Salford Wellbeing Matters Evaluation

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Salford CVS
Making a difference in Salford

Wellbeing Matters

Acknowledgments

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Context: the wellbeing matters programme

The Wellbeing Matters Programme is a Voluntary, Community and Social Enterprise led, person centred and community-based programme for transformation. With its holistic approach, as defined by open ended and flexible whole-person support, it works with individuals to uncover what will be most meaningful to them in achieving their own self-identified goals, and in this way to move together in a journey towards improved health and wellbeing. Its underpinning goal is to thus address the wider determinants of health by connecting people to the existing Voluntary, Community and Social Enterprise ecosystem of services and community programmes, while also supporting this Voluntary, Community and Social Enterprise ecosystem's development and expansion where needed. The programme is part of a strategic move to a fully person and community-centred approach to health over the life course. It takes as axiomatic both the broader social and environmental aspects of health, **and a focus on wellness rather than illness.**[1] Looking beyond a medical diagnosis, it works with individuals as whole human beings and helps develop the social infrastructures that connect them to the wider community as well as those connecting community groups to each other. This holistic approach also integrates with person-centred programmes such as Living Well Salford, a new mental health service targeting those people falling through the gaps between primary and secondary care which focuses on people's strengths to improve their own health, happiness and well-being with the support of a multi-disciplinary team and a wider network of support.

1- Michael Marmot et al., "Fair Society, Healthy Lives," Public Health 126 (2012); Anton Antonovsky, Health, Stress, and Coping (San Francisco and London: Josey-Bass Publishers, 1985).

Wellbeing Matters included three separate workstreams at the time the evaluation started, but workstream 3 transitioned into being embedded into the other 2 workstreams in 2019.

Workstream 1

Creation of an overarching, Voluntary, Community and Social Enterprise led Social Prescribing model for Salford.

Initially, five Community Connectors (CCs) were employed by five Voluntary, Community and Social Enterprise anchor institutions (Inspiring Communities Together, Langworthy Cornerstone, Social Adventures, START, Unlimited Potential). In 2020 a sixth connector was recruited to increase capacity, utilising the funds that had previously been employed the Social Value Development Worker for workstream 3.

The operational delivery of Workstream 1 is overseen by a Social Prescribing Coordinator based at Big Life, on behalf of Salford Third Sector Consortium.

Workstream 2

Developing capacity in local voluntary organisations and community groups to support volunteering and activity around wellbeing to ensure a healthy Voluntary, Community and Social Enterprise eco-system to socially prescribe into. This was supported by five part-time Volunteering Development Workers (VDWs) based at Salford CVS and aligned to a grants allocation from Salford CVS' Third Sector Fund, establishing a Voluntary, Community and Social Enterprise 'Invest to Save' approach.

Workstream 3

Embedding a social and added value approach to achieve health outcomes through the collective action of those both inside and external to the health and social care 'system' (including the Voluntary, Community and Social Enterprise sector) via the focus of doing responsible business, as per Salford Social Value Alliance's 10% Better campaign's wellbeing and health outcome indicators. From 2019 the programme moved to embedding social value rather than seeing it as a separate workstream. Social value is a golden thread that runs throughout the programme.

Workstream 1 was operationalised by October 2018 and started taking referrals in December. At this point, five Community Connectors were in post undertaking training and carrying out the community mapping central to the project. A total of five Volunteering Development Workers were recruited as part of **Workstream 2** (working half time on Wellbeing Matters and half time on another programme, known as Community Assets). **Workstream 3** focused on embedding a social value approach into the programme, initially employing a Social Value Development Worker to both support the Wellbeing Matters programme and the wider Salford Social Value Alliance's 10% Better campaign work. This post was replaced by a 6th Community Connector as the programme evolved.

Building on what works: person and community centred approaches in Salford

In 2018-2019, the University of Salford, working with Salford CVS, undertook a mapping of social prescribing activities across Greater Manchester and a look into best practices in social prescribing nationally. Commissioned by the Greater Manchester Devolution Voluntary, Community and Social Enterprise Reference Group on behalf of the Greater Manchester Health and Social Care Partnership, this research fed into the development of the Wellbeing Matters Programme and its adoption of a holistic approach to wellness[2]. The term 'holistic' remains open to interpretation, but here we follow Kimberlee who describes a holistic service as being 'open-ended and remaining in place as long as needed by an individual; drawing on local services and networks sustained through partnerships between social prescribers and primary care; and addressing multiple needs (i.e. not just addressing diet, but also budgeting, nutrition, addiction, loneliness and employment) to improve health and wellbeing'[3]. The initial report provided three sets of recommendations that prioritised the development of long-term relationships of trust among the many different actors in order to focus on:

1) Developing individual and organisational capacity to support people through a journey to wellness.

2) Increasing long-term investment in support of a holistic approach;

3) Work to develop meaningful outcomes and measurements.

It also recommended that any social prescribing programme align to the adoption of the Person and Community Centred Approach (PCCA). Already embedded in the Salford Locality Plan 'Start Well, Live Well, Age Well' (see Figure 1), this approach empowers individuals and communities to take control of their lives and gain greater responsibility for their health and wellbeing. The Voluntary, Community and Social Enterprise sector played a key role in developing this social model of health for Salford to ensure that people felt engaged and involved from the beginning, and the Wellbeing Matters Programme embodies this approach.

Figure 1 Wellbeing Matters integration with the Person & Community-Centred Approaches of the Salford Locality Plan[4]

2- Andrea Gibbons, Michelle Howarth, and Anne Lythgoe, "Social Prescribing in Greater Manchester" (Salford: SHUSU, University of Salford, 2019).

3- Richard Kimberlee, "What Is Social Prescribing?," Advances in Social Sciences Research Journal 2, no. 1 (2015): 107.

4- GM H&SC Devolution, "Greater Manchester Health and Social Care Devolution Locality Plan for Salford: Start Well, Live Well, Age Well," 2016, https://www.salfordcvs.co.uk/sites/salfordcvs.co.uk/files/Salfords-Locality-Plan-Draft-3-01-07-2016.pdf.

The work involved in the first and the second workstream were understood as closely interlinked within the larger context of the third, putting resources into supporting up to two thousand often vulnerable people into accessing the Voluntary, Community and Social Enterprise sector still reeling from a decade of austerity to receive this volume of people. This report focuses on the ways in which streams one and two worked together to support a wide variety of voluntary organisations and community groups in helping provide much-needed, non-medicalised interventions. It finds that Wellbeing Matters contributed both to the health and wellbeing of Salford residents, and the reduction of unnecessary demand on the NHS and other statutory systems.

In the words of one participant:

> 'She's brilliant, I feel so at ease talking to her, you can open up and actually talk to her honestly. D'you know, but I think it's so good that there's someone like this that you can go and see that can put you in touch with the services in the community rather than having to go and see your GP all the time about it'. ('Vicky')

The 'ripple' effect of this work and impacts from the individual to the population health and system levels are illustrated in Figure 2.

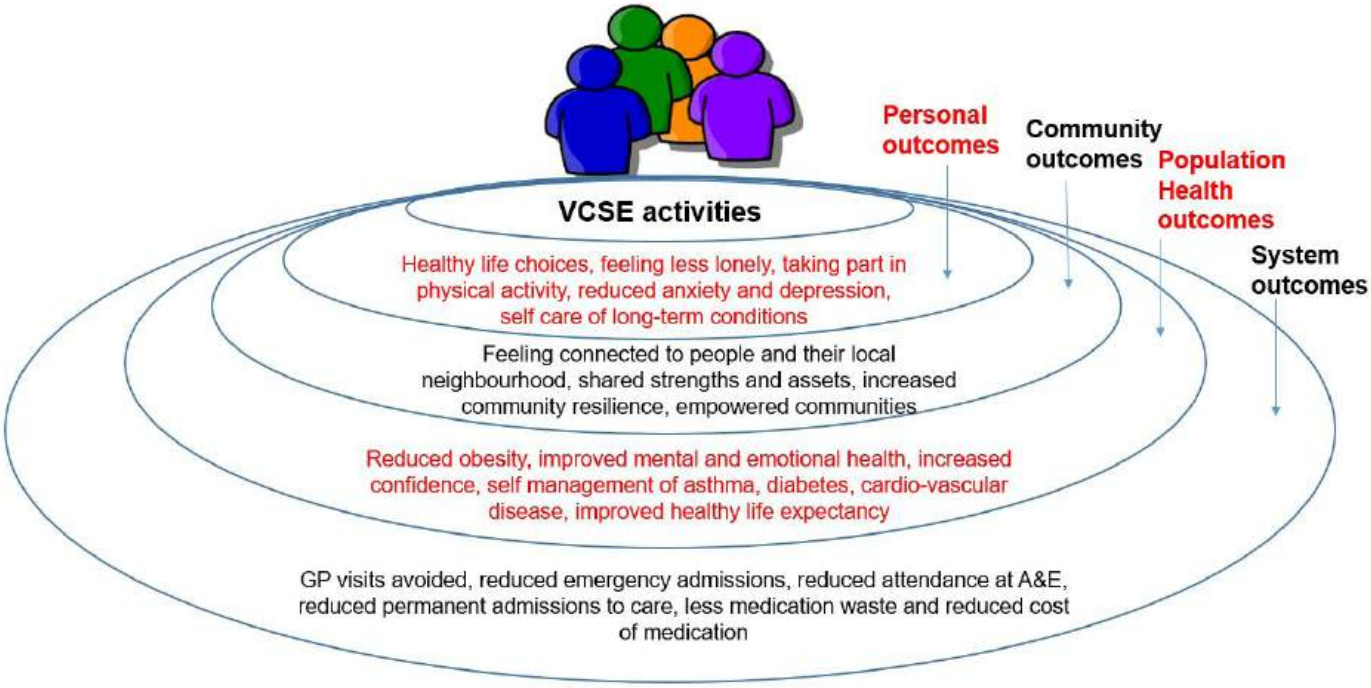


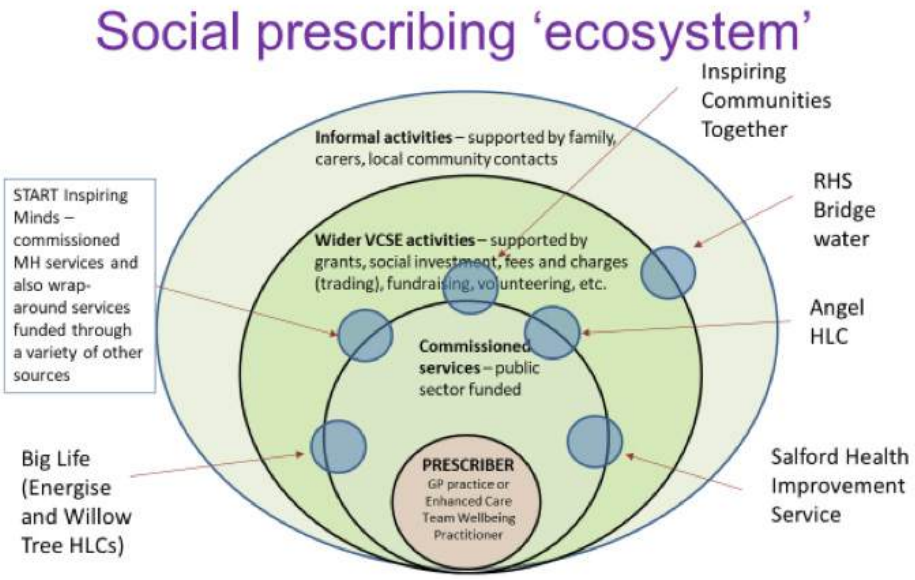
Figure 2 The Ripple Effect

Again, it highlights the way in which the Wellbeing Matters model has been built around active listening and person-centred engagement to facilitate positive outcomes at all levels. The trust developed through this process is key to the programme's success. As one participant told us, 'The best thing about being part of it? Being listened to and being understood', but also knowing that the Community Connector would always follow through with what they said would do. As she continued, 'They've never let me down'. Clarity in the support offered and scrupulousness in delivering everything promised has been a point of pride to the team as part of their commitment to the human being in front of them. This is particularly important for those people who have had bad experiences before in accessing support.

> 'Basically, I'll be fair, I've had support workers before and basically what ... they let me down, they let me down in a big way ... I'd been thinking of committing suicide ... I went back to my doctor's and then discussed it with my doctor and they suggested that I could do with some more support. ... And I've got to admit, they've only been around me for a couple of months but, you know, they've helped a great deal. I come here and I thought to myself, they're going to let me down again. You know what I mean? I felt like I were going to get let down constantly. And do you know, I haven't been. I haven't been'. ('Chris')

It is this commitment, echoed again and again, in participant interviews that allowed people to find new hope and meaning in their lives, enjoy new activities with more confidence, cut completely or reduce medications such as tramadol and morphine, and reduce visits to their GP and local hospital. This commitment is also foundational to the trust developed between the connectors and both GPs and Voluntary, Community and Social Enterprise groups, as explored further below.

A number of building blocks facilitated the development of this holistic 'end-to-end' social prescribing model that worked across multiple organisations and agencies to facilitate the growth of the 'social prescribing ecosystem' as shown in Figure 3:



VCSE providers are increasingly seeking other funding sources to enhance their services, meet demand and 'top up' commissioned for capacity

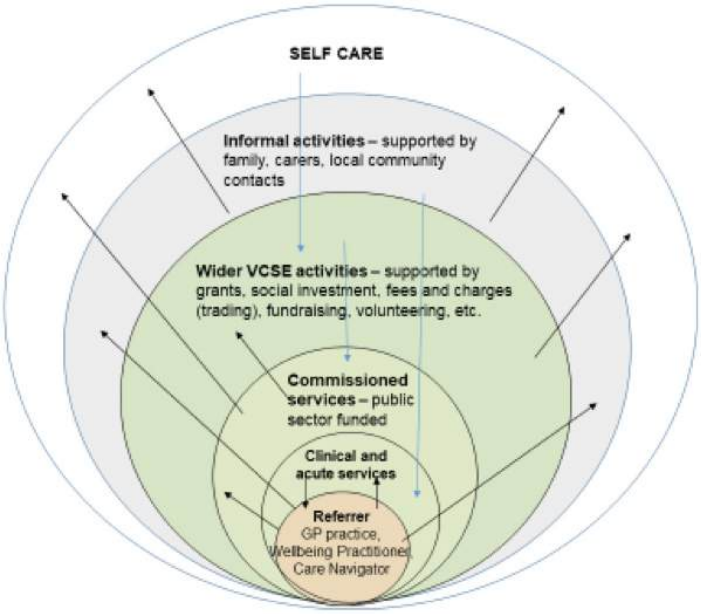


Figure 3 The Social Prescribing 'ecosystem' in Salford

A total of five Voluntary, Community and Social Enterprise anchor organisations each employed a Community Connector, latterly with a sixth, 'floating' Community Connector employed by Big Life, alongside the Social Prescribing Coordinator for Workstream 1 delivery (See the Wellbeing Matters staff structure and referral pathways in Appendix A). This allowed the programme to share out funding and draw on the long-standing knowledge and expertise of multiple community anchor institutions. It facilitated embedded Community Connectors able to build on existing activity, initiatives and relationships and ensured a collective and cooperative model of work across the whole of Salford. While challenging, this has enabled a unified and shared approach among the Community Connectors that still allowed for great flexibility and responsiveness to very different conditions and needs found across the different areas.

The programme was enhanced through the role of Salford CVS as overall programme managers, as well as the relationships with the Volunteering Development Workers from Workstream 2. A challenging post, these took longer to fill and had higher turn-over than the Community Connectors, partly because the workers were employed to work across two distinct programmes of work initially. The relationships that developed however, where Community Connector and Volunteering Development Worker worked together for some time, showed the many strengths of such an approach both in supporting people into activity as well as ensuring Voluntary, Community and Social Enterprise groups had the volunteers, capacity and infrastructure required to take on people who have been referred.

Methodology for the evaluation

Working in partnership, the University of Salford and Salford CVS have undertaken a longitudinal evaluation of the Well-being Matters Programme. The research aimed to provide a comprehensive insight into the programme from a range of perspectives and data as follows:

Interviews with...

- GPs
- Strategic members of staff
- Voluntary, Community and Social-Enterprise Sector Organisations

Focus groups with...

- Community Connectors
- Voluntary Development Workers

- Data collected from the Elemental dashboard

A Realist Evaluation has been used to capture data about the context, mechanisms and outcomes of the Wellbeing Matters Programme, and this framework has been used to structure the report. This has enabled the research team to explore the workstreams in terms of how they were originally developed, the systems used across the anchor organisations and the outcomes for communities and individuals. A range of quantitative and qualitative data has been analysed to provide a holistic picture of the Wellbeing Matters ogramme and provide commissioners with insight into the benefits and challenges that impact on sustainability. For the qualitative data, the University of Salford research team worked with Wellbeing Matters staff to identify a sample of GPs and individuals referred to a Community Connector to take part in individual semi-structured interviews. About half of these were undertaken face to face, the rest either by phone or Zoom due to the onset of lockdown. Likewise, a series of focus groups had been planned for each area to capture the impact of social prescribing on the wider Voluntary, Community and Social Enterprise ecosystem before the onset of Covid-19. In greatly changed circumstances, these were reduced and carried out as individual phone or zoom interviews, still ensuring as diverse a cohort as possible in terms of size, type and area.

The quantitative data has been drawn from the Elemental dashboard being used by Wellbeing Matters staff. While Elemental has proved a powerful and useful tool, both to support the work of the Community Connectors and to collect data, this has essentially been a work in progress and analysis reflects some of the limitations of learning and growing with a new tool that is still maturing. Some of the data collection fields, particularly those capturing demographic data, were only added in late 2019, and thus limit the sample sizes considerably. While successful in capturing raw impact data, such as multiple results from the SWEMWBS (Short Warwick-Edinburgh Mental Wellbeing Scale) and other wellbeing measures, the way this data has been stored by Elemental has made it impossible to fully examine the results for the full sample. These limitations are described in greater detail in discussions of findings. A final goal still just out of reach has been the full integration of Elemental with EMIS and Vision dashboards, to be able to capture the reductions in GP and hospital visits as well as medications, while still safeguarding patient data and remaining GDPR compliant. The University of Salford is continuing to work with both Elemental and Salford CVS to make this integration a reality, as well as to continually improve the dashboard's ability to collect the quantitative data needed to fully assess impact and improve the ability to make real time adjustments to the programme.

The mechanisms: wellbeing matters as a journey

The Wellbeing Matters Programme received 1,995 referrals over the period evaluated – from December 2018 through to the end of June 2020. There were some quite large increases as the programme rolled out, after which the monthly patterns show variation (i.e. some falling off during Christmas holidays, offset by the largest numbers of cases to date being opened in February 2020). While some neighbourhood areas had much higher numbers of referrals than others, all were severely affected by the Covid-19 lockdown in March 2020. Without the onset of Covid-19, the total over the period of study would have likely been hundreds higher, this is reflected on further below.

Total referrals by area and month (n=1,995)

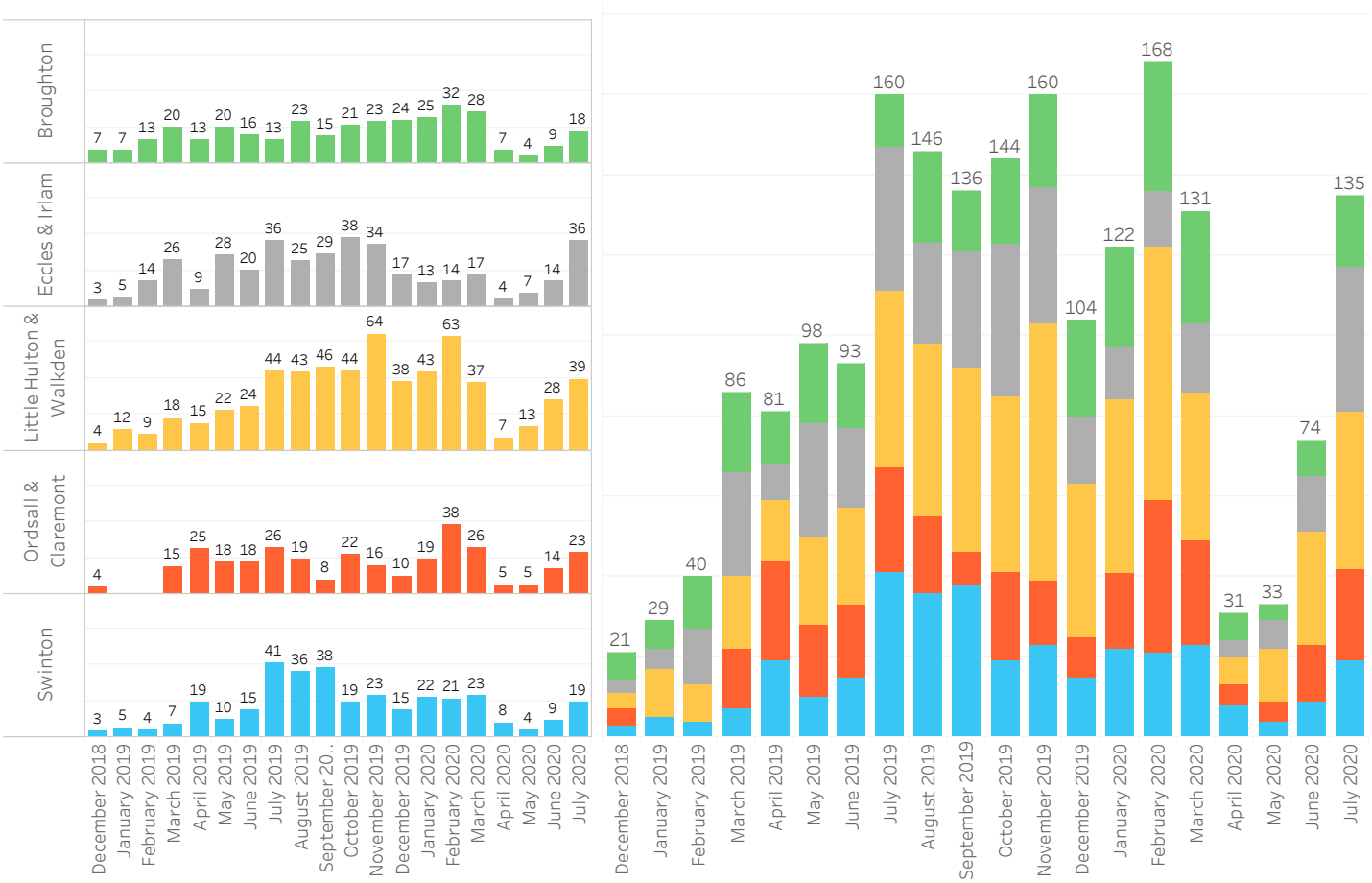


Figure 4 Total referrals by area and month

The increase of people being referred over time was largely due to an awareness-raising campaign undertaken by the Wellbeing Matters team. They produced postcards for GPs and participants, attended Patient Participatory Groups and Primary Care Network (PCN) meetings and delivered GP refresher sessions to ensure that GPs and patients were fully on-board with the referral process. While lockdown hugely reduced GP visits and therefore referrals, the high numbers referred beginning in June as local GP clinics began opening up again show the value placed on the Community Connectors role during this time of ongoing crisis.

Figure 5 Wellbeing Matters informational postcard for patients being referred into the programme

This investment of time resulted in strong relationships with a number of practices who took a lead in referring patients. While the Elemental data shows referrals from almost all practices, the majority of people referred came from a select number in each neighbourhood area (see Appendix C). For most of these high-referring practices, there was at least one champion of social prescribing who really embraced the opportunity to provide more holistic support for their patients, worked with the Social Prescribing Coordinator and their local Community Connector, and promoted the programme internally. This often opened the door for others to participate too. For a number of GPs, social prescribing was very new. It was in seeing the positive results that they were convinced of its worth and encouraged to refer more patients.

> 'As we hadn't had much experience of social prescribing prior to this it was difficult to know what to expect, but the service has exceeded our expectations as to the impact it can have on a patient's health and wellbeing". (GP 09)

Figure 6 Wellbeing Matters informational postcard on programme benefits

This exceeding of expectations was a common thread in the interviews, as the service was seen to help people change their lives in very real ways through engagement in community activities and through volunteering.

> 'I've seen some amazing transitions with people who are... who hopefully they will turn into long-term things in terms of their lifestyles changing or for whatever reason. But if nothing else, giving them a sense of purpose through volunteering is great, and that's something which should be really celebrated'. (GP 01)

Another GP reported that they could see the success in the referral through the reduction in patient visits due primarily to their improved health and wellbeing.

> 'I have learnt what the social prescriber has offered and tried to offer basic options prior to referring so good for their own development which again helps patients. I have seen the benefits to my patients in many ways, they have improved mentally and physically they are coming to see me less'. (GP 10)

While the feedback loops took time to grow and develop and work continues to improve them (particularly around the use of Elemental as a platform - see recommendations), the Wellbeing Matters team provides regular reports to a central contact within each practice about their referrals. Where the Elemental dashboard integrates with the GPs own dashboard, it now allows the GP to see whether a person who had been referred has been working with a Community Connector and the interventions undertaken when they bring up a patient record.

> 'I referred a patient who needed non-clinical support to our local Community Connector via Elemental, he had recently arrived in the UK seeking Asylum. I had a further consultation with him 6 months later about a separate issue and noticed via the Elemental tab in Vision that he had seen [the CC] 4 times since I made the referral and had been connected to local support. It was great to see that he was given the right help by the right person when actually as a GP that was not me'. (GP email)

It is clear that in addition to the difference this non-clinical support is making to people's lives, it is also reducing visits and therefore pressure on the GPs, in turn reducing the pressure on the wider system.

> 'I guess that the more people use it the more successful it is; imagine the kind of money you would save. So, they don't go to their GPs, we don't prescribe them the drugs, they don't have that, these people also go to A&E a lot, if they stop those, all those admissions and attendance, you save enough money to reinvest in the service to make it even bigger and better if you needed it'. (GP 06)

The steady growth of people referred overall (see Figure 4) reflected the increasing knowledge among GPs of the work the programme does and its usefulness. A number of beneficiaries also stated that they would have liked to have known about the programme sooner, if only to have been able to ask their GP for a referral earlier. They also felt that others should be able to benefit in the same way that they had done, and should know to ask for more information about it. In response to such feedback, the Wellbeing Matters team have worked to develop postcards and posters for GP surgeries to inform people (and remind GPs) of the programme (see Figures 5 and 6).

The use of a reminder system helped with some of the other challenges to the referral process, however, the Community Connecters sometimes found that people did not know why they were being referred, and what they could expect. Thus, ensuring that people understood the nature and extent of the support they would receive—and their own active role required to make that process successful—became a key part of the Community Connector's role. Another challenge was that sometimes people who were referred were too complex to be addressed appropriately in a community setting, and a number required clinical intervention instead; 101 referrals of the total 1,995 were deemed 'inappropriate' for these reasons. Where the complexity or severity of the case required a clinical / specialist intervention, Community Connectors fed this back to the GP and advocated on the individual's behalf for the help they needed. It's also important to recognise how people's conditions and needs can change over time.

In the words of one beneficiary:

> 'The Victims support service was very supportive and understood my needs. Unfortunately, my agoraphobia is complex and I now feel I need the support of the mental health team'. (comment from feedback questionnaire)

Ensuring that people are referred appropriately, and perhaps having the ability to have a conversation with the GP where there is a question even before a person is referred is made or if someone's condition deteriorates after a referral, will be important moving forward. A key finding of the earlier research, and in this report, is that an ongoing process of relationship-building and awareness-raising work is needed with GPs to help improve understanding of the programme, its strengths and its limits.

> 'Similarly with GPs ... they said 'I thought that you could do this and I thought you did that' and I've had to re-explain who we are and the type of referrals and the people that we work with, as well'. (Community Connector)

This is something that should improve as the programme continues to build and grow, and social prescribing becomes an increasingly familiar tool for GPs to rely on. This familiarity has been accelerated where the Community Connectors have been co-located with GP's for a period of time, often one morning or afternoon a week. More regular, often informal contact has improved the feedback loop, helped reduce ambiguity and enabled collaborative working with the practices. This also supported wider integration of the Community Connector with other services, such as the Salford City Council Health Improvement Team. While recognised as a benefit, with a small team of six Community Connectors this is impracticable across all practices. Staff also underlined the usefulness of meeting people in community settings where they could get a better sense of what might be on offer and what they might be interested in. This also reinforced the non-medicalised and self-driven nature of the intervention.

The Elemental data helps break down what happened with each referral, as seen in Figure 7. The total of those successfully closed after engagement or currently engaging in activities with the support of a Community Connector is 986 over a period of 19 months, almost 50% of referrals. It is likely that the success rate is higher, as many that were live, could have been closed. This compares very favourably with a more established Voluntary Community and Social Enterprise sector driven social prescribing project in Rotherham that over a period of 33 months supported 722 people into community activities; this represented 36% of 1991 referrals between 2012 and 2015[5]. While some of the difference can most likely be explained by the growth in knowledge of social prescribing among medical professionals due to both wider research and shifts in the NHS 5-year plan between 2012 and 2018, this is still an impressive achievement.

5- Chris Dayson et al., "The Rotherham Social Prescribing Service for People with Long-Term Health Conditions Annual Evaluation Report," 2016, http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-annual-eval-report-2016_7.pdf.

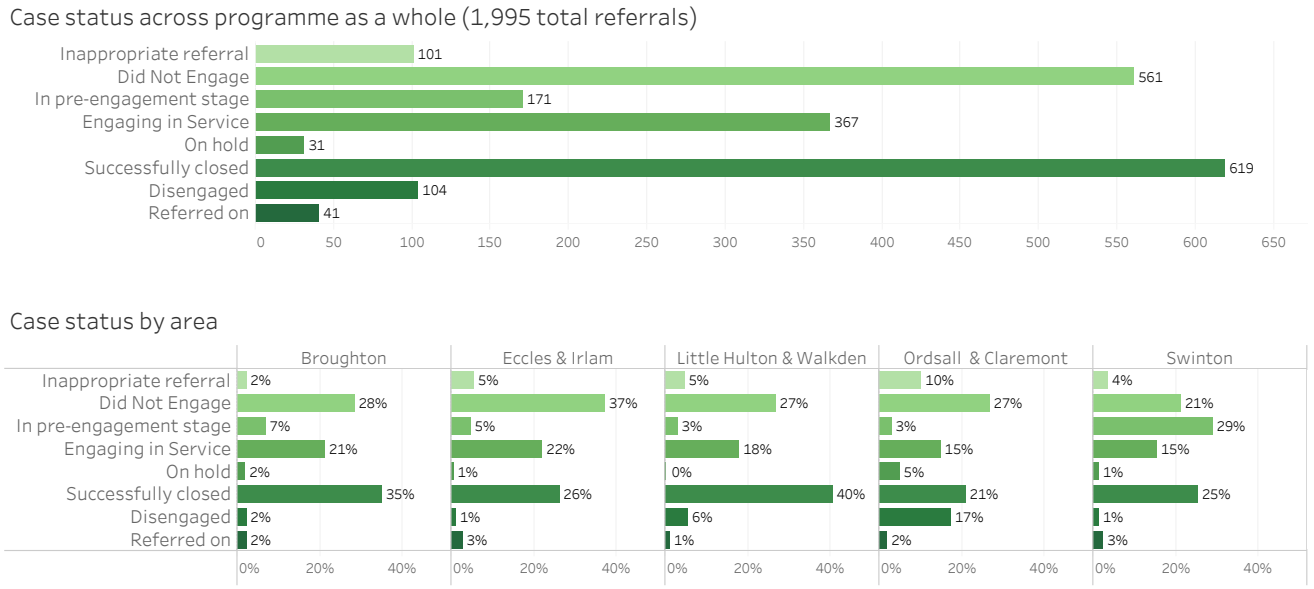


Figure 7 Case status across the programme

The second largest category in Figure 7 is made up of those who did not engage – i.e. those whose contact details were in the system after referral by their GP, but who either declined the service, did not show up to appointments, or who simply did not reply to phone calls, texts or the final letter sent to their address. This group of 561 individuals, for the obvious reason that they have chosen not to engage or respond to attempts to contact them, is the most difficult to analyse. Understanding why people might choose not to participate is a key area where full feedback loops developed through the different digital dashboards and improved relationships with GPs should serve to shed light on in future. What the data does show is that while the largest number of those not engaging were referred for social isolation, more people referred for this reason chose to engage than not (215 to 194). A slightly larger number of those referred for anxiety (196 to 140) and depression (137 to 117), however, chose to not engage than to engage (see Figure 8). Thus for a number of people, non-engagement very likely reflects the nature of the conditions themselves, where interacting with strangers is itself a major hurdle[6].

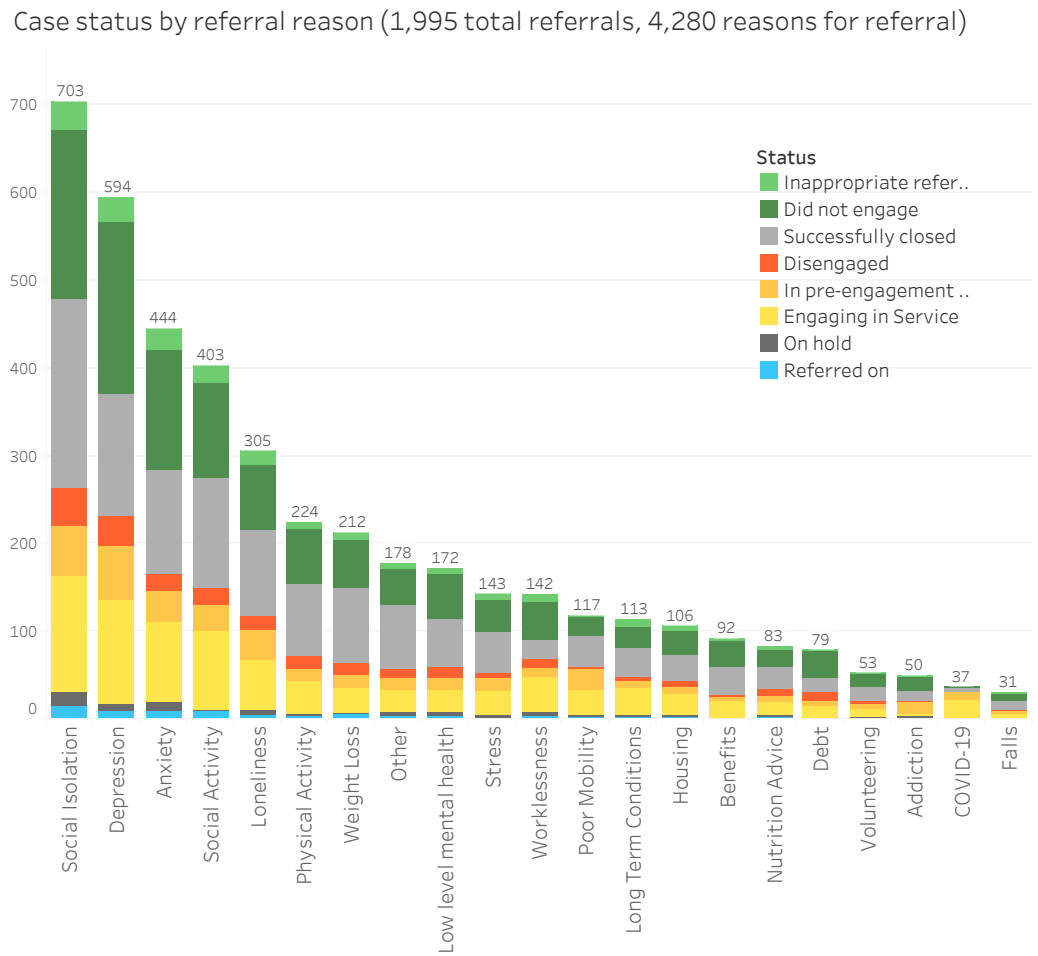


Figure 8 Case status by reason for referral

6- Henry Aughterson, Louise Baxter, and Daisy Fancourt, "Social Prescribing for Individuals with Mental Health Problems: A Qualitative Study of Barriers and Enablers Experienced by General Practitioners," BMC Family Practice 21, no. 1 (December 2020): 194; Kimberlee, "What Is Social Prescribing?"

The issues with mental health and complexity—and the resulting vulnerability of those being referred into Wellbeing Matters—were highlighted as a challenge by almost all of those interviewed, from staff to Voluntary, Community and Social Enterprise sector partners to GPs. For one GP, these challenges may underpin non-engagement:

> 'Often the patients who would most benefit are vulnerable, and may have trust in the GP/ GP practice but be wary of strangers and their motives, and also sceptical re what could help them when they themselves have medicalised their problems'. (GP 09)

Data from the qualitative interviews with beneficiaries who had engaged also underlined how many of them had often severe initial anxieties about meeting with the Community Connectors for the first time. One participant had turned to the GP for help around anxiety being caused by personal issues with neighbours. She told us about the first appointment with the Community Connector:

> 'I was kind of dreading going. I thought, I don't want to go, you know...telling them why I'm here ... It was actually good news after me dreading seeing somebody and having to go through all this...' ('Elaine')

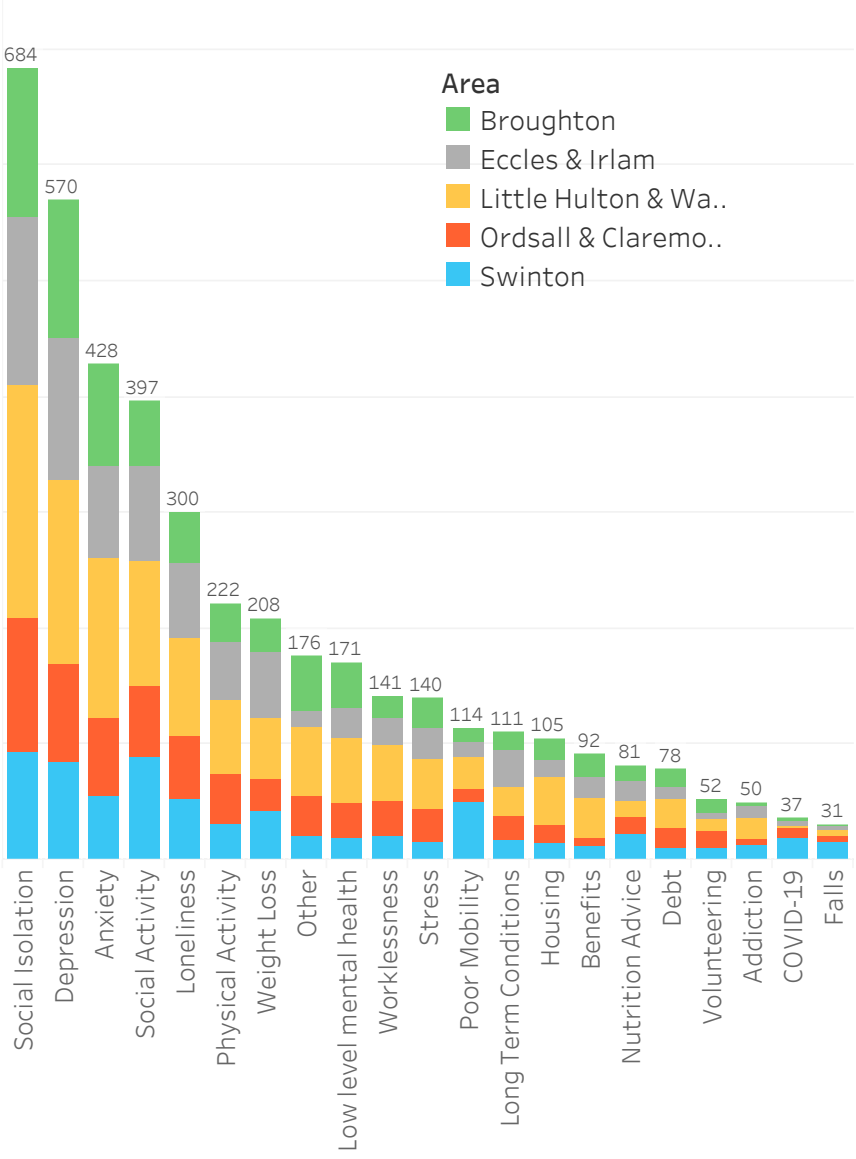
In the words of another:

> 'It was like, I'll be honest the first time I seen [the CC] I was terrified cos I have severe anxiety and [the CC] explained it. I was terrified that day ... I felt so comfortable speaking to her, actually really comfortable, she made me feel really relaxed. I think you even made me a brew if I remember correctly'. ('Dave')

These quotes are representative of those participants interviewed who were referred with issues related to their mental health, a majority of whom felt varying intensities of anxiety before speaking to the Community Connector. Each experienced just attending this first meeting as a large step for them. It also shows the skills of the Community Connectors in helping them feel comfortable and at ease, allowing them to take even greater steps towards achieving their goals.

While depression and anxiety were among the top reasons for people being referred, the primary reason across all areas was social isolation (though for many these were obviously interlinked). While all programme staff described Salford as a fairly well networked community with a thriving number of community groups and voluntary organisations in most areas, there still remains a very clear need for the role of an individual that helps connects people to other people, groups or activities. Depression and anxiety were close seconds, followed by the desire to engage in social activity. The pivotal role that social prescribing can play in supporting mental health where needed is clear. There is some variation in the kinds of referrals by neighbourhood area beyond these top four, but not a significant degree.

Reasons for referral: Programme as a whole



Top 10 Reasons for referral by area

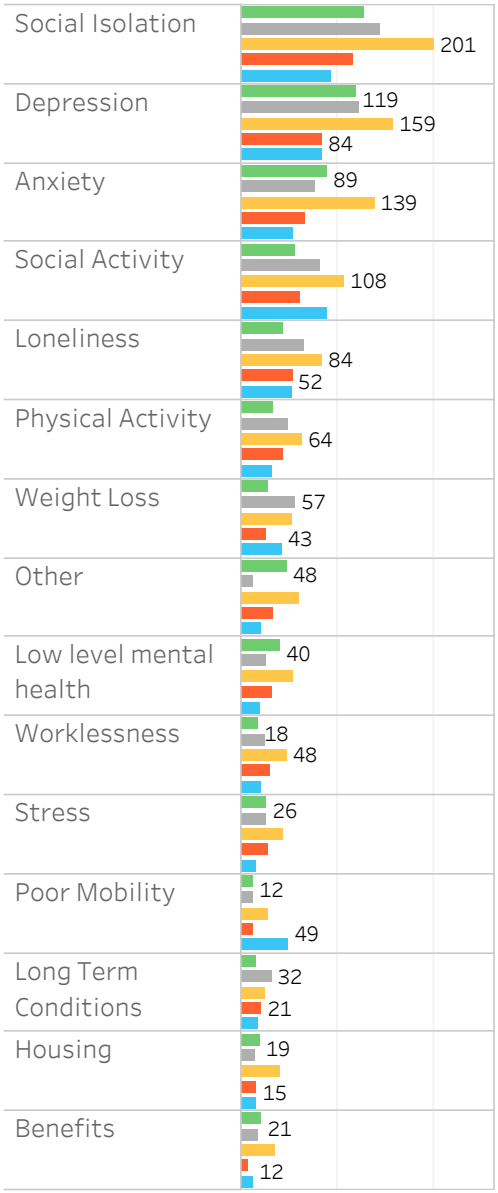


Figure 9 Reasons for referral

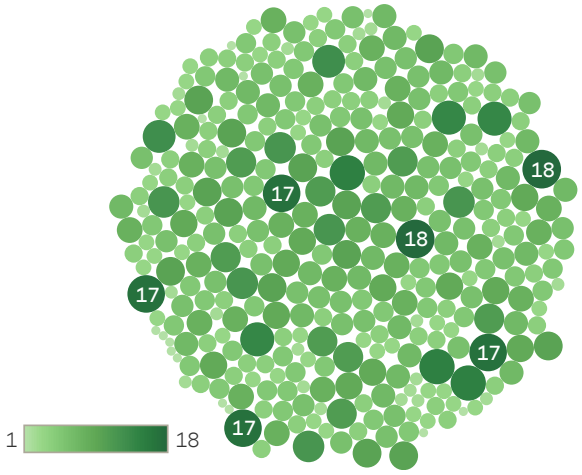
For the most part, Community Connectors were able to support a range of people through a limited number of contacts to achieve successful outcomes, but there were some who clearly needed much more support. The graphics below map the number of contacts – while face-to-face meetings were limited to eight wherever possible, phone calls were also logged, often pushing this number much higher. The Community Connectors and coordinator discussed the difficult line between keeping to the limits of support the programme tried to maintain and ensure no one became dependant on their Community Connector, while also providing the most holistic support possible to help people move to a place where they were able to work towards their personal goals without the Community Connector's help. Figure 10 illustrates that this balance was achieved, with the median and average contacts similar between areas and only a manageable handful in each area requiring more support (though in some instances this was quite high).

Contacts per referral per area

(each circle represents a referral, number of contacts shown by size and colour, all individuals receiving 16+ contacts labeled)

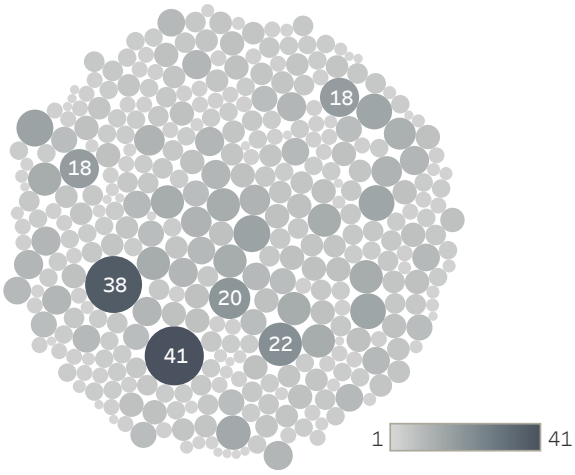
Broughton: 369 referrals

Median contacts: 5; Average contacts: 5.7



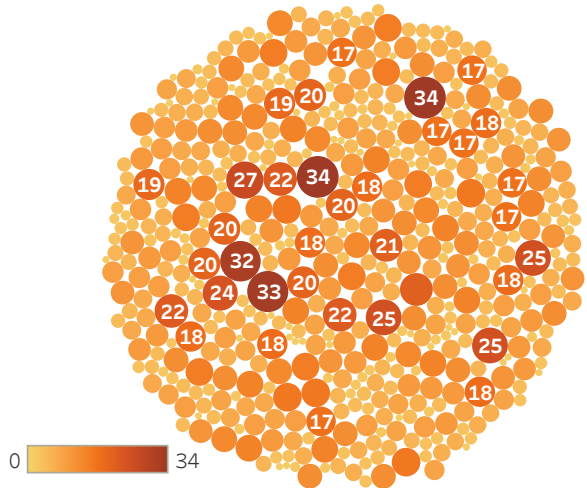
Eccles & Irlam: 390 referrals

Median contacts: 4; Average contacts: 5.3



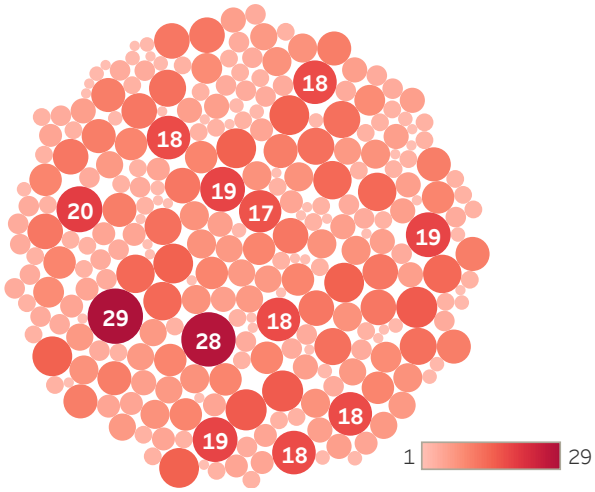
Little Hulton & Walkden: 594 referrals

Median contacts: 5; Average contacts: 6.5



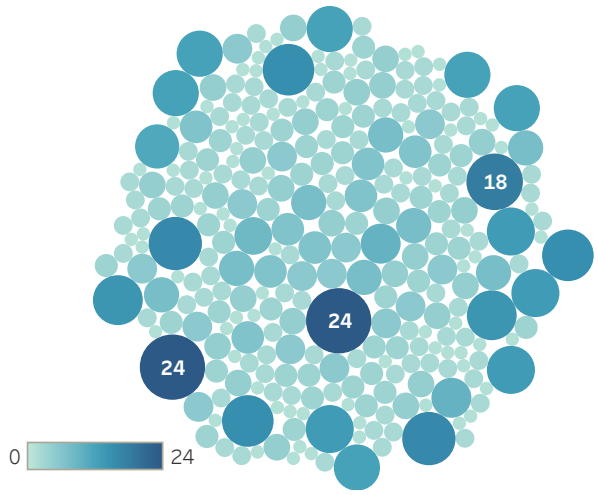
Ordsall & Claremont: 312 referrals

Median contacts: 4; Average contacts: 6.1



Swinton: 358 referrals

Median contacts: 2; Average contacts:3



Total referrals 1995

Median contacts: 4; Average contacts: 5.2

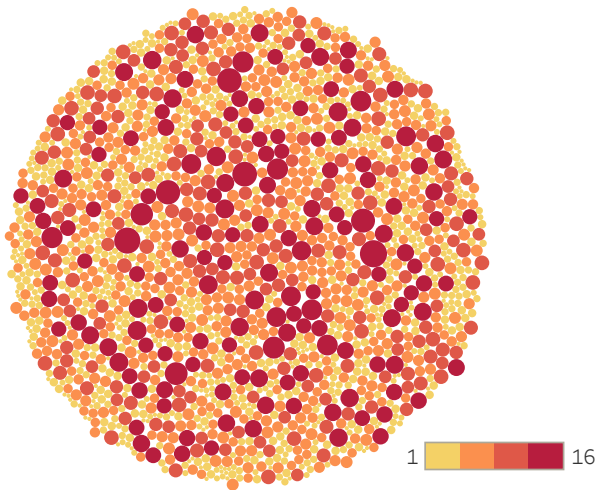


Figure 10 Contacts per referral

A deeper look at the dynamics of an individual neighbourhood area shows varying patterns of contacts. For each case opened each month in Little Hulton and Walkden, the bar chart in figure 11 shows the number of contacts between the individual referred and the Community Connector. The Elemental data here allows us to look a little deeper into the nature of the patient journey. Most people referred do seem to follow a fairly linear progression of a number of meetings with the Community Connector and then a closed case. It is clear, however, that a significant number, in this instance 25 people (marked in orange in the bar chart below), either need to cease contact for a while and then resume their journey, or something happens that causes them to return to the Community Connector as a person of trust and advice. The complexity of cases emerging in Little Hulton and Walkden were highlighted across various interviews, and this chart seems to show a good balance of quick support and case closure for many, but an adherence to holistic support where people's lives or patient journey required flexibility. The outbreak of COVID-19 clearly had an impact on this return, but the pattern exists before crisis as well. (See Appendix D for charts for each area).

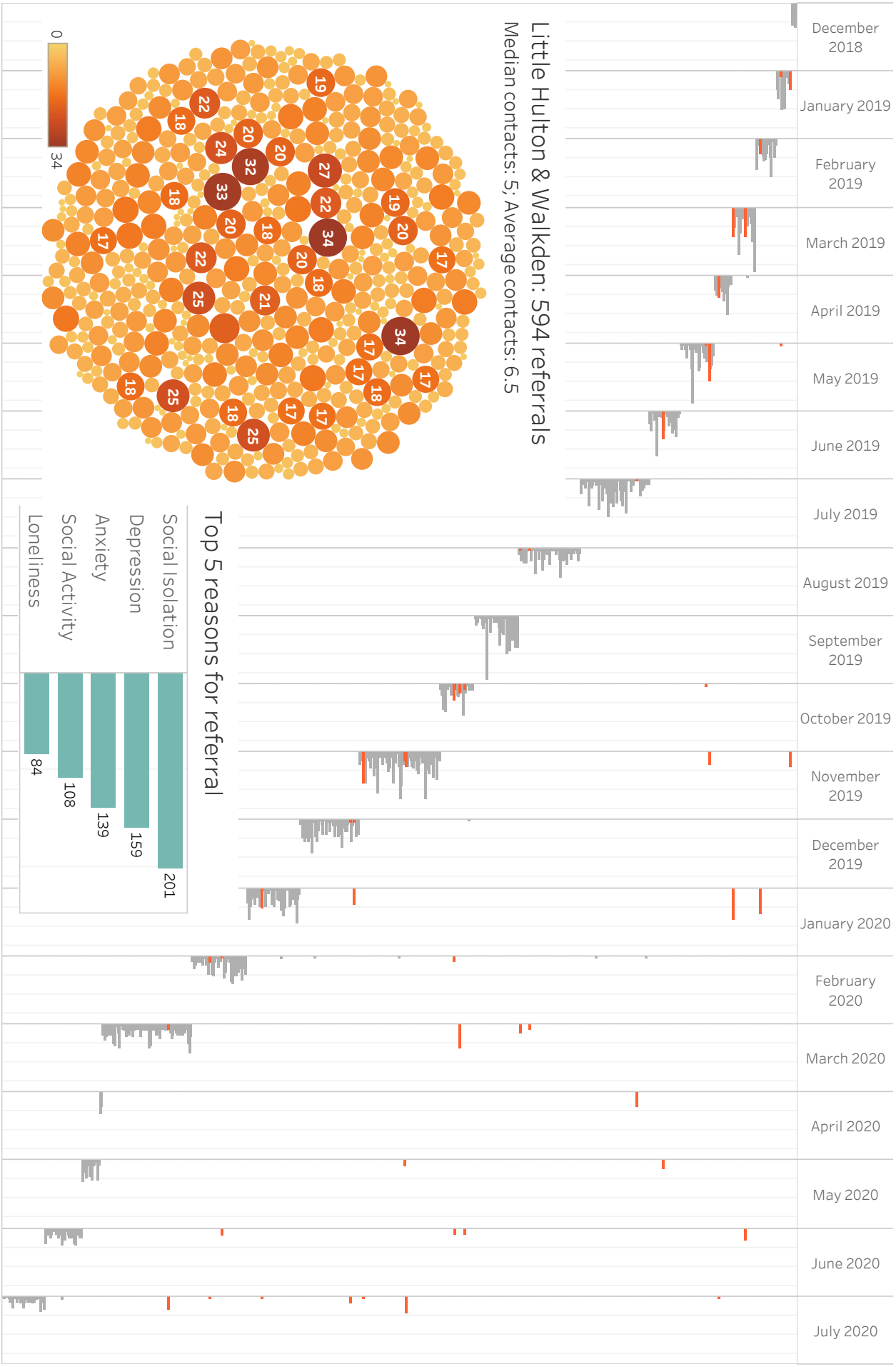


Figure 11 Contacts per referral

The Community Connectors connected people to over 600 different services and organisations, ranging across all size, types and level of formality from Citizens Advice services to 'Tech & Tea', craft and sewing groups, an Iranian friendship group, cycling, ramblers and walking groups, open courses on medieval history and local history groups, ESOL courses and apps among many others. The chart below of the twenty top groups and services people were connected with already gives a good sense of this diversity.

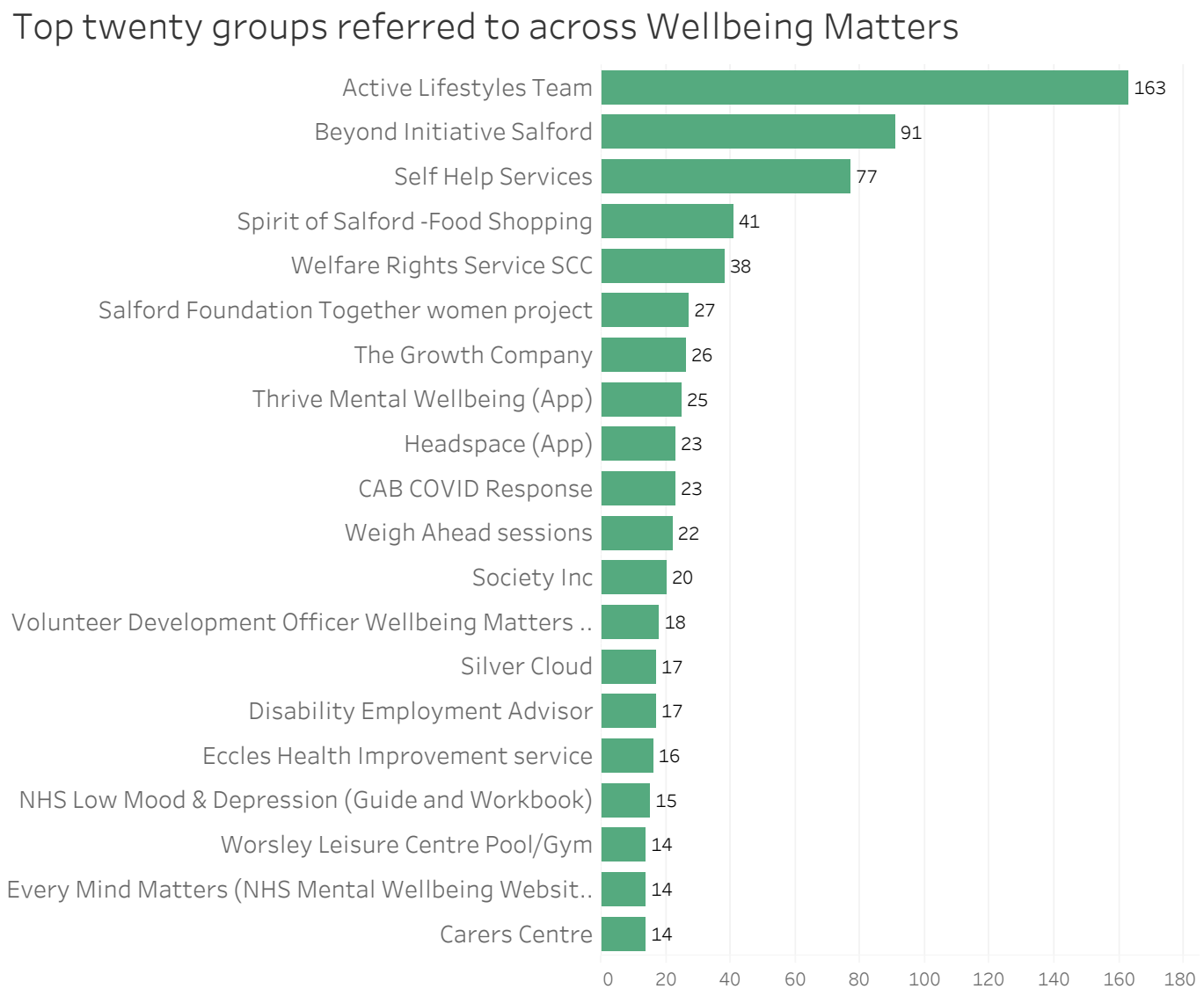


Figure 12 Top 20 groups referred to

Whilst some of the commissioned services are obvious choices, the broad range of hyper-local community support offer demonstrates the value of this Wellbeing Matters approach. It is not until looking at connections in each area that the real depth of knowledge of local community groups and activities really shines through, highlighting the efficacy of situating social prescribing within the Voluntary, Community and Social Enterprise sector. In Eccles and Irlam for example, the Community Connector added 105 different groups and activities using the Elemental dashboard through the process of connecting people. As Figure 13 illustrates below, there are clearly a few groups, such as the Beyond Mental Health support service, welfare rights and active lifestyle services that were needed by many people coming to her for support, but a majority of people who were connected were of one or two people to a wide number of organisations and activities. A similar chart can be found for each area in Appendix E.

Eccles & Irlam: Groups referred into by the Community Connector

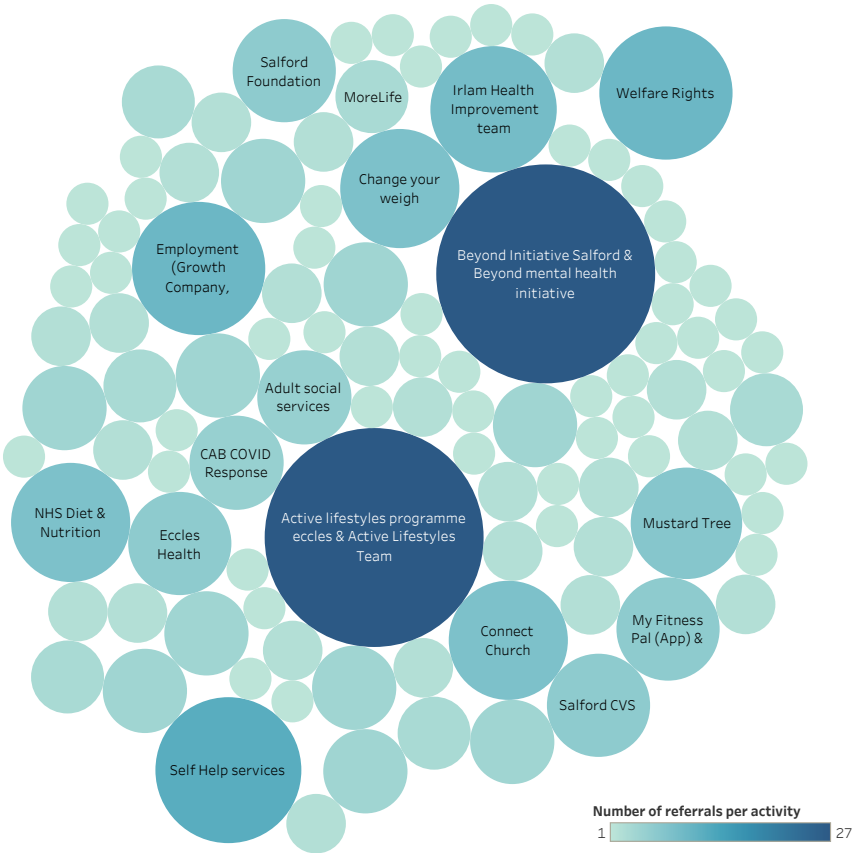


Figure 13 Eccles and Irlam: Groups referred into

The programme undertook its own satisfaction surveys with beneficiaries to create their own positive feedback loop as a way to continuously improve their own processes. These were voluntary, and overwhelmingly positive across all aspects of the programme as shown in figure 14.

Wellbeing Matters Satisfaction Survey

Figure 14 Wellbeing Matters Satisfaction Survey

Outcomes and impact

This evaluation has found that the Wellbeing Matters Programme has demonstrably improved participants wellbeing physically, mentally and emotionally through connection to activity, to community and to resources. Beneficiaries report increased self-confidence, improved connection, less isolation and better physical and mental health. In this section, we present five case studies to illustrate the positive holistic impact of the Wellbeing Matters programme. All names are pseudonyms.

Case Study 1

'My life started shining from the dark'

Sylvia was referred to the programme by her GP to help manage her sickle cell anaemia and severe depression through increased connections to the community. Brought to the country by an abusive husband and without much education, she 'wasn't expecting anything in her life'. Before meeting the Community Connector, she described her feelings of depression as follows:

> '[My] mind is like just blank. I just wake up and then sit down, think about my pain, think about my sorrows, what I've been through, the domestic abuse that I've gone through, how my husband has insulted me, ugly I am and all that, so like, oh, I just forget about life, like that nothing means nothing to me'.

She did not know what to expect from the first meeting but found that meeting the Community Connector was 'the best thing that happened' to her, opening opportunities in life that she did not think were possible. They gave her hope for the first time. One of the things that the Community Connector helped her with was signing up for a college course, which she described as:

> 'You know, her doing that ... I feel like crying ... really like make my life so like shine, my life started shining from the dark'.

In addition to signing up for a college course, the Community Connector helped Sylvia to volunteer with the British Heart Foundation. She learned how to work the till, which she hopes will provide future opportunities for future employment. As she states:

'...later they told me to go to the till. And I was like, how am I going to do this till? I've never touched it before, I don't know how it works. And then the lady I met there, her name was Rose, she was also nice, and she just teach me how to use it. I came home, if you ask my children, I was so excited, I say, yes, now I can work at Tesco, I can work at any shop. I was so happy to learn how to use the till. I was so happy and... You know, those ... that very one have make difference in my life'.

Sylvia's flare ups of sickle cell anaemia were triggered by feelings of depression, often as a result of her abusive husband. The Community Connector helped her to get in touch with Citizens Advice, who reassured Sylvia that her family's right to stay in the UK would not be affected if she divorced her husband. Knowing this relieved a lot of pressure for Sylvia and at the time of the interview she was in the process of divorcing her husband.

Sylvia described the Community Connector as very friendly and taking the time to listen. These qualities helped Sylvia feel comfortable sharing such difficult problems. Above all, it was most important to her that the Community Connector demonstrated 'action instead of words':

'She didn't just say it with the mouth but with action. And that is how every work is supposed to be, not with the mouth but action also have to be taken'.

Sylvia had difficulty in reading and using the computer, which meant that she needed a little extra help, which her Community Connector provided.

'She didn't tell me, this is the website, this is their telephone number, call, this... No. Because I told her, I don't have much education. She said, okay, I will help you. So she did all the research...She didn't even show it to me on her phone ... she printed it'.

The Community Connector provided opportunities for Sylvia to talk about her problems and this greatly reduced the triggers that caused her pain. **Sylvia is visiting A&E less than before and has halved her anti-depressant medication.** She is now able to manage her pain with painkillers, whereas before she had to go to A&E for morphine.

Although Sylvia's case is now closed, she still finds it a great relief that her Community Connector has made it clear that her door is always open if needed. As Sylvia said:

> 'if someone is helping you and then the person just going out from your life sometimes it's very hard. That make you scared'.

Sylvia ended the interview thanking the Community Connector and highlighted the significant impact that the Community Connector has had:

> '...because if you are not happy how are you going to raise your children? So this has really saved my life and saved my children's lives'.

Case Study 2

'They are lifesavers'

Suffering with several 'invisible' illnesses, Kate felt misunderstood and isolated. Her GP referred her to the Community Connector for some extra support. Although she had a habit of seeing someone once and then never again due to feelings of anxiety, she felt comfortable with the Community Connector and continued seeing her. Reasons for staying in contact with the Community Connector were that she 'went out of her way' to help her and listened without judgements. She describes this as follows:

'And, you know, since I've been talking with [the CC], my confidence has come back a little bit and I'm finding myself a little bit more able to...as I'm speaking to you now, and I spoke to [the CC] and all that, like a few months ago I wouldn't have been able to do that. So I think that's all down to [the CC] and the way she listens and understands. And, do you know, she's probably one of many people, and I know fibromyalgia isn't her field, but she knew everything and understood everything before I even told her'.

'I could...I probably told her quite a few half stories without finishing them off and she never made me feel stupid or bad or anything like that, you know?'

Covid-lockdown appeared soon after their first meeting, which made face-to-face meetings and referring her to community groups challenging. However, they kept in touch with weekly phone calls, and the Community Connector made sure that Kate had food as she had a low income and struggled to go to the supermarket (due to anxiety and fibromyalgia). The Community Connector arranged for food deliveries from the Mustard Tree food club. Speaking about the volunteers at the Mustard Tree, she says:

'They're lifesavers, you know? It's incredible what they do. They're volunteers and yet they go in there, they volunteer their time, they talk to you, they give all the food. I mean [the support worker from The Mustard Tree] even rang up my friend to tell her when the food had been delivered so she didn't have to go up and down. You know, they're like...I don't know, they're like angels'.

Kate believes social prescribing should happen 'automatically', as many people who need it might reject the offer due to being in a 'bad place'. Again, this helps give a better understanding of why people may not engage right away, or engage at all, with the service. As she says:

'Because sometimes when you are in that place and a GP will say to you, Would you like to speak to somebody from Wellbeing?, you're going to say, no right away, you know, because you're not in the right place. Whereas if they just refer you, by the time that referral comes through, it's...you could be in a different place and it's, "yeah, I'll go to this and see how it goes." You know?'

In addition to feeling more confident and feeling understood, her physical health has improved too. Kate mentions that she takes many different medications due to multiple conditions (including fibromyalgia, anxiety, depression and a history of a heart attack); however, she has now stopped one of her medications. **Kate now visits the GP less often**, as she can discuss issues, such as quitting smoking, with the Community Connector:

'And also, whereas like with the foot thing and the smoking thing would have been probably a reason to go and see my GP but because I've discussed it with [the CC] and she's looking into it, I've not had to make an appointment and do that'.

Case Study 3

'I can open up a lot more'

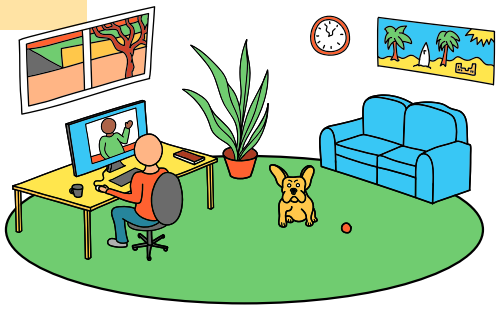
Sophie suffers from post-traumatic stress disorder (PTSD), depression and anxiety – most likely triggered by nearly losing her son five years ago and losing her dad. Sophie had begun to self-harm and have suicidal thoughts which resulted in admission to an inpatient psychiatric ward. Sophie needed someone to talk to, and her GP referred Sophie to the Community Connector. Being referred had a huge impact on Sophie – as described below:

> 'I got involved with [the CC] and since then I've not harmed, not, I still have sometimes some thoughts, of self-harming, but not as bad as it were, since meeting [the CC]'.

Sophie described her first meeting with the Community Connector as 'brilliant' and remarked that they 'talk about anything' and she 'feels relaxed around her'. Sophie meets weekly with a volunteering group that the Community Connector referred her to and described the best thing about being part of this project is that she is able to 'open up a lot more' to friends, but most importantly she has improved her relationship with her family, too:

> 'I feel more outgoing, I feel as though I can open up and talk about how I'm feeling and what's going on in my life and how things are affecting me and I can open up a lot more'.

Sophie mentioned that she used to visit the GP about twice a week to talk about her issues; however, since visiting the Community Connector six months ago, **she has not been back to her GP.** She also mentions that she came off one (of her seven) daily medications. During lockdown, she spoke to the Community Connector once a week, which 'stopped her feeling so isolated'.



Case Study 4

'She's there, no matter what'

'Dave' grew up in care – his mother left him when he was 3 and he never had any family to turn to. Although his mother reconnected with him again 35 years later and set him up with his current accommodation, she then turned her back on him again for the second time soon after. Dave has suffered from depression and anxiety and was an alcoholic for years but has now been dry for six years.
Dave had been suicidal, and made an attempt to kill himself, but was found by the police. Dave described how he is regularly bullied by his neighbours, both face to face and through text messages and social media. His GP referred him to the Wellbeing Matters programme to get extra support, and this has been a lifeline to him. Dave described the difference in support he receives this way:

"GPs? It's bad enough trying to get an appointment with them and you only get 10 minutes with them. Also "it's the trust issue"... But very different with Debs. We'll have a laugh and joke, me and Debs, but we have a serious chat as well, and it's brilliant."

Dave feels he has benefitted hugely from the service – despite not (yet) having taken up any of the connections into other activities / services that have been offered by the Community Connector. For him, the benefit so far has come entirely from being able to talk to the Community Connector, and he spoke highly of her ability to listen to him and take his issues seriously. Dave stated that he doesn't have anyone around him when he's at a low point, and while he knows about the Samaritans, it is currently the reassurance in having an appointment with his Community Connector coming up that's helping him.

"You know for a fact you've got someone to talk to who you can trust and that's what it boils down to: trust."

He also highlighted the importance of understanding and empathy – of not having hard and fast rules to continue to receive support.

'They need more organisations like this, they really do. This is the best one I've known, and I've gotta admit they've actually supported me from day one. Y'know most places could have turned around and said 'Oh Dave, you've missed these couple of appointments now, I don't think you want this, we're closing it now', but no they've not. They give you that opportunity, and that's what people need, the opportunity – to get the help and support they need'.

'They need to keep this open, I don't care – I would stand outside and protest, seriously, if they tried closing this down – because they're that good!'

He has been connected with a community centre where they do gardening and he can build things since he's good with his hands. While Dave is a bit anxious about being with unfamiliar people, yet he is looking forward to the opportunity.

Case Study 5

'She Listens'

'Katie' was originally referred to the Wellbeing Matters programme by her GP due to back pain. Katie had started taking Tramadol 10 years ago and was now addicted. This was having a significant impact on her life as symptoms of Katie's addiction were depression, restlessness and poor sleep. The GP felt that rather than anti-depressants, she would benefit more from a social prescription to help her through the withdrawal from the Tramadol. Katie described how the Community Connector came out to visit her and how she listened. She made Katie feel that it was OK to say whatever it was she was feeling and that she would not be judged. This allowed Katie to really pour things out.

'She said "what can I do to help you...is there anything that you like to do for yourself?"'

This was the question that mattered.

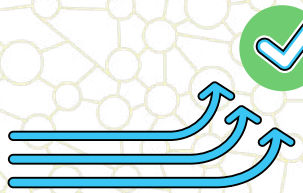
Beyond caring about what mattered, beyond offering her useful advice and support, Katie placed most importance on how the Community Connector **listened to her as a person.** She had initially had no expectations of Wellbeing Matters or social prescribing. She was pleasantly surprised. Together they explored different opportunities—Katie joined a gym and has been making fantastic progress—and the Community Connector always provided positive feedback. She feels that the gym has brought her back to herself, saying **'the answer isn't in a tablet** – it goes deeper than that'. She has been cooking more and experimenting with different healthy foods, feeling like she has more energy, feeling better in herself. **Katie has now been off Tramadol for 6 months and feels great.** In total she had four or five visits with the Community Connector, and is now also seeing her GP less because the tramadol is no longer exacerbating her Meniere's disease. Katie believes she

'could not have come off Tramadol and changed her life without the Community Connector'.

These five case studies highlight the benefit of the Wellbeing Matters programme on people with a range of needs. In each example, the Community Connector worked with the beneficiary to develop a trusting relationship, which they used to provide advice and support. Listening to the beneficiaries and understanding what mattered to them helped the Community Connector to refer the individual to receive appropriate support.

The 'clinical impact' in some of these cases resulted in:

- **Reduced GP visits**
- **Improved mental wellbeing**
- **Improved confidence**



This is echoed in the strong results from the SWEMWBS questionnaires, which show the overall improvement of wellbeing scores averaged across the range of measurements (measured on a scale of 0 to 10) for beneficiaries as shown in Figure 15.

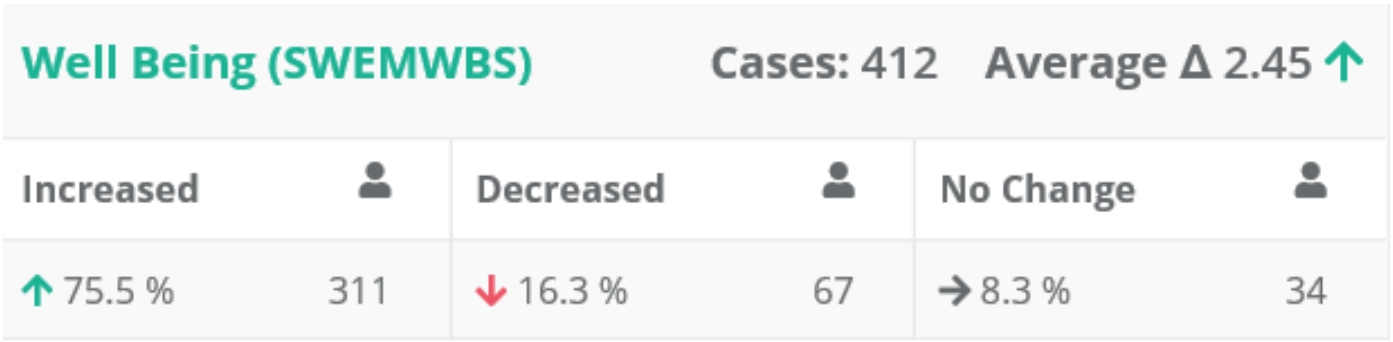


Figure 15 Graphic from Elemental dashboard showing average change across range of SWEMWBS indicators[7]

These improvements in wellbeing demonstrated in the quantitative data and so clearly illustrated in the case studies comes alongside a clear reduction in demand on GP services when needs have been met with more appropriate services as discussed next.

7- The dashboard used by the Wellbeing Matters team has been a work in progress undertaken in partnership with Elemental, one of a handful of start-ups designing systems from scratch to support the recent expansion of social prescribing. Designed to facilitate the day-to-day processes of link workers and analysis around the progress of any one individual, it has been slower for the programmers to provide needed improvements in how this data is collected to facilitate its extraction for more extended analysis of the programme as a whole and the progress of thousands of individuals over time. Given that data for all ten SWEMWBS indicators have been collected at a different number of points for every programme beneficiary, the initial system of data collection has made it nearly impossible to analyse changes over time. This has been one of the more recent adjustments made and still incomplete, which is why the graphic above is still only an average change calculated across all indicators for only those beneficiaries going through the programme since the update was implemented.

Reduced inappropriate demand on health system

One of the goals of the programme is 'to help reduce inappropriate demand on costly areas of health provision in Salford'. Shifting demand into communities, when appropriate, would save money in the longer term.

As one staff member reiterates:

> 'It's not about reducing demand, it's about putting demand in the right places'. (WM1)

> 'It's about maximising people's strengths and showing them, reflecting them back. It's about working collaboratively with other parts of the system, including primary care, not just primary care. I think in terms of the broader impact, I think communities, I think it's connecting people into their community offer'. (WM1)

The wellbeing of beneficiaries clearly improved as a result of taking part in the Wellbeing Matters programme; for some, this translated to reducing the use of other health care services. For example, one beneficiary mentions that she would have visited the GP for smoking cessation and a problem with her foot; however, she sought support from the Community Connector who was able to provide advice and information. Other beneficiaries described how their medication had reduced or even stopped.

Table 2: Summary of some of the outcomes of the beneficiaries

The chart below describes some of the main medical and personal outcomes of the beneficiaries.

Outcomes
- mental health
- critical
- medicines

	Medical condition	Intervention	Medical outcomes	Personal experience of outcomes
'Sylvia'	Sickle-cell anaemia, depression	Enrolment in education programme and volunteering, support with immigration status and domestic violence case	reduced A&E visits, fewer flare-ups, halved depression medication, pain under control using primarily over-the-counter pain meds rather than morphine	'My life started shining from the dark'
'Kate'	Fibromyalgia, anxiety, depression, previous heart attack, self-isolation	The Mustard Tree and The Food Club – for food delivery during lockdown Trying to quit smoking	Visits GP less (she would have gone to GP for smoking and a problem with her foot – now she talks to CC about it) Stopped one medication	Increased confidence, feels understood, 'they are lifesavers'
'Sophie'	Anxiety, depression, bereavement, PTSD, suicidal, self-harming	Referred to different volunteering groups	Not self-harmed since speaking to CC, not been back to GP since meeting CC 6 months ago (used to go 2x/week) Came off one (of the seven) medications	Increased confidence, less isolated, feels she can open up to family a lot more 'I don't feel as isolated as I used to'
'Katie'	Back pain, addicted to Tramadol, depression, poor sleep, anxiety	Talking about issues, gym membership	visits GP less often for pain, stopped taking Tramadol	"could not have come off Tramadol and changed my life without the community connector."
Mr and Mrs 'Smith'	Accident – poor mobility, lacked in confidence	Brain and Spinal Injury Centre (BASIC)	Increased mobility (from not being able to get out wheelchair, Mr Smith is able to stand for 100 seconds; he is now able to wash and dress his upper body)	Increased confidence 'Salford has really looked after us'

	Medical condition	Intervention	Medical outcomes	Personal experience of outcomes
'Miranda'	Anxiety, COPD, isolated, cancer in the past	Didn't refer to services, helped with housing and benefits	Although she still suffers from anxiety, she feels that the talks with the CC has calmed her anxiety down	'When she [the CC] says she's going to do something, she does it'
'Janet'	Domestic violence, depression, PTSD, heart problems	Together Women's Project, waiting to be seen at St. James House, the CC talked to partner to explain how to deal with anxiety issues, helped with social services	Improved mental health, increased confidence, more connected to the community	'I've met a load of new ladies, I'm doing different courses, and it's been really, really helpful for my, you know, depression as well as, like, the abuse side of it all.'
'Elaine'	Distressed and feeling low due to problems with neighbours, felt 'lost'	Tea and Tech (computer course), walk and talk group	Has not visited the GP since being referred to the CC, feels less anxious, increased self-confidence	'The best thing about being part of it? Being listened to and being understood.' 'They've never let me down'
'Chris'	Suicidal, depression, isolated, housing problems, debts, ex-alcoholic, early stage emphysema	Referred to Victim Support, Stop Smoking support group, a woodwork group, referred himself to Six Degrees.	Reduced stress levels	'She has never let me down' 'Instead of being told, I've been asked. And it's good' 'They need to keep this open. I don't care. Do you know, I would stand outside and protest me, seriously, if they tried closing this down.'
'Dave'	Depression, social anxiety, chronic fatigue, fibromyalgia	Re-training programme of health and social care, small courses via Growth Company, helped with benefits, 9-week gym pass	Improved mental health (less episodes of feeling low), feeling less isolated	Gave back purpose, getting back in a routine 'it's provided me with focus and knowing there's someone there'
'Lisa'	Fibromyalgia, socially isolated, past domestic violence, anterior cervical disc fusion, past heart attack, depression, anxiety	Referred to fibromyalgia group, weight loss, counselling and stop smoking group, helped with benefits	Feels more optimistic, better mood	'I definitely tell people about it [The Wellbeing Matters Programme] and how its loads better'
'Ajmal'	Mental health problems	Referred him to the gym, courses and different voluntary groups	Mental health improved, stopped taking anti-depressants	Feels more confident 'I met a lot of people'

	Medical condition	Intervention	Medical outcomes	Personal experience of outcomes
'Nick'	Mental health problems, chronic tinnitus, depression	During lockdown, sent mental health links, helped with signing up for an allotment, free swimming	Improved mental health	'She just keeps me going, which you know, I don't know whatever if it's her role, but she does.'
'Crystal'	Low mood, financial issues, isolated, in a wheelchair (disability)	Talking, food bank, baby massage, helped with benefits	Feels mentally better, goes out more	'I can't thank her enough for what she did for me' 'there is a light at the end of the tunnel'
'Max'	Depression, chronic fatigue, fibromyalgia, bereavement	Support into training for health & social care career, benefit advice, gym	Is glad to be trying alternative activities to try and reduce medications (feels COVID has prevented this)	'it was great and it was a lot of things all at once and I just kept thinking "Yeah, just keep bringing on, I'll keep trying and move forward"'
'Caroline'	Depression, anxiety	Art in Salford (although did not take it up due to being anxious around people), volunteering at RSPCA after pandemic, during pandemic arts and crafts apps and websites	Still suffering from anxiety and depression, but feels more hopeful	'It's made me feel more hopeful.' 'I'm in a better place than I was last July. So it's worked.'
'Ian'	Depression, bereavement, osteoarthritis	Signed up for local angling clubs, provided easy-to-understand information about osteoarthritis	Increased understanding of his medical condition	'I can't praise her enough to be quite honest, she was very good.'
'Alex'	Depression and anxiety, grief for mother with dementia	Debt support and advice, START for art group, Meadowbrook	Now dealing with grief and more socially confident, can now afford to heat home	'She's helped bring my confidence out' "I'm determined not to go where I was again because I was in a very dark place"

Developing a new ecosystem of support

The Wellbeing Matters programme integrated well at a wider level with the new and emerging Living Well model, designed to help organisations think differently about mental health support. A key aim was to support Salford in focusing on people's skills, aspirations and experiences to build a different way of offering support and help — a shared goal between the two programmes. It is understood that the Living Well model will change the way mental health support is approached to help everyone who experiences mental health difficulties to work towards recovery, stay well, make their own choices and take part in everyday life.

The focus is on developing new ways for people to access support that:

- Recognises people's skills, aspirations and experiences
- Is designed by people with lived experience working together with service leaders, clinicians and commissioners
- Is easy to access
- Is located within community settings
- Helps to stop difficult times from getting worse;
- Supports people with relationships, housing, debt and employment;
- Is provided by communities, including voluntary sector, social enterprises and statutory services

Integral to the success of the programme was the formation of supportive and collaborative relationships that enabled the development of trust. Some participants in the Voluntary, Community and Social Enterprise sector highlighted the lack of parity between level of resources invested in the Primary Care provider for link workers as amount of resource invested into the Voluntary, Community and Social Enterprise sector to support the social prescribing offer. Initial concerns emerged in this evaluation both from GPs interviewed as well as a participant from the Health Improvement Service team, who highlighted that the lack of resource could influence the capacity and ability of smaller community groups to receive referrals, particularly those adults made vulnerable by any number of physical or mental health issues. The GPs suggested that this may affect the smaller community groups ability to provide a consistent, safe offer. This is the gap workstreams 2 and 3 were designed to fill. One of the key benefits of the Community Connectors was their knowledge and understanding of the local community assets, which they used to provide reassurance. The following extract illustrates this point:

> 'GPs really struggle to initially trust charities. And I can understand that as well, from their perspective, because they need to know they are referring somewhere that's like safe and can do what it says on the tin, so to speak. So I think having the Community Connectors just really, really helped us to receive those types of referrals. ... now the Community Connector process is there, it's become like almost like second nature now for GPs, which is really refreshing, because now they are seeing more than just medication and they are seeing the client in a more sort of holistic way and picking up on other things that might be going on, for that patient of theirs and rather than just being purely the medical model. So I think it's amazing'. (CG 04)

This represents a big culture shift among GPs in response to the services provided by the Wellbeing Matters team and the improvements they can see in their patients.

The case study below helps give a sense from the point of view of a single community space of the ways in which the Wellbeing Matters programme brought everything together.

Wednesday women's group

The Wednesday Women's Group has been operating for over 25 years providing a social space for women to meet at St Marks Church in Swinton. As part of the Community Connector Wellbeing Matters programme's asset-mapping this group was identified as a suitable referral route and have already welcomed a number of new people for social activity and conversation. Many of the ladies also meet up socially outside the group setting and have attended other sessions such as Tech and Tea (Inspiring Communities Together) and the Tuesday lunch club at Critchley Café (Age UK Salford) together.

Two of the ladies referred by the Community Connector have joined the Tuesday Club sessions on a regular basis as well as the Wednesday Group. One lady who has been very isolated for several years said going to the group **'was as if someone had turned a light back on in her life'.** She could now see options and felt included again.

The group have expressed an interest in increasing their offer and have applied for funding through the Active Ageing programme (led by ICT, administered by CVS) to deliver a physical activity project.

The group have been supported by the CVS Volunteering Development Worker to apply successfully for a Salford 4 Good award and are continuing to receive broader development support from CVS on future planning. The Volunteering Development Worker will now work with them to link them with other local groups and churches so that they can network and showcase the good work that is going on across Swinton.

This provides a more detailed sense of how the two workstreams within Wellbeing Matters work together and exemplifies some of the broader support provided to the Voluntary, Community and Social Enterprise ecosystem as explored further below.

In many ways, this support was no departure from the traditional work of Salford CVS. As one staff member said, 'I think we know what we're doing in terms of capacity building our sector' (WBM staff 2). What the Wellbeing Matters programme actually did was to highlight just how far and effective a little funding could be in improving the capacity of Voluntary, Community and Social Enterprise sector groups to welcome social prescribing 'referrals'.

'I think what we've learned is actually you can achieve so much more if you've got a decent amount of capacity. Because prior to this programme, we do run a Volunteer Centre but on an absolute shoestring. So actually, giving us that additional capacity to focus on neighbourhoods and work more intensively with groups has made a huge difference. It's enabled those groups to capacity build themselves. So it's given them some of the tools they need, whether that's around recruiting volunteers, safeguarding, knowing things that they need insurance, but also accessing grants, you know, I think all of those things'. (WBM staff 3)

This was echoed by members of the community groups themselves who had been struggling with many of these capacity needs before this injection of funding and the extra support it allowed CVS to provide.

> 'Yes. So, CVS have been ... well, a huge support in providing the practical support for the committee. Offering training days ... But it's not just the training, it's the support and the relationship that I value. Because they come ... you get the one to one, you get the team work, they encourage you when you're doing some digging ... what do you call it when you go before the panel? Pitch? We have to pitch for certain things as well. ... for grants ...' (CG 03)

A number of the smaller community groups we interviewed had made the conscious decision to remain as informal as possible. Many were completely volunteer-led and staffed by retirees as a space to enjoy hobbies or crafts with others. Given the ability to talk through with CVS the different levels of organisation and levels of responsibility required to apply for different kinds of funding, they had opted to apply for the smaller pots of funding that supported them to buy supplies or cover expenses for workshops as well as support in finding adequate and affordable spaces and storage for their activities. They also felt more comfortable after training around issues of safeguarding. As one founder of a small community group told us:

> 'step by step I studied their website and I understood that there is some funding available for the group, and then we studied all their policies and we participated in the training ... Mostly we participated in their training, so we learned about (being a) trustee, what are the roles and many things we learn. ... Salford CVS, they awarded us the - was it the Wellbeing Grant? - about a year and a half ago ... So, they've been sort of a major contributor to the success of our project. The support that they've given us, on the phone or through the little workshops that they do, the volunteer funds, the volunteers, they've been amazing. ... So yeah, we have an amazing relationship with them. And if we ever need anything, they're there to give you advice or they will come out to support you. Anything you need...' (CG 10)

This same community group was able to quickly make a very big difference in people's lives through support with language. One example was a patient who:

> '... had a brain operation and was very alone and needed help with the language. ... So he came to [the group] and learned about how to go online and have a chat and had this tablet from the CVS. And then he wanted to solve a housing problem, so I had a meeting with him. I went with him to a meeting to interpret for him free of charge ... because if they want to go through interpreter they have to wait longer, sometimes, weeks, months ...' (CG 08)

Other more established Voluntary, Community and Social Enterprise organisations needed different kinds of support, primarily longer-term funding to ensure staff security. Some who did not need direct services or support from Salford CVS themselves currently recognised the possibility that the funding for their current community development work might not be renewed. They saw CVS as an ongoing and very important resource able to support nascent organisations beyond the lifetime of specific grant-funded projects.

> '...so if we don't get our funding renewed the ladies can carry on with the groups and learn how to put those groups together, apply for funding in their own right. And that is something that Salford CVS will be able to help with. So, I think we will be involved with them a lot more in the next six months'. (CG 05)

For such groups, CVS played a key coordinating and informational role. When asked what made a programme successful, they responded:

> 'It's going to sound quite clichéd, but services actually working together. Because what we find sometimes, especially when people are going for the same pots of funding, is that services start to become quite precious. And that's really unfortunate, because just because we've got funding for something, or you've got funding for something, doesn't mean we have to stop talking. We need to continue to talk, we need to continue to work together, because you're just a little piece in a jigsaw. We all are'. (CG 04)

While funding and training around safeguarding and governance were central to what most of those interviewed most valued, many also really appreciated Salford CVS's support around developing their presence and connection within communities through social media and the development of websites. This was recognised by the Community Connectors, who in turn worked hard to promote groups who wanted their help with that.

> 'So a lot of groups want more people because they might've got funding that they need to monitor for or they actually have got a small group and they actually see, we could support more people because that's the reason why people go into setting up groups. They're predominantly voluntary. They're there because someone's gone through something and this group's really helped them. So they're really passionate about spreading the word, so when we say we'll promote for you and we'll share on Twitter, and we'll speak to the practices for you, and we'll get one of your posters up on their noticeboard. They're really happy that we're able to do that'.

Community Connectors, through their relationships with some of the community groups, were also able to refer them back to the Volunteering Development Workers for additional support where needed. Groups echoed how much they appreciated this, as well as the infusion of new volunteers and connections to other groups and services that CVS and the Community Connectors helped facilitate. For one CVS staff member, this brought an additional benefit:

> 'I think in terms of the learning from workstream two, is that I don't think we've learnt anything phenomenal in terms of what's required, the ingredients to support volunteering and voluntary action within communities. So I think with the CVS we knew that. ... I think it has enabled them to raise some money and to do things a bit differently. It's injected new blood ... and also given them the opportunity to reinvent themselves a little bit'. (WBM staff 1)

One of the Health Improvement Service team commented on the Community Connector's ability to spend time outside the GP offices in supporting someone who needed it.

> '[S]he's lovely ... she did a lot of the hand holding, you know, for people that wanted to go to a group for the first time and was nervous. That relieved a bit of my time to see more people in the GP surgery. So she did a lot of that for me, so anybody ... so I would contact her and just say "This person wants to start a group on such-a-day, such-a-time, are you free? Would you be able to go with her for the first time and see how things go?... and maybe every now and again we'd bounce off each other for ideas or if we had a real difficult one, then we'd ask each other for advice on that particular case'. (HIC 02)

A final aspect of support emerged when gaps were encountered, where Community Connectors realised that they had a number of people with the same needs that no group existed to fill and helped facilitate the effort to develop something to fill it. As one staff member explained:

> '[I]t's not part of the Connector's role to set groups up, that just happened really organically, because there was a gap. ... I wouldn't say that [the CC] set it up, I'd basically say that [she] was a real driving force around those different partnerships coming together. So the veterans champion I think they're called, the veterans champion over at the council, connecting them to [GP] who has a real passion for supporting veterans through primary care. ... And then we've also got a supported living accommodation in Walkden for veterans, for ex veterans. So it all, again, organically, [the CC] connecting the dots, yeah, to those partnerships. ... because people are talking to each other ... those individuals have really found a massive benefit of that. And some individuals have got into have a home now. So they're out of the supported living, they're living independently and starting to get their life back on track. So that was because of that partnership'. (WBM staff 2)

This emphasises the third key strength of the programme – the ability to develop meaningful connection to facilitate a holistic approach.

The significance of relationship building

The Wellbeing Matters programme dovetailed with the key principles of the Living Well model and the Wellbeing Matters programme manager worked hard to facilitate the relationships needed to progress collaborations across organisations, that in turn could support communities and people.

One of the key commissioners, Judd Skelton, reported that:

> 'We realised at the outset of the work regarding Living Well how important it was to ensure that this work progressed in a way which complements Wellbeing Matters and so colleagues from CVS were members of the Living Well Design Team from the outset. This has enabled us to keep factoring in the two-way referral pathways which need to exist between Wellbeing Matters and Living Well; enabling Wellbeing Matters to refer people to Living Well who are presenting with greater complexity and also enabling Living Well to refer people to Wellbeing Matters as part of a recovery pathway. This expected synergy between the two services has resulted the Wellbeing Matters Community Connector for Broughton being an integral part of the Living Well MDT.
>
> Owing to the high rates of referrals to Wellbeing Maters where the presenting need is identified as mental health and as we start to work more closely with PCNs in scaling up Living Well, this joint working between the two services is crucial so we can provide the right type of support at the right time and ensure a much more holistic way of meeting people's needs'.

Relationships are central to the success of both partnership working and the person-centred approach which promoted the non-medical, self-driven approach. The health improvement team member worked well with the Community Connectors to ensure that the beneficiary was connected with the right community groups.

At an operational level, the Wellbeing Matters programme supported a range of needs. According to both GPs and the Wellbeing Matters partners, and as highlighted in the Elemental data, the programme is particularly useful for people with 'low level' or 'low grade' mental health problems that would 'not hit the door of mental health services', such as bereavement, depression and anxiety. These issues are often rooted in social issues, such as isolation, lack of finances or unemployment. As staff describe it, 'the only cure for it is to address the proper issue... the real issue that underlies it'. Supporting people with social problems early may prevent the mental health issues from escalating to a medical problem and, subsequently, reducing the demand on mental health services. Moreover, a member of the Wellbeing Matters staff team stated:

> 'I think the most positive thing I have seen is... and I spend a lot of time with GP's in my role... is that once the penny drops for them they can see how they can collaborate on a whole range of things and not just around Wellbeing Matters and how the voluntary and community sector and the wider Salford infrastructure can provide for their patients in a way that medicine will never be able to'. (WBM Staff)

Feedback about the progress of beneficiaries referred is significant, and the early campaign to raise awareness of the programme amongst GPs had a beneficial impact. GPs tended to measure success by the improved wellbeing of their patients, but this was often signalled by a reduction in their attendance at the GPs surgery.

> 'I have seen the benefits to my patients in many ways. They have improved mentally and physically they are coming to see me less'. (GP 10)

Connection

The ultimate goal of the Wellbeing Matters programme was connection—not just of an individual needing support into meaningful activity, but also between and among different services (public and Voluntary, Community and Social Enterprise sector) and community groups. Both aspects of connection were vital to the success of a truly person-centred programme. Both the Volunteering Development Workers and Community Connectors identified the very strong connections people felt to their local neighbourhoods. This was a strength and source of pride on the one hand, but on the other hand meant that sometimes people would not feel comfortable going alone beyond boundaries often invisible to those who did not know the area well. This meant that connecting people to the right group or activity required an in-depth and very local knowledge, developed through being physically present and visiting the various community spaces, attending local forums and meetings, and regular contacts with key local people and groups. Taken together, this specialised knowledge could not be reduced to a simple list. As one CVS staff member explained:

> '[I]n all my time of working with CVS, what we're always asked is can you just suggest a directory, can you give us a list of every group that exists in the community. Well, of course you can't, because no sooner has the ink dried, or the digital version been created, it's out of date. So the fact that we are connected, we have that reach as a CVS, it's about a living and breathing organism, which is our sector, I think, and those anchors also do within those neighbourhoods, it's really important'. (WBM staff 3)

A working relationship with different community groups and voluntary organisations also ensured that connections were successful and had the best possible chance for a positive outcome for both individual and groups. The smaller groups interviewed were very aware of the complexity of people's lives and the real ways that their group made a difference to people's health. Through talking and listening, the groups were able to understand what mattered to the individual and this enabled them to tailor their support and advice and monitor progression. The following two quotes illustrate this:

> 'Well it helps a lot. A lot of them who have arthritis have said it helps them a lot. And there's ones who've had mental health breakdowns because they've had a bereavement in the family and it's helped them a lot, it's given them confidence to go out again. One or two they've had back problems, it's helped them doing gentle exercise. There's been quite a number of little things which I didn't know they had until we got talking to them. One or two, they've suffered from depression. They started coming out and for them to get up in a care home and do a bit of exercise they said they would never have done that before. So we just encourage them to join in'. (CG 02)

> '[S]he's able to move ... this particular lady now has been able to make changes in her life, gain confidence and she will be moving home. And she values the support, and that will continue, because she wants to continue with the quiz time and coffee morning'. (CG 03)

The Wellbeing Matters programme enabled a wider connection to the social prescribing ecosystem, resulting in a greater awareness of the community assets for GPs.

> '... as a group, over the years, we've been saying to CVS, "Can we not have doctors refer people to us?" ... But we had never heard of social prescription, and it's the very thing that we always wanted, for GPs to send people over. And then, we were so, so excited when we heard that we can and we do have something to offer ... And personally, the people that have come along with specific learning needs, and they're doing brilliant. And I think wow, this works ... I just think it's fantastic that at last we can be recognised as a local community group, that we can contribute'. (CG 03)

The connections across the ecosystem between Community Connectors, Volunteering Development Workers, voluntary organisations and community groups were also important, particularly for those able to support the more vulnerable people referred. Several commented that they really valued the ability to talk through referrals with the Connector, particularly those who might need a little extra support. One group had started to have brief meetings to discuss the people who were referred to them, which made it very easy to place someone where they might best flourish - 'if it [the referral] is not suitable for my project it could go to another, or we are quite honest and go back and say this service wouldn't be suitable. I think it works really well' (CG05). For some individuals needing a little extra support, the Community Connector worked to set up services that could continue to support an individual beyond their time within the Wellbeing Matters programme:

> 'She's (the CC) our link and she regularly refers to our service, but we do a lot of joint working, because some of the clients she refers are really complex, lots of complex safeguarding, social care issues requiring physio, requiring dieticians, OTs. So she's also like the link for us as well, in terms of communicating with those other professionals, which is really helpful'. (CG 04)

The group also highlighted the importance of developing meaningful connections to those referred:

> '[A] lot of our referrals come through and although on the surface they may appear quite straightforward, I think actually when you develop a relationship with somebody, you get much more back. So you then start to open up those conversations that have been hidden for many years, that you know these people may not tell their GP, because the GP, for clients who go into the GP, it's a very bish, bash, bosh sort of service. And that's what they expect and that's what they want, to some degree. ... I am certainly not a counsellor and I wouldn't confess to be one. However, when we can work in a restorative way, and we can be non-judgemental, then we can often find it quite easy to build rapport quite rapidly ...' (CG 04)

Some of the smaller, purely voluntary, groups were very clear that they could not successfully work with people who were connected to them who had higher levels of need. One spoke of the benefit of a more stepped service, where initially people needing high levels of support could be connected with a more structured programme, but at some point might be able to move into more informal group reliant on each of its members being reasonably self-sufficient and motivated to continue.

What comes through in most of the quotes given here, as well as through all of the interviews, is the necessity of building relationships along every segment of the person's journey towards wellness. This required Community Connectors to see the whole person, which several felt to be a strength of the programme.

> '[The CC] is really good at seeing the person. So she works in a very, very similar way to us actually, which is why I think why we complement each other so well, because she doesn't see a diagnosis, she doesn't see a disease, she sees the person who's there, who's struggling'. (CG 04)

While all the Voluntary, Community and Social Enterprise groups recognised challenges, these were less with the connection process. Instead they were primarily around funding, capacity and training around organisational structures, development and knowledge of safeguarding. All hoped to increase their capacity through programmes like Wellbeing Matters and people referred who might then become members or volunteers, but there was a recognition that too many referrals could become an issue and require additional resource. It was clear for some of the smaller groups, that the initial funding provided through the Volunteering Development Workers and the grants available as part of workstream 2 was used to support growth and welcome the new people connected in, which later influenced the vibrancy and strength of the group and open them up to further connections in a virtuous circle. The main focus of the Volunteering Development Workers and workstream 2 funding was thus to facilitate precisely this dynamic, and in this way the wider ecosystem within Salford. This effort showed every evidence of successful growth up until Covid-19 and March's lockdown. At this point the focus shifted to supporting survival, both of groups and their members.

Emergency response and resilience under covid: the importance of social support during a crisis

The Covid-19 pandemic has presented enormous challenges for all of the stakeholders involved in Wellbeing Matters; everyone had to grow accustomed to new ways of working. Nonetheless, this national crisis has also shown the importance of social care in the community. Moreover, the new ways of working have also presented opportunities for future ways of working. When the pandemic hit and lockdown started, face-to-face conversations had to change to digital meetings. Salford CVS has been agile and progressive and supported both the Community Connectors and the voluntary organisations and community groups to access and use digital communications, including Zoom, so that they could maintain their relationships with the beneficiaries. One of the anchor organisations states:

> 'during COVID as well, I think that they've been really good, the connectors, at kind of adapting to the change in landscape. Because obviously organisations have been working in a completely different way, and they've been very good at really understanding those groups and how they've changed their operating model to fit the new challenges with COVID. So I think that in itself is a massive testament to how linked in to the communities they are, and very impressive how ... that they've been able to do that'. (5A)

> 'They've changed their operating model to fit the new challenges with COVID. .... It's a massive testament to how linked in to the communities they are...' (5A)

Voluntary organisations and community groups have tried to stay in touch with people via weekly Zoom meetings and WhatsApp groups. However as not everyone is able to join Zoom meetings due to not having the technical skill and / or equipment necessary, regular phone calls helped to reach out to these people.

> 'It's appreciating that people communicate in different ways and people prefer different methods of communication and I think understanding that some people don't want to speak on the phone or are not comfortable on the phone and it's trying to find a way that we can work around that, in the timescales available so that we still give that quality, person-centred service at the same time. So I have done a few Zoom calls with people, because they've wanted to see my face, because they feel like they are talking to a real person, particularly the ones who are on their own. So yes, I think it's just about recognising what that individual needs and I think we appreciate that telephone calls are hard for people, and for us as well, because we can't always – when you are with someone face to face, you can read the body language, can't you, and you can see the things or hear the things that they are not saying when you are with them'. (Community Connector)

Some groups sent out craft-boxes or activity packs via the post to keep people engaged in the group. Some of the activity packs were hand delivered by CVS staff and volunteers. Interestingly, a voluntary worker from one group (Emerge) mentioned being able to reach more women than before, given that some women are scared of meeting people in person or in groups, and felt more open and comfortable over the phone.

Social prescribing services can clearly play a vital role in supporting the community during and post a national crisis. One GP described how they believed that the asset-based approach could help communities develop resilience post Covid.

> 'Yeah and I think we're seeing the bigger picture you know as we climb out of Covid, and the economic and social crisis that's ahead of us now ... the only way to support the communities is to have the communities healing themselves and for that we need the communities really offering that resilience and support, rather than external agencies coming in to help all the time, it's the solution within the community'. (GP 05)

There were a number of ways in which the Voluntary, Community and Social Enterprise sector in Salford has helped the community, one of which was through organising food deliveries. An example of this was described by one of the anchor organisations below:

> 'And we got a lean mean food delivery machine going, taking orders over the phone. 15 basic items and they could have a few extra items and we get deliveries from Fareshare. So it's all food that would be going to waste. You know, it's excess food and also Big Life. And it's just been amazing really. I think we've racked up to 700 deliveries now and some of the stories have been great. People just don't know what support's out there and the council are saying we've told everybody. But we just come across person after person who doesn't know where to go for help. For example, we found a supported housing project in Ordsall where the caretaker was trying to shop for all the isolated, elderly people in that place. And I found out, it wasn't by us, but through the bush telegraph, or whatever – and this was a Friday – so we just boxed up loads of food and took it down there and they were all out on the doorsteps and clapping and cheering. It was like, oh god. You know, it choked us up completely. So that feels like a very worthwhile thing to do. And we really got it down to a fine art. It's like a mini flipping Amazon with [laughter] everything lined up and order picking and going in boxes, numbered boxes. And we've got a couple of volunteers and about three or four people with cars who'd go out and deliver the stuff. So we're doing about 80 to 100 people a week now'. (4A)

Another example is that of a mental health offer called 'Beyond' that has been developed in response of the pandemic and is delivered by three Voluntary, Community and Social Enterprise organisations, including one of the Wellbeing Matters anchor organisations, and partly funded by Salford CVS's grants programme. Community Connectors can refer beneficiaries directly into Beyond, who are able to assess their mental health needs. According to one Wellbeing Matters staff, 'at the last count, we've referred 52 people to [Beyond]'. One Community Connector describes 'that she would not know where she would be if it wasn't for the Beyond project':

> '...for me, the Beyond Project came in at the perfect time, when we'd all been asking this question, we need this stop gap, we need something in between and it's come in and it's been an absolutely fantastic service. So I think that – and also GPs as well, we've had feedback from GP, one GP had commented that the service had exceeded their expectations, took the stress off GPs, so they are not having to deal with the social issues, they can concentrate on the medical issues. So for me, getting that feedback was a lovely thing for me as well, that we are helping doctors as well as medical staff'. (Community Connector)

Our evaluation findings illustrate that the Wellbeing Matters programme has been of value to both the individual beneficiaries and also to the wider health care system. Despite initial challenges, particularly around the referral processes, influenced by lack of GP engagement and awareness, and some confusion between the roles of the Wellbeing Matters and the Health Improvement teams, the data reveals that the programme has achieved its aims. The next section explores what has worked, and key recommendations for the future.

What has worked?

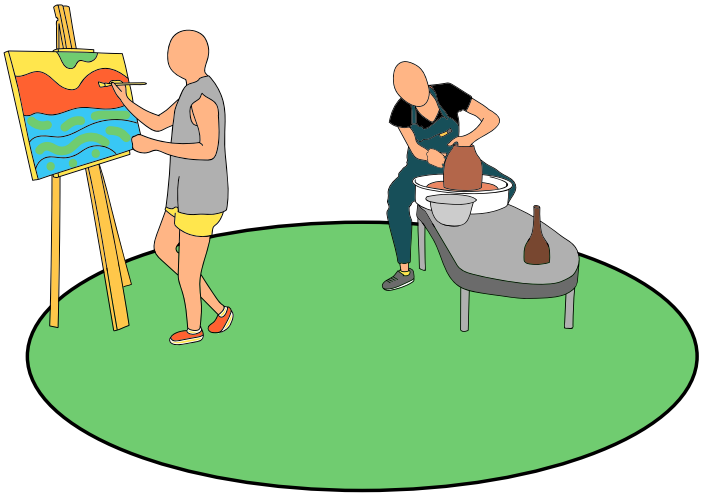
Our 2019 report, 'Social prescribing in Greater Manchester', contained a range of recommendations and set out the following key principles:

- **Ensuring holistic, joined up services**
- **Good relationships**
- **High levels of flexibility**
- **Supporting long term resources and secure staff**
- **Up to date resource mapping**
- **Ensuring adequate, sustainable funding and capacity**
- **Building an evidence base**
- **Maintaining relationships- needing a leap of faith from GP's**

The data from this latest evaluation indicated a range of factors that contributed to the success of the Wellbeing Matters programme. These factors were broadly influenced by the original 2019 recommendations and reflect how the programme has utilised the evidence base to make a difference to communities. The Wellbeing Matters programme built on the wider Greater Manchester Person Centred and Community Approaches model and embraced the social prescribing ecosystem to offer a service that is person centred, and effective. This success has been influenced by the support from GPs, utilisation of a holistic model, exploitation of existing relationships and a flexible, responsive model that has continued through Covid 19. Our findings indicate that the Wellbeing Matters programme has successfully utilised the key recommendations from the 2019 report and embedded a programme of work that is also aligned with the Locality Plan for Salford. This integrated approach has offered a flexible model that has been able to adapt to the changing, and often challenging circumstances. We report next on what has worked predicated on key recommendations and the added value in terms of successes. These findings have influenced the development of clear recommendations to support the programme and help ensure sustainability.

GPs: The leap of faith

> 'I feel that I'm more aware that there are things going on in their local community that can support people'. (GP 03)



One of the key recommendations in the 2019 report highlighted the need for GPs to embrace social prescribing as a legitimate and effective non-medical solution to support patients with a non-clinical need. A 'leap of faith' was needed by some GPs to enable the Wellbeing Matters Programme to be fully embedded, facilitated by a digital platform like Elemental able to integrate with their existing dashboards and make it quick and easy to refer patients. Our findings suggest that initial numbers of people referred to the Community Connector were low as many GPs either struggled with the idea of social prescribing – or were simply unaware. Hence, the leap of faith took time to develop and led to a targeted campaign by the Social Prescribing Coordinator and senior team at Salford CVS to raise awareness of the Wellbeing Matters Programme and its social prescribing offer. The programme was promoted at meetings with Primary Care and Commissioners and across the health and social care system at strategic forums such as the Health and Wellbeing Board and Adult Advisory Board, among others. Information was placed into Primary Care newsletters, promoted through Salford Primary Care Together (the GP Federation) and leaflets used to provide details about the programme and discuss the core attributes and role of the Community Connector. This was followed up with the use of reminders to prompt the GPs to make referrals, which then led to a significant increase in the number of number of people referred (see Figure 4).

The Elemental data illustrates the growth in referral rates and highlights where some improvement was still needed. The impact of the Wellbeing Matters Programme for GPs was most noticeable by the reported reduction in GP consultation with those who were referred. This was also replicated in the qualitative data (see chart of summary outcomes), which includes beneficiaries who stated that they visited their GP less; similarly, the GP data reveals that they saw less of some patients referred. This is significant and suggests referral to an appropriate community asset had helped the beneficiary and reduced inappropriate GP visits. However, progression data within Elemental was not routinely accessed by all of the GPs, which led some to query the progress of the patient after being referred. Hence, in the absence of the Elemental feedback, GPs used indicators such as decreased workload as a successful outcome and were reassured that the Community Connectors were able to manage and support beneficiaries' social aspects of care. The Wellbeing Matters Programme was considered to be successful, and, importantly, improved GPs greater awareness of community assets and what may be available to patients.

Holistic joined up services

> 'We can see people both in terms of what they can do and what they offer, what their strengths are rather than what their illness or disability is. But also ideally see them in a social context'. (WBM staff)

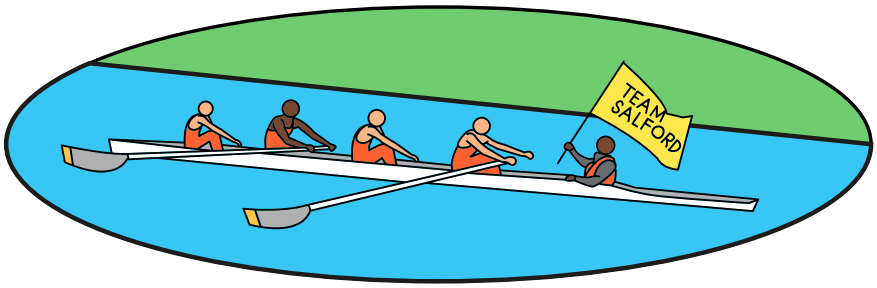
Our findings suggest that over the past 18 months, the Wellbeing Matters Programme engaged with a range of partners and has been embedded with other services – for example, the Living Well mental health programme. The use of an integrated, personalised approach has expanded the scope of the social prescription through dedicated asset mapping of the city's neighbourhoods. The social prescribing ecosystem has been operationalised and provided an asset-based infrastructure within communities. Overall, the Wellbeing Matters programme has integrated well into the community through the Community Connector and Volunteering Development Worker's relationships with beneficiaries, voluntary organisations, community groups, charities and social enterprises.

The development of relationships was predicated on the Voluntary, Community and Social Enterprise sector's philosophy, which was congruent with personalised approaches. As such, the Voluntary, Community and Social Enterprise sector was ideally placed to provide support that is wrapped around the person, rather than a service. This philosophy was reinforced by Salford CVS's senior managers and the CEOs of the Voluntary, Community and Social Enterprise anchor organisations at a strategic level through membership and representation on committees and forums which enabled them to operate and influence wider health and social care strategic partnerships. The partnerships with other organisations also provided a helicopter perspective of inequalities and the multiple support that was available. Well-established strategic partnerships have provided a platform for integration, growth and innovation. There is a need to ensure that this holistic approach is supported, particularly during Covid and the changing landscape. Community Connectors need to be able to work closely with the Volunteering Development Workers and local communities to support the most vulnerable through challenging times caused by the global pandemic. The Wellbeing Matters Programme has been able to link in to all 5 Primary Care Networks (PCNs) to become an established partner that works alongside other roles to ensure the holistic approach is sustained. The guidance for PCNs from the NHS Personalised Care Group is clear that social prescribing is most effective when flexible and adaptive in complementing established link worker programmes as well as the existing Voluntary, Community and Social Enterprise sector. The groundwork for such complementary working with Wellbeing Matters is well laid in Salford and should be further developed. The ongoing Wellbeing Matters Programme should build on and support the strengths of the Wellbeing Matters' experienced, committed and knowledgeable Community Connector staff team and the programme's knowledge and support of the wider Voluntary, Community and Social Enterprise sector.

8- NHS Personalised Care Group, "Social Prescribing Link Workers: Reference Guide for Primary Care Networks," 2019.

Good relationships & building trust

> 'if it wasn't for [the CC], I wouldn't be here today'.

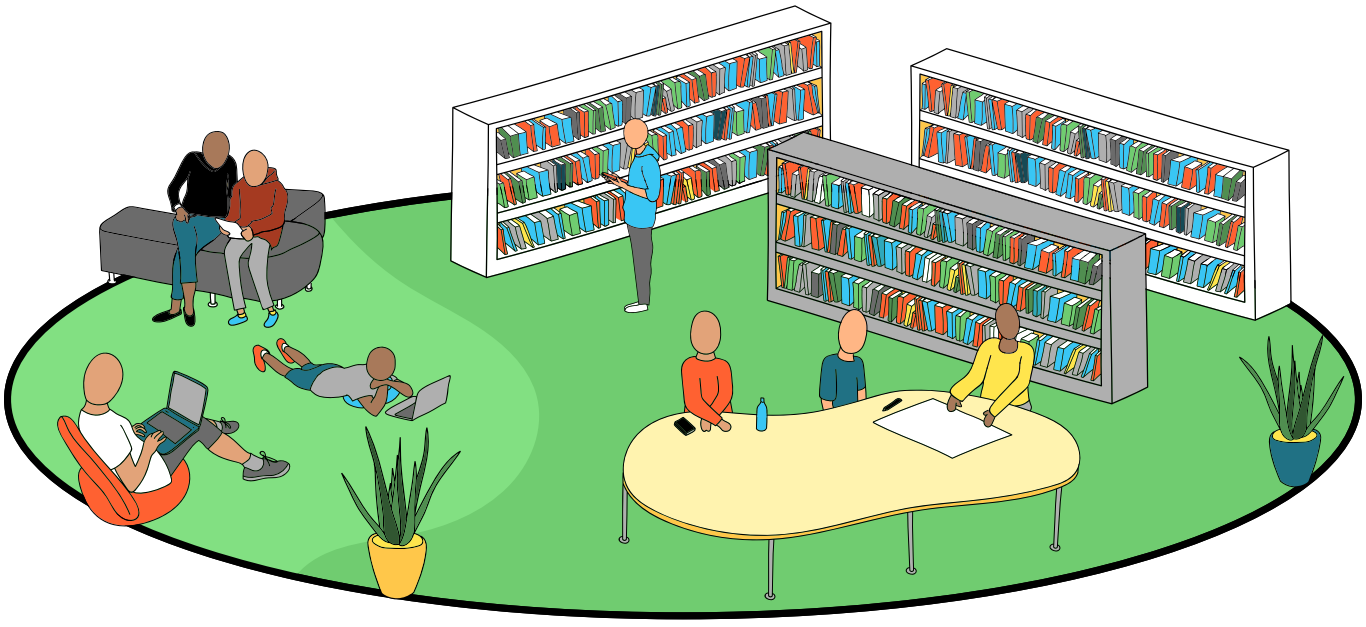


Multiple benefits for the beneficiary have been identified during the course of this evaluation – particularly in relation to the interlocking relationships between GPs, Community Connectors, beneficiaries, Voluntary, Community and Social Enterprise ecosystem and the Volunteering Development Workers working to support it. Building trust has been central to this. Salford is fortunate to be home to a rich and diverse voluntary, community and social enterprise sector, as highlighted in many of the interviews. These range from very small, informal groups centred on hobbies or shared interests and run by volunteers to well-established community centres and groups and charities. There is also significant variation between and within different geographical areas of Salford due to historical patterns of funding, community development and even 'regenerated' areas. Our research has highlighted how the Community Connectors activity in their geographical patches helped develop the relationships and presence needed to identify the wealth of informal activity taking place, to make connections and provide effective support. Relationships of trust were empowered through a supportive and flexible infrastructure enabling the Community Connectors to work across multiple agencies, geographic boundaries and professional groups. Community Connectors were local residents who originated from Salford and were familiar with the neighbourhoods, geographical areas, and communities. Initial asset mapping, and working with the Volunteering Development Workers enabled the Community Connector to use this intelligence to enable them to locate and collaborate with smaller community assets. Working in partnership with the wider Voluntary, Community and Social Enterprise sector, and using personalised approaches with beneficiaries, the Community Connectors were able to identify gaps in provision, particularly in relation to mental health, to influence service development. The established relationships and trust provided an opportunity for the Community Connector to reach out to other voluntary organisations and community groups to ensure that they were aware of services that could be used in the social prescribing referral. Beneficiary feedback demonstrates the ways in which the Community Connectors used flexible, personalised approaches to establish the trust needed to really understand what mattered to the person. Relationships, and time to facilitate them, were a key contributing factor to the success of the Wellbeing Matters programme.

What needs to be developed? key areas for growth

The original 2019 locality level recommendations proposed that there should be support and capacity for mechanisms to support the sustainability of the Voluntary, Community and Social Enterprise ecosystem. Similarly, it suggested a need to support link workers through training and peer support networks to facilitate an effective, holistic social prescribing offer. Other key recommendations highlighted the need to shift investment to support a holistic approach to social prescribing, and, finally, determine meaningful outcomes to enable the development of an evidence base. We have drawn on these earlier key recommendations along with the triangulated data to help determine areas for growth and development. This analysis reveals four key areas for growth and development: the education and support of the Community Connectors; the development of referral pathways; the support and development of the multi-layered structure and organisation of strategic programme governance; and the need for sustainable funding and resources for the Voluntary, Community and Social Enterprise sector and the governance required to empower the ongoing work. These will be further discussed alongside clear recommendations for development.

1. **Growth and support of the community connectors**
2. **Flexible referral pathways**
3. **Governance and organisation**
4. **Sustainable funding and resource**



9- Gibbons, Howarth, and Lythgoe, “Social Prescribing in Greater Manchester.”

Growth and support of the community connectors:

One of the original 2019 recommendations advised that capacity be supported through the development of long-term, embedded link workers able to help patients navigate multiple organisations, activities and systems to improve their health. This also included the implementation of peer support networks, and facilitation of ongoing training, and potentially develop a certification programme with the possibility of career progression.

> 'So one of the learnings is that we know that in order to make this work, the role of the Community Connector is absolutely vital. So that link worker role, you have to resource it properly, you have to make sure that those people are supported, they have access to training and supervision, because that is a lynchpin role'. (WBM staff 1)

Our findings demonstrate that the Community Connectors reported that there was no 'typical' day and many of them were faced with supporting beneficiaries who had multiple needs. They worked tirelessly to support a wide range of beneficiaries and our findings and case studies illustrate the impact that this has had on people's wellbeing, lifestyle choice and social connectivity. The work of the Community Connector is not without challenges, and the need to ensure that they are supported both emotionally and through education was highlighted in the data. This evaluation has highlighted the flexible and comprehensive support that the Community Connectors have received as part of the Wellbeing Matters programme team. For example, since 2019, the Community Connectors have been integrated into the GM Link Worker support network and key members from the Wellbeing Matters programme are actively working with the GM Social Prescribing Steering group working towards the development of training for Connectors and Link Workers. During 2020, national developments such as the National Academy for Social Prescribing, for which Salford CVS are the wider GM partner, and the newly launched Institute of Personalised Care (IPC) have been introduced to provide peer learning, and modules that can be freely accessed by link workers and other roles working within the social prescribing ecosystem. Hence, there are a range of support opportunities could be utilised and/or implemented to enable Community Connectors to help and empower beneficiaries.

This may include:

A consistent 'base' from which the community connector works

A continuation of regular and targeted training, structured supervision and feedback from managers and peer support

Access to Institute of Personalised Care modules

Continued work within the wider Greater Manchester and Northwest social prescribing networks

Flexible referral pathways

Interviews with the GPs who participated in this evaluation revealed that most patients who were referred had 'low level' or 'low grade' with anxiety, depression, loneliness. The findings suggest that most people who were referred were appropriate, but there were a significant number that were not. Of these, patients referred often had unmet clinical needs – usually relating to their mental health. This issue was reflected in the qualitative feedback from the Community Connectors, GPs and anchor organisations, which highlighted the need to develop a referral criterion that can help the referrer make an evidence-based decision about the most suitable approach for the person.

The current referral pathway is predominantly through GPs, however our findings suggest that there may be a need to enable referrals from a wider range of organisations such as housing, adult social care and mental health services to ensure an equitable offer and prevent individuals in need being missed. This may also enable the Community Connectors to manage their caseload and capacity as a result of the increasing volume of the number of people referred in some GP practices. However, it is also recognised that widening the referral pathway may both increase demand without increasingly resource and dilute the ability of the Wellbeing Matters programme to demonstrate 'clinical' outcomes data such as reduction in inappropriate GP demand. A range of referral pathways predicated on evidence-based referral criteria could be implemented to mitigate this and enable suitable and timely referral and support for beneficiaries.

However, this would require additional funding to develop:

Direct referral from any health care practitioner

Direct referral from a social care practitioner

The implementation of direct referral from the other services such as fire, housing

Reasons for non-engagement to help reduce non-engagement levels

Governance and organisation

The Wellbeing Matters programme has demonstrated value for the wider Voluntary, Community and Social Enterprise, health and social care system. At a strategic level, the approach taken to develop a multi-layered governance system was borne out of the need to ensure integration across the sector and embed the wider PCCA work. In doing so, the governance model in place utilised established Voluntary, Community and Social Enterprise Anchor organisations within the five health neighbourhoods across Salford, who were already members of the Salford Third Sector Consortium (Salford CVS' partner in the original Wellbeing Matters proposal). There were several advantages noted, mainly around the positive collaborations, ability to draw on existing relationships and reach across Salford and embedding existing systems and processes into the Wellbeing Matters programme. The layered governance system that this resulted in meant that there was an awareness of some of the complexities involved and the need to ensure that consistent awareness of the holistic model was maintained. However, some disadvantages reported was the lack of a uniform or corporate visible approach, as staff had different employers for instance. Community Connectors also had different email addresses from each other and being managed by different organisations sometimes led to varying support offers and training.

The importance of feedback was highlighted by key stakeholders such as GPs to understand the impact of the social prescribing offer and ensure that the Wellbeing Matters programme remained current in GP decision-making. For example, feedback and communication could be improved if the Community Connectors were partially co-located in GP practices or more fully embedded into multi-disciplinary teams. Whilst this may be problematic during the Covid global pandemic, and recognising the recovery model approach to 'digital first', post-Covid, options to collocate Community Connectors could help raise awareness of the GP's own capacity to check the progression of their social prescription, as well as improve their understanding of the process and benefits to their patients. The increased use of Elemental's reporting mechanisms could help facilitate a more frequent feedback loop and strengthen the communication channels. While the Community Connectors already use Elemental to provide information about the progress of the beneficiary, this feedback needs to be re-emphasised to GPs.

A range of approaches/options could be used to support the governance and communication:

Highlight Elemental feedback mechanisms to referrers

Improve feedback continuity so that GPs and others get used to the service rather than keep reiterating the name

Wider recognition of social prescribing models and the need to highlight a consistent approach to a holistic model

Embed the Community Connector within the Multi-Disciplinary Team to ensure greater integration and feedback

Further improve the Wellbeing Matters brand and consider harmonising access points such as email addresses

Reduce disparities in line management approaches in order to ensure that Community Connectors have a consistent experience and opportunities for training and development

Funding long term resources and secure staff

The ecosystem relies on a range of organisations that vary in size, offer and availability - from tiny voluntary and community groups to larger charities and social enterprises. The Voluntary, Community and Social Enterprise sector in Salford, supported by Salford CVS, provides over 115,400 hours of volunteering per week and continues to support the Voluntary, Community and Social Enterprise ecosystem throughout the heightened stresses and demands resulting from Covid[10]. The original recommendations from the 2019 report at a locality level highlighted a number of ways in which social prescribing should be supported. This included capacity development to ensure a sustainable ecosystem through the creation of funding streams in support of collaborative and cooperative working.

The Wellbeing Matters Programme has provided direct support for beneficiaries and Voluntary, Community and Social Enterprise groups and organisations across the ecosystem. For example, our findings indicated that many groups and organisations sought fairly minimal costs such as transport, materials, space. They were able to access smaller pots of funding obtained directly from Salford CVS which were pivotal in helping small groups find the security to expand the scope of their activities. This provided an opportunity to recruit additional members / volunteers, which strengthened the groups in a mutually reinforcing cycle of positive growth. The Wellbeing Matters Programme has worked within a climate of uncertainty and has adapted and responded to the immediate changes presented. Being able to broaden the offer is key to ensuring that outreach and connection with communities remains intact. The work of Wellbeing Matters cannot move forward without funding for the programme as whole, encompassing the roles of the Community Connectors, Volunteering Development Workers and provision of funding in support of the social prescribing Voluntary, Community and Social Enterprise ecosystem. Both capacity and the sustainability of the programme need to be supported. Similarly, there is a need to ensure that the governance structures are enabled to assess the resources needed to be able to continue a flexible and responsive offer.

As CLES's forthcoming evaluation of the Third Sector Fund highlights, Salford continues to face significant challenges around resident health and wellbeing despite the significant impacts of recent interventions, and of course the pandemic has brought into even greater relief the pressures on both the NHS and the Voluntary, Community and Social Enterprise sector[11]. The evolving process of devolution also brings its own impetus to a focus on city and neighbourhood level initiatives. The Third Sector Fund has proven very successful, its parallel analysis to that found in this report also shows a reduction in demand on statutory services through the programme, and an average social return of £1: £23.20 between 2017 and 2020. The impact of the Third Sector Fund, however, goes deeper in the 'virtuous circle' it creates as funding allows Salford CVS to reach and support an increasing number of local initiatives improving the capacity to have a bottom-up view of changing community needs and issues thereby improving its capacity to reach and support local initiatives. This in turn is able to feed into decision making and commissioning at various levels as Salford CVS takes a key role within the 'evolving Salford system leadership' and champions understandings of social value, improving the targeting of resources at all levels, the health of the Voluntary, Community and Social Enterprise ecosystem and in turn the health and wellbeing of Salford residents. This has been so successful that CLES sees this as a model that can be adapted for other localities[12].

The primary challenge looking forward, particularly for this sector, is the need for large, long-term grants to allow them to move beyond survival mode and build sustainably for the future. This is to ensure the health and stability of the multitude of relationships knitted together by Wellbeing Matters staff and Salford CVS that open up the possibilities for connection and fulfilment that changes people's lives. It requires funding the programme workstreams, as well as the multi-year Third Sector Fund administered by Salford CVS, as also recommended by CLES.

10- Damn, Prinos & Sanderson 'Salford State of the Voluntary, Community and Social Enterprise Sector 2017 (Sheffield, 2017).

11- CLES, "Evaluation of the Salford Third Sector Fund Grant Programme 2017-20" (Manchester, 2020).

12- CLES, 48.

In summary:

Work with Elemental to improve data collection and extraction methods to further improve evidence base

Continue to work towards longer-term funding for the programme and its staff team - thus ensuring stability, relationship and trust building and depth of community knowledge

Broaden the offer through the referral system to enable organisations such as adult social care to refer people.

Utilise the evidence base to lobby commissioners to support sustainable funding for the Voluntary, Community and Social Enterprise ecosystem

In line with CLES's recommendations, in addition to full multi-year funding for the Third Sector Fund, to help develop mechanisms for community groups receiving funding to connect with commissioners and help inform future commissioning.

Looking to the future

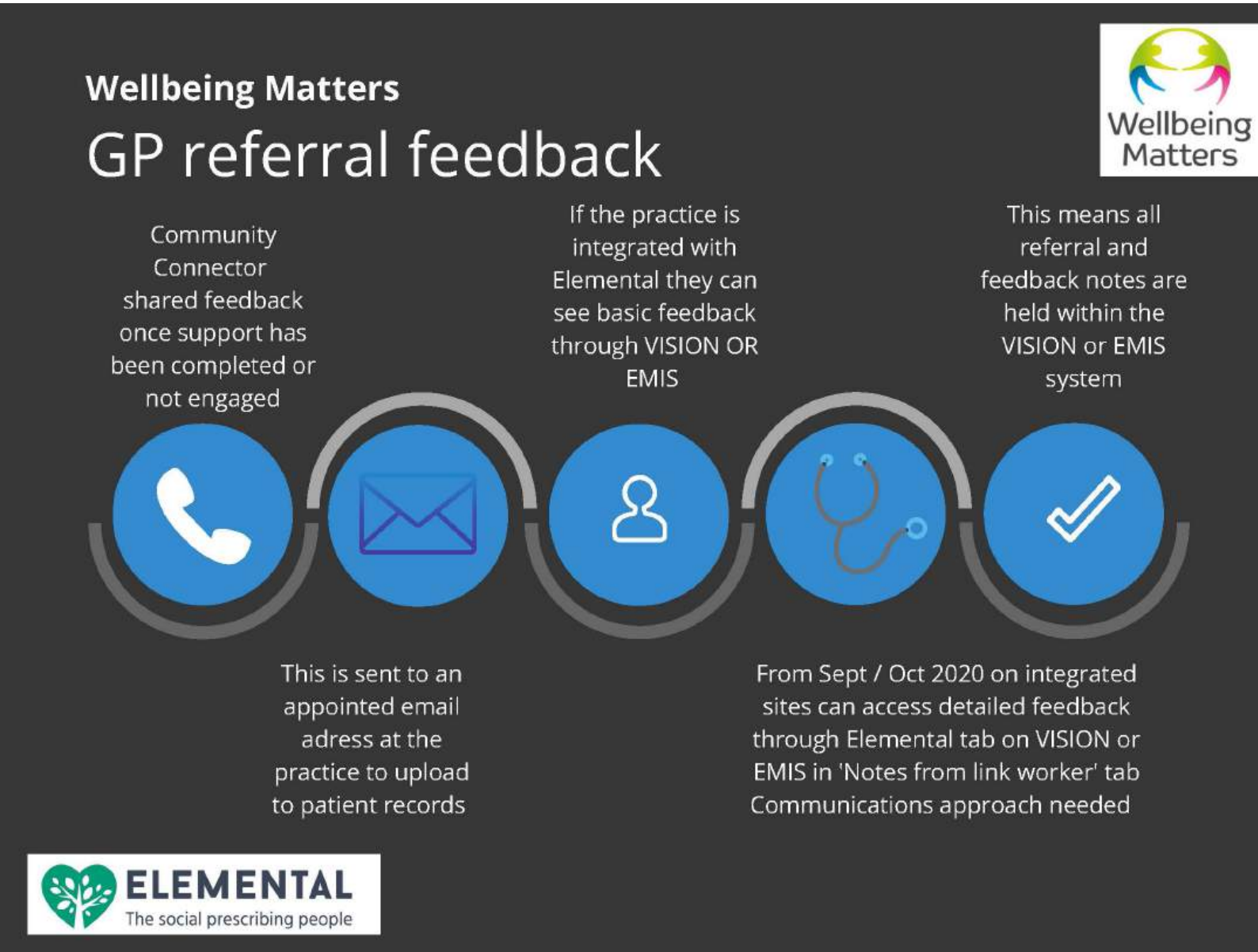
During the course of the evaluation, Wellbeing Matters consistently developed new and improved ways of working. Through regular communication and feedback with beneficiaries, GPs and the Voluntary, Community and Social Enterprise sector groups and organisations, a range of new initiatives have been developed to ensure that the Wellbeing Matters programme continues to provide a personalised, integrated service.

This has included:

The introduction of flexible working arrangements for Community Connectors across the neighbourhoods to ensure capacity parity between them Community Connector.

The ongoing development and promotion of the feedback loops between GPs and Wellbeing Matters staff (see Figure 16)

Figure 16 Promotional postcard showing feedback process via the Elemental dashboard



Conclusion

This evaluation has triangulated data from a range of sources over an 18-month period. The report builds on previous work in 2019 (Gibbons, Howarth & Lythgoe), providing a longitudinal, evidence-based recommendations that can be used to support the future of the Wellbeing Matters programme.

> "as a society, we've become very entrenched in working in that medical model, everyone wants a quick fix, me included by the way, I'm no different, but everyone wants a quick fix. Everybody like, you know, will opt for taking medicine, because we've been conditioned that way, that's the way we've been sort of like lead to believe will be the cure. And medicine needs to take responsibility for that. So why I think I love social prescribing is it's a holistic sort of approach, so it's working on everything about that person, not just the one thing that you present to your GP with. So you know – and that's what I love about mentoring as well, and befriending, because it's so broad, like we can work with somebody around the finances, we can help them with budgeting, we can even go shopping with them, so we can like a little shop with them to role model and to show." (CG 04)

Our data has been drawn from a range of sources including GPs, Wellbeing Matters staff, including Community Connectors and Volunteering Development Workers, and importantly, beneficiaries themselves. Collectively, this evidence has highlighted the beneficial impact that the Wellbeing Matters programme has had on enabling those most vulnerable in life to manage their own decisions and choices through non-medical approaches. The Wellbeing Matters programme has demonstrated significant positive benefits for the wider health and social care sector and communities. The Wellbeing Matters programme therefore is an evidence-based, valuable programme that is worth investing in. Whilst it may be unusual to conclude with an extract from the data, the above quote, taken from one of the community group interviews, sums up how the Wellbeing Matters programme was able to integrate with other services through a holistic model, powered by personalised approaches that focused on what matters to the person.

Appendices

Appendix A: wellbeing matters staff structure and referral pathways

Wellbeing Matters Staff Structure

Salford CVS (Accountable body)

↓

Salford CVS (a registered charity) is the accountable body for the programme, holds the contract, and employs the Wellbeing Matters Programme Manager and directly delivers workstreams 2 (and 3), employing the Volunteering Development Workers.

Salford Third Sector Consortium (a registered charity) is the delivery partner for workstream 1 (social prescribing)

↓

Salford Third Sector Consortium

↓

Salford Third Sector Consortium used its opportunities allocation procedure to identify which of its 85 member organisations, via a competitive process, would provide the social prescribing coordination function (employing the Social Prescribing Coordinator and latterly the 6th Community Connector) and sit on its Board (Big Life were chosen) and which 5 organisations would act as health neighbourhood (PCN footprints) anchors and employ the Community Connectors (Start, Unlimited Potential, Langworthy Cornerstone, Social adVentures and Inspiring Communities Together were chosen)

Voluntary and Community Social Enterprise, Community Connector Community

Wellbeing Matters Referral Pathway

Referrals agents who refer into Wellbeing Matters

GP practices (GP, Practice Nurse, Care Navigators, Reception and front of house teams)

Adult Health and Social Care Contact team

Enhanced Care teams (Ended in 2020)

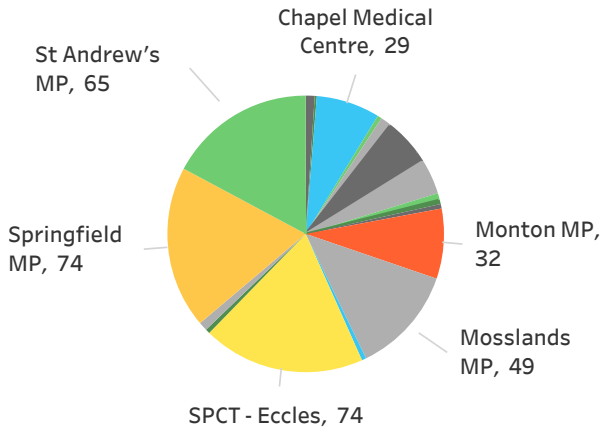
Wellbeing Matters – delivery model

Workstream 1 – Utilises a neighbourhood infrastructure of five VCSE anchor organisations, each hosting a FTE Community Connector, supported by a Social Prescribing Coordinator and 6th 'floating' Community Connector

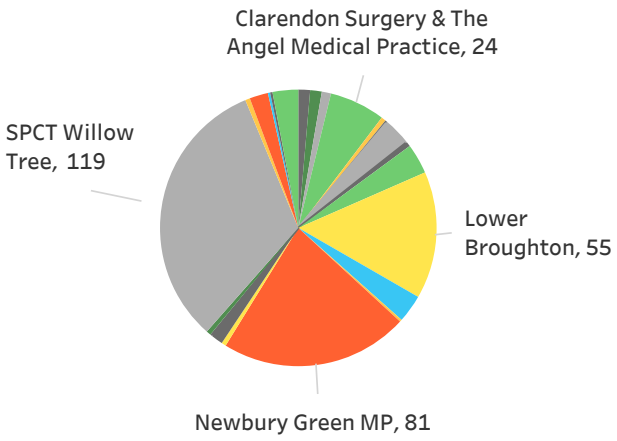
Workstream 2 – Building capacity in local communities so we have a healthy VCSE eco-system to socially prescribe into - supported by 2.5 FTE Volunteering Development Workers and some *Third Sector Fund* grant monies

Appendix B: referring Practices

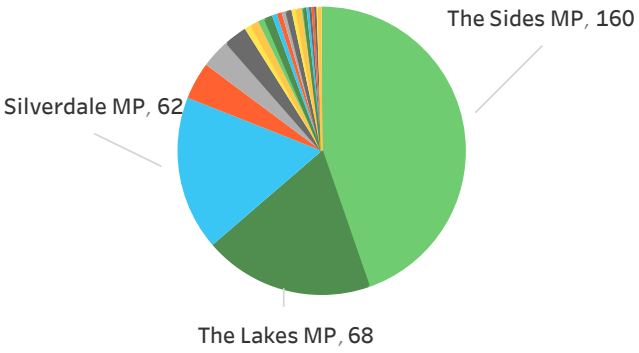
Eccles &Irlam: 390 total referrals



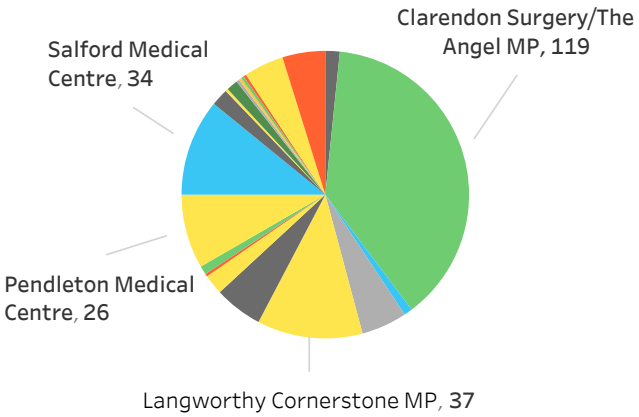
Broughton: 369 total referrals



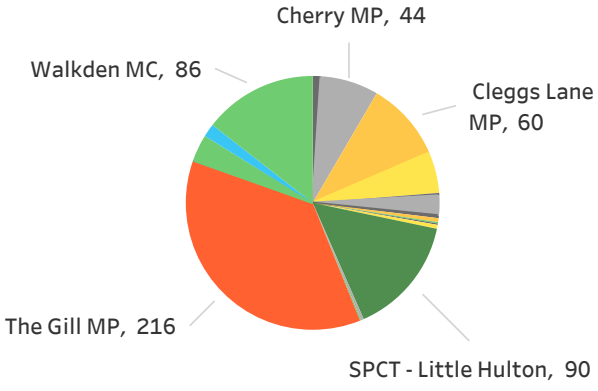
Swinton: 358 total referrals



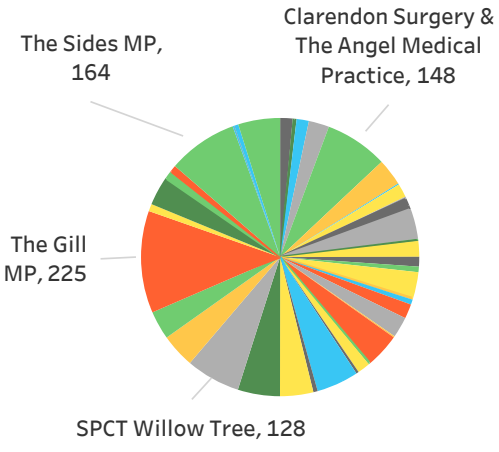
Ordsall & Claremont: 312 total referrals



Little Hulton & Walkden: 594 total referrals

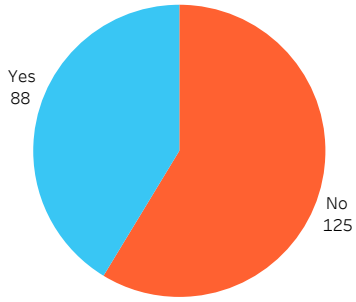


Programme wide referrals: 1,995

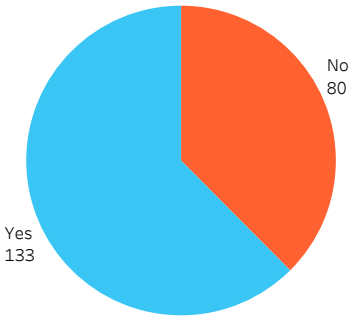


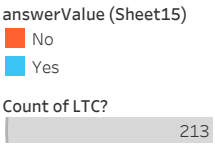
Appendix C: demographic data

Do you consider yourself to have a disability? (213 total responses)

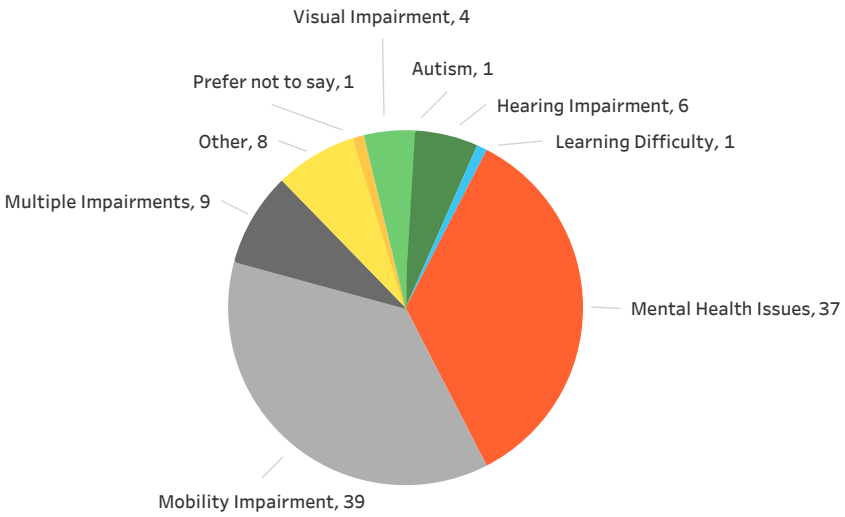


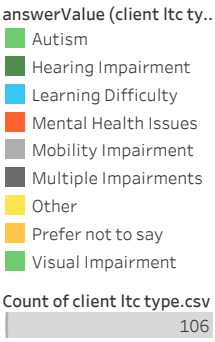
Do you consider yourself to have a long-term health condition? (213 total responses)



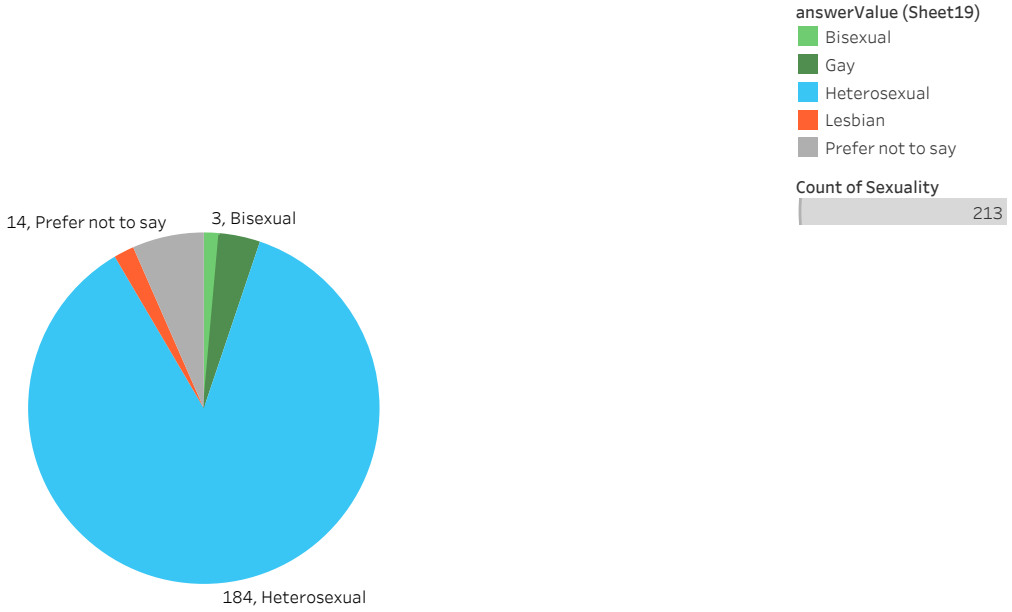


Condition type (106 total responses)

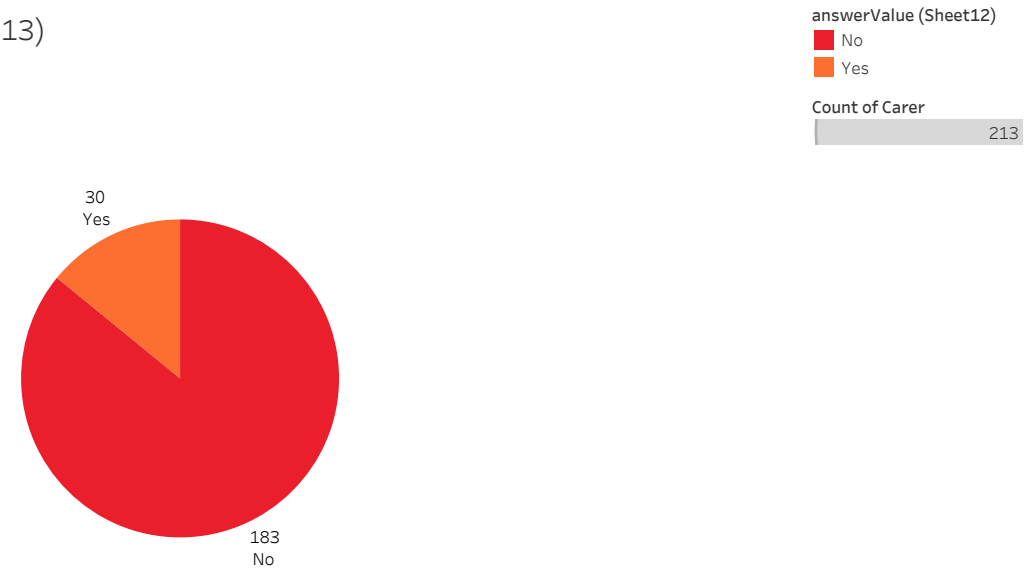


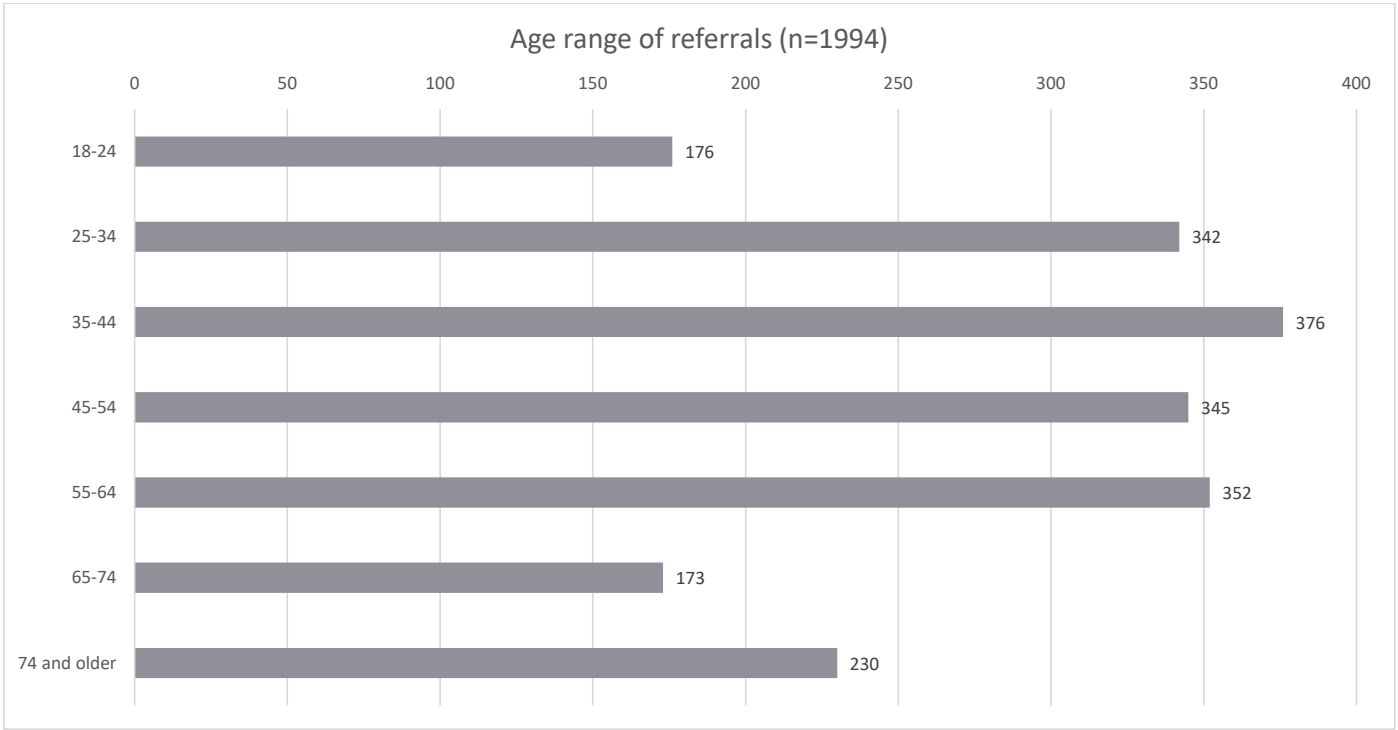


Sexuality (n=213)

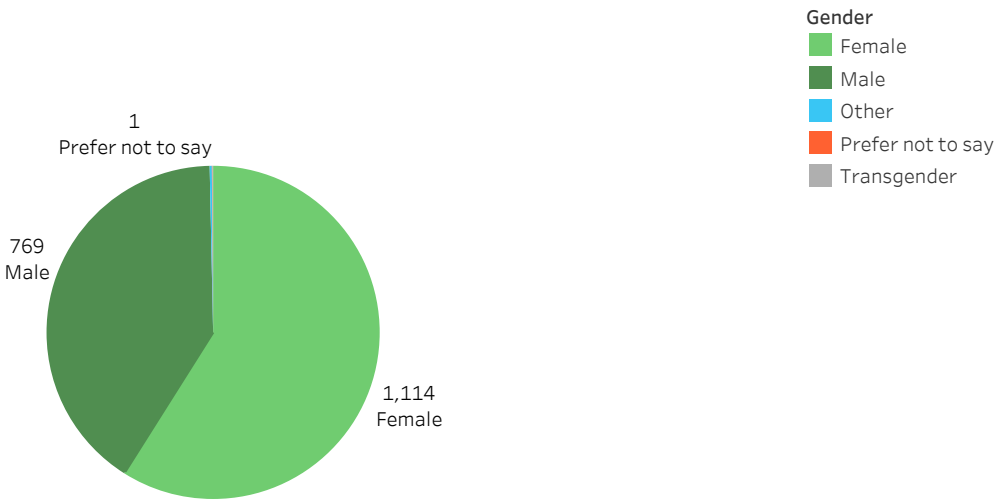


Do you have a carer? (n=213)



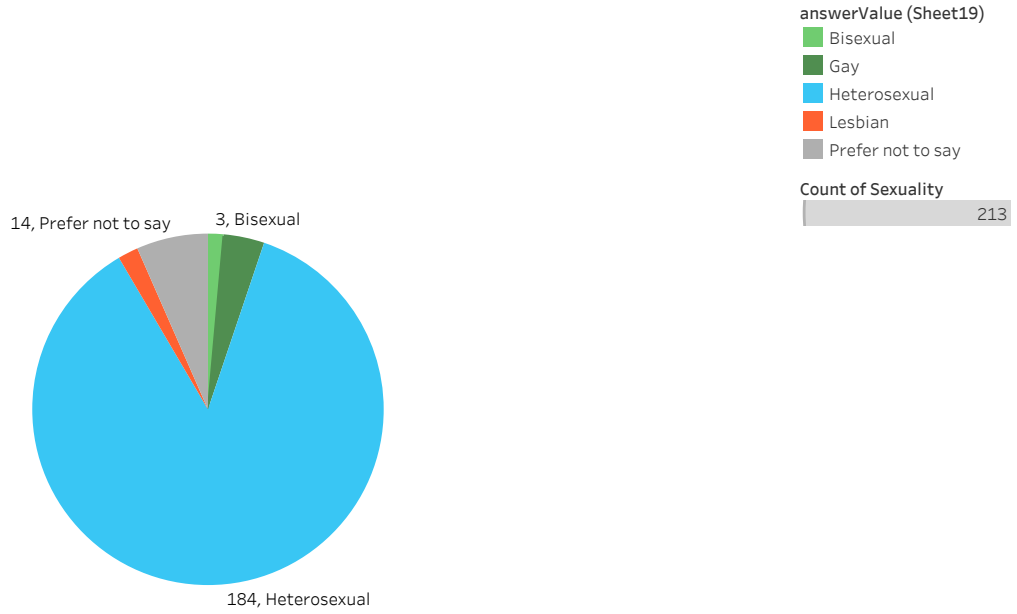


Gender (n=1889)

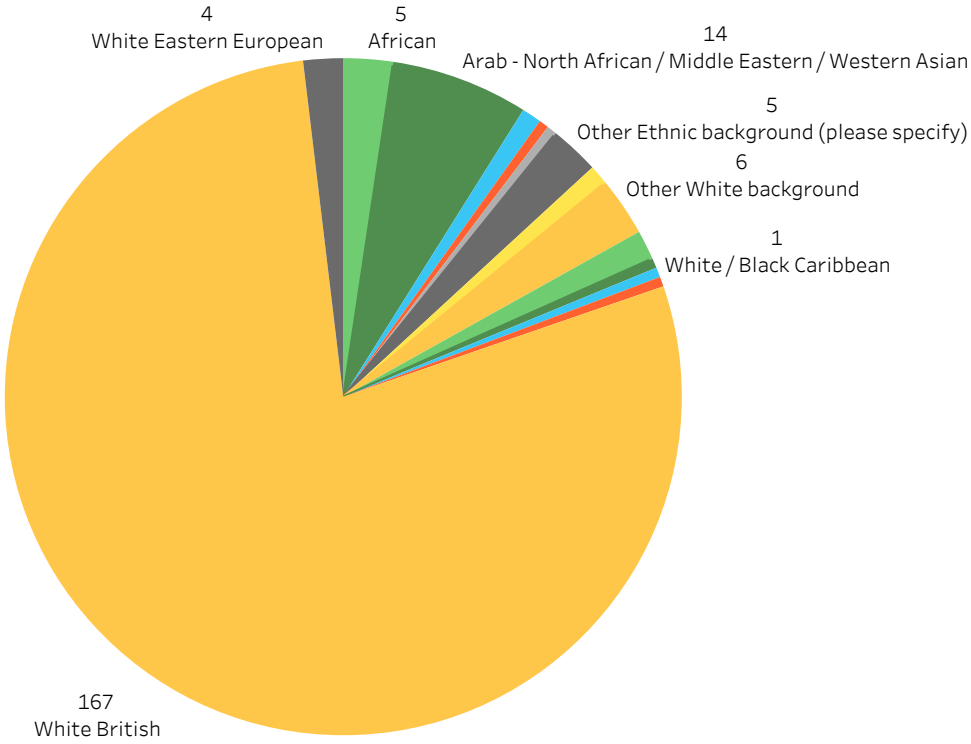


Count of Client.csv and Gender. Colour shows details about Gender. The marks are labelled by count of Client.csv and Gender.

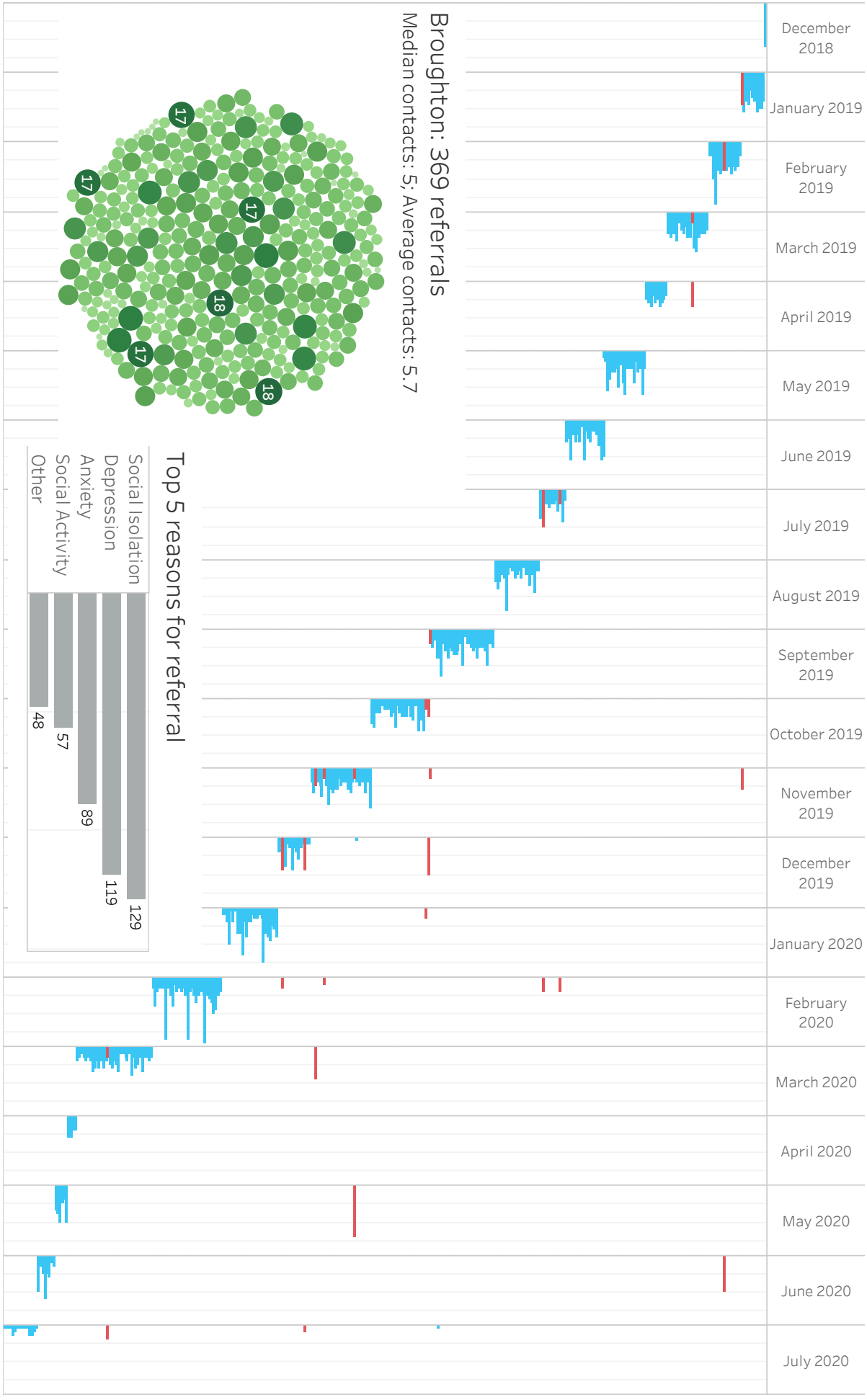
Sexuality (n=213)



Ethnicity (n=213)

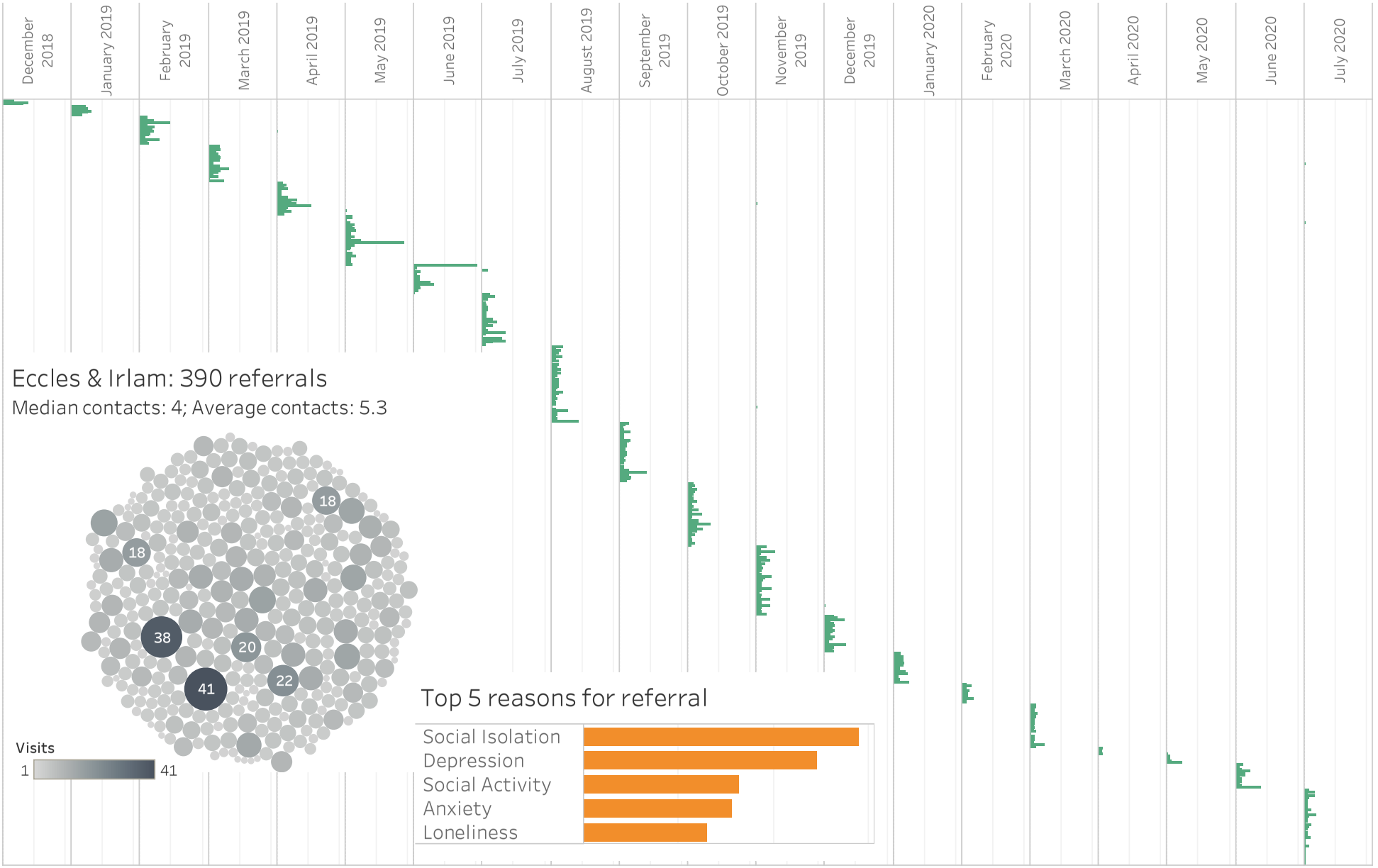


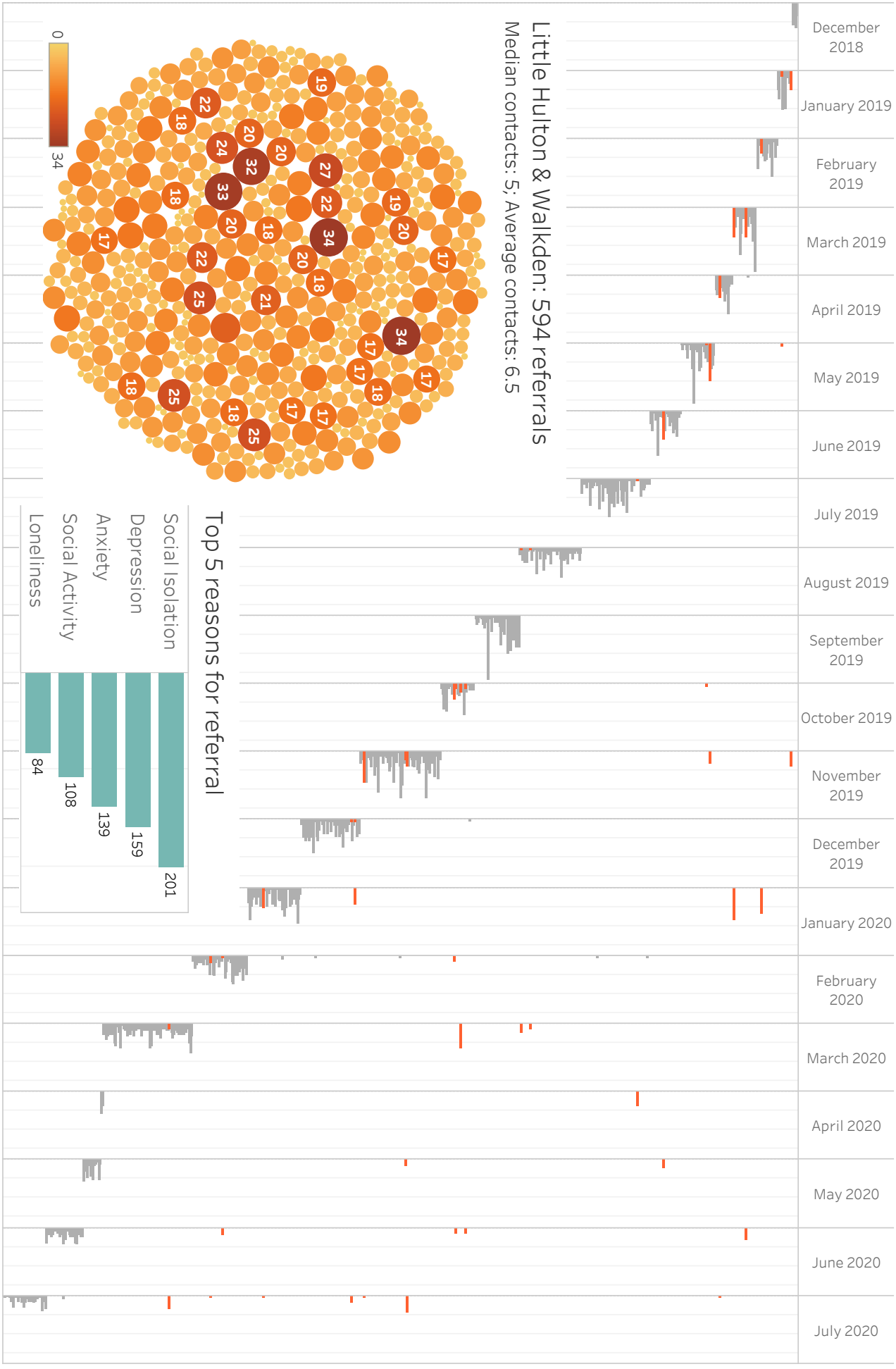
Appendix D: referrals over time by area



Eccles & Irlam: referrals over time

The bar charts by date below show cases opened each month, cases reopened, and number of contacts rather than the time taken.

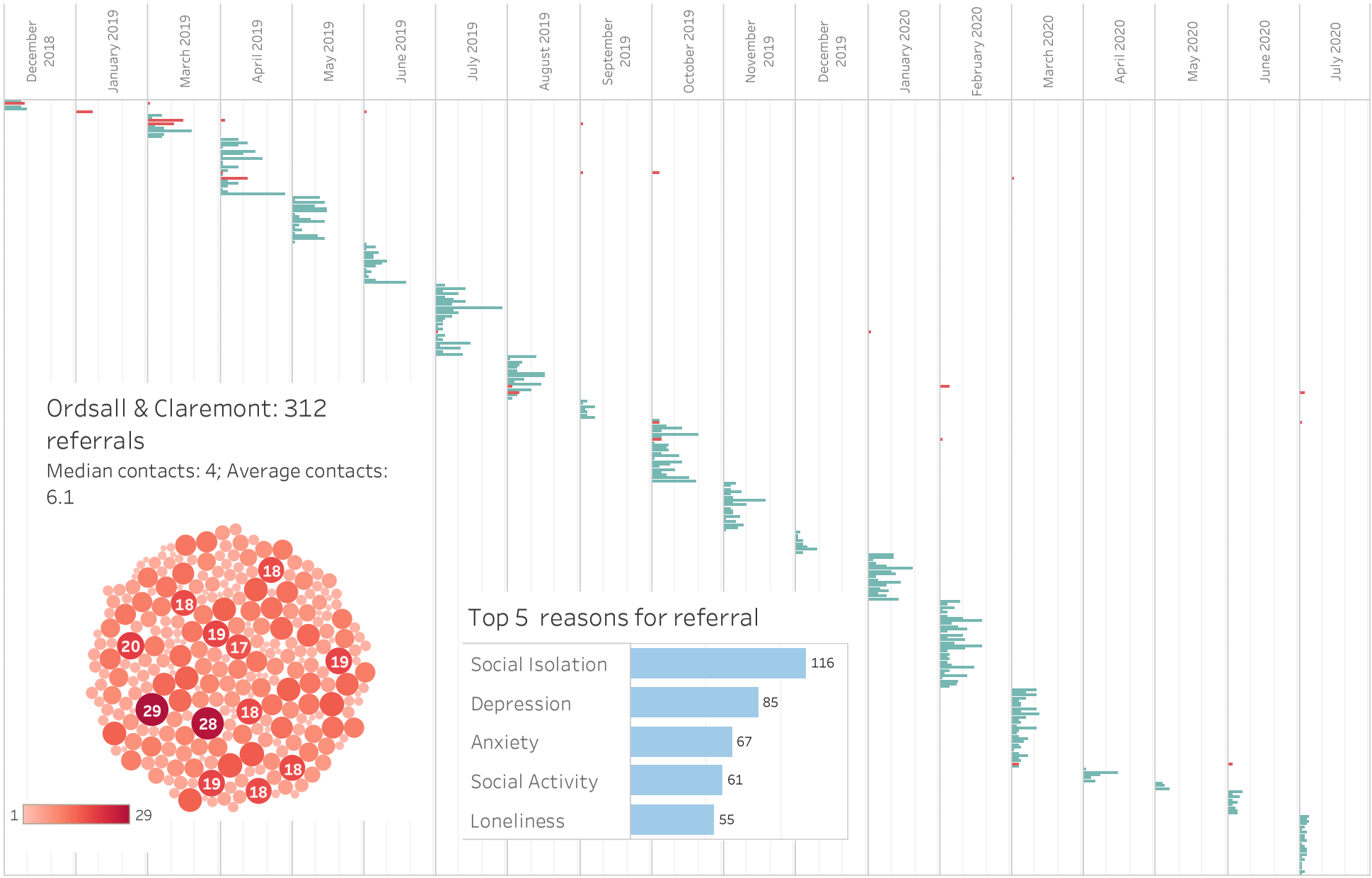




These bar charts show cases opened each month and number of contacts rather than the time taken. Red highlights cases reopened at a later date.

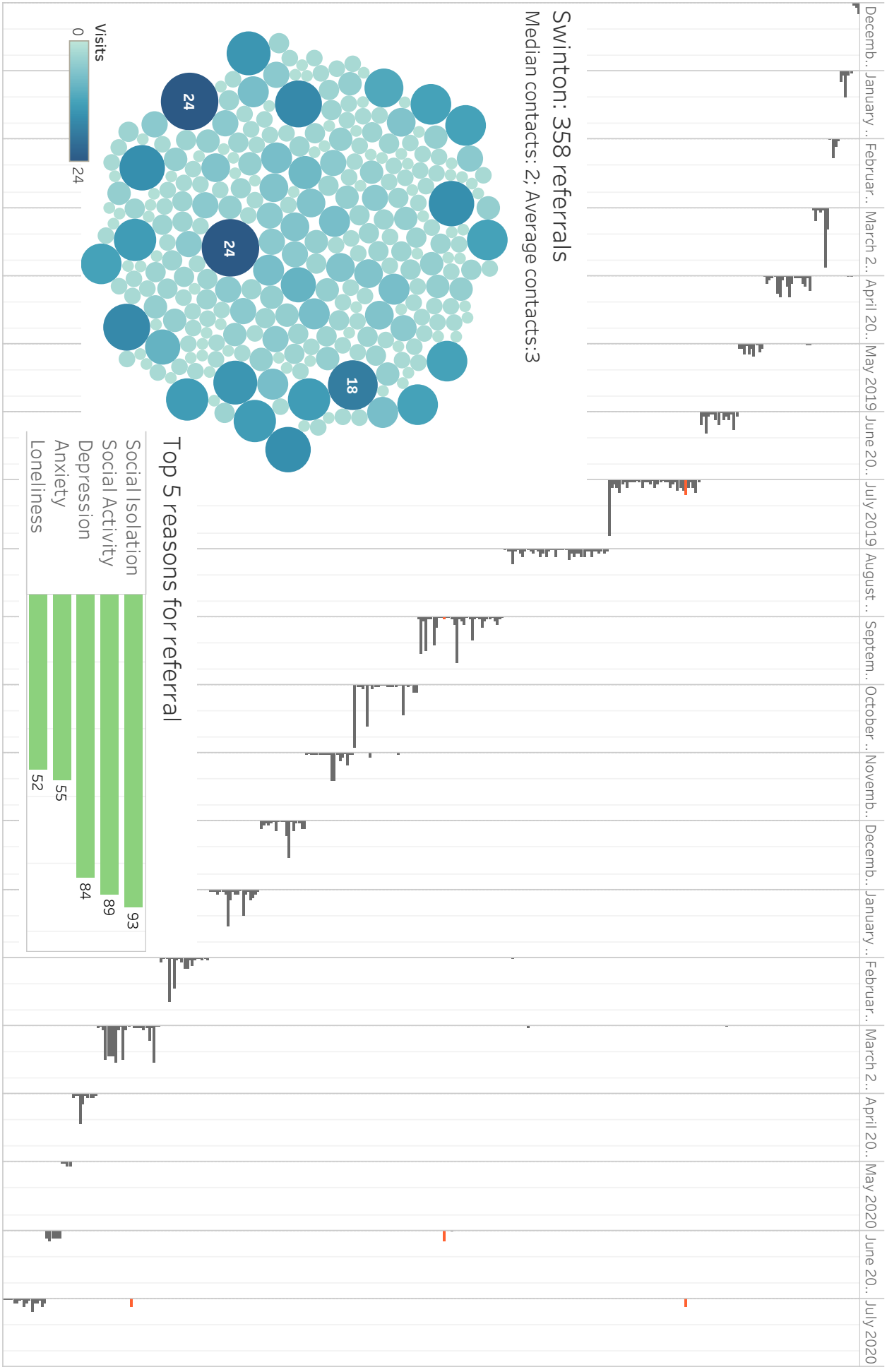
Ordsall & Claremont referrals over time

These bar charts show cases opened each month and number of contacts rather than the time taken. Red highlights cases reopened at a later date.



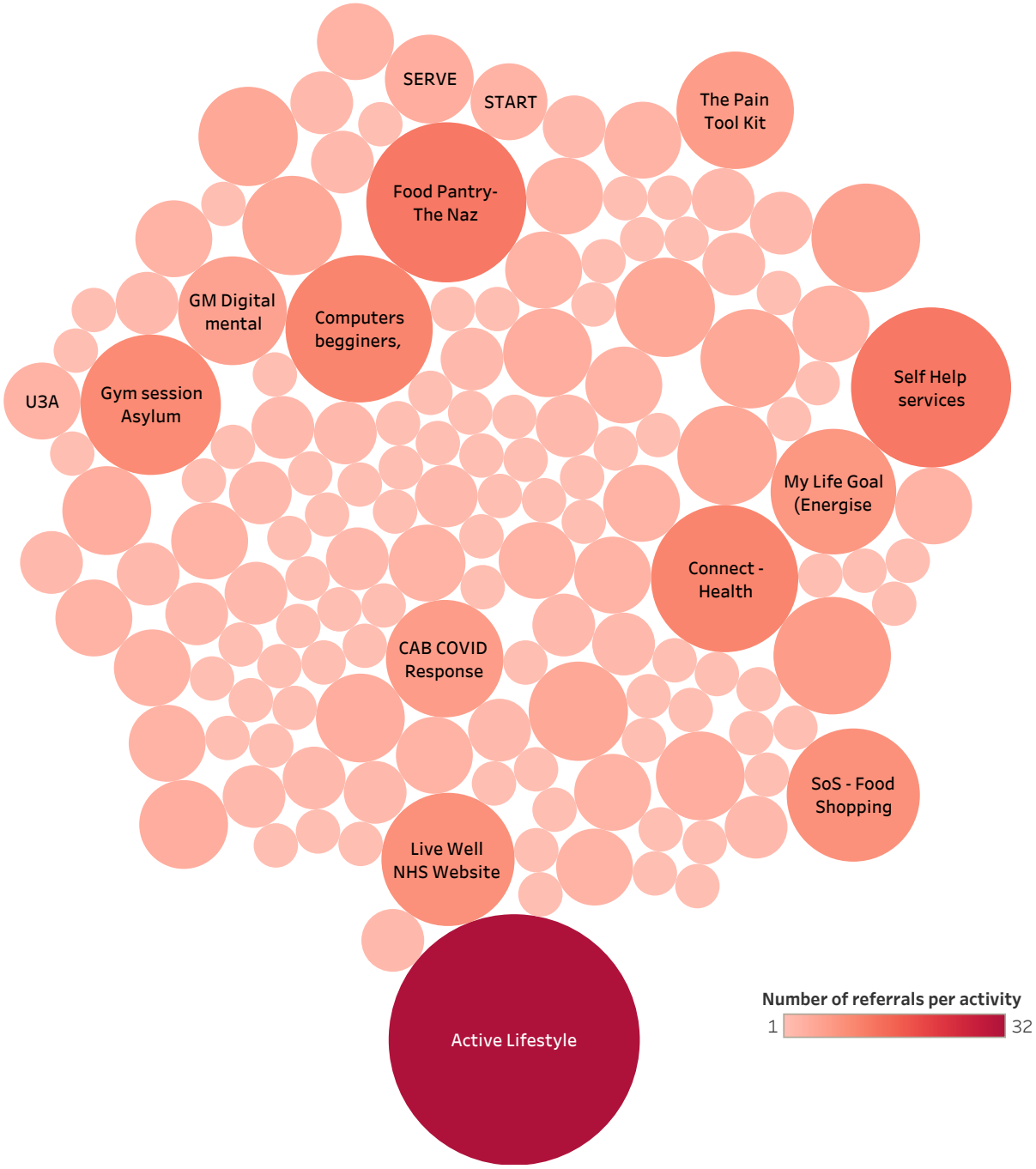
Swinton referrals over time

These bar charts show cases opened each month and number of contacts rather than the time taken. Red highlights cases reopened at a later date.

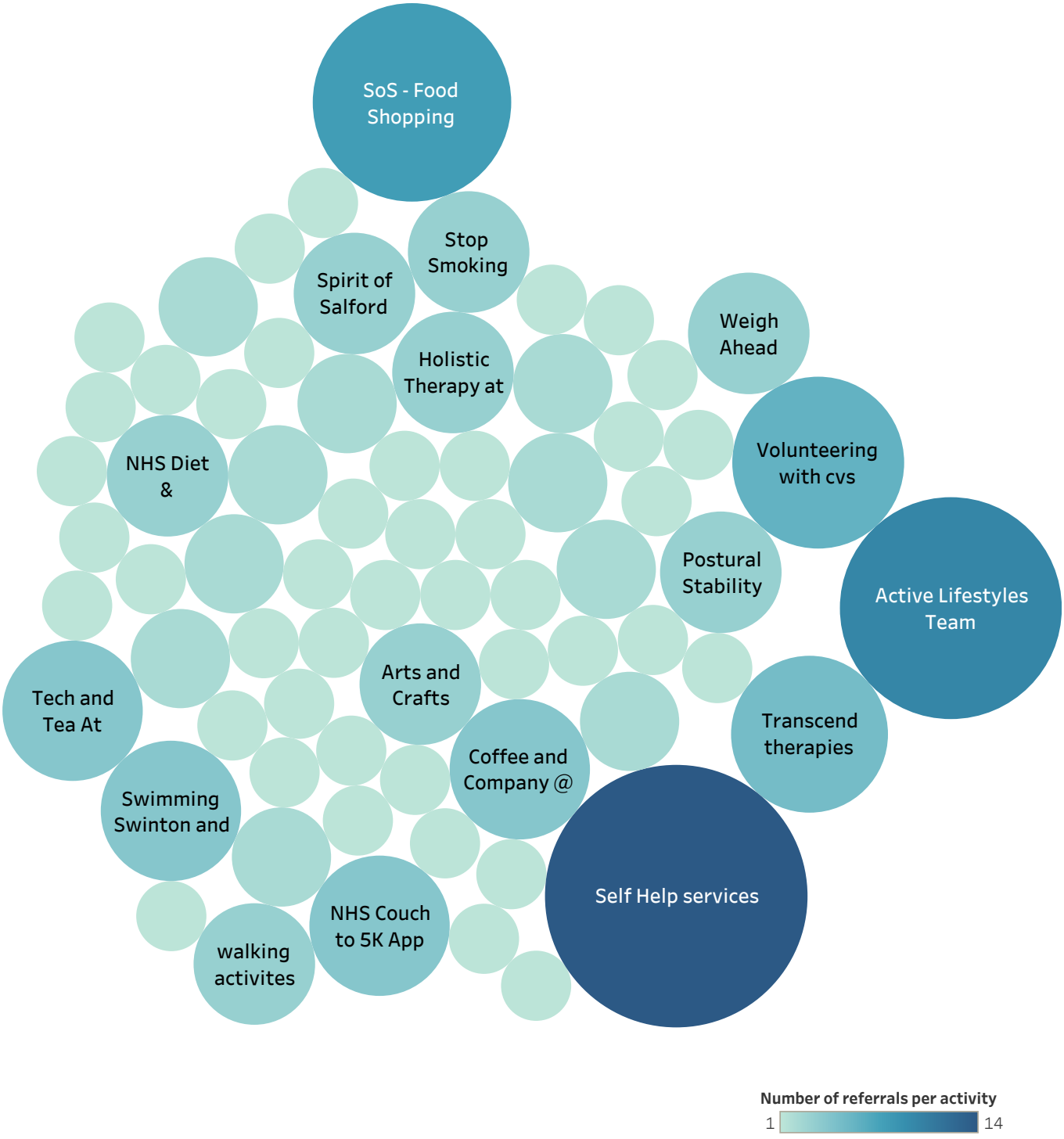


Appendix E: organisations referred into by area

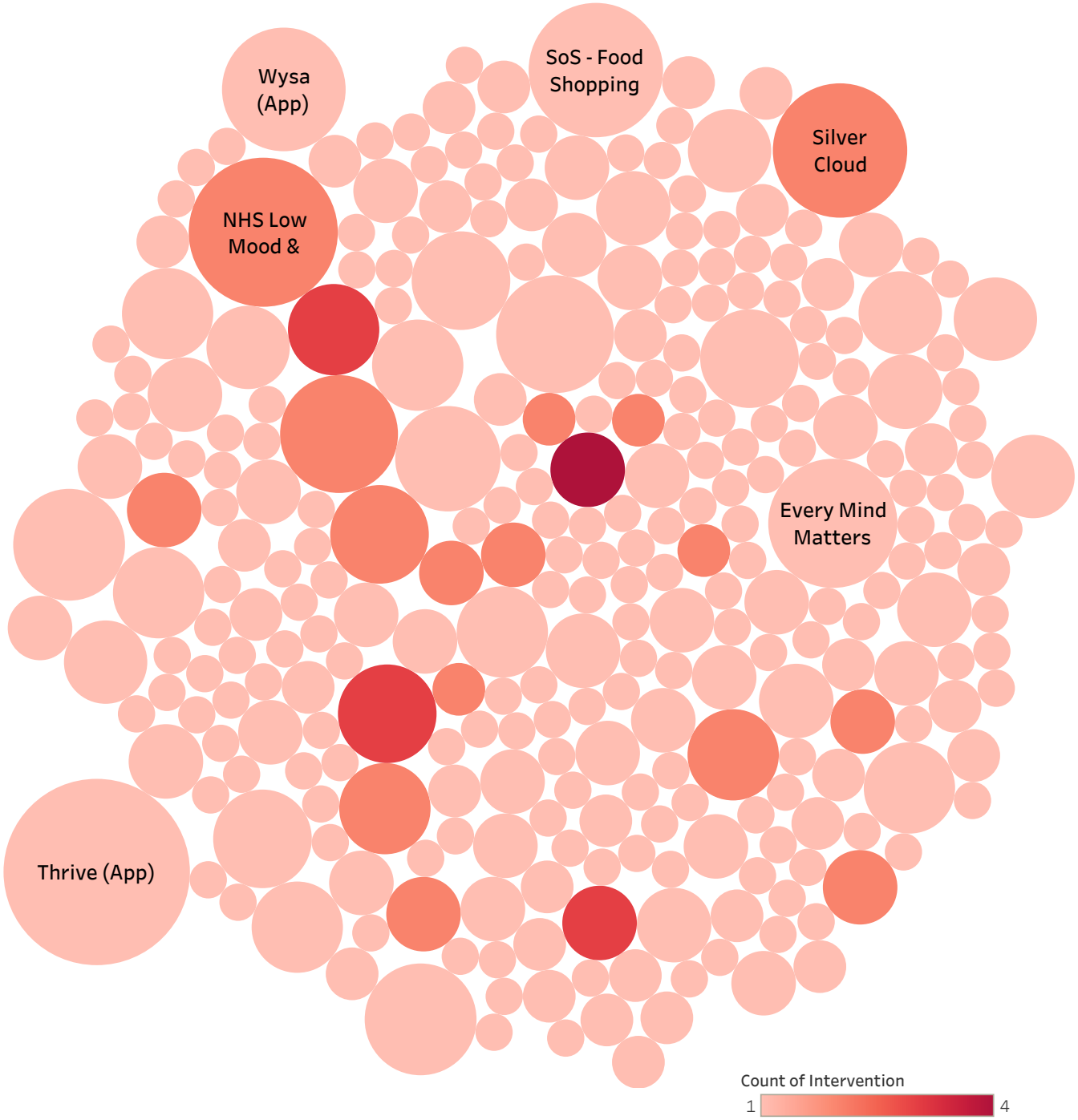
Broughton: Groups referred to



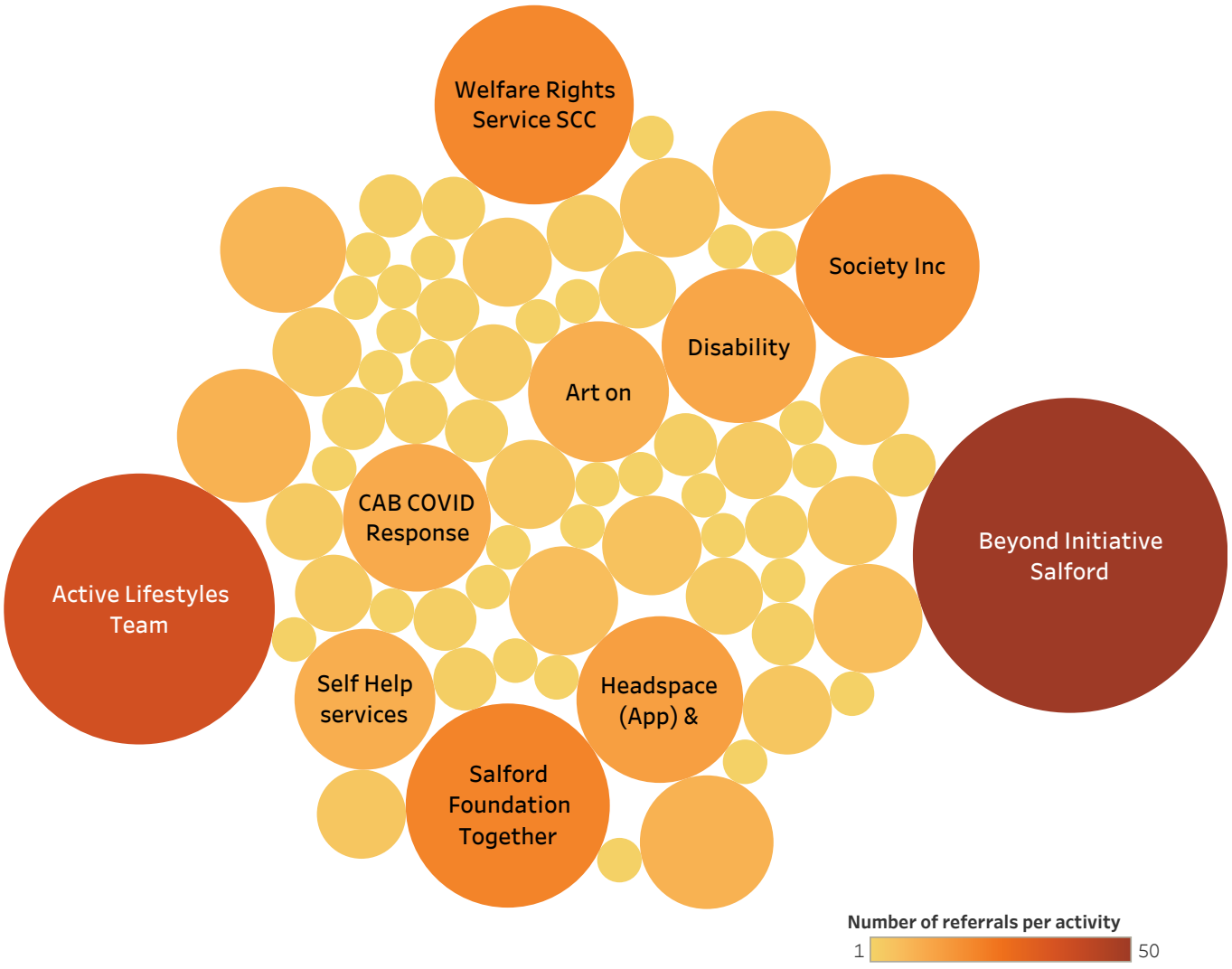
Swinton: Groups referred into



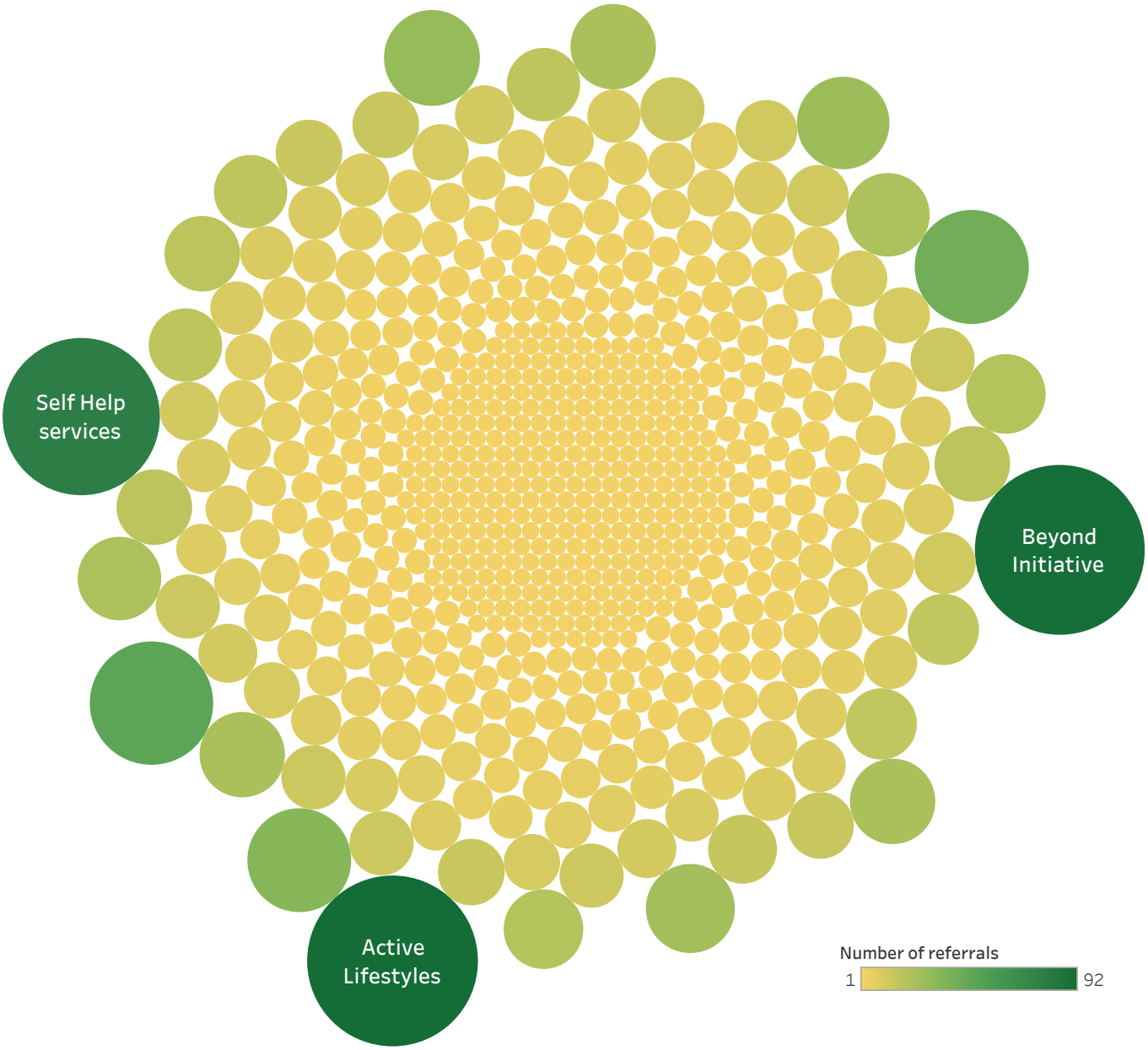
Ordsall & Claremont: Groups referred into



Little Hulton & Walkden: Groups referred into



All activities



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