‘STAYING WELL IN CALDERDALE’ PROGRAMME EVALUATION:

APPENDICES

UNIVERSITY OF LINCOLN

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EVALUATION OF THE 'STAYING WELL' PROGRAMME': KEY INFORMAN SEMI – STRUCTURED INTERVIEWS – TOPIC GUIDE (FEBRUARY 2015)

INTRODUCTION

The purpose of this interview is to explore the early implementation of the 'Staying Well' programme from the perspective of the Steering Group, Project Team, Hub Directors and Project Workers. We are trying to find out a little bit more about the experiences of individuals as they begin to develop the programme and projects. There are no right or wrong answers; the interview is simply about hearing your views around some of the early implementation processes.

We will not use your name in any reports of this work and it will not be made known who took part. However, some of the things you say in the interviews might be used to illustrate and support the findings of the evaluation. It is possible that someone who knows you well might be able to identify you from such comments, but we will make every effort to make sure that this does not happen.

Are you happy for this interview to be tape recorded? Only researchers at the University of Lincoln will have access to the recording and you will not be named on the tape.

ROLE

1. **Could you first give me a brief description of your job role within Calderdale?**
2. **Could you tell me about your role in the 'Staying Well' programme?**
   Prompts:

   - Were you involved in the early planning stages of the programme?
   - What was your input into the early planning stages?

PARTNERSHIPS

3. **Could you tell me how you would define partnership working?**
   Prompts:

   - For example, does partnership involve solely working in integrated teams?
   - Alternatively, is partnership around good working relationships between health and social care?
   - Or, is partnership around pooled or central financial control?

4. **To what extent did partnership working exist in Calderdale prior to the 'Staying Well' programme?**
   Prompts

   - Were there any barriers (or indeed facilitators) to partnership working?
   - Are there particular organisations with whom partnership working is more or less difficult? If so, which are these organisations?
   - How have the different organisations been involved in the 'Staying Well' programme?

5. **Do you perceive that the 'Staying Well' programme will improve partnership working?**
   Prompts:

   - If so, how do you think the programme is likely to improve partnership working? For example, through the involvement of the community, different organisations that perhaps may not be always involved in statutory decision-making?
   - If not, why do you think that the 'Staying Well' programme is unlikely to improve partnership working?

RATIONALE AND OBJECTIVES UNDERPINNING THE IMPLEMENTION OF THE STAYING WELL PROGRAMME

6. **What do you think the rationale was for putting in place the 'Staying Well programme' in Calderdale?**
   Prompts:

   - Were there particular gaps in services? If so, what were these gaps?
   - Was the 'Staying Well' programme put in place owing to 'grass-roots' pressure (for example, requests from older people themselves)?
   - Was the programme put in place **solely** to reduce social isolation/ loneliness? If so, how did you identify that this was a particular need across Calderdale?
   - Was the programme put in place to strengthen preventative care across Calderdale? If so, what areas of preventative care were weak?
   - Do you think the programme was put in place to reduce unnecessary health and social care service use? If so, which services?

7. **What were the key factors considered in the development and design of the 'Staying Well' programme?**
   Prompts:
   - Was one of the key factors to ensure appropriate service development across Calderdale? If so, what was that service development?
   - Did you wish to build community capacity? If so, do you think that you delivered this in the present design? If so, how?
   - Was one of the key factors the need to involve the community and/ or older people themselves?
   - Did you wish to ensure appropriate 'fit' with the existing local 'hubs'?

8. **Were there any initial barriers to the development and design of the 'Staying Well' programme?**
   Prompts:

   - Were you able to ensure appropriate 'sign-up' across the different organisations in Calderdale? If not, where were the barriers in setting up the 'Staying Well' programme?
   - Were there any financial pressures in health and social care that may have caused an initial barrier?

9. **What are the overarching objectives of the 'Staying Well' programme?**
   Prompts: For example:

   - To develop appropriate community capacity to mitigate social isolation or loneliness?
   - To enhance community capacity?
   - To develop the 'market' in third sector provision?

PROJECT DEVELOPMENT AND SUSTAINABILITY

10. **As you know, there are monies available to each 'hub' to develop local interventions. At this stage in the programme, can you tell me how you will be identifying which projects will be developed?**
    Prompts:

    - Will you be working alongside older people's groups to identify the different needs?
    - Are there any plans to develop and send out a survey or questionnaire to gather views?

11. **Are you aware of particular projects that will be set-up?**
    Prompts:

    - [If so,] could you tell me a little about these projects?
    - [If so,] who are the projects focused toward supporting?
    - [If so,] could you tell me why you are prioritising the development of these projects?
    - [If so,] who will be leading on the development of these projects?
    - [If not,] what do you perceive needs to be put in place to mitigate social isolation or loneliness? Could you tell me a little more about why these might be important?

12. **Are you aware of how Calderdale will be sustaining the 'Staying Well' programme and any projects? (Prompts):**
    - [If so,] what arrangements have been made to ensure sustainability?
    - [If so,] are there particular grant streams that may be available to ensure sustainability?
    - [If so and If not,] To what degree do you think sustainability will depend upon proving 'effectiveness' and/ or 'cost-effectiveness'?
    - [If so and If not,] Do you have any concerns about on-going sustainability? If so, could you tell me a little more about your concerns?

'STAYING WELL' PROGRAMME OUTCOMES

13. What are you hoping to be the outcomes of the 'Staying Well' programme?
Prompts:

- To improve quality of life for older people?
- To demonstrate that fewer older people are lonely in Calderdale?
- To ensure greater community capacity that can reduce social isolation/ loneliness?
- To reduce service use in primary and community care?
- To ensure that older people in the community are appropriately supported prior to any crisis?

ROUND-UP

Thank you very much for your time, that's all the questions I wanted to ask. Are there any further comments you would like to make that you don't think we picked up through the discussion?

APPENDIX TWO:

SEMI – STRUCTURED INTERVIEW – TOPIC GUIDES: INTERIM INTERVIEW

EVALUATION OF THE 'STAYING WELL' PROGRAMME': HUB LEADS AND 'STAYING WELL' WORKERS – TOPIC GUIDE (NOVEMBER 2015)

INTRODUCTION

The purpose of this interview is to explore the interim implementation of the 'Staying Well' programme from the perspective of the Hub Directors and Staying Well Workers. We are trying to find out a little bit more about the experiences of individuals as they move through the programme and projects. There are no right or wrong answers; the interview is simply about hearing your views around some of the activities and interim outcomes.

We will not use your name in any reports of this work and it will not be made known who took part. However, some of the things you say in the interviews might be used to illustrate and support the findings of the evaluation. It is possible that someone who knows you well might be able to identify you from such comments, but we will make every effort to make sure that this does not happen.

Are you happy for this interview to be tape recorded? Only researchers at the University of Lincoln will have access to the recording and you will not be named on the tape.

OPENING QUESTION

1. **How well do you think the Staying Well programme is progressing in your area?**
   Prompts:

   - What has worked well?
   - What has perhaps worked not as well?
   - What do you perceive as the rationale behind some things working better than others?

PROJECTS AND ACTIVITIES

2. **Have you funded or supported the development of specific projects or community activities to mitigate social isolation or loneliness?**

3. **Could you tell me a little about those projects that you have put in place to mitigate social isolation or loneliness?**
   Prompts:

   - What are the focus of those projects? That is, what are people doing as part of those projects?
   - What was the rationale behind putting those projects in place?
   - Could you tell me why these particular projects have been prioritised?

- Who is leading these projects?
- Is the leadership something that you have taken on or, has the organisation and development of the projects been devolved to community groups?
- Have some of the projects worked better than others? If so, why do you think that's the case?

4. **In your experience, have there been particular challenges in setting up these projects?**
   Prompts:

   - Could you tell me a little about what have been the main challenges?
   - Were there particular actions that you put in place to mitigate these challenges?
   - Did you perceive these actions to be successful or effective in mitigating the challenges?

5. **What do you perceive are likely to be the outcomes from these particular projects?**
   Prompts

   - Do you think these projects will improve community cohesion?
   - Do you perceive that the projects will support older people to become less lonely or less isolated? If so, how do you think such changes might be delivered?
   - What impact do you think the projects might have on the health and social care economy?
   - Do you think that involvement in such projects may increase or reduce use of statutory services?

COMMUNITY PARTNERSHIP

6. **Do you perceive that the 'Staying Well' programme has improved partnerships across the community?**
   Prompts:

   - If so, how do you think the programme has improved partnership working? For example have you seen a greater number of community actions or projects around the 'Staying Well' banner?
   - If not, why do you think that the 'Staying Well' programme has not improved partnership across the community?

7. **Do you perceive that there has been a culture change across the community in exploring ways to mitigate social isolation or loneliness?**
   Prompts:

   - Could you give me some examples of where you perceive there has been a culture change?
   - How far do you feel that the 'Staying Well' programme has contributed to that culture change?

8. **Do you perceive that there has been improved partnership with your health and social care colleagues?**
   Prompts:

   - If so, can you tell me a little more about that? For example, have there been improvements in working with some sectors but not others?
   - If not, why do you think there hasn't been perhaps improved partnerships?

PROJECT DEVELOPMENT AND SUSTAINABILITY

9. **What are the challenges around sustaining the 'Staying Well' programme and any projects?**
   Prompts:

   - What arrangements have been made to ensure sustainability?
   - Are there particular grant streams that may be available to ensure sustainability?
   - To what degree do you think sustainability will depend upon proving 'effectiveness' and/ or 'cost-effectiveness'?
   - Do you have any concerns about on-going sustainability? If so, could you tell me a little more about your concerns?

IMPACT TO DATE

10. **Overall, what would you say has been the value of the 'Staying Well' programme in your area?**
    Prompts:

    - Do you perceive that there have been changes in the quality of life of older people in your locality? If so, could you tell me a little more about the changes that you have seen?
    - Do you think that it has ensured the development of community capacity?
    - Has the intervention had an impact on primary and community service use?
    - Do you perceive that older people in the community are appropriately supported prior to any crisis?

ROUND-UP

Thank you very much for your time, that's all the questions I wanted to ask. Are there any further comments you would like to make that you don't think we picked up through the discussion?

APPENDIX THREE:

SEMI – STRUCTURED INTERVIEW – TOPIC GUIDES: EXIT INTERVIEW

EVALUATION OF THE 'STAYING WELL' PROGRAMME': HUB LEADS AND 'STAYING WELL' WORKERS – TOPIC GUIDE (FEBRUARY/ MARCH 2016)

INTRODUCTION

The purpose of this interview is to explore the overall implementation of the 'Staying Well' programme from the perspective of all individuals involved. We would like to find out about the experiences of individuals participating in projects or community activities, how they have gone and your own experiences. There are no right or wrong answers; we would simply like to hear your views about 'Staying Well' and some of the outcomes associated with the projects or community activities.

Your name and location will not be identified in any of the reports, however some of the things mentioned might be used to illustrate and support the findings of the evaluation.

Are you happy for this interview to be recorded? Only researchers at the University of Lincoln (i.e. myself, Tom George and Dr Karen Windle) will have access to this.

OPENING QUESTIONS

1. **How well do you think the 'Staying Well' programme has progressed in your area over the time-frame of the programme?**
   Prompts:
   - What has worked well? What has perhaps worked not as well?
   - What do you perceive as the rationale behind things working better than others?

2. **If you had to carry out a project that was similar to the 'Staying Well' programme, what would you do differently?**
   Prompts:
   - How would you ensure the management of the project worked for you?
   - How might you manage the micro-commissioning – would you do the same things or would do these differently? If so, how?
   - How would you approach finding the population – again, is there anything differently you would do, or what were the strengths of your approach?

PROJECTS AND ACTIVITIES

3. **Since we last spoke, have you further funded or supported the development of additional projects or community activities to mitigate social isolation or loneliness? (If NO go to Question 3).**
   Prompts:

- What are the focus of these projects? Why have they been prioritised?
- Who is leading these projects? Is this something you have taken on, or has the organisation/ development of projects been devolved to community groups?
- Have some of the projects worked better than others? If so, why do you think that's the case?

4. **How have the current projects or community activities implemented in your area been going?**
   Prompts:

   - Could you tell me about some of these projects?
   - Have some been more successful than others? And if so why do you think this might be the case?

5. **Have there been any successful outcomes from these particular projects or community activities?**
   Prompts

   - Do you think these projects have improved the quality of life of individual's within your locality?
   - Do you think these projects have improved community cohesion?
   - Do you perceive that the projects have supported older people to become less lonely or less isolated? If so, how do you think these changes have occurred?
   - Do you perceive these projects or community activities have had an impact on the health and social care economy?
   - Do you think that involvement in such projects has increased or reduced the use of statutory services?

YOUR EXPERIENCE

6. **How has 'Staying Well' impacted on your professional role?**
   Prompts

   - Do you feel you have developed as an individual?
   - Have you improved your skills and practice?

7. **Did the December flooding have an impact on 'Staying Well' within your area?**
   Prompts

   - If so how did this have an impact on the day to day running of 'Staying Well'?
   - Could you tell us a little bit about how you supported the community in recent flooding's?

COMMUNITY PARTNERSHIP

8. **Do you perceive that the 'Staying Well' programme has (further) improved partnerships across the community?**
   Prompts:

   - If so, how? E.g. have you seen a greater number of community actions or projects around the 'Staying Well' banner?
   - If not, why do you think the 'Staying Well' programme has not improved partnership across the community?

9. **Do you perceive that there has been a culture change across the community in exploring ways to mitigate social isolation or loneliness?**
   Prompts:

   - Could you give me some examples of where you perceive there has been a culture change?
   - How far do you feel that the 'Staying Well' programme has contributed to that culture change?

10. **Do you perceive that there has been improved partnership with your health and social care colleagues?**
    Prompts:

    - If so, can you tell me a little more about that? E.g. have there been improvements in working with some sectors but not others?
    - If not, why do you think there hasn't been perhaps improved partnerships?

PROJECT DEVELOPMENT AND SUSTAINABILITY

11. **Since we last spoke, have there been any arrangements made to ensure sustainability of the 'Staying Well' programme?**
    Prompts:

    - Are there particular grant streams available to ensure sustainability?
    - To what degree do you think sustainability will depend upon proving 'effectiveness' and/ or 'cost-effectiveness'?
    - Do you have any concerns about on-going sustainability of 'Staying Well' once this programme finishes in March? If so, could you tell me a little more about your concerns?

IMPACT TO DATE

12. **Overall, what would you say has been the value of the 'Staying Well' programme in your area?**
    Prompts:

- Do you perceive that there have been changes in the quality of life of older people in your locality? If so, could you tell me a little more about some of the changes you have seen?
- Do you think that it has ensured the development of community capacity?
- Has the intervention had an impact on primary and community service use?
- Do you perceive that older people in the community are appropriately supported prior to any crisis?

ROUND-UP

Thank you very much for your time, that's all the questions I wanted to ask. Are there any further comments you would like to make that you don't think we picked up through the discussion?

APPENDIX FOUR: COST TEMPLATE

COSTS OF IMPLEMENTING STAYING WELL PROGRAMME

1. Project name: STAYING WELL Hub:

Please provide total budget for the 'Staying Well Programme' in the Hub	**£**

2. Direct Expenditure: Project Management at Hub

These particular costs refer to the project management necessary to implement (design and set-up) the project (e.g., 'Winter Pressures Cell' etc, local project management etc.). Please do add rows as necessary.

Job Title (e.g., Business Lead, Director etc)	% of time spent on 'Staying Well' project (e.g., 25% of workload)	Length of time involved with the 'Staying Well' project (e.g., 3 months, 6 months, ongoing).	Annual Salary	Overheads	Is this staff resources in addition to what would have been incurred *without* implementing the Staying Well Programme (Yes/ No)

3. Direct expenditure – Staff (Management and operational staff of the 'Staying Well Programme')

Please add extra rows as necessary.

Job title	% of full-time (if full-time please put 100%)	Annual Salary	Overheads	Which organisation pays salary (e.g., Calderdale Council etc).	Is this staff resource in addition to what would have been incurred *without* implementing the Staying Well Programme (Yes/ No)	Length of time s/he will need to be in post (e.g., 18months, 2 years etc).
		£	£			
		£	£			
		£	£			
		£	£			
		£	£			
		£	£			
		£	£			
		£	£			
		£	£			

4. Additional resources necessary for Staying Well programme set-up

Item	Overall cost	% of full time role (if full-time put 100%)	Annual Salary	Overheads	Is this resource in addition to what would have been incurred without implementing the Staying Well Programme (Yes/ No)	Were these monies drawn from the Staying Well budget (Yes/ No)	Please indicate from which budget these monies were drawn (if not the Staying Well budget)
IT costs (including computer hardware and software)	£						
Workforce training	£						
Developing marking materials	£						
Financial administration							

5. Additional expenditure required to implement the Staying Well Project

Please add extra rows as necessary.

List Item	Total cost (£)	Were these monies drawn from the Staying Well budget (Yes/ No)	Please indicate from which budget these monies were drawn (if not the Staying Well budget)
	£		
	£		
	£		
	£		
	£		
	£		

APPENDIX FIVE: PROCESS MAPPING

START:

- What are the aims of the project?
- What part do you play – what is your role?
- What do you feel you need to help you achieve the aims of project?
- Who do you help?
- Why these people?
- What part of the process works well?
- What isn't working so well?
- What has already been changed?
- What is the greatest problem or barrier experienced on a regular basis?
- Suggestions and improvements/

FINISH

Staying Well Programme

Calderdale Evaluation

Questionnaire

Staying Well Programme

Individual Code	SW				
Area	SW				

Staying Well Programme Questionnaire

Introduction

Dear Participant,

Calderdale Council, local GPs and voluntary organisations are piloting a project called 'Staying Well' which aims to improve the health and wellbeing of local people.

We hope that by helping people to get more involved in local activities and helping people develop projects of their own we can enable people to live happier and more independent lives for longer.

The University of Lincoln are collecting information to give us an independent view on how the Staying Well Project is working and your experience is really important. None of the information is for use by the Council.

The Community and Health Research Unit (CaHRU) from University of Lincoln have created the questionnaire we would now like you to complete. It will allow them to see how you view your life at this time. They will contact you again in about four months' time asking you to complete another survey to find out about how you are feeling at that point.

Your views are very important and will give us a better understanding of how the Staying Well Project has worked.

We very much appreciate your support in this process. If you have any questions please contact Rebecca Porter, Research Assistant or Dr Karen Windle, Reader, School of Health and Social Care, Bridge House, University of Lincoln, Brayford Campus, Lincoln, LN6 7TS. E-mail: reporter@lincoln.ac.uk / kwindle@lincoln.ac.uk . Telephone: 01522 886367.

Yours Sincerely

Dr Karen Windle
Reader in Health
Community and Health Research Unit (CaHRU)
University of Lincoln

How to complete the questionnaire

Please answer the questions by:

Ticking the box, like this ✓

Or writing in the text box, like this | I enjoy gardening |

Administration Use

Post code:..... NHS number:.....

Date of interview:..... Name of interviewer:.....

Date of birth:.....

Gender: Male ☐ Female ☐

Staying Well Programme Questionnaire

2

About yourself

We would just like to ask you a few questions about yourself, please try to answer as honestly as you can.

1. **Please take a moment to think about all the different people you interact with *(friends/family/formal and informal carers)*-** Please write in the text box.

a) What do you think people would say you are good at?

b) What activities do you like doing best (e.g., baking, walking, swimming, gardening, etc)?

c) Have you ever acted as volunteer in a community organisation? (Please tick one box only)

Yes ☐ No ☐

If you answered yes, can you please list in the box below the sort of things that you did or still do? (Please write in the text box)

Staying Well Programme Questionnaire

4

Your quality of life and health

In this section, we would like you to think about your health and your quality of life.

2a) How would you describe your health in general? (Please tick one box only)

Very good	☐
Good	☐
Fair	☐
Bad	☐
Very bad	☐

b) Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole? (Please tick one box only)

So good, it could not be better	☐
Very good	☐
Good	☐
Alright	☐
Bad	☐
Very bad	☐
So bad, it could not be worse	☐

Social Support

3) For this section we would like you to think about your social support network. This can include family, friends, and neighbours.

a) How many relatives do you see or hear from at least once a month? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

b) Thinking about the relative with whom you have the most contact – how often do you see or hear from that person? (Please tick one box only)

Less than monthly	☐
Monthly	☐
A few times a month	☐
Weekly	☐
A few times a week	☐
Daily	☐

c) How many relatives do you feel at ease with so that you can talk about private matters or can call for help? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

d) How many friends do you feel at ease with so that you can talk about private matters or can call for help? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

e) How many of these friends do you see or hear from at least once a month? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

f) Thinking about the friend with whom you have the most contact – how often do you see or hear from that person? (Please tick one box only)

Less than monthly	☐
Monthly	☐
A few times a month	☐
Weekly	☐
A few times a week	☐
Daily	☐

g) When you have an important decision to make, do you have someone you can talk to about it? (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

h) When other people you know have an important decision to make, do they talk to you about it? (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

i) Is there anyone who relies on you to do something for them each day? (Please tick one box only)

Yes ☐ No ☐

j) Do you help anybody with something each day? (Please tick one box only)

Very often	☐
Often	☐
Sometimes	☐
Seldom	☐
Never	☐

Social Support Continued

4) Thinking about the way you feel now, please indicate for each of these statements, the extent to which they apply to your situation.

a) I experience a general sense of emptiness (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

b) There are plenty of people I can rely on when I have problems (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

c) There are many people I can trust completely (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

d) I miss having people around (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

e) There are enough people I feel close to (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

f) I often feel rejected (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

5) We would like you to think about your social support network and any help they may provide.

a) Do you receive any practical help on a regular basis from any friends, neighbours, a partner or family members? (Please tick all that apply)

Yes, from someone living in my household	☐
Yes, from someone living in another household	☐
No – (***please go to question 5***)	☐

b) How many different people provide support? (Please tick <u>one</u> box only)

1 – 2	☐
3 – 5	☐
6 or more	☐

c) Who would you say helps you the most? (Please tick <u>one</u> box only)

Spouse/partner	☐
Son/daughter	☐
Other family member/friend/neighbour	☐

Care and health services

6) **We would now like you to think about any care and /or health services you might have used in the past month.**

a) What care services have you received in the last month? (Please tick all that apply)

I haven't received any care services (not applicable)	☐
I received home care/home help	☐
I have had meals delivered to my home	☐
I attended a day centre	☐
I saw a local authority social worker or care manager	☐

b) How many times have you seen a GP at the surgery in the last month? (Please tick <u>one</u> box only)

Not at all	☐
Once	☐
2 or 3 times	☐
4 or 5 times	☐
6 or more times	☐
Don't know	☐

c) How many times have you seen a GP at home in the last month? (Please tick one box only)

Not at all	☐
Once	☐
2 or 3 times	☐
4 or 5 times	☐
6 or more times	☐
Don't know	☐

d) How many times have you seen a community nurse in the last month? (Please tick one box only)

Not at all	☐
Once	☐
2 or 3 times	☐
4 or 5 times	☐
6 or more times	☐
Don't know	☐

Your health today

7) **In this section we would like to ask you about your health today, please indicate which statements best describe your own health state today.**
Please tick one box only for each section.

a) **Mobility**

I have no problems in walking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

b) **Self-care**

I have no problems with self-care ☐

I have some problems washing or dressing myself ☐

I am unable to wash or dress myself ☐

c) **Usual activities** *(e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ☐

I have some problems with performing my usual activities ☐

I am unable to perform my usual activities ☐

d) **Pain/Discomfort**

I have no pain or discomfort ☐

I have moderate pain or discomfort ☐

I have extreme pain or discomfort ☐

e) **Anxiety/Depression**

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

f) **Compared with my general level of health over the past 12 months, my health state today is:**

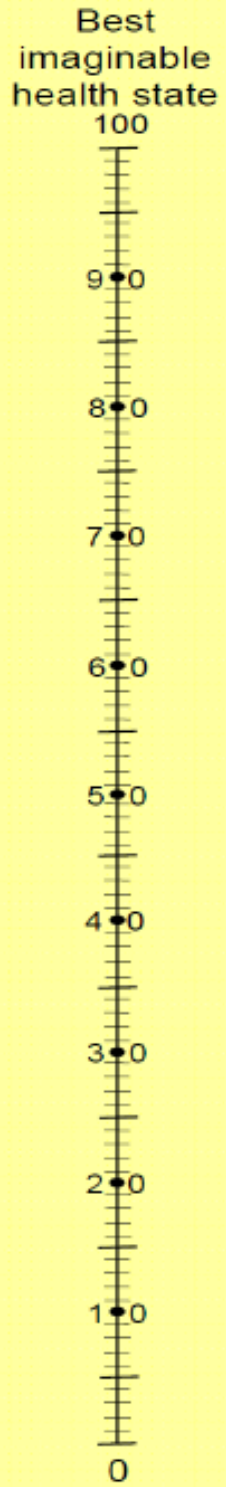
Better ☐

Much the same ☐

Worse ☐

g) To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line to whichever point on the scale that indicates how good or bad your health state is today.



About you…

8) In this section, we would like to finally ask you some questions about your personal circumstances.

a) What is your marital status? (Please tick one box only)

Single, that is never married	☐
Married	☐
Widowed	☐
Divorced	☐
Civil Partnership	☐
Cohabiting/living as married	☐
In a relationship but not living together	☐
Prefer not to say	☐

b) Who do you live with? (Please tick one box only)

Alone	☐
Spouse/partner	☐
Parents	☐
Son/daughter	☐
Other (please specify)	☐
Prefer not to say	☐

c) What is your main language?

English ☐

Other, please specify below:

☐

d) How well do you speak English? (Please tick one box only)

Very well ☐

Well ☐

Not Well ☐

Not at all ☐

e) What is your permanent accommodation? (Please tick all that apply)

Bungalow/Flat ☐

Semi-detached house ☐

Detached house ☐

Terraced house ☐

Residential home ☐

Supported setting (e.g., supported housing, residential care home) ☐

Tenant of a Registered Social Landlord (e.g.,Anchor Housing) ☐

Prefer not to say ☐

f) Are you…? (Please tick all that apply)

Retired	☐
Doing voluntary work	☐
In part time education/training	☐
In full time education/training	☐
Looking after home/caring for children or others	☐
Working full time	☐
Working part time	☐
Self employed	☐
Looking for work	☐
Not looking for work	☐
Prefer not to say	☐

g) Do you (or your partner, if appropriate) receive any state benefits? (e.g., State pension etc. Please tick one box only)

Yes ☐ No ☐ Prefer not to say ☐

h) If you do receive any benefits, could you please tick the boxes below to say which ones you receive?

State retirement pension	☐
Pension from former employer	☐
Job seekers allowance	☐
Income support	☐
Employment support allowance	☐
Family credit	☐
Housing benefit	☐
Personal independence payment	☐
Other state benefit (please specify below)	☐
☐	
Prefer not to say	☐

i) Which of the following best describes you? (Please tick one box only)

White – British White – Irish	☐
White – Gypsy or Traveller	☐
White – any other background	☐
Mixed – White and Black Caribbean	☐
Mixed – White and Black African	☐
Mixed – White and Asian	☐

Mixed – any other mixed background	☐
Asian or Asian British – Indian	☐
Asian or Asian British – Pakistani	☐
Asian or Asian British – Bangladeshi	☐
Asian or Asian British - Chinese	☐
Asian or Asian British – any other background	☐
Black or Black British – Caribbean	☐
Black or Black British – African	☐
Black or Black British –any other Black background	☐
Other	☐
Prefer not to say	☐

j) Do you consider yourself to be: (Please tick one box only)

Heterosexual or straight	☐
Gay or lesbian	☐
Bisexual	☐
Prefer not to say	☐

k) Have you ever identified as a transgender person? (Please tick one box only)

Yes ☐ No ☐ Prefer not to say ☐

l) What is your religion? (Please tick one box only)

No religion	☐
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	☐
Buddhist	☐
Hindu	☐
Jewish	☐
Muslim	☐
Sikh	☐
Any other religion (please specify)	☐
☐	
Prefer not to say	☐

Final Questions

9) **Finally, we would just like to ask you a few more questions about how you completed the questionnaire and if you would be happy to answer some more questions in the future.**

a) Did someone help you with this questionnaire today? (Please tick one box only)

No	☐
Yes – Carer	☐
Yes – Family member or Close Friend	☐
Yes – Staying Well team project worker	☐

b) Did you on behalf of the user complete this questionnaire (acting as proxy)? (Please tick one box only)

Yes ☐ No ☐

c) The research team would like to ask you some questions in four months' time.

There are three ways to receive the questionnaire, please tick which way you would prefer to receive the questionnaire

Postal Questionnaire	☐
Web-based questionnaire	☐
Telephone interview	☐

If you have any other comments about this questionnaire please express them below (this could include comments from the interviewee or problems completing the questionnaire)

Thank you for taking the time to complete this questionnaire

If you have any further questions please contact:
Rebecca Porter, Research Assistant or Dr Karen Windle, Reader, School of Health and Social Care, Bridge House, University of Lincoln, Brayford Campus, Lincoln, LN6 7TS. E-mail: reporter@lincoln.ac.uk / kwindle@lincoln.ac.uk . Telephone: 01522 886367.

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Staying Well Programme Questionnaire

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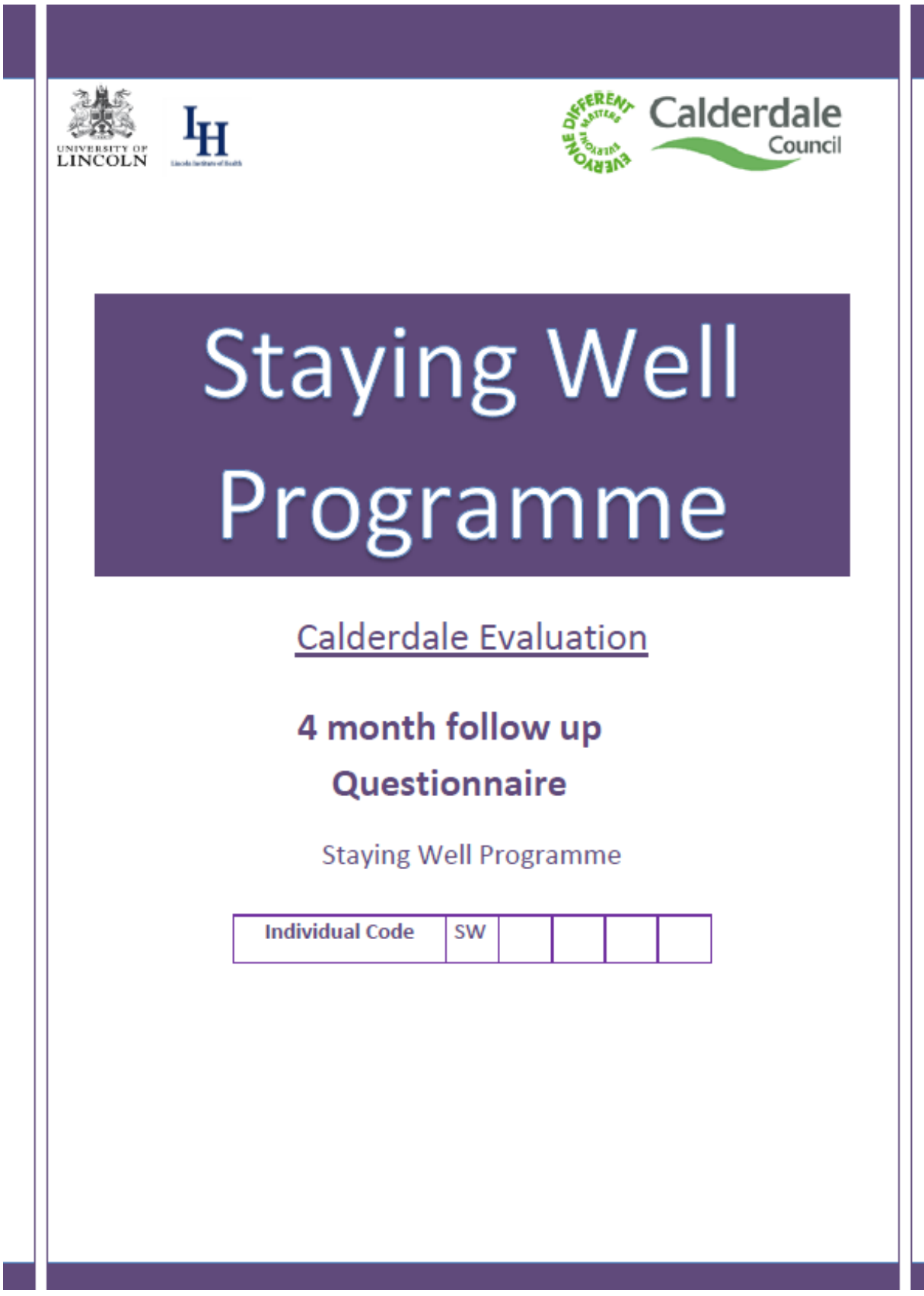
APPENDIX SEVEN:

'STAYING WELL' IN CALDERDALE FOLLOW – UP QUESTIONNAIRE



Staying Well Programme Questionnaire

Introduction

Dear Participant,

You will remember that you were contacted by a member of the 'Staying Well' programme, who may have worked alongside you to find out how your health and well-being could be supported and improved.

As part of that contact, you helpfully completed a questionnaire to support the evaluation of this programme. **Your views are very important**. Without these, we don't know if the 'Staying Well' programme is helping you. Also, we need this information to make sure that future funding is available.

We now want to know if anything has changed for you, for example, is your health better or worse? Have you been able to find other activities or support? We would be enormously grateful if you could once more complete this questionnaire. It shouldn't take too long and if you need help to do so, please do phone either myself or Rebecca Porter on the contact numbers given below.

Thank you so much for your time. Once more, your views are really important to us, and we would like to know how things have gone for you over the last four months.

We very much appreciate your support in this process. If you have any questions please contact Rebecca Porter, Research Assistant or Dr Karen Windle, Reader, School of Health and Social Care, Bridge House, University of Lincoln, Brayford Campus, Lincoln, LN6 7TS. E-mail: reporter@lincoln.ac.uk / kwindle@lincoln.ac.uk . **Telephone: 01522 886367**.

Yours Sincerely

Dr Karen Windle
Reader in Health
Institute for Health
University of Lincoln

How to complete the questionnaire

Please answer the questions by:

Ticking the box, like this 

Or writing in the text box, like this | I enjoy gardening |

Staying Well Programme Questionnaire

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About yourself

We would just like to ask you a few questions about yourself to see if anything has changed since the last time we contacted you, please try to answer as honestly as you can.

1. **Please take a moment to think about all the different people you have interacted with in the past 4 months *(friends/family/formal and informal carers)*- Please write in the text box.**

a) What do you think people would say you are good at?

b) Are there **any new activities that you have done** over the last four months (e.g., walking, volunteering, attending a new group, etc)?

Staying Well Programme Questionnaire

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c) In the **past 4 months** have you acted as volunteer, or plan to act as a volunteer in a community organisation? (Please tick one box only)

Yes ☐ **I plan to** ☐ **No** ☐

If you answered 'Yes', or 'I plan to', can you please list in the box below the new groups that you have volunteered with? (Please write in the text box)

Staying Well Programme Questionnaire

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Your quality of life and health

In this section, we would like you to think about your health and your quality of life in the past 4 months.

2a) How would you describe your health in the past 4 months? (Please tick one box only)

Very good	☐
Good	☐
Fair	☐
Bad	☐
Very bad	☐

b) Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole? (Please tick one box only)

So good, it could not be better	☐
Very good	☐
Good	☐
Alright	☐
Bad	☐
Very bad	☐
So bad, it could not be worse	☐

Social Support

3) For this section we would like you to think about <u>your social support network over the past 4 months</u>. This can include family, friends, and neighbours.

a) How many relatives have you seen or heard from in the **last 4 months**? (Please tick <u>one</u> box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

b) Thinking about the relative with whom you have the most contact – how often do you see or hear from that person? (Please tick <u>one</u> box only)

Less often than monthly	☐
Monthly	☐
A few times a month	☐
Weekly	☐
A few times a week	☐
Daily	☐

c) **In the past 4 months,** how many relatives have you felt at ease with so that you can talk about private matters or can call for help? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

d) **In the past 4 months,** how many friends have you felt at ease with so that you can talk about private matters or can call for help? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

Staying Well Programme Questionnaire

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e) How many of these friends do you seen or heard from in the **past 4 months**? (Please tick one box only)

0	☐
1	☐
2	☐
3-4	☐
5-8	☐
9+	☐

f) Thinking about the friend with whom you have the most contact **over the last four months** – how often do you see or hear from that person? (Please tick one box only)

Less often than monthly	☐
Monthly	☐
A few times a month	☐
Weekly	☐
A few times a week	☐
Daily	☐

g) **During the past 4 months**, when you have had an important decision to make, did you have someone you can talk to about it? (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

h) When other people you know have an important decision to make, have they spoken with you about it **over the plast four months?** (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

i) During the **past 4 months,** has there been anyone who relies on you to do something for them each day? (Please tick <u>one</u> box only)

Yes ☐ No ☐

j) **Over the past four months,** have you helped anybody with something each day? (Please tick <u>one</u> box only)

Very often	☐
Often	☐
Sometimes	☐
Seldom	☐
Never	☐

Social Support Continued

4) Thinking about the way you feel now, please indicate for each of these statements, the extent to which they apply to your situation.

a) I experience a general sense of emptiness (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

b) There are plenty of people I can rely on when I have problems (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

c) There are many people I can trust completely (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

d) I miss having people around (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

e) There are enough people I feel close to (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

f) I often feel rejected (Please tick one box only)

Never	☐
Seldom	☐
Sometimes	☐
Often	☐
Very often	☐
Always	☐

5) We would like you to think about your social support network over the past 4 months and any help they may provide.

a) In the **past 4 months**, have you received any practical help on a regular basis from any friends, neighbours, a partner or family members? (Please tick all that apply)

Yes, from someone living in my household	☐
Yes, from someone living in another household	☐
No – (***please go to question 6***)	☐

b) How many different people provide support? (Please tick <u>one</u> box only)

1 – 2	☐
3 – 5	☐
6 or more	☐

c) Who would you say helps you the most? (Please tick <u>one</u> box only)

Spouse/partner	☐
Son/daughter	☐
Other family member/friend/neighbour	☐

Care and health services

6) **We would now like you to think about any care and /or health services you might have used <u>in the past 4 months</u>.**

a) What care services have you received in the **past 4 months**? (Please tick all that apply)

I haven't received any care services (not applicable)	☐
I received home care/home help	☐
I have had meals delivered to my home	☐
I attended a day centre	☐
I saw a local authority social worker or care manager	☐

b) How many times have you seen a GP at the surgery in the **past 4 months**? (Please tick <u>one</u> box only)

Not at all	☐
Once	☐
2 or 3 times	☐
4 or 5 times	☐
6 or more times	☐
Don't know	☐

c) How many times have you seen a GP at home in the **past 4 months**? (Please tick one box only)

Not at all	☐
Once	☐
2 or 3 times	☐
4 or 5 times	☐
6 or more times	☐
Don't know	☐

d) How many times have you seen a community nurse in the **past 4 months**? (Please tick one box only)

Not at all	☐
Once	☐
2 or 3 times	☐
4 or 5 times	☐
6 or more times	☐
Don't know	☐

Your health today

7) In this section we would like to ask you about your health today, please indicate which statements best describe your own health state today.
Please tick one box only for each section.

a) **Mobility**

I have no problems in walking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

b) **Self-care**

I have no problems with self-care ☐

I have some problems washing or dressing myself ☐

I am unable to wash or dress myself ☐

c) **Usual activities** *(e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ☐

I have some problems with performing my usual activities ☐

I am unable to perform my usual activities ☐

d) **Pain/Discomfort**

I have no pain or discomfort ☐

I have moderate pain or discomfort ☐

I have extreme pain or discomfort ☐

e) **Anxiety/Depression**

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

f) **Compared with my general level of health over the past 12 months, my health state today is:**

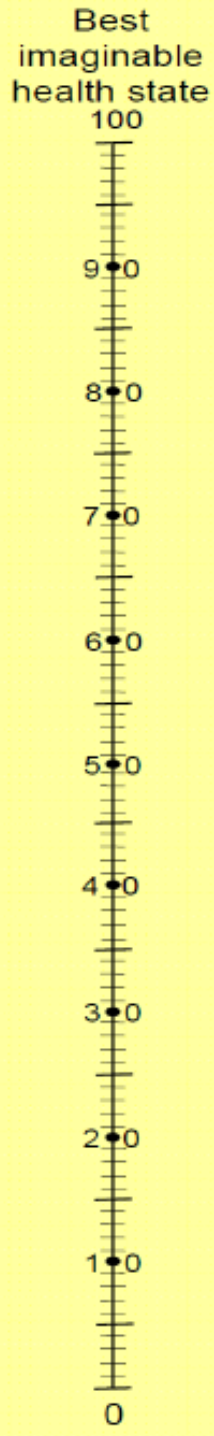
Better ☐

Much the same ☐

Worse ☐

g) To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line to whichever point on the scale that indicates how good or bad your health state is today.



About you...

8) In this section, we would like to finally ask you a few questions about your long term health conditions and personal circumstances of the last 4 months.

a) Which of the following long term health conditions have you been diagnosed with? (Please tick all the options that apply to you)

- ☐ Cancer
- ☐ Cardiovascular disease (e.g., heart disease, stroke, high blood pressure)
- ☐ Chronic back pain
- ☐ Chronic bowel disease (e.g., irritable bowel syndrome, Crohn's disease)
- ☐ Chronic fatigue syndrome
- ☐ Chronic kidney disease (e.g., kidney failure)
- ☐ Chronic neurologic problems (e.g., Alzheimer's, dementia, epilepsy, muscular disease)
- ☐ Chronic respiratory disease (e.g., asthma, chronic obstructive pulmonary disease [COPD])
- ☐ Chronic skin disease (e.g., psoriasis)
- ☐ Diabetes
- ☐ Liver disease (e.g., liver cirrhosis)
- ☐ Mental health problems (e.g., schizophrenia, bipolar disorder, depression)
- ☐ Musculoskeletal problems (e.g., arthritis, rheumatism, osteoporosis)
- ☐ Thyroid problems
- ☐ Other - please specify:.....
- ☐ Prefer not to say

b) How many long term health conditions are you currently diagnosed with? (Please write down the number of long term health conditions in the box below)

c) Have you claimed or are in the process of claiming any additional benefits in the **past 4 months**?

Yes ☐ No ☐ Prefer not to say ☐

d) If you do receive any benefits, which ones do you receive? (please tick all that apply)

	Already received	Claimed / in process of claiming in past 4 months
State retirement pension	☐	☐
Pension from former employer	☐	☐
Job seekers allowance	☐	☐
Income support	☐	☐
Employment support allowance	☐	☐
Family credit	☐	☐
Housing benefit	☐	☐
Personal independence payment / DLA	☐	☐
Attendance Allowance	☐	☐
Other state benefit (please specify below)	☐	☐
Prefer not to say	☐	☐

Final Questions

9) **Finally, we would just like to ask you a few more questions about how you completed the questionnaire.**

a) Did someone help you with this questionnaire today? (Please tick one box only)

No	☐
Yes – Carer	☐
Yes – Family member or Close Friend	☐
Yes – Staying Well project worker	☐

b) Did you on behalf of the user complete this questionnaire (acting as proxy)? (Please tick one box only)

Yes ☐ No ☐

Thank you for taking the time to complete this questionnaire

If you have any further questions please contact:
Rebecca Porter, Research Assistant or Dr Karen Windle, Reader, School of Health and Social Care, Bridge House, University of Lincoln, Brayford Campus, Lincoln, LN6 7TS. E-mail: reporter@lincoln.ac.uk / kwindle@lincoln.ac.uk . Telephone: 01522 886367.

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Staying Well Programme Questionnaire

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'STAYING WELL IN CALDERDALE' PROGRAMME EVALUATION:

SUMMARY INTERIM REPORT

UNIVERSITY OF LINCOLN

Dr Karen Windle, Reader in Health, Healthy Ageing Research Group, School of Health and Social Care, University of Lincoln.

Professor Steve McKay, Distinguished Professor in Social Research, School of Social and Political Sciences, University of Lincoln.

Dr Janet Walker, Principal Lecturer and Deputy Head of School, School of Health and Social Care, University of Lincoln.

Dr Martin Culliney, Research Fellow, School of Social and Political Sciences, University of Lincoln.

Thomas George. Research Assistant, Healthy Ageing Research Group, School of Health and Social Care, University of Lincoln.

Jolien Vos, Graduate Research Assistant, School of Health and Social Care, University of Lincoln.

Nadya Essam, Independent Consultant and Visiting Research Fellow, Brocas Arvensis and University of Lincoln.

Rebecca Porter, Research Assistant, School of Health and Social Care, University of Lincoln.

EXECUTIVE SUMMARY

The 'Staying Well Programme' was set up across Calderdale Metropolitan Borough Council in November 2014. The programme incorporates three aims: a reduction in loneliness and social isolation for older people; an increase in community capacity and improved intersectoral working. The programme put in place four 'Staying Well' workers within the existing community hubs of Elland and District, Halifax Opportunities Trust, Hebden Bridge and North Halifax. The Staying Well workers were tasked with: identifying lonely and isolated older people (those aged 65 and over); signposting them to appropriate community services; map and identify gaps in existing community provision and; support the implementation of new locally designed provision.

Evaluation methods

To assess the effectiveness and cost-effectiveness of the 'Staying Well Programme', the evaluation has adopted a multi-method approach. A range of qualitative and quantitative methods have been administered, including: base-line and interim semi-structured interviews and process mapping with strategic and operational staff; 'before and after' structured questionnaires with older people themselves; and collation and analysis of pre-collected data and cost data. In the final stages of the project, we will assess community outcomes and carry out a number of final 'end of project' interviews.

Early findings

- Participants are demonstrably lonely and socially isolated.
- Differences are seen across the hubs with the highest levels of loneliness seen in Halifax Opportunities Trust and the lowest in North Halifax Hub.
- Over half of the participants were either already 'socially isolated' or at 'high risk' of social isolation. Three quarters of sample were at some risk of social isolation.
- Many of the participants are in poor health, reporting between a fifth and a quarter lower health-related quality of life compared with the overall average UK population.
- Participants in Halifax Opportunities Trust hub reported the lowest health-related quality of life and Hebden Bridge the highest.
- Over two-thirds of the participants had problems with mobility; two-thirds reported moderate or extreme pain or discomfort and over half the sample moderate or extreme anxiety and depression.
- Those participants at lower risk of social isolation reported better health-related quality of life.
- Anxiety and depression has an impact on loneliness and health-related quality of life; those anxious or depressed are more likely to be lonely.
- Participants reported a relatively high use of local authority social work/ care management support and GP visits.

- Whilst the majority of participants report high levels of need (e.g., over two-thirds reported some problems with mobility) many individuals being supported are below the threshold for adult social care support.
- One hub, Elland and District, is also supporting a number of younger adults with learning disabilities owing to the paucity of service provision and wider support across the community.

Barriers and facilitators to implementing the 'Staying Well Programme'

- Overarching programme structure initially unclear and minimal guidance seemingly provided as to how staffing models, roles and responsibilities should be structured.
- There were reported delays in devolving funding to the hubs to develop and invest in community driven initiatives
- Serious delays were reported in in identifying and appointing the Social Prescribing volunteers resulted in limited support and provision in general practices.
- Communication between the central programme management and hubs was perceived as limited.
- Limited engagement by health organisations (GPs, community health) despite hard work on the part of the central team and hubs.
- Early barriers and difficulties have been minimised through greater devolution of financial and management structures and processes.

Discussion

- Whilst the 'Staying Well in Calderdale' programme was set up to provide early identification and prevention, participants present a range of complex needs.
- In response, 'Staying Well' workers have extended their role and remit, moving toward a Community Navigator model of provision.

CONTENTS

BACKGROUND

The 'Staying Well Programme' was set up across Calderdale Metropolitan Borough Council in November 2014. The programme incorporates three aims: a reduction in loneliness and social isolation for older people; an increase in community capacity and improved intersectoral working. The programme put in place four 'Staying Well' (SW) workers within the existing community hubs of Elland and District, Halifax Opportunities Trust, Hebden Bridge and North Halifax. The SW workers were tasked with identifying lonely and isolated older people (those aged 65 and over) and signposting them to appropriate community services. As part of this role, SW workers would also map and identify gaps in existing community provision. Working alongside their hub colleagues, the older people themselves and the wider community; the SW workers would also support the development of range of interventions that would mitigate loneliness and social isolation (e.g., cultural activities, befriending schemes, cinema courses). In addition to the SW workers, the North Bank Forum for Voluntary Organisations was commissioned to place volunteers in five GP practices to act as 'Social Prescribers'. Each would receive referrals from the GP and work alongside alongside the older person to emerge needs, wishes and wants and to identify suitable support. Where relevant, these older people would also be referred onto the hubs (Neighbourhood Scheme Workers) if longer term support was seen as appropriate.

To explore the effectiveness and cost-effectiveness of the 'Staying Well Programme', Calderdale Metropolitan Council, their health and third sector partners, requested an evaluation of the programme. Specialists from the University of Lincoln were awarded the tender following a competitive process.

This summary Interim Report provides relevant background literature, highlights those methods applied (to date) as part of the evaluation and gives details of the early progress toward the overarching objectives of the 'Staying Well Programme'. A discussion around the findings is then given along with early recommendations. Finally, the next steps of the evaluation are explored.

LITERATURE SUMMARY[1]

DEFINITIONS

The terms 'social isolation' and 'loneliness' are often used interchangeably by policy makers and academic commentators. However, there are distinct meanings to these concepts. Loneliness is a subjective, negative feeling associated with loss (e.g., loss of partner or children relocating); whilst social isolation has been described as imposed isolation from normal social networks. Older people (as individuals as well as carers) have specific vulnerabilities to loneliness and social isolation owing to *'loss of friends and family, loss of mobility or loss of income'* (Age UK, Oxfordshire, 2012). In our analysis, we have separately measured loneliness (de Jong Gierveld *et al.,* 1985) and social isolation (Lubben and Gioranda, 2004).

WHAT IS THE ISSUE?

The statistics on population ageing in the UK (and in many developed countries) are well known. Those aged 60 and above currently account for approximately 20 per cent of the population and this proportion is expected to rise to 24 per cent by 2030 (Dickens *et al.,* 2011). In the next 20 years, the population of those aged over 80 will treble and those over 90 will double (Greaves and Farbus, 2006). In exploring prevalence, it is estimated that across the present population aged 65 and over, between five and 16 per cent report loneliness, while 12 per cent feel socially isolated (O'Luanaigh and Lawlor, 2008). In looking at the experiences of a nationally representative sample, Victor *et al.,* (2005) found that two per cent of individuals reported that they were 'always lonely', five per cent that they were 'often lonely' and 31 per cent rated themselves as 'sometimes lonely'. Such figures are likely to expand with increasing family dispersal and growing numbers of older people and the 'older-old' − those aged 80 and over (Masi *et al.,* 2005).

WHY IS IT IMPORTANT?

Social isolation and loneliness impact on quality of life and well-being with demonstrable negative health effects. For example, being lonely has a significant and lasting effect on blood pressure with lonely individuals having higher blood pressure than their less lonely peer. Such an effect has been found to be independent of age, gender, race, cardiovascular risk factors (including smoking), medications, health conditions and the effects of depressive symptoms (Hawkley *et al.,* 2010). Similarly, lonely and socially isolated individuals are more likely to develop dementia than those without feelings of loneliness (Holwerda *et al.,* 2012); have higher rates of depression and mortality (Greaves and Farbus, 2006; Ollonqvist *et al.,* 2008; Mead *et al.,* 2010); higher health and social care use and earlier admission to residential or nursing care (Pitkala *et al.,* 2009; Holt-Lunstead *et al.,* 2010).

[1] Summary literature review has been drawn from two prior publications, Windle *et al.,* 2011 and Windle, 2015.

EFFECTIVE INTERVENTIONS

It is often reported that group interventions, e.g. day centre type services, self-help and self-support groups, are more effective than one-to-one services, e.g. befriending, mentoring (Findlay, 2003; Cattan *et al.,* 2005; Oliver *et al.,* 2014). However, there are differential outcomes: some group activities have no impact while there are specific one-to-one interventions that are seemingly effective.

There is good evidence that **befriending interventions** reduce loneliness (Butler, 2006) and depressive symptomology (Mead *et al.,* 2010). Whilst a small number of **Social prescribing services** (SPS) have been in place since the late 1990's (Kimberlee *et al*., 2014), their wider adoption has been a relatively new intervention, ensuring primary care (GPs or practice nurses) or VCOs (Keenaghan *et al.,* 2012) are able to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services. For example group activity or mobility sessions and drop-in reminiscence groups (Brandling and House, 2007; Horne *et al.,* 2013). Drawing on the existing service evaluations, SPS can seemingly reduce secondary care service use, reduce anxiety and depression and improve physical activity and self-efficacy (Dayson *et al.,* 2013; Kimberlee *et al.*, 2014). In contrast, evaluations of **mentoring provision**, an intervention that works with the older person to achieve individual goals, (often) on a short-term basis (e.g. 12 weeks), have yet to demonstrate effectiveness; a case-control trial reported that there were no improvements in depressive symptoms, physical health, social activities, social support or morbidity (Dickens *et al.,* 2011). Similarly, there is as yet no conclusive empirical evidence that **computer or internet usage** impacts on loneliness, or physical or psychological outcomes (Slegers *et al.,* 2008).

Of the group interventions, a 12-week 'closed' group that aimed to develop 'self-efficacy' in terms of social integration found no change in loneliness (Kremers *et al.,* 2006; Martina and Stevens, 2006). **Social group activities** (e.g. hobby or educational classes – art, singing, therapeutic writing) seemingly report greater effectiveness, achieving reductions in loneliness, improved physical health, reductions in falls and, where measured, statistically significant differences in mortality (Cohen *et al.,* 2006; Pitkala *et al.,* 2009; Savikko *et al.,* 2010).

Wider community engagement, **volunteer schemes** and **'time banks'** have long been demonstrated as effective in mitigating loneliness and social isolation, improving emotional well-being and supporting older volunteers to maintain independence and health (New Economics Foundation, 2002; Narushima, 2005; Trickey *et al.,* 2008; Rushey Green Time Bank, 2009; Heaven *et al.,* 2013). 'Time banks' that use hours of time rather than currency, with the type of support volunteers undertake dependent on their own skills (as well as the needs of the wider community), have proved to attract socially excluded groups, widening and strengthening community capacity (Seyfang and Smith, 2002; Knapp *et al.,* 2013)

RESEARCH QUESTIONS

A multi-method approach was adopted to respond to the four broad components of the evaluation: the type of interventions *(projects)* and their impact on individual users *(people)*, communities *(places)* and intersectoral working *(partnerships)*. In particular, the research questions are focused on the three aims of the programme: reduction in loneliness and social isolation, improved community capacity and intesectoral working. The following table details the overarching agreed research questions (see Table 1).

Table 1: Research questions

Projects and partnerships	People and communities
• What types of interventions have been funded, target audience, activities included, pathways between services and support? • How are these interventions implemented, including engagement with older people, partnership working, skills required, resources levered? • How do the interventions develop and change over the life of the programme and what are then challenges and barriers they face? • What is the impact of the programme on partnership or integrated working across the health, health, social and third sector care environment? • What are the costs and benefits of each project? • What is the potential for scaling up to prevent social isolation in the future?	• Do the interventions demonstrably reduce loneliness and/ or social isolation? • What impact does the intervention have on individual (and, where relevant, carer) wellbeing, quality of life, independence, health status and experience of services? • What is the overall impact of the programme on outcomes for local communities?

Those questions being responded to within this Interim Report include:

- **What is the target audience of the 'Staying Well' programme?**
- **How has the Staying Well programme developed and changed over time and what have been those facilitators and barriers to progress? *and***
- **What is the role and activity of the Staying Well workers?**

METHODS

The research methods applied to capture effectiveness and cost-effectiveness are provided below (see Table 2). Where relevant, further details are provided as to areas of enquiry and the numbers of participants.

Table 2: Methods, area of enquiry and number of participants

Method	Areas of enquiry	Type and number of participants
Early implementation semi-structured interviews	• Job role and role within 'Staying Well' programme. • Type and extent of partnerships prior to the 'Staying Well' programme. • Rationale and objectives underpinning the 'Staying Well' programme. • Barriers and facilitators to implementation. • Likely programme outcomes. • Project development and sustainability.	Total number of interviews =38. • Programme management/ Steering group staff (n=22) • Hub Staff (n=16)
Process maps	• Perceived aims and objectives • Role of participants in achieving aims and objectives • Type of individuals being supported • Structures and processes of the work • Barriers and facilitators to implementation	• Elland and District Hub (n=4) • Halifax Opportunity Hub (n=6) • Hebden Bridge Hub (n=2) • North Halifax Hub (n=5)
Structured questionnaires (base-line and four month follow-up)	• Participant assets (e.g., strengths, preferred activities, volunteering activities). • Quality of life (Bowling, 2002) • Social Isolation (Lubben social network scale) • Loneliness Scale (de Jong Gieveld) • Health-related quality of life (EQ-5D3L) • Individual service use (Beecham and Knapp, 1992) • Demographics (e.g., marital status, accommodation, work/ retirement, benefit receipt, ethnicity, sexuality, faith).	Total number of returns to date = 186. • Elland and District (n=30) • Halifax Opportunities Trust (n=41) • Hebden Bridge (n=75) • North Halifax Trust (n=30) • Social Prescribers (n=10)
Cost data	• Total budget • Direct expenditure on staff (management and operational staff) • Additional resources necessary for set-up (e.g., IT, workforce training, marketing, financial administration) • Additional finance to implement SW project (e.g., on-going marketing, development of projects)	Cost data returned from: • Overall SW programme management • Elland and District • Halifax Opportunities Trust • Hebden Bridge • North Halifax Trust
Pre-collected project data	• Numbers of individuals • Demographics (e.g., gender, age, ethnicity) • Referral route • Activity (e.g., type(s) of provision offered • Length of case • Case-loads	Collection and analysis on-going
Measuring community outcomes	• Changes in individuals' social networks and environment; people (personal relationships) and places (those agencies/ organisations to which people belong or that matter to them.	November 2015
Interim set-up interviews	• Activities undertaken • Projects developed • Improvements in partnerships	November 2015
Final interviews	• To be designed	February 2016

EARLY FINDINGS[2]

AIMS AND OBJECTIVES

Drawing on data from the interviews and process mapping, participants highlighted a number of aims and objectives of the 'Staying Well' programme; each of which links with the overarching stated aims of the evaluation: reduction in loneliness and social isolation for older people; an increase in community capacity and improved intersectoral working (see appendix two, Figure 7). Participants reported that the central aim of the programme was to identify those lonely and socially isolated **individuals**, working alongside them to identify appropriate provision along with supporting on-going attendance. There was recognition that the programme should provide a 'linking' function, improving **organisational** partnerships across Calderdale. Similarly, staff would be encouraged to work with other health, social and third sector care organisations to highlight the importance of measuring and identifying social isolation and loneliness in all older people; referring into the Staying Well programme where necessary. A further expressed aim was to liaise with a range of **community groups** to identify gaps in provision, identifying and building interventions that would be appropriate to community needs; reducing loneliness and social isolation through building support networks and activities that would enable communities to work 'better together'.

CHANGES IN THE TARGET PARTICIPANTS.

In comparing the early implementation interviews and the later process mapping exercise, changes were seen in the type of participants supported by the 'Staying Well' workers. In the early interviews, it was envisaged that the focus would be on 'upstream' practice, supporting older people aged 65 and over who had yet to engage with formal health or social care services. At the process mapping exercises (four months later) it became clear that there had been some necessary 'drift' in the inclusion criteria. The age 'limit' had been lowered to include all adults over 50 who were either isolated or lonely *or*, 'at risk' of isolation and loneliness. One hub, Elland and District, had also extended their target population to included younger adults with learning disabilities. Whilst staff were working alongside those individuals below the threshold for social care support, a range of assessment and support was also being put in place for those individuals in receipt of formal health or social care ('downstream practice'), but for whom little support had been delivered to mitigate their social isolation or loneliness. Similarly, the majority of individuals being referred to the 'Staying Well' programme were reported to be in poor physical and mental health (see appendix 2, Figure 8).

[2] It should be noted that owing to the early implementation phase, the numbers of questionnaires received from each hub do not allow for significant statistical differences to be reported. We report the distinctions between the hubs as 'likely' variances. The final analysis will be able to demonstrate if such contrasts are statistically significant.

AGE RANGES

The data from the base-line self-completed structured questionnaires (Table 2, above) would seem to support this change in focus. Whilst the mean age is 73 and over half the sample are aged 75 and over (55%), there is a far wider age range that would have perhaps have previously been expected, with almost a fifth (19%) aged 59 or less (see Table 3, below).

Table 3: Age range of participants (structured self-completion questionnaire).

Age range	Percent (n)
Aged 30 to 49	5 (7)
Aged 50 to 59	14 (18)
Aged 60 to 74	26 (34)
Aged 75 and over	55 (72)
Totals	100 (131)

In addition, differences are seen across the hubs. Elland and District is supporting individuals aged 31 to 101 (range, 70), whilst North Halifax is working alongside those aged 56 and over (see Table 4).

Table 4: Age range by hub

Staying Well Hubs	Youngest	Oldest	Range	Mean	Median
Elland Hub	31	101	70	80	87
Hebden Bridge Hub	39	94	55	72	69
Halifax Opportunities Trust	35	94	60	69	75
North Halifax Hub	56	95	39	76	76
Social prescribers	52	96	44	75	81

ISOLATION AND LONELINESS

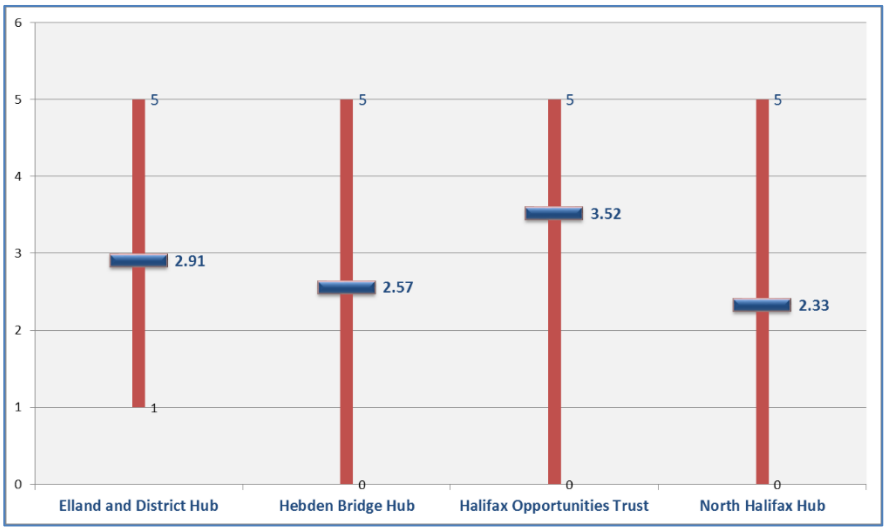
In exploring levels of loneliness, the de Jong Gierveld scale (de Jong Gierveld *et al.,* 1985) was used. This ranges from 'not lonely' (a score of zero), to 'very lonely' (a score of 6). The mean score was 2.85 and over half the sample scored between three and six, indicating high levels of loneliness.

Table 5: Loneliness scores (2 and above and perceived as lonely).

de Jong Gierveld score	% (n)
Loneliness score = 0	10 (15)
Loneliness score = 1	15 (23)
Loneliness score = 2	23 (34)
Loneliness score = 3	9 (14)
Loneliness score = 4	17 (25)
Loneliness score = 5	26 (39)
Loneliness score = 6	0 (0)

Again, differences were seen across the hubs, with those participants from Halifax Opportunities Trust reporting the highest levels of loneliness (mean, 3.52) and those in North Halifax, the lowest (2.33) (see Figure 1, below).

Figure 1: Mean loneliness score by hub (de Jong Gierveld scale).



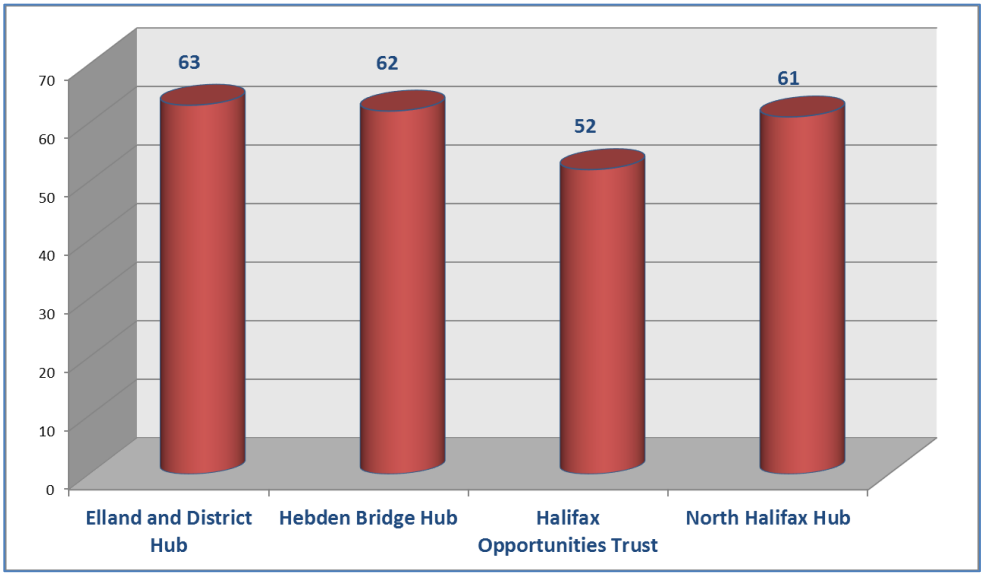
Through analysis of the Lubben Social Network Scale (Lubben and Gironda, 2004), it was found that over half of the participants (54%) were either already 'socially isolated' or at 'high risk' of social isolation; with three-quarters (75%) of the sample at some risk of social isolation (see Table 6).

Table 6: Risk of social isolation (Lubben Social Network scale).

Risk of social isolation	% (n)
Participant isolated	26 (36)
Participant at high risk of isolation	28 (38)
Participant at moderate risk of isolation	21 (28)
Participant at low risk for isolation	25 (43)
Totals	100 (136)

In exploring the differences between the hubs, it can be seen that although participants in Halifax Opportunities Trust reported the highest levels of loneliness (see Figure 1, above) the proportion reporting social isolation was lower than individuals being supported by the other hubs (Figure 2, below).

Figure 2: Participant 'social isolated' or at 'high risk of social isolation' by hub



HEALTH STATUS

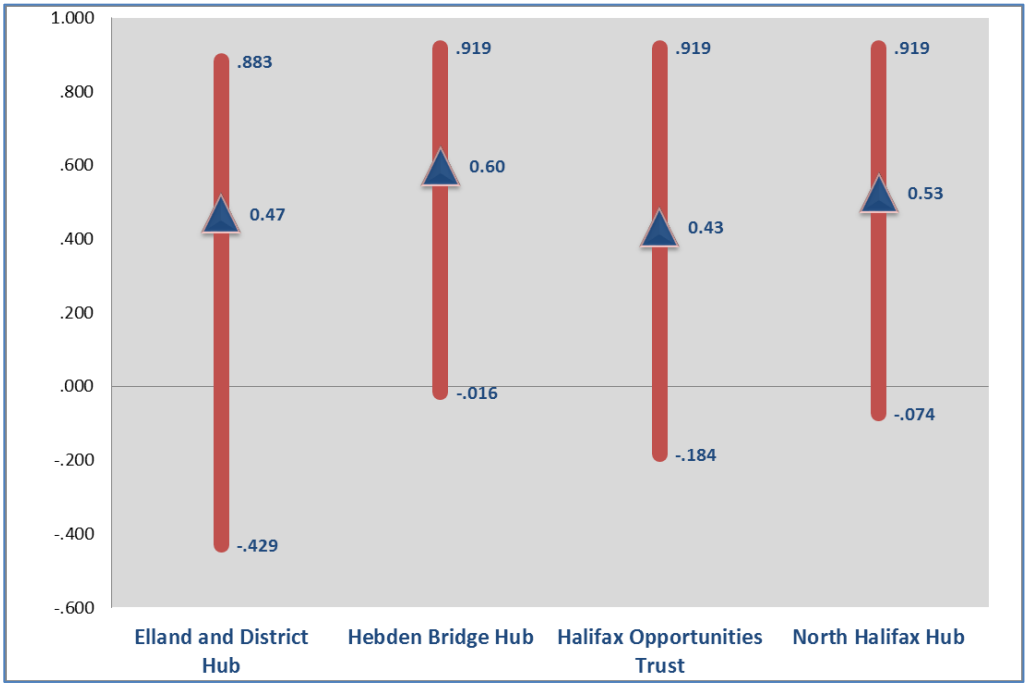
In the early planning and implementation stages of the 'Staying Well in Calderdale' programme, it was perceived that the focus would be on improving well-being, capturing participants *before* they needed to use more formal or statutory care services. From our analysis, it would seem that many of the participants are in poor health. Using the EQ-5D (Dolan *et al.,* 1995) to measure health-related quality of life, the reported mean score was 0.53, which can be equated to 53% of perfect health. Comparing these findings with the overall average UK population, it can be seen that participants using the 'Staying Well' programme report between a fifth and a quarter lower health-related quality of life (see Table 7, below).

Table 7: Age range by mean EQ-5D scores compared to 'average' UK scores.

Age Range	'Staying Well' participant HRQoL Scores (EQ-5D3L)	Average UK HRQol Scores (EQ-5D)
Aged 55 to 64	0.16 (16% of perfect health)	0.80 (80% of perfect health)
Aged 65 to 74	0.60 (60% of perfect health)	0.78 (78% of perfect health)
Aged 75 and over	0.50 (50% of perfect health)	0.73 (73% of perfect health).

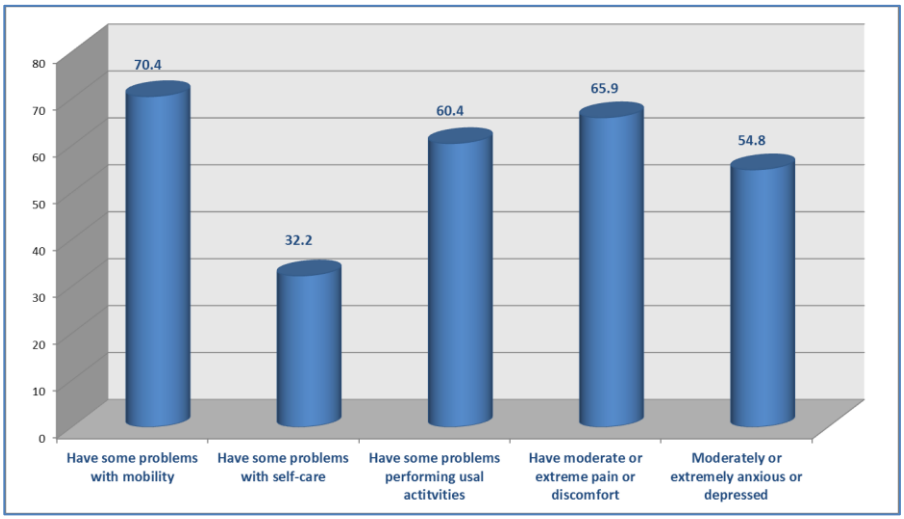
Differences were seen across the hubs (see Figure 3, below). Those participants in Halifax Opportunity Hub reported the lowest scores (43% of perfect health), whilst those in Hebden Bridge had the highest (60% of perfect health).

Figure 3: Range and mean (arrow) of health-related quality of life scores (EQ-5D3L) by hub.



Responses to the different domains of health-related quality of life were explored: levels of mobility; problems with self-care (e.g., washing or dressing); difficulties in performing usual activities (e.g., shopping, visiting friends); pain or discomfort and; anxiety/ depression. It was found that a high proportion of individuals reported either some difficulties or, an inability to carry out the task. For example, (see Figure 4, below) over two-thirds of the participants stated that they had some problems with mobility (70%), whilst two-thirds (66%) reported moderate or extreme pain or discomfort. In addition, it should be noted that over half of the sample (55%) reported that they were either moderately or extremely anxious or depressed

Figure 4: Participants reported problems across the different EQ-5D domains.



In exploring the differences between the hubs (see Table 8, below); participants being supported by Elland and District would seem to report the greatest difficulties with mobility and usual activities. Similarly, two-thirds of those in North Halifax (64%) and Halifax Opportunities Trust (69%) report moderate or extreme anxiety or depression.

Table 8: Domains of the EQ-5D by hubs

Hubs	Some problems in mobility (%)	Some problems in self-care (%)	Some problems in usual activities (%)	Moderate or extreme pain or discomfort (%)	Moderate or extreme anxiety/ depression (%)
Elland and District	83	43	79	69	48
Hebden Bridge	53	22	41	61	43
Halifax Opportunities Trust	82	45	74	76	69
North Halifax	79	28	57	61	64

Further analysis was carried out to explore the impact of participants' health status on the risk of social isolation (see Table 9). It was found, (perhaps not surprisingly), that those participant's at low risk of social isolation, reported 62 per cent of perfect health; whilst in contrast, those who were socially isolated, reported 42 per cent of perfect health.

Table 9: Risk of isolation (Lubben Social Network Scale) by EQ-5D scores.

Risk of social isolation	N	Mean
Participant isolated	33	.42
Participant at high risk of isolation	36	.54
Participant at moderate risk of isolation	26	.56
Participant at low risk for isolation	34	.62
Total	129	.54

A further finding from this initial analysis is the impact that anxiety and depression has on social isolation and loneliness. As can be seen from Table 10 (below), those who are moderately or extremely anxious or depressed are more likely to be lonely (scoring 4 and 5 compared with 2) than their less anxious peers. Additionally, anxiety and depression has an impact on levels of reported health status. If an individual is not anxious or depressed, they report 73 per cent of perfect health. In contrast, if they are extremely anxious or depressed, their health status falls to 19 per cent of perfect health. Such a score is equivalent to that reported by older individuals in residential care homes (Kind *et al.,* 1999). Anxiety or depression would seem to have less impact on social isolation with *all* individuals (whether depressed or not) being at high risk of social isolation (scores 21 – 25).

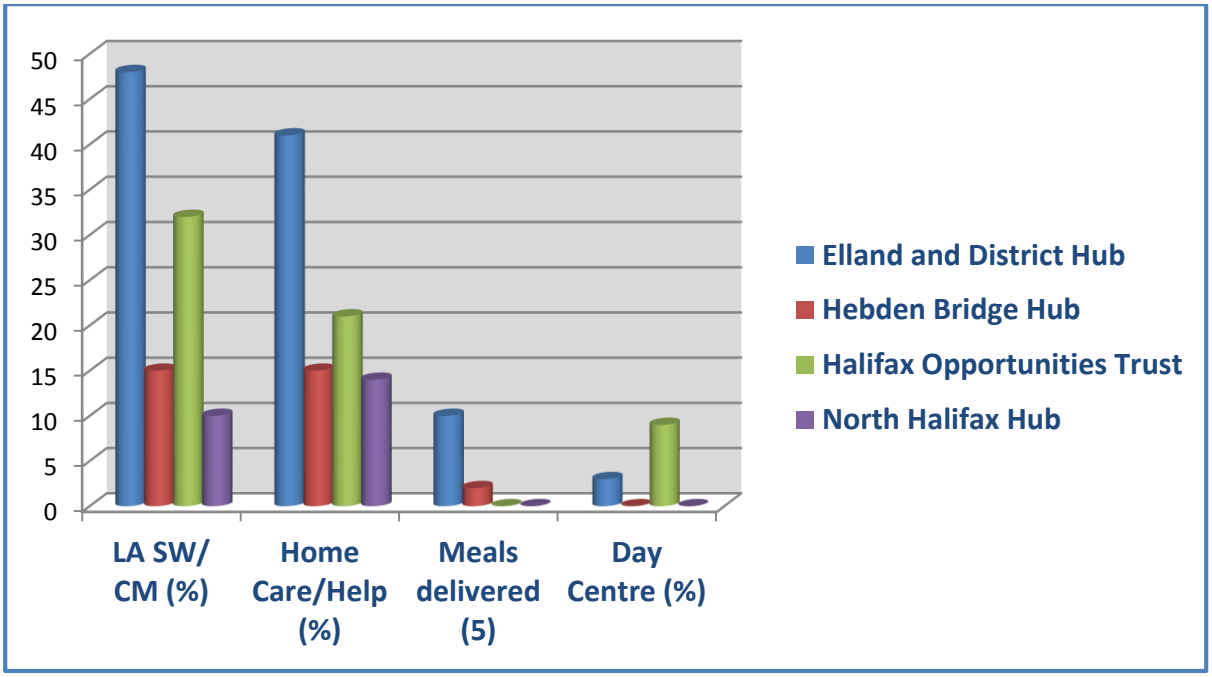
Table 10: Levels of anxiety/ depression by health status, social isolation and loneliness.

Anxiety/depression		EQ-5D Score	Lubben Social Network Scale Score	Total loneliness score
Not anxious or depressed	N	74	65	66
	Median	0.73	25	2
Moderately anxious or depressed	N	70	53	65
	Median	0.62	25	4
Extremely anxious or depressed	N	19	16	17
	Median	0.19	21.5	5
Total	N	163	134	148
	Median	0.66	25	3

SERVICE USE

Despite the initial implementation plan that individuals should be captured before they begin to use formal care services, a relatively high use of local authority social work/ care management support and home help was found (see Figure 5, below). Participants supported by Elland and District Hub reported the highest level of adult social care support; almost half the sample had seen a local authority social worker or care manager over the last month and four in 10 were in receipt of home care or home help.

Figure 5: Percentage of participants with some form of formal care in place by hub.



Participants being supported by Elland and District Hub had also visited their general practitioner (GP) more regularly than their peers from the other hubs (see Table 11, below). Only a quarter of the sample (24%) reported not having visited the GP, a third had visited two or three times in the last month and one in 10 identified attending four or more appointments. However, just over a fifth of the sample in the three other hubs (21%) had also visited their GP two to three times in the last month.

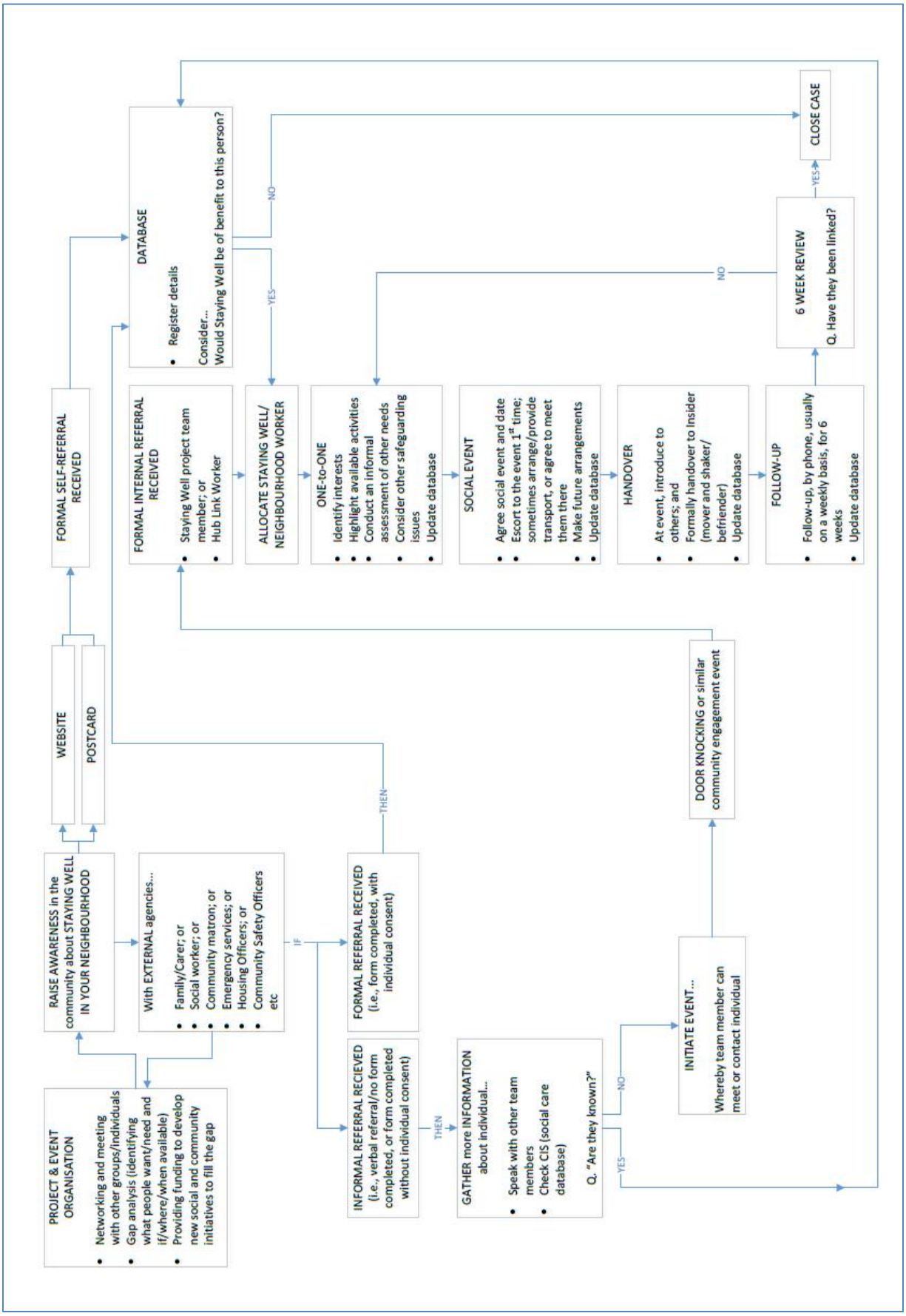
Table 11: Number of times participant has visited GP surgery over the last month by hub (%)

Hubs	Number of times seen GP at surgery (%)			
	None	Once	2-3 times	4 or more
Elland and District	24	18	31	10
Hebden Bridge	45	34	21	0
Halifax Opportunities Trust	47	18	21	10
North Halifax	41	38	21	0

STRUCTURE AND PROCESS OF THE STAYING WELL WORKERS

Process mapping exercises were carried out with the Staying Well and Neighbourhood Schemes Team workers to detail their activities and focus (see Figure 6, below). The Staying Well workers have seemingly structured their work to meet the overall aims of the project, focusing toward individuals, organisations and their local communities. They report a person-centred approach in working alongside the individual; carrying out an assessment, emerging needs, providing information and advice, referring onto other organisations as necessary, identifying suitable services and accompanying the individual to selected activities. In addition, they work alongside organisations, raising awareness of the impact of social isolation and loneliness and identifying the type of services that the Staying Well workers offer. Finally, they work closely with their local communities to identify need; designing, developing and implementing new social and community initiatives.

Figure 6: Summary process map detailing Staying Well/ Neighbourhood worker activity.



IMPLEMENTING THE STAYING WELL PROGRAMME - BARRIERS AND FACILITATORS

All new models of preventative services, necessarily developed, scoped and structured through wider community and older people consultation, take at least 12 months to demonstrate sufficient capacity and consequent activity (Glendinning et al., 2008; Windle et al., 2009; Forder et al., 2012; Hendy et al., 2012). Commissioners and providers will then need further additional time to identify the impact of the service on the older person's care pathway, assess whether savings are being demonstrated and understand where there may be opportunities for innovation or decommissioning (Windle et al., 2009).

In line with these previous research findings, there were a number of barriers during the early implementation phase of the 'Staying Well in Calderdale programme' (see appendix two, Figure 9). As with many innovative interventions (e.g., see Forder *et al.,* 2012), the overarching programme structure necessarily evolved with each hub designing and structuring their staffing models, roles and responsibilities. There were delays in: devolving funding; appointing staff; identifying and applying targets; developing overarching programme branding and; putting in place the Social Prescribing team. Communication between the central programme management and the hubs was seen by the Staying Well workers as limited, leading to the perception that decisions made as to structures, processes and future progress of the 'Staying Well programme' were centrally mandated and opaque. In particular, there was a lack of clarity as to whom the Staying Well workers were accountable. For example, employed by Calderdale Metropolitan Council, their line management was seemingly centrally based; yet their placement in the hubs led to confusion around lines of management and performance targets. The links between the social prescribers and the Staying Well workers was also unclear and undefined. Two social prescribers were able to build good links with their particular hub; whilst others struggled owing to available time and the limited number of referrals.

The early development of the 'Staying Well' provision was also affected by a low-level of referrals; particularly from health care. The hub leads and Staying Well workers are working hard in developing links with local GP practices and health trusts and a gradual increase has been seen in the number of referrals. Nevertheless, all health trusts and GP practices have yet to fully engage.

On-going discussion across the 'Staying Well programme' has ensured that many of the early barriers and difficulties have been mitigated and minimised. The central programme management team would seem to becoming more responsive to the range of information requested by the hubs (e.g., guidance to support their activities, structures and processes). Similarly, there has been greater financial and management devolution. In short, the 'Staying Well' workers reported that they have worked alongside their colleagues in the hubs to 'work things out for themselves'; ensuring an appropriate local response.

DISCUSSION

The 'Staying Well in Calderdale' programme has been tasked with reducing loneliness and social isolation, building community capacity and improving intersectoral working. Taking into account that all innovative programmes take at least 12 months to demonstrate sufficient capacity and activity, this interim report can only provide early findings.

It is clear that the hubs are identifying and working alongside demonstrably lonely and socially isolated individuals. These individuals also present a range of complex needs; their health-status a fifth or quarter lower than would be expected for an 'average' population. Difficulties with mobility, ability to undertake usual activities and specifically, levels of anxiety and depression; all combine to limit the extent to which participants are able to engage with activities in a timely way. Nevertheless, the Staying Well workers through assessment and identification of activities and supporting the older person's attendance, indicates that there are likely to be improvements seen in levels of loneliness and social isolation.

Similarly, although there were only early indications that community capacity was being built and partnerships strengthened across the health and social care environment, such findings are likely to be demonstrated owing to the extension of the role and remit of the 'Staying Well' workers. To ensure that all three objectives can be met, the Staying Well Workers have adopted a Community Navigator model of provision. Community Navigators, often employed by the voluntary sector, but with a core role in multidisciplinary teams, identify available services, signpost and support access (Windle *et al.,* 2009, 2010a).

In taking on this role, the 'Staying Well' workers are acting as a 'link' between statutory and voluntary organisations and their task of building community capacity, supporting the facilitation of appropriate service integration (e.g., see Anderson and Larke, 2009). While the Care Navigator role has been implemented in many different ways (Cameron *et al.,* 2009; Egan *et al.,* 2010; Pedersen and Hack, 2010), the identified core tasks consist of assessment of need, education, collaboration, communication, support, coordination and follow-up of care across the relevant pathway (Lemak *et al.,* 2004; Ferrante *et al.,* 2010; Griswold *et al.,* 2010); each of these tasks being carried out by the 'Staying Well' workers. Prior research had demonstrated that such a role has reduced 'out-of-hours' GP services and Accident and Emergency use, led to fewer repeat attendances at GP surgeries by patients for non-clinical matters, improved take-up of outpatient clinics and improved health-related quality of life (Ferrante *et al.,* 2010; Bhandari and Snowden, 2012; Manderson *et al.,* 2012; Windle, 2012).

The costs of each of the hubs were not available at the time of the Interim Report. However, if the 'Staying Well' programme mirrors prior research findings, it is likely to demonstrate far lower costs than case or care management (£42 per visit as opposed to a £238 unit cost for a social worker), demonstrate per person 'savings' in service use, improved benefit take-up and health-related quality of life (Windle, 2012). In short, the programme is likely to be demonstrated as cost-effective.

It is hoped the further six months of the evaluation will capture participants' changes in social isolation, loneliness, service use and health-related quality of life. Similarly, we hope to detail the effectiveness and cost-effectiveness of the wider role of the 'Staying Well' worker in building community capacity and improving intersectoral working.

RECOMMENDATIONS

Drawing on the evaluation findings and analysis, the following recommendations are put forward for consideration.

People and communities

1. The Staying Well workers are working alongside and supporting those with 'high-level needs'. These are not individuals who need a 'little bit of help', rather many of the participants demonstrate complex needs that demand a range of support and activity. It may be necessary to explore how such high-level support can be further integrated alongside statutory health and social care provision.
2. From the initial analysis, it would seem that depression and anxiety has a disproportionate impact on the ability of participants to engage with interventions or activities. Further work may wish to be carried out to ensure that such undiagnosed need amongst participants is appropriately recognised and a pathway developed.
3. There are seeming indications that the Staying Well workers may be 'picking-up' participants whose needs are not being (or cannot be) met by appropriate statutory service provision (e.g., adult social care). Further discussion may wish to be undertaken to refocus the provision toward early intervention and prevention.

Projects and partnerships

1. There is a need for further discussion around the most appropriate way to provide accountability. The Staying Well workers perceive the present programme management structure to be a barrier to the implementation of clear lines of accountability. There is a need for one 'accountable' officer, ensuring appropriate communication links between the programme, partner organisations and hubs.
2. Appropriate and timely communication needs to be put in place. Regular cross-hub meetings need to be facilitated.
3. It is argued that there should be recognition that the hubs have developed their own locally appropriate processes and procedures. Thought may wish to be given to transferring to the hubs the overall line and performance management of the Staying Well workers.
4. Urgent work needs to be undertaken at a programme management level to strengthen and develop partnerships in health, particularly GP support, but also links to mental health providers.
5. Appropriate and adequate links need to be made between the social prescribers and the hubs. This includes communication, referrals and transparency of structures, processes and activity.
6. Stronger links between the evaluation team and the hubs need to be developed through quarterly meetings with each hub.

APPENDIX ONE: REFERENCES

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APPENDIX TWO: ADDITIONAL FIGURES

Figure 7: Aims and objectives drawn from early implementation interviews and process mapping exercises.

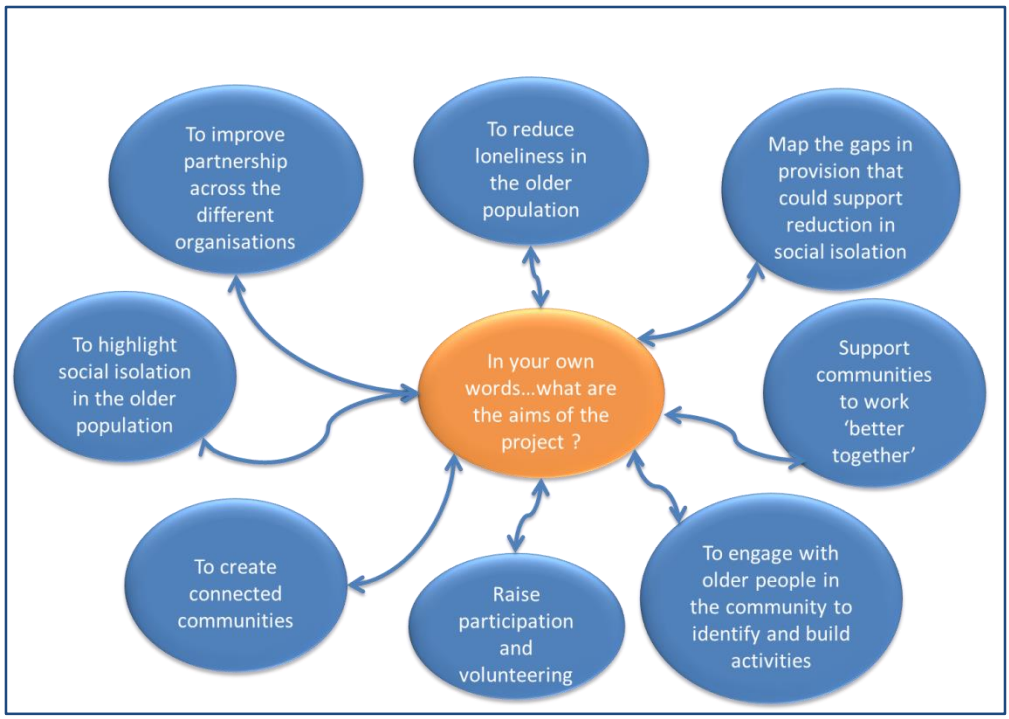

Figure 8: Target 'audience' drawn from responses at the process mapping exercise.

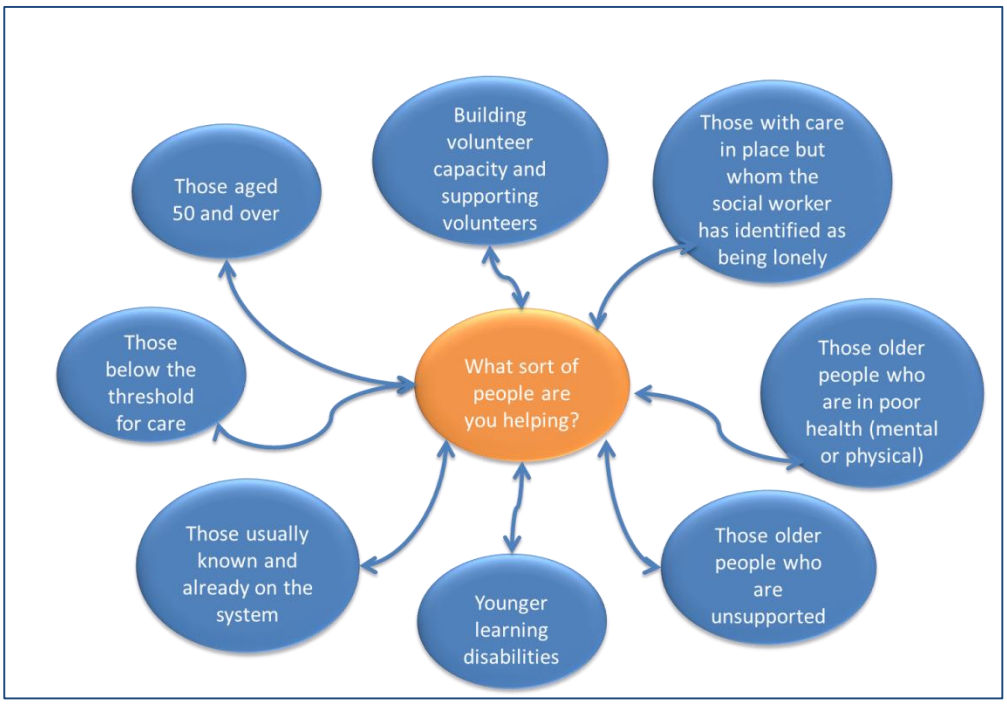

Figure 9: Barriers and facilitators to implementation (Data summarised from the process mapping exercises).