Evaluation Report for Community Connectors Project;
Linking to Sefton Council Public Sector Reform
(Early Intervention and Prevention).

Title
The impact of Community Connectors project on Adult Social Care and residents in Sefton.

By: Gina Harvey

Date/Version:
December 2018
Version 1
Executive Summary

Introduction

The Community Connectors project was set up by Sefton Council for Voluntary Service in partnership with Sefton MBC. It is a borough wide service which helps to reduce the levels of loneliness, social isolation and low level mental health experienced by residents. Enabling individuals access to local support through a range of early intervention and prevention services that already exist, many in the voluntary, community and faith (VCF) sector such as luncheon clubs, debt awareness, social activities, befriending, foodbanks, as well as commissioned services such as Living Well Sefton.

The evaluation of Community Connectors aims to assess the impact of this early intervention and prevention initiative on diverting inappropriate referrals away from the Adult Social Care pathway in Bootle.

The objectives of the evaluation are to:
- Establish the impact of Bootle Community Connectors on the Adult Social Care call log in Bootle (are numbers decreasing, increasing or staying the same?)
- Establish the impact of Bootle Community Connectors on client’s (a) loneliness and mental wellbeing scores and (b) activity in terms of access to local groups.

Evaluation methods

The Evaluation used a mix method approach:

- Quantitative data; total of 51 service users, this includes gender (30 males / 21 females), ethnicity (50 White British / 1 German), where referrals came from, services and organisations clients were signposted and introduced to, difference in wellbeing score and loneliness score, and difference in digital media usage.
- Qualitative data; 7 semi structured interviews with service users during their final meeting with the Community Connector.

Results and findings

Although the majority of referrals came from Adult Social Care, a high proportion were from other services such as GP’s or Health & Wellbeing Trainers, which shows that Community Connectors is being used as a early intervention and prevention method as opposed to Adult Social Care.

Adult Social Care call log has reduced from 920 in June 2017 to 576 in November 2018. Part of this is due to the partnership work between Sefton CVS and Sefton MBC.

Between June 2017 – end of October 2018:

- 30 clients have completed the Community Connectors project
- 100% of these clients reported reduced feelings of loneliness and social isolation
- 100% of these clients reported an improvement in their mental wellbeing
- 26% reported an increase in digital media usage, which was used as a tool to reduce loneliness and social isolation
- 48 people have been supported to attend 24 different local groups and services

The evaluation also highlights that people that drop out of society can become isolated as services is available for self-referral or referral by other services. People become invisible often until the point of crises and then report to Adult Social Care or emergency services. Easy self-referral in to Strand-By-Me has shown to be approachable for people who feel they need support, it resulted in quick response. Although only 5 of the referrals were self-referrals, these were some of the most successful cases, whereby clients were fully engaged with the project from the beginning. The response from Community Connectors seems to be immediate and supportive which keeps people attending and engaging.

The evaluation also highlights that Community Connectors project has facilitated the connection of people with people, which in turn can help them to help others, possibly through volunteering. Although none of the participants to this study became Volunteer Community Champions, some did become volunteers at Strand-By-Me.

**Conclusion**

To conclude, Community Connectors project has shown has supported people to change their lives for the better. Clients are attending more local groups, engaging with more people, more often and feeling less lonely and isolated. The mental wellbeing has improved considerably, their confidence has improved and have a more active life.

The partnership working between Sefton CVS and Sefton MBC has been remarkable and should be used as a benchmark for other local authorities and third sector organisations.

**What still needs to be done:**

- Work with Sefton MBC to establish a clear and direct referral pathway from the Contact Centre to Sefton CVS Community Connectors.
- Identify a way of exploring whether or not clients are seeing friends outside of the groups, or whether they are seeing more of their family or neighbours etc, and identify how best to monitor and evaluate this.
- Identify a way of contacting clients post project to see if they are still attending the same groups, how often, and measuring their levels of loneliness and isolation and mental wellbeing, and identify how best to record this.
FULL REPORT

Introduction

According to Sefton Council's ward profiles there are over 23,000 people over the age of 65 living alone in Sefton. It is possible that many of these people experience isolation and loneliness. Often these people have low level mental health needs such as anxiety, stress and depression. With limited social networks relatively minor situations can quickly escalate to crisis e.g. debts, illnesses and problems with neighbours. When in crisis many people are likely to contact public service agencies such as Adult Social Care (ASC) and the Police.

The Community Connectors project was set up by Sefton CVS in partnership with Sefton MBC. It is a borough wide service which helps to reduce the levels of loneliness, social isolation and low level mental health experienced by residents. The purpose of this study is for Sefton CVS and Sefton MBC Public Health to use the research findings of Community Connectors as a case study for their Early Intervention and Prevention programme (EIP3). We will use the positive outcomes as best practice for service improvements on other programmes/projects, and we will also learn from identifying those things that do not work.

The evaluation of Community Connectors aims to assess the impact of this early intervention and prevention initiative on diverting inappropriate referrals away from the Adult Social Care pathway in Bootle.

The objectives of the evaluation are to:

- Establish the impact of Bootle Community Connectors on the Adult Social Care call log in Bootle (are numbers decreasing, increasing or staying the same?)
- Establish the impact of Bootle Community Connectors on client's (a) loneliness and mental wellbeing scores and (b) activity in terms of access to local groups.

Programme rationale and logic

Health inequalities faced in Bootle ward:

According to the Sefton Ward Profiles there are a total of 31,684 residential properties in Bootle, which represents 27% of the borough housing stock. There has been a 1% reduction in the number of households compared to 2001. This is in contrast to the 1% increase seen across Sefton as a whole. Bootle has a rate of 24 vacant and void properties per 1,000 properties, higher than the rate in Sefton (20).

Of the 31,684 residential properties in Bootle; 35% are resided in by only one person, a rate of 346 per 1,000 properties. This is higher than the Sefton, North West and England rates (32%, 31% and 30% respectively).

There are 35 Lower Super Output Area's across Sefton that fall into the most deprived 10% of areas nationally, 30 of which fall into the Bootle township area. This equates to over half of the 53 LSOA's that make up the township. There are three LSOAs within Bootle Township that fall within the worst 1% nationally, all of which are in the Linacre Ward area, and 21 that are in the worst 5%. This means 56.2% (40,725) of Bootle township residents live in areas in the most Deprived 10% nationally, with 4% (3,778) of residents living in areas that are in the most deprived 1%. 
Latest available information (May 2014) shows the number of working age people in Bootle township claiming benefits is 12,675 or 27%. The percentage of Bootle township claimants is not only higher than the Sefton rate of 17%, but considerably higher than the regional rate of 16% and over double the national rate of 13%.

Between January and December 2014, Bootle township accounted for 38% (5,572 of 14,507) of Sefton’s crimes reported to Merseyside Police. Equating to 76 crimes per 1,000 residents, higher than the rate in Sefton as a whole (53 per 1,000 residents). Between January and December 2014, Bootle township accounted for 41% (3,766 of 9,209) of Sefton’s Anti-Social Behaviour (ASB) reported to Merseyside Police. This equates to 52 incidents per 1,000 residents, higher than the Sefton rate of 34 per 1,000 residents.

Between January to December 2014, Bootle accounted for 49% (4,910 of 9,990) of Sefton’s Environmental issues reported to Sefton council. This equates to 67 issues per 1,000 residents which is considerably higher than the rate across Sefton as a whole (37 per 1,000 residents).

In total 35% (20,176) of residents within the ward stated that they did not have any form of qualification. This equates to 345 per 1000 residents, higher than the Sefton rate of 251 per 1000 residents. According to the Census 2011, general health within the Bootle township is on par with the rest of the borough, with 75% (54,546) of residents describing their general health as either very good or good, lower than the percentage seen across Sefton as a whole (77%). 25% (18,147) of the township’s residents state that their daily activities are limited in some way; higher than the Sefton rate (22%). Twenty four of the 52 LSOAs in Bootle are within the top 20% areas with residents deemed to have bad or very bad health, with seventeen being in the top 20% for long-term health problems. 12% (7,142) of the townships residents are providing unpaid care, slightly lower than the figure for Sefton (13%).

Between 2008/09 and 2012/13 there have been 12,026 hospital stays for alcohol related harm in the Bootle township. In order to allow comparison with other areas this has been turned into a standardised admissions ratio (SAR). Bootle has an SAR of 159, considerably higher than that of Sefton (119) and England (100).

The wider effects of Community Connectors on health inequalities:

All clients are given the opportunity to become a Volunteer Community Champion. However those clients who took up a volunteering position afterwards chose to volunteer at Strand By Me. In doing so, they have attended a Volunteer training day, where we provided MECC (Making Every Contact Count) training, Safeguarding Vulnerable Adults training, and Dementia Friend workshop. As a result of attending they have become more knowledgeable and informed.

The Community Connectors was originally an 18 months fixed term project, due to end in December 2018. However this has been extended and is now due to come to an end in March 2019.

There have been times during home visits, general engagement phone calls, volunteer forums, and when developing our partnership with Adult Social Care when we identified unintended effects of our service; these have been both positive and negative. We have fed these back to the relevant people, many of which have been rectified, and used in bids for funding applications.
An example of a negative unintended effect:

- We first started attending Adult Social Care triage team on a weekly basis in June 2017. Once the team identified a client on their call log who didn’t meet the criteria for a Social Worker assessment they were referred to Community Connectors. We completed a referral form and the triage team would update their database to say this client had been assigned to Sefton CVS Community Connectors team, which automatically removed the client from the call log. Initially this was a positive result as we could see an immediate reduction in the number of people on the call log/waiting list.

However, there were a few cases upon completing a home visit the client wanted us to help them with loneliness and social isolation, but still needed a Social Worker Assessment and it was clear from meeting the client that they definitely did meet the criteria for Social Care. Because these clients had been removed from the call log, they had also been removed from the waiting list which meant they had to be added again, but went to the bottom of the waiting list as opposed to being contacted at their initial place in the queue. We worked with Adult Social Care staff to rectify this so no clients were removed from the queue even when they were allocated to Sefton CVS for the Community Connectors input, until the Connector had completed an initial home visit to make this decision.

An example of a positive unintended effect:

- We currently have 3 members of a local group in Maghull called Yarnigans who have registered as Community Champions and have attended our first training day which took place in Bootle. As a result of attending the training day they set up another 2 Yarnigans groups in Bootle upon hearing there was a demand for a knitting group.

Having read outcomes of similar projects around the country, including Lambeth (2), Frome (3), Derby (4) and Hebden (5) it is clear from these that supporting people to integrate with activities happening in their local community is key to reducing their feelings of loneliness and isolation.

Description of the initiative / programme

Community Connectors Project:
Service Client Profile: Age 18+ who are at risk or feeling lonely and isolated, with low level mental health needs, and not meeting eligibility criteria of Adult Social Care.
Service delivery area: Southport, Maghull and Bootle.
Service delivery time scale: 14 week supported intervention.

Client with Adult Social Care:
Contacts to ASC will be triaged at first point of access; triggers will identify the appropriate pathway for callers who would not be offered social care assessments. These clients are collected on a weekly basis and referred to Community Connectors.

Referral to Community Connector:
Upon referral, a Community Connector will arrange to visit client in their own home. They will carry out the Warwick Edinburgh Mental Wellbeing Scale and De Jong Geirveld Loneliness Scale with the client, as well as developing a rapport around their likes and dislikes, their ability and confidence to travel on public transport, and gauging what they require assistance.
with. They are paired up with a volunteer Community Champion who makes contact with them to help them achieve their weekly tasks or a goal of attending a local group. Both the Community Connector and Champion keep in contact with the client throughout their 14 weeks and the Connector will meet with them around week 7 and week 14 to conduct the 2 questionnaires again. Upon completion of the project, the client is given the option to become a Community Champion. They will also help people to build individual resilience by facilitating opportunities to connect, be active, take notice, and keep learning and give. People’s self-esteem will be increased by encouraging them to be contributors through sharing their skills, knowledge, experience and interests.

The aim for the client: The intervention of the Community Connector and Community Champion will provide opportunities to help the client increase their social circle by travelling with them to different local groups and organisations, and introducing them to people there so they can make new friendships. It will also help them to feel more confident in completing weekly tasks such as going to a supermarket, or simple DIY tasks such as changing a lightbulb, so they can do these tasks themselves or have family and friends to turn to for help, before small tasks become a big issue which are left un-tackled and emergency services or Adult Social Care become involved.

Referrals received from: Sefton Adult Social Care, Self/family referral, GP/Health Professional, local group or organisation. Our flyers and posters are visible in Sefton Council Contact Centre, GP surgeries, local supermarkets, places of worship, leisure centres, libraries, and our service is promoted on social media (Facebook and Twitter). It advised for Social Workers, Occupational Therapists and other professionals to provided service information to their patients and clients. According to the 2011 Census 96% of Bootle residents deem themselves to be White British, therefore all of our promotional resources are only available in English language.

Evaluation

For the purpose of the CLAHRC evaluation project we focussed on the Bootle area. Sefton is a very diverse area, with high levels of deprivation in the south of the borough. Areas such as Bootle generally have higher health inequalities than the rest of the borough, and some higher than national average. The further north you travel in Sefton, the more affluent the areas are. For example people living in Southport (north Sefton) are likely to live 11 years longer than those living in Bootle.

The socio-economic circumstances in which our clients live and work could limit their ability to access our service, and adhere to it such as:

- Our paid staff work Monday to Friday. Some clients may require assistance out of normal working hours. As a result our volunteer Community Champions are encouraged to have some availability during evening and weekends. For example we have a male client, who lives alone and is lonely and socially isolated who wants someone to watch the football on TV with him during the weekend.
- Our Bootle Community Connector is male and has had many female clients. When pairing up clients with Community Champions we do ask if they would prefer a male or female volunteer, and when Community Champions are recruited we also ask them if there are any specific groups of people they prefer not to work with. This helps us to make a successful match as soon as possible. If we identify the client stops engaging with us we can ask if they would prefer a female Community Connector, and we can bring in Hannah from Southport or Gill from Maghull.
Sefton CVS has worked in partnership with Sefton MBC Adult Social Care team, particularly the triage team. The Southport and Formby Liaison Officer, who is employed by Sefton CVS visits the triage team on a weekly basis to collect referrals.

Arvato Contact Centre, who initially takes the calls for Adult Social Care also allowed the Community Connector Coordinator in to their call centre to listen in to live adult social care calls, and provided briefings to the call handlers on community programmes which may be able to help callers. For example, diverting calls away from Adult Social Care when they do not meet the criteria, and providing an alternative option such as Community Connectors. Members of the local community have become Volunteer Community Champions and help out clients on a weekly basis. They are given the opportunity to attend monthly volunteer forums with their local Community Connector, and also invited to attend volunteer of the year events.

**Evaluation methods**

**Quantitative approach**

The Community Connector Coordinator collects personal data on each client referred to the service, which is pulled together to form monthly board reports, quarterly reports and annual reports. This includes 2 questionnaires which the clients complete themselves. They complete these in the presence of the Community Connector. One advantage of using this method is the Community Connector can collect the data immediately and help them to understand the statements in each questionnaire. It does have it’s disadvantages; the client may answer as he or she thinks the Community Connector would like them to. To overcome this we could send out the questionnaires at a later date but it is highly unlikely we would receive any back.

**Qualitative approach**

We have also conducted face-to-face interviews with clients, and public advisors. All interviews were conducted as part of Community Connector final meeting with clients. Building a rapport and trusting with the clients has facilitated these interviews.

Attempts were made to contact all clients referred to Community Connectors, however 21 either chose not to take part or were unable to contact. Unfortunately these are collated as ‘closed cases’ and not differentiated as ‘did not opt in’ or ‘unable to contact’.

Along with the help of the 2 Public Advisors, the Project Lead put together a list of open questions for semi structured face to face interviews with clients who completed the project. This included questions such as:

‘Tell me a little bit about how life was before Community Connectors got involved’

‘Do you still have any barriers to getting out and about, if so what are they?’

‘What has changed since the Community Connectors involvement?’
A voice recorder was used, and interviews were transcribed. Thematic analysis was used to identify main themes that emerged from the interviews.

Results and findings

General data collected by Community Connectors for all clients:

- Name
- Address including post code
- Date of birth
- Contact phone number & email address
- GP name and surgery
- Where client has been referred from
- Which Community Connector client has been assigned to
- Which Community Champion client is matched up with
- Dates of initial visit and consent
- Difference in mental wellbeing
- Difference in loneliness
- Difference in digital media usage
- Whether client wishes to become a Community Champion
- Which groups clients have successfully been signposted to

Between June 2017 – end of October 2018 72 participants from Bootle were referred to Community Connectors; 51 consented to anonymised quantitative and qualitative data being
used in this evaluation. This included 30 males / 21 females and 50 White British / 1 German.

In Bootle the majority of referrals come from Adult Social Care, but a high number from 'other organisations' (such as GP’s, Health & Wellbeing Trainers, and hospital departments such as therapy team, Stroke team). This shows Community Connectors is being used as an early intervention and prevention measure.
At our first visit to Adult Social Care triage team in June 2017, there were 920 clients on their call log waiting to be assigned to a social worker. In November 2018 there were 576. There has been a significant reduction in cases waiting to be allocated.

Part of this reduction could be:

- as a result of the Contact Centre diverting inappropriate cases away
- Shirley King taking referrals from the call log to Community Connectors
- GP’s referring onto community interventions as a first port of call as opposed to social care.
- Other measures used to try and reduce the call log.

This graph shows the number of Adult Social Care cases waiting to be allocated. From September 2017 there was a steady reduction in cases waiting to be allocated, with the exception of June 2018. In June 2018 one of the care providers wrote to their clients which resulted in an increase of people calling to speak to Adult Social Care. All of these calls were logged on the ASC call log which caused the spike in numbers.

Between June 2017 – end of October 2018:

- 30 clients have completed the Community Connectors project
- 100% of these clients reported reduced feelings of loneliness and social isolation
- 100% of these clients reported an improvement in their mental wellbeing
• 26% reported an increase in digital media usage, which was used as a tool to reduce loneliness and social isolation
• 48 people have been supported to attend 24 different local groups and services

Main themes:

Falling out of society

Participants reported the process in which they became lonely or isolated from society. Most participants described how they continued feeling lonely without being aware of any support available.

“I was very lonely. I felt I was the only person in the world with a messy house. I couldn’t get out on my own”.

“I have paranoid schizophrenia. I suffer from it every day and it stops me from doing things I want to do”.

They described how their situation got worst over time, for some they were aware of their situation and needed support. However did not have the confidence or the support to seek the support they required.

“I wanted to go out places and maybe someone to help out in the house.”

“Couldn’t sleep much. I drank quite a lot to go to sleep. My diet could have been improved”.

The services available do not go looking for these people; they have to make the first move, unless they are referred by others which is unlikely as they in effect become invisible often until the point of crises and then report to Adult Social Care or emergency services.

“Being able to pop into the shop and see the Community Champion; that was part of the process because if you weren’t there I don’t know which way Id have gone”

Easy self-referral

The need for easy self-referral through a presence in communities, which mirrors the work of Prochaska and DiClemente Stage of Change Model. The open access into Strand By Me allows the individual to make a self-referral at the point when they are most ready.

‘I walked into the Strand By Me shop and found out what you done for the clients.’

Self-referral then seems to result in quick response and thus the moment for change is caught and build upon. Although only 5 of the referrals were self referrals, these were some of the most successful cases because they were fully engaged with the project from the beginning.

‘I came to Strand By Me to ask for help and I did get help. It put me in touch with a woodwork service which I’m still going to.’
‘I met Derek the Community Champion at Strand By Me and from thereon he helped to sort things out for me.’

This has clearly been a valuable asset to some of our clients who are recommending this for others.

‘I feel sorry for anyone who hasn’t got something like Strand By Me to help them. I reckon that when you go to sign on there should be some sort of information on where you can go— not just dealing with your finances. I think they should say to you to go to Strand By Me, because that’s a really positive outcome and I was made up to be part of it.’

**A structured supportive services**

In addition to the referral to the structured delivery, there is also the support wrapped around. Participants reported how they support was available every time they approached the services.

‘Community Connectors was great because I could walk in to Strand By Me and bounce everything off you in a private room.’

‘I’m getting lots of support from the other companions and the staff’

The ongoing support is important as it enables people to get through ‘the wobbles’ when they occur. Again, the response seems to be immediate and supportive which keeps people attending and engaging.

‘Being able to pop into the shop and see the Community Champion; that was part of the process because if yous weren’t there I don’t know which way I’d have gone.’

**Reconnecting with society**

The outcome of the service/process is to reconnect people with people, which in turn can help them to help others, possibly through volunteering. Although none of the participants to this study became Volunteer Community Champions, some did become volunteers at Strand By Me; the very community based support shop they first accessed for help, and although they did it to give something back, in turn their own well being is improved.

‘I look forward to doing the volunteering; it makes me feel better.’

‘My life has more structure now as I’ll go to work and do some voluntary work at Bootle Tool Shed.’

This is mirrored in one BMJ journal article where the aim of the study was to examine the association of volunteering with mental well-being among the British population across the life course (7).

The participants also reposted how there involvement with the service has enabled them to reconnect with their family members and enhance their relationship.

“My brother in law has been quite helpful. He comes regularly; at least once a week to visit”.

---
'He [son] came down and went ‘can I have the real mum. That’s the first time in months I’ve sat down with you and had a proper conversation.’

**Enhancing confidence**

Positive outcomes as identified by clients. These tend to be around how their confidence has improved and how fuller their life is now.

‘My confidence has improved and we’ve all became friends.’

‘I came here and then went to Bootle Tool Shed and my confidence grew more and more.’

‘My life is fuller now, big time, and I’ve got everything around me that I need.’

There are examples around how clients have gone on and used their new found confidence to better fulfil their lives:

‘Because this gave me a more positive attitude I think it helped me to get a new job.’

‘I now have a job, I have friends, and I feel I can ask family and friends for help if I need to.’

**Discussion**

Linking the above findings back to the original expected results from the logic model, there are many things we have achieved but some yet to be ironed out.

We expected a clear referral pathway to be established as a short term goal, when in fact we didn’t realise just what would be needed to achieve this. This is something which still needs to be discussed further and actioned. A Community Connector referral form needs to be embedded into the Contact Centres computer systems to make an instant referral possible. However, because the Contact Centre was due to be changing from Arvato back to Sefton MBC this wasn’t something which could be arranged within the time frame. It is most definitely something that Community Connectors would like to see happen in order to progress the project and create a more streamlined referral process.

Adult Social Care triage team and Contact Centre staff were briefed early on during the Community Connectors project so they are confident at which calls to divert, and how. Unfortunately due to the lack of clear referral pathway, call handlers have had to ask callers to ring Sefton CVS directly to refer onto Community Connectors. We were also fortunate to organise and agree the information sharing between Community Connectors & Adult Social Care quite early on in the project life.

Another short term expected outcome would be that clients engaging with Community Connectors will feel less lonely (as measured by the De Jong Gierveld score), and have an improved mental wellbeing score (as measured by the WEMWBS), and better knowledge of digital technology, which is shown in the results section above.

The medium term results included diverting inappropriate cases on the Adult Social Care call log to Community Connectors. Again this is something which occurred quite quickly on in the
project life. Once the inappropriate cases were diverted and Contact Centre staff were briefed on the services we noticed less and less inappropriate cases on the call log. As a result, we still visit the triage team on a weekly basis but we noticed an increase in complex cases whereby we work with the client alongside the Social Workers.

Another medium term goal was to assist individuals referred with deficits to identify their assets and have the opportunity to become Community Champions upon completion. Although none of the clients who completed became a Community Champion, many of them have become volunteers at Strand By Me, which is a shop within Bootle Strand Shopping Centre which is there to help, support and signpost visitors. The volunteering roles here range from meeting and greeting visitors, assisting group leaders, and many have become Digital Champions and assist people to use the computers there.

The anticipated long term results included:

- More residents accessing community services. We know this has been successful as more and more people are accessing local groups and services, many of which are run within Strand By Me or the Strand Shopping Centre.
- Increase in social support circles. We know that clients are feeling less isolated as a result of attending groups. What we do not know is whether they are necessarily seeing these same people outside of the groups, or whether they are seeing more of their family or neighbours etc.
- Continued mental wellbeing and reduced loneliness. This is something we have been unable to measure. One aspect to include for the future of Community Connectors would be ongoing monitoring, at set periods following completion of the project. There are many different events which happen during the year, which all clients are invited to (i.e. Christmas events, Jo Cox Great Get Together etc) and our clients are invited by post to attend these events; many of whom do!
- Those who would previously have called Adult Social Care would know to call Community Connectors directly to refer someone. We have seen a huge uptake of GP’s referring to Community Connectors since Conal was based there in the summer, which shows they are using this as an early intervention and prevention method. Health & Wellbeing Trainers are also referring their clients to us when they identify those experiencing loneliness and isolation.

Overall, the reduction in inappropriate calls to ASC results in:

- More appropriate workload for social workers
- More time to allocate to crisis cases
- Meeting service level agreements
- More cost effective service

Reduced inappropriate calls to emergency services results in:

- Better quality service
- Reduction in cross-organisational bureaucracy
- Ability to identify urgent needs quicker
Not solely for the evaluation, Community Connectors underwent a cost benefit analysis earlier on in 2018. I have attached a summary as an appendix.

Conclusion

To conclude, it is clear that the Community Connectors project has been successful during the past 18 months and has helped people to change their lives for the better. Clients are attending more local groups, engaging with more people, more often and feeling less lonely and isolated. The mental wellbeing has improved considerably, their confidence has vastly improved and their lives are fuller.

The partnership working between Sefton CVS and Sefton MBC has been remarkable and should be used as a benchmark for other local authorities and third sector organisations.

Acknowledgements

I would like to express my thanks to Sefton CVS and Sefton MBC for nominating me as the intern and project lead for this evaluation. Thank you to Conal Devitt and clients for conducting and taking part in the interviews.

Thank you to our Public Advisors; Lucy Holmes and Tim Fletcher for attending the CIG support groups, external meetings and continued support. Your knowledge on the local area and issues of loneliness and isolation has been invaluable.

Thank you to Lesley Harper and Dr Shaima Hassan; my facilitators for this evaluation. You have been a superb support throughout. Thank you to all those involved in CLAHRC PPP2; staff and fellow interns.

I’d like to dedicate my evaluation report to the memory of Dr Ruth Young.

References

1. Sefton Council ward profile:
   https://www.sefton.gov.uk/media/1310386/linacre_ward_profile.pdf
Appendices

- Warwick Edinburgh Mental Wellbeing Scale
- De Jong Gierveld Loneliness Score
- Cost benefit analysis summary