

Good Neighbours and Good Friends –stay young and stay together in North East Lincolnshire.

What we are trying to achieve

We want to develop a new sense of community in which older people are valued, and good neighbourliness is the norm, where older people meet together to develop and deliver their own community life in their own neighbourhoods.

We will encourage and support older people to be active in their local communities, promoting community resilience and self-reliance. We want to achieve communities where every older person has someone to talk to, someone who cares about them, and nobody is lonely or isolated.

We aim to ensure that every older person is supported so that when any older person is in danger of isolation, they will be able to access the personalised professional help they might need to enable them to retain or regain their independence and sense of being in control of their own lives.

Through this approach we will give older people control over what services are delivered in their community, when and how.

Our approach: Summary

Our activities form a coherent approach to recreate good neighbourhoods that give older people a sense of belonging and having a worth in their community. Everyone will be encouraged and have suitable opportunities to get involved, to use their skills and life experiences. They will lead to a culture change where older people are valued and supported to remain active, independent and in control of their lives. Everyone will be encouraged to develop their own personal plan / goals with peer support available.

By building capacity and supporting new ideas and activities, we enable older people to take control of what is provided, where and when, boosting their confidence and ability to deliver new activities.

The hub and forum ideas support older people to meet, make friends and shape their communities and services. It will provide a welcome, practical help and skill sharing, maintaining people's confidence when faced with difficult situations, and boosting people's sense of self-worth as they assist their peers.

Our collaborative approach creates a different relationship with professionals facilitating older people taking control of their lives by planning their social activity and when necessary health and social care. The Dementia Friendly approach will ensure that people living with dementia and their carers remain active.

Developing better information and local transport solutions will remove barriers and create personal solutions for older people to get involved in the activities that they want, while active older volunteers will support people to engage when they are alone and feeling isolated.

The healthy living element promotes people being active and mobile, reducing the dangers of becoming frail and housebound.

Developing recycled computer resources will enable more older people to access and use computers, enabling them to stay connected, involved and in touch with friends and family even if they are unwell or housebound.

Working through organisations, frontline staff and places where older people go will help us identify and approach all single older people; to build a friendship database where older people with similar interests can meet, and enabling services to reach them when necessary. It will support a variety of friendship networks if people are frail or house bound. Our approach to bereavement and long term conditions has been piloted and enables older people at risk of isolation to be identified and receive the appropriate levels of community or professional support to retain or regain their social involvement and avoid isolation.

Our approach: Detail

We will create a series of Good Neighbour communities, based around both real and virtual hubs, where older people are supported to develop their own forum and local network of Good Neighbours, of all ages.

These communities will look different in each area as the needs and existing assets are not the same. We will use local community researchers to build the picture of how to approach each neighbourhood and what might work in different places. We will try out different things and evaluate them before trying them in different localities. We will build up expertise among local older people and organisations that can be shared as learning locally and beyond.

All older people in a Neighbourhood will be entitled to become members of their Forum with membership bringing certain entitlements for example for check-ups, a health MOT, or potentially other benefits provided by partners or sponsored by private sector.

By Releasing Community Capacity we will support people and organisations to work together differently to create collaborative solutions and to build the skills and approaches within neighbourhoods to support the development of neighbourhood hubs, forums and activities. Forum will be linked to create a North East Lincs wide network of older people for sharing, learning and to make decisions on priorities for older people and services provided. We will create a forum website and hold events several times each year, including a Good Neighbour Day to bring communities and older people together at larger meetings and events- as The North East Lincs Older People's Forum and a celebration of Good Neighbours.

How will the Good Neighbour approach work?

Neighbourhood hubs will be developed where older people meet. These may be:

- large community centres or facilities where the Hub will always be available
- small places where older people meet or use - cafes, libraries, leisure facilities, church halls, residential homes - and that older people believe is the best - which may only be open or available at certain times in the week
- and they will have an internet element and a referral process including an older people's database

In each Neighbourhood:

- People of all ages will be encouraged to become Good Neighbours. This will mean becoming volunteers giving their time to some of:
 - taking part in campaigns such as " We say good morning round here", encouraging people to be neighbourly, to speak to each other and to help each other
 - getting involved in local activities and services
 - helping to identify other older people at risk of isolation
 - taking part in friendship groups, buddying and befriending
 - visiting other older people and encouraging them to get involved in local activities
 - encouraging people of all ages to get involved in their Neighbourhood

- supporting inter-generational activities for the whole community
- organising the Hub
- supporting older people with:
 - personal transport planning
 - making plans and arrangements to get involved and avoid loneliness
 - working with professionals to support the development of personal care plans
- Older people will continue to be trained as community researchers and to build on our conversations approach to gathering insight and shaping the approach.
- Older people will be involved in developing local solutions, with support and training to encourage them to recognise and use their skills to develop groups, clubs and local services
- Seed-corn funding will be available to help people plan and start new services, and to work towards making them self-sustaining
- Local time banking and skill sharing initiatives will be encouraged, building on our already successful approach
- The Hub will hold regular sessions where older people can meet, have tea, conversations and decide upon and arrange their own activities.
- Advice, information, practical support will be available - e.g. in form filling, dealing with utilities, computer skills, benefits advice
- Space and opportunity will be created where people can access and learn how to use laptops and tablets; and potentially with a computer bank where people can return unwanted equipment for recycling into the community
- Good Neighbourliness and Well-being will be everybody's job. Frontline staff will identify isolated older people and will have conversations with them about the new approaches, the support available and will work with them to ensure they meet a good Neighbour volunteer. Our RCC Programme promotes well-being conversations as everyone's job, and we are developing an Every Contact Counts approach
- We will involve social care staff, community based public sector staff, police, fire, housing providers, care homes and a range of organisations including churches, shops, post offices, cafes. We will encourage all local organisations and businesses to become part of our Good Neighbour movement
- Doing community / peer led support planning with professional input to build up 1-2-1 contacts and personal activity plan for anyone with higher level / more complex needs, potentially becoming part of the formal social care assessment process. Multi- professional and community teams will provide professional assessment and planning when this is required, but a Good Neighbour peer will always be available to be part of the team

This will link to the approaches being developed by the Council and CCG to create neighbourhood hubs and have services currently provided centrally will be accessed locally, with support from a range of statutory and provider organisations; ensuring advice, information and preventative approaches are available locally in neighbourhoods. Some agencies will be attaching specific groups of staff to individual neighbourhoods.

How will we support people at risk of isolation

Using recognised and established approaches to assessing hierarchies of need, we will build a layered approach to encouraging people to get involved or stay involved identifying how to support people and who should provide this support (this fits with various professional approaches to hierarchies of needs, including social care assessments, and to NICE guidelines for example around bereavement.

One: Social or emotional changes leading to isolation; but still healthy and mobile - signposting providing information on available community and self-help activities, clubs and volunteering, including support on personal transport planning, and healthy lifestyles.

Two: One to one support into activity through “Good Neighbour” buddies and friends, supported by professional advice, and training to ensure people feel equipped to help each other, including e.g. people living with dementia. We will create dementia friendly neighbourhoods.

Three: One to one helps with professional support and bespoke programmes, potentially including “re-ablement” to enable to participate fully when there are health or mobility issues to overcome. Professional support will be available to people following bereavement, surviving cancer, long term illnesses, and those living with dementia.

Professional and technical support

We recognise that for some people in level two and almost everyone in level 3, then some specific professional help and support will be needed to facilitate, enable, or re-able them to become active and involved in their local Neighbourhood. In our Approach, we have identified the factors that have the biggest impact, and building on our tried and tested Collaborative model, have developed new approaches based on existing local partnerships that will:

- Provide a hub and spoke model where expertise is available when needed
- still provide co-produced expertise, based on a mixture of professionals, appropriate organisations, community, service user and peer participants
- Support our network of Good Neighbourhoods providing advice, training, information and support with projects as necessary
- Provide 1-2-1 planning and support for individuals in these circumstances to ensure that they are able to be involved in their neighbourhood, or have contact with other like-minded people to ensure they do not become isolated.

Activity - Healthy lifestyles

Our aim is to support healthy lifestyle and older people staying active, supporting the network of groups and clubs locally to develop and offer a wide range of activities and support. We will create a resource of specialist equipment, training and advice, based at KGV where individualised specialist programmes can be developed; where specialist equipment can be based; where initial assessment and support can be provided when necessary, and working as a community resource of equipment and expertise that can be taken out into communities, into community organisations to provide specialist equipment locally and to provide expertise to train local community groups to use equipment and to develop their own healthy lifestyles and exercise groups, potentially linking exercise and movement with healthy cooking, cooking for one, community meal creation etc.

Bereavement –

Our aim is to develop a Collaborative community approach, which focuses on building resilience in bereavement for individuals and communities.

- Raise the profile of risk factors for poor grief reaction
- Assess the bereavement need of individuals
- Provide information regarding the experience of grief and support services
- Increase availability of information regarding bereavement care and support
- Support befriending support services in a variety of forms
- Provide therapeutic interventions including one to one, couple and family support
- Work collaboratively and in partnership with other professional groups to deliver therapeutic interventions
- Provide bereavement support and debriefing to health and social care staff groups involved with dying people

Cancer and long term conditions

Our aim is to ensure that those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible. To provide a new model of aftercare for people with a cancer diagnosis following their successful completion of treatment.

All patients receive a holistic needs assessment, and the areas of need are identified jointly the support would be agreed in conjunction with the individual and designed around the individual's need. ***Most patients are encouraged to attend a health and wellbeing programme following an assessment and a one to one holistic needs assessment.***

The cancer survivorship team includes trained nurses and support worker to identify and work on a person centred approach to support people to reach their maximum health and well-being state.

- A six week health and well-being course which provides education and support for people to develop skills in self-management, health education, builds peoples self-esteem.
- A provision of one to one psychological support helping people to face their fear of recurrence, changes to body image and relationships, and mindfulness.
- One to one support including self-education, including practical sessions on cooking healthy, sexuality and body image, supporting people to attend a photography class for the first time.
- The service runs a walking club along-side the learning disabled teams.
- The service also offers a piloga class a mix of pilates and Yoga delivered by a highly trained yoga and pilates expert who has received bespoke training in maximise health and wellbeing for people with cancer. Of which all insurances are covered within the organisations liability cover.
- Signposting to other services including arranging exercises session,
- Fast track to health services in the case of possible recurrence.
- Supports cancer survivors to support each other including new survivors

Dementia Awareness

We will build dementia awareness and resilience into all of our communities through our Good Neighbourhoods.

- We will create a dementia alliance co-ordinator providing training to local neighbourhoods to build neighbourhood dementia awareness and local Dementia Alliances.
- We will establish a source of referrals and information that will link between professionals and neighbourhoods. This will lead to every person living with dementia and their carer being offered help and support with an individual approach to their staying active; along with more aware settings where everyone can feel comfortable in taking part in activities.

Transport

Transport has been identified as a key issue by older people, and is the missing link in enabling many older people to remain active. North East Lincs has good services available, but the issue remains. We will develop a transport project to explore what the real transport issues are, and to develop local and voluntary solutions that help people get to activities, and to take part in sustainable travel activities that both promote their independence and their wellbeing. We will use a hub/ co-ordination / expert approach:

- to help to develop local neighbourhood or activity based solutions that make best use of existing services and creates innovative solutions where needed including volunteer car schemes
- that promotes people to think differently about transport, using sustainable solutions, including feeling safe to walk to activities
- local volunteers will be trained to support people developing personal transport plans, and personal transport surgeries will be offered

What this means for an older person

An elderly person living alone and at risk of becoming isolated.

1. The person is identified through a network of local volunteers, neighbourhood watch, frontline workers (royal mail, refuse collection, health professionals, police, fire) or through the places they visit such as the pharmacy (including delivery service), supermarkets, cafes, churches, or by self-referral resulting from local newsletters
2. The individual who has made first contact will make contact with the local coordinator and agree how to approach the conversation with the individual, and who / how to involve people, particularly if there is potentially a high level of medical or social care needed. First conversations will be about listening, establishing common ground, and will not be run by professionals. It will be about friends and neighbours supporting each other
3. According to the level of need identified, conversations take place to encourage the person to meet for a coffee somewhere they are comfortable to start to explore what they might be interested in, what they might come to; who they might want to meet etc., what barriers they are (Training will be provided to people to have this conversation); and then support will be provided to encourage them to come to a group / event/ club / forum; professional support will only become involved where there are specific needs, or where people are identified through specific routes, such as bereavement as needing this input
4. People will be encouraged to come to a healthy living programme to develop a personal programme with exercise groups, healthy eating, cooking for one, looking after your mental health etc.
5. The person will be encouraged to create their own “plan” – which might simply be a set of steps they will take, and how, not a formal plan document; and this may include personal transport planning
6. They will be enrolled as a member of the local forum, which will encourage them to get involved in activities, to build the good neighbourhood, to meet people to talk, to share ideas, to get information or help in an informal setting, to guide the statutory services, and to decide on how any resources are used locally to build capacity.
7. Support might take the form of a mix of going to activities and / or support at home through buddying and befriending matches for the most frail or housebound.
8. All older people will be eligible to be a member of their local forum. Active older people, especially those who are socially isolated will be encouraged to join both the capacity building programme to build up their own personal skills and to use their existing skills to develop clubs and groups locally; and to help build and run the forums.
9. The local forum will be part of the neighbourhood hub, which will also offer personal transport planning; access to information, advice and practical support; healthy living and cooking advice; access to food banks; access to computers and tablets; with training and support; and potentially the opportunity to buy refurbished / recycled equipment donated by local organisations; possibly using low cost loans
10. They will also be encouraged to become volunteer good neighbours, and get involved in everything from keeping an eye on, and visiting people, to door knocking, organising good neighbour activity, participating in volunteer car schemes, GP and hospital support activity;

helping people to shop; supporting and taking part in skill sharing and time banking arrangements. We will link into existing networks, work with them, and identify gaps that need to be grown.

11. A NE Lincs wide forum meeting will take place quarterly and every year at least two events will be held to celebrate Good Neighbourhoods, coordinated through the forums.

Exact arrangements will develop differently in individual communities according to their needs and to what older people wish to develop and support. The focus will be on

- Being person centred
- Neighbourliness, putting people in touch / bringing them together; and encouraging people to be welcoming of each other
- Offering space and opportunity for people to meet; and forum to express and organise themselves
- Encouraging people to recognise and release their capacity and skills and helping to build new capacity in communities to enable good neighbour communities to operate effectively

How we will deliver this approach

The manner in which we develop and deliver the approach is partly dependent upon the outcome of our Big Lottery bid. However, all partners agree that this approach is the most appropriate way to support older people in the future. To that end, it will be a consideration in the planning processes of all partners and during resource allocation. The underlying principles of this approach will be part of any new developments. However, the pace and manner in which specific project elements are taken forward will depend upon resource availability, and whether the bid is successful.

- The project will be led by a project manager who will oversee the development of the approach, and its evaluation; as well as looking after the governance of the NE Lincs Forum; they will lead the asset mapping
- An information worker will lead on the development of innovative approaches to communications and information sharing; social marketing and Good Neighbour Campaigns. They will have a budget for information development and sharing, and for social marketing campaigns
- An administrative worker who will develop and manage the database of older people; will coordinate the database of volunteers and make contacts between isolated older people and local coordinators or specialist input
- Training for all front line workers
- Five local good neighbour co-ordinators who will develop the teams of volunteers, the local hubs and forums, will ensure that isolated older people in their areas are being involved in local activities; that personal plans and transport plans are being developed; that groups of older people are being supported to develop their own activities; that they will develop to take on the capacity building and skills development
- There will be a budget for capacity building / development and a budget for providing seed corn support to new activities and groups that older people want to develop for themselves. Small sums will be available to help new groups get started, but not for staff. This approach has been demonstrated to work in NE Lincs

- Transport coordination to provide training and support to coordinators with personal transport planning; to provide expertise in the development of local transport solutions
- Activity and Healthy living support - equipment and expertise developed at KGV and these then used to support coordinators and older people's clubs; with KGV providing short term personalised training programmes and the opportunities for people to meet socially and make use of the centre
- A small specialist team, based at the hospice will provide support to people following bereavement, using the 3 tier approach outlined above and ensuring 1-2-1 support initially with a professional and then with a volunteer is provided to support people back into activity
- A similar specialist team providing professional support to individuals recovering from cancer, and working with the existing early intervention / cancer collaborative teams to further develop the collaboratives' approach around cancer, COPD and other life threatening / limiting illnesses
- Providing a small team to provide support to individuals living with dementia and their carers

Appendices

Background: Understanding Needs

Local policy context

North East Lincolnshire has long taken an innovative approach to supporting communities to support themselves. It has a track record of successfully delivering approaches and projects that are built around community participation and collaborative approaches to delivery. North East Lincolnshire's approach to Collaboratives with communities and Professionals working together in innovative ways to solve problems, and the local approaches to social enterprise and new organisational forms to address old problems in new ways have been recognised nationally.

The local Health and Well-being Strategy sets out the need to move from addressing symptoms to focusing on the underlying issues that affect people's well-being, working to create:

- Healthy Places so that the underlying conditions in which people live, work and age contribute positively to people's well-being
- Healthy Services where there is greater collaboration and co-production based around the needs of the citizen to produce better aligned and equitable solutions
- Healthy lifestyles, with a much greater emphasis on prevention, early detection, and individual and community solutions to challenges.

The strategy recognises the need to put communities at the heart of health and well-being, and for new approaches to Partnership working. It includes a focus on maintaining and enhancing the independence of vulnerable groups, with a focus on healthy ageing, and on fostering healthy and sustainable places.

In taking forward this approach, partners have created the Releasing Community Capacity Programme, an asset based approach that builds on these successes to find new ways to support communities and professionals working together to create new solutions to challenges, sharing skills and expertise, and empowering people in communities to take the lead in developing new approaches, services and projects. This approach is already leading to real, measurable change locally in building involvement and community resilience.

North East Lincolnshire CCG has also developed a local strategy for health services, based in extensive consultation, "Healthy lives, Healthy Futures". This includes key messages that:

- People are expected to be able to manage their own health at home
- Services should be delivered close to where people live

As an asset-based approach, our approach builds on our history of successful engagement.

- We have several Collaboratives shaping service delivery and supporting communities to address their own priorities. These include Falls, Skin, Cancer and an Older People's Health and Well-being Collaborative. These have several hundred participants; hundreds of trained community researchers, and their own older people led governance arrangements, while providing a range of clubs and initiatives for older people.

- Participative arrangements have been promoted to encourage people to engage in partnerships and in addressing difficult challenges, and we have in place ACCORD, a community participation forum with over 300 members, and ENG-AGE, an older people's engagement body that works to address issues and challenges identified by older people, including working with transport providers to look at one of older people's most pressing concerns locally.
- This collaborative / partnership approach has been used by the CCG to develop joint arrangements for the commissioning of ALL health and social care services in North East Lincs. This is known as the Triangle, consisting of a lead GP, Commissioning Manager and community representative drawn from ACCORD. The commissioning of services for older people is led by a triangle, and all three parts of the triangle are actively engaged in the development of our Ageing Better approach.
- Partnerships and Collaborative arrangements have been developed to address some of the more difficult challenges facing communities, particularly ageing communities with a Bereavement Partnership, Dementia Alliance and Carers' Forum at the forefront of these.
- Through these arrangements, extensive research and engagement has taken place into understanding needs locally. For older people, this is set out in the "Ageing Well" study carried out into the needs of older people in North East Lincolnshire in 2012. This study involved older people in its design and delivery, involving extensive field work and Appreciative Inquiry approaches. This body of work is central to the approach to supporting older people in North East Lincolnshire.

Demographics

North East Lincolnshire has an ageing population that is growing older more quickly than the national average. People are living for longer, but they are also living for longer in poor health.

- According to the 2011 census there were 159,616 residents in North East Lincolnshire LA, of which 56,400 are over 50, and 28,287 (17.7%) of these were aged 65+ years.
- The ratio of older to younger people reaches 31% in 2014.
- Almost 11,000 people aged over 65 live alone within North East Lincs, over 7,500 women, and over 3,500 men. This is predicted to increase to over 12,000 by 2020. Around half of over 75s live alone.
- In North East Lincolnshire, over 21 people aged over 65 die each week, with death due to frailty increasing by 5% each year.
- 17,000 people over 65 have a long-term limiting illness.
- ward residents aged 65+ years as a percentage of the total ward population ranged from 27.0% (Haverstoe) to 11.2% (Sidney Sussex)
- And almost 2,500 are diagnosed as living with dementia.
- In 2013 24,799 people are living as cancer survivors (since Macmillan cancer survivor service started 91% of referrals are over 50, 42% over 70). This service has been working with isolated cancer survivors and can evidence significant improvements for people supported through the one to one personal support service.
- Compared to the LA average of 17.7% of the resident population being aged 65+ years, eight wards had a higher percentage of residents aged 65+ years as a total of the ward population, and seven wards had a lower percentage
- The numbers of older people by ward of residence ranged from 2,844 older people (10.1% of all NEL older people) in Humberston and New Waltham ward, to 899 older people (3.2% of all NEL older people) in West Marsh ward.

- It is estimated that there are over 16000 carers in North East Lincolnshire, with one in 5 being over 65 themselves

Table North East Lincolnshire people aged 65 and over living alone, by age and gender, projected to 2020

	2012	2014	2016	2018	2020
Males aged 65-74 predicted to live alone	1,480	1,580	1,620	1,640	1,640
Males aged 75+ predicted to live alone	1,938	2,006	2,108	2,176	2,312
Females aged 65-74 predicted to live alone	2,430	2,520	2,580	2,640	2,640
Females aged 75+ predicted to live alone	5,002	5,185	5,246	5,429	5,612
Total population aged 65-74 predicted to live alone	3,910	4,100	4,200	4,280	4,280
Total population aged 75+ predicted to live alone	6,940	7,191	7,354	7,605	7,924

- Source: www.poppi.org.uk. Crown copyright 2012.

Needs

North East Lincolnshire is a very varied area, and we face a number of challenges.

There is evidence of increasing poverty among older people, with the various agencies and organisations reporting increasing demand for support, and during 2013/2014 over 300 older people accessed the local food bank provided by CARE, and this is not the only local food bank.

More people need social support or preventative services. Smoking, excessive alcohol consumption, low income and poor living conditions all add to the complexity. We estimate that we will be supporting 1000 people with complex needs in the community; over 6000 accessing preventative services; and 25,000 encouraged to live healthy lifestyles.

Older people have less income than elsewhere, with 1/3 of the area in the 20% most deprived nationally. Few older people volunteer or participate in sport and active recreation. They are less satisfied with their home and neighbourhood than elsewhere. Crime and fear of crime are high. More need housing support but there is a shortage of suitable housing.

North East Lincolnshire has an area of 192 sq kilometres and is predominately urban with centres of Grimsby, Cleethorpes and Immingham, the rural area is sparse but does contain significant numbers of rural communities. Some of these lie on the fringe of the urban area or on main transport corridors, however there are still residents who are unable to easily access mainstream public transport. Census data for 2011 states 30.8% of households do not have access to a car or van. Accessing appropriate transport for essential and social journeys is challenging for many people, including the elderly and infirm.



In many parts of the district conventional public transport is good, especially along the main roads or corridors. There are several villages and small settlements where access to a bus or train service is poor or non-existent. Public transport to the more isolated and smaller communities can be problematic, in terms of providing a service which meets the varied needs of the community at an affordable price while also providing a service which is viable for the service provider¹.

In essence, there are four different areas and sets of challenges:

- The Cleethorpes area and wards close to the coast have large numbers of older people. Many people choose to retire to Cleethorpes, which has a much higher than average number of older people;
- or to our small rural communities, making it more difficult to access services. In both instances, the social networks do not exist, and transport is a major issue locally;
- there are substantial numbers of older people living in deprived wards in Grimsby, and the community infrastructure is weak in places;
- Immingham is socially isolated and geographically fragmented, much of its traditional industry has changed, and many young people have moved away, leading to isolation among a traditional community.

Isolated older people in NE Lincs can be split into three categories:

1. Physically isolated older people - quite often the very frail and unwell elderly people who may be housebound or have limited mobility
2. People whose isolation results from specific illnesses - which might include people who are living with dementia, or who have survived cancer, and possibly the carers and partners of this group
3. Socially isolated but potentially mobile older people, living alone, possibly after suffering a bereavement, and possibly lacking confidence; who feel that they don't know people or what is going on locally; and possibly in a younger age group than those who are very frail (e.g. 50-70)

We have engaged with older people in a number of ways in the last five months:

¹ RURALITY ISSUES IN NORTH AND NORTH EAST LINCOLNSHIRE Gaps, Hotspots and Local Priorities 2010 <http://www.vanl.org.uk/publications/rural-gap.pdf>

- We have publicised the Partnership and approach in the media, and through leaflets and posters; and invited people to get in touch by email and telephone, and to come to a variety of organised events and meetings
- Partners have engaged with the people they work with, their service users and their members to find out more about isolation
- This has included Partners from all sectors, including the Police, Fire Service, Social Care, Housing Association as well as a large number of community organisations and care providers
- We have drawn on existing knowledge from front line staff, care and health professionals including GPs
- We have gone to the places that people meet, with a “Have your say day” in Grimsby Market, at the Seniors Day at Cleethorpes Cinema, and through Partners holding conversations at their social clubs, meals clubs and other activities and events

We have engaged with well over 1000 older people through these approaches. We have built up a narrative on the issues and challenges facing older people. We have added this to the existing knowledge and experience gained through:

- Ageing Well, large scale research into the needs of older people in NE Lincs in 2012
- A Good Place to Grow Old - the older people’s strategy 2009-2012
- The Carers’ Strategy: Engagement with carers identified that, “Overall there is a lack of information & no signposting to services. Information needs to be clearer, accurate, up to date & timely. A tangible directory of contacts & services should be provided. 97% of carers at the Carers Strategy Consultation Event felt information was the most important service.”
- The work of the End of Life Care Partnership which is undertaking a national one to one support pilot for the survivors of cancer
- The work of the Dementia Partnership which has found that
 - **44%** of people with dementia feel they **lost friends** after being diagnosed
 - **61%** of people with dementia **feel lonely** always, part or some of the time
 - **67%** of people with dementia **do not** always feel part of the community
 - **77%** of people with dementia feel **anxious or depressed**

Through our current engagement people have told us that:

- It is alright as long as you have your partner and your health. If you can stay fit and active, then age is just a state of mind.
- We want to feel valued in our community, for people to recognise that we have something to give; and we want to encourage good neighbourliness and respect, looking at each other in the street and saying “good morning”. We want to encourage people to be good neighbours to each other.
- Transport is always an issue.
- There may be lots going on but we don’t always know about it; nor have anyone to go with. We need better information.
- We want clubs, places to meet, but it can be daunting going by you.
- And things have to be affordable as lack of money can lead to isolation.

- There are exercise classes and similar things; and there are places you can play bingo - but not always a lot for people who don't want these things; and more exercise / leisure / dancing classes are always good.
- We just want social settings where we can decide what to do, have a coffee, play music, may be even dance, but we don't necessarily want organised activities - we want dating or friendship clubs.
- We value the social side of things, being able to talk to each other and we want eating together to be a social activity. We want to be able to meet others to get help to sort practical things out. We want to be able to organise trips out and holidays together.
- We want these things locally, in our village or our neighbourhood, and not just in town.
- We want these things in the evenings and at weekends, but we need to feel safe getting to them.
- Support and services are often available for people who are very frail, but not for people aged, say, 50-70 who retire, become carers or are widowed, and are fit, don't consider themselves "old", and don't want to do traditional things.
- But frail older people tell us that they feel isolated because they cannot get out, particularly in severe weather or winter, and they do not feel that there are lots of things for them to do.
- We value our independence and want to stay active; and we are concerned to ensure we can get help and support with things when we need, including advice and information and access to safe repair / "handyman services".
- We don't have an older people's forum where people can say what they think, and meet other people.

The messages have been consistent in all discussions conducted by all partners. It echoes the findings of the 2012 study into the key issues for older people's well-being. It gave some overarching messages:

1. Feeling part of the local community, staying active and helping to contribute is of key importance to the older people involved in this research. 'Having a purpose' was mentioned many times.
2. Social interaction seems to be of key importance and there is a need to ensure access to social networks etc. is not just easy for the confident or the supported.
3. Many people referred to the need to restore a sense of community and mutual support. How might it be possible to replicate what happens in some streets where people look out for each other to others?

Issue	Key finding			
	Field work	Appreciative Inquiry	Care Trust Plus questionnaire	Longevity research
Family/friends/social networks./ avoiding loneliness	✓	✓	✓	✓
Positive outlook – having a focus in life/hobbies	✓	✓	✓	✓
Helping others	✓	✓	✓	✓
Keeping active	✓	✓	✓	✓
Good health care	✓	✓	✓	
Exercise	✓	✓	✓	✓
Access to free transport	✓	✓	✓	

