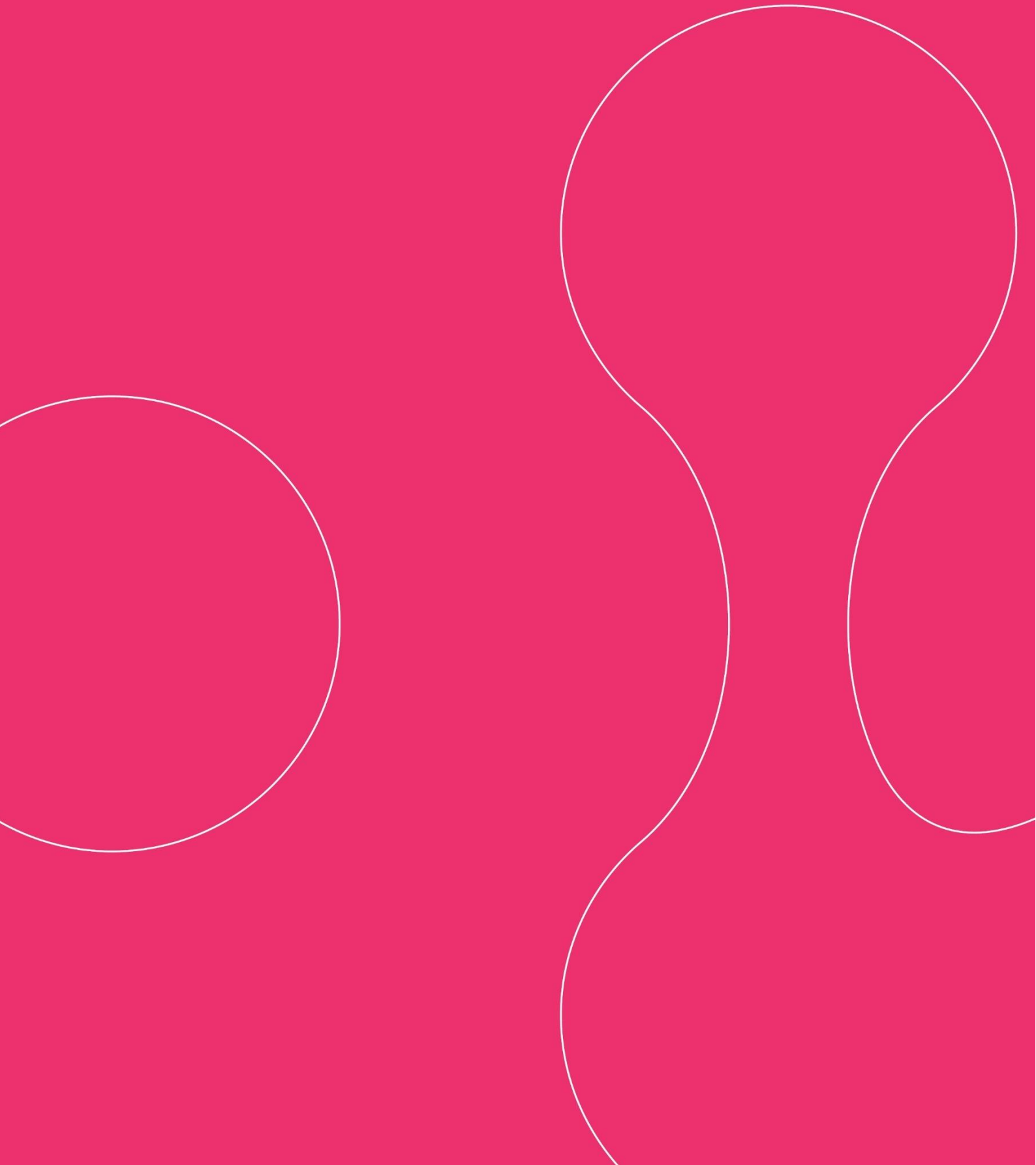




**Year One Evaluation
of the North East
Economic Inactivity
Trailblazer –
Summary**

**A Kada Research
Report**

for North East Mayoral
Strategic Authority
May 2026



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1 Introduction

The North East Mayoral Strategic Authority secured £10m in funding for the Economic Inactivity Trailblazer, delivering support to 2,000 people and employers between April 2025 and March 2026. The Trailblazer is part of the national Get Britain Working strategy aiming to tackle economic inactivity through bringing together health, employment and skills provision to reduce health-related inactivity.

The year one evaluation reviews the delivery and performance of activities, highlighting impacts and providing reflections and lessons for future activity.

1.1 Programme summary

Economic inactivity is defined as people not in employment who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks.¹ In 2024, the Get Britain Working White Paper outlined the Government's strategy to invest £240 million to tackle economic inactivity levels, supporting the ambition of a national 80% employment rate.² As a key part of this strategy, eight place-based Economic Inactivity Trailblazers were launched to accelerate a more locally led and joined-up approach to tackling economic inactivity.

In the North East Mayoral Strategic Authority (North East MSA) area, the Mayor secured £10 million in funding from the Department for Work and Pensions (DWP) for the Economic Inactivity Trailblazer which aims to support 2,000 people who are not working due to ill health as well as employers.³ The first year of the Trailblazer ran from April 2025 – March 2026. The North East MSA is the Accountable Body for the delivery of the Trailblazer. By testing new solutions, underpinned by system integration, the Trailblazer seeks to reduce health-related inactivity and is centred around three strategic priorities:

- Priority one: Improving pathways to employment by coordinating and maximising existing support
- Priority two: Testing new and innovative approaches to engage inactive residents and provide integrated services. The support focuses on six cohorts (young people, neurodiverse residents, individuals accessing primary care, social housing tenants, women, and employers) and a small grant programme for charities and community groups who positively engage with economically inactive residents.
- Priority three: Driving systems reform to create sustainable, joined-up delivery models.⁴

1.2 Programme context⁵

The North East MSA region has the highest rate of economic inactivity of all combined authorities in England (26.3% economically inactive of those aged 16-64 compared to 21% for Great Britain). The

¹ [Economic inactivity - Office for National Statistics](#)

² [Get Britain Working White Paper - GOV.UK](#)

³ [Economically Inactive Trailblazer Project](#)

⁴ Priority three activity is not included in the year one evaluation.

⁵ All data references drawn from Adult Population Survey – using most recent data from the October 2024-September 2025 period. ONS 2026. [Available here](#).

region's economic inactivity has risen since the COVID-19 pandemic, increasing by three percentage points in five years, while the UK's overall rate has dropped by 0.1 percentage points. This spike in the North East is largely due to a rise in health-related inactivity. With the region facing the highest rates of ill health in the country. By reducing inactivity linked to ill health to national levels would mean 45,000 more economically active people in the North East.⁶ Recent data (2024/25) demonstrates that those with short-term and long-term illness contribute 33.1% of economically inactive people in the North East MSA region (2.8 percentage points higher than the UK average), a 1.7 percentage point increase since 2019/2020. Other key drivers of inactivity in the North East include caring responsibilities, and low levels of qualifications. Economic inactivity is compounded by wider barriers such as poverty, housing, and digital exclusion. This multitude of factors demonstrates a need for a coordinated approach to addressing the persistent economic inactivity challenges and long-standing inequalities.

1.3 Evaluation objectives

In response to the three strategic priorities of the Trailblazer, this evaluation aims to assess the effectiveness, sustainability and scalability of interventions by considering four key objectives:

- Assess the effectiveness of the Trailblazer activities in supporting residents with health conditions towards, and within, employment
- Capture lessons learned and examples of good practice through primary research, identifying what has worked well, challenges encountered during delivery, and how these challenges have been addressed
- Provide an evidence-based narrative by triangulating programme monitoring data with primary and secondary evidence to show which activity is most effective and provides value
- Inform future programme design and funding decisions by identifying transferrable learning and implications for sustainability and scale.

1.4 Evaluation method

The evaluation investigates year one delivery of the Trailblazer using a mixed-methods approach, combining quantitative analysis of monitoring and secondary data with qualitative research involving delivery leads and wider teams, participants, and employers.

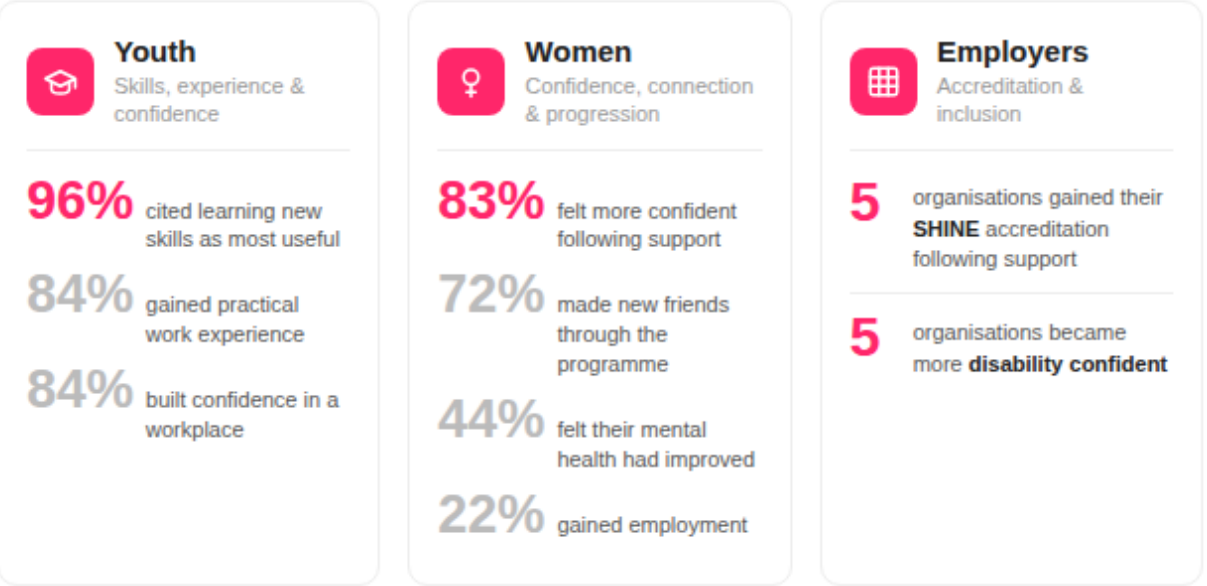
- Qualitative methods: Stakeholder and delivery partner interviews, beneficiary focus groups and one-to-one interviews. These provided detailed evidence on delivery, progress and impacts from the perspective of both delivery teams and beneficiaries.
- Quantitative methods: Monitoring data (performance and participant schema data) and participant survey responses. This provided measurable evidence on reach, participation, referral pathways and outcomes.

Qualitative and quantitative evidence was synthesised and triangulated to build the evaluation findings.

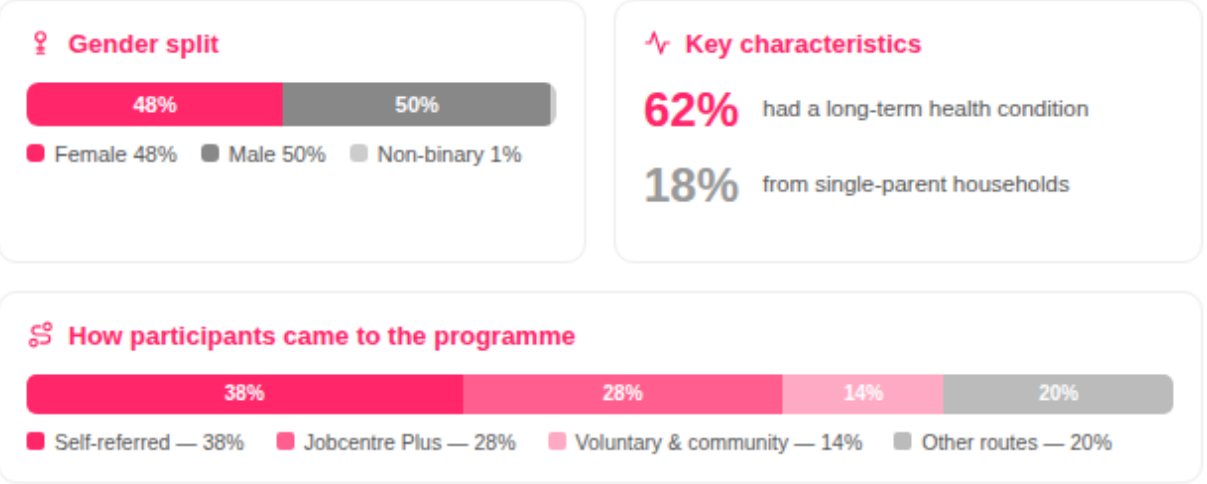
⁶ The North East Local Growth Plan 2025-2035. [Available here](#).

2 Trailblazer summary in numbers

01 Outcomes by strand (from participant surveys)



02 Participant reach and mix (from participant onboarding data)



3 Engaging and supporting economically inactive residents

Year one demonstrated that effective engagement and support for economically inactive residents depends on trusted, community-based delivery, trauma-informed and relationship-based practice, integrated and co-located services, and a no-wrong-door approach to triage.

3.1 Engagement

Promotional activity was most effective when tailored to place and cohort. Leaflets, social media, themed days, and proactive outreach in community spaces all generated interest, with word of mouth proving particularly valuable. Word of mouth recommendations to others were a frequent source of new participants. For community-based groups, Facebook advertising worked well. While for those facing digital poverty or with English as an additional language, multilingual physical leaflets distributed through letterboxes or placed in community venues were more appropriate. Employer engagement was most effectively reached via LinkedIn and existing provider networks.

Hyperlocal, community-based delivery was a key success factor. Providers embedded in their local area were perceived as more trustworthy and better placed to understand specific barriers residents faced. Co-locating support in already familiar settings, such as mosques, libraries, family hubs, community centres, reduced the complexity of pathways in and reached people who would not otherwise have sought support. A no-wrong-door approach, consolidating multiple services in one accessible location, was effective in reducing drop-off for those facing complex barriers. The use of pop-up hubs in communities also helped to engage with residents who had previously accessed services.

"...a very key thing with the community hubs is to really make it about the community and treat the community holistically, because through that you will naturally and organically get economically inactive people through the door"

In-person referral consistently outperformed online application routes, particularly for those with limited English or digital skills, and was identified as an important first step in building the provider-participant relationship. The strongest referral networks combined JCP (especially for young people and neurodiverse participants), GPs, link workers and social prescribers (for those with health-related barriers), community health groups, and word of mouth. NHS involvement added credibility and improved uptake. Clear, consistent messaging and simplified referral routes were identified as essential to making the offer legible within a busy support landscape.

3.2 Support

All local authorities operated a triage service, assessing eligibility and directing residents to the most appropriate programme or support. This meant residents did not need to navigate between programmes themselves. Post-triage, participants received wraparound support from dedicated employment advisors alongside access to training, employer engagement, and confidence-building activity. Local authorities also tested targeted provision for specific groups, such as digital hubs for young people, ESOL, financial wellbeing, and new partnerships with voluntary and community

organisations. Delivery by hyper-local and trusted organisations was key to understanding and supporting the different needs and priorities of local areas.

Across both priorities, the quality of the relationship between participant and support worker was central to participant outcomes. Providers invested time in building trust before introducing formal employment activity, particularly for those with negative prior experiences of statutory services. Pairing each participant with a single consistent advisor avoided the frustration of being passed between services and ensured continuity of support. Delivery by staff with lived experience similar to participants' created environments free from judgement and further strengthened trust. This was most prominent on the women's strand.

The holistic, person-centred approach was identified as one of the Trailblazer's core strengths and as fundamentally different from traditional employment support. Rather than focusing solely on job outcomes, support addressed the full range of barriers, e.g. health and wellbeing, debt, housing, social isolation, before or alongside employment activity. This recognised that meaningful engagement with employment support was only possible once underlying issues had been addressed. Delivery was gradual, non-linear, and paced by the participant rather than by contract, with format and frequency of participant contact adapted to individual need and progress, although delivery models did vary between projects. Recognising small steps as meaningful progress, for example, rebuilding routine, attending a session, growing in confidence, was central to this approach and important to sustaining engagement over time.

"We have to provide more personal support, whether it's social isolation, whether it's housing. If someone is worrying about the condition of where they're living, we can't possibly ask them to think about work or think about training. We take a more of a holistic approach".

3.3 Personalised support

No wrong door. A no-wrong-door model, in which residents did not need to understand which programme they were on or navigate between services themselves, was central to effective engagement. Triage directed people to the most appropriate support regardless of how or where they first made contact. This approach was particularly important given the complexity of the support landscape, with multiple programmes targeting similar cohorts. Clear, consistent messaging and simplified referral routes reinforced this principle in practice.

Trusted, community-based delivery. Delivery in familiar, trusted community settings removed barriers to first contact and reached people who would not otherwise have sought support. Hyperlocal providers with an embedded community presence were perceived as more trustworthy and generated stronger engagement than centralised or unfamiliar services. Local providers were seen as having a vested interest in their area, making their advice and support feel more relevant and credible to participants. However, it is important to recognise that across larger geographies, the two football club community foundations had a brand which young people trusted.

Trauma-informed approach. For specific project cohorts, especially those supporting women and vulnerable groups, some participants had experienced domestic violence, discrimination, severe mental or physical health conditions, or prior negative experiences with statutory services. Recognising the physical and mental capacity required to seek support, effective providers adopted a trauma-informed approach throughout.

Co-location and integrated support. Instances of co-locating multiple services within a single accessible hub, combining employment advisors, health services, skills providers, and VCSE organisations, reduced the complexity of pathways into support and enabled more joined-up care. Shared physical space generated informal collaboration between teams, strengthening referral routes and mutual awareness of respective offers. Given the strong link between economic inactivity and long-term health conditions, integrating health and employment support within the same delivery model was identified as essential rather than supplementary.

Relationship-based practice. The quality of the relationship between participant and support worker was an important factor in effective delivery. Providers who invested time establishing trust before introducing formal employment activity saw stronger engagement and better outcomes. A single consistent advisor throughout was key to the most effective projects. Delivery by staff with relevant lived experience further deepened trust, creating environments free from judgement where participants felt safe to be open about their circumstances.

Tailored methods. Different cohorts required fundamentally different engagement approaches. Themed days, proactive community outreach, and word of mouth were most effective for general community engagement. In-person referral was essential for those with limited English, low digital literacy or accessibility, and no experience of accessing support. Trusted clinical or community referral partners were the most effective route to those with health-related barriers. No single promotional or referral method worked for all groups. Voluntary and community organisations used the channels they know work best for their target cohorts and some local authorities tested and adapted their approaches to specific cohorts as they went to increase engagement.

Targeted design. The Trailblazer's person-centred model was deliberately designed to be more appropriate for those furthest from the labour market than traditional employment programmes. Maintaining a deliberate focus on the most complex cases requires output expectations that reflect the time and resource this involves. The sole output metric reported to DWP was the number of participants engaged, which placed less pressure on projects to aim for high numbers in terms of employment. A consensus across all providers is that each individual has unique circumstances and even within a project group each individual has unique needs and support requirements and that the design of the Trailblazer supports this.

4 Lessons on delivery models, partnership working and participant support

Year one demonstrated that effective support depends on flexible funding, careful employer engagement, and a willingness to recognise volunteering and soft outcomes as meaningful progress. Exit planning, continuity of support, and strong partnership working were identified as priorities for year two.

4.1 Delivery models

The seven North East local authorities were funded to deliver priority one projects with a focus on testing new ways of working to support system change. There have been new approaches adopted by some local authorities, although this is not consistent across all seven. New delivery models include Sunderland City Council commissioning six VCSE digital hub providers coordinated under a council-led umbrella with shared sign-up, North Tyneside Council teaming up with health services as the entry to employment support, and Durham trialling pop-up hubs.

The test-and-learn concept enabled providers to adapt delivery in real time based on participant feedback, with approaches that worked being embedded as delivery progressed. Recognising and recording soft outcomes and distance travelled, using tools such as RAG-rated charts, outcomes stars, and action plans, was important both for evidencing impact and for sustaining participant motivation. This was identified as fundamentally different from previous employment support programmes, which focused primarily on job entries.

Across both priorities, effective triage was identified as an essential foundation. Enabling teams to direct participants to the most appropriate support from the outset and ensuring residents did not need to navigate the system themselves. Local authorities with existing triage infrastructure mobilised faster and adapted more readily to the new cohort, suggesting that building on established capacity is preferable to starting from scratch.

The Trailblazer's flexible funding model which covered practical costs, such as transport, childcare, and interpreters, was a critical enabler of the holistic approach and distinguished it from more prescriptive programmes. Without this flexibility, providers would have been unable to address the practical barriers preventing engagement with employment support.

A recurring tension across both priorities was between person-centred delivery and compliance requirements. DWP-branded paperwork was off-putting for participants with prior negative experiences of statutory services, and monitoring requirements placed disproportionate strain on smaller providers. A related risk for year two is that overly ambitious output targets may incentivise providers to prioritise participants closest to the labour market at the expense of those with the most complex needs, which would be counter to the Trailblazer's core purpose.

4.2 Partnership working

Partnership working was central to the Trailblazer's ambition to coordinate and streamline the employment support system, and year one generated important learning about what enables and constrains effective collaboration. Partnership working has been a continued feature of the Trailblazer with local authorities engaged, via the Technical Officers Group, in the development phase contributing to discussions on programme design, commissioning priorities, and delivery models.

Where partnerships were strongest, they were built on pre-existing relationships developed through earlier programmes, particularly the North of Tyne UKSPF activity, which had established collaborative rather than competitive working practices across Newcastle, North Tyneside, and Northumberland. Local authorities entering the Trailblazer without this shared history faced a greater barrier in building effective partnership networks. This suggests that investing early in relationship-building, rather than assuming it will develop organically through programme delivery, is essential.

In priority one specifically, new partnerships have been formed across the local authorities. Gateshead Council has established an employment partnership for the first time, with Northumberland, South Tyneside Council and Durham County Council also convening different council teams to work together on employability for the first time. North Tyneside Council and Newcastle City Council built on existing external partnerships by working more closely with DWP. Sunderland City Council are working with six VCSE partners for the first time and have a Trailblazer post joint funded by Public Health as part of more joined-up internal working. This activity lays the foundation for year two activity, where the recently completed provision mapping will enable more partnerships to be developed.

Co-location of partners within hubs generated practical benefits beyond the resident offer. The hubs were located in existing local authority facilities such as leisure centres, in 'pop up' venues, and for one local authority area on the high street – being local and accessible is key. A friendly and inviting atmosphere supported engagements with residents, with one hub creating a 'partner charter' which provided guidance for how residents should be engaged. Shared physical space created informal opportunities for collaboration, which strengthened referral routes and increased awareness of respective offers between teams. Demonstrating that physical proximity can drive system integration in ways that formal partnership structures alone cannot.

The relationship between priority one local authorities and priority two providers developed unevenly, partly due to limited early communication about which organisations had been funded. Some local authorities reported duplication between priority two projects and existing local provision and felt that earlier engagement during the selection process could have reduced this. The mapping of local support systems carried out in year one provides a strong evidence base to coordinate provision more effectively in year two.

At a strategic level, alignment with Connect to Work was more straightforward than with the Health and Growth Accelerator, where referral routes ran through GPs and were harder to mobilise. Demonstrating that integration with health partners requires more time, relationship-building, and clinical buy-in than integration with employment-focused partners and should be planned accordingly. Strategic links with DWP, JCP, and ICB partners will become increasingly important as WorkWell is introduced.

Communication from the North East MSA to project leads and within local authorities were identified as areas for improvement. Local authorities and small grants recipient delivery leads noted that a lack of

timely clarity on eligibility, outputs, and priority two partnerships stalled delivery and created confusion. A stronger convening role from the North East MSA was consistently identified as a priority for year two. Communication within local authorities was also an important learning point to ensure strategic decisions are effectively communicated across teams and departments to support the delivery of interventions such as the Trailblazer.

4.3 Participant support

Across both priorities, the Trailblazer demonstrated that supporting economically inactive residents requires a fundamentally different approach to traditional employment programmes. Several consistent lessons on how to support participants effectively emerged from year one.

Flexible funding was a critical enabler that distinguished the Trailblazer from more prescriptive models. The ability to cover practical costs meant providers could respond to immediate participant needs in real time, removing barriers that would otherwise have prevented engagement from progressing. Without this flexibility, the holistic model would not have been deliverable in practice. The continued promotion, clear guidance, and simple claims process can improve and support the use of the flexible funding in year two.

Employer engagement required careful design to be effective. Framing conversations around social value, inclusion, and community benefit was more successful than leading with vacancy filling. Careful matching of participants to opportunities was essential; while poor matching risked alienating employers and undermining future relationships. Providers with stronger pre-existing employer networks saw employers returning for future recruitment, highlighting that employer relationships need to be nurtured over time rather than activated on demand. A liaison role supporting employers through placements, particularly on the youth strand, helped sustain employer confidence and prevent placements breaking down.

For participants furthest from the labour market, volunteering provided a valuable incremental step. Through offering structure, routine, and work-related skill development in a lower-pressure environment with hours that could be adapted to individual circumstances. This was a more sustainable progression route for some participants than moving directly into work.

The Trailblazer's recognition that progress is not always visible in employment outcomes was an important design principle. Tools such as outcomes stars, RAG-rated charts, and action plans gave participants the ability to visualise their own progress, which in itself boosted confidence and motivation to continue. Providers noted that without these tools, the real impact of support for those furthest from the labour market would have gone unnoticed.

Ensuring continuity of support upon participant exit was a consistent concern across providers. Where participants had not yet reached employment readiness, abrupt endings risked undermining the progress made – a risk which is reinforced by short funding cycles. Planning exit referral strategies from the outset of delivery was identified as a lesson for year two.

When it comes to reaching participants, local authorities in priority one have all engaged with new participants by virtue of the focus on economically inactive residents. Some have introduced new triage services, but not all, and there are mixed results when it comes to the number of 'walk-ins' especially in rural areas or where there is only a small number of hubs. Pop-up hubs taken to communities have

helped reach communities who have not engaged with services before and more in-community activity in year two can help deepen this reach.

5 Participant progression and outcomes

Year one generated a range of positive outcomes for participants and employers. Outcomes include employment and new qualifications, improved health, reduced isolation, and more inclusive employer practices. Progression was enabled by structured goal setting, wellbeing activity, skills development, employer interactions, and peer mentoring.

5.1 Outcomes

Hard employment outcomes were most commonly achieved by participants who were closer to the labour market at the start of provision. Where participants moved into paid work, common sectors included administration, childcare, art, and community support. A significant number of participants obtained qualifications at Level Two or above in sectors of interest to them, providing a foundation for future job-seeking. Many participants who found work or were actively job searching did so within their local area. This was a particularly positive outcome for rural and coastal communities where participants had previously assumed they would need to travel to urban centres for work opportunities.

For those further from the labour market, meaningful progress took the form of improved confidence and self-esteem, development of time management and communication skills, rebuilding of daily routine, and reduction in social isolation. For many socially isolated participants, Trailblazer activity provided the only regular social contact in their week, with new friendships formed that extended beyond the programme. On the women's strand, a notable impact was participants regaining a sense of individual identity and purpose beyond caring roles, which increased confidence and supported steps towards the labour market.

"We've got one participant who didn't engage well with people socially and really struggled to maintain eye contact when he first started on the project, but he's one of the ones that's moved into a job. But when we did his participant voice, it wasn't the job that he was kind of shouting about. He was shouting about how much more confident he is and how much more able he is to interact socially because he's gradually interacted with it within the Trailblazer project"

"...some people who kind of have gone from like not even wanting to leave the house to kind of meet on a regular basis, having a coffee and things like that, so just small steps"

"...the confidence when that's been boost[ed], it's like the mental health as well. You can see them brighter and lighter every single time they come"

Participants were supported to access treatment for health conditions they had previously been unable to address. In some cases, providers acted as advocates at GP appointments, securing referrals. Practical support addressed immediate needs that were preventing any progress towards employment. These impacts, while not directly captured in employment output metrics, significantly improved participants' wellbeing and readiness for future support.

Employers who engaged with the Trailblazer developed greater confidence in employing economically inactive residents and implemented more inclusive practices. Specific changes included rewriting job

adverts and developing workplace policies around childcare and menopause. Employers progressed through Disability Confident levels and, on the neurodiversity strand, created sensory-friendly environments and inclusive job design. Demand for employer support grew through word-of-mouth recommendations across the business community.

At a programme level, the Trailblazer strengthened relationships between employment and health services, with new partnerships brokered between NHS, JCP, community groups, and VCSE providers. For priority one, the primary measurable system impact of year one was the mapping of local employment support ecosystems and the laying of foundational partnerships. The true measure of system change will be evidence in future years that residents previously excluded from support are being reached and that cold spots of engagement no longer exist.

5.2 Enablers of progression

Trailblazer participants progressed at different speeds and from different starting points. Across all projects, there have been common success factors enabling progression.

Goal setting from the outset. Goal setting was built into the initial stages of support and was not restricted to employment outcomes. Participants worked towards smaller, self-defined steps, such as improving sleep, rebuilding routine, managing daily tasks, recognising that stability was essential for any meaningful progress towards work. This approach reduced pressure, helped participants engage on their own terms, and gave both provider and participant a shared framework for measuring progress.

Wellbeing activity. For participants facing barriers related to mental health, self-care, and emotional regulation, low-intensity therapeutic activities were used to build the personal resilience needed to engage with more structured employment activity. These were particularly well received on the women's strand, where participants often lacked dedicated time to focus on their own needs. Improving participants' ability to manage their mental health also increased the likelihood they could sustain employment in the longer term.

Skills and qualifications. As participants developed confidence and stability, focus shifted to building the skills and credentials needed for employment. This included CV writing, interview preparation, and sector-specific qualifications, chosen to reflect participants' own interests rather than available vacancies, increasing the likelihood of sustainable and meaningful work.

Employer interactions and placements. Observation days, work trials, and paid placements gave participants direct experience of workplace environments and employer expectations, which was particularly valuable for young people who were anxious about what the job market involved. This also helped to break down preconceptions about particular industries or roles, and expanded horizons by showing what entry-level roles could lead to. Providers worked closely with employers to ensure placements were appropriately matched and inclusive, and a dedicated liaison role on the youth strand helped prevent placements breaking down. Word of mouth recommendations from engaged employers brought new businesses into the programme, broadening placement opportunities across the region.

Peer mentoring. On the women's strand, participants who had completed earlier cohorts returned as mentors or group facilitators, using their own experiences to build trust and credibility with new

participants. This peer support model reinforced the non-judgemental environment and demonstrated to current participants that meaningful progress was possible.

Active disengagement prevention. Providers proactively followed up with participants who missed sessions through phone calls, home visits where appropriate, and private check-in conversations. Perfect attendance was not expected, and non-engagement was not judged. Instead, understanding why a participant had not attended was used to improve future delivery and re-establish contact. Embedding feedback throughout delivery allowed providers to adjust activity in real time, increasing the proportion of sessions participants found beneficial and wanted to return to.

6 Recommendations

Year two projects should continue the holistic, person-centred model. Priority one projects can use the community infrastructure mapping to broaden and deepen VCSE partnerships to support hyper-local delivery. Priority two projects will have more time to refine their activity and build on momentum and success generated to date.

Year one of the Economic Inactivity Trailblazer has achieved impressive amounts in a short period of time. The North East MSA mobilised and commissioned a range of projects delivering different priorities, and providers responded equally fast to engage a large number of participants. Therefore, the following recommendations focus on continuing work, systems change and increasing impact in year two.

- 1. Protect the person-centred, holistic model and ensure that providers are not incentivised to focus on participants closest to employment at the expense of those with more complex barriers.** Wraparound support that considers all aspects of an individual's life, not just those directly related to employment, is central to the Trailblazer model. Continuing to enable providers to focus on distance travelled rather than job-outcome shows commitment to ensuring no residents are left behind and multiple complex needs can be met. Providers should signpost individuals who are more work-ready to Connect to Work.
- 2. Fully utilise strengths of hyperlocal VCSE providers as part of a 'no wrong front door' approach to reach the communities which large providers, local authorities, and national programmes often cannot.** The importance of hyperlocal delivery resonated strongly across providers and participants, with activity held in trusted community spaces often key to overcoming both physical barriers (such as access to transport) and personal barriers (such as anxiety) to engagement. Many providers had existing relationships with a variety of local services in health, housing, debt and demographic-specific support, strengthening the local inward and onward referral system. Priority one projects should use the provision mapping to more comprehensively partner with a network of hyperlocal providers. This partnership working will fill a critical gap left by ending the small grants strand of activity, and reduce duplication of activity between priority one and priority two delivery. Cross-referrals, communication and knowledge-sharing between large regional providers and hyperlocal organisations are encouraged, and competition to recruit participants avoided.
- 3. Systems change can reduce the administrative burden for small providers.** Small hyperlocal organisations face a disproportionate challenge when it comes to paperwork, whether checking for participant geographical eligibility, or onboarding and output claims reporting. Priority one projects managed by local authorities and delivered in partnership with a network of community organisations provide an opportunity for more centralised administrative support such as an independent infrastructure body/organisation, allowing organisations to spend more time delivering and more consistency in monitoring data collection.
- 4. We would encourage DWP to allow more flexibility in administrative requirements, especially at onboarding stage.** A barrier to participation for some individuals is the level of personal information required to enter on DWP-branded paperwork. Some residents have distrust of bodies like DWP, sometimes resulting from prior negative experiences of statutory services or fear of losing benefits entitlement. Project staff have supported and reassured participants as best they

can and, in some cases, have not shown participants DWP-branded material. A change from DWP to make onboarding materials less intrusive would assist providers and the North East MSA.



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