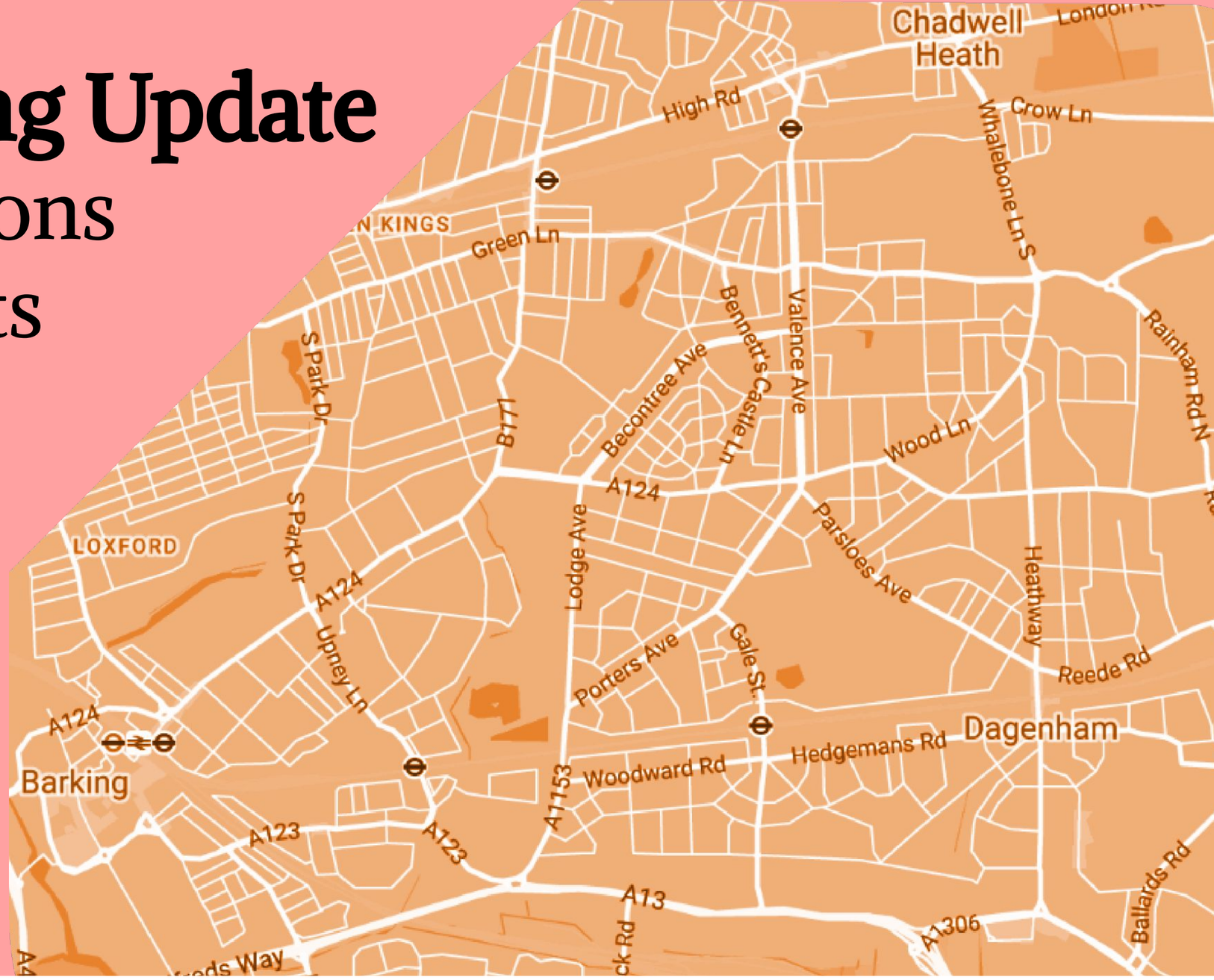
Connect Learning Update

Building connections alongside residents drawing on adult social care

July-Nov 2025

Connect BD COLLECTIVE



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Connect

Report Contents

About this report

This document tells the story of what's been happening in the Connect programme since our last learning report in July 2025. Conceived as a novel approach to addressing social isolation in Barking & Dagenham, Connect brings together a partnership of Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations to help local residents find connection and belonging. This VCFSE partnership, comprising members of the BD Collective, and broader national organisations, has been working together for over 18 months to work alongside residents and explore the ingredients of a connection-friendly borough. This document updates the story of that journey, the impact we've made, and further learning along the way.

The first section recaps the nuts and bolts of the approach we're taking to working alongside people (shared in detail in our July 2025 report), while later sections update in on the onwards progress of people who've moved on from the programme and introduce some of the new residents we've been working alongside, before sharing our learning around working effectively with a new cohort of Barking & Dagenham residents.

This report has been co-authored by Michael Roberts and Emily Brook of Care City, and Elspeth Paisley of Community Resources. All Connect partners have been involved in shaping the content and the insights we share about here.

1. Context & background:

An evolving cohort of residents

Background: The Connect model

Based on our initial period of co-design work, starting in Sep 2023, Connect has developed a way of working alongside residents that is unified around a collective vision for the programme, which all partners on the project are committed to exploring and bringing to life as part of their work. **Our vision is of an environment that helps connections to spark and flourish over time.**

The way we work in Connect is shaped by this "environmental" lens. The project co-design helped us to define **three different but overlapping environments** that exist around people who are socially isolated. And we've see it as our role on the project to explore and shape these three environments, so every person can be surrounded by a the conditions that enable connections to spark and flourish for them. These three environments are the:

1. **Personal environment**: The immediate circle of family, friends, and practical conditions that exists around a person
2. **Societal environment**: The broader socially-focused organisations, activities, assets and opportunities that exist in a neighbourhood
3. **Service environment**: The public service landscape

Different partners on the project have focused their efforts on exploring different aspects of this overall environment, but all are also exploring how they overlap, and how different sectors can work together to create enviroinments that support connection. The following page gives a visual representation of this initial framework for thinking about Connect, containing some of our early assumptions about the things that would need to be present in these environment, which we would test, adapt and add to.

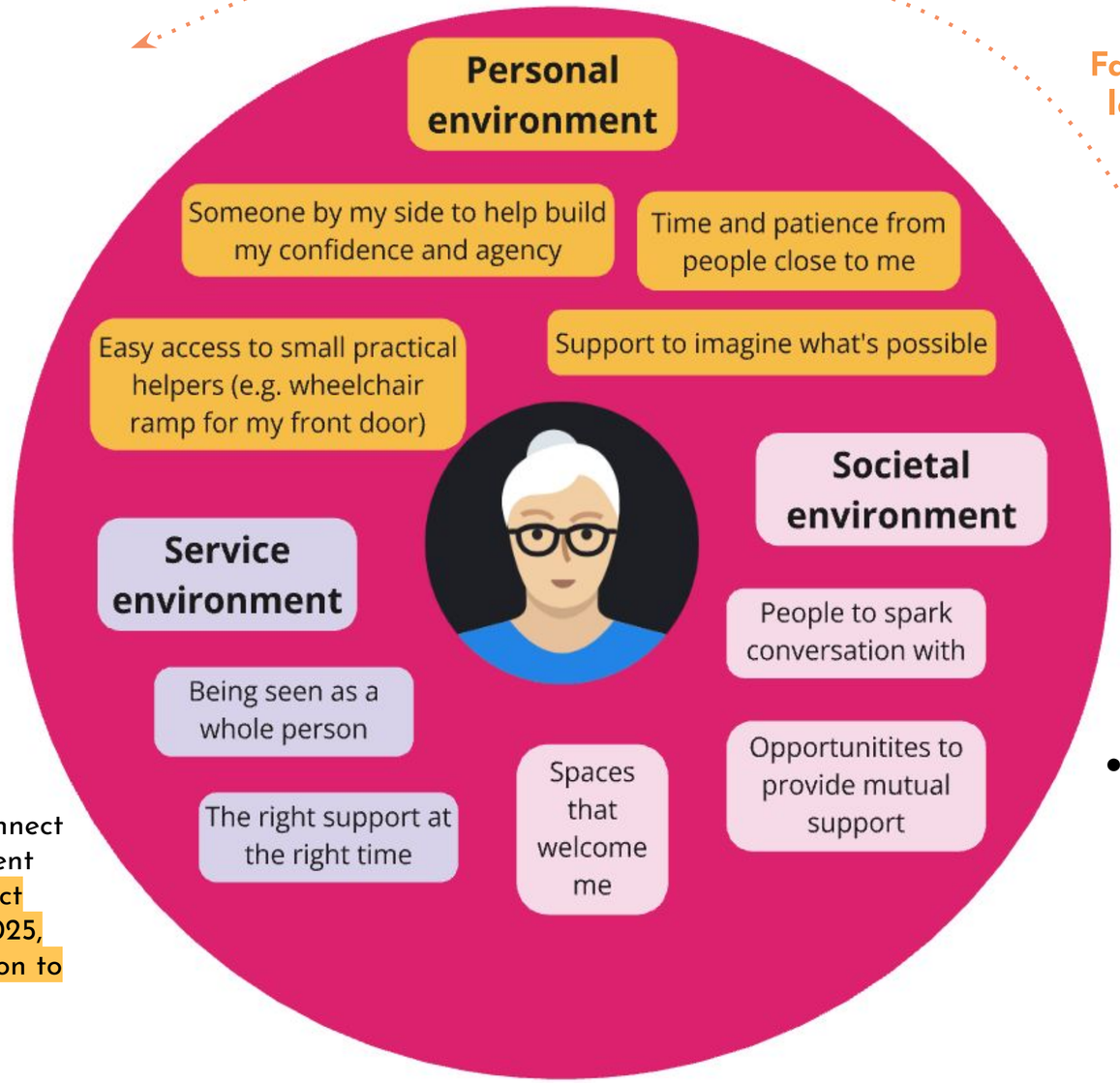
How does it work?

We've been exploring **what needs to be present within people's environment** for meaningful connection to spark and sustain

And **how we need to work together** to bring these things to life

- **Three VCFSE Delivery Partners** holding the relationships with resident referred in
- **Cross-organisational learning sessions** every week
- **Capturing lived experiences** as we go

- **1:1 Catalysts working 1:1 alongside residents** to surface what matters to them, help them build confidence, co-create an approach to acting on their desires.



- **Services coming together** to actively connect the dots' around a person and test different ways of working - this aspect of the project has been on pause between July - Nov 2025, given funding constraints, with an ambition to re-engage elements in 2026.

- **Residents Groups and VCFSE organisations** prototyping ways to create a more connected place

1:1 Support

If the programme is relevant, residents referred into Connect are matched up with a "**1:1 Catalyst**", who is employed by one of the three VCFSE delivery partners working within the Connect partnership (Independent Living Agency, Harmony House, and Humourisk CIC). 1:1 Catalysts then work 1:1 alongside someone who is socially isolated to:

- Surface what matters to them
- Identify and overcome obstacles to connection
- Build a person's confidence by helping them refocus on their desires, strengths and skills
- Help them access opportunities and assets in the borough
- Support them to imagine and experiment with new ways of sharing their skills

Each resident might meet their 1:1 Catalysts weekly initially, before finding a suitable rhythm. Often this entails first meeting someone in their own house, before going out and doing more together in the community. An important part of our original model is that these relationships have been designed to be **open-ended** - we've seen working alongside residents to be most effective when it is up to them to determine the pace at which they try new things, experiment with new connections, and arrive at "dependable friendships" that mean they are ready to "graduate" the programme.

Our early framework for working alongside people 1:1

Be an equal - alongside me, Not telling me what to do

Work with me to understand what matters to me

See me as an asset - building agency together, not assuming need or problems

Be facilatitive and empowering

Designing with people

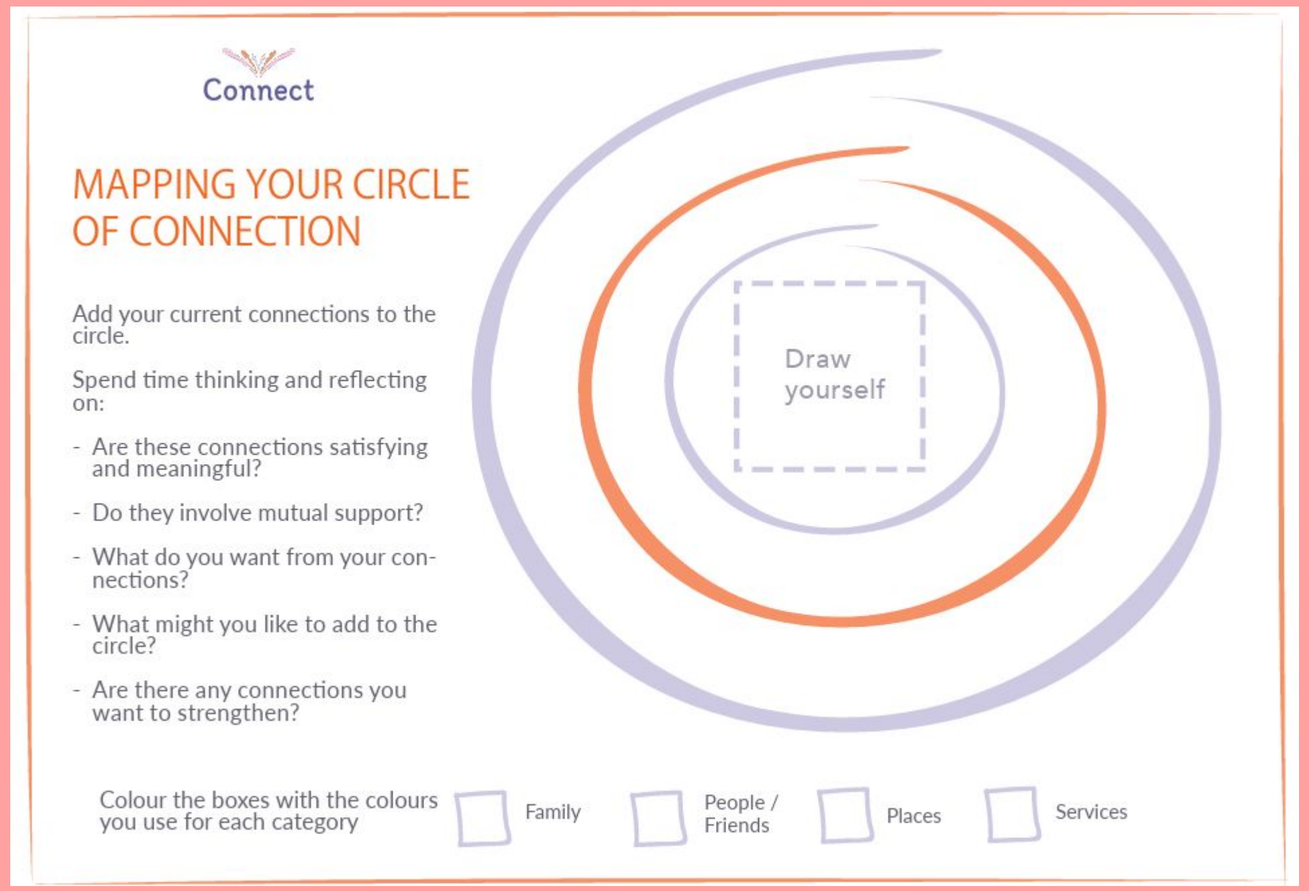
Centred on human relationships

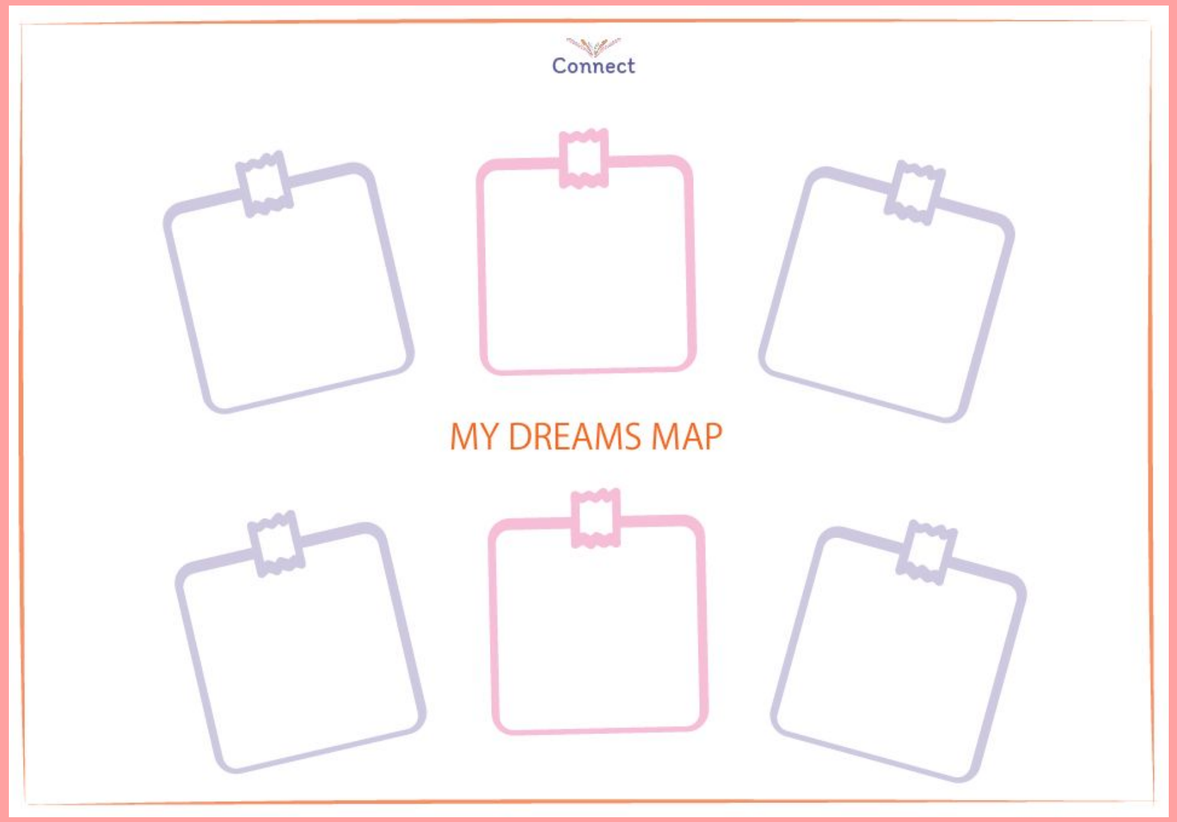
Curiosity beyond obvious 'presenting'

Tools and supports we are using to support our work and learning

Since the start of Connect, we've been using **SIGNAL—a structured tool that helps people reflect on what matters most in their lives.** Through a guided conversation and a visual Lifemap, residents explore core areas of wellbeing and begin to take practical steps toward greater connection, control, and confidence. This is helping us surface and learn about factors that may not come up naturally in conversation and get under the surface of what matters to people. A detailed example of SIGNAL's use and benefits for learning can be seen in this case study. Since July 2025, SIGNAL is not only being used within the 1:1 aspect of Connect, but also by an organisations engaging with the Neighbourhoods prototyping, after some perceived its benefits for residents engaging the broader neighbourhoods prototyping work.. Alongside SIGNAL, we're using a broader range of conversational tools specifically designed to help open up different kinds of conversation and help people connect with their strengths and ambitions. Some examples are shown on the next slide.

We're also deepening our ability to support residents using the "**Small Good Things Fund**" - **a small pot of money residents can use to access small, but in principle unpredictable, helpers** - things that may help them meet unique challenges in their immediate conditions. For instance, the Fund could be used to help people purchase a new mobility aid, test out a new activity, or buy a suitable pair of glasses so they can see the people they're talking to. Conversations around the fund have helped us to learn together, as conversations around money often quickly surface the crux of matters. Decisions about the use of the Small Good Things Fund have been made in partnership between residents and their 1:1 Catalysts. More recently we've also developed this process, so 1:1 catalysts bring some proposals to the broader Connect team, to help crowdsource or refine ideas.





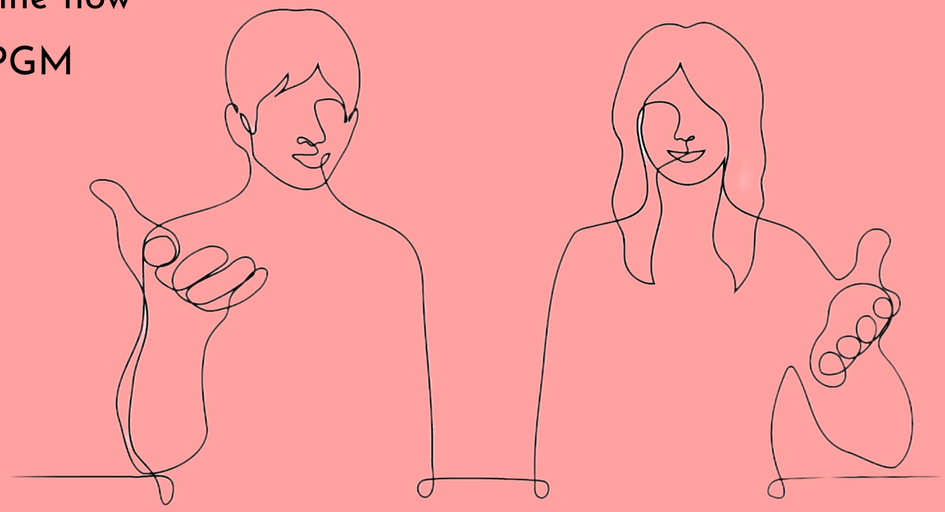
Some example tools we're using to help us have deeper conversations alongside residents

Connect Neighbourhoods

In addition to working alongside people 1:1, Connect's "Neighbourhoods" work is engaging with a wider range of local VCFSEs and resident groups to explore the ingredients of friendly communities and what needs to be present within the "societal" environment around people? These organisations are exploring questions that have emerged from delivery partners working 1:1 with residents that touch upon those key conditions for a friendly and connected borough:

- **How do we create spaces where people leave feeling better than they arrived?**
- **How do we create activities with magnetic pull that keep people coming back?**
- **How do we create spaces that recognise and encourage people's desire to contribute?**

Each Neighbourhoods organisation is prototyping small new ideas, using a participatory grantmaking (PGM) process, to help them explore these questions over time, and refine how they engage their communities. Additional funding was not available to top up this PGM pot between July - November 2025, though an underspend from the previous period enabled us to sustain this Neighbourhood thread of the programme. Organisations continuing with us as part of the PGM process into this next phase were: Elevate Together, Community Resources, Shed Life and Sure Steps Wellbeing.



An evolving focus for the programme

Since July 2025, we have adapted our criteria for people eligible for 1:1 support through Connect. The previous phase was open to all adults experiencing social isolation in the borough. In this phase **(since July) we have focussed on working alongside residents engaging with the Adult Social Care (ASC) sector** - primarily those drawing on a domiciliary care package. The purpose of this was to help us learn about what different factors might be driving isolation in this group, and what different types of relationships they might need in their lives.

Focusing the Connect approach upon a different group of residents was seen as **a good stress test for the model**, and the beginning of continued explorations into value Connect could deliver in different contexts and alongside different services.

Focusing around people engaging with ASC was seen to have potential as a strong preventative investment. This change in focus was conceived as a targeted test of the model in context of sector that is struggling to keep up with growing demand on high-cost services. Given our changing focus, we codesigned a new process for taking referrals into the programme from ASC teams in Barking & Dagenham, and we have been implementing this since July, taking 26 further referrals. We have also continued working with residents referred in from the previous phase who were yet to feel ready to “graduate” Connect (n = 57).

Adapted learning questions

In light of working with a new cohort of residents, and new referral pathways through adult social care, we shaped some new high-level learning questions for July - Nov 2025, to help us explore effective working in this new context. These are shown below.

What causes social isolation?

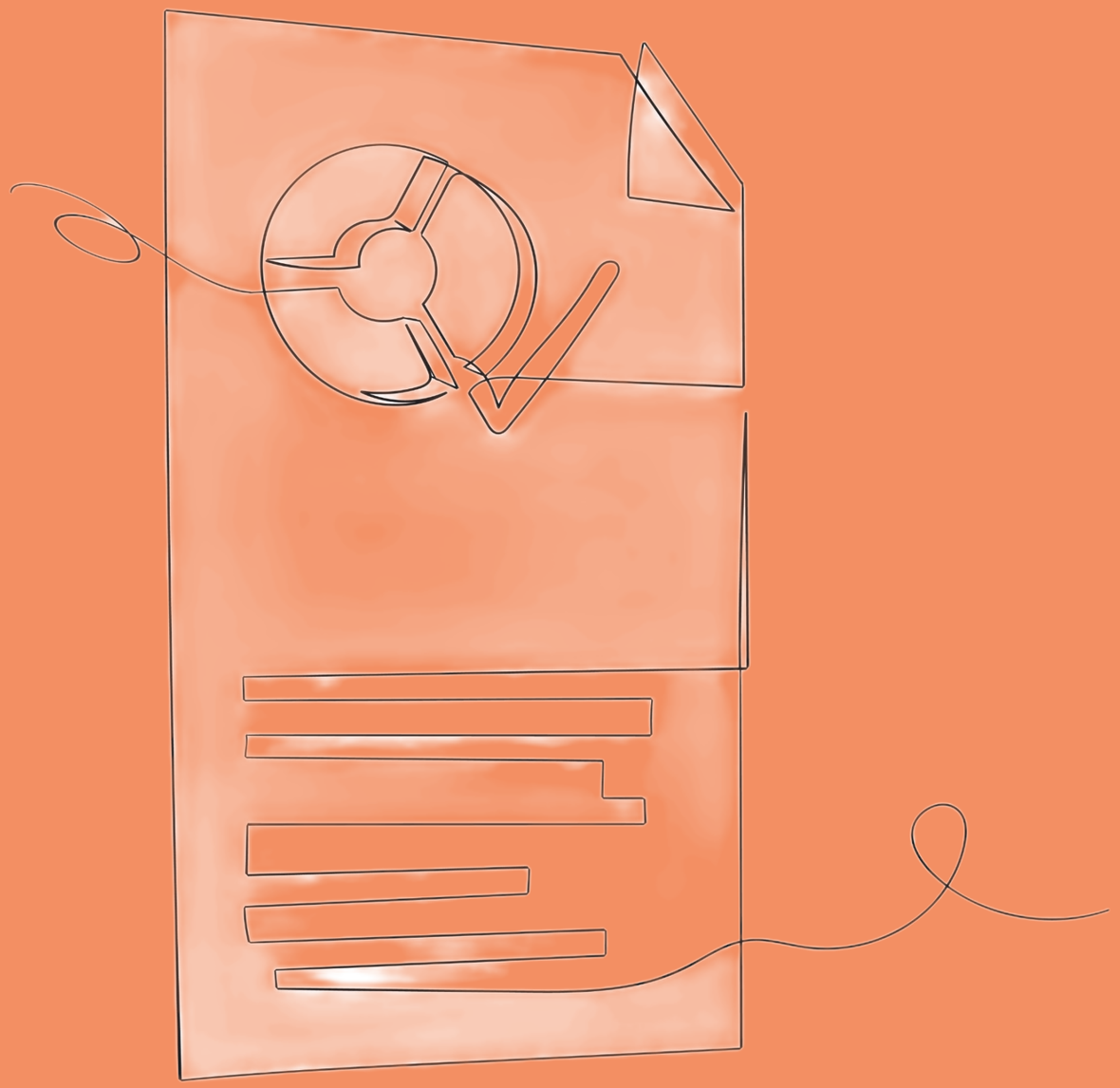
What works to help people connect into dependable friendships?

How do we walk alongside people so *they* want to see change and build their agency to overcome barriers to connection?

What's needed from service integration to support those who are in complex situations?

How does service use change when people become sustainably connected?

What we've learned against these is shared in Section 4: What we're learning.



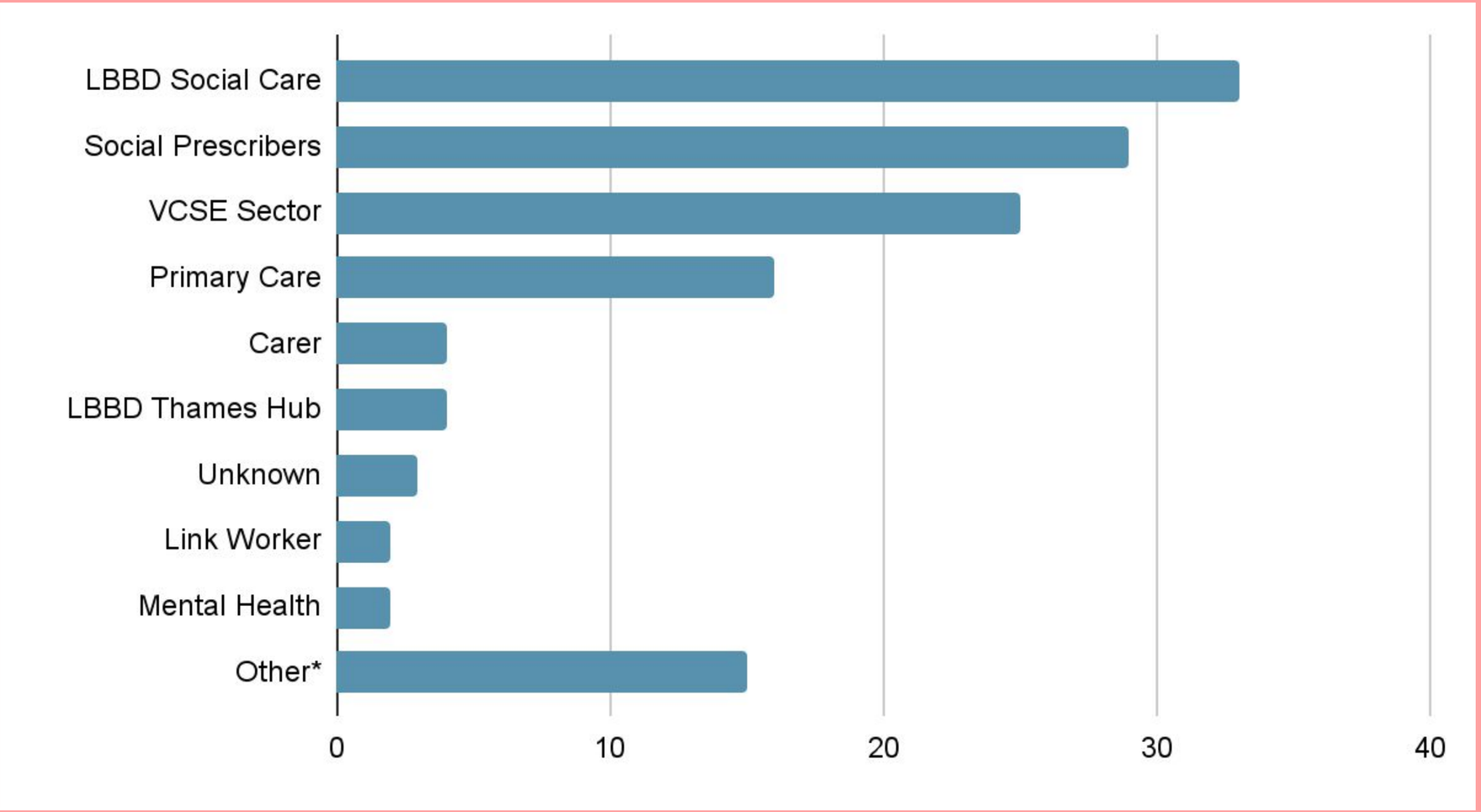
2. Key Figures

Referrals

SIGNAL data

Resident Referral Sources (total: 133)

The below chart aggregates data from July 2024 - November 2025, showing latest figures on referral sources into Connect..



Other* sources with <2 referrals::

1 - Addiction Services
1 - BHRUT
1 - Community Matron
1 - Community Nurse
1 - Community Nurse (via social prescribers)
1 - Community Stroke Nurse Specialist
1 - Hospital Consultant
1 - LBBD Revenue Team
1 - LBBD Care Tech Team
1 - LBBD (Unknown team)
1 - NELFT Community Services
1 - Occupational Therapy
1 - Physiotherapist
1 - Self referral
1 - Via GP pop up

Referrals numbers update

Between July - November 2025, we received 26 new referrals into 1:1 support. Of these, the majority came through social workers. Three came from teams external to Adult Social Care (LBBD Thames Community Hub & Revenue Team), and were later confirmed as actively engaging with ASC services:

- 17 - Social Workers (across teams)
- 4 - LBBD ASC - Unknown team
- 2 - LBBD Social Care Navigator
- 2 - LBBD Thames Community Hub
- 1 - LBBD Revenue team

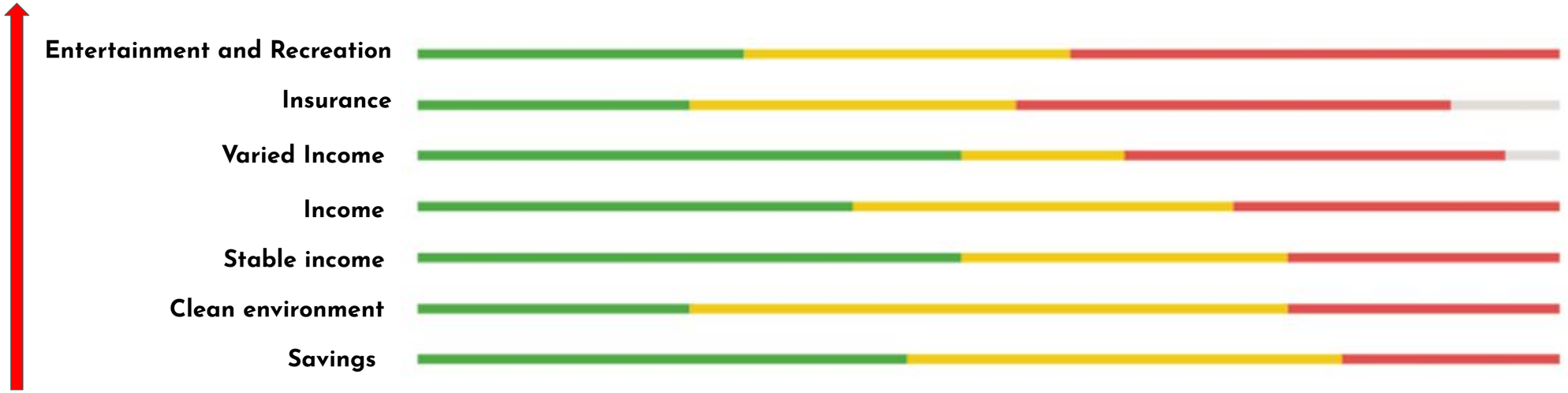
Of new referrals coming in through Adult Social Care (or confirmed as engaging with Adult Social Care support):

- We were actively working alongside 14 as of November 2025
- We were on pause after starting with 5 (mostly due to hospital readmission) with bespoke plans to re-engage each resident
- 7 have refused support or were not the right fit for the programme (e.g. due to higher support needs)

Of the 57 residents continuing from our first year of Connect (ending July 25) into this extension, all but 4 have since moved on from the programme and “graduated”. The remaining four will continue to engage the programme into 2026 (see “What’s next?”)

The below charts show data from **20 residents of working age** engaging with Connect, who've completed baseline and/or follow up Lifemaps between July 2024 - Nov 2025). Of these, 18 have worked 1:1, and 3 have engaged with Neighbourhood teams. The first chart illustrates areas of their lives that residents scored as most "red" - defined as "I'm stuck and need help".

Most Red



In contrast, the below chart shows areas "most prioritised" by residents - things they wanted to initially focus on improving. Seeing how these two differ offers a route to better understand (i) the barriers of greatest significance for residents locally (ii) which barriers residents feel have the most potential to unlock greater connection for them, and (iii) where residents feel most able to make a difference to their life.

Most Prioritised

The below charts, shows corresponding "most red" and "most prioritised" areas for **15 older residents** (defined as over 65) who'd completed baseline lifemaps between July 2024 - Nov 2025. In this case, we see some understandable differences in areas marked most red (e.g. "future preferences" coming out #1) and some overlap (e.g. with regard to Clean environment and Entertainment and recreation scoring highly). We see fewer money-related indicators red (with the exception of "Access to credit"). Areas most prioritised also show differences, with "Eating a healthy diet" coming out top, and "Communication", "Dental care" and "Group activities" with high positions.

Most Red

Most Prioritised

Looking further into SIGNAL data can help us see other patterns that help us understand more about the "causes" of social isolation. It's well established that social isolation emerges from a complex interplay between many historical and present conditions that predispose, precipitate or perpetuate isolation over time, so ub most cases we can't confidently say that any specific factor is "the cause", or the most important. However, it's helpful to look for recurring patterns in the data that may indicate conditions of significance for people experiencing social isolation in Barking & Dagenham, amidst this "snapshot" of life as it is now for them, provided through their Lifemaps. For example, across both the data for younger and older people engaging Connect, "**self-esteem**" comes out top for both in the "most yellow" category, with few people, marking this green.

This reiterates learning from our last learning learning report, in which we reflected on how pivotal it felt to help people feel like "they matter" within 1:1 working - a sense of *not mattering* was a recurrent factor perpetuating social isolation. When we were able to form deeper relationships with residents, it emerged that this was often linked to traumatic events and experiences in people's past, which had long-lasting impacts. Despite the above, we've seen few people prioritising self-esteem as something they want to work on. This may be explained through the aid of Maslow's "hierarchy of needs". Here, self esteem as a priority sits atop more foundational needs around things like food, living conditions, and health, which we've seen people prioritise more strongly in Connect lifemaps. Nonetheless, what we see in the data further suggests the importance of supporting people on this issue, and finding the rapport with residents to be able to support self-esteem productively. **As a key component of individual and community agency, supporting residents to develop self-esteem will be essential to building momentum around asset-led community development in the borough in broader initiatives.**

When we look to **average changes** for residents who have done follow-up Lifemaps, amongst older people **we've seen an average of over 13 new green indicators, which is well above average 4.6 change in Lifemaps across projects nationally.** In follows-ups we have also seen the disappearance of red indicators around "Entertainment and recreation", which raises the question of whether this is less of a problem of poor options available for this locally, and more of a challenge in terms of perceptions of what's available or the ability to access that.

The latter point may link to findings that "**Clean environment", "Reliable transport" and money-related indicators feature consistently highly across resident challenges and priorities** - it's very likely that difficulty in accessing or paying for transport, and/or a poor perception of the local environment, further perpetuates isolation, which is something we've seen coming out in conversations during Lifemap facilitation when people are talking through their priorities - it's definitely *not* a case that people simply don't want to engage. Another point worth noting is the **consistent prioritising of healthy diet**. We're seeing many residents make links between mobility and health, with diet as a conscious contributor to both. This appetite for healthier approaches to food and diet can be addressed in the upcoming Healthy Weight work in the borough, and it will be possible to link in with residents directly through the aid of SIGNAL data, where this is a priority of theirs.

When we compare carers and non-carers in SIGNAL data for working age people, we also see a significant difference. **Overall, non-carers are 10% greener**, but in certain dimensions the difference is bigger, particularly in Housing & Infrastructure (62% green compared to 79% green for non-carers), Income & Employment (39% green compared to 57% green for non-carers, Interiority & Motivation (50% green compared to 67% green for non-carers). All carers undertaking SIGNAL lifemaps have been female, and within carers, it has been the younger age group (24-49) where we have seen more self-recognised challenges ("reds").

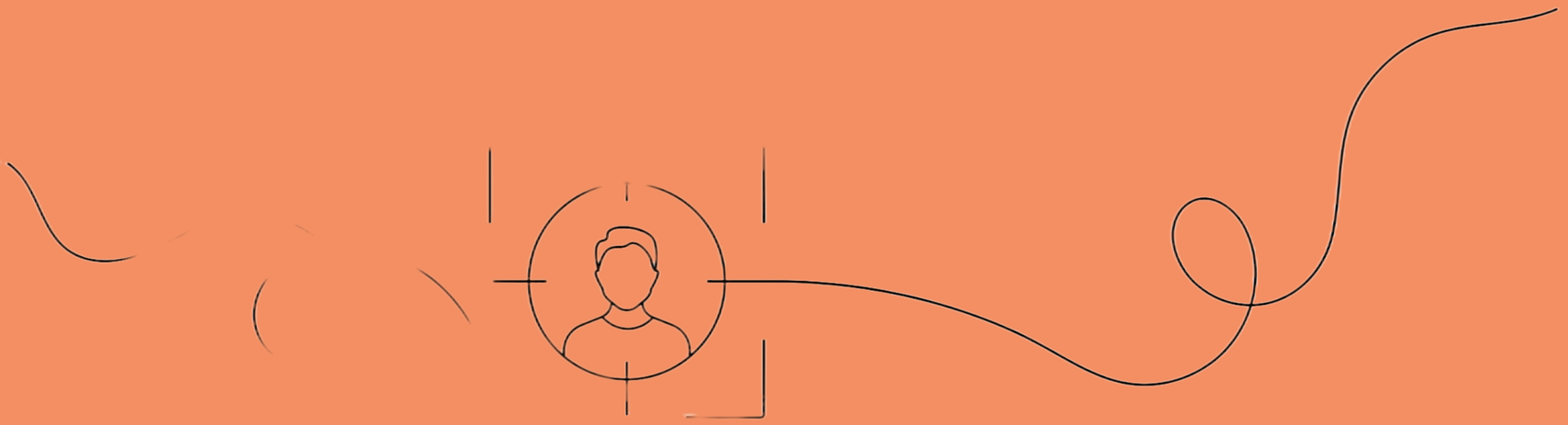
What is surprising is that, amongst working age adults, **we've seen on average *more* greens overall from people who report having a physical health condition, than those who do not**. What we do see though is that **reporting a mental health condition shows the reverse**, with fewer greens and more reds overall, especially relating to Income & Employment. Again, we cannot draw conclusions from this about the biggest impacts upon social isolation locally, though they do reveal issues to explore, so we better understand how these factors interact as contributors to social isolation in the borough. In addition to what we've seen in the data, further insights emerging from team reflections on the causes of social isolation locally, based on 1:1 work, include:

- **Life transitions:** Isolation often begins or intensifies at points of change, rather than being a long-term trait, with tiggers we're seeing including bereavement, health deterioration or diagnosis, retirement, housing changes, and the end of structured support
- **Loss of confidence**: A strong recurring theme is not lack of opportunity but *lack of confidence to engage*. This may manifest in anxiety to leave the house, fear of new social spaces, past negative experience of community spaces, and a fear of "burdening" others.
- **Disruptions in identity**: We're seeing that isolation is often linked to how people see themselves, and a sense of losing touch with who they used to be, or difficulty in adapting identity with age - for example, we've heard about people being "past it", disconnected from past hobbies and friends. and slowly losing the sense of who they were when they did live a more connected life.

3. Resident Updates

Resident “Pen Portraits”

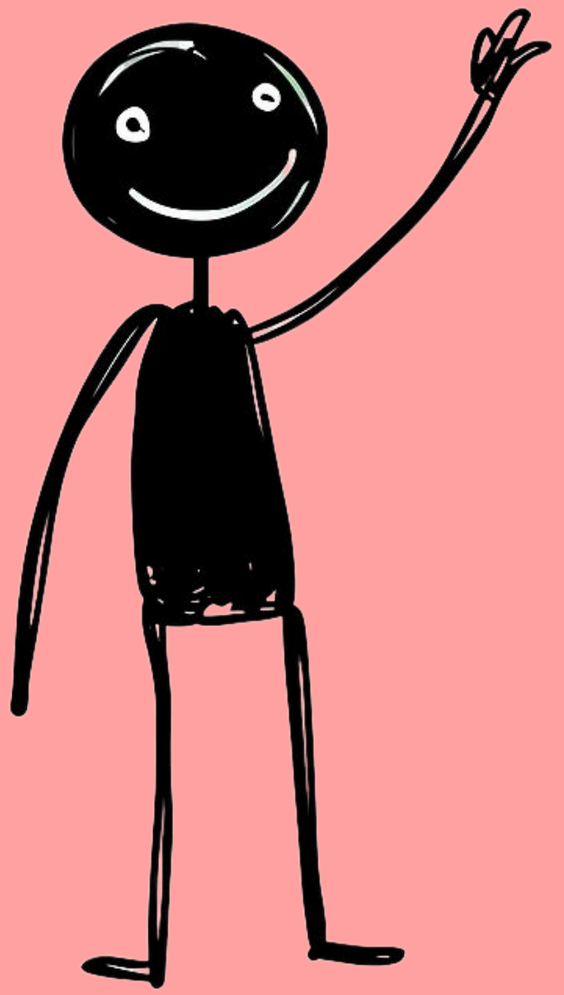
Stories of onward progress



Resident “Pen Portraits”

The following slides a glimpse into the diverse group of residents we’ve been working alongside 1:1, since July 2025..

The majority of these residents have been referred in by Adult Social Care services, while some have continued from the last phase of work. Within the following anonymised “Pen Portraits” we’ve outlined some of the background experiences and obstacles that residents came into the Connect programme with, their ambitions, and the work we’ve done alongside one another.



Name:	Fatima	Referred to Connect by:	Social Worker	In:	October 2025

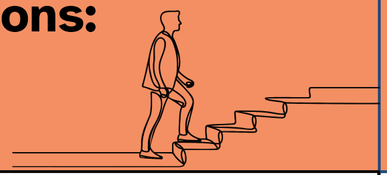
Background:

Fatima has a very supportive daughter, but her daughter doesn't live locally and is a busy teacher with limited time.

Fatima has PTSD, and wanted to work alongside a woman.

Fatima was reassured the project that the Connect project is supported by the council

Ambitions:



To get outdoors more - Fatima was stuck in the house, without people to support her to get outside (she only went out with her daughter)

To do some of the "normal" things that people take for granted (eg. getting back to the mosque, going out for coffee)

What we've been up to together, In Connect:

A long first chat revealed ongoing problems with Fatima's carers (verbal abuse / money requests). Lisa (Fatima's 1:1 Catalyst) made a safeguarding referral and advocated for Fatima to raise the issue..

Lisa and Fatima have gone out shopping for fruit & veg and went to Greggs for a coffee and pasty.

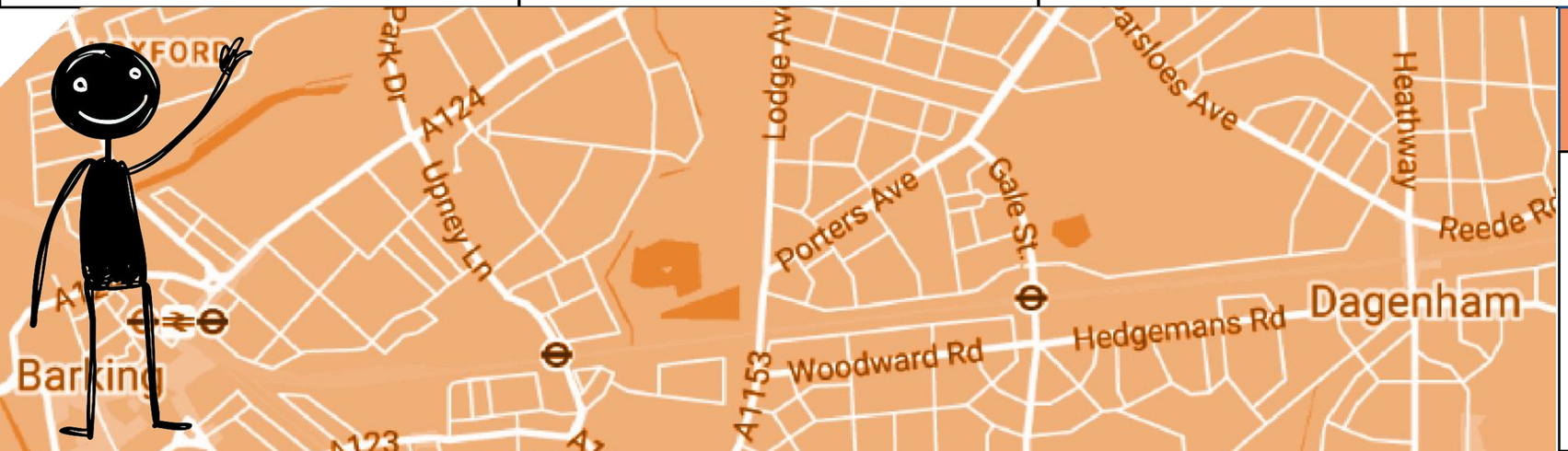
Fatima was interested in the Independent Living Agency's Healthy Futures project, so Lisa linked her in.

It's meant that:

Fatima shared she built up the confidence with Lisa's support to ring the Intake Team and has managed to change her care provider.

Fatima and Lisa have a bus ride planned for next week - the first time in years.

Fatima has shared very positively about the benefits of getting some fresh air and engaging in normal life activities again, building up her confidence and motivation to do this more.



May be ready to "graduate" Connect, when:

Fatima feels confident in being able to get out - able to connect with community without always relying on her daughter's support.

Fatima feels confident in her care team.

Name:	Blessing	Referred to Connect by:	Social worker (learning disability service)	In:	September 2025

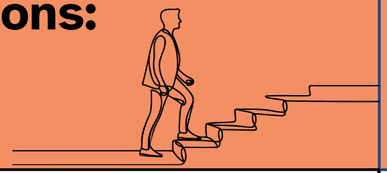
Background:

Blessing has learning difficulties and is shy, with her father doing a lot of advocating for her.

Blessing's family is from Nigeria but her first language is English.

She has found it difficult getting onto a college course, and was put on one she didn't choose - people has assumed things about her (e.g. that her first language is not English) that took away her autonomy.

Ambitions:



To become a beautician - Blessing wants to work in hair and makeup (this is her dream rather than her parents dream - the latter of which is shaped by comparisons with Blessing's sister). Blessing has mannequin head ready to use!

To meet more people and get outdoors socially.

What we've been Up to together In Connect:

Meeting at the library to talk (at first with Blessing's dad and then on her own)

Linked up with Independent Living Agency's back to work support - help with CVs, and finding a college place

Lisa has booked a makeover with Blessing

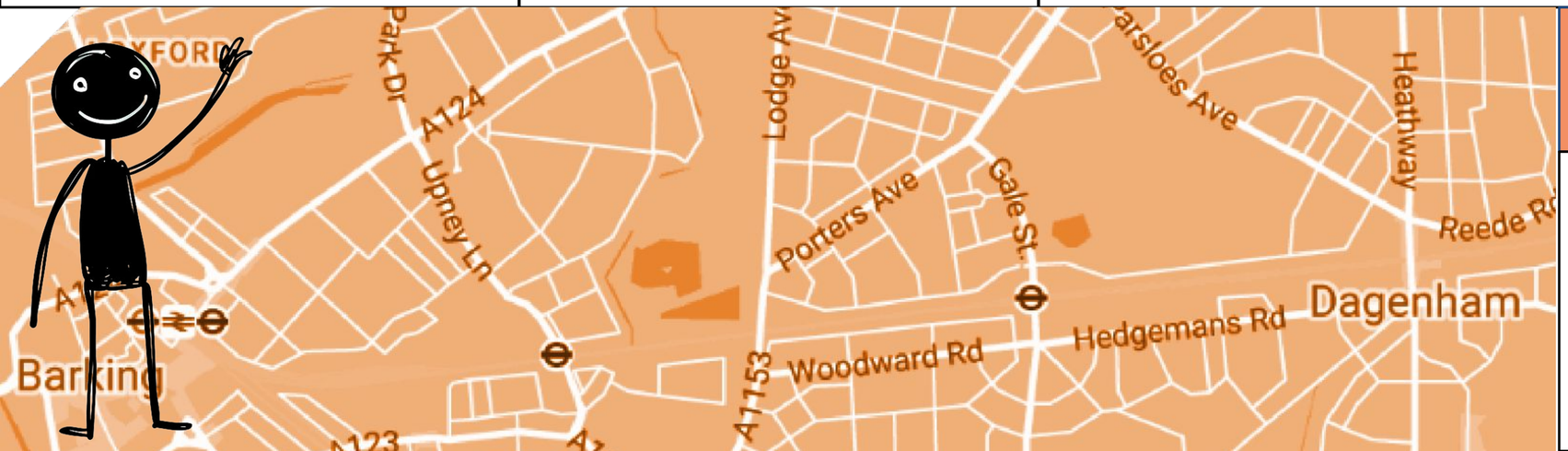
Exploring interests and getting to know Blessing to help her open up more.

It's meant that:

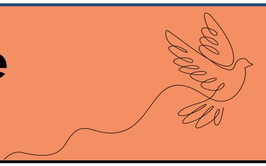
Blessing has been able to open up when she's on her own - a big change from when she wouldn't talk at first. Her social worker commented that she was happy to see Blessing come out of her shell, when visiting Blessing in a local group.

Blessing is moving towards finding a course she actually want to do.

Blessing's dad has felt able to leave her on her own and to trust her to make her way home independently.



Might ready to graduate Connect when:



Blessing feels confident mixing more with people

Blessing is accepted onto the college course doing what she wants to do or knows how to pursue this when she's ready.

Name:	Peter	Referred to Connect by:	Social Worker	In :	October 2025

Background

Peter lives on his own in 2 bed flat.

He has learning difficulties and his mental health is very low due to anxiety and depression.

Peter shared that he has no friends around him after previous bad experiences with supposed “friends” led him to disconnect and self-isolate.

Ambitions:

Peter felt that mixing and meeting new people at different groups would help him have a more confidence in himself

Peter wanted to move beyond isolation and feeling alone so much, knowing that he enjoys talking and listening to others.

What we’ve been Up to together In Connect:

Unpacking what Peter likes to do (go for coffee, have chats and walks in the park) - then identifying places and groups for Peter to pursue his interests to get used to socialising.

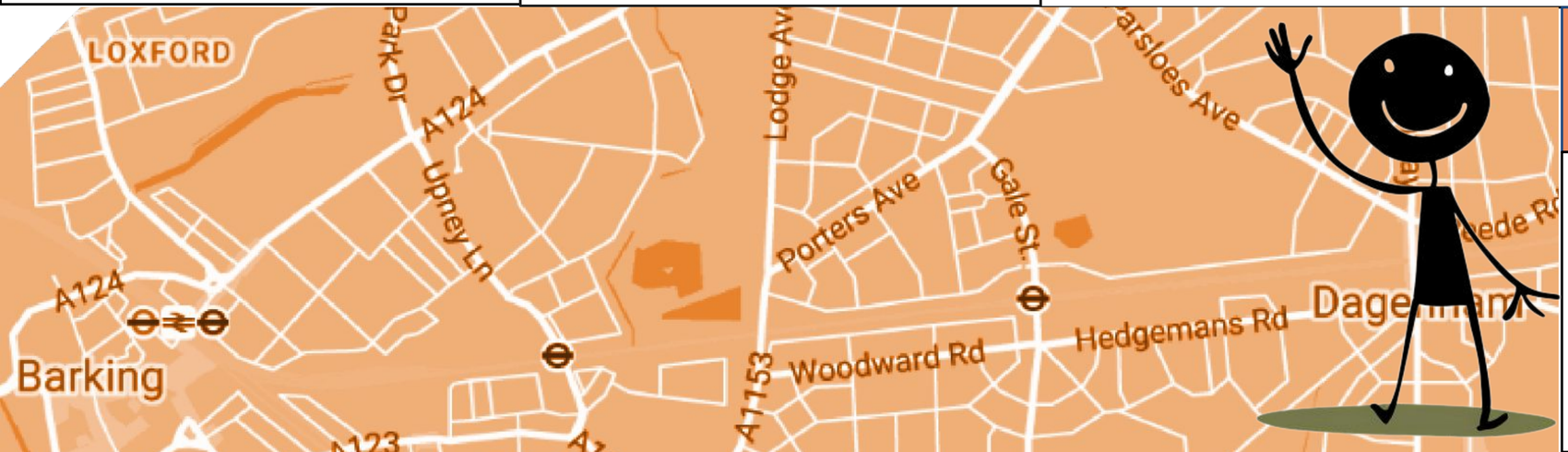
Finding a place for Peter to be on Christmas day so he’s not on his own again (as he was over the previous 2 years) - Since his mum passed away, Peter has been spending Christmas on his own and wanted to spend it with other people in the community who are also on their own.

It’s meant that:

Peter now has a better sense of what is available for him to join locally and has a plans to help him form more authentic friendships after past negative experiences.

Peter met one of the volunteers in a local yoga group who he went to school with and has an opportunity to reconnect with someone here, which Lisa (his 1:1 Connect Catalyst) has encouraged.

For the first time in years, Peter has company on Christmas day.



Might be ready to graduate Connect when:

Peter is going out on walks to park in the community mixing and talking to people in difference activities groups.

Peter’s confidence and his mental health has improved thanks to more dependable friendship and support around him.

Name:	Michael	Referred to Connect by:	Care Coordinator	In:	December 2024

Background:

Michael is housebound

Michael is diabetic and has, heart problems and an underactive thyroid.

Michael's primary social contact is with his carers with little family around him.

Due to his condition, Michael has other health problems like bed sores.

Ambitions:

To get out of bed and go down the road in his wheelchair.

To find more company and social contact, especially during the daytime.

What we've been Up to together In Connect:

Michael has been supported to get a hoist, to support him with getting up and about when he feels able.

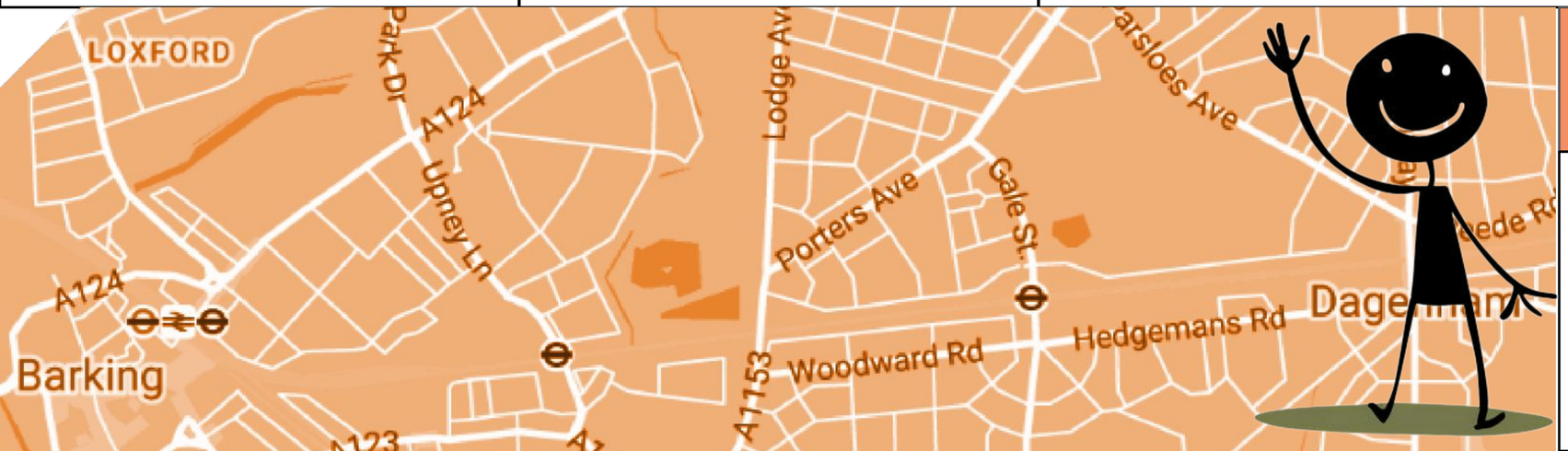
Michael has been talking with Susie (his 1:1 Catalyst) about his past work as a builder and a cab driver, how how he used to like travelling and his family.

Together they've been exploring how to help Michael talk to the doctors more and they arranged a weekly community nurse visit to visit Michael to help him manage his condition

It's meant that:

Michael has more people to talk to during, and is reconnecting with his sense of identity through conversation with the Connect team

Michael has more contact with healthcare professionals who are able to help him manage his chronic health challenges.



Might ready to graduate Connect, when:

- Michael feels more able to get up and about after a schedule of upcoming tests
- Michael feels able to use his online skills to connect with others while still housebound.
- Michael feels like he has opportunities to contribute. We're going to ask him whether he would like to speak to someone about care technology.

Name:	Steve	Referred to Connect by:	Social Care Navigator	On:	September 2025

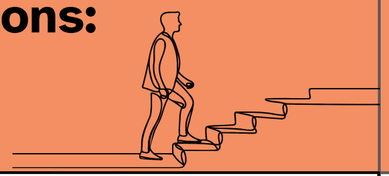
Background:

Steve was coming up to an operation, which would either improve his mobility or not (dependent on an MRI scan).

Being housebound is quite new to Steve, the operation felt quite ‘all or nothing’.

Steve used to love gardening, his son lives nearby and does his shopping. His son also takes him for hospital appointments.

Ambitions:



Lots of Steve’s focus was on his upcoming operation.

He was upbeat, but also talked about being resigned to decline if the operation doesn’t work and wanted to build confidence and plans around what will happen

What we’ve been Up to together In Connect:

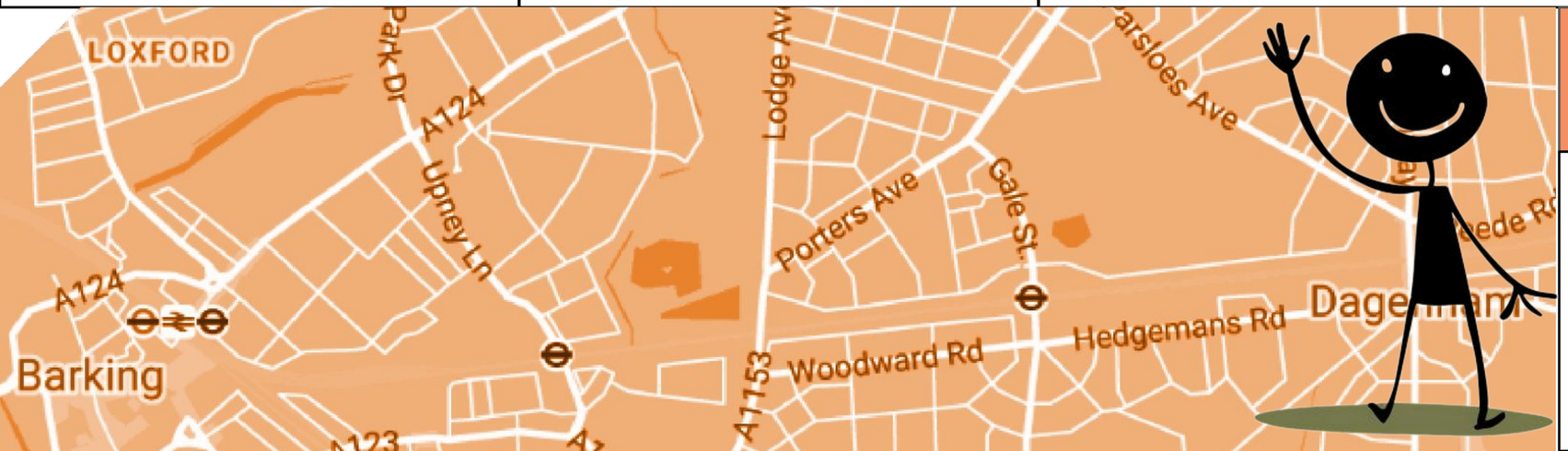
Talking over the phone - Steve has been embarrassed about his commode, so for the moment we’re bonding over the phone.

Building trust - We’re building the foundations of a relationship so Steve is open to an in-person visit and keeping in contact while in hospital

Steve has found out he won’t be given access to physio after his operation, despise wanting it. so Susie is advocating for an alternative.

It’s meant that:

Steve has felt comfortable in opening up to Susie and getting to know her.



Might be ready to graduate Connect, when:

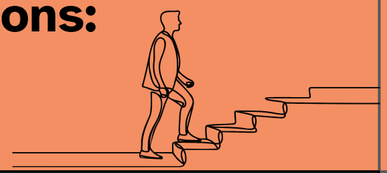
The future is clearer, and Steve is able to focus his mind beyond his operation, so we can open up different conversations about what Steve would like to do (there are plans to ask encourage him to contribute his gardening skills)

Name:	Winston	Referred to Connect by:	Social Worker	In:	September 2025

Background:

Winston is our new oldest Connect resident (at 94). He carried the olympic torch, was a medal winning cyclist, and has raised big sums of money for the MS Society. He has mobility problems, so his friends help him get around. Winston loves snooker and goes once a year. Being related to the former Queen Mother, he's about 400th in line to the throne. His friend is writing his biography.

Ambitions:



To be around more people again

To get a bit more active.

Together with my 1:1 catalyst I've been:

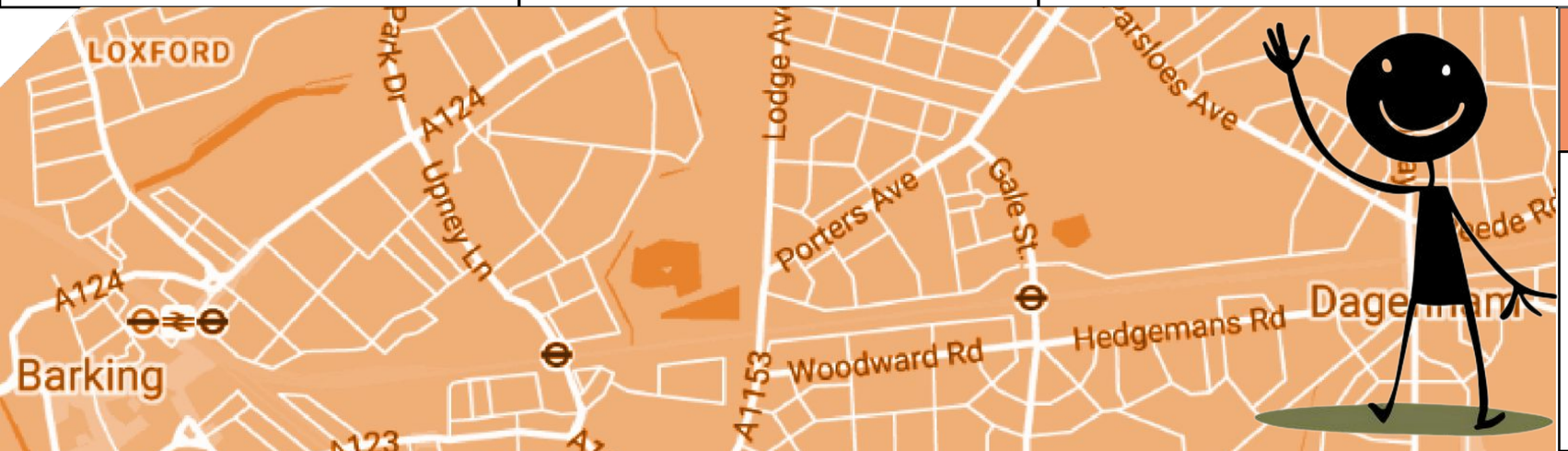
Winston has been linked into local lunch groups and is considering coming to the men's snooker and bowls group at Harmony House.

It's meant that:

Winston's face lit up when we talked about snooker, he's happy that he can play with being in a wheelchair.

He didn't know what was out there in the community that was accessible and friendly for him to go to, so that's made a big difference. We're having a great time getting to know him as well.

Winston has set up a dominoes group on his own - and is now supporting other people to come together in Harmony House.



Might be ready to graduate Connect, when:

Winston is confident in having enough dependable connections - we don't think it will take long.

His confidence was a bit shaken by losing sight in one eye, but he has a good network that should provide him continued support..

Stories of onward progress

We're following up on the longer-term impacts of the Connect programme for residents supported 1:1. To do this, we've caught up with the stories of seven residents featured in either our mid-project evaluation (Jan 2025) or in case studies, and collected findings onto "What happened next?" slides integrated within the original stories. The following slides show some individual and wider impacts seen 7-10 months after the stories were first written up. Some stories have been de-anonymised since previous sharing, following consent from residents.

Lucy: About me

“I’m like an onion with different layers.

I’m a mother of five, age 56, and originally from Nigeria. I’ve been living here in Thames View estate since 2003 - I’d never heard of it before. Even now when I say where I live to people, I just say “Barking Riverside”.

Before then, I was living in the USA, in Maryland, and I moved here not long after the September 11th attacks - it was scary. We moved to another place in Barking, and lived in East Ham, before coming here..

A lot of my family have health conditions - my son, Joshua, has sickle cell anemia and my daughter is in a wheelchair. I also have complex health and wellbeing needs. I go to Barking hospital for my mental health and I’ve had lots of problems with my eyes. As you can see, I’m able, but I don’t go out often - I don’t like going out generally.”

Barriers to Connection

"I have **mental health needs,** which means I'm going to the hospital a lot. I also have difficulties with **walking and my eyesight**".

"When we first came onto the estate, we found that some people are not very friendly. Even getting to the GP was awkward. Some of **the receptionists would tell me there was no capacity, but with very awkward behaviour, like "these people are coming to invade"**.

There are **health conditions in my family** too that makes things difficult. My daughter is disabled and has social anxiety."

Before meeting Susie, I was walking around with a stick and a wheelie suitcase, for support. **I didn't want to look like someone who needed help**. But my family found it embarrassing to be around me when I used the suitcase."

My hopes for Connect

"I joined other groups before finding Susie and Connect, but I didn't find they helped me. I was looking for something else.

I had therapy previously, but it gave me flashbacks and made me feel worse. During COVID, they put me on a group Zoom call with people who already knew the therapist, but I didn't. I was never pulled into the conversation and people would talk about what they wanted to do, and it only gave me more thoughts. One day I had to shout on the Zoom, I felt like I was becoming small and needed other people to share with. **I wanted to find more people to talk to, with more empathy, to get things out of my head.**"

I discovered Connect through:
Barking mental health hospital

I'm working alongside:
Susie

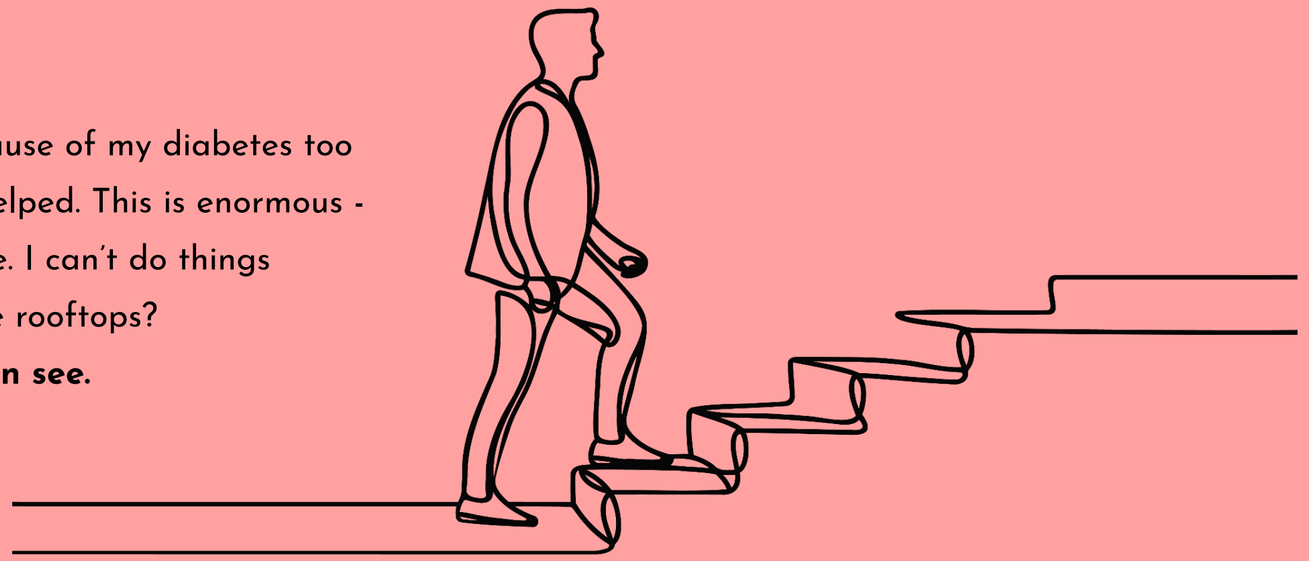
Some steps we've taken together

Since joining Connect, I have time to talk to Susie one to one about what's going on with me**. It's like the therapy I never had** - you can feel the empathy. Even just asking "how do you feel today?" It gives me headspace. It's like I've emptied things. My doctor is very happy because they can see when I talk about Susie and Shed Life I'm brighter. They said they can see that I'm alive and tell me "keep going there". Susie calls us through the week, which helps bring positive energy when I'm down. You feel that somebody really cares - they understand. **I see that me and my children are happier.**

I'm not being assessed at Shed Life. Everyone just goes and does whatever they want to do, but everyone feels included. **We do creative things together and they've helped me to feel more creative**. There are materials to use for sewing, colouring. I love it, and I've donated a sewing machine to help. It's like medication, and my outlook to living is more vibrant.

Susie helped me get a mobility aid through the Small Good Things Fund - one that looked nice.
Now, I'm able to go out with pride.

She also helped me get my glasses. I have a complicated eye condition. Because of my diabetes too it's an expensive prescription. I wasn't able to get this myself and the fund helped. This is enormous - even my children were talking about it it has made a serious, huge difference. I can't do things otherwise and I can't thank them enough - maybe I should go shout from the rooftops?
Without seeing, I can't do my sewing - **I'm more engaged now because I can see.**



How I interact with services and support in the borough

Before Connect

"At the **hospital**, I had an appointment almost every week."

"Everyone in my family takes **medications** every day."

Since Connect

"**My doctor said** that it's good I'm going out of the house - I know that I have a responsibility to get myself to look forwards to going to things. I don't want to go to appointments usually, but I always want to go to Shed Life, which is progress. If it was on everyday, I'd come every day"."

"**I don't need the same level of mental health support now. There are less difficult thoughts because of the activities I go to.** Instead of going through the motions and flashbacks, there is something positive to look forwards to. Shed Life is like a light in the dark for me."

Things we might work on together next

Explore art therapy and other creative hobbies

"We're going to keep being creative, me and James. I like to draw, but thanks to working with James, I don't draw stick men anymore! I am drawing to represent my feelings. It could be a tree to represent an emotion. Art therapy is what I want to do more of. I'm also looking forwards to writing a book. I have ideas. I started one called "Life is a Mirror" and I'll work on it at Shed Life. It will have affirmations about how you can channel your inner strengths. Because you fall that doesn't mean you can't get up again. It will be inspirational and motivational."

Get involved in more Shed Life opportunities

"I think 2025 will be a good year because I have more Shed Life and I think there will be more things to do""

Bring family into support

"We've just brought my daughter, who is 28, into Shed Life, where she'd made a connection with Abby [another Connect one-to-one worker]. We know it will be good for her."

Continue to reduce support needs, by maintaining recovery

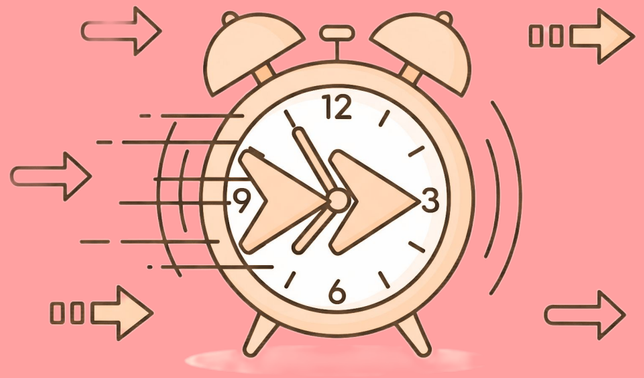
"When I go into hospital for appointments, I have ambulance transport to take me there and back as a day patient. I still have a support worker and support coordinator."

ECONOMIC IMPACT ASSESSMENT

Type of benefit	*Benefit*	Taxpayer savings*	Individual savings	Individual life improvement	Total
Health costs	Reduced mental health support required	£14,950			
	Reduced frequency of hospital visits	£5,980			
Wellbeing	Increased ability to access and navigate world through mobility aid and prescription glasses			£13,000	
Grand Total		**£20,930**		**£13,000**	**£33,930**

**Savings values are annual*

10 months later....



Lucy

What happened next?

Lucy is continuing to thrive and grow as part of the Shed Life Community. The group is helping her build **healthier relationships with her family**, and together they are supporting Lucy's children to pursue their own ambitions.

Building on a passion for textiles, Lucy is sewing culturally inspired scrunchies and other items. The group is stoking her entrepreneurial spirit, and **these items are being sold to generate income**, inspiring further plans for Shed Life to roll out a programme supporting people to become sole traders.

Wider ripples that we are seeing:

The **local mental health team** have commented on the benefits Lucy has experienced through Connect and they are **sending more people to the ShedLife group** for support (to the extent that it's now too many!)

Lucy supported her daughter Elizabeth to join the ShedLife community and receive 1:1 support. Elizabeth has since grown in confidence and been supported in her ambition to become a writer. She is **writing a regular column for the Barking & Dagenham post**, joining writing communities that Connect has linked her into, and she is often too busy to join the group.

Elizabeth

(Lucy's daughter)

Family unite to create comic

TRYING something new can be exciting but when it's your first time doing something that you've never done before, it can be quite daunting.

Well, for me, creating a comic was something completely new but I did it recently with a group called Shed Inc, which is part of a project called Shed Life.

The group met once a week, it was for residents interested in art or creative writing, my mum Lucy and my brother Joshua were part of the group too.

My mum loves creative writing and my brother loves drawing and I like to do both.

The purpose of our comic book 'Powers' was to encourage young children to keep up their reading and its message was that we all have our own superpower.

Creative writing is my superpower, so I was eager to get started on the storyline with the other members of Shed Inc.

In the first workshop, we drew spontaneously on large paper and then joined all our pictures together to make one big image, which was fun and relaxing.

This helped us get in the zone, focusing us to start of the comic book.

We next created our own characters and their profiles; we were given storyboard templates with different sized frames to map the story and actions. We roughly sketched and made notes in each frame, using bigger frames to slow the action and several smaller frames to speed up the action eg, running, chasing and combat scenes, also including close-ups of the action.

Here, **Elizabeth Adeniji-Williams** explains how her mum and brother joined her to become members of Shed Inc to create a comic book designed to inspire young residents.

It was nice to share our ideas and develop characters together. Artist Lillian Ip-Koon led the workshops, she listened to our ideas, encouraged us to add detail, asked us questions and wrote down our ideas and stuck them to our sketches.

As a creative person and a writer this has been an interesting experience and a really helpful process for me to think about writing my own comic book.

Shed Inc was a group for residents who were part of Connect, a council commissioned project to connect people into their communities and make new friendships. The project has also been supported by the council's Community Chest funding, and Barking Riverside Ltd, Community Fund.

■ *To find out more, email: connect@communityresources.co.uk, or for Shed Life/Shed INC contact us at the Thames Community Hub, or email: humourisk@gmail.com.*

Members of Shed Inc got creative in producing a comic book Image: Humourisk

Joshua: About me

I'm 24. I grew up on the Thames View estate, with my mum Lucy. I went to school around here. I had friends there, and I still see them sometimes. Three of my friends come to see me at home too - we play games together.

My whole family are very creative - we like art. My sister does photography and mum does sewing, while I like drawing and comics.

It's very convenient living here - the shops and the bus stop aren't too far from our house. We also live close to the library and GP.

I've had quite a few health issues in my life as I have sickle cell anemia."

Barriers to Connection

"My secondary school experience was good, but I've **missed a lot of school because of my health issues** - I didn't even get to go to prom. Often I was in for six weeks, then out again for two weeks, and so on. I'd rather stay at home when I need medical attention, but my mum and siblings advise me to go to the hospital. Back in July, I was in hospital for three or four weeks.

This has made it hard to stay connected sometimes. **I was staying at home a lot - didn't really go out anywhere**.

My mum has had to fight a lot for me during school as I've been in hospital a lot - she had to work hard to get people to give me work, or sit with me."

My hopes for Connect

"I wanted to **find people to spend time and talk with**, make friends and have fun.

I don't always get out the house a lot, so I wanted to **build my confidence.**"

I discovered Connect through:
My mum Sharon

I'm working alongside:
Susie

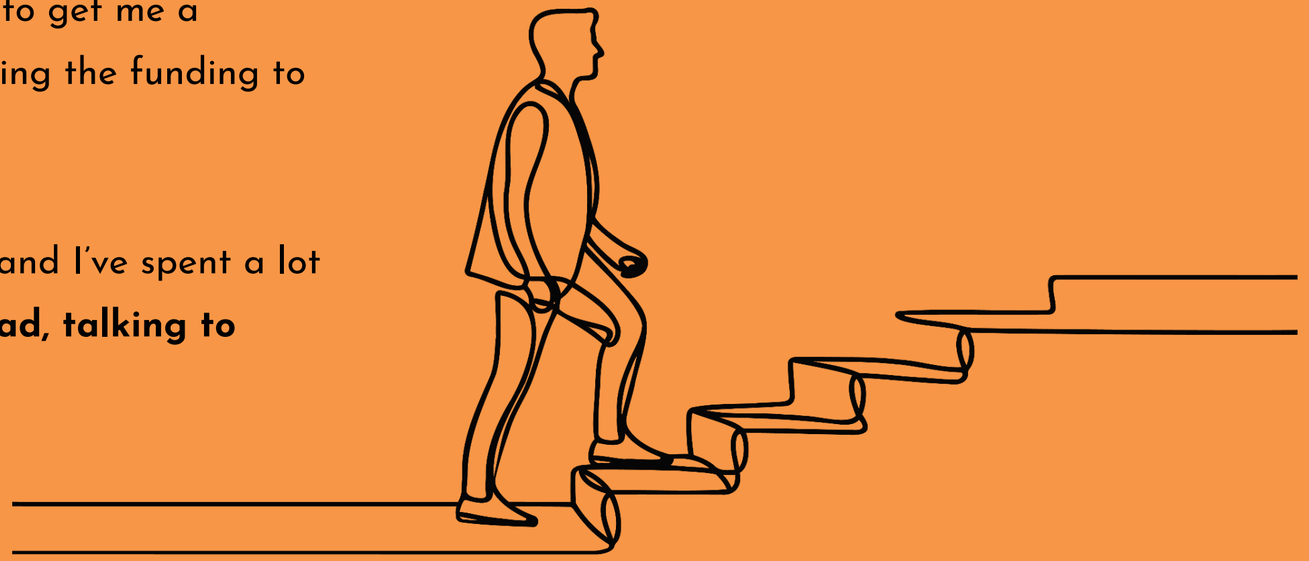
Some steps we've taken together

"Susie has introduced me to Shed Life - a weekly, drop-in community group in the Thames Community Hub. **I've made lot of friends there** which has helped me be way more comfortable. It's like a family there. **I'm able to speak to other people**. Before then I would just try to keep myself to myself and sit in the corner.

I'm volunteering at Shed Life now too. I welcome people coming for the first time. Susie said I had good interpersonal skills which is a big bonus, as they can't manage everyone in the group. **I've built up my social skills** through this.

I like to draw, and using the Small Good Things Fund they were able to get me a refurbished iPad to help me draw and create a comic. Now they're using the funding to start "ShedInk", which will be days where we'll work on comics.

Because you're always busy in Shed Life, it's nice when it's just Susie, and I've spent a lot of time talking to outside of this. **I can get everything out of my head, talking to Susie."**



How I interact with services and support in the borough

Before Connect

"I've been in **hospitals** a lot with my health - I'd be in them for weeks at a time. It's very boring as there's not much to do there. Now I'm [18] and not on the pediatrics ward there's not even a TV."

"I was often visiting **A&E** too."

Since Connect

"I've gotten better at managing my health and wellbeing - before I went to hospital, I'm not going to lie, **I wasn't taking my medicines a lot, like I should have been doing. Since then, I've made sure to stay on top of it** - I set an alarm on my phone to wake me up to take it and then I'll go back to sleep.

I've not been into hospital since meeting Susie in July and joining Shed Life"

Things we might work on together next

Pursuing creative hobbies

“I’m looking forwards to continuing to write my comic using my refurbished iPad.”

Drawing family into support

“My mum and I have plans for the rest of the family to help support them too through Connect, and my sister will be joining the project soon too.”

Welcoming more people to the Shed Life community

“I’m looking forwards to the Shed being built [which the group has been working towards for a long time] and being open three days a week. I’m sure we’ll have even more people coming.”

ECONOMIC IMPACT ASSESSMENT

Type of benefit	*Benefit*	Taxpayer savings*	Individual savings	Individual life improvement	Total
Health costs	Fewer visits to hospital	£13,524			
Wellbeing	Major improvement in social connection and confidence through Shed Life			£17,043	
	Improved wellbeing due to consistently taking meds			£6,500	
	Increased access to creative activities and shared interests with others			£6,500	
Grand Total		**£13,524**		**£30,043**	**£43,567**

**Savings values are annual*

10 months later....

Joshua

What happened next?

Joshua is continuing to develop and support others as part of the Shed Life community. The group has commented on how **Joshua's confidence has grown enormously** since taking on responsibilities.

Joshua continues to be an **official volunteer for Shed Life**, as part of which he is bringing people together and supporting them to build relationships. Being more active as a volunteer, Joshua is in much **better physical condition and able to manage his sickle cell anaemia.**

Wider ripples we're seeing:

Joshua has built up a friendship with a local White British man employed as a refuse collector, who joins the Shed Life group in his orange uniform - he is known the group as "Mr Orange". Group members have commented on benefits and importance of such **friendship between people of different ethnic and cultural backgrounds**, to build social cohesion in a neighbourhood where this isn't always strong. Together, Joshua and Mr Orange are trying out new hobbies - most recently, roller skating.

Pat: About me

“I’m 85. I was born in this area and I’ve lived in this house over forty years. I love the house - my family have adapted it so it’s easier for me to walk.

I worked for social services in the council for 44 years, looking after babies before they were adopted. I got to a hundred and stopped counting! I’ve got a plaque up at the doctor's down the road, opposite where I lived where I was young, thanking me and my late husband for working in the borough and looking after children.

I do a lot of jigsaws in the house to keep my mind occupied”

Barriers to Connection

"Almost all my friends have died - I lost eight in a year last year. I know a couple of people close by - one on the corner, one up the road - some people pop in and bring some biscuits, but I've found it quite lonely.

My husband died about a year ago and about two weeks later I **had a stroke.** Now my brain doesn't always think right. I haven't got my balance. I could only move my eyes at first, so I've achieved a lot since. I'm not a miserable person, but the first christmas without my husband was big for me - I was in hospital in a room on my own. It was the first time I thought "I've had enough". But the thought of my girls brought me back again - my girls have been so good that I think "If I give up, I've wasted their time".

My daughters are wonderful but they live far away - in Brentwood and Islington - to come it takes them 1.5 to 2 hours, then they have the same journey back... They're good girls they look after me well.

I've been to groups, for tea and biscuits. It's nice and people are friendly. At one though **I'm the only one who's had a stroke, so I struggle - they do it on a long table and you don't really get to talk to people easily**. They play a card game, and a quiz, but it's hard for me because I can't write because my hands wont let me. And a lot of the info about stroke support here is out of date."

My hopes for Connect

"Before meeting Abby [who I'm working alongside at Connect], I was housebound. But I've always been one to get out. Even when I lost all my mates, I still went to Romford, and to the bingo on my own. I can't do that now - I can't go anywhere - so **I wanted help getting out and about.** Eventually I'd like **to be able to get out on my own.**

I also wanted to know more about what's happening locally and get myself there.

If anyone says we know somewhere, or let's do someone, I'll do it."

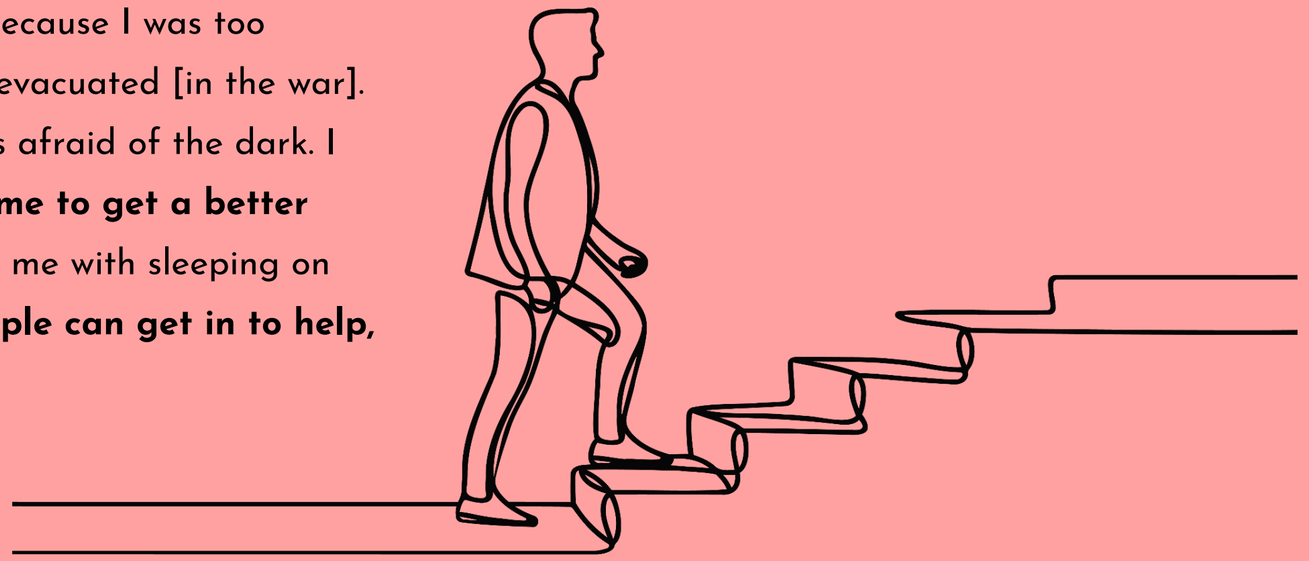
I discovered Connect through: My GP

I'm working alongside:
Abby

Some steps we've taken together

"**We've been going out a lot**. It's wonderful to have someone to help me get out. I got on the bus with Abby for the first time in years, otherwise I have to use taxis for everything. We went out to a shop together to pick out a walker - we went to try them all out. My kids wanted me to have a three wheeler, but apparently you need really good balance for that - so we found another one that suits me. We chat when we're out and about to people, but you don't meet many people around here - it's a bit quiet. Still, **this has given me a new life - I couldn't get out before.**

I've achieved a lot from when I first came out of hospital. I couldn't even be on my own then. I had to have a person in £100 a day just to have her sleep in the night, because I was too nervous, which linked back to when I was terrified as a child, when I was evacuated [in the war]. I slept with my mum until I got married, and then with my husband. I was afraid of the dark. I still sleep with all the lights on. Now I'm doing better, **Abby has helped me to get a better lock now for the door after** we got locked out together. This has helped me with sleeping on my own - **I feel safer - and it means if something happens to me, people can get in to help, when they couldn't before.**"



How I interact with services and support in the borough

Before Connect

"I've been in **hospital** a lot, in and out, in and out - about 10 days each time. After my stroke, I did 6-8 weeks in there. I loved the stroke unit - they was good company the six or seven of us in there. We used to talk and have a laugh. It was good and I learned a lot - it was them that got me this far."

"I had **carers** come in, for my husband, but I said I don't want carers and I stopped them as soon as the 6-weeks [reablement] finished - it's a lot of money. I thought that "we worked all our life for that, me and him". When you're like me, everything you do you have to pay for - I'm not on income support."

Since Connect

"They rung me the other day from the **hospital** and asked "How's your heart?" I said "it's okay", so **they said "okay we will [discharge you and] put you over to the doctor now", so I won't be needing to see them anymore"**

"I used to call the GP all the time, but I don't do that now - I realise it's a waste of time - they usually can't talk to you"

Things we might work on together next

Finding comfortable limits of mobility and independence

"I'm not sure how much I'll be able to get out on my own. I think I might have got as a far as I can go, with regards walking, after the stroke - I think I've lost a lot of my confidence. It's wonderful to have someone to go out with - that's important. I have a lady who comes to the house to teach me yoga, and I know that the day after yoga, I feel good. It's helping me get more confident. She takes my stick away and says don't use it when she's here. I'm alright for the hour until the very last bit where its all legs out. I seem to go blank, I think that's my brain - it's had enough."

Doing what we can in an imperfect world

"I don't think I'll ever travel out here now as I don't think it's very safe around here - my neighbour parks his van on the drive, to help."

Exploring environmental adaptations

""My daughters wanted to get a slope, for the front steps. I wouldn't be able to get the walker out down the steps.
I've only been going out since I've had Abby and I really look forwards to it. Also I can't shower easily with the bath I have."

Finding lasting mobility support beyond Connect

"I ring up for a patient transport and tell them I need one for my hospital visits, for my bloods, because I'm on my own. They take me and bring me back, which is how's it's been since the stroke. It's alright but you wait so long - 2-3 hours for an ambulance, coming back. Sometimes, I refuse to go to hospital. Even when I had three falls in one day - people are in there up to ten hours laying in the corridor - I thought I'm not having that no more."

Finding the best ways to engage with primary care

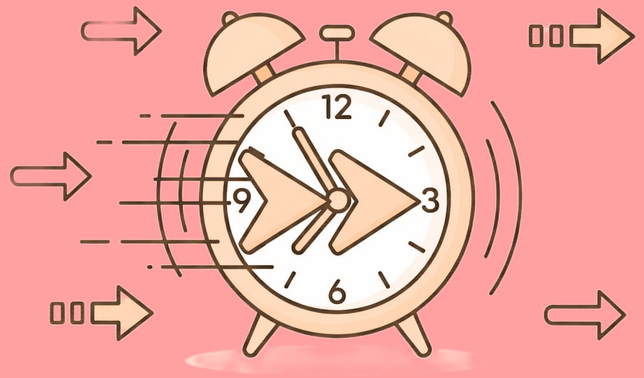
"I've got a GP booked up for the end of this month, because you can't get hold of a GP. So, if anything went wrong, I've got an appointment, because I take a lot of drugs. To be honest I've been like that for years though"

ECONOMIC IMPACT ASSESSMENT

Type of benefit	*Benefit*	Taxpayer savings*	Individual savings	Individual life improvement	Total
Health costs	No longer regularly calling GP	£780			
	Less frequent trips to the hospital trips required	£9,660			
	Less frequent trips to the hospital reducing need for patient transport / ambulance	£1,836			
Personal costs	Less reliant on frequent taxis		£195		
	Reduced need for overnight care		£26,000		
Wellbeing	Improved access and interaction with outside world			£17,043	
Grand Total		**£12,276**	**£26,195**	**£17,043**	**£55,514**

**Savings values are annual*

10 months later....



Pat

What happened next?

Pat is no longer feeling a burden on others, which means she now has a **better flow with her family** - they go out a lot together and she feels more comfortable asking for her family's help.

Pat is now **reaching out to her neighbours** for support when she needs it - they help her with small tasks like getting her newspaper and they check in regularly.

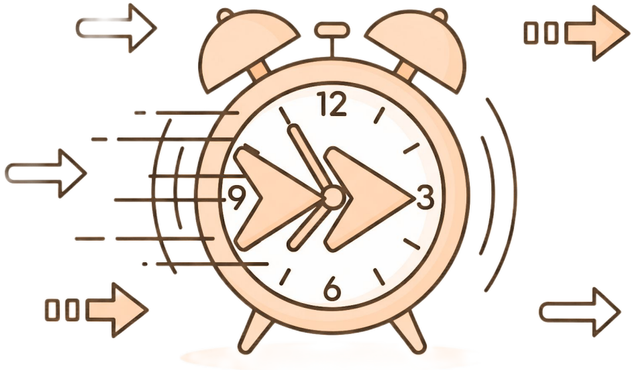
Pat is still not completely confident getting out on her own, but she has a good sense of what is and isn't safe for her to do. She is **coming to terms with the limitations to her mobility,** and focusing on what she is still able to so, and living life to the fullest.

Wider ripples we're seeing:

Pat has developed a new routine of going to stay over with friends at weekends and **providing company and mutual support to one another.**

Delfa's story

7 months later....



Delfa

What happened next?

Delfa has been so busy that she's still looking for a window to complete her second lifemap (after seeing the benefits of completing a first one to in providing the structure she needed to move forwards).

When she's not hosting friends for Sunday lunch, Delfa is going to the Golden Years group in Thames View, **reconnecting with where she used to live**, or she's joining the Harmony House Luncheon club.

Delfa is now much **more settled in her housing**, after being supported to navigate a move away from accommodation that wasn't suitable. She is **proactively making appointments to guide her in dealing with money and debt** in the local library, without needing the same level of support and prompting to address challenges like this.

Wider ripples we're seeing:

Delfa is actively exploring ways she can help others in her community, in the way that Connect has helped her. For instance, on her recent birthday, Delfa **invited all her neighbours to join a BBQ** that she hosted in the communal gardens of her apartment block.

Jeanette

What happened next?

Below, we can see changes in Jeanette's lifemap, whose story we explored in an earlier case study. The larger of the two circles shows more recent indicators. As we might anticipate given the unpredictability of life's ups and downs, not all have moved in what we'd superficially call the "right direction" (not necessarily a bad thing - we've heard sometimes SIGNAL can help people more accurately assess what they've neglected over time, even if that moves them "down the scale"), the majority have tended "greener" over the course of engaging with Connect.

Gerald: About me

“I’m 73. I was born in Barking & Dagenham, and my dad is from Hackney.

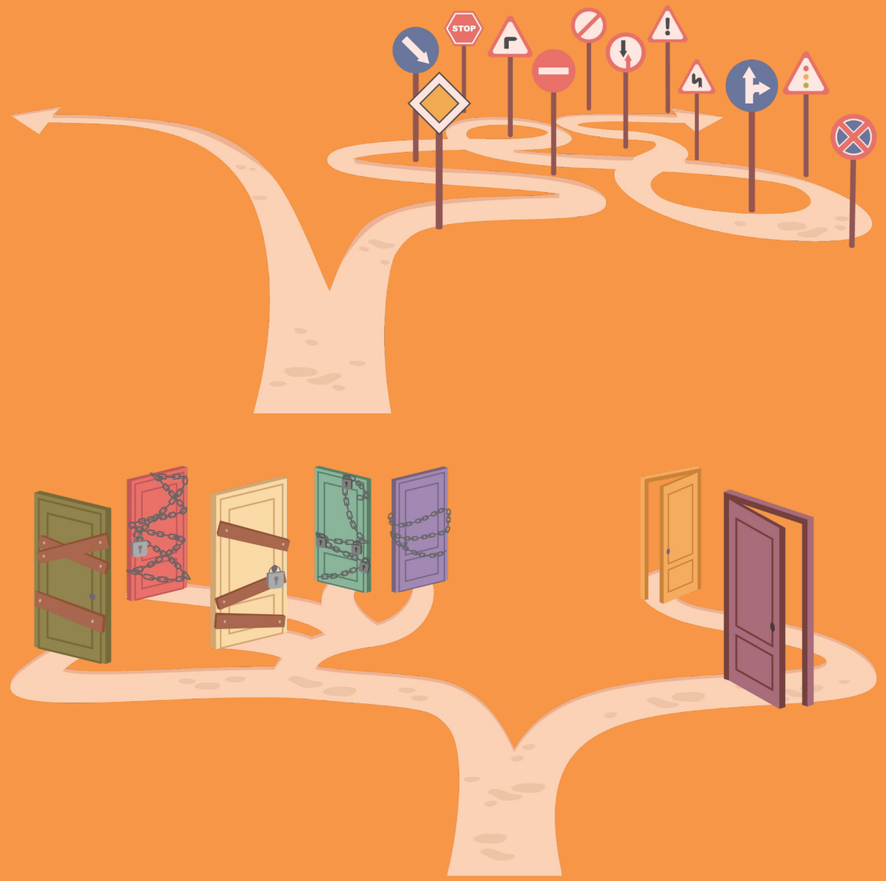
I love music.: Blondie, ACDC, the Rolling Stones. I also listen to a lot of Radio 2 and 4, which helps me win all the quizzes we do in Shed Life.

My dad was in the war and he looked after me really well after - I was never hungry like other kids after the war. He died when I was only 17, and when my mum remarried I had a stepdad who was abusive and violent. We had lots of fights.

When I was young I had a bad accident which damaged my arm, and I developed mental health issues. I met my wife in a mental health drop-in and loved her - we’re not together anymore.

I’ve always worked, which I’m proud of. But I worked in bad conditions, like in a printers and manual jobs outside in bad weather, without proper warm clothes or health and safety. It caused me a lot of illness.”

Barriers to Connection



Since my wife died, I've not been looking after myself as well. I still keep my flat the same as when she was there. **Lockdown changed a lot too. I haven't been cutting my hair, and I haven't been washing** since the window broke in my bathroom - it's always too cold, and **I can't raise my hands to wash properly** because of my arthritis. Nothing's been adapted to help with this.

Because of how I look, people are surprised I'm not homeless. People are rude and avoid talking to me. And people have bullied me because of how I look, like the kids on the estate. The barber cutting my hair - he said he didn't want to use the good clippers on me!

I have **schizophrenia.** A lot of mental health people have got involved, and I've been hospitalised a few times for that. One time when I came out of hospital, back in the 80s I was living in a flat without central heating and not enough food. When I went to the doctors, he called an ambulance because I was malnourished.

I don't sleep well - I can be up for three days in a row, listening to the radio or reading books - and this affects how I am around other people too.

My hopes for Connect

I found Shed Life when it was being set up in 2018 and have been going to their events since then - I get on really well with Susie and talk her ear off all the time - I've only missed it three times in six years.

It was just before Christmas that I started to work one to one with Susie and MJ through Connect - so now it's not just the Wednesday meetings. **The housing office told me I was going to be evicted from my house because of its condition and I wanted help to stop that."**

.

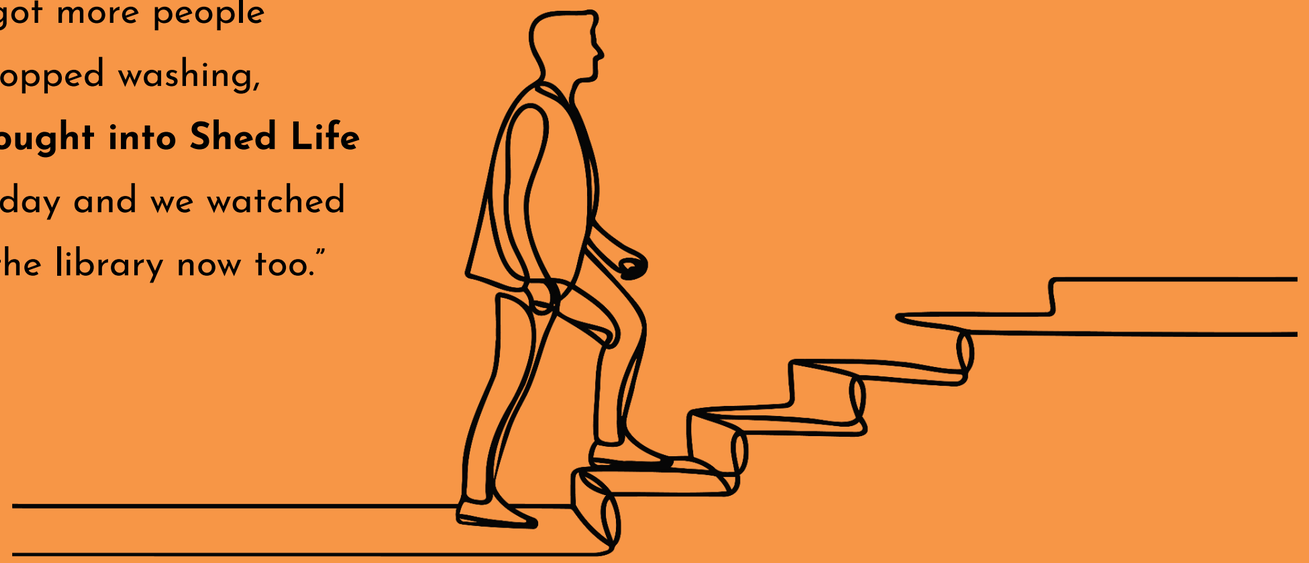
I discovered Connect through: Humourisk's "Shed Life"

I'm working alongside: Susie and Onye

Some steps we've taken together

Because of the threat of eviction, Susie and MJ have been working with me to sort my house out. They came to my house for the first time and saw that it needed more than just a clean - it needed a total refresh. MJ's dad owns the furniture store in Barking and they're donating some of the new furniture. Once the housing officer saw what they were doing for me, she was so moved that she held back on the eviction and said she'd come over in her spare time to help! **Susie explained to the housing woman that I was a founding member of the Shedlife group and that I helped them get the first survey done so we could build the Shed**. Back when they needed a survey, lots of men in suits came, and I said I'd be willing to donate £100 to help get it built. Apparently the next day they messaged Susie to say they'd be able to do it without the big costs, after hearing what I said.

Recently, **I've got another couple to join Shed Life and they're really grateful for the group.** One of the women sat outside library for 6 weeks with anxiety about joining. Now we've made friends. I've got more people to talk to now. My family stopped inviting me for Christmas when I stopped washing, but **I didn't spend Christmas on my own this year**. **The couple I brought into Shed Life invited me to their house on Christmas day.** I stayed with them all day and we watched five John Wayne Westerns. It wasn't half good. We meet everyday in the library now too."



How I interact with services and support in the borough

Before Connect

"I've had lots of people trying to help me over the years, but it's hard with my schizophrenia. **Lots of agencies and befriending** people - lots of **stays in hospital** but they can't deal with me.

I was told I was going to be evicted by the **housing** woman before Christmas.

I only go the **doctors** to get my injections and tablets"

Since Connect

"Since Susie and MJ have helped me sort my flat, **the housing woman has told be I'm not going to be evicted - she's even been over to help clean**"

Things we might work on together next

Finding ways to sustain independent living

“Susie said they’ll have a look at whether we can use a service the Independent Living Agency offer to help with paying bills. I put all the dates I need to pay for things in my calendar, but it really works me up.”

“My neighbour has offered to take rubbish down every week since Susie started advocating for me and what I can offer people.”

Stay local to Shedlife and new community

“Shedlife feels like a family so don’t want to move far from here.”

“I can’t wait for the Shed to be built as I’ll be able go three times a week. They call me “the radio” as I’m always talking in the background and they use a pretend remote control to try to turn me off. I’m a bit calmer now that I’ve got more people to talk to though, and I’ll keep seeing them.”

ECONOMIC IMPACT ASSESSMENT

Type of benefit	*Benefit*	Taxpayer savings*	Individual savings	Individual life improvement	Total
	Home improvements			£3,250	
Wellbeing	Less socially isolated			£17,043	
	Threat of eviction rescinded			£19,500	
Grand Total				**£39,793**	**£39,793**

10 months later....

What happened next?

Gerald remains in his newly renovated flat, and is no longer at threat of eviction and having to move out of his neighbourhood.

For several months, Gerald was receiving support improve his personal hygiene from other members of the Shed Life community. As of August 2025, working in partnership with the Independent Living Agency and Gerald's social worker, Gerald was set up with a Direct Payment, enabling him to pay for 11 hours per week of personal care, though **this need was delayed, and it's level reduced, thanks to ongoing mutual support provided by Shed Life group members.**

Gerald is still receiving support from a psychiatrist for his schizophrenia, though, in his last appointment, he was informed that he has is in stable condition with no acute mental health need. His consultant has remarked that **"it is clear that Gerald is receiving excellent support from his friends at the Shed Life project [and] remains independent in several respects, walking to the Thames Hub / Library most days, and purchasing bread rolls and cheese for his lunch".**

Gerald comfortable in his refreshed flat, alongside Susie

Gerald’s newly installed accessible shower

4. What we’re learning

Recap of previous learning

Learning since July

Recap of Previous Connect Learning

The below showcases key learning themes from June 2024 - - June 2025, which are detailed here.

Gently encouraging attention away from needs and towards a richer life is helpful, possible (and can help meet needs too!)

Connect

“Treat people as an asset, and great things can happen”

Connect

Authentic connections come from a sense of mutual humanity

Connect

We need to be intentional about welcoming people into new spaces and be watchful of getting lost in “delivering” activities.

Connect

Being explicit about our values (i.e. each person matters) can bring others on the journey with us

Connect

Fixed identities and behaviours can get in the way of connection, while a sense of security helps people to experiment

Connect

Conversational tools can show that we value each person and help us put their ambitions in the lead

Connect

Creating opportunities to contribute helps people see themselves in a new light, but requires curiosity to get right.

Connect

Learning since July 2025

The following slides outline key insights emerging from the most recent phase of work in Connect. These have been presented to show:

- what we've been learning and experimenting with, since working with residents in receipt of adult social care support
- any tensions, limitations, or challenges for us as a team, relating to this learning
- next steps and implications we are seeing

Following the insights, we share a brief summary what these are telling us against our learning questions from this phase.

For 1:1 support to be transformative, it needs investment in sustained relationship–building with residents – it cannot be accelerated by funding deadlines.

Since July, the Connect team has been operating within sustained uncertainty over longevity of the programme and a potential hard stop in November 2025. Combined with a lack of inward referrals from ASC until the middle of August, **this brought an increased urgency to our work and a pressure to "accelerate" resident journeys**. At times this has felt at odds with our "learning-led" approach to partnership:

> ""*[The previous phase] felt more organic - this one more of a conveyor belt. It feels like there's more of a pressure this time round, and* ***it feels like there's no room for human error***" - 1:1 Catalyst

The wording above reveals a shift in feeling that occurs when a programme is operating on compressed timescales. It's been integral to the programme that we work alongside residents in an exploratory and experimental way - we want to move away from thinking in terms of "failure", or "human error", and towards learning. This happens as much as when something *doesn't* work, as when it does, but needs time for people test things. Fear or lack of permission to be exploratory alongside residents is a barrier to working in ways we've found effective to date.

This feeling has been compounded by our growing understanding of the factors underpinning isolation, and how rare it is that residents can be supported beyond it in one or two easy steps. It takes time to unpack personal, social, institutional and historical causes, and it takes trust for residents to disclose challenging experiences that impact their confidence and self-esteem to this day. This feels even more pressing when working with the new cohort of resident, where **we've heard that people receiving care have often "gone through a lot more" and we're often not getting that that detail in incoming referrals.** This has led to an increased appreciation over our initial commitment to put "no time limits" on support. We're aware that this is always aspirational – no programme works without constraints – but **our recent experience has highlighted the importance of feeling we having space to explore** and finding ways to avoid either the team or residents feeling a rush to make progress - bringing an urgency that so often deeply undermines the curiosity definitive of the programme to date, which we know to be effective.

Challenges, Tensions, Limitations

While acknowledging the importance of putting "no time limits" on support, **we've had to continually challenge ourselves not to underestimate the impact we can make quickly** within newly formed 1:1 relationships. For some residents, this might be about surfacing really practical contributors to their isolation (e.g. lack of mobility aids, untidy living spaces that eat away at their self-worth) and **finding solutions to these using the Small Good Things Fund**. For other residents, **we've seen the importance of conversational tools, like SIGNAL**, to bring structure and clarity their challenges and reduce their felt "enormity" by focusing in on one or two things. Once people have momentum, and feel greater self-efficacy, the mountain of challenges no longer seems so unmanageable. What's more, we've been surprised at how quickly some people have felt able to share about difficult experiences - they sense that they "need to talk" about specific topics they find uncomfortable. **Knowing that many people are keen, but hesitant, to talk about challenging topics, we need to lean on tools like SIGNAL to help broach topics (or an "opportunity" for them), where they don't emerge organically**.

Based on this, what do we want to do next?

Difficulties we've felt around timescales feel like a unique challenge to this phase - they do not feel like inevitable consequences of the people we're working with, nor are they fundamentally about amounts of information we get up front.

Most foundational is the need to sustain our ability to be exploratory and experimental in how we work. We see that we as VCFSE partnership are most effective when we think of our role this way, build the conditions we need for exploration, be protective of them. **We need to lean into this role and avoid overdrawn expectations of how much that same approach is possible in the service sector we partner with**.

To support this, we are working to:

- extend the programme for **longer chunks of time**.
- sustain emphasis on the experimental nature of the approach and **thinking beyond "failure"**
- **rethinking our mutual expectations** about how "relational" we can or need to make a referrals process into Connect

Moving beyond a "fixing people" mindset is essential, but requires deeper place-based thinking

As a team, we're more deeply understanding our role in **bringing community around people** and the perils of trying to "fix" people. For example, when one of the Neighbourhood organisations tried using SIGNAL, they were first hesitant about surfacing so many different "problems" (reds) that they wouldn't know how to address. They then described how they came upon a mindset aligned to the programme - *"we, as individual organisations, don't have to solve people's problems"* - - **Connect is instead about supporting residents to meet their evolving priorities, moment by moment by drawing in the right local assets.**

We're also better unearthing the "hidden" assets we can bring around people. During some recent "ripple effect mapping" (see next slide), we unpacked how we can lean on informal knowledge and connections around us. In this case, **a local grassroots mums group called upon a member's friendship with a child development expert, scheduling an informal information and Q&A session to share expertise and put minds at ease about developmental concerns** - this might otherwise have gone through long-winded service channels. We're keen to seed similar thinking in 1:1 working - supporting residents in establishing grassroots groups (e.g. for dominoes) rather than needing to respond to this *as organisations*.

Challenges, Tensions, Limitations

We've still noticed a pull to refer residents into our own initiatives, or into others in the partnership. This is understandable, as these are trusted, and usually highly relevant to what residents are looking to work towards. Nonetheless, we've explored how this can also result from a lack of:

- Knowledge: Not knowing everything happening locally
- Time: Meeting in own own venues is easier for our schedules
- Ambition: When walking alongside residents, we may be able to think beyond "stepping stone" activities, and into ones that more closely align to their deepest ambitions and are more likely to motivare them to continue building momentum.

Based on this, what do we want to do next?

It's important that we're thinking about 1:1 working with the aim to "complement" and drawn in what's available locally, rather than doing everything ourselves. To support this, **we want to build deeper knowledge of what exists in the borough**, which we'll being pursuing through things like:

- deeper collaboration with new Neighbourhood Networks & Health Networks
- onboarding two extra delivery partners working 1:1 with residents.

The Connect team doing “ ripple effect mapping ” to understand wider, unintended, and hidden impacts of Neighbourhoods prototypes

Deficit-focus and shame is at the core of social isolation, but can be deepened by service interactions

We've heard that **people receiving service support often feel they have to play up their challenges** to get support, which can result in a laser-focus on what's "wrong" with them. We've also seen this (negative) ripple through their remaining connections, including through families.

> *"I had to encourage [a resident] to see the positive in her son. She was constantly talking about how useless he is - home playing video games all day" - 1:1 Catalyst*

Moreover, we've also seen how residents can quickly come to blame themselves for their challenges:

> *"My role has been to help [the resident I'm working with] see that what she experienced wasn't her fault" - 1:1 Catalyst*

Some of this is reinforced by the shape of service responses. **Residents can conclude, "I'm the problem, with such a complex set of challenges", because they see the large number of services they've been referred to, and project the complexity of the sector onto themselves.**

Challenges, Tensions, Limitations

While we know that a deficit-focus can encourage helplessness, shame, and a sense that residents need to be "fixed" from outside, we also know that many residents jump at the chance to work through those challenges and actually *don't feel they've had the chance* for them to be heard. **"Some of what looks like shame can also be nervousness or reticence when meeting new people" and, when given the opportunity to share, residents often grab this**

"Don't underestimate how just listening can be a benefit" - 1:1 Catalyst

"She was bubbling over at the chance to talk. I just sat and listened for two hours" - 1:1 Catalyst

Based on this, what do we want to do next?

While we want to foreground strength-based conversations with residents, we want to always give provide opportunities to share personal difficulties too. We will be doubling down on encouraging each other as a partnership not to shy away from digging into "challenging" topics (whether as a listening ear, or a practical helper) due to assumptions about what people "can/can't handle".

Building community agency is challenging without a coherent way of talking across "the system"

Many residents engage Connect from previous experience with the norms of "fixing" conversations within services (or perhaps "being fixed"), which can take away their agency to shape their own lives and condition them to others making decisions for them. This further stresses the need to support people to "self-advocate" shared in our previous learning update. We've seen this show up in a wider range of scenarios in this recent phase of work. For instance, in the context of poor quality care, but also in the context of family relationships and the growing challenge of loneliness for younger people.

> *"We're seeing with [two residents] that they have strong minded parents who can talk for them. By arranging time to talk alone, we're better able to see differences between what they want and what their parents want"* - 1:1 Catalyst.

Nevertheless, the residents we're now working alongside are likelier to be having sustained and significant interactions with services, which can approach interactions with a different lens, and it's a struggle to maintain the consistency of asset-led thinking that helps communities build agency over time.

Challenges, Tensions, Limitations

One the one hand, we know that residents can react well when seeing us as something "distinct" from services, which offers them fresh opportunity and a new language to talk about themselves. However, we also see the urgency of deeper collaborative working between services and VCFSEs to lessen demand and find people in need of most significant support. **This is presenting a challenge in how we best position ourselves as something both distinct from, yet working in partnership with, local services**, and how we might talk about a broader system of support that includes both - something that maintains some enough consistency in approach to make sense to people, while recognising the imperfections, constraints and norms of each.

Based on this, what do we want to do next?

We want to design **improved referral processes** which are easier for services to refer into Connect, alongside **more personal relationships with service professionals** to help identify the people we're best placed to help. We also want to open further **conversations around how we shift power between VCSEs and councils**, so we can protect our commitment to relational working, and home in on a more consistent language between us in support of community agency, while recognising our different needs.

Building bonds within families

"We're testing how to support individual uniqueness within a connected whole – building bonds through games and play within families and communities"
- **Dawn Aruoma** (Founder of Suresteps Wellbeing CIC)

Suresteps Wellbeing CIC prototyping activities to support bonds within families, as part of Connect's "Neighbourhood" work

An evolving cohort is revealing our need to diversify what we can call upon and work more imaginatively alongside services

Aside all the learning shared above is our growing appreciation of the sheer breath of different approaches, knowledge and connections we need, to bring the right things around people - there is no "one size fits all" tactic. Some things feel universal (e.g. a need to feel heard and that "we matter") though when it comes to walking alongside people in practical steps, real imagination is needed. And we're seeing ourselves constantly challenged to broaden our minds here. For instance, we know that people identifying as having "complex needs" benefit from our providing structure and clarity through tools like SIGNAL to bring stability and security to one aspect of life, as a foundation for longer term development. Meanwhile, residents with discrete health challenges are often benefitting from support rebuilding their confidence, testing ways of being more active, or sourcing practical mobility aids. However, we've seen two specific contexts in which we've been especially challenged:

- **Housebound residents**: Since taking adult social care referrals, we've been working with more residents who can't leave their homes. We've worked alongside some to build their confidence and mobility to make this easier, and we've explored improving relationships with neighbours, though we've been challenged by gaps in our knowledge around what can help reduce isolation when getting outdoors looks difficult, or far on the horizon. **Exploring broader ways to bring community around people who are housebound will be a big focus in what comes next. We will also be thinking more about the role of care technology here.**
- **Residents going in and out of hospital**: A significant number of the residents referred into Connect since July have since had to go back into hospital (for both expected and unexpected reasons). This has meant we've had to adapt our approach to sustain relationships, build trust, and work in contexts where simply *coping* feels the short-term priority: more phone calls, more hospital visits, painting the "positive opportunity" to look forwards to while things are difficult now. Maintaining consistent contact has been helpful here, though **we're seeing a bigger need to work alongside services in shaping more community-friendly healthcare environments, and a need to think about the role we might play in helping shape and support that, alongside emerging neighbourhood working models.**

Summary reflection against our learning questions

The learning we've accumulated between July - Nov 2025, has deepened our insight into causes of social isolation at a local level - reiterating the significance of self-esteem and "mattering" noted in our last report, while implicating transport, environmental factors, and income levels as having big impacts within the borough.

We are also understanding more about how we walk alongside people to build their agency and help them into dependable friendships - **we're seeing the importance of being led by relational principles,** rather than funding deadlines, **and how critical it is to be thinking about place**. We need to be growing and learning as a partnership, so we can keep up with the evolving diversity of what's available in the borough and grow our ability to bring that around people. This feels the most critical learning as we plan for a new phase of Connect which will test out the model with a different group. Deepening relationships within the BD Collective, the upcoming Community Benefit Society, and emerging Neighbourhood Networks is essential (along with sharing the benefits of the Connect model with those), while onboarding new delivery partners will give us a chance to strengthen our partnership capabilities.

We know more about working in partnership with services too - there is more that both we and service teams need to do to articulate Connect in ways that support quicker inwards referrals, and to ensure we link in residents that we're well placed ot support. **There is also thinking needed on how we position Connect within the system of support available to residents** and how we get better at speaking a common language that builds community agency.

What we do know is that ***12-15 weeks (what we had to work with practically) generally isn't sufficient* to support adults receiving social care** to (re)build a network of dependable friendships. The likelihood of continued hospital readmissions, the challenges of making Connect effective in the context of large numbers of housebound residents, and the range of factors perpetuating social isolation make short-term working difficult, and they reinforce our sense that **Connect works best in a preventative space, or where time is sufficient to working alongside people through hospital admissions that may make connection-building a bit slower and more stop/start.**

What causes social isolation?

What works to help people connect into dependable friendships?

How do we walk alongside people so *they* want to see change and build their agency to overcome barriers to connection?

What's needed from service integration to support those who are in complex situations?

How does service use change when people become sustainably connected?

5. What’s next?

What's next for us at Connect?

Sharing the Connect model

We've been sharing our learning-led approach to working with emerging Neighbourhood Networks in the borough, and will be doing further work to help transfer knowledge from the Connect partnership over to this new initiative catalysing resident-led community development across the borough. We are encouraging Connect Neighbourhoods organisations to form networks and identifying the most fruitful ways of sustaining our neighbourhoods prototyping activities through these and other initiatives in the borough, including the NNHIP programme and new Health Networks. In light of Connect's impact, we've been selected as a brightspot of learning-led neighbourhoods working to input to the Casey Review's Independent Commission into Adult Social Care. We've also been invited to provide continued input to the Cabinet Office's shaping of the new Test & Learn offer to support partnership working in neighbourhoods.

Scaling the Connect Model

From January 2026, we will begin recruiting two extra delivery partners onto Connect, allowing us to work 1:1 with up to 225 local residents annually. In addition to sustaining our work alongside residents referred in since July from ASC teams, we will be expanding to test the Connect model's ability to address social isolation amongst a wider group, to include:

- People with learning disabilities and autism
- Young adults with poor mental health
- Members of migrant communities