Appendix A: Community Connector Service Case Studies

Case Study 1:

*Name has been changed

Area: Woodchurch
Benefit: Universal Credit
Referrer: Neo Community Cafe

Community Members Details: *Sandra was first referred to Connect Us with issues relating to food/fuel poverty and benefit delays.

Connect Us arranged an initial home visit with Sandra. Priority referrals were made to the food bank, INW debt/welfare benefit team and Besom. Through discussions with her connector Sandra disclosed that she had a 2-year-old living at home with her, one child placed in foster care and adult children living independently.

Sandra shared that she has PTSD and had been in a domestic abuse situation for 20 years but has now been out of the relationship for nearly 3 years. Sandra shared a variety of highly sensitive and complex family issues throughout her life and that she felt like she was struggling to cope. Sandra's 2-year-old was on a care order. Sandra advised that she was fearful that the care order was going to be discharged and she would be left without support.

The Connectors supported Sandra to liaise with the child's social worker and put an agreed plan around the services around her. This included family support Safer Families and nursery through the local children's centre. The Connector also referred Sandra into the Household Into work team as they could also work with her adult children. Information was also provided to Sandra around CGL and Wirral Mind courses for her older children.

Sandra was introduced and supported to attend her local community Centre starting with the Monday Breakfast. Sandra engaged well and built relationships with other volunteers and community members. Sandra moved on to volunteer there and helped with the development and delivery of their social supermarket.

Sandra also attended a variety of courses through the links made in community settings including:

- Paediatric first aid
- Introduction to volunteering,
- Food hygiene
- Resilient parenting

It was agreed that given how connected Sandra now felt and things had stabilised for her, the Connectors would just maintain contact with Sandra through the centre and related activities.

Whilst the Connector was attending a drop in at one of the centres, the Connector noticed that Sandra was not herself and presented upset, angry and frustrated. Sandra had her youngest child with her. The Connector came back to the office to discuss those concerns with her manager.

It was agreed that a call would be made to Sandra to see how things were and offer a home visit. The manager supported the connector on a home visit. They discussed concerns, where things were up to for Sandra and what was still in place.

Sandra shared that her mental health had deteriorated; she had pulled back from volunteering and that there had been some ongoing issues in terms of a court case coming up. However, there were still appropriate services, agencies and support involved for her child. From the conversations, concerns were reduced specifically relating to her child; however, we explored what may be good for Sandra.

On her request Connect Us supported Sandra to call Talking Together Wirral to self-refer. It has also been arranged for her to attend and ACES group and the Gateway programme in the community (in relation to historic abuse).

Sandra was also given contact details for St Vincent de Paul and Energy Project Plus, as her washing machine had broken and there were some issues around energy bills.

Connect Us will remain in touch with Sandra during this time.

Case Study 2:
Date of sign up 22/09/2021
Community Connector area: Moreton, Leasowe, Saughall Massey and New Brighton
Area: Moreton
Benefit: UC with a sick note
Referrer: PCN Health and Wellbeing coach

Community Members Details:
For the sake of this study my community member is called John. John is a 64-year-old single male who lives in Moreton

Reason for referral: Isolation, ill health, mental health, and financial issues

Initial Engagement & Goals: To get out more, find new activities to engage with, sort

out finances and improve mental health

Community Members Journey: John was referred in by Nikki the PCN health and wellbeing coach as he was struggling with his mental health and financially, because of this he had become lonely and isolated. John wanted to engage more within his community and meet new people as he had lost his confidence. John was also struggling financially and looking at ways he could budget his money so I introduced John to the Can-Do Café a place where he could meet new people have a chat and a cup of tea as well as a crate of food for £6. Sadly, John got diagnosed with bowel cancer and had to have an operation. The operation didn't go to plan and there were a lot of complications resulting in John contracting sepsis and becoming very unwell. John needed extra care for when he came home and was really worried about how he was going to manage his money, he needed to update his pip claim and needed support with filling in the forms, so I referred him into INW welfare and benefit team so he could get the right support he needed.

Wellbeing Outcome: John has engaged with several services that he has been referred into. As a result of this John has received his PIP and back pay and is also waiting to receive his blue badge. John is now able to sort out his finances and budget his money and this has improved his mental health which means he is getting out more and engaging with services.

Feedback: I first became involved with Involve Northwest after I was left alone. My father had died, and my mother went into a home. I was not prepared for the loneliness and caused me depression. What with Covid to cope with I had had enough, then in 2021 I was diagnosed with Bowel Cancer. My operation was January 11th, 2022, then a few days later a second major operation. Seven weeks in hospital and many months of recovery, living alone life has become impossible. Involve Northwest has saved my life their representatives (Sam community connector and Simon welfare) have become a valuable part of my life not only socially but with my personal management. I have great difficulty in paying bills, responding to DWP etc. They are always there to help in any way I need. I very much appreciate the assistance they have given me and can now call them friends, I have at least another six months of further recovery and know they will be there when I need them.

Case Study 3:

Initial Engagement & Goals: Rockferry Connector met Community Member at Rockferry salvation Army drop in on a Tuesday morning. (Cold January 22 Morning). Community member disclosed feeling isolated Cold and Hungry – Community member had just moved to Pembroke court in Rockferry. Pembroke

court is a young people's supported Living project.
Community member had to move from Family home due to an allegation regarding Community member's mobile phone. Community member – 24 felt lonely and missing family.
Community member had just moved into a Pembrooke Court Flat with No fuel or food due to waiting for Universal credit to start. Connector explained connect us project and sign posted to several community organisations that Community member could connect to and help with low mood and Isolation.
Community member signed to Connect us project. Connectors supported with Food and Fuel as well as a winter Pack from INW, which consisted of warm blanket and socks.
Community Member disclosed struggles with Maths and English due to SEND at School.

Community Members Journey: Community member decided to engage with a Maths and English course to help chances of employment, engaged with Courses from Feb – April 2022.
Support with Court project helped community member to engage with court paperwork and possible court dates. Community Member self-referred to project – found project helpful and supportive.
Community member engaged with Rockferry Salvation Army every Tuesday to meet adult Family members and Salvation Army staff who encouraged and supported Community members self-esteem and wellbeing.
Connector encouraged Community member to apply for a job and ask Job coach for help with application form and CV.
Community member applied for a post at Two Sisters Factory Deeside. Community member was successful and started full time work beginning of April 2022.
Community member enjoyed working and becoming Financially independent.
Community members Journey through court system concluded with No further action taken and Mobile phone given back. This was a relief to the Community member as they had never been in trouble with the Police before. Community member kept in touch with close Family members and Salvation Army staff who all supported Community members Health and wellbeing.

Signposted to: INW Community Hub- Winter Pack and Good parcel, Wirral Fuel Bank. Spider Project. Journeymen Wirral, Companeros, Open door – mental health support, Volunteering in local Community – Neo – work with Animals and Lifelong Learning – Maths and English courses. Contact Numbers and Information given to Community Member to read and attend if needed with support of a Connector. Reach out team support with CV and Job searching. Support with Court Project.

To Date: Community member Kept in touch with Family and connected to Rockferry salvation Army staff. Community member lives in shared accommodation and drops

into see staff when not working – keeps in touch.
Community member reconnected with Family and continues to build on all Family relationships.
Community member achieved Full time employment and continues to progress in the Job role - more responsibility.

Wellbeing Outcome: Community members Wellbeing has increased with engaging with local community assets, family , educationally, employment and Financially .

Case Study 4:

Community Members Details: Male aged 32

Reason for Referral:

- Housing,
- Historic DA,
- Food poverty
- Debt
- Mental Health and health issues.

Initial Engagement & Goals:

- Would like a place to live where he can call home.
- Better health
- Would like to be divorced from his Ex-Husband.

Community Members Journey: My CM was referred to connect us through INW community hub for food support, I arranged to meet my CM at Egremont community centre to see what additional support we could offer. My CM disclosed that he had been homeless for the last 2 years after a relationship breakdown with his Husband who was domestically abuse, he says that he has never gotten over the abuse and felt he could do with some support around this as it was having a negative impact on his current relationships.

My CM is currently living in an HMO but says the property was not in liveable conditions, and his landlord was not responding to his texts and calls. He was having issues registering for PPP and felt he needed some assistance with this. He is also in financially difficulty with left him in rent arrears and disclosed he had very little food.

My CM would like to apply for PIP due to his mental and physical health issues and would like his benefits looking over to make sure he is getting the correct payments.

To Date: I met up with my CM at Egremont community centre (which was a big step for my CM) as he says his mental health was having an impact on wanting to leave the house, we had a conversation about him leaving his Husband with only the clothes he had on his back, he says his husband had domestically abused him for a long time, and his confidence was at a low.

We discussed The Paul Lavelle foundation, and he was keen for me to refer him to the project, he has attended many sessions at Paul Lavelle and has told me the sessions have been beneficial for him.

I also referred my CM to Martin at INW benefit team, where again he left his home to attend an appointment with Martin at Egremont community centre for support with applying for PIP. Martin successfully filled the form in and sent it off, and when I called my CM to follow up, he says he had received a letter from DWP to say they had received his claim and was working on it.

As my CM was having issues with registering for PPP, I sent him the number for excel housing for support around this, he made the call and arranged an appointment.

Wellbeing Outcome: My CM is now getting the support he needs with his benefits, as well as attending sessions at The Paul Lavelle foundation to support him around historic domestic abuse.

I have given my CM the tools and guidance to support him with his housing issues and he now has the confidence to pick up the phone and make appointments for himself. whereas at one point, this was just too much for him to deal with and had a massive impact on his mental health