Local Friends

Helping ordinary people care for one another

Proposal

Version 0.45

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Contents

Document Status

This is version 0.45 of a working document, currently under development. The latest version of this document can be found by following a link on the web page:

- http://localfriends.pbworks.com/

All the details contained in this document should be understood as a working proposal for how the *Local Friends* scheme could operate; they are presented here as a basis for further discussion.

Further Details

If you are interested in contributing to the development of this scheme in some way, please contact Paul Hazelden by

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Executive Summary

Informal pastoral care for one another is a natural part of healthy community life. There has been a significant breakdown in community life in recent years, and this has contributed to the increase in the numbers of people seeking professional help while not in reality requiring their professional skills: for example, people may attend the local GP surgery asking for help with minor medical concerns when the real cause for their visit is they are 'merely' lonely.

We have an opportunity to build the capacity of people in the local community to care for one another, building on the current skills and activities of local churches. They can provide human contact, listening and basic practical support on a voluntary basis, reducing the need to approach GPs and other professionals unnecessarily. This will have the effect of making people happier and healthier, building community cohesion and saving the NHS and other institutions money.

'*Local Friends*' is the working name of a proposed scheme to build this capacity by providing a trusted 'third party' to support and monitor the local activity.

This document describes aspects of both practice and principle: in order to understand the scheme, you have to grasp both *what* we intend to do and *why* we intend to do it this way. The detailed operational documents will have to separate out these different aspects, but it is simpler to combine them when considering the scheme at this level.

Overview

Summary

Local Friends ('LF') aims to build the capacity of people in the local community to care for one another through building on the current skills and activities of local churches in order to provide human contact, listening and basic practical support on a voluntary basis, thus reducing the workload of GPs and other professionals.

In many communities you can find:

- a significant number of lonely, disconnected people whose isolation causes them to feel unhappy and makes them far more likely to suffer from a wide range of problems;
- a GP surgery which sees many of these people and recognises that many patients come to them primarily because they are lonely or suffer from other non-medical problems; and
- a local church which has a reasonably effective system of pastoral care for its members and their friends and a desire to serve their local community.

Local Friends seeks to help all three groups through partnership working. We aim to build the capacity of people in the local community to care for one another by using the skills and experience of people in local churches to provide human contact and develop a network of relationships, resulting in improved quality of life, a strengthened connection with the local community (both for the participant and the church), and a reduced workload for the GP.

The anticipated benefits include:

- fewer patient appointments at the surgery;
- GPs enabled to concentrate on providing medical care to those they can help;
- improved patient care leads to reduced costs to the NHS in the long run;
- church volunteers gain new skills and confidence;
- the local church builds positive connections with their local community;
- community groups of all kinds have more people participating; and
- local people enjoy improved health and wellbeing.

Local Friends extends the concept of Social Prescribing: it creates a parallel strand of personal contact which can be offered alongside the current activity based options. It also outsources some of the activity associated with Social Prescribing to a small Pastoral Care Team based in a local church or supported by a group of local churches, and supplements it with personal support.

In the short to medium terms, it should be straightforward to monitor the participants in the scheme, to determine the extent to which they engage in the scheme on the one hand and the extent to which they reduce the number of visits they make to their GP on the other. In the longer term, it is anticipated that building a

stronger and healthier community will reduce the number of people who visit their GP each year.

The *Local Friends* activity will be undertaken by local volunteers, so the running costs will be low. One of the support options explored will be to find ways in which the participant can offer support to others: people gain and grow through helping other people, and one way to do this is through volunteering with *Local Friends*. Some training and infrastructure support will be required to make the scheme work, monitor performance, and provide supervision and backup to the volunteers when required; this activity will need to be funded.

The Challenges

Each side in this partnership faces a significant challenge. These challenges, and others, can be overcome.

- For the medical professionals, the primary challenge is the question of trust: can they trust the church to offer pastoral care within generally accepted good practice guidelines and without seeking to convert the people being referred?
- For the church, the primary challenge is that a good deal of their time and energy is already taken up with pastoral care, and many people will have significant concerns about their capacity to take on the support of more people.
- For both parties, there is the additional challenge of relating to another group with a culture and expectations which differs significantly from their own.

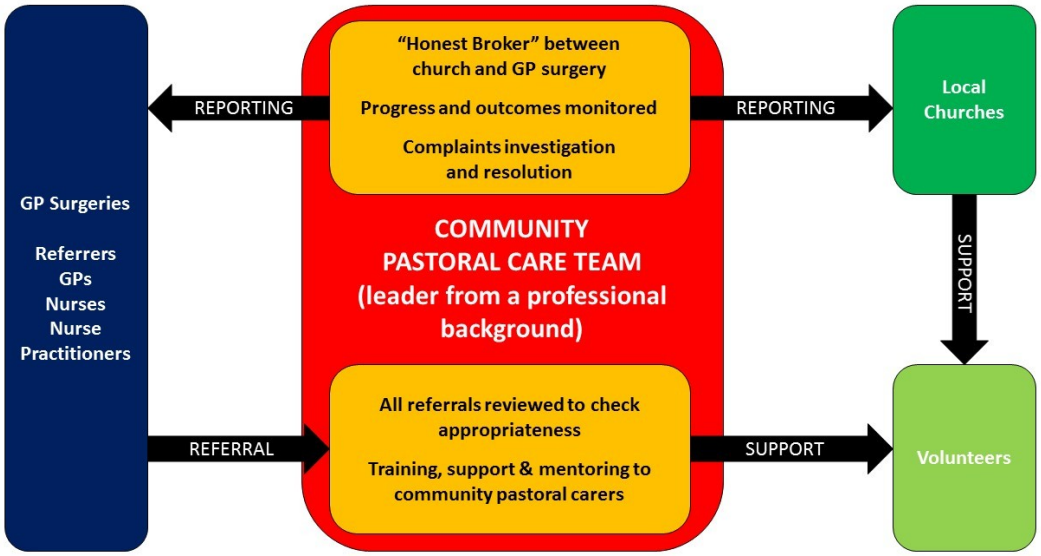
Local Friends provides a trusted third party which addresses each of these challenges.

- For the medical professionals, *Local Friends* offers public guidelines and good practice standards, plus external oversight and accountability for the volunteers.
- For the church, *Local Friends* provides training, support for the supervision of volunteers, and a source of advice and support if the local people are unsure at any point how to care for an individual or how to balance conflicting priorities.
- For both parties, *Local Friends* provides a common meeting point where they find people who speak their language and understand their concerns.

The Outline

- We are offering simple human contact, not solving problems;
- we are seeking to build a friendship which can then be shared and extended to others, aiming to draw people into the wider community;
- we are responding to what the person being visited wants to talk about, not aiming to talk about matters of faith, but not avoiding the subject either;
- we are not offering a commitment to weekly visits for the rest of your life, but open to the possibility of establishing a lifelong friendship.

The Main Elements



The Mechanics

The key requirements for this scheme to operate are simple:

- a contract and operating procedures, so everybody knows what is expected of them; and, most importantly
- trust – both parties being willing to work together in this way and to bridge the cultural gap which divides healthcare professionals and the voluntary sector.

All the usual policies (such as confidentiality and equal opportunities) will need to be in place.

At a lower level of detail, there will need to be:

- a referral process, which will involve identifying what is available and determining what the recipient is currently able and willing to access;
- record keeping with activity analysis and outcome tracking;
- a reporting and monitoring system with scheduled project reviews;
- insurance cover for the activities where this is not already in place through the existing partners;
- a complaints procedure and conflict resolution process; and
- training, supervision and support for the volunteers.

To enable proper oversight and accountability, the scheme should be run be a small independent group, probably established as a CIC.

Proposal

Infrastructure

In the initial stages, LF will exist as a group of independent but similar schemes, each supported by a central non-profit organisation. At present, it is assumed that each scheme will be centred on a single GP Surgery and operated by volunteers functioning as part of a local church or group of churches. For the sake of simplicity, the initial schemes will probably be supported by a single church.

As the schemes develop and mature, it is assumed that new carers will be recruited from beyond the initial church community. Once there are sufficient schemes operating around the city, the referral mechanism may be modified to make use of a single unified contact point, thus enabling the GP to refer people to the scheme even when they live outside the local community; but such a mechanism is beyond the scope of the initial schemes.

Each scheme will provide a minimum 'core' set of services; beyond this, each one will provide a mix of services and facilities suited to the local needs and circumstances. While the services will vary, the policies, procedures and guidelines will be standardised throughout the group: partly to ensure the sharing of best practice, partly to avoid duplication of effort and partly to assist the development of a brand identity.

It is currently assumed that the central non-profit organisation will be constituted as a Community Interest Company ('CIC') under the control of a small board of directors. This company will have several roles.

- Act as an 'honest broker' bridging the culture gap between NHS and faith groups.
- Facilitate initial conversations in the early stages of a new scheme.
- Provide the standard policies, procedures and guidelines to each scheme.
- Provide the initial training for the people involved in a new scheme, and ongoing training for new people as they become involved.
- Review schemes at agreed intervals: partly to check they are still delivering benefits to local people, partly to identify opportunities for increasing or improving the services being offered, and partly to identify and correct any problems before they become significant.
- Provide a resource to be called upon when the people operating a local scheme need support or have questions they cannot answer locally.
- Provide the infrastructure for reporting on the activities and achievements of each scheme.

Because trust will be vital to the success of this initiative, the company will operate a policy of complete transparency: with a few necessary (and documented) exceptions, all the operational details will be open to public view.

Purpose

The fundamental purpose of this scheme is to benefit the people being referred. While nothing can be guaranteed, the medical professional must have a confident expectation that their patient will benefit from the referral.

In addition, our hope and expectation is that as we help the patients, they will experience reduced need for the services of the NHS, and thus save the surgery (and, by extension, other parts of the NHS) time and money. But it must be clearly understood at the outset that the purpose is to benefit the patients, not to save money.

'Benefit' is, of course, a very vague concept, but it is adequate as a statement of purpose. There are ways to measure or estimate well-being, and these will need to be explored as tools to assist in measuring the effectiveness of the scheme, but success cannot be tied to any specific tool or technique for measuring well-being – otherwise the aim of helping people will have been replaced by the aim of achieving set targets.

Financial savings will, of course, be calculated and reported on, but these will not be regarded as measures of the success of the scheme: benefit to the patients is the only standard of success. Without this commitment in place, it will prove impossible to run the scheme: people will volunteer to help others, and will often go to extraordinary lengths to care for people they know; but they will not be motivated to help in the same way if they think the aim of the scheme is to enable a massive institution to save money – however much they like the aims of the institution.

Methodology

The fundamental purpose of this scheme is to benefit the people being referred through the involvement of, and involvement with, the local community. The work of the scheme will be undertaken by members of the local community, acting as volunteers. The work must be done by volunteers for two fundamental reasons.

- Firstly, the size of the need makes this necessary. It is not feasible to pay people to undertake all the activity which is needed.
- Secondly, the nature of the activity makes it necessary. If you are lonely, you need a friend. Human contact with someone who is paid to spend time with you is better than being alone, but spending time with someone who chooses to be with you is far more significant. We need to feel we matter to the people around us.

The expectation is that some of the clients who are referred to the scheme will decide that they could help others in some way, and so become volunteers themselves. The process of clients becoming volunteers will enable the scheme to grow without placing impossible burdens on the initial volunteers, and it will also provide a new way in which the former client continues to benefit from and grow through their involvement with the scheme.

Of course, the volunteers need to be resourced and supported, the scheme needs to be monitored, and so on; all this activity needs specialist knowledge and skills which will need to be paid for. But the aim is to do all the front line work – and as much as possible of the administration – through volunteers.

An assumption at present is that the volunteers will not be paid expenses; if it turns out that this is necessary for the development of the scheme, additional funding will have to be raised. But previous experience suggests that most volunteers will be happy to participate without claiming expenses; and those who need to claim expenses will probably be receiving a range of financial and practical assistance from other sources which may be able to meet the small additional costs.

Referral

A referral is the introduction of a person (the 'client' or 'recipient') to the local LF scheme. Each referral to a scheme will be made by a medical professional based at the surgery for that scheme. GPs can refer; presumably so too can the various types of Nurse attached to the surgery. For the sake of simplicity, we will assume in the following discussion that the referral has been made by a GP; it makes no difference to the subsequent process.

We assume the referral process will happen in much the same way as happens when a referral is made to Social Prescribing; in any case, the referral process must integrate with the wider 'Live Well Bristol' health and wellbeing referral hub for Social Prescribing.

As a 'belt and braces' approach, the client will be given details of the local scheme – probably in the form of a business card with the details printed on them; and the local scheme administrator will be given some details of the client.

A LF referral must be distinguished from a medical referral. The difference is that in a medical referral, the GP decides (in consultation with the patient) what needs to happen and passes responsibility for some specified aspect of their medical care to the specialist. With a LF referral, there is no passing of responsibility for medical care, and the GP may be less clear what will happen as a result of the referral.

Each referral will be made with the hope and expectation that a certain form of help or support will be provided, but this should not be seen as a target to be achieved: when talking to the individual concerned, the care providers may have other ideas which work better for the individual concerned.

Approach

Within the medical model, patients have things wrong with them: these are the problems which the medical staff are tasked with solving. A LF referral takes the patient outside the medical model: they are no longer a patient with a problem to be solved but a person with a life to be lived. While it is the intention that problems will be solved, this will be done within a framework in which problem solving is not the central aim.

In Christian terms, we are not called to fix people, but to love them. We are not called to solve their problems, but to walk with them while they discover how best to deal with the problems they are concerned about – which may not be the same as the problems we identify, anyway.

One common problem when seeking to help people is that they often do not want

to be helped, at least, not in the ways we want to help them: there is frequently a conflict between the objectives of the helper and the objectives of the person being helped. We need to acknowledge the possibility that our objectives do not entirely agree so that, as helpers, we can put aside our objectives and work to help people in ways they are willing to be helped.

It is also sometimes the case that the helper may assume they know what is needed, better than the person being helped does. But whether or not our ideas are better is irrelevant: we can offer what we like, but only the help which is received has the ability to make a difference.

We must be flexible in our approach. There are many textbooks telling us how to help other people in all kinds of situations. But the advice which is offered to the sort of stable and respectable people who read self-help books and flock to attend self-improvement courses may not be so relevant and helpful to people whose lives are in chaos. Again, only the person being helped can determine what is actually helpful to them.

None of us like being told what to do; we are resentful when given no choice about things which affect us. So it is not surprising when those whose lives (in our judgement, at least) are in greater need of turning around very often refuse assistance and fail to cooperate with the people tasked with helping them. One strength of this scheme is that it is chosen, not imposed on them; and any help and support will be offered by a volunteer, an 'ordinary person', rather than a professional. Many people find it much easier to accept help which is offered in this way.

Scope

The scope of the scheme will need to be agreed at the start, clearly identifying who might be able to benefit from it and what can be done for them. There will also need to be a mechanism to update the scope: this should happen as new possibilities open up, but also possibly as we discover that some aspects are not working as well as we had hoped.

The precise scope of the scheme will vary from place to place: different skills and services will be available in different locations, and it would be unhelpful to prevent those running a scheme in one place from doing something which would help people, simply because it is not being done elsewhere. However, as mentioned above, we will probably establish a minimum viable scope. This will assist in developing new schemes, so they can start from a solid base and then grow.

Presentation

It may be the case that the a local LF scheme will need to operate a number of distinct schemes or projects in order to be able to appeal to different demographics. It is possible, for example, that a professional person suffering from work-related stress may be reluctant to access a service if they know it is being well used by unmarried mothers, or helps elderly people with their shopping. The difference may be mainly a question of branding, or it may be that different groups will require help tailored to their specific needs.

How to communicate and ‘market’ the scheme to potential participants is one of the details which will have to be refined during the initial pilot scheme(s).

Other Services

The basic idea behind LF is not a new one, and many people and groups have sought to do something along these lines in the past – some of these are listed below. All the current schemes seem to be good and worthwhile, and it is not our intention to reinvent the wheel or duplicate any existing services in any location.

Every group is supposed to have a USP, a ‘unique selling point’ in marketing language; but we are not trying to be unique, only to do what people have done for thousands of years: support one another in community.

Helping People

The core ‘deliverable’ of the scheme is human contact. Activities may be undertaken, and may be useful in themselves, but the core benefit comes about through the human contact the activity requires or enables, not from the activity itself.

So, for example, an elderly person might need someone to help with shopping. Shopping for someone is a useful activity, but the important aspect is that it serves as a point of contact: the aim is to use shopping to provide appropriate contact (appropriate in both form and duration), rather than seeking to go shopping for as many people as possible in the time available. This is, of course, a counsel of perfection: in the real world, several people may be needing help with shopping, and contact may be rushed as a consequence; but the aim is use the shopping service to provide human contact. The inevitable compromises in the implementation must not be allowed to undermine the necessary clarity of purpose in this area.

The core skill required of the volunteers is the ability to listen. They may also be able to help in other ways, or find someone else who can, but listening is the starting point and the core part of the work.

The second core skill is the ability to encourage and empower: instead of looking for services we can provide to the client (which would help with the fundraising: look at us! See how much we are doing for these poor people!) the aim is to find what they would be able to do and enjoy doing for themselves. Where activities and services are appropriate, the aim is to say, not: “Why don’t you do that?” but rather, “Why don’t you come along with me and we can do it together?”

Feedback

The form and frequency of feedback provided to the GP needs to be agreed. It is assumed that this will happen in both active and passive ways: some form of summary ‘dashboard’ report will be provided on a monthly or quarterly basis; more urgent information will be communicated in the way which works best for the GP (at present, this appears to be a letter on headed notepaper), while other details will be made available on request.

The ‘dashboard’ report can be made public because it will not contain any personal

information; progress reports and other information about individuals will remain confidential, restricted to the people who need access to it: standard data protection rules will ensure that only people who have a valid need will be able to access personal data.

Training and Supervision

Training and supervision will need to be pitched at an appropriate level for the volunteers. Everyone will require to understand and sign up to some minimal guidelines, but beyond this the aim is to keep the mandatory training needs to a minimum, while making further training available for the volunteers who want to learn how to help in specific areas – such as coping with stress, bereavement, addiction and depression.

The purpose of the training is these areas is not to equip the volunteer to 'solve' the problems, but simply to enable them to spend time with people who have these problems while keeping themselves well and without making the problem worse. When someone is enjoying the rest of their life (and eating well, exercising, spending time with friends, and so on) then they will have greater capacity to cope with and address the major problem area(s) in their life.

Spirituality and Evangelism

The paper on proselytising contains the main thrust of the approach we will take in this area. The basic assumption is that spirituality is a natural part of ordinary life, and people are free to address and explore it in the ways they choose, if they choose; nobody should be pressurised to engage with any specific form of spirituality, but help with spiritual issues should be just as accessible to people as help with transport or finances.

Disengagement

When the client is referred to the scheme, contact and activities must be monitored to ensure that, as far as possible, they are being helped in the best possible way. Assuming that the scheme is successful, at some point it will be appropriate to remove them from the list of people who are engaging. This may be because they could not (or could no longer) be helped for some reason, or because they no longer feel in need of help from the scheme.

No longer being helped by the scheme does not mean that they are no longer in contact with the scheme volunteers: it is possible that the friendships which have been established have reached the point where they will be maintained without any formal monitoring. And it is possible that the client will want to offer some form of support to other people, so they remain involved with the scheme but switch from being a client to being a volunteer.

The aim, where possible, is to help people in such a way that they no longer require help. This will not be possible for everyone, but it may be possible to aim to reduce the amount of support people require. In any case, the aim is neither to get as many people as possible being helped by the scheme, nor to move them out of the

scheme as soon as possible, but to provide the most appropriate help and support for each individual, helping them become more integrated into the local community and able to access the help and support they need for themselves while contributing what they can to help others.

What Next?

Next Steps

We will establish a small multi-disciplinary team to act as a steering group: to consider the viability of this scheme; identify hurdles and ways to overcome them; flesh out the details sufficiently to enable it to progress to pilot; and identify one or two suitable sets of partners for the initial trials.

One or two 'proof of concept' schemes are then required to establish that the intended benefits can be achieved in practice.

If this scheme works and grows as we anticipate, the expertise and infrastructure which will be developed can be used as the basis for other work – either extensions of the initial scheme, or independent but related schemes.

At the present time, we are simply noting these suggestions for future reference, as it is important that we do not attempt too much before the scheme is firmly established.

The suggested extensions to the scheme include the following.

- Counselling and coaching. There is a shortage of trained counsellors, so there may be a 'gap in the market' – an opportunity to provide a service which is pitched somewhere in between the present services which require qualified counsellors and the conversations with a totally untrained and unsupervised neighbour or bloke in a pub (which is the only realistic option for most people at present).
- Training. The training element of the scheme could easily be extended to provide more specialised courses for unqualified volunteers. Areas such as emotional intelligence and conflict resolution would be natural extensions of the initial material.
- Partnership. The Pastoral Care Team could be supported by several churches working in partnership. This is likely to involve a slightly more complicated set of negotiations when establishing a local scheme, but is unlikely to make much difference once the scheme is under way; in any case, much pastoral care on the ground takes place through informal connections which are largely indifferent to the details of who attends which church.
- Other faith groups. Where an established faith group has a pastoral care system in place, there is no reason why they should not participate in this scheme on the same basis as any Christian church-based pastoral care group. We aim to start with Christian groups because that would seem to be the easiest pace to start, not out of any intention to be exclusive.
- Care leavers. When our children become adults, they generally leave home but we continue to love and care for them, to offer emotional support and advice. We tell them they may have left, but it is still their home, and they are always welcome. When children leave the care system, they are on their

own, and many fail to thrive. If children brought up in comparatively stable families continue to need adult support, how much more so those who have been in the care system, no matter how effective and supportive it may have been while they were still in it. Once we have a functioning and reliable pastoral care system, it should be relatively straightforward to extend the support to young adults who have recently left the care system.

- Unified contact point. As indicated above, it is possible – once sufficient schemes are operating – that a single unified contact point may be implemented, to provide a single reference point for referrals wherever the patient may live. This might also facilitate greater flexibility in the delivery of care, for example where the patient works outside the local community and would appreciate support being provided during their lunch break.Appendices

Common Issues

In the initial stages of the scheme, volunteers will not be expected to do very much beyond meeting and talking with the scheme participants: the core aim is to provide human contact, friendship and support. However, relationships often grow in the context of shared activity, so other points of contact may develop – from groups of friends meeting informally for a coffee, to participation in groups interested in music and art, bridge clubs, book clubs, gardening or model railway groups, five-a-side football, or raising money for the local PTA.

Our expectation is that the contact and possible subsequent participation in local activities will result in a number of benefits to the clients being referred. There is considerable evidence that social isolation tends to increase either the risk or the severity – or both – of many conditions, so the simple act of building local connections and friendships can pay a significant role in reducing a wide range of harm.

For example, dementia is one common condition in which social isolation is a risk factor. Social contact can play a role in reducing the severity and impact of dementia even when the people involved have no direct training in dealing with dementia. Similar considerations apply to other conditions such as bereavement, stress and depression. This does not mean, of course, that no specific training about these issues should be provided; only that significant help can be provided without extensive in-depth training.

Other Schemes and Groups

There are a number of other organisations and schemes which cover some of the same ground as LF. We are seeking to learn from their experience. Details of these organisations and schemes can be found in the ‘Resources and References’ document.