

Final draft

An Evaluation of the Ageing Well Pilot Project, Lewisham

Dr A Turnbull, July 2008

An Evaluation of the Ageing Well Pilot Project, Lewisham

Annamarie Turnbull, July 2008

CONTENTS	Page
Executive Summary	3
Recommendations	4
Background to the Ageing Well Pilot Project	5
Evaluation aims and methods	8
Strengths, weaknesses and gaps in the evidence base for preventative services with older people	11
Evaluation findings - Meeting the needs of older people	18
- Partnership working and care pathways	28
Appendices	
Appendix 1 - The projects' timelines – Set up and staffing – Activities	
Appendix 2 - Client case studies	
Appendix 3 - Some of the group activities being run by the Ageing Well Projects	

Acknowledgements: My thanks to the people who facilitated this evaluation. These included many busy health and social care workers and volunteers who provided me with much thoughtful feedback on the challenges of supporting older people. I am particularly grateful to the older people who gave their time to speak at length with me about their lives and their experiences of the Ageing Well projects. Although their names have been changed I hope their individual voices are heard clearly in this report.

Executive Summary

The Ageing Well pilot projects are successfully meeting the needs of referred older people in Lewisham for preventative interventions at primary and secondary levels.

The projects are providing a range of services that meet older people's needs for companionship, friendship and regular social activity outside their homes. Many of these older people are living alone and Ageing Well has provided opportunities for more support in the home as well as opportunities to engage in activities in the community.

Practical support is also plentiful. One of the big successes of the Ageing Well projects has been attention to the 'little things'. These are the hardest to quantify but the older people using the projects report that they make the most difference to them.

Another success is how the services are being delivered – flexibly, responsively and respectfully, dealing with the issues that are important to the older people themselves, no matter how small. This personalised approach has proved to be particularly effective in reaching older people, many of whom are reluctant to approach services.

Sensitive assessments are being undertaken of people's needs, often in their own home and revealing a range of difficulties that they are facing but of which the referring agency was unaware. This is leading to a significantly increased take up of service entitlements and to appropriate signposting to other services. The information needs of older people are being met imaginatively with a strong local focus.

The Ageing Well projects have developed partnerships with both statutory and community and voluntary services. Good working relationships have been established with nurses in GP practices, physiotherapists and particularly with occupational therapists. Referrals from social workers tended to be for older people who were already in receipt of support and often were not suitable for the primary and secondary preventative services that the Ageing Well projects are providing.

The three Ageing Well projects have been recording information and monitoring their services in different ways – some record more information than others. This has made it difficult to track the progress of clients and compare across projects; more importantly it means the three projects cannot demonstrate their effectiveness in delivering specific preventative outcomes in a consistent way. This is vital for securing future funding for preventative work.

Recommendations

Recommendation 1

Future preventative work with the 'younger old' should maintain the focus of developing personalised services and strategies around areas where there is strong research evidence for efficacy, namely social interaction, exercise, and diet.

Recommendation 2

Future preventative work should ensure the initial focus on primary prevention and the 'little things' continues. This is contributing to improved quality of life for the older people the Ageing Well projects are working with and is highly valued by them.

Recommendation 3

Detailed assessments and individual work on welfare benefits has meant substantial financial gain for clients. This work should be prioritised in future preventative initiatives.

Recommendation 4

Preventative services should continue to build on the Ageing Well Project's excellent information dissemination and prioritise providing advice and information consistently for all older people approaching the projects.

Recommendation 5

Greater attention should be paid to the interface with referring health and social care professionals. More formal and detailed referral procedures that include regular feedback to the referring agency could be developed.

Recommendation 6

To build and develop the quarterly monitoring of the work to record relevant data about older people who have been referred and the outcomes of the referral. This information needs to be recorded consistently across all projects and any future preventative projects.

Introduction

This report provides an evaluation of the three Ageing Well pilot preventative services.

The central focus is 'at risk' older people's experiences of their involvement in the three projects, in particular the impact of the pilots on three areas where there is strong research evidence of potential efficacy for preventative work with older people: social engagement, exercise and diet.

While the Ageing Well Pilot Project is not continuing in its current form it is hoped that the findings and recommendations will be addressed in the future development of preventative services for older people in Lewisham.

Background to the Ageing Well Pilot Project

How the Ageing Well Pilot Project developed

A number of policy drivers coalesced to focus the development of the Ageing Well Pilot. In 2005 the Department of Health initiated the £60 million Partnerships for Older People Project (POPP) as part of its ongoing agenda to 'develop services to engage, enable and empower older people'. The strategic aim of the project is to test and evaluate (through pilots established during 2006/07 and 2007/08) innovative approaches that sustain prevention work in order to improve outcomes for older people. Lewisham was unsuccessful in its application for POPP funding and a Borough-wide prevention project was therefore not feasible.

The White Paper 'Our health, our care, our say' (2006) identified seven outcomes for adult social care to reflect the broad vision of offering people more control, more choice and more high quality support to enable them to access services and play a fuller part in society. The outcomes were incorporated into the Commission for Social Care Inspection's (CSCI) 'Outcomes Framework for the Performance Assessment of Adult Social Care' and inspections of 'Independence, wellbeing and choice' were launched in 2007.

In Lewisham Local Area Agreement (LAA) funding of £400k and funding of £50k from New Deal for New Cross Gate, the latter to be spent in the New Deal catchment area, enabled the pilot project to be developed. The pilot built on the ideas and thinking behind the POPP submission and the outcomes framework and aimed to focus on areas which already had some voluntary sector infrastructure that could be developed.

Location

In devising the project a careful assessment of the location of Lewisham's older residents was made and resulted in the development of three areas in which to focus the work. Overall the projects were to be focused on areas where 59% of the Borough's population of 25,401 people aged 65 plus lived.¹

Ward Focus of Ageing Well Pilot Project

Area one – south east: Grove Park, Downham, Whitefoot, Bellingham

Area two – south west: Catford South, Forest Hill, Perry Vale, Sydenham

Area three – north west: Evelyn, New Cross, Telegraph Hill, Heathside and Lethbridge estate.

Throughout this report the three elements of the Ageing Well Project are referred to as follows:

South-east Ageing Well Project – AW-SE

South-west Ageing Well Project – AW-SW

North-west Ageing Well Project – AW-NW

Rationale for the three projects

Lewisham's Well-Being Strategy for Older People distinguishes between primary, secondary and tertiary prevention and explains that,

'Currently most health and social care resources are directed to tertiary prevention. Our aim is to promote an approach in Lewisham, which focuses more strongly on the levels of primary and secondary prevention'.²

Preventative activities are defined as follows:

Primary - stopping a negative outcome happening in the first place.

Secondary - responses to support those living with existing conditions, to minimise their severity and reduce the likelihood of complications developing

Tertiary prevention - specialist interventions to address complications of a given condition and maximise quality of life

The service specifications for each of the three projects that comprise the overall Ageing Well Project focus the projects on primary and secondary prevention.

'The purpose of the project will be to test out the effectiveness of early intervention and prevention work with older people. The project will

¹ *Health and Older People LAA funding, Discussion paper number three*, September 2006

² Ageing Well in Lewisham, Lewisham's well being strategy for older people (draft)

- support older people to manage their long-term conditions,
- improve their quality of life
- delay or prevent the need for more intensive interventions.

It will also work closely with other statutory and voluntary sector service providers to develop a co-ordinated approach to preventative work and to create clearer care pathways into preventative services. The project will also contribute towards the achievement of a number of targets set out in the Healthier Communities and Older People block of the Local Area Agreement'.

Ten expectations for each project were outlined,

'The project will be expected to:

1. Identify older people who are at risk or who have significant emerging needs
2. Assess those needs and support the older person to access services
3. Signpost people to existing services or commission additional services from local organisations where their capacity needs to be expanded
4. Stimulate the development of new local services where none are currently available
5. Work closely with other providers of preventative services in the project area to develop a co-ordinated approach to prevention and define the care pathways into prevention
6. Define work with other providers through simple service level agreements
7. Work closely with social care managers to ensure that referrals from them are systematic and links with social care formalised
8. Work closely with all three project areas ... in conjunction with project consultants, to ensure that cross project learning takes place
9. Work with the consultants to ensure that robust monitoring and evaluation of the project takes place, and that the project contributes to the achievement of key LAA targets for older people.
10. An expectation is that some money will be allocated by each project to support local community-based groups to carry out innovative prevention work in the Borough.'

Three organisations, with differing histories and strengths were chosen to deliver the Project. These were

- ❑ AW-SE – Ageing Well in Downham
- ❑ AW-SW - Lewisham Churches Care
- ❑ AW-NW - Age Concern Lewisham and Southwark.

Evaluation aims and methods

The evaluation sought to establish how effective the three projects were in:

- a) Meeting the needs of older people with significant emerging needs and preventing or delaying their need for more intensive interventions
- b) Working in partnership with statutory and voluntary sector providers in the locality to develop a co-ordinated approach to preventative interventions and clear prevention care pathways.
- c) Contributing to the delivery of a number of targets in the LAA Healthier Communities and Older People block.

In addition it addressed the ten items in the projects' service specification in order to analyse how the projects have responded to these.

Establishing the effectiveness of preventative interventions, and particularly their ability to delay the need for more intensive services, requires a longer timeframe and a more targeted and specific intervention programme than that available for this project permitted. In addition the late start of the evaluation and confidentiality issues within two of the projects prevented the development of a number of evaluation tools. Nevertheless, a range of measures were used to evaluate the immediate impact of the projects.

Meeting the needs of older people

In exploring older people's physical and mental wellbeing, quality of life and community involvement it was originally hoped that a tool such as FACE (the Single Assessment Process proforma) might provide baseline data on physical and mental wellbeing that could be revisited after 12 months in order to assess changes. However this was not feasible. The projects had each devised their own assessment processes and these were recorded in different ways on the projects' databases. Instead the evaluation used a case study approach. This has the advantage of presenting in detail the complexities of older people's needs and of the projects' varied interventions adequately, but the disadvantage of providing little quantifiable evidence overall. The evaluation has relied heavily on the assessments made by the projects at the outset of their work with clients and recorded on their files and databases. This was augmented by detailed interviews with clients and stakeholders, including social workers and occupational therapists. The experiences of a sample of clients were analysed in detail to record outcomes, using the model developed by Glendinning et al

(2008).³ Qualitative data on clients' quality of life and place within their local communities was not systematically recorded by the projects. Nevertheless a wealth of data emerged from the databases, files and stakeholder interviews to augment the case studies.

Partnership working and care pathways

It was hoped that an extended SWOT analysis would examine how partner agencies, delivering prevention interventions, work together and what changes took place over the lifetime of this project. The evaluation instead analysed a sample of social work client files and analysed the project managers' individual accounts of the strengths and weaknesses of their projects. These were collated using one-to-one interviews and written reports to the Steering Group. In addition the evaluation examined the work of one project's 'local area panel' (AW-SW).

This work provides valuable learning on the

- establishment of care pathways into preventative services
- working of local practitioner and user networks
- variables that affect the establishment of local preventative services.
- organisational structures to support preventative services.

Meeting LAA targets

Quantitative data was collected on the number of older people referred to the project, the interventions made, including the services people were referred on to. This provides some measure of the projects' contribution to the achievement of LAA targets for

- the improved management of long-term conditions (heart disease, circulatory disease, diabetes, stroke, cancer)
- activities that aim to improve quality of life and physical and mental well-being (physical activity, attendance at cultural events, etc).

Unfortunately the projects' monitoring systems had been established before the start of this evaluation and while these provided information on activities, information on long-term conditions was more limited.

³ C Glendinning et al, *Progress and problems in developing outcomes-focused social care services for older people in England*, Health and Social Care in the Community, Volume 16, No 1, 54-63, 2008

Action research methodology

Action research requires the involvement of all participants in both reviewing and attempting to improve the objects of research. This perspective was the foundation of the pilot. The project managers played an important role in documenting and sharing with the evaluator the achievements and difficulties they faced and how they sought to better the projects. The evaluator was pleased to be able to contribute her expertise to support the interventions in sheltered housing developed by one project (AW-NW).

Final draft

Strengths, weaknesses and gaps in the evidence base for preventative services with older people

Background

There is ample research evidence from older people that work with them in low-level preventative services improves their quality-of-life. Studies have shown how 'a little means a lot' to the well-being of older people.⁴

What is more contentious are the questions of whether or not provision of low-level preventative services lessens the cost of supporting people as they age, and which preventative interventions are most effective in supporting older people.⁵

A frequently stated rationale for promoting preventative services is that they reduce the need for intensive services in the future thus saving costs. With a growing ageing population it is argued that current delivery of health and social care services cannot be sustained and investment in low-level preventative services will lead to less reliance on the current over-stretched services in the future.

At the policy level there is also some rhetoric around discussions of the efficacy of early intervention and low-level services. One statement from the Office of the Deputy Prime Minister's Social Exclusion Unit illustrates this.

'Shifting the emphasis to providing low-level services, earlier - before people develop intensive needs - means that there will be less need for intensive services in the future. This is better for individuals and less costly'.⁶

With the current level of research knowledge, these assertions cannot be substantiated, and indeed some research provides evidence that undermines such claims.⁷

There is very little authoritative research literature on the outcomes of preventative services for older people. Much of the available literature reviewed is grey

⁴ See for example, H Clark et al, *'That little bit of help': The value of low level preventive services for older people*. Bristol: The Policy Press in association with Community Care Magazine and JRF. (1998) K Hill et al, *Understanding Resources in Later Life*, JRF, 2007, S Lambert et al, and *Ageing Well Programme in England and Wales, Final Evaluation Report*, Age Concern 2007.

⁵ Curry N, *'Preventive Social Care: Is it Cost Effective?'* Kings Fund Publication attached to the Wanless Social Care Review 'Securing Good Care for Older People' (2006).

⁶ ODPD, Social Exclusion Unit, Excluded Older People Project, presentation 19 May 2005

⁷ Research in Practice for Adults, *Evidence Cluster: Prevention*, 2006 cites a Canadian study that concluded that older people receiving preventive home care were at 50 per cent higher risk of both death and loss of independence than those not receiving the service.

literature, that is papers, reports, technical notes or other documents produced and published by governmental agencies, academic institutions and other groups that are not distributed or indexed by commercial publishers. Within this literature there is little quantitative evidence and limited and inadequate monetization evidence on preventative services.

There is also the methodological issue of whether in the end it is even possible to quantify the impact of social care interventions. One summary of this issue concluded:

‘Attributing cause and effect of a social care intervention is extremely complex. This complexity is compounded by the lack of clarity with regard to the definition of prevention and the hazy boundary between social care interventions and wider community services. There is also a lack of consensus as to whether the quest to quantify the impact of interventions is actually desirable in itself or whether it is a matter of trying to quantify the unquantifiable, running the risk of undermining the contribution of qualitative research.’⁸

The research literature is therefore inevitably weighted towards qualitative evidence with an emphasis on the perceptions of older people themselves. Of course it can be argued that the experiences and beliefs of older people *are* the best evidence for assessing preventative services, but it is disappointing that the evidence base for interventions is not wider.

Current initiatives to address the gaps in the evidence-base for preventative services

The POPP initiative was outlined earlier. One aim of this programme is to expand the preventative evidence base and it is therefore worth highlighting the interim findings of the POPP evaluation.

- ❑ ‘There are early indications that POPP pilot sites are having a significant effect on reducing hospital emergency bed-day use when compared with non-POPP sites
- ❑ Pilot sites are reporting improved access for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
- ❑ Partnerships between statutory organisations and the community and voluntary sectors have improved if compared with the perceived quality of partnerships prior to the initiation of POPP.
- ❑ Pilot sites are reporting that older people’s involvement has increased within steering groups, commissioning, recruitment, provision and evaluation.

⁸ Curry N (2006). ‘Preventive Social Care: Is it Cost Effective?’ Kings Fund Publication attached to the Wanless Social Care Review ‘Securing Good Care for Older People’.

- Older people's health (including mental health) and well-being needs are becoming better integrated within the wider strategic agenda.⁹

At the same time LinkAge Plus a smaller national policy-driven initiative, being evaluated by University of Warwick Business School, is attempting to 'build an evidence base that supports the economic, as well as the social case for fully joined up / holistic services for older people.'¹⁰

The Local Authority Circular on 'Transforming Social Care' reiterates the intention to refocus services for older people,

'Social care and wider local government services need to work with the NHS, the voluntary, community and independent sector to harness the capacity of the whole system. It needs to shift the focus of care and support, across the spectrum of need, away from intervention at the point of crisis to a more pro-active and preventative model centred on improved wellbeing, with greater choice and control for individuals'.¹¹

Much of this circular expounds the ideas presented in the Social Care Institute for Excellence's Adults' Services Knowledge Review. This review highlighted the need for more personalization of services to focus on the outcomes desired by older people themselves and reiterated the need for greater emphasis on outcomes widely desired by older people that relate to three issues: change, maintenance or prevention and the processes of receiving services. (See case studies in this report) It concluded that 'there is still a lack of evidence on the effectiveness of initiatives in improving user outcomes'.¹²

Evidence for specific preventative interventions

Turning to the evidence on specific interventions the table below outlines the current situation. The conclusions here are that there is evidence that some areas of preventative work appear to improve physical and mental health outcomes for older people. These are diet, ceasing smoking, falls prevention, exercise, social engagement and psychological interventions. In other areas there is a much weaker evidence base. The table overleaf illustrates this.

⁹ National Evaluation of Partnerships for Older People Projects: *Interim Report of Progress*, October 2007

¹⁰ *An Interim Evaluation of LinkAge Plus*, University of Warwick Business School, 2007

¹¹ LAC Circular 2008 (1) 17 January 2008

⁸ C Glendinning et al, *Outcomes-focused Services for Older People*, SCIE, 2006

The Evidence Base for Preventative Interventions			
	Action	Potential impact	Evidence
Physical Health			
Diet	High fruit and vegetable intake (5 or more servings daily)	Protective for cardiovascular disease; respiratory function; macular degeneration and cataracts; cancers including breast, prostate, colorectal and stomach; diverticular disease; diabetes	Strong ¹³
	High complex carbohydrates, non-starch polysaccharides (eg potatoes, bread, pulses, pasta)	Protective for cardiovascular disease; cancers including breast and colorectal	Strong
	Reduced saturated fat (<15% food energy intake) and total fat (<35% food energy intake)	High saturated fat intake increases risk of coronary heart disease; cancers including colorectal, prostate, and breast; large bowel disease; osteoarthritis	Strong
	Reduced sodium	High sodium intake increases risk of stroke, stomach cancer, osteoporosis, respiratory disease	Strong
Smoking	Stopping smoking	Smoking increases risks of many cancers including lung, stomach, larynx, colon; cardiovascular disease and thereby vascular dementia; respiratory disease; osteoporotic fractures; stomach ulcers	Strong
Physical activity		Protective for cardiovascular disease; diabetes; osteoporosis; cancers including colorectal	Strong

¹³ From 1997 Khaw Kay Tee and her colleagues have published a number of authoritative studies on the evidence of healthy eating and lifestyles on longevity.

		and breast; depression	
Multi factor intervention	including medication, home, vision and posture review / modification	Falls prevention	Strong ¹⁴
Focused training	Strength, balance and co-ordination training	Falls prevention	Some
Home care	Personal care, housework, shopping etc	Live independently longer	Weak
Housing adaptations	Rails, showers	Falls prevention and live independently longer	Weak ¹⁵
Mental Health			
Social networks	Maintaining/building social ties	Improved quality of life and lower mortality	Some ¹⁶
Exercise	Mixed exercise of moderate intensity	Improved mental health	Strong ¹⁷
	Strength and resistance exercise		Strong
	Aerobic exercise programmes (brisk walking and toning and stretching)		Strong
	Walking programmes		Strong
Health promotion	Group-based health promotion programmes		Strong
Psychological interventions	Cognitive training, psycho-social education, relaxation and support		Strong

It should also be noted that most of the research for the efficacy of these interventions was undertaken over relatively short time periods, for example six months to a year. Long term impacts are rarely tracked.

¹⁴ *Implementing the Older People's NSF Falls Standard: Support for commissioning good services*. London: Department of Health. (2003)

¹⁵ F Heywood, *The health outcomes of housing adaptations*. Disability and Society, Vol 19, No 2 pp 129 -143. (2004)

¹⁶ See discussion below

¹⁷ Evidence for each of the interventions below is presented in Draft Guidance, *Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care*, NICE, Issue date: April 2008

A review of the evidence base on prevention by RIPA, but which excluded interventions relating to diet, stroke prevention and mental health, concludes:

‘There is strong evidence for falls prevention; evidence against on the grounds of cost effectiveness and the impact of preventive home care; and there is at present no conclusive evidence regarding low level preventive interventions, housing adaptations, or the economic case for preventive services. Further research is required to explore whether preventive services are effective. In the interim fall prevention work is to be recommended, while all other approaches should be treated with caution until conclusive evidence is available to support their use.’¹⁸

Activities

Activity theory lies at the heart of many preventative services for older adults. This rests on the belief that involvement in activities increases well-being. According to activity theory people give up many roles as they age; retiring from work, being widowed, leaving organisations, clubs, groups etc. These changes may create a reduced sense of identity and individuals therefore need to become involved in activities that develop substitute roles for those that have been lost. It is therefore argued that activities in late life are essential to restore one's "self" and boost a sense of well-being.

Research developed to test activity theory shows that most people benefit from a high level of activity in old age, although new activities are not necessarily substitutes for previous activities and the quality of an activity is important. To be worthwhile, activities must have meaning to the participant: they can be solitary (knitting, reading); informal (chatting with friends on the telephone); or formal (joining a club). Hobbies, volunteering, caring for a home and pets, sharing life with family and friends, and getting out and about, have the greatest value for a positive sense of well-being.¹⁹

More recently research has suggested that the *quality of social relationships* is a key factor in the activities undertaken by older people.

‘When the quality of social relationships was taken into account, the amount of activity had no independent effect on the respondents' wellbeing. Moreover, it was social relationship *quality* (evaluator's italics), a facet of informal activity that has generally been neglected in activity research, that emerged as the most influential variable in the association between activity and wellbeing. Thus, the findings provide empirical backing for the assertion

¹⁸ Research in Practice for Adults, *Evidence Cluster: Prevention*, p4

¹⁹ P Kossuth and V Bengtson, '*Sociological Theories of Aging: Current Perspectives and Future Directions*', in J Birren and V Bengtson, eds., *Emergent Theories of Aging*. New York: Springer Publishing Company, 1988.

that the quality of social ties matters more than activity participation *per se* as predictors of a good old age'.²⁰

There is also a growing body of evidence that seeks to differentiate the needs of old and 'older old' people – the latter being those aged 80 and over.²¹ This is a significant issue for Ageing Well in Lewisham, as the Project currently provides services for all aged 55 plus and does not differentiate between different age groups. This issue will be addressed in the final report.

While this evaluation looked broadly at the impact of the Ageing Well Project it also focused on what can be learnt from the pilot about how to address those issues where we might expect some of the most successful outcomes for individuals. Here the evaluation focused on three areas where the Project has the skills and resources to work – quality social ties, diet and exercise.

²⁰ H Litwin and S Shiovitz-Exra, 'The association between activity and well-being in later life: what really matters?', *Ageing and Society*, 2006, 26, 225-242 See also, L Berkman and SL Syme, 'Social Networks, Host Resistance, and Mortality: A Nine-year follow up study of Alameda County Residents.' *American Journal of Epidemiology* 109: 186-204, 1979

²¹ E Grundy et al, *Successful Ageing and Social Interaction – A Policy Brief*, London School of Hygiene & Tropical Medicine and International Longevity Centre – UK, 2007

Evaluation Findings - Meeting the needs of older people

This section outlines what the projects did over the two year timescale and how they met the needs of older people in the three areas.

The CSCI Independence, Wellbeing and Choice inspection of Lewisham took place in March 2008, while the Ageing Well pilot was underway.²² The findings and recommendations detailed in the CSCI inspection report are consistent with those found in this evaluation, where the recommendations with regard to future preventative work with older people focus upon personalisation, partnership working, information dissemination and data collection and analysis.

The detailed timelines presented in **Appendix 1** provide learning on the set up, staffing and running of these preventative projects.

Set-up, Staffing and Running the Pilot

Key issues

- the projects were working to very different timescales, due to differences in available resources over the initial set-up periods.
- the individual projects developed in line with their existing and distinct strengths: namely AW-SE had firmly established support with a wide range of activities including one-to-one support and attention to the 'younger old' particularly in relation to exercise. AW-SW developed their range of existing activities focused on increasing social interaction. AW-NW had no existing local presence. Here advice and information support proved a strength.
- AW-NW's lack of staffing disrupted the work and meant that the project did not develop until its final six months
- the time and resources needed for the development of administrative systems and induction and training of staff was substantial
- a wide range of group activities were provided – including hydrotherapy, chair exercise, social groups, craft groups, information and advice sessions, shopping service and lunch club

²² CSCI, Independence, wellbeing and choice, London Borough of Lewisham, March 2008

- joint initiatives between AW-SE and AW-SW were successful particularly in relation to shopping groups and the lunch club .
- joint staffing between AW-SE and AW-SW enabled shared learning. Given its location it was not possible for AW-NW to benefit from this.
- volunteers are a valuable asset to the projects and need to be supported by policies reflecting best practice in volunteering
- there were both a core of similar approaches and development of distinct approaches to preventative work in the three projects - AW-SE built on existing successful services e.g. falls prevention/exercises but also developing new initiatives such as a sitting service to provide carers with respite. AW-SW developed information and resource work and towards the end of the timescale a campaigning/awareness raising role.
- AW-SW benefited from a lively and enabling multi-agency Area Panel to inform and drive its work, and older people themselves helped initiate the ferrules and 'on the buses' projects.
- the pilot was supported by an Advisory Group and a Management Group. The project managers reported that these forums were useful, but time-consuming.

The projects' databases

Each of the projects developed an Access database to record key data about its work with clients. The differing perspectives of the workers and differing practices of capturing data led to the development of superficially similar, but conceptually distinct datasets. Below is a summary of comparable information from each of the projects which gives an indication of the overall reach of the Ageing Well Project. Individual differences in recording however mean that the summative information cannot be taken as comprehensive; nevertheless it does provide a demographic profile of the Project's client base and a picture of where referrals come from. Some information from the databases was recoded by the evaluator to enable this summary to be completed

Referrals to the projects

The information below relates to referrals recorded on the databases for three quarters: April to June, July to September and October to December 2007.²³ During this period, 252 people living in Ageing Well's catchment areas were referred or referred themselves to the three projects.

Sex: Unsurprisingly, the majority of clients were women, with men comprising only 20% (50) of the total referrals recorded for the three quarters²⁴.

Age: The Project is targeted at older people aged 55 plus. For almost a third (74) the age of the client was not recorded on the database²⁵. Analysis of the ages of the remaining 178 clients shows that almost 50% were aged 80 plus and 21 clients (12%) were in their nineties or older - the Project supports at least one centenarian. In AW-SW 56% (55) of those whose ages were recorded were 80 or older.

Ages of Older People referred to Ageing Well - April – December 2007					
	AW-SW	AW-SE	AW-NW	Total	Percentage whose ages are known
90 plus	9	9	3	21	12%
80 plus	19	35	11	65	37%
70 plus	19	19	10	48	27%
60 plus	16	11	4	31	17%
59 or younger	3	5	5	13	7%
Not known	54	11	9	74	n/k
Total	120	90	42	252	100%

Ethnicity: This mirrors the demographic profiles of the areas, with a higher proportion of Black, Black African and Black Caribbean clients in AW-NW. Overall 69% (174) of those referred were recorded as white, with 10% (25) recorded as Black, Black African or Black Caribbean.

²³ Some individuals (approximately 27) in AW-SE did not agree to their details being held on a database – these are kept in paper form and not included in this analysis.

²⁴ Sex was not specified in 5 cases.

²⁵ The project manager explained that in the case of AW-SE were likely to be women in their late fifties to late sixties referring themselves to the project, who did not complete the date of birth box on their registration form.

Ethnicity of Ageing Well Clients – April-December 2007					
	AW-SE	AW-SW	AW-NW	Total	Percentage
White	104	48	22	174	69%
Black, Black African, Black Caribbean	6	9	10	25	10%
Bangladeshi, Turkish, Irish or Other	10	1	1	12	5%
Not known	0	32	9	41	16%
Total	120	90	42	252	100%

Ageing Well's reach: Almost 40% (98) of those people referred to the Project lived in two wards, Downham and Sydenham.

Clients' Wards – Referrals April-December 2007											
Area 1 – south east				Area 2 – south west				Area 3 – north east			
Grove Park	Downham	Whitefoot	Bellingham	Catford South	Forest Hill	Perry Vale	Sydenham	Evelyn	New Cross	Telegraph Hill	Heathside and Letbride
21	50	22	27	17	13	12	48	22	15	1	4

Reason for referral: Only two of the databases record a specific 'reason for referral' and on one database fifty separate reasons for referral were recorded in the period. Therefore there would need to be substantial recoding of this field before a full analysis could be undertaken. Nevertheless it is apparent that the two main reasons for referral are:

- for physical exercise/ mobility issues and
- to increase social interaction.

Older people's physical and mental wellbeing and quality of life

There is a growing literature on what constitutes successful ageing, what older people want and what measures can help us to specify the quality of life of older people. To date however there has been very little attempt to classify and test what older people desire in terms of social care outcomes. One study has used a range of existing research studies to summarise the social care outcomes older people want.²⁶ Fifteen desired outcomes were established in the research and

²⁶ See C Glendinning et al, *Progress and problems in developing outcomes-focused social care services for older people in England*, Health and Social Care in the Community, Volume 16, No 1, 54-63, 2008

these were used as the framework for the file analysis and interviews with Ageing Well clients.

Summary of social care outcomes desired by older people

Outcomes involving Change

1. Changes in symptoms and behaviour
2. Improvements in physical functioning
3. Improving morale

Outcomes involving Prevention or Maintenance

4. Meeting basic physical needs
5. Ensuring personal safety and security
6. Living in a clean and tidy environment
7. Keeping alert and active
8. Access to social contact and company
9. Having control over everyday life

Service Process Outcomes

10. Feeling valued and being treated with respect
11. Being treated as an individual
12. Having 'a say' and control over services
13. Value for money
14. A 'good fit' with informal sources of support
15. Compatibility with, and respect for, cultural and religious preferences.

The case studies in **Appendix 2** detail the range of outcomes experienced by three Ageing Well clients.

What Ageing Well provided

Publicity materials developed by the projects describe Ageing Well services as follows,

'The LAA Lewisham Ageing Well projects work with people aged 55 plus and can provide help to older adults by developing tailor made support packages, based upon the individuals own needs and wishes, to help them to access activities and services in order to help them to maintain a good quality of life and remain independent, which is so important to older people and their families.

The support provided for less active or isolated people includes services to help them do their own shopping; providing accessible transport to enable them to leave their homes to see family or take part in a leisure activity and helping them to access advice and information from occupational therapy assistants, for example.

For older people who want to remain more active in the community we can and have developed a programme of leisure and physical activity sessions. The activities and groups we have developed across the targeted wards in Lewisham are helping to keep older people fit and connected to their communities as well as making new friends or bumping into old ones'.²⁷

Each of the projects has developed a number of distinct services – providing both group support and personalised individual support.

Group support: information and advice sessions, lunch group, men's group, craft group, hydrotherapy, exercise, bingo, dancing, trips, supported shopping and talks/entertainers.

Individual support: simple repairs; shopping; companionship; befriending; respite care; escorting to hospital appointments; one-to-one support – confidence, aids and adaptations and advocacy; referrals and signposting; information and advice - benefits tax, pensions etc; publicity on for example, exercise, adaptations, local shops, ferrule replacement; action research/campaigning – local buses.

As the case studies in [Appendix 2](#) indicate, in relation to both outcomes relating to prevention and maintenance and to service process outcomes, clients had found the Ageing Well projects invaluable. The comments of a number of clients reiterate the ways in which the projects have met their needs.

Group support

'I experience respect and caring from everyone, including the drivers and the volunteers - 100% -. It's absolutely first class - if only the public services were as good we would be flying. (Anna – Tai Chi)

'It's okay here, it gets me out of the house. It gives the missus a break. I like to play the cards and the dominoes. (Jake – Men's Group)

'I come for the company - getting amongst other people'. (Mary – Bingo)

'I wasn't too happy the first two weeks here, but it's lovely now. The Christmas lunch was wonderful - the table was laid so beautifully' (Iris – lunch group)

²⁷ Article for Grapevine, Lewisham's CVS newsletter

'After my stroke assessment they said I needed to get out and about – it's good at the group to talk to one another' (Colin – men's group)

Appendix 3 provides a detailed description of a number of the group activities provided by each of the projects.

Individual support

'I'm so grateful to Ageing Well, I don't know who told me about them, but I phoned them and they've been very good. I like the friendly attitude, they make me laugh even if it's just half an hour with them - It is really good'. (Joan – companionship)

'My wife is seriously ill with COPD – on oxygen permanently - and is sometimes confused. Ageing Well sent someone to give me a break and it worked out marvellously. It was a terrific support. I could feel happy and I could go out with friends. It gave me a break and I was happy Beryl was in safe hands. They are very nice people, very helpful and willing to help me in other ways if I'd needed it'. (Carl – respite support)

The care and sensitivity of staff that is evident in the quotes above was also apparent in staff's file notes. Client files revealed an attention to detail that meant that concerns such as unkempt gardens, uneven paving, broken cat flaps and letter boxes, loose carpets, collecting prescriptions, sourcing a suitable phone for a partially sighted client, the need for a regular walk, forms that were difficult to complete, worn walking stick ferrules, were noted by staff and later dealt with. This attention to the detail of day-to-day living was particularly appreciated by clients. For example, William a 71 year old, living alone and in poor health explained,

'I don't know how I heard about it. I know Valerie (AW-SE worker) knocked on my door. She helped me manage the bedroom to deal with a hole in the carpet. They took it out and laid oilcloth- oh you know, lino. I rely on these people to give me a bit of attention. I do need these people they're great'.

While the projects reach out to all of their local residents aged 55 plus, it is apparent that they have responded to a number of specific groups within the broad band of older people. In AW-SE there has been a distinct attention to younger adults aged between 55 and 65, who make good use of the exercise opportunities provided by the project, and to mental health service users. For example in relation to the latter group the project has identified and responded to a gap in services for those with anxiety disorders. Anxiety disorders often prohibit people from leaving their home or immediate neighbourhood and lead them to abandon basic living tasks. Intensive support has been provided for such clients, but workers have been frustrated at being unable to find other local sources of support for individuals.

Two of the projects benefited from accessing Age Concern's information and advice expertise. The advice line and outreach service in Downham, Bellingham and Deptford generated enquires that proved of benefit to a number of clients, generating substantial financial gains for individuals. In total over £200,000 was recovered.

Ageing Well and the Information Needs of Older People

There are challenges to helping older people find and use timely and relevant information. Difficulties older people face are

- ❑ complex information systems
- ❑ information too general to help meet the specific requirements of individuals
- ❑ need for support and advocacy to get the best from information.²⁸

Older people believe that there is a great deal of information, but that this is difficult to access and use and individuals only turn to formal organisations for information when they are reaching points of great difficulty with aspects of their lives. Key sources of information for older adults are seen as local councils, citizens' advice bureaux, libraries, call centres and press button menu systems. The last two are regarded as remote and impenetrable.

Recent research on accessing information about health and social care²⁹ suggests that effective information underpins many aspects of social policy for older people. In relation to prevention, people with low level needs are typically signposted outside the statutory sector, with varying amounts of information about other sources of help. Professionals do not systematically or proactively provide information about accessing local services and it is rare for them to take responsibility for providing relevant information. So while there is no shortage of information there is a lack of effective signposting: individuals are left to find information for themselves.

This evaluation found that the Ageing Well projects were challenging and addressing this general picture successfully. Partnership with Age Concern's information and advice service is one example and the advice worker in AW-SE explained

'Home visits are necessary but very time-consuming. The first visit can last half an hour to 45 minutes. Here, I find out what benefits are applicable, order the appropriate forms, and wait until the client has collected the

²⁸ Sykes W et al, Opportunity Age Information Indicators Feasibility Study , Department for Work and pensions, 2008

²⁹ D Swain et al, Accessing Information about Health and Social Care Services, Picker Institute Europe, 2007

relevant evidence. They will then ring my direct line and I'll return to help complete the forms. Some clients need multiple visits.'

The AW projects have a key role as information providers for older people, disseminating existing information and signposting people to additional information. AW-SW has gone further and has used its resources to produce its own information and disseminate this across the local community and to campaign for improvements in the bus service for older people. The information compiled and distributed by the projects includes leaflets on exercise, access to advice and information, mobility aids, ferrule replacement, accessible shopping, prescription delivery, venues and retirement groups, group befriending and information on each of the available groups.

The experiences of Ms S, who lives in housing association accommodation in AW-SW's catchments areas, illustrate how difficult it is for some older people to access information.

Ms S

'I was a medical social worker, developed rheumatoid arthritis and had to retire early. I couldn't find any local suitable activities, and I got so depressed. I tried the council for help, but they hadn't come up with anything. Just think that for someone like myself, who is used to getting information it was so hard. The only information I got was about a fortnightly poetry group in the evening, that was too difficult and expensive to get to.

It was dangerous. A district nurse came in every day and a care worker was coming in, and that was it and I thought, "what is the point?" The warden here explained one day when we went down for coffee (in the sheltered housing lounge) that we'd got a lady coming from LCC. (AW-SW) I'd never heard of them. She wanted to talk about keep fit classes - it turned out that it was tai chi.

They also arranged access to a taster course on computers and the funding for IT training. It's disability accessible and transport was provided. It was manna from heaven. I also got involved in an arts interest group Access to Art. We visited galleries once a month. You pay for the entrance and the transport. I was asked if I'd take on the LCC newsletter at Goldsmiths, and I've been doing it ever since. The disability rights handbook keeps me up to date, and I'm involved with the Disability Alliance, and I've had a computer since 1999. I put the newsletter on Publisher. All of this was a lifeline - my family and friends are all miles away and I can't drive any more.

I do have connections with others - people in the arts group keep in touch. I meet up with one contact every few weeks for coffee. I can't go to the tai chi any more

because of my clinic dates, but I obtained books on Tai Chi exercises which I do daily.

I think a project like this is so needed. My only sadness, and I've heard others say this, is that we came upon it by chance. If only we'd known it was available. For example advertised at doctors' surgeries - why aren't information officers telling people about it? There could be leaflets in hospital outpatients' clinics, post offices, for when you're standing in the queue - ideally high streets should have more information boards, but I know that there are problems updating them'.

Local Knowledge of Ageing Well

Ms S's experience also highlight the challenge of ensuring that local projects such as Ageing Well are widely known in their local communities. AW-SE and AW-SW have a high proportion of self referrals and referrals from friends, families and neighbours – indicating that they are known in their local areas. For AW-NW, the newest of the projects, this was not the case for some time, although the project manager reported that in the final months of the project self referrals were increasing.

Despite the work of all three project managers to publicise Ageing Well there was still patchy knowledge about its services, amongst some potential referrers, particularly social care and health providers. It is also unfortunate that this specifically preventative pilot shared the same name as the Borough's overall well being strategy for all older people.

The Ageing Well pilot project failed to present itself as a discrete preventative service and build on the lead of AW-NW, 'Ageing Well in Downham'. Clients and stakeholders repeatedly referred to the other two projects as 'Lewisham Churches Care' and 'Age Concern'. Some stakeholders saw the distinct characters of the three projects as a considerable weakness.

'I don't see the links. They need to be together. With one message and one point of referral. They're not branded.' (Social work manager)

'From the outside it's confusing about what's being offered. They are almost not part of the same entity. As they grow it's quite difficult to see what's what – the services are being offered in different ways. I wish this was a whole borough service that offered a menu of services for individuals to choose (Occupational therapy manager)

Evaluation Findings - Partnership working and care pathways

It was intended that the projects would 'work closely with other statutory and voluntary sector service providers' and one indicator of this is the origin of referrals arising from other agencies and services. Analysis of referral sources suggest that referrals to the Project overall are most likely to come from individuals themselves, rather than from other statutory service providers.

Who Referred to Ageing Well – April-December 2007		
	Number	Percentage
Referred by self	76	30%
Referred by social worker	39	15%
Referred by NHS services	31	12%
Referred by occupational therapist	27	11%
Referred by voluntary sector services	18	7%
Referred by others	61	24%
Total	252	100%

31 referrals came from NHS sources. These include community matrons, district nurses, GP surgeries and physiotherapists.

While AW-SE had built sound links with surgeries, this was less developed in AW-SW and AW-NW. Nevertheless this has been building up appropriately. As one nurse for older people based in an AW-SW practice explained.

'Lots of patients I refer are isolated and don't meet the criteria for social services care or attendance at a day centre. They maybe lack confidence, are just out of hospital, bereaved or in poor health...It's been generally good, with a fairly quick response...there has always been a gap here. For some people you are just waiting for something to happen before you can get support. Ageing Well coming in makes that much better. (Nurse based in AW-SW area)

The intention to develop preventative care pathways was one of the most challenging aspects of the pilot. As social care and health were regarded as key partners and as the managers of the older people's social work service and the occupational therapy service were members of the steering group, it was decided to focus in more detail on how far links and working practices had developed here.

From the 39 referrals from social workers a random sample of a third were selected in order to examine the case files and establish which individuals were referred to Ageing Well and the process and outcomes of the referral. Referrals

to social services had come from the usual range of sources, GPs, hospitals, self, daughter, neighbours and in three cases from the individual him/herself. Ten individuals were over 75 years old. Of the two individuals in their sixties, both were living alone; one was wheelchair dependent and one suffering from dementia and depression. All twelve older people had poor mobility and were unable to leave their homes without assistance. Most were finding many aspects of day-to-day living difficult. Three had specific mental health problems- namely, persistent delusional disorder, vascular dementia and depressive disorder.

Most individuals were already receiving services in their homes, mainly domiciliary care and five were allocated social workers. The referrals to Ageing Well focused on the need for social stimulation and were recorded in three ways; 'befriending', 'socially isolated' and in two cases specifically for the 'shopping service'. The outcomes of the referrals were not recorded.

The social worker who made one referral recalled the practical support and friendship AW-SE provided.

'I was pleased with the intervention. It made a difference to the client's life. I wasn't getting through to Mr C till Ageing Well got involved and they helped him. They helped with his furniture and explained about our work. Through their rapid intervention he is now much more friendly. He was so reluctant to work with us at first, Ageing Well, worked as a go-between. It's good because some people don't like social workers, and Ageing Well did lots of work sorting out attendance allowance and social care funding for improvements to his home.' (Social worker, Older Adults' Team)

The impression derived from the files is that most of these individuals had long-term health conditions and substantial needs, including for social interaction. As one social worker explained,

'There is a need for a befriending service- just a bit of company. Befriending is so vital there is so much loneliness and isolation. They just want time with you, particularly those who are housebound. This is the biggest need, I see.' (Social worker, Older Adults' Team)

Despite presentations on their work by the projects and some positive personal contacts with social workers there was little evidence of the strong network of contact and involvement that is needed as a foundation for successful care pathways.

At its most extreme this was experienced as a general frustration with voluntary organisations. One social worker explained,

'I feel I invest an awful lot of time getting involved with voluntary organisations. I ring to discuss, they take details then they tell me to put it

in writing. Then they come back to me and say ‘well, I don't know’ and I think ‘why did I bother’, because it causes me more problems. They do help me out somewhat, but I get really upset, one man needed help and I was told he was on the wrong side of the street – what?’ (Social worker, Older Adults’ Team)

Partnership working with occupational therapists fared better. Here the manager acknowledged that her staff were not always aware of the voluntary sector and of the possibility of involving Ageing Well in their work, but explained how she saw this developing.

‘I see the Ageing Well projects almost like a broker for the voluntary sector, not just the Ageing Well projects themselves, but others like Carers Lewisham as well. It can be quite difficult to keep up to date with all the voluntary organisations. People have pockets of knowledge. It is very difficult to maintain a directory that everyone can use, where people in the team can get information. It's difficult how we share knowledge across the team. Using the Aging Well projects as a type of brokerage for the voluntary sector in this way is helpful’.

The placement of an occupational therapy assistant at AW-SE for three days a week was acknowledged as a successful contribution to developing care pathways by the assistant, her manager and the project manager. It has resulted in quick assessments and interventions for clients with low-level physical needs, in some cases a more rapid full assessment, stronger knowledge of both the south east and south west of the Borough by the occupational therapists and a good working relationship with the service.

Much successful partnership working was in evidence in the projects but this could be greatly improved by the introduction of more consistent referral and feedback procedures for partners and projects alike.

Meeting the Ageing Well Service Specification

The table below gives a summary of the evaluation findings here.

Service Specification	Evidence from the Ageing Well Projects
Identify older people who are at risk or who have significant emerging needs	All projects established appropriate referrals from local older people.
Assess those needs and support the older person to access services	Projects offer a range of potential support to older people Personalisation and a detailed attention to meeting

	<p>needs is a key priority for the project workers, who emphasise the individuality of each client they work with</p> <p>Clients repeatedly acknowledged the individual care they had received from the projects.</p>
Signpost people to existing services or commission additional services from local organisations where their capacity needs to be expanded	The projects have plentiful evidence of signposting people to existing services. For example AW- SW identified twenty local services commonly signposted
Stimulate the development of new local services where none are currently available	<p>There have been attempts to commission additional services, but success has varied across the projects.</p> <p>Volunteer support was available but limited in all projects</p>
Work closely with other providers of preventative services in the project area to develop a co-ordinated approach to prevention and define the care pathways into prevention	Efforts were made to ensure that all other potential providers were aware of the Ageing Well initiative. See timelines and discussion above for further detail.
Work closely with social care managers to ensure that referrals from them are systematic and links with social care formalised	The projects are here making a contribution to Lewisham's social care Modernisation agenda in promoting independence and widening choice for older people. Links to social care managers were particularly successful in relation to occupational therapy support, where the involvement of an OT assistant with AW-SE and AW-SW provided an important bridge to services.
Work closely with all three project areas ... to ensure that cross project learning takes place	The steering group and management support group provided some opportunities for this and were appreciated by the project managers.
Ensure that robust monitoring and evaluation of the project takes place, and that the project contributes to the achievement of key LAA	This could have been strengthened. See discussion on evaluation methods above. The establishment of the database was cited as an achievement here by one project

targets for older people.	
Define work with other providers through simple service level agreements(SLAs)	In AW-NW SLAs in place for OT assistant (with LBL) with SAGE (for staffing arrangements and resource allocation) and with Age Concern (advice work). Letters of agreement were drawn up for 5 other organisations that were paid directly upon invoices for services after delivery.
An expectation is that some money will be allocated by each project to support local community-based groups to carry out innovative prevention work in the Borough	In AW- NW £62,900 went to 10 local organisations to provide services and/or staff or other resources. AW-SW reported that the requirement to work within the specified ward boundaries deterred local organisations

Appendix 1 - Timelines

Timeline 1 - Set up and Staffing

	AW-SE	AW-SW	AW-NW
Jan – March 2007	<p>Database creation and training</p> <p>Worker appointed to input current users to database</p> <p>Group worker/transport co-ordinator seconded from Sage</p> <p>OT seconded for 3 days from LBL IRTS</p>	<p>Database creation and training-</p> <p>Worker appointed for database and office work</p> <p>Local panel meetings held quarterly throughout the period and facilitator employed</p>	
April - June 2007	<p>Casual driver employed for additional groups</p> <p>Initial meeting with UHL Social work team to discuss referrals</p> <p>Area maps produced and distributed</p> <p>Joint Meeting with duty Social work team to finalise referral process</p>	<p>Increased sessional workers/staff for AW-SW clients (hydro, St Barnabas group, Monday group, Tai Chi, hydro)</p> <p>Area maps produced and distributed</p>	<p>Project manager and support worker in post (mid May)</p> <p>Database meeting to set up new system</p> <p>5 meetings including older adults team meeting</p> <p>Area maps produced and distributed</p>
July – Sep 2007	<p>First joint meeting with social worker and client</p> <p>First appearance in a care plan</p> <p>Meeting with visual impairment team to develop joint working arrangements (referrals, shopping support)</p>	<p>Support worker (28 hrs) started</p> <p>Support worker (18 hrs) started</p> <p>Individual work increased with employment of sessional workers</p> <p>Visual Impairment/deaf awareness training for staff</p>	<p>32 set up/planning/induction meetings</p> <p>Sheltered housing visits</p> <p>Leaflet drop</p> <p>Support worker left project</p> <p>Reminiscence training day</p> <p>Lone person training</p>
Oct - Dec 2007	<p>Development of joint work with Bellingham Community Project (active and frail older people) and of Bellingham lunch group</p>		<p>Support workers Advert placed – appointed end December</p> <p>9 planning meetings</p> <p>Minibus training</p>
Jan - March 2008	<p>Initial meeting with Supporting People – March</p>	<p>P/t worker - assessments</p> <p>P/t worker - office work</p> <p>Website creation</p> <p>Loop system training for staff</p>	<p>Second Support worker started</p> <p>Leaflet drop New Cross and Deptford</p> <p>Manual handling course</p> <p>Food Hygiene course</p> <p>7 planning/monitoring meetings</p>

Timeline 2 - Key Activities (other than those relating to individual work with clients)

	AW-SE	AW-SW	AW-NW
Jan – March 2007	Friday Lunch club Downham (joint with AW-SW) Thursday Fortnightly Shopping to Sava centre, Sydenham (joint project with AW-SW)	Friday Lunch club Downham (joint with AW-SE) Thursday Fortnightly Shopping to Sava centre, Sydenham (joint project with AW-SE)	
April - June 2007	Increased falls prevention groups	Hydro, St Barnabas group, Monday group, Tai Chi, ongoing	Sheltered housing visits Leaflet drop
July – Sep 2007	Referrals from new agencies analysed, show 40% increase Sitting service developed Increase in falls prevention provision	Individual work increased with employment of sessional workers Monday Lawrie Park group starts-sheltered housing cluster project Thursday Men's group starts – St. George's Church, Sydenham 'On the buses' research gathered pace	Credit union leaflet mail merge Leaflet drop Deptford and New Cross Eastbourne trip for Heathside and Lethbridge residents
Oct - Dec 2007		Tuesday Craft Group starts Wednesdays Monthly Men's pub group starts Outdoor walking aids leaflet launched Ferrules leaflet, prescription leaflet and groups in the area leaflets launched	First healthy Bingo Class at Barnes Wallis First Latin in line class at Moonshot Centre Men's group starts at Action 2000 Waldron Centre Buddy Group starts Commodore Court and John Penn sheltered housing events
Jan - March 2008	Bellingham lunch group starts Thursday shopping group increased sessions to weekly to meet demand (joint with AW-SW) Tuesday Shopping Groups a and b Savacentre, Sydenham Both shopping services full (waiting list) Friday lunch group full (waiting list)	Thursday shopping group increased sessions to weekly to meet demand (jointly with AW-SE)	5 Bells men's monthly group starts Commodore Court s weekly group starts Moved monthly men's group to John Evelyn pub and revised to be more frequent Moved Latin in line to Salvation Army centre

Appendix 2 - Client Case Studies

Purpose of the case studies

The purpose of the case studies below is to indicate the circumstances of three individuals referred to each of the AW projects in July 2007. Each outlines the reasons for and outcomes of the referral to the Project and the perceptions of the clients in relation to social care outcomes often desired by older people. The case studies aim to place the voices of the clients at the centre of this evaluation.

There is a growing literature on what constitutes successful ageing, what older people want and what measures can help us to specify the quality of life of older people. To date however there has been very little attempt to classify and test what older people desire in terms of social care outcomes. One study has used a range of existing research studies to summarise the social care outcomes older people want.³⁰ Fifteen desired outcomes were established in the research and these have been used as the framework for the file analysis and interviews with three Ageing Well clients.

The numbers in each case study relate to the individual's responses when considering whether or not they experienced any of these desired social care outcomes. They do not refer only to outcomes achieved via preventative service initiatives, but look holistically at how social care is experienced by the individuals.

Summary of social care outcomes desired by older people

Outcomes involving Change

1. Changes in symptoms and behaviour
2. Improvements in physical functioning
3. Improving morale

Outcomes involving Prevention or Maintenance

4. Meeting basic physical needs
5. Ensuring personal safety and security
6. Living in a clean and tidy environment
7. Keeping alert and active
8. Access to social contact and company
9. Having control over everyday life

³⁰ See C Glendinning et al, *Progress and problems in developing outcomes-focused social care services for older people in England*, Health and Social Care in the Community, Volume 16, No 1, 54-63, 2008

Service Process Outcomes

10. Feeling valued and being treated with respect
11. Being treated as an individual
12. Having 'a say' and control over services
13. Value for money
14. A 'good fit' with informal sources of support
15. Compatibility with, and respect for, cultural and religious preferences.

Iris

Iris, is a 91 year old white woman living alone in a house in Bellingham. Her next of kin is a niece who speaks to her by telephone 'most days if she's not away on holiday'. (8)

'My husband used to warn me that I'd fall down the stairs as I didn't bother putting the light on at night. Well that's what I did, I fell down the stairs. After I hurt my leg I had to visit the nurse every Friday for six weeks at the surgery at Bellingham. There she said, you're getting deaf, but I needed someone to take me to the hospital'.

The Practice Nurse at Bellingham Green Surgery referred to AW-SE to get an escort to accompany Iris to a hospital appointment.

'Ros (AW-SE manager) contacted me, and she explained she wasn't a carer and then Valerie (worker) came. She took me to Lewisham, but it was a long walk from the taxi – the longest I'd done for a long time, but Valerie thought I was very good. And I went to get a hearing aid. I went to King's. They said, there is nothing that can be done. Its wear and tear and age... Valerie is brilliant, she's so helpful'. (10, 11)

At her assessment visit Ros also discussed concerns regarding an uneven path outside the house, Linkline, occupational therapy assistant support, social activities and shopping. Linkline and occupational therapy assistant support were declined as Iris has 'very good neighbours' (8). She uses the LBL shopping bus (7, 8). She agreed to think about attending the Friday lunch group but declined physical activity groups. (12)

'The nurse said I should join a club, she said it's better than talking to myself'. Iris agreed to try the lunch club. 'I wasn't too happy the first two weeks here, but it's lovely now. The Christmas lunch was wonderful - the table was laid so beautifully' (7, 13).

Iris is concerned about her physical functioning and its impact on her basic physical needs and her living environment. She explained a number of ways in which her failing eyesight and weak hands affected this.

'I have someone private to do my hoovering. I do the dusting and the cooking and the washing up, but in the kitchen I have problems with seeing the cooker numbers for cooking. If I write a shopping list for a friend, she can't understand what I've written and I can't see it – I need a magnifying glass... I find eating difficult, I can't see or cut up some of the food here- it's too hard' (broccoli and cauliflower pieces served with the meal at the lunch club) 'This is what I hate, the problem with my eyes, and then I get nervous and drop the food'. (4, 6, 9)

She recognised a number of areas where she now had less control over everyday life. For example explaining, 'There's lots I can't do – I can't get into the bath. But I can wash myself down. I asked my niece for some rose bubble bath stuff from M and S, and she said, but you don't have a bath. I said, but I do wash, I do keep myself clean'... 'I was apprenticed as a dressmaker. I made wedding dresses I really miss the sewing and knitting'. (9)

It was very important to Iris to try to keep active. Despite her initial reluctance she now takes part in the seated exercise session at the lunch club 'I did keep fit for 17 years and I'm not bad for a 91-year-old. The last 24 years I've lived alone and had two heart attacks and have arthritis – I've now got it in my legs, but I sometimes do try to do the exercises at home'. (7)

Discussing social contacts and company, she mentioned her niece and an ex - keep fit teacher who keeps in touch by visiting on her birthday each year. While she thought the lunch club and exercises helped keep her active she said 'I don't know half the people here.' While she spoke to the helpers she did not interact with the other clients. (8)

She felt valued and treated with respect at Ageing Well. 'They are lovely people, very kind and they help me. They are all helpful and work very hard – folding down all those tables is hard work'. (10) Asked if she believed she 'had a say' she replied 'yes, I think so, but I'm not one for speaking much – but last week we had a speaker here talking to us about gas and smoke alarms and that was quite interesting'. (12)

Iris has been attending the lunch club for six months and now sees it as the main way she keeps alert and active. (7)

Colin

Many of the desired social care outcomes are not yet apparent in Colin's life and below the numbers often refer to negative experiences.

Colin was referred to AW-SW by his physiotherapist. Since his stroke he has a slight loss of function in left arm, pain in right leg, and difficulties with stairs and balance. He uses a stick.

When asked to describe himself, Colin said 'I'm West Indian, I'm from St Vincent and I came here in 1960. But I got diabetes and kidney failure. That was 18 years ago, and I had a stroke three years ago, I can't use my left hand. I'm not too well, because I get a lot of pain - daily pain'.

Colin has Type 1 Diabetes, injects insulin twice a day and takes medication for his kidney trouble and for depression. He has two sons and a daughter and 2 grandchildren. His oldest son Les lives in Essex but his other children visit weekly on a Friday or Saturday. His next door neighbours assist him. He contacts them by banging on the wall or sitting outside.

Carers visit Colin twice daily 'Someone comes in twice-a-day, for the injections' and he has domestic help twice a week and a weekly visit from a worker at the Stroke Association.

Colin lives in ground floor Council flat in a poor state of repair: for example the cooker was not working. After visiting to make an assessment Kerry, the AW-SW manager and Kerry AW-SW worker initiated a number of actions to attempt to improve his living situation. These included referrals for assessment by fire safety and crime prevention officers, and occupational therapy. The Stroke Association was also contacted to see if Colin was eligible for attendance allowance. Linkline cannot be established until a phone land line is installed. To date the outcomes of these referrals are not known. (5, 6)

Colin had gone swimming regularly before his stroke and was interested in the hydrotherapy group. After reminders and support from Kerry, the AW-SW worker, Colin got the necessary letter of referral from his GP and bought swimming trunks, finally joining the hydrotherapy sessions in September. He also started to attend the men's group in September. He is appreciating these activities. 'After my stroke assessment they said I needed to get out and about – it's good at the group to talk to one and other I go swimming and I do go to the park sometimes. For the time being it's good. When I go to the swimming pool, I like it there I like it a lot and I go to the men's group and enjoy the company.' (2, 3, 7, 8)

Colin spoke briefly about his diet, but it is not clear how good this is, however he did insist, 'Yes, I like West Indian dishes and I can get good meals delivered from up the road'.

After responding to my questions for a little while Colin wanted to tell me about the problems he was having with his upstairs neighbours. He feels he cannot control this situation and repeatedly told me that they were making him miserable. He was angry and tearful explaining, 'The people upstairs are driving me mad. I don't put pressure on. I am British, whatever they think. I don't know

what to do - but I can't sleep, they bang all the time - I don't know why they are doing this to me. They're trying to drive me insane'. (9)

The group activities that Colin attends at AW-SW are an important means of keeping active and accessing congenial company. He also gains respite from a difficult living environment.

Joan

As with Colin, many of the desired social care outcomes are not yet apparent in Joan's life – the numbers often refer to negative experiences.

Joan lives in a roomy one bedroom flat in a converted Victorian house that is split into smaller flats. The house has a garden and basement. Introducing herself she explained 'I contacted Age Concern about a fire alarm, there is one, but it was outside my flat, and I was worried if there was a fire, so they came and gave me two more. (5) I'm 74 this year. I've got COPD plus a temper, have I got a temper - the council just won't give me a shower and I can't have a bath and I feel so dirty'.

When the AW-NW manager, Helen, visited to make her assessment she noted how mobility was the main problem for Joan. Issues explored with her then were accessing dial-a-ride, Linkline, contacting her social worker for an occupational therapy assessment and attendance at a craft activities class.

The layout of her home limits her. 'It's difficult here, because of the levels, but I don't want to move because I've got good neighbours. I pay someone to help with the housework and I can't do the hoovering. In the kitchen I've got no wall cupboards, so bending down is very difficult. If I kneel, well, that's murder'. (6)

She lives in a house at the top of a steep hill and this further restricts her. I'd be more active if I didn't have all the hills round here and it's quite an awkward house to get around, even to get out to the garden I need help. I can't go to the dentist any more because he's up a big flight of stairs. On Wednesdays, I have a friend who comes from Canterbury and who takes me shopping. But sometimes I just sit in the car. Getting my pension is a worry. They're closing my local post office I'll have to go to the big one on the main road. I can't queue; I can't be near people wearing perfume. It makes me cough. I won't go out on my own and I'm worried. If I cough I can wet myself. It's awful'.

Joan was not clear about who had visited her to assess and help meet her needs. 'What is a social worker I don't know? I don't know if I've seen one. I've seen a lot of people but they said I've not got enough points for a shower. They were useless, they gave me a seat but that wouldn't fit inside the bath properly.

So they gave me something to sit on top. What's the point of that? I might as well sit with a basin of water'.

Speaking about her symptoms she explained, 'Changes in symptoms yes, it's definitely getting worse. When I came out of hospital last time I could wash all my curtains, but I couldn't do that now. I've put on a lot of weight, I really have gone downhill. I can't sleep at night so I am always tired and I've been told I won't get any better. One letter says there is a suspicious shadow on the lung, but I'm not going back to the GP. The less I go there, the less I go to hospital. Its terrible in hospital, you just lie there'. (1, 10)

'I'm low at the moment because I can't have a bath and I feel dirty and I wash my underwear at night and put it on the radiator to dry. But I don't really care what I'm wearing any more - I've stopped caring. I think that's what gets me down. I never used to be a miserable person. I get itchy. I think that's the medicine, and I do feel so dirty' (3).

Joan knows her diet has deteriorated. 'Now I don't eat properly any more, chopping vegetables is a nightmare – especially swede. I only snack. I do make soup and mince and put them in small containers in the freezer. You get sick to death of it. I eat skips, the prawn cocktail ones. I'll eat a whole pack in one go. Do you know if you said have a roast dinner or a packet of skips I'd have the skips. I do eat yoghurt, though'. (4)

Joan does not feel in control of her everyday life and is worried about her home. 'They tell me they are definitely not putting in a shower, but I have to get one I have to get an estimate, but I've had some real cowboys here – when they did the bathroom and when I got the plastering done'. Once I had a cleaner from social services, a two-year-old could do better. She just used one hand and said my Hoover was too heavy to use. I got my cleaner from a friend of a friend who told me about her. She's really good. I'm not phoning the council on anything any more, because first of all it's, we are recording this, we may be recording this, then there's - press one, press two and then you're speaking to a person and you can't understand what they're saying to you. It's not their fault, but they shouldn't employ people who you can't understand, can't speak clear English' (9, 12).

In relation to social contact and company Joan has some good support from neighbours and friends. 'As you get older that you don't get out enough to make friends, most of my friends have left London, but I have a couple of good neighbours, but they are at work and have families of their own. I can't even get a morning newspaper no-one will deliver around here. Since I was 27 I've been on my own and I've always been very independent, so I find it very hard... My very good friend Mary has come over immediately from Canterbury when I've needed help, but I feel so guilty. I've got a lad of 22 - Roger, he's really good, his Mum's got MS. I used to look after him for her. He comes up every Thursday

and cooks for me and helps me change the bed. He won't do any housework though, I think it's because he does so much for his Mum, but he's really good' (4,6,8).

Joan is struggling with the tension between the difficulties of her current living situation and her appreciation of nearby support. 'I do need a downstairs flat, but I don't want to go into a block of flats or those sheltered flats and I don't want to go where I don't know anyone. If I went elsewhere I'd be very, very lonely' (5, 9).

She is interested in trying to find ways to keep alert and active – but no appropriate classes have been found. 'I don't want to do those old people's groups- you know Bingo. I'm interested in dolls houses, and I used to do porcelain dolls that it is now so very expensive – even when you get material from the market. Most of the small haberdashers are closing and it's very hard to get materials. I do like the sewing, but I'm not as good as I used to be with the cutting out. Not so precise with my hands. People bring me trousers to take up. I don't think they understand - it's not the same. I've got a pair of my own trousers to put up. I gave the dolls away, it was all the dusting, but I regret that now'. Night times she finds the most difficult. 'I still smoke in the night. It's so long the nights when you're not sleeping. Neighbours have suggested tapes - books on tape. That would be a good idea and I do crosswords.' (7).

While AW-NW anticipated this case would be closed when a volunteer befriender was found, this has proved to be difficult. Karen, an AW-NW worker, is currently visiting Joan. 'Helen's very good she always makes me laugh. She's introduced me to a couple of people. Someone came but I think she broke her ankle and can't come. Karen is coming, and she is teaching me to crochet and I'm teaching her how to knit and I've seen her twice now. We can have a laugh together'.

AW-NW is playing an important role in Joan's life. 'I'm so grateful to Ageing Well, I don't know who told me about them, but I phoned them and they've been very good. I like the friendly attitude, they make me laugh even if it's just half an hour with them - It is really good'.

Appendix 3 - Some of the group activities being run by the Ageing Well Projects

Spending time at Ageing Well activities both as an observer and as a participant observer provided the opportunity to understand how the groups are organised and what they mean to the clients who are part of them.

Bingo at Barnes Wallis Community Centre (AW-NW)

Bingo is a popular sedentary leisure activity for older people, particularly women. The Bingo session at Barnes Wallis Community Centre is run weekly from 1.30 to 3.30. Richard, the driver collects participants from their homes and takes them to the community centre in a minibus. Richard explained how he hoped that this helped build confidence in getting people to go out. But how sometimes he'd knock and they'd say, 'I can't be bothered today'. Most women attending the session were very frail with limited mobility, and/or poor vision. One later explained how it took time to build confidence to leave her flat. 'I appreciate having the bus and now I trust Richard getting on and off it'. Eight women were attending the session that day, but numbers fluctuate. The participants each pay £2 for the twelve games and refreshments and there are prizes of basic groceries, with an emphasis on healthy eating. Sharon, who runs the session explained how she tries to include some unusual items - that week it was Macadamia nuts and fruit teas. She recalled how one week, nobody wanted the tin of rice pudding, because it was organic. The electrical bingo machine is borrowed from a local sheltered housing unit and with its flashing red numbers gives the session a professional feeling; as well as helping those with poor vision. It also militated against the somewhat gloomy setting – a large and dark hall with no natural light.

While the games were under way Richard popped out to a local shop to buy bread and milk for two players - a regular task. After six games, Richard and Sharon served tea, coffee and biscuits and each of the women told me in turn why they came to the sessions.

'It's quite good. We like each other and chat'. (Pam1)

'It's something to do, but it's a bit slow for me'. (Win)

'You meet other people from other parts of New Cross'. (Pam2)

'It's the only time I go out unless my daughter visits'. (Sue)

'It's something to do, somewhere to go, it makes a change, I enjoy being with people'. (Iris)

'For the company - getting amongst other people'. (Mary)

'It gets you out of the building (sheltered housing unit). I look forward to it'. (Dot)

Ethel who is 100 years old, commented, 'I like mixing with other people. It's a little bit of interest, you feel you might win something and the prizes are sensible and useful'.

None of the participants were interested in more active activities, and 'I wouldn't like to do anything physical. Not like exercise or swimming' was a typical response when the women were asked what other activities they would enjoy. After the session Sharon who also runs the salsa dancing sessions for older people, explained

'The two groups are very, very different – this group wouldn't want even seated exercises and the others wouldn't want bingo'.



Hydrotherapy Session at Eltham Centre (AW-SW)

Hydrotherapy is a group exercise programme using the buoyancy property of water to assist people to exercise. People referred to hydrotherapy may have chronic pain problems and/or decreased mobility and need to be keen to exercise.

The hydrotherapy sessions takes place at the Eltham Centre in the neighbouring borough of Greenwich. This fortnightly session, therefore, entails a lengthy minibus journey to and from the pool. Participants have to book the sessions individually with the Centre at a cost of £3 a session. The bus arrived at the Centre at midday, with the two workers, Kerry and Donna, and eight participants. It was a long walk from the bus to the pool as two people had zimmers and two were on sticks. The small pool was warm, and attractively lit with changing

coloured lights, but the moving water in the Jacuzzi made it noisy and observers were asked by the instructor not to speak. By 12.20 five people were ready for the session - three had come to watch and assess whether or not they would be interested in attending future sessions. There were four other local participants. At first there were concerns, because this was the first visit to the pool and unlike the previous pool the group had used, there was no rail around the edge for people to hold. Nevertheless, all went into the water: three via the hoist. One woman held the edge of the pool for the entire session. The instructor, Wendy was an older person herself and skilfully managed the exercise programme. The first 10 minutes comprised gentle stretching movements. Then she suggested that people might swim the width of the pool. Only one person felt confident enough to do this. By 12.45 pm participants were using floats, and these resistance exercises were followed by gentle exercises to music. At this point, the spectators spontaneously started to copy the exercises from their seats. Speaking with the spectators after the session it seemed unlikely that two would join in later sessions. One explained that while she needed to exercise after a hip replacement she felt that she was well able to follow the exercises she had been given to do at home and that that was sufficient. A second observer with poor vision and mobility did not think she would be able to see the instructor sufficiently and the third said 'maybe'. The session finished at one and everyone moved from the pool to the Jacuzzi for some minutes. After drying and dressing people met downstairs at the coffee bar, before returning to the minibus and the journey back to Lewisham.



Friday Lunch Club (AW-SE and AW-SW)

The club is a joint-venture between AW-SE and AW-SW. At 9.30 am I met with Donna, a project worker, who then checked the rota for picking up clients. We set off in a minibus, driven by Steve. It was a very wet, but not cold, January morning. At the first stop the client said she was not coming out as it was too cold. Donna called people from her mobile, as we approached their homes. Her welcoming messages appear to have persuaded a least one person to come out, as she explained to me later 'I wasn't going to come today because of the rain'. And an hour later the minibus arrived back at Goldsmiths Community Centre with 10 clients. Everyone settled at a large table in the centre's hall and prepared to play bingo. Clients had been asked what activities they would enjoy and the regular bingo sessions were a popular choice. While the session was running tea was served by three helpers, one of whom helped Iris, a 91-year-old woman with poor eyesight. Meanwhile, Donna went out shopping for groceries for three of the clients.

Lunch was prepared by Sue and Gay who run the community cafe. This is a hot two course meal and clients see the menus for the coming weeks in advance so they can request any changes. Lunch was served in the hall where tables were set for six. At lunchtime other ageing well clients, who arrived on a second minibus, and staff joined the diners. The club had started in the cafe but had moved to the hall as the numbers grew. Now up to 20 people can attend. The cost for the meal and activities is £4.

By 1.30 pm the bingo tables had been removed by the staff and the chairs rearranged for an exercise session. Tonia led a session of gentle seated exercise for 25 minutes that seven clients joined. Others remained at the tables talking. Then the workers served everyone with another cup of tea or coffee. By 2.30 people had collected and being helped into their coats and were ready to leave on the home journey.



Men's Group (AW-SW)

This takes place in the excellent modern premises of St George's Church in Forest Hill. After lunch in the café on the ground floor the group moved upstairs to a bright and airy room overlooking the street. There are modern kitchen facilities at one end and plenty of space for activities. The only drawback is that members had to go downstairs to the toilets. When I arrived the eleven group members were seated at two tables and in two teams enjoying a lively quiz session. The quiz had been devised by Ian who runs the sessions assisted by another Ian, who also drives the members to and from the venue.

After the quiz a tape of gentle music was played in the background while tea and coffee were served. There was also a large chocolate cake to share. Ian had brought this to celebrate someone's recent birthday, and the men played cards and dominoes and talked. I spoke with members of the group.

Phil is 92 and lives alone. He can't get out by himself, and since having a stroke his eyesight has deteriorated. This means that he is unable to care for his garden, which worries him. He enjoys the company and the quizzes.

Jake was referred to the group by Liz, his physiotherapist. He had had a stroke and has shoulder pain, and weak, leg and hand on his right side. He is a diabetic.

'It's okay here, it gets me out of the house. It gives the missus a break . I like to play the cards and the dominoes. I enjoy it very much. I used to hate dominoes as a boy in St Lucia, because all the lazy boys in the dance

hall used to play dominoes. But now I'm 71, and I enjoy it here, I do! But I really miss work and not being able to drive'.

Nick had also had a stroke. He explained that his main problem now was his speech, which he believes 'will improve with practice and time'. He had attended the Tuesday group, but was the only man there. He enjoys coming to the group and also attends another group for those who have had strokes, fortnightly at St Laurence's.

In his forties, Carl was the youngest member of the group. He was recommended to AW by his community matron. He rarely leaves home except to do his shopping and explained 'I really like coming here – it's a great group'.

By 3.30 pm everyone had made their way downstairs to wait, while Ian brought the minibus for the journey home.

