Evaluation of social prescribing models for older adults:

Wellbeing Connectors, Health Connectors and Connector Points

Nepean Blue Mountains Primary Health Network (NBMPHN)

Final Report
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artd CONSULTANTS

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

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This project and report are supported by funding from the Australian Government through the Primary Health Network (PHN) Program. Wentworth Healthcare is the provider of Nepean Blue Mountains Primary Health Network.

This work was completed with the assistance of Ella Ibbitson, Monique Pryce and Janice Peterson from the Nepean Blue Mountains Primary Health Network.

We appreciate the feedback and contributions of the service providers delivering these programs and the older participants who were interviewed. We thank them for their time and insights and trust that their views are accurately represented in this report.

ARTD consultancy team

Kate Williams, Kerry Hart, Sally Evans and Sophie Henness

Expert advisor

Cristina Thompson

We acknowledge that we work on the traditional lands of the Darug, Gundungurra, Wiradjuri peoples. We pay our respects to Aboriginal Elders past and present.

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Contents

Abbreviations, acronyms and common terms

ASPIRE	Australian Social Prescribing Institute of Research and Education
Care finders	Care finders are a free service to help people access aged care services and connect with other relevant supports in the community.
Connector Point	This program based in community organisations to help people seeking social activities and connections, drawing on the online My Health Connector Directory of local activities as a resource.
Connectors	This encompasses both Wellbeing Connectors and Health Connectors.
DoHAC	The Australian Government Department of Health, Disability and Ageing (previously known as the Australian Department of Health and Aged Care)
FTE	Full-time equivalent
GP	General Practitioner
Health Connector	This component of the program is based in general practices. Practice nurses are trained as Health Connectors to administer intake and assessment, deliver social prescribing, and follow up process.
ISCOA	Improving Social Connectedness of Older Australians
KEQ	Key Evaluation Question
LGA	Local Government Area
MBS	Medicare Benefits Scheme
NBMPHN	Nepean Blue Mountains Primary Health Network
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners
RACH	Residential aged care homes
UK	United Kingdom
Wellbeing Connector	Wellbeing Connectors are based in the community, taking referrals from general practices, community centres, other service providers, and self-referral from older adults within the target group. Wellbeing connectors provide free support to connect older adults with local lifestyle services and activities.
The Program	The Health Connectors, Wellbeing Connectors and Connector Points.

Summary

Snapshot

What we did

Program data
Monthly reports, intake and follow-up forms

Qualitative data
Total of 33 interviews with older adults and other stakeholders

Document review
Program documentation, previous evaluation report and selected references

What we found

1 Effective referral pathways exist into and out of the programs	Older adults were recruited or referred via general practices, Connector Points, other community organisations, and promotional activities. Each program played a unique role, and their interactions have the potential to strengthen the overall impact. Participants were linked with a wide variety of activities.
2 Almost 100 older adults have received support with social connection	Extroverted, confident individuals and those with better health and/or younger age are more likely to engage with the program and activities. A key enabler for self-referral was community outreach by Wellbeing Connectors, while Health Connectors were key to reaching and recruiting older age groups and men. Connector Points served as useful sources of information and referral.
3 Support to attend the first session was a valuable component	The support available from Wellbeing Connectors to attend the first session made an important contribution to engagement in activities, as did efforts by Health Connectors and Wellbeing Connectors to follow up informally with participants. The My Health Connector Directory, used by all 3 programs to identify activities for social prescribing, is valued but requires updating.
4 Older adults reported positive experiences and better quality of life	All 12 older adults who were interviewed for the evaluation said they would recommend the program to others. They appreciated the support they received and reported increased opportunities to socialise and improvements in physical and mental health. Program data showed increases in quality of life, on average, from the intake to the follow-up assessment.
5 Programs align with the values and mission of commissioned organisations	Some of the factors associated with sustainable innovations are present in the Connectors and Connector Point programs. In particular, the purpose and design are consistent with the values of commissioned organisations and there are perceived benefits for the organisations and their clients. Connectors are working within favourable contexts with supportive cultures and leadership.

What we recommend

Recommendation 1

NBMPHN could consider reviewing processes for referrals, intake, regular check-ins, and follow-up assessments to see whether they can be more standardised, efficient, and incorporated into routine practice.

Recommendation 2

There are many competing priorities within general practice, and it is likely that continued input by NBMPHN will be needed to sustain the Health Connectors program.

Recommendation 3

The community outreach by Wellbeing Connectors adds considerable value, as does extra support to attend the first session. Allowing time for this is an important element to sustain the program.

Recommendation 4

The My Health Connector Directory is a crucial resource which could be improved by ongoing reviewing and regular updating of the directory by the NBMPHN.

Recommendation 5

Lack of transport is a major barrier to uptake of activities, acknowledged by NBMPHN. Brokerage funding is outside the scope of this program but the NBMPHN should continue to work with community transport providers.

Recommendation 6

The Wellbeing Connectors must continue to be supported to exit their clients at the expected timeframe (26-week engagement period) to free up capacity for new participants.

Executive Summary

This report presents the findings of three social prescribing programs: Wellbeing Connectors, Health Connectors and Connector Points. The evaluation was carried out by ARTD on behalf of Nepean Blue Mountains Primary Health Network (NBMPHN).

Social prescribing is based on the knowledge that there are many influences on health, including social isolation and loneliness, which can lead to increased risk of chronic conditions and mental illness. It aims to improve participants' health and wellbeing by addressing their non-medical needs through referral to activities and supports.

The social prescribing programs that were the subject of this evaluation were funded by the (then) Department of Health and Ageing under its early intervention initiatives. The target group is **community-dwelling older adults** (aged 65+, or 55+ for Aboriginal and Torres Strait Islander people). NBMPHN used this funding to implement a new Wellbeing Connector program and to continue and expand the existing Health Connector program.

The **Health Connector** program started in mid-April 2024 and is based in general practices. Practice nurses have been trained as Health Connectors to administer the intake and assessment processes, deliver social prescribing, and follow up.

NBMPHN commissioned 2 community-based organisations to deliver the **Wellbeing Connectors**. These roles are based in the community, taking referrals from general practices, community centres, other service providers, and self-referral from older adults within the target group.

The **Connector Point** program is funded from the same source with a similar target group. This program works out of community-based organisations (e.g., neighbourhood centres, multi-cultural centres and Aboriginal health centres) to help people seeking social activities and connections, drawing on the online **My Health Connector Directory** of local activities as a resource. The Health Connectors and Wellbeing Connectors also use the My Health Connector Directory to identify activities that may be suitable for individual clients. The directory lists over 984 local health and lifestyle services.

What we did

The aims of the evaluation were to:

- assess the impact of the programs in improving quality of life and reducing loneliness and social isolation among older participants;
- document processes of implementation, assess what has worked well, and understand what improvements can be made to the programs.

We designed a theory-based, mixed methods evaluation incorporating program data (intake and follow-up assessments, monthly reporting by Health Connectors, Wellbeing Connectors

and Connector Points) with 33 qualitative interviews and a document review, to address five key evaluation questions:

1. How effective were referral pathways into and out of the programs?
2. Were the programs implemented as intended?
3. Were the programs appropriate for the target population?
4. To what extent did the programs achieve the expected outcomes for older adults?
5. What aspects of the programs are likely to continue beyond the end of the funding cycle?

Full details of the evaluation methods can be found in Appendix 1.

What we found

The Connectors and Connector Point programs have succeeded in raising awareness within the community and in addressing the non-medical needs of a substantial number of older adults in the NBMPHN region. Positive interactions among the programs – and information exchange between the Wellbeing Connectors and community organisations that serve the target audience – demonstrate the potential for increasing their collective impact.

It is vital for Connectors to understand and accommodate the needs of older adults. An effective Connector has charisma and warmth and brings curiosity and genuine interest to their interactions with older adults. Older adults have a reasonable expectation that they will be treated with dignity and respect. They want to have full control over the extent to which they engage in activities that are recommended. Connectors are consistently achieving the right balance of providing support without being patronising or *'bossy'*.

The Connectors model works best for people with a strong need for social connection, high self-efficacy and trust in social institutions such as health and community services. Ideally, participants will also be independently mobile with access to transport (either driving themselves or subsidised community transport services). The model does not work as well for people who are chronically isolated, have less confidence, have limited mobility or poor hearing, or are struggling with mental or physical illness.

WHO-5 quality of life measure

The **WHO-5** is one of the most widely used measures of subjective well-being and has been demonstrated as reliable and valid across different populations and cultures.[1,2] For both the Wellbeing Connector program and the Health Connector program there was a positive difference between the pre-score and post-score means, showing that feelings of wellbeing

[1] Topp CW, Ostergaard SD, Sondergaard S and Bech P (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and Psychosomatics, 84*: 167-176.

[2] Sischka PE, Costa AP, Steffgen G and Schmidt AF (2020). The WHO-5 Well-Being Index – validation based on item response theory and the analysis of measurement invariance across 35 countries. *Journal of Affective Disorders Reports, 1*: 100020

had increased for those participating in the program. Of the 9 participants that we were able to access both intake and follow-up forms, 7 (78%) of the Health Connector participants recorded an increase in WHO-5 score at the follow-up session. Similarly, of the 14 participants that we were able to access both intake and follow-up forms, 10 (71%) of the Wellbeing Connector participants recorded the same or an increase in WHO-5 score at the follow-up session.

A summary of **findings against the key evaluation questions** is provided in the table below (the full version of this table can be found in the Discussion chapter).

	KEQ	Findings
1	How effective were referral pathways into and out of the programs?	• Older adults were referred or recruited via general practices, Connector Points, other community organisations, and marketing carried out by Wellbeing Connectors and the PHN. • Each program played a unique role, and their interactions strengthened the programs overall. • Health Connectors were more likely than Wellbeing Connectors or Connector Points to recruit males and those in the oldest age groups. • A total of 96 older adults received social prescriptions connecting them with activities in their communities. • Older adults were linked with a wide variety of activities including exercise groups, community lunches, crafts, music, singing, and digital literacy. • The main barriers to uptake of the social prescriptions were lack of transport and physical limitations. • Connector Points hosted a total of 180 conversations with older adults over 9 months (Jul 24-Feb 25); some clients made multiple visits to use the online directory.
2	Were the programs implemented as intended?	• Older adults who took part said they were seeking greater social connection to improve wellbeing. Some were bereaved, had lost contact with friends or family, were new to the area, or had caring responsibilities. All had experienced loneliness and felt a need for more social contact and for new, enjoyable experiences. • One of the key enablers for implementation was the availability of Wellbeing Connectors to support participants to attend the first few sessions. The emotional and practical support provided was highly valued by participants.

	KEQ	Findings
		• Another key enabler was the promotional work carried out by Wellbeing Connectors and the PHN which attracted many referrals and self-referred participants. • For the Health Connectors, recruitment has dropped considerably in recent months, possibly due to time constraints and the pressure of other tasks. It is difficult for practice nurses to set aside dedicated time for the Health Connector role.
3	Were the programs appropriate for the target population?	• From the perspective of participants, processes for intake, assessment of health status and needs, and matching with activities are working smoothly. • Regular informal follow-up by the Connectors (e.g., a brief phone call or chat with the nurse while attending the practice) helped promote engagement. • There is a need for greater integration of the Health Connector role into the workflow of general practices. • The My Health Connector Directory, created for the ISCOA program, is valuable but requires updating and improvements to the search function. • The extra level of support available from Wellbeing Connectors makes an important contribution to engagement in activities. This is especially useful for participants who are anxious or lacking in confidence.
4	To what extent did the programs achieve the expected outcomes for older adults?	• Older adults reported positive experiences of the programs, including increased opportunities to socialise, feeling more included in their communities, and improvements in physical and mental health. • All the older adults interviewed for this evaluation said they would recommend the program to others. • Participants particularly appreciated the support they received, which built their confidence, capacity and motivation to expand their social worlds. • Program data showed that quality of life, measured by the WHO-5 tool, increased from the intake to the follow-up assessment on average. • Due to the length of the engagement period, a limited number of participants (n=23) had both intake and follow-up scores. For these participants, paired

	KEQ	Findings
		comparisons showed that the vast majority reported an improvement in quality of life. • Other stakeholders – particularly Connectors and activity providers – reported benefits for older adults who attended activities, such as improved confidence, communication skills, and mental health.
5	What aspects of the programs are likely to continue beyond the end of the funding cycle?	• Some of the factors associated (in the academic literature) with sustainable innovations are present in the Connectors and Connector Points programs. • The main constraints on capacity to sustain the programs are workforce availability and funding. Without dedicated funding and accountability, Health Connectors' time will quickly be absorbed by other tasks in busy general practice environments. • Prospects for sustainability could be enhanced by NBMPHN continuing to work with community transport providers, and by continuously updating and improving the online directory. • It is too early to see evidence of capacity building in the community, but there are indications that the Wellbeing Connectors have the potential to foster supportive environments for older adults through awareness raising, information exchange and filling gaps in existing services.

What we recommend

In summary, the main recommendations are as follows:

- NBMPHN could consider reviewing program processes, particularly for Health Connectors, to improve efficiency and help incorporate them into routine practice.
- There are many competing priorities within general practice, and it is likely that regular input from NBNPHN – of resources, guidance, and encouragement - will be required to sustain the Health Connector program.
- There is a need to ensure that Wellbeing Connectors have time set aside for communications and community outreach, in addition to their direct work with clients, as this has the potential to add considerable value.
- The My Health Connector Directory is a crucial resource for all 3 programs but requires updating and improvements to search facilities.
- Transport brokerage funding is not in scope for this program, however NBMPHN should continue to work with community transport and informing Connectors and Wellbeing Connector commissioned organisations on transport options available to participants in areas where there is limited access to public transport.
- Due to the nature of the work, there is a risk of Connectors getting over-involved and becoming stressed. Maintaining workforce capacity will mean ensuring that Connectors are well supported within their organisations.
- Program data show a high workload associated with follow-up calls. They must continue to be supported to exit their clients at the end of the 26-week engagement period.
- NBMPHN could consider providing regular feedback (based on program data) to commissioned organisations to keep them informed and to demonstrate the value of the programs to the community.

Report

1. Introduction

NBMPHN has engaged ARTD to conduct an evaluation of the Health Connector program, the Wellbeing Connector program, and the Connector Point program. The aims of the evaluation are:

- assess the impact of the programs in improving quality of life and reducing loneliness and social isolation among older participants; and
- document processes of implementation, assess what has worked well, and understand what improvements can be made to the programs.

NBMPHN will use the findings of the evaluation to inform continuous improvement of the programs and assist with decision-making and planning around social prescribing in future.

1.1 Background

In response to recommendations of the Royal Commission in Aged Care Quality and Safety, the Australian Government Department of Health and Aged Care (DoHAC)[3] provided funding for **early intervention** initiatives designed to delay entry into residential aged care homes (RACH) and reduce avoidable hospitalisations. Initiatives under the early intervention program are aimed at community dwelling older people, defined as those aged 65 years and over, or 55 years and over for people of Aboriginal and Torres Strait Islander heritage. Funding for early intervention was distributed through Primary Health Networks (PHNs), which are regionally based, non-profit organisations that have knowledge of local population health needs and expertise in commissioning services to meet those needs. NBMPHN has used a portion of this funding to implement a new Wellbeing Connector program and continue to expand the existing Health Connectors and Connector Point program.

The **Health Connectors** and **Wellbeing Connector** programs are designed to identify and meet non-medical needs of older adults to keep them healthy for longer. These programs are based on the knowledge that there are many influences on health, including social isolation and loneliness, which can lead to increased risk of chronic conditions[4,5] and mental illness.

The role of **social determinants of health** in preventing disease and maintaining health have long been recognised. More recently, **social prescribing** has emerged as a strategy to address social determinants by providing a 'gateway to non-medical management' of

[3] This is now the Department of Health, Disability and Ageing.

[4] Freak-Poli R et al. (2021). Social isolation, social support and loneliness as predictors of cardiovascular disease incidence and mortality. *BMC Geriatrics, 21:* 711.

[5] Moffatt S et al. (2023). Impact of a social prescribing intervention in North East England on adults with type 2 diabetes: the SPRING_NE multimethod study. *Public Health Research, 11 (2).*

complex health and psychological issues.[6] Currently used in at least 17 countries, social prescribing involves the person with identified needs working with a trusted person (often described as a 'link worker') to co-create a 'prescription' to improve their health, wellbeing and social connections.[7]

1.1.1 The programs

The current **Health Connector** program has been running since mid-April 2024 and, like a previous pilot program[8], is based in general practices. The reception staff, nurses or GPs identify older adults who might benefit from the program, such as frequent attenders or people who have had recent life events such as bereavement or diagnosis with a chronic condition. Identification processes may be informal (professional judgement) or formal (Health Care Assessment). Practice nurses have been trained as Health Connectors to administer the intake and assessment processes, deliver the social prescribing, and follow up.

The PHN's goal was to expand the number of practices involved in the Health Connector program. The Health Connector role was funded initially for a certain number of hours per week over 12-18 months. The program currently operates in two practices in the Penrith Local Government Areas (LGA),one practice in the Blue Mountains LGA, one practice in the Hawkesbury LGA and one practice in the Lithgow LGA Following this period, the PHN supports the practice to enable sustainability and then reallocate funding to other practices, thus building capacity and capability in practices across the region to identify, assess and refer older adults who might benefit most from social prescribing.

Wellbeing Connectors is a new program, and the Connector roles have similarities to the 'link workers' in models of social prescribing in the United Kingdom. Two community-based organisations have been commissioned to deliver this program. Springwood Neighbourhood Centre has engaged two Connectors to cover one full-time equivalent (FTE) position which service two LGAs, Blue Mountains and Lithgow. The Benevolent Society recruited one full-time Connector to service the other two LGAs in the region, Penrith and Hawkesbury. These roles are based in the community, taking referrals from general practices, community centres, other service providers, and self-referral from older adults within the target group. Publicity for the program will be generated by the PHN's promotion and the Connectors' own activities.

The **Connector Point** program is funded from the same source with a similar target group. This program works out of community-based organisations (e.g., neighbourhood centres, multicultural centres, council run libraries and Aboriginal health centres) to help people

[6] Moffatt S et al. (2023). Impact of a social prescribing intervention in North East England on adults with type 2 diabetes: the SPRING_NE multimethod study. *Public Health Research, 11 (2).*

[7] Sonke J et al. (2023). Social prescribing outcomes: a mapping review of the evidence from 13 countries to identify key common outcomes. *Frontiers in Medicine, 10*: 1266429

[8] Thompson C, Morris D and Bird S (2022). *Evaluation of the Improving Social Connectedness of Older Australians project pilot: Informing future policy considerations.* Wollongong: Centre for Health Service Development, University of Wollongong.

seeking social activities and connections, drawing on the online **My Health Connector Directory** of local activities as a resource. The Health Connectors and Wellbeing Connectors also use the My Health Connector Directory to identify activities that may be suitable for individual clients. This online resource was developed by the NBMPHN as part of the previous pilot program.[9]

In addition to using the same directory, there is potential for **increased interactions among the three programs** to create a larger overall impact. For example, Connector Points can refer community-dwelling older adults to Health Connectors or Wellbeing Connectors if they feel they would benefit from a detailed assessment of their needs and support to initiate social connections. If preferred, the Health Connectors can refer patients to the Wellbeing Connectors to complete the full assessment and intake process, rather than doing so themselves. Referral may be appropriate if the patient requires additional time, presents with more complex needs, lacks confidence to attend activities alone, or would benefit from extra support.

1.1.2 Target group

The eligibility criteria for participation were defined by (then) DoHAC as part of its grant requirements for the early intervention initiatives. The programs are aimed at community dwelling older people, defined as those aged 65 years and over, or 55 years and over for people of Aboriginal and Torres Strait Islander heritage. People living in Residential Aged Care Homes (RACH) are not eligible to take part. Almost a quarter (24.5%) of residents in the Lithgow LGA are aged 65 years and over, with smaller proportions in the Blue Mountains (22.5%), Hawkesbury (16.6%) and Penrith (12%) Local Government Areas (LGAs)[10] In the Australian population overall, the vast majority (90%) of people of this age have at least one chronic health condition.[11]

1.1.3 Intended outcomes

The range of outcomes that might be expected from the social prescribing models includes reduced social isolation and loneliness, improved wellbeing, improved chronic disease management, prevention of unnecessary hospital admissions, prevention of early entry to RACH, and community asset building and mapping. For efficient data collection we will target the priority outcomes that NBMPHN hopes to demonstrate from these programs, namely reduced loneliness and social isolation and increased quality of life.

[9] Thompson C, Morris D and Bird S (2022). *Evaluation of the Improving Social Connectedness of Older Australians project pilot: Informing future policy considerations.* Wollongong: Centre for Health Service Development, University of Wollongong.

[10] Wentworth Healthcare (no date). Practice nurse Health Connector training presentation for the Improving Social Connections of Older Australians project.

[11] Ibid.

1.1.4 Service model

The first visit to a Connector involves an assessment of needs and 'prescription' of appropriate services, in discussion with the client or patient. The social prescription may include referral to a variety of non-medical services and supports such as social and lifestyle activities, exercise, and so on. An addition to the model for the Wellbeing Connectors (but not the Health Connectors) is the ability to help the client get started by accompanying them to the activity the first time, or by trying to arrange transport, in order to facilitate uptake and participation. The Wellbeing Connectors also carry out capacity building activities with local service providers and other organisations around identifying potential clients and smoothing the referral pathways. Multiple follow-up appointments are available, if needed.

1.1.5 Evidence base

The international evidence base for social prescribing includes comprehensive description of delivery processes and target groups[12], a systematic review of outcomes for patients and the health system[13], and published guidance on program design[14] and evaluation.[15]

Social prescribing is a well-established model in the United Kingdom (UK). A 2022 national survey of social prescribing for older people provided a snapshot of the factors that influenced success of these programs across the UK. Enablers included adequate support for attending activities, personalised and tailored prescriptions, accessible activities, establishing trust and empowering older adults.[16] Barriers included stereotypes and stigma about needing support, financial challenges such as the cost of attending activities, and older adults' lack of confidence about participating. Findings highlighted the importance of sustainability, including commissioning approaches to encourage longer-term funding and collaboration among organisations. There were also opportunities to address gaps by developing a strategic framework for social prescribing. This could focus on promoting equity, diversity and inclusion, encourage the development of community infrastructure and local knowledge, and ensure that design and delivery of social prescribing is informed by evidence.

Interest is growing in Australia, boosted by the establishment of a research community, the Australian Social Prescribing Institute of Research and Education (ASPIRE). In late 2019, a roundtable on social prescribing was co-hosted by the Royal Australian College of General Practitioners (RACGP) and the Consumer Health Forum. Social prescribing has been included in the *National Preventive Health Strategy 2021-2030* and the *Primary Health Care 10 Year*

[12] Oster C, Skelton C, Leibbrandt R, Hines S and Bonevski B (2023a). Models of social prescribing to address non-medical needs in adults: a scoping review. *BMC Health Services Research, 23*: 642.

[13] Sonke et al., 2023

[14] Oster C, et al. (2024). The process of designing a model of social prescribing: an Australian case study. *Health Expectations, 27*: 14087

[15] Hamilton-West K, Gadsby E, Zaremba N and Jaswal S (2019). Evaluability assessments as an approach to examining social prescribing. *Health and Social Care in the Community, 27*: 1085-1094

[16] Cousins E (2023). *Social prescribing for older people: a summary of findings from our recent questionnaire.* National Academy for Social Prescribing and Independent Age. Accessed from policycommons.net/artifacts/4306201

Plan 2022-2032. Researchers from the University of Sydney have undertaken a national mapping of social prescribing initiatives implemented by PHNs.[17]

Evaluation findings for **Health Connectors** are available from a pilot funded by the (then) Department of Health from 2019. The pilot program, *Improving Social Connection of Older Australians* (**ISCOA**) involved NBMPHN and Perth South PHN. It was evaluated by the Centre for Health Service Development at the University of Wollongong. Key lessons included:

- It is an opportune time to build on the pilot, due to public recognition of the importance of social connection for health (i.e., a receptive context for change exists).
- Integration of the Health Connector role into the workflow of the general practice and Medicare Benefits Scheme (MBS) billing arrangements is 'necessary and achievable'.
- People in the Connector role require training, support and resources to be effective.
- Conversations with older adults need to be tailored to individual needs and use positive, non-stigmatising language.
- It is crucial for providers to have clear objectives and a collective understanding of the theory of change underpinning interventions.
- Social 'prescriptions' should take existing community assets into consideration, and should be intersectoral, drawing on health, aged and social care.
- A wide range of referral pathways are required to ensure that those in need are appropriately identified and referred to the Connector programs.
- The interventions may be most beneficial for the younger people within the target age ranges or those who have recently experienced life transitions.[18]

1.2 The structure of this report

In Chapter 2 we describe the program theory and key evaluation questions. (Details of methods can be found in Appendix 1. Five chapters of findings (Chapters 3-7) are followed by a final chapter in which we discuss and interpret the evidence and outline the implications for continuous improvement.

[17] Pathak, A., De Morgan, S., Sharma, S., Walker, P., and Blyth, F. (2024, June 25-27). *Mapping social prescribing initiatives implemented by Primary Health Networks* (Poster). EACH24 – Australian Social Prescribing Institute of Research and Education (ASPIRE) International Social Prescribing Conference, Sydney, Australia.

[18] Thompson et al. (2022).

2. The evaluation

We adopted a theory-based evaluation design. Insights from the literature, along with a review of program documents, provided a starting point for a **theory of change** (Figure 1).

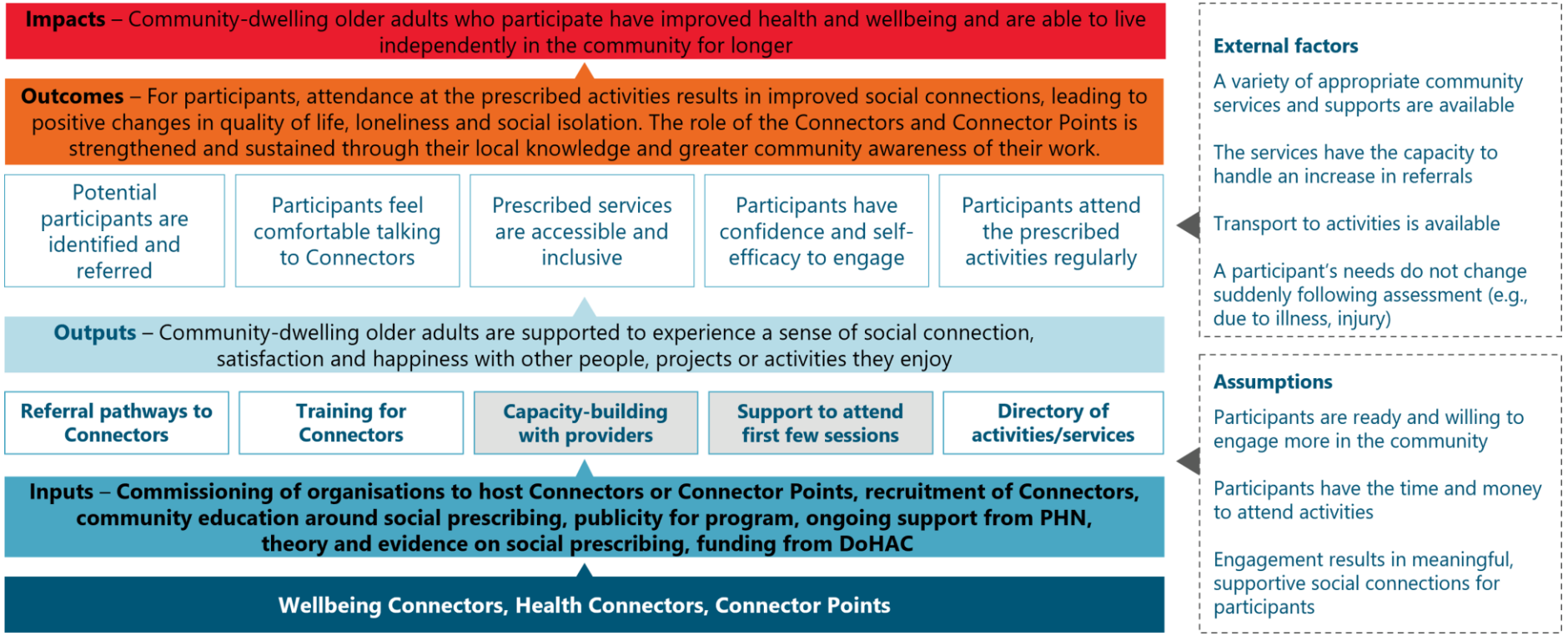
Figure 1. Theory of change

The theory of change was shaped around six processes, common to social prescribing programs, which were identified in a recent scoping review.[19] Based on the theory of change, literature and program documents, and discussions with program leadership, we drafted a

[19] Oster et al., 2023a

logic model which was then discussed and refined at a workshop with NBMPHN staff members on 10 December 2024 (Figure 2).

Figure 2. Program logic model



Note. Grey boxes apply only to the Wellbeing Connector program.

2.1.1 Key evaluation questions

The Key Evaluation Questions (KEQs) (Table 1) guided the collection and interpretation of data and provide a structure for the findings section of this report.

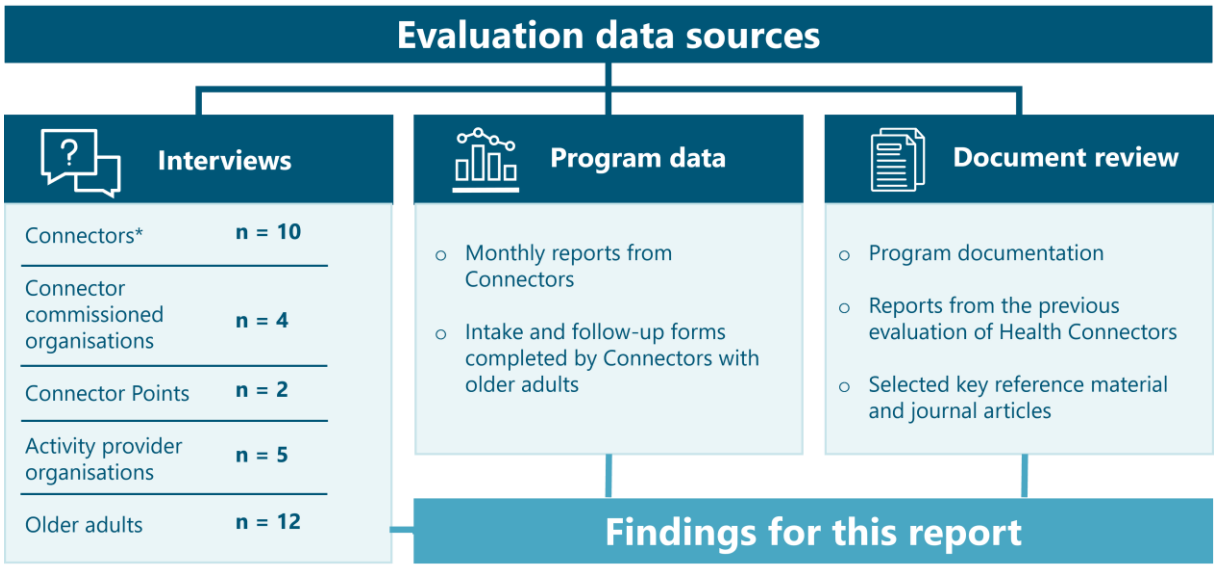
Table 1: Key evaluation questions

No.	Questions and sub-questions	Evaluation Criteria
1.	How effective were referral pathways into and out of the programs? • How well did the programs work together to identify and recruit the target population? • Was the program able to attract appropriate referrals from a variety of sources? • How effective were the programs in connecting older adults with appropriate activities?	Coherence
2.	Were the programs implemented as intended? • To what extent were outputs achieved? • What factors facilitated implementation? • What were the barriers to implementation?	Effectiveness
3.	Were the programs appropriate for the target population? • How did the programs respond to the needs of community-dwelling older adults in general, and to the needs of marginalised groups in particular? • To what extent did the programs capitalise on lessons learned from previous programs?	Relevance
4.	To what extent did the programs achieve the expected outcomes for older adults? • How did participants experience the programs? • What changes were observed in quality of life, social isolation and loneliness? • Were there any unintended consequences, either positive or negative?	Impact

No.	Questions and sub-questions	Evaluation Criteria
5.	What aspects of the programs are likely to continue beyond the end of the funding cycle? • To what extent are factors likely to promote sustainability present in the commissioned organisations? • To what extent did the programs succeed in building the capacity of local community assets to support community-dwelling older adults?	Sustainability

The scope of the evaluation was informed by engagement and consultation with NBMPHN program staff including the inception meeting and program logic workshop. These discussions led to the design and refinement of the evaluation methods which are described in Appendix 1 and summarised in Figure 3.

Figure 3. Evaluation methods



Note. *This total includes one interview with a pharmacist who provides home-based medication reviews and consultations as well as acting as a Health Connector. When attributing quotes in the following chapters, this individual is identified as a Health Connector.

3. Recruitment and referral to Connectors

In this chapter, we present data on recruitment into the program based on the records provided to NBMPHN (and the evaluation team) by the Connectors and Connector Points (program data). This is followed by analysis of interview data regarding the effectiveness of referral pathways and recruitment of the target population into the Wellbeing Connector and Health Connector programs, including the role of the Connector Points.

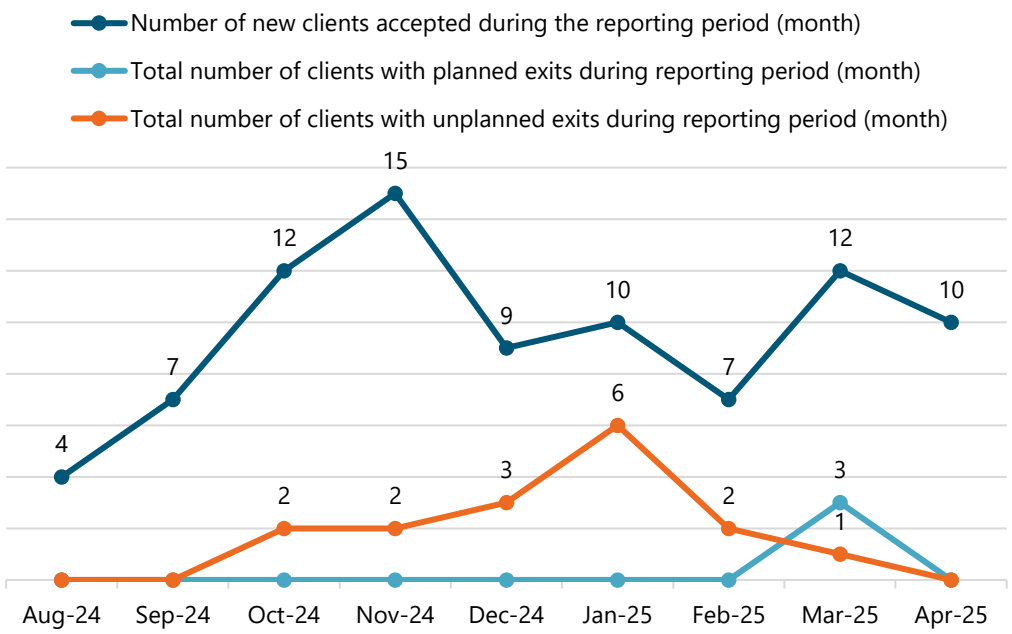
3.1 Program data on recruitment and attendance

All practices keep a record of referrals to the Health Connector program, and this information is also stored in patients' files. Some practices have more formal record-keeping processes than others. Wellbeing Connectors also keep records of their interactions with clients.

3.1.1 Wellbeing Connectors

A total of 86 older adults were recruited by Wellbeing Connectors between August 2024 and April 2025 (Figure 4**Error! Reference source not found.**). Of those, 56 intake forms were provided to the evaluation team. Of these, where gender was recorded, 37 (74%) were female. Approximately half of the participants were aged 75 years and older (Table 2).

Figure 4. Wellbeing Connector client intake and exits over time



Note: Unplanned exits refers to clients leaving the program prior to the 26 week engagement period.
Source: Wellbeing Connector Monthly Performance Report (August 2024 to April 2025)

Table 2. Participant age – Wellbeing Connector

Age (years)	Count	Percentage
50-54	0	0%
55-59	1	2%
60-64	1	2%
65-69	12	21%
70-74	13	23%
75-79	11	20%
80+	18	32%
Total	**56**	**100%**
Missing	0	

Source: Wellbeing Connector intake forms

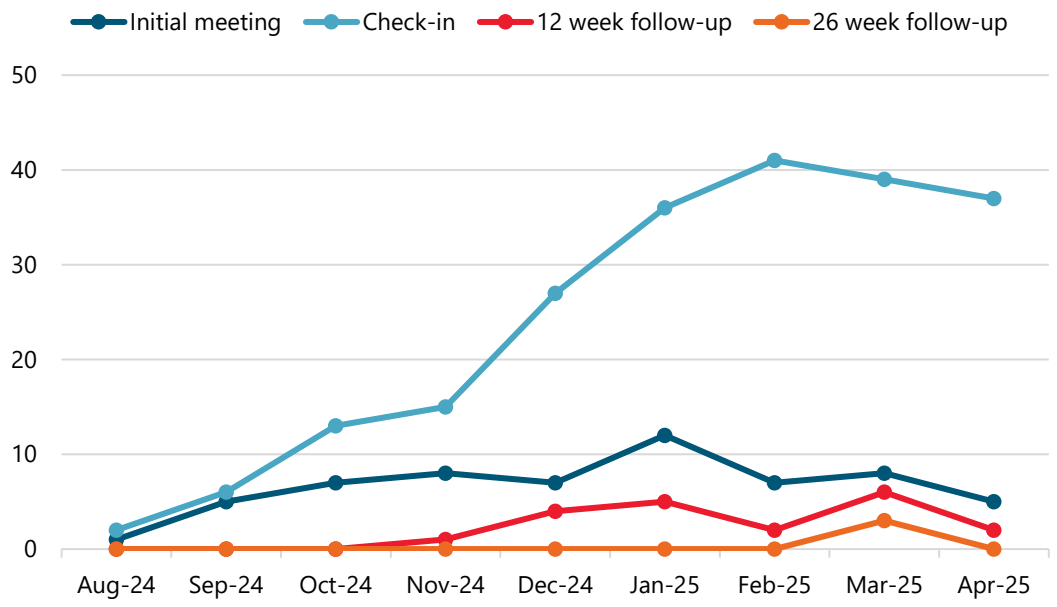
Table 3. Participant characteristics – Wellbeing Connector

	Aboriginal		CALD		LGBTIQA+	
	Count	Percentage	Count	Percentage	Count	Percentage
No	53	98%	44	79%	54	96%
Yes	1	2%	12	21%	2	4%
Total	**54**	**100%**	**56**	**100%**	**56**	**100%**
Missing	2		0		0	

Source: Wellbeing Connector intake forms

By April 2025, 20 participants had attended a 12-week follow-up and 3 participants a 26-week follow-up (Figure 5). The number of regular check-ins increased sharply from November 2024 and averaged 30-40 per month between January and April 2025.

Figure 5. Wellbeing Connector client attendance over time

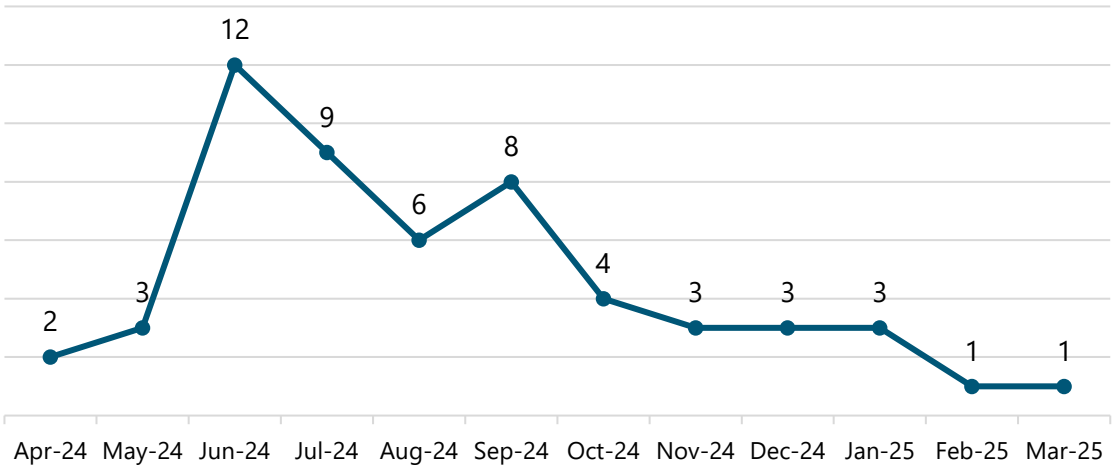


Source: Wellbeing Connector Monthly Performance Report (August 2024 to April 2025)

3.1.2 Health Connectors

A total of 56 of the intake forms provided to the evaluation team originated from Health Connectors. Of those, 31 (56%) were for female participants. The vast majority (71%) of participants were aged 75 years and older (Table 4).

Figure 6. Health Connector number of intake forms over time



Source: Health Connector intake forms

Table 4. Participant age – Health Connector

Age (years)	Count	Percentage
50-54	1	2%
55-59	1	2%
60-64	3	5%
65-69	5	9%
70-74	6	11%
75-79	17	30%
80+	23	41%
Total	**56**	**100%**
Missing	0	

Source: Health Connector intake forms

Table 5. Participant characteristics – Health Connector

	Aboriginal		CALD		LGBTIQA+	
	Count	Percentage	Count	Percentage	Count	Percentage
No	48	92%	43	77%	53	95%
Yes	4	8%	13	23%	3	5%
Total	**52**	**100%**	**56**	**100%**	**56**	**100%**
Missing	4		0		0	

Source: Health Connector intake forms

3.1.3 Connector Points

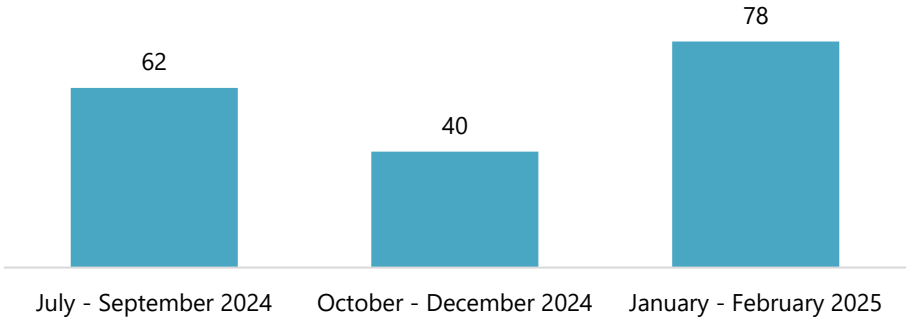
There was a total of 180 contacts ('conversations') at Connector Points over 9 months. Table 6 summarises the types of conversations and the activities older adults indicated they were interested in. They sought information on a variety of activities, ranging from volunteering and walking groups to support with health issues and hearing problems.

Table 6. Summary of Connector Points requested services

Time period	Number of conversations	Number of locations	Summary of most requested services
July - September 2024	62	5	Community pantry; social supports; medication information and health supports
October - December 2024	40	7	Seniors program; volunteering; walking groups and health support
January - February 2025	78	7	Hearing; volunteering; social groups and health support

Source: Pharmacy and Community Connector Point Data July 2024 to February 2025

Figure 7. Number of conversations at Connector Points



Source: Pharmacy and Community Connector Point Data July 2024 to Feb 2025

In 2025, additional data were collected on the demographics of the older people using Connector Points (Table 7). It is notable that most of the people seeking information were in the younger age group, 65-75 years. Very few were in the oldest age group.

Table 7. Connector Point program data (January to February 2025) – LGA of client

	Count	Percentage
Penrith	49	63%
Hawkesbury	26	33%
Blue Mountains	2	3%
Lithgow	1	1%
Total	**78**	

Source: Pharmacy and Community Connector Point Data, January and February 2025

Table 8. Connector Point program data (January to February 2025) – Gender of client

	Count	Percentage
Woman	48	62%
Man	30	38%
Total	**78**	

Source: Pharmacy and Community Connector Point Data, January and February 2025

Table 9. Connector Point program data (January to February 2025) – Age of client

	Count	Percentage
65-75	51	65%
75-85	22	28%
85-95	5	6%
Total	**78**	

Source: Pharmacy and Community Connector Point Data, January and February 2025

3.2 Referral pathways

According to the interview data, there were four main sources of referral to Connectors. The first was via **general practices** where the Health Connectors worked as nurses; these referrals came from the GPs or through the nurses themselves identifying (either formally or informally) an older adult's non-medical needs and creating an opportunity for a chat and assessment. **Connector Points** and other **community organisations** were important sources of referral. In addition, the Wellbeing Connectors conducted various **marketing and promotional activities** which resulted in self-referrals from older adults who had identified their own need for more social connection and actively sought information and support.

3.2.1 General practices

Several participants who were interviewed identified that they had found the Health Connector through visiting their GP, often for other health or medical reasons. Health Connectors were adept at identifying those who might benefit from this type of program. Occasionally, referrals to the Health Connectors originated from the GPs following consultations about other issues. A meeting with the Health Connector could take place following a scheduled appointment with the GP or nurse, or sometimes a follow-up appointment was made specifically for the Health Connector assessment.

'We identify people who need support. [Health Connector] identifies a lot of patients [for the program] – they might be seeing a patient for a wound dressing and notice [in conversation with the patient] that the HC program is relevant for them and so chat to them about it. Sometimes a GP will mention to [the Health Connector] their concerns about a patient and then when [Health Connector] sees the patient they can talk about the program. We then check with [the patient] if they are happy to be involved in the program.'
– General practice manager

'I've had it once or twice now that the doctor finds someone is potentially in need of the Health Connector program so books a separate standalone session just to discuss that.' – Health Connector

3.2.2 Health Connectors to Wellbeing Connectors

One unexpected finding was the frequency of referrals from Health Connectors to Wellbeing Connectors. This appeared to be happening regularly in one location. The ability to refer to the Wellbeing Connector was seen by Health Connectors as a strength of the programs but has not been taking place across all regions.

During the interviews, several Connectors outlined the referral process. The Health Connector would identify suitable patients that may find value in the program and would then pass on their details to the Wellbeing Connector.

'Usually in the initial assessment, I let people know about [the Wellbeing Connector], tell them [they] know a lot of activities available, if you're happy for her to contact you then I will pass on your details to her.' – Health Connector

'The Health Connector meets with a patient, explains the program, emails me (with permission of the patient) the person's name, address, date of birth, some of their interests, if they require transport, and I call the person within a day or two.' – Wellbeing Connector

The main reason for this arrangement was that Health Connectors had less time available to conduct assessments and follow-up with older adults and less knowledge of local activities. They therefore viewed the Wellbeing Connector as an important resource. One Wellbeing Connector also noted that having a strong relationship with the local Health Connector led to an increase in referrals.

'Having [the local Wellbeing Connector] available has made a lot of difference, as when we identify patients [suitable for the program] we can pass them on to [the Wellbeing Connector] and she looks after every aspect of support.' (Health Connector)

'If we had Health Connectors in more GP practices, we'd get more referrals – Health Connectors are a great entry point to refer to us.' – Wellbeing Connector

One participant said that they were initially at a GP seeing a Health Connector for an unrelated reason before they were linked in with a Wellbeing Connector. The Health Connector was able to identify a need for the program and to refer appropriately.

'[Referral to Wellbeing Connector] was very timely as I was trying to find something to do and I'm not good at computers [so I wouldn't use them to search for things to do]. [The Health Connector] was very good at picking up that I needed support.' – Participant

3.2.3 Connector Points

Connector Point representatives that we interviewed indicated that they identified potential participants and showed them the My Health Connector Directory website or passed on information about activities. One Connector Point said that having the **funding for electronic tablets** enabled them to access the My Health Connector website, with listings of available activities, more easily, thus better supporting their clients. Participants were sometimes '*surprised*' that the options available in the directory included social activities as well as health-related programs.

'To people who are comfortable accessing and looking at the website by themselves – some people come in here and access the website 3 or 4 times.
By supporting people to access the My Health Connector website, we can get an idea of what supports they want.' – Connector Point

One Connector Point we spoke to indicated that they were more likely to see women seeking information on social programs and activities.

'More women than men are seeking social support; men are not as open at saying they want this. Women often want garden related activities, sewing classes. A couple of people have asked for walking groups.' – Connector Point

The Connector Points are standalone sources of information about local activities, and they also sometimes serve as a useful referral pathway into the Wellbeing Connector program. Older adults were referred to the Wellbeing Connector if they appeared to be '*a little bit hesitant or shy*' or '*anxious about joining a group*', again highlighting the important role of the Wellbeing Connector in facilitating social engagement for some participants. However, this sometimes required the older adult (who had been referred by the Connector Point) to contact the Wellbeing Connector themselves.

3.2.4 Other community sources of referral

Community-based organisations played a key role in referring individuals to the Wellbeing Connectors and, to a lesser extent, the Health Connectors.

'A lot of our participants come to us because they are isolated and lonely … our activities get you out and about a bit more, get you meeting some people. So many people are so lonely.' – Activity organisation

Connectors noted that community awareness of the role helped to drive referrals. They worked to increase awareness by participating in local events and regular activities. One Wellbeing Connector said that they found utilising their existing contacts from a previous professional role was useful in getting referrals.

'A key thing that has been the main reason why I get referrals here is that in my previous role I was in another service in the PHN so a lot of providers are already familiar with me and when they heard I'd gone to a new role, they already knew who I was and my work ethic and quality of service.' – Wellbeing Connector

It appears that informal community networks can facilitate awareness and encourage participation. Connectors noted that self-referrals could originate from previous interactions with community activities or conversations with others already involved in the program. Word-of-mouth referrals were also mentioned by some participants, who said they had heard about the program through friends or through attending community events.

3.2.5 Promotional activities

Part of the Wellbeing Connector role involves attending local events and conducting promotional activities to increase awareness of the program. The PHN prepared a flyer on the program that the Connectors could distribute to organisations. These organisations included service clubs such as Rotary and Probus; businesses such as hearing specialists; libraries and other council-run services; non-government organisations; community groups, such as craft groups; neighbourhood centres; aged care providers and care finders; local hospitals, allied health service providers, and pharmacies.

'In small towns, pharmacy staff often know older people well, pharmacies are more likely to refer [to the Wellbeing Connector] than GPs as pharmacies have more time to make the engagement with the person.' (Wellbeing Connector commissioned organisation)

The promotional activities carried out to date appear to have been effective, given that some of the participants we spoke to said they had found out about the program through a local paper or through a Seniors Expo held in the area. One participant expressed the need for more advertising and mentioned that there should be more considerations for those who are legally blind to ensure that '*more people know about it*'. A representative from one of the activity provider organisations suggested that the Wellbeing Connectors could run their own, dedicated events to promote the program.

One Wellbeing Connector has created a **social calendar** that is distributed to all participants monthly. This is a physical document that is either posted out to older people who have already attended an initial session or given in person to new participants. The social calendar details the variety of local activities and programs available, to cater for most interests. It also highlights whether activities require participants to have My Aged Care funding. The Wellbeing Connector said that '*having a nice, structured, regular platform for them to receive information is really important'*.

The regular mail-outs include a letter reminding recipients of the Wellbeing Connector role and providing contact details. The calendar is also distributed to a wide range of community organisations, and they are asked to inform the Wellbeing Connector of upcoming events to include in future calendars, thus encouraging an **ongoing exchange of information**.

'I'm getting calls and emails saying can I please get another copy of the calendar. So, I'm proud of that initiative because it's a good way to bring people in. I feel like my role is streamlining and centralising [information about] all those events.' – Wellbeing Connector

Many people commented on the usefulness of the calendar, the range of activities listed and the ease of reading it.

'I love the calendar that [Name] does, I absolutely love the way she does it, she is so creative and it's uplifting even just to look at.' (Activity provider organisation)

'I'm going to get back on the weekend to the calendar because there is one thing I would really like to do. There was something to do in the gardens and I thought I'd like to do that.' – Participant

3.3 Older adults' reasons for joining

Older people came to the program with little or no expectations. In most interviews, participants could not identify what they had been told about the program prior to their speaking with a Wellbeing Connector or Health Connector.

Most participants we spoke with indicated that they had been experiencing feelings of loneliness or social isolation for some time, due to bereavement or loss of contact with friends and family. These challenges were a key reason they decided to join the Health Connector or Wellbeing Connector program, in the hope of finding activities or programs to alleviate those feelings.

'All my friends are busy'. – Participant

'I have no family around me, so I need to do things to help myself in terms of keeping busy.' – Participant

'I am very much on my own and don't have any family around.' – Participant

'I'm usually very [socially] active. [But] it was a very lonely period over Christmas and New Year – I had no visitors and no phone calls, and I felt I had to do something about it. My friends have either died or given up driving so we don't meet anymore.' – Participant

Participants noted other reasons for joining. Some were relatively new to the area, others were acting as a carer for a partner or family member, while others had medical conditions which had limited their ability to participate in the community. They all felt the lack of social connection. Importantly, they all appeared to recognise their need to increase their opportunities for social connection to look after their own wellbeing.

'A lot of people at [area] are locals, they have people they know from living in the community. I haven't, I don't know anybody except one lady.' (Participant)

'I hadn't been in the mountains all that long, I didn't know many people here.' (Participant)

'My husband has early dementia and depression. The last two years have been very hard. When we went to the doctor's surgery for podiatry, I got suddenly upset so [Health Connector] said, "we want to look after you too," and I said, "I think I have to get out more". Most of my friends and family live a long way away.' (Participant)

'I have my medical problems, like my knees are starting to play up a bit now. But I still get around. I've always been a walker so I'm not a person who sits in the corner all day, I try to help myself as best I can.' – Participant

One participant said that she had attended one session with her neighbour as a support and realised that she was interested in speaking to the Wellbeing Connector as well, because they '*made me feel comfortable*'.

3.4 Enablers and barriers to recruitment

It appears that many of those approached to take part in the program agreed to the intake meeting and assessment. This was particularly the case for the Wellbeing Connectors, where the majority of older adults who took part were self-referred and therefore motivated to seek help. The following sections explore the personal and contextual factors that make it easier for a person to benefit, and the challenges to recruiting others who might benefit but are not participating for various reasons.

3.4.1 Who is likely to benefit most?

Wellbeing Connectors, Health Connectors and auspice organisations were asked about the kind of people that are likely to get the most out of the program. Interviewees identified the following characteristics and resources as helpful for engaging in the program and activities.

Naturally extroverted individuals

Connectors believed that certain personality types, who were most interested in experiencing new things and had a positive outlook, would find it easier to engage with activities. Key characteristics were confidence and strong need for social engagement. More reserved individuals and those struggling with mental health issues would find it more challenging and may be held back by '*fear and apprehension*'. This demonstrates why it was so important for the Connectors to accompany certain participants to activities.

'People who are quite confident and happy to do things alone, we can't provide intensive support for every person. Personality and how confident you are.' (Wellbeing Connector)

'Those who are genuinely looking for a social life. They tend to have a happier disposition, and they're not bogged down by depression, PTSD, grieving.' (Wellbeing Connector)

'People who love change – a lot are rigid, they don't want to try new things – but a few elderly people, they love change and trying new things.' (Health Connector)

'If you're a more social person, more outgoing, you're more likely to go for it. Others who are shy or reserved or potentially on the spectrum might be too intimidated to go, they are always going to find it challenging. Fear and apprehension may get the better of them regardless of the situation and who is referring.' – Activity organisation

Physical health and younger age

Participants with good physical health were likely to get more out of the program by finding it easier to attend events and activities. Frailty and advanced age were significant barriers to participation. One Health Connector noted that the physical barriers to accessing activities limited the full potential for some participants.

'When a person is very frail, or there are physical barriers, it's less likely to work out.' (Health Connector)

'[Those aged] 60-75 years are more likely to take up an activity, but it depends on mobility and transport. Most [still] have their licence [at that age].' – Health Connector

'The ones we catch the earliest [get the most out of it]. Once they are depressed, bereaved etc, they're really hard to reach. [They'll say,] 'I'm too old to do that now'.'
– Health Connector

'The biggest barrier is physical limitations. We don't have a wheelchair lift on the bus, so they need to be able to step up. They also need to be independently mobile and able to toilet themselves. We can cater for vision and hearing impairments – [but] for some clients, cognition levels also limit what [the program] can do for them.' – (Activity organisation

Contextual factors

There were a few other factors raised in interviews that could affect an older adult's ability to make the most of the opportunities presented by the programs. For example, one interviewee said the experience of joining a 'small town' community could reduce a participant's comfort with the program.

'It is intimidating when you don't know anyone – in a small town where everyone knows everyone. That can sometimes be more intimidating than being in a big city.'
– Activity organisation

One Wellbeing Connector noted that the type of referral – and, hence, the motivation of the individual – impacted the engagement with the program. This interviewee felt that self-referral was preferable as it indicated the person was willing to engage.

'Those who won't get much out of the program are those who are referred as a suggestion by a medical practitioner and so won't be as committed.' (Wellbeing Connector)

'Readiness for social engagement [is necessary].' – Health Connector

3.4.2 Challenges with recruitment

The program data suggest a steady demand for the program; there was an uptick in the number of enquiries at the Connector Points in January and February 2025 (Figure 7). The Wellbeing Connectors have conducted a combined average of 10 intake assessments each month since September 2024 (Figure 4). In contrast, intake by the Health Connectors appears to have dropped off considerably in the later months of the program (Figure 6).

One possible explanation for this pattern of slowing recruitment is the time constraints on the Health Connector role, which is funded (by NBMPHN) for a few hours each week and is

carried out by practice nurses alongside their usual duties. Generally, nurses felt their Health Connector role fitted in with some of their other roles in the practice, especially the Medicare-funded **75+ Health Assessment**, which is a comprehensive review of an older patient's physical and psychological health. However, it was less straightforward to talk about the Health Connector program with patients who were visiting the practice for other assessments or procedures, such as GP management plans or chronic disease management, because *'it doesn't necessarily fit as easily, and the age range is quite broad with the GP management plans.'*

Some nurses said that, ideally, they would like to be able to set aside time each week just for the Health Connector role and have organised appointments with patients to discuss the program and the initial assessment, but this was not always feasible, as (to some extent) they had to be available to attend to patients and carry out procedures on demand.

> *'I would love to go, "All right, Tuesday morning, all I do is this," but that doesn't really work for my doctor.' – Health Connector*

It appears that time constraints and pressures of other tasks can mean it is often easier for the nurse to talk about the program as part of a scheduled, comprehensive health assessment with patients; however, this limits the intake of other patients who may benefit.

When the Wellbeing Connector program began, the Connectors spent a great deal of time promoting the program to organisations, with the view to receiving referrals to the program; as the program has progressed, they continue to promote the program in the community, but this has become less of a focus as demand for their services has increased. It is not part of the Health Connectors' role to promote the program externally. Nevertheless, they promote it (to the extent possible) within the practices where they work.

This suggests that if the plan is to broaden the number of people involved in the program, there may need to be more dedicated funding for Health Connectors, so that they are able to book in appointments specifically to conduct the initial assessment. It will be important to allow time for Wellbeing Connectors to continue their promotional work to build awareness of the program across their communities, and within organisations that are sources of referral.

4. Social prescribing activities and outputs

In this chapter we present evidence on the extent to which program activities led to the expected outputs of the Wellbeing Connector and Health Connector programs. The activities include referral pathways, Health Connector training, and the My Health Connector online directory, plus, for Wellbeing Connectors, capacity building with providers and support for older adults to attend the first few sessions of the new activities. In combination, these are expected to lead to the following outputs, specified in the program logic:

Community-dwelling older adults are supported to experience a sense of social connection, satisfaction and happiness with other people, projects or activities they enjoy.

4.1 First meeting with the Connector

All participants who answered this question (n=6; most had contact with a Wellbeing Connector) said that, at their first meeting, the Connector talked about the program and asked them what activities they were interested in doing, '*She asked what sort of interests I had, do I belong to any groups, would I like to belong to, and do more than I do [now].*'

For those struggling to think of what activities they may be interested in, participants were very happy that the Connector was able to suggest possible activities they may like to do:

'Recommended heaps of stuff …' – Participant

'She gave me details of the program – it was an answer to my prayers' – Participant

'I felt excited when I met [Name] and we talked about the activities I could do.' – Participant

Some participants mentioned that the Wellbeing Connector came to their house for that first meeting, with one saying they preferred to meet in their own home as they felt more comfortable, *'it's nicer to be sitting in my lounge room and chatting freely.'* This was echoed by a participant whose initial meeting with the Connector was in a public space, and the participant said they felt uncomfortable answering personal questions when people might have been able to overhear, *'what we talk about is quite private.'*

Participants said they felt very good after the first meeting with the Connector, with some describing feelings of *'excitement'* and *'elation'* that they were going to become involved in activities. This was particularly the case for a couple of participants who felt particularly lonely at the time they engaged with the program.

'I felt elated. Before, I felt pretty depressed, the world felt like not a good place ... I went through that first Christmas without my husband. Everything closes down and everyone is away. I found that period difficult. For [Name] to come and suggest [activities] was great.' – Participant

4.1.1 Building a rapport

Participants often described characteristics and behaviours of Connectors that contributed to their feelings of ease and comfort at the initial meeting and afterwards. These included personal warmth and a sense that the person was genuinely interested in and concerned about them and, importantly, did not patronise them. Participants gave positive feedback about a variety of Connectors across the program, and there was no negative feedback.

'It wasn't just that they HAD to listen, [they were] genuine. They didn't use a script.' – Participant

'[Name] is very nice, you don't feel rushed or talked down to. [Name] is interested in people.' – Participant

'[Name] is marvellous. Very friendly and open.' – Participant

One of the Wellbeing Connector commissioned organisations emphasised the need for the Wellbeing Connector to have skills to work independently, and ability to work in the community alone. Good knowledge about the local services and supports available was essential.

4.1.2 Completing the intake assessment

Three older adults described the process of answering the questions on the initial assessment (referred to as '**Form A**') as fine, with one saying they understood that the Connector had to ask the questions because *'they need to know (my answers) so they know what I want to do and what I'm capable of doing.*'

Four participants said they didn't remember the form, and there was no comment on this question from five participants. In combination, this feedback suggests that completing the initial assessment does not stand out as an onerous or intrusive aspect of the intake process – rather, it is acceptable to older adults.

Four Health Connectors provided feedback on this question, with two saying Form A worked well with participants. The tool for measuring quality of life (the WHO-5) was described as *'pretty straightforward'*, and *'flows well'*. Another Health Connector said they tended to *'ask our own questions in our own way'* according to what best suited their patients. However,

another said that sometimes they needed to explain the questions a few times, but once people understood why the questions were asked, they had no problem in answering them.

The three Wellbeing Connectors similarly felt that Form A worked well, with one saying that participants understood what the questions meant and were keen to provide answers:

> *'People are dying to tell you about their lives, they have so much [to tell], their history is so rich and their loneliness is so prominent … if anything they are looking for someone to actively listen.' – Wellbeing Connector*

One of the Health Connectors and one Wellbeing Connector were concerned that people may answer the WHO-5 questions based on how they were feeling now, rather than averaging out how they have been feeling over the last two weeks. The meaning of one of the loneliness items (particularly the words '*in tune*') was unclear to some Connectors initially. This feedback suggests a need to update and reinforce the training with Connectors around how to administer these questionnaires. This training was conducted with Connectors when the issue was first raised with NBMPHN.

4.2 Identifying suitable activities

Health Connectors described how they tried to find out about participants' interests by *'asking about hobbies or interests, what matters, what are your goals, what would be a good outcome for you'*, with the aim of ensuring a good match with the participant and the activity or activities prescribed. One Health Connector said that if people were struggling to think of things they would suggest some 'non-threatening' activities such as yoga, exercise, and 'walk and talk'. One Health Connector, who conducts home visits, said that they sometimes had the opportunity to pick up ideas on hobbies from what they saw in the house.

Wellbeing Connectors also seek information about what might appeal to participants, asking open questions such as, *'tell me all about you, what do you like, what don't you like?'*. One said that if participants find it hard to think of things they would like to do, they will suggest events that focus on social interaction rather than activities, for example, community lunches. If there is nothing available that matches a participant's specific interest, they will suggest activities that have some similar aspects.

4.2.1 Sources of information about activities

Once Health Connectors have an idea of participants' interests, they then go onto the **My Health Connector Directory** online and look for activities with the aim of matching availability, location and weekday that suits the participant. Health Connectors rely on the directory to provide up-to-date information about local activities. One specifically noted the My Health Connector Directory was the only resource they knew:

'Except for the directory, I don't have much information, I haven't lived in this area for very long.' – Health Connector

This Health Connector had started to do their own research, asking patients what sorts of activities they were involved in, scanning the notice board at the local library, and conducting internet searches for local activities, so that they had information and could make recommendations. None of the other Health Connectors referred to resources other than the directory. This suggests limited knowledge of other avenues to explore, potentially limiting opportunities for participants to engage in activities.

Another Health Connector said that once a patient had chosen an activity, the Health Connector would make a phone call with the patient to check the contact details were still correct and then print the details for the patient (so that they had a paper copy of the information). This was their way to ensure they were making an appropriate referral to an activity rather than providing outdated contact details and potentially disappointing or frustrating the patient. They did this because they had found that some listings in the directory were not current.

It appears that Wellbeing Connectors generally have more knowledge than Health Connectors of activities currently available in the community, and this makes sense given part of their role is to engage with community organisations to promote the program and to explore opportunities for participants to engage with activities.

One Wellbeing Connector collates information on each participant's identified activity preferences and presents it to them on paper, having identified that participants prefer information presented in this form rather than relying on internet searches, emails or SMS. The information is provided in person or sent via the post.

Participants echoed what Connectors said regarding how activities are chosen. Many said the Connector asked what they were interested in and then tried to match that with an activity that was located close by:

'[Name] gave me options to choose from a list of 11 things, I chose a few.' – Participant

One participant said the Connector did not immediately know of an available course on the topic they were interested in but was continuing to research if there was anything available. Another noted that, on reflection, they decided not to follow up on a suggested activity, and the Health Connector rang to ask them why they had decided not to attend this activity. Having established that this activity was not suitable, they discussed it further and the Connector suggested an alternative activity which the participant was very happy to engage with.

4.3 Support provided by the Connector

After making social prescriptions, the Connectors supported older people by linking them with the activity providers. Wellbeing Connectors were available to accompany people to the first visit or session if required, and this support sometimes extended for several visits.

4.3.1 Warm referrals to activity providers

Referrals to activities tend to be informal, with the Wellbeing or Health Connector organising an introductory meeting, although this varied according to the activity and the participant's preferences and needs. Interviewees indicated that the participant's age and physical health affected how they were referred into activities.

'We'll have a conversation - [it] doesn't have to be a formal referral.' (Activity organisation)

'It comes down to their level of motivation – and they may have to address other health issues first. We might make an appointment with their GP, or at other times I'll jot down the details [of the activity] and I'll check in with them later.' – Health Connector

Whether Connectors or participants made the first call to a suggested activity varied. For participants connected with Health Connectors, it was usually the participant who made the initial call as the Health Connectors didn't have time to do this, although they still tried to ensure that the person had the support they needed:

'If someone says yes, they are interested in an activity, then I'll print details of activities and ask if they're happy to contact the activity. If they're nervous to do that, I'll call their carer or their child to help make that contact.' – Health Connector

For those participants connected with Wellbeing Connectors, it often depended on the level of the participant's confidence and capability as to who made the initial call. One Connector noted that to make the initial visit to an activity as smooth and comfortable for the participant as possible, they communicated with the organisation beforehand to see if someone from the organisation can meet the new person when they arrive.

The organisations that provide the activities attended by older adults also provided support (where possible) to make it easier for new people, referred by the Connectors, to attend. For example, one of the organisations provides transport for participants if needed. This is invaluable, as we heard many stories of participants being restricted from attending activities because of a lack of transport.

The same organisation also introduces participants who are new to the program to other attendees, which is especially important for those new attendees who are anxious or nervous. One participant, having attended a social function where no-one approached them to chat,

emphasised how good it would be if someone met you (when you first attended an activity) and introduced you to people there.

4.3.2 Accompanying the person to the first activity

The Wellbeing Connector program offers the opportunity for participants to be accompanied by the Connector to an activity, particularly for the first visit, if required.

> *'Support to attend the first meeting is always offered to everyone – they've come to us because there is a barrier [to attending activities].' – Wellbeing Connector*

One Wellbeing Connector works alongside a support worker who accompanies participants to activities a couple of times if required, with the aim of connecting the participant with someone at the organisation who can then support them. Leaders of the organisations that were commissioned to provide Connectors and activity provider organisations talked about the importance of participants having this option, especially for participants who are anxious or lacking in confidence about going, or don't have many outside connections.

> *'It is absolutely worthwhile and necessary [to provide this support]. These are marginalised people, they're vulnerable … it's important to have that role to help people navigate, ease them into the process. Once they're there, they'll be fine.'*
> *– Connector commissioned organisation*

One commissioned organisation stressed the need for an explicit limit to the number of times the Connector attends an activity with a participant, to ensure the sustainability of the program. One of the Connectors also noted that, as they were getting more and more clients, their capacity to offer ongoing support would become limited. This view was somewhat at odds with that of another Connector, who felt that the support provided should be flexible to meet the varied needs of participants, this reflects the flexibility described in the guidance.

Interviews with older adults reinforced the importance of providing support for the first visit (or the first few visits) to a new activity. Some participants were too anxious to attend a new activity by themselves where they knew no-one:

> *'When I first met [Name], I was suffering from anxiety and panic attacks, I told her that's why I don't go to things. [Name] said she can come with me to activities and support me.' – Participant*

Not all participants required this level of support. Some were comfortable to contact a suggested activity by themselves and then attend on their own. This created its own challenges, however, as Connectors did not have the opportunity to observe whether the person was comfortable and whether they enjoyed the activity, and to suggest changes to

activities if the experience was not a satisfactory one. In these cases, Connectors felt it was important to follow up with a phone call after the first visit to ask how it went.

Very elderly women who are living alone were identified as a group that seemed more reluctant or timid to go somewhere unfamiliar by themselves, whereas 'younger' older adults who had only recently retired were less likely to need this type of support.

4.3.3 Emotional and practical support

As well as Wellbeing Connectors accompanying some participants to their first visit to an activity, Connectors [including some Health Connectors] also provided more general support and encouragement, often through regular check-in phone calls.

> *'At first a participant did a tester session, they were nervous, not sure they wanted to continue participating. [Name] spoke to the participant, and they came this term.' – Activity provider*
>
> *'They might go along [by themselves], that's the aim. Sometimes you'll check in and they haven't, so it's just encouraging them, I make a phone call.' – Wellbeing Connector*
>
> *'[Name] followed up to see if I had contacted the organisations she had suggested.' – Participant*
>
> *'She's in touch often to let me know things that are going on – things that come up that I might be interested in, she lets me know.' – Participant*

The encouragement provided by Connectors was important to participants. One participant noted that although they were *'not good at talking'*, the Wellbeing Connector ensured that they did not feel uncomfortable.

Some participants felt so comfortable with the Wellbeing Connector that they said if they had any concerns or questions, they would approach them:

> *'I feel I could call [Name] anytime if I wanted to know something or do something.' – Participant*

4.4 Engagement with prescribed activities

In this section of the report, we present data on the types of activities to which older adults were referred, based on the referral records (program data). We then present qualitative data which sheds light on the extent to which social prescriptions were taken up, and the barriers to engaging with the activities prescribed by Connectors.

4.4.1 Content of social prescriptions – program data

The intake forms include an open text response regarding the types of activities the older people were referred to. For the Wellbeing Connector program these referrals tended to be for exercise groups including seated yoga and community walking groups (30%) and general social groups (30%). Other activities also included crafting groups and musical groups or choirs (Table 10).

There were similar activities referred by Health Connectors (Table 11) with social groups (46%) and educational courses (23%).

In some intake appointments no activities were referred by the Connectors. In some cases this was due to multiple issues discussed during the appointment or the need for more time to develop rapport with the client.

Table 10. Activities referred to by Wellbeing Connector

Activity	Count	Percentage*
Exercise groups (e.g. seated yoga, walking groups)	12	30%
Social lunches and groups	12	30%
Craft group (e.g. sewing, knitting)	10	25%
Active Care Network	7	18%
Music and choir	6	15%
Village Café (monthly community event offering wellbeing support)	5	13%
Intergenerational programs	5	13%
Care finder	3	8%
Other (e.g. library, digital literacy, gardening group)	17	43%
Total number of participants with activities referred	**40**	
No activities referred during intake appointment	11	

*Note: *Participants were often referred to more than one activity or support. Coded from qualitative responses.*

Source: Wellbeing Connector intake forms

Table 11: Activities referred to by Health Connector (intake)

Activity	Count	Percentage*
Social group (e.g., Men's Shed, Older Women's Network)	26	46%
University of the Third Age (Educational courses)	13	23%
Exercise	8	14%
Craft group (e.g., crochet, sewing)	4	7%
DisabilityCare Australia Fund	3	5%
Wellbeing Connector	3	5%
Book club	2	4%
Music	2	4%
Other	16	29%
Total number of participants with activities referred	**56**	
No activities referred during intake appointment	1	

*Note: *Participants were often referred to more than one activity or support. Coded from qualitative responses.*
Source: Health Connector intake forms

Health Connector monthly reporting also indicates a significant amount of time was spent on preliminary sessions, with a greater number of potential clients considered for the program. There were a higher number of clients with no activities referred to during these appointments, in comparison to the intake sessions. Of the 202 sessions coded as 'initial' in the monthly reports across the 5 Health Connector locations, 104 clients were either interested in the Health Connector program or received a referral to an activity. Listed reasons for the remaining 98 that did not receive an activity referral included the client feeling fulfilled already, too busy to add more to their schedule, lack of local transport, busy with medical appointments or already engaged in the Wellbeing Connector program.

4.4.2 Uptake of social prescriptions

The available data did not allow us to identify factors which consistently influenced whether participants followed through with referrals to activities. Stakeholders noted that uptake often depended on individual characteristics and personal motivations. There were differences between locations, reflecting local context and the unique dynamics of local communities.

> *'A lot are interested at first – and then don't go because they're "not feeling it".'*
> *– Health Connector*
>
> *'It's a mixed bag re whether people take up the referral.' (Wellbeing Connector)*

There were differing opinions on how male and female participants interact with the program and take up the referrals. Some stakeholders said it was particularly difficult to recruit men into the program, while others said men tended to need the program most.

'It tends to be that men are less likely to take up the offer. You'd think that person would benefit but they are not interested or have their own routines and wouldn't consider trying something new. Whereas women seem to be a bit more willing to try something.' (Health Connector)

'Women are more stoic, they're all right on their own, often they have kept their friends, whereas males, if they have lost their partner, they are very lonely, very lost. They are the ones we send to the hub for the lunches and [Wellbeing Connector] then works on them – [eventually] some are good enough to help others.' (Health Connector)

4.4.3 Barriers to uptake of activities

The most common barrier to community participation for older adults was **lack of transport**. Participants from locations with greater availability and accessibility of transport were more likely to take up activity prescriptions, simply for logistical reasons. Stakeholders mentioned the availability, the accessibility and the cost of transportation as compounding issues. Accessibility is particularly a problem in the more rural and regional areas where older people can be limited to activities in walking distance.

'Transport is a big issue. They may not have their licence anymore, they just haven't got transport, so that would be the main barrier.' (Activity organisation)

'Organising their own transport, they need someone to sit down with them and organise it every week. Only a few can organise it for themselves.' (Wellbeing Connector)

The difficulties created by lack of transport were emphasised in interviews with several participants, who spoke about their reluctance to drive to places that were unfamiliar, where they were not confident about navigating and parking. They were also reluctant to call on family members to drive them, not wanting to create a burden or interfere in their busy lives.

'Self-worth is a barrier – they don't feel worthy of asking people (such as family) to go out of their way to take them [to an activity].' (Health Connector)

'There are lots of activities in the Nepean area and not so much near where I live (in the Windsor area), so it's not as easy to get to when I don't drive.' (Participant)

The cost of private transport (e.g., taxis) was prohibitive for some older adults living in areas where there were few public transport options and for those not eligible for subsidised community transport. Some activity organisations provide transport, but this was not universal and sometimes came with a cost.

'I found the community put on transport, but I do feel a bit upset with them because I have to pay.' (Participant)

Sometimes the Wellbeing Connectors transported participants to activities using a company vehicle, but this was not sustainable beyond the first or second visit, given the number of potential participants in some Connector locations. Another *ad hoc* solution involved linking participants together so that those who were still driving could provide transport for others.

Though out of scope for this program, there is potentially a need for the program to come with some brokerage funding attached, which could be used to fund transport for those who need it. This is especially important for participants living in more remote or rural parts of the Connector catchment areas, where public transport is limited or non-existent.

Another barrier to uptake of activities, mentioned by most stakeholder groups, was **physical limitations** related to health concerns and disability. **Caring responsibilities** for partners who were unwell or frail prevented some older adults from taking part. Poor physical and/or mental health can affect older people's **confidence**, which can also be a limiting factor. They may worry about making a commitment to attend an event or session and then not feeling well enough on the day. Flexibility – and reassuring people that they are not letting anyone down if they can't make it on the day – is the key to encouraging some older adults to give things a try, according to one Wellbeing Connector.

'Asthma, arthritis, follow up with health appointments, chronic illness, some are carers for partners and don't have time for themselves.' (Health Connector)

'People want to attend activities, but they are scared to leave their house.' (Health Connector)

'People don't like committing. I say a lot in my intakes, "It's completely free, it's completely voluntary, I'll work with you, if you wake up and you're not feeling up to it, that's okay, we can cancel our appointment and try again the next week".' (Wellbeing Connector)

Of the participants we spoke to, five said that they had **conflicting activities or events** happening on the same days of the referred program which meant they were unable to attend. Other barriers only mentioned by one or two stakeholders included the cost of some programs and the complexities of socialising following bereavement.

5. Outcomes for older adults

This chapter presents evidence on the extent to which the programs achieved the expected outcomes for older adults in terms of improved **quality of life** and reduced **loneliness and social isolation**. First, we present program data from the follow-up assessments. This is followed by qualitative findings on the **experiences of older adults** who took part, and the views of other stakeholders on the outcomes they observed. **Unintended consequences** are also dealt with in this chapter.

5.1 Follow-up assessments

Connectors are expected to conduct follow-up assessments at the 12-week and 26-week mark (Wellbeing Connectors only) following the intake meeting. At this stage of implementation, very few follow-up assessments have been completed, partly because few program participants have been in the program long enough, but also because of logistical challenges, particularly for the Health Connectors. Nevertheless, informal follow-ups are occurring which allow Connectors to get a feeling for how participants are faring and whether they have taken up the activity referrals. Wellbeing Connectors conduct regular check-ins with participants, often by phone, while Health Connectors tend to check in opportunistically, when participants are attending the practice for other reasons.

> *'Sometimes I will catch people incidentally [while they're in the practice] and ask how the activity has been going.' (Health Connector)*
>
> *'I usually try to follow up every fortnight unless it's apparent that a client doesn't need it or they're happy to do just the 12 week follow up. The majority of them like it when I follow up.' (Wellbeing Connector)*

A Wellbeing Connector said they followed up at 3 and 6 months all those who had completed the intake, even if they had not taken up the activity referral. One Health Connector suggested they could systemise the process for doing follow-up assessments, with reminders to contact participants at the 12-week mark: *'put a reminder in the file, make an appointment, book a follow-up.'* Another Health Connector had tried various ways to connect with participants to complete the follow-up assessments, known as 'Form B':

> *'They might be in for another reason, and I would opportunistically ask them to do Form B, or I phone them rather than bring them in specially, or I would try to line it up with another appointment. This strategy has been successful in getting follow-ups done.' (Health Connector)*

One Wellbeing Connector said they had two participants who had been in the program longer than 12 weeks, and they had done one of the 12-week assessments by phone as that suited the participant. Another Wellbeing Connector had completed two 26-week assessments by phone or email, depending on the participant's preference.

Some Health Connectors said they were unable to contact some participants for the follow-up assessment. Connectors suggested this may be because the participant might have gone to the activity but dropped out before the 12-week mark; others may have had some health issues that held them back from continuing to attend; or they have may have moved away. One Health Connector noted that at a follow-up assessment, *'the lady was still interested [in attending the activity] but was held up with other appointments.'*

5.2 Quality of life – program data

This section draws on data provided to NBMPHN by the Wellbeing Connectors and Health Connectors[20], and reports on the key quantitative outcomes for older people: quality of life, loneliness and social isolation.

5.2.1 WHO-5 quality of life measure

The **WHO-5** is one of the most widely used measures of subjective well-being and has been demonstrated as reliable and valid across different populations and cultures.[21,22] The five items are each rated on a scale of 0-5, giving a raw score of up to 25, which is then multiplied by 4 to give a final score out of 100 (Figure 8).

Figure 8. Items and scoring principle for WHO-5 quality of life measure

The WHO-5 questionnaire

Instructions:
Please indicate for each of the 5 statements which is closest to how you have been feeling over the past 2 weeks.

Over the past 2 weeks...	All of the time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
1 ... I have felt cheerful and in good spirits	5	4	3	2	1	0
2 ... I have felt calm and relaxed	5	4	3	2	1	0
3 ... I have felt active and vigorous	5	4	3	2	1	0
4 ... I woke up feeling fresh and rested	5	4	3	2	1	0
5 ... my daily life has been filled with things that interest me	5	4	3	2	1	0

Scoring principle: The raw score ranging from 0 to 25 is multiplied by 4 to give the final score from 0 representing the worst imaginable well-being to 100 representing the best imaginable well-being.

Figure source: Topp et al., 2015, p.168

[20] Due to the nature of the Connector Points program as a source of information and referral, they do not collect data on outcomes for older people.

[21] Topp CW, Ostergaard SD, Sondergaard S and Bech P (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy and Psychosomatics, 84*: 167-176.

[22] Sischka PE, Costa AP, Steffgen G and Schmidt AF (2020). The WHO-5 Well-Being Index – validation based on item response theory and the analysis of measurement invariance across 35 countries. *Journal of Affective Disorders Reports, 1*: 100020

Pre- and post-program WHO-5 scores are shown in Table 12 by program. For both the Wellbeing Connector program and the Health Connector program there was a positive difference between the pre-score and post-score means, showing that feelings of wellbeing had increased for those participating in the program (that is, post-scores were consistently better than pre-scores).

Table 12. WHO-5 scores before and after participation

	Pre-program		Post-program		Difference in mean score
	Number of participants	Mean (SD)	Number of participants	Mean (SD)	
Wellbeing Connector	51	43.37 (24.07)	24	50.33 (24.41)	+6.96
Health Connector	56	47.07 (20.72)	10	59.60 (23.29)	+12.53

Note: the raw score ranging from 0-25 is multiplied by 4 to give the final score from 0 representing the worst imaginable wellbeing to 100 representing the best imaginable wellbeing.
The differences are not statistically significant.
Source: Wellbeing Connector intake and follow-up forms and Health Connector intake and follow-up forms

Of the 9 participants that we were able to access both intake and follow-up forms, 7 (78%) of the Health Connector participants recorded an increase in WHO-5 score at the follow-up session. Similarly, of the 14 participants that we were able to access both intake and follow-up forms, 10 (71%) of the Wellbeing Connector participants recorded the same or an increase in WHO-5 score at the follow-up session (see Table A 1).

There was an increase in mean score post-program regardless of whether the older adults had attended an activity or not, though that increase was greater for those that had attended one of the referred activities or supports.

Comments and qualitative data from the intake and follow-up forms note limitations of the WHO-5 quality of life measure including not capturing the ongoing implications of chronic illness and disability. It also depends on the older persons mood at the time of answering, which may not accurately reflect their feelings of the last two weeks.

5.2.2 Loneliness and social isolation

Older people were also asked to respond to the following three items (validated by research) to measure **loneliness and social isolation**:

- *How many of your friends/relatives do you see or hear from at least once a month?* (Response categories: none, one, two, three or four, five to eight, nine or more) [23]

[23] In their Australian study of the relationships between social health and cardiovascular disease, Freak-Poli and colleagues (2021) defined social isolation as engaging in social or community activities less than once per month and having contact with four or fewer friends or relatives per month.

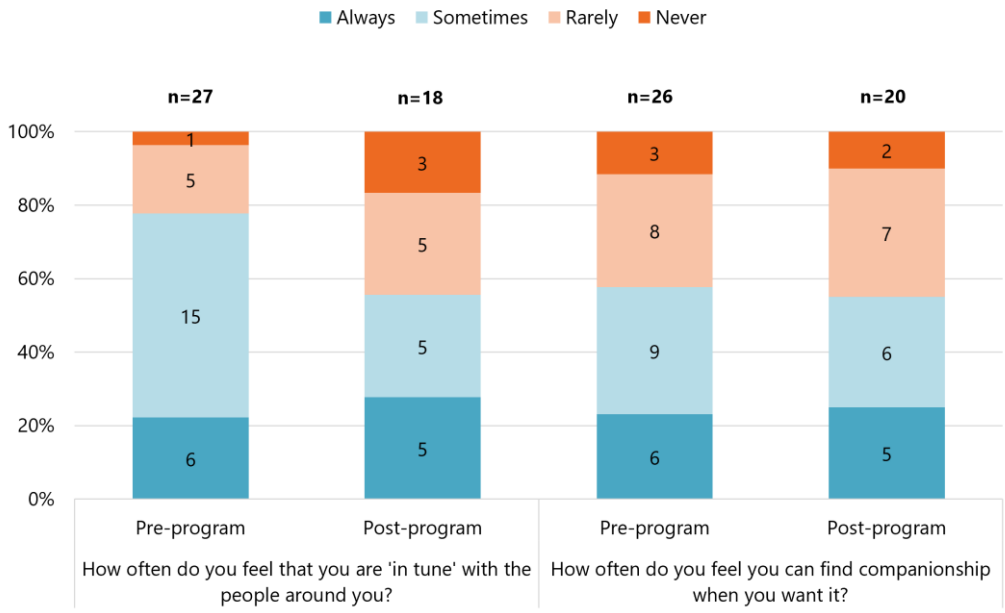
- *How often do you feel that you are 'in tune' with the people around you?* (Response categories: never, rarely, sometimes, always)[24]
- *How often do you feel you can find companionship when you want it?* (Response categories: never, rarely, sometimes, always).[25]

There were too few follow-up forms with these additional questions received to compare the pre- and post-program responses for the Health Connector program. These questions were also not answered fully in all Wellbeing Connector intake and follow-up forms.

Of those that responded to the questions regarding how often they feel they are 'in tune' with the people around them, 6 (22%) older people felt they *always* felt this way and 15 (56%) felt that they *sometimes* felt this way. In the follow-up forms, completed after 12 weeks, 5 (27%) *always* felt that way and 5 *sometimes* felt that way (27%).

Of those that responded to the questions regarding how often they felt they could find companionship when they wanted it, the proportion of responses remained similar between the intake and follow-up forms.

Figure 9. Loneliness and social isolation



Source: Wellbeing Connector intake and follow-up forms

Of the 24 intake forms, 30% had seen or heard from 5 to 8 relatives or friends in the last month (see Figure A 1). The numbers of friends or relatives seen or heard from in the last month largely depended on whether the participant still lived near family or had moved to a different location more recently.

[24] Russell DW (1996). UCLA Loneliness Scale (Version 3): Reliability, Validity, and Factor Structure. *Journal of Personality Assessment, 66*, 20-40.

[25] Russell DW (1996). UCLA Loneliness Scale (Version 3): Reliability, Validity, and Factor Structure. *Journal of Personality Assessment, 66*, 20-40.

5.3 Outcomes reported by participants

We interviewed older adults and asked them if participating in any of the recommended or referred activities have made a difference to their life. For some who have been able to attend activities and participate in events it is evident that it is having a positive impact. One older adult said their participation in the program had *'changed my world'*.

5.3.1 Social life and community connection

Most participants mentioned the increase in socialising with others as a result of attending the activities. For example, one participant was happy that the Wellbeing Connector, who had connected some participants with a time-limited program, was organising to get attendees from the now-finished program together so they could continue to meet regularly and build closer friendships.

There were also reflections from participants on changes in the way they thought about their community following participation in activities. For some, it was an opportunity to meet and interact with other older people experiencing similar feelings of loneliness and isolation. Participants expressed gratitude that such activities were available.

'Oh gosh yes. Just amazed at the amount of people who are quite often struggling in their own life but are willing to spend time picking you up and bringing you home. People who say, 'do you need anything from the shops?' I live in an area with the population that are ageing.' – Participant

'My friends in Sydney, I'm still in touch by phone, I tell them what I'm doing, they say there's nothing like that here. They still have their husbands. But when you don't, it's nice to know there are people and organisations that are working to get those sorts of people together.' – Participant

5.3.2 Changes in mental and physical health

Participants reported changes in their mental and physical health, noting that the improved sense of connection provided purpose, while others reported new, healthy habits which would improve their longer-term health.

'At the end of the day I look forward to what I have on tomorrow. Yes, it has lifted some of the depression.' – Participant

'I'm eating better, and I have a lot of new friends. I have been having coffee with a lady that lives nearby, and I go to the lunches at the Springwood Hub. Life is pretty good again.' – Participant

We asked participants if they had learned or renewed any skills, like arts and crafts or games. One participant was enjoying rediscovering her crafting and knitting hobby, finding ways to adapt to her changed abilities and finding *'empowering'* new techniques. Another participant was enjoying seeing others express their creativity and imagination in an art-based activity.

5.3.3 Willingness to recommend the program to others

All participants we interviewed said they would recommend the program to others. Participants tended to mention the nature and knowledge of the Wellbeing Connectors and Health Connectors as the main reason to recommend the program. Increased awareness of activities and increased feeling of connection were also mentioned by participants. Interestingly, there was a strong sense that it was important to older adults that they were treated with respect, not 'bossed around', and remained in control of what they chose to do.

'[Wellbeing Connector] is very helpful. She knows how to establish rapport without being bossy. She's very knowledgeable about the programs available and had a good network.' (Participant)

'Yes. Because it is good – it makes people aware of the activities that are around their area. And it's up to the people then if they want to do the activities or not.' – Participant

Participants were also asked to identify the **best part** about the program and the activities. The highlight of the program was the support of the Wellbeing Connector or Health Connector. One participant said that the person in the role *'makes you feel safe'*. Many of the participants interviewed appreciated the ability of Wellbeing Connectors to attend events and activities with them.

'I like that [Wellbeing Connector] can come with me – I would feel anxious on my own, and wouldn't know where the activities are and where to park, etc. I think I would only need [Name] to come with me one or two times until I had confidence to get back on the horse and then I'd be fine to go by myself.' – Participant

'[Wellbeing Connector] is responsible for a lot of that change. If I'm left on my own, I don't do those things.' – Participant

A small number of participants noted that they would not have been aware of the activities available to them without the program and the support.

5.4 Outcomes reported by others

Other stakeholders – particularly Connectors and activity providers – reported that participants benefited from participating in the program. They believed that the benefits

included **improved confidence** as participants interacted with the various groups and programs and discovered that they were more capable than they had imagined. One stakeholder said the activities were helping older adults *'realise they were worthy'* and had much to contribute. Another said the support for participants *'makes them feel special'*.

'Older people feel invisible. Even just having a chat with [Wellbeing Connector] or being shown opportunities to engage is a good start – someone is giving them attention.'
– Wellbeing Connector commissioned organisation

'They are often quite grateful. Not everyone pursues [the activities] long term but they are grateful for the time we spent identifying activities and the things we came up with.' – Health Connector

Communication skills also improved as some participants had previously had long periods of time when they had not interacted very much with others and they had lost social skills.

'The program is in the early stages still. But I have talked to a few patients and have seen that some have come out of their shell.' – Health Connector commissioned organisation

For some participants, stakeholders reported **improved mental health** via interactions and connections with others, which potentially reduced their anxieties. For example, Health Connectors and general practice staff had noticed a reduction in *'attention-seeking behaviour'* by lonely, elderly patients, and improvements in patients' sleep patterns and mood. The rationale was that giving people a reason to get up and go out gives them *'something different to think about and do'* – it is a source both of distraction and of mental and physical stimulation. Stakeholders felt this was particularly effective when the activities were *'not threatening or demanding – you're not forced to talk about personal things'* and when older adults could decide to engage at their own level and pace.

'People living alone go through a lot of mental issues, memory issues. When they go out, and have more people in their lives, it makes them different. I have noticed, and two patients have shared information with me, that they have made so many friends there.'
– Health Connector commissioned organisation

'You might feel a bit lonely, a bit isolated. You might not see your family much, or your friends. You might then be able to get out [of the house] for whatever reason and you're having a coffee, you're having a bit of a chat for a couple of hours and then, when you go home, your mind is thinking differently because of that chat, that little social interaction.'
– Activity provider organisation

'It improves your mental health … which then improves your physical health.'
– Activity provider organisation

There is some evidence to suggest that the benefits may be broader than social connection among older adults. One Health Connector found that the rapport that they built during the initial assessment enabled them to identify other problems impacting participants' lives, such as domestic and family violence. Referring one older adult to an activity provided their partner with respite from caring duties. Participants in 'Ageless Play' (intergenerational program) reflected that the children who took part seemed to be improving their confidence and the parents were keen to keep the relationships with older participants going once the program ended.

5.5 Unintended consequences

Interviewees did not identify many unintended consequences, and the majority were unexpected positive outcomes. For example, one Wellbeing Connector noted that the older adults with whom she was working were getting to know each other during the journey to the activity, and this consequence was also identified by participants themselves.

'When I do take different clients to something like the Village Café, they all make friends, and they exchange numbers. So, it's not just connecting clients with activities but connecting other clients with each other.' – Wellbeing Connector

There were also unintended negative consequences. Two Wellbeing Connectors described two separate instances of inappropriate behaviour which necessitated them to review referrals and, in one case, led to an older adult exiting the program. These incidents point to the difficulties of defining what 'social connection' might mean to different individuals.

6. Sustainability

This chapter considers whether factors that are likely to promote sustainability of the programs are present, and whether the program succeeded in building the capacity of local community assets to support community-dwelling older adults.

6.1 Factors likely to promote sustainability

Sustainability can be defined in various ways, but is typically understood *as 'the continuation of the programs and practices that were implemented within organisations, systems, or communities after initial implementation efforts or funding ended'*.[26] Based on a review of sustainability literature, Wiltsey Stirman and colleagues proposed a framework consisting of four key elements that contribute to sustainability: innovation characteristics, contextual factors, organisational capacity to sustain the initiative, and the processes and interactions undertaken during the implementation of the initiative.[27] We use this to frame our analysis of the sustainability of the Connector Points, Wellbeing Connector and Health Connector programs (Table 13).

Table 13. Factors and elements associated with sustainability of initiatives[28]

Sustainability factor	Elements
Innovation characteristics	• Fit of the initiative • Ability of the initiative to be modified • Effectiveness of benefit of the initiative • Ability of the initiative to maintain fidelity/integrity
Context (internal and external)	• Organisational climate, culture and leadership • Organisational setting (structure; policies) • System/policy change
Capacity to sustain	• Champions and available workforce • Funding and other resources • Community and stakeholder support/involvement

[26] Blasinsky, M., Goldman. H., Unutzer, J. (2006). *Project IMPACT: a report on barriers and facilitators to sustainability. Administration and Policy in Mental Health and Mental Health Services Research*, 33(6):718-729.

[27] Wiltsey Stirman, S., Kimberly, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). *The sustainability of new programs and innovations: a review of the empirical literature and recommendations for future research*. Implementation science, 7, 1-19.

[28] Wiltsey Stirman et al. (2012).

Sustainability factor	Elements
Processes and interactions	• Engagement, relationship building, collaboration • Shared decision making among stakeholders • Adaptation/alignment, integration of rules/policies • Training and education • Collaboration/partnership • Navigating competing demands • Planning and ongoing support • Evaluation and feedback

6.1.1 Innovation characteristics

There is some evidence that the purpose and design of the Connectors and Connector Points programs were **consistent with the missions and values** of the organisations commissioned to deliver these programs. For example, one organisation which hosts a Wellbeing Connector noted they had run similar programs in the past, so the program was *'a good fit'*.

Representatives of commissioned organisations nominated a range of **benefits for them and their clients**, especially the ability to access additional supports for those who needed more than their organisations could offer.

Health Connector commissioning organisations saw the Health Connector program as beneficial in enabling them to address patients' needs better, outside of medical support. A representative from a Wellbeing Connector commissioning organisation said that through the program's focus on connecting people to activities and social supports, the program is *'creating connection and capacity of individuals' connection to the community and strengthening that community fibre'*. Another benefit identified by Wellbeing Connector commissioned organisations was that having the Wellbeing Connector program within their organisation enabled two-way referrals to happen, further enhancing the breadth of support they could offer clients.

One activity organisation, which is mandated only to provide short-term support to clients, said the capacity of the Wellbeing Connector program to provide clients with access to long-term supports meant they could better support their clients.

In addition, the possibility of cross-referrals among the three programs was viewed as a strength in catering to different levels of need.

'It's another key support for people.' – Connector Point

'Being able to help more people who need a bit of a push [to join an activity].' – Connector Point

Other benefits mentioned by organisations included:

- Through the My Health Connector Directory website, organisations could find out about other organisations in the community and connect with them.
- One activity organisation, which was setting up a program to build social connection, was finding it difficult to communicate its message to potential participants. For this organisation, the Wellbeing Connector was valuable in helping to link older adults with the new program.

Perceived **benefits to the community** in general were also noted. Commonly, organisations said the Connectors and Connector Points provided much-needed interaction for people who were socially isolated. One organisation noted that the Connector program is particularly needed in their remote region, with people living far apart and minimal activities available.

'There are a lot of people coming to us looking for social support.' – Connector Point

'What [Wellbeing Connector] is trying to do is valuable and needed.'
– Activity provider organisation

One of the Connector Points noted that when people connect with them, they can become aware of other services and activities available at the commissioned organisation that may address other needs they have.

Although questions around delivering the programs with **fidelity** were not addressed during the interviews, there is no reason to think this would be a problem in future, as the programs follow a straightforward protocol with standardised intake and follow-up assessments. They do not require Connectors to undertake complicated or time-consuming training. The basic approach may require **modification** (and additional resources, such as access to interpreters or cultural safety training for the Connectors) to suit different cultural groups; this could be explored in future development of the programs and tested in future evaluations.

6.1.2 Internal and external context

The Health Connectors and Wellbeing Connectors appear to be working within favourable internal, organisational contexts, with supportive cultures and leadership. This relates to the fact that the leaders of commissioned organisations viewed involvement in the Connector programs as an opportunity to further support their clients or patients with needs that would not otherwise be met with available resources. For some commissioned organisations, the Connector programs complemented other services they offered to the senior community.

'Most of our patients are aged, retired … we feel a responsibility to look after our patients' health. We see the program as providing additional support for our practice to support patients. For example, people who are single and have no supports; a lot of the

aged population who can't drive. We're always looking to improve our service and our quality of service.' – Health Connector commissioned organisation

'[I joined the program because] I saw this need with the patients … this repeated theme of loneliness and social isolation. It was not just people living alone – it was broken relationships with kids, or the kids live far away and are not checking in.' – Health Connector

'We applied for funding because the program aligns with our values – empowering people to live their best life, targeting people who are vulnerable. We see Wellbeing Connectors as another potential way to reach people and make an impact.' – Wellbeing Connector commissioned organisation

The two Connector Points we interviewed saw the program as an opportunity to provide information on activities to the community.

'We thought it (the website) was a good idea; and a good opportunity for us to see people in the community and give them information.' – Connector Point

'[We joined the program] to promote the My Health Connector website.' – Connector Point

It is more difficult to comment on the external context, as this was not a focus of the evaluation. Nevertheless, there is growing recognition and awareness of the importance of social connection in maintaining health and wellbeing throughout the lifespan. The evidence base for social prescribing, which is seen as a promising way to address non-medical needs, is also growing rapidly. Given the fact that the ageing population is a major concern for funders and policy makers in Australia, it is likely that the external funding context for social prescribing will be favourable for the foreseeable future.

6.1.3 Capacity to sustain

Workforce availability and funding are the main constraints on the capacity to sustain these programs. Regarding workforce, it appears to be critical to **recruit Connectors** with the right personal characteristics and local knowledge, as discussed above (Section 4.1.1). Regarding funding, this also appears to be essential for sustainability. Without the **dedicated funding** – and the associated accountability requirements – it seems likely that the Health Connectors' time will quickly be absorbed by other tasks in the busy environment of the practice nurse. One Health Connector commissioned organisation said that the funding attached was key for them to be able to take on the program. A Health Connector in another practice emphasised that the payment for the program was essential in creating time for them to explore patients' social needs along with their health needs. Another Health Connector commissioned organisation representative said there was no problem with the program itself, *'just time and availability [of the nurse acting as Health Connector]*. These comments indicate that expecting

general practices to continue to deliver the Health Connector program without dedicated funding – and ongoing monitoring – may be unrealistic.

6.1.4 Processes and interactions

Key processes to consider for sustainability of the Connectors and Connector Points programs are the My Health Connector Directory (see box) and the issue of transport, which is a major limiting factor on participation of older adults in social activities. The Wellbeing Connector's role includes facilitating access to transport, but this is difficult to achieve when there are few options available that older adults can afford and/or access easily. One of the Wellbeing Connector commissioned organisations suggested that, while out of scope for this program, brokerage funding was needed so that the program itself could arrange and, if necessary, pay for participants' transport to and from activities.

Feedback on the My Health Connector Directory

As indicated above, the directory is a key resource for the Connector and Connector Points programs. Interviewees appreciated the ability to search for activities according to location and timing, and said it was easy to find and navigate through the website. However, there were also comments that indicated that the directory was not always a reliable source of information. Suggestions for improving the functionality of the website were offered.

- It could be more comprehensive – currently it does not list all activities available, and Connectors and Connector Points would like to see more information about the organisations and activities that are listed.
- It could be more up to date – some Connectors said that many of the listings were not current.
- Alternatively, the search function could be improved.

The key interactions that will influence sustainability are those that occur among the three programs, which each play a unique role in identifying, recruiting and providing a service to older adults. Qualitative feedback suggests that the three programs are interacting well, with the Connector Points as a source of information and an entry point to the Connectors, the Health Connectors identifying patients with non-medical support needs, and Wellbeing Connectors available to cater to clients who required higher levels of support. The quantitative data show that the Health Connectors are picking up a larger proportion of those in older age groups, who may not independently approach a Wellbeing Connector.

6.2 Capacity building in the community

Although it is too early to see evidence of capacity building, it appears that the programs – particularly the Wellbeing Connectors – have the potential to foster a supportive environment for older adults within local communities. One way they could do this is by raising awareness of the needs of this population and the supports available to them. The

early promotional work by Wellbeing Connectors provides some insight into how this capacity building role could unfold, given sufficient time and resources.

One interviewee praised the way a Wellbeing Connector tried to ensure as many organisations as possible knew about the program and how to refer people to it. Another talked about the importance of the role in acting as an information exchange within the community, providing organisations with an opportunity to publicise their programs and activities to an audience that is likely to be receptive.

> *'[Name] is really good at exchanging information between groups and getting information out there. She lets everyone know what is out there.' – Activity provider organisation*
>
> *'Part of the role is finding the social connections.'*
> *– Wellbeing Connector commissioned organisation*

As discussed above, the role is consistent with the purpose and mission of commissioned organisations and extends their existing offerings. A representative of one of the commissioned organisations said the Connector program aligned with their values, *'empowering people to live their best life; targeting people who are vulnerable.'*

A representative of one of the commissioned organisations explained that the Wellbeing Connectors' roles filled a gap that existed in community services for older adults. This interviewee believed that the Connectors' sometimes provided additional support than they are expected because it directly assisted people to access the social activities and connections they needed.

In turn, situating the Wellbeing Connectors within these organisations meant they had access to resources and contacts that helped them deliver their role better. For example, some activities are only available to people who have My Aged Care funding, and the Wellbeing Connectors were able to check relatively easily with staff in the (co-located) Care Finders program to see whether participants had the necessary funding. One of the commissioned organisations also offers relevant social, cultural and music activities for seniors, making it easier for the Wellbeing Connector to make referrals to these kinds of activities. In these ways, the role of the Wellbeing Connector has the potential to strengthen links between community organisations and the community-dwelling older adults they serve.

7. Discussion

In this final chapter, we summarise findings against the KEQs (Table 14). Based on the evidence presented in this report, we then make some recommendations about how NBMPHN might foster good practice and continuing improvement in its Connector and Connector Point programs and strengthen the evidence base through future evaluations.

7.1 Key evaluation questions

Evaluation results presented in chapters 3-7 are summarised below against each of the key evaluation questions (KEQs).

Table 14. Findings against key evaluation questions

	KEQ	Findings
1	How effective were referral pathways into and out of the programs?	
	• How well did the programs work together to identify and recruit the target population?	• Older adults were referred or recruited via general practices, Connector Points, other community organisations, and marketing carried out by Wellbeing Connectors and the PHN. • Each program played a unique role, and their interactions strengthened the programs overall. • The emergence of referral pathways from Health Connectors to Wellbeing Connectors was a positive development which alleviated time pressures for the former and created a reliable recruitment stream for the latter. • Health Connectors were more likely than Wellbeing Connectors or Connector Points to recruit males and those in the oldest age groups.
	• Was the program able to attract appropriate referrals from a variety of sources?	• In the first 9-month period (Aug 24-Apr 25) the 3 Wellbeing Connectors (2FTE) recruited 86 older adults and submitted 56 intake forms. • A further 56 intake forms originated from Health Connectors over 12 months (Apr 24-Mar 25).

	KEQ	Findings
		• Connector Points hosted a total of 180 conversations with older adults over 9 months (Jul 24-Feb 25); some clients made multiple visits to use the online directory.
	• How effective were the programs in connecting older adults with appropriate activities?	• A total of 96 older adults received social prescriptions connecting them with activities in their communities. • Older adults were linked with a wide variety of activities including exercise groups, social groups and community lunches, crafts, music, singing, intergenerational programs and digital literacy. • The main barriers to uptake of the social prescriptions were lack of transport and physical limitations (e.g., health concerns and disability). Caring responsibilities and low confidence also limited some older adults' participation.
2	Were the programs implemented as intended?	
	• To what extent were outputs achieved?	• The Connector programs succeeded in supporting almost 100 older adults to experience a sense of social connection through tailored social prescriptions. • As a group, Connector Points served as useful sources of information and referral, either to activities directly or to Wellbeing Connectors (when people required extra support). • Older adults who took part said they were seeking greater social connection to improve wellbeing. Some were bereaved, had lost contact with friends or family, were new to the area, or had caring responsibilities. All had experienced loneliness and felt a need for more social contact and for new, enjoyable experiences.
	• What factors facilitated implementation?	• One of the key enablers for implementation was the availability of Wellbeing Connectors to support participants to attend the first few sessions. The emotional and practical support provided was highly valued by participants. • Another key enabler was the promotional work carried out by Wellbeing Connectors and the PHN which attracted many referrals and self-referred participants.

	KEQ	Findings
		• Through mechanisms such as a 'social calendar', the program has started to establish itself as a continuously updating information exchange between community organisations and their potential clients.
	• What were the barriers to implementation?	• Naturally extroverted individuals and those with good physical and mental health and/or younger age were more likely to engage. Others who could benefit from the programs are harder to reach – targeted efforts may be needed to broaden the range of participants. • For the Health Connectors, recruitment has dropped considerably in recent months, possibly due to time constraints and the pressure of other tasks. It is difficult for practice nurses to set aside dedicated time for the Health Connector role.
3	Were the programs appropriate for the target population?	
	• How did the programs respond to the needs of community-dwelling older adults in general, and to the needs of marginalised groups in particular?	• From the perspective of participants, processes for intake, assessment of health status and needs, and matching with activities are working smoothly. • Health Connectors were adept at picking up on cues that suggested a person might be suitable for the program, particularly during the 75+ Assessments. • Open questions were used to elicit information about people's interests to match them with suitable activities. If people struggled to think of things, the Connectors tended to suggest *'non-threatening'*, general activities to get them started in the program. • Regular informal follow-up by the Connectors (e.g., a brief phone call or chat with the nurse while attending the practice) helped to promote engagement with activities. • There is no evidence to suggest that Connectors programs were especially attractive to marginalised groups and these groups were not specifically targeted in recruitment. If this is an aim for the program in future, appropriate recruitment strategies could be co-designed with community representatives.

	KEQ	Findings
	• To what extent did the programs capitalise on lessons learned from previous programs?	• Efforts to incorporate lessons from the evaluation of ISCOA were partially effective. Health Connectors were provided with training and ongoing support by the PHN, with funding for some dedicated time each week. Wellbeing Connectors appeared to have adequate time and resources available for the role. • As recommended by the ISCOA report, conversations with older adults were tailored and carefully handled to avoid patronising or stigmatising language. • Diverse referral pathways exist, both into the Connectors programs and out to activity providers. • It appears that efforts to integrate the Health Connector role into the workflow of general practices have not been entirely successful. Streamlining and standardising program processes, along with ongoing resources and support, may be needed to ensure the program remains viable and sustainable. • The My Health Connector Directory, created for the ISCOA program, is valuable but requires updating and improvements to the search function. • The extra level of support available from Wellbeing Connectors makes an important contribution to engagement in activities. This is especially useful for participants who are anxious or lacking in confidence.
4	To what extent did the programs achieve the expected outcomes for older adults?	
	• How did participants experience the programs?	• Older adults reported positive experiences of the programs, including increased opportunities to socialise, feeling more included in their communities, and improvements in physical and mental health. • All the older adults interviewed for this evaluation said they would recommend the program to others. • Participants particularly appreciated the support they received, which built their confidence, capacity and motivation to expand their social worlds.

	KEQ	Findings
	• What changes were observed in quality of life, social isolation and loneliness?	• Program data showed that quality of life, measured by the WHO-5 tool, increased from the intake to the follow-up assessment on average. • A limited number of participants (n=23) had both intake and follow-up scores. For these participants, paired comparisons showed that the vast majority reported an improvement in quality of life. • Few participants answered the questions on loneliness and social connection. No changes in these outcomes were seen, due to the limited data available. • Other stakeholders – particularly Connectors and activity providers – reported benefits for older adults who attended activities, such as improved confidence, communication skills, and mental health.
	• Were there any unintended consequences, either positive or negative?	• Very few unintended consequences were identified, and most were positive. For example, participants sharing transport to activities got to know each other. • One Health Connector reported that building relationships with older adults allowed them to identify other issues that were affecting their lives. • There were two separate incidences of inappropriate behaviour which led to a review of referrals and highlighted the difficulty of defining what 'social connection' might mean to different individuals.
5	What aspects of the programs are likely to continue beyond the end of the funding cycle?	
	• To what extent are factors likely to promote sustainability present in the commissioned organisations?	• Some of the factors associated (in the academic literature) with sustainable innovations are present in the Connectors and Connector Points programs. • The purpose and design are consistent with the missions and values of commissioned organisations around helping vulnerable people and strengthening the community. • The benefits for those organisations were acknowledged by the representatives we interviewed. The programs provide opportunities for community-based organisations and general practices to access

	KEQ	Findings
		additional supports for older adults who need more than their organisations can routinely offer. • Health Connectors and Wellbeing Connectors are working within favourable contexts, with supportive cultures and leadership. • The main constraints on capacity to sustain the programs are workforce availability and funding. Without dedicated funding and accountability, Health Connectors' time will quickly be absorbed by other tasks in busy general practice environments. • Prospects for sustainability could be enhanced by NBMPHN continuing to work with community transport providers, and by continuously updating and improving the online directory.
	• To what extent did the programs succeed in building the capacity of local community assets to support community-dwelling older adults?	• It is too early to see evidence of capacity building in the community, but there are indications that the Wellbeing Connectors have the potential to foster supportive environments for older adults through awareness raising, information exchange and filling gaps in existing services.

7.2 Recommendations

In this section we make recommendations about improving and sustaining the Connector and Connector Point programs, based on existing good practice that we have observed and documented during the evaluation, and on stakeholder suggestions and feedback.

1. Although it is not a complicated intervention, effective delivery of the Connectors programs relies to some extent on fidelity to the basic model. Embedding the programs into the commissioned organisations, including general practices, will require **efficient processes** for referrals, intake processes, regular check-ins, and follow-up assessment. NBMPHN could consider reviewing the existing processes to see whether they can be made more standardised, streamlined and better incorporated into routine practice.
2. The full potential of the Health Connector role is not currently being realised. Encouraging more cross-referrals to the Wellbeing Connector may be a way to address capacity issues for Health Connectors. Additional funding may be required to enable Health Connectors to book appointments specifically for the intake assessment. It may be

worthwhile to investigate other issues that are limiting their ability to recruit participants. There are many competing priorities within general practice, and it is likely that regular **input** by NBMPHN – of resources, guidance, and encouragement - will be required to sustain the program.

3. The role of the Wellbeing Connector in forging links between community organisations and the older adults they aim to serve has the potential to add considerable value to the program. To realise this potential there is a need to ensure they continue to have protected time set aside for **communications and community outreach** in addition to their direct work with clients.
4. The **My Health Connector Directory**, created for the ISCOA program, is a crucial resource. The Connector Points and Health Connectors are completely reliant on the directory as they do not have the opportunity to conduct community outreach and information exchange in the same way as the Wellbeing Connectors. Interviewees highlighted a need to update and improve this resource.
5. Lack of transport is a major barrier to uptake of the prescribed activities. Brokerage funding is outside the scope of this program but the NBMPHN could continue working with **community transport providers**, particularly in areas where there is limited access to public transport, or for those who are not eligible for free community transport.
6. Due to the nature of the work, there is a risk of Connectors getting over-involved and stressed. Maintaining **workforce capacity** will mean ensuring that Connectors are well supported within their organisations with regular supervision and opportunities to de-brief. Training in trauma-informed practice could be beneficial so that they can recognise and deal with unwanted client behaviours effectively. Although their time is limited, and it will be challenging, it is important to offer opportunities to get together occasionally to share experiences and ideas, and to update or reinforce their training, which is currently provided in regular Community of Practice Meetings.
7. The Wellbeing Connectors must continue to be supported to **exit their clients** at the expected timeframe (26-week engagement period) They have to negotiate a delicate balance between providing support and encouraging dependency. The program data shows a high workload associated with follow-up calls and Wellbeing Connectors themselves have acknowledged that they will have insufficient capacity to continue to support individuals indefinitely.
8. Evaluation evidence needs to be provided to general practitioners and commissioned organisations so that they can continue to see the value of the Health Connector and Wellbeing Connector roles. NBMPHN could consider providing **regular feedback** (based on program data) to commissioned organisations to keep them informed.

7.3 Conclusions

The prevalence of social isolation and loneliness among older adults was clear from all data sources. The Connectors and Connector Point programs have clearly communicated the impact of social isolation and loneliness and the importance of addressing non-medical needs to maintain and improve health. They have succeeded in raising awareness within the community and in addressing the needs of a substantial group of participants in the NBMPHN region. Positive interactions among the programs – and information exchange between the Wellbeing Connectors and community organisations that serve the target audience - demonstrate the potential for increasing their collective effectiveness and impact.

An effective Connector has charisma and warmth and brings curiosity and genuine interest to their interactions with older adults. It is vital for Connectors to understand and accommodate the needs of older adults. They are accomplishing this very well, for example, by being flexible around participants' medical appointments and health challenges, and by providing paper copies of activity recommendations and information to those who are not comfortable with email or online resources. While they are grateful for the investment of time and effort in helping them, older adults have a reasonable expectation that they will be treated with dignity and respect. They want to have full control over the extent to which they engage in activities that are recommended. Connectors are consistently achieving the right balance of providing support without being patronising or *'bossy'*.

The Connectors model works best for people with a strong need for social connection, high self-efficacy and trust in social institutions such as health and community services. Ideally, participants will also be independently mobile with access to transport (either driving themselves or subsidised community transport services). The model does not work so well for people who are chronically isolated, have limited mobility or poor hearing, or are struggling with mental illness. Offering the opportunity for a chat with a Connector might not be sufficient to activate behaviour change for certain groups – which may include those who need it most. This evaluation report offers evidence and recommendations to support the further development and improvement of this promising social prescribing innovation.

Appendices

Appendix 1. Detailed methods

A1.1 Document review

We conducted a brief desktop review of key documents relating to the evaluation of the Wellbeing and Health Connector program. The documents included:

- Program documentation such as requests for quote, contracts or memoranda of understanding with participating organisations, and materials used for reference in planning and designing the programs;
- Reports from the evaluation conducted by the Centre for Health Service Development (CHSD), University of Wollongong, of the previous Health Connector program at NBMPHN (and Perth South PHN);
- Selected key reference material including evaluation reports and journal articles, website content from ASPIRE (and other peak organisations), to understand the conceptual framework, theory and evidence base for the programs.

These documents informed the development of the evaluation plan, data collection methods and materials, analysis approach and interpretation of findings.

A1.2 Initial data review

Data collected by the organisations delivering the programs is sent to NBMPHN. We completed an initial review of the program data to ensure completeness and to explore the possibility of collecting any additional items necessary. This initial review assisted us to understand what key evaluation questions we could answer with the data.

A1.3 Interviews with Connectors and commissioned organisations

Between February and May 2025, we collected evaluation data via interviews with Connectors and their commissioned organisations delivering activities. We interviewed 3 Wellbeing Connectors, 5 Health Connectors and 4 representatives from their commissioned organisations. We sought assistance from NBMPHN with recruitment; by sending an email to introduce the evaluation team, explain our purpose and what we were asking Connectors and services to do, and encourage them to take part.

Interviews were conducted online by Kerry Hart, Kate Williams, and Sally Evans using Microsoft Teams or phone to record and automatically transcribe the discussions, with the participants' consent. Targeted questions addressed:

- the recruitment or selection, training, skills, experience and professional background of the Connectors
- experiences of delivering the program, including referral pathways and supporting the older people participating in the program

- perceived barriers and enablers to the program and any ideas for improving the programs.

A1.4 Interviews with service providers

Previous evaluations have highlighted the importance of contextual factors, particularly the availability and effectiveness of suitable non-medical services and supports, in determining the successful delivery of social prescribing models.[29] This led us to suggest collecting qualitative data from local providers of relevant services and supports.

Between April and May 2025, we interviewed 5 organisations that participants attended and 1 pharmacy contact. We also interviewed 2 Connector Points. These interviews were conducted by Kerry Hart and Kate Williams using Microsoft Teams or phone to record and automatically transcribe the discussions, with the participants' consent. Targeted questions addressed:

- background on the services and supports they offer
- the ease of referrals from the Connectors, and their perspectives on the appropriateness and uptake of these referrals
- changes that have occurred as a result of the programs and any ideas for improvement.

A1.5 Interviews with older participants

In the evaluation of the pilot ISCOA program in NBMPHN found no significant changes in health-related quality of life, self-rated health or loneliness for older participants. Experiences, however, were very positive, with a large proportion of interviewed participants reporting reduced loneliness and improved wellbeing, most being more willing to join groups or activities, and high levels of satisfaction.[30] These findings led us to suggest that collecting qualitative data directly from participants would be essential to obtain a full picture of any effects the program may have had on desired outcomes.

We interviewed 12 older participants in April 2025. We recruited participants with the support of the Connectors, to protect the privacy of contact details. Kerry Hart, Kate Williams and Sally Evans completed these interviews over the phone.

To reduce the risk of creating any distress for participants we took care to avoid personal issues and instead focussed the conversation on the following topics:

- expectations and initial impressions of the programs
- experiences of the programs over time
- self-reported outcomes of the programs
- overall views, including whether they would recommend the programs to others.

[29] Oster et al., 2023a
[30] Thompson et al., (2022)

A1.6 Program data

Health and Wellbeing Connectors collected and sent data to NBMPHN. Data included intake forms, follow-up forms and monthly reporting.

- Number of clients/patients using the programs
- Reach of the programs to the target groups in terms of age, sex and geographic spread
- Needs of clients assessed qualitatively through the interaction with Connectors
- Participation in community activities at the time of assessment and at follow-up
- Services and supports to which clients/patients are referred, and (potentially, depending on the content of Form A) the reasons for these recommendations
- Rates of return for follow-up assessments
- Rates of uptake of services and supports
- Quality of life at the point of assessment (WHO-5 scores)
- Loneliness and social isolation at the point of assessment
- Change in quality of life, loneliness and social isolation at 12-week follow-up (both Connectors) and 26-week follow-up (Wellbeing Connectors only).

In addition, aggregated data were made available on the users of the Connector Points. This included the number of conversations completed with older people. It also included (from January 2025) the location of these conversations, the gender of the older person and the type of activity/support/service recommended.

Data analysis

Program data were provided to us in Excel or PDF from NBMPHN. These data were cleaned and combined into Excel files before being analysed in RStudio. Interview data were coded in NVivo. Team members worked together to create and refine a coding framework based around the KEQs (deductive coding) while incorporating emerging ideas (inductive coding). The data were then analysed using iterative categorisation, a type of thematic analysis which retains connections with the original data so that it is auditable.[31]

[31] Neale, J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction, 111,* 1096-1106.

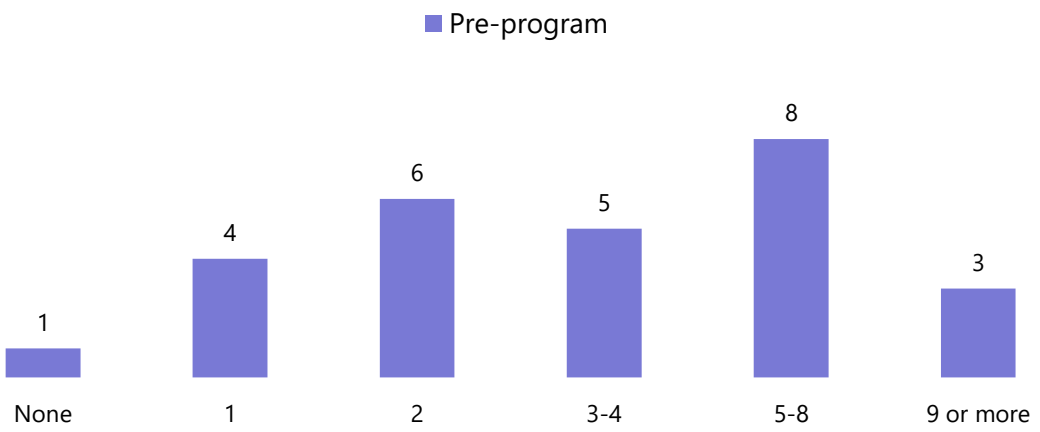
Appendix 2. Additional data

Table A 1. WHO-5 scores before and after participation

Group	Client	Pre-program	Post-program	Difference in score
Wellbeing Connector	Client A	72	44	-28
	Client B	48	48	0
	Client C	56	68	+12
	Client D	48	52	+4
	Client E	52	64	+12
	Client F	52	64	+12
	Client G	56	80	+24
	Client H	20	48	+28
	Client I	8	0	-8
	Client J	64	60	-4
	Client K	12	12	0
	Client L	100	96	-4
	Client M	40	56	+16
	Client N	8	20	+12
Health Connector	Client A	60	80	+20
	Client B	36	52	+16
	Client C	60	56	-4
	Client D	68	76	+8
	Client E	48	60	+12
	Client F	20	72	+52
	Client G	60	64	+4
	Client H	100	0	-100
	Client I	76	88	12

Source: Wellbeing Connector intake and follow-up forms and Health Connector intake and follow-up forms

Figure A 1. Number of friends and family seen or heard from in last month



Source: Wellbeing Connector intake and follow-up forms

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