

Appendix 3: Enabling Health and Wellbeing in Later Life

Wednesday 2nd March 2011

EVENT REPORT

The event was attended by 70 participants from around Scotland. Participants included researchers (15), policy and National programme leads (6), clinicians and support workers working directly with older people (13), local programme managers (26), third sector workers (5), a lay representative (1) and representative from independent companies (2). Information was provided for 43 National and local programmes of work which have been set up to tackle health and wellbeing in later (See List of Participants' Projects below)

Reshaping Care for Older People

The morning sessions included a presentation by Margaret Whoriskey (Joint Improvement Team) who described the key drivers for change and current development of older people's services. She discussed the National programme of work "Reshaping Care for Older People" which has recently announced a Change Fund to provide time limited support to Community Health Partnerships and NHS boards to support the development of services including community based programmes of work (www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/) .

The research base: what do we know?

Helen Frost (Research Fellow Scottish Collaboration for Public Health Research and Policy) presented the evidence base for intervention that might prevent or delay disablement or enhance the wellbeing of older people. This highlighted the relatively strong evidence base for balance and strengthening exercises to prevent falls; for the use of comprehensive geriatric assessment with older people in general but not frail older people and for advice about and provision of assistive devices and environmental modification in the home. The areas where there is evidence against practice or no evidence base were also discussed, for example the evidence against home visits delivered in isolation and the current lack of evidence for telecare. More detail of this work is available from the Scottish Collaboration for Public Health Research and Policy website (www.scphrp.ac.uk).

The presentation was followed by round table discussion about the current use of the evidence base, current evaluation of practice and about how these areas could be improved. The following discussion points were raised:

Perceptions of the current evidence base and its influence on practice

- The evidence base is currently focussed on acute care and upstream interventions.
- Practice often runs ahead of the evidence base (this was particularly apparent with telecare).

- There are good examples of the use of the evidence base, for example the falls prevention work.
- Translation of research is difficult and often things are cherry picked which might mean that the original effect of an intervention is weakened.
- Practice is currently driven by Government targets and measures of activity rather than the evidence base.
- There is not always development (funding) in areas where there is a good evidence base e.g. Exercise.
- The risk culture often gets in the way of putting the evidence base into practice e.g. peers can not deliver exercise programmes which could be effective because of lack of insurance.

Perceptions of the current evaluation of practice

- There is a current lack of a systematic evaluation of changes in practice.
- Audits are carried out and data collected but this is often not used for quality improvement or service development.
- Evaluation is carried out as an afterthought and is not integral to service development.
- There is some innovative work around the use of Talking Points as an evaluation framework but there is a need for more development of this as a service evaluation tool.

What can be done to improve the use of evidence in practice?

- Practitioners need help to translate the research into practice to help ensure that the evidence base does not get watered down.
- There is a need for better links between what works and the funding of new initiatives (e.g. Change fund).
- There is need for a better evidence base for upstream interventions.
- Practice for where evidence shows that the intervention is ineffective should be withdrawn.

What can be done to improve evaluation?

- There is a need for some central support to develop standardised outcomes including developing tools to measure outcomes most important to older people.
- There is a need for minimum datasets collected over time and used for quality improvement.
- Focus on outcomes that are important to older people.
- Build on Self Directed Support work as this is seen as a potential way of focussing on outcomes which are important to older people.
- There is a need for high quality independent evaluations of the community based interventions.
- Funding guidelines for practice development should advocate clear plans for evaluation as a key requirement and funding should be allocated to this evaluation.
- Practitioners need help to access sources of funding for evaluation work.

What things need to be taken into consideration?

- Measureable change takes time and Government funding needs to be sufficient to allow changes to occur.
- We should not discount interventions just because there is not an evidence base but they should be used with caution until an evidence base is available.
- Prevention interventions are often complex but they can still be evaluated.
- Evaluation has to take into account issues of dropout because of deteriorating health and loss of sample due to death.

What can we do now?

In the afternoon presentations were given by six programmes at round table discussions (See Table 1). More details of these can be found in List of Participants' Projects below. These were a variety of programmes aimed at tackling social isolation, exercise and activity levels, falls prevention and the outdoor environment. Most of them used a community based approach including the use of older people as volunteers. There was tangible energy both by speakers and people attending these sessions about the value of these type of initiatives in generally improving wellbeing, keeping older people active and engaged with their communities so less socially isolated and in providing opportunities for development through volunteering opportunities. Some of the common issue raised by discussions of these programmes included:

- Problems with overcoming the risk culture when using volunteers.
- The need for more effective ways of evaluating these type of initiatives particularly whether there are sustained benefits, but balancing this with the risk of overburdening volunteers and older participants.
- Issue with embedding community approaches into NHS practice including issues of engaging GPs and issues with sharing of personal information.
- The importance of a good infrastructure for transport to get people to activities in their communities.
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- Providing proper training and support for volunteers and ensuring sufficient funding is in place for this.
- The need to share local experiences across areas but a recognition that not everything will work in every area i.e. differences between rural and urban, the need to keep initiatives local to ensure that the personal elements that a local service can provide are not lost.

Table 1 Round table discussion of new and developing programmes

A	Jackie Doe/Carolyn Wilson – Perth & Kinross Healthy Communities Collaborative (1.1)
B	Maire Cox - Inclusive Design for Getting Outdoors (I'DGO) (2.1)
C	Margo Sinclair – Angus Gold 50+ (3.2)
D	Bob Laventure – Someone Like Me (3.7)
E	Nicky Thomson – Good Morning Glasgow(4.3)
F	Kate Stephen – 040 (4.4)

So what's next?

The final session was a round table discussion looking at "What next" for Research, National and local policy and programmes:

The suggestions made included;

Research

- Make research/evidence base more accessible to practitioners to facilitate getting research into practice.
- Ensure that both the development of interventions and evaluation considers the personalised goals/outcomes that are important to older people.
- Ensure that research considers all of the desirable outcomes
 - personalised outcomes,
 - health outcomes
 - cost benefits
 - targets
- Focus research on upstream community based physical activity and social support programmes.

National Policy and Programmes

- Reduce and simplify National policy
- Move health and social care budgets from Government control.
- Start a policy debate about moving society away from being so risk averse.

- Provide long-term investment in National and local programmes to give them enough time to work.
- Shift focus and resources to preventative strategies current focus still seen to be too far down stream in acute care, intermediate care and re-ablement
- Shift the focus away from the rigid measurement of targets.
- Engage with GPs particularly around advocating physical activity for older people.
- Ensure a joined up approach to the development of services

- Provide more opportunities to share good practice, particularly work resulting from the Change fund.
- Share good examples of the Integrated Resource Framework analysis

Local

- Channel funds from local service closure into local community based initiatives.
- Ensure that services are relevant to the local context

Each person attending the event also made two pledges a personal pledge and a pledge that they would take back to their place of work.

Summary

This was a well attended event which was seen as an excellent and much needed opportunity to share good practice in the area of enabling health and wellbeing in later life and to discuss the use of that evidence base. The idea of using of the evidence base to develop practice in this area was welcomed as were more comprehensive approaches to evaluation of new services and programmes of work. There was a feeling that current practice is not always evidence based and that practice development can often be driven by policy and the need to meet government targets. There was, however, agreement at all levels that new developments through Reshaping Care for older Peopleshould take on board and use the best available evidence. There was, however recognition that the evidence in this area was still developing and that in some areas practice would need to be developed based on a weaker evidence base. In this case monitoring and on-going evaluation of their impact and outcomes for older people are essential.

Practitioners and practice developers would benefit from assistance in interpreting and applying the evidence base and in developing integrated evaluations of new and existing services.

Enabling Health and Wellbeing in Later Life
“Sharing knowledge and experience to
make a difference”

Wednesday 2nd March 2011

University of Stirling
Event Programme and
List of Participants’ Projects



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Programme

09.30	Registration, coffee and time to read materials	
10.00	Welcome.	Sally Wyke
10.05	Reshaping Care for Older People	Margaret Whoriskey
10.15	Creating an Older and Better future	Mike Stevenson
11.00	COFFEE	
11.15	The research base: what do we know Introduction: Findings of a scan of the evidence base Work at tables: Are we doing some of the things that work? Any surprises? What outcomes matter? What are the gaps in the research? What changes practice and influences programmes?	Helen Frost
12.15	LUNCH	
13.00	What can we do now?	
13.35	Learn more about programmes and evidence base – choose your topic from 7 presentations and 1Q+A session that will take place at tables	
13.35	Break	
13.45	What can we do now?	
14.20	Learn more about programmes and evidence base – choose your topic from 7 presentations that will take place at tables	
14.20	COFFEE	
14.30	So what's next? Individual writing and table discussion of what's next for: Research National policy and programmes Local policy and programmes Each person attending	

Who needs to do what?

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- 1.4 **Eastwood Community Older People's Service – East Renfrewshire**
- 1.5 **Friday Social Group - Stirling**
- 1.6 **Ageing Well Project - Edinburgh**
- 1.7 **Mearns and Coastal Healthy Living Network - Aberdeenshire**
- 1.8 **Peer Health Mentoring – Greater Glasgow and Clyde**
- 1.9 **Perth and Kinross Care Home Meaningful Activity (CHAN)**
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Section 3 Physical Activity, General Rehabilitation and Self Management

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- 3.4 **Self Management of COPD – Greater Glasgow and Clyde**
- 3.5 **The BALL Project – Be Active Life Long - Moray**
- 3.6 **New Model of Care for Older People (specifically within orthopaedic and stroke rehabilitation pathways) - Edinburgh**
- 3.7 **Someone like Me**
- 3.8 **COPD: Home Pulmonary Rehabilitation Service – Glasgow City**
- 3.9 **Health Improvement Services – Glasgow**
- 3.10 **North Glasgow Homecare and Reablement Project (HARP) - Glasgow**

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- 7.1 Reshaping Care for Older People
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Section 1 – General and Participatory Health Promotion

Title	Perth and Kinross Healthy Communities Collaborative (1.1)
Aim	The programme aims to give local people skills and confidence to work in co-production with professionals from a range of agencies and organisations and use these partnerships to effect changes in communities, which would result in improvements in health care and social well being.
Who it helps	Primarily people from specific communities who are over 50 but we are gradually growing to include those from communities who are marginalised in communities including those with learning differences and those with severe and enduring mental health issues.
Components	Using “Plan, do, Study, Act” (PDSA) methodology and the findings of the “Mental Health and Wellbeing in Later life” Report, teams are empowered to identify issues and come up with and test ideas to impact on the mental health and wellbeing of themselves and their peers in their communities
Why it is good?	This “bottom up” approach has empowered local older people to make a real difference in their communities.
What would you do differently?	Nothing
Contact	Jackie Doe – Project Manager - email jackie.doe@nhs.net tel: 01738 473718

Title	Social Experimentation for Active Ageing - European Areas Regeneration Network – Quartiers en Crise (1.2)
Aim	The overall aim is to address “the social needs of older people by seeking to improve social policy in relation to the social and economic activation of older people who are not being reached by current policy measures”.
Who it helps	To help older people’s social and economic activation, especially labour market activation. In Edinburgh there is an additional aim: to extend and promote good practice in age management within Edinburgh businesses. Helping employers to extend good practice in age management will deal with some of the barriers older people face when trying to enter or sustain paid employment, consequently helping older people’s labour market activation.
Components	<p>Four locations are taking part in this project (Prague, Czech Republic, Edinburgh, UK; Maribor Slovenia and Herefordshire, UK), with each location carrying out a baseline study; a small scale experimentation pilot; and a local evaluation. A transnational evaluation will also be performed. In each partner location, a Local Action Research Group (LARG) has been established in order to share information, discuss implementation, and review progress. The LARG is multi-sectoral and multi-disciplinary in make up.</p> <p>The pilot social experimentation study in Edinburgh will focus on older people and later-life labour market participation, looking at age management issues in, and into, the workplace. A focus group for unemployed older workers looking at barriers to employment will also be held.</p>
Why it is good?	Research has shown that although legislation on age discrimination has been in place for a number of years (Employment Equality (Age) Regulations, 2006) and has informed policies within businesses, practices and attitudes within some businesses are still age discriminatory. The research will measure the impact of an intervention to extend good practice within a small number of businesses in Edinburgh. It will shed light on employer’s policies, practices and attitudes towards older people and barriers they faced when trying to implement good practice in age management.
What would you do differently?	Study is still being conducted
Contact	Dr Valerie Egdell – Research Assistant – email v.egdell@napier.ac.uk Tel: 0131 455 4714

Title	Living Longer Living Better (1.3)
Aim	By adopting a partnership approach that promotes quality of life of older people we will further shift the balance of care from acute to community based care; ensuring that services in the community are responsive to the needs of older people by the provision of high quality services and support which will enable older people to live as independently as possible in a suitable and safe environment with choice and control over their future needs
Who it helps?	Over 65's
Components	<ul style="list-style-type: none"> • The promotion of active ageing by ensuring that older people have access to recreational activity and healthy living advice and can participate in the life of their local community. • Management of long term conditions to ensure optimum independence and promotion of Self Care • Expanded Preventative and Anticipatory Care services enabling more older people to remain independent for longer in their own home • Improved 24 hour responsive services for older people reducing unnecessary admissions to hospital, residential and nursing care • The development of Intermediate Care Services within the home and close to home preventing unnecessary admissions to hospital, facilitating early hospital discharge and preventing premature admission to residential and nursing care. • Improved support to carers who provide support to older people allowing them to feel valued, supported and key partners in care • Improved integrated health and social care services in the community to ensure high quality, efficient and cost effective services which enable more older people to remain independent and living at home • Develop a workforce where there is no ageism and the staff have the skills that meet older people needs, understand needs of older people and foster an enabling and rehabilitative approach • Ensure a seamless pathway through hospitals in Moray which meet standards of care for older people and ensure the value of each move is beneficial to enabling them to return to maximum independence as close to home as possible • An expanded range of housing and care options for older people to have real choice and control about how and where they live • Improved information and advice about services and facilities for both staff and User/Carers • Cross cutting themes of user/carer involvement, Telehealthcare and communication • Were identified as integral to all work streams
Why it is good?	Involved older people from the start. Strategy reflects their needs and their solutions to problems including the brand name. Now have an older peoples reference group which are evaluating the implementation of the strategy
What would you do differently?	Keeping up the momentum in the implementation phase can be frustrating as other priorities come on board
Contact	Sandra Gracie -Strategy development officer – email - sandra.gracie@nhs.net tel: 01343 567184

Eastwood Community Older People's Service (1.4)	
Title	Eastwood Community Older People's Service (1.4)
Aim	To promote independence and quality of life for people over 65yrs.
Who it helps	<ul style="list-style-type: none"> • Over 65s • Fallers • Frail, chronic/acute illness, complex needs • Disabled with potential to improve. • Those at risk of hospital admission • Those at risk of admission to long term care
Components	<p>Multidisciplinary health and social work professionals who work with the individuals and other service providers including voluntary sector, to enable older people and their carers to return to previous activities where possible or to adjust /adapt to improve their quality of life, through the provision of information and by learning alternative skills.</p> <p>MDT members: District Nurse Physiotherapist Social Worker Occupational Therapist Dietician Rehabilitation Assistants. Administrator Service Manager</p>
Why it is good?	This service provides the local area with a resource which offers the opportunity to address older people's complex needs in a holistic and personalised assessment and planning framework, which seeks to avoid unnecessary admission to hospital and care, work with day hospital and other specialist services in the acute setting and also reduce the numbers of referrals and providers coming into older people's lives which can lead to anxiety and reduced outcomes.
What would you do differently?	I would seek more financial resources to enable less dependency on social work budget and provide flexibility in the type of supports provided.
Contact	Anne Dean – Community Older People's Service Manager – email -anne.dean@ggc.scot.nhs.uk tel: 0141 300 1217

Friday Social Group (1.5)	
Title	Friday Social Group (1.5)
Aim	To provide a leisurely/relaxing day for a group of seven service users
Who it helps	Older people with a learning and physical disability
Components	A variety of leisurely activities such as, table top gardening, craft work and day outings.
Why it is good?	Friday Social Group is aimed at a group of people who are supported to access things in the community during the week. This project was set up in response to the changing needs of the service users.
What would you do differently?	To have a more clearly defined eligibility criteria
Contact	Monica Smith – Support Co-ordinator – email smithmo@stirling.gov.uk – tel: 01786 849081

Ageing Well Project (1.6)	
Aim	To promote healthy lifestyles for people over 50 in the North East and South Central Edinburgh. The project is part of the UK Ageing Well Network which aims to increase the expectation of good health in later life.
Who it helps?	Older people who are socially isolated, recently bereaved or retired
Components	The project works on a peer health mentoring concept. Our volunteers who are all 50+ help achieve this by encouraging and supporting participation in physical activity. All of our volunteers go through a core ageing Well training programme and many then take further training in seated exercise and health Walk Leading
Why it is good?	The ageing population is increasing; physical activity levels are known to decrease as people get older. Our aim is to encourage health and activity rather than provision of care. Research suggests that older people are more receptive to people of their own age, hence the success of the peer health mentoring model in encouraging physical activity in this age group. We currently provide – Health Walks, Dancing, Chair-based exercise, cycling, allotment project, indoor Kurling, buddy swimming and digital photography.
What would you do differently?	I would like to see the concept of Ageing Well spread over other Edinburgh areas where older people are socially excluded.
Contact	Kath Laing – Ageing Well Co-ordinator – email - kathlaing@edinburghleisure.co.uk tel : 0131 458 2184

Mearns and Coastal Healthy Living Network (1.7)	
Aim	To improve the health and well-being of older people through developing and continuing a set of preventative measures in partnership with other organisations and the local community.
Who it helps?	Older people from 65+ living in towns and villages south of Stonehaven down to the Angus Border.
Components	Increased independence for older people in their own homes for as long as possible, <ul style="list-style-type: none"> • Reduced social isolation of older people. • Increased diet and fitness of older people • Increased capacity of older people to contribute to the well-being of the community. • Improved partnership working.
Why it is good?	Target group is involved in the management, planning, consultation and evaluation of the project.
What would you do differently?	
Contact	Fiona Murray – Public Health Co-ordinator – email- f.murray@nhs.net - tel : 01569 792074

Title	Peer Health Mentoring (Older People) (1.8)
Aim	<ul style="list-style-type: none"> • Enabling our P.H.M to maximise awareness of local health in care services visiting older peoples groups. • Maximising effectiveness at the interface between health information and service users.
Who it helps?	<ul style="list-style-type: none"> • Older people who use or require health in care services. • Older people who are patients, service users, carers.
Components	<ul style="list-style-type: none"> • Volunteers who train to become PHM(s) • Employees of NHS or Partnership Agencies
Why it is good?	<ul style="list-style-type: none"> • Local knowledge, understandable information, Peer led. • Greater understanding to patients of information resulting in a greater input to their long term condition.
What would you do differently?	<ul style="list-style-type: none"> • To have a greater drive on publicity or have greater time input from those in the lead. • Very early in project evaluation will decide
Contact	Irene Bannerman – Older Persons Service development Co-ordinator email – irene.bannerman@ggc.scot.nhs.uk – tel: 0141 232 9150

Title	Perth and Kinross Care Home Meaningful Activity Network (CHAN) (1.9)
Aim	<p>The programme's aim</p> <ul style="list-style-type: none"> To establish a Perth & Kinross Care Home Meaningful Activity Network which will: <ul style="list-style-type: none"> Support Care Homes to drive up standards of care and meet Care Commission inspection requirements around the provision of meaningful activity to improve quality of life and mental health and well-being of care home residents. Facilitate the development of activity delivery within care homes, the range of activities and how these can be adapted. Provide opportunity for sharing good practice, networking and support. Meet local organisational priorities e.g. P&K Live Active and physical activity, P&K CHP, mental health and well-being, falls prevention
Who it helps	<p>ALL residents living in care homes ALL staff working within care homes Dedicated activity leads</p>
Components	<p>The programme's components</p> <ul style="list-style-type: none"> Large Care Home Meaningful Activity Conference held March 10 3 Network planning meetings held supported by the steering group Care Home Network Member Commitment Statement form developed Care Home Commitment and Registration Form developed (for Managers) Communication channels and structures put in place Considering another large care home conference in 2011 <p>Exploring longer term inter-care home events to increase physical activity opportunities, social networks etc for residents.</p>
Why it is good?	<p>This "bottom up" approach has empowered local older people to make a real difference in their communities. Over 120 people attended the initial conference held in March and over 30 staff attended each of the network planning meetings demonstrating that there is a real appetite for this type of development. The care home staff have been actively involved in the planning of the network and contributing to all aspects including – the role and purpose of the group, the commitment required from the "Activity Leads" and the commitment from the "Care Home Managers" the communication structures required, the content of meetings, training on chairing and minuting meetings etc. In taking this approach the steering group anticipate the network becoming self sustaining with minimal strategic support longer term. Key to the longer term success of the initiative and the improvement of activity provision within care homes is the dedication and commitment of the Activity Leads who will be instrumental in reporting back to ALL staff within their individual homes and encouraging/motivating those staff to make "meaningful activity" everyone's business.</p>
What would you do differently?	
Contact	<p>Carolyn Wilson- Perth & Kinross Falls Service/healthy communities collaborative Service Manager email carolynwilson@nhs.net - tel: 01738 473146</p>
Title	Positive Ageing Group (1.10)

Aim	<p>The Positive Ageing Group aims to promote a positive attitude to ageing and the changes which it brings to all areas of life. By so doing the group seeks to promote physical and mental well-being among the target group of older adults with mental health problems.</p> <p>The U.K. inquiry into mental health and well-being in later life in its first report ‘Promoting Mental Health and Well-being in Later Life’ 2006, listed five main areas that influence mental health and well-being in later life;</p> <ol style="list-style-type: none"> 1. Discrimination 2. Participation in meaningful activity 3. Relationships 4. Physical health 5. Poverty <p>The group aims to begin to address these five areas through its comprehensive programme.</p> <p>The group also seeks to implement Recommendation 1 relating to occupational therapy interventions of NICE public health guidance PH16 ‘Occupational therapy interventions and physical activity interventions to promote the mental well-being of older people in primary care and residential care’</p> <p>Using the assessment tool for PH16, the group meets all 3 criteria relating to occupational therapy interventions</p>
Who it helps	Older adults with mental health problems
Components	<p>The objectives of the group are;</p> <ol style="list-style-type: none"> 1. To provide an opportunity for sharing experiences and expectations related to ageing, and by so doing to increase confidence and self esteem. 2. To provide information using local advisors on a range of topics including; health and well-being, nutrition, staying active, home and community safety 3. To encourage the use of community resources including local transport schemes.
Why it is good?	<p>Over the twelve weeks of the programme we have seen all the objectives being met. In preparing for the group staff knowledge and skills have been increased, through research, training and networking with other professionals from a variety of disciplines including Community Older Peoples Team, Falls Team, local police office, local sports centre. Staff have been able to present the group at the Support Workers Training Meeting and a submission has been made to the NICE shared learning database.</p>
What would you do differently?	
Contact	<p>Elizabeth Smith Technical Instructor, Glenkirk Centre Edwina Gray Head OT, Glenkirk Centre –01412321300</p>

SECTION 2 - *External Environment*

Title	Inclusive Design for Getting Outdoors (I'DGO) (2.1)
Aim	To identify the most effective ways of shaping outdoor environments inclusively so that they are supportive of, and accessible to, people of all ages, backgrounds and abilities. We are targeting a range of scales; from the places in and around people's homes to local neighbourhoods and wider urban environments.
Who it helps?	We support the needs and preferences of older people and disabled people, always seeking to improve their independence and overall quality of life.
Components	<p>The project is built around a core group of international academics in three leading research centres: the Edinburgh- based OPENspace; SURFACE Inclusive Design Research Centre at Aalford; and the WISE (Wellbeing in sustainable Environments) research unit at the University of Warwick.</p> <p>The second phase of our research I'DGO TOO, was launched in 2007 and, as scheduled is ongoing. Involving over 3,580 older people across the UK to date, it places a critical focus on the way in which current planning and design policies and practice influence "everyday" outdoor environments for older people: an area where evidence is currently lacking. We know from the first phase of I'DGO (2003-2006) what the likely benefits will be but also where certain design features may actually create problems, especially if badly maintained or focused solely on the needs of one user demographic.</p> <p>We are currently looking at Home Zones and other types of "shared space", pedestrian-friendly neighbourhoods, tactile paving and residential outdoor space, particularly with reference to high density housing.</p>
Why it is good?	Now in its ninth year, our project has involved over 4,350 participants aged 65 or over in the UK and, taking into account the many different hopes, expectations, needs and abilities of our sample, our findings are fine-tuned to individual preferences; drawing on transactional theories and a multi-method approach.
What would you do differently?	The extreme winters of 2009 and 2010 have been problematic, but perhaps they will serve to underscore a whole new phase of research on the ways in which weather and climate influence older people's access to outdoor environments.
Contact	Maire Cox – Communicator – email – m.cox@eca.ac.uk - tel: 0131 221 6055

SECTION 3 – Physical Activity, General Rehabilitation and Self Management

Title	Cardiac Rehabilitation (3.1)
Aim	To optimise recovery for patients who have a “cardiac diagnosis”
Who it helps?	Patients with cardiac diagnosis and older patients who often have multiple diagnoses/problems
Components	Supervised exercise; Education/info Relaxation/Mindfulness Goal setting
Why it is good?	Pts are selected; we try to offer best option e.g. Individual work &/or group community/hosp.
What would you do differently?	Probably be able to offer/provide transport and parking facility.
Contact	Ann Alexander – Specialist Physiotherapist – email- ann.x.alexander@nhslothian.scot.nhs.uk tel :0131 537 9292

Title	Angus Gold 50 +(3.2)
Aim	To provide accessible, appropriate physical activity opportunities for older people
Who it helps?	Older people, particularly those less able and/or isolated.
Components	<p>Angus Gold, a partnership between Angus Council Community Learning and Development (CLD) Service and Angus CHP has been involved as part of a Task Group in particular providing seated exercise training in Angus.</p> <p>The Task Group, with representation from social work, leisure services, CLD, HEALTH, Voluntary sector and community members identified the need for physical activities to be provided in places where older less able people could easily access them such as sheltered housing, residential care, day care, village halls and hospital wards.</p> <p>By securing funding from Fairer Scotland the task group was able to host for days of training from Vitalyz a company providing accredited training that specialises in exercise provision for the care sector. Thirty four people successfully completed the training and are delivering seated exercise across Angus in a variety of settings. Subsequently, the Angus Cardiac Group ran two training days for eighteen patient/volunteers from groups supporting people with a variety of long term conditions.</p> <p>Building on this success, Angus Gold supported a small group of volunteers to apply for funding to the National Endowment for Science Technology and the Arts' Age Unlimited Programme to set up a new community group called Volunteer Gold. Their success in securing in excess of £10,000 will enable a pilot project to provide seated exercise, delivered by volunteers, to people in their own homes – initially in Brechin and the surrounding area. It is hoped that evidence from the pilot will enable further applications to be made to other funding bodies. The training of the first Volunteer Gold volunteers will take place early in 2011 and it is hoped that some places will be available to staff working with older people</p>
Why it is good?	<p>Seated exercise not only improves physical health it impacts on mental health and well being as well. It provides an opportunity to improve/maintain mobility but also for social interaction.</p> <p>The seated exercise initiative owes its success to partnership working, the identification of an accredited course that was tailored to those participating in the training and successful funding applications. And last but no means least to the many staff and volunteers committed to working with older people across Angus.</p>
What would you do differently?	<p>The programme has developed more through happenstance than design. The Task Group had just been formed when the Fairer Scotland money became available.</p> <p>The development of Volunteer Gold would have been more straightforward if we had already had a sizeable group to take the project forward rather than recruiting a management committee after receiving funding.</p>
Contact	Margo Sinclair – Healthy Ageing Co-ordinator – email - sinclairm@angus.gov.uk tel: 01307 468859

Title	An exploratory study to determine the relationship of levels of habitual activity with dietary intake, functional ability, body composition and quality of life in the older adult (3.3)
Aim	<ul style="list-style-type: none"> To determine the relationship of levels of physical activity with dietary intake, inflammation, body composition, functional ability, fatigue and quality of life in the older adult To inform physical activity targets for the ageing population to optimise functional status and quality of life.
Who it helps?	The older adult population
Components	Measuring levels of habitual activity, dietary intake, energy expenditure, blood pressure, inflammatory markers, functional ability, body composition, fatigue and quality of life in the older adult.
Why it is good?	The study will help inform guidance on optimum activity levels for the over 65's
What would you do differently?	Currently in the early stages of research so it is difficult to determine at this stage.
Contact	Jacklyn Jones – PG Programme Leader Dietetics QMU Edinburgh – email- jjones@qmu.ac.uk tel : 0131 474 0000

Title	Self Management of COPD (3.4)
Aim	To enable where appropriate for patients with COPD to self manage their condition
Who it helps?	Patients with COPD
Components	<ul style="list-style-type: none"> General Practice Nurses District Nurses Pharmacy
Why it is good?	To inform patients how they can improve their lifestyle by making small changes to their daily living routine.
What would you do differently?	Pilot still has six months to run before evaluation can take place.
Contact	Linda Harley – Health improvement Senior: Long term Conditions NHS Greater Glasgow & Clyde email – lharley@nhs.net – tel:07738939058

Title	The Ball Project – Be Active Life Long (3.5)
Aim	To promote Health and Well Being
Who it helps?	Older people over 60
Components	Physical Activity, refreshments, Social, Arts or Crafts Activity
Why it is good?	It empowers older people, It gives them the opportunity to “own” and manage their own group. Responsibility for organising the programme, responsibilities for their own monies. The more able in the groups support the less able and there are “knock on2 positive effects such as developing friendships, supporting one another in times of need etc. There have also been other development subsidiary projects and training that has evolved from this programme.
What would you do differently?	Nothing
Contact	Irene Weeden – Development Office & Strategy Officer – email – irene.weeden@moray.gov.uk tel: 01343 567142

Title	Phased Implementation of the New Model of Care for Older People (specifically within orthopaedic and stroke rehabilitation pathways) (3.6)
Aim	To shift the balance of care within these pathways, with a higher proportion of rehabilitation and care able to be provided within community settings, thereby reducing the hospital-based component of patients’ journeys.
Who it helps?	Currently applied to predominantly older people with orthopaedic and stroke rehabilitation pathways, specifically those living within Edinburgh
Components	Additional staffing and resourcing of existing range of hospital and community services facilitating increased capacity at the latter stages of these rehabilitation pathways.
Why it is good?	Achieves the long term strategic goal to shift the balance of care and provide increased proportions of patient rehabilitation and care through joking provision within community settings.
What would you do differently?	Address small, specific gaps within the applied staffing model, and allow for more structural flexibility in the adaptations to the pathways.
Contact	Jamie Hetherington – Implementation Manager email – jamie.hetherington@nhslothian.scot.nhs.uk – tel:0131 537 5094

Title	Someone Like Me (3.7)
Aim	Cascade training programme for professionals wishing to train peer mentors to engage other older people into wellbeing and physical activity opportunities and support them through behaviour change.
Who it helps?	People in a variety of settings but those who may require encouragement and support to make lifestyle changes.
Components	Cascade training over 2 days with accompanying assistance in planning, training resources and support. Key components involve developing listening and communications skills, understanding how to help other people, problem solving and knowledge relating to physical activity and wellbeing
Why it is good?	Engages older people in their own learning can be applied in different settings and can be adapted for different targets.
What would you do differently?	Provide greater guidance on recruiting volunteers and advice on how to integrate into a variety of local programmes
Contact	Bob Laventure – Consultant -Older people and physical activity email – bob.laventure@ntlworld.com – tel: 02476 741143

Title	COPDHome Pulmonary rehabilitation Service – Glasgow City(3.8)
Aim	Shifting The balance of care by identifying services and supporting and maintaining peoples’ safety in their own homes or community setting.
Who it helps?	People diagnosed with COPD
Components	<ul style="list-style-type: none"> • 1.Domiciliary Respiratory Care Service including Pulmonary Rehabilitation for High Risk Patients • 2.Using Single Shared Assessment, District Nurses to assess care packages of patients with moderate diagnosis of COPD and at least one admission to hospital. • Care Pathway Event –Multidisciplinary/Agency Care pathway mapping event informed gaps/barriers in the system from Primary Care to Acute Care.
Why it is good?	<ul style="list-style-type: none"> • Optimises the respiratory care delivered at home to COPD patients with limited access to GP and outpatients services which offers potential to improve patients’ quality of life and reducing risk of hospital admissions • Identifies gaps in service provision; removes barriers to patients care; reduces readmissions • Established core barriers within the care pathway and the opportunity of how these issues could be addressed.
What would you do differently?	As this funding was non-recurring, for the pilots, it was difficult to develop these into sustainable services.
Contact	Janice Kinnaird – Project Manager – email – janice.kinnaird@ggc.scot.nhs.uk tel:07899875215

Title	Health Improvement Services (3.9)
Aim	To share good practice across Glasgow's health improvement teams in developing programmes of work in relation to older people with mental health problem.
Who it helps?	Older people with mental health problems
Components	<p>The programme's components</p> <p>Key elements of good service provision have been drawn up, as follows:</p> <ul style="list-style-type: none"> • Health Improvement is connected into local development groups. • Strategies to develop Tier 1 self-care element of the patient pathway is strengthened for older people with mental health problems. • Community health workers promote connection to the local community for isolated older people as part of health interventions. • Promote the quality of human contact as an essential focus of a patient-centred, individualised service. • There is a range of accessible activities within the locality to offer opportunities for older people with mental health problems for social contact, including peer support. • Links to the Anti-Stigma Partnership in Glasgow are established with a view to developing resources to highlight mental health issues for older people. • Good practice is shared through the formation of an Action Learning Set. <p>These elements provide a framework through which Health Improvement Services can detail existing performance; identify areas of good practice, and action plan to fill gaps.</p>
Why it is good?	<p>It aims to highlight the need for a specific focus on including older people with mental health problems in health improvement activities.</p> <p>It provides a template for Health Improvement Services to look at performance and identify gaps.</p>
What would you do differently?	
Contact	Jill Carson - Jill.carson@nhs.net

Title	North Glasgow Homecare and Reablement Project (HARP) (3.10)
Aim	<p>Reablement is a short term, time limited and outcome focussed service that concentrates on home care provision, ensuring personalised care packages, tailored to individual need whilst encouraging individuals to actively work towards maximising their independence.</p> <p>HARP's aim is to identify a role for Occupational Therapy (OT) working alongside Home care to provide a Reablement approach to Home Care provision, thereby providing appropriate, personalised Home Care packages, promoting independence in daily living tasks.</p>
Who it helps?	Clients living in the north of Glasgow who receive a Home Care package and would benefit from maintaining or maximising their independence in daily living tasks.
Components	<p>Community referrals are received from Social Work Home Care Assessors. Details are also collected of all clients discharged from hospital with a care package. These clients are assessed and incorporated into the project as capacity allows.</p> <p>2 OTs provide a functional OT assessment and advise Social Work Home Care Assessors and Cordia (Home Care provider) staff on appropriate levels and type of Home Care that would best facilitate a Reablement approach. The OTs also provide specific OT interventions and ADL equipment, and refer onto other agencies such as rehabilitation as appropriate. Treatment is directed by client centred goal planning and MOHOST (Model of Human Occupation Screening Tool).</p>
Why it is good?	<p>The project so far has shown a significant reduction in care packages for clients following a period of Reablement and therefore shows cost effectiveness.</p> <p>However, Reablement is as much about providing the right level and type of Home Care as it is about changing the amount of care given and time provided. It improves confidence, motivation, empowerment and choice and maximises independence. It impacts positively on quality of life as it allows tailoring of care packages to suit individual need. It is also proven to maintain any increase in independence for longer than a mainstream Home Care service.</p>
What would you do differently?	<p>We feel that, had Cordia been actively involved in the reablement process, care packages could have been reduced further, or more tasks changed to increase independence and quality of life in a significant number of cases.</p> <p>Closer liaison and joint working with staff in the acute sector, such as ward staff and hospital OTs, to target appropriate hospital discharges would allow the OTs to provide Reablement to more clients receiving a new care package on hospital discharge and minimise dependency on Home Care staff earlier.</p>
Contact	<p>Hilary Bell, Lead OT/Lead AHP/ Service Redesign Programme Manager: Hilary.Bell@ggc.scot.nhs.uk Louise Wilson, Occupational Therapist: Louise.Wilson@ggc.scot.nhs.uk ToniFugaccia, Occupational Therapist: Toni.Fugaccia@ggc.scot.nhs.uk</p>

Section 4 – Loneliness

Title	Moose in the Hoose (4.1)
Aim	To reduce social isolation felt by many older people living in care homes in Edinburgh, by placing trained volunteers in care homes to help residents have access to Internet and e-mail, webcams etc so they can keep in touch with family and friends. The project also works with one day centre.
Who it helps?	Older people living in care homes and those attending day centres in Edinburgh
Components	Specially trained volunteers go into care homes and day centres across Edinburgh to get to know and help residents keep in touch with friends and family by using Internet, email etc. The project has 24 volunteers and 2 members of staff who give support to volunteers when they are in the care homes.
Why it is good?	Computer technology has enabled lots of older people keep interested and stimulated by having access to email etc. Volunteers have been very successful in using access to music and quizzes as a way of reaching older people with dementia, whilst others have become webcam experts and kept family links across the world. We have also won a number of local and national awards.
What would you do differently?	The success of the project depends on the willingness of the care staff to refer people to the project. This is now considered one of the prime conditions when looking at branching out into any more care homes.
Contact	Terry Blair – Manager Moose in the Hoose Project – email - terry@aceit.org.uk tel: 0131 477 3883

Title **Keeping in Touch Edinburgh (KiTe) (4.2)**

Aim	<p>To introduce older people within their own homes or sheltered housing to the benefits and fun of the computer. Through delivering “taster sessions” to older people, the fear and lack of confidence can be removed and the older person will hopefully be motivated to either attend a class or for KiTe to deliver one to one tuition.</p> <p>It is hoped that the older person will become stimulated and enthusiastic and their new interest will help prevent loneliness and possible depression.</p> <p>The taster session already completed has demonstrated the social aspect as well as the computing as tenants of the sheltered housing complex have met for the first time and found common ground.</p>
Who it helps?	<p>As a pilot we are targeting older people within sheltered housing complexes belonging to Viewpoint Housing Association. Eventually we would like to deliver our service within the community in general.</p> <p>We are a Voluntary organisation – not for profit which trains volunteers who have a desire to relate to older people. We use Laptops and mobile internet and require a flexible and enthusiastic approach. Our aim is to encourage older people around computers and to demonstrate the difference they can make to their lives by encourage the use of email and webcam communication – eventually preparing the older person to manage this for themselves in order to keep in touch with friends and family across the world. We will also introduce internet shopping to reduce the need for heavy shopping trips and encourage independence for as long as possible.</p>
Components	<ul style="list-style-type: none"> • Not for profit company limited by guarantee • Trained volunteer delivery • Home delivered taster sessions to encourage the removal of fear and lack of confidence • Encourage motivation to continue either attending external class or KiTe delivering one to one sessions.
Why it is good?	<p>Having completed one pilot of taster sessions and started a second with a third in February, it has become clear that there is a real need within the community to support older people and technology. Many have decided that computing is not for them and yet once persuaded to come along and have fun, they get a chance to see for themselves what they can do given the chance.</p> <p>I have also discovered that many older people are either given a laptop or buy one and are then totally stuck. They do not know where to start or even how to switch it on! This is an area that KiTe can develop and build a support package which will reduce the risk of the older person giving up.</p> <p>By taking our service to the older people themselves, this allows ease of attendance for them thus removing one hurdle. Many have mobility issues and may never manage to a class outside but we can fill this gap for them.</p>
What would you do differently?	<p>We are a new voluntary organisation - company limited by guarantee and have recently won an award from Nominet and Scot UnLtd. We are planning our aims and delivery carefully by running pilots and evaluating. We are at the stage of recruiting volunteers to train and will be able to buy more equipment.</p> <p>We have a long way to go but as a volunteer with Moose in the Hoose I have learned a great deal already and have been helped by Jenny Ridge and Terry Blair.</p>
Contact	Tish Chalmers- Company Director – email tish.chalmers@googlemail.com tel: 0131 453 3463

Title	Good MorningGlasgow (4.3)
Aim	To enable older people to retain their independence, living in their own homes and

	<p>communities. We do this by providing daily telephone befriending calls which alert to deterioration in health and wellbeing and when a Good Morning Call goes unanswered.</p> <p>By being interested in people and listening effectively befrienders build a trusting relationship which helps us monitor the wellbeing of members. When we recognise that people aren't coping and need extra support we'll offer extra support and/or refer to statutory and voluntary sector agencies.</p>
Who it helps?	<p>Those who feel lonely. In Scotland, 19% older people are often or always lonely, (Spotlight Report 2007: Age Scotland as Help the Aged, 2007.) In particular we help those who feel vulnerable living alone – they feel safer knowing that potential health problems will be alerted to if they fail to answer their phone. Our long-standing motto:</p> <p>5 fruitful conversations a day are as important to your health as 5 pieces of fruit!</p>
Components	<p>Befriending via daily telephone conversations. Alerting to recognised deterioration in wellbeing <i>and</i> when a Good Morning Call goes unanswered. Pass on bogus caller alerts from the Police.</p> <p>Promote local events/services. Monthly Good Afternoon get-togethers to visit places of interest. Monthly newsletter. Safety pack: cold alarm, Safe Can, Memo Minders, attack alarms and Message in a Bottle.</p>
Why it is good?	<p>Clients have verified how Good Morning makes them more able to live independently as they: are less isolated and excluded, have boosted self confidence and esteem, feel safer at home, are better connected to the community, have improved sense of health and wellbeing and feel cared about, (ref Annual Report 2010.)</p> <p>The benefits have been recognised in the Scottish Parliament:</p> <p>'Good Morning Glasgow Doing a Great Job for Glaswegians:</p> <p>..The Parliament acknowledges the tremendous contribution that the Good Morning Project has made to the lives of many vulnerable Glaswegians; congratulates it on its award-winning telephone-based befriending service...demonstrates the invaluable contribution Good Morning Glasgow makes to individuals and the community as a whole, and considers that similar services could benefit people throughout Scotland.' (ref S3M-3352. February 2009).</p>
What would you do differently?	<p>What you would do differently if you designed it again</p> <p>We've been developing software, working procedures and good practice guidelines (based on National Care Standards) since 2000. Telephone befriending with an alert role is a relatively new concept in social care, but, as the benefits become known in academic and political circles, it is increasingly popular. The Good Morning service is also cost effective. It is a light touch, low cost service with a substantial impact. Compared to volunteer visitor befriending services the cost per unit (client) is significantly cheaper.</p> <p>There are many aspects I have changed in the last decade e.g.; promoting to potential clients, the required skill-set of staff, staff training, use of volunteers, use of home befriending, partnership working with GPs and Social Work Services etc.</p>
Contact	Nicky Thomson- Manager – email – good.morning.glasgow@gmail.com – tel:0141336 7766
Title	O4O: Older People for Older People (4.4)

Aim	To support communities in setting up services which will help older people to live independently in their own homes/communities for as long as possible. To view older people as assets.
Who it helps?	<ul style="list-style-type: none"> • Older People • Rural Communities
Components	<ul style="list-style-type: none"> • Social action research • Community survey • Community / social enterprise development • Transnational learning and comparison
Why it is good?	Added to discussion about the role of individuals and communities in caring for older people; transnational learning from the context and experience of other regions in the Northern Periphery of Europe; achieved a range of practical outputs which improved the lives of older people in rural communities; produced policy briefings; tested policy / political rhetoric suggestions for communities and people to do more for themselves (Big Society) in real life which resulted in examples of barriers and promoters for success.
What would you do differently?	Aspects of project application which refer to EU funding, i.e. common costs; have more development workers; follow up evaluation to test sustainability and longer term effects.
Contact	Kate Stephen – Project Manager – email – kate.stephen@uhi.ac.uk – tel: 07920 703891

Title	The Getting Together Project(4.5)
Aim	To identify and engage with older people 60 plus living in the community who do not have

	access to services for a variety of reasons and by working with volunteers (aged 50 plus), identify potential health or social problems, look for solutions and promote wellbeing through social inclusion.
Who it helps?	Older people 60 plus living in the community who do not have access to service.
Components	<p>Participants: The project has recruited 8 volunteers aged 50+ and 6 older people (60+) 2 older people living in rural areas and 4 in urban areas.</p> <p>Procedure: Volunteers have received relevant training and been matched with an older person who engaged with the project through the Project Coordinator. Volunteers are visiting the older person in the community over a period of approximately six months, gathering information relating to health and well being and any issues of concern. This information is fed back to the project co-ordinator who will identify appropriate local resources and, through the volunteers, facilitate access where possible. Care will be taken to listen to what the older person wants rather than match them to available activities.</p> <p>Location: The study is being carried out in both North and South Lanarkshire. We were aware that there are a number of initiatives already supporting older people. Our aim has been to avoid areas where there is adequate provision.</p>
Why it is good?	The project is ongoing so it is too early to clearly identify benefits as volunteers are in the early stages of engaging with their older person.
What would you do differently?	Allow more time for the project particularly for volunteer and participant recruitment.
Contact	<p>Yvonne Simpson Getting Together Project Coordinator – email - yvonne.simpson@uws.ac.uk tel:01698 283100</p> <p>Pauline Banks - Professor of Older Person’s Health – email- pauline.banks@uws.ac.uk Tel: 01698 283100</p> <p>Helen Kane – Research Assistant – email - helen.kane@uws.ac.uk – tel:01698 283100</p>

Title	Community Connecting (4.6)
Aim	To “connect” or reconnect isolated older people to community resources and/or help build

	social networks
Who it helps?	Older people with a range of needs who are socially isolated or at risk of becoming socially isolated.
Components	Community Connector will work with the older person to identify “goal(s)” and a matched volunteer will support (up to a four month period) to achieve these goals.
Why it is good?	It offers personalised solutions for older people in helping combat social isolation. It shifts the balance of care from traditional day services to community based services.
What would you do differently?	From the outset to tell assessors to identify social isolation in older people instead of persuading older people to accept a day service.
Contact	Doreen Copeland – Development Manager Older People’s Day Services email – doreen.copeland@edinburgh.gov.org.uk tel: 07872 056244

Section 5 – Falls and Bone Health

Title	Perth & Kinross Falls Service (5.1)
Aim	The Perth and Kinross falls service aims to improve outcomes for older people by providing

	interventions to reduce falls risk and the subsequent injury thus maintaining an older person's quality of life, independence, mobility and overall health and well-being..
Who it helps?	Primarily those over the age of 65
Components	<p>Falls Prevention – through</p> <ul style="list-style-type: none"> • Delivering a Falls Education Package to staff from all agencies who work with older people (day care, care homes, community care, hospital in-patients, sheltered housing warden, bus drivers, home care etc) this covers falls - causes, consequences and prevention strategies, referral and management pathways and root cause analysis of falls • Public Awareness Campaigns through presenting falls awareness to groups of older people in the community and raising awareness through e.g. P&K information booklets, posters, fliers, tea-towels, calendars etc. and articles in the local press. • Working closely with the P&K Home Safety Partnership and Community Safety developing joint initiatives including a mobile “Home Safety Unit” which can be transported anywhere in P&K displaying a number of home hazards including falls, our P&K Home Safety Officer providing “one-stop” home safety visits, joint home safety events etc and also working closely with the Council Road Safety Department around condition of pavements etc. • The early identification of fallers and appropriate pathways into falls assessment services to reduce future falls risk. Currently working very closely with community alarm/telecare service, ambulance service, home care, sheltered housing warden, SSA, Optometrists, Pharmacists as well as a range of other Health and Social Care professionals who all have protocols and can refer directly to the Falls Assessment Service. • Are acting as a pilot site for Scotland for both the Community Alarm Service in testing out the role of a “Community Alarm Falls Screener” and also the ambulance service referring directly to a falls clinic service. • Providing specialist multi-disciplinary Falls Assessment Services. • Providing evidence based Falls and Postural Stability Exercise Programmes run by Physiotherapy and P&K Leisure Services
Why it is good?	The P&K Falls Service has been developed by redesigning existing resources. It covers all aspects of falls from prevention to early identification to the specialist assessment of people who are falling.
What would you do differently?	<p>The service has evolved over a number of years responding and adapting as required. This was a new service in Scotland thus a lot can be learned from it and likewise if designing it again, lessons from elsewhere in Scotland would have shaped the process.</p> <p>Tayside has only recently completed its “Falls and Bone Health Improvement Plan” and future developments would be based on this.</p>
Contact	<p>Carolyn Wilson – Perth & Kinross Falls Service/healthy communities collaborative Service Manager– email – carolynwilson@nhs.net Tel: 01738 473146</p> <p>Jackie Doe – Project Manager – email - jackie.doe@nhs.net – tel: 01738 473718</p>

Title	Community Falls Prevention Programme (5.2)
Aim	To support people in NHSGG&C 65 years and over who have experienced a fall

Who it helps?	People 65 years and over
Components	Self referral to one central point of access, referrals accepted from all health and social service. Home hazard environmental assessment, occupational and physiotherapy assessment if appropriate, medication review, medical review referral on to a range of health and social service including provision of a 12 week exercise programme.
Why it is good?	All interventions are based on research evidence and support health outcomes.
What would you do differently?	Invest in better IT for data gathering and sharing information
Contact	Margaret Anderson – lead for Falls Acute & Community email – margaret.anderson@ggc.nhs.uk – tel:0141 427 8311

Title	“Positive Steps” “Little Steps” (5.3)
Aim	1 To avoid trips and falls 2 Improve their bone health
Who it helps?	Older people
Components	2 boxed resources with an educational programme of 20 table top slides, training scripts & associated hand held teaching aids. Educational programmes are delivered informally to older people & facilitated through cascade training from falls leads to local care providers (e.g. Sheltered Housing Wardens, day care supervisors, voluntary workers). The boxes are stored & marketed via the local CHP Ayrshire & Arran health resource shop & are loaned across the locality to various care environments, NHS & voluntary organisations.
Why it is good?	Fall & bone health experts are a limited resource. These programmes allow the continuing process of improving awareness amongst older people through the process of cascade training delivered in a relaxed, informal & known environment. The content of the boxes were jointly designed with older people, those asked to deliver the awareness training & with NHS specialist critical review The messages delivered are positive & self empowering to the older person Process remains relatively inexpensive (funding was sourced via project proposals) Evaluation is ongoing - preliminary findings are positive
What would you do differently?	Keep more closely to project time scales
Contact	Dr. Heather Hall – Ayrshire & Arran Falls Lead – email - Heather.Hall@aapct.scot.nhs.uk tel:01292660827

Title	Otago - Stirling (5.4)
Aim	Prevention of Falls
Who it helps?	Vulnerable elderly at risk of falling

Components	Exercise and rehabilitation
Why it is good?	It has an affect on confidence
What would you do differently?	More contact after initial sessions
Contact	Anne Murray – Social Day Care Worker – email – murraym.anne@yahoo.com tel:01786 448920

Title	Fife Falls Response Service (FFRS) (5.5)
Aim	<p>Objectives of the Fife Falls Response Service (FFRS):</p> <ul style="list-style-type: none"> To provide appropriately trained and equipped staff to respond to the uninjured fallen person aged over 65 years in their own home (extended to all ages from March 2008). To reduce the number of injuries/fractures by referring to specialist/preventative services To provide a single point of contact available 24/7 with a 30 minute response time (from receipt of call to person's home) To reduce fear of falling and the loss of independence caused by falling and being unable to get help. To improve the health and safety of staff who currently respond on an adhoc basis.
Who it helps?	<p>Criteria for accessing service are:</p> <p>Fife residents over 65 years of age (extended to all ages from March 2008)</p> <p>fallen in the home environment</p> <p>no visible signs of injury</p> <p>aware of their surroundings</p> <p>able to move without causing/ increasing pain</p> <ul style="list-style-type: none"> have no physically able person(s) who could assist them (with guidance) to rise from the floor.
Components	<p>There are two elements to the Falls Response Service:</p> <ul style="list-style-type: none"> Response element:The MECS team is dispatched to assist the person to rise from the floor, if the criteria are met. NHS follow up element:MECS team passes details of people to NHS for follow up using assessment tool to guide referrals/interventions. <p>NB: Fife Falls Response Service is a small part of developments in NHS Fife and Fife Council to address falls prevention and management. In 2006 Fife NHS in collaboration with voluntary sector Fife council and other local groups developed a strategy for Falls Fractures and Osteoporosis.</p>
Why it is good?	<ul style="list-style-type: none"> The total number of calls to the Fife Falls Response Service has remained fairly constant despite an increase in the total numbers of people over 65 and the widening of the criteria to include the service for those under 65. The rates of hospital admissions for falls were rising slightly in the years prior to implementation of the FFRS, since when the rate had tended to fall slightly. There has been a decrease in the numbers of people aged 65 and over attending small fracture clinics. The rate of hospital admission for hip fracture has been falling steadily between 2002 and 2009, however the reduction in rate has slowed since 2006. Both CHP and Council staff commented positively on the Fife Falls Response Service itself. Anecdotal comments from service users also praised the MECS service for its quick response time and the professionalism of its staff.
What would you do differently?	<p>It has been suggested that some investigation takes place around unmet need to provide support for family members or neighbours who support those with community alarms by acting as Keyholders. A letter for Keyholders is being developed to provide information about referral to the CHP's Falls and Bone Health check list and care plan.</p> <p>CHP Staff have commented on the frailty of those being referred. Some way of identifying those at risk of falls was needed at an early stage rather than waiting on the person to fall before a referral is made.</p>
Contact	<p>Mrs Norma Hamilton-Dyernormahamilton-dyer@nhs.net telephone 01592 226882</p> <p>Information above was taken from the Monitoring Report Fife Falls Response Service</p>

Section 6 – Dementia

Title	Dementia Care Service (6.1)
Aim	To assist older people to gain easier pathways into early memory/cognitive assessments and community supports
Who it helps?	Older people without formal diagnosis of dementia and their carers
Components	Assessment and memory/mood testing, review of needs and referrals to specialist services.
Why it is good?	It provides a quick response, is informal and sees people at home in their own environment
What would you do differently?	
Contact	Gail Burgess – Dementia Care Co-ordinator – email gail.burgess@ggc.scot.nhs.uk tel:0141 232 7100

Title	Dementia Telecare (6.2)
Aim	Shifting the balance of care by identifying services and supporting and maintaining people safely in their own homes or community setting
Who it helps?	People diagnosed with Dementia
Components	<p>Telecare: Using assisted technology to provide a safer home environment. Community Psychiatric Nurses identify patients who may benefit from assisted technology and referred to OT's for home assessment.</p> <p>Training/Education: Education sessions were provided by Stirling Dementia Services to informal carers and patients. Upskilling training delivered to formal Carers (Cordia) Psychiatric Liaison Nursing Staff providing upskilling training to staff in residential/nursing home.</p> <p>Care Pathway Event: Care pathway mapping event informed gaps in current service provision, links with various organisations/external agencies to implement redesign of Older People's Mental Health Services.</p> <p>Information Event: CHP staff including psychiatric nurses, occupational therapists and social workers, plus 11 external agencies provided information to carers/patients/relatives.</p>
Why it is good?	The project facilitated the bringing together people from various organisations to enable reshaping of services to provide person-centred approach, identify gaps in service provision, evidence good practice, facilitated timely discharge, identify barriers in the system to improve care, improved knowledge and skills.
What would you do differently?	With the funding constraints on this project, it would be difficult to sustain specific initiatives within the project.
Contact	Janice Kinnaird – Project Manager – email – janice.kinnaird@ggc.scot.nhs.uk tel:07899875215

Title	
Rutherglen early diagnosis dementia support group (REDDS) (6.3)	
Aim	<ul style="list-style-type: none"> • to provide an education group for people with dementia (education group) • 2) to provide ongoing support to people with early stage dementia
Who it helps?	People with a new diagnosis of dementia and their carers
Components	People are referred from old age psychiatry with a diagnosis of dementia. Once there are enough referrals for a group, a 6 weekly education meeting takes place. Thereafter the group join with existing social support groups
Why it is good?	The programme allows people with dementia to retain a greater degree of autonomy than would otherwise be the case
What would you do differently?	This has been in existence since 1999 and the model has been refined over the existence of the group.
Contact	Sarah Boyd, Rutherglen Community Carers, 4 Wallace Street Rutherglen G73 0141 613 2003

Title	
Values History (6.4)	
Aim	To develop a values history for individuals with dementia to allow them to express preferences for future care based on current attitudes and beliefs
Who it helps?	People with dementia
Components	People with dementia and their carers are interviewed using a semi-structured interview to produce the document know as a values history. This work began as a PhD project, but after completion funding has been obtained to continue it.
Why it is good?	The programme allows people with dementia to retain a greater degree of autonomy than would otherwise be the case. It is made available with consent to medical and other carers to influence future care.
What would you do differently?	It is time consuming and therefore expensive, so can only be developed for a relatively small number of people. Further funding would be needed to expand, but this is unlikely to be forthcoming
Contact	Winn Forsyth, Rutherglen Community Carers 4 Wallace Street Rutherglen G73 0141 613 2003

Section 7 - National and Health Board Wide Programmes

Title	Reshaping Care of Older People (Community Capacity and Co-production Work /Stream) (7.1)
Aim	To enable and support all older people to enjoy full and positive lives at home or in a homely setting. The programme specifically values older people as assets and seeks to invest in community capacity to develop a mutual care approach based on a philosophy that is focused on the capacity and capability of older people in a way that promotes the concepts of supported self care and self management.
Who it helps?	All older people in Scotland, their carers and communities
Components	<p>The programme's components</p> <p>The three core 'outward facing work-streams are</p> <ol style="list-style-type: none"> 1 – CommunityCapacityBuilding and Co-production 2 – Care Settings 3 – Complex Care <p>These are supported by two support work streams</p> <ol style="list-style-type: none"> 4 – Work Force 5 – Funding
Why it is good?	<p>The rapid growth in the elderly population and decrease in resources requires a radical approach to how services are planned and delivered using the capacity of the public sector and third sector as well as that of communities, neighbours, families and individuals.</p> <p>This approach sees people as assets not burdens and encourages co-production and the building of capacity in the wider community.</p>
What would you do differently?	The design principles are robust the challenge will be implementation
Contact	Gerry Power – JIT – Scottish Government – email – joseph.power@scotland.gsi.gov.uk tel:0131 244 2374

Title	Implementation of the Delivery Framework for Adult Rehabilitation - Grampian (7.2)
Aim	One of the programmes key workstreams is Falls and Fracture prevention. I have been involved in writing the Grampian Falls and Bone health Strategy and also improving access to Physical Activity for Older People. I am also involved in working closely with Health Promotion within Grampian about a campaign about active ageing
Who it helps?	People at risk of Falls and Fragility Fracture and also the wider population who might need support in order to retain their place in society as they grow older
Components	<ul style="list-style-type: none"> • Falls and Bone Health Strategy - Improving access to Strength and Balance sessions • Improving the availability of opportunities for exercise and Physical activity as we age • Public Health campaign
Why it is good?	Because we hope to integrate the key messages within Health and Local Authority, because we hope to create a strategic approach, because we hope to make it sustainable, because we want to offer choice, because we look at it in terms of not just Physical activity but as a way of sustaining the individual as they grow older in terms of function and contribution to society
What would you do differently?	
Contact	Anne McKenzie – Rehabilitation Co-ordinator email – anne.mckenzie@nhs.net tel: 01343567322

Title	Talking Points: Personal Outcomes Approach (7.3)
Aim	To improve outcomes for people using health and social care services and their carers
Who it helps?	People using health and social care services including older people as well as improving outcomes for staff
Components	<ul style="list-style-type: none"> • outcomes based assessment, support planning and review • supporting outcomes focused practice • using outcomes based information for service planning and improvement • supporting communication about outcomes
Why it is good?	Based on solid research foundations, this programme has been developed in partnership between research, policy and practice over the past 7 years. The programme has mushroomed because it works for people, staff and organisations. It is consistent with other initiatives including user involvement, personalisation, enablement, recovery and an assets approach to health.
What would you do differently?	What you would do differently if you designed it again Working collaboratively across organisations was very successful in sharing learning and maintaining consistency in the first few years. If doing it again, this approach would be maintained
Contact	Emma Miller – Professional Lead for Talking Points (with JIT) email – emma_miller@talk21.com tel: 0141 632 0200

Title	Implementation of Co-ordinated Integrated & Fit for Purpose – A Framework for the delivery of Adult Rehabilitation in Scotland 2007 in Forth Valley (7.4)
Aim	<p>The vision behind the framework is the ongoing development of a modern, effective multi-disciplinary multi-agency approach to rehabilitation services.</p> <p>The Forth Valley programme concentrates on earlier anticipatory interventions to prevent unnecessary hospital admissions or admission to care establishments; falls prevention & bone health; early & appropriate access to services to muscular-skeletal problems; exploring ways of producing health gains through enabling return to productive activity and employment; linking with partners to facilitate development of re-enablement projects; improving access to information and rehabilitation services; access to information in relation to self management of long-term conditions.</p> <p>It underpins the delivery of rehabilitation in a multi-disciplinary/multi-agency context and is working towards offering a clear vision, in relation to rehabilitation, to individuals carers and services</p>
Who it helps?	All stakeholders involved in the delivery and receipt of adult rehabilitation services in the Forth valley area.
Components	<p>Rehabilitation Co-ordinators are expected to play a key role in:</p> <ul style="list-style-type: none"> • mapping existing local rehabilitation services in health and social care • playing a part in the re-design of services, with the support of a rehabilitation network • facilitate the integration of working between health, social care and voluntary rehabilitation services • promoting case management in the rehabilitation team
Why it is good?	<p>Due to demographic change and existing & growing financial constraints, it is not viable for services continue being designed and delivered as they are at present. The focus on rehabilitation is paramount to ensure that our local population stays as well as it can be for as long as can be achieved.</p> <p>This project helps to focus attention on building on the good aspects of current delivery of rehabilitation services and building new ways of working such as reablement programmes.</p> <p>The aim is for this to be achieved by cutting down on duplication and improving efficiency through linking the vast expertise of the stakeholders involved.</p>
What would you do differently?	<p>What you would do differently if you designed it again</p> <p>This is a two year project. A longer timescale would have been a bonus</p>
Contact	Norma McIndoe – Rehabilitation Co-ordinator – email – norma.mcindoe@nhs.net tel: 01324 624000

Title	Developing Community Based Services for Older People (7.5)	
Aim	To enable more people to stay at home for longer and develop wide ranging community based services.	
Who it helps?	Older people and their carers	
Components	<ul style="list-style-type: none"> • Development of 24 hour emergency care service 31st Jan 2011 • Reablement – going live at the end of February 2011 • Build new GP surgery and day centre in Gullane • Build two 60 bedded care facilities with adjacent day centres in Musselburgh and Tranent • Provide intermediate care beds to enable step-up, step-down care and reduce delayed hospital discharge figures. - Develop the respite strategy • Set up an older people’s day centre network (all 10 older people’s day centres are run by voluntary committees) • Develop a practical support strategy for lower level more preventative services 	
Why it is good?	<p>Demographic and financial pressures, combined with raised public expectations has increased the necessity to change the way services are delivered.</p> <p>This has enabled closer working both internally with other council departments, Health partners and other stakeholders.</p>	
What would you do differently?	The process is ongoing!	
Contact	Anne Browning – Service Redesign Project Manager – email – abrowning@eastlothian.gov.uk tel: 01875 824077	

Title	Flexible Respite Accounts (7.6)	
Aim	Support the personalisation agenda giving greater choice and control and placing this in the hands of the beneficiaries.	
Who it helps?	Older people with dementia living at home and their carers	
Components	<p>Initial assessment phase, this is followed up by the creation of dedicated respite accounts, thereafter the account holder has the freedom to commission their own respite break.</p> <p>Subsequent payment for the service received is made by the council with money being drawn down from the account to pay for the cost.</p> <p>Offers same benefits as direct payments without the complexity of the processes involved.</p>	
Why it is good?	<p>Way of providing a truly personalised service for each individual and their carer at no extra cost.</p> <p>Provision designed to take account of all the factors carers identified as being important – choice, flexibility, control.</p>	
What would you do differently?	Nil at this stage – still a new development so not yet evaluated	
Contact	Jillian Dougall – Service Development Officer (Older People and Dementia) - Jillian.Dougall@westlothian.gov.uk – tel:01506 281934	email

Title	Self Management Fund for Scotland (also My condition, My terms, My Life awareness raising campaign) (7.7)
Aim	To develop a range of community asset based approaches, programmes and resources to support self management for people living with long term conditions, and their carers, throughout Scotland.
Who it helps?	<ul style="list-style-type: none"> • People living with long term conditions • Carers and families • Professionals (health and social care)
Components	81 diverse projects throughout Scotland – covering a wide range of conditions, approaches and resources to support self management. Many projects are focused on health and wellbeing in later life, and learning from others will be of interest.
Why it is good?	The Self Management Fund for Scotland has enabled 81 diverse projects to develop different approaches to support self management – each project has been designed, delivered, implemented and evaluated with people living with long term conditions at the heart. Although different, the projects share many common themes which have been highlighted in the Interim Evaluation Report and Special Reports recently published.
What would you do differently?	Although a high proportion of projects include elements of partnership working across sectors, if we were to do things slightly differently again we would strengthen this criteria. More money would always be welcome – we had £4million to allocate over 2 years – applications were over subscribed to the value of £14million. Future allocations will benefit from the learning generated this far, and may feature more thematic projects.
Contact	Kevin Geddes, Director of Self Management, LTCAS – email - kevin.geddes@lucas.org.uk tel: 0141 404 0231

Title	National Falls Programme (7.8)
Aim	To support the implementation across Scotland of a co-ordinated, integrated person-centred and evidence-based approach (as outlined in “Up and About” (NHS QIS 2010) to prevention and management of falls and fractures in older people
Who it helps?	Directly- Falls Leads, Rehabilitation Co-ordinators and other partners. Ultimately, although some work touches on primary prevention of falls, the focus is on secondary prevention. So the main target group is older people at high risk of falling.
Components	Falls prevention in care homes; training of health and social care staff; development of quality indicators; improving pathways of care with the Scottish Ambulance Service and telecare services. Sharing learning and experience is another key strand of the programme.
Why it is good?	Increasing awareness of this issue; promotes learning from the experience of others and collaborative working.
What would you do differently?	Would have to re-consider the approach given the current financial climate.
Contact	Ann Murray – National Falls Programme Manager – email – ann.murray3@nhs.net Tel:07833095399