Devon LinkAge Plus: Ageing, Inclusion and Rurality.

1. Background.

1.1 *Devon*

Devon one of the largest Shire Counties in England, and a beautiful county in which to live. It has an unrivalled diversity of rural landscapes, moorlands and wildlife: two National Parks; two World Heritage Sites; five Areas of Outstanding Natural Beauty; two varied coastlines of 500 km in length; a UNESCO Biosphere Reserve.

Devon also has the largest road network in Britain. It is over one hundred road miles from Kingsbridge in the South Hams to Ilfracombe on the North Devon coast, and nearly 70 miles from Axminster in the East to Bideford in the North West. A journey into the administrative centre of Exeter from from the farthest towns in the council's area can take an hour and a half by car, or as much as two and a half by bus. The rural distances involved represent a significant barrier to many older people, service providers, and voluntary groups as well as a significant cost for initiatives undertaken within the LinkAge Plus programme.

87% of people living in Devon are satisfied with the county as a place to live – this is the highest satisfaction rating of any local authority area. However, many people are living with significant barriers to access to services.

Population density ranges from 0.45 people per hectare in West Devon (dominated by the Dartmoor national park) to 24.89 people per hectare in the city of Exeter. Access to transport has always been a challenge for policy makers in the county, whilst a number of specific barriers and challenges inhibit the the ability of rural communities to influence local decisions.

Forty-one per cent of the population in Devon is currently aged 50 or over – over 300,000 people. Twenty per cent of the population are 65 or over. This is higher than the UK average, and is projected to increase more rapidly than average. By 2028 over half of Devon's population will be over 50 and the county will have the second highest proportion of people aged over 50 in the country. Devon's population is also increasing in diversity – the Black and Minority Ethnic population has doubled over the last 10 years and is likely to triple over the next 10 years. People from black and minority ethnic communities are making a significant and valued contribution to Devon's prosperity and community life, but significant numbers experience social exclusion as a result of prejudice, discrimination and other factors. As BME communities become more established, their members are choosing to move into the more rural areas.

1.2 *Administration*

Devon's County Council is Liberal Democrat controlled, having moved from no overall control in 2005.

There are eight Local Authorities within it boundaries, the City of Exeter and seven Districts. There are a range of types of political control and in some parts of the County there are Independent traditions remaining.

Until recently there were six PCT's; a reorganisation into one PCT is still being completed.

Local Government reorganisation has been on the agenda for the whole period of the LinkAge Plus pilot – Exeter's bid for Unitary status resulted in a referral of the whole administrative County's boundaries for consideration. This excludes the Plymouth and Torbay Unitary Councils.

There are over 400 Town and Parish Councils in Devon.

Work on natural communities based on where people look for their services has defined 28 coastal amd market towns with their hinterlands, plus the City of Exeter, as the areas with which Devon County Council aspires to work for community planning.

1.3 *LinkAge Plus*

The Devon County Council (DCC) LinkAge Plus Pilot was designed, from the outset to be an action learning programme, and that the specification would continue to develop and action plans be adjusted accordingly for the life of the project.

The pilot sought to:

- Test a single 'Devon Gateway' to expand the range of information already available through the existing telephone service (CAREDirect; integrated into My Devon Customer Service Centre) for all localities in Devon and add the availability of information in people's own homes through web technology.
- Test a "deep outreach" "face to face" mode of access providing mentors in two Devon community planning areas (Exeter and Crediton), to assist older people to access resources and design their own sustainable solutions to problems which might otherwise cause social exclusion, ill health and a need for services. This service would be on a "healthy living centre" model (without walls in rural areas). This element is based on face-to-face interaction with high-risk clients who are more likely to be socially excluded, working closely with GP's. The built on the "Upstream" model which had been test and evaluated in the Mid Devon area.
- Test a "broad outreach" mode of face to face access(1). This is based on providing support and tools to existing front line staff and volunteers to enable them to more effectively support the older people they work with (the "networked front end", or "NFE"). The intention was to examine what the issues were for existing staff and volunteers in providing "joined up" access to information and services in their everyday jobs.
- Build a senior council for Devon, using a "bottom up" approach based on the 28 coastal and market towns with their hinterlands and the City of Exeter, on "Better Government for Older People" principles.

[1] In the Devon pilot we have distinguished between "deep outreach" - the mentoring work which is targeting quite excluded older people - from "broad outreach" which we have described as the "network front end" (NFE for short), using the idea of a "front end" in the same way as that term might describe telephone access or an e-interface. This idea picks up the Link Age Plus challenge to "test the limits of holistic working" by piloting joined up working in the immediate, day to day, interactions older people have with staff and volunteers in their communities.

To support this we developed a 360 Degree Framework – an holistic framework for wellbeing.

We created a framework for a “360 degree well being check” starting from the fields of information identified as important for the wellbeing of older people in the “Sure Start to Later Life” report of the Social Exclusion Unit. This was incorporated in: a tool for individuals, their families and front line staff, to assist in the holistic assessment of older people’s needs; the health and social care Single Assessment Process documentation; the data used by the Care Direct service to answer queries; and in web and paper based versions for the public. The framework was incoorporated into the everyday work of the mentor services.

The “Getting the Most Out of Life” 360 degree wellbeing check framework.

The headline framework was presented as the flower shown here, designed by older people involved with the pilot. This proved easily recognisable, popular, and the design and the self help leaflet it covered were things we were particularly requested to mainstream by staff and older people alike.

Sustainability, rurality and the pilot model

The pilot model was deliberately designed to build on the existing service framework and service model in the County; the broad outreach model deliberately set out to enhance access, and learn how to optimise the impact of the staff and volunteers already on the ground. The mentor role, whilst new, was subject to a controlled trial of effectiveness to establish whether it works better than traditional approaches and was designed to work closely with statutory services, as the original Upstream pilot had done.

This was considered important in the rural environment because:

- Resource constraints
- The appearance of duplication and competition for resources with existing services and voluntary organisations had to be avoided. Devon has a flourishing voluntary and community sector which often works with very small resources.

2. Devon LinkAge Plus learning on inclusion in rural areas

2.1 Community Mentoring

Our “deep outreach” approach, Community Mentoring tackles social exclusion with a healthy living approach. It enables individuals to develop solutions to their needs and control them. It develops capacity in communities to be more inclusive through influencing existing resources and creating new ones working from the needs of isolated and excluded people.

We found that Community Mentoring can:

- facilitate individuals to regain confidence, define and tailor solutions to their needs and control them – close to home
- enable excluded people, often with considerable personal problems, to become net contributors as volunteers, formally as well as informally
- tailor group activities in such a way that some people who have been difficult to accommodate in the past can enjoy them
- tailor micro-opportunities in small villages
- support people to make new friendships
- support people to regain self esteem
- work with diverse BME communities often spread over distances
- replace some statutory services not well tailored to need with better tailored services (e.g using Direct Payments) or - opportunities not services
- enable BME and isolated rural elders to participate in “having their say”, sometimes through non-threatening conversation style discussions. This is more important than we had realised. For example, some Chinese elders were deeply worried about being asked for their opinions.

In the course of LinkAge Plus 658 older people (over 50) participated. A little under half of these were from the Mid Devon area. So far under POPPS over 4,000 people have participated, the majority from small towns and rural areas.

Why does Community Mentoring work?

We think it works because:

- It is not provided by statutory authorities – some older people are still afraid of being “put away”
- It starts with the individual, and works to prevent dependence- the service has no long term or permanent provision
- It crosses the categories statutory services use to organise their work – e.g. adult education, public health, mental health provision, social care
- It marries individual and group/community level work
- It aims to put people back in control and give them a positive social identity and sense of purpose.

Why is Community Mentoring appropriate for rural communities?

- The capacity that is developed is highly tailored to actual local needs of isolated and excluded people
- Its “cross category” nature is efficient in a rural environment – this is a variation on the “joined up” services idea

- Using the “360 degree wellbeing check” and the resources of Devon’s award winning Customer Service Centre (CareDirect) means that isolated rural need not lose out. For example, the service recently assisted a rural elder who did not feel they could afford a taxi (which was necessary to get to a nearby village to socialise). The mentor arranged a benefit health check with CareDirect, which resulted in the person being £40 per week better off, and negotiated a good deal from the local taxi firm.
- It keeps people in the driving seats of their own lives – important for proud rural elders
- It can start from a one-off social opportunity – important for initial cased finding in new areas in particular
- It can improve opportunities for other people in rural areas, perhaps including those whose isolation has not yet led to sufficient loneliness for them to take the step of approaching anyone
- It can act informally to assist people who don’t access services because they do not wan the “clientisation” involved – this has proved to be the way that most people want to use the service

Why is Community Mentoring appropriate for BME elders?

Our community mentoring services for BME elders are specialist and while they share the same service model they have developed differently to secure cultural competence and acceptability.

- In rural areas, information events are held, and people interested in participating, in volunteering, or in paid work are all invited to hear about the service together.
- Members of excluded communities are recruited and their skills improved.
- They are acceptable to their community elders in a way outsiders are not.
- They work together, and with their managers, to provide appropriately and to encourage members of different ethnic groups to associate and develop joint activities.
- They find culturally acceptable routes to the objectives. For example, the service had difficulty attracting some Muslim women whose cultural expectations kept them in the home. These women’s husbands were, in some cases, regular users of a specialist day resource, but it was difficult to get to their wives. Eventually, a prisoner support group was established, with the women making cards to send to Muslim prisoners during Ramadan and at Eid, to encourage the prisoners to stay away from crime when released. This was an acceptable reason for the women to enjoy time together, and has gained the confidence of the prison authorities and positive feedback form the prisoners.
- They clear the way to universal services (such as over 60’s Bus Passes and NHS services).

Examples:

Case study A special trip out: The participant wanted to go immediately into the garden. It was lovely weather and she had been 'in training' for the day. She told her helper that she had increased her times on both her cycling and rowing machine as she was determined to enjoy the day to its fullest.

She braced herself to go straight up the sloping grass lawn with her wheeled walker and headed off for the Bear House. "I will not be beaten by this hill," her helper heard her say, as the helper was being left behind!

With great determination she made the trip to the Bear House. Though the opening was a little tight, she squeezed her walker in through the door and was able to enjoy the wicker interior, the bear skin and the floor made of vertebrae. She asked a passer-by to take a picture of herself and her helper.

She was able to get her walker up and down difficult inclines. At one stage she instructed her helper to hook the walking stick around the walker to act as a break on the steeper slopes.

She enjoyed taking photographs of the views.

She talked of how good Upstream was for her. Her family lived away and she keeps in contact using cards and craft ideas that she has learned from Upstream. Her daughter responds in the same way. She is a very determined woman who keeps fit, despite severe mobility problems, in order to climb the steep hill where she lives.

Case study This participant who is 53 years of age is a recently bereaved man who has only just moved to the area, he has been blind since birth and is aided by a guide dog. He was totally disorientated having not been out in his town much because of caring for his wife before she passed away, his guide dogs had also got out of practice. With the help of the mentor he arranged to have a refresher course with the dogs. Organised some bereavement support and a volunteering role as he is hoping to get back into work. They have done a lot of work on finding their way around the town. They are now looking into social groups and meeting new friends. Mentor supported him at his review at the job centre and supported him to use the bus, which previously he felt he had to use a taxi or didn't go. Helped source a reader to help with post, job search and local events. Identified someone to help him update his computer and found IT tuition from a volunteer.

Case study P is a lady in her 70's who has a facial disfigurement; a Clinical Psychologist referred her. P has never travelled on a bus on her own, never gone out to socialise (in 53 years) without her husband. Because of her condition her mobility is impaired due to balance issues. With the help of a mentor P has applied for a bus pass and that entailed having her photo taken, this was a real achievement for her as her self esteem was very low. She also has gone into her local coffee shop and signed up for Body Active, which is a GP exercise referral scheme. We are hoping to match her up with a volunteer befriender, so she can carry on the social activities after the 12 weeks. She couldn't believe how exhilarating it could be to go out without her husband and have something as simple as a cup of coffee and maybe meet new people/friends. For the first time she actually initiated a conversation with a stranger and the response was very positive and gave P a real boost.

Case study **The Bus-Pass Group.** The Sahara project has established a group of Muslim elders who have been facilitated to get their over 60's Bus Passes and get out and about enjoying Devon using them. It now has a new volunteer who is a British White woman who has converted to Islam. She was able to identify limiting behaviours among group members which she is able to address without challenging the autonomy of the group. For example, wherever they go a fish and chip lunch has been the obligatory mid-day meal as it is known by the Muslims to be halal. She has been able to show them a range of vegetarian cafes and bistros and help them to each read the menu and choose lunch individually, rather that one person block-book for all members. She is also helping them to research their intended destination on the web beforehand and discuss what they might visit while there. A tourist office and a reference library have been visited and the group have now decided that when they first arrive in a place they will divide up and explore then report back at lunch time, after which members have options of where they might like to go.

Case example Participant contacted the service - she is frail, wheelchair user, living in a rural area and does not have an accessible bus service anywhere near her home. She expressed an interest in playing scrabble but was not sure.

Mentor explored a taxi service which could take her in her wheelchair - negotiated a price. Escorted participant on the journey to the nearest scrabble group in main town. The participant's verdict was that it was enjoyable and what she wanted to do, also that she really did want the company, but the journey was too tiring.

The mentor identified another participant in another small village nearby who was also socially isolated and unable to use ordinary bus transport. A local venue was found and small adverts placed - scrabble group commenced in local village hall using shared taxi. Four people now regularly attend, organising it themselves.

"The voluntary work you arranged for me saved my life" Participant.

2.2 Broad Outreach: access to information and services

What we did:

- We conducted focus group work with a range of frontline staff and volunteers, and some carers, in rural areas.
- We ran a series of information fairs across the county, seeking to provide information to older people locally on services offered, as well as develop local networks of services.
- Resource and training were invested in the Devon customer service centre in using the 360 degree tool for the holistic assessment of older people's needs.
- We talked with and took feedback from people coming to the information fairs – information providers and older people

We exceeded our objectives (800 people at information fairs) and were in fact in touch with around 3,000 people at face to face events, including Senior Council meetings. Most of the information fairs were in small towns, and the vast majority of Senior Council meetings. Many people from rural areas attended information fairs. In some cases we advertised free transport. This was less successful for rural elders than running the event on market day. Free refreshments were a draw. (Tea/coffee and "home made" cake adequate and popular). We also offered freebies such as low energy light bulbs (sponsored by EDF) and replaced "sloppy slippers" with good slippers (anti falls campaign by the PCT). On some occasions we offered taster sessions of complementary therapy. This was appreciated by those who took it up. One gentleman who reluctantly agreed to a massage of a strained muscle admitted later that no-one had touched him since his wife died some years previously, but that he would think about having another massage to ease his back after the experience.

Information fairs were very popular, and we have contracted the Senior Council to continue these.

Our findings:

It was noticeable from feedback and views expressed that older people often referred to the desirability of the provision of things that were already available – underlining the need for good information provided in an accessible way.

We confirmed that although a single source of comprehensive information and support is necessary (Care Direct, My Devon Customer Service Centre) it is not in itself sufficient for older people to have easy access to information and services.

Many older people do not naturally turn to call centres for information.

Most older people attending our events were unaware of the Care Direct/ My Devon telephone service. Funnelling all information requirements through that service would not be likely to be successful or sustainable.

Many older people often find telephoning an ordeal, and do not like to speak to someone they think is not local.

Many older people would not or could not use the internet for information.

Many older people often turn to someone they trust, for example a GP or nurse - who may not recognise the approach or be equipped to deal with it if they do – a "closed - or "wrong" - door".

Front line staff and agencies do not know of each others' work to the extent they themselves consider useful in many cases. Feedback establishes that they found networking at LinkAge Plus information fairs very useful indeed.

Our tools – the 360 degree well being check "Getting the Most Out Of Life", the linked website and publicity materials – have been well received; they have demonstrated to people working in the health and social care field that their model of what "holistic" means is partial when measured against older people's real information and service needs.

We need to do more to help front line staff and volunteers when older people approach them – for example, we are working on a simple enquiry service that will ensure an older person gets called back.

Making a comprehensive web-based information resource available to all will assist some voluntary sector services but in itself is not enough.

We believe our pilot has demonstrated that unless everyone working with older people is equipped some of the most vulnerable older people will not have their information and service needs met:

- An awareness of a 360 degree framework
- Awareness of how and where to get information
- Knowledge of local services or where this can be found.

Major obstacles to getting services or information to people who need them in rural areas include distance and transport - these are difficult and expensive to overcome.

Standardising the approach across an area (county) can lose the identification of local needs.

To support local networks of organisations, and therefore the staff and volunteers, a local "hub" – a designated voluntary agency given specific support for this function – could help overcome some of these problems.

In some cases a local area will have an existing network with a natural "hub", and the agencies could provide support through this.

- If such a "hub" does not exist, the network is probably poor too.
- In such cases, a "hub" should be identified and encouraged.

2.3 The Senior Council for Devon.

Our aim was to establish the Senior Council for Devon, with the following features and functions:

- a network of associations of people aged 50 plus and of individuals in each of the 29 community planning areas of the County;
- the fullest possible scope of membership from among organisations of (and for) people aged 50 and over in each community planning area and at each federal level;

- federal arrangements at District Council and County Council levels;
- additional routes for the representation of Black and Minority Ethnic groups and other minority groups of people aged 50 plus, including Lesbian, Gay, Bisexual and Trans-gendered people at District and County levels;
- an established constitution in accordance with best practice and the vision statement;
- the capacity and skills to deliver the described functions.

At the end of the initial set up phase we had groups in 26 of the 29 areas. Consultation with BME and other minority groups established that they did not wish for protected routes to membership at the County level; and we had decided not to have formal federal arrangements at District level but to encourage flexible collaborative working between groups.

This is by far the most locally-based engagement strategy for a County Council of which we are aware; it represents a determined attempt to engage with people, especially rural people, where they live. Although it does not get down to Parish level, nevertheless it is demanding both on the older people and on the statutory authorities.

However, in AGILE (the County's original OPAG, developed during the County's BGOP pilot) the model was built with the District Council level as the basic unit of organisation and older people's organisations (rather than individual citizens) as the membership, activity decayed towards Exeter within a few years and there was little evidence of reach into the member organisation's own membership. Now we have people engaged from all over the County. This is particularly pleasing in relation to participation from people from the rural northern part of the County which has never been represented in this way before.

A postcode analysis of membership of the Senior Council at the end of the pilot in June 08 revealed that the balance of membership was broadly comparable with the urban/rural pattern or residence of the over 50's in the County. There is still a little ground to make on this, but we believe that the contract we have agreed with the Senior Council itself will continue to build rural representation alongside that of other disadvantaged groups.

In addition we concluded that to most effectively disseminate information to older people (in all communities) we needed to use a multi-faceted approach which included using older people themselves as informal conduits. The Senior Council has already shown itself hungry for information and for this role with other elders, promoting information fairs and the use of CareDirect, alongside broadening consultation and engagement with older people in their home communities.

They are also starting to ask very helpful questions, such as "why is there not more information in Doctor's surgeries" and gained a commitment from the PCT to respond when they identify particular information they feel should be and is not in Doctor's surgeries.

3. Devon and rural access in the future

3.1 Devon intends to mainstream Community Mentoring and is looking for sources of continuing finance for it. This section discusses some of the issues and risks in that.

Issues here include, paradoxically, its “cross category “ nature, with benefits to the public service system accruing in different places – GP’s, public health, mental health services - hence the risk is that no commissioner will see it as sufficiently salient to their service to fund it and that a joint funding package will be too complex (ground breakingly so) to broker.

There are also Adult Education interests – but initial exploration suggests a high degree of prescription in and also uncertainly over the national funding regime and no targeting in it of the kinds of exclusion the LAP pilot has explored.

We are refining our understanding of the learning and development needs of mentors. Our view at present, from listening to the providers, is that the skill mix required in each team to fully deliver the model are unusually broad- excellent assessment and interpersonal skills to move people to independence (which we have established are congruent with the mental health “recovery” model) but also community development and groupwork skills to a high level – enabling the staff to “let go” of successful initiatives which they may fear might not be sustained (observed behaviour in the team with the highest level of assessment and “therapy” skills). We are working on the curriculum for the service.

For BME elders, the recruitment and intervention model followed by the Sahara service appears successful. However it is slower than the “mainstream” services. Additionally, in our rural area, we have identified that our labour market among these communities is less well developed than it may be in some larger areas of population. Low levels of skills among potential BME mentors requires considerable energy to address – on the part of the potential mentors as well as the providers. Interestingly this is leading to two unexpected gains: volunteering; and an interest in careers in social care, not previously regarded as of interest by the young people who have become involved with the Sahara project as staff.

Local Government procurement rules are a risk in achieving the kind of partnership with the voluntary sector this service requires and which the Government promotes. It is very difficult to gain acceptance under these rules that any service requires to be placed in the voluntary sector, and the tender process injects real risks. We believe this service can only be sensibly provided in the voluntary sector of a number of reasons (including user acceptablilty, requirement to influence and set up local voluntary sector provision, volunteer support and development).

Finally, District Council involvement will be important in promoting the use of their leisure services for these excluded groups. The providers of mentoring are tackling this locally. However, not all Devon Authorities have expressed interest in the free swimming for the over 60’s initiative, and the impending shadow of Local Government Reorganistion has inhibited a more strategic approach as yet.

3.2 Devon will be considering the findings of LAP with regard to information before Christmas 08. It is anticipated that the 360 degree framework will be a continuing feature. Other findings may play well with the broader strategy for health and social care in Devon – broadly integration, personalisation and localism. So, in rural areas, making services accessible at primary care level is intended to assist with making them more accessible in rural areas. Devon has a high level of Community Hospitals, and these are to have a role as hubs of information and services for healthy living.

3.3 Monitoring the progress of the Senior Council on its contract will enable us to understand if the early promise of rural reach and information spread are delivered on.

3.4 Devon's integrated local delivery system for health and social care, based locally on clusters of primary care teams, will improve access for rural dwellers. The voluntary sector is being integrated also into these "Complex Care Teams" on a (funded) basis of equality.

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