An Evaluation of the Wirral Health-Related Worklessness Programme

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Acknowledgements

The research team would like to thank the following for their support with the delivery, implementation and interpretation of the evaluation:

- Julie Webster, Nikki Jones and Rachael Musgrave from Wirral Council
- Micha Woodworth and the team of Community Connectors from Involve Northwest
- Mel Bowen, Caroline Williams and The Spider Project
- Alexandra Williams, MSc Public Health student, for support in developing the case studies
- Laura Heeks, Graphic Designer, PHI

Finally, a very special thank you to those people who took the time to share their views, journeys and experiences with us:

- Wirral residents who carried out the Participatory Action Research for the evaluation
- The community organisations, services and activities who took part in the research, including Involve, all of the Community Connectors and all representatives from The Spider Project.
- All of the people who shared their experiences and journeys with us.

Executive Summary

The relationship between health and productivity is a key public health priority in the UK, with evidence showing the positive benefits of employment on individual, communities and the wider society. Unemployment due to health is a priority issue in Wirral. In January 2019, more people claimed out-of-work benefits, Employment Support Allowance and Incapacity Benefit in Wirral compared to the national average. In 2016, 1 in 10 working age residents in Wirral were out of work due to health conditions compared to a national rate of 1 in 17 and 1 in every 7 working age residents in Birkenhead (41% of Wirral total) were out of work due to sickness.

Wirral Council have a number of employment strategies to support people into work. However, local insight found that many people were long-term unemployed and experiencing high levels of isolation, loneliness and hopelessness. Many residents were living in a grey area, being too ill to work but not ill enough to access treatment. An intervention was developed to support those people not in employment and hardest to reach. The intervention used an asset-based approach to deliver upstream solutions to support people to address the challenges that characterised their lives. This approach supported Wirral's strategic direction by ensuring labour market equality and ultimately developing an inclusive local economy.

The Wirral Health-Related Worklessness Programme

In 2017, Wirral Council implemented a Health-Related Worklessness programme, jointly commissioned by the Public Health and Investment teams. In order to take a more upstream approach to tackle socioeconomic inequities, the programme used an asset based community development approach and had three main workstreams:

1. **Driving Change** (leadership and training and key professionals)
2. **Community Connectors** (1-1 support for individuals to encourage access to existing services, groups and networks)
3. **Non-Medical Therapeutic Recovery Service** (interventions to people with low level mental health conditions).

Models of Delivery

Community Connectors (delivered by Involve North West)

Provided door knocking or received referrals from another organisation (housing services, schools, children's centres, GP surgeries, benefits teams, employment services, substance use services, police). Provided signposting and referrals on to community support and organisations, and worked with people to provide tailored one-to-one support for individuals.

Non-Medical Therapeutic Recovery Service (delivered by Move On Up, The Spider Project)

Provided arts-based mental health support. Used personal mentors to tailor support to the needs of the individual. Received self-referrals or referrals from Community Connectors, housing, mental health services, substance use services and employment services.

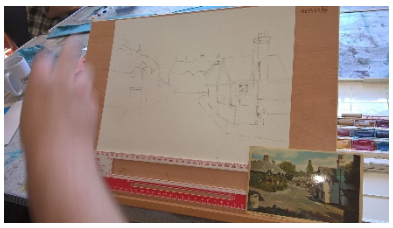
Evaluation

Quantitative and qualitative methods were used in triangulation to explore if and how the Health-Related Worklessness Programme was successful and make recommendations for future delivery:

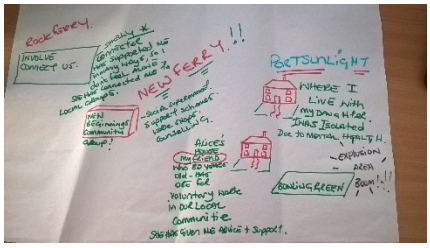
Area Insights and Observations

Researchers shadowed Community Connectors (CCs) from the start of the evaluation; this involved observing CCs in each of the Wirral wards, building relationships and developing understandings of the role of the CC and the local communities.

Qualitative Research



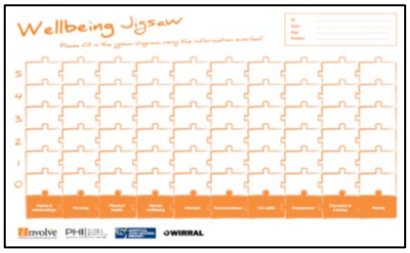
Participatory Action Research (PAR) gathered qualitative evidence for the evaluation. This involved partnering with community members as co-researchers, allowing the evaluation to tap into existing informal, hidden social networks which may have been otherwise difficult to engage.



Social Network Maps

Social Network Maps explored community structures, organisations and social groups amongst people who had engaged with the Health-Related Worklessness Programme. Twelve maps were developed which mapped the physical and geographic features that people felt were important to their health and wellbeing.

Development of a Wellbeing Jigsaw



An outcomes tool was developed with the CCs to capture individual changes and measure a range of outcomes. The Wellbeing Jigsaw was designed to be used as part of a routine monitoring tool for use with, or on behalf of individuals accessing the CCs. The jigsaw allows individuals to set their own goals, which could then be quantified to evidence any outcomes and changes experienced.

Analysis of Secondary Data

Data collected by the CCs and Move On Up was routinely collected and provided to Wirral Local Authority on a monthly basis[A]. Datasets included information about the number of individuals referred and engaging with the programme, including demographics. Wellbeing outcomes were captured using the validated Short Warwick-Edinburgh Mental-Wellbeing Scale (SWEMWBS).

Engagement with the Programme

This evaluation showed that prior to engaging with the Health-Related Worklessness Programme, many people in Wirral were socially isolated, mentally unwell and desperate, and

[A] Please note that the where possible data analysis and calculations are based on the data available (excluding missing data) and therefore may not total 100%. Please see appendix for methodological notes on missing data.

in a perpetual cycle of being too ill to work but not ill enough to access services and support. Many people who engaged with the programme described the circumstances which had led to them becoming extremely vulnerable and isolated. In many cases, these people had not shared their life stories with anyone prior to engaging with the CCs. Some stakeholders recognised the challenges faced by people living in these circumstances.

Was sexually abused as a child and felt mentally abused by his family, but nobody was prepared to give him any help unless he gave up cannabis.

"You try and deal with being alone all week; not even a milkman to talk to or nothing like that…smoking cannabis takes the frustration away and makes life a bit more bearable". (Leasowe, SU21-M)

There are people with very complex issues and barriers that need support (Department for Work and Pensions)

There's a huge mistrust to the administration of the welfare system and that's a barrier to doing anything positive within communities. The media portrays a lot of these people from the community in a negative light and that is having an impact. (Social Landlord)

Started to get bullied at work. Thought she had dementia, was being sick, had bowel problems. Felt she didn't want to be here anymore. Had medication from doctor for depression said this wasn't enough. Had to live on £74 a week benefits, wasn't enough and as a result she got into debt and had to borrow money from her mum. (Eastham, SU12-F1)

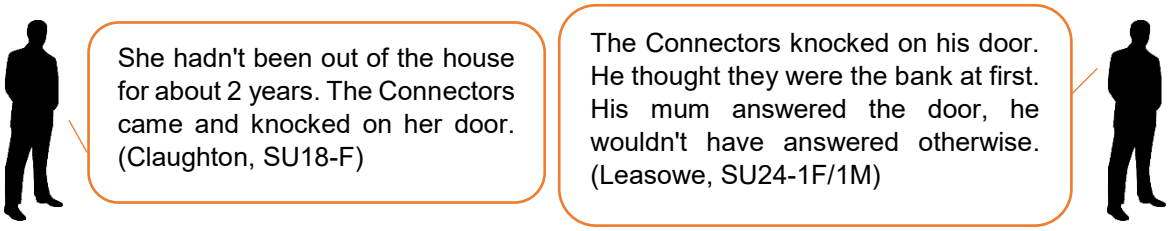
Evidence from routinely collected data show the characteristics of those people who engaged with the Health-Related Worklessness Programme between March 2017 and December 2018.

Community Connectors

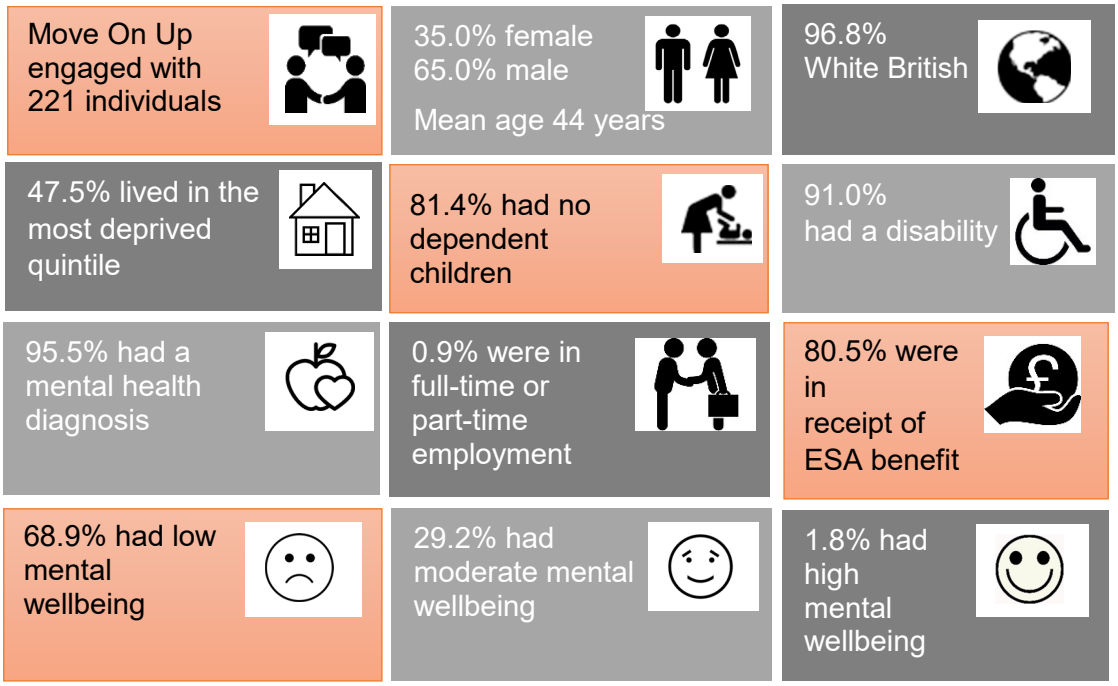
CCs engaged with 2,177 individuals	55.4% female 44.4% male Mean age 44 years	95.9% White British
59.9% lived in the most deprived quintile	64.8% had no dependent children	84.3% had a disability
65.2% were unemployed or long-term sick	6.8% were in full-time or part-time employment	85.9% were in receipt of benefits
75.4% had low mental wellbeing	22.2% had moderate mental wellbeing	2.4% had high mental wellbeing

Of the 2,177 individuals referred to the CCs, 71.4% (n=1,555) self-referred. Door knocking was one of the most effective methods that the CCs used to engage with the community, particularly with those people who were very isolated, vulnerable and wary of statutory organisations. Many were not aware of the CCs prior to the door knocking, suggesting they would be unlikely to access this service without this method of engagement. Other CC referral sources included housing services, schools, children's centres, GP surgeries, benefits teams, Department for Work and Pensions (DWP), employment services and substance use services. Referral type did not vary by month or significantly by ward.

The majority of individuals resided in either the Birkenhead (51.1%, n=1,104) or Wallasey (25.8%, n=558) constituencies. Individuals resided in 22 wards in Wirral, with higher proportions living in Birkenhead and Tranmere (15.6%, n=336), Bidston and St James (12.8%, n=277) and Upton (10.5%, n=226).



Non-Therapeutic Recovery Service (Move On Up)



Of the 221 individuals referred to Move On Up, 165 were new Spider Project members. Two-fifths (n=92, 41.6%) of the individuals self-referred to the Move On Up project. Other referrals included housing, mental health services, substance use services and employment services.

Most individuals who attended Move On Up resided in Birkenhead (45.7%, n=101) and Wallasey (33.0%, n=73) constituencies; this was made up of 22 different wards with higher proportions living in Birkenhead and Tranmere (14.0%, n=31), Liscard (10.9%, n=24) and New Brighton (9.0%, n=20).

He found out about this through his parole officer. The CAB also referred him. He would have come earlier if he had known about it. (SU64-M)

Has been coming to Spider for about 10 months. He was a bit apprehensive about coming, because he hadn't been out of the house properly for about 2 years. He had a high powered job and feels that the stress caused him to have a breakdown. He was sectioned and spent time in hospital. (SU66-M)

Programme Impact

People experienced a wide range of outcomes as a result of engaging with the CCs and Move On Up. Stakeholders all described their experiences of working in partnership with CCs to bring about positive community action and support. Here, views were positive, with stakeholders acknowledging that the CCs provided a service that was needed within the local community. Many spoke of the importance of local partnerships and networks between people and organisations.

I've learnt new skills, help with getting into a counselling role. Met new people and made new friends, a reason to stay abstinent. Better understanding of my mental health. S-NA

I wouldn't leave the house if I didn't come here- I come at least three days a week. S-NA.

The Connectors are more likely to get over the doorstep than the police, and other statutory services, so they are able to go in and identify vulnerability very quickly. (Safer Wirral Hub)

Building Community Capacity and Social Capital

The PAR activities and other qualitative data provided evidence of how the Health-Related Worklessness Programme supports people to make positive steps towards sustainable employment. In particular, findings demonstrated how CCs helped to build communities, improve capacity within communities, and have a positive impact on the local environment.

The community has changed; trust has been built up, whereas before everyone was seen as a 'grass'. (Birkenhead, SU28-F)

Supporting Mental Health and Wellbeing

Spent most of last year at home. Suffers from anxiety and depression. "I find it easy to get into isolation, gets me out of the house and doing something". (Leasowe, SU15-F)

Evidence from the PAR, the interviews and the secondary data all showed the positive impact that the Health-Related Worklessness Programme had on people's mental health and wellbeing. Everyone we spoke to described the positive impact that the programme had on their lives and described that? this had an impact on isolation, stress, depression, anxiety; changes which had occurred as a result of them tackling issues including housing and debt.

Supporting and Developing Community Assets

Our analysis demonstrates that the programme successfully embedded an ABCD approach within its delivery model. The intervention utilised, developed and sustained a wide range of personal, physical and community assets.

Quantifying Change

The Wellbeing Jigsaw provided further evidence and clarity regarding the specific outcomes achieved as a result of engaging with the CCs. Mental health needs and isolation were the most identified needs amongst individuals completing the Jigsaw. Figure 1 shows an increase in mean scores across all ten outcome measures over a series of jigsaw assessments with individuals identifying a need, setting a goal and taking positive action towards achieving and maintaining their target.

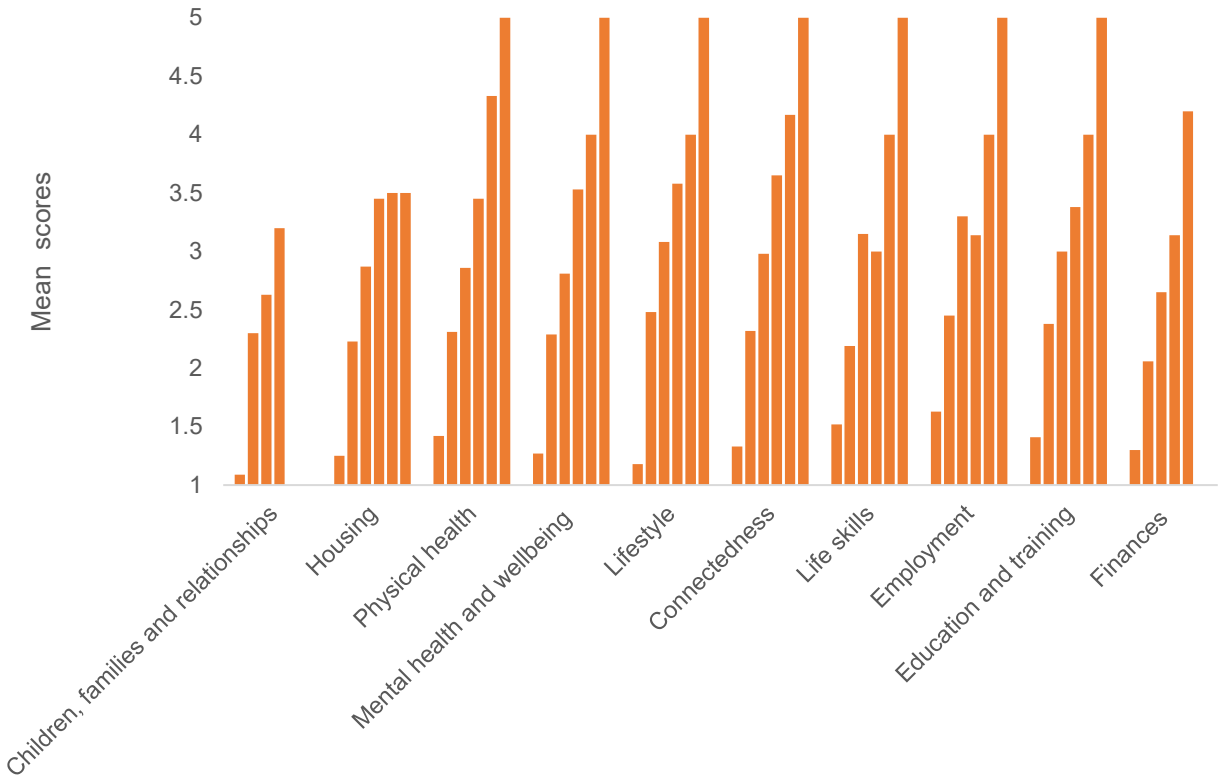


Figure 1. Wellbeing Jigsaw mean scores

Pathways to impact

Our findings show that an asset based approach creates impact; using local resources and engaging local people as CCs had a positive impact in Wirral. Our evaluation shows that CCs are well placed to access and support those people who are furthest away from employment and those for whom employment had not previously been an option. Time taken to build trust and respect are key to the success of this intervention. A clear partnership model must underpin the approach, with clear channels of responsibility, communication and purpose defined with local partners. Local productivity strategies need to ensure that interventions reach those most in need in order to address, *and not exacerbate*, health inequalities. The biggest impact will be made by targeting those people who are *most in need* of support. This is hard work and resource intensive, but worthwhile.

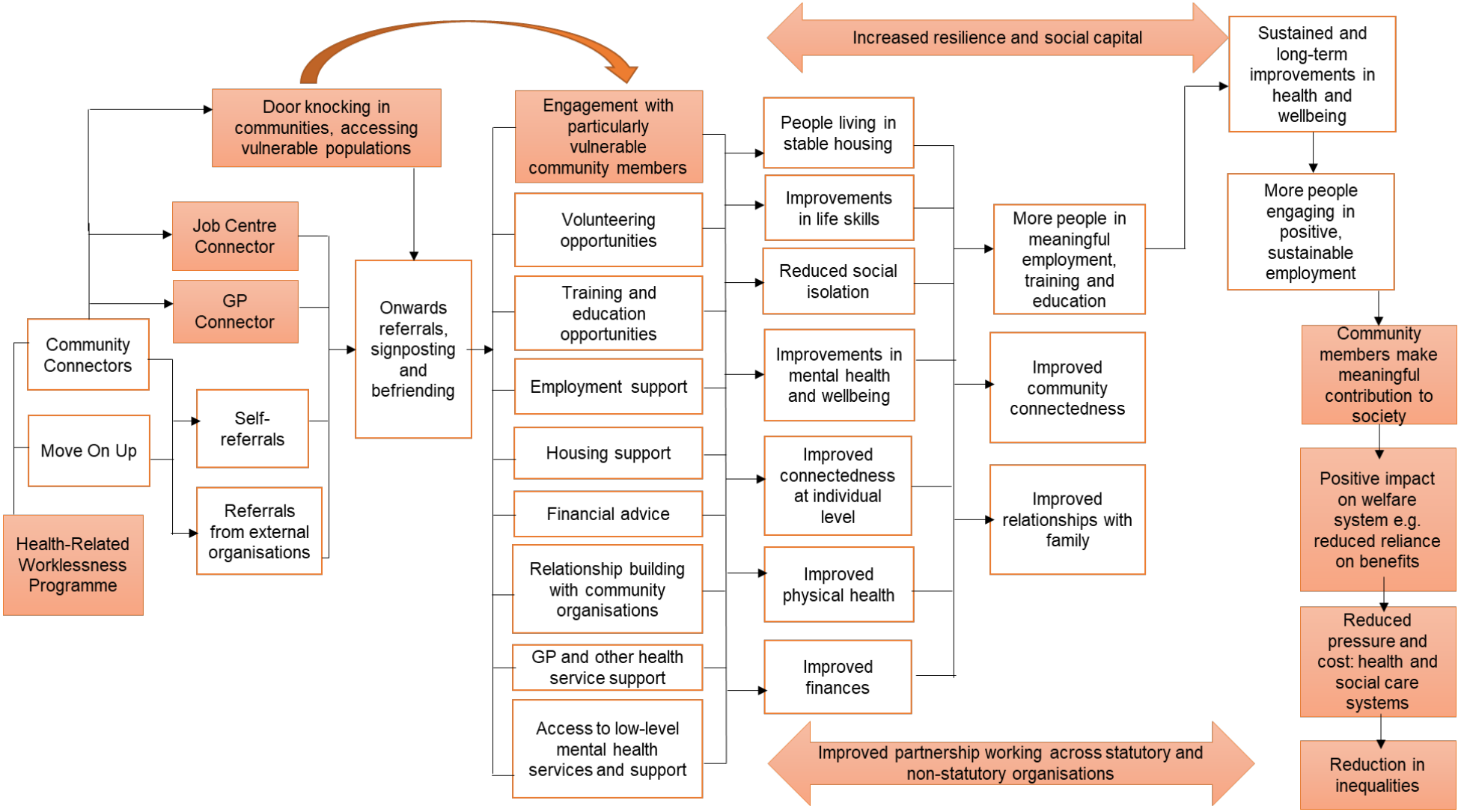
What were the crucial mechanisms that enabled success?

The Health-Related Worklessness Programme was developed with a view to supporting communities to build capacity and resilience to take responsibility for their own health and wellbeing. The person-centred asset based approach was central to the success of this and

enabled people to engage with services on their own terms, with no pressure and no judgement. The CCs and Move On Up used a strong partnership model of mutual support and collective action to ensure that interventions provided individualised support which considered needs and aspirations. CCs were able to provide specialist support or, in some cases, could outsource this where required. Whilst this was effective, it was resource intensive and challenging for Connectors to offer tailored support to everyone they engage with. This intensive support often led to very small, but very positive, changes for people.

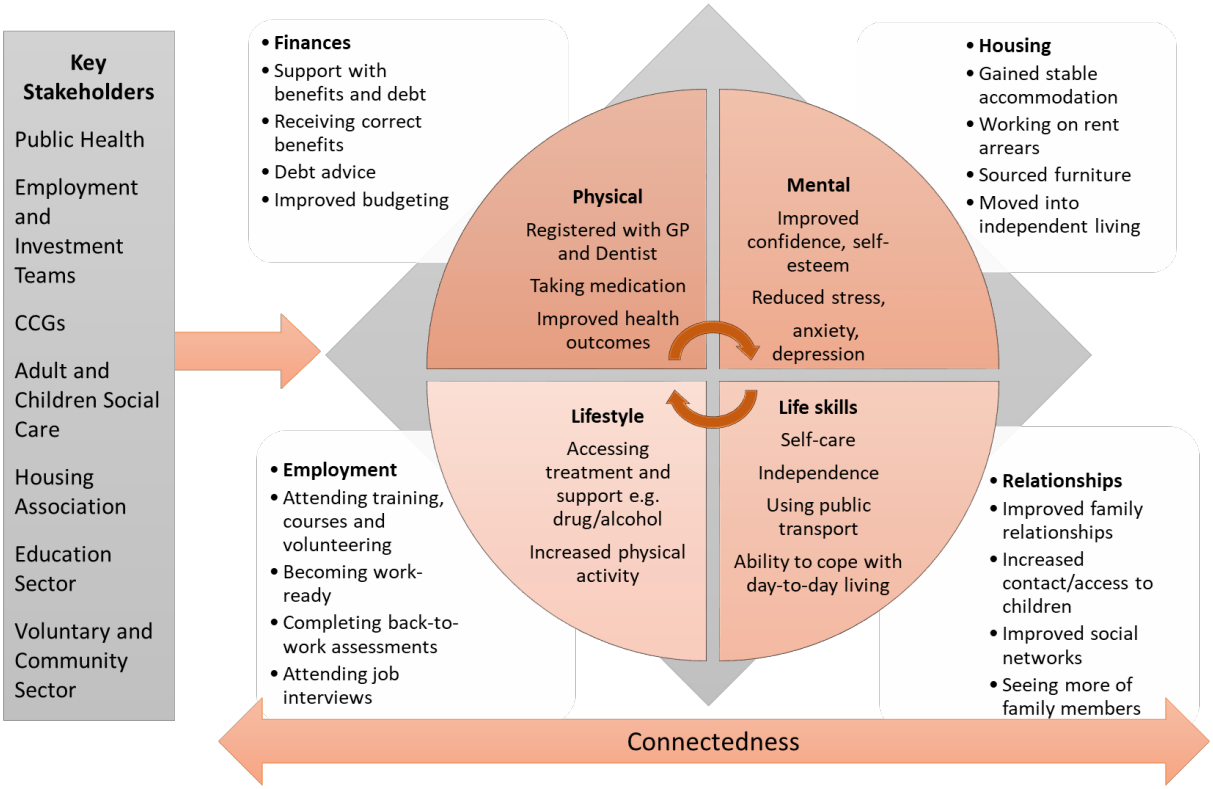
The Theory of Change shows the support offered by the programme and the associated short, medium and longer-term outcomes.

Theory of Change



How does the programme inform system level change?

The Health-Related Worklessness Programme contributes to the outcomes of other services, including supporting people to gain secure and stable housing, improving relationships with family members and providing debt and benefits advice.



These findings have implications for the commissioning, delivery and monitoring of statutory and non-statutory services and are of relevance to stakeholders involved in delivering health and social care outcomes. The evidence can also inform the development of key strategic local objectives and contributes to the work of the Centre for Local Economic Strategies in highlighting the potential of anchor institutions to support local economic growth.

Recommendations

Maximise impact: Ensure that CCs are available within local communities in Wirral. Continue to link in the Job Centre with CCs in order to maximise the impact of the intervention with those who are most vulnerable. **Use segmentation and/or profiling to identify the communities who are most in need** of support (and potentially less receptive to intervention) to inform where the Connectors are needed the most.

Redefine the role of the GP Connector: Engage the GP Connector with other CCs within their ward to **understand the needs and assets within the local community** and support an integrated approach.

Integrate social prescribing activities: **Social Prescribing Link Workers should be part of the care pathway**, referring patients directly to a CC who will visit them at their home the following day. Further evaluation should consider whether the Social Prescribing Link Worker duplicates the role of the GP Connector.

Continue to drive an upstream approach: Work-related support should be locally driven. **CCs are best placed to identify local need and subsequently mobilise action** with individuals and/or communities, engage with key partners and organisations to facilitate support where required. Partners from DWP, Merseyside Police and local housing organisations all provided examples of where they had developed and sustained partnerships with the CCs and the outcomes associated with this.

Provide wrap around support for CCs: **Work with the Primary Care Network** to ensure partners and organisations are aware of the remit of CCs. Whilst CCs can reduce the demand on more intensive services, the complexities of the CC client group needs to be made clear to partners. Wrap around support from wider services in Wirral is required so that CCs are not relied upon to provide the longer-term, specialist support that they are not trained to provide.

Consider the impact of disinvestment: Review the impact of disinvestment in local mental health services to provide evidence of **who the threshold gap most affects** and the potential impacts of this.

Inform system-level change: Use local networks (e.g. Primary Care Networks) to support an integrated approach to health and wellbeing. Consider how social prescribing link workers can form part of the CC care pathway. Embed strategic recommendations to support system-level change such as ensuring all local anchor institutions have policies in place to support community and social businesses.

Develop a shared narrative: Ensure that small but meaningful changes in physical, social, environmental and economic outcomes are valued. Collect data to evidence steps towards meaningful employment. **Collect softer outcomes using the Wellbeing Jigsaw alongside routinely collected data**. Continue to gather case studies to evidence journeys to impact to inform future commissioning.

Understand impact of future work programmes on health inequalities: Collect evidence to understand the reach and impact of continued local employment and productivity strategies. Closely monitor activities to ensure that opportunities are presented to those members of Wirral communities who are most in need; *if not, there is the risk that an activity such as this will shift poverty to other areas of Wirral and ultimately widen inequalities*.

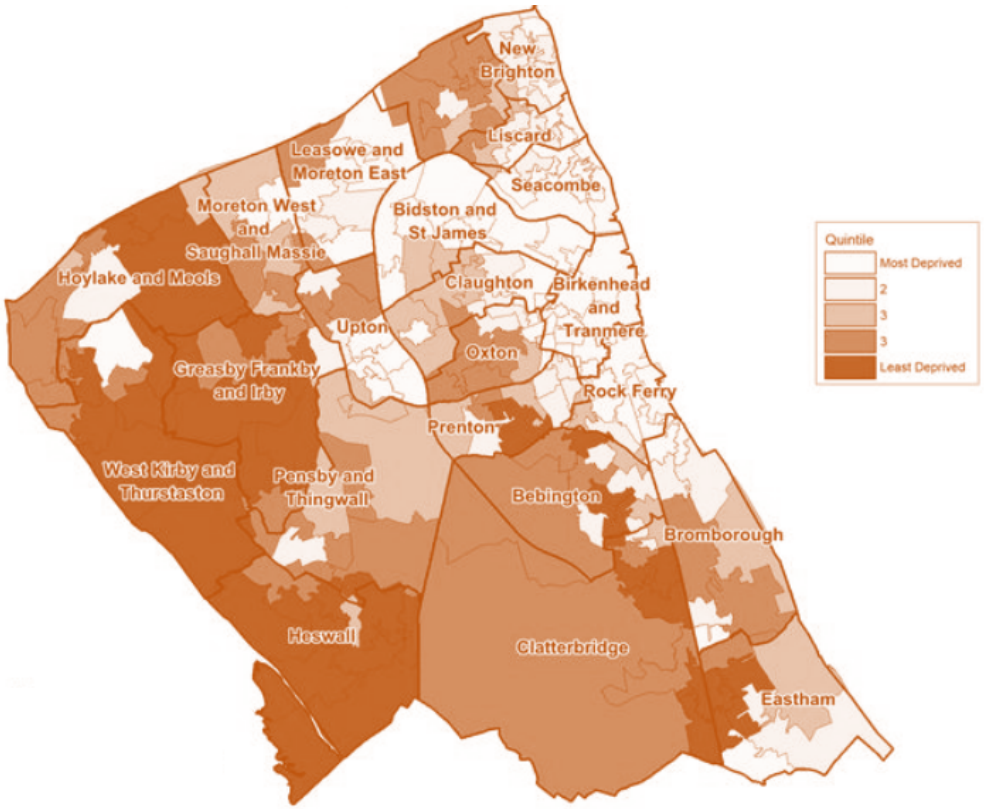
Contents

1. Worklessness in Wirral

The association between employment and health is widely recognised. Being out of work is associated with poor physical and mental health, higher GP visits, higher rates of hospital admissions and higher rates of mortality[1, 2]. Benefits of employment include social and personal development, income and material wellbeing[3]. However, employment must be meaningful and sustainable; poor quality employment and low income can negatively affect health[4].

The relationship between health and productivity is a key public health priority in England. Public sector spending must include a focus on worklessness, improving opportunities for people to move into sustainable employment[5]. Recent emphasis has been placed on the role of the health sector in contributing to economic and social progress; the World Health Organization[6] highlight the role of health and wellbeing systems in being *"essential to a stable, functioning economy"* (WHO, 2019, p1[6]).

Employment is an indicator for deprivation. Locally, the 2015 Index of Multiple Deprivation[7] showed that Wirral ranked 66th out of 326 authorities for deprivation. There were 10 areas in Wirral classified as being in the 1% most deprived in England (eight in the Birkenhead Constituency and two in the Wallasey Constituency). Current figures show that Wirral has lower life expectancy than the national average (12.5 years lower for males and 10.1 years lower for women in the most deprived areas of Wirral)[8], lower than average rates of employment (70.8% compared to 74.4% nationally)[8] and higher numbers of children in low income families (20.4%) compared to the national average (16.8%)[8]. Wirral is ranked 302 out of 379 on economic productivity[9].



Deprivation in Wirral (IMD 2015) Overlaid with Ward Boundaries

Data show that unemployment due to health is a priority issue in Wirral. Figures show that more people in Wirral were claiming out-of-work benefits compared to the national average (3.4% compared to 2.4%) and more people of working-age claimed Employment and Support Allowance (ESA) and Incapacity Benefits (9.7% compared to 6.1%) (January 2019 data). Mental health was the most common primary condition, accounting for 51% of ESA claims amongst the working-age population in Wirral; the highest of the local authorities across the Liverpool City Region[10]. One in 10 working age residents on the Wirral are out of work due to health conditions compared to a national rate of 1 in 17[10] and 1 in every 7 working age residents in Birkenhead (41% of Wirral total) are out of work due to sickness[10].

Wirral Council has a 'Tackling Health-Related Worklessness Programme' (led by the Investment Strategy) which includes a number of initiatives to support people into employment. These include: Households into Work, which provides support for households with any issues which are preventing them from gaining or seeking employment; Wirral Worklessness Support Service, providing specialist job coaches to support adults aged 30+ find sustainable employment; Wirral Youth Employment Gateway Service, providing specialist support for 16-29 year olds to find sustainable employment; and Wirral Intermediate Labour Market Programme, a programme which supports local businesses to provide recruitment opportunities to young people not in employment, education or training.

Despite the success of these initiatives, local insight revealed that some people living in Wirral communities were long-term unemployed and experienced high levels of isolation, loneliness and hopelessness[11]. The research found that many Wirral residents were living in a 'grey area' where they were experiencing low level mental and/or physical health problems that made them too ill to work, but were not accessing any services or treatment for these problems. Some did not feel they were ill enough to request and receive treatment, whilst others experienced their problems worsening before reaching crisis[15]. An intervention was needed to support those people who were not in full-time or part-time employment and who were most vulnerable and hardest to reach. The focus for the initiative needed to be upstream, supporting people to address the challenges that characterised their lives and preparing them to move towards the employment opportunities on offer. This upstream approach supported Wirral's strategic direction by ensuring labour market equality and ultimately developing an inclusive local economy[12].

Wirral Health-Related Worklessness Programme

In 2017, in response to the evidence, Wirral Council implemented a Health-Related Worklessness programme, jointly commissioned by the Public Health and Investment teams. In order to take a more upstream approach to tackle socioeconomic inequities, the programme used an asset based community development approach and had three main workstreams:

1. Driving Change (leadership and training and key professionals)

2. Community Connectors (1-1 support for individuals to encourage access to existing services, groups and networks)

3. Non-Medical Therapeutic Recovery Service (interventions to people with low level mental health conditions).

What is Asset Based Community Development?

Asset Based Community Development (ABCD) draws upon the capabilities and assets of local communities to bring about and sustain positive health and wellbeing outcomes (Harrison et al, 2019; Blickem et al, 2018; Kretzman and McKnight, 1996).

ABCD is an organic, innovative and natural process, characterised by reciprocity and connectivity (Harrison et al, 2019). This approach has the potential to target social determinants of health by enabling communities to set their own objectives; drawing on the skills and knowledge of individuals and developing networks of exchange and support (Harrison et al, 2019; O'Mara-Eves et al, 2013).

ABCD moves away from developing local services that are based on needs, deficiencies and problems; it has the potential to tackle health inequalities during times of austerity and in response to the changing landscape of localised health care (Harrison et al, 2019; Blickem et al, 2018; Foot, 2010, 2012; Kretzman and McKnight, 1996).

Models of Delivery

Community Connectors (delivered by Involve North West)

- Provided door knocking or received referrals from another organisation (housing services, schools, children's centres, GP surgeries, benefits teams, employment services, substance use services, police).
- Provided signposting and referrals on to community support and organisations.
- Worked side by side with people, providing one-to-one work with individuals to find out what they needed.
- Continuously mapped the local areas and linked people and organisations together.

Non-Medical Therapeutic Recovery Service (delivered by Move On Up, The Spider Project)

- Received self-referrals or referrals from Community Connectors, housing, mental health services, substance use services and employment services.
- People were able to join this abstinence based recovery service as a member with a weekly arts-based timetable to support wellbeing and health.
- Provided a personal mentor to conduct a one-to-one needs-led assessment that was tailored to the individual.

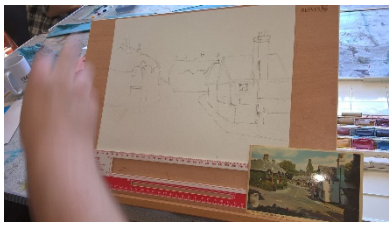
2. Evaluation

We used qualitative and quantitative methods to explore effectiveness, efficiency and value. We used a Realist approach to explore and understand mechanisms of change and evaluate what worked, for who, and in what settings. Evaluation activities informed case studies to evidence social value outcomes and demonstrate theories of change. An overview of each method is provided below.

Area Insights and Observations

Researchers shadowed Community Connectors (CCs) from the start of the evaluation; this involved observing CCs in each of the Wirral wards, building relationships and developing understandings of the role of the CC and the local communities. Through the observations, researchers collected information regarding community assets and issues specific to local areas. This included local community organisations and buildings described as 'assets', along with any issues or key concerns identified by the CCs and/or

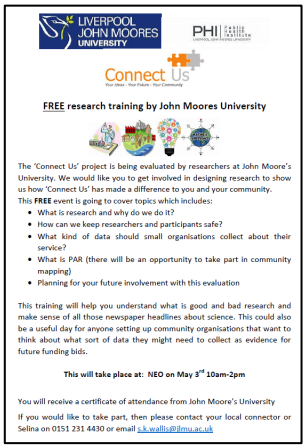
observed by the researcher. These observations also provided the opportunity to identify case studies and community members to incorporate into the Participatory Action Research element of the evaluation.



Qualitative Research

We used a Participatory Action Research (PAR) approach to gather qualitative evidence for the evaluation. This involved partnering with community members as co-researchers, allowing the evaluation to tap into existing informal, hidden social networks which may have been otherwise difficult to engage. PAR promotes ownership of findings by those that stand to gain the most, leading to practical, realistic and relevant messages. This method ensures findings are grounded in real world experiences and use common language of community members.

The opportunity to take part in the PAR element of the evaluation was introduced to community members during the observation phase of this study. Posters and flyers were also produced which invited community members to participate in the sessions. A bespoke training session was developed by LJMU and delivered to people interested in carrying out the PAR.


LIVERPOOL JOHN MOORES UNIVERSITY

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Connect Us

FREE research training by John Moores University

The 'Connect Us' project is being evaluated by researchers at John Moore's University. We would like you to get involved in designing research to show us how 'Connect Us' has made a difference to you and your community.
This **FREE** event is going to cover topics which includes:

- What is research and why do we do it?
- How can we keep researchers and participants safe?
- What kind of data should small organisations collect about their service?
- What is PAR (there will be an opportunity to take part in community mapping)
- Planning for your future involvement with this evaluation

This training will help you understand what is good and bad research and make sense of all those newspaper headlines about science. This could also be a useful day for anyone setting up community organisations that want to think about what sort of data they might need to collect as evidence for future funding bids.

This will take place at: NEO on May 3rd 10am-2pm

You will receive a certificate of attendance from John Moore's University

If you would like to take part, then please contact your local connector or Selina on 0151 231 4430 or email s.k.wallis@ljmu.ac.uk

The training provided an introduction to research, research training, research ethics and data collection approaches. Attendees were invited to use creative methods such as Photovoice, art and writing to evidence their experiences of the Health-Related Worklessness Programme. Training was held in two community locations in March (Involve Northwest) and May 2018 (the Neo café).

LJMU researchers supplemented the data collected through PAR by carrying out face-to-face interviews and focus groups with people who had engaged with the Health-Related Worklessness Programme and wider stakeholders. This ensured that the depth and breadth of evidence collected met the objectives of the evaluation. A total of 121 people took part in interviews or focus groups. In addition, 38 photographs, six poems, one video and various pieces of art were incorporated into the evaluation.

All of the photos included in this report were taken as part of the PAR element of the evaluation and depict key aspects of the Health-Related Worklessness Programme, which were meaningful to the people who engaged in it.

Participants

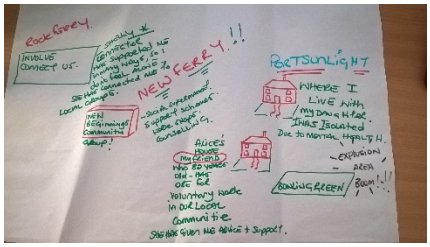
The evaluation captured the experiences and outcomes of people who had engaged with either the CCs or the Move On Up programme. Here, evidence was gathered about how they came to be involved in the programme, the types of support they had received and the impact and outcomes this had on their lives. A total of 64 Wirral residents took part in interviews or focus groups.

A wide range of stakeholders shared their experiences and perceptions of the programme; this gave insight into the development and maintenance of local partnerships and pathways. A total of 38 stakeholders were interviewed, which included representation from Magenta Living (the largest social landlord in Wirral), drug and alcohol treatment providers (including

Wirral Ways to Recovery), the Safer Wirral Hub, a drop-in centre supporting homeless people, a community integrated care organisation, a dementia carers group and local charity shops.

Sixteen CCs were interviewed; this provided context about the delivery model, the partnership working and the experiences of implementing the programme.

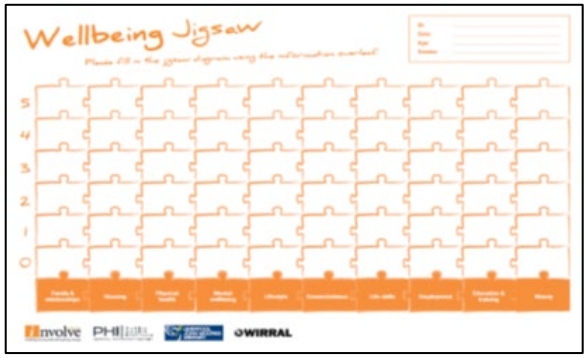
Service commissioners were also interviewed to obtain their views on the role of an asset based approach and explore enablers to effective working.



Social Network Maps

We used Social Network Maps to explore community structures, organisations and social groups amongst people who had engaged with the Health-Related Worklessness Programme. Twelve maps were developed with people during workshops at the Spider Project and the Neo cafe, using the approach advocated by Pathways through Participation[13]. Participants were asked to map the physical and geographic features of their local community that were important to their health and wellbeing. Participants were also asked to consider their experiences and attitudes towards these features. The maps provided knowledge and context to our understandings of local communities and gave a sense of opportunities and barriers that existed within local landscapes. The maps were analysed thematically to explore the community assets that were commonly highlighted.

Development of a Wellbeing Jigsaw



An outcomes tool was developed with the CCs to capture individual changes and measure a range of outcomes. The Wellbeing Jigsaw was designed to be used as part of a routine monitoring tool for use with, or on behalf of individuals accessing the CCs. The jigsaw allows individuals to set their own goals, which can then be quantified to evidence any outcomes and changes experienced.

The connectors used outcomes categories to help individuals to set goals, including physical health, mental health and wellbeing, finances, housing, children, families and relationships, lifestyle (smoking, alcohol and drug use), connectedness (reduced isolation, developing networks), life skills (e.g. personal care), employment, and education and training. The CCs and individuals used the below scale to identify needs and goals to work towards. The Wellbeing Jigsaw was piloted by the CCs with a small cohort of clients across two phases during the evaluation.

The Wellbeing Jigsaw was piloted by the CCs with a cohort of 136 individuals across Birkenhead, Tranmere and Rock Ferry, Eastham, Leasowe, Prenton, St James, Wallasey, and Woodchurch. Individuals were aged between 19 and 71 years (mean age 43 years) and 29.1% (n=39) were aged 45-54 years, and just over half (n=68, 50.5%) were male.

The Connectors used the tool to record any identified issues relating to the key categories, any actions taken (e.g. referrals made and attendance at groups etc.) and the different stages individuals progressed through until they achieved their goals. The key below adapted from

the Outcomes Star14 was used to track progress, with a score of five highlighting that the goal was achieved.

0	I do not think that there is an issue to be addressed
1	I acknowledge an issue and would like to address it
2	I would like to look at ways in which to address this issue and seek help
3	I am taking positive action to address the issue
4	I am seeing improvement in the situation but still require support
5	I have achieved my objective and can confidently maintain the situation

The Wellbeing Jigsaw also allowed the Connectors and individuals to record exactly what those needs, goals set and goals achieved were. Not all jigsaws recorded full notes and free text[B], but where available, this allowed journeys to be further tracked.

Analysis of Secondary Data[C]

Data collected by the CCs and Move On Up was routinely collected and provided to Wirral Local Authority on a monthly basis. This data was provided to the research team on three occasions during the evaluation for the interim and final reporting. The research team developed data sharing protocols between LJMU and Wirral Local Authority; the data were then collated, cleaned and analysed using the SPSS statistical IT package. The dataset included information about the number of individuals referred and engaging with the programme, including demographics (gender, age, ethnicity, residence, disability and employment status), alongside any intervention received during their time with the programme (including signposting and referrals to other organisations). Outcomes data included information around numbers (and details) of individuals who went on to start volunteering, enter education and training and start or re-enter employment.

Wellbeing outcomes were captured using the validated Short Warwick-Edinburgh Mental-Wellbeing Scale (SWEMWBS). This consists of seven questions that contribute to a total wellbeing score. Service users rated how often they felt optimistic about the future, felt relaxed, dealt with problems well, thought clearly, felt close to other people and felt able to make their own mind up about things. Individuals were asked to use the scale to rate how they felt over the last two weeks. Total scores provide an indicator for low, moderate and high mental wellbeing. Individuals were asked to complete the scale at assessment (pre-test) and at a follow up (post-test). The CCs and Move On Up staff routinely collected the measures and provided individual scores to Wirral Local Authority as part of their routine data collection.

The research team also explored data collection with the GP Surgery where the GP CC was located. Read Codes (clinical coded thesaurus) were used by a GP analyst to collate information regarding the number of GP appointments for these individuals engaging with the GP CC. The data exercise was carried out to understand the level of engagement with the GP Connector and whether this had an impact on the frequency of appointments made with GPs. The research team and GP practice manager also aimed to compare changes in appointments

[B] Free text was available for need n=3,817 (103 individuals), referrals n=297 (115 individuals), outcomes n=433 (111 individuals).

[C] Please note that the where possible data analysis and calculations are based on the data available (excluding missing data) and therefore may not total 100%. Please see appendix for methodological notes on missing data.

over time, along with the number of medications prescribed, especially for individuals with long-term conditions; however it was not possible to provide data for this element.

What We Didn't Do: Learning from the Methodology

We had originally planned to incorporate three Action Learning Sets (ALS) to act as a catalyst for the PAR. Our initial ALS plan included the following:

- Researchers to engage with community members during observations and invite them to attend an initial ALS meeting within the community
- Use the meeting as an opportunity to share details about the evaluation, share research interests and ideas, consider training needs
- Explore skills amongst the group (e.g. photography, art, observations, shadowing)
- Agree a plan for PAR
- Hold two further ALS to bring together research evidence and interpret findings

Our ALS plan changed as soon as the observation phase of the evaluation commenced. We realised that many community members were more vulnerable, socially isolated and experiencing poor mental health than first anticipated; many did not know each other and did not want to talk to strangers in a group setting about the difficulties in their lives. It was also difficult to organise meetings in a location that was accessible to all; issues such as the weather and travel were seen as barriers to this. Instead, we adapted our approach to the following:

- The observation phase of the evaluation enabled the researchers to discuss PAR with communities and groups, rather than arranging a specific meeting to do so
- It was more effective to tap into existing community meetings than organise separate ones; here the researcher attended existing groups to discuss the evaluation and opportunities for PAR
- The PAR worked particularly well with people who were engaging with the Spider Project; this organisation uses art and creativity and provided people with workshops and materials
- The research training evolved to be relevant to the population and included information about data collection and research for small organisations; this was carried out in community venues rather than expecting people to travel to LJMU.

The evaluation commenced in April 2017. Qualitative data collection was undertaken between May 2017 and December 2018. Quantitative data were received and analysed up to and including March 2019. Ethical approval was obtained from the LJMU Research Ethics Committee prior to any data collection taking place (ref: 17/PBH/038).

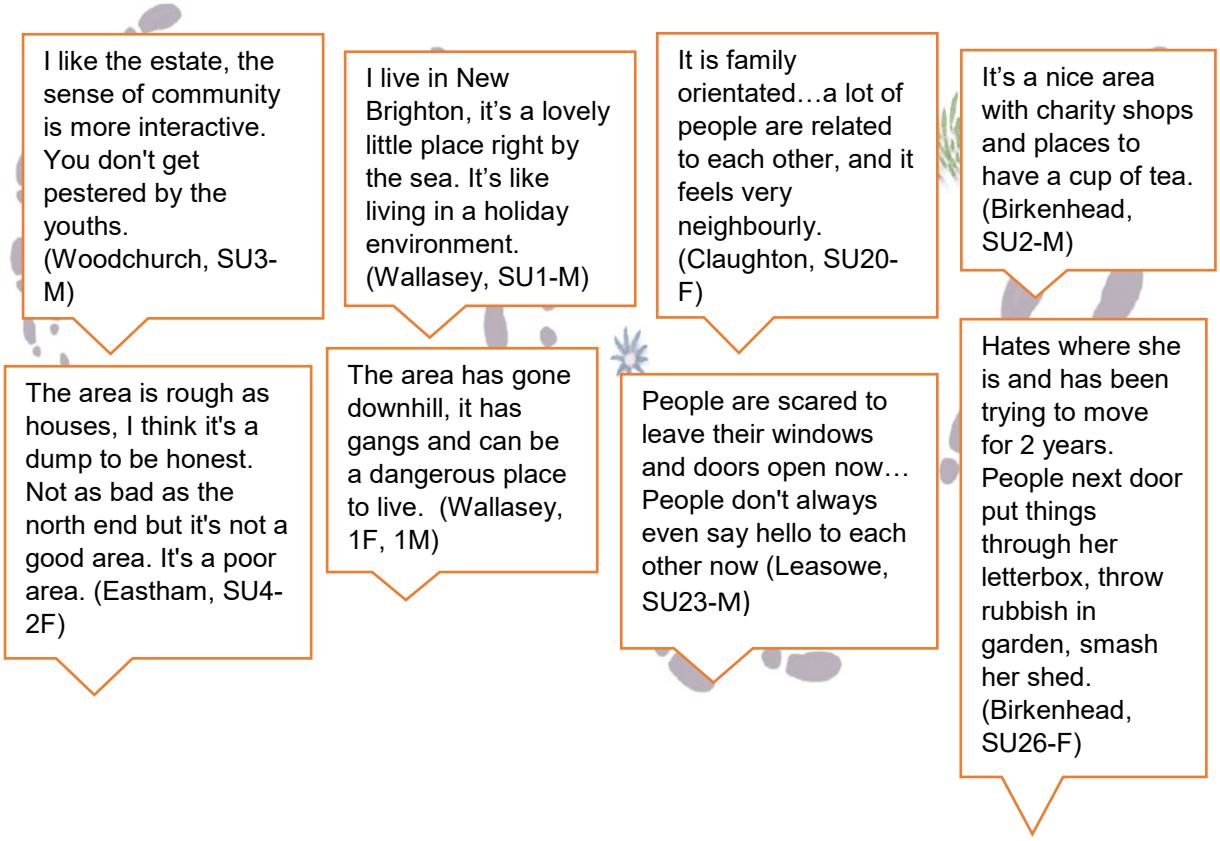
Findings

A Picture of Life in Wirral

“I was drinking quite heavily and felt negative about myself. I still drink but not to the extent I was. I was literally locking myself away in my flat. Just getting up when I woke up and not doing anything”

3. A Picture of Life in Wirral[D]

The people we interviewed described their experiences of living in Wirral, before they engaged with the Health-Related Worklessness Programme. Community, family and friends were all cited as having a positive impact upon the area in which they lived. Despite positive elements, residents described crime, safety and low aspirations as negatively affecting their experiences of living in Wirral.



People spoke about the complex issues which characterised their lives. Social, physical, economic and environmental factors were all instrumental in influencing their behaviours and in motivating them to want to change. These findings echoed those elicited through the previous insight work[15], where people spoke of desperation and despair. These findings also elaborated on the previous insight work[18], providing the context to explain *why* people continued to live in a perpetual grey area and providing the insight into *why* people were socially isolated and had poor mental and/or physical wellbeing. Many people who engaged with the programme described the circumstances which had led to them becoming extremely vulnerable and isolated. In many cases, these people had not shared their life stories with anyone prior to engaging with the Community Connectors. Some stakeholders recognised the challenges faced by people living in these circumstances.

[D] Please note that the where possible data analysis and calculations are based on the data available (excluding missing data) and therefore may not total 100%. Please see appendix for methodological notes on missing data.

Was sexually abused as a child, and felt mentally abused by his family, but nobody was prepared to give him any help unless he gave up cannabis. You try and deal with being alone all week; not even a milkman to talk to or nothing like that…smoking cannabis takes the frustration away and makes life a bit more bearable. (Leasowe,SU21-M)

Worked in bar to earn some money. Saw a man get stabbed and killed, affected her a lot. Started to get help with CV after that and was able to get voluntary work as receptionist. Now has job working as an administrator, through the voluntary work. (Eastham, SU12-F2)

Started to get bullied at work. Thought she had dementia, was being sick, had bowel problems. Felt she didn't want to be here anymore. Had medication from doctor for depression said this wasn't enough. Had to live on £74 a week benefits, wasn't enough and as a result she got into debt and had to borrow money from her mum. (Eastham, SU12-F1)

He has had issues with alcohol in the past. Has suffered from depression and had problems with zero hours contracts. The issues with zero hours contracts contributed to his relationship breaking down, and as a result he found himself homeless. Four years later he is still recovering from this. (SU63, 1m)

There was a lot about what was meant to be mild mental health, actually it was not mild and there are a lot of complex cases out there that get referred in or you meet them on door knocks or at other agencies. Something that starts off quite simple when they get to know you they start disclosing more and more and it's just they fell through the nets and they've suddenly found an ear and they want to talk to somebody. (Community Connector)

There's a huge mistrust to the administration of the welfare system and that's a barrier to doing anything positive within communities. The media portrays a lot of these people from the community in a negative light and that is having an impact. The socially isolated people are there it's just about engaging them and getting them motivated. (Social Landlord)

There are people with very complex issues and barriers that need support (Department for Work and Pensions)

Almost everyone who participated in our evaluation described the mental and/or physical health conditions which characterised their lives. For some, these conditions had led to unemployment. For others, it was the reason they could not get a job. People described a range of physical health conditions that had made it difficult for them to work; for many, this had led to isolation and depression. Others described a range of mental health problems, which were often exacerbated by their circumstances, including problems with housing and debt. Many people we spoke to described trying but failing to get help, particularly from mental health services. Reasons for this included them not knowing where to go for support, not meeting the requirements to receive the support they needed, being placed on a long waiting list or the support they were receiving not 'being enough'.

I was ill, on a lot of medication having a lot of falls and stuff. Came out of work due to ill health, had sedentary job for 30 years sitting down. Had severe pain, prescribed amitriptyline. Feeling sleepy so had to go on day shifts which was hard as not used to communicating/socialising with people. (Wallasey, SU3-M)

I was drinking quite heavily and felt negative about myself. I still drink but not to the extent I was. I was literally locking myself away in my flat. Just getting up when I woke up and not doing anything. (Birkenhead, SU2-M)

Did a University degree...came home and felt lost. Didn't know what to do with herself, said mental health suffered, starting having panic attacks and bad thoughts, didn't want to leave home. (Eastham, SU12-F2)

She had been trying to get support prior to meeting the Connectors. She had tried to talk to counsellors and wasn't getting the support she needed. (Birkenhead, SU28-F)

She had depression and anxiety that was connected to her house and landlord (Leasowe, SW22-F)

Bailiffs came to the house and she didn't know what to do; she tried going to the doctors and telling them that she felt she had mental health problems. Then she came into Spider (Claughton, SU17-F)

She was feeling suicidal, and couldn't find anyone to help her (Birkenhead, SU26-F)

Evidence from routinely collected data show the characteristics of those people who engaged with the Health-Related Worklessness Programme between March 2017 and December 2018. This quantitative data provides demographic details about the population engaging with the initiative and characteristics relating to employment, disability and poor mental health, which reflect the qualitative findings.

Community Connectors

CCs engaged with 2,177 individuals	55.4% female 44.4% male Mean age 44 years	95.9% White British
59.9% lived in the most deprived quintile	64.8% had no dependent children	84.3% had a disability
65.2% were unemployed or long-term sick	6.8% were in full-time or part-time employment	85.9% were in receipt of benefits
75.4% had low mental wellbeing	22.2% had moderate mental wellbeing	2.4% had high mental wellbeing

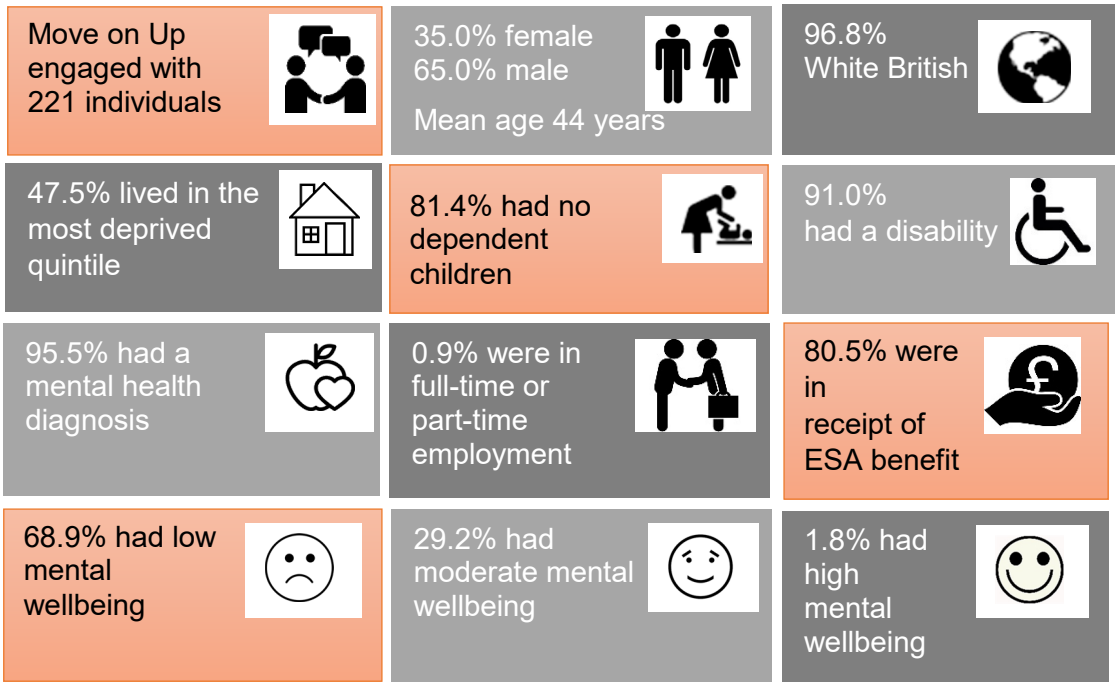
Individuals who engaged with the CCs were aged between 15 and 87 years of age (mean age 44 years). The majority of those referred were of working age (18-64 years [n=2,008, 92.7%]) and over half of individuals were aged between 30 and 54 (n=1,236, 57.1%).

Almost two-thirds (65.2%, n=1,408) were not working due to long-term sickness or disability and 16.9% (n=259) were unemployed. Smaller proportions were retired (6.8%, n=147), a carer (3.5% n=76), house husband/wife (1.7%, n=36), student (0.6%, n=12) or not working due to short-term sickness (0.3%, n=7).

Of the 84.3% who self-reported having a primary disability, 53.0% (n=968) had a mental health disability and 43.3% (n=791) had a mobility or physical disability. Three in five (60.2%, n=807) reported a secondary disability.

Of the 85.9% receiving benefits, over two-thirds received Support Group ESA (38.0%, n=705), and 10.2% (n=189) received Work Related ESA. Almost a quarter were receiving Universal Credit with a sick note (23.3%, n=433) and 8.5% (n=157) were receiving Universal Credit without a sick note. A small proportion were receiving Personal Independence Payment (PIP)/Disability Living Allowance (DLA) (4.4%, n=82) and 15.6% (n=290) were receiving 'other' benefits.

Non-Therapeutic Recovery Service (Move On Up)



The individuals who engaged with Move On Up were aged between 18-78 years (mean age 44 years), with a third (33.6%, n=74) aged between 45 and 54 years of age; 98.2% (n=216) were of working age.

A large proportion of individuals (91.0%, n=201) had a disability, this included 88.1% (n=177) of individuals with a mental health disability. The majority of individuals also reported that they had a mental health diagnosis (95.5%, n=211).

Only 0.9% (n=2) of individuals were employed. The majority of individuals were in receipt of support group ESA (n=178, 80.5%), with 10.0% (n=22) receiving Universal Credit and 2.3% (n=5) receiving incapacity benefit.

Finding a way in

"I've not had help before. I've never really knew what I wanted to do in life."

4. Finding a Way In

Interviews explored ways in which people had become involved in the Health-Related Worklessness Programme. Here, people shared their experiences of awareness and perceptions of the programme. Routinely collected data provided information about referral pathways for the CCs and Move On Up.

Community Connectors

Of the 2,177 individuals referred to the CCs, 71.4% (n=1,555) self-referred. Door knocking was one of the most effective methods that the CCs used to engage with the community, particularly with those people who were very isolated, vulnerable and wary of statutory organisations. Many were not aware of the CCs prior to the door knocking, suggesting they would be unlikely to access this service without this method of engagement.

> She hadn't been out of the house for about 2 years. The Connectors came and knocked on her door. (Claughton, SU18-F)

> The Connectors knocked on his door..He thought they were the bank at first. His mum answered the door, he wouldn't have answered otherwise. (Leasowe, SU24-1F/1M)

> She had depression and anxiety… the Connectors came to knock on her door. She found both the people who came to her door very easy to talk to; they had also both been through similar issues themselves. (Leasowe, SW22-F)

> The Connectors came to her door, other people in the community sent them to her (Birkenhead, SU28-F)

Other CC referral sources included housing services, schools, children's centres, GP surgeries, benefits teams, Department for Work and Pensions (DWP), employment services and substance use services. Referral type did not vary by month or significantly by ward.

Following the first month of the initiative (n=22, 1.0% in March 2017), referrals were consistent, with around 5% referred to the Community Connectors each month. The most referrals were made in May 2017 (7.8%, n=169).

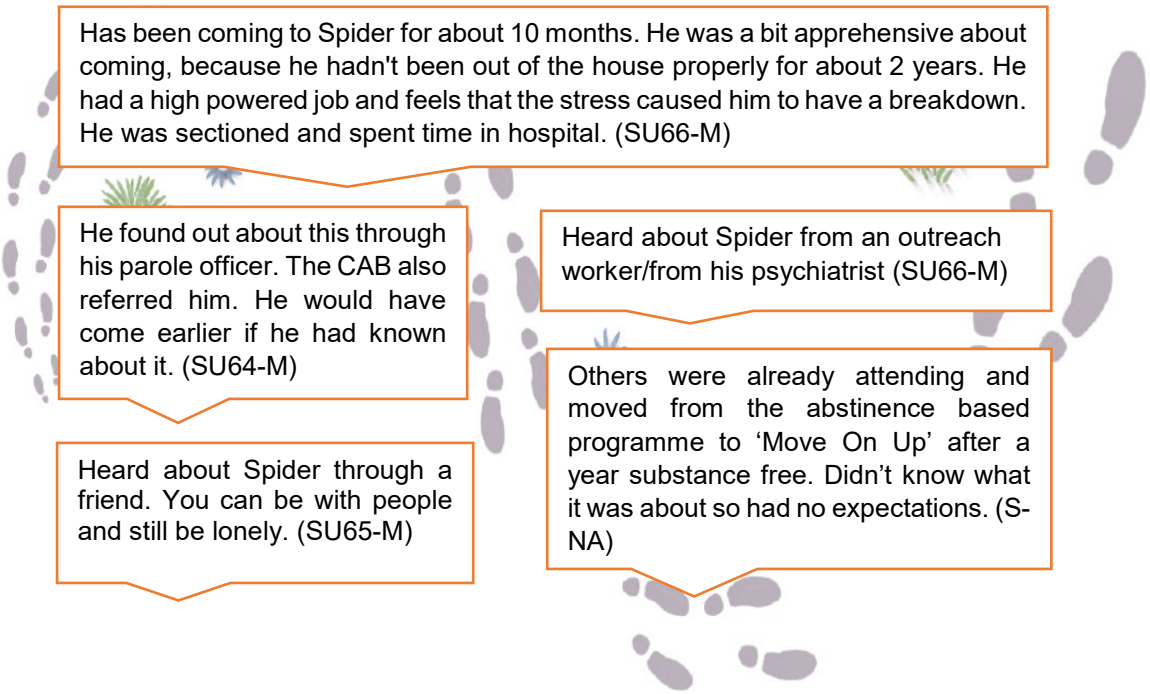
The majority of individuals resided in either the Birkenhead (51.1%, n=1,104) or Wallasey (25.8%, n=558) constituencies. Individuals resided in 22 wards in Wirral, with higher proportions living in Birkenhead and Tranmere (15.6%, n=336), Bidston and St James (12.8%, n=277) and Upton (10.5%, n=226).

Non-Therapeutic Recovery Service (Move On Up)

Of the 221 individuals referred to Move On Up, 165 were new Spider Project members. Two-fifths (n=92, 41.6%) of the individuals self-referred to the Move On Up project. Other referrals included housing, mental health services, substance use services and employment services.

Most individuals who attended Move On Up resided in Birkenhead (45.7%, n=101) and Wallasey (33.0%, n=73) constituencies; this was made up of 22 different wards with higher proportions living in Birkenhead and Tranmere (14.0%, n=31), Liscard (10.9%, n=24) and New Brighton (9.0%, n=20).

Interviews and PAR explored how and why people became involved with the project. Some of those who self-referred described being told about the project by friends. Others were already attending Spider and moved from the abstinence-based programme to Move On Up after a year substance free. Not all interviewees had heard of Move On Up or were aware that they were part of the Move On Up programme. It was often difficult to distinguish whether people were describing their experiences of accessing Spider or Move On Up.



Engagement & Experiences

“He went with me at first and then when I got a bit more confident I started going on my own. If he hadn’t have gone with me the first time then I mostly likely wouldn’t have gone because I’m the type of person that would like someone there that’s a familiar face”

5. Engagement and Experiences

Evidence of engagement and experience was routinely collected via a range of sources, including qualitative data collection (interviews and PAR activities with community members). Due to the nature of the services provided, the routinely collected CC data was more in-depth than Move On Up, providing details of signposting, referrals, uptake and engagement. Move On Up data provided an overview of the numbers and types of activities that people accessed through the programme.

Most individuals who engaged with CCs were signposted or referred on to other services. Of these, most went on to access the activity they were referred to. People were referred to a wide range of services and, in most cases, multiple services.

99.4% (n=2,164) signposted to services

73.4% (n=1,598) referred to services

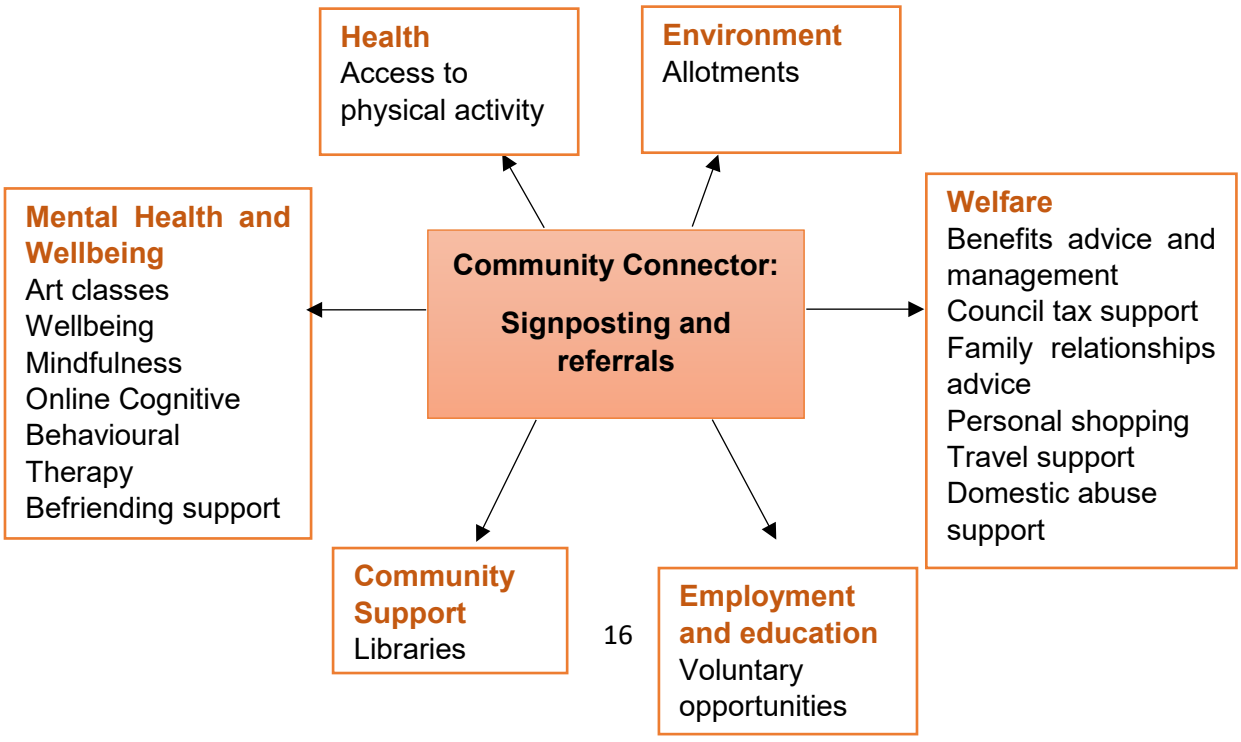
95.6% (n=1,527) accessed the activity they were referred to

67.7% (n=1,033) received support from the referral organisation

It was evident from the start of the evaluation that the CCs in particular were receiving referrals for individuals who required intensive and specialist support; in many cases these related to mental health. This reflected the multiple, complex needs of this population. Early work was required to liaise with partners to ensure that referrals to CCs were appropriate and to clarify the role of the CCs in supporting individuals with below-threshold needs.

Of those referred to a CC (for who data were available for [96.8%, n=2,104]), just under half (49.2%, n=1,035) engaged and were supported by the service they were referred to. As expected, update was higher for areas with more individuals engaging with the CC (Birkenhead and Tranmere).

Types of support provided could be categorised into a number of key themes. Analysis of both quantitative and qualitative data elicited the same types of themes:



Individuals who accessed Move On Up engaged with between one and five activities (mean = 4). The individuals accessed a total of 925 activities, with half of these accessing up to five activities each (53.4%, n=118,). Activities included art, photography, creative writing, IT, music, film, drama, cooking, holistic therapies, wellbeing, relaxation and exercise.

Support Received: Community Connectors

People described the range of services that they accessed as a result of engaging with the CCs. Here, findings reflected the vulnerabilities and co-morbidities that people experienced. Many people required the support of services that were not directly related to employment, but provided welfare, social, health and psychological support. Most people needed support from a range of services to address immediate needs (such as housing, welfare and mental health) before considering activities related to supporting people to take steps towards sustainable employment. Many people described needing help but not knowing where to turn; others described feelings of being beyond help. Often, the CCs were integral in providing people with the support and confidence to access a service in the first place.

> He went with me (to the service) at first and then when I got a bit more confident, then I started going on my own. If he hadn't have gone with me the first time then I mostly likely wouldn't have gone because I'm the type of person that would like someone there that's a familiar face. (Birkenhead, SU2-M)

> Before I did this I felt quite closed off. (CC) even says to me now if you want to go for a coffee or anything we can meet up. It's just knowing that people are out there who care. He keeps in touch, he rings me and I'll ring him. (Birkenhead-SU2-M)

> She has had difficulty with being paid benefits wrongly, and with filling in benefit forms. She split up with her husband, but feels she was made to feel bad because she took 6 weeks to inform the DWP. She was told she had had been given an overpayment, and other benefits were stopped. The service tried to help her with benefits, and her issues were later resolved following consultation with other organisations. She received a hamper from the organisation at Christmas, which included useful things such as toilet roll as well as food 'it changed everything'. (Claughton, SU18-F)

> Since his partner has been ill, he hasn't been seeing anybody. The Connectors helped him to get his life back. Goes to a group every morning. Goes to Spider regularly, does photographic/filming courses, history. Involve brought in a charity that helped him buy furniture; Involve have been fantastic. They are always at the end of a phone of he needs anything, and they also contact him. "They've shown me the light at the end of the tunnel. I was just prepared to give up". One of his goals was to make friends, which he has done. (Leasowe, SU23-M)

> He has got on the waiting list for Assisted Living thanks to the Connectors knowing how to do it; he had been trying for 2 years to get onto the list before that. (Leasowe, SU24-1F/1M)

> Being dyslexic I panic about being in stressful situations. When I'm put under pressure to read or write I fall to pieces. I'm very nervous if people suggest I go on courses, it seems like they are trying to be helpful, but inside I'm going, no, leave me alone! (Wallasey, SU1-M)

Support Received: Non-Therapeutic Recovery Service (Move On Up)

Characteristics of the people who engaged with Move On Up were similar to those experienced by those who engaged with CCs. People talked about the ways in which the service had provided them with health, social and emotional support. A difference between the CC client group and the Move On Up client group was apparent in terms of the type, level and intensity of support required. The door knocking provided by the CCs established relationships with people in the community who were very isolated, vulnerable and did not know how or where to access support. Many people who used Move On Up experienced isolation and vulnerabilities but described finding out about the service from friends and self-referring to the project, suggesting that support networks may already be in place.

For Move On Up, it was not always possible to distinguish whether people would have accessed these activities anyway, or whether their engagement could be directly attributed to being referred to the Move On Up programme. When asked during interviews, many of the members we spoke to had not heard of the CCs.

People who used Move On Up described the support they received from the service and the range of activities that they had accessed. For many people, the health, social and emotional support provided them with opportunities to access mental health support and reduce their feelings of isolation.

> Being at Spider gave faster access to mental health support (has bipolar and had been sectioned previously) and helped him get the right medication. Sees a psychiatrist every 3-months. He stressed importance of having Spider to provide additional mental health support. He would be stuck at home self-harming. But instead has a job now at a substance use support service and has been 8 months drink free. (S-NA)

> It's helped me get faster support into services, medications and RASA, Stein Centre. (S-NA)

> I don't have any friends outside of Spider- the thing that keeps me going is that I can come to Spider. On your own you get anxious, see patterns that don't exist, you overthink, your problems get worse, distraction from being here makes you a lot better off. (S-NA)

> I come to get out of the house, for the last few years I've stayed in the house on my own. I have no friends. (S-NA).

> My Support worker tried to get me to come for a year, tried to put them off but I had to do something, so eventually came but didn't like it at first. Sat outside on my own. But slowly started talking to people- its good there's no expectation/pressure to participate. Best thing about it people didn't push you or challenge you- 'Why aren't you doing this or that'. There's time to build up step-by-step. (S-NA)

> I used to go for coffee with friends then would go to the pub so I was looking for company. It sounded interesting, the guitars, when I saw the programme there were lots of things I was interested in, So I am not by myself. The drama group has been important for confidence, on the spot and having an audience, I came for the social aspect, the staff are helpful and friendly. (S-NA)

> I wouldn't leave the house if I didn't come here, I come at least three days a week…If you don't come in, if you have a dip, someone will contact you, they ask you to get in touch. It's having someone that cares. (S-NA)

As a creative arts and wellbeing recovery community, Spider provides a wide range of holistic therapies and creative activities. Many members described their positive experiences of engaging with these.

Activities, writing groups to express yourself- make up a story. (S-NA)

He has been coming for a few months. Attends painting classes. He has had a breakdown in the past. (SU65-M)

Cycling group – a number of them had taken part in a suicide awareness/prevention cycling ride along Wirral way and decorated a Lambanana on display at Woodchurch. (S-NA)

The whole ethos of being involved in different activities helps communication- I go to the running group. I didn't do anything that I do here previously. (S-NA)

I'm a scientist by training but I love the arts, jamming together. (S-NA)

In addition to the holistic and creative activities, members described receiving practical support, such as help with CV development, interviews, attending courses and using computers.

Skills groups, interpersonal skills starting next week and again in January, I am doing it again. I need to repeat it, I take a long time to learn. (S-NA)

Caroline visits from Involvement North West, she supported with the transition from benefits to full time work. Gave advice on how many hours you can work and still receive ESA. (S-NA)

I've been on an interpersonal skills course, solving problems, mindfulness, body language. You can talk to anybody here-if they can help you they will or put you in touch with someone else that can, outside agencies like GPs or Wirral Ways. (S-NA).

Talent matching on a Monday helps you find connections. For example if you have a skill or like doing something they will connect you with other services that can help/work with you. An example of one male who likes making personalised things. They linked him into a contact who helped him set up a facebook page and gave advice on how get funding. (S-NA).

Outcomes & Impact

"Without them I'd probably be a raging alchie now, because I felt that crap about myself"

6. Outcomes and Impact

The PAR, social network maps, Wellbeing Jigsaw and routinely collected data provide a wealth of evidence about the outcomes and impact of the Health-Related Worklessness Programme. The routinely collected quantitative data provides evidence of outcomes relating to employment; the Wellbeing Jigsaw and qualitative data provide evidence of the breadth of impact pertaining to wider social value outcomes, including social, economic, environmental and physical aspects.

6.1 Building Community Capacity and Social Capital

"It's about progress, it doesn't matter about working or how much money you have, it's about being happy and connected. Most people in society are disconnected".

The PAR activities and other qualitative data provided evidence of how the Health-Related Worklessness Programme supports people to make positive steps towards sustainable employment.

It was clear that the Health-Related Worklessness Programme affected change associated with an improvement in social capital. Social capital refers to the personal relationships, support networks, civic engagement, and trust, and reciprocity, which is recognised as integral for communities to provide a positive contribution to the local economy[16]. In particular, findings demonstrated how CCs helped to build communities, improve capacity within communities, and have a positive impact on the local environment.

> They are just perfect. We need more people like them. The community has changed; trust has been built up, whereas before everyone was seen as a 'grass'. (Birkenead, SU28-F)

> People can be in the worse area and the worse people with drug and alcohol problems. All it takes is one person to ask if you are okay, it makes you feel worthwhile. Everyone has something to offer. [It's] made a difference having the service as gets people out of isolation and sets up centres. It's the old fashioned way of helping one another. People need to trust one another. (Leasowe, SU15-F)

> When you connect with someone who you know is going to be reliable, even if they're paid to be reliable, it's a lifeline. These Connectors could do so much more if they were allowed to, if they were trained to and if they had the money to. (Birkenhead, SU21-M)

> I feel more connected and part of the community and know what's going on because of the Connectors...They make you feel like you're part of it and like you're important and they make you feel like you've got something to give. (Wallasey, 29.01.18, 1f, 1m)

People described a range of outcomes that were achieved as a result of engaging with Move On Up. As highlighted previously, not all of the people we spoke to were able to separate their experiences with the Spider Project from those provided by the Move On Up; it is therefore difficult to assess whether these changes would have happened anyway.

I've learnt new skills, help with getting into a counselling role. Met new people and made new friends, a reason to stay abstinent. Better understanding of my mental health. (S-NA)

I wouldn't leave the house if I didn't come here- I come at least three days a week. (S-NA)

Confidence grew, trust in Spider to be ongoing support but also be required to push myself. To be able to accept change and new situations. The support has been given in a way with strict guidelines, this has given me structure in my life again and I can carry this into other situations. Using art, it takes me to a place I can relax. There is help when I get stuck. It takes time. I create something real that I can be proud of. (S-NA)

The stakeholders we interviewed all described their experiences of working in partnership with CCs to bring about positive community action and support. Here, views were positive, with stakeholders acknowledging that the CCs provided a service that was needed within the local community. Many spoke of the importance of local partnerships and networks between people and organisations. Stakeholders described specific examples of how the CCs had supported them within their role and the impact this had.

The Connectors are more likely to get over the doorstep than the police, and other statutory services, so they are able to go in and identify vulnerability very quickly. For example, we had an elderly man around the Rock Ferry area who was hoarding and the connectors went in and helped him establish a life again, but they came to us for support to get the fire service involved in the removal of the rubbish out of his house. It's just having that connection, being able to pick up the phone and say we need help with this chap here whose been housebound for some time. He's agoraphobic, but we also need to keep him safe in his house as well. That's just one of the many examples (Safer Wirral Hub)

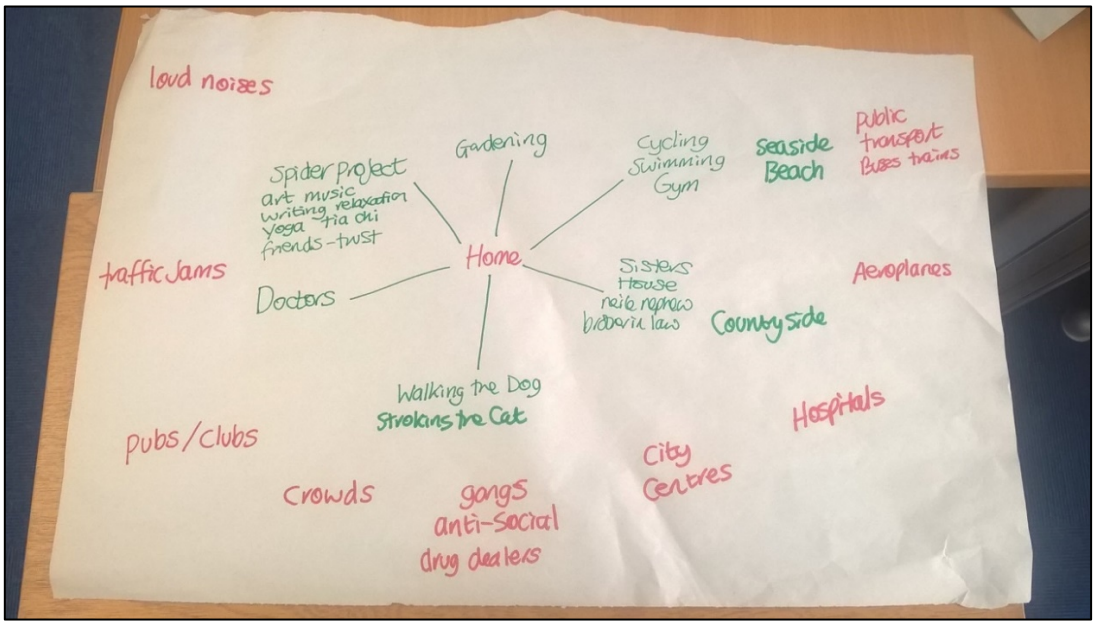
The Connectors have been fantastic. I worked closely with them at Woodchurch, I did door knocking with them to get the word around Upton when I had the Upton group and when I was moving here I didn't know where to turn because I didn't know the area and they were brilliant. They're connecting me to people who may have halls I could use, space I could use, just generally helping me out, mentally as well because the move was a shock, I wasn't in a good place I'd lived there for 16 years. (Phab, Bebington)

The connectors have helped us get volunteers and they have told people we are here. If they have signposted people to the shop we have been able to tell them about some things going on (Dementia and Carers Group)

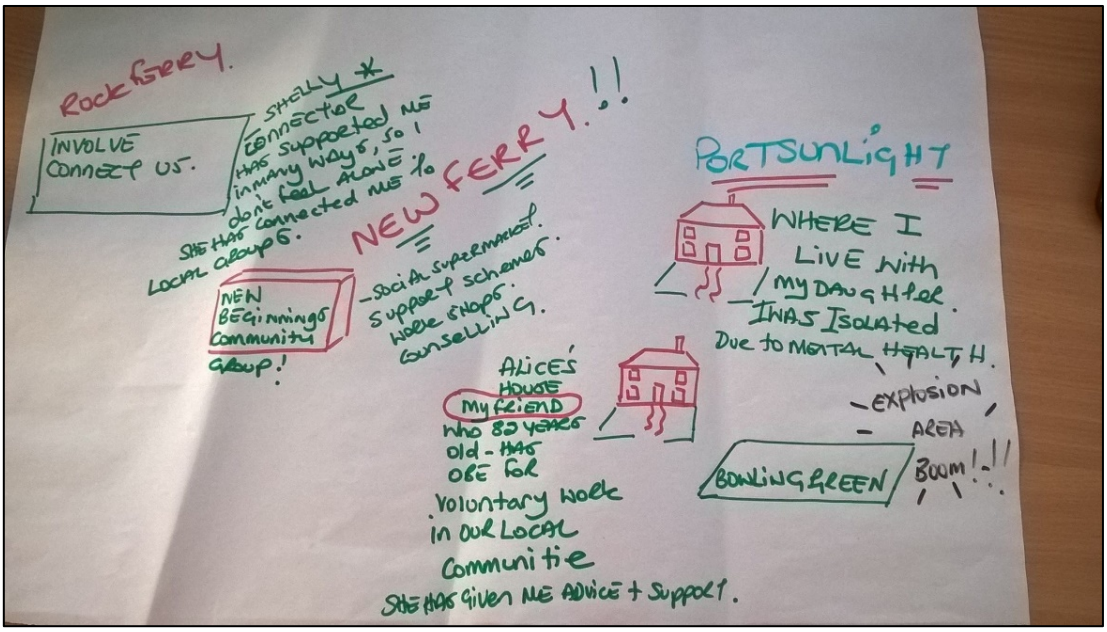
The twelve social network maps further demonstrated the importance of community networks, drawing out a range of organisations and assets that had a role in people's lives. Some people mapped both positive and negative aspects of their social networks, whereas others focused on positive organisations/assets and highlighted how these made them feel. Analysis highlights the community assets and organisations that were frequently mapped and reflects

the key qualities and criteria of true ABCD[17]. Those people who mapped the positive and negative aspects of their social networks focused on their personal experiences, with some describing loud noises, traffic, antisocial behaviour and crowds affecting their social networks (e.g. map 1). Others described aspects of their social networks and how they use these, including engagement with friends, family members and CCs (e.g. map 2). Two people mapped their social networks in reference to key issues which characterised their lives; one a positive map of places they frequently walk their dog (e.g. map 3) and another which mapped places where the amount of alcohol is consumed (e.g. map 4).

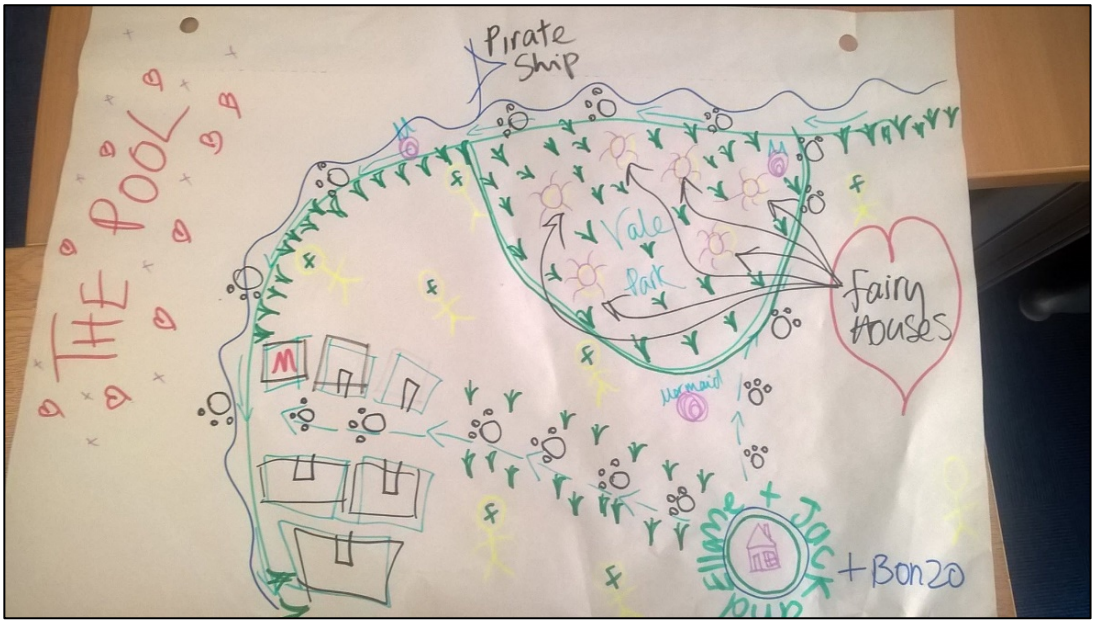
Map 1:



Map 2:



Map 3:



Map 4:

6.2 Supporting Mental Health and Wellbeing

Evidence from the PAR, the interviews and the secondary data all showed the positive impact that the Health-Related Worklessness Programme had on people's mental health and wellbeing. Everyone we spoke to described the positive impact that the programme had on their lives and described the this had impact on isolation, stress, depression, anxiety; changes which had occurred as a result of them tackling issues including housing and debt. The CCs were described as 'life saving' and providing people with a lifeline.

If you are happier within yourself then you're happier where you live, the workshop is in Birkenhead and I go on my pushbike, I love it, I cycle along the Prom and I'm happy, I've got a purpose. (Wallasey, SU1-M)

"I find it easy to get into isolation" "Gets me out of the house and doing something". Said spent most of last year at home. Suffers from anxiety and depression. Wanted to do something. Centre helps to get out of isolation. (Leasowe, SU15-F)

The service got her out of the house, and interested in doing things again, and feeling like she is capable of doing things again (Claughton, SU18-F)

He has got on the waiting list for assisted living, with help from the Connectors. He had tried for 2 years, previously, to get on the waiting list, without success. (Leasowe, SU21-1M/1F)

Feel better about the area since meeting the connectors- "been shown the way, there's lots of support". (Wallasey, 29.01.18, 1f, 1m)

Before she started using the service, she would not ask for advice or guidance, and was burying her head in the sand about her debt. Without the service, she doesn't feel that she would have started engaging with others and 'having human contact' again. (Claughton, SU17-F)

People used art, photographs and poetry to describe the impact that the Health-Related Worklessness Programme had on their lives. Meaningful photographs are embedded throughout this report. As previously described, Move On Up provided the idea opportunity for the creative aspects of PAR. A number of poems were created by people here to describe their journeys.

I came a long way
In my endeavours to
Create my own persona.
I feel so relaxed.
When I first came to Spider,
Learning aspects of art,
Watercolours Group-wed-morning-paint pictures
With an arrange of colours
And create images.
Once again
Good therapy for me
"Mentally and Physically"
Writing Group (Creative) Thurs. afternoon
EG poetry and short stories.
It's good to occupy my mind
To Create and Impress.

Matter of mind struggled to find that
inner peace and tribulation of mind.
Unknown to me the Spider web would
soon entwine me in golden thread.
A chance to shine, my eclipse now done,
learning new things, with glory it brings.
Tight little sessions, warm faced reflections
with like minded spirits, what now for that
which inhibits.
Released from dire moorings, imagination
now soaring.
From a darkened stone to a sunlit ray,
this Spider and it's joyous prey

My Recovery Home

I came here to better my life
I walked through the door and the staff were nice
When I first came my mind was shut off
I didn't know what to do, so was put off
I started to get involved a bit more
I do things now I'd never before
Now my mind is open and free
I can honestly say Spider has helped me
It's give me a sense of faith and hope
It's a place I call my recovery home
It's a place where you're not alone
The members here are nice and kind
I love this place it makes my smile shine
When I came here my problems started to dwindle
My love for life has started to rekindle
So if you come here it will improve your wellbeing
So give it a try but don't leave without believing and seeing
I can say I'm living proof
Your life will get better while under this roof

Sadness and despaired, made heavy the stagnant air,

Twas a time not so long ago, this mind of mine refused to grow.

Blissful in the pit, solitude was comfort.

Spider then opened the door,

Little by little confidence grew, like the spider web glissading with silken hue,

Stronger the mind becomes to better fight the demons that raged within.

Through printed word on page, the mind was freed. To seed its words and quelled the darkness, the emptiness inside.

When once the wish to die, kept its shadow upon the eye.

Words now form that aid to unseat the pain, sadness and despair.

And now hope is abundant in the air.

Spider 81027062

I open my eyes to another day,
The ceiling looks the same,
Nothing has changed
The same feeling as I go through the same routine as I make my way to the kitchen
Bathroom, living room curtains, kitchen, kettle on
I grab a bowl and stare at the choices of cereals
Which one, which one, which one today, no not today, not hungry
My coffee is made and I am now sitting in the living room, coffee in hand
I stare out the window, it doesn't matter what the weather is like
It doesn't change how I feel, not much does,
Not the cry of a happy child, the birds chirping their summer song
They are only the other side of the window,
But from this is of it they could be a on another planet.

I open my eyes to another day,
The ceiling is the same,
The cracks are still there, but that is not my problem,
I get out of bed and make my way to the kitchen,
Bathroom, living room curtains, kitchen, kettle on
I grab a bowl and stare as I do at the choices of cereals
Which one, which one, rice krispies I think
My coffee made and sitting looking out the window
Coffee on the side and bowl in hand
The day looks pleasant, the sky is clear, happy cries from kids playing down the road
I look at the calendar and consider what I will to do
Venture out my safe area, what a thought that would be
But now it is thought and considered an option
People to meet, safe area to sit and ideas to expand
What a change from six months ago
Before spider saw me there

In addition to the data collected using the PAR methods and the Wellbeing Jigsaw, wellbeing outcomes were also captured from people engaging with the CCs and Move On Up using the validated Short Warwick-Edinburgh Mental-Wellbeing Scale (SWEMWBS)[18]. This consists of seven questions that contribute to a total wellbeing score. People who engaged with the Health-Related Worklessness Programme rated how often they felt optimistic about the future, felt relaxed, dealt with problems well, thought clearly, felt close to other people and felt able to make their own mind up about things. Individuals were asked to use the scale to rate how they felt over the last two weeks. They were asked to complete the scale at assessment (pre-test) and at a follow up (post-test).

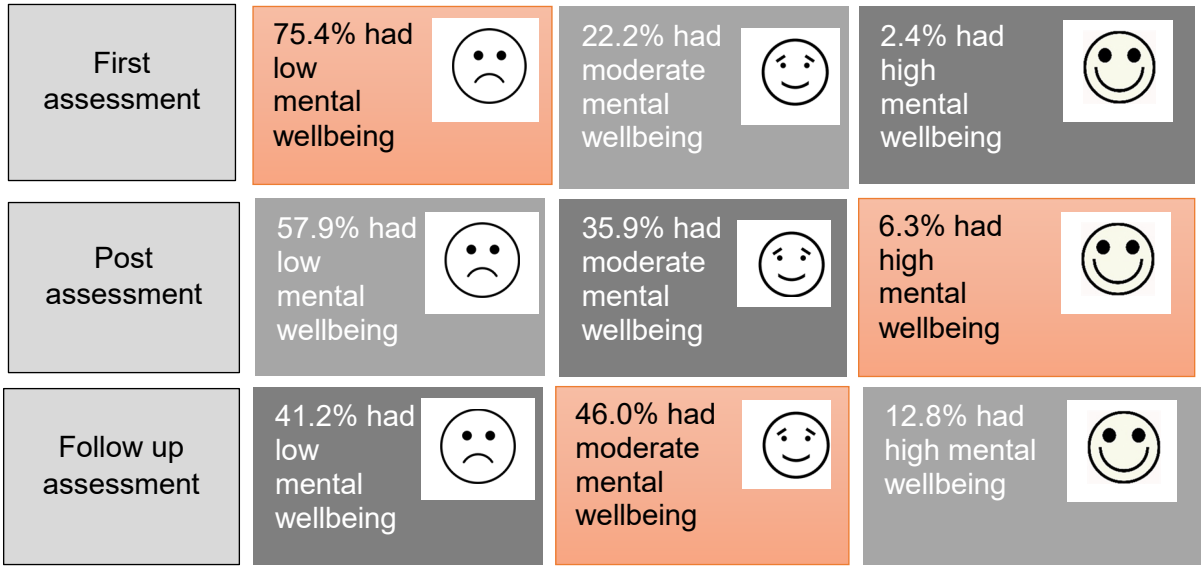
SWEMWBS: Community Connectors

The SWEMWBS was undertaken for 2,164 (99.4%) individuals at pre-test, and for 1,807 (83.0%) individuals at post-test. A further 1,490 (68.4%)) individuals undertook a third SWEMWBS six months after their first assessment.

The SWEMWBS scale improved between the pre-test (mean 18), post-test (mean 21) and at six months (mean 24). The improvement in total mean score across the tests suggests that individuals' general wellbeing did improve during their time with the project.

Of those completing the post assessments (n=1,807), almost three quarters (n=1,286, 71.2%) had an improvement in mean score, with 1,226 (67.8%) individuals having a meaningful change in mean score (2+;95.3% of all improved scores). Over one-quarter (n=487, 27.0%) of the scores remained the same as the pre-test, whilst 1.9% (n=34) decreased. The completion of assessments at follow up highlights a high number of individuals remaining engaged with the connectors.

When comparing the post score to the score at the six month review (n=1,490), almost two thirds (n=956, 64.2%) had an improvement in their mean score between the post assessment and 6 month review, with 918 (61.6%) having a meaningful change in score (96.0% of all improved scores). A third (n=496, 33.3%) had no change in score and 2.6% (n=38) had a decrease in their mean wellbeing score.



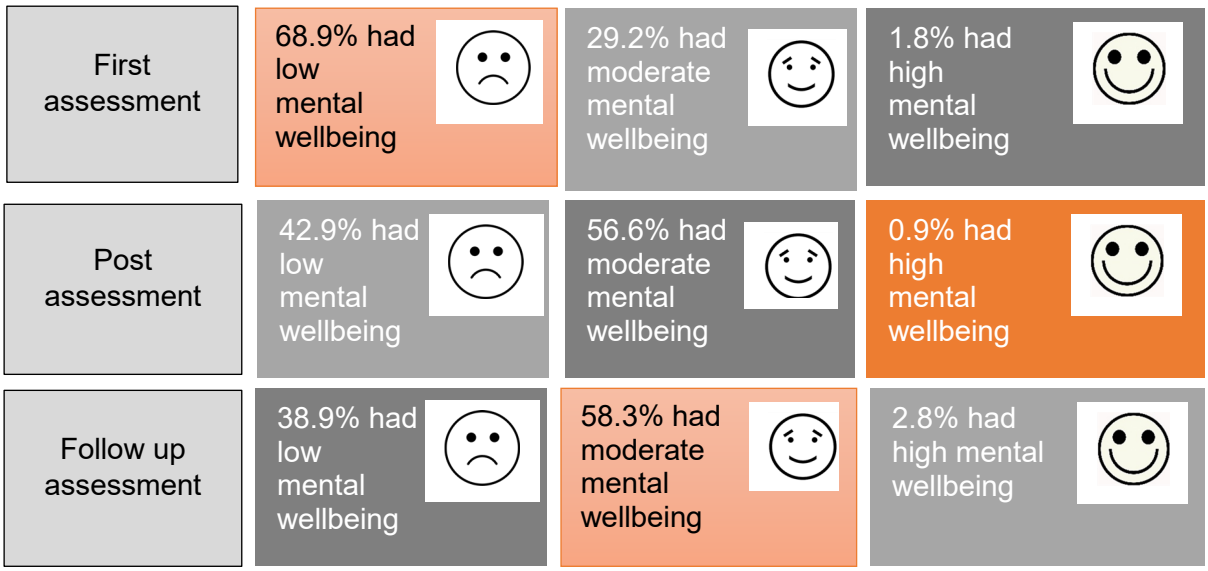
SWEMWBS: Non-Therapeutic Recovery Service (Move On Up)

Wellbeing outcomes were also captured for Move On Up members. Here, SWEMWBS was undertaken for 99.1% (n=221) of individuals at pre-test and for 48.0% (n=106) of individuals at post-test (6 weeks later). A further 32.6% (n=24) undertook a third SWEMWBS six months after their first assessment.

The total mean score for the SWEMWBS scale improved between the pre-test (mean 20), post-test (mean 23) and at six months (mean 24). The improvement in total mean score across the tests suggests that individuals' general wellbeing did improve during their time with the project.

Of those completing the post assessments (n=106), over two thirds (n=72, 67.9%) had an improvement in mean score, with 61 (57.5%) individuals having a meaningful change in score (2+;84.7% of all improved scores). A quarter (n=27, 25.5%) of scores decreased, and a small proportion of scores remained the same at the post assessment (n=6, 5.7%).

Considering scores for individuals who completed the 6 month review (n=72), around two thirds (n=48, 66.7%) had an improvement in their mean score between the post assessment and 6 month review, with 36 (50.0%) having a meaningful change in score (75.0% of all improved scores). Over a quarter (n=20, 27.8%) of scores decreased and 5.6% (n=4) had no change in their total wellbeing score.



6.3 Supporting and Developing Community Assets

Recent research has shown that a number of key criteria and qualities must be present in order to claim an ABCD model has been used[16]. Analysis of all primary and secondary data has been explored with reference to these criteria. Our analysis demonstrates that the programme successfully embedded an ABCD approach within its delivery model. The intervention utilised, developed and sustained a wide range personal, physical and community assets.

The Wezzy Gardens

Community Connectors discovered a group of individuals. There we met a lady who disclosed she had a long history of poor health and benefits. They found in speaking to her that she had high community spirit and good relationships with her neighbours. She described how they often sweep their own streets and look after each other's children. Upon discussing goals and aspirations it became apparent there were some members of the community who were passionate about transforming a piece of overgrown wasteland. One individual in particular said she had been trying to find out who owned the land for two years and could not make any headway as everyone seemed to be denying ownership and the land was a blot to their community. Antisocial behaviour was an issue and so was dumping of waste on the land.

The Connectors contacted Wirral Council to explore ownership of the land. The community formed a community group named 'The Wezzy Gardens' and have been extremely proactive with their work. The Connectors supported a Spark fund application and the group was successful in gaining £300 to kick start the buying of materials and tools needed for the project to begin.

The Group did a fundraiser and raffled off donated prizes such as Tranmere Rovers tickets, family ticket for entry for Europa Pools and free membership to The Hive. With the money they raised, the group bought essentials for the clearing up of the space, which included brushes, suitable bags for the rubbish, gloves etc. The children in the community had huge involvement in the clearing up process.

ABCD must support and develop personal resources, physical and community assets. Evidence is provided to demonstrate the existence of these assets in Wirral. Specific examples of named assets are the taken from those included within the social network maps. Interviews and Wellbeing Jigsaws elicited examples of many more. We have not listed all community assets here; this list would not be exhaustive and would not therefore provide a true reflection of all the assets engaged with the Health-Related Worklessness Programme.

Types of assets	
Personal resources	***Relationships with people including (but not limited to):*** Community Connectors Family members Friends GP
Physical assets	***Physical places and green spaces including (but not limited to):*** Countryside The beach Birkenhead Priory Hamilton Square Bowling Green
Collective, community or social assets	***Community organisations, activities and groups including (but not limited to):*** Connexions Spider Project Wirral Mind Libraries Shops including local supermarkets and community supermarkets Health centres (e.g. Stein Centre, Clatterbridge, mental health services) Dentist Wellbeing College Pub Coffee shop Leisure Centres Schools and Colleges (e.g. Wirral Met) Children's Clubs Church

6.4 Volunteering Outcomes

Available data show that a total of **182 people (8.4%)** started volunteering as a result of engaging with the CCs. Quantitative data showed that this was with a range of organisations and charity shops including Age UK, Barnados, Cancer Research, Salvation Army, YMCA, Wirral Women & Children's Aid (WWACA) and Mencap.

- **Projects included:** BEE Wirral, Befriending at Vines, Bob's Place, Bridge Cottage, Circle, Core Project, Fareshare, foodbanks (including NEO), Flourish, Phoenix House, Headway, Hive Youth Zone, Homestart, Hope Place, Leap Frog, Leaswowe Community Advocacy, Spider, Silverbacks, Lowfields Conservation Project Eastham, Make it Happen, Mindfulness Moreton, Military Breakfast Club, Mums and Tots groups, Music and Memories, Open Door, The Phabulous Community Charity Bebington (PHAB), Scope, Social Action – the Great Get Together, Stitch Together, Tomorrow's Women Wirral, Tranmere FC, Poppy Appeal, Wirral Connect, Wirral Mind
- **Community groups/centres included:** Carbridge Centre, Wezzy (Westborn) Garden, Autumn Club Leasowe, Community Cupboard, Community Soul, Community Woodwork Shop, Community Photographer, Crossbow Club, Dance Club, Dementia group, Fishing Club, Forum Social Supermarket, Friends of Birkenhead Park, gardening groups, youth clubs, residents associations, community bingo, Daisy's Diner, after school club, schools, dog walking, decorator (INW), hedgelayer, horse and pony sanctuaries, Inspire coffee shop, litter picking, New Ferry Team Rooms, Nightingales Café, Soul Café, Church and missions scouts and libraries.

6.5 Formal and Informal Education Courses and Classes

A total of **5.4% (n=118)** started formal and informal education courses and classes. These included formal courses (including GCSEs) at college and university (including LJMU, Open University, Wirral Met, Countess of Chester, Hugh Baird College and Liverpool Community College). Other courses included:

- Courses at Wirral Ways to Recovery, PHAB, CAP, Wirral Connect, Tranmere FC, Wirral Change, Talent Match, Spider, St James Centre, Purple Tree, Leap Frog (peer mentoring), Hiveability, Inspired Dreams, Kare Plus, Reachout, Crosby Training
- Awareness courses in ADHD and alcohol recovery
- Practical skills including budgeting, CAP Life Skills, confidence, self-esteem, wellbeing and resilience, mindfulness, relaxation
- Princes Trust
- Adult learning, adult lifelong learning, Foundation courses, TEFL
- Adults learning computer courses (levels 1 and 2), NVQ level 2 customer services, hygiene level 2
- Other courses included: animal management, Barista training, bike mechanic, brick laying, business training, computer courses, community organising, wedding planning, accounting, welding, railway, English and maths, sign language, security guard, retail, park training, parent courses, NHS training, nursing, environmental science, nail technician, learning to knit, MOT mens course, guitar lessons, hairdressing, forklift truck training, foster carer course, plastering, photography, local history, food hygiene, tilling, mentoring, floristry, first aid and dog grooming.

6.6 Employment Outcomes

A total of **4.8% (n=105)** gained or returned to employment. This included full-time and part-time employment in roles including bike mechanic, bus driver, care assistant, care work and carers, forklift truck driver, hairdresser, retail, lecturer, insurance broker, plastering, car washing, school assistant, school teaching assistant, building site work, taxi driver, cleaner and porter. These roles were at organisations including:

- Age UK, New Life retail, Asda, Poundland, Premiere Foods, Matalan, Tesco, Home Bargain, Big Issue, Bookers Birkenhead, call centres, Clatterbridge Hospital, Hive, restaurants, Hickories West Kirby, FM works, Farmer Pack, LJMU, Ford, Marine Social, Options care work, Pharmacy, Port Sunlight Village Trust, Remploy, primary and secondary school, security, St James Café, Steel Force, Public House, Tulip, the Contact Company, Wirral Council, Involve NW, Avon, ICT Your Housing, Mersey Travel, Autism Together, YMCA and MOD.

> I started to get help with CV after that and was able to get voluntary work as receptionist. Now have a job working as an administrator, through the voluntary work. (Eastham, SU12-F2)

> Initially I was making mud kitchens out of pallets. I was needing to access a workshop and this gave me the opportunity to do it. You just sort of question 'why are these people trying to help me', (CC) put me in touch with John, we had a chat; I explained, thinking even if I can just get a couple of week use of the workshop. They gave me a set of keys. (Wallasey, SU1-M)

> One of the things, as a volunteer, I'm now a sessional tutor, we don't know anything about their backgrounds or if they move on. One girl told me she had a major crash when finished a maths degree and when she came she wouldn't talk to anybody. When she left here she went to a job as a software engineer. So you've got people coming here at all different levels, from higher education to almost no education, that's a big challenge when you're a tutor. (S-NA)

> Reach Out come into Spider and help with employment support. They help you get volunteering experience. They help with smart clothes for job interviews and transport costs. They pay for transport for first month of new job. (S-NA).

6.7 Quantifying Softer Meaningful Changes

The Wellbeing Jigsaw provided further evidence and clarity regarding the specific outcomes achieved as a result of engaging with the CCs. Where notes were recorded, 387 needs were identified for 103 individuals. Needs varied between one and 11 per individual. The majority of individuals had between one and five identified needs (mean need 4). These findings echo those obtained through the qualitative data and routinely collected data, with people requiring support for a wide range of complex health, wellbeing and social needs. The Wellbeing Jigsaw adds further context to our understanding by highlighting the breadth of change brought about by the Health-Related Worklessness Programme and specifically the CCs.

Mental health needs and isolation (both n=83) were the most identified needs amongst individuals completing the Jigsaw. This is unsurprising given our knowledge of the population. However, the Wellbeing Jigsaw provides more sensitive understandings regarding the type and intensity of these needs. Further, this information can be quantified to provide a reliable picture of needs and impact. People experiencing mental health needs and isolation recorded their reasons behind their scoring; these included:

- Mental health issues and conditions, anxiety, depression, low mood, low confidence, boredom, bereaved, anger, OCD, suicidal thoughts.
- Isolation, not leaving the house, not seeing others, having so family, friend or support network.
- Physical health conditions and issues (including health issues impacting on ability to work and ill health due to loss of job), disabilities, autism, dementia, not registered with GP and/or dentist.
- Lifestyle issues including substance use (alcohol and drugs n=16), poor diet (including because of lack of income/housing status), physically unfit, personal and household care.
- Family breakdown, estranged from family members, losing access to children, not seeing children and other relatives, caring responsibilities.
- Financial issues and worries including debt, financial struggles, none, loss of or incorrect benefits, budgeting issues and rent arrears.
- Housing issues, poor living conditions, poor quality housing, homelessness, at risk of homelessness, unsuitable and unsecure housing, need for affordable housing.
- Unemployment and training needs included support to improve skills and opportunities for employment, support with reading and writing (including completing benefits forms).

Engagement/onwards referrals

Individuals working with the CCs set goals that they wanted to achieve. These were recorded within the Wellbeing Jigsaw and included improving skills for employment prospects, access to training and education, opportunity to volunteer, to gain or re-enter employment, improve housing and reduce risk of homelessness, access correct benefits, reduce anxiety, increase confidence and improve mental health, reduce alcohol intake and stop smoking. The individuals also wanted to learn new skills, attend new places, meet new people, and engage with friends, family and the community.

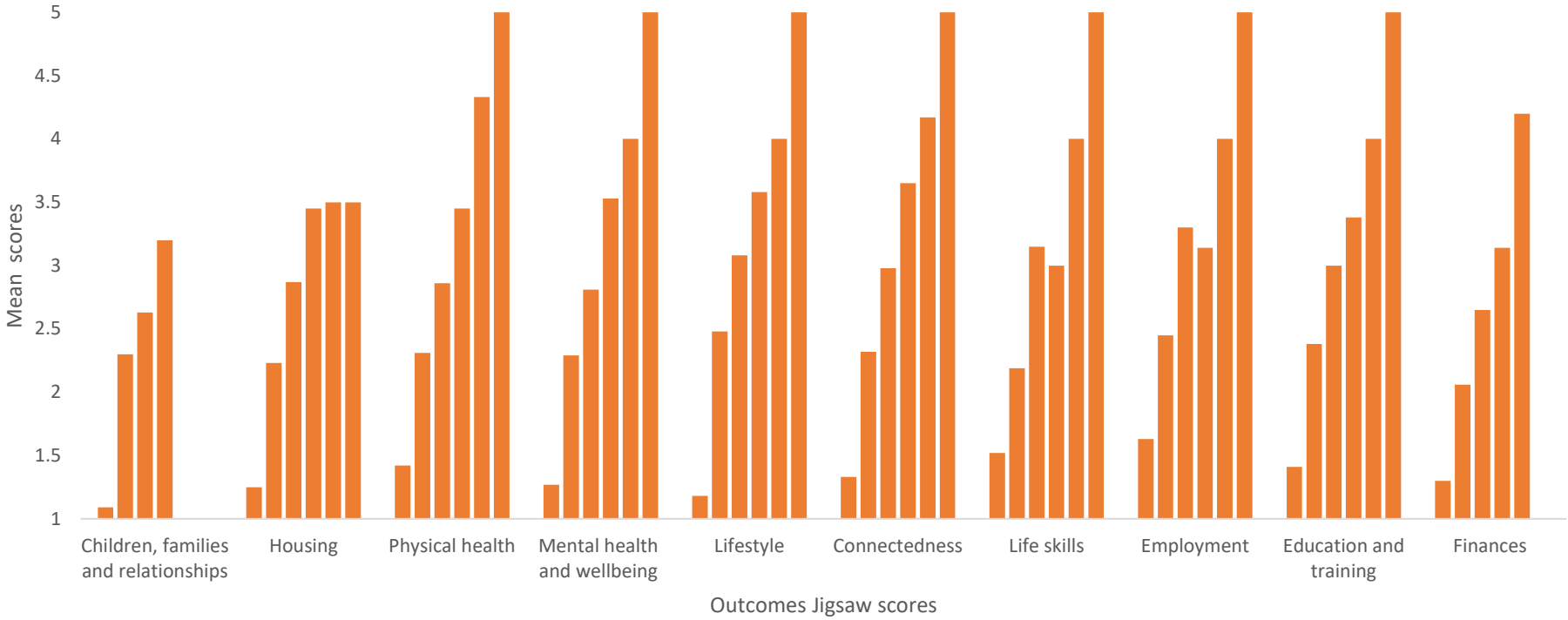
Details of signposting and referrals were recorded for 115 individuals, this included engagement with 297 external organisations. Individuals engaged with between one and nine organisations each, with 91.3% (n=105) engaged with up to four organisations (mean number of organisations per individual n=3). Examples of services signposted, referred to and accessed included:

- Employment services including Reachout, Remploy and DWP.
- Housing services including Whitechapel, Magenta, vulnerable tenants team and Excell.
- Benefits and debt including Involve North West debt and benefits advice, foodbanks, NEO, One Stop Shops, Citizens Advice Bureau, solicitors and legal advice.
- Training and education services including Lifelong Learning, Leapfrog, Talent Match, college and universities.

- Community projects and groups including Spark Funds, Breeze, Spider, Silverbacks, Princes Trust, Friends of Birkenhead Park, reading group, exercise classes, Carbridge Centre, breakfast and lunch clubs, church and mission groups, Social Supermarket, music and art groups.
- Mental and physical health including Inclusion Matters, Open Door, confidence courses, social worker, Tranmere Rovers Football Club (TRFC), GP, Well on Wirral, gym pass and N-Compass.
- Other organisations including Tomorrow's Women Wirral, Age UK, Wirral Ways to Recovery and New Beginnings.

Figure 1 shows an increase in mean scores across all ten outcome measures over a series of jigsaw assessments with individuals identifying a need, setting a goal and taking positive action towards achieving and maintaining their target. When considering mean scores, goals were achieved (scale 5) for physical health, mental health and wellbeing, lifestyles, connectedness, life skills, employment and education and training.

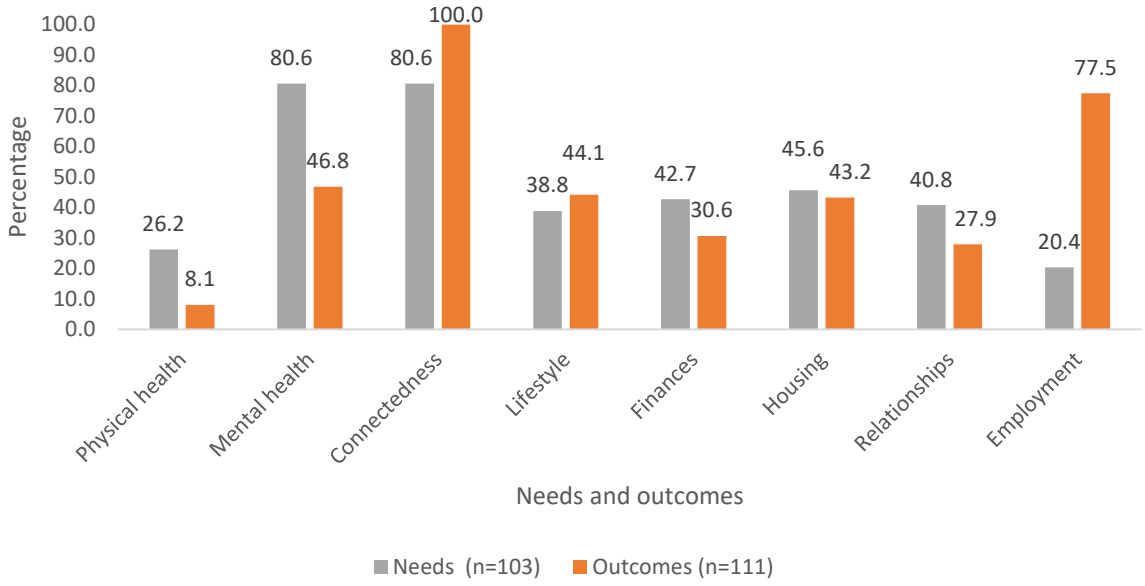
Figure 1. Wellbeing Jigsaw mean scores



Whilst the Wellbeing Jigsaw did evidence that individuals had multiple needs, it also evidenced that multiple outcomes were achieved, with 433 outcomes achieved for 111 individuals. Number of outcomes per person ranged from 1-10 (mean number of outcomes n=4) and 90.0% (n=100) had multiple outcomes (2-10).

Of individuals completing a jigsaw (n=136), employment (n=21, 15.4%) and physical health (n=27, 19.9%) were the least identified needs, compared to higher needs for mental health and isolation/connectedness (both n=83, 61.0%). Figure 2 shows the proportions of need and outcomes for all individuals with a reported need (n=103) and outcome (n=111). Whilst employment was not listed as a high priority at the beginning of the engagement with the CC (15.4% of all jigsaws and 20.4% of individuals identifying a need), the outcomes achieved were much higher, with 77.5% (n=86; 63.2% of all jigsaws) achieving an employment outcome (accessing training, volunteering, becoming work ready or returning to employment). Every individual with a reported outcome, reported some form of improvement in reduced isolation and feeling more connected to their community (n=124; 91.2% of all jigsaws).

Figure 2. Proportion of needs identified and outcomes achieved (for individuals with an identified need and outcome)



A breakdown of outcomes included:

Lifestyle	Connectedness	Employment, education, training
Attended Wirral Ways to recovery Reduction in alcohol intake Maintained sobriety Accessing drug treatment Reduced drug use Stopped drug use Reduced and stopped smoking Accessing food bank Increased physical exercise Accessing walking groups Accessing gym Exploring dancing classes Playing football Following healthy eating plan Passed theory test Leaning to drive	Attending groups Engaging well with referral services Getting out more Leaving the house more Meeting new people Feeling more connected Developing a support network Increased social network Reduced isolation Engaging with community Feeling part of the community SPARK fund applied for and groups established	Attending courses Accessing training Wanting to improve skills Gaining new skills Wanting to become work ready Working towards being work ready Becoming work ready Looking to volunteer Volunteering Seeking employment Completing back to work assessments Attending job interviews Working part time Working full time Started own business
Mental health and wellbeing	**Physical health**	**Housing**
Improved mental health Feeling better/in a better place Feeling more positive Feeling more settled Reduced feelings of stress Engaged with MH service Improved self-esteem Improved confidence Improved mood Reduced anxiety Reduced depression Feeling optimistic Seeking/attending therapy	Registered with GP Taking medications Engaging wit GP Registered with dentist Accessing dental care Improved health Reduced appointments with support worker	Looking into housing options Registered on property pool Actively bidding for properties Moving into independent living Viewing accommodation Moved house Gained stable accommodation Decorated house CC sourced furniture Maintaining tenancy Working on rent arrears Upkeep of house/cleaning Home improvements Gardening
Finances	**Family relationships**	**Life skills**
Completing benefits forms Successful benefits application Awarded ESA support Receiving correct benefits Sought debt advice Managing debt Reduced debt Budgeting Saving money	Improved family relationships Increased contact with family Feeling closer to family Increased contact with/access to children Seeing more of family members	Learning new skills Ability to cope with daily tasks Using public transport Self-care Independence

The jigsaw data builds evidence of a person's journey with the Health-Related Worklessness Programme, specifically through engagement with the CCs. A number of people's journeys are presented to provide further context and narrative around the range of social, physical, economic and environmental outcomes that were brought about as a direct result of the programme.

St James ward, male, aged 59

Disabled wheelchair user, isolated and anxious. Referred to Silverbacks on the day that he engaged with CC. The CC assisted with his first visit to Silverbacks, which was the first time he had left the house in three months. One month later, he was reported to still be attending Silverbacks regularly without being assisted by the CC.

St James ward, male, aged 22

Struggling with low confidence and boredom, looking to get our more, learn new skills and increase social circle. Not registered with a GP and receiving no benefits. Referred to Princes Trust after engaging with CC. Registered with a GP, and referred for benefits advice and looking at benefit support. Reported to be engaging well with Princes Trust and 'loving it'.

Birkenhead ward, male, aged 51

Isolated and suffering with anxiety. Doesn't see children. Looking to become work ready. Engaged with CC. reported improvements in mood, self-esteem and confidence. Gained access to children and reported improved relationships. Developing a support network, gained voluntary work and is developing skills to become work ready.

Prenton ward, female, age unknown

Was struggling with dental issues, which were affecting her confidence. After engaging with CC, she registered with a dentist, went to an appointment, returned to have a dental procedure and new teeth fitted. Was reported to be feeling more confident with new teeth, was connecting more with others and mental health improved.

St James ward, female, aged 28

Mental health issues including depression. Bereaved and isolated. On medications and sleeping most of the day. Carer for brother who lives with her Wants to socialise and looking for activities to fill her day. CC referred to art group and to Reachout for employment advice. Accessed art group, redecorated house, helping brother to move to a new flat, back working in her art studio, not sleeping of a day and reported improved mood.

Eastham ward, male, aged 55

Ill health (recent multiple strokes) and recently left hospital after long stay. No permanent accommodation (sofa surfing). Bereaved, suffering with depression and low mood. Looking to get to the point of 'self-care'. CC supported GP visit to arrange care support, signposted to Bee Wirral Music Project and for benefits advice. Keyworker at Whitechapel provided housing support. Reported improved contact with children, moved to assisted living, improved mood and 'talking to others'.

Leasowe ward, male, aged 50

Living in a tent (for last 9 years). Engaged with CC. Referred to Whitechapel and attended housing assessment, was assessed for a housing bond and started to bid on properties. Went on to view a property, signed a tenancy for a flat, sorted his council tax and moved and started to settle in. Before engaging with CC he reported poor mental health, alcohol abuse and poor personal care. He was given a donation of new clothing and provided with wrap around support to adapt financially after year spent living on the street. Is now reported to be feeling more settled and has reduced alcohol consumption, is coping with daily tasks and reported improvements in lifestyle. Previously had no relationship with family, since gaining own flat, he has been back in touch with his children.

6.8 Exploring the Role of the GP Connector

To further explore the impact of the Health-Related Worklessness Programme, data was collected from the GP Connector between April 2018 and March 2019. This information had been gathered by the GP Connector and shared by the GP practice manager and data analyst. Read Codes (clinical coded thesaurus) were used by a GP analyst to collate information regarding number of GP appointments for individuals engaging with the GP CC. The data exercise was carried out to understand the level of engagement with the GP Connector and whether this had an impact on the frequency of appointments made with GPs.

A total of 17 females and 10 males completed a social prescribing plan as part of their work with the GP Connector to identify their goals and outline planned activities with the GP Connector between April 2018 and March 2019.

Overall, the majority of patients were seen to engage with the GP Connector once or twice. The exception to this was one individual who had seen the GP Connector 16 times during the period of March 2018 to February 2019; it is not possible to ascertain the reasons for these various appointments and whether they were linked/related in their focus or new issues presenting each time.

The majority of those accessing the GP Connector were of an older age-group, being aged 45+ years (n=22, 81.5%), with those aged 65 and above being responsible for more than half of those being seen by the GP Connector (n=14, 52%). More females (n=17, 63.0%) than males (n=10, 37.0%) accessed the service.

Most (n=24/27) patients had attended the GP (ranging between 1 and 9 appointments) and 10 had attended the practice chiropodist (ranging between 1 and 8 appointments).

It is not possible to infer causality regarding engagement with the GP Connector and whether this has led to reductions in GP/other health practitioner appointments. Information regarding the purpose of the GP appointments and whether these were issues that could be addressed by the GP Connector was not available.

- One example showed a male 45-54 years who had six GP appointments prior to completing his social prescribing plan. The plan, however, was only completed in January 2019 so we would need to be able to build up a picture after this to see whether this pattern of engaging with the GP increased/decreased.
- A second example showed a male aged 18-24 years who had nine GP appointments post-social prescribing plan. Whilst a third (male aged 45-54 years) had eight chiropodist appointments post-social prescribing plan; it may be that engaging with the GP Connector led to an increase in GP/other medical practitioner appointments initially, however we would need to follow this for a longer period of time to assess the outcome of this and whether GP appointments tailored off once appropriate support/signposting was received)

Three patients had been admitted to hospital over this duration of time (April 2018 to March 2019) - all of whom were 75+ years, (with one individual being admitted twice); it is not possible to ascertain from the data the reasons for these admissions.

6.9 What Would Happen Without the Health-Related Worklessness Programme?

People were asked to describe what would happen if they had not engaged with either the CCs or the Non-Therapeutic Recovery Service, and whether the changes they described would have happened without their engagement with the programme. Everybody attributed the changes directly to the CCs or Spider, describing that the changes would not have occurred if the programme had not been in place. As mentioned previously, people using Move On Up often referred to their experiences with Spider; it was therefore difficult to attribute changes directly to Move On Up.

Life Saving

Engagement with the programme was described as 'life saving'. Individuals reported finding it difficult to ask for support. One participant recalled leaving home when she was 16 and had 'fended' for herself and had not previously asked for or received support. She described her experiences with the CCs, describing how easy the Connectors were to get along with, and how she would not want help from anyone else apart from the Connectors now. The participant is much happier since meeting the Connectors, she had felt suicidal in the past but the connectors have made a difference to her life and made her feel like 'life is worth living'. The Connectors have put a safeguarding plan in place for her so that she has numbers to call if she feels suicidal.

Another participant described the difference engaging with the Connectors had made to his life. He described feeling like he was on his own before he met the Connectors, his wife went to work and he felt isolated and suicidal with no one to talk to. He has two young children aged three and seven so wanted some help from a service as wants to be able to be a good dad. He praised the positivity of the Connectors and described how they had helped him to feel more positive about doing something. He gave an example of his volunteer role as a school governor and how he wants to quit when he does not feel well but, the connectors have helped him look at the situation differently and he now feels proud of the role.

No Other Service Can Compare

The programme was highlighted as unique and participants described how 'no other services can compare'. The rapport and relationships built with the Connectors was seen as important in ensuring the individuals felt cared for. Participants described how when they had received support from other services in the past, they often felt 'forgotten about', whereas the Connectors kept in touch and maintained communication which provided reassurance. One participant described how the CCs would follow up to check she was doing ok, which was seen as supportive, and again amplified the feeling of no longer feeling alone. This participant expressed that she would like to see the programme continue. Another participant described how the approach of the Connectors is different in that individuals feel empowered and feel like they 'have a say' in what they want to do, reinforcing the idea of recognising their assets. Both participants said that they would not know what to do if the funding (for CCs) stopped. They both said it would have a negative impact on their lives and they would 'go downhill'.

The changes in my life wouldn't have happened without the connectors. (Claughton, SU16-M)

The connectors are full of hope and ideas and they're positive. They can bring a positive out of a negative. (Wallasey, M)

It would be negative, they give you motivation to do things, I don't know what I will do when it happens, they're doing so much good work, I would be very sad. (Wallasey, NA)

If you ring other services such as the Samaritans, you don't know who you're going to speak to. However, with the Connectors, I've built up a rapport. (Leasowe, SU22-F)

They let you talk, and let you say what you want. Some other organisations I've dealt with I've dealt with before, in the past, they're telling you what they want you to do. (Leasowe, SU23-M)

Life is worth living. (Wallasey, F)

Involve is different, because they have employed someone who actually cares. (Claughton, SU18-F)

Mr A's journey

Before Connect Us:

"I was in a desperate situation. I might not have appeared like it from the outside. I was recovering from surgery. I had my small bowel removed, but prior to that I'd gone bankrupt and lost my business, as a landlord of a pub. ***I was on the verge of suicide****."*

*"****There's nothing to do in New Brighton****. It's not exactly full of industry, there's nothing except for the arcades. Stuff for tourists really"*

"I bumped into (the connector), ***he asked me what I wanted to do****. I told him,* ***thinking he wouldn't be able to do anything about it*** *and he went right, here you go then, phone that chap, he'll answer all your questions"*

"Being dyslexic I panic about being in stressful situations. ***When I'm put under pressure to read or write I fall to pieces****. I'm very nervous if people suggest I go on courses, it seems like they are trying to be helpful, but inside I'm going, no, leave me alone!"*

*"****This is the first time I've ever let anyone in****. I was suspicious of everyone and anyone I thought to go with the government or a statutory organisation.* ***People have offered services but I just avoided them"***

Now:

*"I feel like I've got something to go on for rather than depressed, out of work, worried about money, you know, the usual shit that goes on with life. It's given me the opportunity to go for something I'd have never had the opportunity to go for****. I don't drink anymore, I'm happy in myself****. The biggest change in my life is that I have a bit of hope.* ***There is light at the end of the tunnel****."*

"[the connector] has popped down again to talk about other options, to help me online to start selling"

*"****Meeting [the connector] and the others has totally restored my faith in human nature. I wouldn't be here without them****."*

"I was amazed that [the connector] managed to find a chink in my armour. Normally I don't talk to people. It was almost like, you know, when you meet someone and feel like you were meant to meet them. That's how I felt with [the connector]. ***I was like, why are these people helping me, what's the catch? Even now I still have to pinch myself"***

Mr B's journey

"I'd previously lived in Spain, I'd had a pub for three and a half years. I liked meeting new people and interacting with them when I had the pub. ***I found I missed the interaction with people****. I wanted it back but didn't know what to do."*

Now:

"After four years I was ready to do something with my life. I have found the connectors service has given me that opportunity. I was stuck I my house before vegetating and now I'm going out and doing things."

"I enjoy painting and have started to paint again. I made my own art easel. I have my own canvas, I now go out and buy my own paints in Liverpool.

I would also like to learn more about painting."

Before Connect Us:

"My 17 year marriage broke down. I didn't expect it to end. ***It was like someone had taken a sledgehammer to my chest.***

I lived in Liverpool then I moved to Woodchurch and felt isolated. I have a little dog..I would take him out but wouldn't do anything else. I became my own jailer for four years."

"It became a habit, being alone. *I was happy in my own world. Then the Connectors came and saw me. They said about coming to the centre. A week after seeing them I went."*

"I have only been attending centre for 3 weeks. Already talking about volunteering. Used to work as a mechanic, carpenter and Gas Engineer. I have a lot of skills on offer and would like to pass them onto to others.

I have already been to see about a furniture making session Kerrian has been putting on, he suggested I go along and see what people have been making."

Mrs C's journey

Before Connect Us:

"I moved to Woodchurch three years ago after my husband died. He had rare condition called Evans Syndrome. I have an Autistic daughter who I live with and I have an 18 year old son.

Before we moved back into the area after my husband died, I used to put on events with my son to raise money for the condition my husband died from.

For two years we put on an event in Birkenhead Park just after my husband died. We had over 8,000 people attend. It was after that I had mental break down and couldn't cope any more. I went into a manic state."

"I felt suicidal and had tried to commit suicide. I was hearing voices in my head and felt very isolated.

I couldn't leave the house or take my daughter out as I couldn't face crowds of people or get on a bus.

We had each other, we just plodded on."

"I met one of the Connectors and she introduced me to [name] the manager who needed help putting on events.

I agreed to help [name] put on the events. It also gave more support with my daughter."

"At first it was hard as I felt I took on too much too soon as I was at the centre every day, but my mental health was affected. But with the help of [name] I was able to do what I could and take my time.

It's been good having my daughter come to the centre with me. She comes a few times a week with me, when she's not attending college."

Now:

"Coming to the centre has given me more to do with life and has been a positive experience.

I meet new people."

7. Pathways to Impact

The Health-Related Worklessness Programme achieved clear outcomes relating to lifestyle, connectedness, employment education and training, mental health and wellbeing, physical health, housing, finances, family relationships and life skills. Stakeholder interviews provide evidence about why this approach worked in fostering and maintaining partnerships across organisations and in developing social capital. Findings found no significant differences in the types or intensity of outcomes achieved across the wards in Wirral.

7.1 An Asset Based Community Development Model

Findings from the evaluation show that the Health-Related Worklessness Programme demonstrates the qualities and criteria associated with ABCD:

	Foundations /Building blocks	Methods	Mechanisms*	Outcomes*
Key criteria and outcomes of ABCD	Personal assets of individuals. Physical assets of environment. Collective assets such as existing networks.	Asset mapping: inventory of personal, physical and collective assets. Encourage investment from community.	Building trust and trustworthiness Developing relationships. Engagement with target population. Engagement with political powers. Identifying collective goals.	Improved use of resources. Improved relationships and collective efficacy. Achieve collectively-defined goals. Trust and trustworthiness Improved health.

*text highlighted in orange relates to newly identified mechanisms found in Harrison et al (2019, p.3) [19] study.

People engaging with the programme described the importance of being able to engage with services on their terms, with no pressure and no judgement. CCs were viewed differently to other organisations, with people describing them as innovative, independent and having advocates who have community interests at heart. The term 'working at the speed of trust' was often used to describe the CC approach to building relationships.

> The individuals are hard to reach so you need time the engagement is the hardest bit. Once you get them engaged and hooked in a programme then they will stay but it's getting them through the door on day one and that's where the approach of the connectors is needed. (Engagement Officer Social Housing)

> It is very different, it's very innovative. You need the right people to do that job, and having met them all I think what helps is having a mixture of age range, ethnicity, experience, the ways they communicate within the community. I haven't seen anything like it on the ground before. The connectors add additionality and a service we can't provide. (Safer Wirral Hub)

It's the first experience I've had that's worked with any organisation, it's all been positive. A softly softly approach works much better, the fact that he lets me do it at my own pace, it's reassuring, at my own pace there's less pressure. If he asked me to do it I would feel obliged, because he's such a nice fella, so I'm glad he hasn't asked me. Meeting (the CC) and the others has totally restored my faith in human nature. He's in exactly the right job, any other job and he'd be wasted. To meet someone and have that instant respect for them. I want to see the project continue, I wouldn't be here without them. (Wallasey, SU1-M)

Connectors listen, don't judge and will always get back to you if you need some help. Connectors are knowledgable about the area and know what's around. [I] Wouldn't change the service. (Eastham, SU12, 2F)

Areas are difficult to infiltrate. There are (geographic) areas that aren't open to statutory services to support. I think some householders would be apprehensive about coming to the police, the ASB team, because they'd be classed as snitches. Whereas you get the Connectors into an area and it's a great way to get across the door, for someone to communicate and listen and understand what the issues are and feed them back, and doing that anonymously as well, which helps us put the right people and the right services into the area at the right time. (Safer Wirral Hub)

The connectors are reaching out and attempting to engage with people and that's hugely important. Social isolation is a massive issue, changes in the system mean the poorer people are more isolated than ever, technology isn't helping that so engaging with people is really important and public services are less financially able to do that. (Social Landlord)

The personalised approach to identifying assets and support needs was viewed as particularly positive by stakeholders. Here, all participants recognised the importance of addressing and supporting individuals and felt this was well addressed by the CCs.

It's quite a big area and there's a big variation in the needs in the different areas and how affluent they are. Oxton and Prenton wouldn't have the same issues and needs as north Birkenhead. It can be difficult to pitch as service on what you think is needed. They have different needs and that's where the Connectors project is working as they work in different areas so they can tailor their approach based on what those areas needs instead of taking a blanket approach to all of the Birkenhead parliamentary area.
(Engagement Officer, Local Authority)

The individuals are hard to reach so you need time. There's a lot of support out there, maybe even too much support. The ideas behind connectors when it was first set up was looking at there's people out there who need the support, the support is available but they don't know about it and the agencies providing the support don't know how to find the people that need it (Engagement Officer, Social Housing)

7.2 System-Level Outcomes

Representatives from statutory and non-statutory services described the success of the delivery model, where partnership working was viewed as integral. All stakeholders described positive experiences of engaging with the Health-Related Worklessness Programme and gave examples of how and why this was successful.

The Connectors popped in and told us what they did. We met and talked through what we already did in the community and what we'd like to do. There has been a group that wanted to set up bingo for the community so we've been able to offer them the use of the building at a reduced rate, so about 30 elderly women come and play bingo on a Wednesday night. That's enabled us to get to know more people from the community and wouldn't have happened if Connect Us hadn't got in touch.

We've had referrals from people the Connectors have met, tenants out of the community. Rather than duplicate services we want to join the gaps and Connectors have helped, instead of us trying to find partners to refer people to I have used the connectors for that engagement and linking up and having that bit of time for them.(Engagement Officer, Social Housing)

It's gone very well. I think collaborating with us has helped the connectors get established more quickly in the neighbourhoods, giving them access to all the partners the police have. (Safer Wirral Hub)

Case Study: Department for Work and Pensions (DWP)

Model of Delivery

"There are pockets of areas in Birkenhead where nobody ever comes out of their front door so the only way to engage with them is door knocking. A lot of organisations assume that in DWP we have contact with everybody but there's a number of the 16,000 who stop sending their sick notes in once they've passed a medical we've had no contact with in years. They are the ones we need to get to. So we've asked X if they could put some workers in here which was a tough ask but through doing that they've made some contact with people they might not have before. That's helped to engage people back with us. Our work coaches are working with them too.

I've been door knocking with them, they are great they are breathing life into the area and connecting services together, as well as supporting individuals which they do extremely well. I made some connections with other organisations when I went door knocking. They know what's going on in group level so they are bringing people in to us and I have seen great progress in what they are doing."

Connections to Other Organisations

"The Connectors have led us to know what's going on in the community around the Universal Credit being introduced. The connectors took us to Charlie Thompson Mission and that has led to us having a presence there supporting homeless customers there and also the YMCA; I've put a member of staff in outreach there. They have reintroduced me to services that I haven't been in in years."

Impact

"I think it's better than I expected. I was worried about a customer who wouldn't look up off the floor and we didn't know what was going on. I asked would he mind if we spoke to a Connector and he said yes. The Connector went to his house and he was living in appalling conditions, it looked like he was squatting, it had no roof, no electricity and lots of people living there. The Connectors referred onto the housing unit who rehomed everyone living there, they also connected him back into housing options team to get him rehoused and his benefits had fallen down and we were able to help with that. That was only because they were able to get in and get that detail out. Then we all worked together to try and support that customer."

Sustainability for the Future: An Asset Based Approach

"There are people with very complex issues and barriers that need support and it's not my job and it's not the Connector's job so that's where the conversations are going now. This is a very different approach, I didn't understand ABCD at first but when they were going around and promoting the cafe within the church, they were using it, we were using it, their job is to bring people back and use their talents to see if this will spin off into other things and other services for people. They were saying to people that space is there and if you want to set up a venue in there you can, what skills have you got that you can give back, in that respect that's how they were doing it. I think this is sustainable because the overheads just aren't there, people are using their time and their own resources to support individual initiatives and generating a bit more life into the communities by doing so."

8. Conclusions and Recommendations

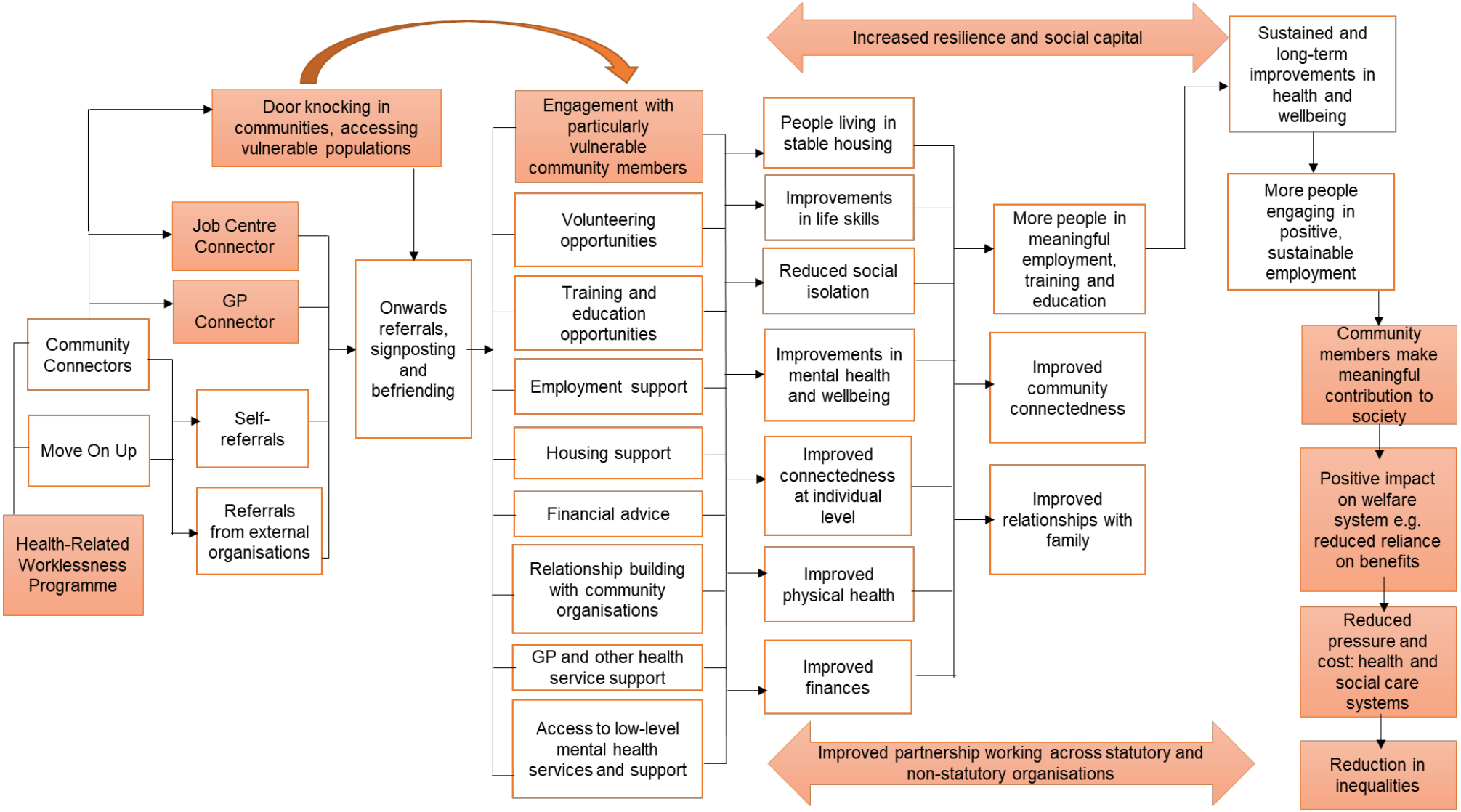
This evaluation showed that many people in Wirral were socially isolated, mentally unwell and desperate, and in a perpetual cycle of being too ill to work, but not unwell enough to access services and support. Further, our research highlighted the reasons *why* people were stuck in this grey area. Community Connectors uncovered the hidden communities experiencing these issues and identified the wide-ranging and often co-existing physical, mental, financial, employment, housing and relationship problems that exacerbated these issues. The research highlighted how the use of an 'upstream' model to uncover these hidden communities and offer support using an ABCD approach provided people with the motivation to take responsibility for changing their lives.

Developing a Theory of Change

A Theory of Change has been developed to show the small but meaningful changes that occurred as a result of the programme, along with the longer-term outcomes associated with this. The Theory of Change evidences the links and assumptions between programme activities and outcomes, highlighting how the door knocking was a particular activity that effected change.

"A big issue for the commissioners of the project is to show outcomes. You can't show an increase in mind-set so that's a real challenge. The outcomes, changes, can only ever be realised long-term and the commissioning will only ever be short-term. If someone starts living a more active lifestyle, the impact on society is not going to be realised until that individuals lived their entire life. It would be a tremendous loss for the project to finish and in terms of public health I think it's the right thing to do. All you can do is measure small steps forward (Social Landlord)"

Theory of Change



8.2 What elements of the programme were most successful?

The delivery model: An asset based approach can work

Our evaluation findings reflect previous research in this field; many people out of work experience situations of desperation, extreme levels of social isolation, poor mental health, vulnerabilities, co-morbidities and very low aspirations. These issues need to be recognised and supported before many people are ready to consider taking steps to sustainable employment. Local productivity strategies need to ensure that interventions reach those most in need in order to address, *and not exacerbate*, health inequalities. The biggest impact will be made by targeting those people who are *most in need* of support. This is hard work and resource intensive, but worthwhile.

Our findings show that an asset based approach can do this; using local resources and engaging local people as CCs has had a positive impact in Wirral. Our evaluation shows that CCs are well placed to access and support those people who are furthest away from employment and those for whom employment had not previously been an option. Time taken to build trust and respect are key to the success of this intervention. A clear partnership model must underpin the approach, with clear channels of responsibility, communication and purpose defined with local partners.

Recommendations

Ensure that CCs are available within local communities in Wirral. Continue to link in the Job Centre with CCs in order to maximise the impact of the intervention with those who are most vulnerable. **Use segmentation and/or profiling to identify the communities who are most in need** of support (and potentially less receptive to intervention) to inform where the Connectors are needed the most:

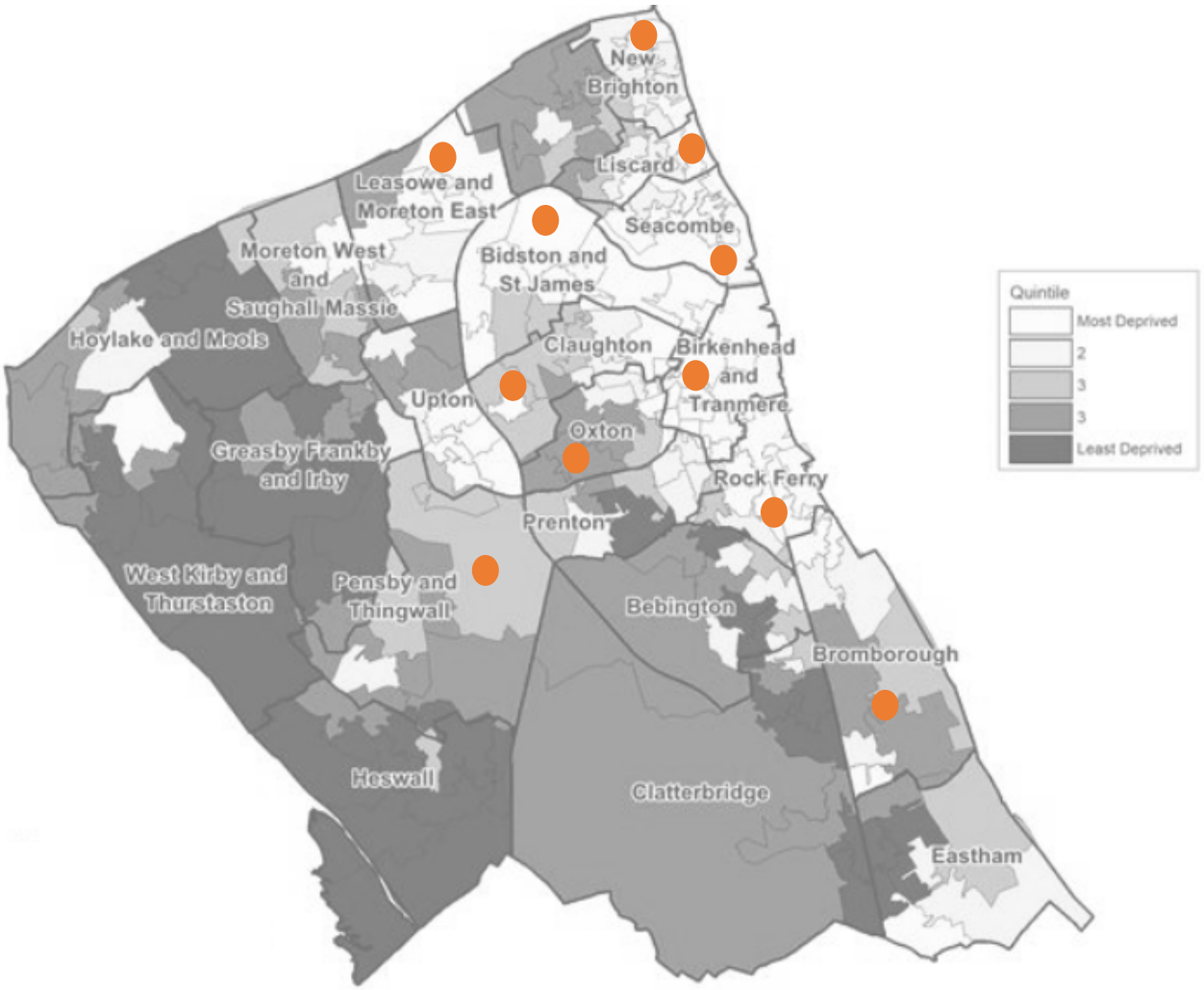
- Findings from our primary research and health profile reviews suggest that resources could be targeted at the wards in Wirral which reflect populations with the characteristics most associated with worklessness:
    - High deprivation, low life expectancy, high unemployment benefits, high JSA claimants for more than 12 months, high percentage of children living in poverty, high percentage of households lacking central heating, high numbers of people living with life limiting illnesses and high crime rates.

Recent data (February 2019) shows that Birkenhead and Tranmere, Seacombe and Rockferry had profiles which were all worse than the national average on these items. Bidston and St James and Liscard scored poorly on all but one item (high JSA claimants for more than 12 months).

Woodchurch, Claughton, Leasowe and Moreton East, Bromborough and New Brighton scored poorly on all items except high JSA claimants for more than 12 months, percentage of households lacking central heating and crime rate.

In addition to the wards highlighted above, Pensby and Thingwall scored worse than national average for percentage of people living with life limiting illnesses.

Suggested areas of focus for future CCs:



Findings showed no differences between the wards and outcomes, suggesting that the model of delivery is effective. Future efforts should include people at risk of becoming vulnerable, including those in precarious employment, carers, low-income families.

8.3 What were the crucial mechanisms that enabled success?

Recognition that one size does not fit all

The Health-Related Worklessness Programme was developed with a view to supporting communities to build capacity and resilience to take responsibility for their own health and wellbeing. The asset based approach was central to the success of this and enabled people to engage with services on their own terms, with no pressure and no judgement. The CCs were viewed differently to other organisations, and were seen as independent advocates with community interests at heart.

The CCs and Move On Up used a strong partnership model of mutual support and collective action to ensure that interventions provided individualised support which considered needs and aspirations. CCs were able to provide specialist support or, in some cases, could outsource this where required. Whilst this was effective, it was resource intensive and challenging for Connectors to offer tailored support to everyone they engage with. This intensive support often led to very small, but very positive, changes for people.

Our research also found that an intervention that works in one locality will not necessarily work in another; community members, community drivers and geographic factors all affect this. Issues such as transport and accessibility of local activities were central to this.

Recommendation

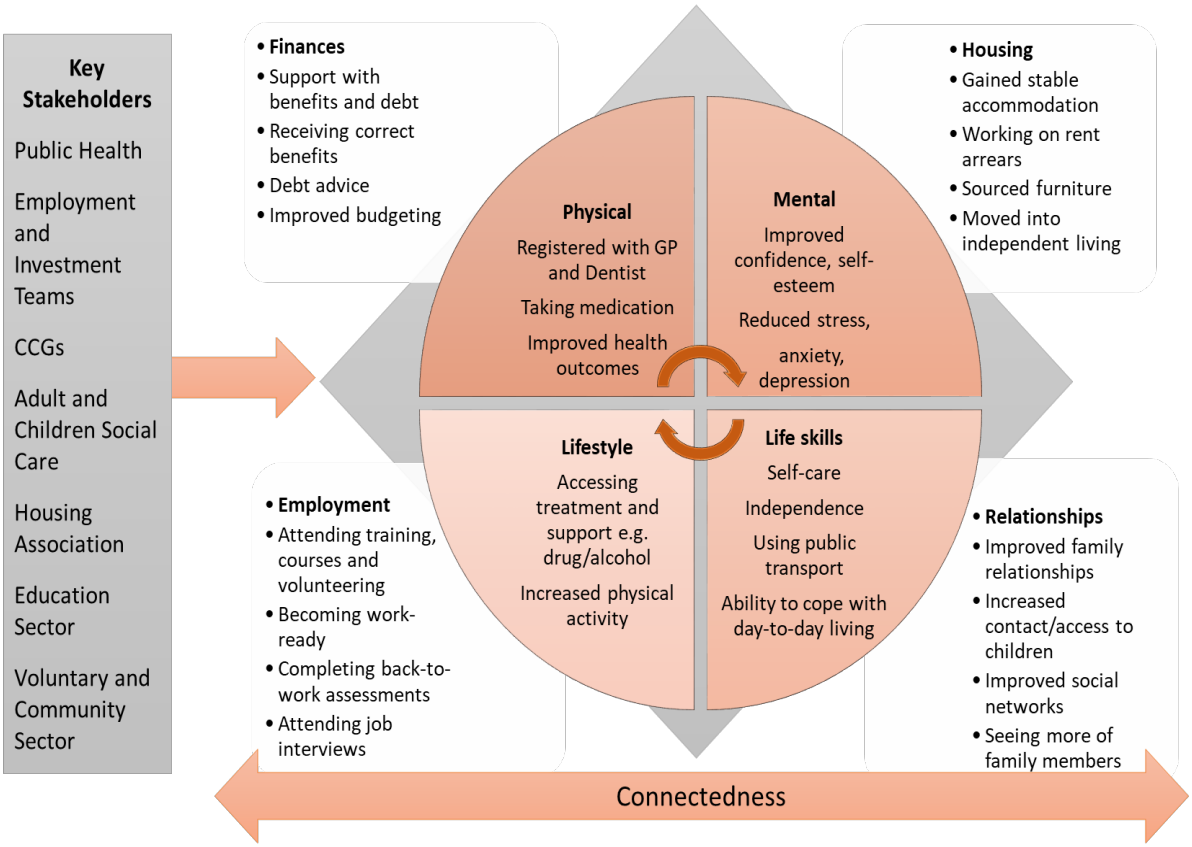
Work-related support should be locally driven. **CCs are best placed to identify local need and subsequently mobilise action** with individuals and/or communities, engage with key partners and organisations to facilitate support where required. Partners from DWP, Merseyside Police and local housing organisations all provided examples of where they had developed and sustained partnerships with the CCs and the outcomes associated with this.

The people were central to the success of this programme

People were the drivers behind the success of the programme; this reflects findings from previous asset based community development work. CCs demonstrated an understanding and empathy for the people they are working with. A non-judgemental approach means they are more likely to engage with people who are wary or have had negative experiences with previous organisations. CCs were comprised of local residents who often had experienced similar issues to the people they engaged with, such as addiction, homelessness and poor mental health. As a result, the Connectors were able to demonstrate empathy and understanding and were able to quickly build trust and respect. All of the CCs demonstrated personal qualities that enabled them to build and sustain relationships with people living in communities, from statutory organisations and from the third sector. The importance of having the right people for the role cannot be over-emphasised.

8.4 How does the programme and evaluation inform system level change?

The Health-Related Worklessness Programme contributes to the outcomes of other services, including supporting people to gain secure and stable housing, improving relationships with family members and providing debt and benefits advice. The model below represents key individual-level and socio-ecological outcomes along with key stakeholders who will affect and be affected by the Health-Related Worklessness programme.



These findings have implications for the commissioning, delivery and monitoring of statutory and non-statutory services and are of relevance to stakeholders involved in delivering health and social care outcomes (including health and wellbeing boards, the voluntary and community sector and local Healthwatch). The evidence can also inform the development of key strategic local objectives including Wirral Ways to Work and Wirral Vision 2030 (a partnership between Wirral Council, health services, the police and fire services, the education sector, voluntary sector and local businesses to promote investors and businesses) and the role in the Liverpool City Region devolution commitments to increase local economic growth.

This evidence also contributes to the work developed by the Centre for Local Economic Strategies (CLES) which highlights the potential contribution of 'anchor institutions' to support local economic growth. Here, organisations are defined as anchor institutions if they make significant contributions to the local economy, are unlikely to leave a geographic location due to strong investments in capital and have purchasing power. Examples of anchor institutions include local authorities, universities, CCGs and housing associations[20]. Anchor institutions have the potential to support local businesses to contribute to local socioeconomic and community development.

Taking Ownership of the 'Grey Area'

The stakeholders who contributed to this evaluation recognised the system-level challenges and barriers faced by community members, local assets and statutory and non-statutory organisations. These included access and waiting times for local mental health services, challenges accessing support and information for housing, debt and benefits advice and the worries people faced in wanting to contribute to community activities (e.g. volunteering) but not wanting to appear too well to work. Our research acknowledges how the Health-Related Worklessness Programme contributes to the outcomes of other organisations, however,

developing collective action to take ownership of these issues requires a cultural shift and will take time.

Recommendation

Use local Primary Care Networks to support an integrated approach to health and wellbeing and work to reduce demand on GPs and consider how social prescribing link workers can form part of the CC care pathway.

Disseminate the findings of this research with key groups and networks, including those who design and develop partnerships across systems. Primary Care Networks may present a good example of an opportunity to highlight the role of CCs in contributing to system-level outcomes.

Learning from the CLES evidence to procure services locally and socially and ensure moral and ethical employment will also support system-level change. A key recommendation from the CLES (2019) report included ensuring local anchor institutions have policies in place to support community and social businesses.

Developing a Shared Narrative

Ensure that small but meaningful changes in physical, social, environmental and economic outcomes are valued. Our research found that people made many positive steps towards meaningful, sustainable employment; however, this did not always result in employment within the programme/funding timeframe. Further, such positive steps are not always captured in routine monitoring and evaluation.

Using the Wellbeing Jigsaw and qualitative research has evidenced the breadth and depth of outcomes associated with the Health-Related Worklessness programme. This evidence provides a shared narrative that connects the work undertaken by a wide range of statutory and non-statutory public sector services in supporting unemployment.

Service providers and delivery partners were keen to highlight the resource-intensive and specialised support they provide to individuals to help them move towards employment. For example, many people engaging with the Wirral Worklessness programme had started to work in voluntary settings as result of improvements in confidence and self-esteem (self-reported and measured via SWEMWBS).

Recommendation

Collect data to evidence steps towards meaningful employment. **Collect softer outcomes using the Wellbeing Jigsaw alongside routinely collected data**. Continue to gather case studies to evidence journeys to impact to inform future commissioning.

Collect evidence to understand the reach and impact of continued local employment and productivity strategies. Closely monitor activities to ensure that opportunities are presented to those members of Wirral communities who are most in need; *if not, there is the risk that an activity such as this will shift poverty to other areas of Wirral and ultimately widen inequalities*.

Recommendations for Programme Recommission

Redefine the role of the GP Connector

The GP Connector role has posed challenges with a change of staff mid-way through the role. Obtaining buy-in from GPs was more difficult than expected. The initial GP Connector was located in a surgery whose local patient population was largely an elderly cohort, as a result many fell outside the target population. People who were referred to the GP Connector via the GP were not always clear about the role of the Connector and why they had been referred. This Connector was also working outside of the core Connector team so did not benefit from the group knowledge or support. The GP Connector role would be maximised by spending time in the local community working with local groups, assets and organisations and participating in activities such as door knocking.

There was evidence of other CCs who had built up successful relationships and referral pathways with their local GPs. The GP Connector role has the potential to support vulnerable community members; particularly carers, those in precarious employment and those in low-income households.

In order for the GP Connector to be successful, the care pathways associated with CCs need to be clear to both GPs and their patients; the role and remit of the CC and onward referral pathways need to be explicit. The benefits of CCs need to be clear in order to make better use of CC capacity.

Distinctions also need to be made between the role of the CCs and social prescribing. Whilst social prescribing is an effective way for GPs to prescribe for the social problems that patients present with, this may not support community members who are most isolated and do not access their GP. Social prescribing features in the NHS long-term plan[25] as a method to support individuals to manage their own health, with an aim to engage 2.5million people in social prescribing within the next five years. Primary Care Networks will bring community-based health professionals together to proactively support the health and wellbeing of the wider population[25]. This is a key network for CCs to become part of.

Recommendation

In order to maximise their impact, the GP Connector would benefit from engaging with the other CCs within their ward to understand the needs and assets within the local community and support an integrated approach. CCs could **utilise the role of local Primary Care Networks** to support an integrated approach to health and wellbeing and work to reduce demand on GPs.

Social Prescribing Link Workers should be part of the care pathway, referring patients directly to a CC who will visit them at their home the following day. Further evaluation should consider whether the Social Prescribing Link Worker duplicates the role of the GP Connector.

Findings from this evaluation need to be shared with GP practices. Further, it would be beneficial to **obtain feedback from patients who have used GP Connectors to evidence how and why this approach works**; this information could be collected via GP Practice Patient Forums and facilitated through the Link Worker.

Maximise programme impact

The CCs were able to uncover the hidden communities who were experiencing a range of co-existing physical and socio-economic problems. This upstream approach was effective in

supporting people who may not otherwise have received support to now be in a position to access the pre-employment support on offer.

Recommendation

Adding investment to the CC element of the Health-Related Worklessness Programme, by focusing on widening the geographical reach and integrating care via connections with Primary Care Network and GPs [e.g. via Social Prescribing Link Workers]), with maximise the impact of this programme.

Provide wrap-around support for Community Connectors within the wider system

Our process evaluation found differences in expectations regarding the roles and responsibilities of CCs. Some community members and partner organisations raised caution regarding the expectations placed upon the CCs. Some people felt extra capacity was needed to keep building on the positive outcomes they had experienced whilst others expressed concerns about the wellbeing of the CCs in carrying out a potentially stressful role. This was particularly evident at the start of the contract, where CCs received high levels of referrals for individuals requiring more intensive support than they were expecting to provide, particularly regarding mental health.

Some stakeholders and community members described how further investment in infrastructure and resources would be needed in order to bring about meaningful community-level changes. It was acknowledged that more time would be needed to demonstrate a shift in outcomes. These findings add weight to the argument to further invest in the Health-Related Worklessness Programme, particularly in the CCs.

There is a gap between the thresholds for people to access statutory services and demand; disinvestment in local services has made access to specialised mental health care difficult, with people not meeting thresholds or experiencing long waiting times for support.

Recommendation

Ensure that **health and wellbeing support is provided** for CCs, particularly Volunteer Connectors who may be more at risk of suffering with poor mental health.

Work with the Primary Care Network to ensure partners and organisations are aware of the remit of CCs. Whilst CCs can reduce the demand on more intensive services, the complexities of the CC client group needs to be made clear to partners. Wrap around support from wider services in Wirral is required so that CCs are not relied upon to provide the longer-term, specialist support that they are not trained to provide.

Review the impact of disinvestment in local mental health services to provide evidence of who the threshold gap most affects and the potential impacts of this.

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Appendix – methodological notes

Seondary data analysis – missing data

1. Referral date missing n=4 (0.2%)
2. Gender missing n=2 (0.1%)
3. Ethnicity missing n=2 (0.1%)
4. Age missing n=12 (0.6%)
5. Working age missing n=12 (0.5%)
6. Children missing n=2 (0.2%)
7. Disability 1 missing n=13 (0.6%), disability 2 missing n=836 (38.4%)
8. Constituency missing n=12 (0.8%)
9. Ward missing n=18 (0.8%)
10. Employment missing n=16 (0.7%)
11. Benefits missing n=17 (0.9%)
12. Uptake of signposting/referral by ward available for n=2,088 (96.0%): yes n=1,030 (99.5%), no n=1,058 (98.9%)

Wellbeing Jigsaw analysis – available data

1. Free text was available for need n=3817 (103 individuals), referrals n=297 (115 individuals), outcomes n=433 (111 individuals)
2. Please that in some cases it may be that 0 has been used to identify the issue, rather than a score of 1 (meaning that needs may be higher than reported here), however this assumption cannot be made for all jigsaws and therefore 0 has been removed from the analysis.
3. Recorded scores across the jigsaw (categories 1-5) were available for: Relationships n= 111, Housing n=150, Physical health n= 127, Mental health n=267, Lifestyle n=155, Connectedess n=261, Life skills n= 83, Employment n=127, Education n=119, Finances n=167

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