Devon LinkAge Plus Findings Paper Final
Community Mentoring:
Inclusion and Wellbeing

Introduction

Community Mentoring was of interest to statutory commissioners because of the early findings in the original Upstream evaluation that it could improve wellbeing and assist isolated and lonely people to find and control solutions to common problems in later life.

LinkAge Plus married the mentors' methods with a framework for a 360 degree wellbeing check and trialled it in two areas to improve access to common resources and social inclusion.

The Devon My Life My Choice programme ("POPPS") extended this trial across the County and added specialist BME services.

The Linkage Plus and My Life My Choice services are the subject of a controlled trial of effectiveness and an economic study which will report in 2009.

This paper provides an account of the programmes, the outcomes and participants that are its focus, and the results that have been achieved for some users.

Summary findings

Over 650 people in LinkAge Plus and over 5,000 people so far in My Life My Choice (MLMC) have used the service.

We have established that community mentoring is a person-focussed service, designed to enable participants to solve problems with user controlled solutions.

Some participants have experienced substantial, even transformative, benefits, including moving from a position of dependence to being net contributors as volunteers, in some cases despite continuing personal problems which they control themselves.

Some people have been able to reduce or end reliance on statutory services.

The service also shows early signs of being able to assist with combating rural disadvantage.

The service also shows flexibility in being able to be adapted to combat the disadvantages faced by BME elders, including those in rural areas. (The early evidence on BME elders comes mainly from MLMC funded services, hence it is only touched on in this report. A report on mentoring in BME communities, and learning for the overall model, will be produced as part of the Devon MLMC programme in 2009.) Our key observation from LinkAge Plus is that while some BME elders may be happy to engage in integrated opportunities, many are not, at least at first, and marketing the service to the "general" community does not attract BME elders. Specific marketing is essential, alongside recognition that valued activities among some BME groups may be different to those for other excluded groups.

The service crosses the common categories of service provision used by the statutory sector, and there are choices available about positioning the service within its target group, particularly how far it is appropriate to go with potential participants with substantial mental health problems. These may provide challenges to statutory commissioners in long term implementation of the model.

We found that Community Mentoring can:

1. facilitate individuals to regain confidence, define and tailor solutions to their needs and control them – close to home

2. enable excluded people, often with considerable personal problems, to become net contributors as volunteers, formally as well as informally

3. tailor group activities in such a way that some people who have been difficult to accommodate in the past can enjoy them

4. tailor micro-opportunities in small villages

5. support people to make new friendships

6. support people to regain self esteem

7. work with diverse BME communities often spread over distances

8. replace some statutory services not well tailored to need with better tailored services (e.g. using Direct Payments) or - opportunities not services

9. 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.

1 Purpose and Context of the Report

1.1 This report sets out an account of the "Deep Outreach" Community Mentoring service piloted in Devon as part of the Department for Work and Pensions (DWP) funded LinkAge Plus Programme 2006-8 and continued in 2007-9 as part of the Department of Health funded "My Life My Choice" (the DH POPPS) Programme at October 2008:

- Why Devon County Council and its partners were interested in the service model and what they hoped it would achieve
- A description of the service
- Description of the pilots
- How we measured activity
- Who is using the service
- Outcome measurement– the controlled trial and additional means.
- Its place in the pattern of local service
- Its costs and benefits
- Outcomes evidence

1.2 This report constitutes:

- The final report on mentoring in the LinkAge Plus (LAP) Programme
- An interim report on mentoring in the My Life My Choice (MLMC – Devon POPPS)) Programme.

This dual approach has been taken to maximise the learning from both LAP and MLMC on mentoring from all information available at this point.

It is authored by Sue Younger-Ross, programme lead for Community Mentoring in both programmes, and produced by the staff of the LAP and MLMC programme It is drawn up from information available through LAP and MLMC routine reports, from observation over the period of the pilot including focus groups with mentors conducted by LAP programme staff, and from other information from the providers (for example the Upstream website www.upstream-uk.com).

It draws on the original evaluation of the Upstream mentor project (Peninsula Medical School October 2005) and an interim report on the characteristics of participants in LAP/MLMC funded mentoring by the Peninsula Medical School (October 2008). The Peninsula Medical School (PMS) and its staff are not responsible for the use made of their material or conclusions drawn from it in this report.

The work described here is the subject of a controlled trial of effectiveness and a study of its costs being undertaken by PMS under the title The Devon Quality of Life study, which will be reported in 2009. This will provide a higher standard of evidence than the original evaluation of Upstream, and indeed higher than is usually available for an intervention of this kind, being the closest that could be commissioned (for ethical and practical reasons) to a randomised control trial.

Under the MLMC programme Link2 continued in Exeter, and the Time for Life consortium of Upstream, Age Concern Devon (lead organisation) and Westbank Healthy Living Centre provided a service across the rest of Devon.

Age Concern Devon was also contacted to provide a specialist service for Polish elders. The Hikmat BME Centre were contracted to provide a service for elders of broadly South Asian and Chinese backgrounds. This report draws on some early experience of these specialist services, but does not constitute an evaluation of them in their own right, which will be available in 2009.

1.3 Acknowledgements

This report acknowledges the contribution and involvement of:

> Upstream; its Director Simon Goodenough and its staff
> Age Concern Exeter; its Director Martyn Rogers, service manager Nichola Weate and staff (who provided the LAP funded pilots, Upstream and Link2)
> Time for Life, the consortium headed by Age Concern Devon; its Director Ann Ovens, Sue Howell-Richardson, the Directors and staff of Westbank and Upstream
> The Hikmat BME Centre: Brenda Laker, Fiona Hutton and the staff of their Sahara Project (who provided the additional MLMC projects)

The Community Mentoring Implementation and Sustainability Group set up under the MLMC Programme, whose members are:

- Chair: Sue Younger-Ross, Workstream Lead (DCC)
- Ian Pearson, Strategic Commissioning, Mental Health (Devon PCT)
- Clare Cotter, Practice Based Commissioning Adviser (Devon PCT)
- Julia Page, Health Improvement, Public Health Commissioning, Devon PCT
- Dr Peter Twomey, GP, founder, Upstream.
- Anne Ovens, Director Age Concern Devon, Time for Life Consortium Lead
- Sue Howell-Richardson, Project Manager, Time for Life (provider Time for Life and Polish project)
- Martyn Rogers, Director, Age Concern Exeter (Provider, Link2)
- Nichola Weate, Service Manager, Link2 (provider)
- Brian Clifton – Senior Council for Devon
- Jean Daley – Senior Council for Devon
- Bob Newton – Senior Council for Devon
- Fiona Hutton, Hikmat BME Centre (provider, Sahara BME Service)
- Brenda Laker, Manager, Hikmat BME Centre (provider)

Linkage Plus staff particularly concerned with Community Mentoring of this report: Donna Miljus and Gregory Warner.

Also the research team at PMS (whose work is drawn on but have no responsibility for this report:

Professor John Campbell (Professor of General Practice)
Mr Andy Dickens (Research Fellow and Trial Co-ordinator)
Ms Rachel Edwards (Associate Research Fellow)
Dr Colin Greaves (Senior Research Fellow in Primary Care)
Dr Colin Green (Senior Lecturer in Health Economics)
Mrs Annemarie Hawton (Research Fellow in Health Economics)
Dr Suzanne Richards (Project Lead, Senior Lecturer in Primary Care)
Dr Rod Taylor (Associate Professor in Health Services Research)

2 Why Community Mentoring?

Mentoring was first piloted in Devon by the Upstream Healthy Living Centre in Mid Devon. The initiative was led by local GP Dr Peter Twomey who had been concerned about people coming to him for help whose needs could not be properly addressed by a medical intervention.

Upstream was chosen by the Big Lottery as one of five "pathfinder" Healthy Living Centres, which funded the original project and the formative evaluation research conducted by PMS.

The research report on this project identified the underlying conditions and trends: "As the proportion of older people increases, more are living alone. A recent UK survey indicated that 12% of people over 65 feel socially isolated. Social isolation and loneliness is consistently associated with reduced well being, health and quality of life in older people. Depression in particular is associated with social isolation and affects 1 in 7 over 65s. A careful review of the literature suggests that interventions which promote active rather than passive social contact, and encourage stimulating creative activity, with support and guidance from a mentor, are likely to impact positively on the health and quality of life of older people." (Dr Colin Greaves, Upstream report October 2005 http://www.upstream-uk.com/Research-and-evaluation.html)

The PMS final report recorded:
That a comparison of scores on entry into Upstream and at 5.5 (mean) months later showed:-
Clinically significant improvements in mental health scores in 60% of users, with 30% experiencing a high degree of change
A statistically significant reduction in depressive mood; the number of users with clinical levels of depression fell from 45% to 35%
A statistically significant increase in numbers engaging in physical activity, from 65% to 77%.
No significant change was found in physical health scores. The author comments "The lack of a decline may be a positive outcome in this high-morbidity group"
The author also commented: "These results were consistent with the qualitative data on outcomes, with psychological benefit (and reduction in depressed mood) being the most widely reported benefit. Around two-thirds of participants experienced clinically meaningful levels of psychological benefit, with around a quarter experiencing high levels of benefit."

2.1 A 12-Month Follow Up showed:-

- Improved depression scores were maintained although the mental health improvements were not
- Physical health scores now showed a trend towards improvement
- The overall health utility index combining mental and physical components improved significantly
- Social support scores also improved significantly

The author commented: "The picture is broadly consistent with a sustained increase in health quality of life, and particularly depressed mood, with additional benefits in terms of perceived social support and physical health emerging over time."

2.2 Additionally, feedback suggested high user satisfaction:

"Noticeable benefits were reported for 15 of 18 interviewees who had received the intervention. The range of benefits reported is summarised below:

- Psychological and social benefits
- Reductions in depression and loneliness
- Increased alertness /cognitive awareness
- Increased well-being and optimism
- Less dwelling on concerns /worries, better sleep
- Increased social interaction and community involvement
- Increased sense of self-worth and willingness to engage in life

- Collateral benefits for carers and family (both in seeing loved ones enjoying life more, and in the respite opportunities provided)
- Health behaviour and health benefits
- Increased physical activity, more energy
- Healthy changes in diet and less heavy drinking
- Less health visits, reduced medication use
- Potentially reduced risk of falls (due to alertness effect)
- Facilitated rehabilitation of co-ordination /mobility post-stroke

2.3 Four of the eighteen interviewees provided striking testimonies of stronger 'transformational' change affecting multiple aspects of their' lives. These were consistent with the notion of recovery from depression, involving increased sense of meaning in life, increased social and physical activity, and more attention to self-care."

2.4 The Upstream model had a high emphasis on creative and learning activities in groups, but included other activities such as walking groups, Tai Chi, and in very rural areas, groups which were flexible in what they did to reflect and retain members' interests and involvement. Nevertheless the organisation's own account of its effectiveness stressed the creative and learning activities; this is commented upon further later in this report. Group work and community development work to create capacity in communities for social inclusion were an explicit part of the model. Moving groups towards being participant-led were integral parts of the method of avoiding, and reducing existing dependence on formal services.

2.5 The PMS report on the Upstream programme interested the local health and social care community, who saw the potential for a new service addressing the needs of lonely, depressed, anxious and isolated individuals in ways they found acceptable and enjoyable. The GP's involved saw the potential to provide for people whom they had not been able to help effectively. This led to a desire to test the approach further, and Devon County Council and the then six PCT's in Devon became interested in:

- How far this approach could really move services "upstream' in a cost effective way;
- How far this service approach might be more effective than usual services, more acceptable to users than usual services, and for whom;
- How far it could be demonstrated that the approach directly impacted on NHS costs, and how far resources could be moved from secondary care to this service, at a time when Practice Based Commissioning was being planned and the Department for Health was encouraging this type of thinking.

3 LinkAge Plus

At the same time, Devon County Council was considering "information barriers" – where information is viewed as one part of what individuals need to access the goods and services they need for a healthy and fulfilling life.

LinkAge Plus was undertaken by DWP as part of the Government's plans for implementation of the national strategy on ageing. At commencement the four LAP objectives were stated to be:

1. To build a robust evidence base for joined up services in terms of delivering better outcomes for older people

2. To build an evidence base that supports the economic, as well as social, case for fully joined up/holistic services for older people

3. To test the limits of holistic working

4. To build a body of good practice and lessons learned for other partnerships and communities so as to encourage wider application of the approach, beyond our pilot sites.

3.1 The target LAP Quality of Life improvements were stated to be:

1. Independence within inclusive communities
2. Healthy, active living
3. Fairness in work and later life
4. Material well being

3.2 In their LinkAge Plus agreement with DWP, the Council proposed to test a "single gateway" to information and services by:

- The creation of a holistic framework to underpin a 360 degree wellbeing check based in fields which had been identified in Government research as important for the social inclusion of older people
- Improvements to the information held by CareDirect (at the My Devon Customer Service Centre) and on the web to cover these fields

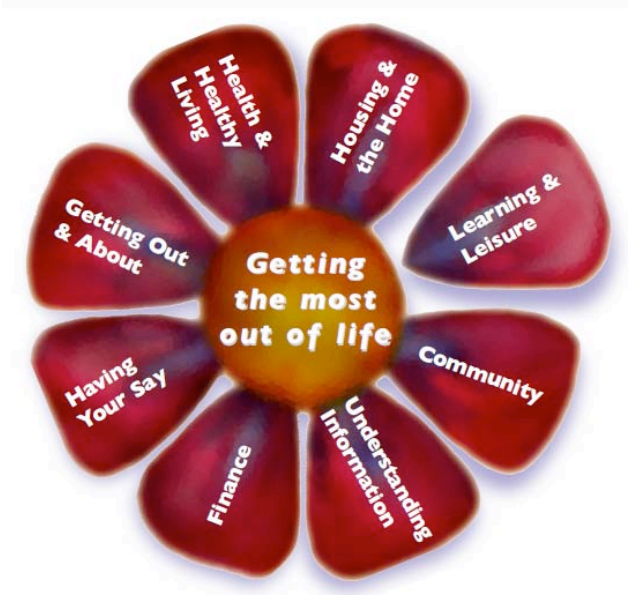


Figure 1: The LinkAge plus 360 degree framework: Getting the Most out of Life"

- The use of these tools with frontline staff and volunteers to explore their support needs in getting information to people they worked with (these latter two called "broad outreach")
- Getting information (and services) to older people who by reason of isolation, depression etc were unlikely to seek it and might not be able to make positive use of it or even resist it (deep outreach)

3.3 Marrying the 360 degree tool with the mentor's methods, with the support of CareDirect as an information source, appeared a promising approach to overcoming the information barrier for harder to reach people, and to address potentially three of the four quality of life improvements. This led to the inclusion of the Upstream and the Link2 pilots in the LinkAge Plus programme as "deep outreach".

4 My Life My Choice:

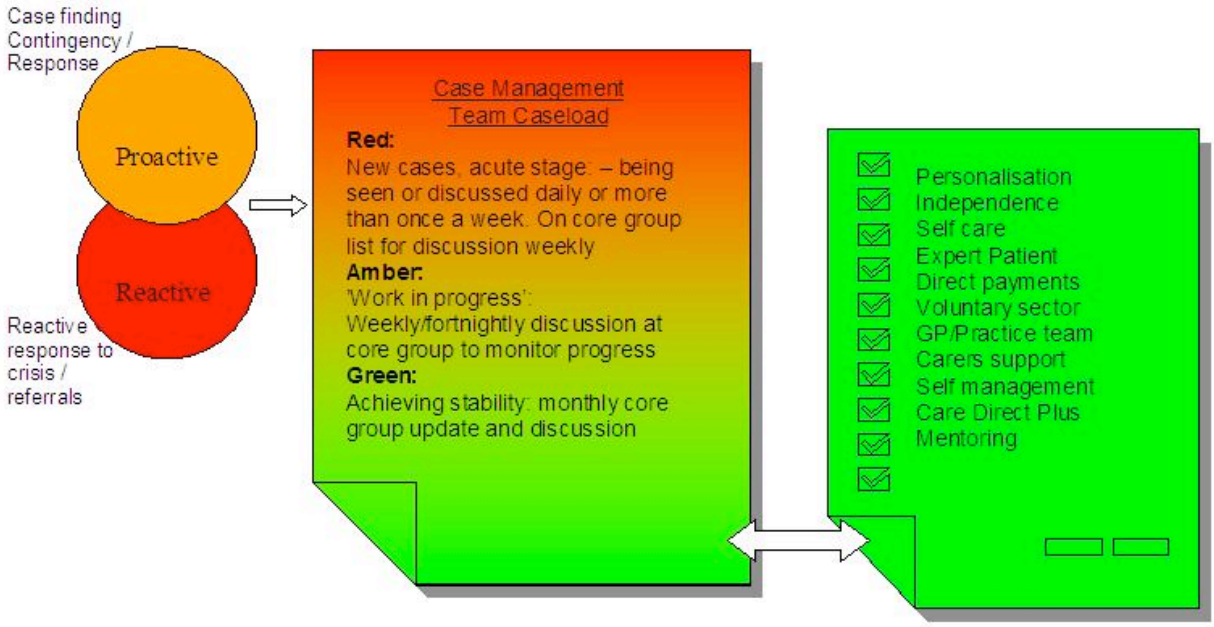
4.1 The Devon MLMC strategic aims were stated in the original bid as:-

- Help more people be healthier and independent for longer and to support carers,
- Arrange things so that fewer older people have to go to hospital in an emergency when there is no real need for it, or have to go into residential care homes if they do not want to
- Reach older people who scarcely use the services we have at present e.g. people in very rural areas, people who are from minority groups in the County, for example from Chinese, Muslim or Polish backgrounds
- Enable people to design and manage their own solutions rather than accept a lack of service or a service which is not what they want

4.2 The Devon My Life My Choice proposal involved a complete service re-design of health and social care in the community. This would be achieved by providing integrated delivery, with the key reform being the creation of local multi-disciplinary teams at primary care level to better serve people whose complex needs required a higher degree of coordination than traditional service models could provide. The focus was on a preventive approach across the spectrum of need, and the integration of the voluntary sector on the basis of equality within the teams (called Complex Care Teams, CCT's).

5 Figure 2: Complex Care Teams – the "whole system", including mentoring

Teams should experience less reactive 'push' into case management and develop a more proactive and dynamic approach which 'pulls' people into and through case management to self care and other support elements.



5.1 Early experience of the LinkAge Plus funded pilots led senior managers to include a roll out of the mentor service across Devon, and specific mentor services for Polish, Chinese and Asian elders to address disadvantage among these groups.

This MLMC community mentoring programme highlighted:

- The potential for co-working with statutory agencies – social services, primary care and mental health – and for substituting for these services when appropriate, using the model for people with greater needs;
- Extension to very rural areas, including those very remote from traditional services;
- The question of whether the model could be part of the personalisation agenda for health and social care;
- Whether the approach, in drawing in a broad group of older people into social, creative and health promoting activities, could reduce morbidity more generally and therefore demand on formal services;
- The potential of the model for addressing the disadvantage suffered by Black and Minority Ethnic communities – which could include improving their access to health and other universal services;
- An additional focus on formal volunteering, which had started to emerge in the LAP funded Link2 programme but which had not been a feature of Upstream's approach.

The controlled trial was extended to increase the power of the research and an economic evaluation (also by PMS) added.

In it categorising all POPPS pilots, DH defined Devon's Community Mentoring Scheme as "early intervention".

6 Description of the service

Case study 'Alison' age 66, was referred to Link2 by a CPN from CMHT. Alison lives with her husband and one son. She had been seen intermittently by the team for 20 years since one of her sons died. Both husband and son work full time and have hobbies at evenings and weekends which ensured they were hardly ever at home. Alison's life revolved totally around housekeeping. She was referred with low mood, mild agoraphobia and lack of confidence and very little self worth. Her only hobby was reading.

Link 2 started her on a stepped programme doing some bus practice with an enabler. She then helped her join a local coffee morning group where she helped make the drinks. She then started helping at her local school listening to children reading – but she had to stop that after a few weeks due to considerable back pain from sitting for too long. Link 2 then introduced her to our 'Cake group' which is a small group who meet in the centre of town weekly for tea, cake and chat. It took her weeks to cope with going into town alone on the bus, but she did achieve it.

Following this she attended our Women's Anxiety Management group which she said was extremely helpful. She also made friends in the group.
Her husband then insisted they move house to another area in Exeter, and Alison lost all confidence in going out and using the bus as all the land marks were different. She then had a few weeks of an enabler re-orientating her to the new area, and attending the Cake Group from a different bus route.

Since then she has progressed to 'running' the Cake group – phoning round other members and generally keeping an eye on everyone. She sends me the monthly stats.
Alison is now planning to join our "Pick n Mix" Group with one of her friends from the Cake Group. She is wanting to start some charity work soon unless her back problems prevent her. She says "Link 2 has made SUCH a difference to me."

Alison has had no further need of the mental health services**.**

6.1 The description of the service draws heavily on the description provided by Dr Colin Green in the original evaluation of Upstream:

Community Mentoring is a personally tailored, goal oriented service for people aged 50[1] and over, aimed at tackling the *social isolation*, and consequent exclusion which frequently follow on common events in later life, such as bereavement, illness or disability.

Social isolation is defined as:-

(i) A state of mind, characterised by feelings of loneliness, depressed mood and low self-esteem, as well as dissatisfaction with the social situation and a perceived lack of friendship and meaningful interactions with others.

(ii) A set of behaviours characterised by low levels of social interaction. This may be to a greater or lesser degree caused by physical (e.g. disability, illness) psychological (e.g. low self-esteem) or environmental constraints (e.g. housing, access to activities, fear of crime).

(iii) Low levels of social support in terms of material support (e.g. money transport), informational support and emotional support.

6.2 Mentoring tackles isolation and social exclusion with a "healthy living" " and social re-engagement approach based on a holistic assessment of individual psychology, needs, interests and capacities. It aims to enable older people to regain independence and healthy living habits, (including social interaction), as well as an increased sense of self-worth and to prevent further decline leading to

[1] It is believed that mentoring may have applications for other isolated and excluded adults.

more ill health and hospital admissions. It is consistent with this approach that people who use it are referred to as participants, rather than as users, patients or clients.

6.3 The aims are:

- To re-engage people in social activities which are personally meaningful and enjoyable to the individual. If social interactions are not personally meaningful, they are unlikely to address the psychological impact of social isolation

- To help participants in the service to develop the tools, knowledge and experience which will allow them to confidently engage in and self-determine their own chosen personal and social activities in the future.

Put more simply Community Mentoring works at the individual and community level to:

- Attract/identify participants who are isolated, lonely or depressed or otherwise at risk of social exclusion
- Encourage and support them to identify their own needs, set targets and plan to achieve them with the support of the mentor, in order to become as independent as possible, supported by, and contributing to, their own communities
- Stimulate and facilitate individuals and community groups to become free-standing, independent and inclusive, promoting good health and wellbeing.

6.4 Although Community Mentors work closely with statutory (and voluntary) health and social care services, the service has open referral so that individuals can approach it themselves or have a family member or carer do so. Although the description of the service is focussed mainly on the individual and groups, carer benefits are also a feature - either in their own right or because the situation of a cared-for person has improved.

7 The LinkAge Plus Pilots

7.1 The pilot areas were selected:

a) Where there was a good chance of progress within the short programme period, because organisations were in place that either already had staff in place (Upstream) or already had a scheme with some similarities that gave a good basis for development (Exeter, which had a scheme for mental health service users incorporating some similar design features); this meant that potentially lengthy periods of negotiation did not prevent maximum service delivery

b) To provide a contrast of urban and rural work, important for a County with large rural areas.

7.2 Link2

The provider organisation

Link2 was provided by Age Concern Exeter, a Registered Charity and Company Limited by Guarantee.

Age Concern Exeter is an established organisation serving the City of Exeter. Its website says this about itself:
"We are a member of the national Age Concern federation and we base our work on the following four principles:
- *Ageism is unacceptable*
- *All people have the right to make decisions about their lives*
- *People less able to help themselves should be offered support*
- *Diversity is valued in all that we do."*

Its recorded income in the financial year 2006/7 was £906,532. (Source: AC Exeter website)

It provides a wide range of day and other services, exercise and computer classes, music and dancing, a café, information and advocacy services, complementary therapies etc.

7.2.1 What Age Concern Exeter says about the service.

The AC Exeter website says this about its mentor service: " *Older people become isolated for a variety of reasons, and Link 2 aims to help find enjoyable, social, accessible activities, which increase someone's quality of life.*

When someone is referred to us, perhaps by the doctor, Social Services, psychologist, relative or by the person themselves, we visit them at home and we talk about the help we may be able to offer.

So, here are some examples of people helped by Link 2

- *Cynthia loves children but has no family of her own and was very lonely and she now helps in her local school listening to the children read two mornings a week.*
- *Bob was very anxious about going out but has now joined a small friendly games group and plays cards and scrabble every week.*
- *Gerald had found adjusting to retirement very difficult, and became depressed. He has joined a computer course here at Age Concern Exeter and can now email his family abroad.*
- *Sally was recently bereaved and struggling with being alone. She now goes to a craft group once a week, and a coffee morning that includes a visit to the mobile library followed by a pub lunch out with the group.*
- *Mary, who had a drink problem, has now joined a social group that meets weekly. She has made friends and meets up with others through the week.*

Link 2 not only helps people to find things that suit them, but also provides support to enable people to settle into the group/club/activity. After a few weeks we review how things are going, and can then change the activity – or more often – can add something else for a different day of the week.

Service users of Link 2 have said:-

- *It helps to have some information of what is available.*
- *I now have friends at my group. I don't think I shall go back into the depression.*
- *I look forward to my days out so much."*

7.2.2 Organisational features of the service

The Link2 service has six part-time mentors, who mainly have health and social care backgrounds, and some of whom have been with the organisation for some years. They are also able to call on the services of a large group of "enablers" who often put the plans the mentors and participants draw up into action. For example, when an older gentleman whose wife had died after a long illness needed to start over again having been a carer for years, the female mentor was less appropriate than the older gentleman enabler who was found to accompany him on his first few trips to his previous clubs etc. While some of the mentors work flexible hours, all the enablers are paid on a sessional basis, adding to the flexibility the service can provide.

Between July 2006 and April 2008 Link2 contributed a total of 369 to the total of 658 participants to which Devon was committed. Link2 received funding of £110,000 from the LAP programme.

7.2.3 The City of Exeter

Exeter is a University City with a population estimated at 119,600 in April 2008. It is often perceived as prosperous. For example since 1998 employment has increased by 40%, the third highest growth rate in the UK.

"Looking at the latest mid 2005 population estimates of population at risk, used in constructing the Indices of Multiple Deprivation 2007 and adjusted to exclude the prison population in order to fit the definition of 'at risk', an estimated 3,735 older people are living within the 12 Super Output Areas (SOA's) falling within the 25% worst SOAs nationally. Figures for 2006 estimate the population of those aged above 60 at around 23,500 individuals for the entire city so we can safely assume that around 15.9% of the elderly population could potentially face hardships in one way or another."

(Source: "The Geography of Deprivation in Exeter" Exeter City Council Economy and Tourism Unit April 2008)

- The population grew by 15.8% in the last between 1994 and 2001, lower than its surrounding parishes (17.9%) but higher than the County as a whole (14.8%).
- Residents of retirement age now represent 16.2% of Exeter City's population compared to 18.5% for England and a Devon average of 20.6%.
- The percentage of households occupied by a lone pensioner in Exeter is 15.3% (but smaller areas have in excess of 20%) compared with a Devon average of 16.6% and an England figure of 14.4%.

(Exeter Baseline Profile, Devon County Council January 2007)

The City's community strategy states: *"In the future the age of the people living in the city is likely to change with fewer people under 45 and more over 60. This is mainly due to lower birth rates and higher life expectancy."*

The number of people from black and minority ethnic communities was comparatively low in the 2001 Census - 2.38%, compared with Devon as a whole at 1.1% and a national average of 9.1%. The proportion is, however, rising. ("The Geography of Deprivation in Exeter")

7.3 Upstream

The provider organisation

Upstream is a Healthy Living Centre operating in Mid Devon. It is a Registered Charity and Company limited by Guarantee.

7.3.1 Its stated aims are:

- To develop a new approach to health and well-being, especially for more vulnerable and isolated people, by encouraging self improvement in health, well-being and quality of life within the context of people's local communities.
- To rekindle and bolster people's passion for living by helping them to engage in stimulating creative, leisure, learning and social activities and to prolong active and independent life.
- To trial and evaluate the approach, and to disseminate learning so that it becomes embedded in statutory and voluntary sector delivery (source – Upstream website)

Its recorded income in 2007 was £200,195. (Source: Register of Charities) Upstream's activities go well beyond community mentoring, but it will be noted that it is a significantly different kind of organisation to Age Concern Exeter, with different opportunities and challenges as a result.

7.3.2 What Upstream says about the service.

"Community Mentors are a key feature of the successful outreach approach initiated by Upstream…... Upstream mentors are part-time, paid staff, often with creative or teaching skills, working in the community within clear management structures and governance. They are becoming an integral part of the health and social care structure.

They identify, encourage and support people who are more isolated or at risk of becoming isolated, or who are losing confidence, as well as people who have had serious health issues and are recovering from treatment and support from the multi-disciplinary team. They work with adults across generations and give support to carers and minority ethnic groups. They help to motivate and support people through community involvement; they signpost people to existing activities in the community where appropriate and they help to develop small creative and social groups that become independent, or rather 'inter-dependent', supported by and contributing to their own communities. The job description and skills of the mentors have evolved in response to Upstream's 'action research' and consultation with professionals and participants which has been independently evaluated. The role of Community Mentors has been praised by health and social care authorities and by central government as an example of good practice, exploring a new way of working with vulnerable people in communities.

In one sense, mentors are 'teaching' people to 'learn' again. They have individual caseloads but work as a team. The respect and trust that grows between the participants and mentors is crucial to success. Mentors are not seen as 'counsellors', 'befrienders' or health and social care professionals. Their job is to enable people to become as independent as possible, supported by, and contributing to, their own communities, gaining an improved sense of well-being and quality of life in its widest sense. Regular peer development is an important aspect of the work alongside skills training from a clinical psychologist, health and social care professionals, and others." (Source: Upstream website)

7.3.3 Organisational features of the service

Upstream has five part-time mentors with creative or teaching skills.

Between July 2006 and March 2008 Upstream contributed a total of 289 to the total of 650 participants to which Devon was committed. Upstream received funding of £99,900 from the LAP programme.

Its Director Simon Goodenough also contributed the greater part of the Mentoring Manual http://www.devon.gov.uk/index/socialcare/older_people/linkageplus/community-mentoring/tools-for-providers.htm as well as the model with which the LAP programme started, and his inspiration and commitment were important to the success of the Devon LAP programme as a whole.

7.3.4 The Mid Devon District Council Area

The Mid Devon Community Plan 2006 – 2009
http://www.middevon.gov.uk/media/pdf/l/m/Mid_Devon_Community_Plan_06-09_v2.pdf
says this about the area Upstream serves:

"Mid Devon is a rural district lying in the heart of Devon, equidistant from the north and south coasts and bordering Somerset to the north-east. There are three main towns - Tiverton, Cullompton and Crediton - with scattered villages throughout the rest of the district.

The population of Mid Devon was estimated at 71,200 in 2003. Over half the population (53%) lives in the scattered villages making up the rural hinterland, with the balance divided between

the three principal towns Tiverton (pop. 18,300), Cullompton (pop. 7,800) and Crediton (pop. 6,700).

The population has grown by 20% in the last 20 years, and is expected to increase at the same rate to give a population of 77,200 by 2011. Much of the increase is due to inward migration from other parts of the UK. The largest increase is in those of retirement age who now represent 21.9% of Mid Devon's population compared to 18.5% nationally. A significant proportion of young people move out of the area for education or work. The Black and Minority Ethnic population makes up only 0.8% of the population with no single sizable ethnic community.

In such a rural district, access to vital services can be a significant problem for some people, particularly those on low income. 62% of the district is in the 25% most deprived in the country for 'Access to Housing and Services'. Over 55% of rural parishes do not have a Post Office. 18% of parishes have no public transport whatsoever, while a further 26% have only one service a week.

Although Mid Devon generally rates very well in national statistics, a number of areas within the district are doing significantly worse than average. Small parts of Tiverton, Cullompton and Crediton do disproportionately badly for income, education, skills and training when compared to other areas nationally, while 62% of the district is highlighted as having rural access problems."

7.4 The Model

Both pilots were contracted using the same specification, the core of which is included at Appendix A

This was different in emphasis to the existing service of both providers, albeit Age Concern Exeter needed to recruit and induct new staff whereas Upstream had an existing staff group in situ. At this point AC Exeter chose to recruit staff very like the existing staff group providing their mental health service, mentioned above.

8 The MLMC Programme

The Devon "My Life, My Choice" scheme includes a roll out of the trial of mentoring across the County.

8.1 An exercise was undertaken with voluntary sector experts (including the Devon Association of Councils of Voluntary Service, Age Concern Devon and the Westbank Healthy Living Centre (the only other healthy living centre in the County)) alongside the existing providers to define the essence of the service as the divergence between the two pilots under the LAP programme had been observed. (e.g. divergence in emphasis on creative activities, backgrounds of the staff, presence of enablers in Exeter). This included skill definition and a training curriculum. The service specification was drawn up by Devon County Council following this exercise.

The core specification for the MLMC service is included at Appendix B.

8.2 At this stage, following experience of the LAP programme, decisions were made that the core model did not rely on an a priori view that creative and learning activities were pre-eminent. Rather the alternative emphasis was adopted, which was of enabling people to set their own goals and targets, and facilitating these where appropriate in groups which were either formed according to the wishes of participants, or were identified and enabled to become inclusive of those needing support to independence.

Creative and learning activities were not ruled out, but seen as a part, albeit an important one, of the "menu" likely to be needed by isolated and excluded people.

8.3 A competitive tender exercise was conducted according to EU standards. A recent participant in one of the schemes assisted the evaluation of the tenders alongside other stakeholders.

The result of the exercise was that two providers would between them provide the service across the County for two years:-

- Age Concern Exeter, providing the service in the City, "Link2" which ran seamlessly on from the LAP funded programme. The total finance for this service was £59,235.00 per annum for each of two years.
  and

- The "Time for Life" consortium, led by Age Concern Devon and including both the Devon Healthy Living Centres[2], specially formed to provide the service, which was called "Time for Life". The total finance for this service was £440,825.00 per annum for each of two years.

8.4 Devon identified a credible provider of the specialist services for Asian and Chinese elders in the Hikmat Black and Minority Ethnic Day Centre, a small service in Exeter. The contract for this service, with an integral evaluation, was awarded by negotiation because the County identified no competition to run it. Because of the timescales, the service was run over one rather than two years, and both streams (Asian and Chinese) were run as one workstream. A specialist steering group was established by Hikmat for this service. Total finance was £165,000.

8.5 The third BME group identified in the original bid for DH funding were Polish elders. Although the original preference had been to seek a Polish community organisation to deliver the service, and some contacts were made, it was decided that the complexities of the service might overwhelm the organisations which had been identified, none of which were providers of services in the health or social care area. Instead, and to take advantage of the infrastructure created through the main projects, a negotiated solution was found whereby Age Concern Devon would contract for the service across Devon including Exeter, and a specialist steering group was established. Again because of time constraints this service was to run for one year only, and integral service evaluation was built in. An additional agreement was reached with the Hikmat Centre to offer specialist advice on culturally competent practise to assist development as needed. Total finance for the service was £75,000.

8.6 A Community Mentoring Implementation and Sustainability Group (CM ISG) was established; see membership at acknowledgments above.

9 How we measured activity

9.1 The LAP programme focussed strongly on the model as it had been received and understood from Upstream, that is, on people who were identified by whatever means as being in the target group and interested in the service, who had a one-to-one service from a mentor before moving on to independence in activities they chose for themselves. The agreement with DWP was for 650 people to be served in this way. What was counted was described as "referrals", but all evaluative and costing activity relates to completed episodes with these participants – i.e. when the case was closed to active mentoring. The research was also specified on this model. This model is described as *"individual mentoring"* in the reminder of this report.

9.2 With the roll-out of the MLMC funded service, it became possible to take a more in depth and broader view of the functioning of the services. In addition to the measure of *"individual mentoring"*, people choosing to access the service in other ways were also measured, to gain a better picture of the *beneficiaries*: people joining groups without a one-to-one service; people who were signposted to activities and services they knew they wanted (but which they could not find); people who did not want the degree of "clientisation" that formal service provision involves (for example, signing forms for permission for personal data to be held) but who nevertheless wished a one-off one-to-one consultation with a mentor informally. The agreement with DH was that the

[2] The Westbank League of Friends and Upstream.

Devon MLMC programme would deliver a service to 2,300 *beneficiaries*, of whom 200 at least would be from BME backgrounds.

9.3 In addition, numbers of groups/activities and volunteers developed were captured in MLMC. This was not the case with LAP: a focus on the development of groups and activities had not been suggested by the model received from Upstream, which this may have been a feature of the degree of maturity of the organisation when the LAP programme came onstream; volunteers had not been a focus in LAP because the Upstream model promoted a notion of "participant" volunteering and mutual support in groups and rejected the idea of "traditional" volunteering. That volunteering became an explicit focus of routine monitoring during MLMC is one indication of the development of the model over time, and reflects concern to promote volunteering among excluded adults.

10 Who is using the service?

10.1 **The service is successfully targeting isolated older people**

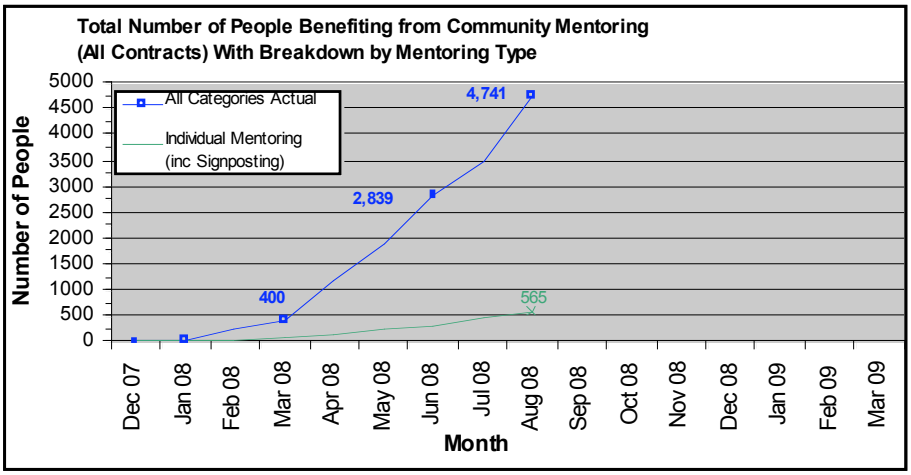
In considering individually mentored participants in both the LAP and MLMC services, the PMS report: "Devon Ageing and Quality of Life Study *A preliminary report documenting the profile of service users of the Devon Community Mentoring Service"(2008)* concluded:

"The socio-demographic and social activity profiles of mentoring clients were significantly different from those of community respondents across all domains. The general disparity between samples provides evidence that the mentoring services are targeting and working with a sub-set of Devon residents who might be defined as being socially isolated. For example, community mentoring clients were more likely to live alone, reported fewer close family or family within their social network and were less likely to belong to a club, group or organisation. The distribution of the frequency of social contacts with family and friends over the last year also varied significantly, with a greater proportion of mentoring clients reporting the lowest frequency of contact. However care must be taken not to over-interpret these data, as the proportions within some of the response categories were broadly similar between samples."

10.2 **The service is attracting people who wish to use it in an informal way.**

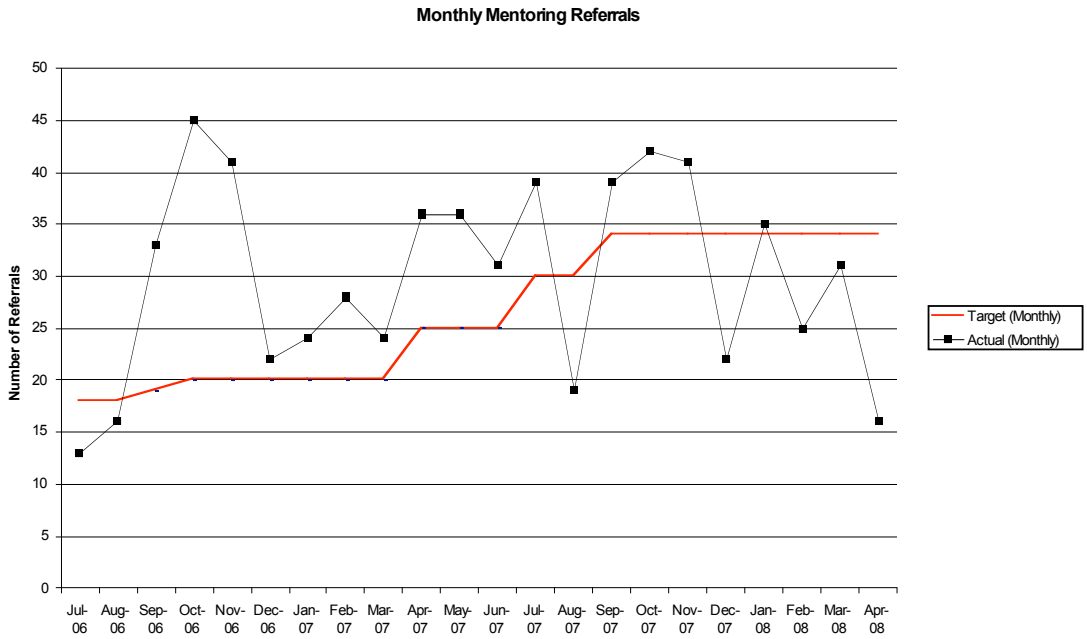
> ***Case study*** A mother and daughter new to the area were finding it hard to settle in. This was causing a strain on their relationship which was upsetting. Through Upstream groups and activities recommended by the Upstream mentor, they have been introduced to new friends and interests and are now independent and active in village life.

The following table using MLMC data illustrates the substantial proportion of people who choose to use the service in an informal way (total beneficiaries = "all categories actual") when compared with formal users ("individual mentoring including Signposting") at August 08.



10.3 We may be able to detect a pattern in when people wish to use the service

An unexpected and marked seasonal variation in referrals ("individually mentored" people) was recorded in LinkAge Plus, which the Director of Upstream considered had been their previous experience also. There were dips in the winter months but referrals were also low in August. The providers attributed these to the preferences of older people themselves, who, they felt, showed less interest in becoming involved in things when the weather was hot as well as when it was inclement. This feature involved both providers so was not a rural or urban feature.



To meet the 650 target in 24 months an average referral rate of just over 29 referrals per month was required. In fact the total was slightly exceeded in 22 months; this allowed time for the last participants referred to be assisted with LinkAge Plus funds.

It is not yet possible to analyse MLMC data in this way as the largest service, TfL, has been in a process of active expansion for most of the delivery period.

10.4 There is a variation in the use of the service by statutory referrers.

> ***Case study*** Mr.H – referred via G.P. isolated at home due to debilitating condition– lost his job, early 50's – has joined walking group and due to join a younger social group. Has been placed as voluntary support worker with voluntary organisation weekly social group.

Referral data available show broadly who has been referred by statutory services, and who has come forward informally. This data is only collected for "individually mentored" participants, and this discussion relates only to those cases.

At this point we are not assuming a difference between the people referred through these sources. Provider managers have not identified a distinct difference, nor do they feel that one or other are more likely to be inappropriate – so on their judgment, older people themselves are as likely as statutory sources to identify appropriate need.

We do assume that in the case of statutory referrals some statutory service worker had noticed some aspect of the life of a person with whom they were dealing which led them to believe that the person would benefit from the service – and that the referral was potentially also in the interest of the referrer or their service.

10.5 Since the services are working with very broad eligibility criteria, designed to be inclusive and based on ability to benefit, it is possible that refining them could lead to perceived better value for money for statutory services, a better "fit" with their interests and needs, leading to improved chances of the service being sustained. This should be approached with caution. Over-targeting could also adversely affect the services' ability to generate self sustaining solutions for participants (by involving those with more personal capacity).

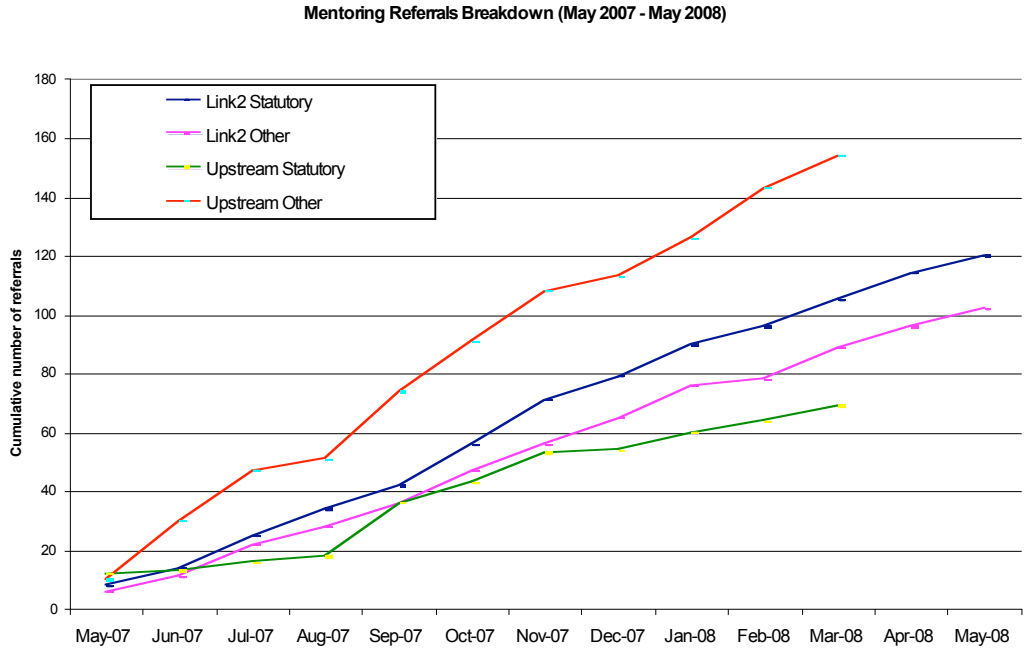
We have the following data:

- In the original Upstream evaluation the following referral pattern was noted: statutory bodies (54%), word of mouth (31%) and self-referral (13%).[3]
- In LinkAge Plus the referral patterns were: AC Exeter Link2 statutory, 54%, non-statutory 46%; Upstream, statutory 31%, non-statutory 69%; combined Link2/Upstream statutory 42%, non-statutory 58%;
- In MLMC, to the end of August 2008, for those referrals for whom source of referral was recorded statutory source referrals were 45% and non-statutory 55% (rounded) (this figure may change as no source was recorded for 14%).

[3] The highest single sources of statutory referral were GP surgeries (19%), with Social Services adding (8%) and reablement teams (10%).

10.6 Figure 3 below illustrates the interesting difference between AC Exeter and Upstream in referral source during the LAP pilot. The Upstream Director directly attributed their slower overall referral rate to a reduction in statutory referrals and the graph demonstrates the difference:

Figure 3 LinkAge Plus Statutory/Non-Statutory Referrals (cumulative)



The fact that both Upstream in its initial phase and Link2 in LAP were able to sustain a statutory referral proportion of 54% without feeling that the service was unbalanced suggests that this rate can be safely targeted.

Case study Mr.P – referred by G.P. isolated, poor support network. Difficulties mentally and physically following stroke. Initially tried mainstream groups at Age Concern, but concentration and conversation difficulties proved too much for him. He was linked to a Social Services day centre– but he found this under stimulating. Mentor service negotiated specialist support. Mr P. now has two days a week with social support. Mrs.P also using 'Take a Break' scheme for respite.

The pattern of statutory/informal referrals so far suggests that better use could be made of the services by statutory services, for example in generating alternative solutions to traditional day care for some older people. If this can be achieved, more people could benefit from the model, and extra costs associated with marketing the service to potential participants and referrers could be also be reduced generating better value for money.

10.7 **What influences statutory/non-statutory referral patterns?**

During both the LAP and MLMC programmes, the health and social care services were undergoing immense changes to their structure to provide fully integrated community services. This seems a likely explanation of the collapse of statutory referrals to Upstream between its original evaluation and the LAP programme. In Exeter, some of the re-organisation had already occurred by the time of the LAP programme, as it had been the pilot area for the Complex Care Teams, which may account for their differential rate.

It is also possible that the Upstream area in Crediton and surrounding areas was to some extent "mature", that local GP's and others had referred the "backlog" of people they felt would benefit, and that word of mouth in the community was beginning to replace the need to be told about the service by a GP or other worker. This would not be the case in Exeter.

Another potential factor was identified in focus group work with the mentors during the LAP programme.

Extract from the report: "**LinkAge Plus Devon: Summary of Deep Outreach Focus Groups Learning Issues":**

"The clients/participants referred to each of the two services reflect the areas of success that each team has developed. This success stems in part from the relative occupational backgrounds of the mentoring teams.

Upstream mentors all have teaching qualifications. Two have counselling diplomas and two have specialisms in Art and Drama. The team are especially successful at tailoring and creating new activity groups, as well as maintaining existing ones. Mentors not only assess and design suggested activities, but also set up and run the groups.

Age Concern Exeter mentors are all trained Occupational Therapists (OTs). One is also a qualified teacher, and another a qualified nurse. Their success with clients with complex needs, especially with regard to mental health, has seen the majority of their referrals coming from the statutory sector – offering clients with needs that match their OT skills. Mentors assess and design suggested activities, but are assisted by a pool of enablers in running activity groups.

The main difference in approach between the two groups was the emphasis placed by the Age Concern Exeter mentors on a holistic, 360 degree assessment of the client's needs. They felt most strongly that only by addressing all aspects of the client's health and wellbeing could the cause(s) of their isolation be dealt with. The Upstream mentors did not have such an emphatic approach, yet recorded consistently successful outcomes with their client base……"

"Although the two services had mentors from different occupational backgrounds, they identified common training requirements in a successful mentor.

Both teams appreciated the need for an understanding of the types of medical conditions that a mentor will be presented with. Equally, although mentors are not counsellors, both teams recognised the advantages that those with counselling training had.

The main difference in emphasis on training between the two teams stemmed from their occupational backgrounds and the types of client/participant they worked with. The Age Concern Exeter mentors (reported) 75% of their clients with complex needs involving mental health issues. They understandably felt that mental health training was essential. The Upstream mentors encountered such cases, but were limited in the help they could give this group and received most of their referrals for older people who suffered isolation for other reasons. The Upstream mentors recognised the need to have knowledge of such health issues, but demonstrated that they could help a large number of participants without the specialised training that OTs underwent."

Case study Mrs D – referred by Community Psychology Services. She is a single parent with five children, two still at home. She has chronic depression and social anxiety. She struggles to manage with running the house. She would like social contact, but high anxiety prevents this. An enabler is to be set up to accompany her to a local social group near her home. She is also going to attend an anxiety management group run by the mentor service.

10.8 Whilst it is possible that the different backgrounds of the staff groups involved may influence the language used to them by referrers and by them in describing their participants (as was suggested by one manager) it seems more likely that the case mix of their participant groups was in fact different. Age Concern Exeter had a staff team already well known in the city for work with people with mental health issues, and had a manager with considerable experience in that area. Upstream, despite having two members of staff with counselling skills, described itself and its staff

(as can be seen from the quotes from its website) in fundamentally different terms. The orientation of their local mentoring organisation would be clear to statutory services who were aware of them.

10.9 Following the focus groups we concluded:

- While we can identify common skills, and processes and methods (which are defined in the mentor manual (www.devon.gov.uk/index/socialcare/older_people/linkageplus/community-mentoring.htm) it seems that the types of case offered and taken up by mentor services vary with the professional background and skills of the workers. So, in Exeter, where the staff have OT backgrounds and there are recognised mental health competencies in the staff, statutory services are referring numbers of people with significant mental health problems. The service offered by Upstream is theoretically the same as that offered in Exeter; however, at first sight the participant group served appears different.

- Because of the nature of the case mix being handled by the Exeter group, and the increasing complexity and input required by people they are working with, the input required is increasing and this will tend to reduce the number of cases that can be handled within a particular time with a given resource. This kind of variation in "case mix" needs to be considered in evaluating the service.

- In both cases, there is a risk of the services being undervalued by the statutory services. Both models potentially exclude some who could benefit from mentoring. Our conclusion is that services need a balanced skill set and balanced case mix, leading to the widest possible benefit from the service.

- Alternatively, if commissioners require a particular focus, they need to be aware of the implications in cost terms, and that (from early indications) if participants with significant mental health needs are to be maintained in ordinary community groups, ongoing input to those groups may be required.

> ***Case study*** Mrs. P – referred from Community OT needing social contact as long term anxiety and depression resulting in social anxiety – severe at times. Is walking to a social group near her home with the help of an enabler at present; feels that she will have confidence to continue this alone soon.

11 Outcomes

11.1 Measurements– the controlled trial and additional means.

The main aim of the controlled trial is to examine the effectiveness of a community-based mentoring service. The economic study will expand the range of economic data available to allow a more in depth examination of the impact of the use of the service for users and agencies.

The methodology and tools for the controlled trial and economic study were agreed with the national evaluators for LA and POPPS and follow usual protocols.

The following summarises the specific objectives with the tools/measures and whether these are being studied in the formal evaluation or by other means.

Objectives	Tools/measures	Method
Quality of life	Quality of life will be measured using the SF-12 (version 2).	DQOL Effectiveness Study (Peninsula Medical School)
Social engagement	Social engagement: will be measured using the RAND Social Health Battery and MOS Social Support Survey.	DQOL Effectiveness Study (Peninsula Medical School)
Mental and physical health	Physical health status: SF-12 physical health component score. Mental health status: The Geriatric Depression Scale (Depression) and SF-12 mental health component score.	DQOL Effectiveness Study (Peninsula Medical School)
Use of services i.e. primary health care and social services	Resource use: Mentoring, NHS and Social Services resource use data will be gathered by retrospective examination (with permission) of participants' medical, health and social care records, and of routine data collected by the Link Age Plus service (where appropriate) after the six month follow-up has been completed.	DQOL Economic Study (Peninsula Medical School)
Additional aspects of benefits for BME participants	Analysis of case studies, tailored questions to users (validated UCL).	Service evaluation, Sahara and Polish projects
Characteristics of participant group	Descriptive analysis of mentoring clients, and of trial participants/non-participants.	DQOL effectiveness study (early report, due October 2008)
Costs of intervention – final	Cost estimates via interviews with service providers, work sampling (mentor activity), and feedback forum with service providers Staff time-use sampling.	DQOL Economic Study (Peninsula Medical School)
Costs of intervention — interim	Case time-use sampling	Sustainability group and providers.
Costs benefits analysis (informed by above)	Comparison of service costs with costs of standard services.	DCC Adult and Community Services Finance Service
Balance of effort: formal participants; Informal participants; group and community capacity development	1. Work sampling (mentor activity). 2. Additional staff group comparisons	1 DQOL Economic Study (Peninsula Medical School) 2 Additional management reports

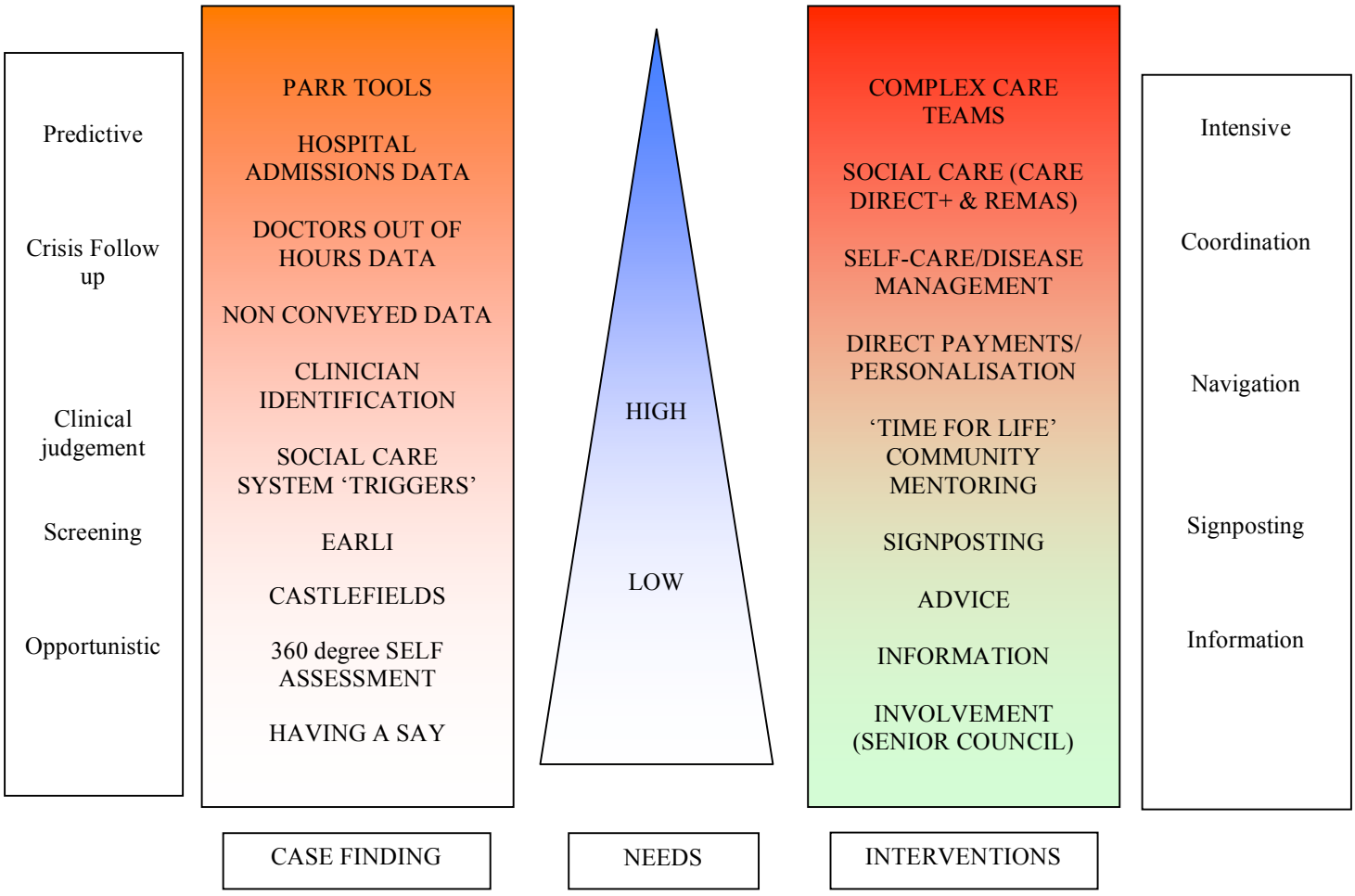
11.2 As part of routine monitoring LinkAge Plus and MLMC collected data on referral patterns, illustrative case studies, and conducted focus groups with mentors.

As the measures of service usage have broadened since the research was commissioned (as described above), the CM ISG will examine the (internally collected) data on outcomes, informal participants and group/community work as well as the results of the research in making recommendations to the commissioners. Additionally the Sahara and Polish services, which are not part of the controlled trial[4], are conducting their own evaluations to an agreed model informed by the work of the University of Central Lancaster. A case study approach will be used to "triangulate" to see if BME users experience similar benefits to others, and these users will also be asked a short series of questions about their health at referral and follow up. As mentioned above, since this approach was determined, additional potential benefits for these groups have been identified and further thought is being given to capture of information on them.

12 The place of mentoring in the pattern of local service.

12.1 The place of mentoring with regard to Complex Care Teams (joint health/social care) is shown in the Figure 4 below.

Figure 4. This illustrates the way Complex Care Teams and the Community Mentoring service inter-relate in a whole system re-oriented to early intervention)



[4] Because of 1) timescales; 2) the scales of the projects and services, which meant that no meaningful comparisons could be made; 3) concern to assure cultural sensitivity in research activity.

11.3 In the course of the programme questions have been raised about the relationships between mentoring and:

- Adult education - especially in relation to learning and creative activities – where mentoring is providing creative and learning activities in forms that are acceptable and accessible to excluded older people
- General Practice – the original idea of Upstream, reducing inappropriate demand on hard pressed GP's from people whose needs are not primarily medical
- Formal Mental Health services - raised in relation to the Upstream findings on depression and mental health, also by the Exeter Link2 project, and later MLMC projects TfL and Sahara
- Public Health and health promotion services – in relation to the particular groups served – viewing mentoring as a service that tackles social exclusion with a healthy living approach
- Adult social care – where mentoring can not only contribute to moving some people from dependence on services to independence, but contribute to the modernisation agenda, assisting people who are eligible for social care to design and control their own solutions using Direct Payments of Individual Budgets
- Equality and diversity requirements of mainstream services and the NHS BME Community Development Workers (part of Public Health) – as a tailor made service model mentoring may be ideally adapted to enabling BME groups access opportunities most take for granted, and assisting rural-dwelling people very remote from other services to put together their own solutions

Additionally, its value to the NHS has been questioned. The success of the service as a "preventive" service ***in terms acceptable to the NHS*** has been difficult to evidence, as it does not set out to impact directly on hospital usage. Only weak incentives have as yet been identified to move resources from the largest budgets – NHS acute care – to this type of "upstream" preventive service.

This questioning, and a review of available case studies and contract monitoring suggests that Community Mentoring, precisely ***because*** it is user-focussed and participant designed/defined, crosses the categories used by statutory services to organise their work, and identifies/attracts participants before their need is acute, but while trained assessors can judge that risk exists. [5]

11.4 In LinkAge Plus terms, there is prima facie evidence of successful joining up of services, albeit informally, and this questioning confirms it.

However, in considering sustainability of the service long term, it constitutes a risk: it is possible that the benefits may accrue to the services in a way they perceive as fragmented and marginal; leading to reluctance to joint fund the service.

> ***Case study*** A physiotherapist referred this participant. She had suffered a heart attack in 2007 which resulted in her brain apparently being starved of oxygen for 45 minutes– doctor apparently surprised by her survival – believed that she would never walk again. Article in medical journal with evidence from a 24 hour tape of her heart.
>
> The mentor worked alongside the couple and the existing healthcare services, trust was gained and they were empowered to venture out again.
>
> Confidence was built and self-belief established and developed. Improvement in mobility indoors and out – she has started washing up, making hot drinks and generally surprising her husband by increased activity. Her mobility has improved and is now able to walk outside with her walking aids and is less self conscious.
>
> Both husband and wife attend with mentor escort.
>
> They have now attended a charity auction in an evening and this was the first outing in an evening since the incident.

[5] The Link2 MLMC Mentoring team categorised their cases in August 2008 as follows: issues straightforward – no immediate risk 25%; clear potential for deterioration 45%; physical disability 10%; serious mental health issues: 20%

Suggestions to go out and join into events are now coming from the participant herself. They have recently organised a charity stall at a local fun day.

These are huge steps forward in confidence and self-esteem following a life-changing event.

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.

12 Costs and benefits.

12.3 Final

The economic evaluation will provide information on costs and some information on benefits to support decisions on long term funding of the programme. This information is expected in 2009.

12.4 Interim

Costs – "individually mentored" participants measure

Material in this section is subject to confirmation as further data becomes available. It relates to "individually mentored" cases (finished episodes).

DCC's estimates from the LinkAge Plus pilots (Exeter Age Concern and Upstream, both similar in size) suggested a cost per completed case in the region of £300. (Department for Work and Pensions Working Paper number 42). This was based on a very simple division of the costs incurred by the number of cases completed, and took no account of group or community level work. These pilots were also:

- fairly small, so economies of scale might be expected if the service were scaled up;
- working very hard to meet the targets, which had been estimated on advice from Upstream, and it was considered that further experience was required to see if this could be maintained or bettered in the longer term
- one pilot was urban, the other rural, so the extra costs of rural provision might raise the average cost in a predominately rural County.

In order to better understand the service the MLMC providers have worked with the idea of a "session", as well as with overall time input for individually mentored people. A session involves direct one-to-one work between a mentor or enabler and the participant. There are no assumptions or rules about how long these should be, and in some cases could be conducted over the telephone, but would never be simple telephone calls or messages.

One provider selected a number of cases at referral on which to record sessional and cost data. They were selected as likely to constitute together a representative sample of their work in terms of complexity and resource use from the data available at referral.

The range established from this exercise is 1- 15 sessions per finished episode. The cost variation established is £29.28 - £1,118.65 per finished episode (including mileage costs). However both these figures are outliers in the range.

In what follows we have considered costs including and excluding mileage for a sample of 10 rural cases; it was not possible to identify travel time and cost that separately, but the mileage travelled gives some indication of the likely proportion of travel time involved. Urban cases will obviously cost less for these items in the Devon environment.

Table 1 is a rural sample. Although these are all rural cases with a wide cost variation at first sight, the consistency with the DCC LinkAge Plus estimate is striking.

Table 1 Rural Sample

Case Number.	Number of Sessions	Cost of finished episode including travel costs	Cost of finished episode excluding mileage costs
1	15	£1,118.65	£841.63
2	2	£81.59	£70.95
3	11	£370.04	£324.44
4	10	£430.54	£384.18
5	5	£176.96	£134.75
6	15	£520.75	£451.89
7	8	£351.68	£309.88
8	6	£279.45	£231.95
9	1	£29.28	£27.76
10	7	£240.80	£211.92

It will be seen that:

- The £1,118.65 case is almost £500 more expensive than another case also needing 15 sessions, the difference being substantially travel – mileage and time.
- Including all travel costs, 7 out of 10 cases cost less than £375 – and these are all rural cases. Excluding mileage, 7 out of 10 cases cost less than £325.
- Excluding mileage costs, the average cost in this sample is £298.94; including these the average in this sample is: £359.97.

The main factors in the variation are:

- Distance – in a rural county distance costs both for the transport itself and staff time. The services are based as locally as possible, and attempt to group visits wherever possible (they are incentivised to do this by a fixed price contract and targets), but this factor can add substantially to overall cost.

- Level of the staff conducting the intervention (after the assessment) – for reasons of complexity or to avoid excessive travel in rural areas.

- Risk – in a few cases a joint visit may be required because safety for a lone worker cannot be established with the referrer.

- Resource availability. In very rural areas, and for BME groups, extra work may be required because of a need to establish more of the resources required by participants – there is, simply, less available in the community or already provided by the voluntary sector. (In some cases there is also a need to bring people together by making some kind of "offer" before potential participants can be identified, although this would not impact on the type of costs considered above.)

- Complexity of the case (and case mix): cases range from people with complex mental health problems to people whose distress and need are evident but who require and respond to personalised but fairly simple interventions, for example two visits to assess and set up a long term solution.

Case mix may vary between teams. One team reports their case mix as follows:

- Simple – 1-3 sessions: 42.6%
- Medium – 4-8 sessions: 29.5%
- Complex: 9+ sessions: 27.9%

It will be noted that in the sample reported above the ratios are as follows:

- Simple – 1-3 sessions: 20%
- Medium – 4-8 sessions: 40%
- Complex – 9+ sessions: 40%

The overall case mix will influence the final average price per finished episode but this data is not yet available. Should the case mix reported by the team above be more representative than the reported sample the average cost per finished episode may be lower overall.

12.5 Costs – the "beneficiary" measure

If the broader measure of beneficiaries is used, the picture changes.

A projection was made on the basis of the trajectory of service delivery in MLMC at the end of August 2008 (see table below). Assuming all the known resources available to the providers had been used to provide for the projected users by 30/06/09, a MLMC unit cost per beneficiary was calculated in the region of £100 and could be lower. As the service model explicitly adopts the idea that after groups are set up participants are responsible for their own costs and for sustaining the activity, maintenance should be nil. [6]

Date	31/3/08	30/06/08	31/08/08	30/06/09
Cumulative total beneficiaries	400 actual	2839 actual	4741 actual	12949 projection

It should be noted that Time for Life is still in active geographic development, and the picture is less clear for the BME groups.

12.6 **Does the model produce savings- or other benefits?**

[6] However experience with providers suggests that there will be a continuing cost for at least some groups. This may be more likely to be the case with groups including people with mental health needs. More work is being done on this, as it may also relate to staff skills and attitudes.

Case study Mr B. age 54
Lives with wife. He has MS and is in a wheelchair. He is bored and has no hobbies since stopping work. He started going to the gym with male Enabler to help build upper body strength to help with transfers and ease burden on his wife. He has grown in confidence since becoming less dependent on his wife. He has started coming to a group as a volunteer, and has started doing some admin volunteering for one morning a week in a local charity. He and his wife are much happier.

Further work is being undertaken on the extent to which the service substitutes for long term services. However, for example, if each day of day care costs in the region of £30 (estimate) then only 11 weeks (at one day per week) need to be avoided to produce an economic benefit for a participant costing £300. This ignores the costs to public bodies of case management, assessment/ brokerage, review, audit and inspection. No comparisons with the costs of, for example, public health promotion programmes, mental health maintenance programmes etc have been made at this stage.

The broad range of the intervention means that all the following scenarios are possible in individual cases (and have occurred):

- No directly identifiable savings – users are enabled to take up universal rights (e.g. bus passes) which health, social or other barriers (e.g. connected with language and culture) would have prevented – savings are "down the line" in terms of the health promotion effects of the activity and access facilitated.

- As above, but participants engage in tailored opportunities to promote health and wellbeing, usually in some form of group, often user-led to address loneliness and isolation which underlay depression, anxiety and other issues.

- Savings are produced in terms of simple service substitution, e.g. as above for day care. Alternatively, inappropriate use of NHS services, such as GP appointments, medication, or ambulance call-outs may be reduced.

- Savings are produced in more complex cases where a long term, user led solution is substituted in whole or part for other services, for example mental health maintenance services.

- Dependent service users are enabled to avoid, reduce or stop services and become net contributors as volunteers.

- Members of disadvantaged communities are enabled to make appropriate use of health or other services at appropriate times, reducing the risk of deteriorating health.

- Carer stress is reduced.

12.6.1 To this point the account here has mainly focussed on those cases identified as "individual mentoring" – the focus of the formal evaluation. However, the extension of the original LAP-funded pilots with POPPS funds has produced geographic expansion and time to consider the other ways older people are choosing to access the service, and benefit from it. These are: group and community level work, to establish the groups which are often part of the solution for participants, or to improve and maintain the inclusiveness of groups so that they can benefit from participating in them; informal use of the service. This interim account will not address the latter, but turns now to the group and community level work.

Group and community level work is essential to the long term solutions required by individual mentored participants, but also benefits people who approach mentors informally, and older people more generally for whom more local or more acceptable social or health promoting opportunities are made available.

Initial data from work sampling suggests that the distinct costs of group and community level work are relatively modest: a range of 2.8-25.4% of work time for the staff included in the work sampling so far (range attributable to work roles), with a mean of 12.9%. The benefits of improved community inclusiveness and availability of a broadened range of options for older people have not been separately assessed and are outside the scope of the controlled trial and economic study. The final programme report will use a case study approach to address the benefits to older people (who are not formal users of the service) of these opportunities.

It is considered that data for the specialist services for Asian and Chinese groups may be different because of the wide range of ethnic groups represented, and the need to negotiate access, to communities themselves, and through for example families or religious gateways for female participants. This will not be available until the completion of the MLMC programme and will also be included in the final report.

12.7 **Where does the benefit accrue?**

> ***Case study*** Mr N – age 81, with advanced sight loss, has started 'side by side' cycling with an enabler. Has started having a volunteer visitor and has joined one of our social groups and is making friends. Depression has lifted to extent of being able to be discharged from caseload of Community Psychiatric Nurse.

Further work is being done on likely area of benefit accrual, but a range of potential statutory sector beneficiaries have been identified by a review of case studies:

- GP's and their immediate teams of health staff
- Complex Care Teams (integrated health and social care local delivery teams)
- Mental Health services (Devon Partnership Trust, community services)
- Public Health (Health Promotion Devon, NHS Health Trainers and Community Development Workers).
- Wider health services, e.g. acute trusts (who have benefited from the assistance of the specialist BME services)

The economic evaluation may assist with identifying the pattern of benefit accrual and further management work is being done on this also.

> ***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.

13 Summary of Outcomes Evidence so far: LAP and MLMC.

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.

Table 2: Summary

Outcome	Progress
Partner organisations Partner organisations will benefit from reduced inappropriate or unnecessary use of services, and from improved equity of access from some disadvantaged groups	Some case level evidence for reduced inappropriate or unnecessary use of service. We continue to examine this to see if evidence can be produced from this relatively small service. There is some evidence of improved access to services for example bus passes and transport for targeted BME groups in project areas.
Wider stakeholders Wider stakeholders will benefit from improved equity of access to their services	There is case level evidence of improved access to services for targeted BME groups in project areas.
Older People of Devon Older people in Devon (who are not participants/service users) can expect to benefit from an improved range of opportunities for activities and social contacts, more locally. Collateral health benefits for family, friends, carers and the wider community to flow from this. Receivers of mentoring services themselves become givers – virtuous circle, gains in social capital.	The services have provided a wider range of options for older people, e.g. Linking Voices Choir in Exeter. Some evidence of collateral benefits at case level, but not assessed formally. Some evidence at case level.

Outcome	Progress
Service Users **Outcomes as defined by the provider contracts are:**[7]	
Improved mental and physical well being	Some case level evidence; this is subject to confirmation by the controlled trial
Improved quality of life	Some case level evidence; this is subject to confirmation by the controlled trial
Making a positive contribution	Some case level evidence; evidence of participants becoming volunteers.
Choice and Control	Some case level evidence; this is subject to confirmation by the controlled trial
Freedom from discrimination	Some case and service level evidence; to be confirmed by further management analysis and evaluation.
Economic well-being (not direct target – services to use Care Direct if indicated in individual cases)	Not reported by providers; further consideration being given.
Personal dignity	Increased coping skills. Feelings of competence and independence widely reported among and by service users who have released their stories.
Outcome as described in 2.3 above not explicitly covered by the above: improved social engagement	Case and project level evidence subject to confirmation by the controlled trial.

Case study This participant is a lady in her 50's who has had a car accident and then stroke leaving her with very limited mobility and after a long stay in hospital a lack of confidence. The mentor has enabled her to access the GP referral exercise scheme, Body Active to help build her strength. They are going to explore swimming for the disabled. She has lost much of her sight, so mentor supporting her to access volunteer to help her get used to her specially designed computer program. Now looking for someone to help her use her sewing machine! Matched with a befriender to provide on going support.

Case study Extract from a card sent by relative of new Polish participant16th August 2008:- ***'Thank you for the meeting and to say that you are the first person to fully understand how to speak to my Mother. My husband and I have dealt with many 'professionals' over the years with visits to hospitals with Mum, and usually she has never understood a word said to her. I hope that you and your colleagues arrange more visits. Thank you once again'.***

Early experience of the Hikmat BME project (Sahara) suggested that the programme might have significantly different (possibly additional) benefits for the target groups: for example in improving work prospects by improving the confidence of low-skilled BME workers, and improving equal access to universal services for BME communities, for example bus passes and healthcare. Volunteering was not a feature of the original plan, as Hikmat believed this would not be attractive to members of the target communities, yet early indications are that a number of people are volunteering, as a means to help their communities and to improve job

[7] Based on the seven outcomes for social care

prospects. Social care was understood to have little value as an idea among some Devon minority communities, yet after brief experience some younger workers were reported as considering training for it. Understanding how to promote social interaction for those older Muslim women whose cultural expectations meant they stayed at home was an early interest. Some of the solutions were surprising to the programme. For example we found that it was acceptable for Muslim women to get together to make and send cards to Muslim prisoners for Ramadan and Eid to decrease their prospects of re-offending on release. As long as chaperonage was also secured, these women were able to enjoy creative activities together for this purpose. It is clear that some of these outcomes/benefits are outside the outcome framework for the main projects, established in LAP, and this requires further consideration.

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.

13.1 **Why does Community Mentoring work 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 people 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

13.2 **Why does Community Mentoring work 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 ensure they are culturally appropriate and therefore acceptable to potential users.

- In rural areas, culturally specific information events are held, and people interested in participating, in volunteering, or in paid work are all invited to hear about the service together. A great reliance is placed upon local knowledge of informal network patterns. Where a new project is starting in an area it is essential that culturally specific events are held. Excluded people do not attend universal "information events".

- Members from the BME community are recruited as mentors after much discussion and deliberation and their skills subsequently improved.

- Coming from similar ethnic backgrounds with knowledge of religious, gender and ethnic issues these mentors are more acceptable to their community elders in a way outsiders are not.

- Working together with their managers they provide opportunities for people from different ethnic groups to participate, and together they develop joint activities.,

- They find culturally acceptable routes to reach 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.

- They can encourage the use of universal services (such as over 60's Bus Passes and NHS services).

Appendix A

LinkAge Plus Service Specification

D1 Introduction

D1.1 Upstream Healthy Living Centre is a specialist organisation with acknowledged expertise in running mentoring services for older people in conjunction with GP's in Mid Devon. The aim of this Agreement is to broaden and expand this existing service.

D1.2 In this context Upstream Healthy Living Centre will act as a pilot for Devon County Council's "Link Age Plus" project. This is an 'action research' project during which feedback from monitoring and evaluation will modify delivery methods. The Service Provider will co-operate with a parallel pilot undertaken by Age Concern Exeter.

D1.3 The aims of the Service shall be to:

- Promote a balance of good mental and physical health among older people;
- Reduce older people's reliance on statutory health and social care services;
- Increase the ability of older people to make their own positive health choices;
- Increase the ability of older people to comment on public and voluntary services;
- Produce guidance on delivery of the Service including preventative services.

D1.4 Whilst sharing the aims of the project, the two pilots will explore how best to implement these aims in their differing rural and urban contexts and will draw shared conclusions for the wider benefit of Devon. They will identify the similarities and dissimilarities between appropriate methods of delivery in their different environments. The Service Provider will similarly co-operate with other pilots within the project. It is understood that the fulfilment of this specification is subject to full co-operation between all the organisations involved in the Link Age Plus project.

D2 Objectives

D2.1 The objectives of this Service are to:

- Develop and refine a service that meets the relevant needs of older people and involve older people in shaping that service;
- Engage the interest and co-operation of health and social care professionals, other services and communities, and to gauge their responses to the effects of the Service;
- Explore the best value and most appropriate methodologies of the mentor approach, bearing in mind different rural and urban environments;
- Explore and if possible identify indicators that might enable the Service to anticipate the need for, and benefits of, preventative intervention;
- Increase co-operation between voluntary sector organisations and between the voluntary and statutory sectors;
- Where desirable, develop specialist intervention within social and leisure contexts or within specialist groups;
- Facilitate professional development and training for mentors to increase their value to the community and to their professional partners;
- Support the project in its efforts to identify ways in which to sustain the Service in the long term.

Appendix A

LinkAge Plus Service Specification (cont.)

D3 Outcomes

D3.1 The outcomes from this Service will be:

- More people will make more use of more services and activities;
- Older people will be better able to make informed choices about services related to health and social care in the broadest sense and to engage with such services;
- Health and social care professionals will be better informed about other services related to health and social care in the broadest sense and will be better able to signpost people to those services;
- Services, and access to services, will be better suited to the needs of older people;
- Older and more vulnerable people will have improved self-confidence, increased social contact, and will be more likely to take better care of themselves;
- More people will benefit from improved measures that will prevent ill-health and promote the long-term maintenance of good health.

D4 Description of Service

D4.1 The Service Provider will use its resources including its director and staff mentors to:

- Work with professionals, communities, individuals and the Devon Customer Service Centre to identify and where appropriate to monitor potential Service Users;
- Signpost people to desired and appropriate services provided by other agencies and organisations and assist people to engage with those services;
- Visit people as necessary to assess and engage their interest and participation in stimulating, social and leisure activities;
- Organise small groups of such activities as appropriate;
- Encourage people to continue activities independently in the community or in their groups or individually after the initial Upstream intervention;
- Monitor the progress of Service Users as appropriate;
- Record and collate information arising from the Service;
- Provide consultancy and co-ordination for the project as required.

D5 Geographical Area

D5.1 The geographical area covered by this Agreement is that of Mid Devon and especially, but not exclusively, the environs of Crediton.

D6 Units of Service, Volume & Availability

D6.1 A unit of Service shall be defined as a person who is in contact with the Service or who is referred to the Service. Not less than 12 and not more than 20 people per month on average throughout each 12 months or equivalent part thereof shall be served unless otherwise agreed with a target average of not less than 17. The number of people participating in groups actively run by the Service Provider at any one time shall not exceed 25 and no person participating in such a group shall do so for more than 12 sessions unless otherwise agreed by the Service Provider.

D6.2 The Service shall be available on normal working week days excluding public holidays and at normal working day hours.

D6.3 The times and venues of activity groups will be agreed with Service Users.

Appendix A

LinkAge Plus Service Specification (cont.)

D7 Service Delivery Standards

D7.1 The Service Provider shall provide the Service in accordance with its obligations under this Agreement and with all the skill, care and diligence to be expected of a competent provider of services of this type.

D7.2 The Service Provider shall ensure that sufficient numbers of people of appropriate ability, skill, knowledge, training or experience, are available so as to properly provide and to supervise the proper provision of the Service and to meet the assessed needs of Service Users, as detailed in the Service Users Care Plan, where this has been supplied as part of the referral process.

D8 Service Users

D8.1 One of the purposes of the project is to explore the wider indicators relating to the health and well-being of Service Users that can be used to identify the need for, and benefits of, preventative intervention and to encourage the acceptance of those indicators and benefits by health and social care professionals. At one end of the spectrum will be people whose health and well-being is already identified as being at risk through isolation, social exclusion, health inequality, mental or physical condition. At the other end of the spectrum will be people in whom the risk has not yet been recognised. In exploring the relative merits of broader and narrower boundaries defining who might become appropriate Service Users, the Upstream and Age Concern pilots will explore the potential differences suggested by rural and urban environments.

D9 Referral to the Service

D9.1 There will be open access to the Service. It is likely that people will be referred to the Service through many routes including but not exclusively: health and social care professionals, other service professionals, community organisations, private institutions, family, friends and self-referral.

D9.2 The Service Provider in co-operation with Age Concern will be exploring differences and similarities in methods and sources of referral relating to the different environments of the pilots.

D10 Review of Individual Service User

D10.1 Reviews of the support required by individual Service Users will be undertaken by the Service Provider in conjunction and in agreement with the Service User. Reviews will be linked, as appropriate, to informal monitoring and formal questionnaires as agreed under D12.

D11 Discharge from the Service

D11.1 Discharges will take place on an open-ended basis by agreement with individual Service Users. Discharge from the Service will not preclude the Service Provider undertaking occasional monitoring and subsequent evaluation.

D12 Monitoring & Evaluation linked to Outcomes

D12.1 The monitoring of this Agreement will be subject to agreement between the Service Provider and Service Purchaser and in co-operation with the Peninsula Medical School which is the organisation contracted by the Link Age Plus project to conduct the formal evaluation of the pilot.

D13 Review of the Agreement

D13.1 This Agreement may be reviewed at any time upon the request of either the Service Purchaser or the Service Provider.

D13.2 This Agreement will be reviewed prior to the termination date stated in Condition A2 in order to determine whether the Agreement is to be renewed for a further period.

Appendix B

"My Life My Choice" Service Specification

D1 Introduction

D1.1 Devon County Council Adult and Community Services Directorate has procured the provision of Community Mentoring Services for a period of two years in each of seven contract areas, between them covering the whole of the County, with funding secured from the Department of Health Partnerships for Older People Projects (POPPs). The Devon "My Life My Choice" programme partnership includes the Devon County Council Adult and Community Services Directorate, the Devon NHS Primary Care Trust, Northern Devon Healthcare NHS Trust, South Western Ambulance Service NHS Trust, Royal Devon and Exeter NHS Foundation Trust, the Devon Partnership NHS Trust and the Devon Association of Councils of Voluntary Service. Devon's programme title "My Life My Choice" reflects its key theme.

D1.2 Community Mentoring is a personally tailored, goal oriented service for people aged 50 and over, aimed at tackling social isolation (see Appendix 3 Section 1.2) and consequent exclusion which frequently follow on common events in later life, such as bereavement, illness or disability. A full description of mentoring and an explanation of the terms that are associated with it are attached at Appendix 3.

D1.3 The initiative is a large scale trial of this new approach which has shown some initially promising results. The contracts to be let will support the building of evidence about what works in this field. As such they will be subject to tailored contract management arrangements and will be the subject of a formal evaluation, building on earlier small scale trials. This will work alongside specialist contracts to be let for mentoring work with priority minority ethnic groups: Asian, Chinese and Polish elders.

D1.4 The centre piece of the "My Life My Choice" programme is a substantial re-design of local primary health and social care teams into multi disciplinary teams for people requiring complex care and this will operate at GP Cluster level. For the first time across the county, the voluntary sector will be represented as an equal partner on these bodies through a paid role referred to as the Voluntary and Community Sector Coordinator (VSC).

D1.5 There is no commitment to continuing the contract after the two year period. Consideration will be given to the question of whether and if so how Community Mentoring should be provided dependant on the results of the independent evaluation which has been commissioned from the Peninsula Medical School.

D1.6 Note: Services should not be titled "Community Mentor Services" and the staff should not be called "mentors". "Mentoring" is a generic term denoting the service concept contained in these papers. Providers have agreed the name of the service and how they intend to market it to professionals and older people and their carers. Promotional materials must be approved by the Service Purchaser to ensure that the marketing of the Service adheres to the service principles and these stipulations.

Appendix B

"My Life My Choice" Service Specification (cont.)

D2 Objectives

D2.1 The Community Mentoring Service will support the "My Life My Choice" strategic aims by:-

- helping more people be healthier and independent for longer;
- supporting carers;
- arranging things so that fewer older people have to go to hospital in an emergency when there is no real need for it, or have to go into residential care homes if they do not want to;
- reaching older people who scarcely use the services we have at present, e.g. people in very rural areas or people who are from minority groups, e.g. from Chinese, Muslim or Polish communities;
- enabling people to design and manage their own solutions rather than accept a lack of service or a service which is not what they want.

Within this, the aims of Community Mentoring are to:

- re-engage people in personally meaningful social activities (i.e. activities which are personally meaningful and enjoyable to the individual);
- help users of the service to develop the tools, knowledge and experience which will allow them to confidently engage in and self-determine their own chosen personal and social activities in the future.

D3 Outcomes

D3.1 Outcomes for the mentoring service, which will be linked to monitoring requirements, will be:

- Improved mental and physical well being:-
  - reduced depression,
  - improved physical activity,
  - improved feelings of self worth, confidence, self esteem,
  - establishing satisfactory home conditions which will support health, e.g. warmth,
- Improved quality of life:-
  - increase in social contacts,
  - improved uptake of ordinary community facilities,
  - reduced burden of care to informal (unpaid) a carers,
- Making a positive contribution:-
  - positive sense of social identity,
  - sense of contribution to groups,
  - feeling valued and belonging,
  - contributing through paid or voluntary work,

Appendix B

"My Life My Choice" Service Specification (cont.)

D3.1
- Choice and Control:-
  - sense of control of life,
  - choice and control of activities,
  - facilitated input to local consultations, particularly in relation to health and social care, in a conversational style integrated with the service as a whole,
- Freedom from discrimination:-
  - equal access to the service and facilitation of equal access to goods and services for:
    - people from minority communities,
    - men and women,
    - people of all ages over 50,
    - all, regardless of sexual orientation
- Economic well-being:-
  - improved financial security, especially benefit take up,
- Personal dignity:-
  - increased coping skills,
  - increased feelings of competence,
  - increased independence,
  - reduction in inappropriate usage of public services e.g. emergency hospital admission and GP over-use,
  - an increase in appropriate usage of community facilities and public services.

D3.2 In addition to the outcomes listed above other desirable outcomes for the Service, from inter-generational work, will be:-
- an increased sense of community safety,
- reduction in fears for safety, including fears in relation to young people.

D3.3 Outcome measures will be defined by the commissioner in collaboration with the Peninsula Medical School who will conduct the formal evaluation.

Appendix B

"My Life My Choice" Service Specification (cont.)

D4 Description of Service

D4.1 The primary responsibilities of providers of Community Mentoring services will be to:-

- establish service governance arrangements which involve key stakeholders, including local older people and voluntary sector representation,
- establish a system of prioritisation, including by sub-areas in the locality, to ensure a clear focus of service availability to people who are most at risk of social isolation and exclusion,
- establish and maintain good relationships with local statutory and voluntary services and older people and their carers and, using these links, to access a comprehensive "map" of community facilities and provision (it is the responsibility of the VCS to provide this) and ensure that mentors have access to and awareness of this, if there is any delay in the provision of this map then the Community Mentoring Service will make arrangements to obtain this information directly,
- promote mentoring to referring agencies and to establish clear lines of communication for referral and feedback,
- promote mentoring to the community, older people and their carers and establishing routes for open access to the service in the community,
- provide mentors in such numbers and of the competence described below as required,
- provide mentors with suitable training and skills to assess and engage with individuals across the spectrum of need outlined,
- provide access to a range of activities and services that will maximise the ability to tailor social engagement activities to the needs and interest of individuals; this will include developing these opportunities where necessary,
- meet the general standards expected of organisations working in the health and social care field,
- establish and maintain close working relationships, on a basis of full confidence, with the local statutory and voluntary sectors and local older people's organisations,
- establish and maintain accurate records as prescribed and agreed with the commissioner,
- establish audited self monitoring arrangements to continually review effectiveness and provide evidence of value for money,
- establish and maintain guidance, resources and processes for promoting the sustainability of groups set up or supported to fulfil service user's needs,
- review on a regular basis the operation of groups that they have set up to ensure that those referred are continuing to gain benefit from attendance,
-
- maintain professional oversight of the mentor's work and standards and to provide them with regular opportunities to review their practice,
- review on a regular basis the operation of any groups to which they have referred vulnerable older people to ensure that these are still operating and that those referred continue to benefit from attendance, provide evidence of understanding of work with volunteers and voluntary organisations, and to maintain a positive approach to these appropriate to the organisation's type, provide a consistent quality of service across the designated area,
- routinely feed back to the VCS gaps identified in the types of activity available in relation to expressed needs of individuals.

Appendix B

"My Life My Choice" Service Specification (cont.)

D4.2 Community mentors' roles may be fulfilled in different ways; the role described below is not a job description; but all components are considered to be appropriate to paid staff positions. The role of the Community Mentor will be to:-

- help the individual develop a positive sense of social identity and self-esteem,
- help the older person to access services and activities which match their individual needs, facilitating them to design these where necessary and feasible;
- assist the individual with integration into their local community, which will include encouraging the community to develop its capacity to support its vulnerable members,
- assist in maintaining life time interests where these have been abandoned unwillingly or the older person feels that there is an insuperable barrier to continuing and, in achieving lifetime ambitions to do new things,
- help the older person to find an interest in new things where they do not as yet feel an interest and cannot decide what they would enjoy doing,
- conduct a rigorous assessment of the needs and potential interests of each individual in order to complement assessment material conveyed during the referral process (a standard assessment methodology for the service will be prescribed),
- agree an action plan and goals with each person,
- address the needs identified within the action plan by:-
    - signposting to services provided by other organisations if the individual has the confidence, ability and the willingness to engage with them,
    - introducing the individual to facilities and opportunities in the local community where these exist and are appropriate,
    - establishing friendship or social groups wherever possible on the basis of shared interests and a close proximity to the individuals own homes.

D4.3 Service Delivery Methodology

- Community Mentors may use a range of methods to complete assessment, goal planning and action planning stages of the work. These methods may include group-based activities, accepting that these can only be based on referral information and may have a therapeutic value in themselves.
- Community Mentors may help develop new facilities in the community which are geared to the community's current interests and needs. By doing this, Community Mentoring Services will assist the development of social cohesion more generally and in particular help develop the capacity of communities to support vulnerable members.
- Mentors may also use cross-generational work to enable older people and young people to become comfortable and friendly with each other to develop mutual respect and improve feelings of community safety.
- Mentors will need considerable input and support for activities in individual cases where self-esteem and /or confidence are low in order to assist the building of confidence and social interaction skills. This could include co-attendance, help in arranging transport, emotional support and encouragement.
- In rare cases where there is no realistic prospect of the individual being able, within a reasonable timescale, to go out and enjoy social activities the Mentor should agree goals that can be met at home. In these cases Mentors should always seek other ways for the individual to connect with their local community.
- Long term support is not the aim of mentoring and organisations providing Community Mentoring Services should consult with the referring agency about ongoing support arrangements.