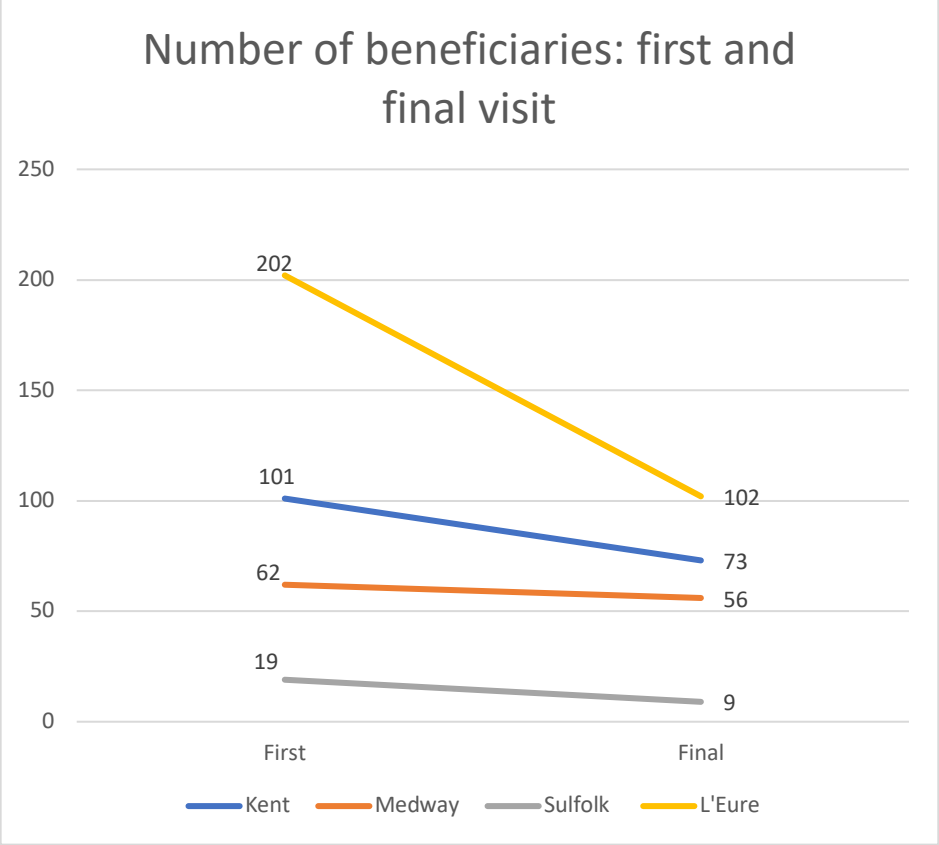


Figure 6. Number of Beneficiaries, data present for the first and last visit

Gender

Our data recording protocol was designed to capture the following gender categories (Figure 7): male, female, non-binary, prefer not to say.

In Kent, 71% of the sample were female and 29% were male.

In L'Eure, 75% of the sample were female, 23% were male and for 2% of beneficiaries the question was not discussed.

In Medway, 42% of the sample were female and 58% were male.

In Suffolk, 42% of the sample were female and 58% were male.

Overall, across all the partners, 70% of the sample is female, 29% male and for the 1% of beneficiaries the question was not discussed.

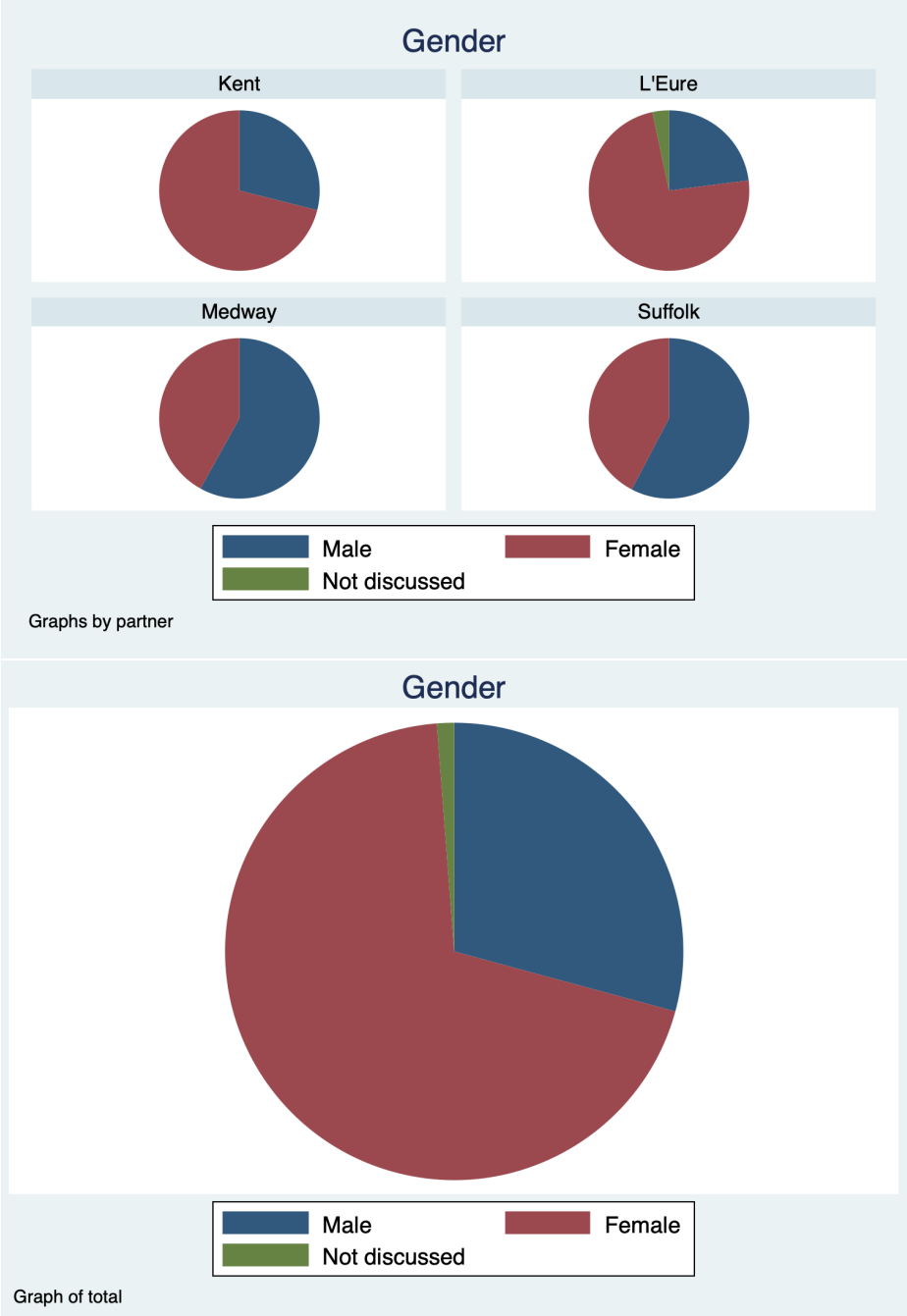


Figure 7. Gender

Age

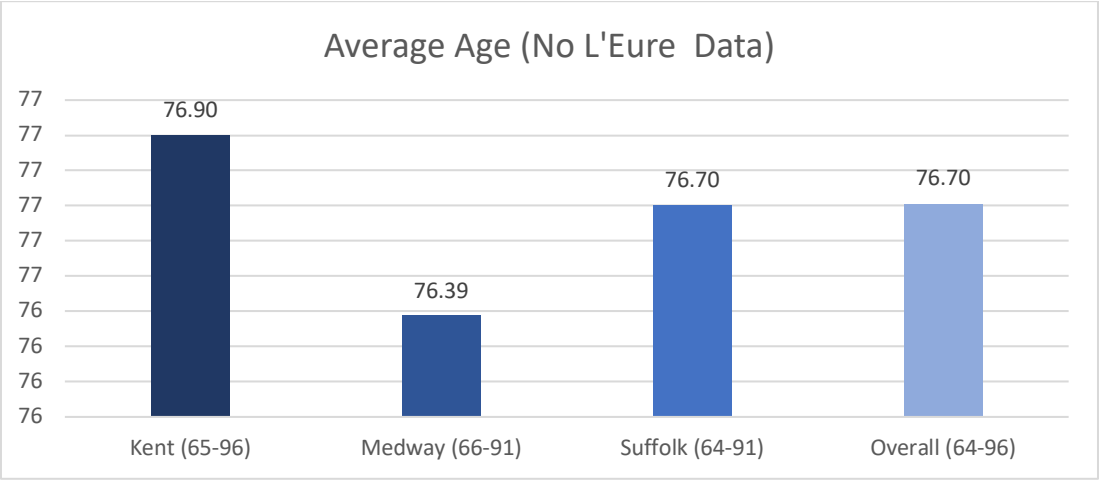
In regards to the age limitations, Connected Communities was designed to engage individuals 65+ in the UK and 60+ in France. Figure 8 shows that the overall average age across three partners (Kent, Medway, Suffolk) was 77.

Kent beneficiaries age ranged from 65-96 and average age being 77.

Medway ages ranged from 66-91, average age being 76.

Suffolk ages ranged from 64-91, average age being 77.

L'Eure did not share age data, which would have likely impacted the average age and age range as beneficiaries in France were eligible for participation at the lower age cut-off, 60+ in comparison to English partners, 65+.



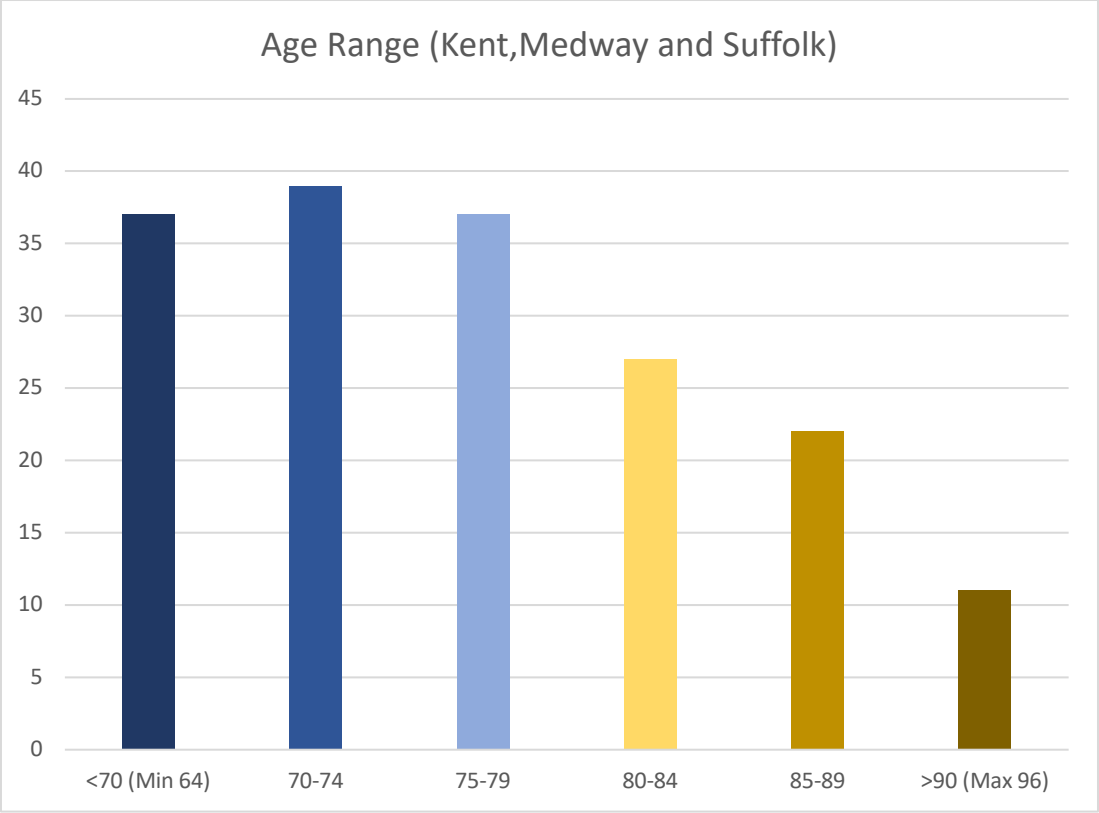


Figure 8. Age

Ethnicity

Figure 9 shows that the majority of beneficiaries are White across Kent, Medway and Suffolk, although it should be noted that ethnicity has not been recorded for all beneficiaries. L'Eure recorded "origin" rather than ethnicity due to a desire to respect cultural sensitivities surrounding the idea of asking one's ethnicity. All L'Eure beneficiaries responded their origin to be French.

In Kent, 71% of the beneficiaries were White, 3% were Black, Asian or from other ethnic minority and for 26% this question was not discussed.

In Medway, 31% of the beneficiaries were White, 3% were Black, Asian or from other ethnic minority and for 66% this question was not discussed.

In Suffolk, 94% of the beneficiaries were White and for 6% this question was not discussed.

Overall, 54% of the beneficiaries were White, 3% were Black, Asian or from other ethnic minority and for 43% this question was not discussed.

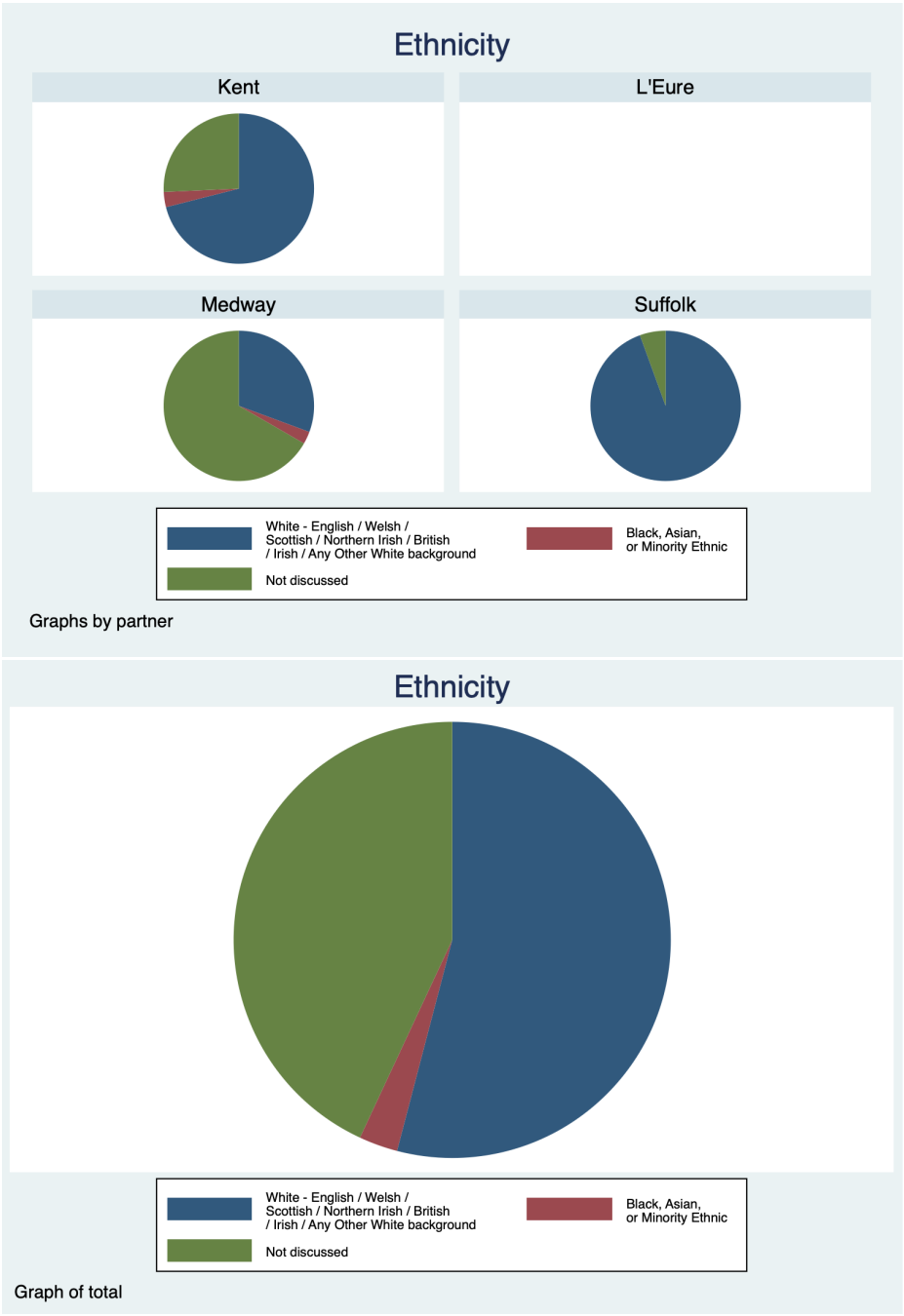


Figure 9. Ethnicity

Marital Status

Figure 10 shows that the most of the beneficiaries are widowed across most of the partner locations. This marital status is telling, given that bereavement is found to be one of the underlying causes of loneliness. More work is needed to understand the differences in coping mechanisms among beneficiaries, and how these impact the relationship between loneliness and grief.[6]

In Kent, the data shows that:

- 5% are unmarried
- 37% are widowed
- 19% are separated or divorced
- 8% married or civil partnership
- 4% refuses to answer
- 27% unable to answer

In L'Eure, the data shows that:

- 6% are unmarried
- 47% are widowed
- 20% are separated or divorced
- 27% married or civil partnership

In Medway, the data shows that:

- 9% are unmarried
- 39% are widowed
- 13% are separated or divorced
- 13% married or civil partnership
- 25% not discussed

In Suffolk, the data shows that:

- 7% are unmarried
- 34% are widowed
- 17% are separated or divorced
- 12% married or civil partnership
- 29% unable to answer

Overall, the data shows that:

- 6% are unmarried
- 42 % are widowed
- 18% are separated or divorced
- 19% married or civil partnership
- 6% not discussed
- 1% refuses to answer
- 8% unable to answer

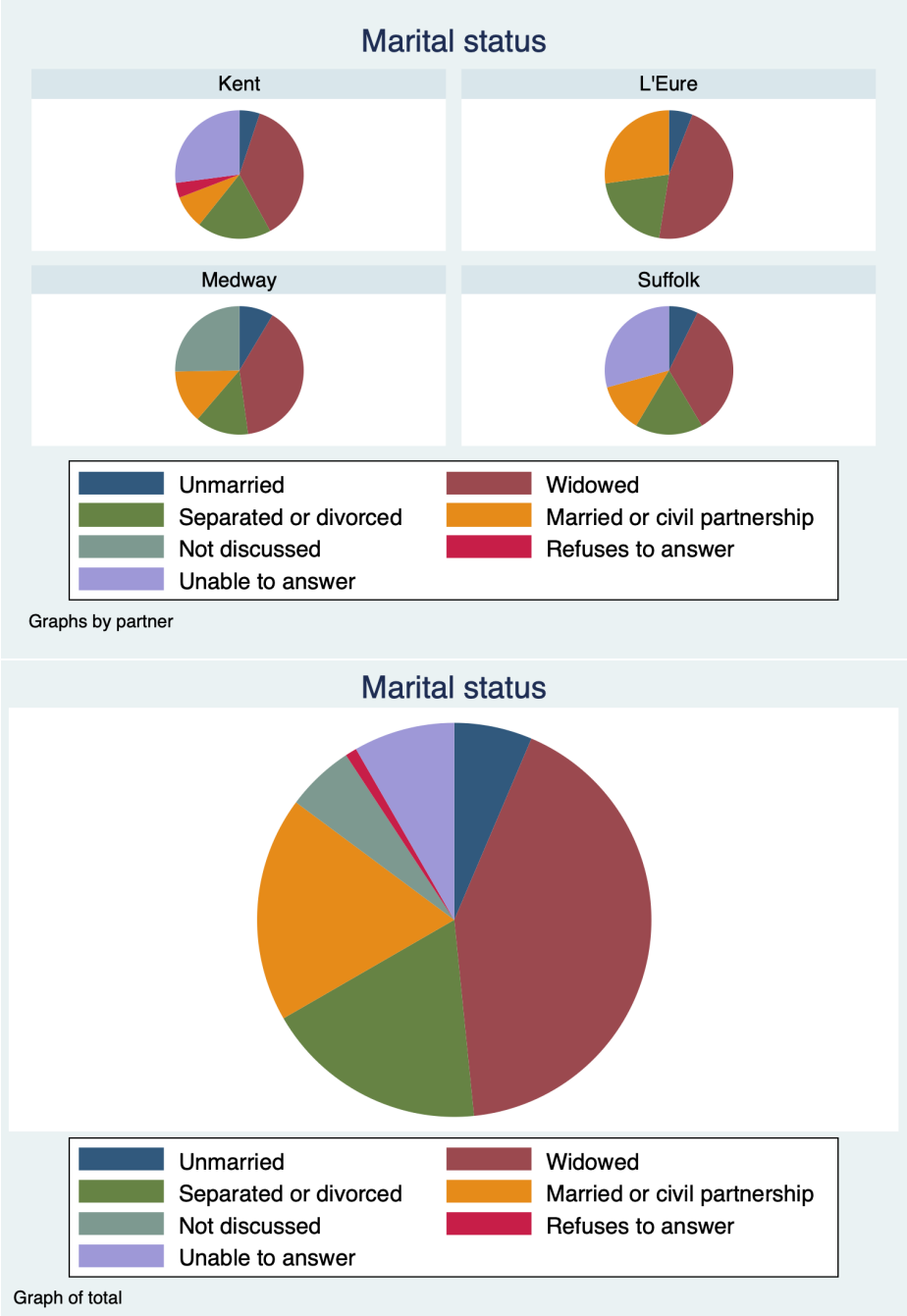


Figure 10. Marital Status

Highest level of education attained

Figure 11 shows that the majority of the beneficiaries achieved a secondary school degree across the partner locations.

In Kent, the data shows that:

- 71% have secondary education
- 25% have higher education
- 1% have post-graduate education
- 3% refuses to answer

In L'Eure, the data shows that:

- 23% have primary education
- 56% have secondary education
- 6% have higher education
- 14% refuses to answer

In Medway, the data shows that:

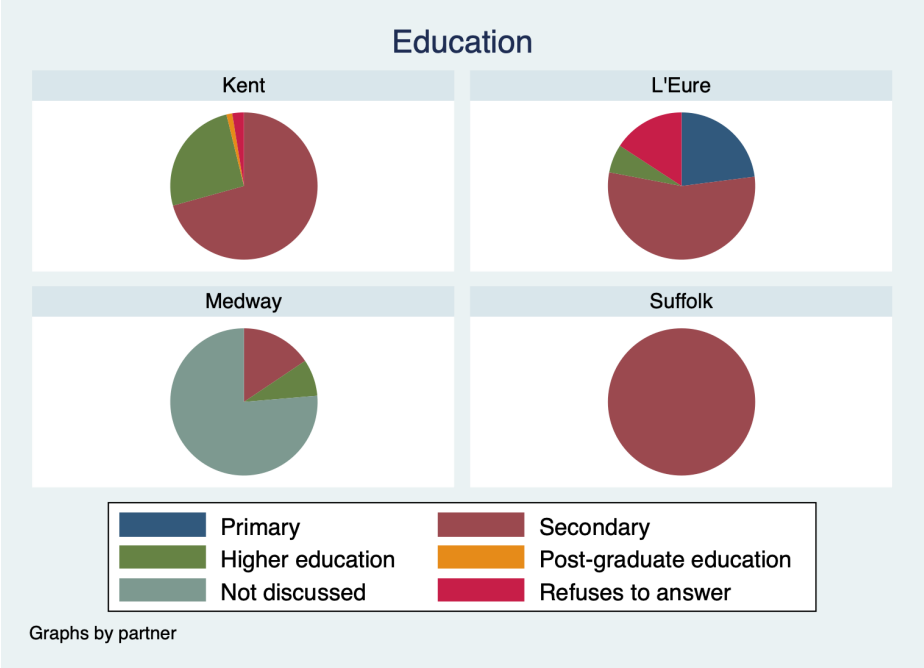
- 16% have secondary education
- 8% have higher education
- 76% not discussed

In Suffolk, the data shows that:

- 100% have secondary education

Overall, the data shows that:

- 12% have primary education
- 50% have secondary education
- 11% have higher education
- 1% have post-graduate education
- 18% not discussed
- 8% refuses to answer



Graphs by partner

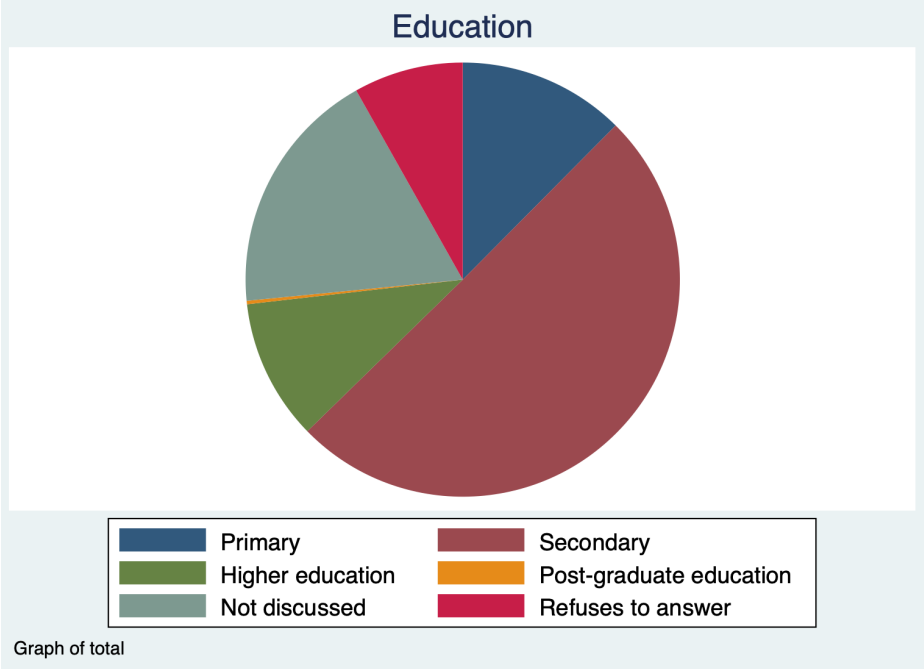


Figure 11. Education

Income

A lack of disposable income can be one of the underlying causes of social isolation as well as other physical and mental health conditions. We asked beneficiaries to provide a self-assessment regarding their income (pension, savings, part-time work) and the extent to which they feel it covers their living expenses.

Figure 12 shows that majority of the beneficiaries report that they current income just about covers their living expenses.

In L'Eure, the data shows, that the current income covers beneficiaries' expenses:

- 2% nearly none of the time
- 5% some of the time
- 93% just about always

In Medway, the data shows, the data shows that the current income covers beneficiaries' expenses:

- 1% nearly none of the time
- 4% some of the time
- 48% just about always
- 47% not discussed

In Suffolk, the data shows, the data shows that the current income covers beneficiaries' expenses:

- 100% just about always

Overall, the data shows, the data shows that the current income covers beneficiaries' expenses:

- 1% nearly none of the time
- 4% some of the time
- 65% just about always
- 30% not discussed

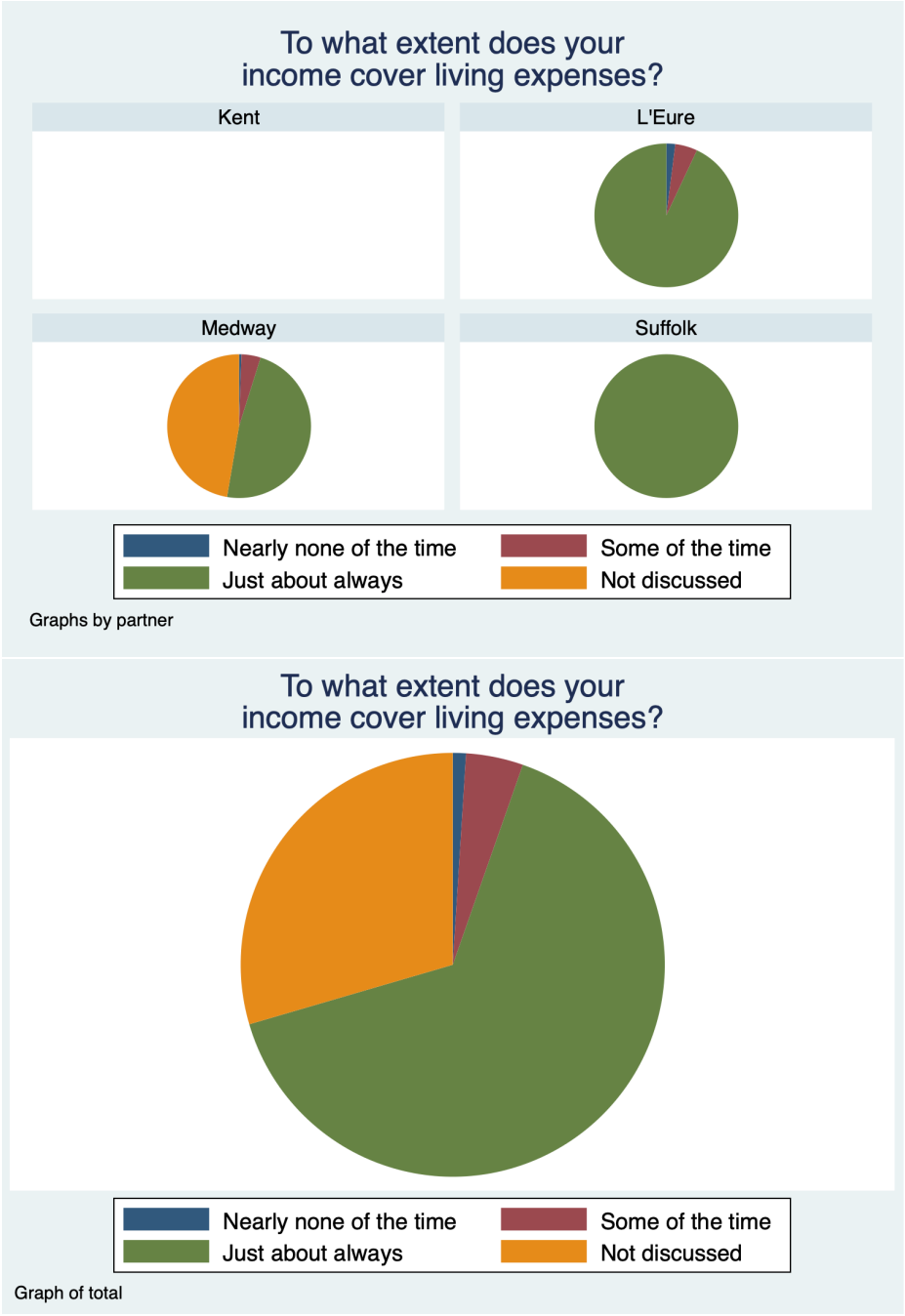


Figure 12. To what extent do you feel that your current income (pension, savings, part-time work) covers your living expenses?

Is the beneficiary living alone or with others?

Older adults are at a higher risk of losing a family member or a friend, where with age one's relatively established social network changes over time, which could potentially result in one feeling social isolated and/or lonely. In order to better understand underlying causes of social isolation and loneliness, we have asked beneficiaries about who they are living with.

The data in Figure 13 shows that in:

Kent beneficiaries are living
- 56% alone
- 1% sheltered accommodation
- 1% supported housing
- 16% with relatives
- 27% no response recorded

L'Eure beneficiaries are living
- 26% alone
- 9% with relatives
- 65% no response recorded

Medway beneficiaries are living
- 60% alone
- 19% sheltered accommodation
- 21% not discussed

Suffolk beneficiaries are living
- 80% alone
- 20% with relatives

Overall programme beneficiaries are living
- 43% alone
- 4% sheltered accommodation
- 1% supported housing
- 9% with relatives
- 5% not discussed
- 38% no response recorded

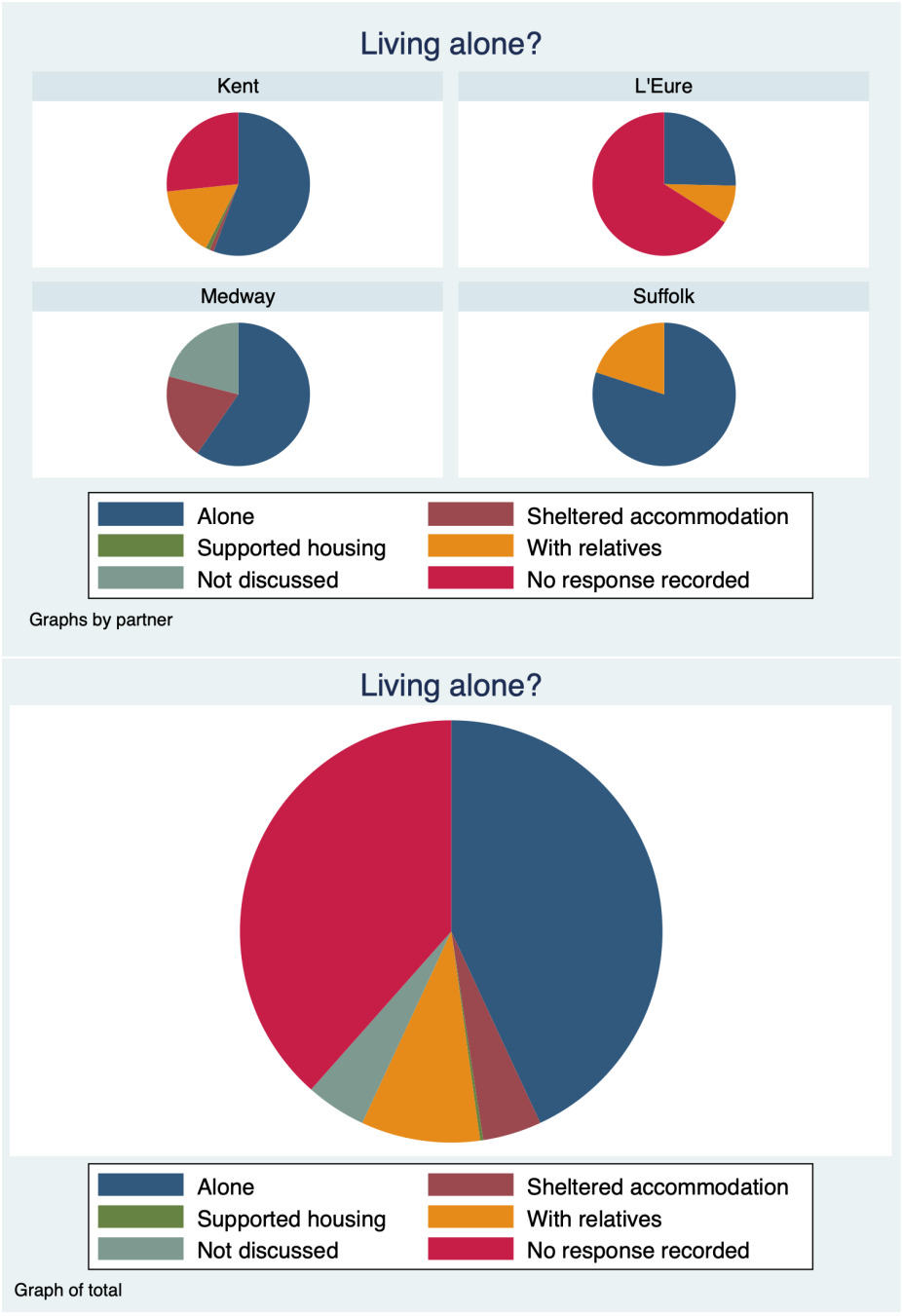


Figure 13. With whom is the beneficiary living, if anyone?

Housing Status

Housing status was recorded as it impacts overall health and has been linked to feelings of loneliness and isolation. Figure 14 shows that:

In Kent,

- 61% beneficiaries own home
- 22% beneficiaries rent home
- 17% beneficiaries live in social housing

In L’Eure,

- 69% beneficiaries own home
- 28% beneficiaries live in social housing
- 1% prefer not to say
- 2% does not wish to reply

In Medway,

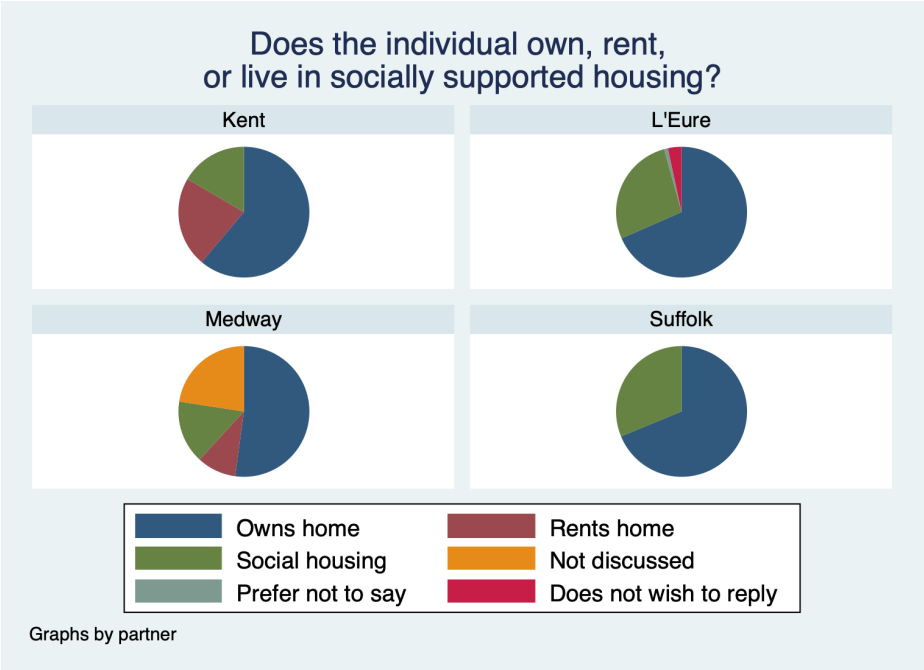
- 52% beneficiaries own home
- 10% beneficiaries rent home
- 16% beneficiaries live in social housing
- 22% not discussed

In Suffolk,

- 69% beneficiaries own home
- 31% beneficiaries live in social housing

Overall,

- 63% beneficiaries own home
- 7% beneficiaries rent home
- 22% beneficiaries live in social housing
- 5% not discussed
- 1% prefer not to say
- 2% does not wish to reply



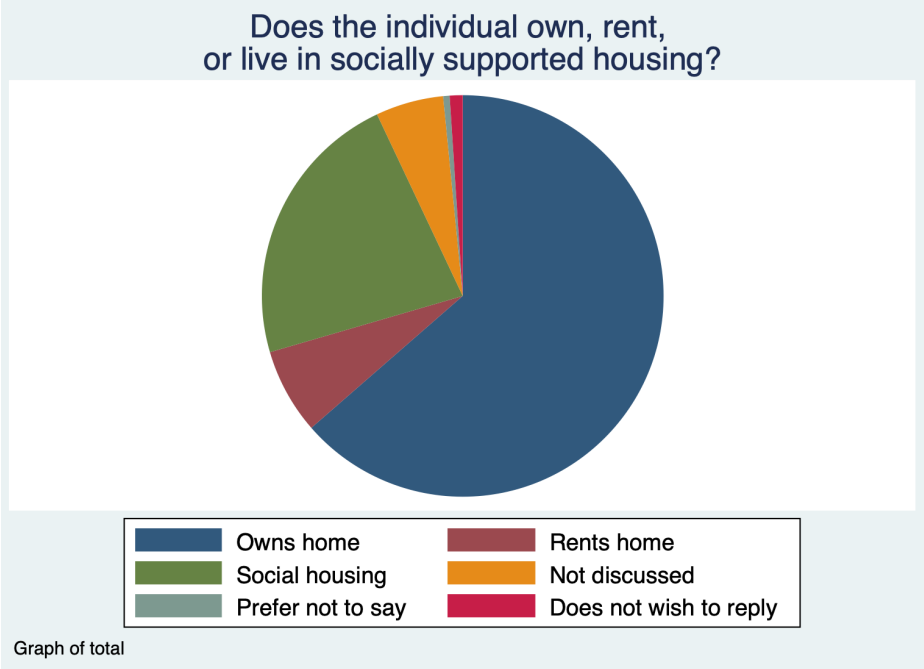


Figure 14. Housing

Critical or traumatic event experience

Critical life transitions such as bereavement, divorce, retirement, and a medical diagnosis are just some of the life changes that can contribute to social isolation and loneliness, negatively impacting wellbeing and other aspects of one's life.

A life changing event such as stroke is likely to negatively impact one's quality of life and result in higher levels of loneliness. A recent study has shown that stroke survivors are at least 70% more likely to report experiencing higher levels of loneliness when compared with healthy individuals.[7]

A case study from our Kent partners, Mrs B, illustrate how once active and social individual's quality of life decreased after suffering stroke, reducing her ability to participate in social activities, leading to a loss of physical and mental confidence to engage with others, ultimately resulting in loneliness and social isolation.

Figure 15 shows that beneficiaries experienced one of the following:

In L'Eure,

- 16% accident or traumatic experience
- 18% death of loved one
- 28% health event
- 38% not discussed

In Medway,

- 4% accident or traumatic experience
- 27% death of loved one
- 18% health event

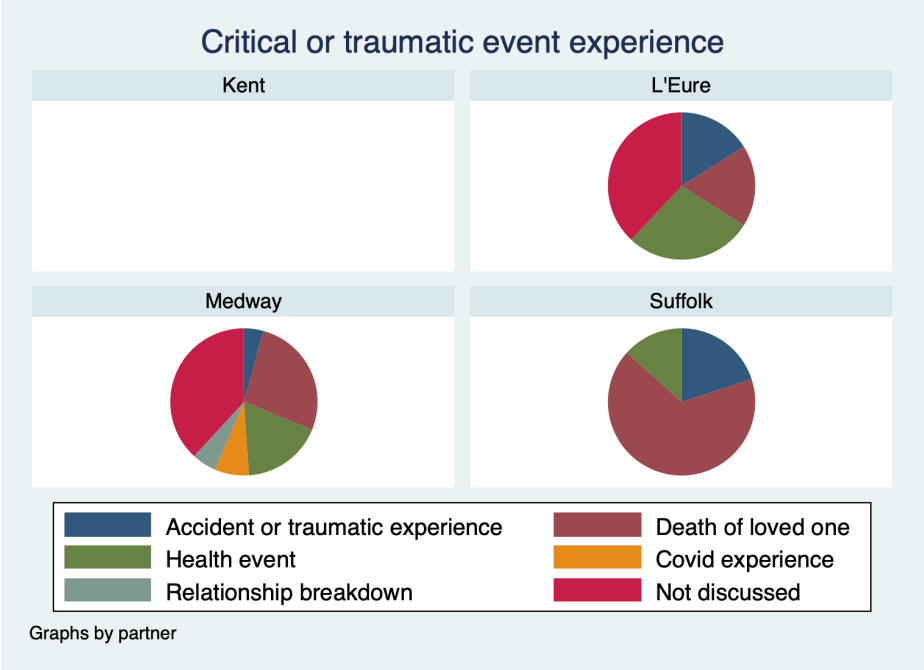
- 8% covid experience
- 5% relationship breakdown
- 38% not discussed

In Suffolk,

- 20% accident or traumatic experience
- 67% death of loved one
- 13% health event

Overall,

- 10% accident or traumatic experience
- 28% death of loved one
- 21% health event
- 4% covid experience
- 3% relationship breakdown
- 34% not discussed



Graphs by partner

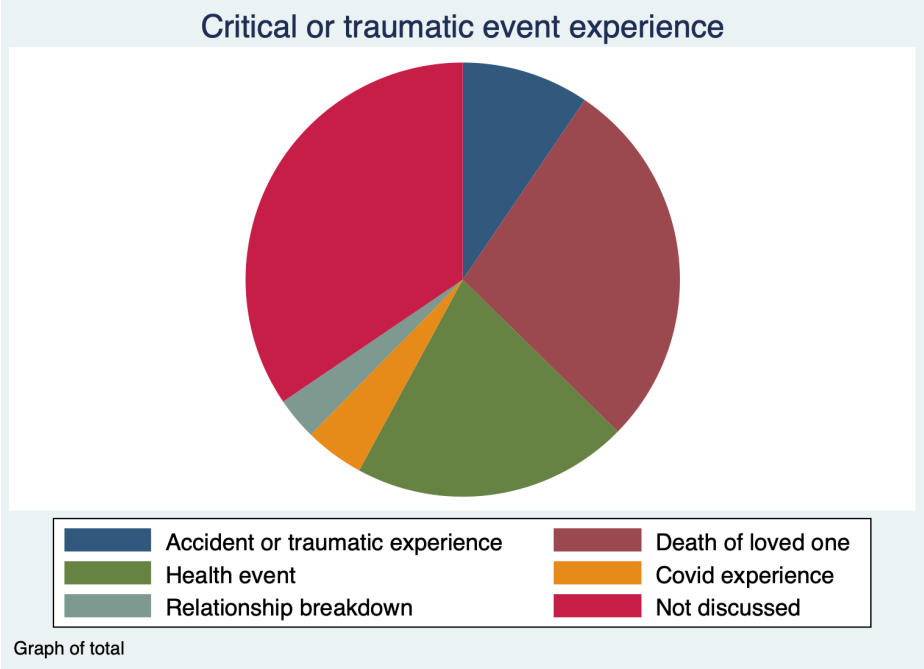


Figure 15. Critical life event

Health: Long-Term Health Conditions, Physical Activity and Habits

Many partners report working with individuals with complex health needs, disabilities and long-term health conditions that have impacted their life and their engagement with the Connected Communities.

Figure 16 shows that a third and more of the beneficiaries have long-term health conditions and complex care needs.

In L'Eure, 23% of the beneficiaries report having a long-term condition (Yes/red graph legend).

In Medway, 33% of beneficiaries report having a long-term health condition.

In Suffolk, 17% of beneficiaries report having a long-term health condition.

Overall, 26% of all the programme beneficiaries report having a long-term health condition.

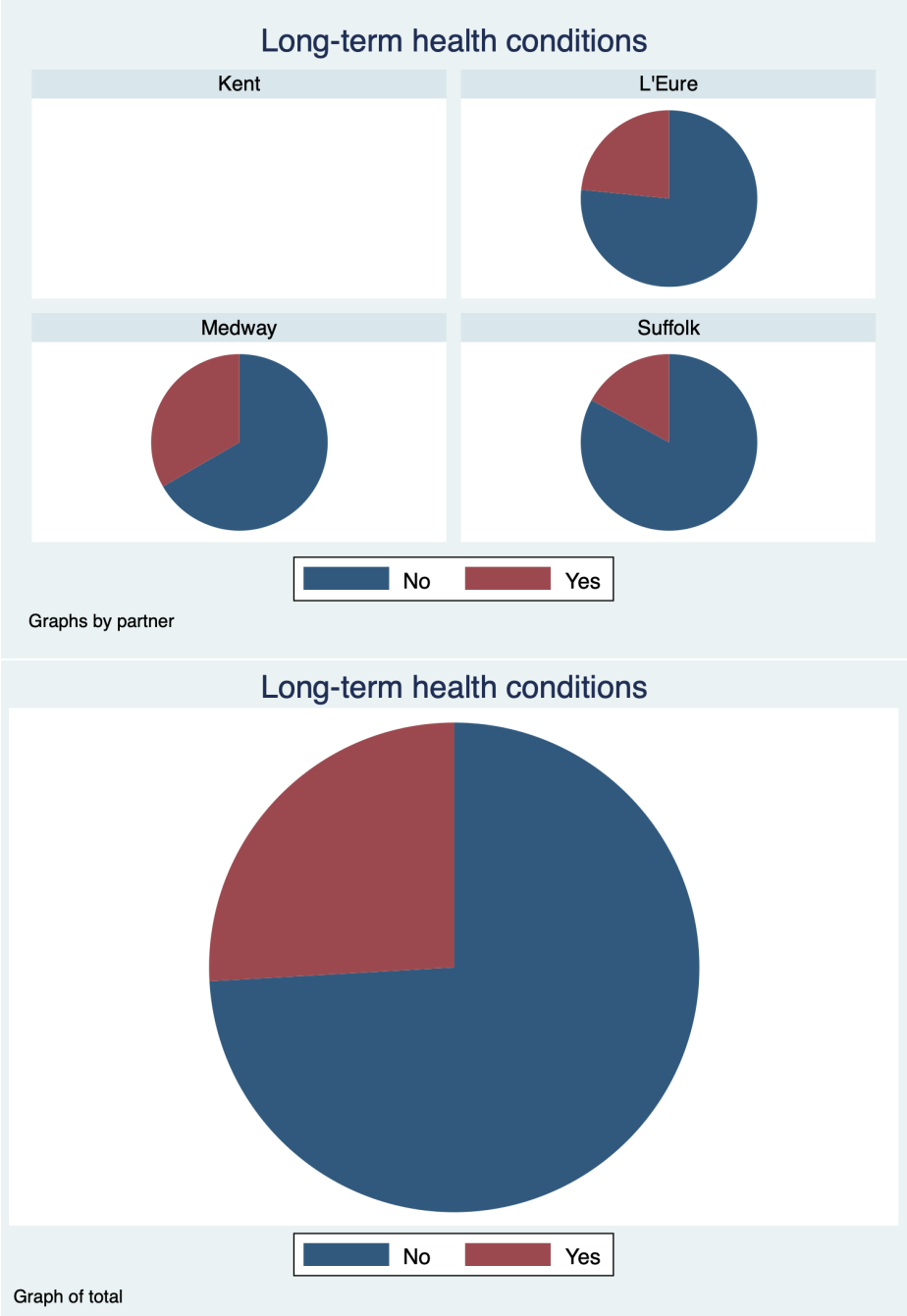


Figure 16. Long-term health condition/s

Kent provided notes reflecting the co-morbidity of health issues that they have encountered while working with beneficiaries.

> "*Low dose anti-depressants, stroke (affects motor movement and speech), cancer, beneficiary going through a number of surgeries*."

> "*High blood pressure, prone to migraines, does not see the GP due to a dispute. Attends Cognitive Hypnotherapy and is experiencing mental health issues*."

> "*Essential tremors, Arthritis in knee and back (walking stick), has been referred to mental health line by GP (depression).*"

"*Hip problems, heart problems, T2 diabetes and ongoing stomach problems*."

"*Moved into palliative care*."

Case studies, such as Malcom, 64-year old man living in Kent, illustrate the complexities that those who deliver social prescribing often face when seeking to deliver a service. Malcom is a widowed man, who lives alone and who had to retire from his work 9 years ago due to poor health. Malcom worked in the field of engineering and electric and was active member of his community. Due to poor health, financial and disability constraints, he had limited opportunities to engage with others.

During the last couple of years, as his symptoms of the chronic obstructive pulmonary disease (COPD) worsened, feelings of loneliness and social isolation emerged as a result of being unable to engage with others. Kent Connectors worked with Malcom to understand his needs and interests and help find solution together. Malcom expressed that he has interest and skills in metal works, creating furniture making and engineering projects and the Connectors suggested Men's Shed, a community organisation that provides spaces for men to connect, engage in craft and carpentry types of activities with an aim to help improve health and wellbeing. Connectors helped Malcom with the transportation and disability issues arranging minibus service through a charity organisation, The Christ Church Community, which enabled Malcom to join activities in Men's Shed. Since then, Malcom has created numerous pieces of art and engaged with others, all which has greatly helped improve his physical and mental health. This example shows a complex set of conditions, starting from health to financial factors, to life events such as bereavement, all which can in some cases result in feelings of loneliness and social isolation and poor wellbeing.

Image 1. Malcom and his art

Physical Activity

In regards to physical activity some people exercise every day and others do not exercise at all. Beneficiaries in L'Eure seem to be less physically active than those in Medway.

In L'Eure, data on physical activity was noted for one point in time, so a t-test cannot be performed. We can describe the physical activity among L'Eure beneficiaries as follows (Figure 17):

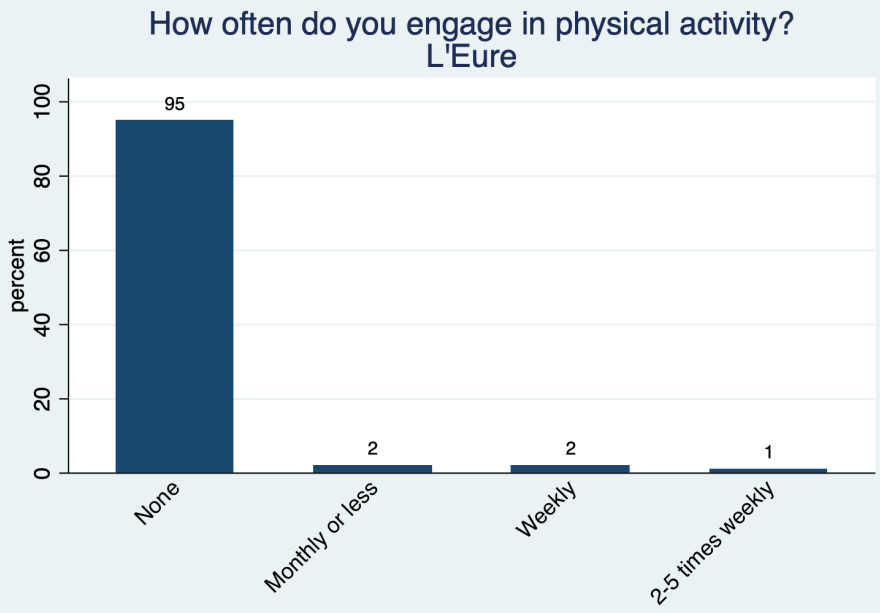
- 95% do not exercise at all
- 2% less than once a month or monthly
- 2% every week
- 1% two-five times per week
- None of the beneficiaries report that they exercise everyday

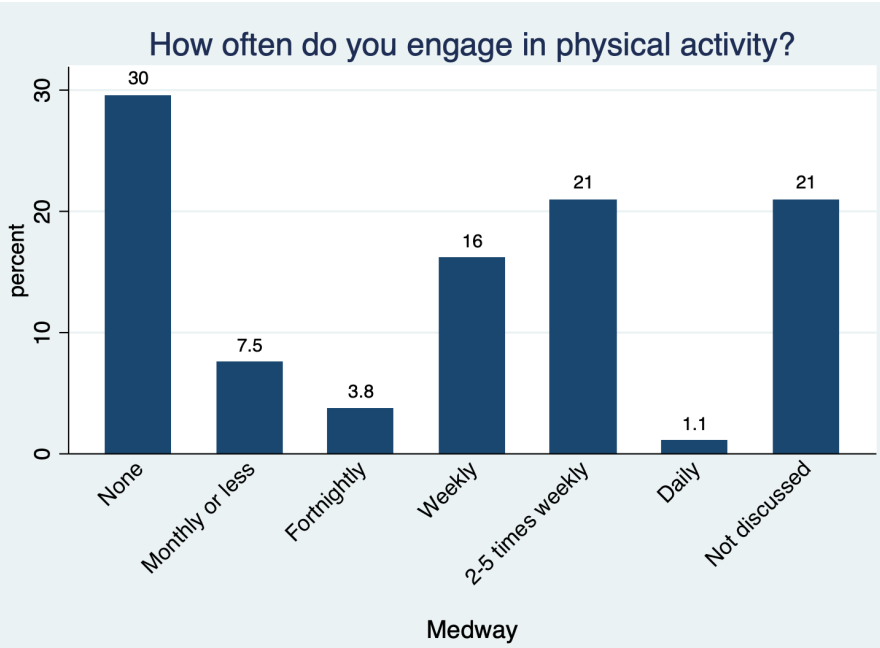
In Medway (Figure 17):

- 30% of beneficiaries do not exercise at all
- 8% exercise monthly or less
- 4% fortnightly
- 16% weekly
- 21% exercise 2-5 times a week
- 1% daily
- 21% not discussed

In Suffolk, data on physical activity was noted for one point in time, so a t-test cannot be performed. We can describe the physical activity among Suffolk beneficiaries as follows (Figure 17):

- 50% of beneficiaries do not exercise at all
- 8% fortnightly
- 8% exercise 2-5 times a week
- 34% exercise daily


How often do you engage in physical activity?
L'Eure
percent
0
20
40
60
80
100
95
2
2
1
None
Monthly or less
Weekly
2-5 times weekly


How often do you engage in physical activity?
percent
0
10
20
30
30
7.5
3.8
16
21
1.1
21
None
Monthly or less
Fortnightly
Weekly
2-5 times weekly
Daily
Not discussed
Medway

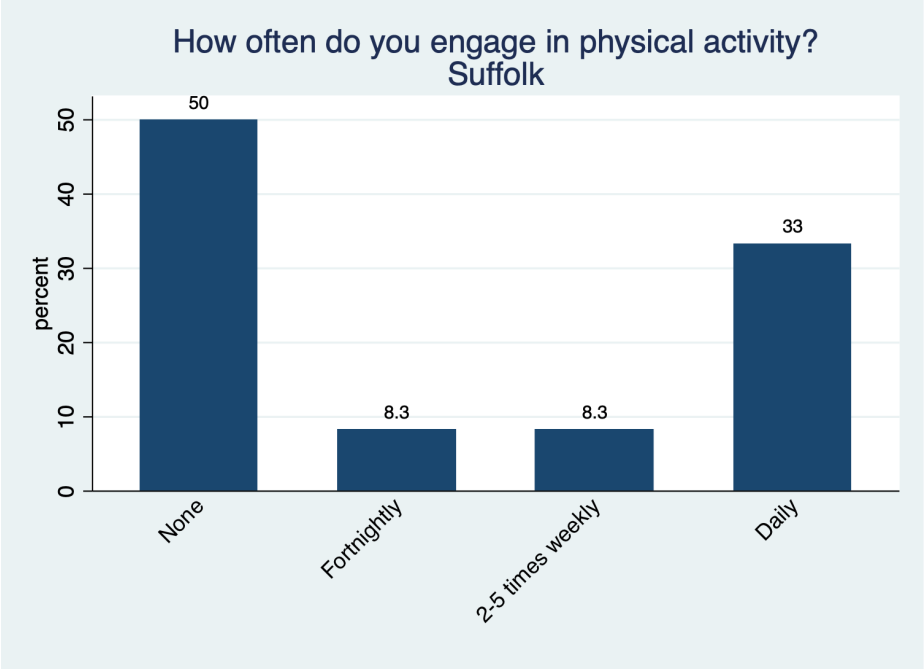


Figure 17. Physical Activity – L'Eure, Medway, and Suffolk percentages

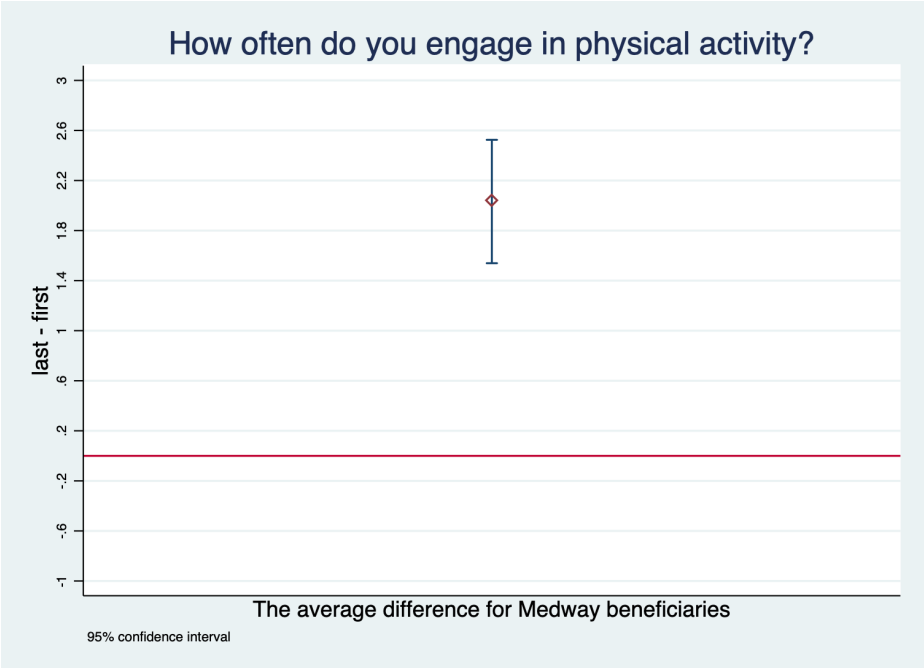


Figure 18.Physical Activity – the average difference for beneficiaries in Medway

Figure 18 when Medway social prescribing *plus* beneficiaries are examined together we see a statistically significant change in physical activity (p < .001). On average a beneficiary's physical activity increases by 2 on a 7-point scale, when comparing last to first visit physical activity scores.

Smoking

Majority of the beneficiaries are non-smokers across all partners. Figure 19 shows the distribution for L'Eure, Medway, and Suffolk.

In Medway:

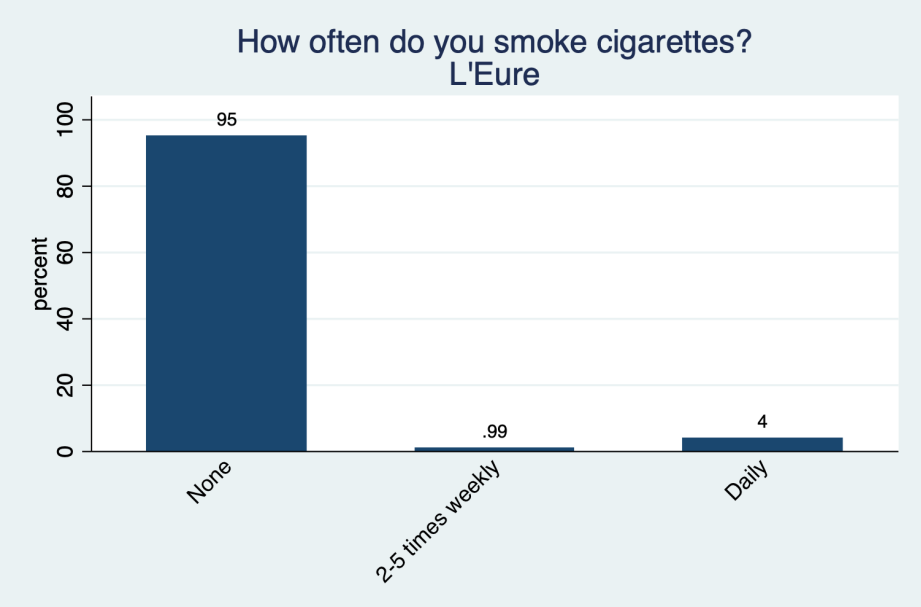
- 72% of beneficiaries report being non-smokers (none)
- 0.5% of beneficiaries report smoking 2-5 times weekly
- 6.5% of beneficiaries report smoking daily
- 21% not discussed

In L'Eure:

- 95% of beneficiaries report being non-smokers (none)
- 1% of beneficiaries report smoking 2-5 times weekly
- 4% of beneficiaries report smoking daily

In Suffolk:

- 22% of beneficiaries report being non-smokers (none)
- 2% of beneficiaries report smoking daily
- 76% not discussed



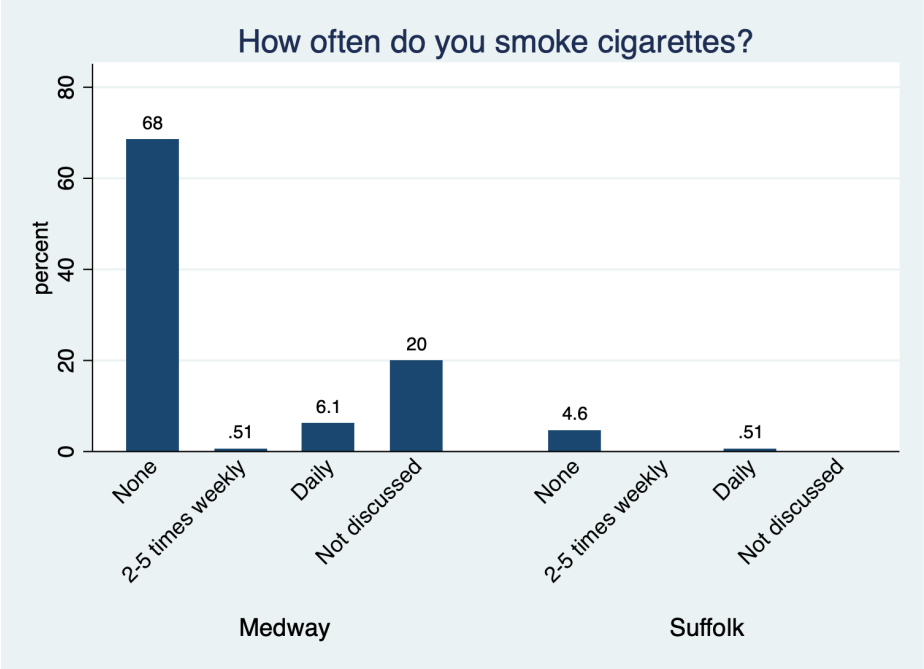


Figure 19. Smoking – L'Eure, Medway, Suffolk

Drinking

Majority of the beneficiaries are not drinking across all partners. Figure 20 shows the distribution for L'Eure, Medway, and Suffolk.

In Medway:

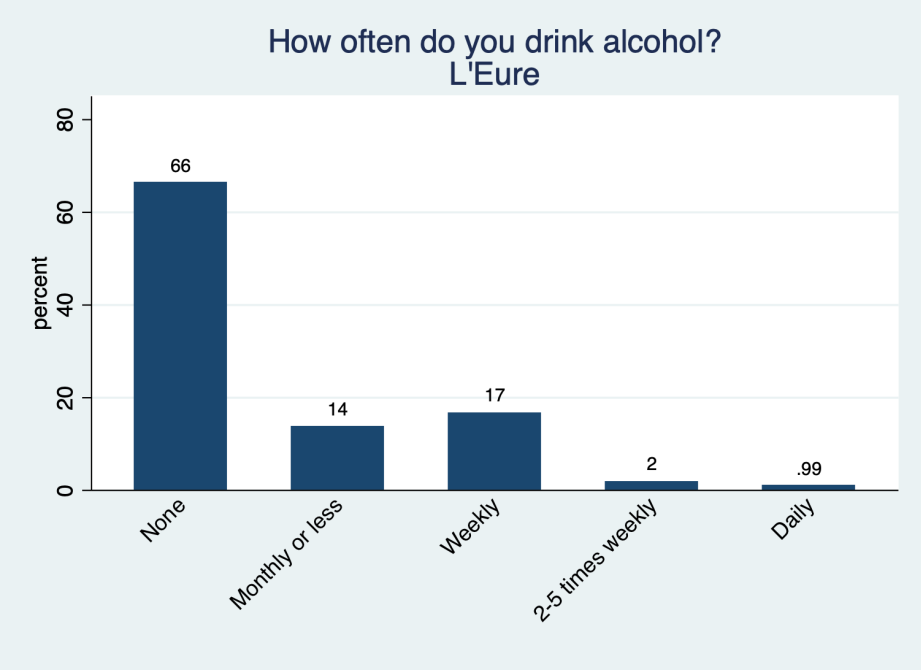
- 57% of beneficiaries report that they do not use alcohol (none)
- 7% of beneficiaries report drinking monthly or less
- 3% of beneficiaries report drinking fortnightly
- 6% of beneficiaries report drinking weekly
- 1% of beneficiaries report drinking 2-5 times a week
- 5% of beneficiaries report drinking daily
- 21% not discussed.

In Suffolk:

- 15% of beneficiaries report that they do not use alcohol (none)
- 5% of beneficiaries report drinking monthly or less
- 80% not discussed.

In L'Eure:

- 66% of beneficiaries report that they do not use alcohol (none)
- 14% of beneficiaries report drinking monthly or less
- 17% of beneficiaries report drinking weekly
- 2% of beneficiaries report drinking 2-5 times a week
- 1% of beneficiaries report drinking daily



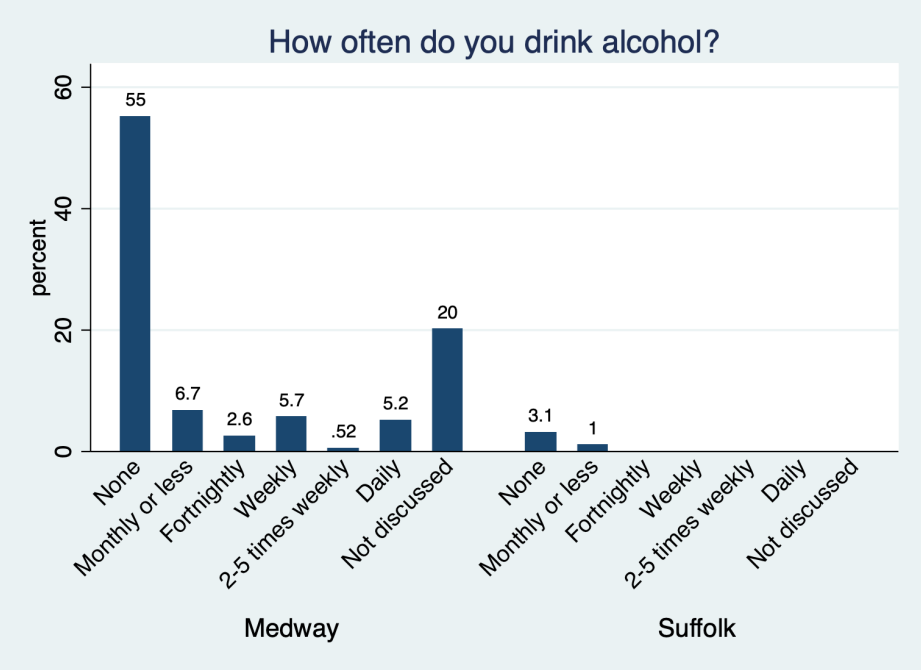


Figure 20. Drinking – L'Eure, Medway, Suffolk

Evaluation Analyses

Paired sample t-test

In the analyses presented in this section we employed statistical methods to compare beneficiaries' attributes before and after their participation in Connected Communities. The statistic we employed is called a *paired sample t-test,* which can be used when individuals have provided a pair of responses (measurements) before (first visit) and

after (last visit) their engagement in a particular activity or a programme.[11] A *paired sample t-test* is used to compare mean responses before and after a 'treatment/activity' for a group of subjects (participants or beneficiaries).

The t-test will indicate whether the mean change per beneficiary between before and after programme participation is significantly different from zero. If the change is significantly different from zero, we say that the probability of observing such a difference by chance is very small, and we conclude that the difference is real. We call such a difference "statistically significant".

A "statistically significant difference" is an observed difference in the outcomes which is unlikely to have occurred due to chance alone. The probability of observing a statistically significant difference purely by chance is expressed using a term called a "p-value". A very low p-value associated with a difference indicates a very small probability of finding such a difference by chance. We typically say that a p-value must be smaller than 0.05 in order to conclude that a difference is statistically significant, or real.

A p-value ranges from 0 (no chance) to 1 (absolute chance). For instance, getting a p-value value of 0.5 means that there is a 50% likelihood that the observed change in outcomes is due to chance, we would deem a difference with such a p-value to be statistically insignificant. It means that we have no certainty that the observed difference is an actual change. In comparison, a p-value equal less than 0.05 would be considered statistically significant for our purposes, as it means that there is only a 5% likelihood that the observed difference in outcomes is due to chance alone, and that we are at least 95% certain that a difference exists.

As a p-value approaches 0, we become more certain that the difference in the outcomes is real. With a p-value of 0.05 we can say that we are 95% certain that the observed difference is real. With a p-value of 0.01 we can say that we are 99% certain that the observed difference is real. A p-value of 0.005 or lower would mean we are more than 99.5% certain.

The estimates of the range of certainty for our estimates are depicted visually with *confidence intervals*. The graphs in the section ***Evaluation Analyses*** show a point estimate for each particular outcome, which is depicted with a small circle/dot on the graph. Each point also has a confidence interval around it, or brackets indicating the range in which we are 95% certain the point lies. The wider a confidence interval, the less precise we are about the estimate because it is based on a small number of data points (beneficiaries for whom we have the data). For instance, in *Figure 25. "How often do you feel lonely?" – Partner-level average difference for beneficiaries* we can see that for Suffolk, the change in loneliness score is statistically significant, however the wider confidence intervals show that we must be less precise about our estimate for Suffolk in comparison to Medway and Kent.

In short, the *paired sample t-test* will help to determine whether there is a statistically significant change in beneficiary responses for the outcomes of interest, when comparing responses between the first and last visit (period of interaction with Connector). The data was processed and analysed using the STATA software programme.[12]

For all the outcomes of interest below, we report the size and nature of changes in attributes which exhibit statistically significant changes between before and after programme participation. For each of these, we include a p-value indicating the likelihood that the difference we find is due to chance or randomness. If a particular group or attribute does not exhibit a statistically significant change, we simply report that no change is evident.

Scale

Below we detail each measure we employ for outcomes of interest. They are each discussed fully in previous reports as well. Some of the measures we use reflect better outcomes as the scale increases, and some of them reflect worse outcomes as the scale increases. Given that we are reporting the difference in question responses between a beneficiary's first and last visit, it might be confusing to think about what sort of results would indicate a beneficial change for a beneficiary.

For example, the loneliness measure below asks how often the beneficiary feels lonely. As the frequency of feeling lonely increases, a person is feeling lonely more often. Therefore, a beneficial change for the person answering the questions would be when the frequency *decreases* over time. On a scale of 1 to 5, where 5 is the most lonely possible, the beneficiary whose loneliness is decreasing might see their loneliness rating go from a score of 5 to a score of 3. Subtracting their pre-programme score of loneliness (the first score recorded) from their post-programme loneliness score (the last score recorded) would mean calculating:

$$3 - 5 = -2$$

Therefore, a person experiencing beneficial changes in loneliness would have a *negative* change score.

For happiness, however, the measure below asks how happy the beneficiary feels. As the scale for happiness increases, a person is feeling happier. Therefore, a beneficial change for the person answering the questions would be when the score increases over time. On a scale of 0 to 10, where 10 is the happiest possible, the beneficiary whose happiness is increasing might go from a pre-programme score of 6 to a post-programme score of 9. Subtracting their pre-programme (their first) score of happiness from their post-programme (their last) happiness score would mean calculating:

$$9 - 6 = 3$$

Therefore, a person experiencing beneficial changes in happiness would have a *positive* change score.

All of the questions below were asked of beneficiaries using identical text across partners, and when the questions were taken from other survey instruments, the standard (original) text was chosen. As UoE conducted the evaluation analysis, however, the team realised that it might be confusing to have some differences reflect a beneficial outcome if they are positive, while others reflect a beneficial outcome only if they are negative. Therefore, **all the measures below have been scaled such that a positive difference (when subtracting the pre-programme score from the post-**

programme score) reflects a beneficial outcome for the beneficiary. For some of the measures, such as the measure for happiness, a beneficial outcome means that subtracting the first score from the last will yield a positive difference without any adjustments. For measures like the measure for loneliness, we simply reverse the original scale when conducting the analysis so that a positive difference found when subtracting the first from the last score will also mean a beneficial outcome.

To clarify that all outcomes are beneficial when increasing over time, we give each measure below with the scale used to analyse it, rather than the scale used to ask the question of the beneficiary.

Differences across partners

Each partner collected the information they needed and wanted to record. For some, this included all the measures the partnership had agreed, while for others, contextual constraints dictated that they would not ask some of the questions. When a question was not asked by a particular partner, we simply do not report information regarding that question for that partner. When a question is missing that would go into an average or composite score, we calculate the score without the missing information and average the responses that we do have. This accommodation is relevant for the wellbeing an loneliness composite measures, below.

Interactions, Loneliness and Connectedness: COVID-19 Related Changes

We were also interested in understanding if people's daily interactions/habits, a sense of loneliness and connectedness has changed since the emergence of COVID-19 pandemic. In June 2020, all partners met and agreed to add questions about beneficiaries' COVID-19 experience to the data collection. Medway was the only partner that provided UoE Team with this information.

During COVID-19 pandemic, with periods of social restrictions being implemented between March 2020 – December 2021[8] in the UK and similar periods of restrictions in France[9], the reports have indicated increases in loneliness across the globe.[10] The questions partners designed asked beneficiaries to reflect on their interactions/habits, loneliness, and connectedness compared to before the pandemic. Medway asked this question 3 times. We would expect that the benefits of social prescribing *plus* participation would cause a beneficiary's loneliness compared to pre-COVID to decline over time, and their interactions and connectedness compared to pre-COVID to increase over time.

The nature of beneficiaries' interactions/habits when compared to pre-COVID levels changes over time. We can run a t-test of proportions to see whether the proportion of beneficiaries engaging in a particular habit changed between their first and last visits. Figure 21 shows the proportions of beneficiaries in Medway who, when asked to recall how they felt before COVID-19 pandemic emergence and reflect on any changes in their daily interactions and habits during their first (1), second (2) and last (3) visits as a part of the social prescribing *plus* programme, reflect that:

- 8%-10% of beneficiaries report living life as normal compared to the time before COVID-19 pandemic emergence (there is no statistically significant difference in answers over time);
- 4%-18% report being more engaged when compared to the time before COVID-19 pandemic emergence (this difference is statistically significant at p < .05), which could be due to COVID-19 restrictions being slowly lifted as well as positive impact of social prescribing *plus* (there is not enough data to analyse this issue further to separate these two potential effects);
- 2%-3% of beneficiaries report not leaving the house (this difference is statistically significant at p < .05);
- 2%-11% report to only associate with family compared to the time before COVID-19 pandemic emergence (this difference is statistically significant at p < .001);
- 5%-13% of beneficiaries are practicing social distancing rules during the first visit compared 4% doing so in the last visit (potentially a period when COVID-19 restrictions ease), when compared to the time before COVID-19 pandemic emergence (this difference is statistically significant at p < .001);
- 1% receive visits only from carers (there is no statistically significant difference in answers over time)
- People who receive visits from family and friends drop from 5% to 3% over time, when compared to the time before COVID-19 pandemic emergence (this difference is statistically significant at p < .05).

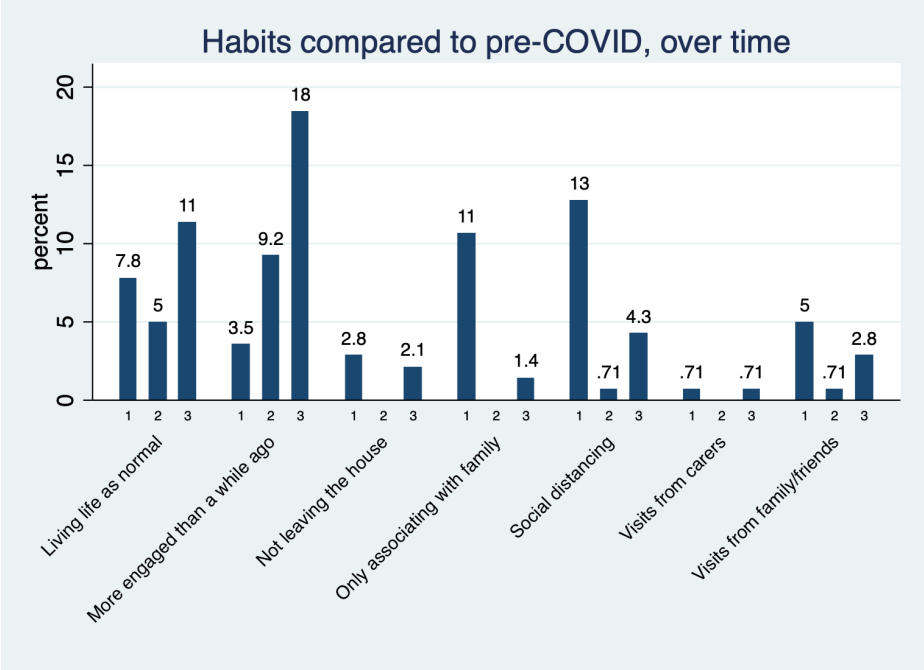
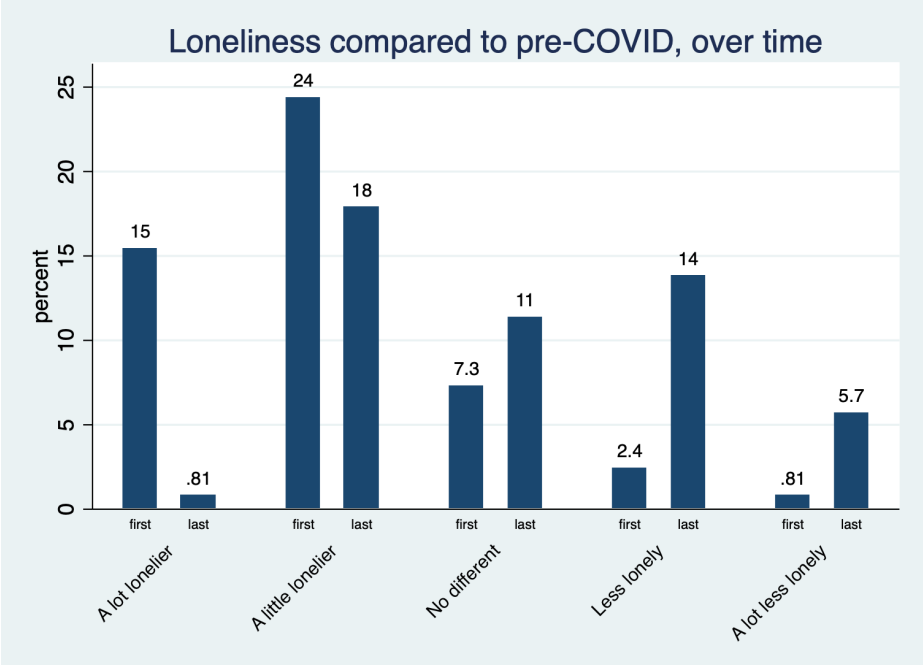


*Figure 21.*Compared to the way this participant felt before the Covid-19 pandemic occurred, does the participant indicate any change in their daily interactions/habits? - Medway

Figure 22 shows that in Medway, when asking beneficiaries to recall how they felt before COVID-19 pandemic emergence and reflect on any changes in their loneliness levels during first and last visit, we do observe a statistically significant change between the first and last time people are asked the question, as follows:

- Beneficiaries are 14% less likely to report feeling a lot lonelier than pre-COVID during their first visit in comparison to during their last visit. This indicates a statistically significant reduction in loneliness prevalence during the 12-week interaction with Medway Connectors (p < .001). The reduction could be due either to COVID-19 restrictions easing, social prescribing *plus* programme participation or some other factor that is not being accounted for. The effect of these two and other potential factors cannot be delineated given the number of the data received.
- Beneficiaries are 6% less likely to report feeling a little lonelier in the last in comparison to first visit (p < .001);
- Beneficiaries are 4% less likely to report feeling no different in the last in comparison to first visit (p < .001);
- Beneficiaries are 12% more likely to report feeling less lonely in the last in comparison to first visit (p < .001);
- Beneficiaries are 5% more likely to report feeling a lot less lonely during the last visit in comparison to the first visit (p < .001).
- The difference in loneliness levels between first and last visit (with the time before COVID-19 pandemic emergence being a benchmark) is statistically significant at (p < .001), where on average a beneficiary's feeling of loneliness reduces by 1.31 on a 5-point scale.



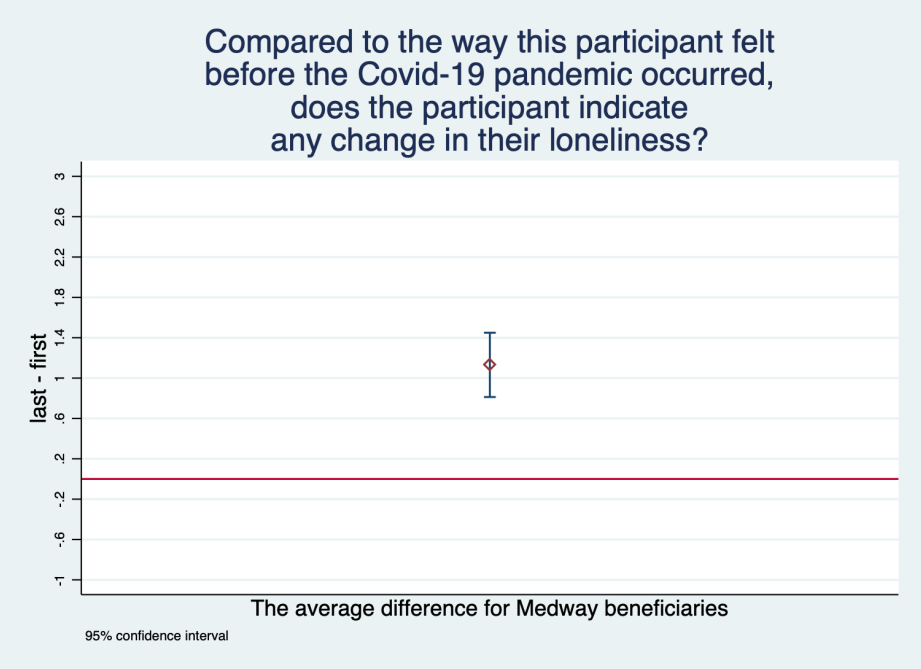


Figure 22. Compared to the way this participant felt before the Covid-19 pandemic occurred, does the participant indicate any change in their loneliness? - Medway

Figure 23 shows that in Medway, when asking beneficiaries to recall how they felt before COVID-19 pandemic emergence and reflect on any changes in their connectedness levels during first and last visit, we do observe a statistically significant change between the first and last time people are asked the question, as follows:

- Beneficiaries are 17% less likely to report feeling a lot less connected to others during their first visit in comparison to their last visit (p < .001). A feeling of being less connected to others than before COVID-19 emergence seem to be more prevalent among beneficiaries during their first visit when compared to last visit, indicating a potential improvement in a sense of connectedness during the 12-week interaction period with Medway Connectors. This could be due either to COVID-19 restrictions easing, social prescribing *plus* programme participation or some other factor that is not being accounted for. The effect of these two and other potential factors cannot be delineated given the number of the data received.
- Beneficiaries are 10% less likely to report feeling less connected in the last in comparison to first visit (p < .001);
- Beneficiaries are 3% less likely to report feeling no different in the last in comparison to first visit (p < .001);
- Beneficiaries are 14% more likely to report feeling a little more connected to others in the last in comparison to first visit (p < .001);
- Beneficiaries are 10% more likely to report feeling a lot more connected to others during the last visit in comparison to the first visit (p < .001);
- The difference in connectedness levels between first and last visit (with the time before COVID-19 pandemic emergence being a benchmark) is statistically significant (p < .001), where on average a beneficiary's feeling of loneliness reduces by 1.58 on a 5-point scale.

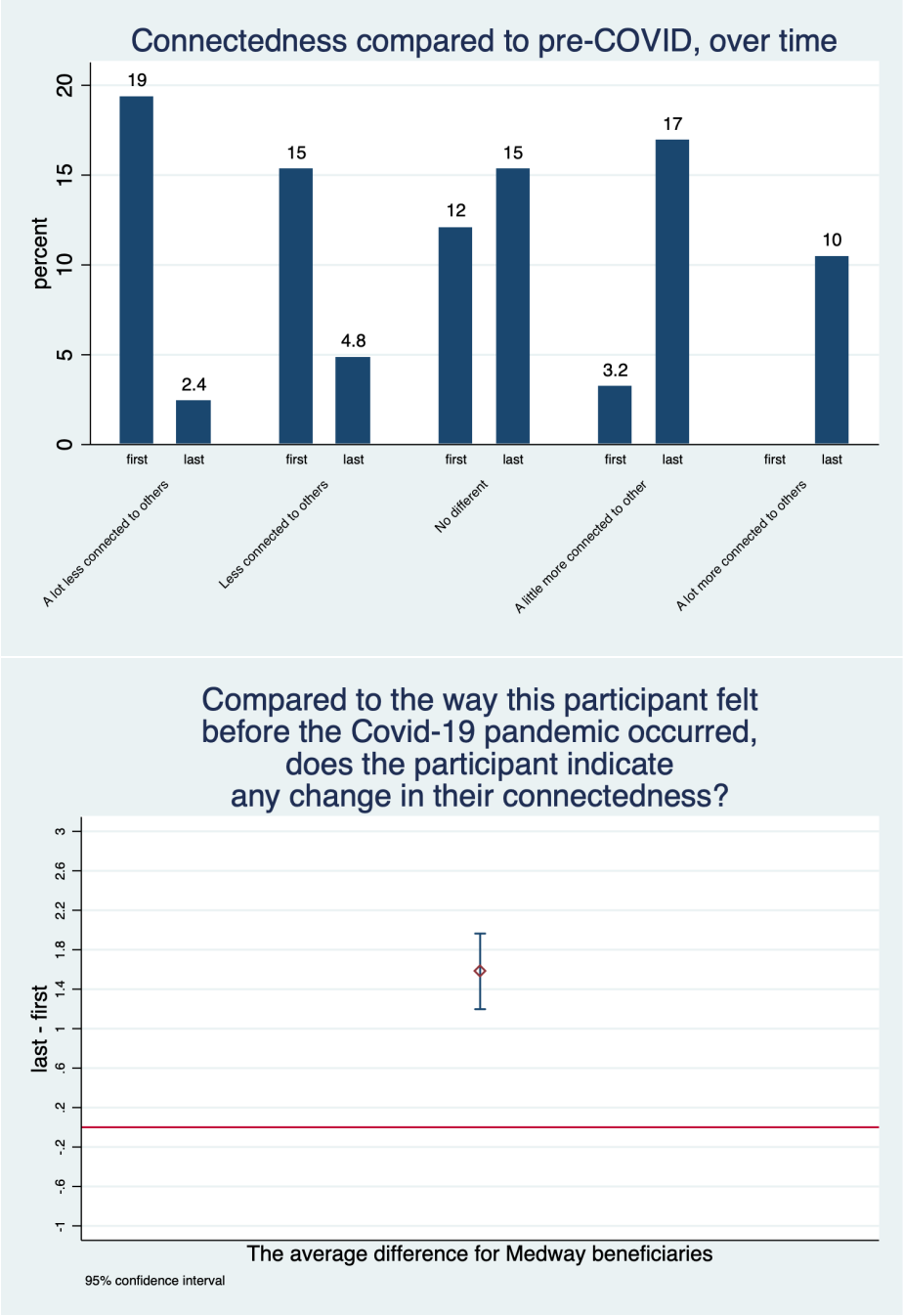


Figure 23. Compared to the way this participant felt before the Covid-19 pandemic occurred, does the participant indicate any change in their connectedness? – Medway

Loneliness

Partners measured loneliness in two different ways. As agreed by all the partners, Medway, L'Eure and Suffolk asked 1 loneliness question, which is referred to as a "direct" loneliness question and is used in the Community Life Survey. Kent is the only partner that collected responses on loneliness utilising additional 3-item UCLA questionnaire, which with the addition of the one direct loneliness question from the Community Life Survey is referred to as the Office for National Statistics, ONS4 loneliness scale.[15] Kent decided to use a full ONS4 loneliness scale recommended

by the UK Government Office for National Statistics (ONS).[13,14] UoE Team suggested use of the ONS4 measure of loneliness, however, the partners expressed their concerns about the number of questions in the survey and agreed to reduce questions regarding loneliness to 1 item.[1] Given that all partners used the 1-item "direct" question from the Community Life Survey to assess beneficiaries' levels of loneliness, the partner comparisons are based on that one question.

Source of wording	Question	Choices/options
Community Life Survey	How often do you feel lonely?	1 - Often/always 2 - Some of the time 3 - Occasionally 4 - Hardly ever 5 - Never
The three-item UCLA Loneliness scale	1. How often do you feel that you lack companionship?	1 - Often 2 - Some of the time 3 - Hardly ever or never
	2. How often do you feel left out?	1 - Often 2 - Some of the time 3 - Hardly ever or never
	3. How often do you feel isolated from others?	1 - Often 2 - Some of the time 3 - Hardly ever or never

Table 2. Loneliness Measure/s

All Partner Comparisons

All the partners provided responses to "direct" question "How often do you feel lonely" listed in Table 2.

In Figure 24, when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in loneliness (p < .001). On average a beneficiary's loneliness decreases by 0.54 on a 5-point scale, when comparing last to first visit loneliness scores.

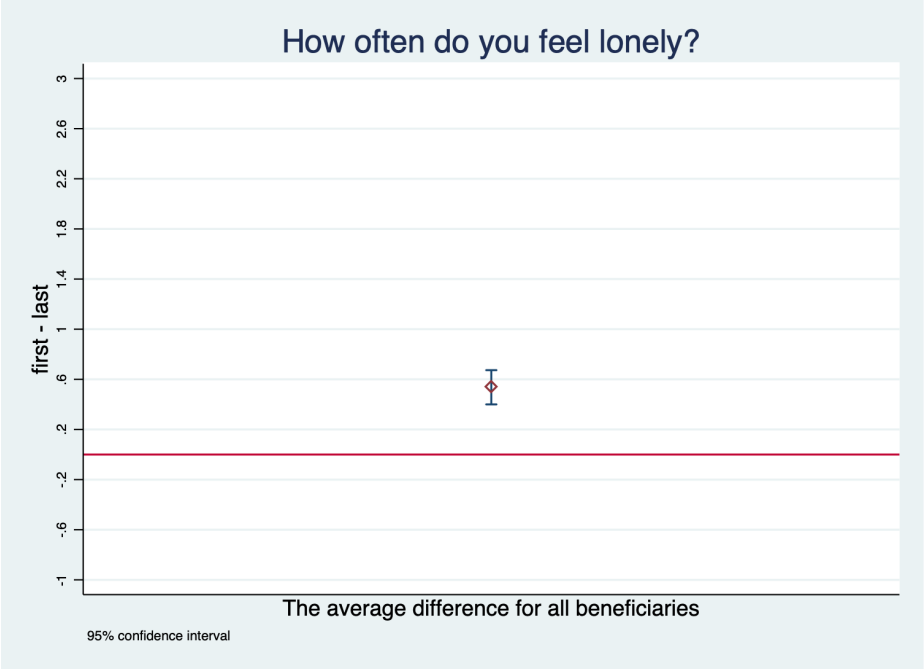


Figure 24. "How often do you feel lonely?" –The average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 25, we observe in:

- Kent an average reduction in loneliness score of 0.76 on a 5-point scale, a change which is statistically significant (p < .001).
- Medway an average reduction in loneliness score of 0.85 on a 5-point scale, a change which is statistically significant (p < .001).
- L'Eure we do not find statistically significant change in loneliness. You can see in Figure 25 that the confidence interval includes 0, which means that the change in loneliness in L'Eure could be 0. We have no evidence of change in loneliness in L'Eure.
- Suffolk an average reduction in loneliness score of 1.09 on a 5-point scale, a change which is statistically significant (p < .005).

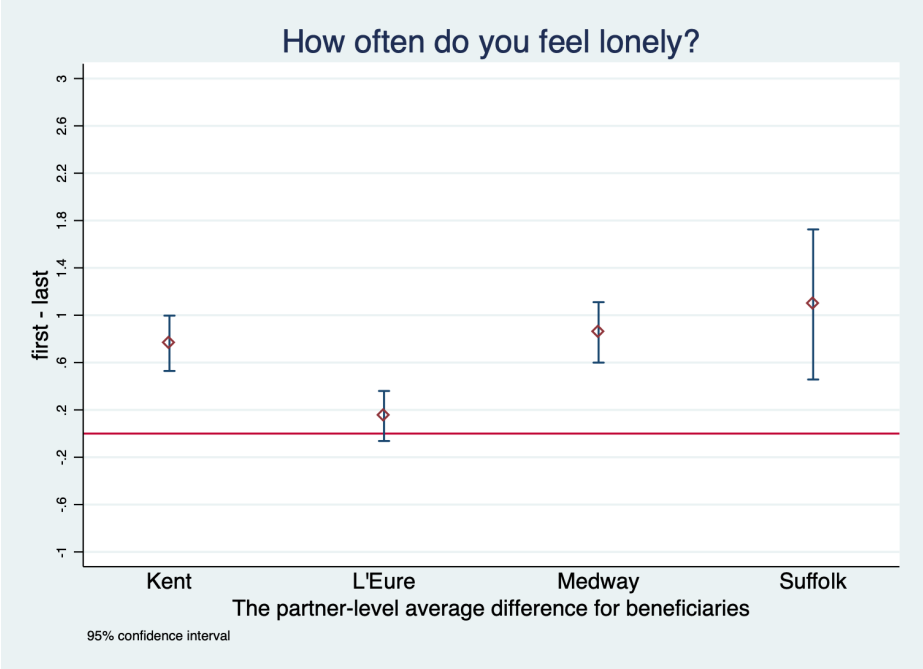
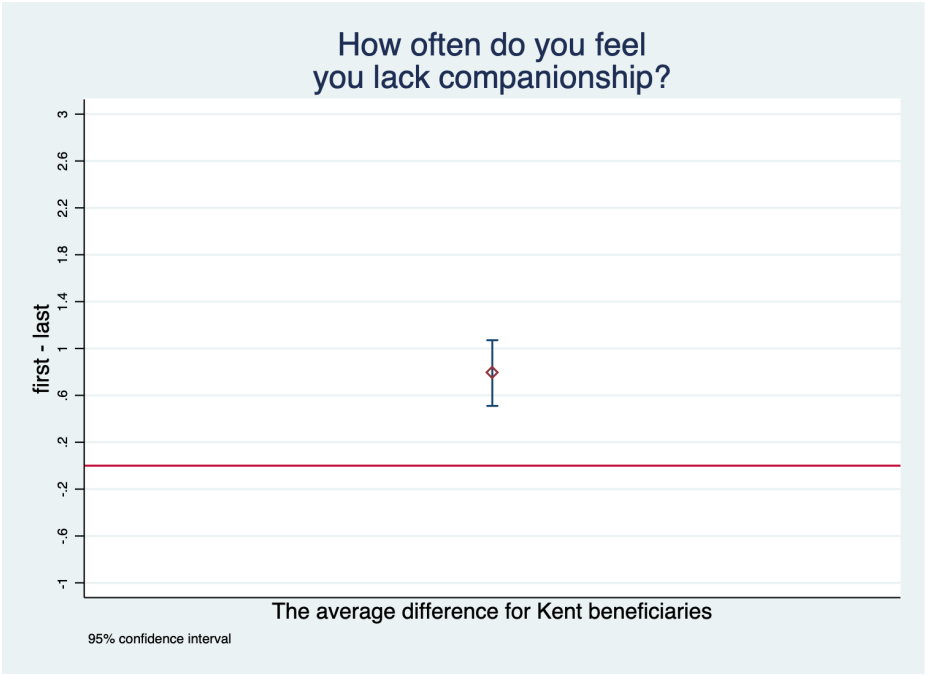


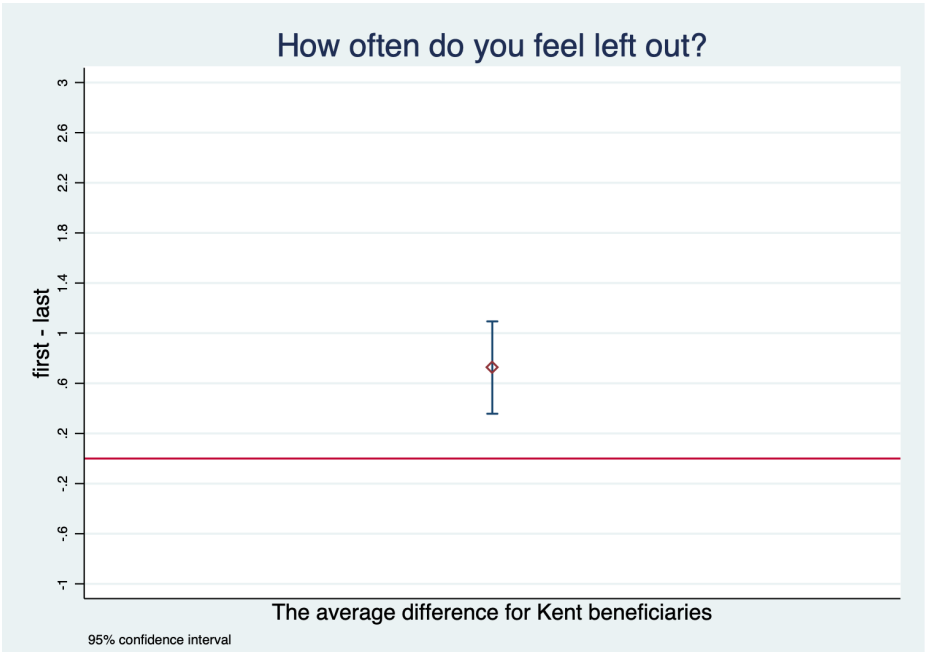
Figure 25. "How often do you feel lonely?" – Partner-level average difference for beneficiaries

Kent County Council

Kent collected responses on loneliness utilising additional 3-item UCLA scale. Figure 26 shows that on average, during their last visit in comparison to the first visit, beneficiaries report:

- Lacking companionship less by 0.73 on a 3-point scale, a change which is statistically significant (p < .001).
- Feeling less left out by 0.95 on a 3-point scale, a change which is statistically significant (p < .001).
- Feeling less often isolated from others by 0.79 a 3-point scale, a change which is statistically significant (p < .001).


How often do you feel
you lack companionship?
first - last
3
2.6
2.2
1.8
1.4
1
.6
.2
-.2
-.6
-1
The average difference for Kent beneficiaries
95% confidence interval


How often do you feel left out?
first - last
3
2.6
2.2
1.8
1.4
1
.6
.2
-.2
-.6
-1
The average difference for Kent beneficiaries
95% confidence interval

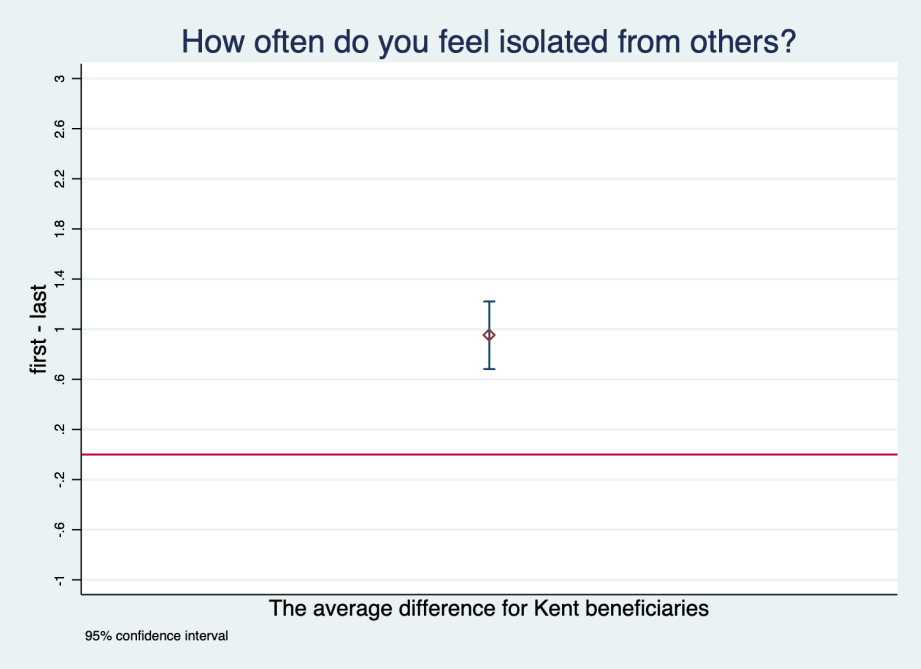


Figure 26. 3-item UCLA loneliness scale - Kent

Kent used a full ONS4 loneliness scale which includes 1-item "direct" question from the Community Life Survey and 3-item UCLA questionnaire. Figure 27 is the total score for the full ONS4 loneliness scale and it shows that on average beneficiaries report feeling less lonely by 0.81 on a 3-item scale, a change which is statistically significant (p < .001), when comparing last to first visit loneliness scores.

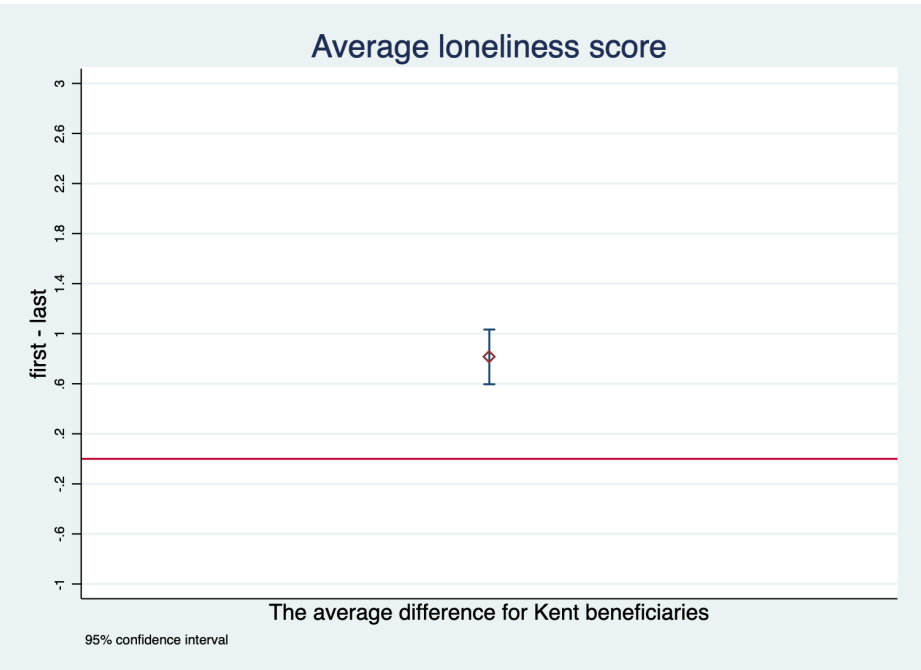


Figure 27. ONS4 loneliness scale - Kent

Case studies also provide additional insights into how Connected Communities programme have helped programme beneficiaries feel less lonely. In one of the cases in Kent, a beneficiary, Mrs C, experienced loneliness and social isolation as a result of recently moving into the area and not knowing many people as well as feeling disconnected due to a lack of transport and own personal health, being partially sighted. Connector helped Mrs C feel more connected with others in the community by supporting her to attend a local church coffee morning, introducing her to Kent Association for the Blind and arranging transport through the Kent Karrier Scheme.

> *"Mrs C was very socially isolated and lonely. Working together we supported her by putting together a tailor-made personal action plan."* ***Liz Lovatt / Community Connector***

> *"It is an excellent service, it has helped me make some friends and connected me. I have even got a holiday booked with the local blind club!"* ***Mrs C / Beneficiary***

Kent Connectors also report working with individuals who, in addition to experiencing loneliness where also experiencing a variety of other issues that might have exacerbated feelings of loneliness.

Financial hardships, a lack of life, social and digital skills have led one Kent beneficiary to feel socially isolated and lonely due to unresolved issues with a local authority due to a car parking fine which could have led to greater health and financial stress. By addressing financial burdens and improving digital skills that contributed to feelings of loneliness and isolation, beneficiary became more active and able to seek friendships and connect with family members.

> *"From our first meeting, it was clear that Mrs D is very aware that her lack of digital skills is holding her back and limiting her ability to join activities; make new friends and keep in touch with her family. However, the worry and anxiety of the parking fine issue was severely impacting her ability to concentrate on anything else. As she could prove that she had paid the original fine I intervened on her behalf to get the problem resolved, and with the help of her District Councillor she has received a full refund. Now she can focus on getting 'tech-savvy', learning how to text, email and surf the Internet to tackle her isolation and loneliness with the help of a digital mentor that I have put her in touch with."* ***Neil Staveley / Community Connector***

Eure departmental Council

Looking at the *case study reports*, during the COVID-19 periods of social restrictions, some individuals reported their health worsening due to social distancing guidelines. In L'Eure, 76 years old beneficiary, Hervé, reported experiencing loneliness and worsening health due to his children not being able to visit due to COVID-19 lockdown. Hervé was living alone in a small studio since his divorce. A touchscreen tablet provided by the service has enabled him to stay in contact with his children and grandchildren, following in-person reunion.

Medway Council

Case studies reveal that for a beneficiary in Medway, Mary, feelings of loneliness emerged after losing her husband just before the COVID-19 pandemic occurred, shortly after losing a close friend during this time. Mary stopped socialising, started to feel lonely and isolated, which was having a detrimental effect on her physical and mental health. Mary wanted to make new friends but did not know how. Connector worked with Mary to help her build confidence to engage in community groups and activities, which made a positive difference in Mary's life and make her feel less lonely.

> *''I am so pleased Better Connected introduced me to a coffee morning, where everyone is friendly and made me feel so welcome. I now go to exercise classes, craft groups, carpet bowls and regular walks. I used to be lonely, but not anymore.''* ***Mary / Beneficiary***

> *''Mary was keen to get out the house and lots of different groups and activities. She wanted to get her social life up and running again. Helping Mary was enjoyable, and it was so lovely to see the way she jumped right into all these different community groups growing with confidence.''* ***Catherine Drew / Community Connector***

Social Isolation (T3.1.3 Deliverable: Report on social isolation and well-being)

All the partners provided responses to 4 social isolation questions listed in Table 3. The four questions assess various aspects of beneficiaries' social interactions, starting with how *close to* people in their local area and how much they can *depend on* them; how often they *socialise with* others outside of their immediate household; how much they *talk to* others; and how often are they engage in *activities with* groups and clubs that they belong to.

The 4 social isolation questions are a sub-scale of the Duke Social Support Index (DSSI) referred to as a *social interaction sub-scale*. The higher scores indicate more social interaction. The guidelines in the literature do not offer conclusive information on how to summarise scores for the *social interaction sub-scale*. The 4 questions response options differ between the questions as can be seen in Table 3. Thus, the analyses below show responses to each individual question.

Source of wording	Question	Choices/options
Duke Social Support Index (DSSI)	Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to?	0 - None 1 - 1-2 people 2 - More than 2 people 88 - Beneficiary refuses to answer

	How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?	0 - None 1 - Once 2 - Twice 3 - 3 times 4 - 4 times 5 - 5 times 6 - 6 times 7 - 7 or more times 77 - Not discussed 88 - Refuses to answer 99 - Unable to answer
	How many times did you talk to someone (friends, relatives or others) on the telephone in the past week?	0 - None 1 - Once 2 - Twice 3 - 3 times 4 - 4 times 5 - 5 times 6 - 6 times 7 - 7 or more times 77 - Not discussed 88 - Refuses to answer 99 - Unable to answer
	About how often did you go to meetings of clubs, religious meetings, or other groups that you belong to in the past week?	0 - None 1 - Once 2 - Twice 3 - 3 times 4 - 4 times 5 - 5 times 6 - 6 times 7 - 7 or more times 77 - Not discussed 88 - Refuses to answer 99 - Unable to answer

Table 3. Social Isolation Measure

All Partner Comparisons

In Figure 28, when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in social isolation for '**close to and can depend on people in their local area (excluding family)'** question ($p < .001$). On average a beneficiary's sense of having a number of people that they feel close to and can depend on increases by 0.28 on a 3-point scale, when comparing last to first visit scores. In short, beneficiaries report that they feel that they have more people that they are close to and can depend on during the last visit in comparison to their first visit.

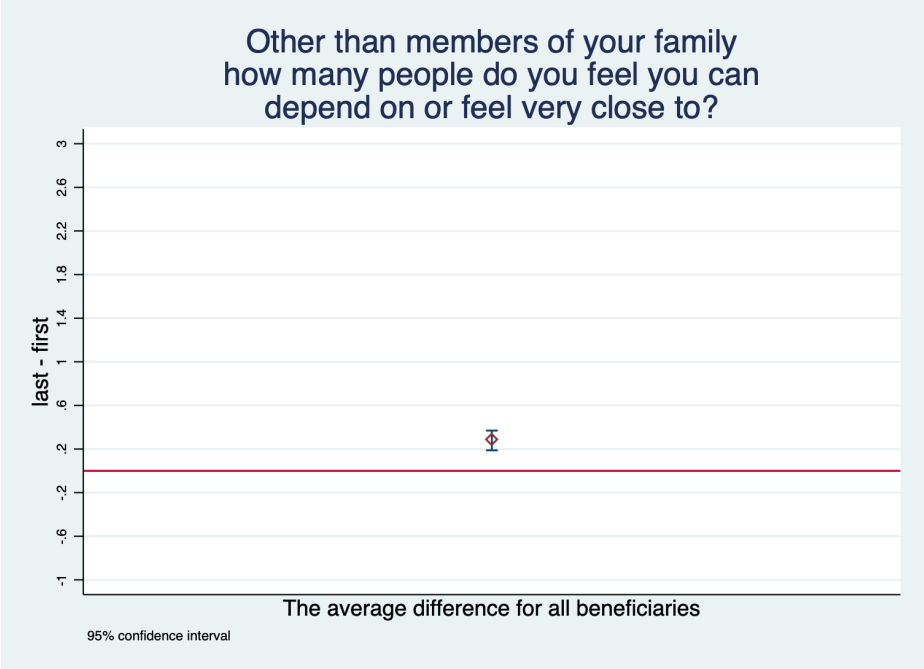


Figure 28. Social Isolation "close to and can depend on people in their local area (excluding family)" – The average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations for '**close to and can depend on people in their local area (excluding family)'** at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 29, we observe in:

- Kent, on average, a beneficiary's sense of having a number of people that they feel close to and can depend on increases by 0.38 on a 3-point scale, a change which is statistically significant ($p < .005$).
- L'Eure, on average, a beneficiary's sense of having a number of people that they feel close to and can depend on increases by 0.19 on a 3-point scale, a change which is statistically significant ($p < .005$).
- Medway, on average, a beneficiary's sense of having a number of people that they feel close to and can depend on increases by 0.32 on a 3-point scale, a change which is statistically significant ($p < .001$).
- Suffolk no statistically significant change in a beneficiary's sense of having a number of people that they feel close to and can depend on. You can see in Figure 29 that the confidence interval includes 0, which means that the change for this particular aspect of social isolation in Suffolk could be 0. We have no evidence of change for this particular aspect of social isolation in Suffolk.

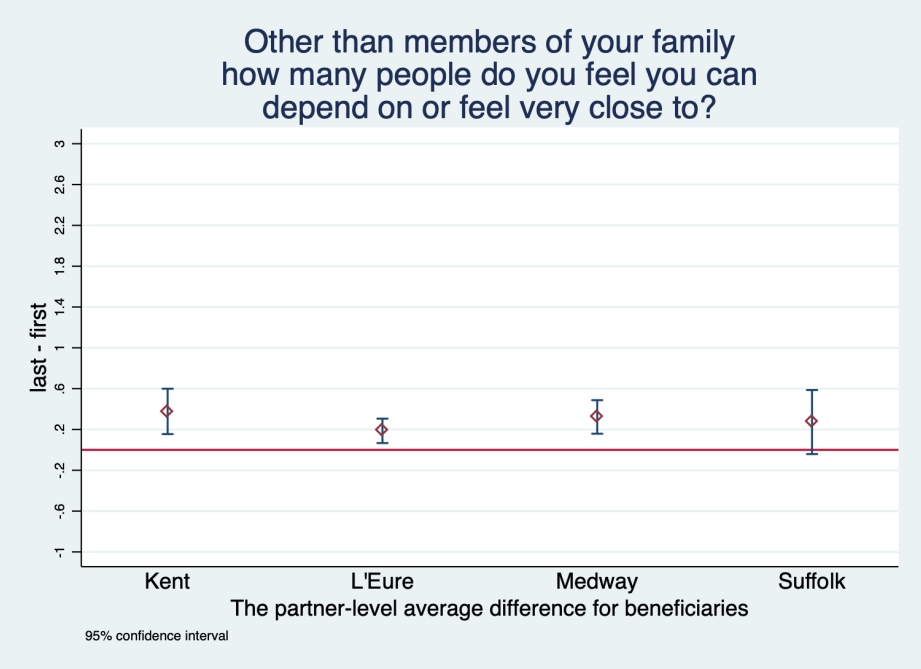


Figure 29.Social Isolation "close to and can depend on people in their local area (excluding family)" – The partner-level average difference for beneficiaries

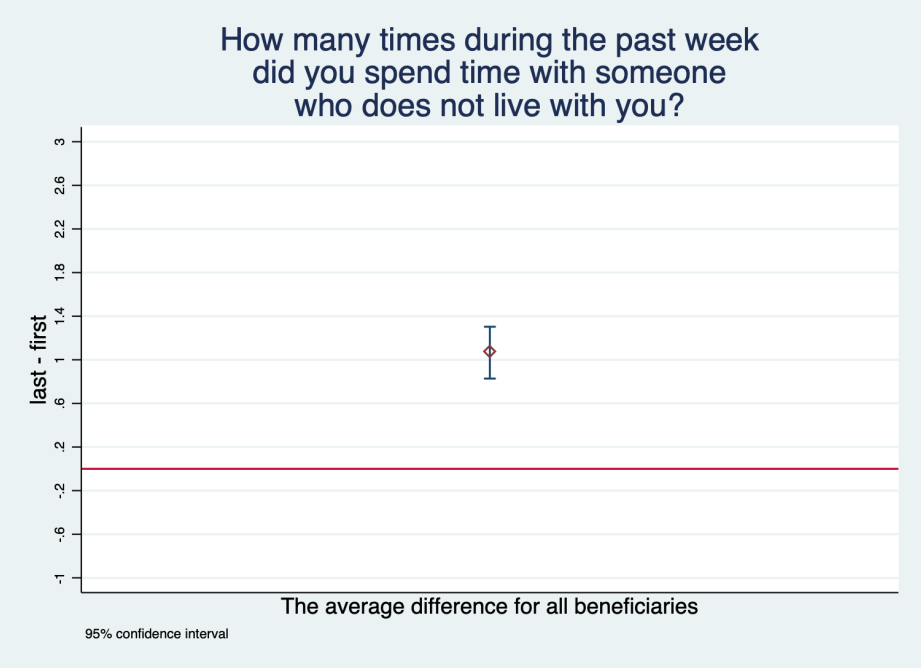


*Figure 30.*Social Isolation "socialise with someone who does not live with you " – The average difference for all beneficiaries

In Figure 30 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in social isolation for '**socialise with someone who does not live with you'** question (p < .001). On average a beneficiary's level of social interaction increases by 1.07 on a 8-point scale, when comparing last to first

visit scores. In short, beneficiaries report that they are spending more time with someone who does not live with them during the last visit in comparison to their first visit.

Looking at all the beneficiaries' responses across partner locations for '**socialise with someone who does not live with you'** at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 31, we observe in:

- Kent, on average, a beneficiary's level of social interaction increases by 1.12 on a 8-point scale, a change which is statistically significant (p < .001).
- L'Eure, on average, a beneficiary's level of social interaction increases by 0.50 on a 8-point scale, a change which is statistically significant (p < .005).
- Medway, on average, a beneficiary's level of social interaction increases by 2.02 on a 8-point scale, a change which is statistically significant (p < .001).
- Suffolk no statistically significant change in a beneficiary's level of social interaction. You can see that the confidence interval includes 0, which means that the change in this particular aspect of social isolation (socialise with others) in Suffolk could be 0. We have no evidence of change for this particular aspect of social isolation in Suffolk.

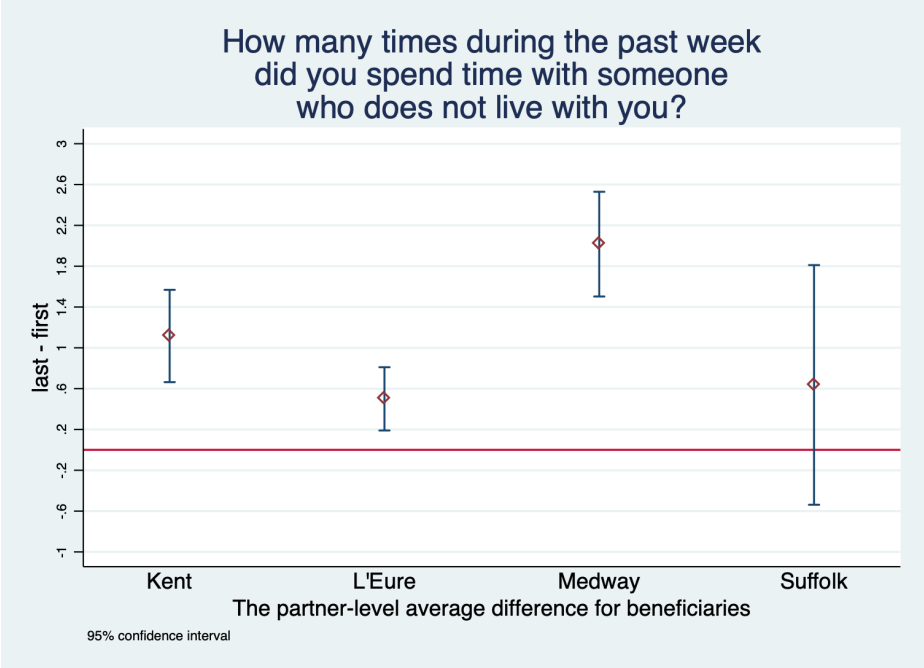


*Figure 31.*Social Isolation "socialise with someone who does not live with you " – Partner-level average difference for beneficiaries

In Figure 32 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in social isolation for '**talked with someone on the phone'** question (p < .001). On average a beneficiary's level of communication on the phone increases by 0.63 on a 8-point scale, when comparing last to first visit scores. In short, beneficiaries report that they talking more on the phone with someone who does not live with them during the last visit in comparison to their first visit.

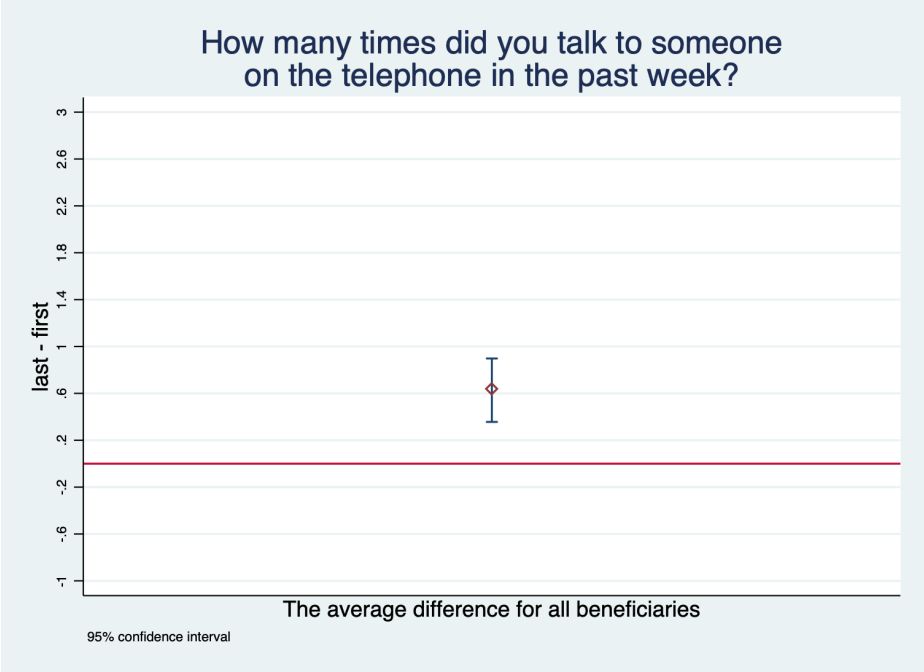


*Figure 32.*Social Isolation "talked to someone on the phone " – The average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations for '**talked with someone on the phone'** at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 33, we observe in:

- Kent, on average, a beneficiary's level of communication on the phone increases by 0.72, a change which is statistically significant ($p < .05$), low level of statistical significance.
- L'Eure no statistically significant change in a beneficiary's level of communication on the phone. You can see that the confidence interval includes 0, which means that the change in this particular aspect of social isolation (talking on phone) in L'Eure could be 0. We have no evidence of change for this particular aspect of social isolation in L'Eure.
- Medway, on average, a beneficiary's level of communication on the phone increases by 1.21, a change which is statistically significant ($p < .001$).
- Suffolk no statistically significant change in a beneficiary's level of communication on the phone. You can see that the confidence interval includes 0, which means that the change in this particular aspect of social isolation (talking on phone) in Suffolk could be 0. We have no evidence of change for this particular aspect of social isolation in Suffolk.

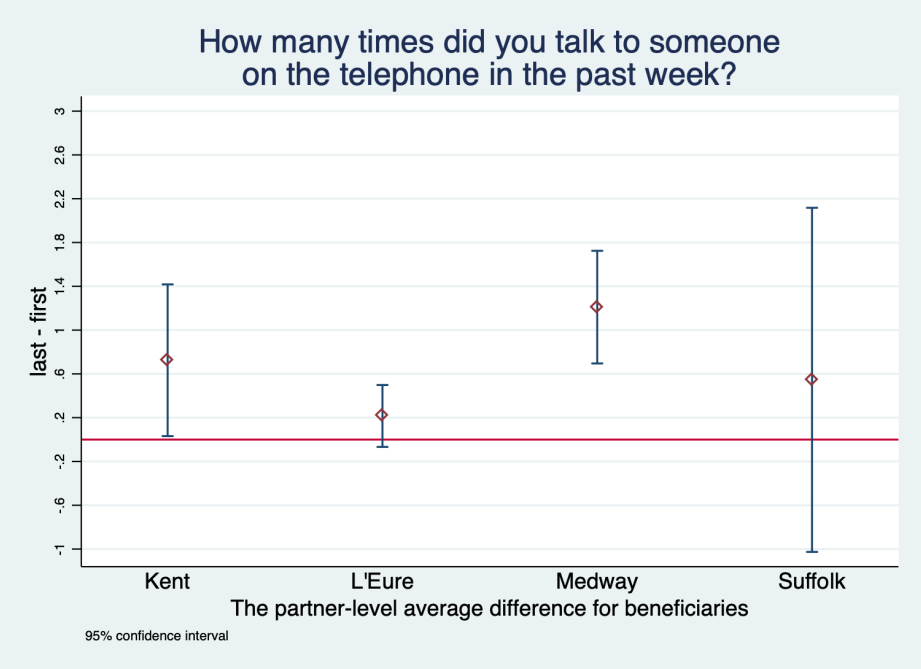


Figure 33. Social Isolation "talked to someone on the phone " – Partner-level average difference for beneficiaries

In Figure 34 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in social isolation for '**group activities'** question (p < .001). On average a beneficiary's level of engagement in group activities such as clubs and meetings increases by 0.67 on a 8-point scale, when comparing last to first visit scores. In short, beneficiaries report that they are going more often meetings to the clubs, religions meetings and other group events during the last visit in comparison to their first visit.

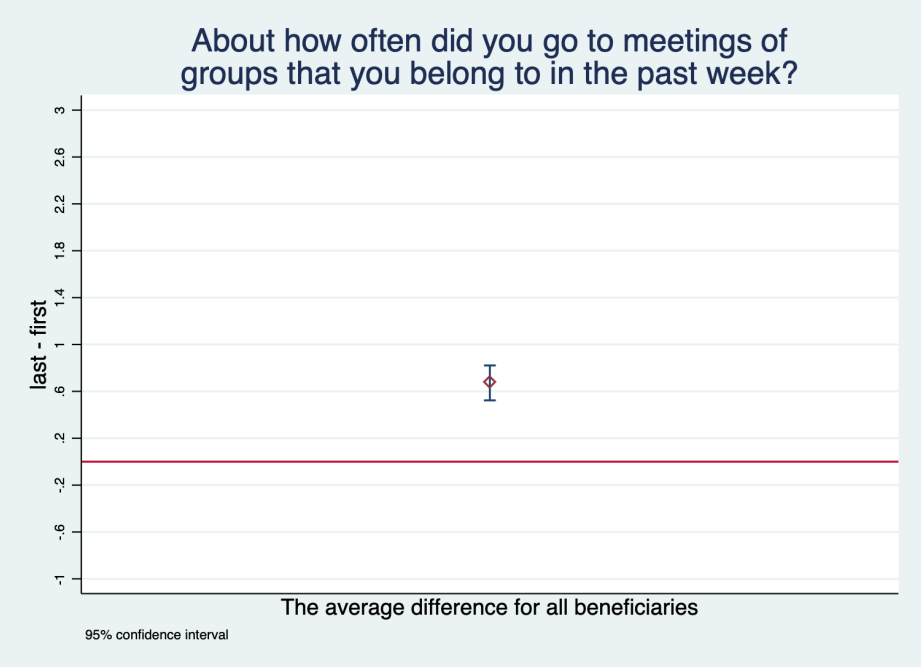


*Figure 34.*Social Isolation "engaged in activities with groups and clubs that you belong to" – The average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations for '**group activities'** at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 35, we observe inFigure 33:

- Kent, on average, a beneficiary's level of engagement in group activities increases by 1.02 on a 8-point scale, a change which is statistically significant (p < .001).
- L'Eure, on average, a beneficiary's level of engagement in group activities increases by 0.24 on a 8-point scale, a change which is statistically significant (p < .01).
- Medway, on average, a beneficiary's level of engagement in group activities increases by 1.11 on a 8-point scale, a change which is statistically significant (p < .001).
- Suffolk no statistically significant change in a beneficiary's level of engagement in group activities. You can see that the confidence interval includes 0, which means that the change in this particular aspect of social isolation (engagement in group activities) in Suffolk could be 0. We have no evidence of change for this particular aspect of social isolation in Suffolk.

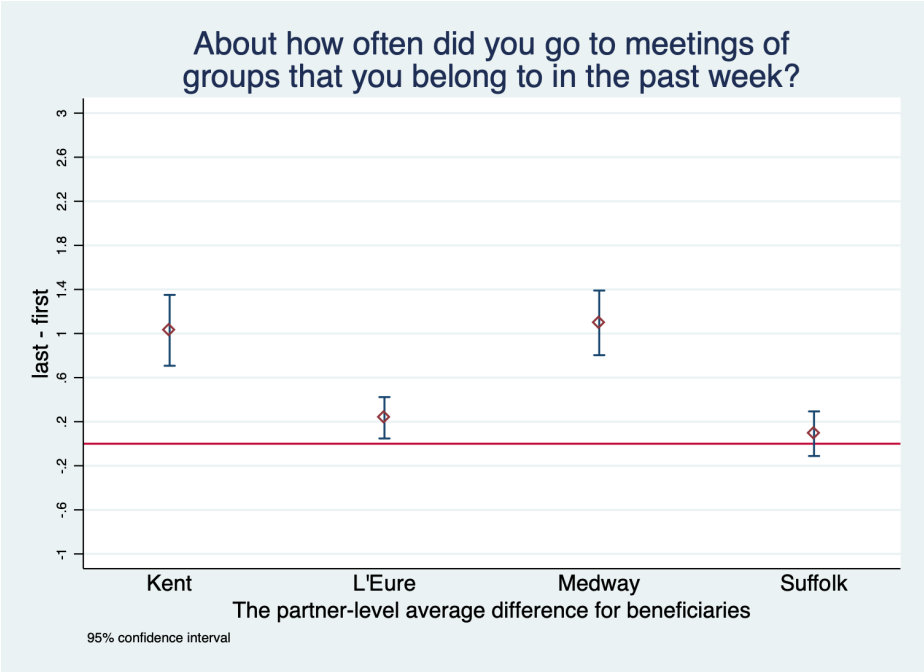


Figure 35. Social Isolation "engaged in activities with groups and clubs that you belong to" – Partner-level average difference for beneficiaries

Kent County Council

Social isolation due to critical life events such as divorce are commonly observed in those who report feeling socially isolated. In one such *case* in Kent, Mr G split up with his wife of many years, lost a bellowed dog and needed to sell his property. While being an active community member and a skilled bricklayer working all over the world, he was diagnosed with essential tremors, which impacted his mobility. All these life events have resulted in Mr G feeling a lack of support and a loss of friendship, becoming quite socially isolated over time. Kent Connectors offered to support Mr G

to reconnect with activities and individuals in his community by attending weekly events at a local café, a nearby social club and an art club. All these activities have helped Mr G to reconnect with others and feel less isolated.

> *"Mr G was previously an independent person but in recent years life has changed considerably for him which has left him somewhat lost. We were able to re-connect him with things that are just around the corner and relate to interests of his. He still has situations that he needs to deal with (including selling his house and finding somewhere else) but despite these uncertainties, now he feels more supported, able to focus and think about this. Being able to discuss an action plan, possible blocks and concerns and using our training to address those concerns, has helped Mr G move forward at last."* ***Mandy Quy-Verlander and Karl Aylett / Community Connectors***
>
> *Medway Council*

Meaningful friendships are important for our health and wellbeing. For instance, a case study from the Connected Communities service in Medway (Better Connected), illustrates how the service have helped Margaret to form new and meaningful friendships and improve her social relationships. Margaret had been feeling socially isolated, she did not have many friends and found she wasn't going out very much in order to socialise. Margaret really wanted to make meaningful friendships, and was keen to volunteer for a charity but did not know how where to start. Medway Connectors supported Margaret to engage with local community groups (ex. Place of Welcome). This has helped Margaret make new friends and empowered her to seek to join groups independently with help from the connections she has made during the initial referral activity.

> *''I found Better Connected very helpful, they networked with different organisations to help me find groups and activities. I now volunteer for two charity organisations, which Better Connected help me find. They have made a big difference, I now have meaningful friendships.''* ***Margaret / Beneficiary***
>
> *'' I feel Margaret really approached everything that she was made aware of, so positively. This helped with what I did, as there was rarely any obstacles and Margaret was willing to try most things. It's so lovely to see Margaret socialise and flourish within the community.''* ***Catherine Drew / Community Connector***

Another example of where Medway Connectors helped is the case of Sandra who expressed that she is struggling with day to day life due to experiencing isolation. Sandra felt like she had no one to talk to, did not want to bother her family with her worries and with time started to experience loneliness in addition to isolation. Once Sandra received support from the Connectors with meeting new people and attending new activities, she was able to make new friends and started to feel less isolated.

> *"Taking part in the Better Connected programme is the best thing I have ever done. I get out more than ever now and I never feel shut out or isolated anymore. Everyone I have met have been so lovely and welcoming.''* **Sandra / Beneficiary**

"Supporting Sandra has been very rewarding, she has taken everything on with great enthusiasm. Sandra is so much more confident now and attends at least three or four groups a week. Sandra has made some really strong connections with people, by attending the groups and activities. It is lovely to see Sandra so happy and confident." ***Catherine Drew / Community Connector***

Wellbeing (T3.1.3 Deliverable: Report on social isolation and well-being)

All partners agreed to measure wellbeing using the UK Office for National Statistics standard 4-question battery, called *ONS4 wellbeing* measure.[16] Medway, Kent and Suffolk provided responses to all 4 questions, while L'Eure only has recorded responses for the first (life satisfaction) and second item (worthwhile). Thus, all partner comparisons will be only possible for these two questions. Comparisons for happiness and anxiety questions/aspects of wellbeing will be presented for Kent, Medway and Suffolk.

ONS4 wellbeing	Overall, how satisfied are you with your life nowadays?	0 - 10, where 0 is "not at all" and 10 is "completely"
	Overall, to what extent do you feel the things you do in your life are worthwhile?	0 - 10, where 0 is "not at all" and 10 is "completely"
	Overall, how happy did you feel yesterday?	0 - 10, where 0 is "not at all" and 10 is "completely"
	Overall, how anxious did you feel yesterday?	0 - 10, where 0 is "completely" and 10 is "not at all"

Table 4. Wellbeing Measure

All Partner Comparisons

In Figure 36 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in life satisfaction question ($p < .001$). On average a beneficiary's sense of life satisfaction increases by 1.11 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report that they feel more satisfied with their life nowadays during the last visit in comparison to their first visit.

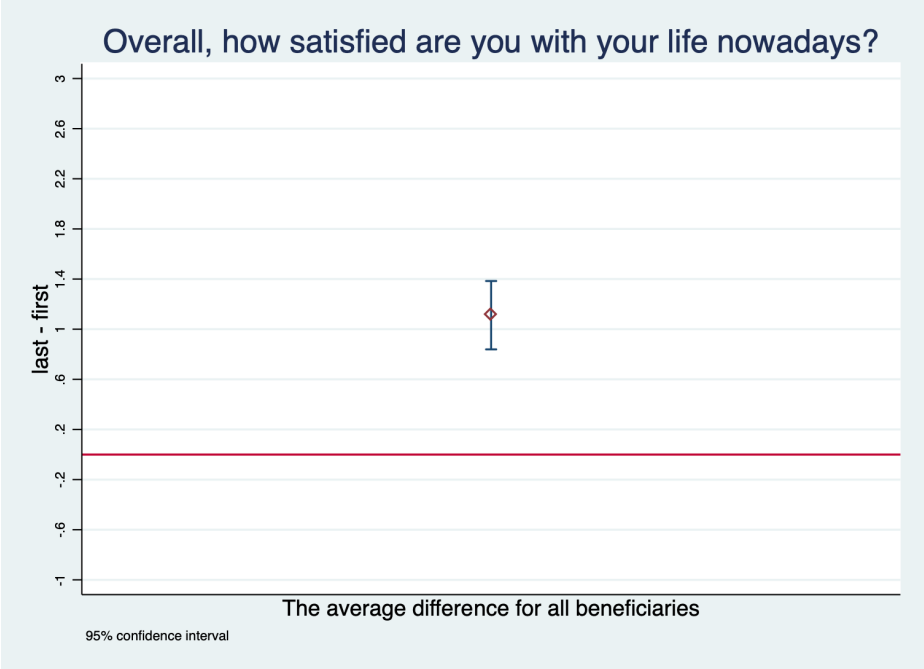


Figure 36. Life Satisfaction – The average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations for **life satisfaction**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 37, we observe in:

- Kent, on average, a beneficiary's sense of life satisfaction increases by 1.67 on a 11-point scale, a change which is statistically significant ($p < .001$).
- L'Eure, on average, a beneficiary's sense of life satisfaction increases by 0.46 on a 11-point scale, a change which is statistically significant ($p < .005$).
- Medway, on average, a beneficiary's sense of life satisfaction increases by 1.44 on a 11-point scale, a change which is statistically significant ($p < .001$).
- Suffolk, on average, a beneficiary's sense of life satisfaction increases by 1.91 on a 11-point scale, a change which is statistically significant ($p < .005$).

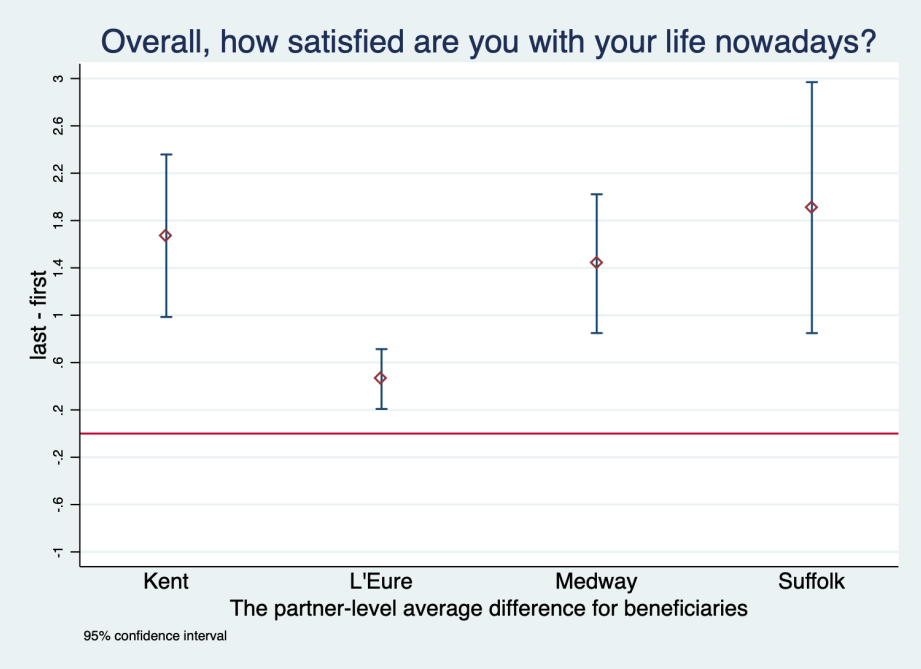


Figure 37. Life Satisfaction – Partner-level average difference for beneficiaries

In Figure 38 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in life being worthwhile question (p < .001). On average a beneficiary's sense of things they do in their life being worthwhile increases by 1.18 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report that they feel things they do in their life being more worthwhile during the last visit in comparison to their first visit.

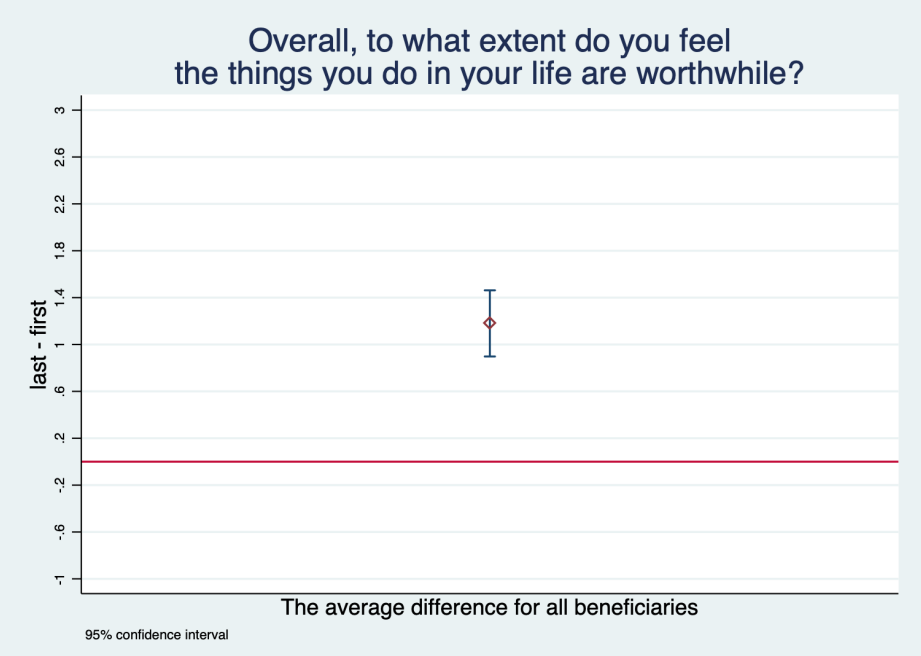


Figure 38.Life Worthwhile –The average difference for all beneficiaries

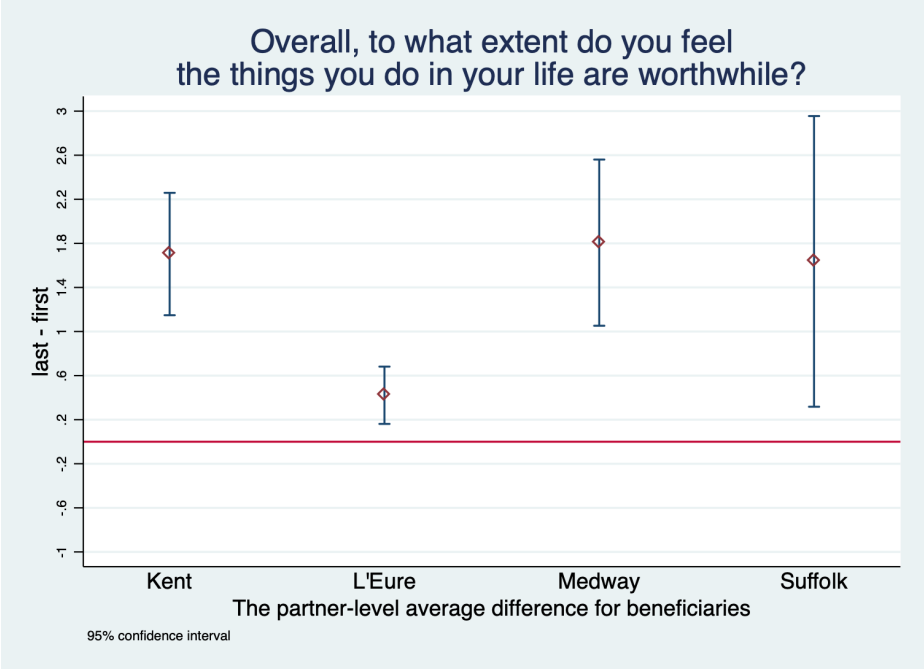


Figure 39.Life Worthwhile – The partner-level average differences for beneficiaries

Looking at all the beneficiaries' responses across partner locations for **life being worthwhile**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 39, we observe in:

- Kent, on average, a beneficiary's sense of life being worthwhile increases by 1.70 on a 11-point scale, a change which is statistically significant ($p < .001$).
- L'Eure, on average, a beneficiary's sense of life being worthwhile increases by 0.42 on a 11-point scale, a change which is statistically significant ($p < .005$).
- Medway, on average, a beneficiary's sense of life being worthwhile increases by 1.81 on a 11-point scale, a change which is statistically significant ($p < .001$).
- Suffolk, on average, a beneficiary's sense of life being worthwhile increases by 1.64 on a 11-point scale, a change which is statistically significant ($p < .05$).

In Figure 40 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in happiness scores ($p < .001$). On average a beneficiary's happiness increases by 1.25 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report that they feel more happy during the last visit in comparison to their first visit.

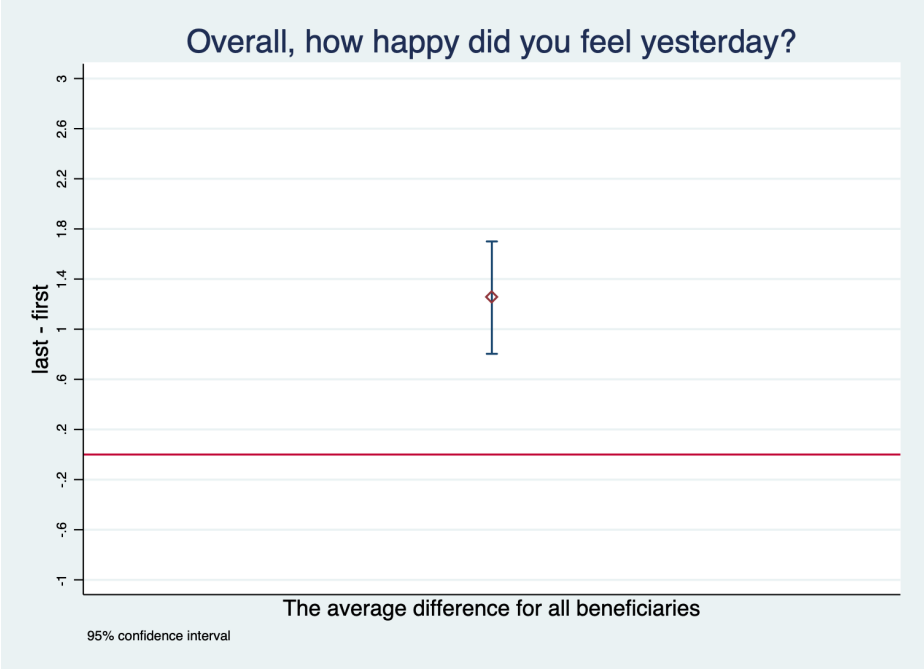


Figure 40.Happiness – The average difference for all beneficiaries (Kent, Medway and Suffolk)

Looking at all the beneficiaries' responses across partner locations for **happiness**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 41, we observe in:

- Kent, on average, a beneficiary's happiness increases by 1.16 on a 11-point scale, a change which is statistically significant (p < .005).
- Medway, on average, a beneficiary's happiness increases by 1.25 on a 11-point scale, a change which is statistically significant (p < .001).
- Suffolk, on average, a beneficiary's happiness increases by 1.8 on a 11-point scale, a change which is statistically significant (p < .01).

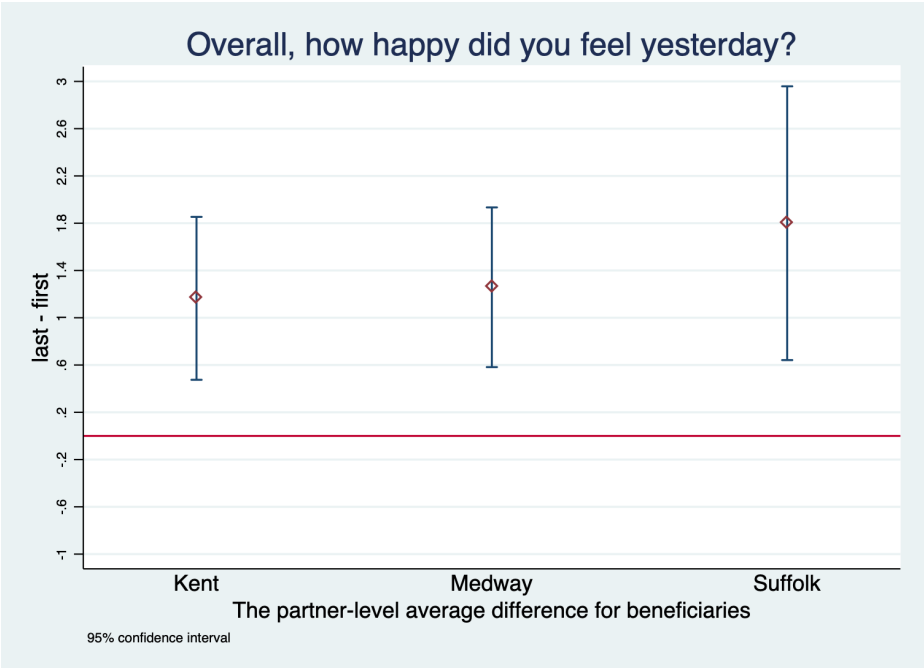


Figure 41.Happiness – Partner-level average differences for beneficiaries (Kent, Medway and Suffolk)

In Figure 42 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in anxiety (p < .001). On average a beneficiary's anxiety decreases by 0.98 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report that they feel less anxious during the last visit in comparison to their first visit.

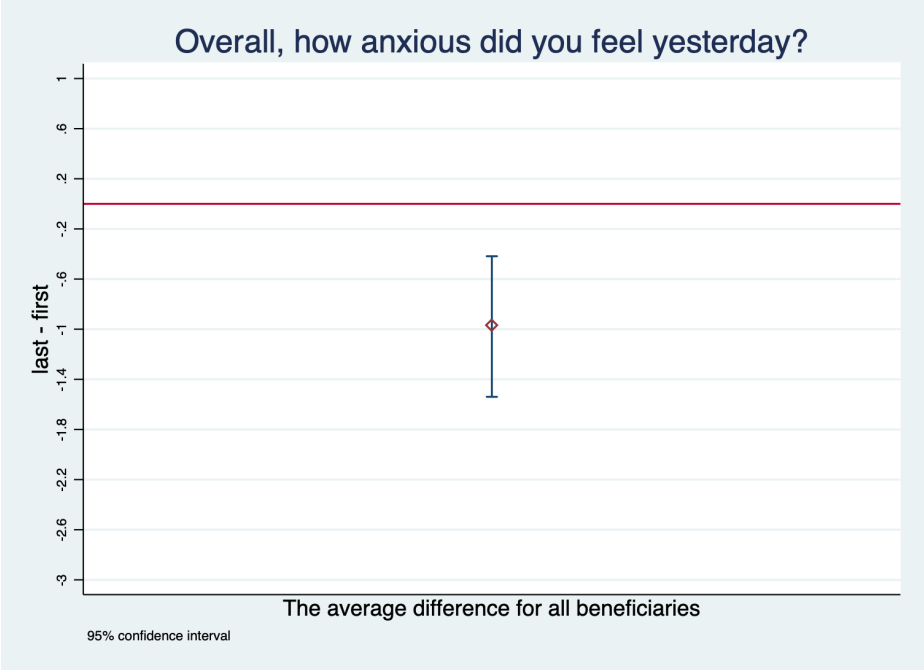


Figure 42.Anxiety – The average difference for all beneficiaries (Kent, Medway and Suffolk)

Looking at all the beneficiaries' responses across partner locations for **anxiety**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 43, we observe in:

- Kent, no statistically significant change in a beneficiary's level of anxiety. You can see that the confidence interval includes 0, which means that the change in anxiety in Kent could be 0. We have no evidence of change for anxiety in Kent.
- Medway, on average, a beneficiary's anxiety decreases by 1.39 on a 11-point scale, a change which is statistically significant (p < .005).
- Suffolk, on average, a beneficiary's anxiety decreases by 3.09 on a 11-point scale, a change which is statistically significant (p < .05). In this case, a decrease of 3.09 is the point estimate, represented by the tiny red diamond for Suffolk. You can see by the brackets and length of the line above and below the diamond that the confidence interval is quite large, indicating that the actual decrease could be as large as a 4.9-point drop, or as small as a 1.3-point drop. Because the estimate is based on such a small sample of beneficiaries, the range of our estimate cannot be any more precise.

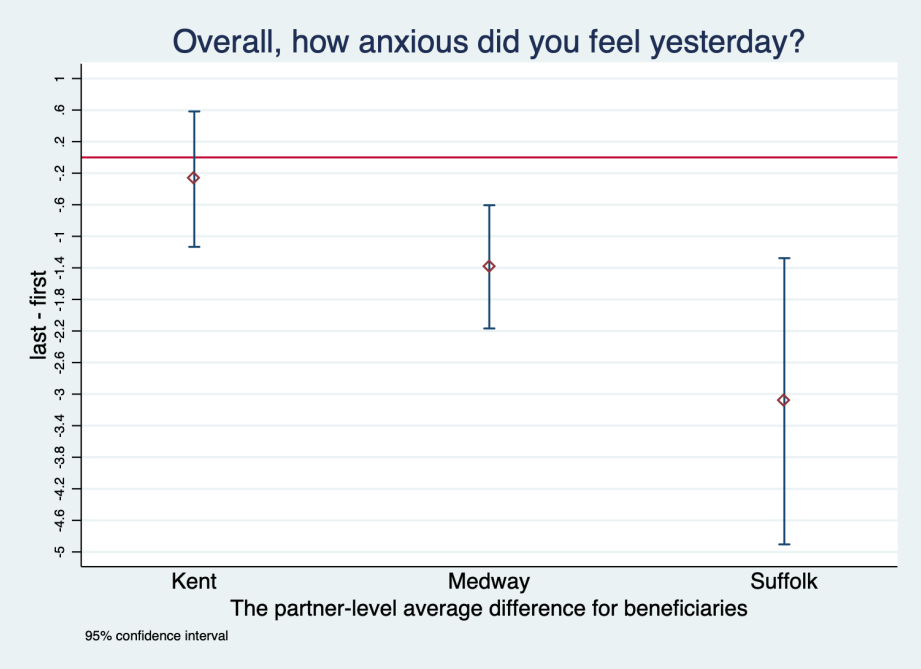


Figure 43. Anxiety – Partner-level average differences for beneficiaries (Kent, Medway and Suffolk)

In Figure 44 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in the overall wellbeing score (p < .001). On average a beneficiary's wellbeing increases by 0.70 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report greater overall wellbeing during the last visit in comparison to their first visit.

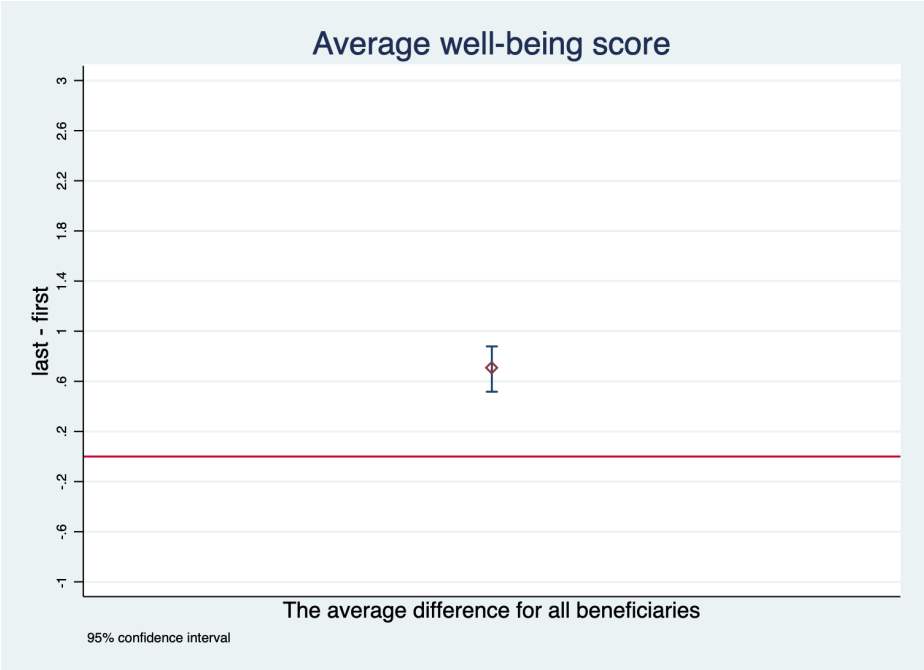


Figure 44. ONS4 Wellbeing Total Score – the average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations for **overall wellbeing**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 45, we observe in:

- Kent, on average, a beneficiary's sense overall wellbeing increases by 1.06 on a 11-point scale, a change which is statistically significant ($p < .001$).
- L'Eure, on average, a beneficiary's sense overall wellbeing increases by 0.44 on a 11-point scale, a change which is statistically significant ($p < .005$).
- Medway, on average, a beneficiary's sense overall wellbeing increases by 0.78 on a 11-point scale, a change which is statistically significant ($p < .005$).
- Suffolk, on average, a beneficiary's sense overall wellbeing increases by 0.55 on a 11-point scale, a change which is statistically significant ($p < .005$).

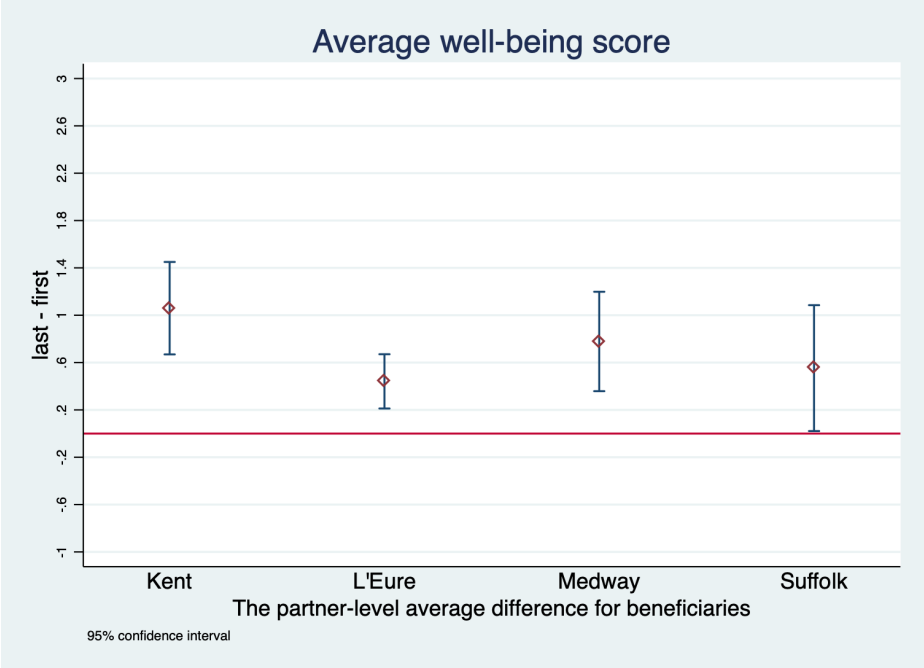


Figure 45. ONS4 Wellbeing Total Score – Partner-level average differences for beneficiaries

Kent County Council

Kent Connectors and staff members have reported that the questions about one's feelings such as "Overall, how happy did you feel yesterday?" and "Overall, how anxious did you feel yesterday?" have been received negatively by some of the beneficiaries. Beneficiaries reported that questions about "yesterday" triggered unwelcomed emotions and in some cases made them feel worse, despite having a very good and positive session with their Connector prior to this question being asked.

The two questions on feeling happy / feeling anxious are a part of the ONS4 wellbeing, 4-item battery, recommended by the UK Office for National Statistics (ONS) as a wellbeing measure to be used nationally and locally in the UK.[16] The feedback that Kent noted with their beneficiaries should be shared with the ONS office.

Case studies show that Kent beneficiaries greatly benefited from engagement in Connected Communities services, with case studies illustrating how the service has helped improve their quality of life. The cases of Mr V and Mrs B are particularly interesting as they illustrate the power of social prescribing – beneficiaries overcoming

consequences of a serious health diagnosis, improving their health and contributing the to the community.

Mr V experienced reduction in his quality of life after suffering stroke. As a former professional photographer, he had a keen interest in film making and editing, however after suffering a stroke in 2015 he struggled to cope with the impact that stroke had on his ability to continue to pursue his interests. Connector introduced Mr V to Screen South, a Folkestone-based cultural development organisation that focuses on digital creativity and Men's Shed. Mr V felt supported and welcomed and enjoyed his new activities. He volunteered to utilise his video and media skills to help improve publicity for Men's Shed in Folkestone. Since he joined Men's Shed, the attendance in the organisation greatly increased and he became one of the leading members. This case illustrates the power of an engaged individual to help rebuild their own resilience and resilience of their community through social prescribing.

Mrs B experienced numerous health issues following her experience with stroke, which led to poor wellbeing, reduction in social activities, loss of physical and mental confidence to engage with others and outside world, social isolation and loneliness. With the support of Kent Connectors (Community Wardens), Mrs B overcame so many of the issues that she was facing and worked actively with her Connectors to improve her health and wellbeing. Mrs B who once was confined to her house, is now able to travel as far as London and Essex to visit relatives and friends, and host them in her own house (cooking and entertaining guests). As a result of participating in Connected Communities programme, Mrs B reported improvements in mobility, speech and cognition and other aspects of her physical and mental health as well as reduced isolation and loneliness. Above all, Mrs B's quality of life improved greatly so that she was able and willing to contribute to her community. She created new groups for other individuals who suffered stroke, and as a result felt lonely and isolated to help with their health. She also contributed to the University of Kent research project and shared her personal experience dealing with stroke and utilising social prescribing by presenting in classes and working closely with a Masters Research student to improve her understanding of stroke and coping mechanism.

Bereavement can greatly impact various aspects of life, from one's health and social life to overall wellbeing. In the case of Joan from Medway, losing her husband just before the COVID-19 pandemic emerged meant that she had lost support and companionship and was reluctant to leave the house, making her feel isolated and less satisfied with her life. With the help of Medway Connectors, Joan attended new activities and group sessions in the area and became involved in craft sessions, which helped her make new connections in her community and improve her overall wellbeing.

> *"Better Connected have introduced me to craft groups and this has helped me make new friends. Doing this has helped me have a better outlook on life. Better Connected have helped make this possible. I would recommend this to anyone feeling isolated."* ***Joan/ Beneficiary***
>
> *"Watching Joan thrive in the community has been wonderful to see. She wants to give everything a go and is not afraid of trying out new things. Knowing that Joan*

is busy most days with groups that I have referred her to, or made her aware of, is brilliant.'' ***Catherine Drew/ Community Connector***

Suffolk County Council – East Suffolk Council

Suffolk partners report on a case where an 89-year old woman, living with her 63-year old son, whose health struggles have impacted her health and wellbeing, was greatly helped by engaging with the Connected Communities services. Her Connector says:

> *"The mother's needs were very complex, and exasperated by her 63-year-old son coming to stay with her after losing his job, home and wife. The whole situation affected the mother's physical, mental, and social wellbeing. The relationship become strained and due to a conversation I had with the mother, it soon became apparent that helping her son would give her back her confidence and allow her time to make those connections again with her friends. Two people's lives changed for the better – both had interests again outside the home and a feeling of self-worth".* ***Community Connector / Karen***

Trust

Trust is assessed by asking beneficiaries to respond, on a scale 0-10 (with 10 being the highest): 1) how much people can be trusted; 2) how much public officials can be trusted. The partners that provided the data are Kent, Medway and Suffolk.

ANES Report Community Life Survey	In general, how much do you think people can be trusted?	0 - 10, where 0 is "not at all" and 10 is "completely" 77 - Not discussed 88 - Refuses to answer 99 - Unable to answer
	In general, how much do you think public officials can be trusted?	0 - 10, where 0 is "not at all" and 10 is "completely" 77 - Not discussed 88 - Refuses to answer 99 - Unable to answer

Table 5. Trust Measure

Three Partner Comparisons

In Figure 46 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in trusting other people question ($p < .001$). On average a beneficiary's level of trust in people increases by 1.09 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report that they trust people more during the last visit in comparison to their first visit.

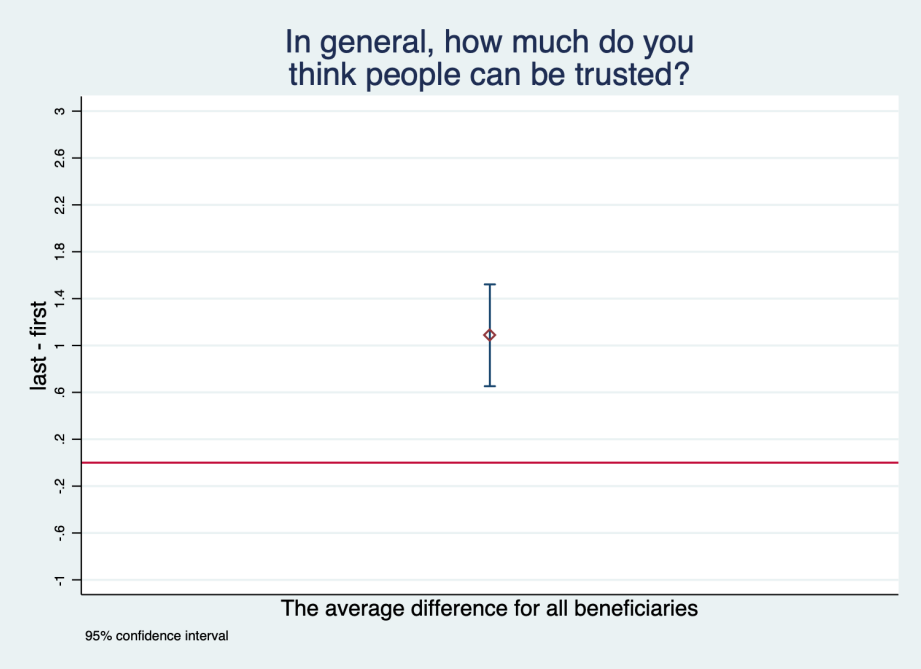


Figure 46.Trust People – Kent, Medway, Suffolk, the average difference for all beneficiaries

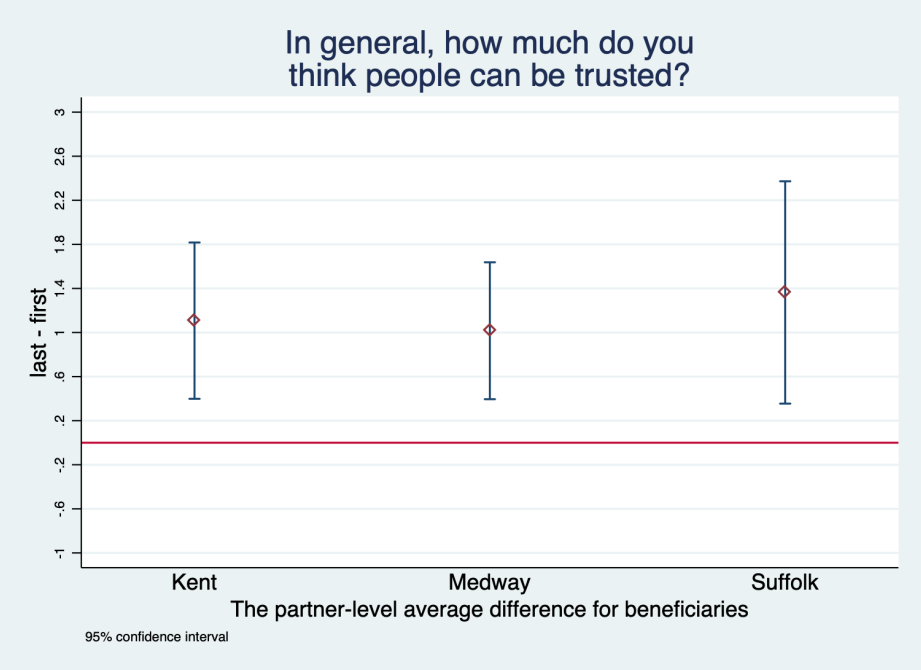


Figure 47.Trust People – Kent, Medway, Suffolk partner-level average difference for beneficiaries

Looking at all the beneficiaries' responses across partner locations for **trusting people**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 47, we observe in:

- Kent, on average, a beneficiary's level of trust in people increases by 1.11 on a 11-point scale, a change which is statistically significant ($p < .005$).
- Medway, on average, a beneficiary's level of trust in people increases by 1.02 on a 11-point scale, a change which is statistically significant ($p < .005$).
- Suffolk, on average, a beneficiary's level of trust in people increases by 1.37 on a 11-point scale, a change which is statistically significant ($p < .05$).

In Figure 48 when all social prescribing *plus* beneficiaries are examined together we see a statistically significant change in trusting public officials question (p < .005). On average a beneficiary's level of trust in public officials increases by 0.72 on a 11-point scale, when comparing last to first visit scores. In short, beneficiaries report that they trust officials more during the last visit in comparison to their first visit.

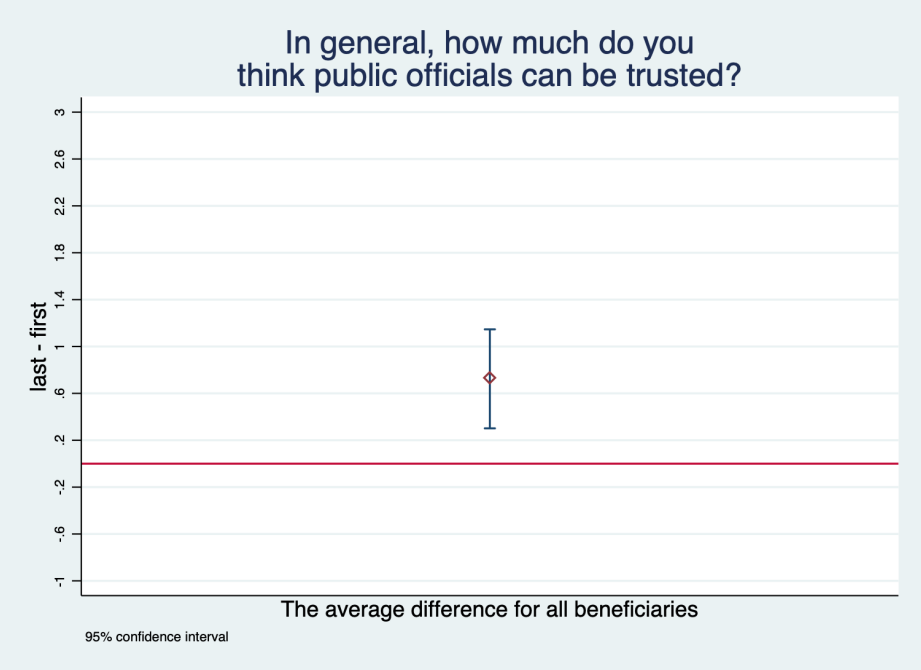


Figure 48.Trust Officials – Kent, Medway, Suffolk, the average difference for all beneficiaries

Looking at all the beneficiaries' responses across partner locations for **trusting officials**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 49, we observe in:

- Kent, on average, a beneficiary's level of trust in officials increases by 0.85 on a 11-point scale, a change which is statistically significant (p < .05).
- Medway no statistically significant change in a beneficiary's level of trusting officials. You can see that the confidence interval includes 0, which means that the change in trusting officials in Medway could be 0. We have no evidence of change for trusting officials in Medway.
- Suffolk no statistically significant change in a beneficiary's level of trusting officials. You can see that the confidence interval includes 0, which means that the change in trusting officials in Suffolk could be 0. We have no evidence of change for trusting officials in Suffolk.

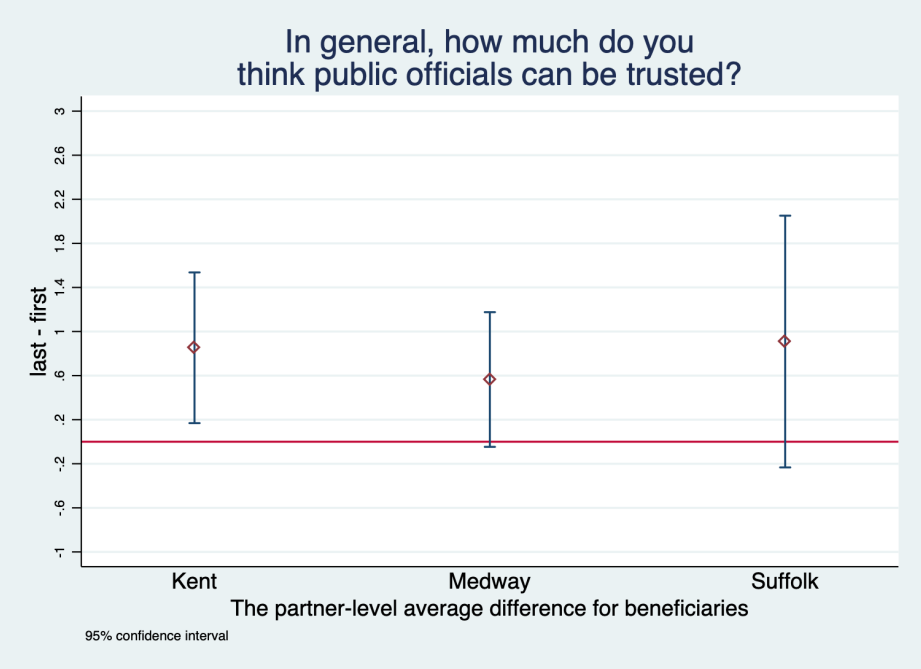


Figure 49.Trust Officials – Kent, Medway, Suffolk, partner-level average difference for beneficiaries

Civic Participation: Community Connectedness

Connected Communities programme and social prescribing in general is seen as a way to improve community connections and overall community participation. Building social networks and enabling individuals to connect better with each other and their communities has been one of the goals of Connected Communities programme. This is evident in many of the case studies mentioned in this evaluation report, in particular the case study of Mrs B and her efforts to transform her life and life of others who were impacted by similar health conditions such as her. After participating in Connected Communities programme, Mrs B was not only able to participate more in community life, she also helped establish new groups, helping others and her community to become more resilient.

While selecting the measure for social connectedness UoE Evaluation Team came across a varied conceptual and methodological approaches in regards to this measure. UoE team conducted a systematic review of the literature and found that there was very little consistency in how social connectedness is defined and measured across various social prescribing programmes.[17] Nonetheless, partners agreed to utilise a measure of connectedness/community participation which is a compilation of questions/measures from the Community Life Survey as can be seen in Table 6.

As the question about community connectedness/civic participation was not deemed as the essential question by the partners, the decision was made to record this question at least one time during the programme duration and mark “not discussed” if it was not discussed when the data was recorded. Given that the question was not asked consistently either during a beneficiary’s first and last visit (beneficiary’s interaction with a Connector), the analyses provided in this section are only of descriptive nature. The collected data does not allow for investigations into change in community connectedness and civic participation, but it allows for a descriptive

explanation of how many beneficiaries engaged in these types of activities at some point during their participation in Connected Communities. The only partners that provided the data for this measure are Medway and Suffolk.

Community Life Survey	Select activities that this beneficiary has participated in over the past month.	1. Contacted a local official such as a local councillor, MP, government official, mayor, or public official working for the local council (Please do not include any contact for personal reasons e.g. housing repairs or contact through work). 2. Attended a public meeting or rally, taken part in a public demonstration or protest 3. Signed a paper petition or an online/e-petition 4. Voted in local elections 5. Participating in a voluntary group or organisation 6. Volunteering for a local charity or group 7. Helping out a neighbour or friend in need. 8. Did not do any of these things. 9. Not discussed. 10. Other: please explain

Table 6. Social Connectedness / Civic-Community Participation

Medway Council

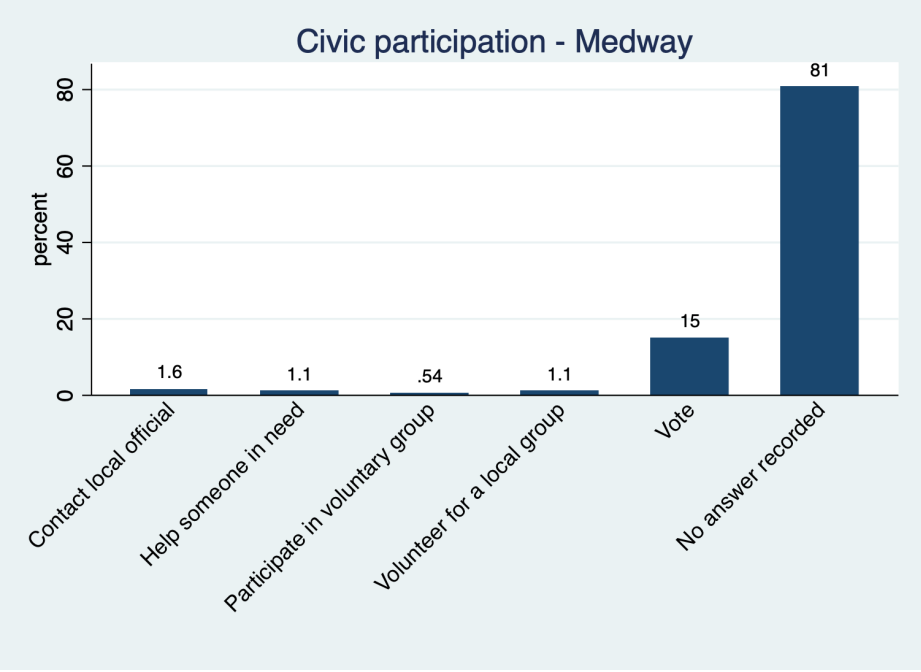


Figure 50. Social Connectedness / Civic-Community Participation–Medway

Suffolk County Council – East Suffolk Council

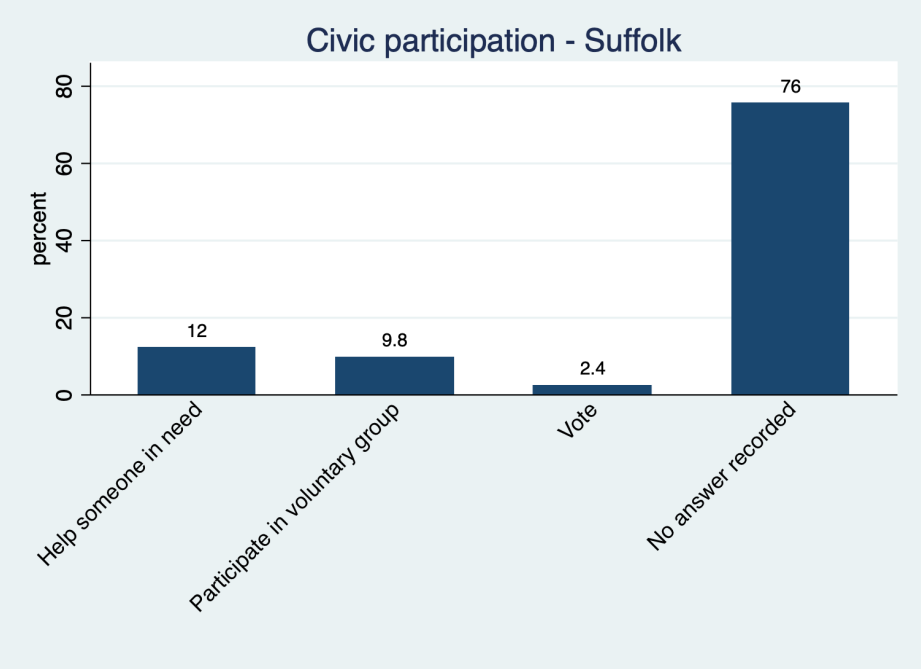


Figure 51. Social Connectedness / Civic-Community Participation –*Suffolk*

Figure 50 and Figure 51 show that for the majority of the beneficiaries these responses were not recorded (81% in Medway and 76% in Suffolk). For those who responded, the most common civic/community participation activity in Medway was "voted in local elections" (15%), while in Suffolk the most common activity was "helping a neighbour or a friend in need (12%), followed by participating in a voluntary group or organisation (10%).

Satisfaction with Connected Communities Programme

All Partner Comparisons

All partners agreed to ask participants how satisfied they were with the Connected communities, with responses ranging from 'very dissatisfied' to 'very satisfied' as can be see in Table 7.

Overall, how satisfied are you with your experience of using our social prescribing services?	1 - Very dissatisfied 2 - Dissatisfied 3 - Neutral 4 - Satisfied 5 - Very satisfied

Table 7. Programme Satisfaction

In Figure 52 when Kent and Medway social prescribing *plus* beneficiaries are examined together we see a statistically significant change in satisfaction with Connected Communities programme – social prescribing *plus* (p < .001). On average a beneficiary's sense satisfaction increases by 0.71 on a 5-point scale, when comparing last to first visit scores. In short, beneficiaries report that they feel more satisfied the programme during the last visit in comparison to their first visit.

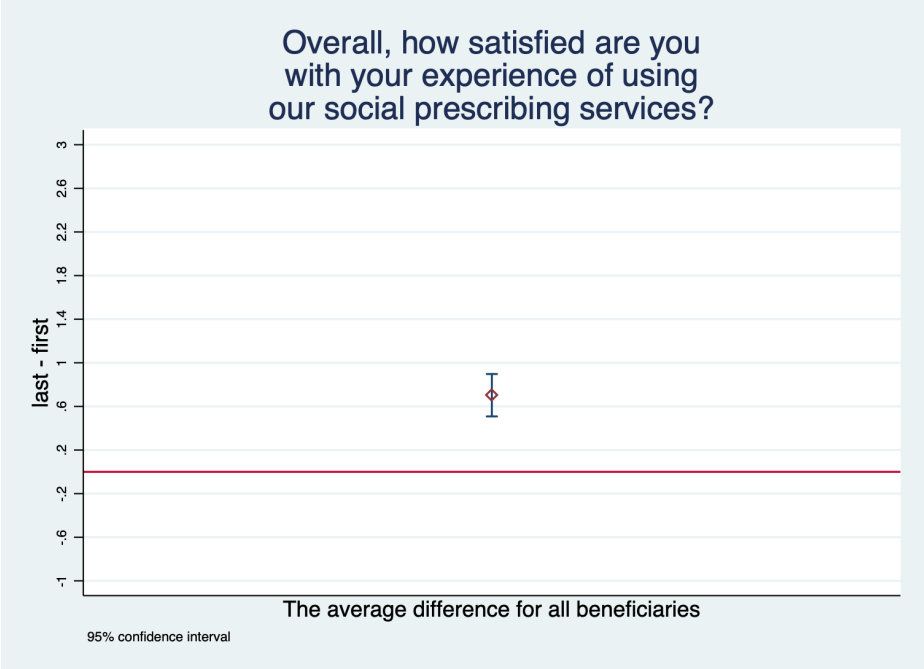


Figure 52.Beneficiary Satisfaction with Connected Communities—The average difference for all beneficiaries

Looking at beneficiaries' responses across Kent and Medway for **satisfaction with the programme**, at the follow-up (last visit) in comparison to the time before engaging with Connected Communities service (first visit), Figure 53, we observe in:

- Kent, on average, a beneficiary's sense of satisfaction with the programme increases by 1.08 on a 5-point scale, a change which is statistically significant (p < .01).
- Medway, on average, a beneficiary's sense of satisfaction with the programme increases by 0.62 on a 5-point scale, a change which is statistically significant (p < .001).

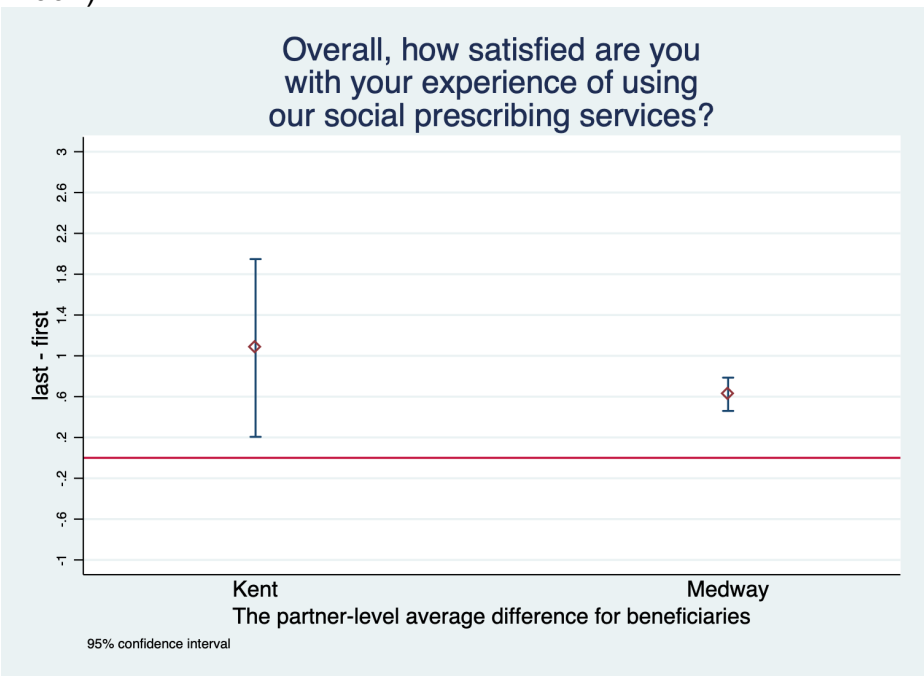


Figure 53. Beneficiary Satisfaction with Connected Communities – Partner-level average difference for beneficiaries

Suffolk and L'Eure report answers no more than once for each beneficiary, so we cannot test for changes over time. We can, however, describe how beneficiaries felt overall about the programme. Figure 53 shows programme satisfaction for Suffolk and L'Eure. In L'Eure, 50% of beneficiaries are neutral in their feelings about the programme, 17% are satisfied and 33% are very satisfied. In Suffolk, all beneficiaries are either satisfied or very satisfied.

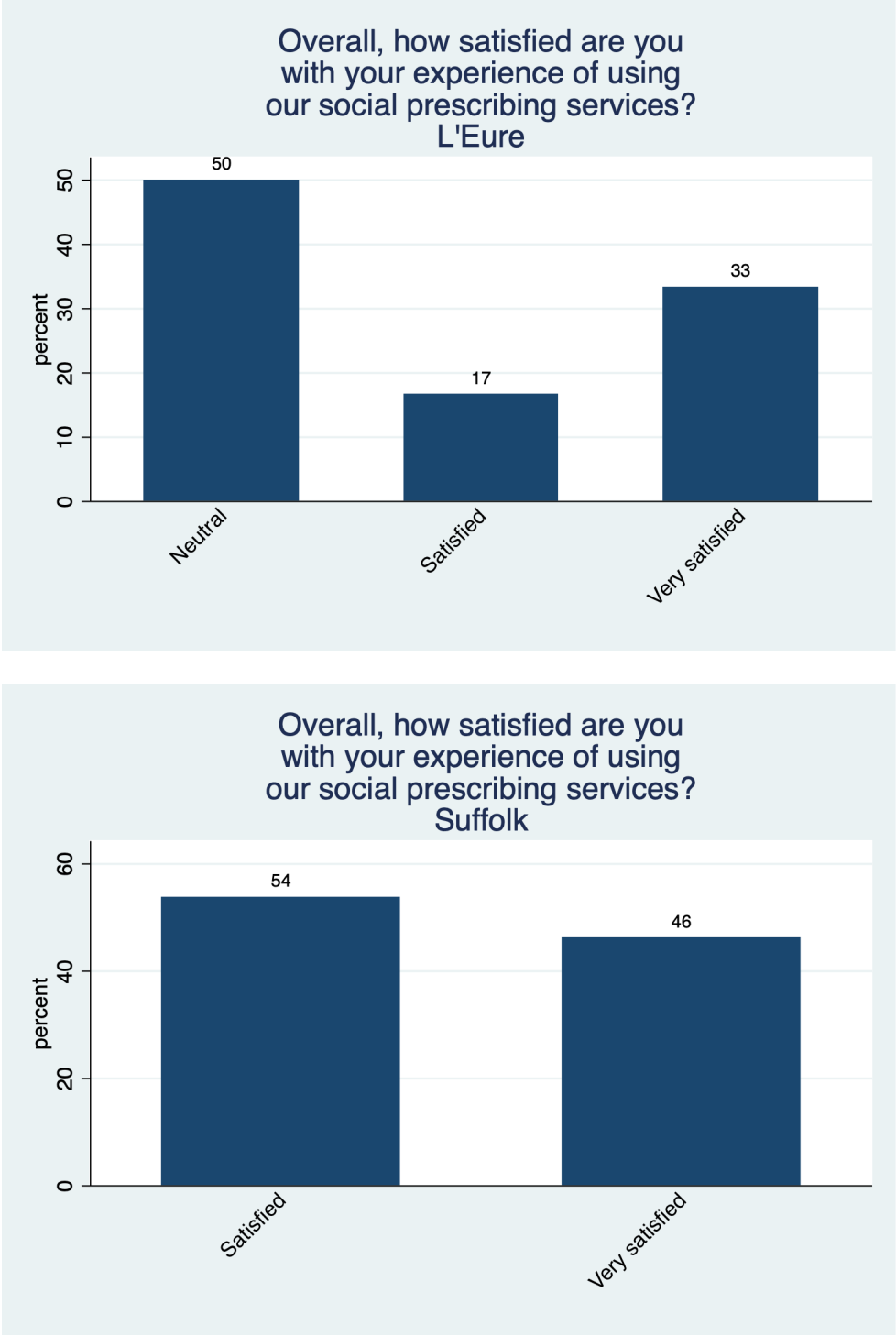


Figure 54. Beneficiary satisfaction with Connected Communities at one point in time - L'Eure and Suffolk

Health and Social Care Service Usage

In order to assess the impact of Connected Communities on the system, health and social care services, UoE Team proposed that partners record the beneficiary's self-reported usage of services at the first and last visit with the programme. These services would include GP visits, A&E visits, hospital visits, and usage of social care services, or APA payments in France. For each, the beneficiary would be asked about their use of the service "over the past month".

Partners agreed that health and social care usage is an important target of impact from social prescribing. However, partners decided that these should not be required evaluation questions. Therefore, L'Eure and Suffolk recorded this information no more than once for each beneficiary. Kent did not share this information with the partners. Medway provided it for both the first and last visit for beneficiaries. Suffolk also provided the data for first and last visit, however, due to a small number of responses, the evaluation is limited.

Eure departmental Council

In L'Eure, when it comes to GP visits in a past month, 20% beneficiaries report not visiting a GP, 75% report visiting a GP once and 5% report visiting a GP two times (Figure 55).

Figure 55.L'Eure GP visit in a past month

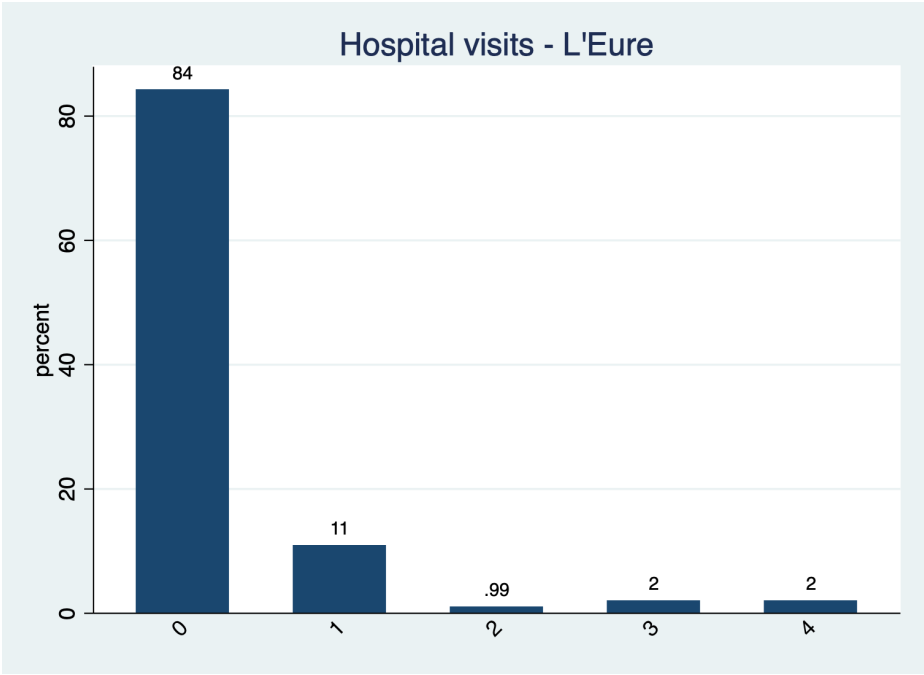


Figure 56. L'Eure hospital visit in a past month

L'Eure visits to the hospital data show that 84% of the beneficiaries have not visited hospital in past month, 11% visited hospital one time, 1% visited hospital two times, 2% visited three times and 2% visited hospital 4 times in the past month (Figure 56).

L'Eure responses regarding autonomy payments (APA) show that 29% of beneficiaries reported to Connectors that they were receiving autonomy payments (Figure 57).

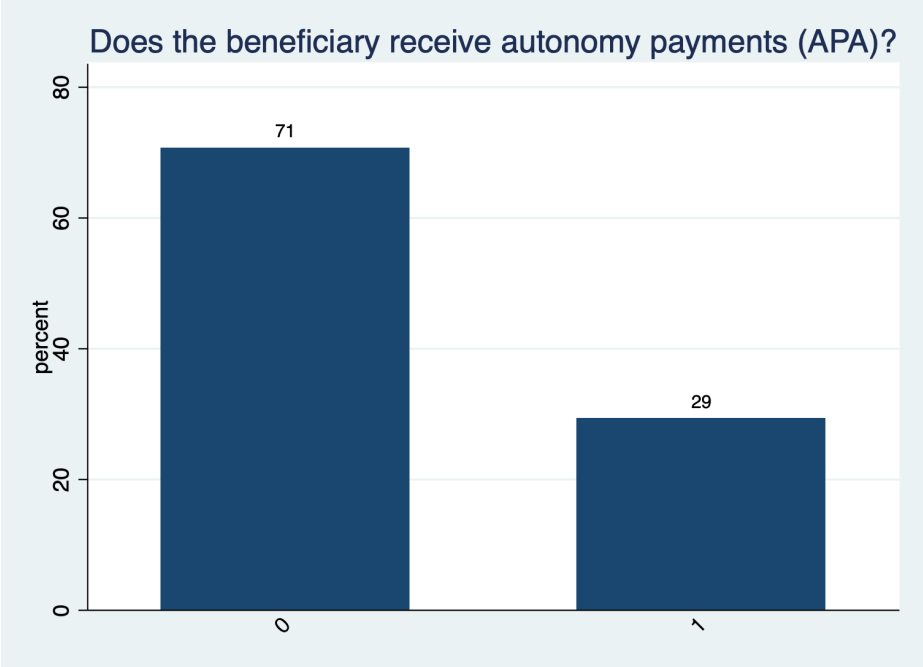


Figure 57. L'Eure APA service usage

Medway Council

Medway was the only partner that provided information on both first and last visit for health and social care usage. When examining the information, however, we find that few, if any, beneficiaries changed their responses over time. So there is no difference in health and social care usage whatsoever.

In Medway, Figure 58, Figure 59, Figure 60, and Figure 61 show that:

- 90% of beneficiaries report no GP visits in the past month;
- 57% of beneficiaries report no A&E visits, hospital visits, or social care usage in the past month;
- 22% of beneficiaries report visiting A&E, visiting the hospital, or using social care 1 time in the past month.

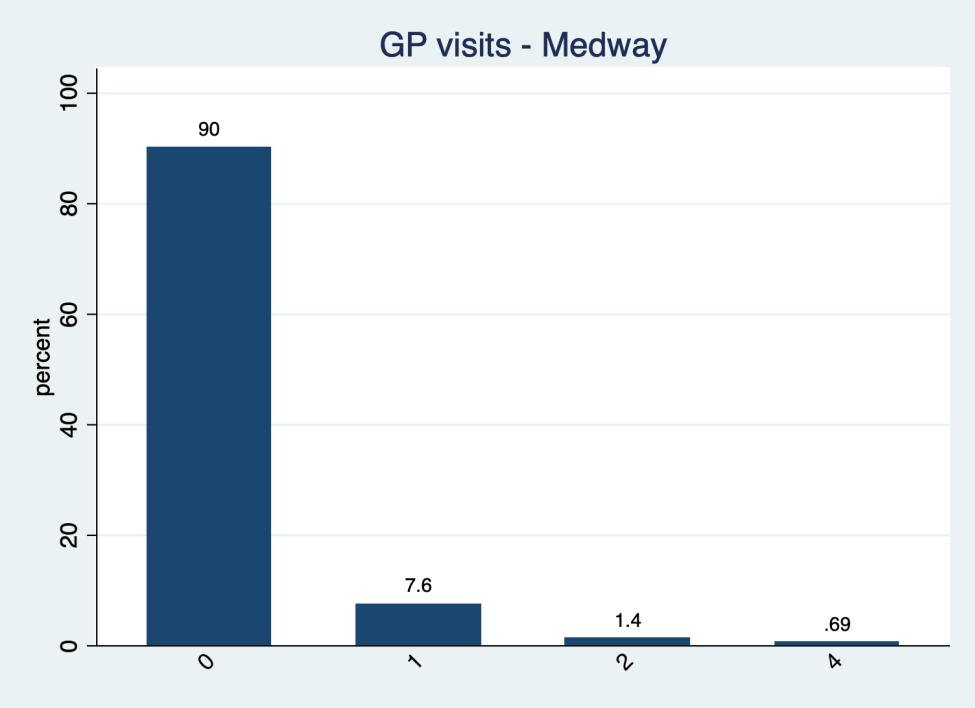


Figure 58. Medway GP visits in the past month

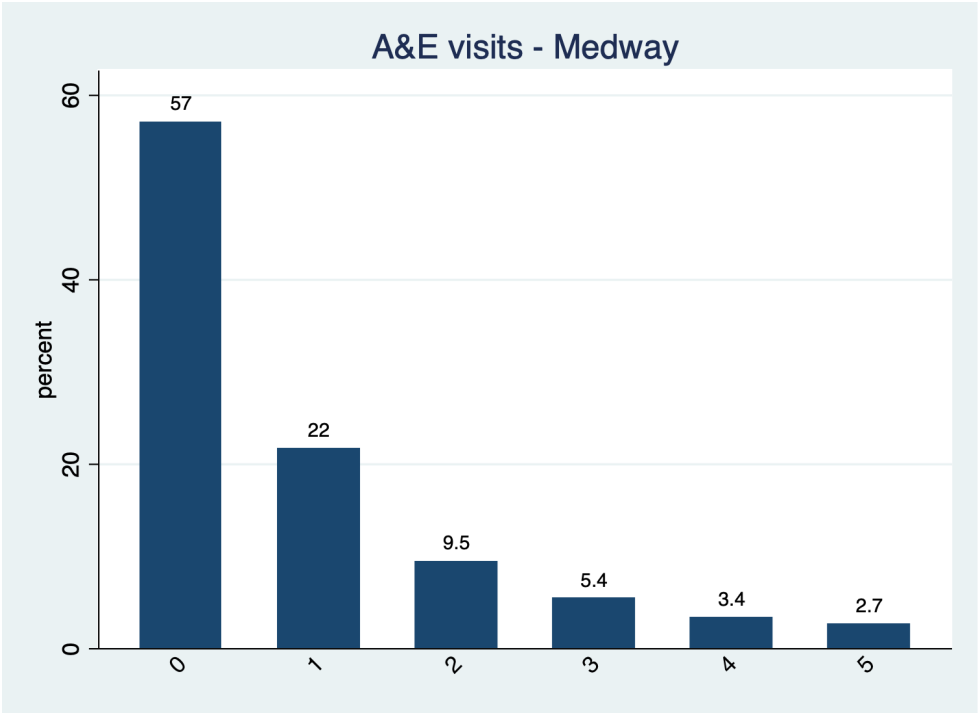


Figure 59. Medway A&E visits in the past month

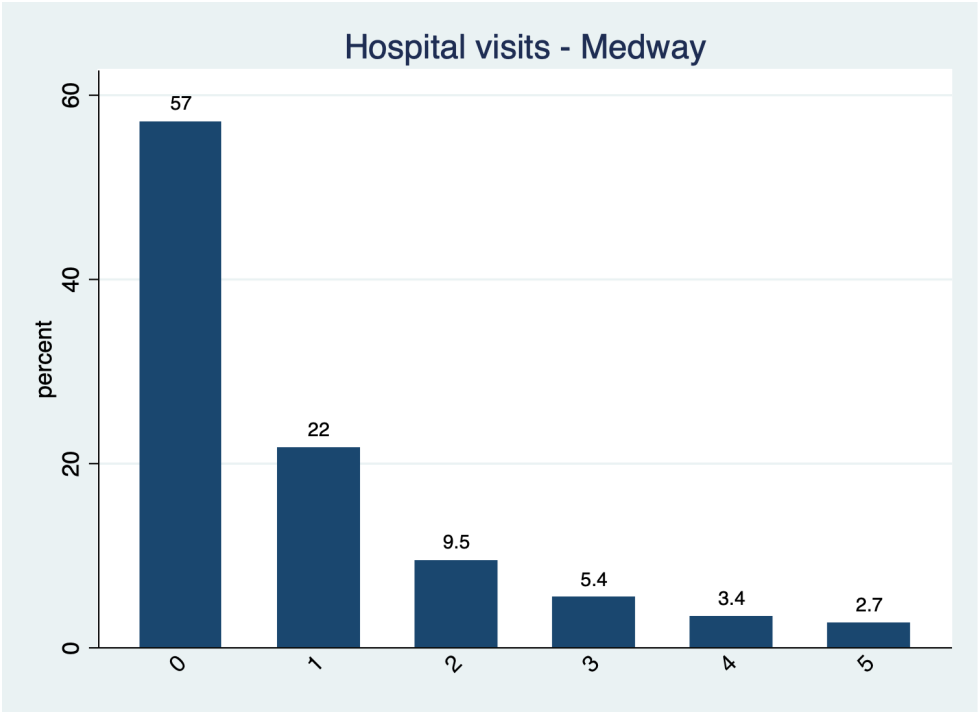


Figure 60. Medway hospital visits in the past month

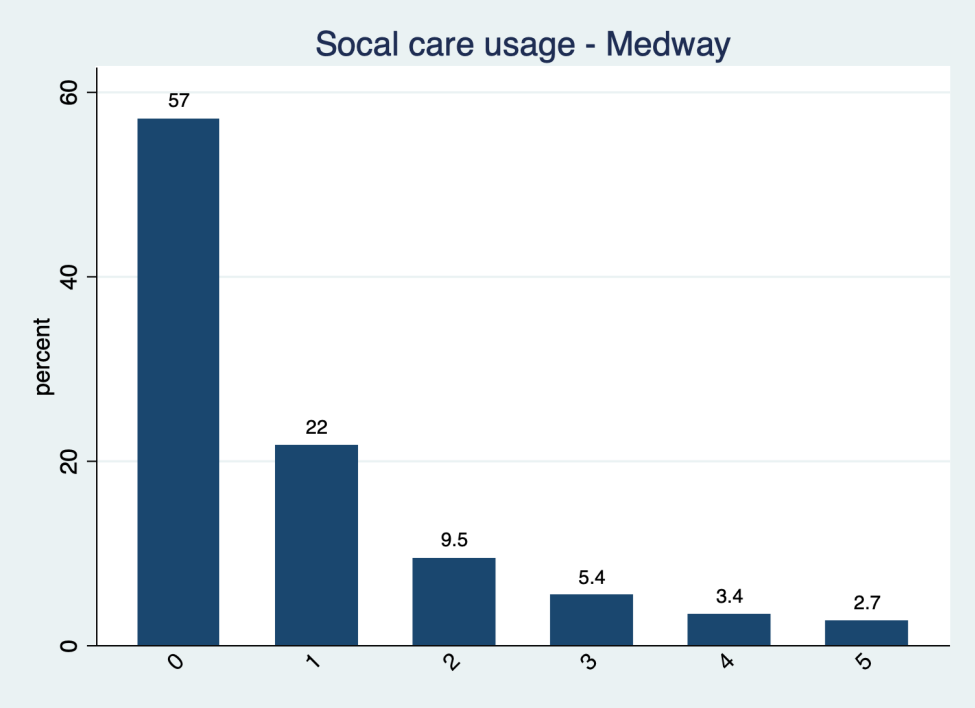


Figure 61. Social Care Usage – Medway

Suffolk County Council

Suffolk provided information for general practitioner (GP) visits for 4 individuals, 2 of which reported visiting the GP once, 1 reported visiting twice, 1 visited 3 times, and 1 visited 4 times. One Suffolk beneficiary reports visiting A&E twice. Suffolk does not report hospital visits.

Participating in other social prescribing programmes

Medway Council

Medway is the only partner that asked beneficiaries about their participation in other social prescribing programmes besides Connected Communities. When asked this question during their first and last visit:

- 58 beneficiaries reported that they are not participating in other social programmes during their first visit and 53 during their last visit (yellow line, Figure 62).
- 3 beneficiaries reported that they are participating in other social prescribing programmes once a week, with this number increasing to 5 in the last visit (grey line, Figure 62).

- 0 beneficiaries responded that they are participating in other social prescribing programmes 2-5 times a week and 4 beneficiaries saying this in their last visit. (blue line, Figure 62).

- 1 beneficiary responded less than once a month during first visit and 0 beneficiaries responded in this category at the last visit (orange line, Figure 62).

This information is useful to know for a number of reasons:

1) majority of the beneficiaries in Medway did not participate in other social prescribing programmes and as such any observed changes in their health outcomes are not due to participation in other social prescribing programmes;
2) Connected Communities programme has reached individuals that other social prescribing programmes have not reached yet.
3) 5 out of 62 individuals began engaging with other social prescribing programmes while being a part of the Connected Communities – it is possible that engagement in one programme will enable greater engagement across other programmes and community activities.

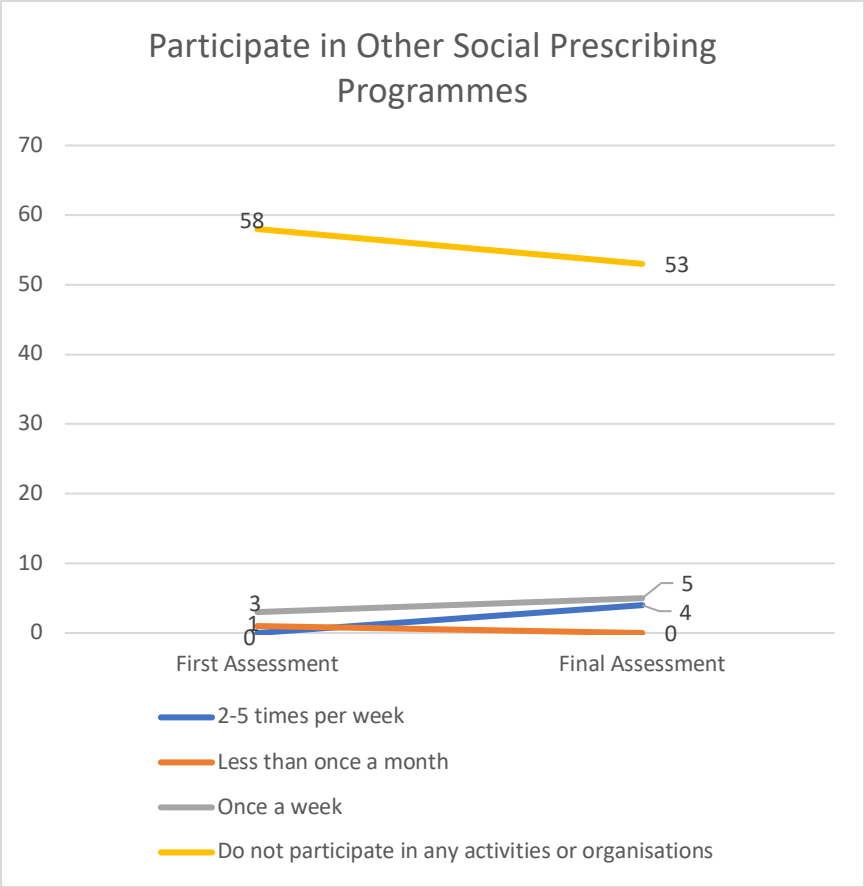


Figure 62. Are you currently participating in any other social prescribing programme or a programme of a similar nature? If yes, how often?

Follow-up

On their own initiative, Kent created additional follow-up questionnaire to assess greater detail on beneficiaries' opinion regarding the quality of service and satisfaction with the programme and beneficiaries' post-programme views on being able to maintain changes made during programme participation. Kent reports that 39.1% of beneficiaries strongly agree and 34.8% agree that they can maintain the lifestyle changes the Connectors helped them put in place (Figure 63).

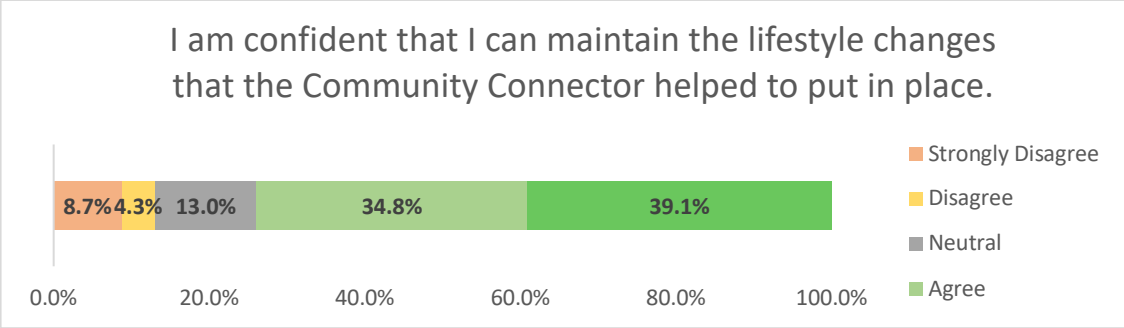


Figure 63. Kent, follow-up questionnaire - graph provided by Kent

4 Community-Level Analyses (T3.1.2 Deliverable: Community, County and National Reports - CCNR)

The small quantity of community-level data the UoE Team received at the community level prevents meaningful analyses and estimates of the impact of Connected Communities. We therefore present data below to provide a descriptive insight into the trends of care costs and the number of care requests across various short and long-term cost categories. We in no way offer these to be an assertion of Connected Communities' impacts.

A general trend that we observe across the three English partners is high costs (Medway, Kent, Suffolk) and increases in the costs of residential care (Medway, Suffolk) over the last 2-3 years. Interestingly, the number of requests for home care services is also increasing. If we imagine that an increase in the costs of residential care might lead individuals to rely on home care services more, we can see how these increases make the value and need for social prescribing even greater.

We advise local authorities to further test and explore the potential link between increases in the costs of residential care and its impact on other social care services such as home care. If the link exists, reliance on home care puts additional pressures on carers and care agencies, with more resources and staff time needed in this sector. A better understanding of the trends in social care would also enable social prescribing services to tailor their social prescribing programmes to help mitigate increases in social care usage. The impact of social prescribing on social care usage is the least explored area of social prescribing.

Basic Descriptive Statistics

Kent County Council

Kent provided community-level data aggregated across pilot and comparison areas. The information reports short-term and long-term care usage from June 2018 to December 2022. The categories of care included: direct payments, homecare, nursing long-term care, residential long-term care, and supported living. Figure 64 shows monthly costs of care across the whole of Kent. The yellow line indicates an increase in the costs of residential care, while the light blue line shows increases in

SIS/supported living. The lowest cost care category expenses are homecare, direct payments, and nursing care.

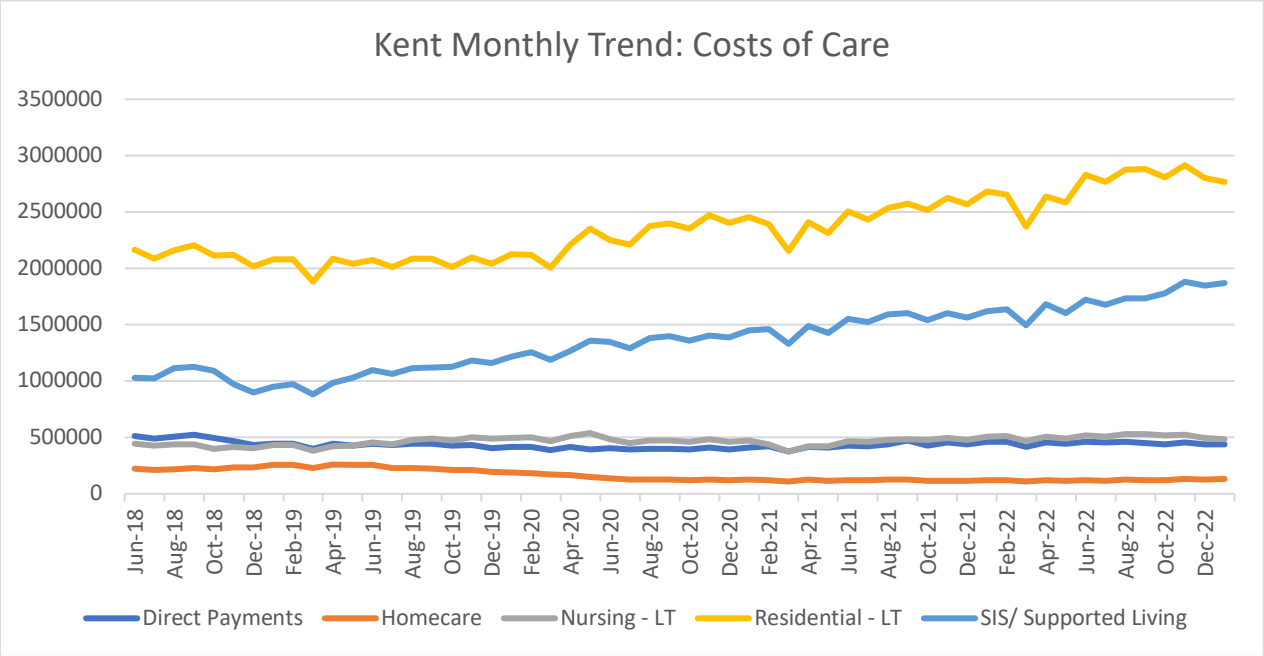


Figure 64. Kent Monthly Trend - Costs of Care

Kent shared data on the number of care requests as well, indicating "<10" when the customer number per category was less than 10 individuals. Figure 65 shows that the highest numbers of requests from June 2018 – December 2022 were received for homecare going from roughly 790 requests to 840. Despite being the most costly care option, the number of requests for residential care followed the number of the requests for home care as the second highest category (yellow line, Figure 65). The highest increase over time is for SIS/Supported Living, which moves from approximately 450 in April 2018 to 590 in December 2022. In comparison, requests for direct payments have decreased (from 450 to 320, dark blue line). The number of requests for nursing care has stayed relatively the same (grey line).

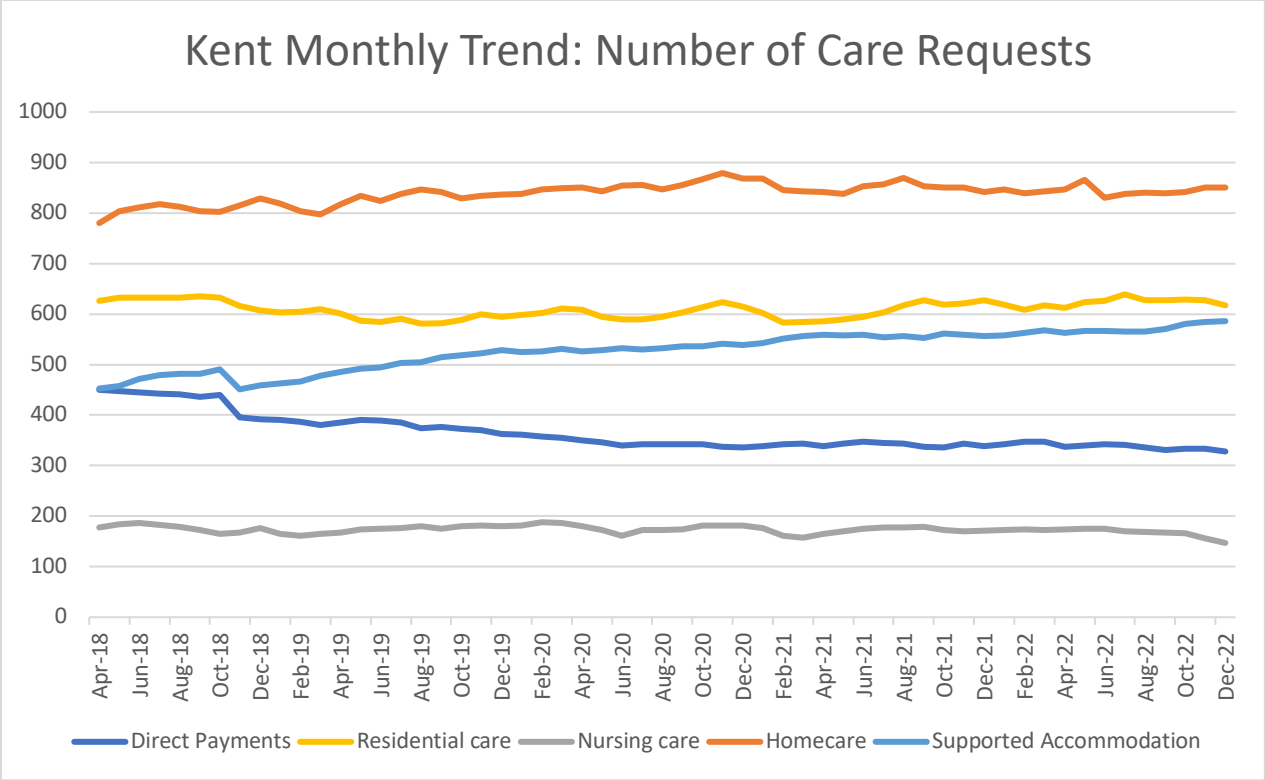


Figure 65. Kent Monthly Trend – Number of Care Requests

Increases in costs of residential care and supported accommodation and in requests for homecare, residential care and supported accommodation demonstrate a continued need for social prescribing in Kent.

The trends in the areas where Connected Communities were implemented (Pilot) in comparison to the areas where the programme was not implemented (Comp/Comparison/non-Pilot) indicate that the needs for homecare, residential and SIS/supported living as reflected in the number of care requests (Figure 66; Figure 67; Figure 68) and costs (Figure 69; Figure 70; Figure 71) are higher in Pilot when compared to non-Pilot areas throughout April 2018 – December 2022 period.

As mentioned above are unable to test the impact of Connected Communities on the number of the requests for any of the care services presented in this section given the small number of individual-level data provided for analysis. However, if we had sufficient amount of data to conduct analyses, we would first need to match or find ways to account for the differences in the characteristics of Pilot and non-Pilot areas (population size, age, income, education, resources such as other social prescribing programmes and VCSE opportunities to engage, etc). Following this, we would then be able to test the impact of changes in individual outcomes at the community-level.

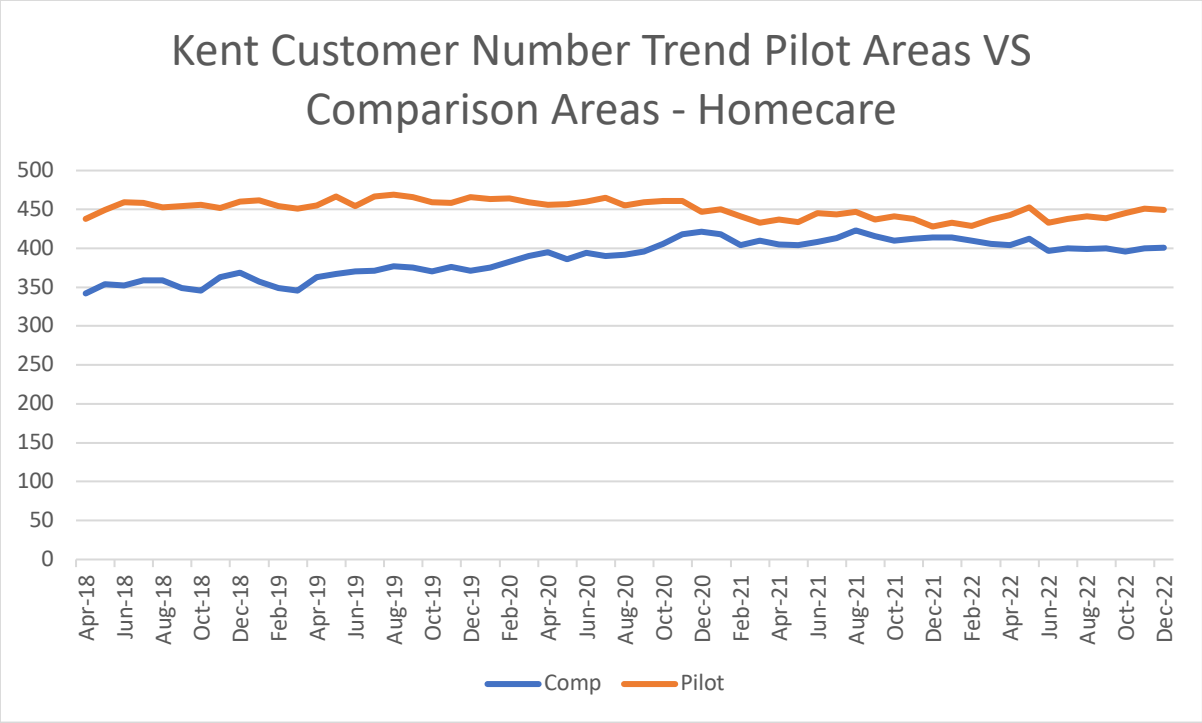


Figure 66.Kent Homecare: Comparison vs Pilot area – Number of Care Requests

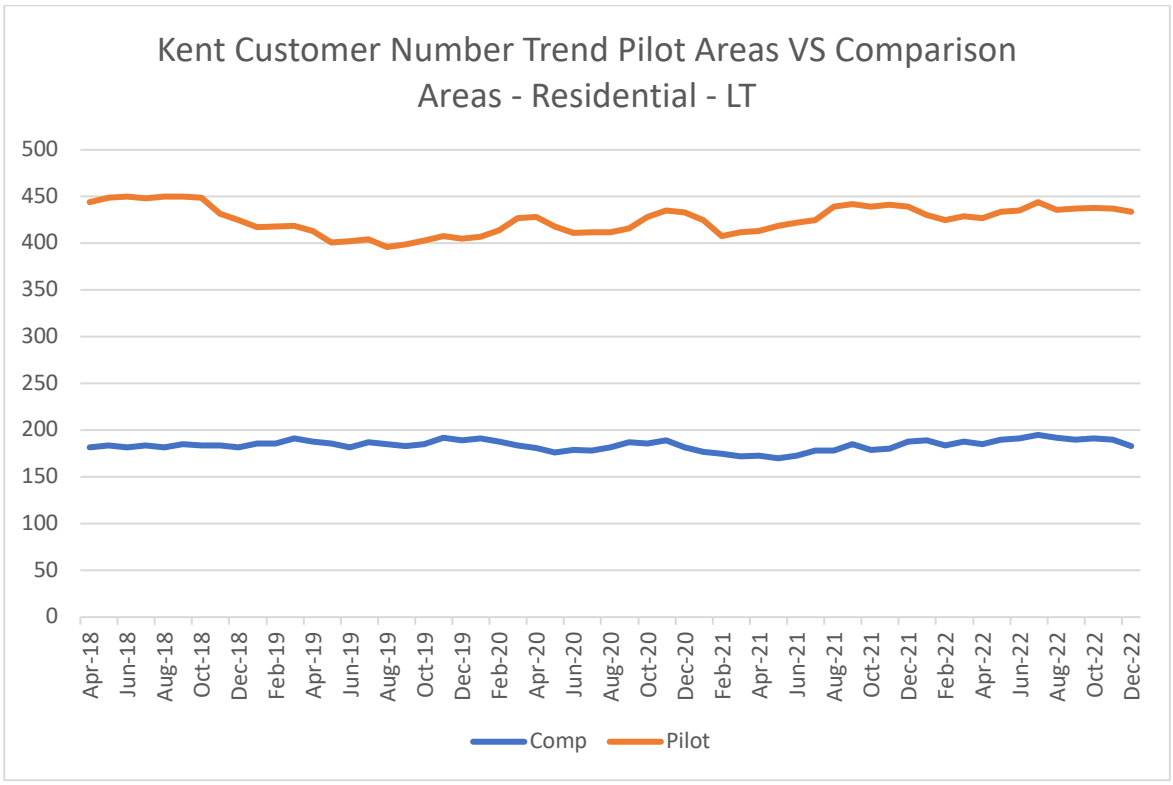


Figure 67.Kent Residential: Comparison vs Pilot area – Number of Care Requests

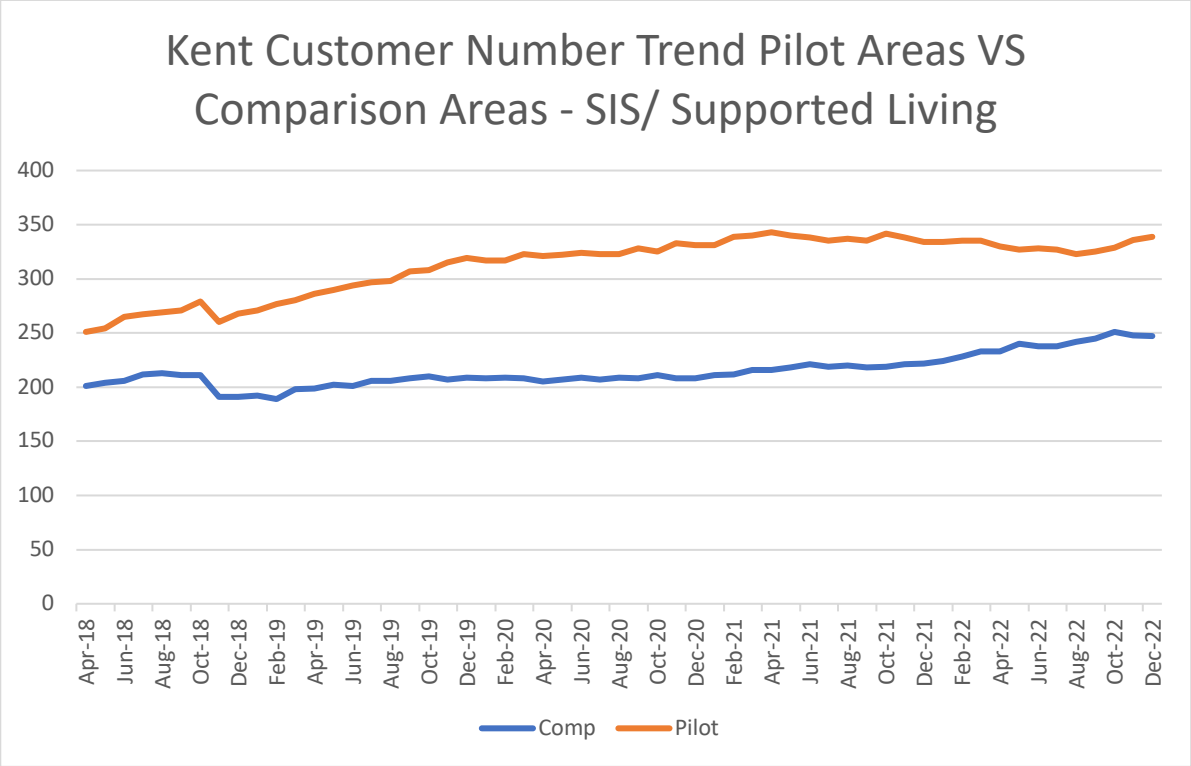


Figure 68.Kent SIS/Supported Living: Comparison vs Pilot area – Number of Care Requests

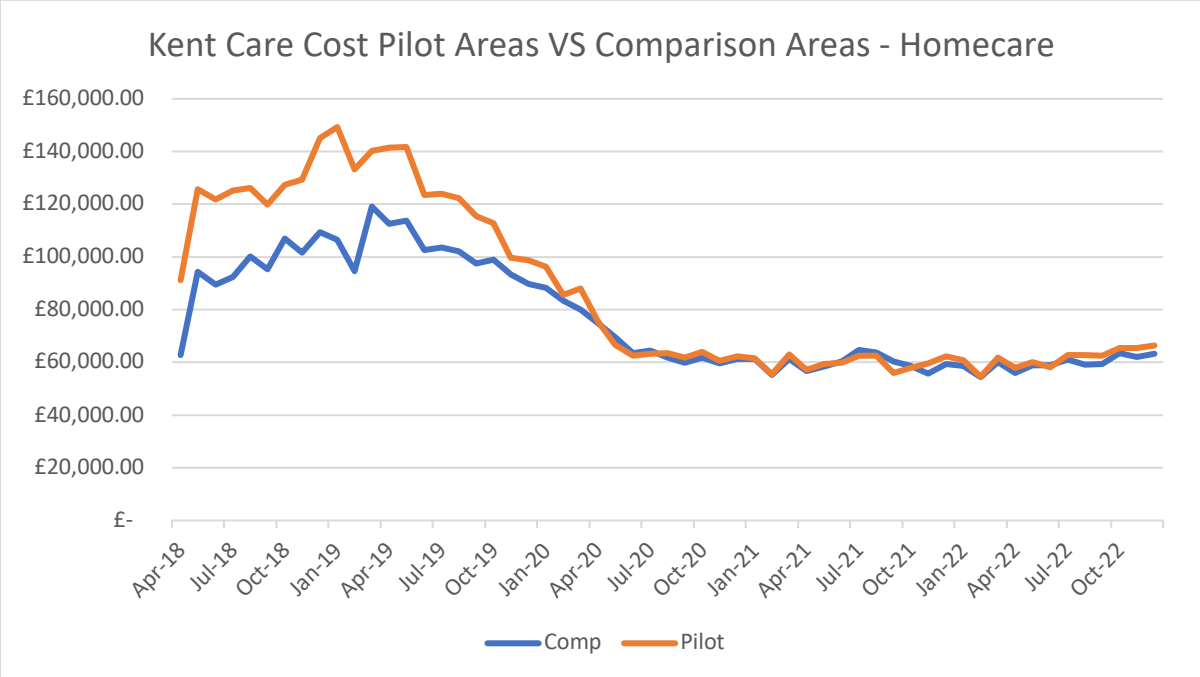


Figure 69.Kent Homecare: Comparison vs Pilot area – Cost of Care

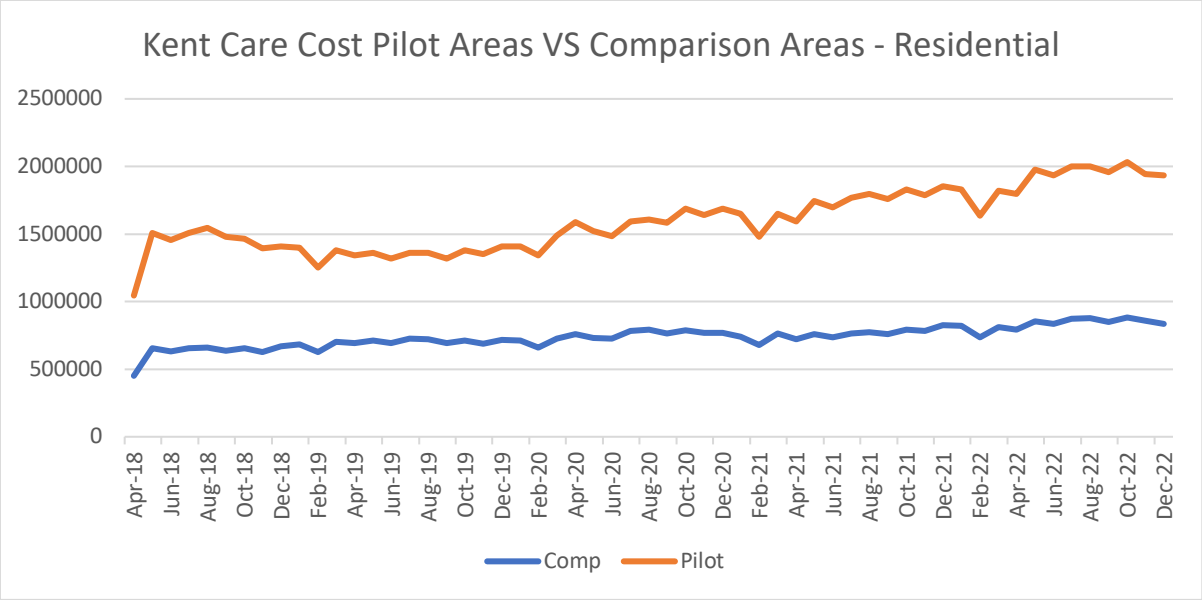


Figure 70.Kent Residential: Comparison vs Pilot area – Cost of Care

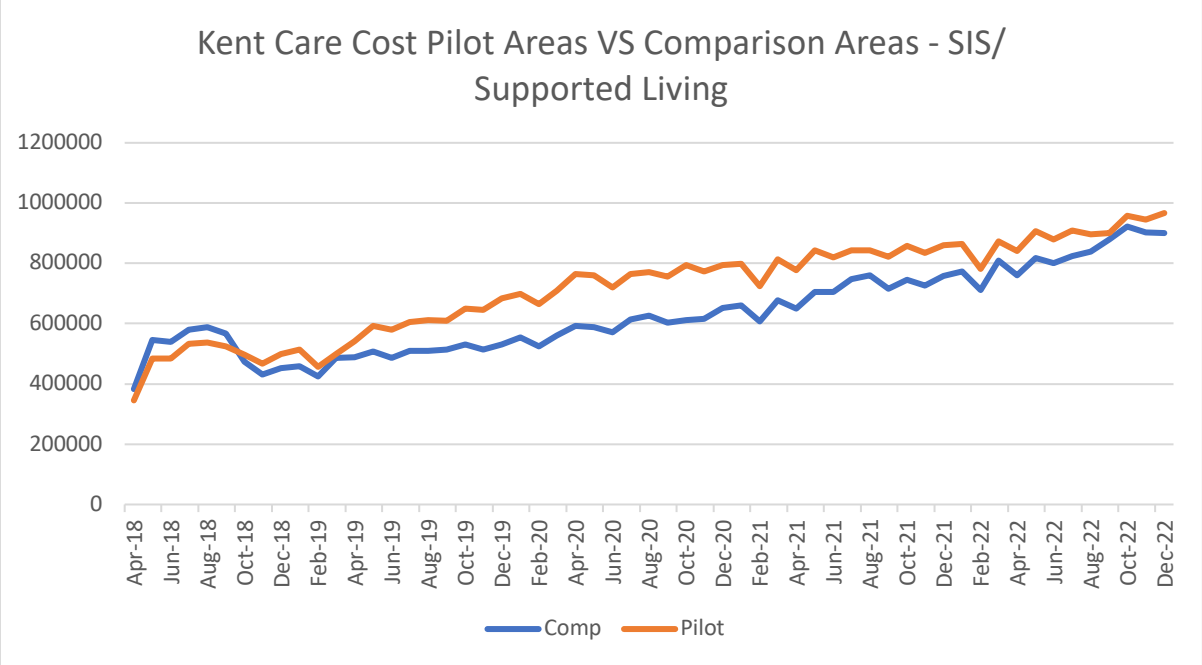


Figure 71.Kent SIS/Supported Living: Comparison vs Pilot area – Cost of Care

Eure departmental Council

L'Eure did not provide detailed community-level data, only yearly-level data on unemployment rate (2017), revenue (2017), the number of elderly people in nursing homes and expenditures (2019), and the number of people receiving APA (Allocation personnalisée d'autonomie) and expenditures for the whole territory of L'Eure (2019) as shown in Table 8.

Unemployment level (2017)	13,4% *Source : INSEE 2007, 2012 and 2017 population census, principal exploitations, geography as of 01/01/2020.*
Median income (2017)	€13.9 (average net hourly wage) €21 060 (median disposable income per consumption unit) *Sources :* *-Insee, Annual Declaration of Social Data (DADS) and Nominative Social Declarations (DSN), employees file at place of residence in geography as of 01/01/2020.* *Insee-DGFiP-Cnaf-Cnav-Ccmsa, Social and fiscal localised file (FiLoSoFi) in geography as of 01/01/2020.*
Number elderly people in nursing home (2019)	**Number of places: 4,950** **Average occupancy rate: between 96, % and 98** *Source: Department of l'Eure*
Amount spent in nursing home (2019)	*Social housing assistance: 30,608,829 euros *APA in residential care: 15,767,464 euros **TOTAL: €46,376,293** *Source: Department of l'Eure*
Number of people in receipt of the APA in residential care (**2019**)	**3,682 as of 31/12/2019** *Source: Department of l'Eure*
Amount of expenditure for the APA in residential care (**2019**)	**15 767 464 €** *Source : Department of l'Eure*
Number of people in receipt of the APA at home (**2019**)	**5 935 as of 31/12/2019** *Source : Department of l'Eure*
Amount of expenditure for the APA at home (**2019**)	**25 881 472 €** *Source : Department of l'Eure*

Table 8. L'Eure community-level infomration

Medway Council

Medway provided the data on yearly costs of care from January 2019 to March 2022 and monthly-level data on the number of customers during the January 2019 to October 2022. Similarly to Kent, the cost of residential care is higher than any other care cost in Medway (Figure 72). The next category with highest costs is “other long term care”, followed by direct payments, homecare, nursing care and supported accommodation. Figure 72 shows an increase in the yearly trend of the cost of care for

"other long term care", nursing care and supported accommodation. Interestingly, it also shows that the trends in the residential care costs follow the trends in the costs of homecare. For this and other reasons mentioned in the sections above, the relationship between the residential care and home care should be examined in more detail.

When it comes to the number of care request, the highest number of requests is for home care, with slight increases and decreases over the January 2019-September 2022 period, with current trend being on an increase. The number of care requests for residential care, direct payments, supported accommodation, nursing care and "other long term care" appears to be relatively unchanged over the January 2019-September 2022 period.

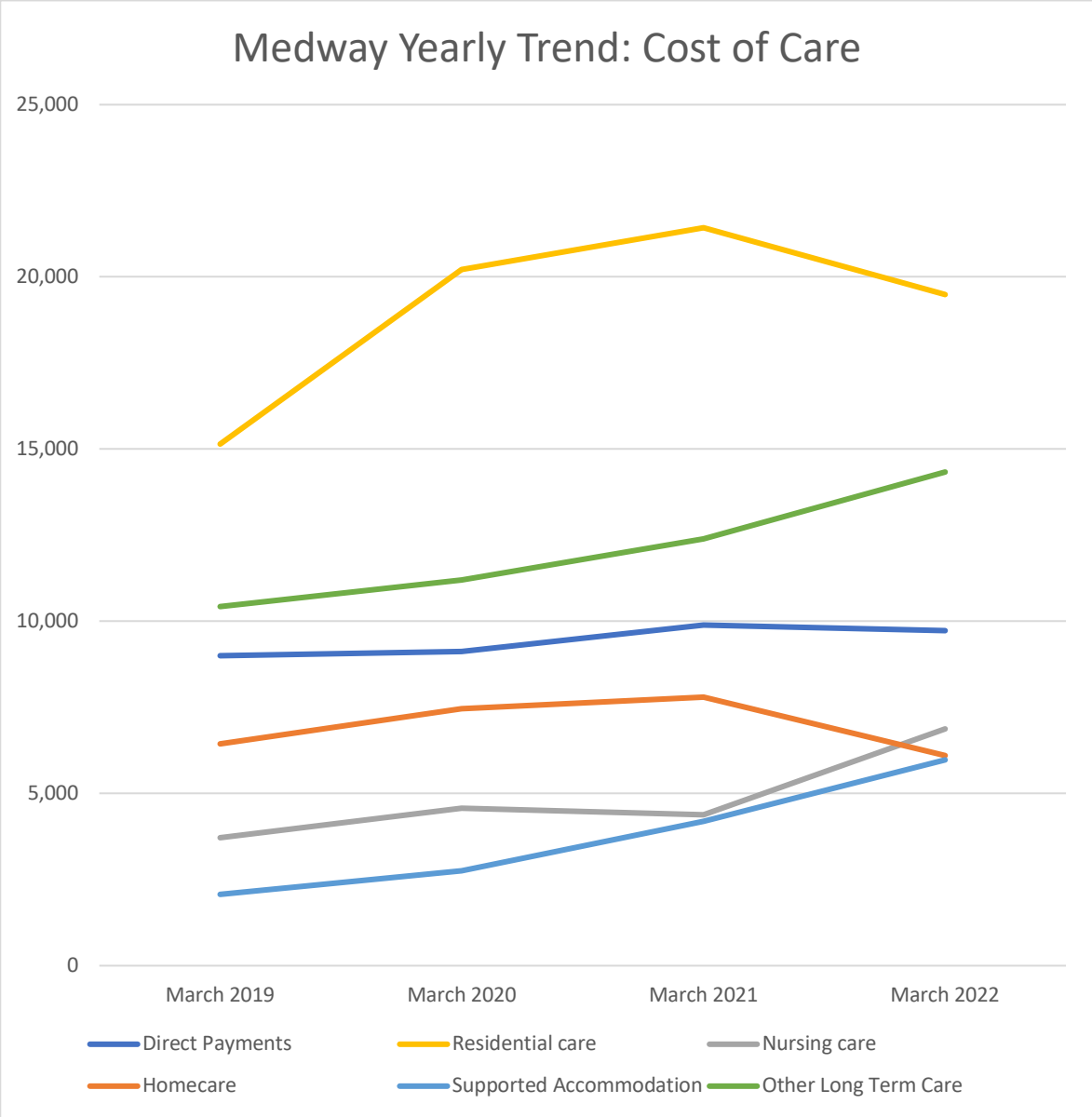


Figure 72. Medway Yearly Trend – Cost of Care

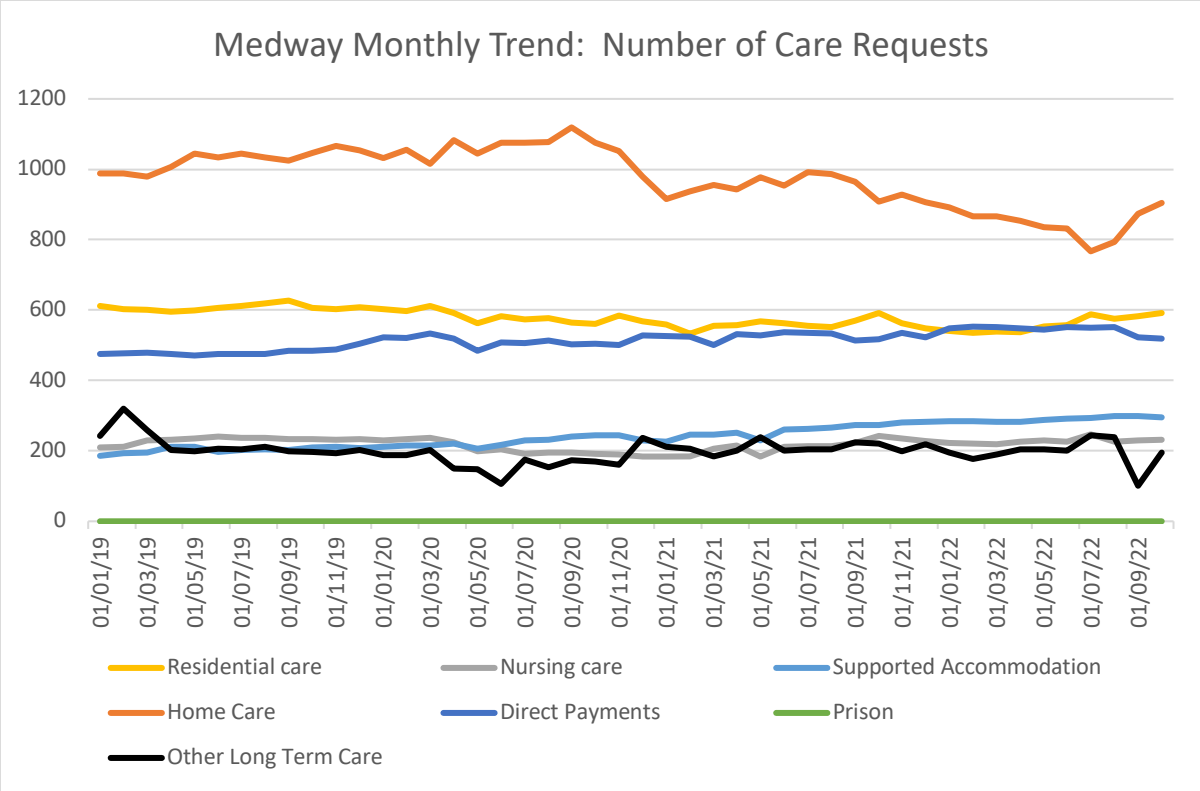


Figure 73. Medway Monthly Trend - Number of Care Requests

Suffolk County Council – East Suffolk Council

Suffolk was one of the first partners to provide detailed community-level data regarding short and long-term care usage, during the January 2019 to January 2023 period. The categories of care included: direct payments, domiciliary care, nursing care, residential care, extra care housing and respite.

In Suffolk, we observe an increase in the costs of care for residential care and domiciliary care services during the January 2019 – January 2023 period and slight increases in the costs of care for nursing care and direct payments from May 2022 until January 2023 (
Figure 74). Interestingly, the number of care requests for homecare is on the increase (Figure 75) and follows an increase in the costs of residential care trend seen in
Figure 74. This is another example where costs of residential care and the number of requests for homecare could be potentially linked and require further investigation by local authority departments and potentially new social prescribing initiatives.

In Suffolk, there is also an increase is the number of care requests for “other long term care” and slight increase in the number of residential care requests from May 2022 until January 2023. Requests for other care categories such as direct payments, supported accommodation, and nursing care remain relatively stable over the 3-year period.

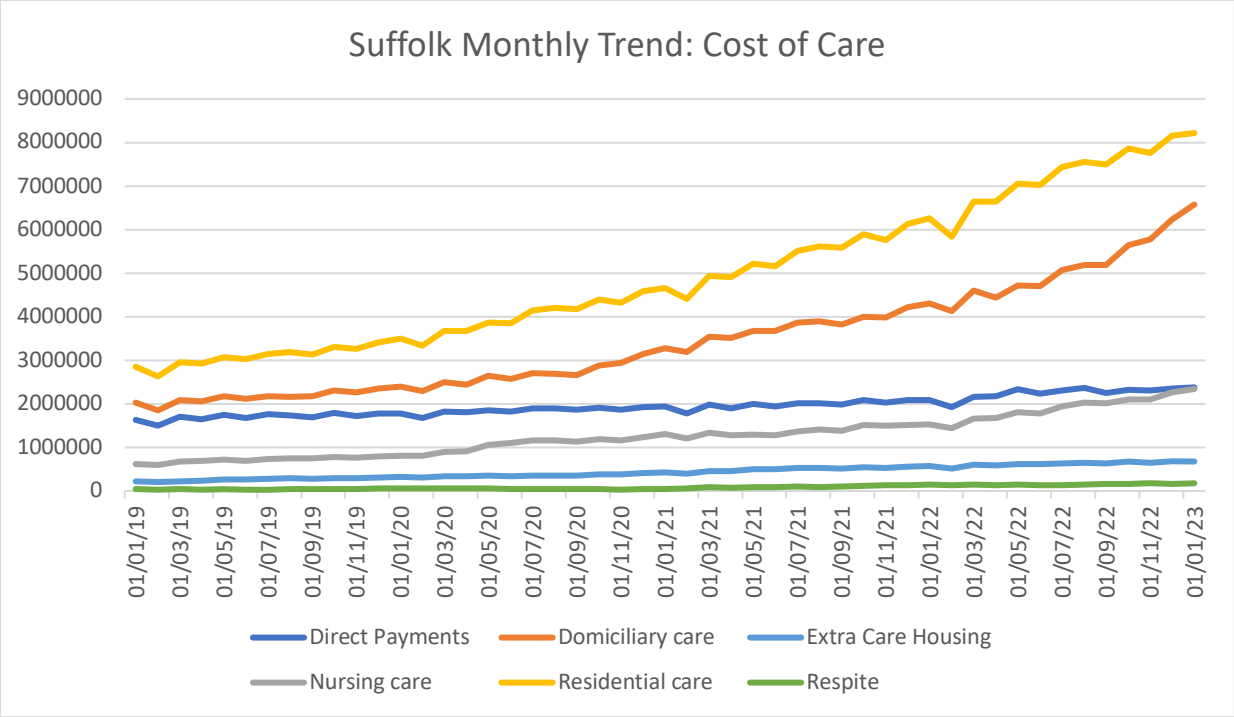


Figure 74. Suffolk Monthly Trend - Cost of Care

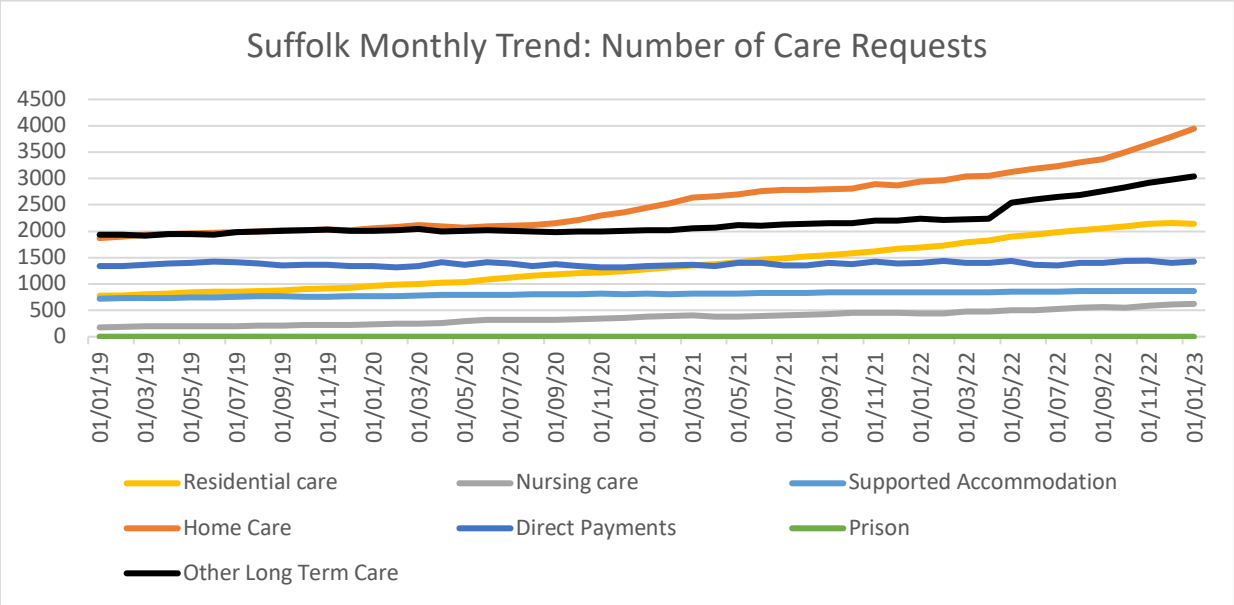


Figure 75. Suffolk Monthly Trend - Number of Care Requests

Given a very small number of the individual level-data shared by Suffolk with the UoE team (19 beneficiaries in total), impact of the changes at the individual level is unlikely to be reflected in the community-level outcomes. Figure 76 and Figure 77 are shown here to illustrate the potentials for the analyses if more individual-level data was provided. For instance, Figure 76 shows that the cost of domiciliary care in Woodbridge (Pilot area – Connected Communities implemented) and in Stowmarket (non-Pilot) area – Connected Communities not implemented) were equal in November 2020, with the cost of domiciliary care decreasing Woodbridge since then, an area where Connected Communities was implemented.

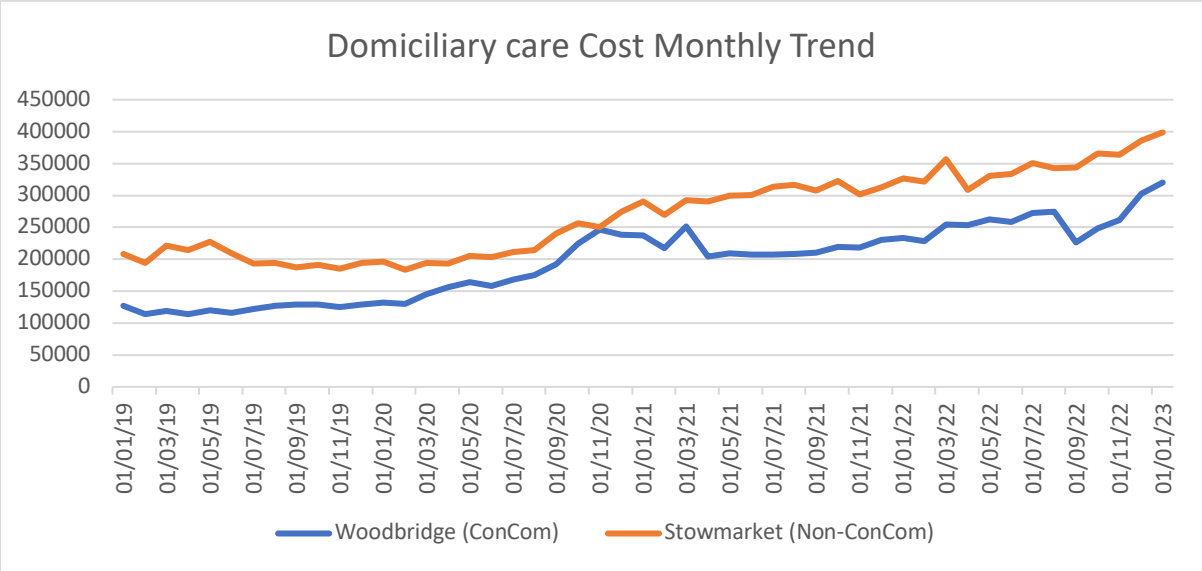


Figure 76. Woodbridge (Pilot) vs Stowmarket (non-Pilot) comparisons

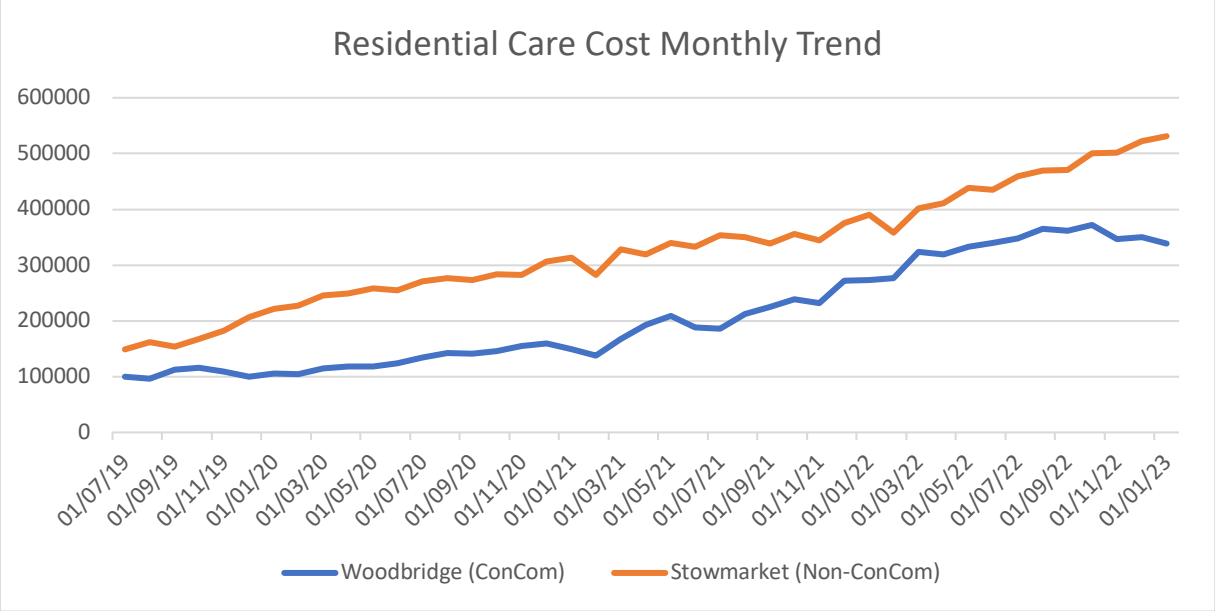


Figure 77. Woodbridge (Pilot) vs Stowmarket (non-Pilot) comparisons - Residential Care

5 Referrals made directly to other services

In cases where Connected Communities Connectors decided that an individual referred to the service did not meet the eligibility criteria or needed a type of help that the programme did not offer, referrals were made to other services that could address needs more adequately. The referral information shown in the graphs below come from the category of soft cases –people who the Connectors spent time and effort to help, even though they did not participate directly in the Connected Communities 12-week programme of social prescribing activities. These beneficiaries were helped in

finding assistance elsewhere, such as specialised care for particular health needs or legal services.

Medway has provided an exceptional level of detail regarding their soft referral pathways, including information on referral sources, reasons for referral, actions, and support that Connectors provided to 398 individuals in addition to the above individuals who undertook the 12-week Connected Communities programme. Figure 78 shows that the majority of referrals to Connected Communities were made via the COVID welfare hub (83%), followed by self referral (4%), adult social care (3%), voluntary and community services (2%), family and friends (2%), and care agencies (2%). The remaining 4% came from care navigation services (1%), housing associations (1%), primary care (1%), and unknown sources (1%).

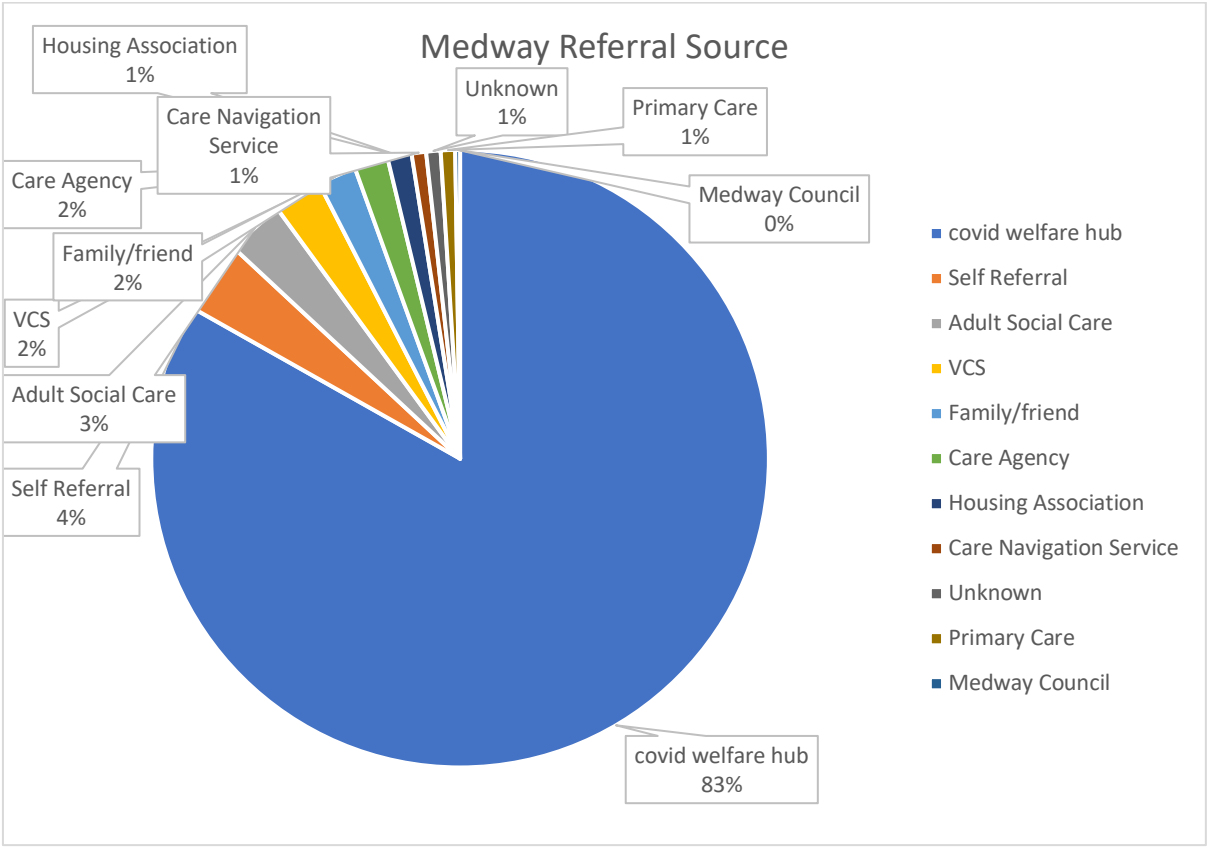


Figure 78. Medway Referral source - soft cases

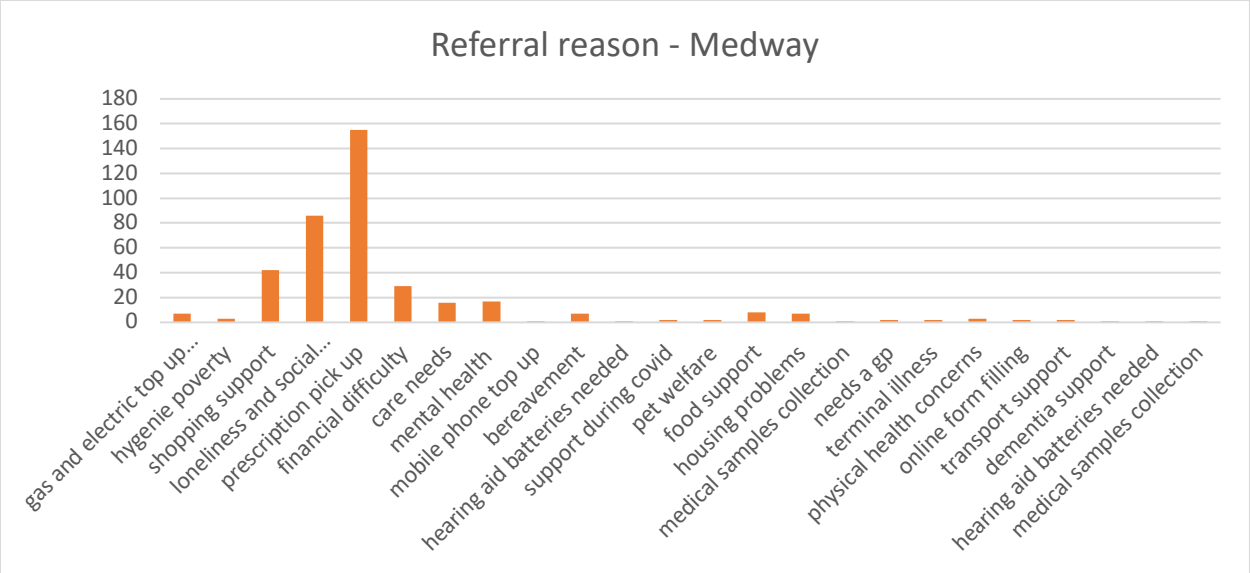


Figure 79. Primary referral reason - soft cases

Figure 79 shows that the main referral reasons were for prescription pick up (155), loneliness and social isolation (86), shopping support (42), and financial difficulties (29). Remaining reasons were mental health needs (17), care needs (16), food support (8), fuel needs (7), bereavement (7), housing (7), hygiene poverty (3), physical health concerns (3), covid-specific support (2), pet welfare (2), needing a GP (2), terminal illness (2), online form filling (2), transport support (2), mobile phone top up (1), hearing aid batteries (1), medical samples collection (1), dementia support (1). Those with requests for prescription pick up were referred to other appropriate community organisations who could help individuals with this type of need. Interestingly, the next highest category, loneliness and social isolation (86) would have been deemed an adequate referral for Connected Communities, however these individuals have other complex needs that were beyond the programme capacity to address. Some of the individuals needed mental health support, health care support, housing advice, practical support with everyday activities or expressed a need to belong to local neighbourhood groups without further participation in the programme.

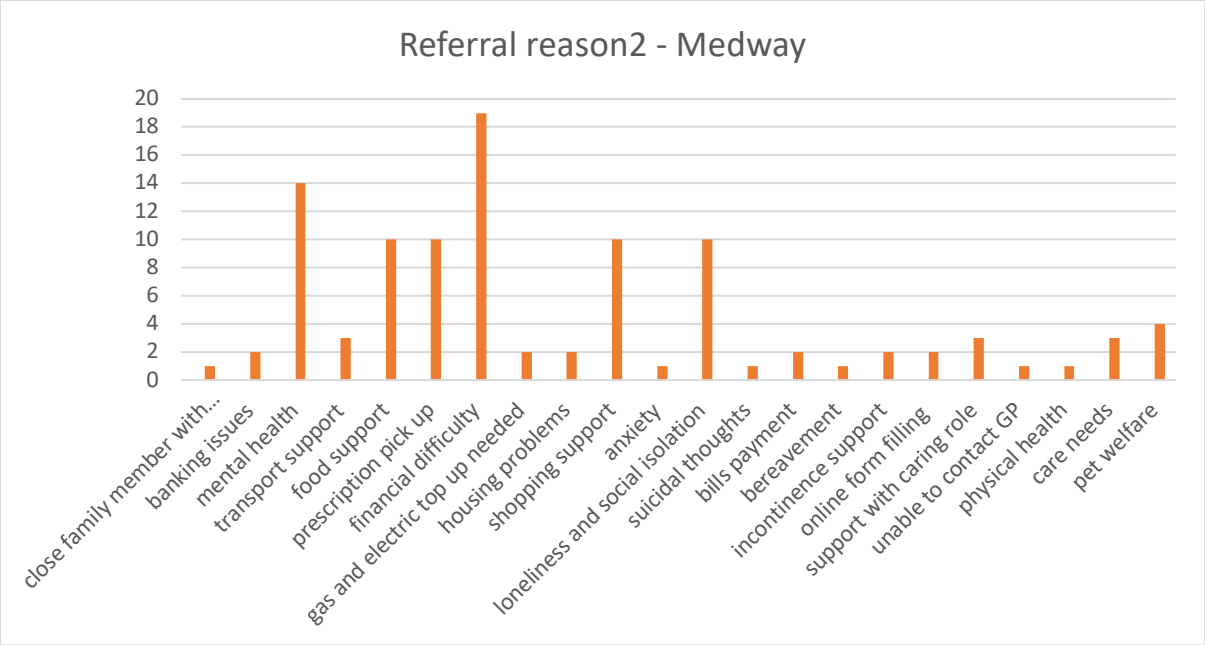


Figure 80. Secondary referral reason - soft cases

Figure 80 shows that some individuals also had secondary reasons for being referred to Connected Communities, such as financial difficulty (19), mental health concerns (14), food support (10), prescription pick up (10), shopping support (10), loneliness and social isolation (10), pet welfare reasons (4), transport support (3), support with caring role (3), care needs (3), banking issues (2), gas and electrical top up needs (2), housing problems (2), bills payment (2), incontinence support (2), online form filling (2), the terminal diagnosis of a close family member (1), anxiety (1), suicidal thoughts (1), bereavement (1), unable to contact GP (1), physical health reasons (1). Medway recorded the third reason for referral as well, however, for the purposes of the analyses here that level of detail was not included.

The myriad of the reasons illustrates a wide range of needs that exist in Medway as well as the level of inadequate referrals made to Connected Communities. These results demonstrate the need for a greater understanding about the potentials of social prescribing among the community members and organisations who refer individuals to social prescribing programmes.

Medway also provided detailed data on where they referred individuals once they deemed a referral to be inadequate for Connected Communities.

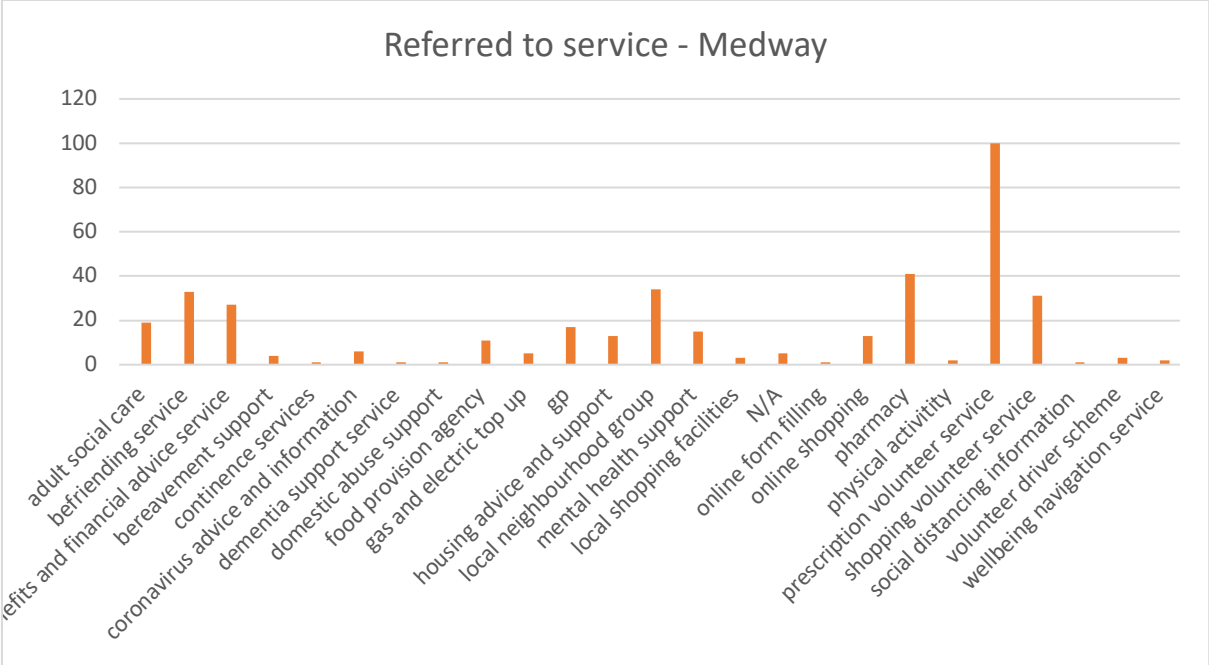


Figure 81. Medway Primary referrals to other services - soft cases

Figure 81 shows that the individuals who did not fit requirements to participate in Connected Communities were primarily referred to the following services: prescription volunteer service (100), pharmacy (41), local neighbourhood group (34), befriending service (33), shopping volunteer service (31), benefits and financial advice service (27), adult social care (19), for GP (17), mental health support (15), housing advice and support (13), online shopping (13), food provision agency (11), for coronavirus advice and information (6), gas and electric top up (5), for bereavement support (4), local shopping facilities (3), for the volunteer driver scheme (3), for physical activity (20), wellbeing navigation service (2), continence services (1), dementia support service (1), domestic abuse support (1), online form filling (1), social distancing information (1).

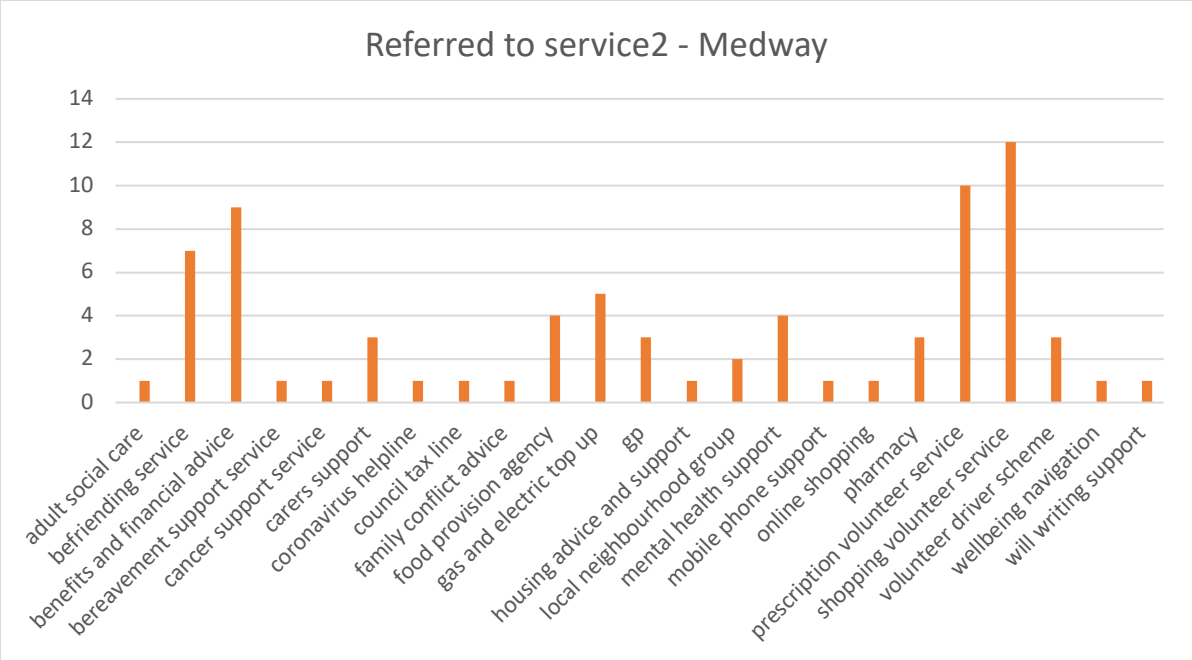


Figure 82. Medway Secondary referrals to other services - soft cases

As seen in Figure 82, individuals who did not fit requirements to participate in Connected Communities were referred to the other services besides their primary referral including the following: shopping volunteer service (12), prescription volunteer service (10), benefits and financial advice (9), befriending service (7), gas and electric top up (5), food provision agency (4), f mental health support (4), GP (3), carers support (3), pharmacy (3), volunteer driver scheme (3), for local neighbourhood group (2), adult social care (1), for bereavement support service (1), cancer support service (1), for coronavirus helpline (1), council tax line (1), for family conflict advice (1), housing advice and support (1), mobile phone support (1), online shopping (1), for wellbeing navigation (1) and for will writing support (1).

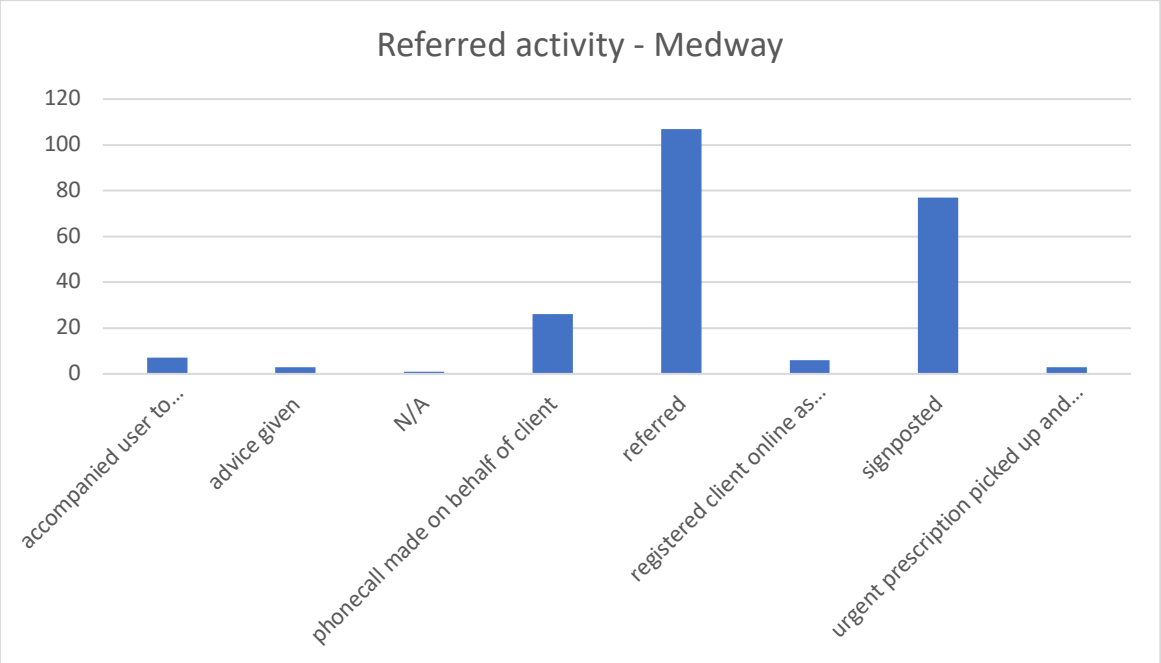


Figure 83. Medway primary engagement with soft cases

Medway also provided information on the secondary type of actions they have taken to ensure that the individuals who could not participate in Connected Communities were helped by other organisations. Figure 83 shows that these activities included: 107 referrals to other organisations, 77 signposts, 26 phone calls made on behalf of individuals, 7 cases where they accompanied individual to an activity/service, 6 cases where they registered client online as extremely vulnerable, given advice in 3 cases and 3 cases where they arranged urgent prescription pick up and drop off by member of the team.

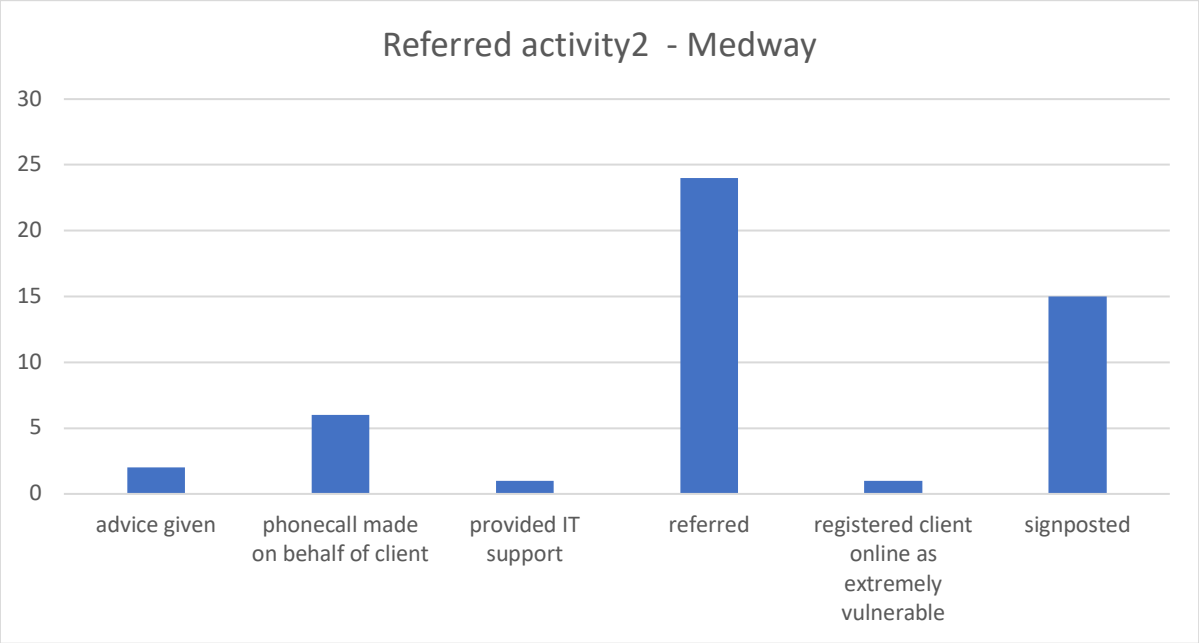


Figure 84. Medway secondary engagement with soft cases

In some cases, individuals needed further help and Medway collected information on secondary types of activities and engagement with beneficiaries that needed referrals to two or more services in addition to the primary referral to other sources. For secondary activity Medway reports engagement in (Figure 84): 24 referrals to additional services, 15 signposts to more activities, 6 additional phone calls made on behalf of individuals, advice was given in 2 cases, in 1 case IT support was provided and 1 individual was registered online as extremely vulnerable.

The data collected by Medway on the referral to other sources provides valuable information on:

- the type of referrals that their Connectors received,
- the types of the referrals and needs that could not have been adequately addressed by Connected Communities,
- insights into reasons why the referrals were inadequate and
- very importantly, the activities that the Connectors have taken to address needs of 389 individuals.

For the purpose of the Connected Communities programme and the impact evaluation we categorise these cases as soft cases to distinguish between the hard cases where

individuals engaged in 12 weeks of Connected Communities social prescribing service. However, it is important to note that the soft cases required time and attention from the Connectors.

Kent provided UoE Evaluation Team with 145 individual cases which they have received referrals for and made referral to other services.

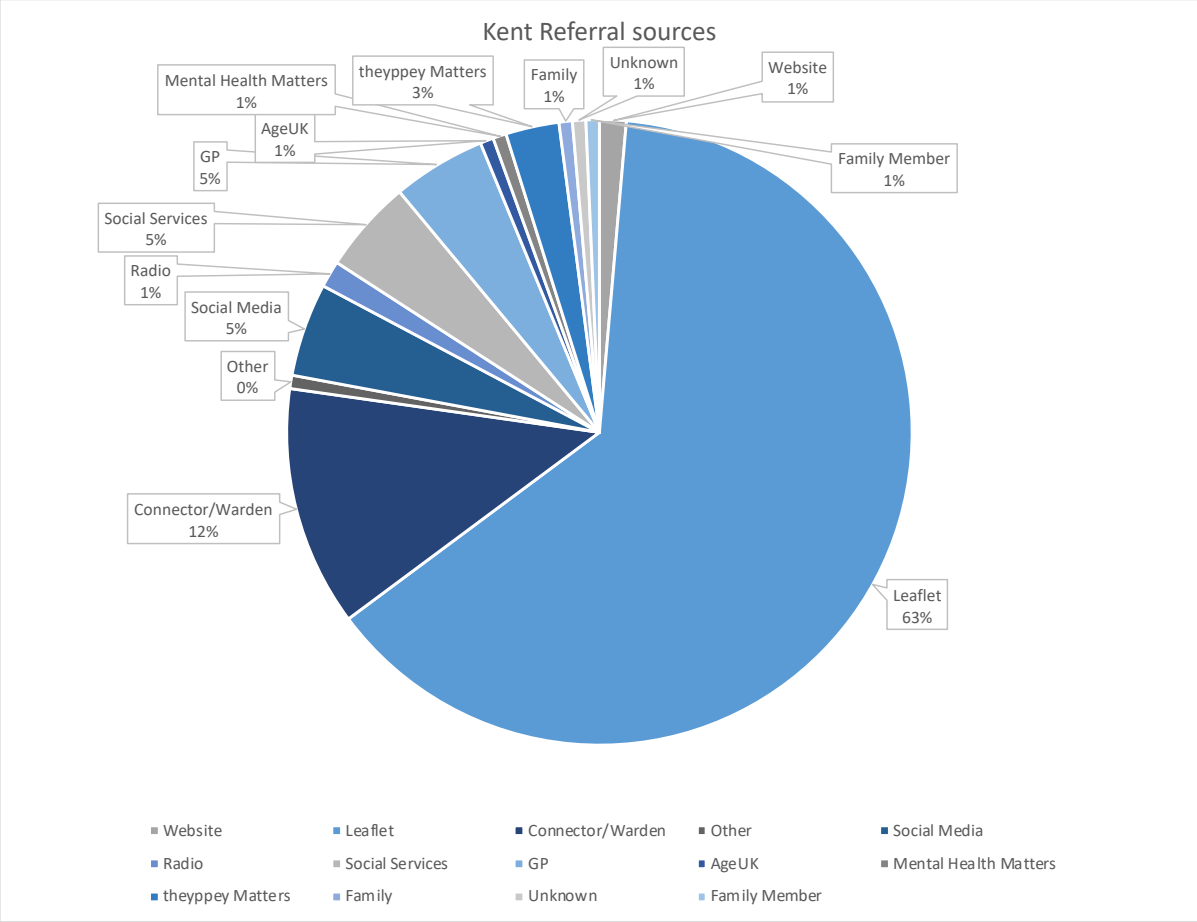


Figure 85. Kent referral source - soft cases

Figure 85 shows that in regards to the soft cases Kent received the referrals mainly through the leaflet (92), Connector/Warden (18), Social media (7), Social services (7), GP (7), Sheppey Matters programme (4), Website (2), Radio (2), through Age UK (1), through Mental Health Matters programme (1), from family (2), through an Unknown source (1) and Other (1). Kent did not provide quantitative level of information on where they referred individuals once they found them to be ineligible for Connected Communities services.

Kent did provide UoE Evaluation Team with qualitative data, notes about the "soft cases" documenting reasons for why the cases were not suitable for the Connected Communities services. The reasons range from referrals made by family members of which individuals were unaware of complex health conditions that could not have been addressed via Connected Communities services, to a lack of access to the transport to attend service appointments and other life circumstances. The most common

reasons for making referrals to other services seem to be: complexity of the case and a lack of transport.

> *"Referral submitted by daughter, individual was unaware of the referral and disinterested in continuing with the service."*
>
> *"Case too complex (Alzheimers) - referred to GP."*
>
> *"Individual unfortunately located too far from pilot area. Referred to the Warden Service."*
>
> *"Individual's husband is in hospital, they does not feel ready to proceed yet and will make contact when circumstances change."*
>
> *"Individual currently under the care of mental health team with depression and anxiety, and has many issues to resolve before we could engage with them, ranging from alleged scams to safe keeping of their house keys. Referred to more appropriate service and can take on the case in future when their situation is more stable."*
>
> *"Received a phonecall from individual known to Warden Service advising they have fallen over and need support from an agency to come and see them. Contacted their Social Worker and advised of the issues. Contacted individual back to advise when Social Worker will be with them."*
>
> *"Phoned to enquire about the Pop Up Cafe run in Swale. Individual expressed an interest to attend, but is uanble to get there due to mobility issues. Details were passed on to a Connector who will reach out and see what can be done about transport to the cafe. Service user may sign up with the service in the future."*

6 Impact of Delivery

Connected Communities delivery required multiple steps and structures to be established before the delivery could take place. One of the first steps in the delivery process was establishing the responsibilities of each partner, which was set at the grant application stage. Once grant application was approved, the partners worked on establishing communication channels and preparing for delivery and integration. Many of the steps have taken considerable efforts by each partner to lead as well as to support others in delivering desired outputs.

Project Management

Connected Communities project management was initially divided between 9 programme partners, all of which had specific roles in delivering Connected Communities services. At least three unforeseen events, all external to Connected Communities, impacted the project management and the resulting implementation.

First, the loss of French partners La Manche, Seine Maritime, and L'Oise negatively impacted project management, cross-border cooperation, and overall partnership building and partner experience. Resourcing devoted to management required greater attention and discussion to ensure that the remaining partners were informed about the resources available to manage various aspects of the programme. Several roles had to be reassigned from departing partners to remaining partners, which meant resources had to be reallocated. The funders delayed in providing official approval of the reallocations, meaning many of the funds could not be implemented (spent) by the time contracts and grant offers were updated.

In the original project design, Lead Partner Suffolk was leading general project management and monitoring, with La Manche acting as sub-lead. With this loss of La Manche, Suffolk lost leadership support, and there was no replacement of La Manche in the role of sub-lead. The partnership was left with no coverage of key management tasks when Suffolk was unable to address all issues, thereby diminishing overall partnership coordination and engagement.

The Project Steering Group (PSG) was formed with 1 representative from each partner to meet, discuss and coordinate the progress of the project at least twice a year. The PSG was to make decisions about project strategy and actions, budgets, and risks, and to be responsible for monitoring delivery. Each partner was meant to host one of the PSG meetings in person. The loss of three French partners put additional pressures on the other partners to organise and host meetings more frequently than each expected. Phone, emails and online communications platforms were relied on to communicate within the partnership. A Basecamp platform was made available, but rarely utilised.

During the PSG meetings, partners updated each other on their progress, challenges and successes with implementing Connected Communities. The focus of the last two PSG meetings was Toolkit development, which all partners participated in and provided helpful and insightful input. All partners reported that more PSG meetings and a greater involvement of Interreg representatives in these meetings would have been beneficial for the programme development and implementation.

The second unforeseen change that affected project management was an internal restructuring in Suffolk County Council. As Lead Partner, Suffolk was to appoint a project management team (PMT) to serve as the intermediary between the Project Steering Group (PSG) and the Secretariat. The PMT was comprised of Project Manager, an External Funding Officer (with a minimum of 2 years of EU claims experience) and a Communications Officer (part of the corporate communications team). Shortly after the proposal for Connected Communities was deemed successful and partners were notified that they would receive funding, Suffolk County Council reorganised its internal structure, moving the management of Connected Communities from the Corporate Services division to the Public Health division. From that point on Connected Communities project management did not stablise. At various times the project had neither a Project Manager nor a Communications Officer.

The Project Manager was required to develop a risk management plan within the first months after funding approval, to share the plan with partners, and to review with

partners regularly throughout the project, updating as needed. Although partner-level project managers did attempt to manage and mitigate risks, the partnership-level risk management plan was not widely shared or communicated by the lead partner, and the plan was not reviewed with partners regularly. This situation has resulted in a number of programme development and implementation challenges not being addressed at the partnership level.

Finally, changes in the structure and goals of the funders themselves affected how Connected Communities unfolded. Many meetings were dominated by concerns about financial claims and reporting, alongside updates regarding project modification and adaption requests. Suffolk was responsible for preparing internal financial reporting, with the support of other partners who prepared progress reports and financial claims. The payment claim processing was often delayed by belated review of the claims on the part of the funder, or with changes in how rules were applied and implemented as the project progressed. Multiple procedural deadlines were disrespected at the expense of project delivery.

Preparation and Design

Table 9. Delivery Overviewbelow lists the components of preparation and design and briefly summarises partner reflections on what worked and what didn't work, lessons learned and the evidence upon which UoE Evaluation Team based their conclusions.

	Data Collection and Sharing	Directory of Services (DOS)	Mapping and Gapping	Connector Role	Volunteer Strategy	Tools to measure outcomes of interest
Evidence of activity	2 year discussion via emails and online about the DSA. Discussion about the CRMS since the programme start.	L'Eure still in the process of developing DOS. Medway and Kent developed joint DOS platform in March 2022. Suffolk utilised the already established DOS called Suffolk Infolink.	Medway detailed gapping and mapping methodology. Suffolk, a map of the community asset mapping, without further elaborating how the approach was carried out.	Kent, Medway and L'Eure provided description of job advertisement.	Medway and Kent shared their volunteer strategy document.	2 in-person meetings and presentations by the UoE team about the selected measures. Three online meetings between UoE Team and Connectors in Kent and Suffolk. Email exchanges to discuss measure selection.
What didn't work	All partners providing the data with differing variable names and recording procedures due to a lack of partner-level oversight on developing CRMS structures.	Lack of accounting for the complex data regulations regarding data protection and management.	COVID-19 disruptions to the services and changes in service availability.	A lack of standards regarding the training and requirements of the role at the time when the programme was implemented.	A lack of strategic emphasis on engagement with the VCSE at the partnership level.	A lack of partner-level oversight to ensure that the selected questions and responses were recorded in a systematic manner. A lack of opportunities to gather feedback from Connectors about the questions being asked.
What worked	Three of the partners delivered data using an Excel spreadsheet and a codebook to structure variable names, data recording and analysis following UoE feedback on data quality.	Utilising existing platforms, community forums, social media (ex. Nextdoor app in the UK).	Continuous mapping and gapping throughout the programme duration.	Connectors and staff actively engaged with social prescribing organisations and structures that provided essential job training.	Individual partner initiatives to engage with the VCSE.	Partners agreeing to follow most of the recommendations made by the UK Office for National Statistics.
What partners would do differently	Devote more attention to both quantitative and qualitative data collection, in particular, case studies. Agree on established structure in advance and closely monitor it's implementation.	Invest more time in researching data regulation protocols in each locality.	Share more about the mapping and gapping approaches across partner locations.	Work more closely together to share experience with developing and/or attending training opportunities and overall experiences of Connectors across partner locations.	Development of a volunteer strategy which is specific to social prescribing.	More effort and time to discuss and co-design evaluation, starting with measure selection.

Lessons learned	Partner-level management and oversight required for successful cross-sectoral and cross-country cooperation.	DOS requires engagement from various aspect of local authority and VCSE organisations, all with their own specific data regulation needs and requirements. Extensive research required prior to commencing creation of DOS.	Changes in services are to be expected with following public health crises such as COVID-19 or other type of crises such as economic instability, changes in government, changes in policy priorities.	While social prescribing has been present in the UK since early 1970s, the scale and the momentum with which it has been implemented in the last 4 years demonstrate that this is an ever evolving field, with more potential changes to the profession to emerge in the near future.	Building relationships with local VCSE organisations essential to effectively delivering social prescribing and other health related initiatives in their locality.	Process evaluation essential to ensure that the programme activities are implemented as intended and result in intended outcomes.
Evaluation	No unified CRMS resulted in delays in data collection, processing and analysis.	Each partner is at different stage of DOS development, making it difficult to evaluate the degree to which the DOS systems that each utilised has supported the work of Connected Communities.	Limited information on mapping and gapping across partner locations – unable to evaluate which method was effective.	No information on how job description, recruitment approach and training impacted Connector recruitment and retention.	Unable to compare and evaluate the effectiveness of volunteer strategies and approaches which have been developed as a part of the Connected Communities programme given that only two examples were shared with UoE Team. Medway's strategy provides the most comprehensive plan linking Connected Communities services to the voluntary sector activities, while taking into account a wider context in the locality.	Feedback from the Connectors indicates that some of the selected measures were viewed as unhelpful, potentially emotionally triggering (ex. ONS4 wellbeing questions on happiness and anxiety). Input such as this at the earlier stage would have been useful to discuss the selected measures and make informed decision about their usefulness for tracking beneficiary's' progress.

Table 9. Delivery Overview (Preparation and Design)

Data Collection and Sharing

Developing mechanisms for data collection and sharing extended over the 2 year period, with mixed results in terms of breaking down barriers between the partners, generating comparable data, and therefore contributing to the evaluation of services.

Breaking down barriers to data sharing began with negotiating Data Sharing Agreements (DSAs), which took more than two years to finalise with all partners. Once the DSAs were signed, sharing of the data was mostly efficient, with some additional complications in regards to the sharing of the community-level data. Local authority departments that safeguard the community-level data on social care support and expenditure required additional time to compile the data and decide what type of data could be shared with the UoE Evaluation Team.

Data collection is an important and essential aspect of programme delivery as it provides a mechanism through which beneficiaries' progress and programme impact is captured. For the partnership, data collection included the selection of measures and digital platforms to record the data in a Client Record Management System (CRMS), which we have detailed in previous reports. All partners agreed on a data recording structure by reviewing an excel spreadsheet that the UoE Team shared in July 2020, specifying the questions to be asked and response options. However, each partner implemented the data recording structure in a different way, which only became clear once partners started sharing their first data at the start of 2022.

All these aspects of data collection and sharing were discussed in meetings and via email exchanges. Even though the partnership worked on this aspect of delivery from the start, the data recording and collection is an aspect of delivery that could have benefited from further attention and a better consensus among all the partner leads early in the project. More time with the University of Essex explaining the need for standardisation and collection and sharing, and with partners asking questions and learning how a unified approach would help inform service delivery later, could have secured the buy-in and consent necessary to collect and compare data across case studies and questionnaires.

In addition to designing the survey questionnaire and collecting quantitative data, we also find that more attention within the partnership should have been given to the methods of collecting and reporting case study evidence. Case studies provide a wealth of information to complement quantitative data analyses and gain insights from across diverse individual experiences.[18] Case studies in Connected Communities were presented as short descriptions of a particular beneficiary's experience with service delivery. The University of Essex developed a standardised template for reporting elements of a case study so they could be compared across beneficiaries and partners. It was designed to be visually appealing, respect branding and funding guidelines, and help convey findings to programme and outside stakeholders (Image 2). Unfortunately, this template was not used consistently by all partners, and many partners did not report all information for all cases, but rather selected the best parts of a case to present.

Case studies can differ from each other in terms of how information is displayed. To be considered useful and comparable in demonstrating project impact, a case study should include a description of:

- the project/issue/context in which the study was carried out and the case was recorded
- the activity / intervention which took place
- the outcomes and impact (descriptive observation and testimonials)

Formal evaluation of the case studies collected during a project implementation would then include a clear description of the methodology used to analyse case studies, why data was collected and analysed and by whom, and any positive, unexpected and/or negative outcomes.

Case study reports can include a variety of information, including activities undertaken, ways in which activities made a difference, impact statements such as testimonials, learnings that emerge from a project, and illustrative examples of people's stories and life changes. They can thereby provide in-depth investigation and important insights into the complexities Connectors and beneficiaries face every day.[18] Such information can be presented using various visual tools, including written and audio formats, and analysed using computerised tools for content analysis. Case studies are a powerful way in which stories can be communicated in a clear and compelling manner to a wide range of audiences.

The UoE Evaluation Team is unable to provide this level of analysis as not all the case study reports relied on a uniform structure to report on the above-mentioned elements.

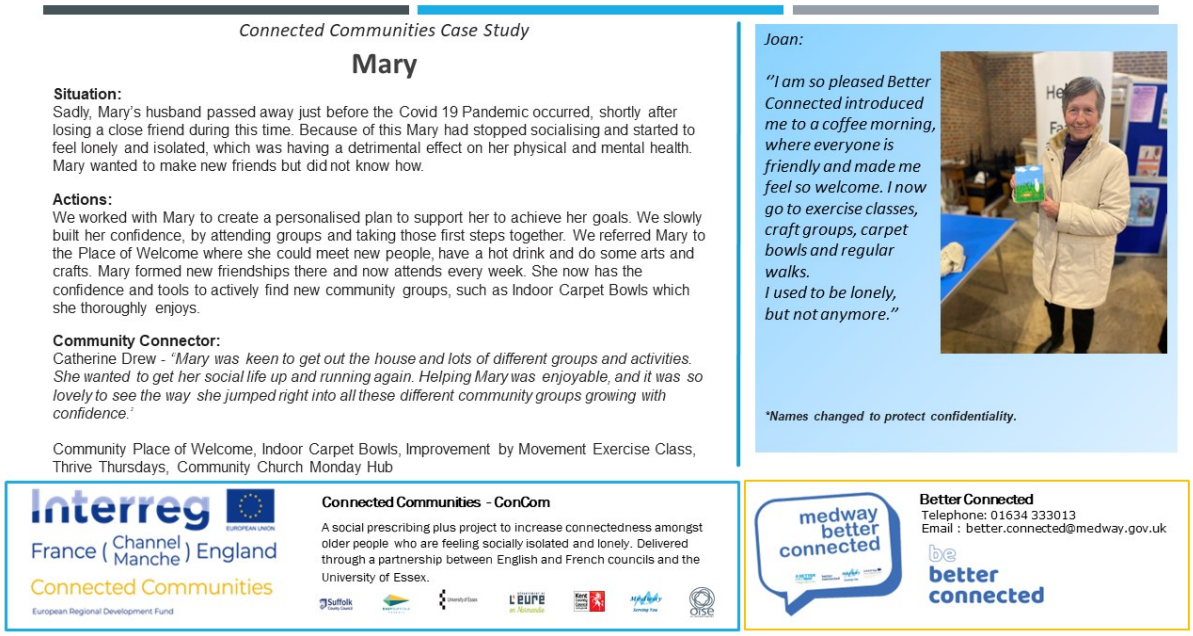


Image 2. Case Study – Medway

Directory of Services

Establishing a Directory of Services (DOS) for each partner area required a detailed examination by each partner of what already exists in their locality, as well as the extent to which any existing DOS could be utilised to support the work of Connected Communities. Suffolk utilised the already established DOS called Suffolk Infolink.[20] Medway and Kent worked together to develop a joint DOS platform since 2019 and launched it in March 2022.[19] The joint platform created a list of existing services and organisations in Medway and Kent in one place. In L'Eure, there was no existing platform to support the work of the Connectors in the area. L'Eure continues to explore the possibilities of building a platform where neighbours and organisations could register their services to support community members in need as well as to facilitate greater connection in their local community.

Given that each partner is at different stage of DOS development, it is difficult to evaluate the degree to which the DOS systems that each partner utilised has supported the work of Connected Communities. These differences stem from the time needed to explore already existing services and the possibilities of adapting those for the purposes of the Connected Communities DOS, as well as the scarcity of software companies[21] offering suitable platforms to map and access community assets.

Mapping and Gapping

Engaging in Mapping and Gapping of the needs and resources in each locality was carried out several times during the programme duration as the needs of individuals and availability of services changed over time. Two partners provided us with the information on the methodology used for mapping and gapping purposes.

Medway approached mapping and gapping methodology development through the following steps: defining community asset mapping, providing reasons for why assets should be mapped, developing clear examples on how to map a locality, providing instructions on how to map a provision around a particular demographic, examining the potentials of their approach to build relationships, and creating networks in a community. Suffolk used the Abram Approach,[22] drawn from a blog post, which offers a basic overview of the mapping and gapping in communities and an image of what a community asset map looks like.

Given limited information on mapping and gapping across partner locations it is not possible to evaluate the relative effectiveness of the methods used, though we do offer a fuller description of these methods in the Toolkit.

Connector Role

Community Connectors, the professionals employed to deliver Connected Communities social prescribing programme, were required to be knowledgeable about the local community, to be trusted members of that community, and to be skilled to co-produce a personalised and care plan for a beneficiary. Each partner developed a job specification for their Connectors that was tailored to the needs of their organisation.

The Kent job advertisement for this post included description of the job purpose, main duties and responsibilities, qualifications, experiences, skills and abilities, knowledge and behaviours. The Medway job advertisement included information on job context, qualifications, emotional and physical demands, financial responsibilities, desired and essential experiences and personal qualities. L'Eure specified that they were looking for Connectors able to engage in mapping and gapping of activities, develop action plans with beneficiaries, work as a part of the team, and motivate volunteers and others to join action to deliver and/or receive social prescribing.

Partners specified the importance of working collaboratively with individuals and organisations in communities, build relationships and support individuals from diverse backgrounds to engage in social prescribing. Interestingly, Kent emphasised knowledge of social care sector, while Medway highlighted the importance of working in public health sector, reflecting the values of their local authority departments which were involved in managing and delivering Connected Communities in each locality.

Partners noted that more was needed to enable learning across partner locations about developing the role of the Connector as well as providing learning opportunities for all Connectors across partner locations to share their experience with each other. Please see the Connected Communities Toolkit for more information.

Volunteer Strategy

Before the onset of COVID-19, partners agreed to produce a Volunteer Strategy as a guiding document to recruit volunteers in delivering Connected Communities as well as to define their approaches to engaging with the voluntary, community and social enterprise sector (VCSE). Once COVID-19 spread to pandemic levels the volunteer engagement in delivering Connected Communities services became nearly non-existent, with many individuals either shielding during prolonged periods of social isolation or being re-deployed to address urgent care needs. Partners instead focused their attention and strategy on building relationships with their local VCSE organisations to spread the word about the Connected Communities service, learn about other services in their communities, and collaborate to effectively deliver social prescribing and other health related initiatives in their locality.

Medway and Suffolk shared their volunteer strategy documents with the UoE Team. Medway's strategy is carefully crafted and potentially impactful given that it focuses on channels to deliver the Better Connected (Connected Communities) programme and provides a general understanding of a wider context in which social prescribing, VCSE and public health operate in their locality. Medway's strategy provides examples of how training, funding and outreach intersect to co-produce sustainable solutions for their local community. In contrast, Suffolk's strategy is more of a general overview of the benefits of volunteering across Suffolk, without any mention of the Connected Communities programme and how it fits within wider context in the region.

Given the limited examples of volunteer strategy approaches, we are unable to compare and evaluate the effectiveness of volunteer strategies and approaches. Please see the Connected Communities Toolkit for more information.

Tools to measure outcomes of interest: loneliness, social isolation and wellbeing

Preparation and design also included developing and identifying tools to measure outcomes of interest such as loneliness, social isolation and wellbeing. UoE Evaluation Team proposed to the partners to adopt measures of loneliness and wellbeing being recommended by the UK Government and Office for the National Statistics.[13,16] The partners accepted the recommendation for the measure of wellbeing (please see above and Toolkit for further explanation of other measures). Kent noted during one of the follow-up discussions in February 2023 that the two wellbeing questions that ask about feelings of happiness and anxiety could be emotionally triggering, and that some of the beneficiaries found them distressing. Continual sharing of these types of findings throughout project delivery was not possible due to the disjointed nature of project management, and would have been useful in informing decisions about the evaluation.

In addition to the above-mentioned individual-level outcomes of interest, UoE Team proposed measures to evaluate the impact of Connected Communities at the system and community-level outcomes. Several studies and reports have identified that individuals who are lonely are more likely to utilise General Practitioner (GP) services, putting pressure on the already overtaxed health care system.[25,26] The evaluation aim was to investigate whether individual experience with loneliness is related to usage of health and social care services. Given that only one partner has provided us with the usage of health and social care services pre and post-participation in Connected Communities programme, our analyses are limited in this aspect.

Partners agreed that more effort and time was needed to discuss and co-design the evaluation, starting with measurement selection. Furthermore, partners also believe that a greater emphasis and engagement of all partners in process evaluation – assessing programme activities to ensure that that each is implemented as intended – would have led to a more positive partnership experience as well as more effective measurement selection and subsequent data analysis and evaluation.

Communication

Connected Communities utilised a variety of communications tools and approaches. Communications involved developing project branding and recognition, service promotion and marketing, within project communication, and communication with external stakeholders (see Table 10 Communications Overview). Table 10 gives an overview of Communications activities and partner reflections on these. We offer these items in table form to highlight how many activities were undertaken, and the value of the reflections we were able to gather. We also include it to point out that more time spent reflecting on outcomes and delivery would have likely yielded insights in several of the categories that are currently blank.

Branding was developed following Interreg and partner guidelines and requirements. Partners sought to liaise with each other to ensure that the logos, format and colour scheme were consistent across partners, although additional branding and communications took place internally and were unique to each partner. For example, Medway held focus groups to gain feedback on service name and visual identity. Medway called Connected Communities *Better Connected* Medway as that name was

viewed as more appealing to the target audience and was a better fit for future work – a possible continuation of the service beyond the duration of the Connected Communities. Similarly, Kent named their service *Positive Wellbeing* after a consultation with the Connectors and their stakeholders. Suffolk used the name *Connected Communities* on their promotional materials, and also developed specific branding and name for the vehicle they used to travel to isolated and hard to reach areas of the county – Vincent Van Go.

Traditional media engagement also contributed to communications and outreach. Partners reached out to their local communities and promoted the service on a wider scale by utilising radio commercials, videos, community events, conferences, press releases, websites, and newsletters. L'Eure produced advertisements in their local newspapers, promoting Connected Communities service as well as providing information about the importance of social health and impact of loneliness and isolation on one's health and wellbeing. Kent and Medway, who tracked their referral pathways in a systematic manner, report that leaflets were one of the most common marketing tools through which referrals were made to their programme (Figure 1; Figure 3). Another important source were VCSE organisations, social care services and already existing services such as Community Wardens in Kent.

All partners developed a strong *online presence* and a following across various social media platforms, posting regularly and engaging with relevant social prescribing bodies, research institutions, and public health and government departments in the UK and worldwide. For instance, based on the Kent's Social Media and Communications Activity Report 01 June 2022 to 31 December 2022 and Kent team members' input, Kent ran several highly focused and targeted multi-channel marketing campaigns in the pilot areas.[27] Kent was able to develop extensive communications channels, engage in numerous activities and track their communications impact because they planned and budgeted for a Social and Digital Media Assistant (SDMA) to assist with the delivery of the project and to manage reporting. Kent also had a dedicated Communications Lead throughout the programme duration. A summary of some of Kent's activities and outputs is provided in the paragraphs below:

> Twelve paid social media campaigns were run targeting family members, neighbours, local businesses, charities and community organisations as well as potential service users in area.
>
> Eight videos of service users telling their own stories of loneliness and social isolation and how the service had helped them were successful in creating awareness. Kent reports that their user analytic systems registered approximately 540,000 views. Three email campaigns were targeted directly to stakeholders, linking to the videos to further tell the service story. Local radio ads, local news editorial and leaflet distribution ensured that information was received by those who were digitally isolated.
>
> Kent's team was also able to utilise Kent County Council's existing social media platforms such as the Public Protection social media channels (Facebook, Nextdoor and Twitter) to organically promote and raise awareness of the Connected Communities project. Kent County Council boasts over 12,000 followers on Facebook and 2,588 on Twitter with access to over 300,000 Kent residents on Nextdoor with the ability to target organically on a ward-by-ward basis. These channels were used to tell good news stories and invite local communities to Connector events.
>
> Kent felt that keeping an integrated awareness campaign running throughout the project was key to building trust and understanding of this new service. Kent reports that the campaigns had a reach of 2.45 million views or listens or reads, meaning that on average, each of the 175,000 people in the pilot areas had access to the information approximately 14 times.

All partners report high levels of engagement across their social media platforms and relatively large numbers of followers considering the programme duration. However, while the partners developed their own social media presence, they did not collaborate closely in this regard. Partners did not announce to the partnership the launch of social media accounts or campaigns, and rarely tagged each other in social media posts. This reduced their outreach and the potential to promote Connected Communities on a wider scale. Despite having one partner, UoE, in charge of partnership-level social media, it was not possible to generate new posts at the partnership level without input and information from partners' separate accounts. A joint social media communications strategy would have been helpful and perhaps generated better coordination.

Events included attendance in person and online at various local VCSE engagement opportunities, local authority events, academic conferences, trainings and workshops. UoE Team attended and organised a number of events such as those held as part of the annual UK Festival of Social Sciences (FOSS), where Connected Communities partners and community members were invited from across the partner locations. The team also attended several academic conferences and events where they presented the Connected Communities framework and findings to academics and practitioners across the UK and globally. UoE presented their academic work on loneliness, social isolation and wellbeing, social prescribing and its impact, and the importance of community engagement.

The team was invited to partner with the Social Prescribing Network to co-host the 4th International Social Prescribing Conference in March 2022, which was attended by more than 1000 individuals, researchers in the field of social prescribing, local authority and national government representatives, members of the community and voluntary sector organisations from around the world. The team presented a session on evaluating social prescribing programme impact, and a session on social prescribing offers in the East of England.

The team was also invited to present at the Befriending Networks Annual Conference on 8th of November 2022. The presentation topic focused on Connected Communities and the team's work on advancing conceptual and methodological approaches to social connectedness. The session was attended by 50 representatives from the VCSE, academia and local authority sector. The feedback that the team received demonstrate the quality of the work that was presented and developed over the years:

- *100% of attendees voted that your segment was well spoken and informative.*
- *The University of Essex presentation was excellent and exactly the kind of research and information I was hoping to get.*

Partners engaged extensively with their local communities by attending and/or organising community activities and by providing micro-grants to local VCSE groups. Medway offered free training opportunities, reciprocated meeting attendance, and added contact information to their and others' newsletter distribution lists.

	Branding	Online presence	Traditional Media	Events	Contacts Database	Communications Strategy
Evidence of activity	Staff uniforms, Suffolk Vincent Van Go van, logos, banners posters, business cards, flyers, newsletters, videos, power point templates and all other materials which were produced and distributed were developed with recognisable branding name.	Social media accounts, Connected Communities website.	Radio, local newspapers, news press releases.	Community and local authority events, academic conferences, trainings, workshops, online and in-person.	One joint contacts database – led by Suffolk.	One joint communications strategy - development led by Suffolk.
What didn't work	Not reported.	Partner accounts developed without much consultation and informing each other of online presence. Partners did not tag each other in posts and did not engage in communications via these channels.	Lacking time and a systematic approach to track engagement efforts and reach at the partner-level.	Lacking time and a systematic approach to track engagement efforts and reach following event attendance at the partner-level.	Issue with data sharing resulted in reduced number of contacts being shared with the Lead Partner.	Lead Partner Communications Strategy being developed and utilised more as a static document rather than an active strategy which could be utilised across partner locations.
What worked	Staff uniforms. Leaflets. Promotional materials given away at the events or directly distributed through people's door.	Developing social media following.	Traditional media outlets potentially more likely to reach populations 65+.	Extensive engagement with VCSE and other organisations working in the field of social prescribing.		Each partner investing significant effort into developing their own communications strategy.
What partners would do differently	A more uniform approach to tracking communications channels and materials at the partner-level to enable comparisons.	Joint social media communications strategy.	Not reported.	Attend and organised more joint events.	System to capture how the contacts database was utilised - solicit feedback from the stakeholders to gain insights into how useful the contacts database was to the overall Connected Communities programme delivery.	Not reported.

Lessons learned	Focus groups (ex. Medway) to develop branding very useful to be able to successfully promote service to target groups.	Designing social media campaigns at the partner-level requires additional management and coordination.	Not reported.	Not reported.	Not reported.	Communications strategy is essential for successful programme development, implementation and dissemination of the outputs.
Evaluation	Unable to compare communications approaches and impact due to a lack of information provided by some of the partners as well as differing approaches. Nonetheless, leaflets seem to be commonly successful across Kent and Medway.	All partners report gaining relatively high number of followers during the programme duration and posts being viewed by the followers. Lack of cross-partner social media engagement potentially detrimental to the overall outreach.	A programme wide system to track communications aims and outputs needed to make an evaluation assessment.	A programme wide system to track communications aims and outputs needed to make an evaluation assessment.	A programme wide system to track communications aims and outputs needed to make an evaluation assessment.	A programme wide system to track communications aims and outputs needed to make an evaluation assessment.

Table 10 Communications Overview

*Not reported: Partners did not share with UoE team their reflections on a particular activity. For example, 'Traditional Media/What partners would do differently' has a note of "No report" because partners did not share with the UoE team what they would do differently in relation to engaging with traditional media. For the fields that contain description, UoE team collected information by reviewing email exchanges, meeting notes and documents shared by partners as well as by soliciting feedback from partners to complete the table and summarise reflections.

UoE Team built an extensive network of stakeholders. Some engagements resulted in further collaborations, while others were limited to one-time. These and many other engagements by the UoE Team and other partners required a systematic approach to tracking these activities, and more time to expand and build upon network potentials.

Contacts database was one of the deliverables that Connected Communities as a programme provided as a structure to track engagement with external stakeholders. All partners were required to provide the list of contacts they had acquired as a part of their engagement. Some partners were unable to share their contacts due to data protection concerns. Suffolk carried out a Data Protection Impact Assessment (DPIA) and addressed the issue of data sharing by proposing that partners carry out additional checks with their stakeholders and offer opportunities and assurance to individuals to unsubscribe. The database was completed in February 2021, however, not all partners were able to share contact information from their stakeholder lists at that time, and no partners updated their lists as the project progressed. Suffolk's team complied the contacts information from partners that were able to share it and used the contacts database to inform stakeholders about the Connected Communities progress, to disseminate outputs and to inform them about the upcoming events.

While this deliverable was essential and important for keeping track of engagement with external stakeholders, the efforts to collect information should have been extended beyond February 2021. Furthermore, more information should have been made available on how the contacts database was utilised and if and how feedback from stakeholders could have been solicited to gather an understanding of how useful the contacts database was to the overall Connected Communities programme delivery.

Communications Strategy whose development was led by the Lead Partner, Suffolk, was delivered in April 2021. It provided information on the project background, target audience, stakeholders, project partners and beneficiaries, communication channels, resources, overall action plan and objectives. The Strategy provided an important overview of the plans to deliver Connected Communities. The number of stakeholder groups identified in the Strategy (Image 3)_ illustrates the immense reach the programme sought to achieve. The groups that were included as key stakeholders come from a wide range of sectors, demonstrating the commitment by the partners to produce a cross-sectoral and cross-country engagement at the highest levels.

Stakeholders
INTERREG
Programme partners
Community members
Policy holders
Public Health
Local voluntary and community groups
VCS infrastructure organisations and volunteer centres
Healthwatch
Social prescribing networks
Public sector partners
District and parish councils

Clinical Commissioning Groups (CCGs) Mental health teams and social care Care and healthcare professionals NHS, Health centres and GP surgeries who are likely to be the project's key referral agents Libraries Churches and other religious institutions Community Foundations Community development professionals Academic and Research organisations Government Departments - Ministry of Housing Communities and Local Government, Department of Health and Social Care

Image 3. Stakeholders

Similarly to the contacts database, more time and effort should have been invested into tracking strategy outcomes and achievements beyond the communications strategy completion date in April 2021. Given that the Communications Strategy did not progress beyond this stage, it ended up functioning as a snapshot of an idea rather than as a strategic or guidance document. A programme-wide system to track communications aims and outputs would have helped evaluate communications outcomes.

Integration

UoE Team led evaluation, dissemination and integration through engagement. We give an overview of Integration in Table 11. Evaluation involved creation of a causal model, data processing and analysis, evaluation report writing, and Toolkit development. Delivering these project elements contributed to evaluations of the process, impact, and value-for-money of the Connected Communities Project. Dissemination and Engagement were central to the delivery of the project and the integration of Connected Communities findings into other locations and geographic areas. Case studies, data snapshots, policy briefs, blogs, workshops, academics articles and conference presentations, and engagement with community organisations, policy makers, and local authority representatives were used to disseminate Connected Communities findings and engage with. While extensive time and effort from all partners went into producing these outputs, the following was lacking from the overall engagement efforts:

- greater coordination across partner locations on sharing the outputs;
- well-grounded and clear communications strategy essential for dissemination and engagement;
- effective mechanism to track reach and engagement with the outputs.

Evaluation is an ongoing process, which starts before service delivery begins and continues until after it ends. Feedback and input from all those involved in a programme is essential for an evaluation to be effective and informative. In order to provide all the elements of evaluation, a systematic tracking of all the inputs (resources), activities (actions and efforts), outputs (deliverables), outcomes

(achievements) and impact (ultimate change) was sought to both establish a baseline for each facet of the project and to assess any changes over time.

	Evaluation	Dissemination and Engagement
Evidence of activity	Created causal model. Data processing and analysis. Developed Toolkit. Produced value for money assessment. Produced 4 evaluation reports.	Case studies. Data snapshots. Policy briefs. Blogs. Webinars. Workshops. Academic articles and conference presentations. Civic presentations. Organisation/board membership. Meeting with public managers and policy makers.
What didn't work	Data processing and analysis negatively impacted by a lack of unified CRMS system.	Being able to utilise communication channels across all partner locations to disseminate outputs. UoE Team unaware of some of the partner communication channels. A lack of coordination at the partnership level to ensure greater dissemination impact.
What worked	Partners coming together towards the end of the programme to systematise data reporting structure. Partners investing time and effort to reflect on the entire programme while providing input for Toolkit.	Attendance at academic conferences, VCSE events, national and local social prescribing events.
What partners would do differently	Co-produce evaluation.	Greater coordination across partner locations on sharing the outputs. Co-produce dissemination and engagement.
Lessons learned	Evaluation is an ongoing process.	Well-grounded and clear communications strategy essential for dissemination and engagement.
Evaluation	A system was needed to 'evaluate' evaluation.	Need for an effective mechanism to track reach and engagement with the outputs.

Table 11. Integration Overview

UoE Team produced regular evaluation reports of project design and delivery assessments. These *process evaluations* informed partners and funders about Connected Communities activities and the degree to which they were being implemented as intended to achieve desired outcomes. *Impact evaluation* reports and *value for money assessments* were also performed and relayed via evaluations and the Toolkit. These documents can collectively be used to assess the proposed evaluation logic and the extent to which any observed changes among beneficiaries or communities can be attributed to Connected Communities.

Evaluation success greatly depends on the commitment of partners to recognise that evaluation is an ongoing process. While Connected Communities partners understood the need for an ongoing evaluation, the time and resources needed for each partner to continually contribute to the endeavour were not adequately estimated. Working in

two different languages and across different local authorities and sectors requires additional time and effort to ensure deliverables are produced on time, that impact is tracked, and that results can considered in time to inform further decision-making and determine any potential changes or refinements in ongoing delivery. All partners agreed that a greater investment of time and resources were needed to co-produce a more helpful and informative evaluation.

Numerous contextual, programme and partnership specific factors impacted ways in which the evaluation was conducted and the impact of Connected Communities was assessed. In the following section we discuss some of these factors.

7 Impact of Partnership and Contextual Factors

COVID-19

COVID-19 pandemic emergence in March 2020 resulted in service interruption, with the local authority resources being diverted to address urgent and basic needs of people in their locality. Partners, in particular those working in public health departments, were required to divert their focus on the pandemic-related health needs and respond to unprecedented demands on their time and resources.

The pandemic also affected the engagement and recruitment of potential beneficiaries across partner locations. It also reduced the number of staff available to work with beneficiaries either due to sickness and prolonged period of isolation or staff time being dedicated to delivering urgent care.

Furthermore, the COVID-19 pandemic impacted opportunities for partners to interact and build a team with a shared vision across the partnership, including a unified delivery and impact strategy. Partner L'Oise departed during this period, which particularly impacted the UoE evaluation team, as L'Oise had been the partner assisting with dissemination, integration and evaluation in France and overall. UoE then had to cover all three of these elements of the project on their own.

Given the potential impact of COVID-19 on levels of loneliness, isolation and connectedness, UoE Evaluation Team proposed changes to the survey questionnaire to try to gauge these impacts. While partners agreed that three additional questions were necessary to capture these impacts, only Medway provided beneficiary responses to these questions (see more in Interactions, Loneliness and Connectedness: COVID-19 Related Changes.

Brexit

The departure of the United Kingdom from the European Union affected Connected Communities participation and service provision, as well as the partnership. Some of the French partners left the partnership after the UK announced the nature of its departure. The loss of La Manche meant team communications lost the key French partner for that work, and the loss of Seine Maritime meant the departure of a French partner in charge of leadership, general management and implementation. This

reduction in the number of partners in turn affected cross-border cooperation and team learning in areas such as health and social care integration, policy development in France, digital services to assist people to indicate needs and allocate resources, and the chances of adopting a unified CRMS and volunteer strategy. It also left L'Eure as the sole remaining French partner.

Re-allocation to remaining partners of tasks, responsibilities, and the funds to support them was not efficient or timely. Negotiations to re-allocate the funds took precious time and resources, with the funds never successfully re-allocated to support delivering proposed activities.

Partner Interactions

As a cross-sectoral and cross-regional social prescribing programme with multiple delivery sites and work streams, Connected Communities required a number of leadership, communication and legitimacy structures to be established for successful programme implementation. Partners have noted a need for greater clarity on how the programme would be delivered while taking into account various contextual and programme specific challenges that emerged throughout the programme duration. Some partners noted a lack of guidance regarding basic steps to implement a social prescribing service in a partnership such as Connected Communities.

Nonetheless, Connected Communities offers insights that could potentially drive a systemic change in how local authorities, researchers, and community organisations work together to address complex health and social needs. With this potential in mind, we asked partners to provide their views on how the Connected Communities partnership influenced their approach to social prescribing delivery moving forward. Partners commented as follows regarding the project:

> *"[Connected Communities has] highlighted that there are many ways to deliver SP (social prescribing) successfully, not one size fits all."*
>
> *"W[e w]ould reconsider procurement and consider delivery via in house [sic.] or a local organisation."*
>
> *"Unfortunately for us, there has been a bit of a lack of partnership working, due to a number of factors (Pandemic but also a lack of willingness from some partners to share their learning), in the project. We did implement a leaflet distribution based on another partner's action which delivered great results for us."*
>
> *"Need to identify routes of engagement early on in the delivery. Referrals are hard to develop, without building strong networks and trusted relationships."*
>
> *"It gave me a clearer understanding of the structures needed to be put in place to implement complex health initiatives such as social prescribing."*
>
> *"[Connected Communities showed me the] importance of creating a strong dynamic with the partners."*
>
> *"[It would have helped to have had] more support and guidance through the world of social prescribing for partners that were less experienced in this field."*

We have also asked partners to reflect on, what, if anything, the partnership could have done to make their work more impactful. Partners offered the following insights:

> *"At times there was a lack of direction and clear communication from the lead partner. Partners were not always kept up to date with changes and key information that impacted on their work/approach to the project. I don't believe that the partnership implemented true co-production, we all tended to go off and work on our projects in silos then come back and briefly update each other. (It's only since the last meeting that I now fully understand how all the other projects work) However, COVID-19 is largely responsible for this as it significantly impacted everyone and meant that we were unable to work as we perhaps would have done without that additional challenge."*
>
> *"Meeting online was difficult and the inability to travel to view projects was a hinderance [sic.]."*
>
> *"I know that COVID-19 and the development of social prescribing locally in that time has made things difficult. The separation between health and the local authorities is troublesome."*
>
> *"Actual cross partner collaboration, more communication between partners, more co-design, co-development, more workshop type meetings [would have been helpful]."*
>
> *"[It would have been helpful to have had a] strategy on co-production. Joint data recording system."*

These responses illustrate a wide range of views in regards to the leadership and project structures. More attention and effort to sustain collaboration during unexpected events such as the COVID-19 pandemic or staff turnover would have potentially helped the programme better cope and adjust to these adverse elements. Establishing a strong spirit of collaboration with internal and external stakeholders is something that Connected Communities and other similar social prescribing programmes should be given time, space and resources to develop further. Instituting clear leadership roles, communicating vision, and a long-term commitment to collaboration are important aspects of building legitimacy, a process that new and potentially short-lived networks are likely to have difficulty with establishing.[28]

Partnership Management

The Joint Secretariat (JS) supplied a representative who was tasked with involvement in a number of administrative aspects of the Connected Communities programme. The JS representative should have overseen appointment of the FLC, delivered mandatory training on financial project management and reporting, participated in project steering group meetings (PSG), regularly reviewed progress reports and payment claims, responded to project modification requests from the partners, and offered mandatory project closure training for all partners' staff. The Connected Communities JS representative did not regularly attend PSG meetings as specified in the programme bid, which negatively impacted decision-making and information sharing between the partnership and the funder.

The JS training on programme closure was held on the 17th of October 2022, with less than 2 months of active programme delivery remaining for Connectors to work with

programme beneficiaries before the holiday period and final delivery date of the 31st of December 2022. During the training, partners were informed about the closure timeline, as well as final report eligible expenditures and outputs and evidence. According to Image 4, the project end date was marked as the 30th of June 2023, with final implementation ending on the 31st March 2023. The partnership had been working toward these dates since the JS had confirmed them verbally with the Connected Communities project manager in June 2022.

The partnership was then informed on December 23, 2022 (a notification many partners did not receive until 3 January 2023 due to holiday closures), that the final project end date would instead be 31st of March, with all deliverables to be completed by the 31st December, 2022. The incorrect information given during the training led to new and unexpected challenges and work pressures on all the partners as they sought to meet a project deadline 3 months earlier than the deadline specified in both June and October 2022. The surprise change also negatively affected partners' staffing and resource allocation.

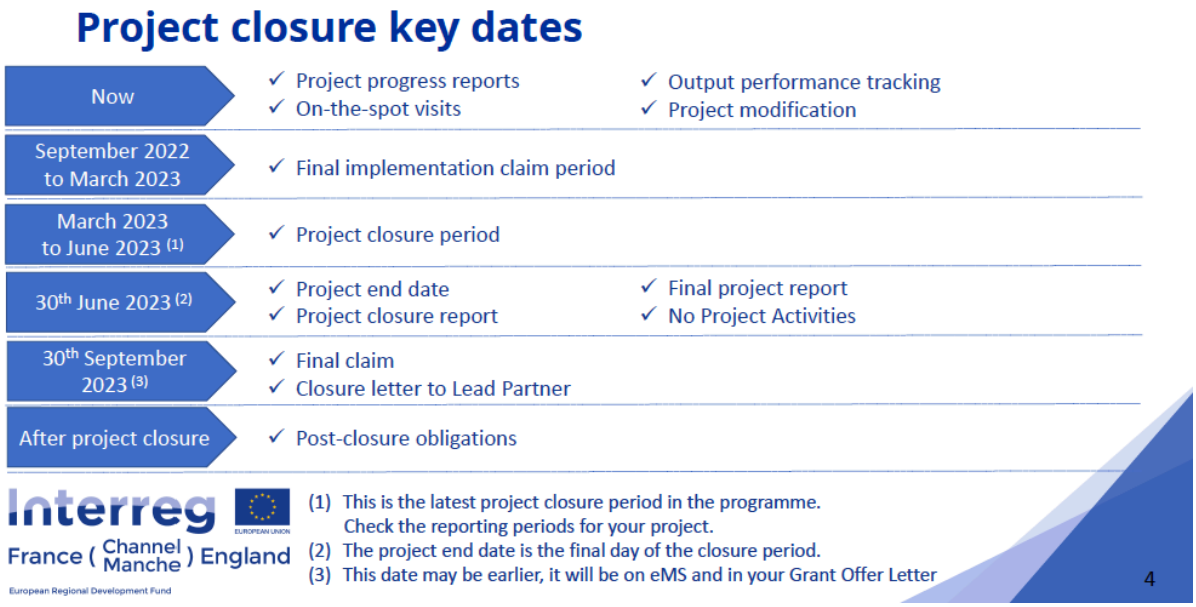


Image 4. Interreg Closure Training slides

Additional changes in procedures and protocols on behalf of the funder resulted in further confusion and extra effort devoted to project management among all partner organisations. These changes regarded evidence needed to authorise claims, work package and budget line delegations, and decisions/information the partners could expect from the funder.

Procedural and reporting requirements of the programme were not adhered to by the funder, resulting in delays processing claims, making decisions, and implementing the funding that was available. The delays in processing claims negatively impacted staff recruitment, with substantive disruptions to staff retention. In the end, uncertainty regarding the programme led multiple employees to move on to other positions within and outside of partner organisations before the project ended. Fewer than 5 of the people originally involved with the proposal remained with the programme for the entire duration.

8 Conclusion

Overall, there were many aspects of Connected Communities that were successfully implemented. There were also other elements that were identified as needing further development and investment. Connected Communities partnership teams have learned from the elements that worked well and those that did not. In summary, the following aspects of the programme worked well:

- Extensive and positive interactions with Voluntary, Community and Enterprise Sector organisations:
    - Promote Connected Communities
    - Collaborate to avoid service duplication & better serve community—*a whole system approach.*
- An increase in awareness of loneliness and isolation among community members and local authority.
- Communication approaches in Kent.
- Building a Directory of Services in Kent and Medway.
- Utilising La Poste workers in L'Eure and Community Wardens in Kent to capitalise on already established trusting relationships with community to generate referrals and participation.

The aspects of the programme that did not work well and required greater attention were the following:

- The lack of a unified Client Record Management System (CRMS) was detrimental to:
    - data management, collection and monitoring
    - impact evaluation
    - coordination across partners.
- The lack of knowledge exchange via workshops and collaborative meetings reduced:
    - Available opportunities to come together to problem-solve, discuss programme progress and utilise each other's competencies.
    - The ability to facilitate collaborative working time.

The partners have learned many lessons while participating in Connected Communities programme, some of which are:

- Recognition of the power of shared vision and how to create it via communication, goal setting, and active action planning.
- Understanding that co-production is only possible when there are clear leadership roles, shared vision, and long-term commitment to collaboration.
- Experience that it is necessary to regularly update risk-management plans for all aspects of delivery.
- Knowledge that all aspects of delivery affect evaluation and programme impact.
- Awareness that a partnership must allocate adequate time to find the balance between data collection and analysis requirements, on the one hand, and the needs of delivery professionals and beneficiaries on the other.

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