

AWOC Dorset

Local Social and Support Group
for people in Dorset who are Ageing without
Children (AWOC)

- Local group has been going for 2 years.
- Approximately 40 members so far.

AWOC IN DORSET

- The population of Dorset is nearly 800,000, with a higher proportion of older people and a lower proportion of young people than the national average.
- There are approximately 380,000 residents in the Dorset Council area (predominantly rural).
- 29% of these are aged 65 and older (compared to 19% in England and Wales).
- There are approximately 400,000 residents in the Bournemouth, Poole and Christchurch conurbation (BCP council area).
- Based on the UK statistics, this means that nearly 50,000 people over age 50 in Dorset County could be ageing without children.

CHALLENGES

- Dorset is a predominantly rural county.
- AWOC members are spread geographically over a large area.
- Lack of public transport.
- There are no AWOC local groups in adjacent counties.
- Barriers to seeking support.
- Impacts of growing older with no support.

OPPORTUNITIES

- Peer Support.
- Reducing Loneliness.
- Information Sharing and Signposting.
- Sharing Experiences.
- Influencing Policy.

SOLUTIONS

- A society where AWOC people are understood.
- AWOC issues are reflected in policy making.
- Localising Services.
- Working with partner organisations.



Local Area Coordination

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local area
coordination®
NETWORK

What is Local Area Coordination

- Local Area Coordination is a 'place' and 'strengths-based approach' that originated from Australia in the 1980s. It is currently being delivered by several local authorities and health partners across England and Wales. These Councils (and partners) make up the [Local Area Coordination Network](#).
- Local Area Coordination improves health and life outcomes, strengthens communities & helps to improve and transform systems. There have been 17 evaluations carried out in England and Wales to date (available [here](#)) that speak to its impact.
- It is based on vision, charter and underpinned by [10 core principles](#). It has several core features (see next slide) – short explainer video link [here](#)
- Central to it is the work of a Local Area Coordinator who we will recruit (with the input of local people) to be based in certain areas.

Core Features of Local Area Coordination



LAC's are rooted in **communities**, not office based. They are **accessible, approachable and flexible**.



The relationship with the LAC lasts for as long as necessary.



Introductions come from anyone or anywhere – **no referral, no eligibility criteria, just a conversation**.



There is **limited or no paperwork** directly with people.



LACs **take time to get to know people**, investing in **trusting relationships**.



LACs work by having **one foot in communities and one in the service system**.



LACs see **people as experts in their own life**. They won't try and prescribe solutions or "fix" people.



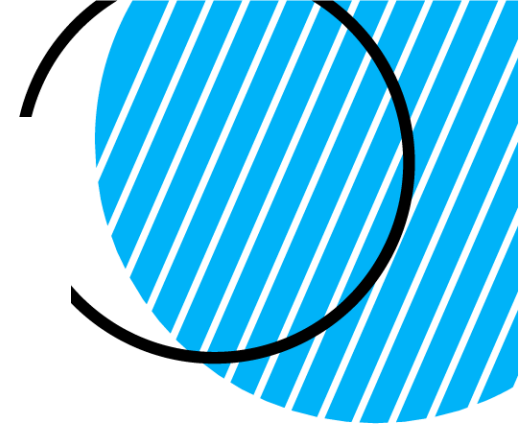
The work of LAC **reduces demand on statutory health and social care services**.



LACs look to **support people through natural community connections**.



LACs **help people avoid getting lost in the gaps between different services and help services work together better**.



The 'Network'

- 12 Local Authority areas – together they form the Local Area Coordination Network convened by Community Catalysts CIC
- 130 Local Area Coordinators
- Over a million people able to draw upon LAC (pop 1 LAC circa 10K) including people in rural communities.



What's Working Well?

Ivan Annibal

Characterising the Problem

- ***A bucolic image of rurality masks many harsh realities.***
- There are many places in rural England where ***access to services*** is very challenging.
- This makes a significant proportion of rural settings very difficult for people at both ends of the age spectrum (the ***young*** and the ***old***) to live in.
- The NHS is a huge system which is ***place blind*** and lacks an appreciation of the granularity needed to address the challenges facing rural places. Indeed it's ***big is beautiful*** mentality often unwittingly drives health inequalities. The ongoing split between health and social care exacerbates effective planning and delivery.
- There are many ***innovative solutions*** which we might apply and a huge amount of international good practice which can and should inform our thinking.
- ***Workforce issues*** are the biggest challenge, ***person centred planning and delivery*** is the antidote.
- Radical and disruptive approaches which put more emphasis ***on primary care, multi-agency working and community ownership, in an environment which accommodates at least some appetite for risk*** are important.

Key Considerations

- The Government Loneliness Strategy 2018 solidified the discussion but said very little of relevance
- Civil society has edged forward with some responses building on the informal and perennial notion of neighbourliness
- Befriending Schemes can be very powerful but are also potentially unreliable and led by volunteers with sometimes changing motives – our analysis demonstrates a social return of £3-£5 per £1 invested
- Warm Hubs in a whole range of guises now offer new connection spaces
- Some examples of individual projects – the Coffee Caravan, “Good Morning West Belfast”
- Care based micro-businesses have a key role to play in this agenda
- Person centred approaches such as Buurtzorg model show how things could operate for the better