Pilmeny Development Project's

Feasibility Study

for

'Community Connector' Project

in Leith/North East Edinburgh

"I am very lucky…. If I can get out, I become happy"

Anne Munro
Maggie MacLeod
February 2010

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‘COMMUNITY CONNECTORS’ PROJECT

Executive Summary of Feasibility Study

Aims

The feasibility study set out to identify whether a ‘Community Connectors’ project in Leith/North East of Edinburgh would fill a gap in current services and meet the needs in the area, drawing on the views of older people and key stakeholders.

‘Community Connectors’ Project

A ‘Community Connectors’ project would help socially isolated older people (including black and minority ethnic elders) who do not meet the criteria for a day care service to access and participate in community services and activities in the area. In addition to being beneficial to older people through engaging them with community based inclusive services, it would contribute to lessening the requirement for high needs services.

Approach/Methods

A desktop study of relevant literature and policies. mapping, consultation and case studies with over 50 individual older people and key stakeholders (from statutory and voluntary sector health and social care agencies) was undertaken.

Main Findings

Literature search

There is a wide range of research and policy documents, European, UK, Scottish and local, which highlight the needs of a growing elderly population. Leisure, social networks and mobility as essential factors in the quality of life of older people are key themes emerging from a variety of literature. Current local city of Edinburgh planning and policy documents noted that the Health & Social Care Department would not be able to give direct services when needs were assessed as low or moderate.

Older People

There was widespread support for the ‘Community Connector’ project proposal from those consulted**.** They agreed it would help get older people out and about in the community and this would be of benefit to those who were more housebound. They brought up the issue of security – older people need to be assured that the project would be ‘safe’ and that they could feel safe and secure with project volunteers/workers. Transport was also an important issue. Black and minority ethnic elders also responded positively but were keen that there would be some specialist approach specifically to meet the needs of BME older people.

They mentioned in particular support following bereavement, joining in educational or cultural activities, being able to get to specialist shops. It was clear from the way in which older people interviewed discussed being active and involved in activities from their own point of view, that this was very important to them. They were clear as to what benefits the

support that the project could offer would bring – building confidence, lessening loneliness, allowing people to have some choice in the activities they wanted to do (e.g. visits to the hairdresser), allowing their family/carers some respite. They wanted the scheme to be flexible to respond as far as possible to what they would like to do.

Health & Social Care Agencies

Agencies consulted were from Health, Health & Social Care, Housing and the Voluntary Sector. Again, there was general support for the 'Community Connector' project proposal. Staff from all agencies acknowledged the needs of older people, recognised the social isolation that some of them experience and the benefits of keeping active and having social networks. They also brought up the additional benefits to carers of having a short break, especially when they knew their relative was doing something they wanted to do. They commented on the social isolation that restricted mobility brings. The lack of activities at the weekend was an issue. Staff noted that pressure on resources meant that they had to a certain extent 'ration' their services and that some services had changed in the kind of support now offered to older people. This has implications for the well-being of older people. Voluntary organisations, for example, are restricted by the criteria and amount of their funding base. Statutory agencies highlighted they had now stopped many services, were not able to meet all identified unmet needs and were having to advise older people to find help elsewhere.

Recommendations

Considerable thought has already gone into the need for, establishing and development of the Community Connectors project. Pilmeny Development Project has undertaken extensive research and consultation over the years with older people and their carers in Leith and NE Edinburgh and with statutory and voluntary service providers. The project also has the backing and support of the Portlee Healthy Living Group. The need for, and potential use of, the project was further ascertained in the course of the Feasibility Study, with support from older people and from statutory and voluntary service providers. As a result of this study the following recommendations are made:

- It is recommended that a 'Community Connectors' 'action research' pilot project be established in Leith and North East Edinburgh area. This would allow for a more in-depth evaluation of outcomes to be carried out, if possible using an independent external source. It would also contribute to discussion/decision to extend the service or set up a similar project in other areas of the city and also help address the issue of the current scarcity of resources available to set up a new project.

- The project should aim to evaluate what works from the perspective of older people.

- A simple but robust form of evaluation should be established from the start of the project

- The focus should be on better lives and better life chances.

- A single, integrated, project is established to provide a service to older people, including BME elders. The co-ordinator would need a relevant range of experience and skills and some of the volunteers and sessional workers would require to be bi-lingual.

- Whilst aiming to work in a flexible in person centred way, the project should have a clear area of focus from the outset as to what it can offer to older people and their carers. It would need to set parameters and should avoid trying to do too many things for too many people - start small and learn and develop from learning what works and what more is needed.

- The referral system should be kept straightforward and simple

- Advertising and information about Community Connectors and what the project can offer should be appropriately and widely targeted, including a simple newsletter to older people using the project to keep them informed and linked to the community.

- The project should establish and maintain interest at a high level in Health and Social Care who have said they have a commitment to preventative services.

- The project should develop a database of activities, services, support needs and service use in a form that could be used for planning purposes.

- Making a small charge for the service should be considered. The disadvantage is the risk that it would make it more difficult for some older people with limited finance to make use of the service. The advantage would be a source of additional income that could be used for beneficial purposes not covered by funding.

- Where possible Community Connectors should look for ways to facilitate and encourage older people to have a role in their community to allow them to develop some sense of purpose and belonging.

- Older volunteers could make a valuable contribution to the project – thought needs to be given as to potential barriers and how to motivate older volunteers.

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1. SCOPE / OBJECTIVES

The scope and objective of this feasibility study are to investigate and assess the need for, and achievability of, setting up a 'Community Connectors' project in Leith and North East Edinburgh. The process of study also aimed to inform health and social care services, and related agencies with a view to seeking their support to develop a proposal and seek resources for a local 'Community Connector' initiative in line with identified needs.

2. APPROACH / METHODOLOGY

The approach was to:

- Undertake a desktop study of relevant literature and policies.
- Investigate whether there were any similar projects running in other areas that would give insight into the viability of the proposed Community Connecting scheme.
- Review consultation to date the older people and undertake additional consultation if necessary.
- Discuss the project proposal with relevant key stakeholders to inform them of the proposal and to obtain feedback of the desirability of the proposed service. Meetings were arranged with staff from Lothian Health, CEC Housing Department, Health and Social Care and the voluntary sector.
- Continue working links with Health and Social Care staff who have a special interest in the proposed project.

3. INTRODUCTION AND BACKGROUND TO THE STUDY

3.1 National

In common with other European countries Scotland has a growing older population and a decreasing number of younger people. Statistics predict that by 2011 there will be 1.047 million and 1.308 million by 2031 people of pensionable age in Scotland. This has led to a rethinking of the way in which services for older people are provided, with an emphasis on joint working and developing appropriate models of care.

Currently, one third of a million people in Scotland are over the age of 75, with an increased likelihood of having higher dependency and greater health needs. However, the great majority of older people live in their own homes at home and most wish to go on doing so. An increasing number of older people live alone.
For example, the number of people over 85 living alone increased between 1991 and 2001 from 30,000 to 44,000, reflecting both a rise in overall numbers and a rise in those living alone. National and local health and social care policies strive to support this wish and whilst these policies deal in the main with the formal health and care needs of older people there is an explicit recognition that "Older people should be encouraged to be physically and mentally active". ('*Adding Life to Years: report of the expert group on healthcare of older people' 2002*).

Together with an increasing number of older people have gone changes in attitudes and expectations of older people. They look for more responsive and flexible services and feel disappointed and let down when these are not forthcoming. The report *Better Outcomes for Older People: Framework for Joint Services 2005* notes that – "older people are clear about the outcomes they want from services. They want:

- to be helped to be more independent;
- to have choice and control over how they manage their lives; and
- to stay in their own homes whenever it is possible, with customised support."

The report adds "they do not particularly mind who provides the service."

In terms of health service policy makers and planners acknowledge the need for "preventative, anticipatory care" (*Building a Health Service Fit for the Future 2005)*.

The *National Outcomes for Community Care 2008* has as four key national outcomes – improved health; improved social inclusion; improved well-being; improved independence and responsibility. One of the performance measures ask for the percentage of users satisfied with opportunities for social interaction.

'*A Sure Start to Later Life: ending inequalities for older people' – Social Exclusion Unit Report 2006* deals directly with the exclusion facing older people. More responsive services for older people are needed because 'too often this exclusion is compounded by the failure of services to react to the complexity of exclusion in later life' (p9). The Report notes that 'The need for and benefits of preventative services has been highlighted throughout our consultation. Prevention is often thought of as something that happens much earlier in the life course. However there is a need for a range of interventions later in life such as ensuring that older people are targeted with active ageing opportunities in the same way as younger age groups.'

It adds that 'Addressing social exclusion among the most excluded older people has to be everyone's responsibility. Individuals, families and communities therefore need to consider the cause and extent of social isolation in their areas and consider developing the most appropriate interventions.'

Older people living alone at home are most likely to experience social isolation but those living in sheltered housing and other forms of residential care may also lack opportunities to participate in activities in the community and to mix with social networks outwith their accommodation.

My Home life; Quality of Life in Care Homes, a report by Help the Aged (2002) in partnership with the National Care Forum and National Care Homes Research and Development Forum, notes the importance of '…. opportunities to engage with neighbourhood and community…….having access to local services and shops.'

All Our Futures: Planning for a Scotland with an Ageing Population 2007: Scottish Executive 2007 – this strategic document commits the Scottish Government to 'act to continue to improve opportunities for older people – to remove barriers and to create more chances for older people to participate and to be involved in their communities…' (p12).

Mental Health and Well-being in Later Life: older people's perspective: Scottish Executive & Healthier Scotland 2004 – this is a report based on research commissioned by the Scottish Executive and Health Scotland. It notes that 'social activity and interacting with others was seen essential to maintaining mental health and well-being' (p1). The report states that 'A lack of social contact for whatever reason, can leave people vulnerable and less likely to take part in physical activity and it was vitally important participants believed, that symptoms of depression in elderly peope were recognised early. The link between the confidence to take part in physical and mental activity and the confidence to interact socially was clearly recognised.' (p16)

Promoting Mental Health and Well Being in Later Life: Age Concern & Mental Health Foundation 2006: this report concludes that 'activity to promote good mental health and well-being in later life could be integrated into current developments in policy and practice, nationally and locally…' (p4). Older people face discrimination because of their age and this has an adverse effect on their mental health, as does social isolation. The report recommends tackling 'the fear of isolation and loneliness that affects people of all ages'. Support should be offered to people following bereavement. Although some changes need to be addressed centrally but 'the majority of activities that older people identify as important to their mental health and well-being can most effectively be addressed by activities at the local, community level.' (p10)

Towards a Mentally Flourishing Scotland: Policy and Action Plan: Scottish Government 2009 – this policy document defines mental well-being as 'how people feel – their emotions and life satisfaction –and how people function –their self-acceptance, positive relationships with others, personal control over their environment, purpose in life and autonomy'. (p5). Staying mentally health in later life is one of the strategic priorities set out in the policy document. The Scottish government is committed to producing an action plan to address issues raised by All Our Futures and the 2006 Age Concern/Mental Health Foundation inquiry.

Research suggests that one to one interventions, such as befriending and home visiting, may be less successful in counteracting social isolation and loneliness and in building self-confidence than the opportunity to meet with others and participate in group social activities -

'Cattan et al's (68) review of 30 community-based intervention evaluation studies, most of which related to either group (n = 17) or one-to-one (n = 10) interventions, indicated that group interventions, particularly those with an education focus or which involved social activities that targeted specific groups (eg, women, the widowed) were effective. Evidence regarding the effectiveness of one-on-one interventions, such as home visiting and befriending, was unclear.'(*Social isolation and loneliness among older people: issues and future challenges in community and residential settings'* Australian Health Review, August, 2008 by Linda Grenade, Duncan Boldy)

'Inactivity and isolation accelerate physical and psychological declines, creating a negative spiral towards premature, preventable ill health and dependency.'
(*Report of the House of Lords Select Committee on Science and Technology on Ageing, 2005*)

'Many older people remained isolated - living in one's own home with no support or contact can be as disempowering as the stereo type of a nursing home'.
(*Older People Shaping Policy and Practice*. Joseph Rowntree Foundation 2004)

Regardless of their living circumstances, it is clearly important that older people have access to services and supports which help them to maintain their social connections.
(Social isolation and loneliness among older people: issues and future challenges in community and residential settings, Australian Health Review, August, 2008 by Linda Grenade, Duncan Boldy)

"There may be help to buy groceries, but no help to get a grandchild's birthday present or to get to the dentist".
(*Mental Health and Well-Being in Later Life: older people's perspective*. Scottish Executive & Healthier Scotland 2004)

3.2 Local

The City of *Edinburgh Council Health and Social Care Service Plan (2009-2012*) states that -

'Social care services have faced rising demand for some years due to the increasing numbers of older people, especially those aged 85+ who have the highest need for services. Within the three year period of this Service Plan, we expect an additional 1,050 people aged 85+ by 2012, compared to 2008 – an increase of 11% over the four years. People are living longer, and for many some of the additional years are marked by ill-health.'

The aims and aspirations noted at national level for more responsive and better integrated services are matched at local level in the *City of Edinburgh Council Day Services Review* 2007 recommendations and in its *Future Model of Day Services*. The proposal which is the focus of this feasibility study (Community Connectors) has taken into account the aims expressed within these two documents

The Future Model of Day Services states -

- 'day services provided in all settings should be targeted towards rehabilitation and enablement by supporting people, wherever possible, to develop or maintain existing social networks, community links and activities' (p47). And

- 'Community connectors will support people to re-establish and maintain links with existing groups and social networks during 'at risk' period – eg bereavement; increasing social isolation; developing symptoms of illness; experience of hospital admission or physical injury.' (p49).

The Review of Day Services for Older People 2007 identifies the importance of the 'unique preventative role' of non-registered services. The Report recommends that:

- 'All day service providers to act as 'community connectors', re-engaging people with mainstream community services and networks.' And

- 'Develop more services which are not centred based to promote choice ad person centred care and support.'

The underpinning principles of Day Services include –

- 'Day services will be person centred. A range of quality home based and centre based services…….will be available within each locality in order to provide choice and to promote inclusion.' And

- 'Day services provided in all settings should be targeted towards 'rehabilitation and enablement' by supporting people, wherever possible to develop or maintain existing social networks; community links; and activities.'

Mainstream community services are at the foundation of the model of sector based day services recommended by the Report.

A City for All Ages, Edinburgh's Joint Action Plan for Older People aims to improve opportunities and services for older people. The ACFAA Action Plan plan promotes active citizenship and social inclusion.

The Council and NHS Lothian *Joint Capacity Plan for Older People 2008-2018, Live Well in Later Life 2007,* has four broad themes – person centred care; choice, control and independence; integrated services and approach; preventative services. It notes that 'non-registered day services have a central role in providing preventative services for older people who are no longer able to access community facilities or maintain their social networks.' These non-registered services are seen as having an essential role in preventative and community based approaches.

The *Joint Carers' Strategy - Toward 2012* notes that carers of older people wish to be 'able to access the range of care that help them caring in the community and maintain their own health and well-being'. Respite is a key need for carers but carers may not want respite away from the person they care for, especially if it is their spouse but they want opportunities to continue to share activities as they have done in earlier years.

Summary

Demographic changes and changes in people's expectations have led to a reconsideration of how best to provide services for people as they age. A key part of this reconsideration is giving older people the opportunity and support they need to remain in their own homes for as long as possible. However, there is recognition that simply to promote independence is not enough – older people need to be given opportunities and support to remain active in their communities, participating in leisure, cultural and other activities. Well-being also needs to be promoted.

Policies and plans highlight the need for a more integrated approach to service provision and greater use of community-based services (and indeed the community itself), including those provided by the voluntary sector.

The move towards greater personalisation may in future allow older people greater choice and more control over how their support needs are met. In order to meet these needs social and community based support and a stronger focus on prevention need to be kept on the agenda for strategic planning for future services for older people.

There is an ever-increasing emphasis on outcomes in the field of social services and social care. Although health outcomes are frequently measured using quality adjusted life years, there is a lack of similar measures in social care, especially in what might be termed preventative or 'low level' outcomes. There is, however, considerable research that links mental well-being with continuing social contact and activity and a decline in mental well-being and physical health with social isolation and lack of opportunities for activity and social networking.

4. FINDINGS

4.1 Desktop study:

Literature review of a variety of policies and plans from national and local government, voluntary sector and academic sectors, including those referred to in the introduction, informed the feasibility study and provided a context for the rationale and philosophy of the proposed project. Other reports are noted below.

4.2 Similar community connecting practice/models:

Community connecting is a well-established approach in promoting the social inclusion of people with learning difficulties and autistic spectrum disorder. Person centred thinking and planning is at the heart of this approach. One model used in the learning disability field organisation is setting up Circles of Support to help families secure the future for a relative with a disability. Equal Futures has taken a lead in establishing and supporting these circles. Local area co-ordination, which has been developed in different ways throughout Scotland, is another approach that aims to increase inclusion and independence for people with learning difficulties.

There are advances in using person centred planning and thinking with older people but there is a far smaller body of practice than with people with learning difficulties. One of the key differences is that for a person with learning difficulties a person centred approach is about giving him/her a sense of control over his/her own life where that has been lacking before. With an older person the emphasis is often about renewing and rebuilding control and confidence when this has been lost because of ill health, a life event, discrimination, etc. A recent publication, *Person Centred Thinking and Older People*, produced by The Older People Programme and Helen Sanderson Associates, looks at ways in which person centred thinking enables older people to have greater control over their own lives, comparing working with older people and working with people with learning difficulties. One key conclusion is that "it is about people's lives and improving their quality of life and sense of control – it is not about health and social care or service based solutions, even if for some people these are crucial for day-to-day survival." (p15)

In the past two years The Older People's Programme, the Centre for Policy on Ageing and Helen Sanderson Associates have run a development programme, *Practicalities and Possibilities*, in 9 English local authorities to ascertain how the principles and practice of self directed support can work for older people who need support to live their daily lives. This programme has the potential for a major change in the way that services are offered to older people but one of the early lessons identified is the need for "clear areas of focus – it really does help to start small and grow developments from learning about what works". It was "extremely hard for people locally to agree 2 or 3 areas of focus in which to start this work – due to a mixture of enthusiam…and not knowing where to start."

In Scotland North Lanarkshire, as part of its Integrated Day Services for Older People, the Council has appointed 'locality link officers' to help challenge earlier consultation findings that some older people had limited access to information about to information about what was available in their community; others had lost confidence about going places on their own; some had health needs that meant they needed special transport and sometimes assistance in leaving their houses.

'New posts of Locality Link Officers have been introduced to support the wider changes in service delivery. These post holders identify alternative resources in the wider community and assist older adults to engage with them. In this way many of the problems of loss of confidence and lack of information can be overcome.

Each locality link officer has responsibility for a budget of £15,000, which can be used flexibly to support activities within the wider community and to allow taster sessions of new activities to be set up within various local resources.'

The role is service based with locality link officers being an integral part of a Locality Planning Group for Older People, a multi disciplinary team of health and social work colleagues. The link officers work with partner agencies 'to develop community facilities and capacity while linking service users to appropriate supports'. The North Lanarkshire Community Care Consultation 2009 (Older People) identified the need to develop further the role of these locality link officers as part of the Council's priority to 'reduce social isolation and assist older people to have better links with their own local community or area of special interest'.

A joint North Lanarkshire Council and NHS North Lanarkshire report – *Working Together Learning Together: Improving Outcomes for Older Adults* (2008), noted that the Locality Link Officer role was working well and was seen as 'very necessary' (p46)

We also tried to find any voluntary sector based models similar to the proposal from which to learn what worked well and where likely difficulties lay. The nearest related example we could find was the *Community Connect plus* project run by Age Concern Dudley. This project was established to 'enable more older people and their carers to access community based services and activities.' It acts as a focal point and broker to help older people and other service providers to get connected. A part time manager using volunteers runs the project. It seeks to 'respond to the needs and aspirations of older people by signposting, supporting and providing opportunities to access activities in local areas and develop social contacts in local communities.'

This project is funded by the reallocation of resources from some of the day care services run by Age Concern Dudley – the rationale being that this reallocation would help support older people than those already attending the day centre. Older People pay for their own activities where necessary.

In consultation the manager/co-ordinator said that the project was successful and well used – feedback from service users was positive. However the project would benefit from having more than one paid member of staff as currently the project does not function during holiday periods etc. Current funding does not allow for this, the parent organisation, Age Concern, is a valuable source of volunteers who give good services. There are limitations, however, on the amount of training many volunteers are willing to undertake and this means it may not be possible to provide a service to an older person with greater or more complex needs.

4.3 Transport

Accessible transport is a key factor and identified unmet needs would need to be addressed in partnership with other agencies and the Portlee Referral & Resource and Health Living Groups. Reports such as *'When the Going Gets Tough - the "where", "when" and "how" of Community Access and Transport for Older People and Carers in Leith'* (CEC Community Education Department 2004) highlighted the need for improved access for older people and carers to community learning opportunities in the area.

4.4 Consultation with older people:

Consultation with older people was structured round the following questions –

- Do you think there is a need for this?
- What do you think of this proposal?
- What benefits do you think this project could bring?
- What drawbacks/problems could there be?

Consultation with stakeholders (from statutory and voluntary sector health and social care agencies) followed broadly the same questions, with the addition of discussion re potential referrals and the interface between their role/remit and any new project.

> 'Explicit indications that their needs are being taken into account, or clearer frameworks for doing so, could help older people feel more valued and included.'
> *Managing Resources in Later Life* – Joseph Rowntree Foundation 2009
>
> 'The limited research suggests that: involving a combination of strategies; involving older people and/or their representative groups in intervention planning and implementation; having well trained, appropriately supported and resourced facilitators and coordinators; utilising existing community resources; and targeting specific groups are likely to result in greater success.'
> *Social isolation and loneliness among older people: issues and future challenges in community and residential settings*
> *Australian Health Review, August, 2008 by Linda Grenade, Duncan Boldy*

Consultation with groups of older people had already been undertaken before the start of the feasibility study with older people attending the North East Edinburgh Care Action Group (NEECAG) older people's forums and with a group of BME service users from the Milan (Senior Welfare Organisation), which offers services to older people from India, Pakistan, Bangladesh and Mauritius. It was agreed not to repeat the exercise with the same groups but we met with two additional groups – residents in a sheltered housing complex and a small group of people attending the NHS Lothian Older People's Rehabilitation and Assessment Unit (OPRA). In total over 50 older people were consulted.

NEECAG Groups -/

NEECAG Groups -

Consultation questions	Responses
Do you think there is a need for this kind of support?	• Noted that these sorts of needs have been identified locally over a long number of years and in many of the consultations NEECAG has participated in. • Agreed there was a need for more activities and people to help elderly to get there and back from them • *'Taxi drivers don't help…so I need someone to help take my arm'*
What do you think of the proposal?	• Agreed it was a good idea and there is a need for a 'Community Connecting' project • Contact the Elderly is a good scheme. but only limited to taking people out on a Sunday to a house for tea
Whatdrawbacks/problems could there be?	• Agreed there was a need for older people to feel secure and that can only be done if it is someone who is 'bone fide' • Need to have something that is organised properly or registered *'older people are frightened to let people in…we need to feel safe and confident that the person can be trusted'* • Noted there might be a problem getting hold of the right sort of people to be 'connectors' as there are staff shortages everywhere in Edinburgh at the moment • Cost would be a factor *'I was paying a carer to help take me out – but they put the cost up to £9 an hour and I had to stop it because I could not afford to carry on'*
Any other comments?	Overall there was general support for the idea and a willingness for NEECAG to be involved in the ongoing monitoring and evaluation, should it be successful in achieving funding/support

Milan Groups

Consultation Questions	**Responses**
Do you think there is a need for this kind of support?	• Agreed there was a need for this sort of initiative, particularly for BME older people • There is a need for BME older people to get help with going shopping (specialist Asian shops etc) and to go to thing such as outings or more social activities • Need for support particularly after a bereavement *'We need support to help us to go out'* *'Going to religious places…older people need these things'* *'After a bereavement when people feel so low … if someone comes and encourages them and can accompany them to the Day care or Lunch Club that would make a huge difference'*
What do you think of the proposal?	• General agreement that this was a good proposal…particularly the fact that there would be a specialist part specifically to meet the needs of BME elders.
What benefits could it bring?	• Education/learning opportunities • Participate in activities with other from shared culture/community • Increased confidence and independence • Improved health and well-being • Reduce social isolation • Relief of stress in BME families *'We learn things when we come out'* *'We want the opportunity to share common issues'* *'We need to discuss things and talk with each other, because we have left our own country…this helps our confidence and to become more independent'* *'I used to go on a health walk every week, but no one comes for me any more...so I have stopped going out... I still want to go…but who can help me?* *'I would only take 2 not 4 paracetemol!'* *'I am very lonely…if I can get out I become happy and feel I can go again'* *'the daughters in law will be very happy!'*
What drawbacks/problems could there be?	• Need for language line or someone to explain this to us in our own language • Service must be culturally and gender appropriate!

OPRA Patients Group

Do you think there is a need for this kind of support?	• General agreement that it would be a good idea. • There is a need to get out regularly, to meet other people. *'Sheltered housing is lovely with nice garden but I could not stay in all day.'*
What do you think of the proposal?	• General agreement that it would be a good idea. Make the service as flexible as possible.
What benefits would it bring?	• People especially like the opportunity to go to the hairdresser. • There are one-off events as well as on-going activities that people would like to attend. • It's good to have a variety of activities. • It would be good to have a regular contact person – home helps, for example, change too often. • It would help build confidence, for example with travel. • Support for hospital appointments. '*I would have liked to have gone on the visit to the People's Palace but there was no-one to help me get about*.' '*There is one old lady age 90 who has no friends or family. I phone her every day.'* *'It's good to have someone help you home and make sure the lights are on, that you are OK.'*
What drawbacks/problems could there be?	• People need to be properly trained to help. • Would need to be flexible to do what wanted.

Meeting with residents group from Jamieson Place Sheltered Housing

This took the form of an open discussion during a regular house meeting. Older people attending (all female) agreed that the proposal would be a good idea. Most people could think of times when they would have liked to go somewhere but could not do so because of lack of help, problems with transport, etc. They could also identify older people they knew who needed both physical help and a bit of confidence building to go on outings, attend sessions, etc.

The staff member present mentioned one elderly man who had become isolated after having a leg amputated and staff resources did not allow her to give him as much time as she would have liked. Some people don't like groups, or lack confidence to come on their own – it would be good to offer them some time one-to-one to do what they would like to do. She found it especially difficult to persuade men to join in activities, outings, etc. Even in sheltered accommodation older people could become quite isolated and needed encouragement and support to mix with others and go out and about. She thought the project proposal was a good idea – people (staff, GPs, etc and older people) would need to be informed about it. Older people might be willing to pay a small amount if participating in the scheme.

Summary

All the older people and carers consulted responded positively to the proposed project when it was explained to them. They spoke of times when they could have benefited but also mentioned other older people whom they know who could also benefit. They acknowledged that life events such as bereavements or time in hospital affected people's confidence and often they needed some support to regain it. Transport was often seen as a problem – people would like to do things but could not because of cost or availability of transport.

Black and minority ethnic people are not a homogeneous group but they face the double discrimination of ageism and racism and it is important that any new service is appropriate for and sensitive to their needs. It may be commonly, and conveniently supposed, that older people in minority ethnic families have an extended circle of support but in reality this is not always the case. Participation in activities and social networks may be especially difficult because of language, transport, and lack of information. Staff and volunteers working with older ethnic minority people would need good levels of cultural awareness and where possible be bi-lingual. Opportunities to participate in community activities and for group social interaction especially targeted at black and minority ethnic should take into account that some people may have financial difficulties.

Although older people usually talked of loneliness rather than social isolation, it was very clear that keeping active and remaining in contact with other people was very important to them. Those who lived in sheltered accommodation spoke appreciatively of the activities and events that were organised for them.

'Health and social care services, however, are only a small part of the support that older people value and only a small part of the experience of growing older.'
(*Older People Shaping Policy and Practice*. Joseph Rowntree Foundation 2004)

'Loneliness and social isolation are known risk factors for various health and related problems among older people.'
(*Social isolation and loneliness among older people: issues and future challenges in community and residential settings*
Australian Health Review, August, 2008 by Linda Grenade, Duncan Boldy)

'Black and minority ethnic elders do not enjoy the same quality of life as their peers, continue to have many unmet needs, from care to quality of life issues, which reduce their potential for participation, have witnessed changing family structures and are growing old in a country that many of them thought they would not remain in after their 'working period'. These experiences are in addition to a lifetime where discrimination and disadvantage have often been an everyday part of their experience'
Policy Research Institute on Aging and Ethnicity consultation response (from A Sure Start to Later Life report 2006)

4.5 Meetings with relevant stakeholders

In the context of this feasibility study stakeholders were health and social care staff who were likely to have an active interest in the service under discussion. The opinions and influence of stakeholders are important for the success of a project and it is important to have their support and their feedback on the need for, and likely use of, the proposed service. It was emphasised that the service was not intended to replace any existing services but was to help older people make better use of existing community services. In addition to the key areas of discussion, staff gave specific examples of specific client needs where the existence of a 'Community Connector' service would have been invaluable. This data has been developed into a number of **Case Studies** which are detailed in **Appendix 1**.

Rehabilitation and assessment staff: in addition to meeting with older people a separate meeting was held with health staff of the Rehabilitation and Assessment Unit. Older people are referred for rehabilitation and assessment from a variety of sources including GPs, hospital discharge, social care, day centres, etc. The usual 'stay' in this daily service is 4 to 6 weeks. A number of the older people attending have suffered strokes but a variety of other conditions are also treated. The aim is to avoid hospital admission where possible. Staff have close contact with and knowledge of frail older people.

Staff emphasised the importance of getting out and about for older people. Those who find it difficult to leave home because of mobility or other problems can become isolated and depressed. Transport is an important issue and the ability to self-travel gives much great independence. Some older people need to regain the confidence to travel by public transport in the aftermath of illness or physical injury.

The Rapid Response Team had operated a successful scheme to support people to travel with more confidence but this had to be stopped because of pressure on resources. The team now concentrates on preventing unnecessary hospital admission through assessment and rehabilitation. There was also a lack of shopping support services.

Staff know of older people living in upper flats, for example, who cannot get to day centres (or other activities) even when transport is available because they cannot easily get downstairs to minibus. In many cases people have to be at the street level door to be picked up. Confidence and mobility can be an issue after hospital discharge even after medical needs have been attended to.

Staying active and having social contacts is important for older people – going regularly for a short walk, doing some local shopping, going to the hairdresser are simple activities which benefit older people physically and psychologically.

Staff welcomed the proposed project and were sure that they and other health colleagues would be able to refer older people who would benefit.

Housing Support & Inclusion Service Team: City of Edinburgh Council Housing Department has four City of Edinburgh Housing Support & Inclusion Service area teams. Staffs in the teams work alongside health and social care colleagues to support vulnerable people in their own homes and encourage their involvement in their communities. This service can be offered, for example, when a person is discharged from hospital or if they have experienced illness or physical disability. The emphasis is housing support – tenancy issues and the practicalities of living at home. Short-term support (normally four weeks) is free. A longer-term service can be offered when a long-term need is assessed but there may be a charge dependent on the person's financial situation.

The member of staff interviewed stated that changes to the Supporting People funding stream had had an effect on the amount and variety to help that could be given to vulnerable people. His staff team continued to work with people in their own home but had to concentrate on tenancy issues – arrears, helping people to manage and maximise income, etc. Teams, who worked with people of all ages, had to concentrate where help was most needed and where short-term support was offered staff were not able to build up longer-term relationships.

Sometimes services could offer support for only one hour per week and people, including older people, did experience social isolation – often scarcely leaving their own houses. They had very limited help with shopping, for example, and this was very time consuming to offer such a service. There is a lack of Saturday and Sunday services and activities – buildings are available but are not used at weekends.

Key issues for offering more support to older people would be transport and recruiting good volunteers. Day care provision is offering a good service for people's essential needs but an additional service such as the proposed project would provide welcome added value.

Home Care Re-Ablement Service: This locality-based service provides a 6-week re-ablement service to help them regain and maintain their independence after illness, an accident or a period in hospital. The aim is to minimise delayed discharges and to help older people have the confidence and ability to look after themselves safely in their own homes in line with local and national policies.

Re-ablement staff help people to remember to take their medication, personal care, assistance with meal preparation, some initial shopping (except for people who use wheel chairs), etc. Occupational therapists can review what rehabilitation may be required, equipment needs, etc. The service is offered for a limited period of 6 weeks – older people who are assesses as needing further help are referred to other Home Care services.

Staff acknowledged that some older people might not be at risk but might take longer to regain their confidence after an accident or hospitalisation. They can become isolated and house bound. Simple activities such as visiting a library, being able to shop for and choose one's own clothes would be welcome. Some people could benefit from having someone to give them information on community activities and networks and to help them plan for the week, ideas on activities, menu planning etc. Carers also benefited when the person cared for were able to engage with other activities.

Transport, and where necessary suitable escorts, was again raised as an issue but overall the staff supported the proposal and thought it could prove beneficial for older people.

Health – District Nursing: District nurses provide nursing services in people's home when they are housebound or have difficulty leaving home. They have frequent contact with frail older people and recognise that many of them were socially isolated, leading restricted lives with limited opportunity to get out and keep active.

The Nurse Manager consulted acknowledged that pressure on resources had meant that staff had to work to tighter criteria and this allowed nurses less flexibility in the way in which they could deliver their services. Social stimulation has a role in preventing ill health but this is seen as the softer side of support. She supported the idea of the project. It would be important to make any referral system as easy and stream lined as possible.

Health & Social Care: We consulted with a day care manager and another member of Health & Social Care staff who have a special interest in services for older people. They strongly supported the proposed project, which they saw as meeting a gap in existing services and one that would be of benefit to older people.

As the proposed project will have volunteers as well as paid staff, it has also been discussed with Rachel Henry, CEC Volunteer Development Officer who is a member of the Portlee Healthy Living Sub Group. She supported the proposal and will be a helpful contact in developing an approach to volunteer training and evaluation in the project.

Voluntary Sector – Life Care Older People's Outreach Project: Life Care run an outreach service as part of their services for older people, which also includes three day care facilities. The outreach project has recently been successful in getting additional funding and now 290 hours per week are available to support frail older people, including those suffering from dementia.

The service is one to one, offered as 2 hours per visit and aims to be flexible and respond to the older person's needs. As this is part of a registered care service personal care can be offered as necessary. Some older people are supported to visit a gallery, the Botanic Gardens, etc; others have up to 5 or 6 hours home based support per week. A charge, £3 per hour, is made for the service. In addition to providing a service for the older person, this outreach also offers respite for the carer of an elderly person by either by supporting the older person at home or taking them out and about. The service covers the whole of Edinburgh.

The service manager described the outreach project as meeting the needs of older people who were not yet ready for day centres and those who were too frail to benefit from day centre activities. It provides a two-fold benefit, helping carers as well as the older people. There is a throughput of service users. Some older people need support and confidence building, for example following bereavement or an accident. They move on when they feel ready to do so. Others become frailer and go into residential care. She quoted the case of one elderly woman, recently bereaved and depressed, whom they will support at home until she is ready to go out again and do things on her own.

Life Care finds that people being referred later to their services when their needs are greater (though this is less true of the Outreach Service) and sometimes referrals lack enough detail or are not accurate. However, Life Care assesses each referral and finds that this gives an opportunity to find out more about the older person's situation and needs and to inform the older person (and their carer if they have one) about what the service can offer. Because mainly people with high levels of needs are referred for a direct service, preventative or lower level services have a lesser priority but this means that needs grow and crisis situations develop because a lower level service was not provided quickly enough, if at all. A number of the people who access the service are referred through Carers' assessments.

The service manager believes that there is a growing amount of unmet need among older people both because of increasing numbers and because agencies that have offered help in the past have now offer a more restricted service. She warned that any new project should be careful not to get high jacked to meet too many and too varied needs outwith the scope of what it set out to achieve or has the resources to deliver.

This service is an outreach care service that offers 'community connecting' to those older people who wish it but is also offers higher level of care to frailer older people. The proposed Community Connector project will concentrate on connecting older people with organisations and services in the local community and liasing with these groups and social services for the benefit of the older person.

***Voluntary Sector –North East Ageing Well project*:** this project is funded by NHS Lothian and is based in the Pilmeny Development Project. It provides a range of health, social and leisure activities for older people in the Leith and North East Edinburgh area. These include a walking group, a 'buddy' swimming group, gentle exercise, and a singing group. The project's support assistant can 'signpost' older people to the various activities on offer. These opportunities are important both for older people themselves and for their carers. Involvement with an Ageing Well activity 'can turn people round', helping with depression and loneliness.
Even a once a week break from caring makes a difference to the life of a carer. The project uses volunteer help but the project worker could involve more people if she could get more help with escorting and one to one support for frailer older people

Summary

There was broad support for the proposed 'Community Connectors' project. Staff from different agencies thought that such a service would provide a very useful and much needed addition to current services that are available for older people. Staff noted that pressure on resources meant that they had to a certain extent 'ration' their services and that some services had changed in the kind of support now offered to older people. This has implications for the well-being of older people. Voluntary organisations, for example, are restricted by the criteria and amount of their funding base. Statutory agencies highlighted they had now stopped many services, were not able to meet all identified unmet needs and were having to advise older people to find help elsewhere. They had questions about how it would interact (but not overlap) with existing services**.** Staff also emphasised the importance of accessible transport for the success of the scheme**.** Potential benefits for carers were also highlighted. The Life Care outreach service receives positive feedback from older people and their carers. There is a risk, however, that a small scale pilot scheme could give rise to too many and too varied expectations – staff interviewed identified a wide variety of circumstances where older people would benefit from extra support but it would not be possible to meet all these needs. The 'Community Connectors' project should therefore have a clear focus from the outset as to what it can and cannot offer older people and their carers.

> 🖹 'It is important to recognise the importance of private roles and the value that having a voice and being listened to brings to older people, who may not be in a position to participate more fully in society'.
> *Managing Resources in Later Life* – Joseph Rowantree Foundation 2009

5. LIASON WITH CITY OF EDINBURGH COUNCIL (CEC) HEALTH & SOCIAL CARE DEPARTMENT

The proposed ' Community Connectors' project would seek to meet an unmet need identified in the City of Edinburgh Council Day Services Review and the Future Model of Day Services (2008), which notes that 'non centre-based services are highlighted for future development within the proposed future model of day services for the city' (p22).

However the CEC Health and Social Care Service Plan 2009 – 2012 addressing overall unmet needs notes -

'In common with other Councils, the City of Edinburgh is not able to meet all needs for social care services. Demand for social care has risen significantly due to demographic change: increasing numbers of older people living longer and increasing numbers of people with learning and other disabilities.'

'If needs are assessed as moderate or low, the Department will not be able to provide or arrange direct services, but will provide advice and information to assist people to find help elsewhere.' (p21)

Care will be provided to those assessed as having a critical or substantial need. Against this background of increased demand and limitations on resources, the needs of socially isolated, housebound older people in Leith/North East Edinburgh has been an issue of concern to local health social care and voluntary agencies. The Portlee Healthy Living Group (a multi agency group set up to address the needs and issues of older people in Leith/NE Edinburgh. For membership see Appendix 2) has supported and promoted the proposal to develop a Community Connectors project to cover the area. The manager of the Pilmeny Development Project chairs and services the Portlee Healthy Living Sub Group and has liased with health and social care staff to inform them of the proposal and to seek support for the idea. As part of the initial stage of the feasibility study we met with Health & Social Care staff who have a special interest in the project to discuss the study and ask to suggestions of key people to meet, etc.

The proposed project meets the criteria set out in a recent tendering process carried out by the CEC Health & Social Care Department for an expansion of day services for older people:

- It fulfils a community connecting approach;
- It fulfils a rehabilitative approach or seeks to maintain the current level of independence/well-being;
- It meets an identified gap in current service provision;
- It is committed to a partnership approach and to co-ordination.

Recent consultation carried out into outcomes by the Review of Day Services for Older People Working Group noted that connection with the wider community, socialisation, maintaining hobbies and interests were among the key things that people want from their day service. It notes that "Day services may be able to meet people's needs to 'have things to do' or to 'see people'… on the day of the service but the individual may still feel lonely or unoccupied on the other 6 days". It acknowledges the importance of knowing what individual needs are unmet when the day services is not available – "This would have value in contributing information towards how well 'whole person' needs are being met and on how well 'whole systems' are working to meet those needs".

A successful 'Community Connector' project could contribute to meetings some of these outstanding needs and to gathering information about outcomes.

6. THE PROPOSED 'COMMUNITY CONNECTORS' PROJECT

Using the data gathered during the Feasibility Study we have developed an outline framework for a proposed 'Community Connectors Project as follows:

6.1 The Project

The 'Community Connectors' project will provide a service to socially isolated older people and their carers in the Leith and North East area of Edinburgh, including black and minority ethnic elders, who are assessed as having moderate or low needs and who do not meet the criteria for a Day Care service but have been referred to agencies such as Pilmeny Development Project from Portlee Referral & Resource Group.

Those older people who are referred will have been assessed as not needing day care (i.e. they are seen as having moderate low level needs but as requiring some level of support). These referrals have helped to highlight the need for the Community Connector project, which also fits Edinburgh Council's strategic plans for services for older people.

Aim:

The 'Community Connectors' project will aim to improve the well-being and confidence of older people through supporting and enabling older people to live independently in the wider community.

The 'Community Connectors' Project will be a focal point and broker for older people in Leith and North East Edinburgh.

Target Group

It will be targeted at older people with less complex needs, in particular those who do not qualify for a direct service from the Health & Social Care Department.

The 'Community Connectors' Project will be culturally appropriate and person centred.

Service offered

The service offered will be short to medium term and will be reviewed on a 6 weekly basis, with the expectation that many older people will build confidence to be independent and require less support from Project staff, or will be able to access community based support from another source.

The project will aim to provide a minimum of 20 isolated older people, initially with up to 16 service hours each over a 6 to 8 week period to enable them to successfully 'Re - Connect' back into the Community.

Through signposting and facilitating access to existing activities and services the 'Community Connectors' Project will ensure older people were able to make better use of these services.

It will work flexibly to help older people to connect with community services and activities in their area.

It will support older people to re-establish, build and maintain links with existing groups and social networks, addressing the issue of social isolation by connecting older people to their local communities.

Management, Staff & Volunteers

A part time co-ordinator, local volunteers and a few sessional staff (for those older people with more complex needs), will work closely with the manager and existing staff from the Pilmeny Development Project (which has a long established community based role in providing services for older people in Leith and North East Edinburgh), to help older people to remain active in the community and will support them in maintaining or rebuilding local social networks and activities.

They will respond to a specific request or will work with an older person to find an activity or event of interest to them. They will look for different ways to meet the support needs of older people. Staff will also work in partnership with social care and health agencies, statutory and voluntary.

Referrals

Portlee Resource and Referral Group and the Portlee Health Living Sub Group will be key sources of referrals of older people. In addition referrals will come from a variety of statutory and voluntary health and care agencies. Carers or older people themselves may refer themselves (or others).

Assessment

An introductory assessment process will be undertaken with each individual older person, to ascertain how the 'Community Connecting' process can best serve their individual needs. (Their transport requirements would also be identified as part of this process. Older people would be encouraged to make use of public transport, taxi card, Handicabs or other community transport arrangements.)

Monitoring and Evaluation

The Manager and Community Connecting Team will integrate an recording and evaluation system that will measure both quantitative, qualitative and 'soft' outcomes (such as regaining or building of confidence).

The Project will be set up initially as an action/research pilot and will therefore aim to engage an external evaluator to provide an independent view of the quality of the work and its achievements.

6.2 Impacts and benefits

a. <u>Benefits to older people would include</u>;

- Opportunities to identify their individual needs and wishes and to consider options as to how these might be met.
- Increased information about, and access to, local community services and activities.
- Receiving support to re-make and maintain links with existing groups, and to build new networks through participating in community activities.
- Black and ethnic minority older people, growing older in a second homeland, will have opportunities to come together to share issues of common concern.
- Support to maintain independent living within the community, helping to prevent social isolation.
- Support to lengthen the capacity to remain independent at home through providing access to services and activities when some additional help is needed.
- Support to regain confidence to go out and about and to participate in activities.
- Support to regain confidence to self-travel if possible.
- Improved physical health and well-being through participation in preventative therapeutic and educational/recreational activity.
- Support for an older person's carer through providing a short break from caring.

For possible benefits the service could offer to identified individual older people see case studies **Appendix 1.**

b. <u>Benefits for community/other organisations:</u>

- Provide a central point of referral via 'Community Connectors' to other services working in Leith and North East Edinburgh.

- Give community service/activity providers more awareness of, and information about, the needs of older people, including BME elders.

- Encourage community service/activity providers to ensure that their services/activities are culturally appropriate and open to a wider range of older people, including BME elders.

- Provide a point of referral for health and social care service providers when an older person would benefit from a preventative community based service.

- Potential for the development of joint training opportunities between statutory and voluntary sector agencies.

- Help to develop a local database of services and activities for older people.

- Benefit from older people being involved in 'preventative' community based services/activities leading to greater well-being and better health, thus reducing the demand for higher level service provision.

7. RECOMMENDATIONS

Considerable thought has already gone into the need for, establishing and development of the Community Connectors project. Pilmeny Development Project has undertaken extensive research and consultation over the years with older people and their carers in Leith and NE Edinburgh and with statutory and voluntary service providers. The project also has the backing and support of the Portlee Healthy Living Group. The need for, and potential use of, the project was further ascertained in the course of the Feasibility Study, with support from older people and from statutory and voluntary service providers.

As a result of this study the following points are made –

- It is recommended that a 'Community Connectors' 'action research' pilot project be established in Leith and North East Edinburgh area. This would allow for a more in-depth evaluation of outcomes to be carried out, if possible using an independent external source. It would also contribute to discussion/decision to extend the service or set up a similar project in other areas of the city and also help address the issue of the current scarcity of resources available to set up a new project.

- The project should aim to evaluate what works from the perspective of older people.

- A simple but robust form of evaluation should be established from the start of the project.

- The focus should be on better lives and better life chances.

- A single, integrated, project is established to provide a service to older people, including BME elders. The co-ordinator would need a relevant range of experience and skills and some of the volunteers and sessional workers would require to be bi-lingual.

- Whilst aiming to work in a flexible in person centred way, the project should have a clear area of focus from the outset as to what it can offer to older people and their carers. It would need to set parameters and should avoid trying to do too many things for too many people - start small and learn and develop from learning what works and what more is needed.

- The referral system should be kept straightforward and simple.

- Advertising and information about Community Connectors and what the project can offer should be appropriately and widely targeted, including a simple newsletter to older people using the project to keep them informed and linked to the community.

- The project should establish and maintain interest at a high level in Health and Social Care who have said they have a commitment to preventative services.

- The project should develop a database of activities, services, support needs and service use in a form that could be used for planning purposes.

- Making a small charge for the service should be considered. The disadvantage is the risk that it would make it more difficult for some older people with limited finance to make use of the service. The advantage would be a source of additional income that could be used for beneficial purposes not covered by funding.

- Where possible Community Connectors should look for ways to facilitate and encourage older people to have a role in their community to allow them to develop some sense of purpose and belonging.

- Older volunteers could make a valuable contribution to the project – thought needs to be given as to potential barriers and how to motivate older volunteers.

ACKNOWLEDGMENTS

Leith Benevolent Association

Maggie MacLeod

Pilmeny Development Project

City of Edinburgh Council Health and Social Care
(Anne Dey and Doreen Copland)

City of Edinburgh Council Housing Support and Inclusive Service Team

Lifecare (Margaret Stuart)

Milan Senior Welfare Organisation

North East Ageing Well Project (Robina Brown)

North East Edinburgh Care Action (NEECAG) Older Peoples Forum
(Leith and Portobello)

North East Older Mens Health and Wellbeing Group

NHS Lothian District Nursing Service (Hector Elliot)

NHS Lothian Older Persons Rehabilitation Assessment Unit (OPRA)
(Leith Community Treatment Centre)

Portlee Residential Centre Healthy Living Group

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'*Person Centred Thinking and Older People'* & development programme, *Practicalities and Possibilities* - The Older People's Programme, the Centre for Policy on Ageing and Helen Sanderson Associates

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Managing Resources in Later Life – Joseph Rowntree Foundation 2009

Policy Research Institute on Aging and Ethnicity consultation response (from A Sure Start to Later Life report 2006)

APPENDIX 1

Case Studies

- Referral from local Health Visitor, who has been in contact with Mrs A, an 86 year old woman who lives alone, is isolated and lacking confidence to go out alone after a lengthy stay in hospital. She lives 3 flights up a tenement stair. There are places at a local church lunch club less than 2 streets away, but no one to help her to get there. A local worker is provided to accompany her from her home to the lunch club and back once a week for a few weeks. After a short time, Mrs A starts to make friends at the lunch club and gains confidence to begin to make her own way there and back.

- Referral from a home care organiser for Mr B who is 88 years old and whose wife died a few weeks before. He is very upset and misses his wife, who did everything in the home. In particular, he has no idea how to use the washing machine and little interest in learning, although he is extremely worried about how he will cope with the washing. A home help is not available at that time and the organiser contacts a local project to see if they can help. Following an assessment visit, a staff member taking on a community connecting takes Mr B to the local laundrette to show him how to do a wash there. Whilst there, he meets the lady in the laundrette who tells him about 'service washes'. He is delighted to discover this service and the staff member only accompanied him twice to do his washing, before he felt so confident and pleased with this arrangement, he felt quite able to do this for himself and no need for a home help either!

- Referral from NE Edinburgh Referral and Resource Group for an older man Mr C who attended a local day centre and who wanted someone to play chess with. A staff member researched where local chess clubs were located and if there was anyone he could play chess with during the day. A local 'after school' chess club was identified and the staff member arranged for him to attend and have a game with some of the school pupils.

- Request from a daughter who is the main carer for her mother aged 91 to the Ageing Well project. Her mother can get out and about with help and support and her daughter was looking for a suitable activity (seated exercise) that her mother could attend for social contact and stimulation. Unfortunately she was not able to take her on the day suggested because she was at work and the Living Well project do not have sufficient staff resources to give one to one support to this elderly lady.

- A recently bereaved, disabled, 85 year old widow from the Indian community who lived alone in Leith, wished to attend religious ceremony at the local Hindu Mandir temple, but she felt she needed support and confidence to go out. She had little understanding of English (mainly due to her level of dementia). A volunteer from the Indian community (who was bi-lingual and was also a Hindu) was identified and carried out a 'community connecting' role, to assist her to attend the Mandir and participate in the ceremony. She was able through the community connecting process, to regain contact with other older Asians who attended the Mandir and who could share her feelings about the bereavement and the problems of 'growing old in a second homeland.'

- Elderly man in supported accommodation who has recently had a leg amputated which has made it more difficult for him to get out and about. Support staff believe that he would benefit from having someone to encourage him to get out of the house and get involved socially.'

- Elderly gentleman in supported accommodation who is active locally but would have liked to have gone on an organised trip to the People's Palace, Glasgow, but would have needed one to one support to get around.

APPENDIX 2

Portlee Healthy Living Sub Group Contact List (2009)

Voluntary Organisation (Community Development)
Anne Munro Manager Pilmeny Development Project

CEC Health & Social Care
Anne Dey Development Manager, Short Breaks & Breaks from Caring
Allan Bald Manager Portlee Resource Centre
Rachel Henry CEC Volunteer Coordinator/development officer

CEC Children & Families
Martin Black Senior Community Worker

CEC Services to Communities - Housing
Derek Anderson /Alison Gowrie

CEC Services to Communities - Library Service
Kathy Softley, Library Development Officer, North Edinburgh
Christine Craig/ Ian Kirkby - Library Access Services

CEC Corporate Services – Culture & Sport
Ruth McAlpine - Special Projects Officer - Get Up and Go

Edinburgh Leisure
Helen Macfarlane Manager & Aisha Sohail 50+ Officer

NHS Lothian
John Palmer – Public Health Practitioner NE Edinburgh
OPRA - Janina Szmaites /Jenny Reid OT

Lothian Community Health Projects Forum
Lesley Blackmore – development worker

North East Edinburgh Ageing Well Project
Anita Jefferies Manager & Robina Brown NE Edinburgh Support assistant

BME Organisations
Milan (Senior Welfare Organisation) - Neena Agarwal Manager
MECOPP (Minority Ethnic Carers of People Project)

Carers
Ruth MacLennan – Care for Carers
Madeline Martin – NHS Carer worker

Learning Disabilities
EDG (Edinburgh Development Group) – Ruth Lowe (SOFI)

Faith In Older People (FIOP)
Maureen O'Neill