Enabling Health and Wellbeing in Later Life Mapping Scottish policies, programmes and initiatives

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Executive Summary

Background

The Scottish Collaboration for Public Health Research and Policy's Later Life Working Group is working collaboratively to develop robust, research-based, evaluated interventions to enable health and wellbeing in later life.

The overall aim of this project was to map the current landscape of policies, programmes and other initiatives in Scotland to provide a description of the policy context into which any future research-based and evaluated intervention will fit. This report identifies national policies, national and local programmes and identifies gaps. However, the map had to stop somewhere, and we did not include condition or group specific policies and programmes, for example we did not includeScotland's National Dementia Strategy 2010 and Caring Together: The Carers Strategy for Scotland 2010–2015.

Methods

Mixed, qualitative research methods included 8 interviews with national stakeholders, a focus group discussion with general practitioners from some of the most deprived areas in Scotland, summaries of national and local policy documents and descriptions of programmes, case studies of three local programmes(drawing on interviews and documents) and a knowledge exchange event with 70 attendees.

Results

National policies

Thirteen Scottish policy documents that either relate directly to, or have major implications for, enabling health and well-being in later life have been published since 2002. They stem from real concern over the best way to respond to demographic change and predictions of the future cost of health and social care services. Together they advocate shifts in the way care is delivered from hospitals to community and home settings, to health promotion and anticipatory care, to self-care and self-management and to personalisation of services. Levers for implementing the change to services have involved targets, benchmarking against outcomes, payment for performance and national programmes to coordinate, support, and direct national investment in local development.

National programmes

National programmes are seen as vehicles through which guidance can be developed, good practice fostered, and investment channelled in new ways of working in local areas.

Our interviewees identified eight national programmes run from Government or national agencies. Government programmes include Shifting the Balance of Care, the Joint Improvement Team (which itself has numerous programmes), the Long Term Conditions Collaborative, and Keep Well. National NHS agencies ran the National Falls Programme (NHS QIS, with support from NHS Education for Scotland), Healthy Ageing (Health Scotland), and also provide two risk prediction tools for use by local programmes and services (SPARRA and the Indictor of Relative Need). Finally, the voluntary or other sectors run four other programmes of activities, including an EU Northern Periphery project that involves participatory approaches to supporting older people in remote and rural areas (O4O), Age Concern's Ageing Well initiatives and the Physical Activity and Health Alliance. The most recent JIT programme, Reshaping Care for Older People, brings together many of the earlier initiatives. Its vision is of older people as an asset, their voices heard, and supported to enjoy full and positive lives in their own homes or in a homely setting.

The national programmes cover diverse activities concerned with:

- new ways of delivering services that make maximum use of technologies and local resources (JIT, Shifting the Balance of Care);
- the importance of measuring and using outcome data (JIT, Social Work Inspection Agency, ISD);
- ways to shift resources from hospital to community based support (Shifting the Balance of Care);
- good quality case management and support for self-management of long term conditions (Long Term Conditions Collaborative);
- anticipatory care (Keep Well);
- risk prediction tools for local use (ISD);
- keeping active in later life (Healthy Ageing, Physical Activity and Health Alliance); and
- reducing social isolation (O4O, Healthy Ageing).

The JIT Reshaping Care for Older People programme places great emphasis on community capacity building and community engagement – emphasising the need to encourage older people themselves in volunteering roles and working more closely with the third sector.

Local programmes - overview
Interviewees identified six main types of programmes to enable health and wellbeing in later life, all of which had been promoted nationally but locally delivered. We focused on four of them.

Intermediate care programmes seek to maintain independence and to support people at home through maximum use of existing local resources such as community hospitals, rapid multiprofessional response teams providing services at home, and 'hospital at home' schemes, often focusing on early discharge from hospital. Some intermediate care programmes are condition specific, targeting, for example, people with COPD.

Case management programmes emphasises the role of a single individual (usually a community nurse - the case manager) who offers intensive and coordinating support to individuals identified as at high risk of (re)admission to hospital. Some approaches also focus on anticipatory care – identifying those at risk prior to their hospitalisation.

Falls and exercise programmes seek to prevent older people having falls (which result in significant disability and costs) through targeting people who have already had falls with a rapid, coordinating response moving onto promoting physical activityto reduce further risk. Falls and exercise programmes are one area in which use of the evidence base is most apparent and particular attention is given to improving strength and balance (there is good evidence this can reduce risk of further falling). Some programmes are integrated into community-based exercise initiatives which can provide on-going support.

Programmes to improve well-being and reduce social isolation are the most likely to be co-developed with third sector organisations and local communities. They are designed to connect older people better to their communities and provide health and lifestyle information. They vary considerably in different parts of Scotland, but include group-based exercise, lunch clubs, social clubs and opportunities for volunteering.

There is evidence of activities covering all of these types of programmesacross Scotland and cross boundary working seems to be the norm. However, there is little evidence that they are all 'joined up' as a single, coordinated approach to enabling health and wellbeing in later life. Rather, the pattern of delivery reflects local enthusiasms, and historical developments.

The focus on community capacity building and community engagement emphasised in more recent policies and national programmes is as yet most apparent in programmes focussed on general wellbeing and reducing social isolation. Given the responsiveness of most policy implementation to financial incentives, current investment in such community capacity building through the Reshaping Care for Older People Programme is likely to have results.

Only a few programmes make explicit reference to either the implementation of national policy or how their approaches are based on research evidence although many are beginning to implement approaches to capturing data on performance and have undertaken at least qualitative evaluations.

How do programmes operate and what makes them successful? The case studies
The four case studies were chosen because they reflect different types of project but all aim to enable health and well-being and to help older people to live in their own homes.

Greater Glasgow and Clyde Osteoporosis and Falls Prevention Service has the longest history, based on an initial pilot conducted in 2001 and formally set up in 2004. It targets people aged over 65 who have already had a fall, but believes its holistic, preventive approach means that it could be extended to a 'general gerontological service'. It is an evidence-based approach (informed by current NICE and Department of Health guidance) that offers initial assessment and onward referral across a range of services in health and social care. It is said to work well because: it is low cost (trained occupational therapy technicians undertake initial assessments and to coordinate personalised input); it has support from across the health and social care divide and in the voluntary sector; exercise classes have widereach because they are locally delivered and free transport is offered; strong links have been developed with other local professionals and services who refer in and out of the falls service, facilitated by the use of locally developed referral pathways. Interviewees want to improve the service by finding better ways to support people with psychological problems or who are overly afraid of further falls and better ways to support people who are socially isolated. A full evaluation has supported their work and findings used to inform developments into the future.

Perth and Kinross Healthy Communities Collaborative also has a relatively long history, being set up as a pilot in 2005 but has continued to operate, changing its work plans and expanding its range in each year of its existence. Its ethos is participatory, older people themselves decide priorities for local development with the support of project workers. In the first year its focus was on falls prevention; in subsequent years the project moved on to projects relating to physical health, physical activity and mental health and wellbeing. It uses the 'plan, do, study act' (PDSA) methodology of the Collaborative approach; project workers support the work of local teams of older people themselves in neighbourhoods across the region. It is said to work because of community leadership, support from senior managers, and close working with other agencies. Like other programmes it faced initial resistance from existing providers, which is being overcome; experience also suggests that local teams need the support of project workers to sustain their activities. There was a limited research evidence

base for its 'upstream' falls prevention work, which instead was said to be based on common sense approaches likely to prevent falls'. Subsequent work was framed around activities suggested in the Mental Health and Wellbeing in Later Life report which does have an evidence base. Attempts to measure quantitative outcomes data have been frustrated, but a qualitative evaluation using 'Talking Points' has recently reported.

Scottish Border's plan '*Transforming Older People's Services'* and in particular the redesign of *preventive and day care services* has only recently been initiated. It has been developed with wide stakeholder involvement and, in line with the current moves for community capacity building and engagement, highlights a major role for the voluntary sector. Part of the programme in the Borders that will receive continued support and further development is the *Neighbourhood Links* scheme. Set up when Social Work Services recognised a need to focus resource on those most in need, it aims to provide support to people who have low to moderate needs and help them access a wide range of community-based resources based on their own interests. Its basis on the Red Cross has been seen as an advantage in reaching older people, and pilot of project workers being available in the local hospital was said to have helped to overcome traditional barriers between health and social care.

The longest running programmes had overcome barriers identified through a combination of local champions, persistence and developing formal referral pathways. They have had clear leadership and support from senior managers with clear work plans and reporting structure. They have used the evidence base where available, particularly in the form of guidance, in part to structure their work. They continue to collect and use referral and outcomes data to guide their work and have commissioned external evaluations.

All programmes recognise the important of primary care in further development; one already makes good use of the SCI Gateway which allows for the secure electronic referral of patient information from general practitioners.

Perceived gaps in policy and practice and barriers to effective working
On the whole the existing policy documents and national programmes were seen as providing a strong foundation for the development of services. There was particular enthusiasm for the national programme, Reshaping Care for Older People and its associated 'Change Fund' which through bridge funding aims tostimulate shifts from institutional care to home and community based care and facilitate subsequent de-commissioning of acute sector provision. This funding will be available to local partnerships including health and social care and the third sector on the basis of Change Plans prepared by these partners.

The ageing of the Scottish population and financial pressures on existing services were said to be clear drivers for change to shift the balance of care. The pressure for better quality of care focussed on the outcomes that are important to the people was also said to be important.

Barriers to policy implementation and practice development that were identified included: the length of time it can take to get evidence into practice because of the complexities of the services and problems that are faced; that good practice cannot be shared because of the absence of data on whether and how it worked; the recognition that much current programmes have focused on people who already have problems but that there is now a need to focus on supporting people to stay healthy and self-manage their problems; barriers to implementing new practice including capacity of local communities and the need for training at all levels; funding for new development,

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or disinvesting in old services in order to develop new approaches continues to be a difficulty (though case studies show this has been possible in some areas and there is optimism about the Change Fund's role); and finally, it was recognised that there were island of excellence all over Scotland, but that very often no single area had got it completely right – there was good practice but it wasn't joined up.

General practitioners and primary care in general were felt to have an important role by many interviewees.   The Nairn general practice based anticipatory care project was highlighted by several people as an example of good practice and GPs were seen as having valuable insight into the triggers that could result in the decline of an older person. Engaging with general practitioners was sometimes seen as a problem, but there was a real keenness to do this. There was also enthusiasm for an expanded role in enabling health and wellbeing in later life amongst the general practitioners who took part in the focus group discussion as long as core services were secure.

Conclusions

Problems, policies and programmes
The need to respond to demographic change and predictions of the future cost of health and social care services drives most of Scottish policy and programme development in relation to enabling health and wellbeing in later life.

Government levers for implementing policies have involved targets, benchmarking against outcomes, payment for performance and national programmes to coordinate, support, and direct national investment in local development. The national programmes such as the Falls Initiative, the Joint Improvement Team and the Long Term Conditions Collaborative have been seen as the main vehicles through which guidance can be developed, good practice fostered, and investment channelled in new ways of working in local areas.

To date, these government promoted programmes have focussed mainly 'downstream' on people who already have problems so as to support them better at home. Programmes that focus 'upstream', before problems become acute, such as those to reduce social isolation and improve general wellbeing, or to promote physical activity, have on the whole been the preserve of the voluntary and third sector or have been developed at a local level. This has resulted in less coordinated, patchier, developments some of which are nevertheless highly innovative.

The move to shift the balance of care from the acute setting to community and home-based care is now well established as is joint working across health a social care. But barriers still exist particularly with the shifting of resources. There is considerable optimism that the community capacity programme through the Joint Improvement Team's Reshaping Care for Older People programmes, and the use of 'the Change Fund' to incentivise and promote these changes, may help move services upstream. The 'Integrated Resource Framework' initiated by the Shifting the Balance of Care programme is also likely to facilitate these shifts but has yet to be experienced in everyday practice.

There are many pockets of good practice in the development of initiatives to enhancethe health and wellbeing of older adults, many of which are in line with the current evidence base. The longest running local programmes were able to articulate and demonstrate their success. They had overcome a range of barriers to integration into routine practice through a combination of local champions, persistence and developing formal referral pathways. They have had clear leadership and support from senior managers with clear work plans and reporting structures. They had used the

evidence base where available and have also used data either from external evaluation or routine data collection to guide further developments.

A clear desire for better involvement in, or integration with, primary care practitioners, was expressed. The development of relationships between professionals and improved systems for referral was felt likely to facilitate this.

Perceived gaps in service provision and imagining a future

The Reshaping Care's vision of older people in Scotland as a valued asset, whose voices are heard and who are supported to enjoy full and positive lives was wholly endorsed in this mapping exercise. There was a clearly expressed desire to 'move things upstream' and to promote health and wellbeing. There was also clear enthusiasm for the use of research evidence, for the collection and use of routine data to guide improvements, and for services to be driven by what matters to older people.

The problems arose in relation to the implementation of the big ideas; frustrations were expressed at the patchiness of developments, at the perceived lack of integration and their perceived powerlessness to make things happen better and faster. Integrating services between health, social and voluntary sectors was a particular priority as was involving general practitioners and other primary care staff in future developments.

There is a clear need to ensure that all current practice and future development of programmes to enable health and well-being in older adults are explicitly based on the best available evidence. This may involve decommissioning of practice for which the evidence base is negative. Where evidence is not conclusive, but programmes of work are introduced because they are perceived to have likely benefit, there is a need for close monitoring and on-going evaluation of their impact and outcomes for older people.

The routine embedding of rigorous evaluation into programme development has been seen as essential. This will require both financial commitment and commitment to allowing sufficient time for programmes of work to become embedded into routine practice. There was a clearly identified need for support for service developers and practitioners to interpret and apply the evidence base. There was also a desire to work with the research community to develop national standards for evaluation and outcome measurement which are both rigorous and centred on the outcomes that are important to older people.

Research and development programmes that focus upstream to bring together older people themselves, community based organisations and health and social care services from different sectors to enable health and wellbeing in later life are likely to be welcomed.

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Boxes

1 Introduction

Scotland's population is ageing and life expectancy is increasing, with the number of people aged over 75 projected to increase by 75 per cent by 2031[1]. Health takes on a particular significance in later life; while many older people lead healthy independent lives, in general, people aged over 70 are more likely to report long-term illness, disability and poor health and are the greatest consumers of health and social care resources. At the same time social changes mean that more people are expected to be living alone, with less access to informal care than in previous generations, and that older carers (especially spouses) will play increasingly important roles in providing care.

There is urgent need for new ideas and innovations to enable health and well-being in later life. The Scottish Collaboration for Public Health and Policy (SCPHRP) environmental scan[2]hasidentified promising groups of interventions to prevent or delay disablement in older people: support to increase physical activity particularly in reducing the rate and risk of falls; comprehensive case review, tailored to need with long term follow-up; increased access to assistive devices and home modifications; and increased access to opportunities for social (group) interaction. However, the review also identified many areas of conflicting evidence partly due to un-standardised use of outcomes and poor experimental design.

Scotland, like other countries, has also responded to the problems with a series of interlinked policies and programmes of activity at both national and local levels. There is a plethora of activities which means that the Scottish Collaboration for Public Health and Policy (SCPHRP) Later Life Working Group comes to a complex landscape of research, policy and programme development.

The research reported here augments SCPHRP's environmental scan by mapping the current landscape of policies, programmes and other initiatives in Scotland. It will contribute to the identification of promising interventions and programmes at individual and system level and help with understanding how new complex interventions for robust evaluation may be styled to 'fit' local circumstances. It has offered an opportunity for knowledge exchange between researchers and practitioners across the country.

2 Aims, research questions and structure of the report

The overall aim of the project was to map the current landscape of policies, programmes and other initiatives in Scotland to prevent or delay disablement and/or sustain independent living amongst older adults to provide a description of the policy context into which any future intervention will fit. Specifically to:

1. identify and describe current Scottish policies and key local programmes that aim either to enable health and wellbeing and/or sustain independent living amongst older adults;

2. summarise views of gaps in current policies and programmes and the feasibility of future primary care based developments, with a particular attention paid to the routine embedding of such developments.

Research questions relate to both aims:

Aim 1

1. Which Scottish policies and programmes are aimed at enabling health and wellbeing or sustaining independence amongst older adults?

2. To which problems are the programmes seen as a solution?

3. How are programmes targeted and to which populations?

4. How do programmes operate?

5. What is defined as success and what evidence then exists of that success?

6. How are such programmes embedded and normalised in routine practice?

7. How are general practitioners working in the most deprived areas of Scotland involved in enabling health and wellbeing?

Aim 2

8. What gaps exist in current programmes that are relevant to primary and community care based developments?

9. What primary care community care based developments are considered desirable, useful and feasible to develop and evaluate in Scotland?

Section 3 briefly describes the methods of data collection and analysis used to meet the project aims and answer research questions.

Sections 4 addresses aim 1, to identify and describe current Scottish policies and key local programmes in a series of subsections: Section 4.1 and appendices 1 and 2 summarise national policy documents published by Scottish Executive or Scottish Government since 2002 and the levers for change that are usually employed to seek implementation of these policies. Section 4.2 describes national level programmes run or coordinated from Government or other national agencies that are specifically aimed at enabling health and wellbeing in later life.Section 4.3 provides an overview of some of the local programmes that have been developed and section 4.4 the more detailed case studies that give insight into how the programmes have been developed.

Section 5 addresses aim 2 to summarise participant views of gaps in current policies and programmes and the feasibility of future primary care based developments, with a particular attention paid to the routine embedding of such developments. Finally, section 6 offers brief conclusions relevant to the further development of robust, research-based, developments.

3 Methods

To answer research questions we used a mixed method qualitative study using five data sources: interviews with national policy and programme leads and Scottish academics well known in the field; analysis of national and local documentation; case studies of programmes of work in different areas (involving qualitative interviews and documentary analysis); a focus group discussion with general practitioners; and a knowledge exchange event.

3.1 Interviews with national policy and programme leads
Eight semi-structured interviews were conducted at a national level (see Table 1).Interviewees were identified first through research team contacts(4 participants) and then by asking current intervieweeswho might offer new or alternative insights (a sampling technique known as 'snowballing') (4 participants).

The interviews sought: an overview of all current activities and programmes that relate to reducing disablement or sustaining independence; how they fit into current organisational structures; what levers of change are in operation; which policy documents have guided or developed thinking and action; more detailed descriptions of innovations or programmes they felt were successful; recommendations of up to two health boards, health and social care partnerships or services that they feltwere successful for further study; and finally, their views on current gaps. All interviews were tape-recorded and transcribed verbatim.

Table 1.Summary of interview participants

National programme/organisation	Current Role
Shifting the Balance of Care	Shifting Balance of Care Implementation Lead
Long Term Conditions Collaborative	National Clinical Lead
Joint Improvement Team	Team Leader Integrated Resourcing Team
Joint Improvement Team	National Telecare Programme Manager
Joint Improvement Team	Assistant Director, Joint Improvement Team
Social Work Inspection Agency	Chief Social Work Inspector
Scottish Government	Falls Programme Manager
GlasgowCaledonianUniversity	Reader in Aging and Health

Analysis focused on identifying and describing policies and programmes and to which problems they were seen as a solution (aim 1, RQ 1 and 2) and to identify relevant policy documents. Thematic analysis also identifiedsome of the barriers and facilitators to developing practice (to help answer RQ 6) and opinions about the gaps in current policy and programmes (RQ 8) and about the role of general practice (RQ 9).

3.2 Identification and analysis of national and local policy documents

3.2.1 National policies

National policy documents were identified through the national interviewees and general practitioner focus group and by searching the Scottish Government website (www.scotland.gov.uk/Home). We used the following criteria to select the policy documents:

- The policy makes specific recommendations about older people services which are upstream

    And/or

- The policy document was recommended by an interview or focus group participant

We excluded policy documents and associated programmes that were condition specific or that focussed solely on carers or that primarily related to downstream services (such as acute care or care homes). For example, we did not include Scotland's National Dementia Strategy 2010 or Caring Together: The Carers Strategy for Scotland 2010–2015.

Table A1(Appendix 1) lists the policy documents analysed and gives more details of their content. Detailed reading of each identified the topics in each that were relevant to this project, which included: older people; ageing; healthy ageing; preventing or delaying disability; sustaining independence.

Having identified the sections that referred to each of these topics, data were extracted and summarised in relation to: the context of the policy; the key problems/issues that the policy addresses in relation to enabling health and wellbeing; and the actions proposed.

3.2.2 National and local programmes

National and local programmes that contribute to enabling health and wellbeing were identified through the interviews, national and local policy documents and web based searching of council and health board websites.

Due to time constraints, and the large volume of programmes, we applied a number of exclusions. We sought programmes:

- whose focus was mainly upstream and preventative (before the individual had accessed acute services);
- that were generic, non-condition specific programmes, focusing on prevention or enablement;
- that seemed to cross traditional health and social care boundaries (this, therefore, excluded medication review programmes);
- that were not specifically devoted to carers, because although important, not all of these would have focussed on older carers' or carers' own enablement/health.

As there is a current comprehensive programme of work on telecare in all regions of Scotland coordinated through the Joint Improvement Team, telecare approaches were not included in this review.

We screened the documents to identify promising programmes and to identify possible case study examples. Screening questions are listed in Box 1.

Box 1. Questions used to screen descriptions of local programmes to identify promising and possible case study programmes

- Is a detailed description available?
- How relevant is the programme to enabling health and wellbeing/ sustaining independence?
- Does the programme appear to be based on the current evidence base?
- Has a population that the programme targets been defined?
- Is the programme integrated with other NHS, social care and third sectorservices?
- Has the programme been evaluated?
- Has the programme been part of a service re-design?

Extracted data were also used to help meet aim 1. Descriptions of services were taken from local project descriptions and web-based information.

3.3 Case studies

Based on the screen of programmes we selected 3local programmes of work and one redesign of day care and preventative servicesto describe in more detail. Detailed documentation of the programmes was gathered from the web and through personal

contacts. Interviews were conducted with leads of these programmes to explore: how the programmes were developed and what problems they address; how they are working in practice and the barriers and enablers to their integration into routine practice; how the programmes are integrated with other parts of the service; how the evidence base has been used in the design of these services and what type of evaluation has been carried out of the programmes.

Interview data and documents were brought together and analysed in relation to how programmes operate, how success of the programme is defined and the barriers and facilitators to successful working.

3.4 Focus group discussion with general practitioners

A focus group discussion with a volunteer sample of general practitioners (GPs) from some of the most deprived areas of Scotland was convened with the support of 'the Deep End', an organisation for general practices in deprived areas supported by the University of Glasgow. The focus group explored GPs roles in preventing and delaying disablement in older people and potential improvements which would assist GPs and the older people that they serve in accessing relevant health care and community based services.

3.5 Knowledge Exchange Event

A knowledge exchange event brought together 71 participantsto share knowledge and experience about the implementation of policy to enable health and wellbeing in practice, how the evidence base is being used and what evidence is still needed, to share experiences of how programmes are working in practice and to identify gaps. Participants worked in small, table-based, groups throughout the day and a member of the research team took detailed notes.

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 life (Further details of the event are provided in appendix 3).

The notes from each small group discussion were analysed in relation to the gaps in services and approaches to service development identified.

3.6 Overall analysis

Data from all sources were integrated so that we could be clear about the basis on which we were able to answer each specific research question and meet each aim. The following section presents this integrated analysis, using relevant data from each method to address the aims as appropriate.

4 Scottish policies, national and local programmes to enable health and wellbeing in later life (aim 1)

4.1 National policies relevant to the enabling health and wellbeing in later life

4.1.1 Policies identified, problems they sought to solve and populations targeted

Interviewees and web-searches identified thirteennational policy documents prepared over the last ten years. They are listed in Table A1 (Appendix 1) together with a summary of the context in which they were written, the problems or issues they sought to address, and actions proposed. Table 2 summarises the key issues and proposed actions they describe.

In summary, all thirteen reviewed documents were driven by concerns about the 'demographic timebomb' of Scotland's ageing population and the impossibility of delivering current patterns of health and social care to future populations. The direction has been to promote preventive, public health or anticipatory care programmes that shift the balance of care from hospitals to communities and to promote self-care and self-management. Integrated services for older people are proposed, especially between health and social care, which are expected to be directed at maintaining independence and improving health and well-being. Targeted screening to identify those at risk of deteriorating health is promoted widely.

The primary care professionals' role in supporting older people has been highlighted by many of the policies examined but they have rarely been consulted or listed in any of the actions proposed. It is notable, therefore, that plans for the implementation of the Quality Strategy (2010)[3]has involved primary care practitioners much more closely. NHS Boards will be responsible implementing the strategy through closer working with independent contractors (general practitioners and community pharmacies) primarily through Community Health Partnerships (CHPs)[4]. Support for Older People has been highlighted as a priority for local 'pathways' to be developed at CHP level with an emphasis on preventing hospital admission, informing and empowering the individual and other self-care activities. Primary care practitioners within CHPs are asked to develop more anticipatory care approaches specifically targeting older people that build on the lessons learnt under *Keep Well* and *Well North*. There will also be a focus on identification of and response to dementia and anxiety in older people.

Table 2.Summary of key issues and proposed actions in recent national policy documents

Problems or issues that it sought to address	Actions proposed
Extending healthy later life, especially in the home	Promotion of activities to stay well, including: • promotion of both physical and mental health and activities to improve/maintain physical and mental health; • promotion of physical activity in over-55s, for example community-based falls prevention programmes; walking activities; • better targeting of resources in deprived areas linking exercise and efforts to improve mental health and well-being; • development of a food and health delivery plan; • making better use of resources held in third sector and community based organisations to achieve these goals.
Promotion of independence and ability to stay at home	Improved interagency working. Improved access to multidisciplinary and multi-agency support teams. Promotion of rehabilitation in older people's home and in the community.
Improved joint service provision, for both health and social care	Development of local partnerships to review and develop joint service provision, including for health promotion, prevention and early intervention services. Review joint service provision for older people with additional needs, e.g. learning disabilities, sensory impairment and physical disabilities.
Reduction of hospital admissions	Use of population approaches (e.g. SPARRA) to identify those at high risk of admission/re-admission. Intensive co-ordinated care management for those identified with most complex needs/highest risk of admission. Use of anticipatory care approaches to identify at risk individuals.
Shifting services from acute sector to primary care to enable older people to remain in the community	Use of population approaches (e.g. SPARRA) to identify those at high risk of admission/re-admission. Use Framework for Rehabilitation to promote rehabilitation in the community. Access to a multidisciplinary Comprehensive Geriatric Assessment to identify and plan for rehabilitation needs. Extending professional roles in rehabilitation to support shift of services to primary care. Highlight care of older people as a priority area for GPs with special interests.
Improved care for chronic disease and other conditions e.g. dementia	Integration of primary and acute care to improve chronic disease management for older people. Improved prevention and early detection for major chronic diseases, such as CHD and cancer. Promote recognition of, and care for, mental health conditions. Use of medication reviews to promote good health.
Improved health screening	Review screening for over-75s, including a focus on falls, mental impairment, increasing dependency, tobacco and alcohol use.
Self-management of minor illness	Use on information and communication technologies to enable self-management in the home.
Identification of health and social outcomes important to older people themselves	Early identification of outcomes, in collaboration with older people, and incorporation of outcomes into care plans.

4.1.2 Levers of change

Scottish Executive and Scottish Government have used two main 'levers' to effect change to implement these policies at local level. The first is targets or outcomes frameworks against which performance of local services is compared, including NHS Health Improvement, Efficiency, Access and Treatment (HEAT) targets[5] and the community care outcomes framework[6]. The general practice 'quality and outcomes framework' (QOF)[7], negotiated at a UK level, has also driven change in primary care practice by payment for performance. Each of these is outlined below.

The second is investment in national programmes to support local developments in new approaches to care. This lever has been heavily used by national programmes such as the Joint Improvement Team and the Long Term Conditions Collaborative (see below). In it national resources are invested into new local services (usually through tender of first and second wave pilots, for example) whilst the national programme provide advice, support and coordination to local providers. These can be seen as national programmes that are locally delivered and are seen as demonstrations of good practice; much effort is put into sharing good practice and learning from experience. The national programmes that contribute to enabling health and wellbeing of older people are described in section 4.2.

4.1.2.1 Health improvement, Efficiency, Access and Treatment (HEAT) targets

NHS performance on health improvement, efficiency, access and treatment (HEAT) targets set out a delivery agreement between the Scottish Government Health Department and each NHS Board, based on the Ministerial targets[5]. HEAT targets relevant to older people are summarised in Box 2. None are specifically focused on enabling health and well-being amongst older people, although targets relating to smoking cessation, alcohol misuse and cardiovascular disease will also affect them. National level interviewees suggested that developing HEAT targets specifically concerning enabling health and wellbeing in later life would help to raise the priority of these activities in NHS Board areas.

Box 2. NHS HEAT targets relevant to older people

Treatment Targets for 2010/11

- Increase the level of older people with complex care needs receiving care at home.
- Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.

Treatment Targets for 2011/12

- Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnershipworking between the acute, primary and community care sectors.

4.1.2.2 The community care outcomes framework – Talking Points

The community care outcomes framework first drafted in 2006allows partnerships (between local authorities and their NHS partners) to understand their performance locally, at a strategic level, in improving outcomes for people who use communitycare services or support[6].

The Framework includes four national outcomes and 16 performance measures[8]. The four national outcomes are:

- Improved health
- Improved wellbeing
- Improved social inclusion
- Improved independence and responsibility

Several of the 16 measures overlap with the HEAT targets. They are grouped under 6 themes; users' satisfaction with services (including safety, involvement in planning and opportunities for social interaction); faster access to services; support for carers; quality of assessment and care planning; moving services closer to users/patients; unscheduled care and identifying 'people at risk'.

Adoption of the framework was not compulsory (whereas NHS Board Chief Executives are accountable to the Chief Executive of the NHS with regard to HEAT targets); however the majority of local health and social care partnerships have now adopted the framework and are being used to benchmark developments in performance over time.

The framework is strongly aligned to the goals of maintaining independence and enabling health and wellbeing. The user focussed nature and strong qualitative elements (provided by the use of Talking Points[9]) represent an innovative approach to measuring effectiveness which has been exploited as framework to explore the person centred outcomes (including quality of life, process and change outcomes see Table 3[10]) in the evaluation of some of relevant programmes identified in this study.

Table 3.Talking Points: Outcomes Important to Service Users

Quality of Life	Process	Change
Feeling safe	Listened to	Improved confidence/morale
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improved mobility
Staying as well as you can	Responded to	Reducedsymptoms
Living where you want/as you want	Reliability	
Dealing with stigma/discrimination		

4.1.2.3 The quality and outcomes framework (QOF)
Currently the delivery of care services through primary care is largely driven by the Quality & Outcomes Framework (QOF)[7] - a payment for performanceapproach to implementing change. QOF measures achievement against a range of evidence-based indicators, with points and payments awarded according to the level of achievement. They are a basic system to incentivise quality of care through payment and are now a fundamental part of the General Medical Services contract. Whilst they are not compulsory, most practices with a GMS contract have participated. There are currently no QOF points which directly relate to activities to prevent and delay disablement or

maintain independence in older people. Several people that we interviewed highlighted the QOF as an essential way of engaging general practice, they however also pointed out that agreeing what QOF points could be awarded for was difficult and were pessimistic about the use of QOF to incentivise enabling health and wellbeing in older people through primary care.

4.1.3 Summary

Thirteen Scottish policy documents that either relate directly to, or have major implications for, enabling health and well-being in later life have been published since 2002. They stem from real concern over the best way to respond to demographic change and predictions of the likely future cost of future health and social care services. Together they advocate shifts in the way care is delivered from hospitals to community and home settings, to health promotion and anticipatory care, to self-care and self-management and to personalisation of services. Levers for implementing the desired change to services have involved targets, benchmarking against outcomes and payment for performance.

Other ways to promote change is through national programmes, and these are described next.

4.2 National programmes relevant to the enabling of health and wellbeing in later life

Interviewees and web searches identified a wide range of activities at national level that have been either directly or partially developed to improve health and wellbeing in older people. Programmes have been set up variously by Scottish Government, NHS in Scotland, Convention of Scottish Local Authorities (COSLA) and several third sector-based organisations. Programmes supported by Government often operate by providing national resources and coordination for locally delivered programmes; this is particularly the case with the Joint Improvement team (section 4.2.2) and the Long Term Conditions Collaborative (section 4.2.3).

The main organisations and programmes are detailed below with summaries of their main action areas, the problems they seek to address and the activities that they have carried out in order to address these.

4.2.1 Shifting the Balance of Care

The Shifting the Balance of Care Delivery Group[11] was set up by Scottish Government Health Department as part of the response to the Kerr Report[12].   It was made up of managers and clinicians from across Scotland supported by civil servants in the Health Department. The group defined 'shifting the balance of care'as changes in clinical and care pathways that may involve "*shifting location, shifting responsibility; and identifying individuals earlier who might benefit from support that might sustain their independence and avoid adverse events or illness*". It focuses on prevention, who delivers services (with a focus on people themselves), the use of volunteers, skill mix and community-based care, and the location of care.

It used currently available research evidence to highlight eight 'impact areas' in which, if changes are made to service delivery, improvements in health and wellbeing are likely[13]. The eight impact areas were combined in an improvement framework that includes specific, evidence based, improvements that can be made.

The Shifting the Balance of Care Group was set up to provide guidance to local Health Boards and partnership on the best ways to shift services (and therefore resource) into community setting. The framework is expected to help local Health Boards and health and social care partnerships identify areas in which to change service delivery so as to

improve the health and wellbeing of the people of Scotland. Its activities and targets are summarised in table 4.

Table 4.Summary of Shifting the Balance of Care

Action Area or Programme: Shifting the Balance of Care	
Problem/issue to which it is a solution	**Activities**
Avoiding admission to hospital or long-term care by providing care to enhance wellbeing, maintain independence and reduce cost of care	Develop evidence based improvements in the following areas: • Maximised flexible and responsive care at home with support for carers • Integrated health and social care for people in need and at risk (Anticipatory care) • Reduced avoidable unscheduled attendances and admissions to hospital • Improved capacity and flow management for scheduled care • Extended range of services outside acute hospitals provided by non-medical practitioners • Improved access to care for remote and rural populations • Improved palliative and End of Life care • Improve joint use of resources (revenue and capital) (Integrated Resource Framework)

Table 3 illustrates that although Shifting the Balance of Care was not developed as a specific approach to change services for older people, several of the high priority areas are relevant, specifically: avoiding admission to hospital through rehabilitation and re-ablement, anticipatory care and crisis prevention, redesign care pathways and telecare.

The delivery group is also involved in initiatives to remove the barriers to change including a multiagency approach to integrated care, work force development and shifting resources. Shifting resources is seen as one of the main barriers to achieving the aims of SBC. The Integrated Resources Framework (IRF) is a programme of work at CHP level which maps current resources and activity patterns, across the whole health and social care system and looks at how these resources can be shifted[14].

The IRF is carried out in a two phase process:

- Phase 1: Explicit mapping of patient and locality level cost and activity information for health and adult social care, to provide a detailed understanding of existing resource profiles for partnership populations;

- Phase 2: Protocols that describe agreed and transparent methods to allow resource to flow between partners, following the patient to the care setting that delivers the best outcomes.

The programme is being piloted with a small number of test sites but will be eventually rolled out to all partnerships. This analysis of resources is of interest to the current project as any future intervention would have to be embedded within the current resources and may require a change in how resources are allocated and used.

4.2.2 Joint Improvement Team (JIT)

The Joint Improvement Team (JIT) (www.jitscotland.org.uk) was established in 2005 by the Scottish Executive Health Department, NHS Scotland and Convention of Scottish Local Authorities (COSLA) to provide direct support and assistance to health and social care Partnerships. Its primary aim was to support the rapid development of improved services delivered through Partnerships, as part of the process of continuous improvement and to develop national programmes of work between health and social care.

4.2.2.1 JIT National Programmes

Many of the national programmes developed by JIT have been particularly relevant to enabling health and wellbeing and promoting independence in older adults. The problem or issue to which each programme is seen as a solution and the activities they are undertaking are described in table 5.

Table 5.Summary of Joint Improvement Team programmes of work

Problem/issue to which it is a solution	Activities
Action Area or Programme: Intermediate care[15]	
help prevent unnecessary admission to hospital or long-term care, or help facilitate early discharge enable older people to improve/maintain their independence	• Developing Intermediate Care Framework for Scotland • Developing evidence/options and materials • Supporting Intermediate Care Demonstrator programmes (6 partnerships including Orkney) • Supporting Learning Network • Contribution to Care of Older People with Dementia
Action Area or Programme: National Telecare Development Programme[16]	
enable older people to live with greater independence and safety in their own homes	• Promoting and supporting telecare development and implementation • Publication of National Strategy • Publication of an external evaluation • Training materials available to support local awareness raising and roll-out, including introductory DVD, Digital Stories collection and themed case studies e.g. Telecare& Dementia, Falls Management • Publication of telecare assessment report • Publication of four workbooks in conjunction with the Dementia Services Development Centre • Development of the Telehealth care action plan to cover period up to 2012

Table 5 cont/….

Problem/issue to which it is a solution	Activities
Action Area or Programme: Care at home[17]	
shift the emphasis on care at home services to re-ablement and rehabilitation models that seek to optimise the capabilities of older people	• Shift the emphasis on care at home services to re-ablement and rehabilitation models that seek to optimise the capabilities of older people by supporting local partnerships to review and redesign home care services to a re-ablement model.
Action Area or Programme: Transport with Care[18]	
provide an integrated transport system which will help older people access community based health care service and community based activities which improve health wellbeing, social inclusion and independence.	• Responding to requests for advice in ad hoc way • Guidance report published
Action Area or Programme: Equipment and Adaptations (Promoted through JIT)[19]	
helping older people to live in their own homes for as long as possible, as independently as possible	• New guidance issued in December 2009 • Publication of Good Practice Guide for the Provision of Community Equipment (November 2009) • Publication of Self Evaluation tool for Community Equipment Services (March 20100 • Supporting Partnerships to implement the Good Practice Guide and Self Evaluation Tool • Major Adaptations scoping exercise (completed in April 2010) • Development of Good Practice Guide for Major Adaptations commenced in April 2010
Action Area or Programme: Community Capacity Building (Recently formed 2010)[20]	
help ensure that community capacity building maintains a high profile in the Scottish Government's Reshaping Care for Older People Programme	• Making available expertise on specific approaches to community capacity building and co-production to all local health and social care partnerships across Scotland and help to develop those approaches together with these partnerships • Work individually with different health and social care partnerships to support specific local community capacity building initiatives.

Table 5 cont/….

Problem/issue to which it is a solution	Activities
Action Area or Programme: User centred outcome measurement (Talking Points)[9]	
combine user and carer involvement with an outcomes approach to planning, delivering, evaluating and improving services	Development of tools, guidance and resources to: • Promote a focus on outcomes at assessment, care planning and review. • Place the person (older person) at the centre of a more personalised approach. • Support staff to use outcomes focused conversations with service users. • Enable information on service user and carer outcomes to be systematically gathered during assessment and review processes. • Support organisations to use this information to improve outcomes at individual, service and organisational levels to plan, evaluate and improve services.

Table 5 demonstrates the considerable activities undertaken by JIT in all areas of health and social care relevant to older people. They work across Scotland in all areas.

4.2.2.2 JIT involvement in the measurement of outcomes

JIT have also supported partnerships to measure outcomes and use the results to improve services,which is integral in developing services for older people. Talking Points is a user and carer outcomes approach to assessment, planning and review that aims to shift engagement with people who use services away from service-led approaches. The use of Talking Points[9] is a key stream of the Community Care Outcomes Framework (see section 4.1.2.2). JIT is also supporting work to implement the older people's Indicator of Relative Need (IoRN™)[21]with ISD, a tool which can be used to identify older people with high support needs or in need of care and as a tool for objectively measuring changes in independence.

4.2.2.3 Reshaping Care for Older People

Although JIT works across all aspects of health and social care a key area of development has been the Reshaping Care for Older People programme[22]. This programme is driven by the recognition that service configurations for care for older people are not sustainable given the predicted demographic and financial pressure over the next 20 years. Lead by JIT, NHS and COSLA the programme aims to engage all interests (public, healthcare, social care, third sector etc.) in reshaping care and support services so that policy objectives are met in ways that are sustainable. The original programme consisted of 8 primary work streams (summarised in Box 3).

Box 3. Original work streams in Reshaping Care for Older People programme

Workstream A - Vision and Engagement
Workstream B - Future funding of Long-Term Care: Demographic Pressures
Workstream C - Care at Home
Workstream D - Future Role of the Care Home Sector
Workstream E - Wider Planning for an Ageing Population - Housing and Communities
Workstream F - Promoting Healthy Life Expectancy
Workstream G - Workforce
Workstream H - Embedding Specialist Care in Whole System Pathways across Acute, Primary and Social Care Sectors

Work stream F "Promoting Healthy Life Expectancy" is of most relevance to enabling health and wellbeing. The remit of the work stream was to:

- Review whether specific actions can encourage and assist people to better prepare, in their lifestyle choices, to maintain their independence and well-being into old age.
- Consider actions which can assist people in old age to remain healthier for longer.
- Consider the management and support of long term conditions into old age.

Parliament has considered the findings of these work streams and an extensive public engagement exercise which took place in 2010. Seventy million pounds of investment in 2011-12 within the NHS Budget is being allocated to a Change Fund[23] for NHS Boards and partner local authorities to redesign services to support the delivery of new approaches to improved quality and outcomes. This Fund will provide "bridge funding" in the form of a change fund for providers to invest in new models of care from April 2011. A recent report, Reshaping Care for Older People: A Programme for Change sets out the current landscape and sets out the vision and immediate actions that are required to reshape the care and support of older people inScotland[24]. Further work is to be taken forward under the following headings;

- Co-production and community capacity building.
- Care services and settings
- Care pathways.
- Workforce development.
- Planning, improvement and support (including use of the Change Fund)
- Demography and funding.

A particularly relevant strand of the Reshaping Care programme, also listed in table 5, is community capacity building and community engagement[20]. This emphasis recognises that traditional approaches to service delivery will not be appropriate in a future with many fewer younger Scots to work as carers, and with major cuts to the public spend envisaged for some time into the future. Community capacity building and community engagement may involve:

- Working with public services and those who use them to develop community capacityand co-production approaches

- Ensuring adequate support for community development and volunteers is in place
- Supporting and incentivising existing community based organisations to providecommunity based supports, activities, clubs, etc.
- Developing and contracting larger third sector organisations to deliver services

These approaches will be an integral part of the plans developed by local health and social care partnerships to spend the Reshaping Care 'Change Fund'.

4.2.3 Long Term Conditions Collaborative

The Long Term Conditions Collaborative[25] is one of a number of initiatives developed by the Improvement and Support Team at the Scottish Government; this team helps to improve the quality of services for patients and their families by supporting NHS Scotland in the use of a range of evidence-based quality improvement techniques. The problem/issue that the Long Term Conditions Collaborative is seen as a solution to, their action areas, and activities are summarised in table 6.

Table 6.Summary ofthe Long Term Conditions Collaborative

Action Area or Programme: The Long Term Conditions Collaborative	
Problem/issue to which it is a solution	**Activities**
Long-term conditions in the older population seen as one of the biggest challenges for NHS Scotland; Better management based on the Chronic Care Model and better self-management is a solution and need further development within Scotland	A range of activities to help CHPs and health boards to deliver improvements in patient centred services and change the way care is provided for people with longtermconditions Improving Complex Care (including for older people) focused on 10 actions that CHP and NHS Board should take[26]: 1. Stratify your population and identify those at high risk 2. Target and deliver a proactive case/care management approach 3. Introduce advanced/anticipatory care 4. Communicate and share data across the system 5. Develop intermediate care alternatives to acute hospital 6. Provide telehealth and telecare support 7. Develop a falls prevention pathway and services 8. Provide pharmaceutical care 9. Ensure timely access, flexible homecare and carer support 10. Promote mental health and wellbeing in later life.

Much like JIT, the Long Term Conditions Collaborative operates nationally to develop frameworks and guidance and locally to develop on the ground changes in relation to the chronic care model[27]. The 6 domains of the Chronic Care Model have been mapped to 6 key components of the model for long term conditions care in Scotland. These are:

- a partnership between informed, empowered people with long term conditions and prepared, proactive multi-professional care teams, drawing on the power of people's stories;

- a strategy (GaunYersel' 2008[28]) and resources to support Self-Management;

- an integrated system of care across primary care, hospitals, social work, housing, community and voluntary sectors;

- decision support (programming evidence-based medicine and clinical guidelines into care and support delivery processes) through quality improvement and workforce development supported by standards, guidelines, education, practice development and Managed Clinical Networks;

- care enabled by information systems that support sharing of data; and

- delivery assured through the national performance framework, HEAT targets and the Community Care Outcomes Framework.

An action plan (Improving the health and wellbeing of people with long term conditions in Scotland: A National Action Plan; June 2009[27]) has outlined 7 high impact changes that will help health boards achieve the vision for long term conditions management (see Box 4).

Box 4. Actions required by NHS boards to achieve the Vision for Long Term Conditions Management

LTCC High Impact Changes

- We empower people living with long term conditions, their carers and the voluntary sector to be full partners in planning, improving quality and enhancing the experience of care.

- e support people with long term conditions and their unpaid carers to be involved in person-centred care planning.

- e commission self-management peer support for people with long term conditions and their carers and provide relevant, accessible information.

- e train staff to have the right knowledge, skills and approach to long term conditions care.

- e provide better, local and faster access to healthcare, social care and housing services for long term conditions.

- e strengthen the contribution of Managed Clinical/Care Networks (MCNs) in improving support for people with long term conditions

- We have information systems that support registration, recall and review of people with multiple conditions, and support data sharing across all partners.

There is also a LTCC Community of Practice website (www.knowledge.scot.nhs.uk/ltc.aspx) which has been developed to improve communication and information sharing between all staff groups and agencies working in the care and management of Long Term Conditions throughout Scotland. The self-management and condition specific work streams are of particular relevance as they cover areas of development that are likely to help those with long term conditions (including older people), manage their conditions and therefore help prevent and delay disability and maintain independence.

4.2.4 National Falls Programme

Falls prevention and management was identified as a priority topic in 2004 by the Allied Health Professionals Clinical Governance network, based at NHS Quality

Improvement Scotland (NHS QIS), by NHS Health Scotland and subsequently by the Scottish Executive in 2006[29]. Falls in older people can lead to considerable disability with physical, psychological and social consequences.   Severe falls leading to a fracture often result in admission to hospital and or long-term care. However, even minor falls can result in fear of falling which can limit a person's daily activities, quality of life and social wellbeing.

In 2007 a Health Department Letter 'Prevention of Falls in Older People' was issued as part of the 'Delivery Framework for Adult Rehabilitation in Scotland'[30] which outlined a number of actions for NHS boards in Scotland, including a requirement for Community Health (and Care) Partnerships to appoint a falls lead. As a result of this NHS Quality Improvement Scotland in conjunction with NHS Education Scotland appointed a programme manager to develop a community of practice amongst other activities (2007-2009). This constitutes the 'National Falls Programme'; the problem to which it is seen as a solution and its activities are summarised in table 7.

Table 7.Summary ofthe National Falls Programme

Action Area or Programme: The NationalFalls Programme	
Problem/issue to which it is a solution	**Activities**
Falls in older people can lead to considerable disability with physical, psychological and social consequences.	• The development of a Prevention and Management of Falls Community of Practice including and an online Falls Community (www.fallscommunity.scot.nhs.uk) (On-going)
	• Mapping Questionnaire for Falls Services to understand current services and identify gaps
	• A new resource "Up and About: pathways for the prevention and management of falls and fragility fractures" (2010)[31]
	• Consultation with older people and carers through reference groups meeting (findings published in 'Up and About' in 2010
	• Training health and social care staff (with NHS Education for Scotland)
	• Guidance on outcome measurement
	• Good practice on case finding, published in "Case-finding: identifying older people at high risk of falling" (2009)
	• Coordination of routine data collection to measure outcomes and to identify the impact of falls on the individual and on health and social services and provide information for resource evaluation, planning and improvement
	• Guidance on use of telecare to improve the prevention and management of falls and fractures with JIT

Up and About: pathways for the prevention and management of falls and fragility fractures' , published in 2010[31] by NHS Quality Improvement is a reference resource for people planning, developing, evaluating and delivering services to prevent and manage falls and fragility fractures across Scotland. It describes key service aims and

actions, illustrated with examples of good practice for four different stages the prevention and management offalls and fragility fractures journey of care.

1. Supporting health improvement and self-management to reducethe risk of falls and fragility fractures (maintenance phase)

2. Identifying individuals at high risk of falls and/or fragility fractures

3. Responding to an individual who has just fallen and requires immediate assistance, and

4. Co-ordinated management, including specialist assessment.

There is a strong emphasis with the guidance on promotion of active aging, supported self-management, anticipatory care and identifying those at risk of falls. Interventions are aimed at identifying then minimising an individual's risk factors for falling and sustaining a fracture. The guidance is based on best available evidence, tacit and organisational evidence and the views and experiences of older people and their carers. The resource is aimed those involved in the planning, development, evaluation and delivery of services which aim to prevent and manage falls and fragility fractures.

4.2.5 Social Work inspection Agency, Multi Agency Inspections of Older People's Services

The Social Work Inspection Agency (SWIA)[32]is a Government agency that acts independently and impartially to deliver rigorous inspections intended to drive up standards and improve the quality of social work services across Scotland. In addition to local authority performance inspections the SWIA also undertakes multi-agency inspections, which are designed to assess multiagency working, including services to support older people and promote their health and wellbeing. Table 8 summarises the aspect of its work directly relevant to older people.

Table 8.Summary of the Social Work inspection Agency, Multi Agency Inspections of Older People's Services

Problem/issue to which it is a solution	Activities
Action Area or Programme: Mental Health and Wellbeing in Later Life	
Collaborative working between health and social work services has seen rapid development over the last ten years. It is important that services are evaluated to check they aresafe and of the best quality possible.	• Multiagency inspections of older people services in two Health Board areas Tayside[33] and Forth Valley[34] • Performance inspections of all local authority social work services in Scotland (including older people's services)

The model and methodology for the multi-agency inspection of older people's services was developed by the National Health Service Quality Improvement Scotland (NHS QIS), the Social Work Inspection Agency (SWIA), and the Care Commission. The methods include service user and carer surveys, interviews, focus groups, and evidencefrom file reading. There was also a fieldwork programme including focus groups, interviews, and meetings withstakeholders such as voluntary and private providers and interviews and questionnaires with managers, and staff, case file reading, self-assessment workbooksand the gathering of advance information from the Information Statistics Division.

Two health board areas have undergone an inspection of their joint older people's services (Tayside MAISOP, 2007[33], Forth Valley MAISOP, 2008[34]). The SWIA has

also undertakingperformance inspections of all local authority social work servicesin Scotland which include older people's services.

These inspections are of interest to the current project because they highlight areas of innovative practice based on a comprehensive review of services. The methods of service review may also be useful in providing a tried and tested framework for whole service evaluation which could be applied to investigate the impact of a new intervention on the whole service.

4.2.6 Healthy Ageing: Mental Health and Wellbeing in Later Life programme and Active for later life

NHS Health Scotland's healthy ageing programme aims to identify and encourage factors that facilitate and promote healthy ageing, and to promote equitable services and policies across the population. Two related programmes of were set up; Mental health and wellbeing in later life and Active for Later Life. The problems they were seen as a solution to and the activities of each programme are summarised in table 9.

Table 9.Summary of NHS Scotland's Healthy Ageing Programmes

Action Area or Programme: Mental Health and Wellbeing in Later Life[35]	
Problem/issue to which it is a solution	**Activities**
Depression, anxiety are common issues for older people.	• developing research to underpin health promoting activities with older people; • building older people's capacity to engage in activities at a local, national and regional level • developing education and information resources
Action Area or Programme: Active for Later Life[36]	
Increased activity can improve health and wellbeing in later life	• web-resource to support practitioners working to encourage physical activity in older people

Mental health and wellbeing in later life[35] was developed in partnership with Age Concern, Scotland, The Mental Health Foundation and NHS Scotland. The overall aim of the project was to promote healthy ageing with mental health and wellbeing identified as being central to the success of the policy. The first three years of the programme focused on developing research to underpin health promoting activities with older people (and in particular understanding older peoples' experiences and perceptions), building older people's capacity to engage in activities at a local, national and regional level and develop education and information resources.

Active for Later Life[36] is a web-resource to support practitioners working to encourage physical activity in older people. Keeping active is acknowledged to be a key factor in maintaining health and wellbeing in later life. The web-resource gives valuable advice on the role played by physical activity in the prevention of falls, and provides support for physical activity in black, minority ethnic groups.

4.2.7 Keep Well

Keep Well[37] is programme of anticipatory care, developed as part of plans to tackle health inequalities in Scotland.The programme focuses specifically at prevention of coronary heart disease and diabetes and aims for health improvement in 45-64 year olds in areas of greatest need. Whilst it is not directly focused on older people it could be viewed as part of an upstream preventative strategy for older people and was discussed as such by members of our focus group discussion with general practitioners.

The intention is to further develop primary care services to deliver anticipatory care, and where appropriate link with other partner agencies. It is summarised in table 10.

Table 10.Summary of Keep Well Anticipatory Care in Scotland

Action Area or Programme: Keep Well[37]	
Problem/issue to which it is a solution	**Activities**
Anticipatory care approaches are needed to identify and target care to those most at risk of deteriorating health and hospitalisation, particularly in deprived communities. Aimed at primary/secondary prevention through general practice for 45-64 year olds in more deprived communities.	• Identifying and targeting those at particular risk of preventable serious ill-health (CHD and diabetes) • Providing appropriate interventions and services • Providing monitoring follow up

Keep Well was a flagship programme for Scottish Government. It was coordinated by the Health Improvement Section and NHS Health, with local organisational teams. It was developed and delivered in different ways in different NHS Boards, with well-funded national evaluation as well as some local evaluations on-going. The national evaluation suggests that: those identified were at high risk of developing CVD in the next 10 years; that the ability of practices to reach patients decreased with extreme deprivation, but this pattern was less apparent in relation to engaging with patients (i.e. patients attending for a health check); older patients in the Keep Well cohort were more likely to attend for a health check than younger patients[38].

4.2.8 Information Services Division (ISD)Health and Social Care Programme (SPARRA and IoRN)

Over the last 20 years, ISD have developed a suite of tools to measure dependency and care needs for older people and risk of hospital admission as part of their Health and Social Care Programme. Whilst not programmes in their own right they are used to support other nationally supported local programmes. The most relevant of these to the current project areScottish Patients at Risk of Readmission and Admission (SPARRA)[39]and the Indicator of RelativeIoRN[21], both described in table 11.

Table 11.Summary of Information Services Division Health and Social Care Programmes

Problem/issue to which it is a solution	Activities
Action Area or Programme: Scottish Patients at Risk of Readmission and Admission (SPARRA)[39]	
Too many older people use hospital services when they could have been cared for at home. Part of the problems is knowing how to target community based resources to support people better to stay at home	• *The development and implementation of the use of SPPARA:* a risk prediction tool developed to predict individual risk of being admitted to hospital as an emergency inpatient within the next year.
Ways to identify those most at risk of deteriorating health and hospitalisation are needed	• The results of SPARRA are distributed to NHS Boards, CHPs and other health agencies on a quarterly basis.
	• They are used to inform multi-disciplinary multi-agency local programmes to direct resource to individuals who may benefit from care management or whose care plan might require re-assessment.
Action Area or Programme: Development of Indicator of relative need (IoRN)[21]	
It is hard to know which older people will most benefit from investment of community-based health and social care resources.	• Designing a questionnaire to inform an algorithm for determining the relative independence/dependence of older people who are living in the community.
Ways to identify those most at risk of deteriorating health and hospitalisation are needed	• The questionnaire covers characteristics such as activities of daily living, food and drink preparation and mental health and behavioural issues to categorise the individual into one of nine groups - where group A is 'most independent' and group I is 'least independent'.

Scottish Patients at Risk of Readmission and Admission (SPARRA) is a way of identifying predicting an individual's risk of being admitted to hospital as an emergency inpatient within the next year. The algorithm incorporates:

- Length of time since last emergency admission
- Number of emergency admissions in the last three years
- Age
- Broad diagnosis group at last emergency admission
- Number of different broad diagnosis groups for admissions in the last three years
- Total inpatient bed days in the last three years
- Number of elective admissions in the last three years
- Number of day case admissions in the last three years
- Deprivation - Scottish Index of Multiple Deprivation (SIMD) Decile
- Board of Residence
- GP Practice standardised emergency admission rate.

This information is provided to Health Boards and CHPs to help them target care more effectively at people who are at a high risk of readmission. More recently ISD have undertaken developments to expand the SPARRA algorithm beyond those with a recent history of hospital admission, to people with long term conditions at risk of

unscheduled admission to hospital, and share information across primary, secondary, tertiary and social care. This work was concluded in December 2010 and has not yet been reported.

The *Indicator of Relative Need* is a questionnaire designed to inform an algorithm for determining the relative independence/dependence of older people who are living in the community. It is designed for use in various ways:

- As a local monitoring tool for showing who is being assessed under the different national eligibility categories.

- As supporting information for validating decisions in care plans, e.g. when considering possible care home admission.

- Alongside other information as a way of identifying individuals with high support needs (with or without a carer).

- When used at follow-up points, as a way of objectively demonstrating changes in (in) dependence, e.g. in intermediate care.

Both SPARRA and IoRN may have a role to play in identifying people who are in need of services to prevent them becoming disabled or losing their independence. IoRN in particular also has useful application in measuring the outcome of such interventions.

4.2.9 National programmes run by the voluntary sector (and others)
People we interviewed identified a range of European and voluntary sector organisations, programmes or initiatives that have relevance to enabling health and wellbeing. These include Older People for Older People (O4O)[40], Ageing Well[41], the Scottish Physical Activity and Health Alliance[42] and AGE Scotland[43]. The problems to which they are seen as a solution and activities are outlined in table 12; further information on each is provided below.

Table 12. Summary of National and European programmes run by the voluntary sector

Action Area or Programme: Older People for Older People (O4O)[40]	
Problem/issue to which it is a solution	**Activities**
Peripheral regions (especially rural areas), have a higher percentage of older people compared with central, urban regions. Traditional service provision is challenged by finding and keeping a range of skilled staff and high costs of travel in remote areas. Older people in these areas may experience exclusion and hardship if they cannot access health and social support. Involving older people helps to combat social exclusion and promote health and wellbeing. O4O supports older people themselves to research needs for services and activities	O4O is an EU Northern Periphery Programme funded project, helping older people help themselves. It is a participatory project in remote, rural and peripheral communities, that is actively: • Engaging with older people's skills, experience and knowledge • Nurturing enterprising and proactive activity among older people • Building older people's capacity for innovation, action, enterprise and voluntary activity O4O has sought to support communities to develop: • developing volunteering (e.g. community transport, community friendship schemes); • timebanks for volunteers; • co-operatives and social enterprises.
Action Area or Programme: Ageing Well [41]	
Many older people don't access opportunities to stay healthy; peer support will help them to access lifestyle changes.	An Age Concern health promotion programme which uses Senior Health Mentors – older people volunteers who are trained to support their peers through individual and group activities for, and with, people aged 50 and over. Local partnerships between Age Concern groups and NHS Boards, Councils and others (including older people) to develop approaches that they think appropriate to their local areas. The kinds of activities set up are: walking groups; smoking cessation; healthy eating luncheon clubs; healthy shopping; health checks and screening opportunities; home safety checks; befriending; reminiscence work; lifestyle change; coronary heart disease; and mentor groups. Local partnerships are asked to • Identify local need • Gauge extent of funding • Set up a project advisory group • Appoint a project coordinator • Develop capacity for Senior Health Mentors

Table 12 cont/....

Problem/issue to which it is a solution	Activities
Action Area or Programme: Physical Activity and Health Alliance[42]	
There is a lot of activity initiatives but people need access to information and ideas on how to promote physical activity	It is a networking Alliance that connects: • people to information - keeping people up-to-date on physical activity and health issues, including evidence, policy and practice across a range settings, sectors and professions involved in physical activity in Scotland. • people with each other - within and across a range of professions, sectors and settings. They aim to share information and experiences. Through networking we are able to help you make the right connections in order to help you do your bit to make Scotland more active. • people to policy - providing the opportunity for you to inform policy development and implementation through consultation and debate. It has a well maintained, up to date, web-site and includes knowledge exchange networks as well as information.
Action Area or Programme: Age Scotland[43]	
Voluntary Sector agencies can work better together so Age Scotland combined Age Concern Scotland and Help the Aged into a single charity to improve the lives of older people.	• Work in communities in a range of activities; what they do depends on local staffing and other partner activities; • Campaign – for more money for older people, against elder harm, against age discrimination; • Run events and lobby at political events; • Offer some direct services in some areas.

Older People for Older PeopleO4O[40]is an EU Northern Periphery Programme project funded under the 2007-2013 programme. Partner regions across the North of Europe are working with communities to assist them in meeting the service and support needs of their older citizens.

Table 12 summarises the activities it has undertaken which involve: identifying needs for services to help maintain older people living at home; identifying gaps in service provision that would help statutory providers to keep older people living in their homes and communities; develop new ways of providing supporting services involving community members; assist in the development of volunteering, social organisations and social enterprises.

There are two O4O projects running in Scotland. The Crichton Centre for Research in Health and Social Issues (University of Glasgow, Dumfries Campus) is undertaking an assessment of the needs of older people in rural areas. This is being carried out in four locations across Dumfries and Galloway. In the Highlands and Islands the Centre for Rural Health, UHI Millennium Institute is carrying out various projects including an oral history DVD project, a social enterprise model to develop community assets and a community transport service.

Ageing Well[41] is a pan-European health promotion programme which uses Senior Health Mentors – older people volunteers who are trained to support their peers

through individual and group activities for, and with, older people (those aged 50 and upwards). The programme was initially launched in the UK by Age Concern England (ACE) in response to targets for health set by the government in the early 1990s.

Ageing Well's aims are to:

- improve the general quality of life of older people
- improve the mental health and well-being of older people by alleviating physical disability, chronic pain and social isolation
- increase the cost-effectiveness of medical and social interventions
- influence policy-making at local and national levels.

A number of Ageing well initiatives have been set up across Scotland. In *Lothian*[41][44]there were four programmes which have delivered a range of projects including: healthcare needs assessment, smoking cessation support, 'Dance for Health' programmes, 'Sing for Health' programmes, depression support groups for men over 75 years, 'Paths to Health' walking groups and pre-retirement talks.

Braveheart in ForthValley was an Ageing Well Demonstration Project toexamine the benefits of Senior Health Mentoring in the area of cardiovasculardisease and its management. Braveheart's randomised controlled trial showed significant improvements inexercise, diet and physical functioning among participants, as well as reductions in outpatient attendances [45].

In the *Ageing West Dunbartonshire*[41]a Development Officer with specific responsibility for promoting health in older people was been appointed within the LHCC. The project has not used Senior Health Mentors Health but the health promotion activity for older people under the scheme is co-ordinated by a group which involves all keystakeholders, including older people and representatives from health and local authority services and voluntary groups. A key project was a consultation which lead to the development of well elderly groups for over 65s. These six week programmes which include talks on healthy eating, positive mental health, safety, stress management, aromatherapy and massage, accessing services, physical activity including seated exercise and Paths to Health act as taster sessions for older people who are then signposted to further information and other relevant services.

The **Scottish Physical Activity and Health Alliance**[42](www.paha.org.uk/Home/)is a network that engages a variety of people from different sectors and professions who are involved in the promotion of physical activity and health in Scotland. They provide a wide range of information on physical activity including physical activity in older people. They hold various roadshows and events to promote discussion on physical activity with a wide range of stakeholders, including the public health professionals and the third sector. In 2010 they held a Summit on Physical Activity in older people (http://www.paha.org.uk/File/Index/91814c9f-2418-41e2-b38d-9e440109f659)and in 2011 local Roadshows will focus on physical activity in older people.

Age Scotland[43]was formed from an alliance between Age Concern and Help the Aged in Scotland. In 2009 the main priorities for the charity were:

- Provide support, development and engagement opportunities for older people's member groups and potential member groups
- Provide and support opportunities for older people's groups and member groups to participate in the wider work of Age Scotland
- Provide relevant high quality information direct to older people and to organisations providing information to older people.

- Be the knowledge based authoritative source for social and public policy on issues affecting older people and to campaign with and for older people to reduce inequalities and disadvantage in Scotland and internationally.
- Build and sustain research and policy development links with academic institutions, research centres and networks to become a focal point for knowledge transfer on older people's issues and population ageing.
- Support the development of an international dimension to the charity's work in Scotland, including stronger relationships with Help Age International.

4.2.10 Summary

A major response to policy implementation in Scotland is to use national programmes as vehicles through which guidance can be developed, good practice fostered, and investment channelled in locally developed services.

Our interviewees identified eight national programmes run from Government or national agencies. At Government Level these include Shifting the Balance of Care, the Joint Improvement Team (which itself has numerous programmes), the Long Term Conditions Collaborative, Keep Welland the National Falls Programme (originally supported by NHS QIS, with support from NHS Education for Scotland, now supported by the Scottish Government). National NHS agencies run Healthy Ageing (Health Scotland) and also provide two risk prediction tools for use by local programmes and services (SPARRA and the Indictor of Relative Need). Finally, the voluntary or other sectors also run four other programmes of activities, including an EU Northern Periphery project that involves participatory approaches to supporting older people in remote and rural areas (O4O), Age Concern's Ageing Well initiatives and the Physical Activity and Health Alliance. More recently, the Reshaping Care for Older People programme aims to see older people as an asset and to support them to enjoy full and positive lives in their own homes or in a homely setting. The programme brings together a lot of earlier initiatives under one plan.

The programmes cover diverse activities concerned with new ways of delivering services that make maximum use of technologies and local resources (JIT, Shifting the Balance of Care), the importance of measuring and using outcome data (JIT, Social Work Inspection Agency, ISD), developing the capacity of local communities to engage in enabling health and wellbeing (JIT), ways to shift resources from hospital to community based support (Shifting the Balance of Care), good quality case management and support for self-management of long term conditions (LTCC), anticipatory care (Keep Well), risk prediction tools (ISD), keeping active (Healthy Ageing, Physical Activity and Health Alliance), and reducing social isolation (O4O, Healthy Ageing).

4.3 Local programmes relevant to enabling health and Wellbeing in later life - overview

4.3.1 Types of programmes to enable health and wellbeing

Interviews identified seven main types of local programmes delivered in Scotland that are relevant to enabling health and wellbeing in later life:

- Intermediate Careservices
- Falls and Exercise Programmes
- Case/Care management of people with complex problems
- Programmes to improve wellbeing and reduce social isolation
- Telecare
- Equipment and Adaptations

Most of them have been developed to implement the national policies described earlier, or are the subject of national programmes locally delivered (mainly JIT). We sought further information on intermediate care services, falls and exercise programmes, case/care management of older people with complex problems and programmes to improve wellbeing and reduce social isolation.

Telecare developments are a huge and expanding field; most NHS Boards and local authorities are delivering a range of services to older people. Because telecare has been comprehensively promoted and reviewed by the Joint Improvement Team we do not include it here. Much detailed information is available through JIT[16].

Likewise JIT has collected together a range of good practice examples for equipment and adaptations [19] and we do not include a description of these activities here.

The problems that each type of programmes is designed to address and the types of activities included in each programme is summarised in table 13.

Table 13.Summary of programmes to enable health and wellbeing amongst older people in Scotland

Type of programme: Intermediate Care	
Problem/issue to which it is a solution	**Activities**
Hospital care for older people is expensive and does not meet their needs. Community based programmes could prevent unnecessary admission to hospital or long-term care, or help facilitate early discharge. The ultimate aim is to maintain independence and to support the management of long-term conditions and minor ailments at home.	A variety of services that usually involves both health and social care services working together. Can include: • rapid response teams (in an emergency a multidisciplinary team can assess a person's need for care and bring in immediate resource to prevent an admission); • intermediate care provided in care home or community hospital settings (respite or temporary 'step-up' care); • intensive home care support (sometimes called hospital at home, usually used to promote early discharge from hospital); • some services are condition specific; those that involve community hospitals tend to involve general practitioners.

Table 13 cont/…

Type of programme: Falls and Exercise programmes	
Falls are a major problem for older people and expensive to manage for both health and social care	• Most falls services are targeted at people over 65 years of age with a history of falls in the last year; • Some are integrated with community-based exercise initiatives which provide on-going classes to maintain fitness, strength and balance; • Some identify people at high risk of falls and fractures and mobilises support to prevent them • Most coordinate response and follow-up.
Type of programme: Care or case management	
If older people at risk of emergency admission to hospital could be identified prior to 'the emergency' the admission could be prevented and they could be better supported to stay in their own homes.	• Most have been established following the development of SPARRA which enables Health Boards/CHPs to identify individuals at risk of readmission to hospital and to offer care/case management to better support them at home; • Individuals identified in this way are offered more intensive support, coordinated by a community nurse working with other local services (often including general practitioners but also rehabilitation and social care teams); • Some include anticipatory care - designed to help prevent exacerbation of illness and future care needs.
Type of programme: improving well-being and reducing social isolation	
Many older people become socially isolated, lonely and depressed as spouses die and opportunities for social interaction is reduced. This leads to low quality of life. There is a need to provide exercise and activity initiatives in community settings	Programmes are designed to connect older people better to their communities and provide health and lifestyle information. Some see older people themselves as important community assets that could be better mobilised. Programmes are often developed with voluntary sector organisations; They are very different but provide a range of opportunities including: • group based exercise (chair based exercise, balance and strengthening, kurling, dance classes); • social clubs (quizzes, storytelling, singing, art, craft, advice and information); • lunch clubs; • education advice (home safety, benefits, diet, nutrition and healthy living); and • opportunities for learning and volunteering (computer training and peer support programmes).

Web searches identified over 50 of these types of programmes in different parts of Scotland and we abstracted summary information.   The results of this exercise are shown in tables A2-A5in appendix 2. For 15 of these programmes sufficient

information was available to consider including them as case study sites (indicated in green in the tables A2-A5).

4.3.2 Screening of programmes for case studies

The fifteen 'promising' programmes were screened according to the criteria described in box 1. The results are shown in table 14.

The table shows that there is a range of good practice examples all over Scotland. There is some evidence that services are being set up which cross boundaries and attempt to provide a more integrated service, for example in North Lanarkshire a community links service provided alongside day-care based intermediate care and in Perth and Kinross, falls prevention provided alongside activities to reduce social isolation.

Most of these programmes appear to be aligned to the current evidence base and concerned to implement national policies, although this is not always clearly stated in the information about them. The evaluation of the programmes appears to be extremely variable. Some have not clearly reported an evaluation in the literature that is publically available. Where an evaluation has been described they are largely internal service level evaluations focussing on how the service has helped meet local, and sometimes national, targets. Several of the programmes have carried out small scale qualitative evaluations. The three exceptions are the Nairn Anticipatory care programme, which has been the subject of an external qualitative evaluation and internal reports on impact on local services[51],the Perth and Kinross Healthy Communities Collaborative which has been the subject of an external qualitative evaluation[56], and the Greater Glasgow and Clyde Community Falls Prevention Programme which has been externally evaluated to compare practice to the recommended Sign Guidelines on falls prevention and to examine how the service is impacting on the rate of falls, admission rates, bed use and fractures[55].

Further details of four of these programmes (highlighted in green in table 14) and the redesign of day care services in the Scottish Borders form the basis of the case studies in Section 4.4.

4.3.3 Summary

National policies and programmes have resulted in several programmes to enable health and wellbeing in later life; we sought further information of four of them.

Intermediate care programmes seek to maintain independence and to support the management of long-term conditions and minor ailments at home through maximum use of existing local resources such as community hospitals, rapid multiprofessional response teams providing services at home, and 'hospital at home' schemes, often focusing on early discharge from hospital. Some intermediate care programmes are condition specific, focussing, for example, on targeting people with COPD.

To some extent, *case management programmes* overlap with intermediate care programmes, the main difference being that case management emphasises the role of a single individual (the case manager) who offers intensive and coordinating support to individuals identified as at high risk of (re)admission to hospital.

Falls and exercise programmes seek to prevent older people having falls (which result in significant disability and costs) through targeting people who have already had falls with rapid, coordinated response, and promoting physical activity, in particular strength and balance to reduce further risk. Some programmes are integrated into community-based exercise initiatives which can provide on-going support.

Programmes to *improve well*-being *and reduce social isolation* are the most likely to be co-developed with third sector organisations and local communities. They are designed to connect older people better to their communities and provide health and lifestyle information. They vary considerably in different parts of Scotland, but include group-based exercise, lunch clubs, social clubs and opportunities for volunteering.

Our web-based searching shows evidence of activities in most of these areas across Scotland and cross boundary working seems to be the norm. The focus on community capacity building and community engagement emphasised in more recent policies and national programmes is most apparent in programmes focussed on general wellbeing and reducing social isolation, although current investment in such partnership arrangements is likely to have results.

Only a few programmes make explicit reference to either the implementation of national policy or how their approaches are based on research evidence although many are beginning to implement approaches to capturing data on performance and have undertaken at least qualitative evaluations.

Table 14.Summary of promising programmes to prevent and delay disablement and enhance independence and wellbeing in older adults

Name of programme	Location	Target Population	Components of the programme	Programme aims	Evidence/ policy base	Evaluation
Intermediate care						
Borders Community Health Teams: Waverley Pilot Intermediate Care Service[46]	Borders	Older adults with complex care needs	• Intensive intermediate care provided in an 8 bedded wing of care home. • Some short term assessment also provided	• To support older residents of the Scottish Borders to live in their own homes as long as possible. • To prevent unnecessary admission to hospital, facilitate hospital discharge and prevent premature admission to residential care.	Mainly policy based.	Internal service level evaluation • Quantitative measure of change in independence (with follow-up at six weeks) and place of onward referral/discharge. • Qualitative questionnaire with patients and carers
North Lanarkshire a basket of intermediate care services[47]	North Lanarkshire, Coatbridge	Older people who are experiencing difficulty in relation to their physical or mental health needs (moving towards those with more complex care needs)	• Integrated day service • Locality links officer	• To provide a comprehensive day service for older people who are experiencing difficulty in relation to their physical or mental health needs, can be discretely supported by appropriate professionals and gain quicker access to other services as their needs change.	Yes evidence and policy discussed	Internal service level evaluation • Qualitative evaluation using (User Defined Service Evaluation Tool). Interviews with service users and focus groups and interviews with carers • Qualitative questionnaires with service delivery team and other stakeholders • On-going monitoring against HEAT and local improvement targets
Lothian Edinburgh CHP – Community Respiratory Physiotherapy Service[48]	Lothian, Edinburgh	Older adults with confirmed diagnosis of COPD	• Community/home based physiotherapy to prevent hospital admission • Six-week, twice-weekly programme of exercises, education and self-management strategies for those primarily at the mild to moderate end of the COPD spectrum	• Improve the care of patients with COPD at most risk of admission • To reduce the number of unnecessary admissions to hospital • Reduce the number of bed day occupancy	Possibly evidence and policy based but not clearly described	Not clear
Dumfries & Galloway Short Term Augmented Response Service (STARS)[49]	Dumfries & Galloway	Over 65 at point of hospital admission or to facilitate early discharge.	• A jointly funded community based service providing time limited rehabilitative care to people in their own homes in order to maximise their independence.	• Facilitate safe discharge from hospital at the earliest possible stage; • Avoid unnecessary admission to hospital; and • Prevent premature dependence on long-term care.	Yes evidence and policy discussed	Internal service level evaluation. Quantitative evaluation of impact on hospital admissions, bed days, A and E admission, bed management, equipment use, onward referral to social care and service user and referrer satisfaction

Table 14 cont/...

Name of programme	Location	Target Population	Components of the programme	Programme aims		Evaluation
Case/care management						
Lanarkshire integrated care management – SPARRA and Lanarkshire Identification of Vulnerable Elderly[50]	Lanarkshire	over 65 year olds with complex care needs	• Care managers (community nurses) assess (medical, nursing, pharmaceutical and social care needs), design and deliver a personalised care plan for each individual (including self-management) • They co-ordinate the patients journey through health and social services by acting as a Key worker. • Proactive case finding using SPARRA, Lanarkshire Identification of Vulnerable Elderly tool and clinical judgement	To enable people with complex care needs to be cared for within their preferred home environment	Possibly evidence and policy based but not clearly described	Not clear
Lothian Impact – SPARRA based case management (NB no report or detailed information located)	Lothian, Edinburgh	Any patient who is aged over 65 and who has been admitted to hospital as an emergency at least once in the preceding three years	• Enhanced clinical assessment • A single point of contact for patients and carers • Work with patients and carers where required to improve their understanding of their condition • Improve compliance with medication and treatment, recognise and identify early signs and symptoms of worsening, and an agreed self-management plan • Work with all involved with the patients e.g. specialist nurses, GP, consultant, community respiratory team, and carer for an agreed anticipatory care plan which will be shared widely to prevent unnecessary hospital admission. • Work in partnership with specialist colleagues and refer for specialist advice and support when required • Patients are identified as being suitable for case/care management following screening of high risk individuals highlighted though SPARRA data.	• improved care of patients with long term conditions and prevention of escalation of health problems • development of an anticipatory care model within primary care • reduction in unnecessary admissions and support to enable early discharge where admissions are unavoidable.	Possibly evidence and policy based but not clearly described	Not clear

Table 14 cont/…

Name of programme	Location	Target Population	Components of the programme	Programme aims	Evidence base	Evaluation
Anticipatory Care/case management						
Nairn Anticipatory Care Project [51]	Moray, Lodgehill Clinic	Vulnerable or 'at risk' older patients	• Provides anticipatory and immediate health and social care support and information to vulnerable or 'at risk' older patients • The service provides person centred care and support and an opportunity for people to be involved in the creation of their Anticipatory Care Plan. • Patients are identified using case finder algorithm using primary care data	To prevent hospital admission and facilitate early discharge	Yes evidence and policy discussed	External qualitative evaluation with patients (interviews) and health care professionals (interviews and focus groups) Quantitative evaluation of hospital admissions and occupied bed days, health status
Falls prevention						
Fife Falls Response service [52]	Fife	Over 65 who have experienced fall within own home with no injury.	• 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.	• To provide appropriately trained and equipped staff to respond to the uninjured fallen person aged over 65 years in their own home • 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 • To reduce fear of falling and 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.	Possibly evidence and policy based but not clearly described	Internal service level evaluation Quantitative evaluation of referral and callout rates, admission to hospital due to a fall, hip fracture and small fracture due to falls
Falkirk Falls Management Project [53]	ForthValley (Falkirk)	Older people at high risk of falls (more than one fall in the last year)	• Mobile Emergency Care Service (MECS) to identify fallers and refer • Falls Management Clinics provide a multifactorial assessment (living environment, medication regime, dietary issues) and offers balance and strength exercise programmes tailored to the individual's needs. • Advice and information	• to use the joint resources available to attempt to reduce the number of falls being experienced by people in their homes and provide early and appropriate education, intervention and holistic assessment	Possibly evidence and policy based but not clearly described	Internal service level evaluation Quantitative evaluation of number of falls experienced per MECS service users

Table 14 cont/...

Name of programme	Location	Target Population	Components of the programme	Programme aims	Evidence base	Evaluation
Falls prevention cont..						
Greater Glasgow and Clyde Community Falls Prevention Programme (CFPP)[54][55]	Greater Glasgow and Clyde	community dwelling older people (aged 65 and older), living in the NHSGGC area who have had a fall	• Single point of referral including triage (to identify people who would be better off with another service – for example if they have injured themselves); • Access to a home assessment within five working days, for people who have experienced a fall; • Help and advice regarding safety at home; • Onward referral to a wide range of specialist services e.g.: physiotherapy, falls prevention classes, occupational therapy environmental assessment, pharmacy review of medications, consultant geriatrician led falls clinics, • Links to osteoporosis services, • Benefits maximisation and money advice and care and repair services.	• To reduce the number of falls, which result in serious injury, and • To ensure effective treatment and rehabilitation for those who have fallen.	Yes evidence and policy clearly stated	External evaluation: • Comparison of service to recommendations in NICE guidelines • Quantitative evaluation of admissions, bed days, fractures and deaths due to falls (before and after introduction of the service)
Perth & Kinross (Scottish Healthy Communities Collaborative Falls Prevention)[56][57]	Perthshire, Blairgowrie, Crieff, Perth, Cupar Angus, Tulloch, Aberfeldy	Over 65s	Used the Plan Do Study Act to develop and number of areas. In year issues around falls in over 65 year olds particularly looking at footwear, vision, environment, medication reviews and exercise. In year 2 Keeping active and physical activity for older people, including chair based exercise, Kurling, Wii training in community groups. In year 3 focus on mental health and wellbeing.	• To reduce falls in the over 65 age group within the geography of the sites by **30%** • To reduce falls in identified care homes by **30%** • To reduce referrals from the care home to a step up facility (hospital) by 50% • To set up falls registers Also • To reduce isolation, promote mental wellbeing, promote active ageing and improve social capital	Possibly evidence and policy based but not clearly described	Internal service level evaluation Quantitative evaluation of: • falls data measured against baseline, • numbers attending sessions • social capital questionnaires and • mental well being Qualitative feedback from participants in the PDSA group

Table 14 cont/…

Name of programme	Location	Target Population	Components of the programme	Programme aims		Evaluation
Programmes to enhance mental and physical wellbeing and reduce social isolation						
Borders Neighbourhood Links[58][59]	Borders	Older people who referred for day care but have lower level support needs	Works with older people who have lower level support needs, providing information, linking people to existing community facilities and opportunities, providing some direct time limited assistance building community capacity where gaps are identified Delivered in partnership with the Voluntary Sector – Borders Voluntary Community Care Forum (BVCCF) and Red Cross - and NHS Borders	To increase social inclusion for older people, thereby promoting well-being, health and independence	Possibly evidence and policy based but not clearly described	Not clear
North Lanarkshire Council Locality Link Officers[47]		Older people who are referred for day care (but have lower level needs)	Identify alternative resources in the wider community and assist older adults to engage with them. Community capacity building 3 Locality links officers based in social work offices	To work with older people in local communities and to build opportunities for participation across a wide range of community and voluntary sector resources and facilities to enhance health and wellbeing	Yes evidence and policy discussed	Possibly qualitative but not clear
Perth & Kinross (Scottish Healthy Communities Collaborative Falls Prevention)[56][57]	Perthshire, Blairgowrie, Crieff, Perth, Cupar Angus, Tulloch, Aberfeldy	Over 65s	Used the Plan Do Study Act to develop and number of areas. In year issues around falls in over 65 year olds particularly looking at footwear, vision, environment, medication reviews and exercise. In year 2 Keeping active and physical activity for older people, including chair based exercise, Kurling, Wii training in community groups. In year 3 focus on mental health and wellbeing, including group exercise, social and lunch clubs	• To reduce falls in the over 65 age group within the geography of the sites by 30% • To reduce falls in identified care homes by 30% • To reduce referrals from the care home to a step up facility (hospital) by 50% • To set up falls registers Also • To reduce isolation, promote mental wellbeing, promote active ageing and improve social capital	Possibly evidence and policy based but not clearly described	Internal service level evaluation Quantitative evaluation of: • falls data measured against baseline, • numbers attending sessions • social capital questionnaires and • mental well being Qualitative feedback from participants in the PDSA development group

4.4 How do programmes operate and what makes them successful? Results of case studies.

4.4.1 Greater Glasgow and Clyde Osteoporosis and Falls Prevention Service

Contacts

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Sources of Information

Skelton, J; Neil F. NHS Greater Glasgow and Clyde Strategy for Osteoporosis and Falls Prevention 2006 - 2010: An Evaluation 2007 - 2009 (2009) www.nhsggc.org.uk/content/default.asp?page=s1361_15

Community Fall Prevention Programme (CFPP) Pathway www.nhsggc.org.uk/content/default.asp?page=s1361_15

4.4.1.1 Who does the programme target?
Community dwelling older people aged 65+ with a fall in the last year from the Greater Glasgow and Clyde Area.

4.4.1.2 How was the programme developed and what problem did it address?
Greater Glasgow and Clyde Osteoporosis and Falls Prevention Service was set up with central funding from NHS Greater Glasgow in 2004. There original idea came from a public health consultant, Dr Caroline Morrison, who had identified that falls were a major public health concern and saw the need for new approaches to tackle the issue. The initial project she developed was small pilot, conducted in 2001 with an Occupational Therapist (OT) and an (OT Tech) identifying and assessing people who had fallen and come into and A and E department in North Glasgow (Stobhill Hospital). This pilot was built on to include a twelve week exercise programme to prevent further falls and more input from physiotherapy.

The service was rolled out across Glasgow from 2004. The roll out was staged by hospital catchment areas moving anticlockwise geographically from the initial pilot area of Stobhill Hospital in the North East of Glasgow: Stobhill 2001; Western Oct 2005; Southern March 2006; Victoria June 2006; Royal May 2007 and then incorporating NHS Clyde: Royal Alexandria Hospital, Inverclyde Royal Hospital and the Vale of Leven in June 2008.

The ethos of the service is rapid assessment and onward referral. The service now operates from a central call centre which receives referrals from a variety of sources including GPs and other community based professionals, social work, relatives or friends or through self-referral. A standard pathway is then followed[55]:

1. Telephone triage conducted by an admin support worker to rule out suspected loss of consciousness or injurious fall which requires initial medical management or person who requires more intensive input from the Community Older Peoples' (rehabilitation) Teams. If patients are referred to the COPT team they will be seen within 24 hours.

2. Appropriate individuals are then seen at a one off home visit by an OT Tech for a multifactorial assessment which includes a series of questions and observations:
   - Home circumstances
   - Identification of Falls History
   - Coping strategies and fear related to falling
   - Osteoporosis risk
   - Foot care/ footwear
   - Continence
   - Nutrition
   - Visual impairment
   - Hearing
   - Cardiovascular symptomology/history
   - Neuromuscular symptomology/history
   - Medication
   - Cognitive impairment (AMT)
   - Mobility
   - Home hazards
   - Person's perceived functional ability
   - Alcohol intake
   - Pain
   - Mini Mental State Evaluation and Hospital Anxiety and Depression Scale.

3. At this stage a variety of interventions can also be delivered including
   - Falls Prevention/Risk Reduction Advice
   - Coping strategies for future falls
   - Information, issued as appropriate
   - Discussion about recommended services indicated by triggers
   - Action Plan agreed and documented with written consent.
   - Copy left with client/carer
   - Copy sent to GP, referring agent and other agreed services as per Action Plan.

4. Onward referral is determined by a clearly defined set of triggers and can be to a variety of internal and external services:
   - Pharmacy Review (over four medications)
   - Medical review at outpatient falls clinic (URGENT only if LOC/syncope/ palpitations)
   - Physio assessment (in house)
   - Occupational Therapy (in house)
   - Community Alarms
   - Benefits Advisor
   - Physio assessment – HFPP (Gateway to Falls Prevention Classes – see below)
   - Podiatry
   - Community Older Peoples' Team (COPT)
   - Occupational Therapy - Social Work
   - Audiology
   - Occupational Therapy – CFPP

- Psychology services
- Dietician
- Physiotherapist – Domiciliary 1-to-1
- Direct Access Dexa Scan
- Social Work/Home Care
- Optician (Advise to attend only)
- Sensory Impairment
- Handy Persons
- Continence Service

5. Everyone who triggers a physiotherapy referral is invited to a 12-18 week Falls Prevention Exercise and Education Class. These are physiotherapy and occupational therapy led sessions over 12-18 weeks with individually prescribed exercise programme within a class format. They also include behaviour, lifestyle and home environment changes promoted via educational sessions. They are delivered in community venues and free transport with journey times of no more than one hour (minibuses and taxis) is provided. Participants receive an individual home exercise programme which is added to the "Keeping Fit and Active as you get Older" booklet and a DVD or video of the same name.

If people opt out of the referral pathway they are provided with the "Keeping Fit and Active as you get Older" booklet and a DVD.

4.4.1.3 How programmes are working in practice and the enablers and barriers to their integration into routine practice?
Enablers
All interviewees were enthusiastic about the programme. A large number of enablers or strong points were highlighted.

*Value for money:*One of the major enablers was seen to be the value for money of the service. This is mainly because the service relies on lower grade OT Techs rather than more senior staff.

Support from a health-board wide working group: The Community Falls Steering working group is attended by representatives from the CHPs, Geriatric Consultants; Social Work; Pharmacy; Social work OT's fracture liaison, the falls service and Planning department. The working group is through to work well to develop the falls service and wider falls related services and initiatives.

Local delivery and free transport for exercise classes: It was thought that the exercise classes had a wider reach than they would otherwise have because they offered local delivery and free transport which was felt to be particularly important in more deprived areas.

*Strong links with other services:*These links were seen to be important for both referral in and referral out and interviewees were particularly pleased with what they had managed to do. Some of the important links raised in interviews included:

- the *Pendant alarm services*which sends a monthly list of people who have fallen to the service for a follow up;
- good links with *general practices* referring into the service facilitated by use of the SCI Gateway

(www.sci.scot.nhs.uk/products/gateway/gateway_prod_overview.htm)
which allows for the secure electronic referral of patient information;

- Good links with the *fracture liaison service* through reciprocal pathways for referral into the falls service and out for DXA scanning for those identified as at risk of fracture. There was also some early work focussing on falls and fractures in care home settings.

- Onward referral and established links with '*Glasgow Life*' the leisure service providers in Glasgow and Clyde and their Vitality Classes (tailored exercise classes for older people). Participants in the 12 week exercise programmes are encouraged to continue with these programmes which are delivered for a small fee but with transport provided.

- There are good working links with *social work*. Social work referral is made if larger pieces of equipment are required. Any initial resistance was overcome through awareness raising and discussion.

- Other good reciprocal links discussed were; podiatry services, dietetics, handy person services, incontinence services, community pharmacy/medication review.

Overcoming initial problems with integration: Interviewees discussed problems they had encountered in the early years of the service had been overcome by developing links between themselves and other services. For example, initial problems of lack of integration between the falls services, the community older people's service and the hospital discharge service were overcome by developing pathways established for referral between them which now work well.

Barriers
There were a range of barriers identified during the set-up of the programme some of which had been overcome and others which were said to require more work.

Drop-out: There were some initial problems described with people dropping out before the home visit because of concerns about being put in a home. This has been overcome by getting more administrative support to allow time to explain and encourage people to sign up to the service.

Access to exercise programmes: One of the barriers to referral to the exercise programmes is the current level of mobility of the individual. Only people with a Tinetti of 19 (Balance assessment tool) can attend as they have to be able to get into the transport provided without assistance. Those with a lower score are referred to the Community Older People's team (COPT) or referred to domiciliary physio and may be eligible to attend day hospital for exercise classes specifically for frailer people.

Initial resistance: There was some initial resistance from some local Community Older People's Teams (COPTs) who felt that the service was duplicating their work. This was cleared up by clearly defining the population of the service which is "fit well but with an identified increased falls risk" as opposed to the "housebound client" seen by the COPT team. Hospital OT were also unhappy that OT technicians where undertaking initial screening and onward referral as they felt that they were not suitability qualified.

Arranging transport to exercise classes: This is considered essential to maintaining the reach of the exercise programmes but because the local authority bus service was not feasible, arranging it was initially difficult. The

service now operates using a variety of private and local authority services and is funded separately through specific health improvement related transport budgets.

Initial low referrals from more deprived areas: There were some early problems with lower referrals from more deprived areas, explained by either "referrer fatigue" or that people living in deprived areas were more stoical or had lower expectations. Referral rates were improved by meeting with a consultant who then met with local general practitioners to raise awareness of the service.

Lack of evidence base for 'upstream' awareness raising initiatives: Interviewees emphasised that the falls service is evidence-based. They felt that a lack of a good evidence for more 'upstream', preventive activities is holding back these activities.

4.4.1.4 Gaps in current service
The service is constantly evolving and these were some of the areas which were identified as potential gaps.

Support for people who have mental health problems, fear of falling or are socially isolated: No direct referral pathway for problems with *mental health* issues, *fear of falling* and issues of *social isolation*. Particularly there was not referral pathway directly to psychological service unless the person is already registered with these services. Respondents through that direct links and integration with services provided by voluntary organisations might help with social isolation. Currently the physiotherapists and occupational therapists have some input but the contact time limits how much input is feasible.

Referrals from *out-of-hours services and accident and emergency* was not working well, and needed development.

The Care Home population in the Clyde area and the residential homes in NHSGG&C wide did not have input from the falls services nor do the inpatient mental health services.

The possibility of a wider remit: Interviewees were clearly proud of their service. They felt that it was currently much more holistic than just falls and that the service could perhaps be opened up to non falls related cases and become "a general gerontological service". They said that the current model of using lower grade support staff for assessment was seen as a potentially cost effective model to follow. There was a recognition that for this to be successful GPs would need to be involved in identifying possible referrals.

4.4.1.5 How success of the programme is defined?
At operational level, interviewees were particularly proud of:
- the rapid assessment and onward referral the team offered;
- exercise classes being taken up by high numbers of people referred (largely attributed to them being locally delivered with free transport);
- the links with all the other services that have been established particularly the opening up of barriers between the services; and
- the cooperation and reciprocal referral between services.

In relation to personal outcomes – having on impact of people's lives, interviewees were particularly proud of:

- the camaraderie on the transport and at the exercise classes.   This peer-based support was said to address some of the issues of isolation and fear of falling that are associated with this group of people;
- the number of thank you letters received by the service suggested it was having a huge impact on older people's lives.
- results of satisfaction questionnaire post classes was always positive

4.4.1.6 How the evidence base has been used in the design of these services?
The service is based on the evidence. The evaluation of the service (described below) benchmarked the service with NICE 21 Falls Guidelines and the more recent Department of Health Prevention of Falls and Fractures Package and found that almost all elements deemed important were present.

4.4.1.7 What type of evaluation has been carried out of the service?
The service collects data on referral rates, uptake to the exercise programmes and location of onward referral for its own quality improvement.

It was also subject to external evaluation as part of the NHS Greater Glasgow Strategy for Osteoporosis and Falls Prevention Strategy (2006 – 2010)[54]. This looked in detail at how the falls prevention service was operating and identified areas for further development and improvements. The evaluation:

- Favourable compared the current servicewith the NICE guidelines 21: Clinical protocol for prevention of falls and the 2009 Department of Health 'Prevention Package' guidance on Services for Falls and Fractures;
- Noted good referral rates into the service;
- Discussed the impact of the falls service on the rate and location of falls and fractures, the number of bed days due to falls, deaths due to falls.
    - The results of the evaluation state that data gather over past 10 years demonstrate a reduction of 3.5% in fracture neck of femur in the over 65's in NHSGG&C. whilst other similar cities have reported a rise in fractures in this population

There is planned evaluation of patient satisfactionwith the falls prevention service which was identified as an area that needed further attention by the above evaluation.

4.4.2 Perth and Kinross, Healthy Communities Collaborative

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Sources of Information
Perth and Kinross Healthy Communities Collaborative Evaluation Report. Emma Miller (Joint Improvement Team) Karen Barrie (Better Together Programme) December 2010 www.jitscotland.org.uk/downloads/1297689472-PandK_HCC_Evaluation.pdf

Perth & Kinross Healthy Communities Collaborative, COSLA award application (2010) (Bronze award) (http://awards.cosla.gov.uk/2010/02/bronze-awards-category-3-%E2%80%93-tackling-health-inequalities-and-improving-health/thi-16-pkc-healthy-communities-collaborative/)

4.4.2.1 Who does the programme target?
The general community of older people, people in care homes and in sheltered housing.

4.4.2.2 How was the programme developed and what problem did it address?
Perth and Kinross, Healthy Communities Collaborative was started in March 2005 following previous favourable experience of the Collaborative approach and use of the Plan Do Study Act methodology in GP Practice within Tayside.

The model for the pilot originated from the National Primary Care Development Team Healthy Communities Collaborative in England, where the Plan Do Study Act methodology had been used in communities with older people focussing on falls. Two areas in Scotland (Perth and Kinross and Argyll and Bute [no longer running]) were keen to pilot this methodology with falls prevention.

In Tayside there was some central NHS funding for the pilot but individual local health care cooperatives (the primary care organisation prior to CHPs) were invited to consider their area for the pilot and were required to find funding for a project manager. Funding was available for a one year project. Set up and running of the pilots were overseen by the National Primary Care Development Team (NPDT) from England.

In the initial period, the five areas of falls prevention targeted were: Footwear, Environment, Vision, Exercise, Medication review. The project team said that they soon realised that it was "more about building community capacity, social cohesion and empowering communities."In subsequent years the project moved on to projects relating to physical health, exercise and activity and mental health and wellbeing in later life. Interviewees described activities in three years of development and in on-going activities.

Year 1
Set up, capacity building, learning the PDSA process: It was essential to spread the understanding of the programme and the methods it would use. Engaging local people as well as professionals was seen as essential. This was done in a planned, staged, way.

a. The Project Manager attended learning and training workshops held in England to learn the PDSA process;

b. Orientation events were held to inform the local communities about the pilot and to get interested people (5-6 older people and 3-4 representatives from statutory and voluntary services) to sign up to local collaborative teams. The first was held in Perth and then more locally in the pilot sites;

c. A residential workshop for interested people was organised (attended by the NPDT). At these events information was presented about falls and some of the projects in England shared their experiences. Participants were also trained in the PDSA methodology. Older people and professionals were asked to generate ideas on how their local communities might engage in activities to prevent falls. The emphasis was very much on working together in a collaborative way not the professional or project leads coming up with the ideas. Ideas varied from small individual changes to larger scale community developments;

d. Local Teams took these ideas back into their communities and tested them out using the PDSA framework. These Teams then met fortnightly to feedback on progress;

e. Asecond learning eventwas held to discuss data from a falls register that was set up to monitor where the falls were happening. This was also an opportunity to discuss projects that might help prevent these falls, including environmental audits of pavements, advertising on buses, buying in equipment to give out at information events.

Activities: It was also important that some actual activities were developed in year 1. These included:

- Medication reviews for persistent fallers in a care home leading to a subsequent decrease in falls in this home;

- Falls awareness raising through community members speaking to other older people at community events and issuing falls prevention literature and poster campaign on Stagecoach buses;

- Footwear advice and walking aid maintenance through checking aids and replacing worn ferrules in local community groups and at promotional events;

- Encouraging people to have regular eye examinations, keep their glasses clean and to be mindful of environmental falls risks by ensuring their homes are well lit and avoiding clutter. This was achieved by stands at promotional events and handing out information and promotional material such as tea towels and glasses cleaners branded with falls prevention messages.

- Older people and the council undertaking environmental audits identifying falls hazards on streets;

- Encouraging people to increase their activity levels through information at promotional events about increasing activity in daily life and through the initiation of activity sessions, such as Indoor Kurling at community groups.

Year 2
*On-going developments:*In year two the project was continued without the support of NPDT but with core funding to make the project manager permanent. The project expanded to take in other geographical areas (see below). A key principle was local development based on local need. The local Teams wanted to expand their remit to areas other than falls prevention and a key area of need identified was the lack of exercise opportunities for older people.

Activities in year 2:   Activities led from locally identified need and included:

- Training 4 volunteer team members and 10 professionals to be qualified Chair Based Exercise Instructors through an accredited training course and arranging chair-based exercise classes.

- Introducing indoor Kurling, a fun activity suitable for all ages and abilities, this has developed rapidly.

- The introduction of the interactive computer console the "Wii" to community groups and care settings has also promoted physical activity and increased social interaction to great effect.

- Team members in Aberfeldy and Comrie leading Stride for Life Walks with Perth and Kinross Leisure

Year 3
*What next?:*In year 3 the local Teams voted on a number of options to expand their work and chose to look at addressing some of the issues raised in the Mental Health and Wellbeing in later life report, produced by the Mental Health

Foundation**Error! Reference source not found.**. This suggested five areas which could be focussed on: Physical Health; Participation in Activity; Discrimination; Poverty; Relationships. A range of activities including lunch clubs, social groups and exercise groups have been set up. The geographical areas have also expanded further with the help of additional funding (see below).

Activities in year 3: Again, these led directly from what the Local groups wanted to focus on and included:

- Physical health – encouraging a healthy diet and participation in physical activity through attendance at local community groups and at promotion events;

- Relationships – Providing opportunities to meet together and socialise through lunch clubs, social clubs and exercise groups;

- Poverty - Provision of free energy saving light bulbs and signposting to benefit advice agencies;

- Participation in meaningful activity – providing opportunities to attend and be involved in the organisation of activities in their own communities (for the Team members).

- Discrimination –Intergenerational activities involving local schools competing against the older people at Kurling and the Wii. Mobile phone and computer training is also provided at community groups and lunch clubs.

On-going work
The PDSA methodology has continued throughout the project as a framework for community collaboration. Work continues on all of the three strands of works; falls prevention; exercise and activity and mental health and wellbeing.

The local Teams continue to meet on a monthly basis usually with an event or group meeting in between. These meeting are attended by a member of the project team. At the monthly meetings participants can raise issues that they think should be addressed at a future event or community group, for example stroke awareness information, leg ulcer information, digital switch over training, boiler scrapage service etc. Teams can also be used as a sounding board for consulting on things like information leaflets. The project staff supportthe teams to set up new local projects and have developed logic models for different types of groups, for example lunch clubs.

The aim is for the Teams to become self-sustaining. Teams however, operate in different ways. Some are primarily supported by the core project staff whereas others have secured their own funding and operate under their own management structures with minimal input from the project staff.

*Staffing levels:*There is now a project manager (team leader) and three project support workers working on the initiative and over 230 volunteers across all the areas.

*Routes into community groups:*There are a variety of ways that older people find out and access the community groups in this project including word of mouth, local advertising, bi-annual newsletter, radio and through social and health professionals. There have been good examples of social care workers bringing their clients to lunch clubs and exercise classes or family carers dropping people off to gain some respite time. GP referral is not well established although there had been some success with involving district nurses in a few areas. One

solution suggested was a social prescribing pad for GPs and district nurses but this had not been taken forward yet.

Location of the project: In year one three areas were included: Perth City-Letham, Hillyland, Feus Road, Fairfield; Blairgowrie, Rattray, Alyth; and Crieff, Comrie, Gilmerton, Muthill. In year two the areas spread to take Coupar Angus and Tulloch into the Blairgowrie team and to set up a new team in Aberfeldy. In year three five additional teams were set up in the Carse of Gowrie. In year 4 a new team was set up in the following areas of Perth city – Kinnoull, Bridgend, Gannochy and Barnhill.

4.4.2.3 How the programme works in practice and the enablers and barriers to integration into routine practice?

Enablers

Community leadership: As is apparent from the above discussion, the focus has been on working with communities to develop what they need. Interviewees felt that on the whole, this had been a success and the approach had been embraced by local communities. There is an emphasis on not providing services that are already there but providing new services or sometimes augmenting existing services. This community led approach ensures that activities do not conflict with activities on both a community and personal level.

Senior management buy-in and resource: It was said to be important that senior management bought into the project and that the CHP and Housing and Community Care, P&K Council now provide core funding.

Close working with other agencies: This was also said to be important, particularly, with Leisure Services, Community Learning and development and a range of multiagency organisations (e.g. Home Safety Partnership).

Barriers

Resistance: The project staff team said they had come across some resistance from some in the medical profession because of the lack of an evidence base for prevention or community-based initiatives.

Referral and uptake: There were said to be some barriers to referral from the health service. Patient confidentiality was said to prevent health professionals passing on patient details without their permission and there is also the issue of the so called "proud" older person who may not have been accessing their GP or other health related services and thus not accessing any of the services offered by the programme either.

Sustainability of the community model: Original plans to set up groups and then step back and allow them to function independently was said to be not feasible because of the nature of small communities and problems with an older population who can deteriorate.   This has reduced the potential capacity of the project because of the limits on staff numbers.

Accommodation: In some areas there has been issue with the availability of suitable accommodation to hold social groups and lunch clubs; existing community resources such as the church and school were already well used by other groups (such as mothers and toddlers).

4.4.2.4 How the success of the programme is defined?

At operational level, interviewees were particularly proud of:

- The activity that the project has generated in local communities;

- The power of older people (peers) passing on messages about falls prevention themselves through community events;

- Being able to bypass 'the system' and act directly on problems that were identified. An example of this was changing walking stick ferules or providing long handled shoe horns at community events;

- Using contacts that older people have in the communities to get things done, e.g. getting posters on buses through local contact in the bus company;

- The ability to identify approaches that are appropriate and that fit into the local community, for example making sure that events do not clash with things in older people's daily routines;

- The number of groups that have been set up and the number of people attending them.

In relation to personal outcomes – having an impact on people's lives, interviewees were particularly proud of:

- Individual feedback from older people who have volunteered on the project who have developed skills, gained confidence, experienced reduced isolation and reduced use of health services;
- Some clear, positive,impact on falls preventionbut the data are very locally specific.

4.4.2.5 How the evidence base has been used in the design of the programme?
The upstream falls prevention work was not based on an established evidence base as this was not available. The activities were described as common sense approaches which are likely to prevent falls. (P&K already had a clinical falls assessment/intervention service based on evidence based research)

The mental health work was based on activities suggested in the Mental Health and Wellbeing in later life report which does have an evidence base**Error! Reference source not found.**.

4.4.2.6 What type of evaluation has been carried out of the programmes?
There has been some attempt to measure the outcomes of the project quantitatively but none was said to have been totally satisfactory. These have included the impact on: falls, perceived mental wellbeing (using Warwick, Edinburgh Mental Wellbeing Scale WEMWBS) and social capital.More recently a qualitative evaluation was carried out by the Joint improvement Team using the Talking Points framework[56].

4.4.3 Scottish Borders Transforming Older People's Services: Day Care and Preventative Services
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Sources of Information
Scottish Borders Council and NHS Borders, Transforming Older People's services 2009, www.scotborders.gov.uk/pdf/26482.pdf

Scottish Borders Council and NHS Borders, The Future of Day Services and Day Hospitals for Older People in the Borders: A Discussion Paper, www.scotborders.gov.uk/pdf/26568.pdf

Scottish Borders Council and NHS Borders, The Future of Day Services and Day Hospitals for Older People in the Borders: A Summary of the Responses to the Discussion Paper, www.scotborders.gov.uk/pdf/26567.pdf

Scottish Borders Council,The Future of Preventative Services for Older People in The Scottish Borders, www.scotborders.gov.uk/pdf/26492.pdf

Scottish Borders Council, Transforming Older People's Services Implementation Plan.www.scotborders.gov.uk/pdf/30363.pdf

NHS Borders, Intermediate Care & Rehabilitation Project: Waverley Intermediate Care Pilot Final Evaluation Report (2009) www.scotborders.gov.uk/council/specialinterest/tops/26494.html

4.4.3.1 Who does the programme target?
Older people using social work services in the Scottish Borders.

4.4.3.2 How was the programme developed and what problem did it address?
Scottish Borders Council has approved an eight year forward-thinking plan to modernise services for older people in the Borders. The review has been done in collaboration with NHS Borders, the Voluntary Sector, the Elder Voice and users of the services and their carers. This has involved the development of documents to describe the services and the areas of need, discussion papers outlining potential options for new services[60][62](which have been subject of consultation with a range of stakeholders) and the production of an implementation plan[63]. Pilots have also been conducted of some of the services particularly Waverly Intermediate Care pilot and pilot of Neighbourhood links (described below).

The main thrust of the developments is to shift away from mainstream residential care homes to new forms of housing with support which will allow people to live as independently as they want to. The main service developments include:

- more intensive home care arrangements
- creating housing with care places
- developing extra care housing places
- re-designing Council care home places
- making sure there are places for short term intermediate care
- commissioning external care home places
- investing in new types of day care services
- producing places in social centres
- establishing different types of preventative services.

The Borders approach was selected for case study on the basis of the documentation available. However, thecostedimplementation planfor preventive was only published in April 2010[63]and our case study interviews did not identify active developments as yet; this is probably because actions are taking place in frontline services amongst staff we did not interview. The implementation plan makes recommendations about the new services and outlines how these should be introduced, including discussion of preventive and day care services which are discussed further here.
Day care and preventive services
The newly designed service willprovide short term rehabilitative (intermediate care) interventions and longer term respite for people with medium and high levels of need in 7 locations in the Borders: Hawick, Jedburgh, Kelso,

Galashiels, Peebles, Eyemouth and Duns (rolled out between 2010-2013). This type of day care will be delivered through day hospitals and will focus on short term intervention enabling people to maximise potential and self-manage their own health care needs.

Day care for people with lower level needs will be focussed around social centres which will be developed in partnership with the voluntary sector. These centres will be available for drop in for those who can get to them independently. They will provide some in house social opportunities in collaboration with the voluntary sector but will also signpost/refer people to other community based opportunities. The focus will be on creating opportunities for older people to stay active and remain engaged in their local communities. They could also provide access to computers and computer training for older people. Preventative services will be delivered through these social centres.

Development of preventative services include;

- further development of the Neighbourhood Links Scheme (described separately in section 4.4.4);

- increased health improvement activities (potential for subsidised access to community fitness facilities for older people);

- gardening and handyman services (including garden sharing schemes facilitated by Neighbourhood Links);

- information resource on the availability of community services;

- activities and opportunities (including increased volunteering opportunities).

The implementation plan also discusses the need to develop specific transport service and the availability and accessibility of public transport to ensure good access to the social centres. None of these developments is well established yet.

4.4.3.3 How theprogramme works in practice and the enablers and barriers to integration into routine practice?

Implementation of the service re-design in the Borders is in the very early stages and as such the enablers and barriers to implementation are not yet clear. Below, however, are some of the issues that were identified in the case study interviews relating to the strategies that have been adopted to facilitate implementation.

Enablers

*Extensive consultations with stakeholders:*Throughout the service redesign there has been extensive consultation with a range of stakeholders including NHS partners, voluntary sector and older people.This was thought to stand the programme in good stead for its implementation.

Good communications: A communications plan has been developed to manage the organisational and cultural change that will be required.

Involvement of primary care: Primary care practitioners are thought to be essential to implementing the service redesign and were involved in the consultations. In particular health centres in the two of the 'early implementer' areas (Kelso and Jedburgh)have been engaged in the change process. In general these practitioners have been welcoming of the changes with the caveats of the service being of the right quality and the continued availability of guaranteed resources.

Barriers
Whilst these have not been encountered yet, there is awareness of the need for work oncommunity capacity building to ensure that third sector is supported in meeting the needs of the service redesign. The Change Fund was identified as a potential source of funding to develop this area. A fund is proposed which voluntary organisation can access to set up community based opportunities.

4.4.3.4 How success of the programme is defined?
This service is in the early stage of implementation and the measures of success have not been clearly defined, however the likely desired impact has been identified as the following:

- Improved personalised outcomes

- Cost effectiveness

- Service outcomes (numbers in care homes decreased (taking into account increased number of older people), decreased emergency admissions and multiple admissions, decreased length of stay if admission is required (These are currently high in the Scottish Borders).

4.4.3.5 How the evidence base has been used in the design of the programme?
The redesign of day care services and preventative services has largely been based on recognition of the need to shift the balance of services, the need for cost effective services and the desire to develop services with strong user-focussed outcomes. Whilst no clear use of the evidence has been stated in documents or in interviews it is likely that the services have been developed on the basis of the evidence available in the national policy.

4.4.3.6 What type of evaluation has been carried out of the service?
The use of Talking points to measure personalised outcomes is being applied as an evaluation tool in some areas, particularly in the on-going evaluation of Neighbourhood links.A full evaluation of the service redesign is planned but has not yet been commissioned.

4.4.4 Borders Neighbourhood links
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Sources of Information
Scottish Borders Council and NHS Borders, Transforming Older People's services 2009, www.scotborders.gov.uk/pdf/26482.pdf

Scottish Borders Council, The Future of Preventative Services for Older People in The Scottish Borders, www.scotborders.gov.uk/pdf/26492.pdf

Community Health and Social Care Neighbourhood Links and Red Cross Buddies, Quarterly Reports July-October 2010 and October – December 2010 (Sent to Researcher by Jenny Miller)

4.4.4.1 Who does the programme target?
Neighbourhood links is a service which is available to anyone over 16 years of age, however a large proportion of the client group are older people. People accessing the service are defined as having low to moderate support needs by social services.

4.4.4.2 How was the programme developed and what problem did it address?
The Neighbourhood links project was originally a two year pilot project which started in 2008. It was funded by the Transforming Older People's Services and Delayed Discharge fund. Based on the success of the pilot the project has been continued. The project came about following a shift in the eligibility criteria for social work services so that only the people with critical and substantial levels of need could access social work service. This left a group with moderate to low needs that would benefit from social contact and other activities in their local area. The project has a preventative focus aiming to keep people active and socially "in touch" with their local community, which should ultimately improve their health and wellbeing.

People undergo an initial assessment which usually comes through a referral from social work but can come from other sources (e.g. health visitors). The assessment considers both personal needs and what interests individual people have. The worker then tries to match the person up with local groups and activities. The support worker can also help with access to basic level support services, for example small items of equipment. There is also a link with a sister project called Red Cross Buddies to provide one-to-one support on a time limited basis to help people "to get back on their feet"(e.g. gaining confidence to go out socially, shopping help for people who have been in hospital). The Neighbourhood links workers are responsible for collating information about locally available opportunities and identifying the need for local capacity building when required.

The service is delivered in partnership with the Voluntary Sector – Borders Voluntary Community Care Forum (BVCCF) and Red Cross - and NHS Borders. There are currently three project workers but there are plans to expand (possibly drawing on the Change Fund).

4.4.4.3 How theprogramme works in practice and the enablers and barriers to integration into routine practice?
Enablers
*Presence of project volunteers in district hospital:*As a pilot some Red Cross Volunteer Buddies were available in the district hospital which is thought to have helped links between health, social and voluntary services.

Awareness of the scheme across sectors: Senior staff and managers are said to have good awareness of the scheme which helps in it being well used.

*Pilot work in two hospitals:*Pilot work with two community hospitals around supporting people on discharge from hospital was said to have helped establish links and there are also established links with local rapid response teams.

The Red Cross brand: The association with the Red Cross was said to have helped older people accept the service as credible.

Barriers

Referral: Initial problems identified with getting other agencies to refer to project, particularly health practitioners is being overcome through awareness raising and good local support.

Resistance to accepting support: Older people are said to be independent and not keen on accepting the offer of support or at receiving support from the voluntary sector instead of social work services. However, being associated with the Red Cross has helped (see above).

*Few links with primary care:*There is currently not a strong link between primary care and the project with very few referrals coming from primary care. Some attempts have been made to raise awareness but there is still an identified need for better links with general practice.

4.4.4.4 How success of the programme is defined?
At operational level, interviewees were particularly proud of:

- being described as good value for money with a big impact for the cost;

- after initial problems now having good awareness of the project across health and social care with referrals from a range of service providers, with the exception of general practice which requires further development.

In relation to personal outcomes – having on impact of people's lives, interviewees were particularly proud of:

- arranging for additional aids to be accessed by service users so they are able to remain in their homes longer, be mobile and independent. This means their confidence is increased because of the sense of safety/security that the aids give – reducing risk of falls, making simple tasks which had become difficult, simple and achievable again;

- Social contacts being re-established by having a Red Cross Buddy to accompany service users which means that health and well-being improves and unpaid carers are given respite;

- New skills being achieved by the personalisation of information and support for access to additional resources – the person is supported in accessing things they are interested in and they can get training in;

- General health and well-being is being raised through attendance at exercise groups.

4.4.4.5 The evidence base has been used in the design of the programme?
There has not been an explicit use of the evidence base in the design of this project.

4.4.4.6 What type of evaluation has been carried out of the service?
Talking points and the Well Being Index have been used as a framework for an internal evaluation with individuals using the service at the point of contact and at six months. These are presented in quarterly reports along with case study examples[64]. There has, however, not been a rigorous external evaluation of the project.

The evaluations using Talking Points have shown a positive impact on quality of life (particularly social contact and having things to do), process outcomes (reliability, responded to, treated with respect, having a say and listened to) and change outcomes (particularly improved confidence). There has also been a positive impact on wellbeing measured before and at six months.

4.4.5 Summary
The four case studies were chosen because they reflect different types of project but all aim to enable health and well-being and to help older people to live in their own homes.

*Greater Glasgow and Clyde Osteoporosis and Falls PreventionService*has the longest history, based on an initial pilot conducted in 2001 and formally set up in

2004. It targets people aged over 65 who have already had a fall, but believes its holistic, preventive approach means that could extend to a 'general gerontological service'. It is an evidence-based approach (informed by current NICE and Department of Health guidance) that offers initial assessment and onward referral across a range of services in health and social care. It is s said to work well because: it is cost effective (having trained occupational therapy technicians to undertake initial assessments and to coordinate personalised input); it has support from across the health and social care divide and in the voluntary sector; exercise classes have wider reach than usual for such services (because they are locally delivered and free transport is offered) and strong links have been developed with other local professionals and services, both to refer in and to refer out of the falls service (this has been facilitated by the use of referral pathways). Interviewees had identified gaps they would be keen to fill, specifically, better ways to support people with psychological problems, fear of falling and who were socially isolated. A full evaluation has supported their work and findings used to inform developments into the future.

Perth and Kinross Healthy Communities Collaborative also has a relatively long history, being set up as a pilot in 2005 but has continued to operate, changing its work plans and expanding its range in each year of its existence. In the first year its focus was on falls prevention; in subsequent years the project moved on to projects relating to physical health, exercise and activity and mental health and wellbeing. It uses the 'plan, do, study act' (PDSA) methodology of the Collaborative approach; project workers support the work of local teams of older people themselves in neighbourhoods across the region. It is said to work because of community leadership, support from senior managers, and close working with other agencies. Like other programmes it faced initial resistance from existing providers, which is being overcome; experience also suggests that local teams need the support of project workers to sustain their activities. There was a limited research evidence base for its 'upstream' falls prevention work, which instead was said to be based on common sense approaches which are likely to prevent falls'. Subsequent work was framed around activities suggested in the Mental Health and Wellbeing in later life report which does have an evidence base. Attempts to measure quantitative outcomes data have been frustrated, but a qualitative evaluation using 'Talking Points' has recently reported.

Scottish Border's plans '*Transforming Older People's Services'* and in particular the redesign of *preventive and day care services* has only recently been initiated. It has been developed with wide stakeholder involvement and, in line with the current moves for community capacity building and engagement, highlights a major role for the voluntary sector. Part of the programme in the Borders that will receive continued support and further development is the *Neighbourhood Links* scheme. Set up when Social Work Services recognised a need to focus resource on those most in need, it aims to provide support to people who have low to moderate needs and help them access a wide range of community-based resources based on their own interests. Its basis on the Red Cross has been seen as an advantage in reaching older people, and pilots of project workers being available in the local hospital was said to have helped to overcome traditional barriers between health and social care.

The longest running programmes had overcome barriers identified through a combination of local champions' persistence and developing formal referral pathways. They have had clear leadership and support from senior managers

with clear work plans and reporting structure. They have used the evidence base where available, particularly in the form of guidance, in part to structure their work. They continue to collect and use referral and outcomes data to guide their work and have commissioned external evaluations.

All programmes recognise the important of primary care in further development; one already makes good use of the SCI Gateway which allows for the secure electronic referral of patient information from general practitioners.

5 Perceived gaps in policy and practice and barriers to effective working(aim 2)

Perception of gaps in policy and practice to enable health and wellbeing in later life were identified through interviews with national leads, in the case study interviews and through discussion at the knowledge exchange event.

On the whole the existing policy documents and national programmes were seen as providing a strong foundation for the development of services. Participants at the knowledge exchange event were enthusiastic about the national programme 'Reshaping Care for Older People' and in particular about the 'change fund' associated with it,which had just receivedapplications for development work from local partnerships of health and social care and the third sector.

The ageing of the Scottish population and financial pressures on existing services were said to be clear drivers for change to shift the balance of care. The pressure for better quality of care focused on the outcomes that are important to the people was also said to be important. Barriers to policy implementation and practice development were also identified.

5.1 The evidence base and evaluation

The evidence base and local evaluation of services through the collection of high quality data was felt to be and important gap and was one of the key issues discussed at the knowledge exchange event.

5.1.1 Perception of the evidence base and its influence on practice

There was thought to be good examples of the use of the evidence base in Scotland, and in particular through falls prevention work led by government but implemented locally. Guidelines, evidence summaries and implementation plans were thought to have been very useful.

However, frustration was expressed that service development was often based on political expediency rather than good evidence and that where there was good evidence, for example about the benefits of physical activity in later life, there was rarely any development funding to promote it. This was expressed as a problem of delay:

> "one of the big issues is how long it takes for something to get from research into policy and then from policy into actual implementation." (Interview 8)

Some people were also concerned about the way evidence was interpreted in practice at local levels. Whilst tacit knowledge and experience-based practice were seen as important, there was a feeling that sometimes people just did their own thing rather than developing evidence based practice.

And just say, you know, not that…I don't want them to go as far as saying don't fund something if it's not at all evidence based because, actually, there's a lot of good practice out there, it just hasn't had the research on it but it's just pushing the fact that if there's a difference, if you've got something with research base, use that research base and add on it, don't do your own thing. (Interview 8)

Participants in the knowledge exchange event expressed this as '*knowledge running ahead of the evidence base*', particularly for telecare and re-enablement programmes. In practice both these initiatives were said to be effective at preventing or delaying disablement and maintaining independence yet there is no hard systematic evidence to support this.

There was a strong argument at the knowledge exchange event that practitioners need help to translate the research into practice to ensure that the evidence does not get 'watered down'. They suggested that the government could leverage better links between research and practice by prioritising evidence-based developments in initiatives such as the Change Fund. Participants argued that there is a need for a better evidence base for upstream interventions and that practice for where evidence shows that the intervention is ineffective should be withdrawn.

5.1.2 The evaluation of practice and new services

Both interviewees and knowledge exchange event participants noted that there had been a range of initiatives delivered but that there was not always an effective mechanism for evaluating their impact.

Again some very, very good evidence which of course doesn't feature [in the] review because it probably isn't at that level of research. There is some very good evidence coming out from south of the border and also from work that we commissioned in Edinburgh on re-ablement, where focusing on a re-ablement model, training your home care workforce and redesigning the way its delivered by having more focused intensive re-ablement, there's evidence now that it's got improved outcomes for people it reduces the care packages people need for 12 month/two year follow up as has been the case in England. (Interview 3)

Again, there was frustration amongst the practitioners and managers at the knowledge exchange event that:

- there is a lack of 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; and

- evaluation is carried out as an afterthought and is not integral to service development.

To improve the conduct and use of evaluation there was felt to be a need for some central support to develop standardised outcomes including developing tools to measure outcomes most important to older people.There was some recognition of the innovative use of Talking Points[9] as an evaluation framework that does this but a perceived need for more development of this as a routine service evaluation tool.

There was felt to be a need for minimum datasets collected over time and used for quality improvement and that funding for practice development should

advocate clear plans for evaluation as a key requirement and funding should be allocated to this evaluation.

Finally, there was also frustration at what is perceived as 'short-termism' from government and health boards. Measureable change takes time and it was felt that government funding needs to be sufficient to allow changes to occur.

In summary there was considerable enthusiasm for the use of an evidence base and for the collection and robust use of evaluation data for quality improvement. There was great frustration at how difficult it can be to achieve this although central support (such as was provided by the Falls programme[29]) and the use of Talking Points[9] was said to be of potentially helpful.

5.2 Supported self-management of long-term conditions.

Whilst there was recognition that policy had advocated supported self-management and involving people in activities to maintain their own physical and mental health, this was still seen as an area that was lacking in practice development and implementation.

> "And, to me, although there is some nice policies in Scotland about keeping people in their own homes and ensuring that you give them lots of support, it's caring and doing things to people, as far as I'm concerned, still, it's not encouraging them to self-manage and to use activity, not just to keep them in their own home but also to keep them socially active, socially included, reduce the pressure of mental health issues" (Interview 8)

Respondents supported the need for more upstream initiatives to help prevent people becoming frail and dependant. Current policy directives on screening were seen as focussing on the most complex high users;however, it was felt to be equally important to find ways of identifying older people, particularly those with chronic conditions, at an earlier stage and support them to self-manage their conditions or maintain their health.

> The work that we did around long term conditions has…it's such a focus around, yes, the complex care, the high users, the 5% percent at the top of the pyramid, but much more …much more upstream down the pyramid looking at supporting self-management, so I see that if we get that right in people at earlier stages in their journey with a chronic condition, that we'll be doing more to prevent or delay the progression of disability and this is…it's a conversation I've had and people sort of…some of my colleagues in policy don't get it yet, they think of older people as, you know, a problem that suddenly appears when you get old and I said, well actually no, people who are frail and dependant in old age, it's because their chronic disease has progressed to graduate to that, they don't just suddenly become old and frail. (Interview 2)

Although it was recognised that some work had been done to support this there was still a need for appropriate structures to develop practice. An example of a good structure to support self-management was the formation of Long Term Conditions Managed Clinical Network in Orkney.

5.3 Barriers to implementing new practice

There was recognition that policies and recommendations in services and service delivery were coming thick and fast, and that this presented potential barriers to the integration of change into practice. The financial capacity to change services

was said to be a key issue, as were issues with staff capability. A performance framework to draw services together was seen as one solution to ensuring that services became integrated in practice.

> *I think there is an issue around capacity and capability that we come up against those a lot. Some of it is around supporting capacity around partnership working. So about that strategic way of working together, lots of governance people work. So again you've a lot of good work going on but it's not necessarily pulled together in a coherent way. So there isn't a performance framework for example maybe to support what people are trying to do. So things fall off, you've got a really good idea, some people might run with it but it falls off the table and nobody picks it up. Often not even a consequence of falling off the table because it's not really integrated in the way people work. (Interview 3)*

Training at all levels was also seen as important, including ensuring new practitioners coming into the system had been properly prepared and ensuring that non medically qualified support staff were trained in the principals of re-ablement and were able support older people in a way that maximised independence. There was a suggestion that there was a need to blur professional roles to ensure that, for example, everyone involved with older people was able to help with exercise training.

> *"I believe if we're really going to make enable, re-enablement work we have to blur the boundaries, a little bit, between the professions. So physios have to support other professions working on moving people on, which includes OT, because occupational therapists often train in these and then find they're not allowed to deliver it locally because the physio says, that's my job, so we need to blur the boundaries a wee bit, we need to ensure there is more talking between the external exercise professionals and the health professionals a bit more, sort of, get them together so they understand each other's roles and knowledge base." (Interview 8)*

Funding was seen as a big issue, particularly moving investment and services around when there is no capacity to double fund (fund a new and old service at the same time), which could be helped by a pump priming approach to new initiatives. However, there was great enthusiasm for the Change Fund to do this and ground level support for the requirement that applications had to come from local partnerships.

There was also said to be a need for a long term view about how resources were used, for example investing in falls prevention initiatives in order to prevent falls which can lead to the use of expensive resources in secondary care.

> *"its how do you move investment and services around within the system. How do you stop doing something and how do you start doing something else? Because you don't have the money to double fund now." (Interview 4)*

Although there was still some issues of silo working between health and social care some felt that this was now less of an issue.

> *"I suppose, challenges that we have when we're in doing some work with an area is trying to build that capacity and capability as how they work. And we do try and promote the partnership context to it. Because there's still a lot of, as we know, silo working, and re-design that goes on*

in parallel universes if you like. So you have lots of good work going on, but it's - people aren't thinking about well if we're doing this what implication does it have for something else within the bigger system. I think that catches people out." (Interview 3)

However, there were still seen to be major problems in integrating primary and secondary health care.

"maybe my perception's different from most people's because I actually think the partnership between primary care, you know, community health and local authority services, I actually think that's a pretty healthy partnership in most areas in Scotland, I think the biggest challenge is between that partnership and acute." (Interview 2)

At the knowledge exchange event there was considerable support for applications for the Change Fund to come from partnerships and to demonstrate that they would result in shifts in the balance of care.

5.4 Good practice but not joined up

Whilst there were said to be many examples of good practice throughout Scotland when we asked people to identify particularly good health boards or partnerships there was a general feeling that no one area had got it completely right. The lack of a joined up service both at higher level and local practice level was also identified.

I think that's difficult, because I wouldn't say there's any one partnership or one board cracked it across the whole continuum. There are examples of partnerships of boards who are doing components really, really well and we need to sort of spread and share some of those models, but I wouldn't say that there's any one that's doing the whole thing. (Interview 7)

Anyway, that's the sort of…that's the kinds of things…I think there's strategic level things, I think there's practice level things, there are whole service development levels about how there are gaps in the system where there are lots of individually good things, but they're not all joined up. (Interview 6)

As stated, this was a source of considerable frustration amongst managers and practitioners at the knowledge exchange event who felt powerless to improve the situation. They felt that a culture that minimised risk was one of the main culprits of the difficulties in integrating services and to evidence-based practice but felt optimistic that the powerful incentive of money from the Change Fund would drive more integrated working.

5.5 The role of general practice in enabling health and wellbeing

5.5.1 Deep end focus groups

Five GPs working in some of the most deprived practices in Glasgow attended a focus group discussion about policies and practices for elderly patients, drawing on their experience, commenting on a presentation about the current policy review and considering what types of intervention would be feasible and acceptable in maintaining independent living at home.

The participants were presented with summaries of some of the recent initiatives to enable health and wellbeing, and facilitate change. However, even the most well-known (such as SPARRA and HEAT targets) were said to have little profile and impact in general practices who instead see themselves as addressing the practical needs of patients on a day to day basis.

> the CHCP did a recent project on it and sent us SPARRA information about our elderly patients and asked us to do a one off project looking at these people to see if there's any relevance to us and I didn't know anything about SPARRA before and we've had no involvement with it since and really,[…….] at a follow up meeting, the view was, is, we didn't learn anything we didn't already know about our patients and there wasn't really anything that we hadn't already been doing to these patients that we could have done to change. (GP1)

They also felt that care of older people had become increasingly fragmented, with acute hospitals becoming less helpful in providing comprehensive care, often addressing only some of a patient's problems, with early discharge and inadequate communication to the practice.

> the main reasons for readmissions for a lot of my elderly patients is [……] they're never sorted out properly, it's almost like a sticking plaster approach, they send them in acute condition, junior doctor will send them out with a list of medications, no diagnosis, no information and the patient says, ah, "I'm still not well" and you're in the dark, that's my main, main concern, is that I'm treating my patients with no information. They come out from hospital, has the basic problem been sorted out and what has been planned for the patient, what's the follow up? Nothing. (GP2)

They felt that joint working between professions and services in the community is patchy, but some did give examples of when it can work well, especially when colleagues know each other by name and have developed mutual respect and trust. For example, there were some good examples given of transparent referral and joined up care in the Falls service but also views that onward referral from this can lead to delays.

> I referred someone to the falls team recently and they were seen very promptly by a home assessment, by an OT and then they've had to wait quite a long time to go up to the hospital to see the medical team, so there was an initial fast response, but actually, maybe the bit that I wanted them to see took longer. (GP3)

District nurses and heath visitors were seen as an invaluable source of cumulative knowledge about older patients, their problems, preferences and circumstances. If shared effectively, such knowledge was said to protect against impersonal, fragmented care. They felt that patient expectations and family resources are lower in deprived areas, providing different types of challenge for primary care teams and highlighting the importance of good team working with community nurses.Participants also said they and their colleagues were hesitant to adopt a proactive approach, because of pressure of work, lack of resources and patients' reluctance to see themselves as vulnerable and needing care; they said that screening of older patients is only justified if it provides new information and if needs can be met and that practitioners prefer a case-finding approach, making use of routine contacts to provide individual advice. They said

that case-finding would allow them to make additional, community-based, services known to patients if only they were better informed about what is available locally.

They said that in severely deprived areas, "elderly people" are younger, in terms of having less healthy life expectancy at a younger age and that the Keep Well target age range of 45–64 is appropriate, therefore, for measures to promote healthy living and maintain independence in older people in deprived areas. They said that Keep Well has worked best in deprived areas when delivered in close collaboration with practices.

> *I find the fifty plus a useful threshold when you are talking about someone who is older then there's less, sort of, stigma, you know, they've not suddenly reached that age of decrepitude and written off by society and if you say, look, it's younger people as well. But then it does also help target those people who are, you know, as you say, biologically older, you know, fifty something and you're wanting to get them to some more of these healthy activities that may actually change their lifestyle and help so, I think the threshold is key and I think younger rather than older. (GP4)*

Finally they suggested that an expanded service is possible, but only if core services are secure.

5.5.2 Other interviewees and knowledge exchange participants

Interviewees also suggested that general practitioners should have a leading role to play in anticipatory care. The Nairn general practice based anticipatory care project[51] was highlighted by several people. GPs were seen as having valuable insight into the triggers that could result in the decline of an older person an observation echoed in the Deep End focus group.

> *"Planning for those people whom at this stage…and even to the extent of knowing…because some very often have partners that are in the same surgery…if one of them dies, these are big turning points in people's lives that can trigger depression or some kind of downturn in their wellbeing, and you really think that there needs to be much more anticipation of those kinds of issues by all health care professionals. But GP's have got a leading role to play in that, so I do think that whole concept of anticipatory care…and much of it can be predicted right now, you know…(Interview 6)*

> *"I suppose what I'm saying is that there is huge potential there, and you know, particularly for people who…they don't go to A&E, the Scottish Ambulance Service don't attend, they don't have community alarms…the GP is in a good position to identify these people earlier on before these kind of injuries occur. Now, there probably issues around GP's understanding, what's available in their locality for example, what the referral routes are et cetera." (Interview 7)*

There was some concern expressed about how aware GPs were of the services that were available to them.

> *"I should perhaps be a bit more cautious about saying that GP's fully understand the network of resources because they don't always. And actually that remains a bit of a problem for them. And they don't*

certainly…some of them don't take the time to understand all of that"
(Interview 8)

This was particularly the case for knowledge exchange participants. For them, general practitioners played a key role in the lives of older people and they really wanted to involve them in on-going and new developments but were frustrated with not knowing how to do so. There was a perceived lack of enthusiasm from many general practitioners for the kinds of approaches they were developing.

The quality outcome framework was highlighted by a couple of people. Whilst it was regarded as useful framework to incentivise GP involvement there was a feeling that it could leave gaps in services because practices may focus more on areas with QOF points. This was regarded as detrimental to some older people's services particularly dementia care and falls which do not have QOF points.

5.6 Summary

On the whole the existing policy documents and national programmes were seen as providing a strong foundation for the development of services. There was particular enthusiasm for the national programme, Reshaping Care for Older People and its associated 'Change Fund' which through bridge funding aims to stimulate shifts from institutional care to home and community based care and facilitate subsequent de-commissioning of acute sector provision. This funding will be available to local partnerships including health and social care and the third sector on the basis of Change plans prepared by these partners.

The ageing of the Scottish population and financial pressures on existing services were said to be clear drivers for change to shift the balance of care. The pressure for better quality of care focussed on the outcomes that are important to the people was also said to be important.

Barriers to policy implementation and practice development that were identified included:the length of time it can take to get evidence into practice because of the complexities of the services and problems that are faced; that good practice cannot be shared because of the absence of data on whether and how it worked; the recognition that many current programmes have focused on people who already have problems but that there is now a need to focus on supporting people to stay healthy and self-manage their problems; barriers to implementing new practice including capacity of local communities and the need for training at all levels; funding for new development, or disinvesting in old services in order to develop new approaches continues to be a difficulty (though case studies show this has been possible in some areas and there is optimism about the Change Fund's role); and finally, it was recognised that there were island of excellence all over Scotland, but that very often no single area had got it completely right – there was good practice but it was not joined up.

General practitioners and primary care in general were felt to have an important role by many interviewees. The Nairn general practice based anticipatory care project was highlighted by several people as an example of good practice and GPs were seen as having valuable insight into the triggers that could result in the decline of an older person. Engaging with general practitioners was sometimes seen as a problem, but there was a real keenness to do this. There was also enthusiasm for an expanded role in enabling health and wellbeing in later life amongst the general practitioners who took part in the focus group discussion as long as core services were secure.

6 Conclusions

6.1 Problems, policies and programmes (RQs 1, 2 and 3)

The need to respond to demographic change and predictions of the future cost of health and social care services drives most of Scottish policy and programme development in relation to enabling health and wellbeing in later life. This need has been felt by government, by NHS and by third sector organisations and has resulted in thirteendifferent policy documents, published between 2002 and 2010, relating directly to or with major implications for enabling health and well-being in later life.

Government levers for implementing policies have involved targets, benchmarking against outcomes, payment for performance and national programmes to coordinate, support, and direct national investment in local development. The national programmes such as the Falls Initiative, the Joint Improvement Team and the Long Term Conditions Collaborative have been seen as the main vehicles through which guidance can be developed, good practice fostered, and investment channelled in new ways of working in local areas. They have certainly resulted in local changes to the way services are delivered, for example in local falls services, intermediate care, and care management services (also in telecarewhich has not been covered in this overview).

However, to date, these government promoted programmes have focussedmainly 'downstream' on people who already have problems so as to support them better at home. Programmes that focus 'upstream', before problems become acute, such as those to reduce social isolation and improve general wellbeing, or to promote physical activity, have on the whole been the preserve of the voluntary and third sector or have been developed at a local level. This has resulted in less coordinated, patchier, developments some of which are nevertheless highly innovative. There was a perception in the interviews that although there was good practice this was not yet joined up locally or consistent across Scotland. Participants in the knowledge exchange event particularly welcomed the opportunity to share good practice from different areas of Scotland. There is considerable optimism that the community capacity programme through the Joint Improvement Team's Reshaping Care for Older People programmes, and the use of 'the Change Fund' to incentivise and promote these changes, may help move services upstream.

6.2 Programme operation, success and the involvement of primary care (RQs 4-7)

As we have seen, the move to shift the balance of care from the acute setting to community and home-based care is now well established as is joint working across health a social care. But barriers still exist. The 'Integrated Resource Framework' initiated by the Shifting the Balance of Care programme has yet to be experienced in everyday practice by any knowledge exchange participants or interviewees. Incentives to shift resources were felt to be hard to operationalise although optimism about the use of the Change Fund ran high.

There are many pockets of good practice in the development of initiatives to enhance the health and wellbeing of older adults, many of which are in line with the current evidence base. The longest running local programmes investigated in more detail in case studies were able to articulate and demonstrate their success. They had overcome a range of barriers to integration into routine

practice through a combination of local champions, persistence and developing formal referral pathways. They have had clear leadership and support from senior managers with clear work plans and reporting structures. They had used the evidence base where available, particularly in the form of guidelinesor good practice guidance, to structure their work. They have also used data either from external evaluation or routine data collection to guide further developments.

A clear desire for better involvement in, or integration with, primary care practitioners, was expressed by interviewees and knowledge exchange participants. The general practitioners who took part in a focus group discussion also expressed a desire to understand better what was available to support people in their local areas. The development of relationships between professionals was felt likely to facilitate this involvement as was the use of secure electronic referral of patient information from general practitioners.

6.3 Perceived gaps in service provision and imagining a future (RQs 8 and 9)

The Reshaping Care's vision of older people in Scotland as a valued asset, whose voices are heard and who are supported to enjoy full and positive lives was wholly endorsed in this mapping exercise. There was a clearly expressed desire to 'move things upstream' and to promote health and wellbeing. There was also clear enthusiasm for the use of research evidence, for the collection and use of routine data to guide improvements, and for services to be driven by what matters to older people. The direction of travel was wholeheartedly supported by interviewees and all participants.

The problems arose in relation to the implementation of the big ideas; frustrations were expressed at the patchiness of developments, at the perceived lack of integration and their perceived powerlessness to make things happen better and faster. Integrating services between health, social and voluntary sectors was a particular priority as was involving general practitioners and other primary care staff in future developments.

There is a clear need to ensure that all current practice and future development of programmes to enable health and well-being in older adults are explicitly based on the best available evidence. This may involve decommissioning of practice for which the evidence base is negative. Where evidence is not conclusive, but programmes of work are introduced because they are perceived to have likely benefit, there is a need for close monitoring and on-going evaluation of their impact and outcomes for older people.

The routine embedding of rigorous evaluation into programme development has been seen as essential by interviewees and knowledge exchange participants. This will require both financial commitment and commitment to allowing sufficient time for programmes of work to become embedded into routine practice. There was a clearly identified need for support for service developers and practitioners to interpret and apply the evidence base. There was also a desire to work with the research community to develop national standards for evaluation and outcome measurement which are both rigorous and centred on the outcomes that are important to older people.

Research and development programmes that focus upstream to bring together older people themselves, community based organisations and health and social care services from different sectors to enable health and wellbeing in later life are likely to be welcomed.

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