HUMAN LEARNING SYSTEMS

Summary

- Reaching People draws on an HLS approach in its work around Social Prescribing with marginalised older people in Leicester
- Our experience suggests that HLS fits well with the principles of Social Prescribing. It enables relationship-building to be central by encouraging us to be more human. It introduces a learning focus which can benefit older people and runs counter to the predominant view that learning stops in older age. And it brings together key people involved in the lives of marginalised older people.

Reaching People: Social Prescribing and Marginalised Older People

Background and Context

I (Rob Hunter) am working with Bharti Mistry, a community connector, for a VCS partnership organisation in Leicester, *Reaching People*, on a project focusing on social prescribing with underserved people aged 65+ in two contrasting areas of Leicester. The New Parks neighbourhood (population approximately 8,000) is in the top 5% in the country on the Index of Multiple Deprivation. Neither Bharti nor I have worked in this area before. Belgrave is in the Index of Multiple Deprivation top 10% and has a strong Gujarati Hindu population. Bharti has worked very successfully in this area over the past six years. Our project is funded by Independent Age. Their particular motivation is to address financial hardship, energy poverty and digital exclusion. As with all projects, we're reporting on numbers but as a campaigning organisation Independent Age, along with project administrators at the National Academy for Social Prescribing, are developmentally interested in what we can learn about how social prescribing can work effectively with the most challenged older people.

The project has a small budget. The initial grant was £25k before VAT, enough to pay Bharti for 3 days per week as a community connector for 6 months. A further grant of £30k has extended that contract for 10 months. I am a volunteer.

Reaching People has no other ongoing work with older people.

|HLS Approach

|Human

Why is this relevant with regards to social prescribing?

'Human' is the essence of social prescribing which in its statutory incarnation attempts to work with the 20+% of patients attending GP surgeries for a non-medical reason. They are expressing dis-ease triggered sometimes by poor housing, financial hardship, social isolation and loneliness, a distressed inner world. Our key approach (after locating them and engaging with them on the doorstep – no easy matter) is to attempt to build a relationship with them, to demonstrate that they count for something – as a human being, not a health or poverty statistic, but as someone with a past, a present and a future.

Relationship-building is central to this task. Many older people have withdrawn from the world and live in narrative foreclosure – self-isolating in their home, their happy place – through lack of self-confidence, fear, internalised ageism, feeling they don't deserve attention.

We have adopted this stance not only because of its congruence with our personal and professional values but because of its longer term efficacy. Our formal task is to 'help people connect to activities, groups and support that improve health and wellbeing' (NASP 2024). While some older people may only need to be given information or signposting, those more marginalised, we find, need 'connecting to themselves' if they are to sustain any connection to external activity. The Human in HLS does not only mean the worker engaging with them as whole human beings – not simply as someone in poverty, as a defaulter, as someone with a housing problem – but, and of course only with their consent, as someone with an inner life whose, for example, hindering thought patterns and low self-regard may sabotage any connections – and also as a person who has many strengths which might be reclaimed and built on in the pursuit of a 'bigger' life. Not what's the matter with them but what matters to them, not what's wrong with them but what's happened to them. What is their unique story? To this end Bharti and I have been working with a Positive Psychology Coach as a clinical supervisor.

What have we done as a project to be more human?

Our attempts to 'be more human' and to acknowledge the full humanity of those older people we work with have taken a number of forms, small and large, tested out in our previous work with Leicester Ageing Together as well as tentative plans for the way forward in our current project:

- Remembering names and what people have told us about themselves. This seems slight but can have a disproportionate impact on those whose self-image is one of not deserving of attention.

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- Run several training courses in community groups and with part-time staff and volunteers on Active Listening. Our stance is that few people in their daily lives get sufficient and regular undivided attention. Giving this to someone frees up their own intelligence to focus on their own material, enabling them to find ways forward when they feel stuck.

- Bharti has built a community on Zoom, continuing as people emerged after lockdown. The focus of the groups varies considerably, from armchair exercise, dancersize, knit and natter, to health information, and sessions on dementia awareness, domestic abuse and the climate emergency. One aspect of humanness in addition to the content is how someone recently who is bedbound had started by logging on with their camera and microphone off, but gradually progressed to saying hello and goodbye, and now takes a leading part in the sessions and feels fully accepted not just by Bharti but seemingly by the whole group in a culture where people with disabilities are sometimes marginalised.

- Your story counts. We have worked with a variety of people on reviewing their lives. Often they have started by being dismissive: my life's just ordinary, not interesting. Our stance, though, is that 'There is no such thing as an ordinary life'. With gentle encouragement, often from their peers, they put their toe in the water, sometimes holding boundaries – 'I'm happy to explore anything but not my relationship with my son'- and often become excited by their reflections and the sharing/contrasting with those of others. We have used two main models. The first is 1:1 mostly in the person's home. The Reviewer talks while the Biographer records, often on a laptop, giving the Reviewer a near-transcript after each session for them to check. Over 6-8 themed sessions the manuscript builds up and the reflective process is often significant: 'I realised my life was not so shitty after all: I've done a lot, haven't I?'. Another model is group-based where, in between sessions, participants undertake to write/represent 700 words on the agreed theme, e.g. my family of origin, the family I co-created, work, interests, health,money, values. In the following session, half is taken up with sharing their '700 words' in a small group, with the other half preparing for the next theme. We are exploring how these individual life reviews might complement community stories and contribute to the development of a sense of community.

- With the help of our clinical supervisor, we are exploring Positive Psychology Coaching. We aren't Psychology qualified but we have formal and informal coaching experience. We think our approach needs a firmer theoretical grounding but are concerned to develop it as rigorous but not exclusive as we see it has substantial relevance to non-Psychology-qualified staff in wider work with people.

- We have taken the first tentative steps in developing a 3Ls programme of educational group work: Live, Laugh and Learn. Live because it's about living fuller lives. Laugh because a key aspiration for many older people is simply 'to have a laugh'. Learn, because Keep Learning is one of the NHS 5 Steps to Wellbeing, and we see learning as key to both handling change in later life – of which there is a great deal, especially around coping with loss: of friends, of status, of faculties – as well as 'reclaiming curiosity'. The class background/life experience and age of those we work with means that few have experience of being in adult learning groups, so there are pros and cons of calling it Learning. We call it 3Ls to provide a badge for a disparate array of activities and structures: one-off sessions; short courses; one-off sessions in existing groups. In our first venture under this badge on a 4-session course on 'digital inclusion' we are testing as a USP, topping and tailing the 2-hour session: 15 mins at the beginning to emphasise the warm welcome, build the group and focus; 90 mins with an external technical tutor; 15 mins at the end to reflect on the cognitive and affective aspects of the teaching, give and receive support to embed the learning, and a short mindfulness exercise before departing.

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> *Our key approach is to attempt to build a relationship with older people, to demonstrate that they count for something – as a human being, not a health or poverty statistic, but as someone with a past, a present and a future.*

What's been challenging in realising this aspiration?

- Locating older people. We assume that focussing on the human implies inclusivity but health and social services focus on acute physical and mental wellbeing – under pressure of austerity and 'using our professional skills'. We contact some people through referrals – but that assumes that (a) other agencies are in contact with them and (b) that their staff see the whole human being and recognise that working collaboratively with others and making such a referral is in the best interests of their client. There are 1,000 over 65s in the New Parks neighbourhood, but informal networks suggest only about 60 are involved with existing social and community groupings. Data protection restrictions or a lack of motivation mean that we encounter difficulties in tapping into local authority and NHS information.

- Societal attitudes to older people: 'authorisation'. Is longevity a blessing or a curse? For those with health, money and a history of some self-actualisation it is probably a blessing. For a great many more, it may well be a curse and retirement a desert. The cynics suggest that those older people who have left the labour market and who do not have acute health or financial problems do not have any need, apart from an adequate state pension, of much attention. Older people come way down the priority list in terms of project funding and so of continuity of provision. There is some self-help but older volunteers are exhausted and not being replaced. Older people tell us frequently they feel forgotten by the rest of society and marginalised, their voice unheard. The rush to 'everything being online' is a manifestation of this. While some effort is being made to support people through digital inclusion courses, these are often crude and focused on instruction rather than learning and taking the whole human being into account. In addition, many older people regret the passing of the Neighbourhood Customer Service drop-in or the staffed supermarket check-out where they can have human contact.

- Feeling safe is an issue for many older people: on the streets and when beset by scams. Such fear can diminish one's agency, which is such an important part one one's humanity.

- Those most marginalised have often settled for a more limited life. Internalised ageism and classism have shrunk their horizons. As a psychiatrist told us: 'their home is their happy place, where they do not have to face threats. Even coming to the front door can be threatening.'

- In older age the dominant societal theme is 'care' and not 'development'. Can we chip away at this: humans develop until the day we die.

Further challenges to the quality of the encounter between the fully human staff member and their organisation and the fully human older person include:

- The service targets that funders and managers require often need people to fit categories: age, geography, disability, degree of hardship. These should be flexibly managed and allow frontline workers areas of discretion.

- Time allocated to each encounter and the overall length allocated to the relationship. We have been surprised and impressed by social prescribing link workers' ability to give quite a bit to both dimensions but understand that many social prescribing schemes are more restrictive. Culture change to a more human-centred way of working takes more time than organisations and politicians often want to give it, switching resources for one area to another in pursuit of 'fair' and even-handed solutions which disintegrate because of shallow roots.

- Older people say they get low at the weekends, at a time when few community organisations ask their staff to work. How can custom and practice change involving community resources?

- The language that professionals use with older people can put up barriers. This is most obvious when interacting with older people whose first language isn't English. And there is research that suggests that many second-language users in retirement lose confidence in the English they spoke adequately in the workplace, as they replace it with the mother tongue they use in family and social situations. The use of jargon by professionals can also get in the way of human connection.

- The limitations in our own attitudes and skills for what is sophisticated work. We have benefited from the clinical supervision of a Positive Psychology Coach and, coincidentally, one of the most effective people that we have connected with in the statutory social prescribing team is a health and wellbeing coach with a Masters in Applied Positive Psychology Coaching. Her work focus is on domestic violence more generally and not on the situation of the 65+. Addressing the inner world of more marginalised older people is a hidden need.

- Many older people, the longer they live, internalise much of society's attitudes to them around age, class, race and gender in particular, acting it out as if it were true. This again can undermine human potential and needs to be countered persistently.

- Developmental engagement. We continue to grapple with finding the right vehicles to engage those considering engaging with activity outside their home. Factors include:

    - Understanding their motivation. What topics might attract them? Are there already opportunities locally or can they be developed? Are they accessible in terms of dates/times/venue?

    - Might the less confident find it easier to access an event/fair/exhibition – something where they may not even need to interact with others – rather than engage directly with a group.

    - How do we ensure any groups are truly welcoming and include 'people like me' as well as those more confident, who might be needed to help the group function more effectively.

- Retirement is a significant phase of the life course. For a short period of time in the late 20th Century, employer-run courses helping people to prepare for this phase were relatively common, even if they were often superficial and dealt solely with finance in older age and volunteering opportunities, avoiding much of the desirable social and emotional content that might have been valuable. Such courses hardly exist nowadays, and the opportunity to support people to stand back, take stock and gear themselves up for a retirement which supports their continuing human development is lost.

| Learning

Why is learning relevant with regards to social prescribing with older people?

There is much for the social prescriber to learn in areas, the marginality of which in mainstream discourse, betray the lack of status of this work: learning about

- older age, its challenges but also its opportunities and possibilities
- individual older people, their associative groupings, and how they see their world
- the community of place they live, its dynamics, resources and relevant history
- the knowledge, skills and attitudes involved in social prescribing as a new and poorly understood discipline and how to work more effectively with older people
- ourselves as emotionally literate workers in training

What have we done as a project to centre our work around learning (e.g. using learning cycles, bringing together different stakeholders to learn together)?

- Bharti and Rob's practice, brought across from Leicester Ageing Together, has had Keep Learning as a core mantra with older people, staff and organisations, matching one of the NHS's 5 Ways to Wellbeing and LAT's own Mental Wellbeing Curriculum.
- Social prescribing with older people in communities as seen above is highly complex and with few guidelines, thus needing constant reflection-in-action and reflection-on-action, learning from experience and 'building our own theory' to guide future action. As such our approach has been strongly influenced by Freire, Kolb, Schön and the 4Fs.
- Rob has had the space and inclination to prioritise individual reflexive practice. Bharti's approach is more intuitive. She is essentially a reflexive practitioner but finding the time and headspace to address this systematically in an all-action, responsive job on 3 days a week is challenging.
- Rob and Bharti have met in person or on Zoom every 3-4 weeks over the last 4 years on a reflexive practice agenda and Reaching People employed a Positive Psychology Coach to offer clinical supervision to Bharti in the Phase 1 of the project and to both Rob and Bharti in Phase 2.
- The project used a 4Fs framework to record its project meetings in 2023, and we are using an evolving Reflexive Session Record in Phase 2. This is focusing on our educational groupwork and is designed to

involve participating older people, volunteers and paid staff in reflecting on the thoughts and feelings emerging from the particular session and support the building of individual and collective theory about taking forward the learning.

- We suggest that a longterm squaring of the circle will be to develop the habit and skills of reflexive practice with the older people we are working with and with part-time staff and volunteers. We are dipping our toe only gradually into the water here.

What's been challenging in realising this aspiration?

- Making time for individual reflexive practice.
- Managing time boundaries in working to the 4F Framework when working collectively. We like the thought of 'building our own theory' about this work but realise that by definition it is messy and incomplete and could do with an outside learning consultant (which is a possibility) to help us make sense of it.
- It is easy for all concerned to get sucked into the action trap, particularly when under pressure to meet numerical targets.
- Our current groupwork is exclusively with Asian elders, mostly women. Supporting them to develop critical thinking and reflexivity when many have learned simply to accept and tolerate will, we think, be an ongoing challenge.
- Many older people have lost sight of themselves as learners. 'I'm too old to learn' and 'we don't do that (learning) around here' are common initial barriers.
- We are only in the foothills of addressing 'collaborative learning' in wider systems e.g. with local paid staff and volunteers.
- The predominant norm in the work with older adults sector, where such work exists, is one of 'care' and 'service'. Learning is not a common part of the agenda. Oh for Social Pedagogy! We continue to work with adult learning partners to see learning as 'beyond the classroom', but financial models are restrictive.
- We are instrumental in a broader Reaching People strategy of supporting community anchor organisations in MOT-ing their relationships with their community as a basis to enhance their authority to collaborate with statutory services in co-decision-making and co-delivery of services. But initiatives such as this, managing upwards and supporting Reaching People in developing as a learning organisation are hard work when current circumstances require people to do more with less.

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|Systems

Why is this relevant with regards to social prescribing?

Social prescribing with the most marginalised older people involves many systems, but it's the current dysfunction of some of those systems which adds to the complexity. Central systems include:

- The system around the older person. Hilary Cottam in Radical Help highlights the importance of the quality of the individual's networks both within communities and through bridging to external networks. As the individual grows older, their personal system is often weakened – through the death of relatives and friends, through physical impairments – making it more difficult to maintain the systems that exist.

- The system that links the older person to appropriate 'activities, groups and support'. In an ideal world there might be an abundance of the latter and many fellow community members who might act as 'connecting systems'. In many communities, these are both often in short supply.

- A system involving local older people with community groups and organisations, local authority and NHS services and private sector agencies in order to develop an 'ageing better' community.

What have we done as a project to create systems that enable better outcomes:

- **Better understanding the local system around each person**

In both New Parks and Belgrave we have spent considerable time both with individual older people and with those in local community groups and organisations and also voluntary organisations whose services are relevant to those older people.

- **Bringing different actors together**

This 'human mapping' and relationship-building activity has often resulted not only in the older people being introduced to 'activities, groups and support' initiated by ourselves or other community organisations but also

made actors in the latter more aware of each other. As mentioned above, in part because of our more developmental and less boundaried work, we have been able to act as a connecting system.

- **Drawing on capabilities within the local community etc.**

In late March we called a meeting to discuss Ageing Better in New Parks and invited: locally active older people; staff co-ordinating in a paid or unpaid capacity local community groups; staff in city council departments and the NHS; staff in the private sector e.g. local domiciliary care agencies, care home managers, the manager of the local supermarket, housing associates. The agenda centred around: sharing what we know of the lifestyles, aspirations and challenges of older people on the estate; what each agency present is contributing, what's going well, what less well and where they could do with support; and what might we do collaboratively to help older people flourish.

Surprisingly, 18 people attended of the 30 invited. A seasoned community activist had predicted 5 or 6. It was a positive meeting, but we had built in insufficient time for thinking about possible next steps and the desirability/possibility of an ongoing Whats App group to promote communication between the different players.

What's been challenging in realising this aspiration?

- In searching for referrals of older people in financial hardship from any sources at the beginning of our project in summer 2023, after initial meetings with managers we got very little response. This may have been because of our perceived lack of authority, of our focus on the benefits to older people rather than to the organisation/service we were meeting with.

- We noted that, since 2015, Leicester City Council grant-funding for the VCSE diminished, neighbourhood offices were closed, services such as Adult Social Care and Public Health were organised on a cross-city basis rather than 'community of place' contributing to weakening partnerships and links between staff and such communities. These changes were in large part because of the council's financial challenges under austerity, and potentially a lack of appreciation of the benefits of forming stronger community links.

- The local management of Social Prescribing, which should have been the ideal partner for our project. Social Prescribing depends on collaboration within and between a number of systems. In some parts of the country, it seems to be working very effectively. In Leicester its management is devolved to Primary Care Networks whose staff often seem not to fully appreciate its potential. From our conversations, it would appear that fellow staff in local authority departments, other NHS services, and local community organisations have limited knowledge or understanding of the NHS social prescribing scheme's practice. There is a monthly information-sharing meeting of the 120+ NHS SPLWs. However central coordination and leadership seems to be needed within the structure.

- The introduction of Integrated Care Boards/Services is relatively recent. In Leicester we have been beset both by silo working and a lack of appreciation of the power of community (as opposed to voluntary organisation) collaboration. However, recently attempts are being made by the ICB, Public Health and other statutory services to prioritise and work together including collaboration with the VCSE sector.

- Local politics. We have not yet come across much conflict but are both very aware of the relatively short-term nature of our involvement and hence being sure to work with and through key local agencies and individuals.

- In New Parks, we expect there will, in the short term, be little new educational groupwork with older people, as the common issue for all agencies on the estate is locating people who might be interested, building relationships, co-producing activity, and retaining interest and commitment. In calling the Ageing Better in New Parks initiative, we are building on a positive collaborative culture in the monthly New Parks Panel meetings and expect greater traction with community groups and older people than with statutory services. We have a 3Ls offer for autumn 2024 but expect very limited take up at this stage.

- In Belgrave, the group work is already well established and will be built on. The local ecosystem is less well-established, and we will need to assess whether to keep ourselves at the centre of the spider's web of bilateral relationships or whether seeing if they are up for working more collectively and strategically.

> *Human, Learning and Systems are clearly as important to understanding and working with the lives of local residents as they are to the work of professionals, organisations and wider systems.*

What have you achieved?

What has adopting an HLS approach enabled you to do?

HLS provides a framework, a validation and a development path for our work of helping individuals connect both to themselves and to local activities, groups and support. Its three core concepts are clearly as important to understanding and working with the lives of local residents as they are to the work of professionals, organisations and wider systems. By its focus in such work both on understanding the systems affecting those lives and stewarding those systems, it strengthens community connection. Community connection sometimes downplays the importance of addressing local authority and health service systems.

At the moment HLS illuminates our work and helps our own theory-building. We have yet to make much progress in finding the forums – and the courage? – more consciously to share this thinking more widely with professionals and other organisations.

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What next?

What is the next challenge for this work?
There are challenges at at least 4 levels:

1. With individuals living in communities:
   The challenge surrounds location, engagement, trust-building and finding the right language that speaks to their lives. The HLS concepts are as relevant to their lives in community as they are to professionals working in organisations.

2. Working with local organisations:
   Staff in community organisations are essentially activists. They can be mistrustful of intellectualising takes on local situations, even of 'building your own theory'. They are often not attracted to off-the-job training into which HLS thinking might be gently injected. Locating curiosity and energy in the local ecosystem is challenging and important.

3. Working with professionals in local authority departments and the NHS:
   The continuing effects of austerity on local authority departments and unclear structures and support in the NHS's social prescribing provision in Leicester, when allied to limited commitment to community development, form the current context of our work. Few professionals have the headspace or confidence to consider alternative approaches unless receiving strong encouragement from their strategic leaders. This makes it ever more necessary, but simultaneously ever more challenging, to find ways of supporting the development of HLS thinking among professionals in related statutory organisations.

4. Contributing to a citywide strategy based on HLS principles:
   This is slightly different from 3 above. A consciously strategic approach may be further down the line but needs consideration from the outset.

There are also two related challenges:

a. We are considering bidding for funds for a strategy involving

   - 12 community anchor organisations in Leicester, many of which are Reaching People members working both together and individually to build their community connectedness based on work already piloted by Reaching People
   - Certain local authority departments more open to HLS principles
   - Social prescribing in related Primary Care Networks

   If successful this could form a foundation for 4 above.

b. Exploring how best to capture and demonstrate impact. New Public Management's 3Ms is so embedded in the organisational culture of statutory services and the public sector generally that we anticipate resistance and reluctance to collaborate. We need to research and persistently make the case – with CPI support – for developing alternative and HLS-informed ways of measuring impact.

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