Ageing Better Programme Learning

BIG LOTTERY FUND

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Community Connector Schemes

About Ageing Better

Ageing Better is an ambitious, large-scale programme funded by the National Lottery and developed by the Big Lottery Fund. It aims to improve the lives of people aged 50 and over by reducing social isolation and loneliness. The programme is running from 2015 to 2021 and is being delivered by 14 voluntary and community sector led partnerships across England. For more information please visit: https://www.biglotteryfund.org.uk/global-content/programmes/england/fulfilling-lives-ageing-better

Introduction

In March 2018, Ageing Better held a learning workshop around Community Connector projects. The aim of the session was to collect learning from eight Ageing Better areas who have a Community Connector type role in their project portfolio.

We defined a Community Connector as any mechanism that identifies isolated people over 50 and works with them to help them transition to less isolated through person-centred structured support. This includes community navigators, social prescribing and approaches that involve people overcoming specific barriers, for example mental health.

About the approach

Ageing Better is a test and learn programme. Alongside formal mechanisms for capturing and cascading information, each area has developed its own local approaches. This means areas are evolving and shaping their delivery as they get feedback on what is working on the ground.

The Ageing Better programme is collecting detailed data on project success through its National Evaluation work, but it has not yet collected enough evidence to say which approaches work in tackling social isolation and loneliness with sufficient robustness. However, there is emerging insight about what works to find and engage socially isolated people aged over 50 and begin tackling some of the underlying issues. These insights are shared within this document.

The aim of this learning is to provide some insights to policy makers, commissioners and practitioners to help them when shaping this type of service. It is drawn from emerging evidence and learning drawn from the areas. As we learn more Ageing Better will add to the evidence base of what works both through the National Evaluation and this more informal learning. The insights and messages contained in these reports will be tested and built on as more or different learning emerges.

Models

While there are different models in the Ageing Better programme, all Ageing Better Community Connector projects have the following four stages:

1. Entry Points - how people find out about the project.
2. First Engagement – what happens at first point of connection.
3. Relationship Building/Activities/Structured Support – the main activities or sessions they take part in.
4. Moving On – what happens next.

All the models also have a support function including management and supervision of staff and/or volunteers.

As well as a similar structure, Community Connector type projects funded by Ageing Better have resulted in several other similarities.

1. **Referral routes** – Most of the Ageing Better programmes represented at the session have a broad range of referral routes. They include GPs, Adult Health and Social Care and other statutory services. However, they also draw on self-referrals, referrals from friends and families and other VCS organisations. Some areas that tried to have a single referral route (e.g. GP Practices) broadened out their referral activities as they struggled to identify sufficient people. Some areas also found they were being passed complex cases which they were not equipped to deal with. This was overcome through ongoing working relationships with referral partners and clarifying the types of circumstances that the service was best able to support

2. **One-to-one conversation** – Most of the Ageing Better areas started their engagement with a one-to-one conversation. For most areas this was face to face but other mechanisms including phone calls are also used. The discussion between the areas highlighted how most Ageing Better projects use positive interviewing techniques to help people build confidence and decide for themselves what they want: *'it's not what's the matter with you but what matters to you'* was a common way of framing this discussion.

3. **Other services will be involved** –The composition of each partnership and the assets available differs across areas, which results in different services being available to people aged over 50. However, all Community Connector models aim to have a wide range of partners to which they can connect, this ensures that people are signposted to the most appropriate support, and effective models adapt to offer sufficiently diverse options. It can also involve helping people access the support they need around debt, housing and benefits which can be major barriers to engagement.

4. **Follow ups** – There is substantial variance between the Community Connector models regarding the length of engagement with the support or service. However, all the models include the Community Connector being proactive with beneficiaries. They follow-up with people, provide regular check-in calls and find out whether people have attended a group or undertaken a specific action and how this has worked for the individual.

5. **Support Functions** – In most Ageing Better areas it has been useful to have a senior member of staff who helps to manage the referrals, caseloads and oversees the overall delivery. This central point helps manage eligibility and appropriateness for the service as well as identifying the most appropriate staff member or volunteer to provide the support. In referrals involving more complex cases additional support for staff and volunteers should be considered, as these cases can create extra challenges, particularly for volunteers. This can be managed through paid staff taking more complex cases or additional volunteer support. The contribution of volunteers should also be regularly recognised and valued.

Making it work at each stage

Entry points and first engagement

1. Provide choice and focus on strengths. It helps if you can provide a choice of where to meet, including the person's home. Strength-based approaches lead to better engagement and more open conversations, this includes identifying what people can do and what they enjoy. This focus on what people can do allows them to then consider how they can overcome any barriers to move into more mainstream activity.
2. Referrals. Keep referral processes between organisations simple. Most Ageing Better programmes have challenges with referrals of people with more complex needs, some of which may not be able to be addressed. As delivery becomes more mature this is being managed by the development of better working relationships with referral partners. It will take time to build quality referral networks, so referral partners understand what the service is capable of delivering. This is important to ensure that only appropriate referrals are received, which can be a particular challenge with pharmacists, businesses and GPs. If you want these partners to be proactive this will take time.
3. Capacity of others. Community Connectors need to work with a wide variety of partners and there can be challenges with the waiting lists and capacity on both sides, including statutory services. Ensure this is recognised and used to help manage expectations.

Relationship Building/ Activities

1. Keep talking to people. As people's confidence increases and they become more comfortable working with a Community Connector it is important to keep refining what is offered and exploring what matters to them. An effective programme is responsive in finding out the strengths and passions of the individual and shaping delivery around this, whilst ensuring flexibility about how you build the relationship. This can mean meeting in different places, or for different amounts of time. There will not be a one size fits all. The end date can be different, but it is important to set expectations and understanding at an early stage about what structure the support will take, what happens next and establishing goals.
2. Create an equal relationship. Move away from the traditional client-worker model to one where people feel listened to and treated as an equal partner. This is an important part of being person-centred. Use positive emotional interviewing to unlock this and, where possible, have a diverse team with a mixed skills set to allow you to work flexibly with people.
3. Collaborate. Put the person first and find activities and services from a diverse range of partners. Wherever possible build relationships between partners so as to reduce competition between organisations and ensure that contracts reflect this effectively.

Moving On

1. Have a framework for managing caseloads. Even in a flexible model where there is no set time limit for engagement there should be a framework in place to review the client's continued engagement in the project. This allows space on caseloads for new participants to join and reduces the risk of dependency or attachment challenges.

2. Allow people to return. Unexpected life events can have a significant impact, allowing people to return to the service after a disturbing or upsetting life event, perhaps without a formal referral may mean they don't need as much support in the future. Recognise people may need to try different things before they find what works for them.
3. Signposting is not the same as moving on. Just because you have told someone about an activity doesn't mean a person has accessed it. There needs to be some follow up and longer-term support or checking-in on progress.

Support functions

We also identified the need for an enhanced support function for staff delivering this type of project. The client group means staff and volunteers can be exposed to challenging circumstances. Support needs to include providing supervision and management. However, it also means providing opportunities every day and more formal opportunities on a weekly basis where staff can reflect on their week.

Key messages for delivering a Community Connector model

1. Building quality, sustainable relationships that have an impact takes time. Budgets need to allow for this time when working out how many people a service will work with over a year.
2. Moving on happens in different ways and at different times. Models need to build in some flexibility to allow for different exit routes or different lengths of engagement depending on the needs of the person they are working with.
3. Loneliness and isolation is complex and there will not be a single project or programme that can solve it. Delivery needs to be flexible, person centred and locally owned.
4. In order to reach the most socially isolated individuals, access and referral should be open and simple. It is essential to have variety and breadth in access points extending beyond statutory health and social care services.

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