THE ROYAL BANK OF SCOTLAND CENTRE
FOR THE OLDER PERSON'S AGENDA

Queen Margaret University College, Edinburgh
Corstorphine Campus, Edinburgh, EH12 8TS Phone: 0131 317 3770, Email: opa@qmuc.ac.uk

External Evaluation of the Dumfries and Galloway Better Neighbourhood Services Fund (BNSF) Vulnerable Older People's Pathfinder: Final Report

Prepared by Elinor Newall, Alan Gilloran, Fiona O'May and Caroline Donaldson

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EVALUATION OF THE DUMFRIES AND GALLOWAY, BETTER NEIGHBOURHOOD SERVICES FUND VULNERABLE OLDER PEOPLE'S PATHFINDER: FINAL REPORT

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SECTION 1: EXECUTIVE SUMMARY

Background

In January 2001, the Better Neighbourhood Services Fund (BNSF) was set up by the Scottish Executive to enable local authorities and their community planning partners to improve services in Scotland in accordance with the Social Justice initiative. Twelve local authorities were asked to put forward strategies for the delivery of better services within neighbourhoods in their pathfinder area. Dumfries and Galloway council developed a strategy for older people called the Vulnerable Older People Pathfinder (VOPP), known locally as 'Guid Services for Older Folk', which was funded by BNSF for a three year period. The VOPP, together with the Scottish Executive, developed a Local Outcome Agreement (LOA), with a headline aim, or outcome, to: "Enable more vulnerable people to stay living in their own homes for longer, by increasing the range, quality and accessibility of preventative services". To that end BNSF has funded a number of projects providing preventative services for older people. This approach is underpinned by a wealth of research that highlights the benefits of low-level preventative services to older people's quality of life (e.g. Clark, et al. 1998).

The time required to develop the LOA and set up the BNSF team meant that the projects selected for funding did not commence until 2002. To allow the programme to run for its allocated three year period, the Scottish Executive permitted the Pathfinder to continue until the end of financial year 2005/2006. However, as the Scottish Executive required external evaluation of all Pathfinders to be finalised by 31st March 2005, this evaluation of the Dumfries and Galloway VOPP is being conducted a year before the BNSF completion date.

Throughout the course of the BNSF programme, several projects have been funded. Not all of the original projects have been continued for the duration of the programme; one project was mainstreamed and the funding for another was ceased. This study reports on the eight projects that were in existence at the commencement of the evaluation. These are: Active Service, Care at Home Training Consortium, Dementia Friendly Communities, Food Train, Guid Guidance for Older Folk Directory of Services, Home Fire Safety Checks, Podiatry, and Rapid Response. In addition, the role of two further groups was considered, The Older People's Services Development Group (OPSDG) and the Home Safety for Older People Working Group. OPSDG consists of approximately 20 older people appointed by BNSF to promote involvement of older people and was designated responsibility for allocating the BNSF monies. The Home Safety for Older People Working Group is a sub-group within the Community Planning structure, which is both led by, and involves, the BNSF team. This group provides an example of partnership working aimed at addressing home safety issues for older people.

Aim of the Study

The aim of this study is to evaluate the impact of the VOPP (hereafter referred to as the BNSF programme) in relation to key questions set by the Scottish Executive. These questions cover five central themes: programme impact; value for money; partnership working; role of communities; and sustainability and mainstreaming.

Methods

A mixed methodology using quantitative and qualitative methods was used in order to capture the experiences of older people using the services, professionals providing the services, and input from community planning partners. Interviews were carried out with each of the project service managers, and the BNSF team, which provided invaluable information regarding the key evaluation questions, and the impact of the projects. These data also informed the content of project-specific questionnaires which were distributed to service users. The data collated from the questionnaires was the primary source of evidence used to assess the impact made by the projects on older people.

Focus group discussions were held with two groups; members of OPSDG and with representatives from the Community Planning Partnership. These were carried out in order to explore the aforementioned central themes, from the perspective of older people, and community planning partners. These discussions also provided an opportunity to explore specific questions in relation to the role of community planning and OPSDG in the development and delivery of the BNSF programme.

Key Findings

Programme Impact

Several indicators were established by BNSF to measure the progress of the programme in achieving the aforementioned headline outcome. The main indicators measured the numbers of older people being assessed by social services as requiring intense service provision or warranting monitoring only, and the number of admissions to long term care. The figures provided by BNSF demonstrated that these indicators were moving in the right direction, with a drop in admissions to long term care and fewer older people assessed as having acute needs. However, with any number of potential confounding variables it is not possible to fully attribute these changes to the impact of BNSF with any certainty.

Questionnaires were distributed to users of the BNSF projects in order to evaluate their impact. Overall, the respondents reported a very high degree of satisfaction with the services delivered, indicating that the quality of the projects was perceived very positively. All of the projects had resulted in improvements to the quality of life of many service users, although the strength of the impact and the particular aspects of quality of life that were affected varied between projects. Projects such as Food Train and Active Service that deliver long-term sustained interventions produced substantial improvements across the board of quality of life for a number of respondents. For those delivering shorter interventions, the impact was less extensive, but still considerable. These impacts occurred through improvements to health, wellbeing, and social inclusion. In so doing, the projects have enhanced the ability of many older people to live independently. Moreover, all of the projects contained key added value in benefits to close family or friends.

Two projects do not deliver interventions directly to older people; the Care at Home Training Consortium (CAHTC), which provides training to carers to improve their practice with for older people and Dementia Friendly Communities which promotes dementia awareness to local organisations and groups in the community. The questionnaires for these projects indicated high levels of satisfaction with the services delivered. The feedback regarding the CAHTC training indicated that carers

perceived substantial improvements to their confidence and skills for providing care. Respondents for the Dementia Friendly Communities service indicated that their knowledge and understanding of dementia had been improved by attending talks and workshops, although a limited number reported having had the opportunity to put this learning into practice.

The evaluation obtained evidence that the programme had impacted upon service planning and delivery for the region in a variety of ways. The key impacts were improved involvement of older people in community planning, an increased focus upon older people in the planning of services by community planning partners; greater partnership working between agencies, and the creation of a 'friendly face' on statutory services that may promote their uptake by older people.

Value for Money

Given the constraints of the evaluation and complexity of the projects, value for money is hard to measure. Consequently the evaluation was particularly focused on an examination of the *value* of each project, in terms of its impact on quality of life of older people. The evidence obtained indicated that all of the projects evaluated had delivered good value for money through their improvements to quality of life and their contributions to the headline outcome for the programme. In providing preventative services, the BNSF projects offer potential for long-term financial savings, by obviating crises and thereby reducing the need for intensive intervention (Clark, Dyer and Horwood, 1998).

Projects have also enhanced their value for money through cost-effective means of service delivery. For example volunteers have been employed that enable projects to provide a more extensive service within their allocated funding, thereby benefiting a greater number of older people. Value for money has also been promoted through the widespread partnership working that has been a feature of the BNSF programme. The value of this work lies not only in having agencies collectively focused on a common goal and thereby reducing duplication of effort, but also in the immeasurable value of shared learning and its potential for improving longer term service planning and delivery.

Partnership Working

As stated above, partnership working has been a particular strength of the BNSF programme. BSNF have not only been directly involved as partners, but as a common link between various disparate agencies, they can be conceived of as the hub of a network. As such, they have created meaningful connections between agencies which have promoted awareness and fostered relationships. In this way the programme has indirectly culminated in partnerships between other agencies. For example, the Care at Home Training Consortium project has utilised partnerships with police and fire services to provide training across a widespread curriculum of safety issues. BNSF have also been integral to the setting up and running of the Home Safety for Older People Working Group. The success of these partnerships has been attributed in large part to the role of BNSF in providing drive, direction and administrative support. These components serve to explicate why BSNF operates as "*the 'glue' that attracts holds together and drives a wide range of preventative services for older people*" (BNSF annual report, 2004; page 1).

Role of Communities in the Programme

Community involvement has been achieved in two main ways; through consultation with older people, and through OPSDG. A survey was carried out by members of the Elderly Forum on behalf of BNSF to discover from older people themselves, the kind of services needed and wanted. These findings validated the focus of the programme on small preventative services and directed the funding towards projects with this remit. The setting up of OPSDG has provided older people with a direct role in community planning through their decision-making powers over the spending of BNSF monies. Although the Lead Officer has ultimate financial control and responsibility with regard to BNSF funds, OPSDG have been allocated decision-making powers with regard to apportioning public money. In this way, they are directly linked into the community planning structure and are effectively a community planning partner. OPSDG represent older people from their communities through a two-way communication process. Issues identified by members of the community are brought to the attention of the group, and can be fed into the community planning structure. The group also report back on their work to the community.

Sustainability and Mainstreaming

There are several examples of mainstreaming in the programme. Mainstream funding has been obtained from the NHS to continue one of the BNSF funded Podiatry posts, with funding for the second post being sought. The Rapid Response project has been mainstreamed within the remit of a new extended and region-wide service, jointly funded by the council and NHS, called the Short-term Augmented Response Service (STARS). A number of the projects have commenced work to obtain mainstream funding and the BNSF Lead Officer has also indicated plans to spend the final year of the programme undertaking work to that end. Of these, possibly the most likely to obtain funding is the Food Train due to the large number of older people highly dependent on its service and the recognition it has received via two national awards. Insecurity regarding longer-term funding is a key barrier to sustaining these projects. Sustainability would therefore be greatly enhanced by mainstreaming, through the security of long-term funding and its resultant benefits, such as the ability to attract staff to permanent positions. The Care at Home Training Consortium may sustain itself through operating a membership consortium whereby the care providers pay to be members in order to receive training for their staff. The BNSF Lead Officer also has plans for sustaining the BNSF programme under its local title of Guid Services for Older Folk, through mainstream council funding.

Issues for Consideration

Some key issues and areas for development in the programme and its projects emerged following the evaluation. These include: promoting the uptake of BNSF projects by older people through increased awareness-raising by the projects of each other's work; enhancing the uptake by older people from minority ethnic groups; and putting in place clear organisational structures and communication pathways to provide contingencies in the event of personnel changes, particularly where projects are facilitated by strong leadership.

Key Lessons and Conclusions

The operation of BNSF as a central hub that links agencies, provides administrative support and directs activities, has served to greatly facilitate partnership working. This would suggest that community planning partnerships in other areas may benefit

from having such a structure in place, although issues such as coterminous boundaries would have to be considered. In order to sustain the benefits of this approach for Dumfries and Galloway, it is suggested that the BNSF team be mainstreamed as a formal hub that specialises in, amongst other activities, the promotion of partnership working to benefit older people.

The successful involvement of older people in the community planning process that has been achieved by BNSF is a significant lesson from the programme. OPSDG demonstrate that older people can be meaningfully involved in the planning and delivery of services, and provide a valued and beneficial contribution. Moreover, the group serves to further challenge tokenistic involvement of older people.

A key lesson concerns the value to older people of preventative services that improve quality of life and promote the ability to live independently. In addition to the potential for long-term financial savings, the value to individuals of avoiding crisis is immeasurable. These benefits, and the continuing growth of the older population, indicate that further investment in such services is warranted.

SECTION 2: BNSF VISION, AIMS AND INTENDED OUTCOMES

In January 2001, the Better Neighbourhood Services Fund (BNSF) was set up by the Scottish Executive to enable local authorities and their community planning partners to improve services in Scotland in accordance with the Social Justice initiative. Twelve local authorities were asked to put forward strategies for the delivery of better services within neighbourhoods in their area. Of these twelve pathfinders, three rural local authorities were selected, one of which was Dumfries and Galloway. Two pathfinders were developed for the Dumfries and Galloway area, one for vulnerable younger people and the second for vulnerable older people. The Vulnerable Older People's Pathfinder is the subject of the present evaluation.

As set out in the Dumfries and Galloway council's previous Corporate Plan (1999-2003), the vision for the Vulnerable Older People's Pathfinder is to "*support the more vulnerable people in our community, including the development of preventative care for older people…*" The BNSF programme links this objective with other seminal documents and statements which progress the basic principle that vulnerable older people not only want to remain living in their own home for as long as possible but also expect to be active partners in service development and delivery. A Local Outcome Agreement was developed by BNSF for the Vulnerable Older People's Pathfinder with a headline outcome to: *"Enable more vulnerable people to stay living in their own homes for longer, by increasing the range, quality and accessibility of preventative services".*

SECTION 3: CONTEXT

Dumfries and Galloway, as well as being the third largest council and health board geographical area in Scotland covering 6439 square kilometres, also has, along with the Scottish Borders, the highest proportion of people aged over 60 in Scotland. The National trend for an increase in the numbers of people in this age group is well known. In terms of the people over the age of 60 in this area, using the 2001 census figures, Dumfries and Galloway has 37,439 people over the age of 60, over 25 percent of the total compared to the Scottish average of 21 percent. The population density for Dumfries and Galloway is 60 people per square mile (1 mile = 1.6 kilometres), with the Scottish average being 168 people per square mile, and most people being located in small villages or towns.

As documented by the Scottish National Rural Partnership's Sub-Group on Rural Services (2000), "The provision of services in rural areas is one of the most important issues affecting the wellbeing of rural communities. However, the size and nature of rural communities means that service providers often face a constant struggle to deliver services which meet the needs of rural communities, while at the same time maintaining the viability of these services. The high unit cost of provision often means that service providers are forced either to withdraw existing services from rural communities or to decide not to provide new services in these communities at all".

As a result, services for vulnerable older people have tended to focus on high level needs, often being delivered after a crisis point. The Dumfries and Galloway Vulnerable Older People Pathfinder (VOPP), funded by BNSF, has enabled an increase in the range and accessibility of preventative and supportive services to assist more people aged over 65, who may be physically frail, have mental health problems, or who have a dementia type disease to live independent, self-determining but supported life in their own homes, within their own communities, for as long as possible. This has been incorporated into the aforementioned Local Outcome Agreement and headline outcome for the Pathfinder.

Policy Context

As set out in the Council's 2000 – 2003 Corporate Plan, the Dumfries and Galloway council aim to "Support the more vulnerable people in our community including the development of preventative and respite care for older people…" In addition, the Scottish Executive places older people at the heart of the social justice agenda, which has identified long term targets as 1) making sure that older people are financially secure and 2) increasing the number of older people who enjoy active, independent and healthy lives. In order to meet these long term targets, the Scottish executive has cited milestones. Through its programme of projects, BNSF takes account of and actively contributes to the following milestone targets being met:

- Increasing the proportion of older people able to live independently by doubling the proportion of older people receiving respite care at home and increasing home care opportunities
- Increasing the number of older people taking exercise and reducing the rates of mortality from coronary heart disease and the prevalence of respiratory disease.

Through previous and proposed future partnership working BNSF has also developed projects to contribute to the following social justice targets:

- Reducing the proportion of older people with low incomes
- Reducing the fear of crime among older people

Statutory agencies have a tradition of providing assistance and responses post-crisis and for the NHS the total cost was estimated in 2000 as some £450 million per year. The Healthy Ageing – Adding Life to Years strategy approved by the Dumfries & Galloway Council & Health Board in November 2001 indicated an intention to move towards an increased preventative and enablement focus. The headline outcome of the BNSF programme, to "*enable more vulnerable older people to stay living in their own homes for longer by increasing the range, quality and accessibility of preventative services"* takes into account this strategy. Other policies emphasise the same points for example Free Personal Care for Older People, Better Government for Older People and Community Planning.

According to the consultation draft of the Health and Community Care Plan (2003 – 2004) for NHS Dumfries and Galloway and Dumfries and Galloway council, the implementation of the Joint Future objectives has been the main focus of the work in relation to services for older people. Agreement has been reached on a structure for the joint management and resourcing of services for older people with a physical disability. The BNSF programme takes into account and addresses the following national priorities and targets of the Community care plan:

- implementing of joint resourcing and management of services for older people
- reduction in number of delayed discharges

Community Planning Partners

Dumfries and Galloway Community Planning partners and the BNSF programme have worked in partnership to develop the Vulnerable Older People's Pathfinder. To this end the Community Planning partners play an important role in terms sharing knowledge and experience and acting as a platform for debate and discussion, which in turn acts to shape the BNSF programme of work.

BNSF project team

The BNSF team comprises Jean Elgar (Lead Officer), Jan Nye (Project Officer), Claire Mitchell (Project Administrator) and Gwyneth Fairbairn (Research and Information Officer), and as a team they work in close partnership with the Older People's Service Development Group (OPSDG).

OPSDG

OPSDG has been established to ensure direct involvement of older people in the planning, development and monitoring of health and social care services including funding and monitoring of BNSF. All existing voluntary organisations with an interest in older people are either represented or attend OPSDG meetings. This group is crucial to the success of the BNSF programme. OPSDG hold decision making powers with respect to the BNSF funds, ensuring the appropriate targeting of BNSF monies, and playing an important role in monitoring and evaluating the development of the project services of the programme.

SECTION 4: METHODOLOGY

Methods

A mixed methodology using quantitative and qualitative methods was employed in order to capture the experiences of both older people using the services, professionals providing the services and input from community planning partners. The evaluation was subject to several constraints, namely the tight timescale of the study, the budget, the large (and primarily rural) geographical area to be covered, and the number of projects to be evaluated, which ultimately dictated the research tools used.

Interviews

Face to face semi-structured interviews were carried out with the BNSF lead officer, and each of the service project managers, and these were supplemented by telephone or email conversations/discussions when specific issues or points needed to be discussed. These interviews were multi-purpose. They were used to gain essential information about the projects that would inform the development of appropriate topics for service user questionnaires and focus groups. They were also intended to function as a forum for project managers to discuss any concerns about the evaluation, or about the BNSF programme in general. Prior to the interviews, project managers were each sent introductory emails which included a list of questions which would be covered in the interview. Attached to the email was the section of the Scottish Executive's Research Specification which contained the main questions which the evaluation was required to answer. These questions were included so that the project managers understood the origin and content of the questions in advance. This was intended to allow the managers to prepare information and documentation and also to promote transparency. The questions covered a significant list of key areas:

- History and day-to-day running of the project
- Profile of service users and staff
- Achievements / successes of the project
- Innovative approaches
- Monitoring of service
- Problems experienced
- Partnership working
- Community / service user involvement
- Value for money; project expenditure
- Mainstreaming and rolling out
- Sustainability
- Unintended impacts: positive and negative
- Working with BNSF
- Views about BNSF as 'glue holding disparate services together'

The breadth of information that was sought meant that some areas were covered in much greater depth than others during the meetings. Subsequent telephone or email conversations took place where further information or clarification was required.

Each of the meetings was tape-recorded with the project manager's consent and transcribed. Recording the meetings enabled conversation about the project to flow without the requirement of detailed note-taking, thereby improving communication

and ensuring that valuable information was not lost. Following the meetings the transcriptions were sent to all the managers for feedback to clarify, amend or add to any points. The majority of the managers took this opportunity to provide feedback and make amendments where appropriate.

Analysis of the interviews involved a process of developing and confirming themes and categories derived from the data. These themes then informed subsequent data collection, namely questionnaire design and the two focus groups. Questionnaires were sent to the project managers for comment before they were sent to service users.

Questionnaires

Although each of the eight projects shared a focus upon older people, they were otherwise very different in terms of the service they provided, for example, a wide variation in the duration for which a service is delivered. A home fire safety check is essentially a 'one-off' service in contrast with the food train which provides long-term, twice-weekly support. Moreover, Dementia Friendly Communities and CAHTC do not provide a service directly to older people, and the Active Service for older people with mental health problems is not delivered to the general older population.

The extent of these variations indicated that the generic questionnaire initially developed for the evaluation would be insufficient to evaluate the individual projects. It was decided therefore to modify the generic questionnaire and create eight project-specific questionnaires. For six of the projects the questionnaires were almost identical, with variations centring on details such as the duration the service had been used. It was important that these variations were kept to a minimum in order to allow collation of the data to evaluate the projects collectively, and also to allow comparisons to be made between the projects. The two questionnaires which were significantly different were those developed for CAHTC and Dementia Friendly Communities. These latter questionnaires were different because they were for service users who are not necessarily older people. The service users of these projects are carers who have received training and various service providers and community groups who have received talks and workshops.

The generic questionnaire that was developed incorporated the majority of the questions which were contained in the 2002 Christmas Survey by BNSF. These questions were retained in the project-specific questionnaires in order that comparisons could be drawn with the baseline information obtained in the Christmas survey. Additional questions were developed to explore the impact that each of the projects may have had on the quality of life of older people.

Throughout the questionnaires space was provided for comments from the service user to provide qualitative information. This was intended to provide more in-depth information about how older people had benefited from the service and the reasons for their reported satisfaction or dissatisfaction with services (project-specific, health and social services). In addition, it was felt that this qualitative information may offer other unanticipated insights about BNSF and the project under consideration.

As the evaluator did not have access to confidential details about service users, the project managers were approached for assistance in distributing and on occasion, delivering, the questionnaires to service users, in order to promote as high a response

rate as possible. The questionnaires were sent out in sealed envelopes, which also contained a stamped addressed envelope to encourage rate of return. The questionnaires were sent unaddressed to the project managers, who then in turn distributed them to a sample (where possible, approximately one third) of their service users*. A total of 1680 questionnaires were sent out, and 539 were returned, representing an overall response rate of 32 percent, though this rate varied within individual projects, ranging from 21 percent up to 80 percent.

All questionnaires were entered into an Excel database, one for each project, and basic frequencies were run using SPSS. The comments and feedback were collated and grouped into themes, where appropriate.

*A significant but unavoidable problem was the restriction of access to service users posed by data protection and confidentiality. This was a problem only in the respect that it obliged the evaluator to rely upon the project managers for the sampling and distribution of questionnaires. In order to minimise bias and to increase the reliability and validity of the research, it would have been preferable to have conducted sampling and distribution independently. However, the need to comply with these restrictions was weighed against the importance of obtaining the views of the older people who use the services that were being evaluated. While this method of sampling and distributing undoubtedly introduces a potential bias, it is worth noting that the majority of project managers would have difficulty in selecting from such a large number of service users those most likely to give positive feedback. Moreover, the service users completed the questionnaires anonymously and returned them directly to the evaluator, and it is felt that these measures will have reduced response bias and promoted the reporting of both positive and negative feedback.

Each of the project questionnaires, along with the results, is presented in Appendices 2 – 9.

Focus Groups

Two focus groups were conducted, one with Community Planning partners who are involved in the Home Safety for Older People Working Group, and the other with members of OPSDG. These were based on a semi-structured proforma which was given to participants in advance of the event. Again, both events were tape recorded with the participants' consent, transcribed, and then analysed.

Ethical Issues

In concordance with current practice, favourable opinion was sought and obtained from NHS Dumfries & Galloway, and Queen Margaret University College. Owing to practical and financial constraints associated with this evaluation, it was deemed not possible to contact individual service users in person, including older people with dementia and/or their carers, and this was clearly stated on the ethical approval application. All information gathered from questionnaire respondents was anonymous, and reassurances given that any responses given by them would have no impact on the service(s) they received.

SECTION 5: DESCRIPTION OF BNSF PROJECTS

The following section provides a description of the eight BNSF projects which have been the focus of the evaluation. However, it is first necessary to provide some contextual information about the Home Safety For Older People Working Group and the Older Peoples Services Development Group.

The Home Safety for Older People Working Group

The Home Safety for Older People Working Group is a sub-group of the Safe and Healthy Communities Forum of community planning in Dumfries and Galloway. This working group is a partnership involving representatives from Police, Care at Home Training Consortium, OPSDG, Fire, Environmental Health, Elderly Forum, Trading Standards, BNSF and Scottish Power. The group is chaired by the BNSF Lead Officer who developed the sub-group in response to frustration with the working group, which was perceived as achieving too little for older people. The group has worked collaboratively since its inception in 2002 and its main activities have been a series of travelling road shows across the region in 2003 and 2004. The road shows reached over 200 people in the first year, however, some of the events were held in fire stations which attracted a low-turnout. In the second year more accessible venues were employed and nearly 700 people attended. The purpose of the road shows was for each of the partners to deliver their particular home safety message. For example, the police promoted the message of avoiding bogus callers, using the door chain and keeping doors locked; environmental health looked at infection control and falls prevention. Funding for the group's activities was successfully drawn from the Community Safety Partnership Award in 2003 and 2004. In 2004, £19,000 funding was used to fund two projects: Exercise classes managed by the council for which 15 people (including older people) were trained to run classes for older people, and Home Safety Packs for the most 'at risk' older people living more than 20 minutes travelling distance from the nearest available fire cover. In 2003 over £30,000 was funded for six projects, which included an audit of home safety issues for older people, construction of home safety training material for paid carers, and a medication review of prescribed medicines for older people. By providing the lead role for this working group in addition to being a full partner, much of the group's achievements can be attributed to the impact of the BNSF programme.

The Older People's Services Development Group (OPSDG)

The Older People's Services Development Group (OPSDG) was developed from the previous Joint Action Group (JAG) for Older People and People with Dementia. The latter organisation was a multi-agency officer-led group with representatives of older people. The poor performance of the JAG led to its being reshaped, and in a climate of increasing involvement of older people there was a clear need for change. Under the auspices of the BNSF programme, the BNSF Lead Officer worked on the development of a new group to be led by older people. The Lead Officer's primary aim in developing this group was to bring older people '*into the very centre of strategic direction and planning and service delivery*'. Over the course of twelve months, work was carried out to that end, and in October 2002 adverts were put in the press for members of the public aged 50 years or over to become part of the core group of OPSDG.

The first AGM of OPSDG was held in September 2003, and thereafter open public meetings have been held monthly in locations across the Dumfries and Galloway region. There are two forms of group membership, the core group, and the affiliate group. The core group consists only of older people, while the affiliate group is made up of representatives with an interest in older people. The adverts noted earlier were used to obtain a representative from each of the four communities of Dumfries and Galloway. In addition to these community representatives there were four places on the group for members of Elderly Forum. Other representatives came from organisations including day centres, health councils, and user and carers groups. On the affiliate group are members representing statutory, voluntary or private agencies, including Alzheimer Scotland, Age Concern, BNSF, and Care and Repair. OPSDG was developed under the chairmanship of the BNSF Lead Officer, however from October 2003 the chair and vice chair, both older people from the core group, were voted in.

The group developed a constitution which outlined its main objectives:

"The main aim of the Group is to promote the welfare of older people in Dumfries and Galloway. The group does this by:

- *Taking older people's issues seriously;*
- *Increasing the influence older people and their carers have on matters which are important to them;*
- *Enabling older people and their carers to inform and influence strategic decision making;*
- *Being a full partner within the formal planning framework;*
- *Making information available to, for and on behalf of older people and their carers;*
- *Collating and disseminating the views of older people and their carers;*
- *Encouraging partnerships between individual older people and representatives of statutory and voluntary organisation;*
- *Striving to improve the quality and standard of life for older people in Dumfries and Galloway.*

OPSDG were given the power of decision making regarding the funding of all BNSF projects. They are also involved in fourteen sub-groups, and have working partnerships with four major services: Police, Fire, Council and NHS. Examples of this involvement include their work on the Council anti-social behaviour strategy and the national Police Strategy for Older People, and with NHS their input to a Health Improvement Strategy. Initially, both the NHS and the council provided financial support for the running of the group, but owing to resource constraints NHS support ceased after a year, and the council is now sole provider of financial and administrative support.

<u>Active Service</u>

Active Service is a project run by the Richmond Fellowship Scotland to support older people with functional mental health problems. The service began in the Dumfries and Stewartry area and the BSNF funding was used to expand it into Annandale and

Eskdale. The majority of the Active Service users have depression, a common mental health problem in older people. A report by Help the Aged indicated that as many as 1 in 8 older people living in their own homes suffer from depression (source: http://press.helptheaged.org.uk). Active Service has an open-referral policy whereby older people may self-refer or be referred by a health or social service professional. The aim of Active Service is to promote mental health and wellbeing and reduce isolation by supporting service users to engage in activities that re-integrate them with their community. The service has a large databank of activities and resources in the area that service users can become involved with. The ongoing objective is to support service users to become involved in these community activities until they are able to do so independently. An important feature of the project is the emphasis on activities open to the whole community that are not mental health specific. This focus is aimed at promoting social inclusion. For example, they have supported one service user to take up golf for the first time and placed another in a volunteer position at an aircraft museum. For other service users the support may be more fundamental such as enabling them to go into town when their ill-health has prevented them from doing so. This kind of support aims to promote confidence and self-esteem in the service user.

In addition to the one-to-one support provided, Active Service has also set up partnerships with two churches to run 'Coffee-stops'. These were set up in response to a need identified by older people themselves for a get-together in the community at which they could meet people of their own age and socialise. This service began in Dumfries and was rolled out to Annan and Hightae through the BNSF funding. The Coffee-stops run weekly with regular attendance of between 50 and 70 people (source: BNSF Monthly Project Status Report). Again, this is a service available to the whole community and attended by Active Service users.

The BNSF funding for the project is indicated in Table 1, and was used to fund a 25 hour support worker and 30 hours sessional staff per week. At present the service supports approximately 17 people, however this number fluctuates slightly over time as service users leave the project and others are recruited from the waiting list. This equates to an average of 200 hours of support provided per month (source: BNSF Monthly Project Status Report). For some service users a short period of support is sufficient, for others the support is required long-term and the project has supported some service users since its inception. The role of the support worker is to provide specialist one-to-one support to service users, co-ordinate service delivery, and write up notes for the service. Sessional workers provide one-to-one support to service users. The service is supplemented by volunteer input with volunteers supporting service users and working in the Coffee Stops service. The amount of support provided is dependent on the needs of the person and on the time the service has available. The project operates a waiting list when at full capacity so that people can use the service when hours become available.

Table 1: BNSF Funding for Active Service

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£25,123.00	£34,505.00	£34,505.00

Dementia Friendly Communities

Dementia Friendly Communities was set up to raise awareness and understanding of dementia amongst local businesses and public service providers in Wigtownshire and Stewartry, and has since expanded into the Upper Nithsdale area. People with dementia can stay in their own environment provided that those in that environment know the best way of supporting them. Generally, most people do not know how to respond to someone with dementia unless they have received training, or have had personal experience. As more people are living longer, the chances of developing dementia are increasing, and therefore there are likely to be more people with dementia within the community. This project gives those providing public services, those working in the community, Council staff and family members the opportunity to learn about dementia and the best ways of helping people, and demystifies the disease.

The BNSF funding for the project is indicated in Table 2 and was used to appoint a worker from Alzheimer Scotland on a part-time basis (21 hours per week), to set up and deliver a programme of dementia talks and workshops. Each workshop comprises an introduction to the project, an explanation of dementia, an exploration of attitudes to people with dementia, and seeks to promote independence for the person with dementia, whilst simultaneously providing positive care. Each workshop is tailored to the needs of the participants, such as providing information and services which are local to the group, working on specific skills, such as advocacy and communication, and ways to make their organisation or group more inclusive for people with dementia. Workshops can range from an hour (mini workshop) up to a half-day (2.5 hours), and ideally comprise between 12 and 15 (maximum) people. Participants are given a workbook to take away which contains information about the exercises, dementia, communication, medication, and contact numbers and advice leaflets.

The talks follow a similar pattern, but are less participative. The project is described in detail, outlining aims and progress, some information on dementia, the importance of an early diagnosis, and how to get one, and details of local support groups and services available to offer help. An average talk lasts for half an hour. In addition to giving talks and running workshops, the project worker has organised drop-ins, has set up displays, attended conferences, visited business to give staff a talk in their lunch break, held open meetings as other methods of disseminating information and awareness.

The project now produces a newsletter update, and has produced a dementia awareness sticker to give to those who have attended talks and workshops, which when displayed in public can provide a visual method of showing awareness of dementia.

Table 2: BNSF Funding for Dementia Friendly Communities

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£10,220.00	£24,877.00	£26,126.00

Podiatry

When the BNSF funding became available the information was circulated amongst a wide range of various service sector providers, including NHS services in Dumfries and Galloway, in order that they could bid for funding. The Chief Podiatrist in the Podiatry department submitted a bid to fund a Senior 1 Podiatrist that would roll out the Annandale & Eskdale and Dumfries & Nithsdale components of the service over a three year period. Additional funding was also requested in the second year for a Senior 1 Podiatrist for the Stewartry and Wigtownshire component for a two year period. The BNSF funding for these posts, indicated in Table 3, was used to facilitate the Service in meeting its Charter Guarantee to see all new patients within six weeks of referral. This charter was set approximately a decade ago. In the intervening period the service has increased its remit in diabetes care, and there has been a continual growth of the older population which places increasing demand upon the service. The service has therefore been increasingly stretched without any addition to its resources. Podiatry is not an older adult exclusive service; however older people make up approximately 90 percent of their caseload (source: BNSF website). The service contributes to the headline aim of enabling older people to stay living in their homes for longer by promoting foot health through preventative treatment and palliative care thereby maintaining and improving mobility.

Older people commonly face problems with their feet because they are more at risk from reduced blood supply, poor tissue viability, and foot infection and disease. Podiatry treatments include nail cutting, advice and education about foot care, reduction of corns or callous and the provision of orthotic insoles. Podiatry also has an important preventative role in diabetes care, as foot complications are common in diabetes. People newly diagnosed with diabetes are referred to podiatry for a check-up. A large proportion of the diabetic population (over 50 percent) are older people (Scottish Diabetes Survey, 2003). Poor mobility or pain and discomfort in the feet can be clearly linked to the general wellbeing and longer term mental and physical health of older people. Painful feet and uncomfortable walking may prevent people from going out to visit friends/family, from enjoying leisure activities or from conducting everyday essential tasks such as grocery shopping. These restrictions may in turn negatively impact on mental health and wellbeing, for example, through increasing social isolation.

Table 3: BNSF Funding for Podiatry

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£18,226.00	£62,000.00	£62,000.00

Rapid Response

The Rapid Response Service was an extended service rolled out from the Nithsdale area to the Wigtownshire area. The purpose of the service was to reduce the number of delayed discharges from hospital, prevent unnecessary admission to hospital and promote service users' choices as to whether to stay at home or come into hospital. The local area has recruitment and retention problems with private care agencies. This means that some patients in the community and awaiting discharge from hospital

have a delay while care packages are arranged. This can result in a delayed discharge from hospital for longer than is necessary to treat the patient's medical requirements (source: Activity Report Wigtownshire Rapid Response Team, October 2004). Rapid Response aimed to address this by providing supported discharge and short-term support services of up to two weeks to patients in their own homes within 24 hours of referral. The BNSF funding for this project is indicated in Table 4, and was used to fund a multi-disciplinary team made up of nursing staff, generic support workers, and a physiotherapy assistant, with additional links into the occupational therapy department in Stranraer and social services' occupational therapists.

The service provided was dependent on the needs of the patient. On referral a member of the team would conduct an assessment of the patient. Some patients may have required someone to come into their home and provide meals throughout the day. For other patients there may have been the requirement for aids and adaptations to allow them to remain at home. Service users may have been referred due to a relatively minor problem such as a chest infection. While such a condition should not require the patient to be hospitalised, it may prevent them from undertaking their normal self-care for a short period of time. Rapid Response therefore provided the necessary support until the patient was recovered, thereby preventing them from being admitted to hospital. For the majority of patients the referral was the result of acute illness or a fall, accounting for 43 percent of referrals. Other health needs included post-operative needs, terminal illness, and mobility problems. For the entire BNSF period the project received 487 referrals, 286 of which were received from January to December 2003. Only one referral was reported to be rejected as inappropriate because full care packages had already been organised and put in place. Three further patients refused help because they felt they could manage unaided. The team conducted check-up visits or phone calls and confirmed this was the case.

The provision of this service is particularly important because once an older person becomes admitted to hospital it can become increasingly difficult for them to leave. Firstly, there is the risk of the person becoming dependent on the contact and support of hospital staff that increases their chance of becoming institutionalised. Secondly, there are particular risks to the health of an older person of being in hospital such as the increased risk of infection. Rapid Response therefore had a preventative role in maintaining the health and wellbeing of older people.

Table 4: BNSF Funding for Rapid Response

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£31,250.00	£75,000.00	£31,250.00

<u>The Care at Home Training Consortium</u>

The Care at Home Training Consortium (CAHTC) was set up with the aim of developing appropriate foundation training for carers. The idea came out of regular approved provider meetings, with representatives from both the independent and statutory sectors, and the council. The overarching objective was to:

'*introduce and implement a programme of developing and training carers throughout the region in order to improve the quality of care received by older people in need of this type of support'* (source: Report on CAHTC, 4th November 2002).

The project manager indicated that prior to the CAHTC approximately 88 percent of carers had little or no training. The Care Commission has implemented regulation of care at home services, which will mean that all care providers will be required to meet new care standards. For this reason there was a clear need for care providers to ensure that their staff were adequately trained for their work. The current qualification available to carers is the SVQ II. To obtain this qualification requires carers to commit to a two year period of study. The project manager indicated that this qualification has had very limited success with many carers having difficulty completing the course. Foundation training and qualifications were therefore indicated that were appropriate to the levels of ability and commitment of carers in general.

At the beginning of the project the manager undertook research to identify the areas where training was required. This research involved discussions with care providers, carers, service users and their family members to identify the key areas training should address. The manager then developed a programme of training in line with the findings from this research and the care standards. The BNSF funding, indicated in Table 5, was used to provide training across extensive areas of practice relevant to working effectively with older people. Training days are delivered on subjects including administration of medications, manual handling, and communication skills. Initially outside agencies were employed to provide this training, however to promote cost-effectiveness a trainer was later employed with outside input used where appropriate. The project has a voluntary Management Committee with representation from the private care providers in the region, the Fire Service, the NHS, Elderly Forum and OPSDG. The only paid workers are the project manager, responsible for the design and development of the training and the day-to-day running of the project, and the trainer.

In addition to the main training, the CAHTC has also developed the Step Into Care Programme. This is a training programme run for carers and unemployed carers with literacy and numeracy difficulties and for unemployed people who would like to move into the caring profession. The Step Into Care programme was developed in partnership with Scottish Enterprise National, Scottish Enterprise Local, the Adult Literacy and Numeracy Partnership and the care providers, and was aimed at addressing recruitment and retention of carers. The programme was funded by Scottish Enterprise Dumfries and Galloway and the Adult Literacy and Numeracy Partnership. The CAHTC has also worked in partnership with Stirling University to develop a nation-wide pilot project called the Home Care Practice Licence. This is a qualification based on the CAHTC training programme that is based on the principles used by the Driving Standards Agency for the UK driving test, having three components: a theory test, oral test and practical test. Through these different avenues the CAHTC project is developing the training and qualifications of home carers to improve the quality and quantity of care for older people.

Table 5: BNSF Funding for Care at Home Training Consortium

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£60,064.00	£92,803.00	£105,000.00

The Food Train

The Food Train project was originally started in 1995 as a small home shopping delivery service for older people in Dumfries by a group of volunteers from Elderly Forum. The funding from BNSF is indicated in Table 6, and was provided to expand the service across the entire Dumfries and Galloway region, with the aim of making low cost home shopping available to all older people requiring it. By providing this service Food Train allows older people to benefit from fresh food and other groceries, thus contributing to a healthy diet and enabling them to live independently for longer. The project now has six operating branches providing the service to the whole region. The project has one paid member of staff – the project manager, and otherwise is run entirely by volunteers. The project manager is responsible to a main board which has an executive committee, chairman, vice chairman and treasurers, with the project manager as company secretary. Decision making is made collectively by the board in order that every region is represented.

The project runs in partnership with local shops and supermarkets. The volunteers collect lists from their customers and these are given to the shops to make up the shopping. The volunteers collect, pay for, and deliver the shopping at which point the cost is recuperated from their customers. The service is provided at a very low cost. Customers are charged an annual membership fee of £1, and £1.50 per delivery, plus the cost of their shopping. Where customers require other assistance, for example with putting away the shopping or writing the list, the volunteers will help with that also. The project aims to promote involvement of its members (customers), with all invited to the AGM. If members are not able to attend, the papers can be sent out on request.

Recently, the Food Train has looked at expanding its remit to include other activities around the home that will benefit older people. The project staff had looked into other provisions available on a private or voluntary basis and found that there was nobody else going into older people's houses at their own request and offering to do small jobs. The project has narrowed down the options to what is practical within their resources: vans, offices and volunteers. Customers were asked to indicate services that might be helpful to them in the annual customer survey. They found that customers would appreciate small jobs being done; things that people take for granted but that they struggle with such as changing light bulbs.

Table 6: BNSF Funding for Food Train

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£42,736.00 £21,550.00 capital	£36,077.00	£49,557.00

The Guid Guidance for Older Folk Directory of Services

The Guid Guidance for Older Folk Directory is now in its third year. The aim of the project was to increase community knowledge on the options, range and availability of services which are available to older people. Research (Clark et al. 1998) indicated that if older people could access services before they hit crisis point, then they were more likely to successfully avoid experiencing a crisis. It was decided to compile a directory of local practical information on a wide range of support services available, which could be accessed by older people directly, without the need for referral. The BNSF funding for the booklet is indicated in Table 7. The first booklet was 80 pages long, and contained the Council's 'approved provider' list of agencies that provided domiciliary care, covering basic housework through to complex care packages delivered by either the statutory, voluntary, or independent sectors. The second edition contained over 50 pages of additional information. This included an 'information bank' which contained details of a wide range of generally useful services and information, several pages of home safety advice, as well as information relating to day centres and care homes. Whilst a lot of the information was already in the public domain, it was not always easily accessible, or collated, making finding it not the easiest of tasks. The publication is now in its third, vastly expanded, edition, and covers 216 pages. As well as updates to the previous information, new material covers topics such as pensions and benefits in the information bank section, as well as sections on health matters, leisure, transport and supported housing.

Whilst the remit of the directory was specifically to provide information that would be of benefit to older people, its usefulness has been widely appreciated by family members, friends and neighbours, and those working with older people. The directory is also used by professionals, such as the Police, who publicly promote its use to counter bogus workmen and increase safety at home for older people, as well being used as a resource by staff in their control centre. Directories are also distributed to post offices, local Council offices, pharmacists, GPs and over 800 other destinations throughout Dumfries and Galloway.

The booklet uses Plain English throughout, and solicits feedback from users of the directory, whether to give updates, give new information for inclusion, or advise of any areas of concern. OPSDG and the Elderly Forum are involved in the continual development of the directory content, and are vital in distributing the document and promoting its use, as well as inputting comments regarding the type and usefulness of information listed each year.

Table 7: BNSF Funding for Guid Guidance for Older Folk Directory of Services

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	£12,000.00	£15,500.00	£20,000.00

The Home Fire Safety Checks

The Home Fife Safety Checks project was developed by the Fire Service out of the Home Safety for Older People Working Group. Through the partnership working with BNSF and OPSDG, the fire service bid for funding to conduct free fire safety checks

for older people in their own homes. The BNSF funding for this project is indicated in Table 8. The safety check involves two fire officers going into an older person's home and checking for fire risks or hazards, for example, checking wiring and testing smoke alarms. The officers carry booklets in which they enter the details of the checks, any faults found, and advice on how to rectify these. Three copies are taken; one is given to the older person, one given to BNSF for their records, and the third retained by the fire officers.

The service also provides older people with free smoke alarms. The project officer explained that two types of detector can be provided. The fire brigade fits the highest specification smoke detectors available. Of the two types, sealed and pendant, where possible, the fire officers will fit the pendant smoke alarm. This is run on rechargeable batteries, which take power from the light fitting. Provided the light is left on for one hour per week, the battery will be charged up. Should the alarm be set off by cooker fumes, then it can be reset by switching the light on and off twice. The fire brigade issues energy saving bulbs with these alarms. The project officer explained that the detector requires a 60 watt bulb, but for older people with poorer vision, this is too dim a light, increasing the risk of trips and falls. Scottish Power provides a 60 watt energy efficient bulb, which has the brightness equivalent to a 100 watt bulb, free to people aged over 60. The fire officer explained that many slips/trips/falls are due to accidents in poorly lit areas, such as stairs. Older people are reluctant to leave a light on all the time because of concern regarding electricity bills. The fire officers provide the bulbs for free and explain to older people that the energy saving bulbs can run for 9 years using the same energy as normal light bulb would need for 1 year. This encourages older people to leave the lights on, helping to prevent accidents as well as charging the smoke detector. These efforts to reduce other risks are a direct result of the Home Safety for Older People Working Group. Another output from this group is that the fire service has widened their usual fire safety remit. During the checks, the fire officers will also look out for slips, trips and falls hazards. If a hazard is noticed that lies outwith the fire officer remit, the officers will feed this back to BNSF who can pass to the appropriate agency.

Older people are alerted to the home fire safety checks in two ways. All older people who attended a Home Safety for Older People Working Group road show were offered a free home fire safety check. In addition, the fire brigade promotes the service through talks given to community groups, clubs and organisations, such as the WRI and rotary clubs, as well as any other groups they may hear about during the course of such talks. During the interview with the project officer, it was stated that their target was to conduct 1000 home fire safety checks, and install free smoke alarms within a twelve month period. At the time of interview, at the six month stage, they had exceeded the half way figure, and subsequent monthly reports indicate that they are well on their way to meeting this target.

This project is important in many ways, but particularly from the fire brigade point of view, fire prevention is a lot easier, more manageable and less costly than fire fighting. From the older person's point of view, feeling safe in their own home, and having risks and hazards highlighted, minimised and/or removed can go a long way to promoting and maintaining independence and quality of life.

Table 8: BNSF Funding for Home Fire Safety Checks

Amount funded: 2001/2002	Amount funded:2002/2003	Amount funded: 2003/2004	Amount funded: 2004/2005
0	0	£11,000.00	£20,000.00

SECTION 6: PROGRAMME IMPACT

The purpose of this section is to explore the impact of the BNSF programme in relation to its key objectives. The section firstly considers the evidence regarding achievement of the indicators set out in the LOA. The extent to which the projects and their outcomes have been achieved as specified in the LOA and in relation to national social justice targets and milestones is then examined. The relationship of the projects to the overarching programme outcomes is explored. The section will examine the extent to which the target group of older people perceive a direct or indirect effect from the projects and report their perception of the quality and quantity of the services delivered. The principal source of evidence for this impact derives from questionnaires distributed to service users from each project. The full data from each is provided in a separate appendix.

Reported in this section are the data that specifically address questions regarding individual project impact. The section will also report some of the primary factors that promoted or hindered the attainment of projects and their outcomes. The latter evidence is primarily sourced from interviews conducted with project managers, and interspersed with information from key documents such as the BNSF Monthly Project Status Reports, and other BNSF records. The final part of the section will consider the extent to which service planning and delivery for older people has changed as a result of the BNSF programme. This will also include an examination of the impact upon the council and other community planning partners. The evidence for this impact is obtained primarily from two focus group discussions, one held with community planning partners, the second with OPSDG, and also from discussions with the BNSF Lead Officer and from BNSF documentation.

PROGRAMME IMPACT: Progress of BNSF Programme against LOA Indicators

The headline outcome for the BNSF programme is to:

Enable more vulnerable older people to stay living in their own homes for longer by increasing the range, quality and accessibility of preventative services.

Several indicators were established by which to measure the progress of the programme in achieving this headline outcome. BNSF have provided data measuring this progress in their 2004 Annual Report (see Appendix 1). These data will be presented with some discussion of their implications. Other data provided from the questionnaires for BNSF projects service users will also be added to provide further evidence regarding programme impact.

The first indicator is a reduction in the rate of increase of older people being referred to social services and assessed as level 1 or 2. The baseline data from 2001-2002 indicated that 719 people were recorded at this level, which was a 39 percent rise on the previous year. A rise in the number would indicate that a larger number of people had been assessed as warranting intense service provision, i.e. having acute needs. The final target for the programme was to maintain the current levels of entry. In 2002 to 2003 the figure rose to 1068. The current situation reported for 2003 to 2004 was 953 people, which is a fall of 12 percent on the previous year.

The second indicator is a decrease in the number of older people being referred to social services and assessed as level 3 or 4. The baseline data for 2001-2002 was 70 people. The final target for the programme was to maintain the current level of entry. A rise in the number would indicate an increase in older people being assessed by social services as warranting monitoring only. The figure for 2002-2003 was 89, indicating a rise on the previous year. For 2003-2004 the figure was 26 people. In the 2004 annual report, BNSF suggested that the observed drop may have been the result of the provision of the Guid Guidance for Older Folk directory. By providing this information the directory may have enabled a greater number of older people to self-refer to non-statutory preventative services, thereby reducing the number of referrals to social services. This is a plausible suggestion; however it is not possible to totally attribute the change to the directory or another cause with any certainty.

The third indicator was to maintain the present level of admission to long term care, although the number of over 65s in the region is increasing. The baseline figure was 319 people, indicating the number of new instances in registered homes in 2001-2002. The final target was to maintain current levels. In 2002-2003 the figure rose to 332 admissions. The current situation indicated a drop to 309 people. A drop in the numbers entering registered homes would suggest an increase in the number of older people able to live independently. This would indicate a successful outcome for the programme; however, again it is not possible to totally attribute this effect to BNSF with any certainty.

The fourth indicator was an increase in user satisfaction. The baseline figure was taken from the BNSF Christmas survey of older people conducted in 2002. The survey found that 32 percent of respondents thought that the support services funded

by BNSF would be useful to them. The final target was to increase this figure to 45 percent. The survey was not repeated in 2003; however the 2005 figures indicated a rise in satisfaction to 41 percent. The present evaluation has conducted a survey of all the BNSF funded projects that included measures of satisfaction with each service by the service users. The full details are presented project by project later in this section. The total numbers reporting whether they were very satisfied, satisfied, dissatisfied, and very dissatisfied were collated, to give the overall percentages of satisfaction with the BNSF programme. Only one project was excluded, the Guid Guidance for Older Folk Directory of Services. This was excluded because the questionnaire did not ask for a rating of overall satisfaction, but rather asked respondents to rate satisfaction with each section of the directory. As this project does not offer a direct intervention it is not guaranteed to be used by respondents, and consequently the number of responses obtained was very low, with few respondents reporting using the majority of sections. The overall satisfaction ratings from the seven projects were as follows: 60 percent reported that they were very satisfied, 29 percent reported that they were satisfied, one percent reported that they were dissatisfied, and one percent reported that they were very dissatisfied, with eight percent not responding. Clearly these ratings are much higher than the BNSF survey response of 41 percent. The difference with the present survey is that the respondents were all users of the projects and were therefore rating a service they had received, rather than estimating whether it would be of benefit. These results indicate that overall the satisfaction with the projects was very high.

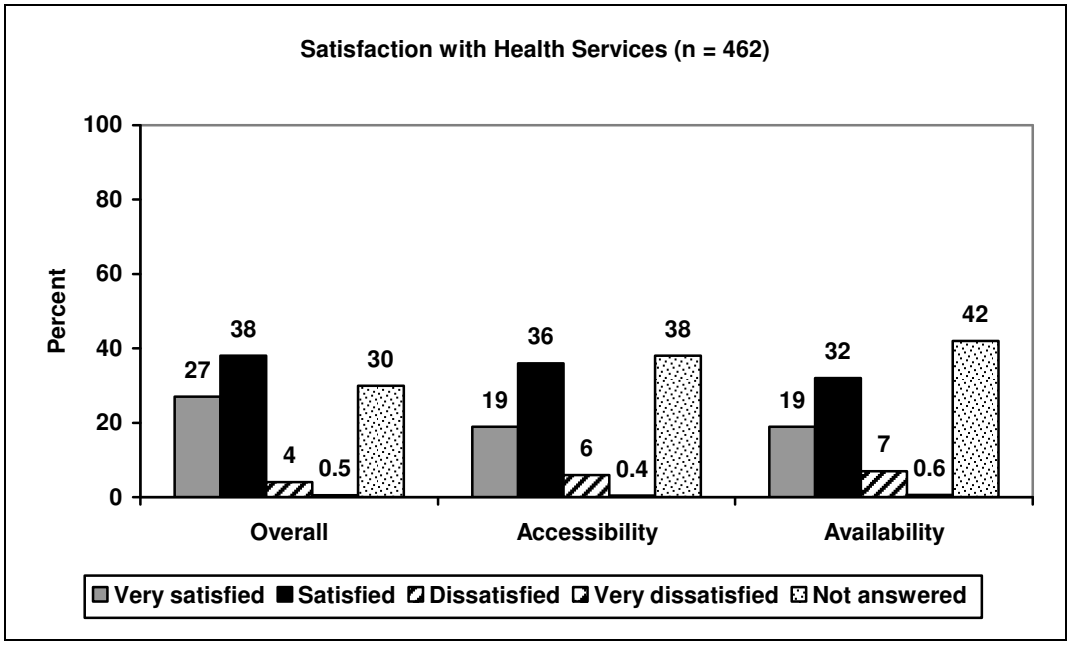
Additional indicators were also presented in the 2004 Annual Report. The first of these was the percentage change in the proportion of people taking exercise or participating in sport or physical activity. The baseline figure was taken from the 2003 survey conducted at the Home Safety Road Shows, with 33 percent reporting regular exercise/physical activity. The final target was to increase the baseline to 36 percent. In 2005 the survey reported an increase of 2 percent to 34 percent. This would suggest that the programme was on-track to achieve its final target. The data from the questionnaires evaluating the individual BNSF projects indicated that the Podiatry service was enabling some service-users to continue to engage in physical activity such as walking. This would suggest that at least one of the BNSF projects is making a direct contribution to this outcome.

The second additional indicator was the percentage of older people stating that health services were accessible and the percentage stating that they were satisfied with health services. The baseline measure used was data from the Partnership in Podiatry project where the outcome is to reduce the waiting time for new referrals to the service to within six weeks, consistent with the charter guarantee. The baseline from before the BNSF funding was 40 percent in Annandale and Eskdale and 77 percent in Dumfries and Nithsdale. The current situation was reported as 84 percent in Annandale and Eskdale and 87 percent in Dumfries and Nithsdale, indicating an increase in satisfaction and accessibility.

The evaluation questionnaires distributed to six of the eight BNSF projects asked respondents to report their overall satisfaction, and satisfaction with the availability and accessibility of health services and social support services (Dementia Friendly Communities and Care at Home Training Consortium were excluded as the service users from these projects were not older people but rather were carers and members of

the community with an interest in older people). The aggregated responses for satisfaction with health services are presented in Figure 1. The graph indicates the percentage of respondents, who reported that they were very satisfied, satisfied, dissatisfied or very dissatisfied with the health services overall, and with their accessibility and availability.

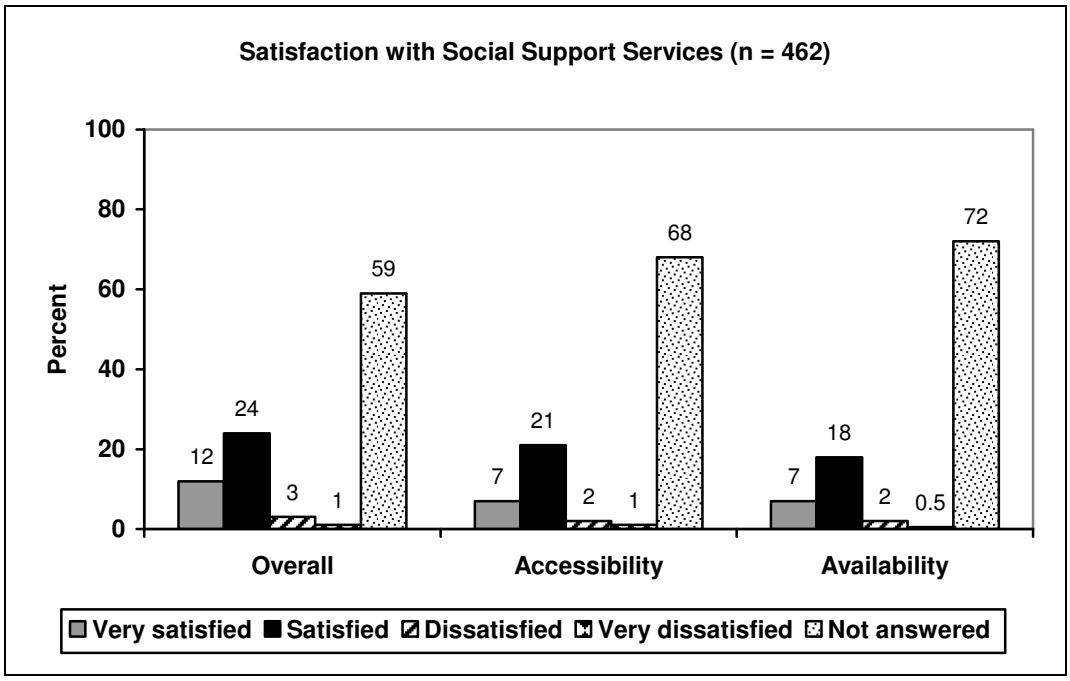
Figure 1: Satisfaction with Health Services



Evidently there were a high proportion of respondents who did not provide an answer to this question as indicated by the 'not answered' columns. The overall reported satisfaction is clearly high, with only 4.5 percent indicating dissatisfaction. Satisfaction with the accessibility of health services was slightly lower, with 55 percent reporting satisfaction, and a slightly higher percentage, 6.5 percent reporting dissatisfaction. The percentage of not answered was also higher, which may indicate difficulty in answering the question. Again, the percentage of dissatisfaction rose slightly for the availability of health services, at 7.6 percent. Overall these data strongly suggest that satisfaction with health services amongst this sample of older people was very high.

Figure 2 presents the percentage of respondents who reported that they were very satisfied, satisfied, dissatisfied or very dissatisfied with social support services overall, and the satisfaction with the accessibility and availability of these services.

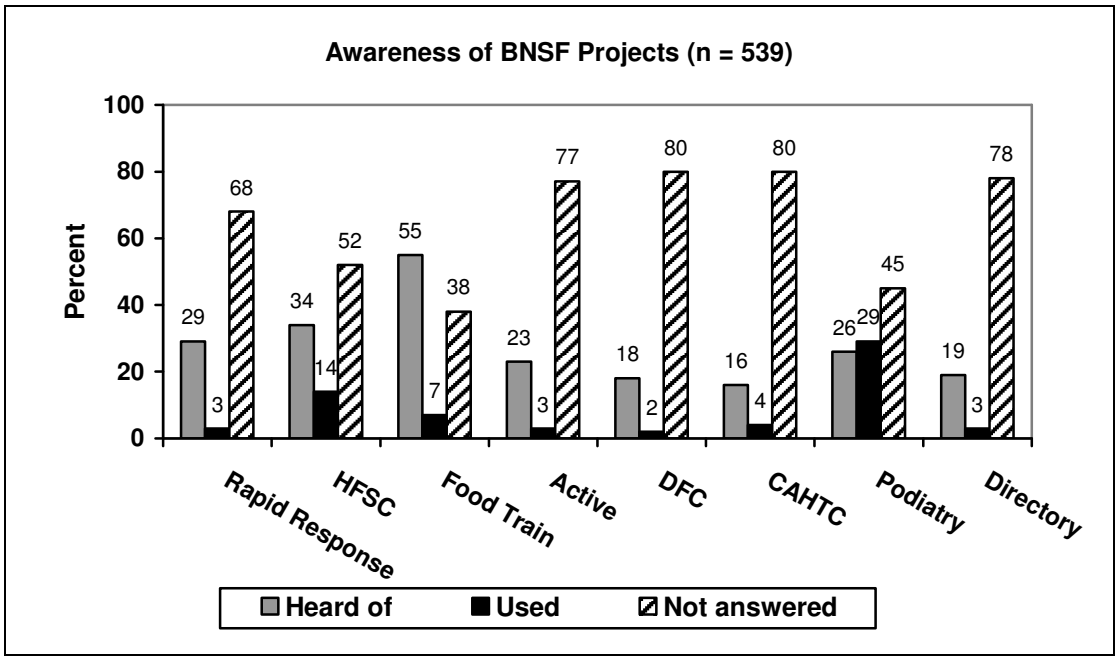
Figure 2: Satisfaction with Social Support Services



The high proportion of not answered would suggest that some of the respondents may not have used social support services to comment on their satisfaction. Of those who provided a response, the majority, 36 percent, reported that they were satisfied, with only 4 percent indicating dissatisfaction. As with the satisfaction with health services, the percentage of not answered rose for satisfaction with accessibility and availability; 28 percent indicated that they were satisfied with accessibility, while only 3 percent reported dissatisfaction. Twenty five percent reported that they were satisfied with the availability of social support services, with only 2.5 percent reporting dissatisfaction.

The next additional indicator is the percentage experiencing better access to information about services. The baseline figure of 32 percent was the proportion of respondents in the BNSF Christmas survey who had heard of the projects funded by BNSF. The final target was for an increase of three percent to 35 percent. The current situation was a drop of four percent to 28 percent from the 2005 survey, suggesting that thus far the programme was not achieving its target. The project-specific evaluation questionnaires asked respondents from each project to indicate whether they had heard of or used each of the BNSF projects. The findings are presented in Figure 3.

Figure 3: Percentage of Respondents Heard Of/Used BNSF Projects



The proportion of not answered are taken in part as an indication of the percentage who had not heard of the projects, however, it is important to note that some respondents did not complete the questionnaires in full, perhaps due to difficulty or lack of motivation for the task. A limitation of the question was that some respondents might be aware of the project but less familiar with its correct name; thus the names used in the question could mislead some respondents to think they were unaware of the project. This was noted by BNSF regarding the directory. The title is Guid Guidance for Older Folk Directory of Services; however BNSF noted that some older people know the directory as 'the lilac book'.

The average percentage of awareness for all of the projects was 36 percent. This was slightly higher than that obtained by the BNSF survey. It may be that service users of the BNSF projects are more aware of the other projects as a consequence of the inter-agency and partnership working between the projects. If the staff members of the projects are more aware of other projects due to their links with BNSF this awareness may filter through to service users through word of mouth and referral. Clearly the greatest awareness was of the Food Train. This is unsurprising as it is a region-wide service with vans displaying the logo and travelling across the region to make deliveries. As the winner of two national awards the Food Train has also received much recent publicity. The high awareness and use of the Podiatry service is also unsurprising as this is predominantly a service used by older people. The Home Fire Safety Checks also had a broad awareness. This may in part be because the project provides a region wide service that was promoted through travelling road shows. The awareness of rapid response is perhaps surprisingly high, given that it was only provided in two areas and only to older people with acute needs. Moreover it is not a service to which patients can self-refer; therefore knowledge might be expected to be lower.

The next additional indicator was the percentage of older people living independently in their own home or community. The baseline figure used by BNSF was the percentage reporting that there were sufficient services in the region to enable them to live in their own home should their health deteriorate. The baseline percentage was 54 percent, with the final target to increase the proportion to 55 percent. The questionnaires distributed to service users of the BNSF projects to evaluate their impact asked respondents to indicate whether the project had enabled them to live more independently and whether they could live independently without the intervention. The findings from these questions are reported for each project in the following part of the section. The data indicate that two of the projects have made a particular contribution to independent living: Food Train and Rapid Response.

The next additional indicator was the percentage of respondents reporting a feeling of isolation. The 2005 survey indicated that eight percent felt that their present circumstances sometimes made them feel isolated. The final target is to maintain the current levels. The evaluation questionnaires for the BNSF projects asked respondents to indicate whether the project had improved the quality and quantity of their social contacts. Three of the projects made a particular contribution to this indicator, Active Service, Rapid Response and Food Train.

The final additional indicator was the percentage reporting improved feeling of wellbeing. The first time this was measured by BNSF was in the updated 2005 survey, with respondents being asked whether in the last four weeks they had felt full of 'get up and go'. The present evaluation questionnaires asked respondents to indicate whether, as a result of the project, they felt their wellbeing had improved. The projects that had a particular impact on wellbeing were Food Train, Active Service, Rapid Response, Podiatry and CAHTC. The details for these findings are presented in the analysis of each of the project questionnaires later in this section.

The extent to which these indicators are a useful measure of the impact of the BNSF programme is questionable. Firstly it is not possible to directly attribute the figures or any changes therein, to the impact of the BNSF programme. Within the constraints of the evaluation, it would not be possible to trace and control for the various confounding variables that may in part be responsible for changes. For example, an increase or decrease in the number of social services staff in the region could result in changes to the number of referrals received and assessed by social services. This could alter the level 1-4 figures used by BNSF to monitor the programme's impact, thus creating a misleading picture. A second limitation concerns the time period in which these measures are being considered. It is debatable whether many of the projects should be expected to impact upon such things as entrance to long-term care, within a period of only two years. The projects are aimed at providing preventative services and interventions for people prior to reaching a crisis point. In the absence of intervention it seems unlikely that many of these older people would reach a crisis point within the short period these projects have been available. Thus, if the projects prevent or prolong the duration before a deterioration or crisis, this may not be seen in the figures for another few years.

What can be stated is that the majority of the figures appear to be moving in the right direction. The purpose of distributing individual questionnaires to evaluate each of the BNSF projects was to provide an in-depth look at the impact of each on their

service users. Through these data, the extent to which the projects are contributing to the headline outcome and improving the circumstances of older people can be considered. The findings for these questionnaires are presented in the next part of this section.

PROGRAMME IMPACT: Active Service

BNSF created the following outcome indicators for Active Service, detailed in the Monthly Project Status Report. The indictors serve to outline what the project should achieve in relation to the overarching aims of the BNSF programme.

- Contribute to a reduction in the rate of older people with functional mental health problems needing institutional care.
- An increase in the number of people accessing services without being in a crisis.
- Contribute to a reduction in the rate of older people with mental health problems requiring admission to long term care.
- An increase in service user satisfaction.
- An increase in the number of people accessing preventative services.
- An increase in the community involvement for people with a mental illness.
- An increase in the awareness of The Active Service among older people in Annandale and Eskdale.

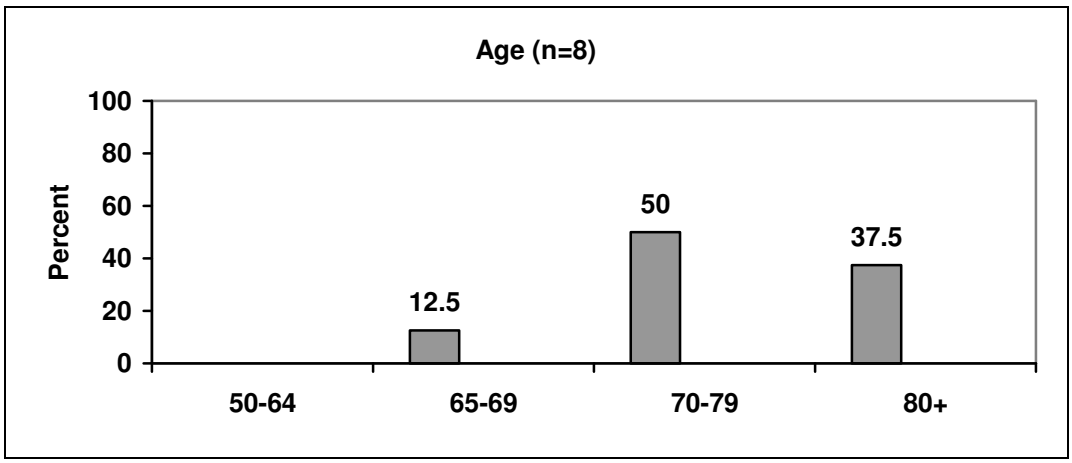
The Active Service project manager outlined initial enquiries conducted by the Richmond Fellowship in which older people with functional mental health problems conveyed a need for services that promoted their involvement and reduced social isolation. There was a significant shortage of supportive, socially focused services for this population and the aim of the Active Service was to address this. The scarcity of services for this population suggests that the outcomes from Active Service would not have occurred otherwise, contesting any assertion of additionality that might be attributed to the project. The project has enhanced its accessibility by operating an open-referral system that allows older people to self-refer. This approach has the advantage of allowing access to people who are not otherwise in contact with health and social services. Where referral is restricted to health and social service professionals there can be a focus on those with severe and enduring mental health problems. Moreover, some people may be hard to reach if they wish to avoid contact with statutory agencies. This referral system therefore promotes access to that section of the population.

Older people with mental health problems can be doubly stigmatised on account of their age and mental illness, therefore their need for socially supportive services is particularly great. Active service is preventative by providing an intervention for people with functional mental health problems before they reach crisis point. In the absence of intervention there may be greater risk of the condition becoming exacerbated and progressing to crisis point. Reaching this point could result in admission to residential or institutional care with a consequent loss of independence. To the extent that Active negates such a crisis the service is clearly meeting the headline outcome of keeping older people in their own home for longer.

Respondent demographics

Eight service users from Active Service completed and returned a questionnaire evaluating the impact of the service, representing a response rate of 80 percent. The questionnaire and full results are presented in Appendix 2. Five of these respondents were female and three were male. The age distribution can be seen in the graph below, and there were no returns from the youngest age group.

Figure 4: Age distribution



The majority, 87.5 percent came from Annandale & Eskdale, with one respondent indicating they lived in the Dumfries area. Four respondents lived alone, two lived with their spouse/partner, one lived with another family member/friend and one lived in residential accommodation.

Respondents' mental and physical health

In the ratings of physical health, three reported their health as good, two as fair, one as poor and two as very poor. In the ratings of mental health, three reported it as good, two as fair, two as poor and one as very poor. The reports of poor and very poor mental health are consistent with the service users' condition. Reports of good and fair mental health are interesting because four of the five respondents later indicated that their mental health had improved since using the service. If the service is improving mental health to a degree that service users perceive their mental health as 'good' it suggests the intervention provided has been effective in alleviating some symptoms of the illness.

Service user satisfaction

The questionnaire data provide clear evidence that service users highly value the input of the Active Service. All of the eight respondents (100 percent) reported that they were 'very satisfied' with the project overall. Three were satisfied and five very satisfied with the availability of the project. Five were satisfied and three were very satisfied with the amount of contact with project staff. This feedback demonstrates that the service users are satisfied with the quality and quantity of the service provided. Furthermore it indicates that they are getting from the service what they feel they need.

Satisfaction with health and social services

The questionnaire asked about satisfaction with health and social services and their accessibility and availability. For general satisfaction with social services six respondents answered, with an even split between those satisfied or very satisfied and those dissatisfied or very dissatisfied. Respondent's comments revealed that their satisfaction was centred on perceiving it as a good service and having a good relationship with workers. Dissatisfaction was the result of feeling a need for more

support than was available or provided. In line with these comments, respondents reported a high degree of dissatisfaction with the availability and accessibility of support services. The large proportion of service users reporting dissatisfaction with social support services is in noticeable contrast to the satisfaction reported for Active Service. The comparison between respondents' experience of Active Service and other social services appears therefore to be highly favourable.

Quality of life

The questionnaire indicated that service users perceive a direct impact of the project on their quality of life. The vast majority of respondents, 87.5 percent, reported that their quality of life was 'much improved' as a result of using the service, with 12.5 percent reporting it was 'a little improved'. Some respondents provided comments to qualify these ratings:

> *Active staff are persistent and persuasive and don't give up on me, and I like the person, I look forward to their visit.*
> *Gave me better social contact and feel more included.*
> *Because I get out and see people.*
> *Find the service good and enables me to go out.*
> *Feel reluctant about going out because I feel nervous but thoroughly enjoy myself when out.*
> *Good people.*

It is evident from these comments that the social contact provided by the project; spending time with the staff and getting out, are critical to the improvement in quality of life. The comments also reveal the difficulty service users have with going out and the role of the support worker in providing encouragement.

Figure 5: Impact of Active Service on Key Areas of Quality of Life

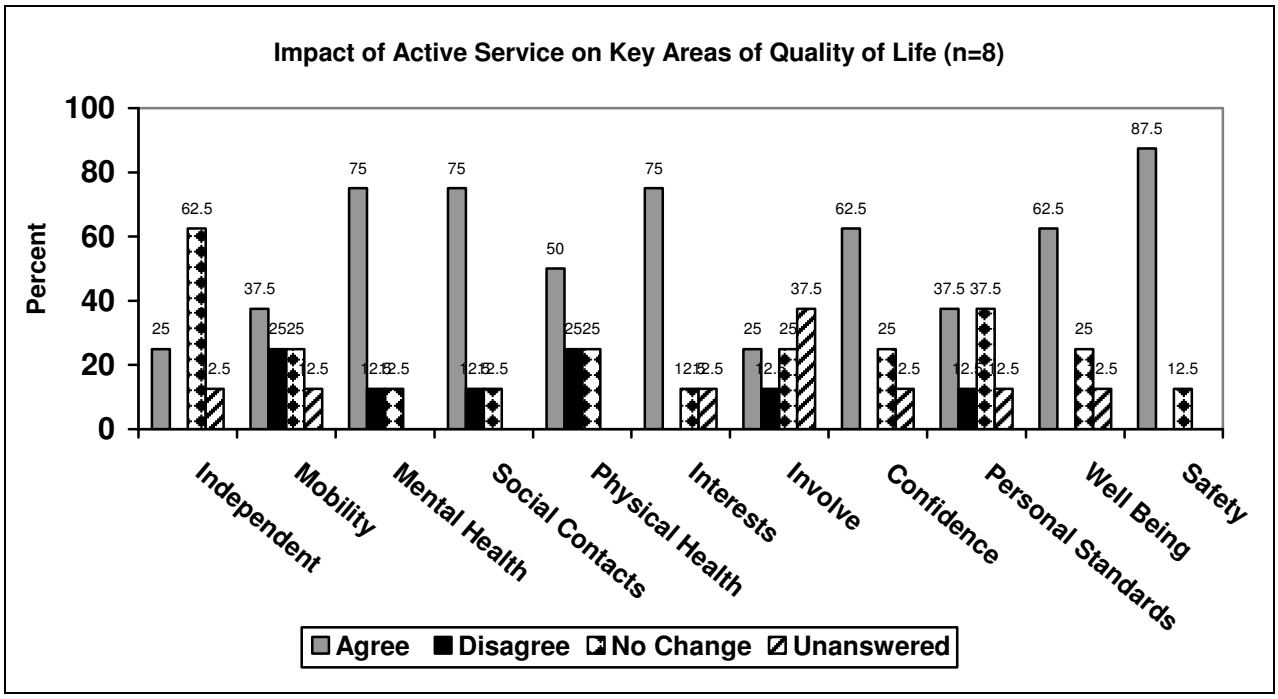


Figure 5 presents the responses obtained from a series of questions regarding the impact of Active Service on eleven areas of quality of life. Respondents were asked to indicate whether they agreed, disagreed or perceived no change with regard to eleven statements as follows:

- I feel more able to live independently
- I feel that my mobility is improved
- I feel that my mental health has improved
- I feel that the quality and quantity of my social contacts have improved
- I feel I am in better physical health
- I am engaged in more activities and interests that I enjoy
- I am feeling more involved in my community
- My self confidence has grown
- I feel able to maintain my personal standards
- My feeling of general wellbeing has increased
- I feel more assured of my safety

The chart clearly demonstrates that for every area of quality of life the service has had an impact. Of all the quality of life indicators, the most significant findings were that 87.5 percent reported feeling more assured of their safety, 75 percent reported an improvement in their mental health, 75 percent an increased engagement with interests and activities they enjoy, and 75 percent an improvement in the quality and quantity of their social contacts. The reported improvement to the quality and quantity of social contacts demonstrates that the service is meeting its main aim of reducing social isolation and promoting inclusion. Similarly, the proportion reporting increased engagement in activities and interests they enjoy, indicate that this project aim is being achieved. The improvement to respondents' assurance of their safety is an interesting finding. Two possible explanations are suggested. Firstly, the regular contact with staff may provide service users with reassurance that if anything negative should happen to them, from injury or failing health to the risk of crime, someone would be in regular contact to provide support and assistance. Another possibility is that service users may feel they are safer from the potential deterioration of their mental health and the consequent implications for their quality of life, by having the support of the project. For improvement to wellbeing, 62.5 percent agreed there had been an improvement. Also significant was the large proportion, 62.5 percent reporting that their self-confidence had grown. Self-confidence has a close relationship to mental health; therefore this finding provides further support for the effectiveness of the Active Service intervention. The high proportions reporting improvements in their mental health and wellbeing are highly significant as they support the claim that Active is a preventative service.

Fifty percent of respondents indicated that their physical health was improved, with 25 percent disagreeing and 25 percent reporting no change. A large proportion of the service users are reported to suffer from depression, which can include symptoms of fatigue. A possible reason why physical health improved is through the improvement of mental health and the consequent alleviation of such physical symptoms. Another possibility is that service users were taking better care of their physical health through the increased motivation that can come with improved mental health, for example by eating better or taking more exercise. This argument may also be applied to the

improvement in mobility reported by 37.5 percent. The same moderate proportion, 37.5 percent, reported feeling more able to maintain their personal standards. Twenty five percent of respondents indicated that they felt more involved in their community, with 12.5 percent disagreeing, 25 percent reporting no change, and 37.5 percent providing no response. This finding could be taken to indicate poor performance by the project, given the emphasis on social inclusion; however the reported improvement in social contact precludes such an inference.

Respondents were asked to indicate whether they could continue to live independently without the input of the project. The majority of those surveyed, 87.5 percent, felt they could continue to live independently without the project. Similarly, as the bar chart indicates, only a quarter indicated that they felt 'more able to live independently' since using the project. One of these respondents explained that they were already dependent upon their spouse for care, indicating that their independence was already compromised. These data do not strongly support the connection between independent living and Active Service. However, it is important to note that making this connection requires service users to imagine a progressive worsening of their circumstances that would diminish their independence. Respondents may have difficulty imagining this scenario for a number of reasons; for example it may be outwith their experience or they may find such a thought threatening. As with all the projects, this subjective measure of the impact on independence should be used tentatively.

Added value

The questionnaires asked whether the project had had an impact on the people close to the service user. The answers revealed a clear added value of the project through the impact on the family and friends. Five of the eight respondents stated that the service had made a difference to the people close to them. Respondents gave comments which provided further explanation:

My daughter is pleased that I can get out and meet other people.
My son has spare time.
My wife does not feel totally alone.

This feedback demonstrates that the project may be providing important respite and a positive sense of wellbeing for family/friends. Such respite could enhance the benefit of the project to service users by reducing the pressure on family/friends and consequently improving the support they feel able to give. For example, respondents were asked if their quality of life had improved in any other ways as a result of the intervention, and one respondent indicated that his wife was more able to cope as a carer because the Active Service allowed her a chance to rest. Even without such additional benefits to the service user, it is apparent that the project may have a role in reducing the burden of care and alleviating anxieties for the health or wellbeing of the service user.

The survey asked respondents to specify what the most important thing was that the project had brought them. All of the respondents provided an answer. Three respondents emphasised the importance of having company and new social contacts. One respondent indicated the benefit of "stimulation, kindness, interests". Two other comments received were:

A little more quality of life.

All round help if needed.

The overall picture evident from the questionnaire feedback is that the Active Service has an important role in the lives of its service users, by improving their mental health and adding to their quality of life. These data indicate that Active is making an important contribution to the overarching aims of the BNSF programme.

PROGRAMME IMPACT: Dementia Friendly Communities

The project started in the Wigtownshire area, was then rolled out into Stewartry and most recently to the Upper Nithsdale area. Whilst each area was prioritised in turn, the project manager maintains links and contacts established in areas already covered, whilst continuing to reach out and develop new contacts.

Each workshop and talk provided has a core body of content, as outlined in the previous section; however, events are also tailored by the project manager to address identified areas of need, or interest in the audience. For example, a workshop given to members of a carers group would differ from one given to wardens of sheltered accommodation, as there may be different issues to consider. Nonetheless, much of the work covered at a workshop will be of relevance to people across the board, whether in their capacity as a service provider, shopkeeper or informal carer.

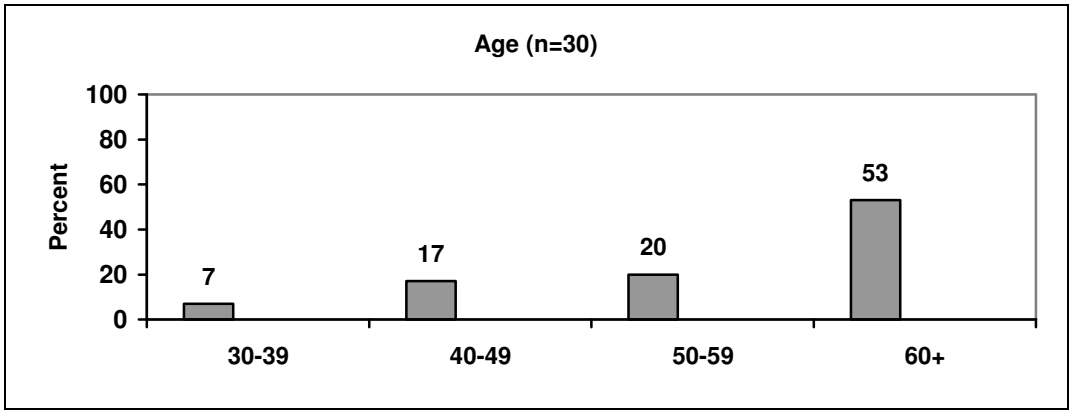
The outcome indicators for the Dementia Friendly Communities project are:

- Contribute to a reduction of older people with dementia needing institutional care
- Contribute to an increase in the number of people with dementia accessing services without being in a crisis
- Contribute to a reduction in the rate of older people with dementia requiring admission to long term care
- An increase in service user satisfaction
- An increase in the number of people with dementia using preventative services
- An increase in the community involvement for people suffering from dementia
- An increase in awareness and understanding of dementia among local businesses and public service providers in Wigtownshire and Stewartry.

Respondent demographics

Thirty respondents who had used the Dementia Friendly Communities service completed and returned a questionnaire, representing a response rate of 25 percent. The questionnaire and full results are provided in Appendix 4. Four of the respondents were male, and 25 were female, with one not giving a reply. The age distribution of the respondents can be seen in Figure 6 below:

Figure 6: Age distribution



One respondent did not reply to this question. The higher number of people in the older age bracket can be accounted for by the fact that many respondents were attendees at events organised through, for example, the Elderly Forum, or the Women's Rural Institute (WRI).

Reasons for attending the event
Respondents were asked to indicate why they had chosen to attend either the talk or workshop, and twenty of thirty gave an answer. These could be assigned to four broad categories:

Because the respondent knew someone with dementia:
Relative with Alzheimer. Wanted to know more about it and what help available.
Several of our Guild members had dementia or had a family member with dementia.

Because they wanted to learn more about the illness:
Insight into problems faced by people suffering from dementia
Symptoms; treatment available; testing procedure

Because they wanted to increase their knowledge of dementia services and support:
More information on community services for people with dementia

Because it was of value to them in their work:
I am a visiting volunteer, I wanted to be able to talk to the resident in a calm friendly way
Ongoing training/awareness via Pass Direct (advocacy service)

These reasons indicate that there is a demand for the service, at both a professional and a personal level.

Service user satisfaction
The questionnaire asked several questions to solicit feedback regarding the usefulness of the events they had attended. When asked whether respondents felt the event they had attended addressed the issues regarding dementia which were important to them, 28 replied. Only 7 percent said no, whereas the vast majority, 87 percent said yes. The two respondents who had replied in the negative did not give a reason. Those who had said yes gave a range of reasons, including gaining a better understanding of what it is like to have dementia and the problems faced by people with dementia:

It opened my eyes to the various problems which arise especially to family and carers of persons affected by dementia.
Helps us to understand the difficulties of sufferer.

These responses suggest that the project was successful in promoting respondents' understanding and empathy for dementia sufferers. Several respondents reported it had increased their knowledge of the illness, and available support and services. This is an important finding as it suggests that the number of people with dementia who access help and support may be increased. For example, if, in the future, a relative or friend of the respondent is diagnosed with dementia, they will be in a better position to obtain advice and support. In this way the project is potentially contributing to the uptake of preventative services.

Increased my knowledge of the conditions and services available.

One person reported a feeling of comfort from having attended the event:

Helped me by knowing that it was common problem and we were not alone.

These responses also indicate that the project was successful in tailoring events to the needs of the target audience.

Only one respondent did not reply to the question whether they felt their knowledge/understanding of dementia and dementia-related issues had increased as a result of attending the talk or workshop. Ninety three percent said that their knowledge and understanding had increased, partly because many had little or no previous knowledge, and for others it had expanded their awareness and skills to deal with persons who have dementia.

It gave you new ways to work with Alzheimer's patients
I was made more aware of what problems sufferers face and possible solutions for the care.

Another benefit outlined by respondents was clarification of information relating to dementia and Alzheimer's:

It was pointed out that dementia is not always Alzheimer's and can be treated.
I did not realise how many types of dementia before the workshop.

These responses are important as they indicate that many service users utilising the project's talks and workshops were relatively unaware of dementia prior to the event, and therefore were appropriately targeted. Moreover, that the respondents perceived their knowledge and understanding of the condition as having improved indicates that the project has been successful in enhancing awareness.

When asked to rate their satisfaction with the DFC event overall, 63 respondents said they were very satisfied, and 30 percent were satisfied. Only one respondent indicated they were dissatisfied, saying:

It was useful but I left feeling I wanted more time to learn more.

Many of those who expressed satisfaction commented on the quality of the talk and speaker. All respondents, with the exception of one non-respondent reported satisfaction with the availability of the event they had attended. Several factors were indicated, such as convenience of the location, consideration given to the timing of the workshop and the fact that often, the speaker attended venues chosen by attendees:

It was a workplace talk.
It was a local venue which is much publicised.
Arranged to suit with our working hours.
Convenient place, time is very difficult to tie in with meals and duty hours.
We arranged for the speaker to come to the Guild meeting.

These responses indicate that the talks and workshops are provided in accessible locations within the community. The ratings of satisfaction indicate a perception that the quality of the project is high. Feedback given to the project manager highlighted an additional benefit reported by a group who had attended a talk. They were surprised by how much they had enjoyed the event and taking part in a small exercise. By having a lot of myths dispelled, many of the negative aspects often associated with dementia were removed.

Service Impact

Given that it was not possible within the constraints of the evaluation to assess the impact of the project upon its intended beneficiaries, that is, people with dementia, the uses to which the respondents had put the project were an important means of evaluating its impact. Feedback from the questionnaires gave some insight into the impact of the project upon attendees. When asked whether they had used the information they had received at the event, nearly equal numbers said yes and no. Forty three percent said they had, and two stated how they had used it directly

It prompted me to take my mother to see her doctor - after blood tests to eliminate vitamin deficiency we referred her to the memory clinic.
Gave father-in-law leaflets and I was able to talk to him with a better knowledge.

Another said they had passed on acquired information to others. However, more than half said they had not used the information, and the most common reason given was they had not had occasion to do so since attending the event:

We have no dementia sufferers in the unit at present.
Have not encountered anyone who required help.
Because there is no one in my circle who suffers from dementia.

These data suggest that the service is having a positive impact to the extent that some users have been able to use the information obtained. The proportion who have not had a use for the information suggests a limitation of the project. However, this can also be interpreted as a preventative aspect of the project, whereby service users who come into contact with people with dementia in the future may be better able to involve and communicate with them, as well as having a greater awareness of the help that is available. Thus the service is preventative by making available important information and skills for dealing with dementia before rather than after they are needed.

Respondents were asked whether their approach to interacting with people with dementia had changed as a result of attending the event. Three quarters of those who replied indicated it had, and fifteen respondents gave examples. Several said it had given them increased awareness and/or better understanding as well as a better ability to attend to the needs of people with dementia:

You think about what you say or the way you put a question to a patient for example.
I have tried to be more patient and understanding, try to speak more clearly, not to offer too many choices, decisions etc.
Understand them more and have a wider knowledge base to attend to their needs.

These responses provide important evidence of how the project is succeeding in promoting the 'friendliness' of the community, by enabling community members to approach people with dementia in a manner more appropriate to their needs. Several respondents who said their approach had not changed indicated it was because they did not know anyone with dementia.

An important aim of the DFC project is to change people's attitude to people with dementia. When respondents were asked whether they felt their attitude had changed subsequent to attending the event, 70 percent said it had, and 20 percent said it had not. The most common explanation given was that they felt they now had improved understanding and patience:

More aware of how people are affected by dementia and their relatives/carers.
Better understanding of condition means you look at things from a different perspective.

One respondent whose mother-in-law had dementia, said that not only had her own attitude been affected, but that after the talk, she had been "… *able to talk to my children and discuss what Alzheimer's was, which seemed to help calm us down".*

Five of the six respondents who had indicated that attending the event had not changed their attitude said that they always tried to behave in a supportive and inclusive manner, or felt they already had many of the skills outlined:

My attitude has always been good and sympathetic to both client and care, I have always tried to be patient and understanding with dementia sufferers.

However, two agreed that although their attitude had not changed, they did feel they had benefited.

Still treat residents with the same respect, however understand more about dementia
Because I was basically doing what they set out already but it helped with ways of communicating.

It could be argued that some people using the service may not need the input, but if, as shown above, there is some degree of learning, then the project is clearly beneficial.

Respondents were asked whether their skills for dealing with people with dementia had improved or increased, after attending the DFC event. Sixty seven percent said they felt it had.

Getting to know more about dementia makes you more able to deal with it.
You don't tax them and keep whatever you are doing short as they find it difficult being made to work out too many things at once.

One respondent had been able to put skills learnt directly into practice:

Mother becomes disoriented very easily, have marked the way to her bathroom with yellow ribbons on door handles.

This is a key example of where the project has had a direct benefit for older people with dementia and their carers.

Respondents were asked whether attending a DFC event had made an impact, at a professional and personal level, with regard to their confidence in interacting with people with dementia. On a professional level, 57 percent said they felt more confident, because they had more understanding and awareness

I find it easier now with more understanding of problems
More knowledge of condition means clarity of thought.

Another said that although they had existing knowledge, the event was a *"good back up"*. The only comment given by a respondent whose confidence had not increased said it was because *"felt confident beforehand as I knew the residents well"*. Many respondents, however, were not working, so this particular question was not relevant to them.

From a personal viewpoint, 73 percent of respondents indicated that as they now felt they had a lot more understanding and awareness of the condition, and how it affects those who have it, that this in turn increased their confidence in their interactions with people with dementia:

Much more confidence due to more understanding of what causes dementia

At times I felt like I wasn't doing things correct but I found I was ok. They also made you realise with a wee bit of adjusting it was alright.

By having their confidence increased, these respondents may be more likely to approach and interact with people who have dementia. This has clear implications for the promotion of social inclusion and tackling isolation, such that social contacts can continue in spite of the illness.

Only ten of the thirty respondents reported having displayed a window sticker as a result of attending an event, which is a relatively low number; however, the stickers had only recently been distributed.

The project manager gave an example of a dementia friendly community in one rural area, whereby staff in the local post office will alert the carer of a lady with dementia if she comes into the post office more than once a day, to carry out the same transaction. This indicates a community which has developed its own 'safe guards'. By implementing these it can help to keep people in their homes for much longer than in an area where there is not such a sense of community.

In a supplementary interview, a Community Councillor, Dumfries and Galloway, with regard to Dementia Friendly Communities, said *"I'm certain that it will greatly benefit the community"*. This person said they felt that the impact of the project had

been huge, although they themselves did not feel a personal impact having not as yet had cause to use the information learned.

Time factors relating to service impact

An important point to bear in mind is that this project was not set up to effect immediate change; rather any major effects are not likely to be seen or felt for quite a while. One of the main aims of the project was to change the view of a community, a task which can not be achieved quickly. People need to understand how their attitudes impact on others firstly, and they therefore need to be able to look at themselves before they can move onto the next stage. This is not a weakness in the project, but rather reflects the nature of change, and which, if continually worked at, could make a big change. Whilst no specific figures are available, the project worker is aware that over the past twelve months, there has been an increase in the number of people consulting their GPs with concerns relating to dementia, as well as an increase in those attending the memory clinic. This may be because more people have attended DFC events, or it may be that they are more dementia-aware generally, or have heard through word of mouth.

Given the nature of many of the informal and sometimes impromptu information-giving events, it is difficult to fully evaluate the impact the project may or may not have had. Certainly, the vast majority of people who have attended events indicated that they have found them informative, clear and their understanding has improved, but for many, they feel they have not yet had an opportunity to put their learning into practice, as they do not know or come into contact with people with dementia. It could be suggested however, that just by having a level of awareness of the realities of dementia within a community setting, the bedrock is there for future development and input.

PROGRAMME IMPACT: Food Train

Accessibility and hard to reach service users

A particular strength of the Food Train project is that it has made an effort to reach the 'hard to reach'. This has been achieved in a number of ways. Firstly the project operates a wide open referral policy. The project manager listed a large number of ways in which older people could come to the service. By far the most common method is self-referral, with service users predominantly hearing of the project through word of mouth. For example, workers in the shops may pass on the information if they see an older person struggling with their shopping. Members of the community including postmen, for example, have also helped by putting leaflets through the doors of older people they know to be isolated or frail. Referrals are also made through statutory and other services, for example GPs, occupational or physiotherapists, social workers, community nurses and hospitals all have leaflets about the food train they can pass out, as well as having the ability to directly refer. The project manager explained that the service is promoted in as many ways as are possible and affordable. The project manager regularly holds talks with community groups such as Elderly Forum branches or church guilds to provide information on the service.

The service does not operate any kind of assessment system, there's no form to fill in, and the staff do not check whether a person is sufficiently frail to require the service. To quote the project manager:

If people phone asking for help then that's good enough… People are often very desperate by the time they come to the Food Train.

The service has further promoted its accessibility by remaining as low-cost as possible to ensure it can be afforded by service users. The charge to customers is the minimum charge set by Companies House, £1 per year, with an additional £1.50 delivery charge to cover costs. This is made possible by employing volunteers, with the only paid member of staff being the project manager who is responsible for all the other tasks involved in running the project.

While this may suggest the potential for 'deadweight', the project manager indicated that there had only been one incident where the service had been misused. In this instance the customer was confronted and the service was stopped, however the offer was given to use the service in the future should the customer's need become greater. The instance of misuse that arose indicates that the project is willing to respond appropriately to ensure the service is reaching those most in need.

Outcome Indicators

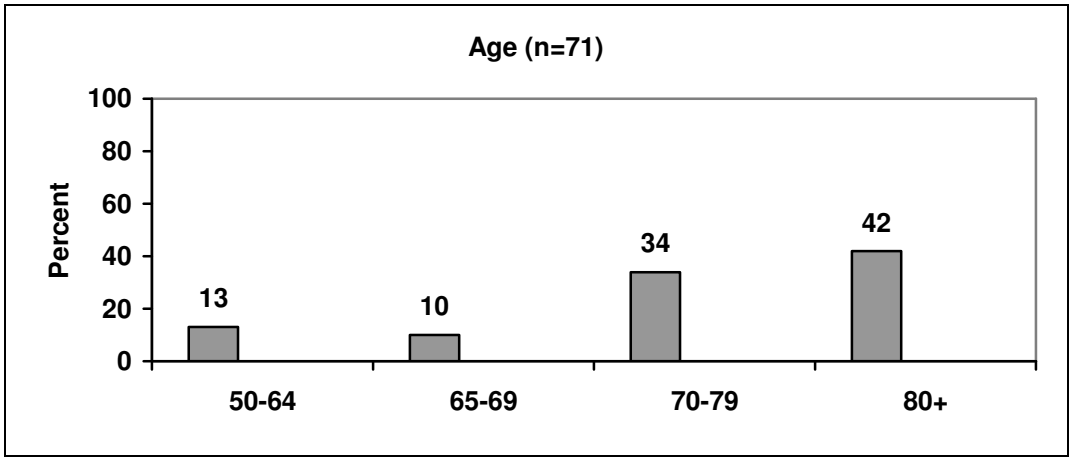
The outcome indicators for the Food Train are:

- Contribute to a reduction in the rate of older people who are housebound needing institutional care.
- An increase in the number of people accessing services without being in a crisis.
- Contribute to a reduction in the rate of older people who are housebound requiring admission to long term care.

- An increase in the number of people accessing preventative services.
- An increase in the community involvement for people who are housebound.
- And increase in awareness of The Extended Food Train Service among the older people of Wigtown West and Mid Galloway.

Respondent demographics
Seventy one Food Train service users completed and returned a questionnaire evaluating the impact of the service, representing a response rate of 47 percent. The questionnaire and full results are provided in Appendix 6. The age range of the respondents can be seen in Figure 7 below:

Figure 7: Age distribution



Nine percent of respondents did not disclose their age. These data indicate that a large proportion, over three quarters, were in the 'older-old' age range that would be expected to be generally more vulnerable. Thirteen percent of respondents were male and 83 percent were female, with the remaining 12 percent providing no response. The very high proportion of women indicates that men were under-represented in the sample.

The majority of respondents, 47 percent, reported living in the Dumfries area, 27 percent reported living in Newton Stewart, 14 percent in Annandale & Eskdale, seven percent in Stewartry, and three percent in Stranraer. The remaining three percent did not provide a response. The vast majority of respondents, 66 percent, reported living alone, with a further 24 percent living with their spouse/partner. One percent of respondents reported living with family members/friends, six percent lived in sheltered accommodation and one percent (1 respondent) indicated that they lived in the Samye Ling Tibetan Centre. The high proportion living alone again suggests that this sample were at the more vulnerable end of the spectrum, lacking the support of people living within their home.

Respondents' mental and physical health
Consistent with their need for the Food Train service, the majority of respondents rated their physical health as fair, 47 percent, or poor, 23 percent. Sixteen percent of respondents rated it as good, seven percent as very poor. Mental health was rated much more highly by the majority, with 68 percent reporting it as good, 24 percent as fair, four percent as poor and only three percent as very poor. When asked whether

they had experienced changes to their health in the previous three years, a clear majority, 89 percent, answered in the affirmative and 11 percent indicated no change. Qualitative comments were sought in the questionnaire to expand on these answers, and 91 percent of those who had indicated change, provided further information. The main complaint reported by 29 respondents was reduced mobility, and this is consistent with respondents experiencing difficulty getting their shopping and therefore using the service. A number of respondents also indicated the main change was increased pain, such as that caused by osteoarthritis or sciatica. For other respondents the change to health was the result of acute and chronic illness including coronary heart disease, cancer and stroke. Again these conditions correspond to the need for the Food Train service. A few respondents attributed change to a general decline in their health, characteristic of increasing age, including increased tiredness and loss of energy. Three percent of respondents indicated an improvement to their health, one of which was the result of a double hip replacement in the previous year.

Duration of service use

Respondents were asked to indicate how long they had been using the service. It is likely that these are mainly subjective estimates of the duration and therefore should be taken as an approximate measure only. Seven percent reported using the service for three months or less, 27 percent reported using it for between three and six months, 17 percent reported duration of one to two years, and finally 44 percent reported using the service for longer than two years. The remaining five percent provided no response. These responses suggest that the survey obtained a reasonable spread of new and old users. It is unsurprising that a large proportion reported using the service for over two years as this is in line with the large number who lived in the Dumfries area where the service originated and ran prior to the BNSF funding.

Service user satisfaction

The survey asked respondents to rate their overall satisfaction with the Food Train. None of the respondents reported overall dissatisfaction with the service. Three quarters, 76 percent, indicated that they were very satisfied, with another 20 percent reporting that they were satisfied. To have such a high proportion rate themselves as 'very satisfied' is a considerable achievement of the project and these reports provide clear evidence that the service provided is highly valued by its users. Satisfaction with the availability of the service produced similar results, with 69 percent reporting that they were very satisfied, and 28 percent that they were satisfied. Only one percent reported dissatisfaction. Sixty three percent indicated that they were very satisfied with the amount of contact with the project staff, and 31 percent stated that they were satisfied. One respondent qualified their satisfaction by indicating that the shops used by the service did not provide all the items required and that this meant they continued to request other help from friends and family. The remaining comments were positive, with respondents praising the professionalism and kindness of the Food Train staff. Evidently the quality and 'quantity' of the Food Train service are greatly esteemed.

The questionnaire asked about changes to the service that respondents had noticed since using it. Again, the majority of comments provided were positive, referring to the growth of the service and the increase in volunteers. These comments can be attributed to the impact of the BNSF funding and the consequent expansion of the

service. A negative comment was made by one respondent regarding a slight increase in the charge paid for the service.

Respondents were asked to indicate whether they received other forms of help with daily living activities. A large proportion, 65 percent, indicated that they did receive other help, with 31 percent not receiving other help. The most common form of help received was privately organised help in the garden, used by 55 percent of respondents. Fifty percent reported receiving regular help from family, friends or neighbours, 47 percent reported receiving privately organised help in the home and 37 percent also indicated receiving social work or NHS aids and adaptations. These other forms of help provide further evidence of the vulnerability of respondents and their need for support to remain living in their home.

Quality of life

In order to assess the effect of the project on quality of life, respondents were asked whether they felt their quality of life had changed as a result of using the service. An overwhelming majority indicated that their quality of life had improved, with 68 percent reporting it was much improved, and 16 percent reporting it was a little improved as a result of the service. Six percent reported no change to their quality of life, one percent reported that it was a little worse, and 10 percent provided no response. These data provide a clear message that the project was achieving its aims, producing a profound, positive change in service users' quality of life.

Figure 8: Impact of the Food Train on Key Areas of Quality of Life

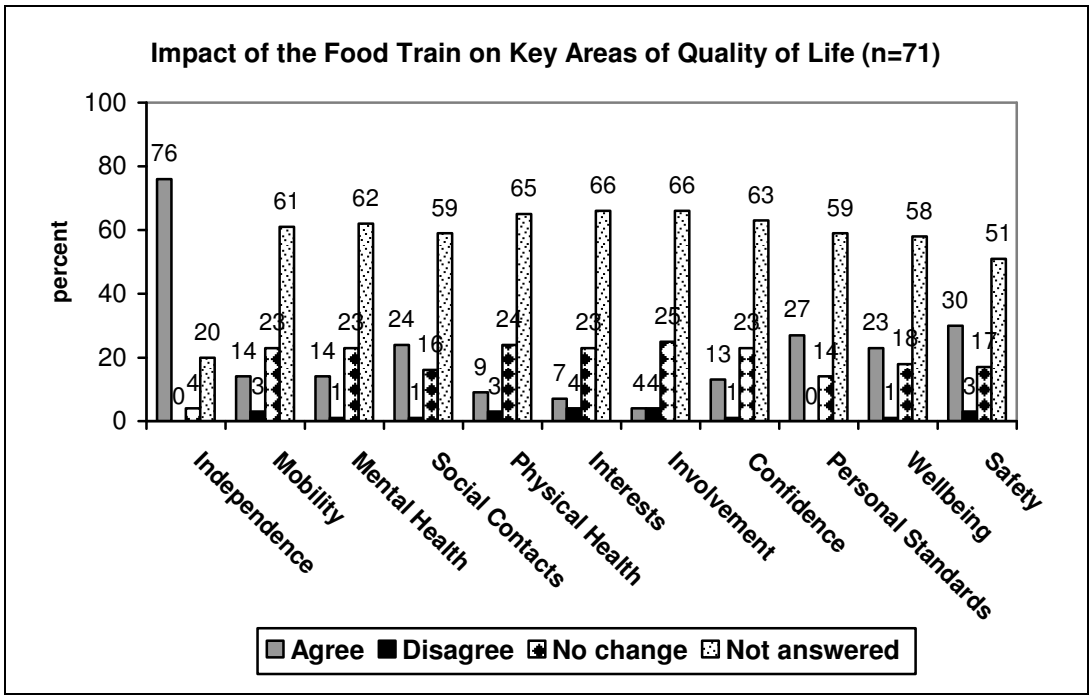


Figure 8 provides a bar chart indicating the impact of the service upon key areas of quality of life. What will be most noticeable in all the charts is the high proportion of questions that were not answered, signified by large columns in the chart for that response. Some respondents will have not answered the questions because they perceived no change to this area of their quality of life. These data may therefore be

taken, in part, as an indication of 'no change'. Importantly though, for other respondents, the lack of an answer is indicative of their difficulty or reluctance to fully complete the questionnaire. Quality of life is a difficult concept to consider; therefore some may have missed the question out for that reason. It is a limitation of the questionnaire method of data collection that people can find the effort involved in completing the questionnaire laborious, and this can result in missing data. It is also a particular limitation of this study that the population surveyed are older people, many of whom are vulnerable due to ill-health or frailty. These factors increase the likelihood of incomplete questionnaire returns. An alternative method of data collection such as one-to-one interviews may have enabled in-depth exploration of these unanswered areas and thereby increased the data obtained. However, within the time and budget constraints of this evaluation such methods were not feasible.

By far the most significant finding is that 76 percent of respondents agreed they were more able to live independently as a result of the project. When compared to the proportion of non-responses, this is particularly interesting as it suggests a high motivation by respondents to report this effect. The implication is that the Food Train has made a very significant contribution to the headline outcome of keeping people in their own home for longer. Only 4 percent of respondents reported no change to their ability to live independently and 20 percent provided no response.

The chart also demonstrates that the service has had an impact across all the key areas of quality of life for some service users. After independence, the biggest impact was upon safety, with 30 percent indicating they feel more assured of their safety. Two possible reasons for this impact are suggested. Firstly, service users may feel safer as a result of the regular interaction with the Food Train staff. This may provide reassurance that someone is checking on them, and relieve concerns about what might happen should they be having difficulties. A second possibility is that respondents feel more assured of that their health is safe due to the reliable provision of food and other necessities.

The next largest impact of the service was upon respondents' wellbeing. Twenty three percent indicated that their feeling of wellbeing had increased as a result of the service, with one percent disagreeing, 18 percent reporting no change and the remaining 58 percent providing no response. Three reasons for this impact are suggested. Firstly, at later points in the survey, respondents provided qualitative information that indicated they were feeling an improvement for no longer having to worry about carrying shopping, and no longer experiencing the physical exertion involved in this task. These two benefits are likely to have increased the wellbeing of some service users. A second possibility is that the input from the staff, the regular contact and interaction provided, had a positive effect on wellbeing through the reduction of isolation. Twenty four percent of respondents indicated that the quality and quantity of their social contacts had improved as a result of the service, which supports this suggestion. Finally, a third possibility is that the provision of healthy food may have improved the diet of respondents and consequently increased their sense of wellbeing.

Twenty seven percent of respondents indicated that they felt more able to maintain their personal standards as a result of the service. These data would suggest that the service had an important role in allowing respondents to keep to their standard of

living, for example by eating the food they prefer. Fourteen percent of respondents indicated that their mobility had improved. The most likely reason for an improvement to mobility is the end of the exertion of having to go food shopping. For some respondents attempting exertion of this kind may have exacerbated mobility problems. Fourteen percent indicated that their mental health had improved. Again, this positive impact may have come from the increased social contact provided by Food Train staff, or from the reduction of worry or anxiety about being able to obtain groceries. For 13 percent of respondents the service had resulted in an increase in self-confidence. This change to confidence may be linked to an improvement in mental health, or by the ability to maintain personal standards.

Nine percent of respondents indicated that their physical health had improved. It is not surprising that the impact on physical health was small, given that a large proportion suffered from chronic and acute conditions that may be unlikely to improve. For those who did experience an improvement to physical health, this may have been the result of the improved diet or reduced exertion suggested earlier. Seven percent of respondents indicated that they were more engaged in interests and activities that they enjoy. A large proportion of the respondents are likely to have been housebound or have limited ability to 'get out and about', therefore this small impact is, again, not surprising. To the extent that there was an improvement, this may have been indirectly through the increase in social interaction. The Food Train may also have provided items in the shopping, for example reading materials or luxuries that respondents value but have difficulty obtaining. Finally, four percent reported feeling more involved in their community. Through the regular interaction with the Food Train volunteers there was an expectation that some respondents may have felt more involved with their community through hearing news and sharing interaction with the staff. This may explain the small number who reported an effect; however the proportion is slightly less than might have been anticipated.

Respondents were asked if they felt they would still be able to live independently if they had not used the food train. Forty percent indicated that they would be able to continue living independently, while 44 percent indicated that they would not, and 17 percent provided no response. These findings provide further evidence that the Food Train has contributed to the headline outcome of keeping older people in their own homes. This evidence is made more compelling by the qualitative comments provided. For those who indicated that they would be able to continue living independently, it was clear that to do so without the service would for many be much more difficult. For example, some respondents indicated that they would have to conduct several shopping trips and carry fewer items at a time. Some respondents explicitly indicated that they could remain living independently but would have to rely heavily on friends and family for assistance.

Yes, but I would make more claims on relatives who help me.
My family would have rallied round if necessary.

For those who did not feel they could live independently, the reasons were mainly that they were housebound or unable to shop alone, or lacked the support of others who could assist them.

Difficult getting out of the house at the moment and driving at present.

I cannot use what little transport there is and I cannot manage to shop on my own. Neighbours not willing to shop for me.

Others gave specific health reasons that would prevent them from being able to get their own shopping.

Partially blind and disabled.
Carrying heavy load of food puts strain on my back and legs.

Most important benefit

Evidently for some users the provision of this service is necessary for them to remain living in their own homes. Respondents were asked what the most important benefit of the service was, and the majority, 23 percent, responded with 'independence'. Without the service some users would have to get their shopping themselves. This would involve physical exertion that over time may be detrimental to their health. Many respondents indicated that the biggest benefit was an end to the burden that shopping had become. Without the service, others would have to rely on family and friends for shopping. This can create anxiety if people have concerns about being a burden or about the reliability of others in providing this support. For example, some respondents indicated that the most important benefit for them was the relief of not having to worry about the shopping. The feedback suggests that in removing these concerns, Food Train may have an important preventative role in protecting both physical and psychological health.

Added value

Beyond the direct impact of the Food Train upon its service users, there is evidence that the project has had a positive impact on other vulnerable populations. This is a key added value of the service that was achieved through the creation of volunteer opportunities. The project manager explained that Food Train have links with a department of the council called Hope Service, which is an employment and voluntary provider for adults with learning difficulties and physical difficulties. Over its period of operation the project has employed various volunteers from this department and at the time of interviewing there were three currently employed from that source. The project also has taken on placements through New Deal, where volunteers can be employed for thirteen weeks at a time. Finally the project has links with the National Schizophrenia Fellowship (NSF) whose employment coordinators and support workers seek out work for individuals with long-term mental health problems. For all of these volunteers the opportunity of working with the Food Train provides learning and experience in an environment that is less pressurised than the regular workplace, which for some may enable a return to work. The project manager indicated that no-one who was physically capable of the work would be turned away, and that everyone's contribution to the project was equally valued. Moreover, the benefit to volunteers was described as a 'power shift' such that they went from being the dependent to the one depended upon. The consequence of this shift was the promotion of their confidence and self-esteem. This method of volunteer recruitment and the resultant benefit to the volunteers was a positive but unintended impact of the project. The manager did not seek these partnerships out, but was approached by the services and capitalised upon the opportunities when they arose. As a result, the project is contributing to the social inclusion of three vulnerable groups over and above the value for older people, namely, adults with learning difficulties,

disadvantaged younger people and adults with mental health problems. This is a key impact of the project on the wider Dumfries and Galloway communities.

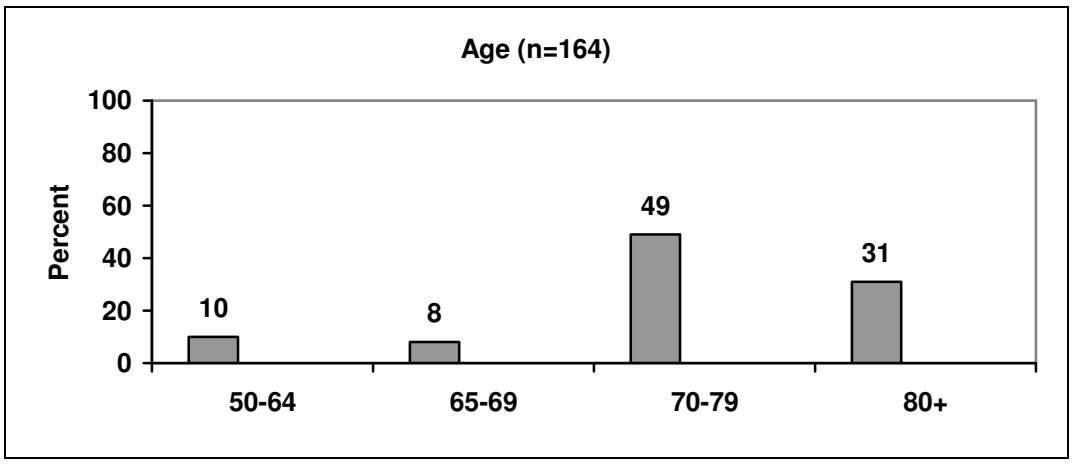
PROGRAMME IMPACT: Home Fire Safety Checks

The main outcome for the Home Fire Safety Checks is to provide an improved quality of life for older people by identifying and minimising the risk of fire in the home, and, as a consequence, reducing injuries.

Respondent demographics

One hundred and sixty four people who had received a Home Fire Safety Check completed and returned a questionnaire, giving a response rate of 36 percent. The questionnaire and full results are provided in Appendix 7. A third of respondents were male, and two thirds were female. The age distribution can be seen in Figure 9 below:

Figure 9: Age distribution



A large proportion of the respondents were from the potentially more vulnerable age group, particularly in terms of being at risk of trips and falls in the home. A quarter of respondents, 27 percent, reported living in the Dumfries area, and another quarter, 26 percent were from the Stewartry region. A further 20 percent reported living in Annandale and Eskdale, 14 percent in Newton Stewart, six percent in Upper Nithsdale and five percent in Stranraer. Only three people did not provide a response.

All 147 respondents who answered indicated they were of White European ethnicity, with seventeen non-responses. The majority of respondents, 58 percent, reported living alone, 35 percent reported living with their spouse/partner, and 4 percent stated that they lived with a family member (2), and a carer (1). The high proportion of people living alone, and in the older age bracket, again suggests possible increased vulnerability with regard to awareness of and exposure to fire and safety risks in the home.

Respondents' mental and physical health

As the people who received this service were selected from the general older population, it was perhaps not surprising, but also rather encouraging, to see that nearly half of the respondents, 47 percent, reported their physical health to be good, and slightly fewer, 44 percent, reported it to be fair. Five percent of respondents indicated their health was poor, and one percent rated it as very poor. Mental health was given much higher ratings, with the vast majority, 79 percent, rating it good, 16

percent rating it fair, and one percent giving it a rating of poor. When asked whether they had experienced a change to their health in the previous three years, just over half, 52 percent said yes, and 43 percent said no. When asked for examples, multiple reasons were given, with reduction in mobility, general deterioration, often attributed to ageing or 'wear and tear', arthritis, having less energy, feeling more tired, worsening eyesight and poorer memory being the most commonly reported. Two respondents reported depression and low mood. One respondent reported that their health had improved, but did not specify how.

Service user satisfaction

The questionnaire asked respondents to rate their overall satisfaction with Home Fire Safety Checks. Over three quarters, 78 percent, of the respondents indicated that they were very satisfied, and the remainder, 17 percent, indicated they were satisfied. This is a very positive finding, indicating that the service is highly valued by its users. This finding may, in part, be attributed to the high quality service provided to people within the comfort and safety of their own home, free of charge. Slightly lower, but still high levels of satisfaction were given by respondents when asked to rate their satisfaction with the availability of the service. Sixty eight percent said they were very satisfied, and 24 percent said they were satisfied. One respondent indicated that they were dissatisfied. Similarly, when asked to report whether they felt that the amount of contact they had had with service staff, 61 percent said they were very satisfied, and 27 percent said they were satisfied. The same respondent as before indicated they were dissatisfied, qualifying their rating by saying *"know nothing about them - no advance warning of visit"*, although it should be noted that the service had to be requested.

Quality of life

Respondents were asked to indicate the extent to which the Home Fire Safety Check had impacted upon their quality of life. Given that this is a one-off intervention delivered within a day, it would not be expected to have a huge impact. Nonetheless, a reasonable proportion of respondents, 16 percent, indicated that their quality of life was much improved, and 20 percent indicated it was a little improved as a result of the service. Forty eight percent indicated there had been no change, and the remaining 16 percent did not respond. Forty nine percent of respondents qualified their answer as to how their quality of life had been affected, with many respondents appreciating the benefits of having a smoke detector fitted.

Smoke detector big help.

Some of these responses moreover indicated the importance of the service in providing 'that little bit of help' by removing the need to carry out small, but difficult tasks.

I no longer worry about getting the ladders to change the battery in the smoke alarm. What a bonus, I hope I last as long as the 10 year alarm!

For other respondents the check increased their awareness of practical safety precautions such as removing plugs.

Fireman point out little things that older people have thought not to be risks.

Small details brought to our attention of which we were previously unaware.

For the respondents who reported no change to their quality of life, the qualitative responses illuminated why. For some it was because the checks simply served to reassure that they had already been doing the right things.

I must have been doing the right things before the visit.
The officer told us that we had taken every precaution available.
Because I was very fire conscious before the checks.

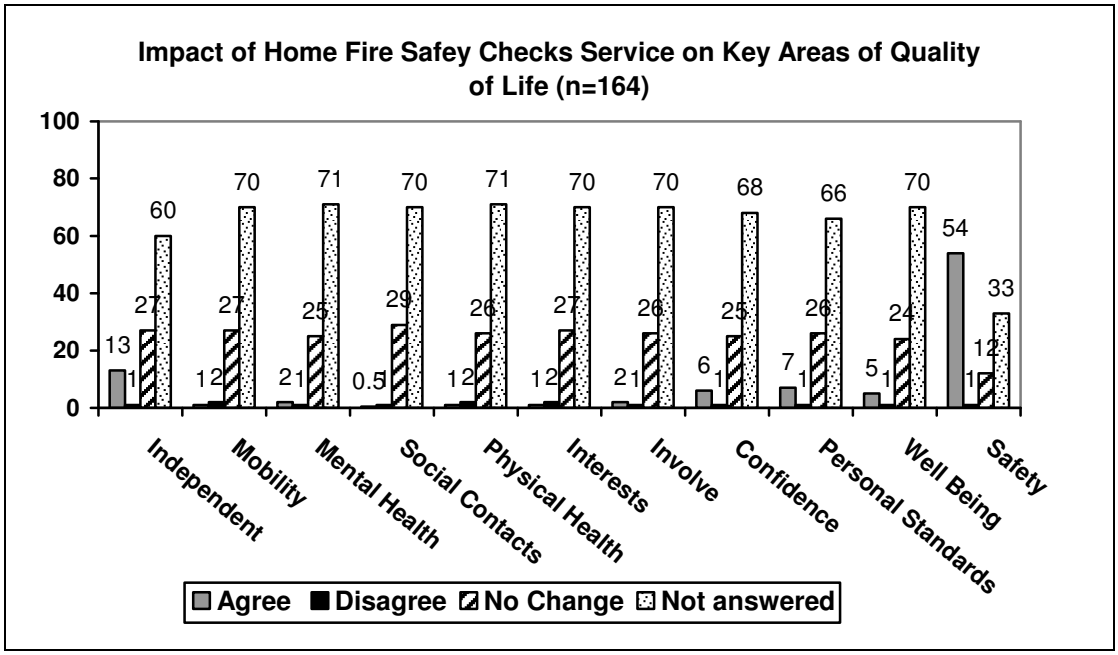
For some respondents the check was appreciated but the intervention was perceived as too small to impact on quality of life.

I only needed a smoke detector and I got some advice on keys.

The responses that indicated ways in which the project had improved quality of life lend further support to the importance of providing small services around the home that add up to an important impact. The value of these services should not be underestimated as their longer-term impact may be great. That so many older people did make a connection between this short intervention and their quality of life indicates the value of the service.

Respondents were asked to indicate their agreement with a series of statements indicating the impact of the project on aspects of their quality of life (see Figure 10 below).

Figure 10: Impact of Home Fire Safety Checks Service on Key Areas of Quality of Life



Thirteen percent of respondents indicated that the project meant they felt more able to live independently. One percent of respondents disagreed, 27 percent reported no

change and 59 percent did not respond. This is a small proportion, however given the earlier stated limitations of the intervention it is a surprising positive contribution to the headline outcome of enabling older people to live at home for longer.

Consistent with the nature of the intervention, only a small number of respondents indicated that the project had improved their mobility, their mental health, the quality and quantity of their social contacts, their physical health, their engagement in interests and activities they enjoy, and their involvement in their community. A still small, but slightly higher proportion, reported that the project had increased their self-confidence, enabled them to maintain their personal standards, and increased their feeling of wellbeing. These impacts may have been mediated through the assurance of safety that a large proportion, 54 percent, indicated had been provided by the project. In feeling safer, older people may feel more relaxed, thereby improving their wellbeing. A suggested reason for the impact on personal standards is that older people may have a high standard of safety for their home that is difficult to maintain with increasing age. Through the project's intervention this standard may have been achieved. The improvement in self-confidence is difficult to explain, however it is possible that some respondents interpreted self-confidence to mean feeling at ease, and the assurance of safety may have encouraged this feeling.

It should be pointed out that a large number of people did not respond to these questions. Evidently the Home Fire Safety Checks do not have a strong impact across the board of quality of life and as was stated, this is to be expected. The preventative nature of the intervention means that it is not alleviating a problem that older people are aware of; so much as it is putting in place measures to ensure that no problem should occur. Having not been aware of any risks to their safety, the service users did not perceive any impediment to their quality of life that the service addressed. Rather, the project's main impact was to provide reassurance for the future that the service user's safety was safe-guarded. The exception to this general assertion, are those service users for whom the project did in fact alleviate an identified problem, such as the respondent for whom the ten year alarm removed the effort and risk involved in climbing ladders to check and change the batteries. In response to a later question, one respondent provided more evidence of this type of effect, indicating that he was no longer so capable of taking the necessary precautions and that his wife did not have the knowledge to do so.

My wife has no electrical knowledge and I am too shaky for steps or ladders.

Respondents were asked to indicate if their quality of life had improved in any other ways as result of the project. Some respondents highlighted how approachable and accessible the fire officers had been when delivering the service. Other respondents reiterated that the project had increased their feelings of safety or peace of mind. The practical safety advice provided by the project was emphasised by some:

Alerted to the fact that electric blanket was unsafe due to age.

The questionnaire asked whether service users felt they would still be able to live independently without the project. Again, as would be expected, only a small minority, five percent, indicated they would not, with 69 percent indicating they would and 26 percent providing no response. Of the respondents who said they

would be able to live independently, a large proportion provided further explanation. Of these, many indicated that they were fit and well and therefore felt they could live independently for some time. Others indicated that they were not in need of any help other than that given during the check.

I just wanted to be sure that I hadn't missed any problems.
Because I didn't need any other help than checking for fire hazards.

Added value
The survey asked respondents whether the project had made a difference to the people close to them. The majority of respondents either said no, 37 percent, or did not respond, 38 percent. However, 26 percent did note an effect, and some qualitative feedback was given to illuminate this. For some the effect was to reassure relatives and promote their peace of mind about the safety of the service user. Other respondents indicated that they had passed the information learned to other people.

One much older neighbour didn't have a smoke alarm.
We discussed with our three grown up children the advice we had been given, they appreciated the discussion.

These responses suggested that an added value of the project is through the cascading of information from service users to others in the community.

Respondents were also asked whether they thought the project had made a difference to their contact with other service providers. This was asked to provide evidence for the referral system in place whereby the fire officers would refer service users to BNSF or other agencies if a need was identified. Only five percent indicated that the project had made a difference, with 57 percent saying it had not, and 38 percent giving no response. Importantly, the one respondent who qualified their answer highlighted that the service had made them feel more comfortable in contacting services.

It makes me feel I can contact other services when required.

Later in this section the role of these projects in developing a friendly face which promotes the accessibility of statutory services is explored. The above quote provides evidence to support this assertion of added value in the project.

Suggestions for change
Respondents were asked if they had any suggestions for changes to the service and 12 percent provided feedback. Two respondents indicated that the alarm was fitted too high. One respondent suggested that all older people should be provided with the service. Four respondents enquired as to whether the service would be followed up in future.

Most important benefit
Respondents were asked to indicate what had been the most important thing that the service provided. Sixty two percent gave a response. Eight percent highlighted their peace of mind, eight percent their increased reassurance, and seven percent noted the increase in their confidence. A large proportion, 12 percent, noted the importance of

having a smoke alarm fitted, and five percent the benefit of knowing escape procedures in the event of a fire. Again, supporting the assertion that the service promotes the accessibility of the fire service more generally, a few respondents highlighted the approachability of the staff.

Other comments

Finally respondents were asked to indicate any other comments they had about the service. The vast majority of these comments centred on providing praise for the staff and gratitude for the service.

The local fireman who visited was very thorough, very professional, and spent a great deal of time reviewing and advising, on a follow up visit the extra fire alarm was fitted. An excellent service.
Very grateful for fitting 10 year smoke alarm and all concerns re: house safety, gas, electricity, well explained by local fireman at Dumfries. At age of 78 there are many things you are unable to do with a heart condition.

Other comments again indicated the cascading effect of providing knowledge and advice that is passed on throughout the community.

In every case people I contacted and who contacted me were most helpful and now I have been 'spreading the Gospel'. I wish to express my thanks for this service.

All of these comments support the general message that the service was highly valued, and in particular highlight the quality of the project as excellent.

PROGRAMME IMPACT: Podiatry

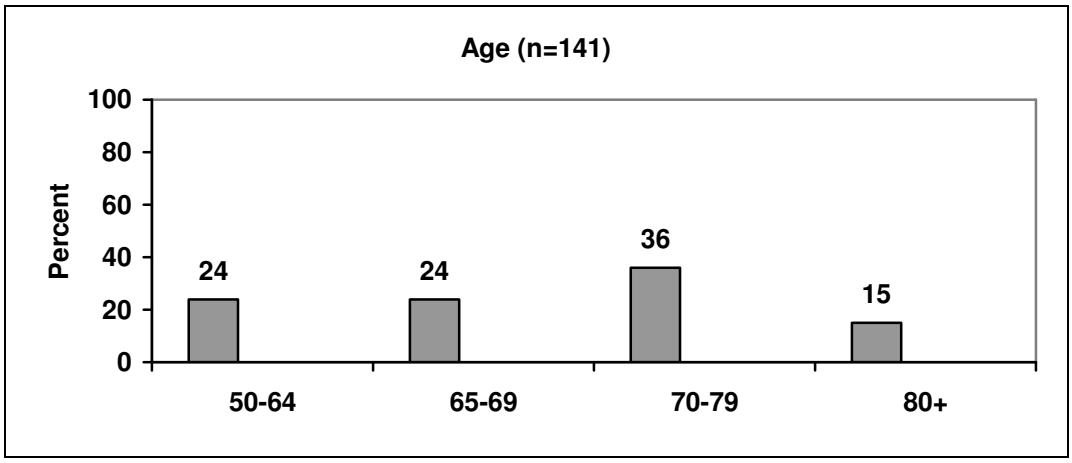
The outcome indicators for Podiatry are:

- Contribute to a reduction in the rate of older people needing podiatric institutional care.
- An increase in the number of people accessing services without being in a crisis.
- Contribute to a reduction in the rate of older people requiring admission to long term care.
- An increase in service user satisfaction.
- An increase in the number of people accessing preventative services.
- An increase in awareness of the Improved Delivery of Podiatry Services among older people of Annandale & Eskdale and Dumfries & Nithsdale.

Respondent demographics

One hundred and forty-one Podiatry service users completed and returned a questionnaire evaluating the impact of the Podiatry service, representing a return rate of 32 percent. The questionnaire and full results are provided in Appendix 8. Male respondents made up 47.5 percent of the sample, and 52.5 percent were female. The age range of respondents can be seen in Figure 11 below:

Figure 11: Age distribution



Thirty eight percent of respondents were from the Dumfries area, representing the largest proportion. Twenty three percent were from the Annandale & Eskdale area, 14 percent were from the Upper Nithsdale area, 14 percent were from the Newton Stewart area, 9 percent were from the Stewartry area and finally 2 percent were from the Stranraer area. The vast majority of respondents, 59 percent, reported living with their spouse/partner. Thirty two percent reported living alone, 8 percent lived with family members/friends, and one respondent lived in sheltered accommodation and another lived with their carer housekeeper.

Respondents' mental and physical health

Forty one percent of respondents rated their physical health as good, with a slight majority, 45 percent, reporting it as fair, 12 percent rated it as poor and 2 percent as

very poor. Mental health was rated much more positively, with the vast majority, 77 percent, reporting it to be good, 18 percent rating it as fair, 4 percent as poor and only 1 percent as very poor. Seventy one percent of respondents indicated that their health had changed in the last three years, 28 percent said it had not changed and 1 percent did not respond. Of the 100 respondents whose health had changed, only one did not provide information as to how. The majority of complaints were of acute and chronic illnesses including stroke, heart disease, and diabetes. Newly diagnosed diabetics are referred for Podiatry treatment therefore it is predictable that this condition would feature. Six percent of respondents specified problems with their mobility and a further 1 percent indicated foot-specific complaints. Other complaints were linked to increasing age and the consequent deterioration of health, rather than the result of acute or chronic conditions. For example 8 percent reported having less energy and feeling more tired. The range of complaints provided serves to explicate the cause of the large proportion rating their health as 'fair'. Three percent of respondents indicated that their health had actually improved over the past three years, and notably one of these was the result of diagnosis and subsequent treatment of diabetes. It is possible that this was recorded as an improvement because the condition was now under control and the respondent may have experienced an improvement in how they felt, in spite of the diagnosis ostensibly representing a decline in health.

Waiting time for service

Service users were asked how long, if at all, they had to wait to receive the service from Podiatry. Forty eight percent of respondents indicated that they had received the service within 6 weeks, as intended by the charter guarantee. Twenty one percent indicated that they waited between 7 and 12 weeks and 15 percent indicated they waited over 13 weeks for the service. The remaining 16 percent did not specify how long they waited. It is important to note that these data are subjective and rely on the service user accurately recalling the waiting time of treatment they may have received some time ago. Moreover, it is not possible to say how long the 16 percent who did not respond waited for their treatment. Nonetheless, it is disappointing to find that less than half of respondents reported being seen within this period.

Service user satisfaction

The overall satisfaction reported with the service was very high. Forty five percent of respondents reported that they were very satisfied, and 44 percent reported they were satisfied with the service overall. Three percent indicated that they were dissatisfied and 3 percent that they were very dissatisfied with the service. A further 5 percent did not provide a response. Greater dissatisfaction was reported with the availability of the service, although this was still rated very positively. Thirty eight percent reported that they were very satisfied and 42 percent reported they were satisfied with the availability, with 11 percent reporting they were dissatisfied and 1 percent very dissatisfied with the service. A further 8 percent provided no response. Finally 42 percent reported that they were very satisfied, and 44 percent were satisfied with the amount of contact they had with the project staff. Four percent were dissatisfied and 1 percent very dissatisfied with the amount of contact received, with a further 8 percent providing no response. These ratings of satisfaction provide evidence that the target population predominantly both value the service and approve the quality and quantity of its provision. The qualitative comments provide further explanation of these reports. The majority of comments elaborated on dissatisfaction, with 15 percent indicating that they felt they waited too long between appointments.

An appointment every 10 weeks leaves my toenails uncomfortably long.
Every 8 weeks would be better than every twelve weeks.

Positive feedback included comments about the improvements to health that were experienced following treatment.

Because my foot is comfortable after being there.
Satisfied, feel comfortable after the service.

These comments serve to highlight the value of ongoing treatment for existing patients to maintain their health. The emphases placed on comfort from both the positive and negative comments moreover suggest that treatment not only has an impact on health but also on the patient's feeling of wellbeing. While some medical interventions may not result in a perceptible difference for patients, podiatry treatment is evidently necessary for the prevention or reduction of pain and discomfort.

Very few respondents noted any changes in the service since using it. This would suggest that the impact of the BNSF Podiatrists was not noticeable to respondents. An important reason they identified was that they had used the service too infrequently to comment on changes.

Other services used
Respondents were asked whether they received any other help with daily living activities. The majority of respondents did not receive any formal help and the largest proportion attributable to formal help was with social work aids and adaptations received by 15 percent. Twenty four percent also indicated that they received regular help from family, friends or neighbours. The high proportion reporting good mental and physical health, together with the majority of respondents not yet having the need for formal support, would suggest that these respondents are primarily at the less vulnerable end of the spectrum.

Quality of life
Respondents were asked whether the Podiatry service had impacted upon their quality of life. The majority of respondents, 33 percent, reported that their quality of life was much improved by the service and a further 26 percent indicated it was a little improved. Twenty six percent reported no change to their quality of life, and 1 percent reported it was a little worse. Finally, 14 percent provided no response. Overall the survey therefore indicated that the Podiatry service had a positive impact on the quality of life of 59 percent of respondents. A large number of respondents provided qualitative information to explain these reports. For 19 percent the most significant benefit was the ability to rely on better and regular foot care which provided peace of mind.

I have been guided on how to have 'healthy feet' and fungal infection has mostly receded.
My feet being taken care of is a big help to me.

Also significant was that a large number explicitly identified an increase in their mobility and consequently, their motivation and ability to engage in exercise.
Feel like walking after I receive treatment.

I have been able to resume my countryside walking.
Regular treatment increases mobility.
Because I do a good bit of walking and feel the better of it.

These responses are salient because they support the assertion that Podiatry contributes indirectly to the promotion of general health and the prevention of illness, for example by increasing exercise and reducing the risk of heart disease. Moreover, they explicate the role of Podiatry treatment in other aspects of quality of life, such as the ability to engage in interests and activities that are enjoyed, and the promotion of social inclusion by enabling people to continue to get 'out and about'. A number of respondents highlighted the importance of treatment in tackling pain and discomfort in the feet

Feet feel better.
Since having my shoes padded to relieve pressure on the soles of my feet (with suspected arthritis) there has been a big improvement.
Discomfort had in feet all adult life (suspected cause fashionable shoes in youth) disappeared. Why do we have to wait until we are 65 years of age?

Interestingly some respondents explained that there had been no change to their quality of life because the Podiatry treatment was only provided as a check-up and part of diabetes preventative treatment. Having had no problems identified there was no improvement to be made.

So far the diabetes has not affected my feet to any extent.

These findings are important because they indicate that the impact on quality of life by the service may in fact be higher than the data suggest. If the data were focused on patients referred because of problems with their feet, and exclusive, for example, of asymptomatic diabetic referrals, the reported impact on quality of life may be greater.

One patient indicated that their quality of life was a little worse as a result of the service. The reason provided was that the service was too infrequent and inaccessible.

Because of difficulty in getting to and from health centre and waiting longer between nail cutting.

While this comment indicates dissatisfaction with the service, it also supports the decision to increase the input into the Podiatry service to reduce waiting times by emphasising the importance of the service.

Figure 12: Impact of Podiatry Service on Key Areas of Quality of Life

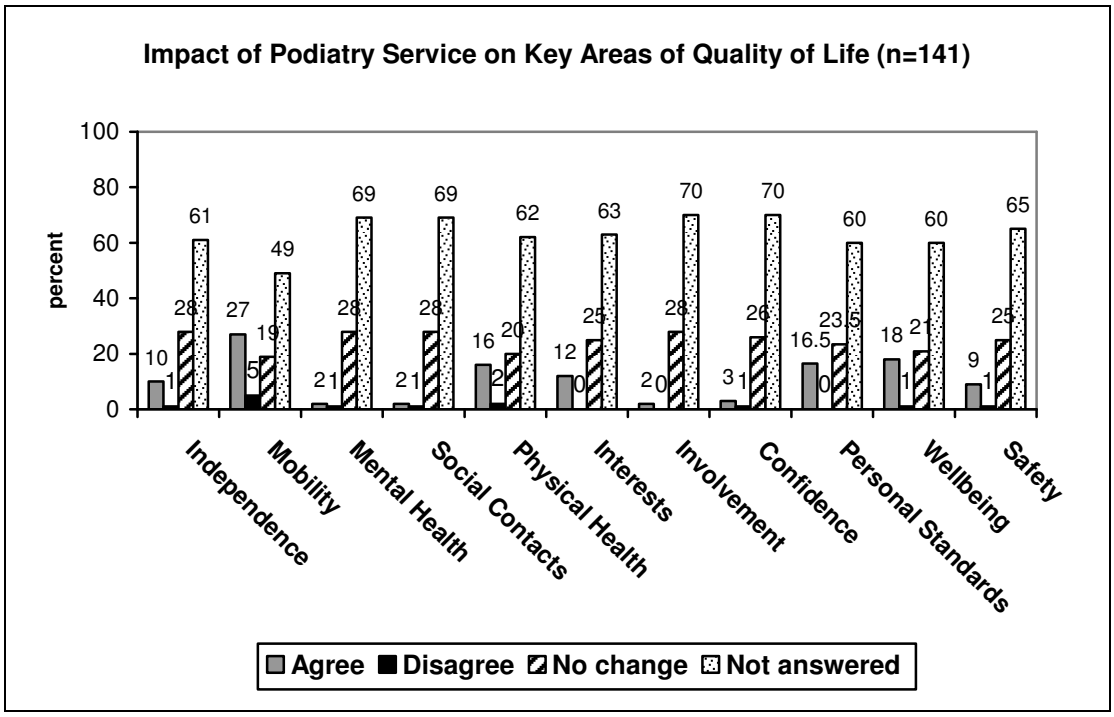


Figure 12 indicates the reported impact of the Podiatry service on the key areas of quality of life. The bar chart demonstrates that Podiatry had an impact on all areas, with a particular effect upon mobility, physical health, wellbeing, personal standards and engagement in interests and activities. The most significant impact was on mobility, with 27 percent indicating that their mobility was improved as a result of the service. Sixteen percent reported that their physical health had improved, and 18 percent reported an improvement in their wellbeing. These findings demonstrate that the treatment provided was having a positive effect on physical health and wellbeing. Sixteen percent also indicated that they felt more able to maintain their personal standards as a result of the service and finally 12 percent reported that they were more able to engage in interests and activities that they enjoyed. It is likely that this increased engagement in interest and activities was the result of improved mobility and physical health.

Ten percent of respondents indicated that they felt more able to live independently as a result of the service. Consistent with this response, 57 percent indicated that they would still be able to live independently without the service, 9 percent felt that they would not be able to continue living independently, and 34 percent provided no response. While the proportions are relatively small, it is quite a significant finding given that the Podiatry service would not be expected to have a direct effect on independent living. Rather the impact of the service on independent living would be expected to occur indirectly through the promotion of other areas of quality of life and health that prolong the ability of the older person to self-care. That 10 percent consider the project as promoting their ability to live independently and 9 percent do not feel they could do so in its absence, is therefore a surprising positive contribution of the service to the BNSF headline outcome.

Respondents indicated that the service also had an impact on other areas of quality of life although this impact was much less. Nine percent of respondents reported more assurance of their safety, 2 percent reported that the quality and quantity of their social contacts had improved, and for 3 percent of respondents the service had resulted in an increase in self-confidence.

Overall these data provide clear evidence that older people perceive a positive impact from the Podiatry service. Through the improvements to mobility and physical health the service has the potential to increase social inclusion by enabling patients to engage in interests and activities they enjoy, maintain their social contacts and continue to mix in their community. The qualitative feedback and quality of life responses indicate that without the service older people can suffer from pain and discomfort in their feet that pose a barrier to such activities.

Added value

A high proportion of respondents, 57 percent, indicated that the service had made a difference to people close to them. For many respondents the main benefit was in not having to rely on people close to undertake foot and nail care, such as cutting toenails.

Because my wife couldn't cope with the cutting of the nails etc.
I don't have to impose on my husband to cut nails.

Other responses indicated that the service promoted the peace of mind of people close by reassuring that the respondent's feet were healthy.

My wife is happier with the condition of my feet.

For some service users the important benefit was the continuation or resumption of joint activities that pain or discomfort in the feet would prevent the respondent from undertaking. These responses provide further evidence of the role of the service in reducing isolation and promoting inclusion.

We are once again able to walk for exercise, though not as much as previously.
Able to go for long walks together. More content, happier.

Finally a minority reported that they complained less as a result of the treatment and were therefore more enjoyable company.

I don't have the pain so I don't moan.
My husband doesn't have to listen to my complaints.

These responses provide clear evidence of the far-reaching impact of this project through the promotion of health and mobility and the reduction of pain and discomfort. It is possible that the contribution of the project to the ability to live independently was mediated through these improvements to quality of life.

Most important benefit

Respondents were asked to indicate the most important benefit of the service, and these responses further highlighted the reduction of pain and discomfort, the peace of

mind of having healthy feet, and the importance of being able to engage in walking and exercise.

Have my feet looked after by experts and have no worry about my feet.
Peace of mind that regular check-up will identify any possible infections and problems.
Comfort – being able to wear shoes comfortably again.
Wonderful to have comfortable feet.
Reduced foot pain.

Other comments
Respondents were finally asked for any other comments regarding the service. Some respondents raised concerns, in particular highlighting their dissatisfaction with aspects of the service such as the administration or the lack of congruity between clinicians regarding diagnosis.

I have no complaints about the clinical care that I received but can only bring to your attention the administration department. They lost the referral from the GP…
There seems to be a discrepancy between people about diagnosis which can be upsetting and unhelpful for treatment.

Many respondents took this opportunity to praise the service and the help provided, further emphasising that the service is highly valued by its users.

Very impressed with service and those I have been in contact with.
It's a good service giving excellent treatment.

PROGRAMME IMPACT: Rapid Response

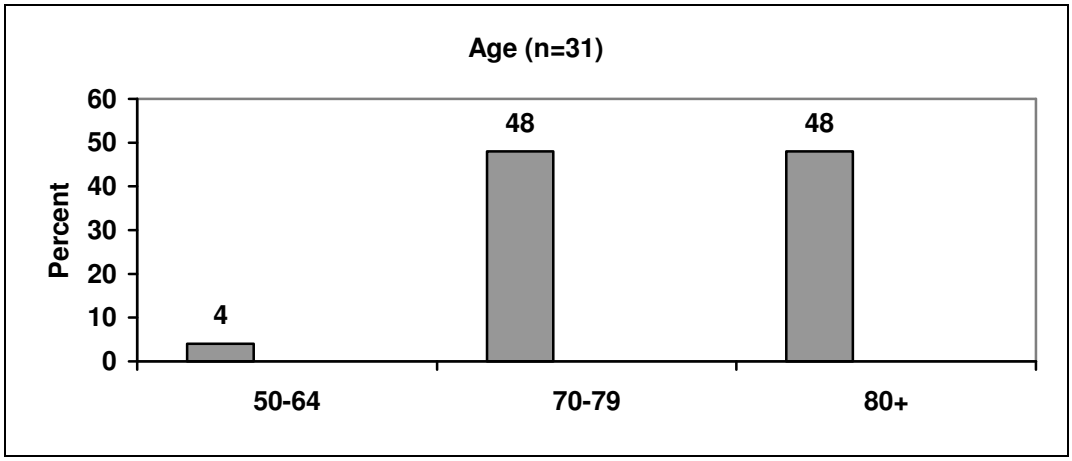
The outcome indicators for Rapid Response are:

- Contribute to a reduction in the rate of older people needing institutional care.
- An increase in the number of people accessing services.
- Contribute to a reduction in the rate of older people requiring admission to long-term care.
- An increase in service user satisfaction.
- An increase in the number of people accessing preventative services.
- An increase in awareness of The Extended Rapid Response service among older people of Wigtown West and Mid Galloway

Respondent demographics

Thirty-one Rapid Response service users completed and returned a questionnaire evaluating the impact of the programme, representing a response rate of 21 percent. The questionnaire and full results are provided in Appendix 9. Sixty eight percent of respondents were female, 29 percent male, and 3 percent did not disclose their sex. This male/female ratio is consistent with the male/female ratio of Rapid Response service users reported by the project.

Figure 13: Age distribution



The age distribution is shown in Figure 13 above. The 65-69 years age-group was not represented in the survey responses. The strong presence of the 'older old' age groups in responses suggests that a large proportion of the respondents were more vulnerable as declining health and isolation proliferate with increasing age. The majority of respondents, 71 percent, came from the Stranraer area with a further 19 percent from the Newton Stewart area and 7 percent from the Dumfries area (3 percent did not disclose their postcode). This is broadly consistent with the area serviced by the project. Over half of the respondents, 52 percent, reported living alone. A further 29 percent reported living with their spouse/partner, 10 percent with family members/friends, 6 percent in sheltered accommodation and 3 percent in a residential home. The number of respondents who lived alone suggests that a large share may have been more vulnerable in that they lack the support of family/friends within the home.

Respondents' mental and physical health

The reports of physical health further indicate that the respondents from this project were at the more vulnerable end of the spectrum. The majority of respondents rated their physical health as either fair, 42 percent, or poor, 45 percent, with equally small proportions rating it as either good, 6.5 percent, or very poor, 6.5 percent. Moreover, 87 percent indicated that their health had changed in the last three years mainly due to acute and chronic illness, with no reports of improvement to health. These ratings are consistent with the older age of respondents and with their need for the Rapid Response service. Respondents would have been referred to the service because of a problem with their health. The majority of respondents, 58 percent, reported their mental health to be good, 29 percent reported their mental health to be fair, 6.5 percent reported it was poor and 6.5 percent reported it was very poor. Given that a large proportion were older, lived alone, and reported fair or poor physical health, it is reasonable to suggest that for some respondents the ratings of fair to poor mental health will be related to these other impediments to quality of life. The high degree of vulnerability indicated by these data provide evidence that Rapid Response was reaching the more disadvantaged older people for whom BNSF is principally intended.

Service user satisfaction

The qualitative feedback indicated that the service was well received by respondents. In response to the question regarding overall satisfaction with the service, 58 percent reported they were very satisfied, 26 percent reported that they were satisfied, and 16 percent did not respond. That none of the respondents reported dissatisfaction with the service suggests that the project met the needs and expectations of the service users. The assessment undertaken by Rapid Response at the time of referral means that only those who are not capable of taking full care of themselves will be provided with assistance. Considering the reports of satisfaction in that context, it is clear that people were receiving the service at a time when they were particularly vulnerable or in crisis. That the project enables an immediate return home or prevents admission to hospital is likely to have made it especially welcome, since consultation work consistently demonstrates that older people value remaining in their home. Viewed in this light it is less surprising that no-one reported dissatisfaction with the project and these data indicate that the target population perceive the quality of the service to be high.

Satisfaction with the availability of the project was similarly spread, with slightly fewer, 48 percent, reporting they were very satisfied, slightly more, 32 percent, reporting they were satisfied, and the remaining proportion, 19 percent, providing no response. The qualitative feedback provided some qualification of satisfaction that may illuminate this slight reduction reported for availability. One respondent indicated that the support provided was appreciated, but not always convenient, and that this had necessitated support from their family at certain times. A second respondent indicated that she was unable to contact staff at the weekend to arrange the start of cover. Again, with regard to the amount of contact with staff, none of the respondents reported dissatisfaction, with 52 percent stating they were very satisfied and 26 percent satisfied. For this question, 22 percent of the respondents did not provide an answer. Evidently the 'quantity' of the project as measured by satisfaction with availability and contact with staff was also rated positively by the target population.

Respondents were invited to provide other comments which further highlighted that the service was highly valued and appreciated:

Cannot praise them too much, I regard them as life savers.
I was very happy to get help when I needed it the most. Thank you.

These comments emphasise the importance of the personal contact provided by the service and indicate the role of the 'human touch' that adds value. Moreover, the feedback highlights that the service is provided at a particularly difficult time in an older person's life, and the following data regarding quality of life must be considered in that context.

Seventy four percent of respondents indicated that they had not previously used a similar service to Rapid Response. Sixteen percent indicated that they had used a similar service prior to Rapid Response and 10 percent did not respond. These findings are what would be expected given that Rapid Response is a unique service that had only previously existed in the Nithsdale part of the Dumfries and Galloway area. The high proportion that had not received anything similar prior to Rapid Response may also suggest that for many it was their first experience of requiring care in their home.

Quality of life

A key finding from the survey was that 32 percent of respondents felt they would not be able to live independently without the support received from Rapid Response. An equal proportion indicated that they would still be able to live independently and 36 percent did not respond to the question. What is notable is that 61 percent reported that they received other help with daily activities. Of the other help received, by far the most prevalent was regular help from family, friends or neighbours. This is significant because it suggests that in spite of the other help received, the project had an important impact upon the ability to live independently. Twenty three percent reported receiving regular support organised by social services after the intervention from rapid response, but only 3 percent report such support prior to the service. This is consistent with the service description whereby the project intervenes at a crisis point and provides temporary support to keep older people at home until regular care can be provided. In total, 29 percent of respondents indicated they were still receiving regular care from social services.

Twenty three percent of respondents gave no answer as to whether their quality of life had changed as a result of Rapid Response. Quality of life is taken in this evaluation to be an important indicator of the impact of a project. It is important to note that this particular service provided short-term support on what is most likely to be a one-off basis. If further care was required by the service user then a care package would be put in place before the Rapid Response service was withdrawn. Any impact on quality of life therefore occurred within a short period of time. Twenty three percent of respondents indicated that they had received regular support from social services after, but not before, they received Rapid Response input. Twenty percent also indicated receiving regular help with personal care after Rapid Response. A limitation that may apply to this project is that the health and wellbeing of the service user is sufficiently compromised to necessitate Rapid Response intervention. It may therefore be less likely for service users to perceive an improvement to their quality of

life under these circumstances. This may go some way to explaining why 32 percent reported no change to their quality of life as a result of the project. However, 23 percent indicated that their quality of life was much improved and 23 percent indicated it was a little improved as a result of Rapid Response, and this is a significant impact.

Two respondents who had reported no change to their quality of life explained that the duration of the intervention was too short to produce an effect.

Too short a duration to affect me in any way.
Temporary help; only 2 visits – regular home help re-started the following day.

While these comments indicate that the intervention was too brief to impact quality of life, it is reasonable to suggest that in the absence of the intervention, if it resulted in unnecessary hospital admission, there would have been a negative impact on quality of life. For those who had reported an improvement, some comments were focused on the practical benefits of the service.

Help with walking aids.
Help with meals and getting ready for bed.

Other service users highlighted the physical and psychological benefits of the service.

Can move around easier.
Helped confidence and mobility.

Finally respondents noted the quality of the service provided as explaining the improvement to their quality of life.

Decisive and able caring.
Met all service needs.

These comments indicate that the service had met with the service users' expectations for the care they required, and that the impact on quality of life occurred at both a physical and psychological level.

Figure 14: Impact of Rapid Response Team on Key Areas of Quality of Life

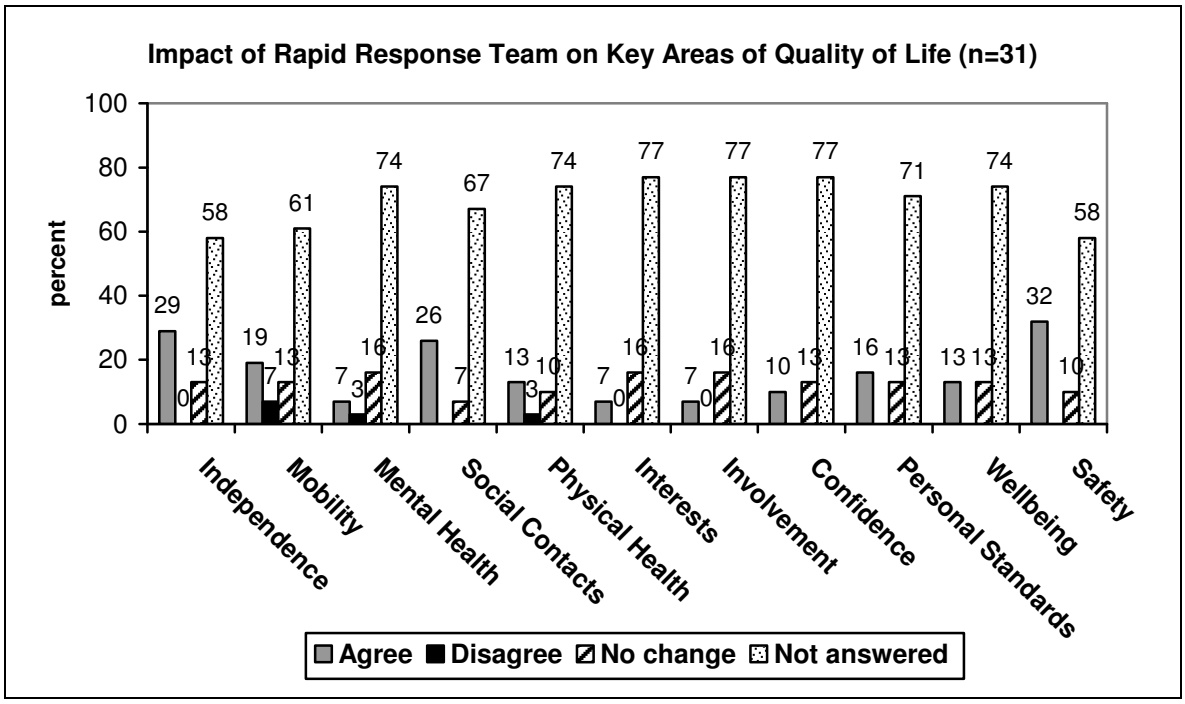


Figure 14 provides a bar chart indicating the proportion of responses received for each of the quality of life indicators asked about in the questionnaire. The chart demonstrates that Rapid Response had an impact on all areas of quality of life, although evidently the impact was greater for some areas than others. The greatest impact reported was on safety; 32 percent agreed they were more assured of their safety as a result of the intervention. While the meaning of 'safety' may be interpreted in many ways, the context would suggest that Rapid Response provided assurance of physical safety where this had been threatened by ill-health. Respondents would therefore have the assurance that if anything should happen, for example a fall or sudden deterioration of health, there would be someone quickly available to help. Having other people in the home to provide assistance may also have reduced service user's feelings of vulnerability to crime. Feedback regarding the most important benefit of the service also indicated that for some respondents the "assurance that help is available" was particularly significant. Thus, it may be that this assurance provides a feeling of safety.

Second to safety the largest finding was that 29 percent reported that they were more able to live independently as a result of the project. Respondents were later asked if they thought they would still be able to live independently without having received Rapid Response. Thirty two percent indicated that they would have been able to do so, 32 percent reported they would not have been able to do so, and 36 percent provided no response. These responses are an important indication of the extent to which the project contributed to the headline outcome of keeping people in their own homes for longer. Many of the respondents will have continued problems with their health that reduce their ability to live independently. That close to a third indicated the project had promoted independent living is therefore particularly meaningful and suggests the project has made an important contribution to that end.

Twenty six percent of respondents reported that the quality and quantity of their social contacts had improved with the Rapid Response intervention. The proportion that reported this improvement suggests that Rapid Response had an important impact on reducing isolation. It is not certain how this was achieved, although for some respondents it may have been the value of interacting with the Rapid Response team. For example, in the comments on the most important benefit of the service some respondents noted the importance of a 'friendly face'. One respondent's feedback exemplified the role of the team in providing this kind of support.

They nursed my husband in 2003 before he died and when they arrived I got hugs from them and they made me feel as if I was with old friends.

For the remaining quality of life indicators the impact was considerably smaller. Nineteen percent reported improved mobility as a result of the project, which may be partly attributable to the input of occupational or physiotherapy from the Rapid Response service. Qualitative comments about the service also indicated that for some it was the confidence to become mobile again that was the most important contribution. Thirteen percent reported that they were in better physical health as a result of the service. As explained earlier, the majority of respondents reported fair to poor health with a number of problems responsible including acute illness. To have a relatively low proportion report an improvement to physical health would therefore be expected. The number that did report improvement may correspond to those with less severe complaints at the time of requiring Rapid Response's assistance, for whom the short-term help enabled a return to full or improved health. The proportion who reported such an improvement can therefore be considered a success of the project.

Sixteen percent of respondents indicated that the project had allowed them to maintain their personal standards and 13 percent indicated that their feeling of wellbeing had increased. Again, the high proportion who reported fair and poor mental health would advise that a low proportion should be expected to report improved wellbeing. Moreover, as was indicated earlier, for many respondents this may have been their first experience of requiring formal assistance in the home. While the help received may have been very satisfactory or met expectations, the experience of requiring help might be perceived as a negative one. Thus the positive impact of the intervention may be somewhat negated by the negative experience of requiring it. This argument may be similarly applied to mental health, with only 7 percent reported an improvement to their mental health as a result of the intervention. Moreover, the service was not primarily targeted at improving mental health.

Ten percent reported that their self-confidence had grown as a result of the service. While this is a small proportion, two respondents went on to state that the most important benefit of the service had been the restoration of their self-confidence. Seven percent reported that they felt they were engaged in more interests and activities that they enjoyed, 7 percent reported feeling more involved in their community due to the intervention. These data may suggest that for a small number, the project enabled them to recover and thus return to the interests and activities that they enjoyed or resume their interaction with their community following a period of ill-health or incapacity. For the small proportion who reported increased involvement with the community, it may also have been the benefit of returning home from hospital and back to their home that produced this improvement.

Most important benefit
Respondents were asked to indicate the most important benefit of the service and 42 percent gave feedback. A variety of responses were provided which demonstrated that the service had impacted in different ways. For some respondents the key benefit was the restoration of their confidence; confidence in self and confidence to become mobile again.

Added value
Forty two respondents indicated that the service had made a difference to people close to them. Qualitative feedback highlighted the reduction of pressure and anxiety experienced by friends and family resulting from the intervention.

Yes, it took a bit of a load off friends and neighbours
Reassured people checking I'm OK
It gave family comfort knowing that I had carers checking on me
It helped my husband to cope better with my disability
It helped take the weight of my husband who is disabled anyway
Great help to my husband

As with the Active Service, this feedback demonstrates that an important benefit over and above the direct assistance to the service user was the respite support for friends and relatives provided as a result of the intervention. Again, the extent to which this respite benefits others, and particularly other older people such as the spouses of service users, constitutes an added value of the service.

PROGRAMME IMPACT: The Care at Home Training Consortium

The outcome indicators for CAHTC are:

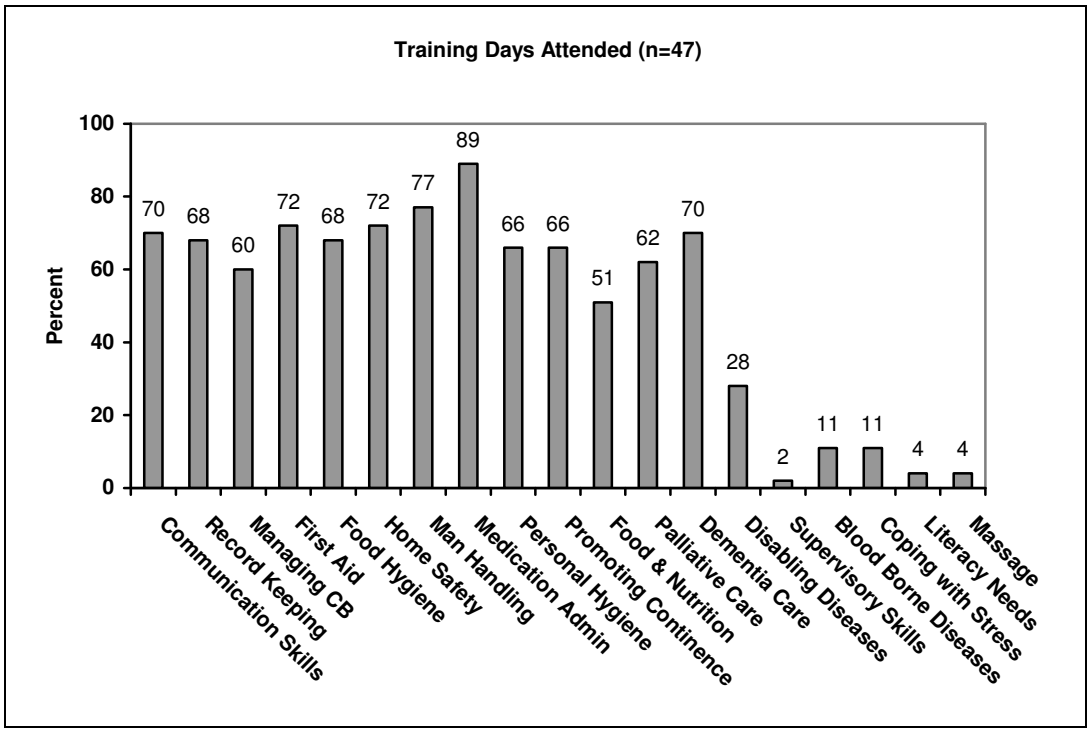
- Reduction in the rate of older people needing institutional care.
- An increase in the number of people accessing services without being in a crisis.
- A decrease in admission of older people to long-term care.
- An increase in service user satisfaction.
- An increase in the number of people accessing preventative services.

Respondent Demographics
Forty seven carers who had received training from the Care at Home Training Consortium completed and returned a questionnaire evaluating the impact of this training on their work. This represented a response rate of 37 percent. The questionnaire and full results are provided in Appendix 3. Consistent with the high proportion of female carers in the profession, 85 percent of these respondents were female, 11 percent were male and 4 percent did not disclose their sex. There was a reasonable spread of carers from each age group; 11 percent were aged 18-29 years, 19 percent were aged 30-39 years, 26 percent were aged 40-49 years, 30 percent were aged 50-59 years, and 11 percent were aged 60 years or over. The remaining 4 percent did not disclose their age.

Previous Training
Respondents were asked if, before receiving the CAHTC training, they had used a similar kind of service. Consistent with the approximate number of carers with little or no training, 72 percent reported they hadn't received a similar service, only 19 percent reported that they had, and the remaining 9 percent provided no response. Of those who indicated they had received a similar service, 11 percent indicated their former or current employer had provided it, and 2 percent indicated receiving training from Alzheimer Scotland. These data clearly indicate the lack of training for carers and support the need for the CAHTC service.

Training Days Attended
Respondents were asked to indicate which of the nineteen training days listed in the questionnaire they had attended. Figure 15 indicates the percentages who had attended each of the days.

Figure 15: Training Days Attended



As the chart demonstrates, a large proportion of the respondents had attended several training days provided by CAHTC. The project manager indicated that some care providers send their staff on several different days, while others, for reasons of cost and staff cover, only allow staff to attend a limited number. Respondents were asked how long they had waited to attend the training. Importantly this is likely to predominantly be a subjective measure, and should be viewed tentatively. The majority, 43 percent, indicated they had waited a period of weeks, while 32 percent indicated they had waited for a period of months, and 26 percent did not respond. It is possible that some respondents included in their estimate of waiting time, the full period in which they had been employed without receiving training. It is not possible to infer how many, if any, were including this period. The vast majority, 87 percent, indicated that their employer had paid for them to attend the training, while 9 percent indicated that they had paid themselves, and 4 percent did not know who had paid. The majority, 81 percent, also indicated that they were paid while attending the training, while 17 percent reported they were not, and 2 percent indicated they did not know. The small, yet significant, proportion who were willing to either pay for their own training or attend without pay indicate a commitment to the training which suggests they viewed the CAHTC project favourably.

Older People Cared For

All of the respondents indicated that they provided care to older people, although the number of older people for whom each respondent provided care varied greatly. Two percent reported caring for 1 older person, 27.5 percent reported caring for between 2 and 5 older people, 25 percent reported between 6 and 10 older people, 27.5 percent reported between 11 and 20, 15 percent reported more than 20 and 15 percent provided no response. These figures indicate that a large number of older people stood to benefit from the improved care resulting from the CAHTC training.

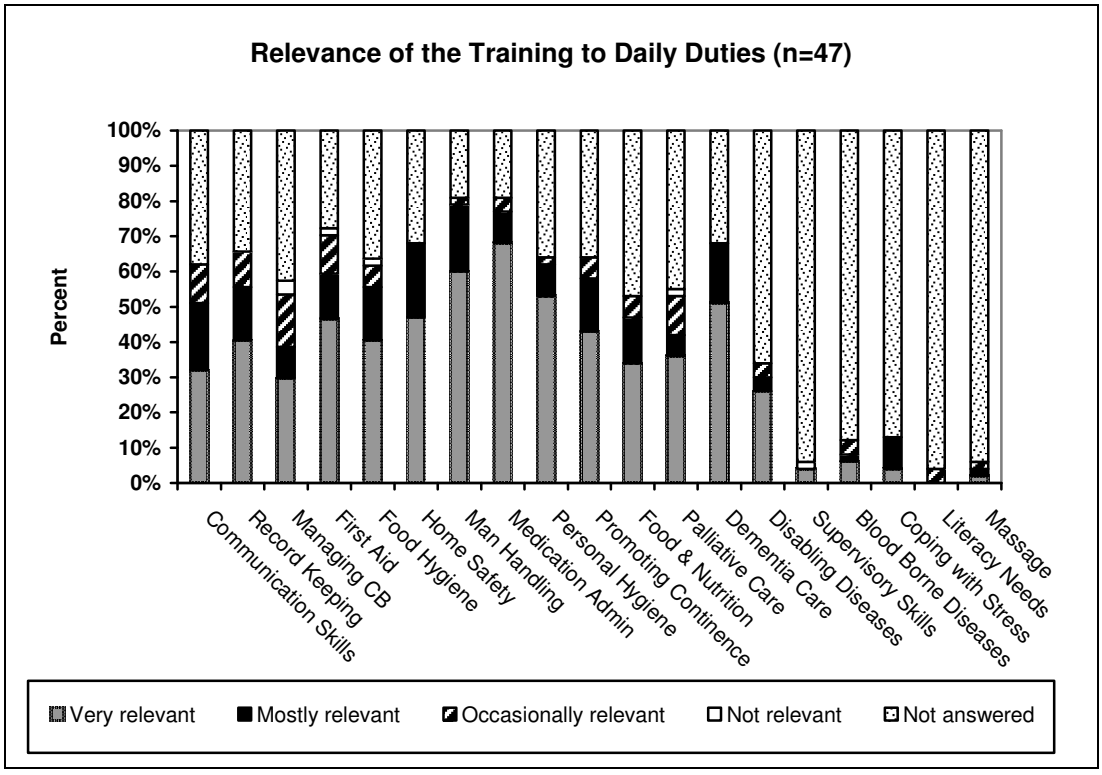
Respondents were also asked to which age groups they currently provided care. Fifty five percent of respondents indicated that they currently cared for people aged 50-64 years, 51 percent cared for people aged 65-69, 81 percent cared for 70-79 year olds, and 85 percent provided care for people aged 80 years and over.

Service User Satisfaction

Respondents were asked how they felt about the training that was provided. Forty-five percent reported that they were very satisfied with the training, 53 percent reported that they were satisfied, and 2 percent provided no response. None of the respondents reported that they were either dissatisfied or very dissatisfied. These responses suggest that the carers viewed the quality of the training very positively. Moreover, it suggests that the training was predominantly addressing the areas they felt were in need of improvement. It seems unlikely that respondents would report satisfaction with training that was irrelevant to their work or which failed to address the areas where they needed assistance. With regard to the availability of the training, 23 percent reported that they were very satisfied, 62 percent that they were satisfied, 11 percent were dissatisfied and 2 percent were very dissatisfied. Again, 2 percent provided no response. Given that some carers were required either to pay for the training themselves or to attend the training without pay, it is perhaps unsurprising that the satisfaction with availability should be less. Even so, these responses still indicate a very positive perception of the service.

Relevance of the Training to Caring

Figure 16: Relevance of the Training to Daily Duties



Respondents were asked to indicate how relevant to their daily duties as a carer they had found each of the training days attended. The responses are demonstrated on

Figure 16. Evident from the chart is that all of the nineteen training days, except 'literacy needs', were considered to be very relevant or mostly relevant by the majority of respondents. These data are particularly salient as they suggest that most of the training provided is considered useful and beneficial for the carers work. The respondents were asked to indicate which of the training days they had found most beneficial to their work, and why. Eighty nine percent provided a response to this question, and a range of answers were given. Twenty six percent indicated that all of the training days they had attended had been of use.

The training days have been equally valuable to me both in my past and present employments because they are relevant to my work and give me better awareness of how to act and react in my job.

Twenty six percent highlighted the dementia care training as having been particularly beneficial. The comments indicated that the main benefit had been the improvement to their understanding of the illness and the consequent feeling that they were more able to support clients.

Finding out how people with dementia react and how to cope with it.
Much easier to understand clients.
Knowing how dementia can affect everyday life and being able to support them at home.

Fifteen percent highlighted the home safety and risk assessment training as the most beneficial. One respondent indicated that they had had little prior experience of this topic, while another noted their increased awareness and ability to undertake preventative measures.

More awareness of potential risks and how to limit these.

These responses suggest that the carers were able to put their training into practice in such a way that would clearly benefit older people by increasing their safety and thereby reducing risks to their health.

For 13 percent the most beneficial training had been the administration of medications. Some respondents stressed the regularity with which they are required to deal with different medications, noting that the training had improved their confidence and awareness for this task.

… Due to vast amount of medication taken, it has made me more aware of how and when and what my clients are taking.

Again, these comments clearly indicate the transfer of learning into practice, thus indicating that the training has impacted upon the actual care provided to older people. Thirteen percent indicated that the manual handling training had been the most beneficial. Where respondents had qualified their response, the feedback indicated that this training had benefited both the carer and the client in receipt of care. The benefits to the carer are apparent, for example the ability to correctly lift or move a client can avoid injury to the carer. Similarly it is easy to envisage where incorrect lifting or movement could be distressing for a client, particularly if this

caused them discomfort. The responses provided, again, indicated that the carers had improved their practice since receiving the training.

How to move people properly.
Make clients feel safe and comfortable.
Reduces stress on one's person.

Nine percent of respondents indicated that the disability awareness training had been the most beneficial, reporting that the training had increased their awareness. Six percent stated the promotion of continence had been most beneficial, referencing the improvement to their skills in handling this aspect of their work. Six percent also indicated the first aid training was the most beneficial, while for 4 percent it was the personal hygiene training. A further 4 percent highlighted the communication skills training, and for 2 percent it was palliative care. Finally 2 percent highlighted managing challenging behaviour noting that it had been very useful in previous work with dementia clients.

As at the time I worked in a residential home with dementia clients found it explained ways to deal with them.

Impact on Older People through Changes to Practice

The respondents were asked to indicate whether, in their opinion, the training had made a difference to key areas of their practice with older people. These questions sought to provide some indication of the indirect impact of the CAHTC project upon older people through the change to carers' practice. For all of the responses it is important to interpret the results tentatively. Respondents may have felt uncomfortable with indicating an improvement to their practice if it suggested that they had been working wrongly before the training. Conversely there may have been an inclination to indicate improvement to demonstrate that the respondent was working well as a result of the training.

Respondents were asked firstly whether they felt their way of working with older people had changed. The majority, 49 percent, agreed that it had changed, 2 percent disagreed, 45 percent reported no change, and 4 percent did not respond. A large majority, 79 percent, indicated that as a result of the training they felt more confident in carrying out their working duties with older people. An improvement to the confidence of the carer has important implications. Firstly, feeling more confident is likely to contribute to their job satisfaction, where feeling insecure at work could produce stress and anxiety. Secondly, this increase in confidence suggests that carers may have been undertaking tasks prior to the training without the assurance they were doing so correctly or appropriately. This finding therefore indicates that the training had improved the care provided to older people. The survey also indicated that a large proportion, 57 percent, had experienced an increase in job satisfaction. This is an important finding because it indicates that the carers may have been struggling or unhappy with aspects of their work that the training addressed. This may have occurred indirectly through increased confidence, or it may have come from the satisfaction of feeling that they were doing their job well. Supporting this assertion was the finding that a large proportion, 60 percent, felt that the quality of care they provided to older people had improved.

Seventy five percent of respondents felt that they were providing a safer environment for the older people that they cared for. Such an improvement has clear benefits for the health and safety of older people for example through reducing the risk of their having accidents such as slips, trips and falls in the home, or through better food hygiene. A comparatively smaller proportion, 28 percent, reported feeling they were working more quickly and efficiently since the training. It may be that some carers felt they were working efficiently prior to the training and that the impact on this aspect of their work had been minimal. For others, the increased portfolio of activities they were able to undertake may in fact have meant they worked more slowly. The majority of respondents, 53 percent, agreed that they were able to carry out more duties for the older persons that they cared for, with 36 percent reporting no change, 4 percent disagreeing and 6 percent providing no response. This finding indicates that the project was to a large degree meeting its aim of increasing the number of tasks carers are able to undertake. Moreover, a slight majority of 45 percent indicated that they found it easier to carry out duties for the older people they cared for.

The survey asked whether respondents felt that their relationship with the older persons they cared for had improved. The majority, 47 percent, agreed that there had been an improvement. This may have occurred as a result of improved communication skills in the carer. Another suggestion is that through increased confidence and greater job satisfaction, the carers were more positive in their interaction with the older people. For some carers there may already have been a good relationship with the older people such that the training did not produce any change. Respondents were asked whether they thought the older persons they cared for were more satisfied with the care received. A slight majority, 45 percent, reported no change, while 43 percent agreed. Research by the CAHTC project manager indicated that many of the older people in receipt of care were particularly vulnerable and therefore mostly unaware of changes in the carer's practice. The proportion reporting a perceived improvement in satisfaction in the client appears therefore to be a very positive finding. The respondents were also asked to indicate whether they thought the quality of life of the older people cared for had improved. Forty three percent felt that it had improved. This is a salient finding because it indicates a strong perception that the improved care was directly and positively impacting upon the lives of the older people. Further evidence to support this claim was that 53 percent reported that the training had benefited the physical wellbeing of the older persons they cared for, and 53 percent also reported a benefit to their emotional wellbeing. Taken together these findings strongly imply that the training had produced a substantial improvement to the quality and quantity of the care delivered to older people, with indirect and positive outcomes for the older persons themselves.

Other benefits of training

Respondents were asked to indicate whether the training had benefited them in any other ways. Thirty six percent provided feedback. The most common response was that the training had improved the confidence of carers to undertake their work. For some this was the confidence to carry out tasks correctly having undertaken a new career in care.

Gave me more confidence as this was a new career for me.

For others the confidence came from reassurance that they had been carrying out their duties correctly.
A lot of the work is common sense and I have always done the work to the best of my ability but the training was very beneficial and it is good to know if I was going about certain aspects of the work the right way.

Other respondents indicated that the training had increased their awareness of clients' needs. Evidently this had resulted in improvements to their practice, and again, an increase in confidence was an important part of this improvement.

I feel more aware of different client needs and that each person is different.

I am more aware of the needs older or disabled people have… and the responsibilities carers have to them

Respondents highlighted the increase in their knowledge and information that had benefited their practice.

I do feel a bit more informed about the technical side of my work but always as a carer who does care.

It has alerted me to other services available which can help my elderly clients.

All of the benefits outlined demonstrate that the training had improved the quality of care or increased the portfolio of care the carers felt able to provide.

A key point to make about these findings is that the carers clearly demonstrated retention of the information and skills they had learned. That the respondents could trace the most important benefits of the training, the most valuable training day, and the impact on their practice, suggests that the impact of the training was sustained over the longer term. The implication is that the carers were using the training in their jobs; otherwise the expectation would be that the information and skills would be gradually lost.

The survey asked whether respondents felt the training had made a difference to people close to them. Seventeen percent agreed that it had, with 64 percent disagreeing and 19 percent providing no response. Of those who agreed, the responses indicated that an important difference was through the reduction of stress in the job that had a positive impact on their family. For others the benefit was the increased confidence people had in them as a carer.

Difficult to explain but having guidance to some problems takes away some of the stress in the job which naturally helps with family.

People you look after more confidence in you.

Suggestions for change to service
Only 17 percent of respondents felt that there had been anything missing from the training, with 9 percent providing no response. One of the respondents indicated that training to promote assertiveness and handle situations with both the person cared for

and their manager would have been beneficial. Other respondents felt that the training could be more practical, and a small proportion indicated that the training could be provided in more depth.

Too much was squashed into a short session in order to finish in a day. Some subjects would benefit from 2 days to have a more in depth discussion.

Respondents were also asked whether they had any suggestions for changes to the training. The responses provided more evidence that the project was very positively received with many highlighting that the training should be provided sooner and for all carers.

Yes it should be made compulsory that every one has the training within a year of becoming a carer.

Training carers at the start of their job and have certain areas where it is compulsory e.g. medication administration.

Other respondents indicated a need for the training to be given more frequently and updated to maintain the carers' skills.

Would like more training to be offered. I feel courses few and far between.

Regular sessions of updating.

Most important benefit

Finally respondents were asked to indicate the single most important thing that the training had given them. Eighty nine percent of respondents answered this question. The majority, 51 percent, highlighted the growth in their confidence to do the job.

More confident knowing that I have learnt a great deal in helping me to carry out a more qualified way in which I deal with the elderly people.

More confidence that I was giving the clients the correct care.

Improved job satisfaction was reported as most important by some respondents. This increase came from a sense that their job was worthwhile and from the pride of doing their job well.

Satisfaction in the work that I do.

A sense of worth and confidence in my job and awareness of my client's needs.

For other respondents the key benefit was their increased awareness and understanding.

Better awareness of people's needs in different situations and realisation that we are all different individuals

More of an insight into some illnesses we were not clear on before and how to deal with these.

Added Value

A significant added value of this project comes from the 'Step Into Care' programme described in the Description of BNSF Projects section. Not only is this programme benefiting older people by ensuring that all carers can receive training appropriate to their particular level of need, it is benefiting the carers themselves by increasing their skills and thus improving their chances of career development. Moreover, by enabling carers to enter the profession, the project is increasing employment opportunities in the region and is helping to address the shortage of carers. This latter point is particularly significant because the shortage of carers is one of the central causes of 'bed-blocking' and delayed discharges from hospital. The project is therefore contributing to a reduction of this problem.

Added value from this project also comes from its extensive use of partnership working in the delivery of training. As is described in the Partnership Working section, CAHTC has linked in with various other agencies including the Fire Service, Environmental Health and Podiatry to train carers in health and safety issues. Through this partnership working the project is enabling such agencies to deliver their message to a wider audience and is therefore providing an important preventative role.

Home Care Practice Licence

Perhaps the most significant achievement of the project in terms of its longer term implications is the partnership between CAHTC and Stirling University in the development of the Home Care Practice Licence. The purpose of this pilot project is to bring in a qualification for home care workers, which is in line with the CAHTC training programme. The project manager explained that Social Services Council for Scotland is talking about insisting on all care workers having a qualification and being registered in line with health professionals in the future. Given that the only current qualification available is the SVQ II, which has had limited success, this clearly indicates a need for a more appropriate qualification. The Home Care Practice Licence would aim to address this by providing a foundation qualification for carers that could act as a stepping stone to the SVQ II and SVQ III, thereby developing a career structure. This programme is a nationwide pilot and the project manager explained that the Scottish Qualifications Authority is interested, and may be able to award it two national certificate credits. Evidently, therefore, the CAHTC project therefore has potential to contribute to nationwide improvements in care practice with far-reaching benefits for older people.

PROGRAMME IMPACT: The Guid Guidance for Older Folk Directory of Services

Respondent demographics

Forty one recipients of the Guid Guidance for Older Folk Directory of Services, (hereafter 'the directory'), completed and returned a questionnaire exploring their use of the directory and its impact. This represented a response rate of 21 percent. The questionnaire and full results are provided in Appendix 5. Thirty four percent of respondents were male and 66 percent were female. Five percent of respondents were aged 50-64 years, 22 percent were aged 65-69 years, 39 percent were aged 70-79 years and 34 percent were aged 80 years or over. The majority of respondents, 37 percent, came from the Annandale & Eskdale area, 24 percent from the Newton Stewart area, 15 percent from the Dumfries area, 10 percent from the Stewartry area, 10 percent from the Upper Nithsdale and finally 5 percent from the Stranraer area. All of the respondents reported either living alone, 58.5 percent, or with their spouse/partner, 41.5 percent.

Respondents' mental and physical health

The majority of respondents rated their physical health as either good, 51 percent or fair, 44 percent, with only 2.5 percent reporting it was poor, and 2.5 percent as very poor. These data suggest that a large proportion of respondents were at the less vulnerable end of the spectrum. This is further indicated by the ratings of mental health, with the vast majority, 83 percent, rating their mental health as good and the remaining 17 percent rating it as fair. Just under half of the respondents, 46 percent, reported that their health had changed in the last three years. Some were suffering from chronic ailments, often linked to older age such as arthritis, osteoporosis and breathlessness. Others had suffered from heart failure, strokes and cancer. Deteriorating eyesight, decline in energy and a diagnosis of diabetes were also mentioned. The remaining 51 percent indicated that there was no change, and 2 percent provided no response.

Service user satisfaction

The questionnaire explored each section of the directory by asking whether recipients had used any of the information in each, who they had used the information for, and their satisfaction with that section. The full results from each section are explored in Appendix 5. For section one, Approved Care at Home Agencies, only two respondents indicated that they had contacted or used any of the services listed. Of these, only one provided an indication of their satisfaction, reporting that they were very satisfied with this section of the directory. Seven percent of respondents indicated they had used the Information Bank of Useful Services section of the directory. Seven percent of respondents reported that they were very satisfied and 2 percent reported they were satisfied with this section.

A much greater proportion of respondents, 51 percent, indicated that they had used the section of the directory dedicated to advice and information on home safety. Twenty nine percent indicated they had not used this section with the remaining 20 percent providing no response. Each area of advice or information was assessed in turn for how helpful respondents had found it – see Table 9 below.

Table 9: Helpfulness of advice or information

Type of Advice or Information Used	**Very helpful**	**Quite helpful**	**Of little help**	**Of no help**	***Not answered***
Avoiding injury by preventing falls	5 (12%)	2 (5%)	0	0	*34 (83%)*
Exercising and keeping fit	6 (15%)	1 (2%)	1 (2%)	1 (2%)	*32 (78%)*
Being safer in the home	8 (20%)	5 (12%)	0	0	*28 (68%)*
Getting a smoke alarm	17 (42%)	1 (2%)	0	1 (2%)	*22 (46%)*
Keeping safe from fire	10 (24%)	1 (2%)	0	1 (2%)	*29 (71%)*
Preventing crime	10 (24%)	2 (5%)	0	0	*29 (71%)*
Making it difficult for the thief	8 (20%)	2 (5%)	0	0	*31 (76%)*
Taking food safety seriously	5 (12%)	4 (10%)	0	0	*32 (78%)*
Taking care of your feet	8 (20%)	4 (10%)	0	0	*29 (71%)*
Avoiding postal scams	8 (20%)	2 (5%)	0	0	*31 (76%)*
Dealing with doorstep sellers & bogus callers	10 (24%)	2 (5%)	0	0	*29 (71%)*
Shopping safely on the internet	3 (7%)	0	0	0	*38 (93%)*
Gardening safely	2 (5%)	1 (2%)	0	0	*38 (93%)*

The information and advice most reported as having been consulted were related to safety, such as getting a smoke alarm and preventing fire, preventing crime and dealing with bogus callers and workmen. The high proportion of unanswered questions can be taken in part as an indication that this part of the directory was not used. As was indicated for the other project questionnaires, this finding may also be partly explained by respondents having difficulty in completing the questionnaire or lacking the motivation to answer all the questions.

Seventeen percent of respondents indicated that they were very satisfied with this section of the directory, with a further 22 percent reporting they were satisfied. None of the respondents indicated dissatisfaction and the remaining 61 percent gave no response.

Twenty percent of respondents indicated that they had used the section regarding day centres. Ten percent reported that they were satisfied with this section, with the remaining 90 percent providing no response. Seventeen percent indicated they had used the section regarding contractors approved by Dumfries and Galloway council. Four percent of respondents reported that they were either satisfied or very satisfied, 2 percent (one respondent) reported that they were very dissatisfied, and the remaining 94 percent gave no response. Seven percent of respondents indicated that they had used the section of the directory regarding care homes; all 7 percent reported that they were very satisfied with this section.

Respondents were asked whether they had recommended the directory to others, or whether they would do so in the future. Seventeen percent indicated that they had already recommended the directory and a further 68 percent indicated that they would do so in future. The high proportion who indicated that they would recommend the directory in future suggests that the recipients regarded it as good quality, and perceived the information as useful.

Respondents were asked to indicate whether they would pay for the directory if it were not provided for free. This question was asked to provide more information about the usefulness of the directory. A slight majority indicated that they either definitely would (10 percent), or possibly would (29 percent) pay for it, with 34 percent indicating they possibly would not, and 2.5 percent reporting they definitely would not pay for it. The remaining 24 percent did not provide a response.

The main aim of the directory was to promote older people's access to information about services in the area that they could utilise. The questionnaire therefore asked respondents to indicate whether they felt their access to information was improved as a result of having the directory. Forty nine percent of respondents agreed that their access had improved, while 24 percent disagreed, and 27 percent provided no response. This is a disappointing finding, as it may have been expected that a much greater proportion would report an improvement from having the directory. It is possible that the proportion reporting no improvement had not yet had cause to use the information and therefore felt no benefit as yet. For some it may also have been that the directory did not contain information that they required.

Quality of life

Respondents were asked to indicate whether they felt their quality of life had improved as a result of accessing the information in the directory. Seven percent reported that their quality of life was much improved, 17 percent that it was a little improved, and 51 percent reported no change. The remaining 24 percent provided no response. Some qualitative responses were given to expand on these reports:

Because living in a small place five miles from the nearest town is not readily available.

Advice from fire and safety department made a difference to some areas.

Both those who had already used, and those who had not yet used the directory commented that having the information collected in one place was of benefit:

Most of the information is available from other sources. It (directory) has the advantage of all the information collected together.

Knowing the information is there when/if required.

Figure 17 : Impact of the Guid Guidance for Older Folk Directory on Key Areas of Quality of Life

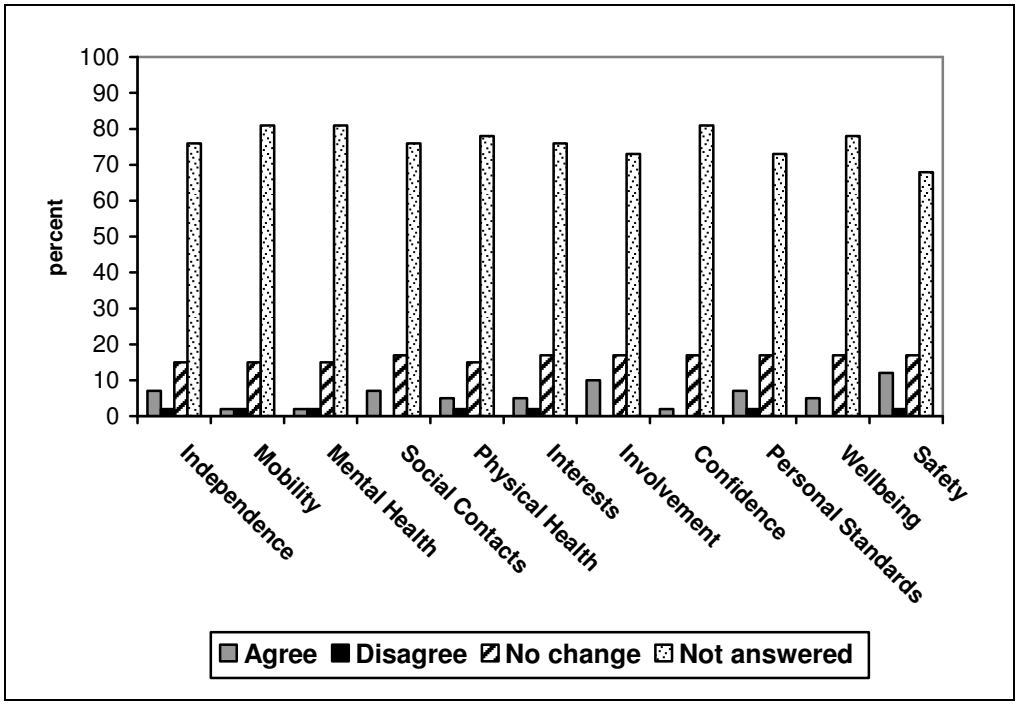


Figure 17 provides a bar chart indicating the proportion of responses received for each of the quality of life indicators asked about in the survey. The directory can be seen to have had an impact across the board, although to a small degree. The greatest impact reported related to safety (12 percent), which as discussed in the section above relates to protection from and prevention of fire, and knowledge about how to prevent crime and make home a safer place. Involvement in the community was the next highest rated indicator, which as one respondent said *"To move from one area in (Central Scotland) to a new one and be accepted into community is biggest boost"* and another said the directory had helped them to make *"contact with organisations not known"*. The high number of non responses to these indicators is not surprising, given that the directory is a resource to be used when, and if, needed, and is not a service as such. This suggests that a large number of respondents surveyed had not had reason to use the directory, and also, even for those that had used it, that as a non-intervention, the directory may not be perceived as something which has a direct impact on a person's day-to-day life.

The above may also explain why only four respondents indicated that they felt having access to the directory had made a difference to people close to them, and why no respondents felt that not having access to the directory would have reduced their ability to live independently.

PROGRAMME IMPACT: Factors Affecting Attainment of Outputs and Outcomes

Thus far this section has provided detailed evidence examining the impact of each of the BNSF projects, exploring their relationship to the overall aims of the programme and their effect upon the lives of older people. The following segment considers some important factors indicated by the BNSF project managers that were responsible for facilitating or hindering the progression and success of their projects. Each of the projects is considered in turn.

The Care at Home Training Consortium

A factor that clearly facilitated the delivery of training for carers by this project has been the partnership working with various organisations. This partnership working was certainly facilitated by the links with the Home Safety for Older People Working Group and through BNSF. In addition to the benefit of facilitating a widespread curriculum of training through this specialist input, the partnership also provided other benefits. For example, the project utilised fire stations as a venue in which to provide the training. Fire stations are available for community training, however knowledge of their availability is not widespread, and the project manager became aware of this through linking with the fire service representative at the Home Safety for Older People Working Group. The project manager also indicated that the rural location of Dumfries and Galloway had probably facilitated the success of the project. She explained that she had attended meetings for the Home Care Practice Licence in which care providers from other areas were surprised that one organisation could successfully liaise with thirty two care providers and have so many organisations represented on the committee.

Dementia Friendly Communities

Some people in rural communities told the project manager they were worried that she was just coming into the local community to give a little bit of information, and would then disappear. This was something that had previously been experienced by communities, and they felt a sense of being let down. In response to this, the project manager described her role very much as empowering people by providing them with skills and knowledge of where to access information and support. In so doing, the project would leave the community suitably equipped not be required to continue in one place indefinitely.

A key characteristic which emerged from the interview with the project manager was flexibility. This was apparent in several ways; through the varying content of talks and workshops, tailored to meet the needs of attendees and participants; through the impromptu nature of some of the events – the project manager has often found that when she goes into a public place, such as a post office, or library to talk to the postmistress or librarian, members of the public will often join in, and she ends up giving a revised talk!

A more frustrating aspect of the service delivery has occurred when an event, such as a workshop, which will often have been requested, and organised well in advance, is cancelled or postponed, e.g. because of staff illness, or relocation of an organisation. Undoubtedly attendance at these events may not be a high priority for some of these

organisations; therefore, it is crucial that the approach taken by the project is tenacious. However, the availability of short-term funding militates against this.

Food Train

The Food Train project manager indicated that an ongoing problem for the project was the retention of volunteers, and in particular having enough volunteer drivers to make deliveries. While this had never resulted in a drop in service provision, it nonetheless placed a stress on the service. The project is in the fortunate position of having very committed volunteers who are willing to be flexible in the hours they work to maintain the service, and the manager will also step in to provide deliveries if necessary. Undoubtedly a crucial factor in the success of the project has also been the dedication and commitment of the project manager. It is evident that the manager has expanded and developed the project, undertaking a variety of roles and responsibilities and working 'above and beyond the call of duty'. Although the running of the project has become practically more than is manageable for one person, nonetheless the manager has continued to deliver the necessary work to ensure its ongoing success.

An important factor that facilitated the expansion of the service was support received from OPSDG. The project manager indicated that when moving the service into a new area there could be uncertainty as to how the service should proceed and how it would be received by the community. The links between the Food Train and OPSDG meant that the project manager could approach community representatives from OPSDG and ask them to help carve out a path in their community, by 'putting the word out' about the service. In describing this kind of assistance from OPSDG, the project manager asserted that:

The communication pathway that it provides Food Train is immeasurable.

The communication pathway referred to is the one between Food Train, OPSDG, and the older people in the communities that OPSDG represent. The role of OPSDG in the various aspects of the BNSF programme and its impact are explored in more detail in the later part of this section and also presented in the sections on Partnership Working and Role of Communities.

Home Fire Safety Checks

The Home Fire Safety Checks project manager did not indicate any particular impediments that had prevented the project from achieving its objectives. What was indicated, however, was that the amount of funding granted by BNSF had been less than the service had bid for. The project manager contended that although the amount was less than was needed, it was nonetheless a need that the brigade were prepared to meet in their drive to reduce fires. Supporting this contention is the fact that the number of home fire safety checks conducted by the service has consistently exceeded the targets.

The project manager highlighted that facilitating the success of the project was the invaluable support of the BNSF team. In particular the team were credited as enabling the project to reach a large audience of older people through their partnerships. The partnership working between this service and other statutory agencies through the Home Safety for Older People Working Group was also an

important factor. Firstly, the primary vehicle for promoting awareness of the service was through the road shows conducted by this group. Secondly, in providing the home fire safety checks the fire officers are observant for other safety hazards in the home that were brought to their attention through the inter-agency working. If such hazards are observed these can be brought to the attention of BNSF and dealt with. Finally, the surveys constructed by BNSF for the group's road shows provided feedback on particular areas for the service to focus on, such as the need for appropriate provision and testing of smoke detectors in the home.

A factor not highlighted by the project manager but clearly indicated in the questionnaire feedback was the professionalism of the staff. Evidently the approach of the fire officers was appropriate to interactions with older people and highly valued for this reason. As a service that is generally not used to working with the older population in such a direct manner, this is an important accomplishment.

Podiatry Service

The Podiatry service experienced a delay in recruiting their first Senior 1 Podiatrist for their Annandale & Eskdale, and Nithsdale component. They reported difficulty in attracting people to the post for two main reasons. Firstly, the post was split between two locations, requiring travel and working in a rural area. Secondly, given that the BNSF money was released retrospectively from month to month with funding only guaranteed for a year at a time, the project was unable to appoint a podiatrist to a permanent position. It is more difficult to attract staff to a temporary and potentially insecure post.

The Annandale & Eskdale and Nithsdale component of the Podiatry service has consistently succeeded in meeting a high proportion of new referrals within the six week period. For example the average compliance with the charter for September 2004 to January 2005 was 77 percent. According to the project manager, prior to the appointment of the BNSF podiatrist the compliance with the charter had been approximately 60-70 percent on average. The appointment of the BNSF podiatrist therefore served to improve service delivery in this component. In contrast, the Stewartry and Wigtownshire component struggled to achieve the guarantee and the compliance in this component was more variable. The average compliance for September 2004 to January 2005 was 43 percent. Overall the impact of the BNSF podiatrist for this second component has been to sustain, rather than greatly improve the service. Where there were difficulties in meeting the charter, the project had to balance the need to meet new referrals with the continued care of existing patients. A large proportion of the continuing caseload would be older people in need of ongoing treatment, for example regular nail cutting. The project manager explained that the service did not focus on achieving the targets for new referrals at the expense of continued care. To have done so would have been to disadvantage some older people. It is an important point that the service was careful to balance these priorities.

One factor that affected compliance with the charter was the recruitment of a Podiatrist from the private sector who brought a number of patients who were eligible for NHS treatment. The project reported that this resulted in approximately double the number of referrals received. Over the longer term a critical reason why the service struggled to meet its guarantee was due to staffing and recruitment issues. There were two concurrent staffing problems for the service. Firstly, one member of

staff had long-term absence due to ill health. The nature of this illness was such that the project could not determine how long the person would be off or how long they would be able to return for. They reported that this uncertainty made it more difficult to make a contingency plan. Secondly, a member of staff took maternity leave and the project was unable to fill the post during her absence. The difficulties in recruiting staff to rural areas that are experienced by health and social services are well-known. There is also the difficulty of attracting staff to a temporary, short-term post which was cited as the main reason for failing to cover the maternity leave. Again this is a problem that has been reported elsewhere by other services (e.g. Scottish Executive, 2003). The teams of Podiatrists working within each component are small in number comparative to the number of patients seen. As a result the loss of one member of staff can have a significant impact on service delivery.

The project reported that without the additional BNSF funded Podiatrist these staffing issues would have had a very detrimental effect upon the service. Having this additional member of staff enabled them to sustain their essential services for the high-risk priority groups of patients. They were also able to meet a greater proportion of new referrals than would have been possible otherwise. There is, however, a question as to whether the service would have made a greater effort to cover the sick and maternity absences which occurred had they not had the additional BNSF post. It is possible that in the absence of the BNSF funded podiatrist, the NHS would have made funding available to cover these absences in order to negate a crisis in the service. Such an analysis was outwith the scope of this evaluation and therefore the comments made are tentative. There is a suggestion however, that had the absences been covered, the BNSF podiatrist would have added to the service provided by the Wigtownshire and Stewartry component. Consequently they would have made greater gains toward reducing waiting times.

Rapid Response:

The Rapid Response project manager explained that at the beginning of the project they were concerned to ensure that the team of staff recruited would be multidisciplinary. This was important to ensure the service could respond flexibly to all patients' needs, however it gave them difficulty in setting up the team. As with Podiatry, there is a difficulty in recruiting staff to the rural area. The project manager also indicated it is difficult recruiting to the nursing, occupational therapy and physiotherapy disciplines. This resulted in a delay in the recruitment of staff until January 2003. Moreover, they were unable to recruit an occupational therapist or a physiotherapist; however that problem was overcome by employing a physiotherapy assistant and linking in with occupational therapy services as required.

The project manager highlighted that a key strength of the project that facilitated attainment of its outcomes was partnership working. A strong relationship existed between the Rapid Response team and the social services in the area. Without that strong relationship and partnership working, the manager asserted that the project would not have had the same success in meeting its discharge targets. An important factor underlying the successful partnership working was the small community in which the project operated. The manager indicated that having a small number of people means that there are repeated interactions between workers from different agencies that allow relationships to form. However, it was also highlighted that the NHS is somewhat fragmented and that the team worked hard to develop partnerships

with A&E nursing staff, GPs, social services, community hospital teams and the voluntary services in order to promote efficiency. The end result of these partnerships was to get the patient home quicker.

Conclusions: impact of BNSF projects

The evidence presented thus far would strongly suggest that BNSF has funded a selection of projects, the quality and quantity of which are highly valued by their service users. It would appear that each of the projects is contributing important benefits to the lives of older people, having a predominantly positive impact on quality of life, and helping to sustain health for this population. The projects have each contributed in some way to reducing social isolation, and some, for example Active Service, have made particular gains for social inclusion. All of the projects appear to have made important contributions to the headline outcome of keeping older people in their own home for longer. This has been achieved by promoting the ability to live independently through the provision of preventative and respite services that are both social and health focused.

Focus group discussions and programme impact

At the focus groups with community planning partners and OPSDG the question was asked whether and why the groups approved the projects BNSF has funded. The consensus at the community planning focus group was that the selection of projects funded by BNSF was appropriate to the needs of older people, guided by consultation with that population, and likely to contribute to the stated outcomes for the programme. Participants indicated that the projects each had a contribution to make to the health and wellbeing of older people.

All the projects look like they would certainly be contributing to the health and wellbeing of older people. (Participant 9, community planning)
I would say that what has been funded is a useful selection; I think it would be difficult to quibble with the selection on principle. (Participant 9, community planning)

A particular strength highlighted by participants was that the projects were selected following consultation with older people about what kind of services they were looking for. The perception of participants was that if the selection reflected what older people stated they wanted or needed, that this was a key indication that the selection had been appropriate.

…We're delivering what they're looking for out there and I think that's more to the point… I think we're delivering what the people were asking for and you can't go wrong if you're delivering what they're looking for. (Participant 6, community planning)

The consultation exercise that was undertaken by BNSF is considered in detail in the section on Role of Communities.

BNSF funding of mainstream services

In contrast with the consensus obtained from community planning partners, the focus group with OPSDG revealed some dissent regarding the BNSF projects. Disagreement was voiced about the appropriateness of funding mainstream services,

in particular the NHS projects: podiatry and rapid response. On one side it was asserted that such services should be paid for within the health board's budget. The contrary argument was need-driven, such that services that are under-funded by the health board have a negative impact on the health of older people and therefore should be funded.

Well I felt a bit dubious about funding certain things because the health board should be funding podiatry. And there were other projects like that that were taking money out of the voluntary sector pot as it were… It's money that should come from the tax system. (Participant 4, OPSDG)

But surely at the end of the day, if we are able to fund these things and improve the situation for the people in our area that is more important than worrying about who in fact should have been funding it. (Participant 7, OPSDG)
But if podiatry gets away with it then occupational therapy could do the same thing. The various offshoots of the health service and the social work department could get additional funding because these are services which are already funded by the health board and the social work department. They're not being sufficiently funded but they're routed into the voluntary sector to get some money from there. (Participant 4, OPSDG)
But all the health service and so on would do is steal it from another department which then would be further down on the list and their service would be reduced. And so it would go on. (Participant 7, OPSDG)

The analysis of the Podiatry and Rapid Response projects certainly supports the assertion that they are improving the situation for older people, by promoting health, wellbeing and quality of life. It is also an important point that if these services are in fact under-funded by mainstream sources, there is consequently a negative impact on older people. Moreover, as is discussed in the section Sustainability and Mainstreaming, the BNSF funding of these NHS services has facilitated their becoming mainstreamed and thus produced a long-term improvement in their provision. The evidence would therefore tend to support the decision to fund these services. An important point about the debate of this issue is however, that it demonstrates the deliberation and discussion that is undergone by OPSDG in deciding how the BNSF money is spent.

PROGRAMME IMPACT: Service Planning and Delivery beyond BNSF

Thus far this section has been focused on programme impact at an individual project level. The following part of the section broadens out the scope to consider the wider impact of the BNSF programme upon service planning and delivery. Some key themes that emerged from the focus groups with community planning partners and with OPSDG will be used to explore how the programme has had an effect. Areas that are considered include the impact of OPSDG on community planning, and changes to service planning and delivery by community planning partners as a result of working with BNSF.

There are a number of ways in which BNSF has had an impact upon service planning and delivery by community planning partners. Perhaps the most evident way in which service planning and delivery have been affected is through OPSDG. Although the Lead Officer has ultimate financial control and responsibility with regard to BNSF funds, OPSDG have been allocated decision-making powers with regard to apportioning public money. In this way, they are directly linked into the community planning structure and are effectively a community planning partner. To that extent, BNSF have influenced community planning by adding a large representation of older people into the framework. Decisions that would previously have been made by paid officials are now being made by older people. OPSDG have an emphasis on action, and to that end they are involved in fourteen sub-groups of community planning forums.

When we first started we said straight away that it wasn't going to be a talking shop. Although we've been only in operation for one year we're already involved in I think its fourteen sub-groups, all working in different directions. (Participant 9, OPSDG)

OPSDG are a vocal and assertive group who take a critical stance toward practice and policy they perceive as unsatisfactory for older people. The group claim to have influence by representing and voicing the views of older people on these sub-groups. Furthermore, representatives from community planning both request to attend and are invited to attend OPSDG meetings in which they can listen to the discussion and views of the group or make presentations of their work and hear feedback. In this way professionals are directly being held to account for decisions which affect older people. This also creates potential for professionals to change or revise service planning and delivery in light of their communication with OPSDG. Focus group discussions indicated that OPSDG perceive their influence to be significant. Firstly, the members feel that they have challenged professionals and provided a direction for their activities.

I think also if you go back through some of the speakers that's attended any of our meetings, whether its health service or whatever, and ask them what involvement we had, or what influence we had or what input was given, I think you'll find that they would say that we did have a lot to say and that we can influence any decision or any policy making through people coming to hear us speaking, getting the views. (Participant 5, OPSDG)

Partners have reported anecdotal evidence to support this assertion. OPSDG had an early reputation as the 'lions' den' indicating their willingness to confront and

challenge. When agencies were required to attend OPSDG meetings they could expect to face difficult questions about their work and its impact upon older people.

When I get up to tell them (OPSDG) what's going on they're not shy about finding out what's what and being critical. Certainly early on they had a reputation of being the 'lions den'. If you had to go and present to OPSDG you would get the difficult questions, no doubt about it. (Participant 9, community planning)

OPSDG clearly perceived this kind of challenge to be novel for professionals; however they also felt that the professionals were willing to respond and utilise the input. In particular, the group indicated that through working with professionals they were demonstrating that older people were able to contribute, and in so doing, the group were challenging stereotypical and negative perceptions of older people.

One of the aspects about the speakers we've had is that its been one hell of a shock to them when they have come and spoken to us because they thought they were coming to speak to older people with their views of older people… we can sort of pick them up on something. They're just not expecting it; they're not used to it. That to me is where we've made a pointed response in waking these people up to the fact that we're not quite gaga yet… After the shock has worn off they're very responsive because they feel they're not talking to the table and that people are actually taking it in and are prepared to question them. (Participant 2, OPSDG)

This theme would suggest that an important impact of OPSDG upon service planning is their role in promoting the involvement of older people in decision making by providing a model of how this can work. By challenging the perception that older people have nothing to contribute the group may be carving a path for future involvement. One limitation of OPSDG's, at times, highly critical approach is the danger that this will put some agencies off. It may be difficult for some professionals to accept the criticism of OPSDG and use their input without feeling alienated. This was discussed with the BNSF Lead Officer. The dynamics of the group were highlighted, and it was explained that in situations where certain members may be particularly opinionated, there are other members who will move to mediate and 'soften the blow'. The Lead Officer described the group as having a 'checks and balances' system. While this is an important point, nonetheless the group's reputation as the lion's den is one that may still be alienating to professionals, although the Lead Officer is of the opinion that this is not the case.

A specific example of where OPSDG have had a direct impact is through their role in the writing of a new police strategy regarding attitudes to older people. This is a strategy that is being advanced and progressed in the Dumfries and Galloway region which, if approved, would be taken nationwide. The group were asked to contribute to the strategy, and members formed a working group with a police sergeant to that end. They were presented with the document already drafted and responded by making substantial changes.

Recently in Dumfries and Galloway the police have been asked to write a new strategy for chief constables and their attitudes to the elderly people. We at OPSDG were asked to come in on this and they'd nearly got a strategy written out which we have taken to pieces and nearly re-written. It has now got to go back and be

produced. This is a pilot scheme for Dumfries and Galloway. If it is accepted by the chief constable of the association it will go nationwide. So we're in on these pilot schemes now where we're recognised as a team to be reckoned with, with a lot of expertise. They're beginning to come here to find out how they should progress these things for the elderly throughout the country. (Participant 9, OPSDG)

Discussions with the BNSF Lead Officer provided an update on how this strategy had progressed following OPSDG's involvement. The strategy was sent back to the group following further work by the police. What was sent back was effectively two documents, the first included a vision statement and strategic direction and the second was an action plan. According to the BNSF Lead Officer, OPSDG were very pleased with the first document which strongly reflected their recommendations and the language they had used. The second document was, however, prepared by another police officer who had not been involved in the working group with OPSDG. The Lead Officer explained that the latter document had effectively reverted to 'police management speak', and thereby did not reflect OPSDG's input and recommendations. Whilst this was a disappointment to the group, they have continued to exert influence.

The limited success of this venture must be viewed in the wider context of involvement of older people. That the group were asked to contribute at all is a considerable achievement, and the retention of their input into half of the strategy only adds to this success. To that extent, their involvement has been genuine and has implications for a nationwide impact as the police strategy is taken forward. Although this was clearly a qualified success, what OPSDG are trying to effect is change at not only an operational, but at a cultural level. Such change can only be expected to occur incrementally. What was achieved was the potential for change through the implementation of the strategy which included OPSDG's revisions. As OPSDG continue to create these small changes, the longer-term impact may be a progressive shift in the culture of working towards one that is more appropriate to the needs of older people. This should occur through their continuing and increasing involvement in community planning. The evidence from this example would suggest that OPSDG have made some progress to that end.

Impact of Home Safety Working Group on Service Planning and Delivery

Another way in which BNSF has influenced service planning and delivery is through the Home Safety for Older People Working Group. By setting up this group BNSF have created and cultivated a multi-agency approach to the planning and delivery of home safety information and advice to older people. From the focus group of community planning partners it was evident that through this partnership working, BNSF had lobbied partners to carry out work that would benefit older people. Partners indicated that the older population were not necessarily their chief priority; however the influence of BNSF had served to focus them in this direction.

Our own action plans within our strategy is to seek out any vulnerable person, and there are quite a number of groups. But because of the focus that BNSF puts on elderly people, then elderly people are very high on our priority. If BNSF weren't there to give that coordination then all the roles could become equal and we'd be focused one day on one and one day on another. What happens through BNSF because of the constant contact we have through the meetings that are set up; if they

were to fall away, because we've all got our day jobs to do, we couldn't put the resources in to concentrate as much on older people. (Participant 1, community planning)

Partners further explained that this focus on older people had not only occurred as a product of their partnership with BNSF and the Home Safety for Older People Working Group. Having found the latter Group to be a successful way of working some indicated that they had gone on to conduct further work for older people as a result. This evidence indicates that BNSF had influenced partners to focus their attention and resources into work for older people.

Home safety is not a statutory function for our organisation, but because its been so successful, just that working relationship with both BNSF and through the Home Safety Group and other meetings we're continuing to put resources into that because it pays benefits. (Participant 5, community planning)

These examples indicate that the BNSF focus on older people has been absorbed by partners. The evidence suggests that BNSF has had a 'ripple' or cascading effect. At the first point of contact, BNSF has brought partners together to work in partnership for older people. However, the effect continues to spread, through partners taking this approach forward in their other work. This is an important way in which the programme has affected service planning and delivery for the region, by increasing the focus of various agencies and services on older people.

The focus group discussions revealed other ways in which the BNSF programme had had an impact on service planning and delivery by partners. An interesting theme that emerged was the impact of the Home Safety for Older People Working Group on the public perception of the partner agencies involved. A theme emerged about services becoming more personable and accessible to older people. This theme applied particularly to the uniformed professions involved with the Home Safety for Older People Working Group. The direct involvement of fire and police officers in the Home Safety road-shows and of fire officers in the Home Fire Safety Checks project meant that these agencies had increased interaction with older people in the community. This kind of interaction is relatively uncommon for such professions whose contact with the public is generally in reaction to an incident. Through this interaction, fire and police officers were perceived by older people as more approachable, or friendly.

…Just a side issue I suppose but very important to people living on their own - developing a friendly face. An old lady recognised a community police officer because she'd spoken to him at a road-show; she met him in the street and asked him to change a light bulb for her… She wouldn't have done that before… Policeman in uniform, well he's on duty, but now he's a friend. (Participant 3, community planning)

Even a policeman when you go to these kinds of strategies recognises that they are not friendly faces. The majority of the public see them looking through car windows now, pulling them up for this that and the other… This puts a face on the policeman that they can talk to in the same language with the same problems. (Participant 9, OPSDG)

By promoting the 'friendliness' of these agencies in the eyes of older people, there is an effect on their service delivery, such that older people can more readily utilise these services. Because this effect was attributable to the work of the Home Safety for Older People Working Group, it is an impact that can be clearly traced to the BNSF programme.

Impact of Guid Guidance for Older Folk Directory on Service Delivery

One further example of how BNSF has affected service planning and delivery was provided at the focus group of community planning partners. Representatives from the fire service and police indicated that they had made use of the BNSF Guid Guidance for Older Folk Directory. The police service representative explained that the directory was handed out to operators in their force control centre. This had promoted their efficiency by collating a large amount of information into one document. Without the directory, operators responding to a query may have had to conduct various enquiries to obtain information before being able to return to the person and provide an answer. Evidently using the directory had enabled them to answer queries more quickly and thus it had promoted a more efficient, prompt service. Additionally, in response to a rash of 'distraction' burglaries along the motorway corridor, the police launched an information/advice initiative, 'Operation Rat', which used and promoted the directory via press releases and television advertising, advising people to check that any tradesmen or workmen were bona fide.

The fire service representative indicated that the benefit of the directory for their organisation was that they could hand it out to service users when conducting home fire safety checks. An example was given where an older lady had sought information on a reputable electrical firm having used a firm in the past that she didn't wish to employ again. The fire officers were able to provide a copy of the directory that would allow her to find an appropriate service. In the past the officers would have had to refer her to the Yellow Pages, the services in which may not have been council approved contractors. By providing the directory they were thus able to be of more assistance and potentially prevent the older person from using a non-reputable firm. These two examples indicate that the directory had served to enhance the service provision of these agencies.

A number of other key themes that emerged from discussions regarding the Home Safety Working Group are discussed in the Partnership Working section.

Impact of BNSF at National Level

A potential impact of the BNSF programme at a national level was indicated in discussion with the BNSF Lead Officer. The Lead Officer was recently involved in a working group from the Association of Directors of Social Work Group, focused on a partnership between Care at Home Services and Podiatry. The Lead Officer was feeding into the group information about the inter-agency working between Podiatry and CAHTC. The information from this group will be used by the Scottish Executive who are currently working to modernise Podiatry, reviewing such things as job descriptions. BNSF's role in this working group was to encourage Podiatry to provide training to care at home staff in basic foot-care for older people. The Lead Officer indicated that the NHS was reluctant to engage in this kind of training due to concerns about litigation. BNSF contend that basic foot care tasks such as nail cutting are within the capabilities of care staff and could have important benefits for older people

through prevention and promotion of foot health. The difficulty Podiatry have in meeting the demand for their service was emphasised. Any preventative measure that reduced the burden on the service and improved the health of older people would therefore be mutually beneficial. This is a good example of how the BNSF team has encouraged other agencies to think outside their remit and engage with other agencies. It is also a key example of how the programme is potentially having an impact on service planning and delivery not just at a local but a national level.

SECTION 7: VALUE FOR MONEY

The following section explores issues related to the value for money of the BNSF programme and the specific projects that are funded. This section firstly considers the success of BNSF in levering in funds from other sources. The value for money of each of the projects is then considered in turn using evidence from the questionnaire data, interviews with project managers, the BNSF Lead Officer, BNSF documentation, and the focus groups with OPSDG and community planning partners. The questions that are considered include an examination of the value of each project in terms of the quality and quantity of the outputs and outcomes delivered with the funding; a consideration of the effectiveness of the projects as a means of delivering these outcomes; a consideration of any evidence of additionality associated with the programme and any evidence that projects have substituted activities, displaced problems, or diverted resources to other areas.

Funding From Other Sources

The BNSF Lead Officer indicated that the main source of funding that BNSF has obtained has been the Community Safety Partnership Fund, which awarded the Home Safety for Older People Working Group £30000 in the first year and £19000 in the second year for home safety projects. As is discussed in the section on Sustainability and Mainstreaming, the Lead Officer had limited success in bidding for Community Regeneration Funding for the continuation of the BNSF projects. A bid was entered last year by a range of partners, led by BNSF, to the Department for Work and Pensions. This funding was sought to address the problem in Dumfries and Galloway that 11000 older people who were eligible to claim Pension Credit were not doing so, resulting in £11,000,000 lost income for the community. The partnership included representatives from BNSF, OPSDG, Elderly Forum, Food Train, Care and Repair, Age Concern Scotland, Alzheimer Scotland, Council of Voluntary Services Federation, Welfare Rights, Dumfries and Galloway Citizens Advice, and Dumfries and Galloway Council's Finance Section. The aim of the partnership was to promote the uptake of these benefits by older people across the region. The Lead Officer explained that while the bid was highly scored it had been unsuccessful. However, at the time of making the bid BNSF had reported on the proposal to the Adult Services Sub-committee to inform them of the work. BNSF submitted a report to this committee indicating that they had identified non-recurring funding that they had like to use for the work outlined in the DWP bid. As a result of this report the council awarded £300,000 to undertake this work. This is a very important project for BNSF as it clearly addresses the social justice milestone to *'reduce the number of older people with low incomes'*. This is particularly salient because none of the other BNSF projects have directly contributed to this goal. Moreover, the proposal also aims for: 'integrated joint working between partners'; 'promotion of independence in older people'; 'improved access to services' and 'better understanding older people's needs in a specific community, region/country setting including needs of ethnic minority elders'.

Active Service

Questions have been raised by OPSDG and BNSF regarding the number of service users that Active Service supports. Specifically there is a concern that the cost per

head of this service is very high, with only 17 individuals currently receiving support. In considering the value of this service it is important to focus on the quality of the service delivered in terms of the specialist intervention and the quantity of one-to-one time provided to service users. Within time and budget constraints the evaluation has not been able to conduct a comparison of this service with equivalent mental health provision in other localities. However, what is apparent from the survey of service users is that the service has had an impact on all of the aspects of quality of life that were asked about in the questionnaire. It is useful to consider project impact in terms of a breadth/depth trade-off. Active Service provides a deep impact for a small number of service users. The depth of this impact is owing to the quantity of support provided at an individual level; service users receive regular and ongoing one-to-one intervention from a skilled worker. It is also important to note that the number of service users must be considered relative to the population of older people who have functional mental health problems. The proportion of this group represented in the service will be much higher than that of the general older population. A comparison between this service and a more generic service could therefore be misleading. Undoubtedly the number of service users supported by this project is small in comparison to others funded by BNSF. What is apparent, however, is that the service users perceive a significant impact of the project upon their quality of life, including their mental health. Thus, while the impact of the project may be small in population terms it would appear that it is very significant at an individual level. This would suggest therefore that the service provided is high in value.

The Care at Home Training Consortium

The CAHTC project is a unique venture addressing a considerable lack of training for home carers. There is no other formal training offered to carers in the private sector available in the region. Consequently there is no evidence of additionality associated with this project. While the direct service-users of this project are carers, the indirect benefit to older people is clear. Their need for care also demonstrates that these older people are likely to be at the more vulnerable end of the continuum, thus the project is reaching those to whom the BNSF funding is particularly intended. The survey data detailed earlier in this section clearly exhibit that the satisfaction with the training and its relevance to caring practice are very high. These findings indicate that the quality of the service is excellent. The 2004 BNSF annual report indicated that project had provided training to 1258 carers, having delivered 1533 training days over the period of BNSF funding. Moreover, the number of older people directly benefiting from this improved provision of care is even higher as carers regularly provide care to more than one older person. Evidently the 'quantity' of the project in terms of its provision and impact is also substantial.

There is evidence that the project has endeavoured to promote cost-effectiveness, for example through recruiting a full-time carer and utilising fire services as a venue for training. The project manager also indicated that OPSDG had encouraged the project to charge care providers to use the training. While in the first year the training was provided at no charge, in the second year care providers were charged £5 per person per day, and in the third year the charge was £10 per person per day. In this way the project is contributing to the cost of training thus enabling the BNSF funding to be stretched further. The project manager also successfully drew down funding from Scottish Enterprise Dumfries and Galloway and the Adult Literacy and Numeracy

Partnership for the Step Into Care programme. Taken together all of the available evidence indicates that this project has delivered excellent value for money.

Dementia Friendly Communities

Whilst there is a cost attached to providing the events, whether a talk or a workshop, and development and production of materials, such as the newsletter and awareness stickers, an important element of the project is highlighting and making people aware of the services and support that are in existence in their local area, and where they can go for help and advice. The DFC project serves, by means of a one-off event, to increase the awareness and understanding of the illness and to empower individuals by providing them with skills to interact with people with dementia. However, it also ensures that individuals are aware that organisations, such as Alzheimer Scotland and the 24 hour Dementia Helpline, can provide ongoing support, both general, with regards to giving information, and specific, such as identifying local services.

The project has been researched, developed and run by one member of staff, who has reached over 500 people through scheduled talks, approximately 150 people who have attended workshops, and by presenting the work of the project, either at conferences, through displays, investigatory phone calls, letters and unscheduled talks, has reached hundreds more people. Additional articles published in the local press and local and national newsletters have also served to broadcast the project and its progress. The feedback from the project questionnaires outlined in the previous section, indicates that it has been very positively received by service users, the majority of whom perceive a growth in their understanding and awareness of dementia. Through this means the project may have an important effect upon the social inclusion of people with dementia. The project is provided at relatively low cost and the evidence indicates that it is achieving its stated outcomes. There is certainly no evidence of additionality, given that the project is a new and unique approach from Alzheimer Scotland. It would appear therefore that what is delivered by Dementia Friendly Communities is good value for money.

Food Train

From the focus group discussions and discussions with the BSNF BNSF Lead Officer and Food Train project manager it was evident that the Food Train is unanimously considered excellent value for money. The quality and quantity of the service delivered is undoubtedly judged very positively by service users as evidenced by the questionnaire feedback. The project manager outlined the costs involved in running the service, and surmised that to provide the shopping service of two deliveries per week for 52 weeks of the year, would cost £5 per person, per year. The service is therefore provided at a very low cost and benefits approximately 300 older people across the region, many of whom have indicated that their independence is contingent upon having the service. There is no evidence of additionality associated with this project, as the only other service that delivers shopping is that provided by the supermarkets at a much greater cost and to the whole population.

The project manager has been persistent in seeking out funding from other sources to promote and expand the service, although not all bids have been successful. For example, funding was sought from the Lottery Fund, the Community Regeneration

Fund and the Rural Challenge Fund. The project received two national awards in 2004, The Queen's Jubilee Award and the Guardian Society Award, demonstrating outside recognition of its achievements. Taken together all of the evidence strongly indicates that the Food Train is delivering outstanding value for money.

Guid Guidance for Older Folk Directory of Services

The directory of services is undoubtedly a very well presented and useful document for older people. The booklet can be provided at relatively low cost given that much of the information used is readily available to the BNSF team through their association with the council. This has probably reduced the effort and consequent expense involved in obtaining such a diverse and voluminous quantity of information. Moreover, savings have been made in the production of the Home Safety Section of the booklet by utilising the partnership with the Home Safety for Older People Working Group to disseminate this information. BNSF indicated that the directory is used by various agencies in their work with older people, such as social workers, police and the fire service. In these ways the information in the directory is being put to use across a wide spectrum of service delivery. This is over and above the uses made by the individual older people who posses a copy. The latter impact is very difficult to evaluate given that the directory is distributed to all of the places where BNSF suspect an older person may gain access to it: GP surgeries, pharmacies, libraries, and so on. There is no way to determine, therefore, who has picked up the directory and to what uses they have put it.

To the extent that the directory achieves its aim of promoting the availability and uptake of information, it is providing an excellent service. As the programme impact section indicates, this is difficult to evaluate as by and large people will only use the directory when it is required; it is not an ongoing intervention in the manner of the other BNSF projects. However, where the information is used, it is allowing older people to employ reputable contractors, to access local services such as day centres, to utilise organisations such as Alzheimer Scotland, and to enhance their home safety through the information and advice provided. In all of these ways the booklet is contributing to uptake of preventative services and the promotion of social inclusion. The potential savings made, for example, from older people avoiding the expense and humiliation of employing a disreputable firm, or the value of accessing preventative services at an earlier stage thereby negating a crisis, are immeasurable. Although the evaluation can only speculate as to the latter impact, it seems likely that within the 12000 copies distributed, such an effect will have occurred for some older people. The directory is therefore considered a very good value service.

Home Fire Safety Checks

The Home Fire Safety Checks project provides immeasurable value for money in helping to prevent the substantial financial and, more importantly, human cost of fire. The project manager indicated that the number of injuries resulting from fire had fallen from 19, plus one fatality, in 2003, to 3 injuries for the first half of 2004, suggesting that the project may have been contributing to a reduction. Importantly though, a clear reduction in the number of fires may not yet be observable within the short time period that has elapsed.

The service has exceeded its targets for the provision of free checks and has been very positively received by service users. The value to service users of increased assurance of safety and the reported improvements to quality of life are important contributions of the service. There is also clear evidence from the project manager that the project has promoted cost-effectiveness, through providing free energy efficient bulbs via the partnership with Scottish Power, and by advertising the checks at road shows to reduce duplication of effort and the use of officer time spent on promoting the service. The evidence presented therefore indicates that this service is delivering excellent value for money.

Podiatry

The data obtained from the survey feedback would indicate that the Podiatry service is highly valued by service users. The project has clearly had a very positive impact upon many aspects of quality of life and the reported satisfaction with the service was very high. The evidence would suggest that Podiatry has made an important contribution to the outcomes of the programme by providing a preventative health service that indirectly promotes social inclusion. Moreover, the project would appear to have contributed to satisfaction with health services. The only concern regarding the value for money of this project concerns additionality, which was discussed under the heading of 'factors affecting attainment of outputs and outcomes' in the previous section.

Rapid Response

The Rapid Response project manager indicated the BNSF funded Wigtownshire Rapid Response had a relatively high referral rate compared to the equivalent project in Dumfries. It was also explained that since the inception of the project the hospitals in the west had managed to meet their discharge target. Delayed discharges had reduced from fifteen in Dalrymple Hospital and three in Newton Stewart to zero. A central aim of the project was to promote efficiency. By reducing delayed discharges to zero the service freed up beds within the hospital and tackled the problem of 'bed-blocking'. The project manager indicated that this has positive financial implications for the NHS as patients can be moved through the system much more quickly. As is discussed in the later Sustainability and Mainstreaming section, the Rapid Response service has now ceased and been replaced by the Short-term Augmented Response Service (STARS). The decision by the council and NHS to fund the latter project reflected the success of Rapid Response and the desire to mainstream and expand its service. The project had supported 487 people over the funding period. These individuals would have received up to 14 days support during the day and night, as required. As was explained in the Programme Impact section, the project received unanimous ratings of either 'satisfied' or 'very satisfied' and had a positive effect upon quality of life for a large proportion of respondents. These data indicated that the service was highly valued by service users. This evidence would suggest that the Rapid Response project has delivered a good value service for the money spent.

Value for Money and OPSDG Selection of Projects

The focus group discussion with members of OPSDG provided information regarding how projects were selected for funding. This information indicated the areas that the

group focus on in determining whether a project will be good value. The projects had to be explicit about what they had achieved and aimed to achieve in future. Evidence of how a project would promote quality of life, health and safety, and independence was sought. In particular this evidence had to show the contribution to the overarching aim of keeping older people in their own homes.

When we joined OPSDG the remit we were given was to keep people in their homes for as long as possible and be able to get as much support as they needed or required… I think that's how I measure it: what good they're doing to keep people in their homes for as long as possible. (Participant 8, OPSDG)
And not only to keep them in their own home but give them quality of life and keep them safe… Everybody wants to stay in their own home. They don't want to go into a nursing home or an old folk's home or anything. When we look and we judge the things they're doing, it's the quality and keeping them in their own home. (Participant 6, OPSDG)

Apparent from much of this discussion was a person-centred focus, informed by the group's own experience of being older and their empathy for other older people. The conviction that older people prioritise their independence clearly underlay the decision-making. For projects seeking to continue their funding, there had to be evidence that their outcomes had been met, and explanations given for where this had not been the case. The group indicated that the monitoring system in place provided the evidence they required to make this assessment and determine the effectiveness of the projects. Moreover there was an indication that the prior experience of group members was used to inform this assessment. For example, members highlighted the role of case history and evidence.

I think too the feedback from each of the projects at the end of they year; you could easily assess how effective they were being by the feedback you got from them. I think that was really important to look at as well. (Participant 7, OPSDG)
Yes, we weren't just jotting things down, there was good case history, there's good historical evidence there of what they've done before and what they wish to do next year. (Participant 6, OPSDG)

Where projects were failing to meet outcomes or having difficulty, OPSDG required to be informed of this and to have the reasons why provided. In the absence of this information the group indicated that a project would be called to account.

The application has to state what they want and what they're doing and it has to state if they're actually doing that and if they've achieved any targets that were laid down when they were initially granted the money. If they're not achieving the targets they have to say why, for example turnover of staff or sickness and so on. These elements of it we have to take into consideration in our assessment. The outcomes, what they actually do has to emerge at some time from their application. If it doesn't emerge we either qualify our allocation of funding or we tell people they'll have to pull their socks up. (Participant 4, OPSDG)

There is evidence to support this assertion that funding would be qualified and that projects would be reprimanded for failing to achieve. The projects are required to submit monitoring forms monthly to BNSF to report on their progress. The

information obtained from the monthly monitoring system is used to inform the decision to continue funding projects each year. It is evident that this monitoring system is the key line of communication between BNSF and the projects. The outcomes of two projects, Helping Hands and Active Service, have been questioned with the result that the former project's funding was ceased and the latter project received an extension for a limited period subject to further review.

A common problem between these projects was a breakdown in their communication with BNSF. Both the Podiatry Service and Rapid Response have also reported outcomes that were not fully met, however the important difference with these projects was that BNSF were kept informed of the project's progress and given clear reasons for any problem. The Podiatry project indicated they had never been chastised by BNSF for failing to meet their targets. They attributed this to having provided BNSF with a full understanding of their difficulties.

When BNSF were gathering the reporting information for OPSDG regarding the continuation of funding into year three, they reported that Active Service had either failed to meet or had only partially met their outcomes. The reason for this was because Active Service had failed to report to BNSF on their progress through the monitoring system. The project were confronted about this failure and made a presentation to OPSDG about their work. Consistent with their reputation as 'the lions den', and by their own acknowledgment, OPSDG challenged the project manager. Questions were asked about the number of service users and the failure to communicate with BNSF. In describing this experience, the Active Service project manager explained that this was an open meeting with the whole OPSDG group and was unsuccessful in resolving the issues. A second meeting was held with a smaller group, and this appeared to create more focus and facilitate a more effective discussion. At this meeting the project manager felt he had been able to explain fully what service was delivered, indicating that the failure to effectively report to BNSF was in part due to not understanding the reporting mechanism and the monthly form. The conclusion of the meeting was that OPSDG continued the funding for a limited period after which the project would again be reviewed. This review is currently ongoing.

The Active Service project manager indicated that having re-established communication between the project and BNSF the project manager and BNSF project officer had worked together to establish an effective reporting system that met the needs of both. The project manager reported that this work had been very useful as it had enabled a revision of some outcomes which had proven unattainable for the project. The work of BNSF to resolve the problem with Active Service and their flexibility in revising the project's outcomes suggests a commitment toward supporting projects to achieve. It also indicates a willingness to respond to and learn from experience.

Cessation of Funding

As alluded to earlier, not all of the original BNSF projects have continued beyond the initial year's funding. With regard to the Helping Hands project, BNSF reported that at the first scoring meeting for the continuation of funding they had received a number of complaints concerning the project, from local businesses and customers. In addition BNSF had not received the necessary monitoring forms from the project

required to score it and therefore were reporting unmet outcomes. BNSF report that they endeavoured to contact the project to re-establish communication by phoning, emailing and visiting the project, but to no avail. The decision was therefore made by OPSDG to cease funding of the project. At the focus group discussion, the group indicated that this decision was not taken lightly.

We actually stopped one altogether last year. They were just not doing what they said they were doing (Participant 9, OPSDG)
It was a difficult decision that... It took a lot of people… (Participant 6, OPSDG)
Yes because there's a lot of people affected by it. (Participant 9, OPSDG)
But it had to be done. (Participant 6, OPSDG)

The effect of ceasing the funding upon those involved was a concern that had to be weighted against using the funding appropriately. The group clearly indicated a feeling of responsibility for their position and the power they had over the use of public money.

We have the responsibility of handling the money that we're allocating responsibly. (Participant 9, OPSDG)

We're all ordinary people sitting round here and it is the public's money, it's the public purse that's paying for all these different things. There's no salary init for us and we need to spend the money well. (Participant 6, OPSDG)

The decisions to cease and qualify funding for these projects provide evidence that BNSF and OPSDG utilise their monitoring system and respond to it accordingly. Moreover, they demonstrate readiness on the part of BNSF and OPSDG to make difficult decisions that show a commitment to quality. This readiness provides reassurance that the value of projects is carefully considered with a clear concern to spend the BNSF funding prudently.

It is interesting that communication is such an important aspect of the running of the BNSF programme. The BNSF team have indicated that a close relationship has been built over time with most of the projects that are funded. This relationship is moreover viewed as critical to how BNSF operates as 'glue'. According to the team, where a project excludes itself from this relationship, this suggests a failure to acknowledge that "the whole is greater than the sum of its parts". The concept of 'glue' is explored in considerable depth in the Partnership Working section of the report.

<u>Value for Money and the Home Safety for Older People Working Group</u>

Discussions with community planning partners revealed that there had been some disagreement in the Home Safety for Older People Working Group regarding the cost-effectiveness of the road-shows following the first year. Concerns were raised about the use of officer time relative to the number of older people who had been involved. The first year of the road-shows received a relatively poor turnout from the public, which was attributed in part to the location used. The road-shows were held in fire stations to reduce cost; however this may have reduced their accessibility to the public. The group can be credited for learning from this experience. The venue was

reviewed and the following year the group ran the road-shows in more accessible locations. The second year saw a substantially improved turnout. The discussion about cost-effectiveness indicated that the financial value of the road-shows was weighted against other values such as the value of the exercise to the communities involved.

If I'd run the road-shows in the first year I wouldn't have felt they were cost effective. But then other people value different things. We had the discussion at the home safety group about the value of the road-shows, and the question was raised about officer time, the miles covered and how many people were actually contacted during that period. There was a counter-argument put forward that there's merit in it beyond the obvious; there's merit in people in the communities knowing that there's somebody bothered to come and speak to them in their local village hall and that sort of thing, which of course isn't quantifiable in financial terms. (Participant 9, community planning)

This notion of 'added value', such as the added value of demonstrating to the community that agencies are concerned enough to 'show face', was a theme that emerged regarding all of the BNSF projects. One aspect in particular that was highlighted concerned the value of human contact provided by these projects over and above the service that is delivered.

I suppose another good thing about these kinds of little activities is that somebody comes and does them. So that's a feeling of support as well, that 'oh the man's going to come and do my garden today', that's probably quite a good feeling for somebody which is above and beyond the fact that their garden is being tidied up. If you could get a robot to come and clean their garden it wouldn't be the same kind of quality of intervention as a human coming and doing the garden and maybe asking how they are. (Participant 9, community planning)

This added value may be particularly applicable to projects such as the Food Train, Home Fire Safety Checks and Rapid Response, where the older person is receiving the service in their own home. These projects may therefore be contributing to an older person's feeling of connectedness with their community.

Questioning the Concept of 'Value for Money'

The suitability of the concept of 'value for money' was generally questioned in the focus groups, with participants asserting that value could not necessarily be measured in monetary terms. According to this view the more pertinent question concerns the value a service has for its recipients. The difficulty in measuring this kind of value was also highlighted.

Sometimes you can't evaluate on money lines, you have to evaluate it on the service you're delivering to that person – it's a personal service. You can't say 'we've saved £20 doing that when you may actually save someone's life. It's in the value delivered, not just in cash but the service. (Participant 6, community planning)

Keeping people at home where they want to be is costing the social services more than it would be to put them in a home, but that's where they want to be. So it's not

all about saving money, it's about still delivering what the person requires or needs or wants. (Participant 6, community planning)
It's difficult measuring value. Money is easy to measure; you see it on a bank statement. Value for money is difficult to quantify. (Participant 2, OPSDG)

The point that is clearly made is that services should not be assessed purely on their cost-effectiveness. The focus group demonstrated a perception that the value which older people place on remaining at home justifies the expense in ensuring they can do so. For example, if it is detrimental to the emotional wellbeing of older people to be placed in residential accommodation, this intervention would not be considered good value for money. This argument may be usefully applied to the Active Service project. While the unit cost of this project may be greater than other BNSF funded projects, the intervention delivered might also have a larger impact in terms of the quality of life of the service users. The value of the service is in the scope of the intervention delivered and the resultant impact. In the case of Active Service, the analysis has suggested this impact is significant.

The value of preventative services
The BNSF programme is broadly focused on providing preventative services. The focus group discussions demonstrated a belief that the monetary value of these services resulted from their reducing the likelihood of incidents such as fire, and prolonging the health of older people. These effects would in turn produce comparative financial savings on the economy. At the OPSDG focus group an example was provided indicating that the overall cost of a fire was in the region of one million pounds. This suggested that only one death would need to be prevented to make the expenditure on projects such as the Home Fire Safety Checks excellent value.

BNSF have been very good in staging these Home Fire Safety Checks and so on along with the fire brigade and all the essential services. These have been a terrific success with something like 200 in the first year, but last year it was going on eventually 700 home checks. Now if only 1 percent of those saved a life, to what I can hear at a police meeting a week ago, a road accident costs about £1million. I don't know what an accident in the home would cost to investigate but its got to be a terrific saving on the economy to make this kind of progress with the older people, making them aware of the problems that they probably don't even see, and making them aware that the services are there and that they're friendly. (Participant 9, OPSDG)

The Home Fire Safety Checks project manager echoed this argument, providing a clear example of the kind of preventative exercise that could have averted a fatality. Moreover, the manager added the point that the value of a human life cannot be measured in monetary terms and the value to the community of avoiding such an incident was highlighted.

When I see the return for our questionnaires, an elderly person saying 'I didn't realise my smoke alarm didn't work until the fire fighters did a smoke test and replaced it. One that I can remember in particular the fire fighters pointed out three faults, one and two are sorted out and three they pointed out a bare wire on an electric heater in a bedroom. To me that probably was over £1million saved, because the effect of that on the health service and the local economy if that person had

suffered in a fire and become a fatality – you can't put a price on that. So when I see these types of returns coming through, we see the value of the service that's being provided for a very small amount of money. (Home Fire Safety Checks project manager)

These arguments concerning the value for money of preventative services are very important. Each of the projects has clearly provided evidence for indirect improvements to the health and wellbeing of older people resulting from increased quality of life, reduced social isolation and increased inclusion. The secondary effects of these contributions upon, for example, spending on health and social service provision, are potentially great. Moreover, the accumulation of small impacts created by each project to the BNSF outcome as a whole could result in a significant impact. What must also be considered is the value of prevention to the service user. To provide a preventative service that prolongs independent living and quality of life will undoubtedly greatly enhance an older person's experience of living. Thus the value of prevention has to be considered at this level. All of the BNSF projects have made an important contribution to that end.

SECTION 8: PARTNERSHIP WORKING

The following section explores the evidence of partnership working in the BNSF programme. The section examines the involvement of community planning partners in shaping and influencing the development and delivery of the programme, and considers the role of the community planning process and structures to that end. The role of BNSF in facilitating partnership and inter-agency working is also considered. Important evidence is provided to support and develop the concept that was purported in the 2004 annual report of BNSF as 'glue'. The main evidence in this section is derived from the focus group discussions with community planning partners and OPSDG and from discussions with the BNSF Lead Officer.

BNSF has involved and consulted with community planning partners in the development and delivery of the programme in three main ways:

1. Through reporting to community planning partnerships on the progress of the programme.
2. Through OPSDG
3. Through the Home Safety for Older People Working Group

Direct Reporting to Community Planning Partnerships

From discussions with the BNSF Lead Officer and the focus group of community planning partners it is evident that BNSF have made an effort to inform partners about the BNSF programme. The Lead Officer reports directly to two of the three community planning forums: the Inclusive Communities Forum and the Safe and Healthy Communities Forum. BNSF report annually to the area committees and report to Local Rural Partnerships (LRPs) where possible. LRP meetings are, however, themed which restricts BNSF from reporting on their work until it is applicable. Evidence from an interview conducted with a community council representative in the Dumfries and Galloway area would indicate that this reporting mechanism is effective in conveying the message. The representative indicated that she was very familiar with the programme having seen various presentations conducted by the Lead Officer at area committee meetings. At the community planning focus group, the Lead Officer was described as pro-active in seeking out partners and ensuring they are aware of the programme. Moreover, her commitment to involving partners and promoting partnership working received praise.

Well certainly I would say that as far as community planning goes Jean has always been careful to have partners round the table… So I would say there's a commitment there to engage with community planning partners (Participant 9, community planning)

A consultation exercise was conducted in the early stages of the programme with older people, and is described in the following section, Role of Communities. The findings from this consultation were fed back into the community planning structure through the mechanisms described, thereby providing the opportunity for feedback and comments from partners, and thus 'closing the loop'.

I believe BNSF went out to the older persons first to ask them what they wanted and then went back to community planning and put to them the ideas that were coming through. (Participant 6, community planning)

Through these various mechanisms BNSF has ensured that community planning partners are aware of, and can contribute to the work of the programme.

OPSDG

Community planning partners have also had a role in BNSF through OPSDG. As was indicated in Section 5, OPSDG are involved in fourteen sub-groups in community planning including the Home Safety for Older People Working Group. Partners from the council and various departments and agencies have also attended OPSDG meetings and given talks. Furthermore, OPSDG members are pro-active, inviting partners to attend. These methods of interaction and involvement provide partners with a number of opportunities to influence the group. Given that OPSDG decide on the funding of BNSF projects, these interactions therefore provide partners with a close connection to the development of the BNSF programme.

Home Safety for Older People Working Group

Community planning partners have had a direct role in the development and delivery of part of the programme through their involvement with the Home Safety for Older People Working Group. This is a sub-group of the Safe and Healthy Communities Forum that is chaired by the BNSF Lead Officer. The Lead Officer is credited with starting this group in response to her frustration that the main forum was achieving too little for older people.

You see Jean got frustrated in that group because she felt it wasn't getting enough done for older people… So she proposed they have a sub-group of that group looking at older people's issues specifically. That was how the Older People's Home Safety Working Group got formed with community planning partners round the table and Jean chaired it. And so all the actions that have come out of that group you could attribute to Jean's influence and BNSF's influence and that group has achieved quite a lot. (Participant 9, community planning)

Partners involved in the group attributed much of its success to the input of the BNSF team. As the above quote indicates, the setting up of the group was directed by the Lead Officer. The main actions to have come out of the Home Safety for Older People Working Group are the road-shows conducted in 2003 and 2004. Other activities resulting from this group include the distribution of home safety packs, a survey of older people regarding home safety issues and the construction of home safety training material for paid carers.

The focus group discussions revealed a number of benefits for partners of being involved in the group and part of the partnership working. Partners highlighted the benefits of the group being small in comparison to the rest of community planning. The smaller group enabled partners to learn about each others' roles and contribution. It also promoted closer working relationships between partners that could be utilised outside the group.

The beauty of the small group is that you not only get to know what each other do, you also get to know the people involved, the personalities, so you can pick up the phone and say "I'll just speak to X or Y" and I did that the other day, sent an email and someone gave me the answer all within days. If you didn't have that relationship then that could take weeks. (Participant 5, community planning)

As we talk through issues and proposals around the table you get a feeling for what the other agencies are concerned with, what their difficulties are and what they need from you… So I think there's value in that even beyond what's being delivered on the ground. Because I think we're all now, I'm certainly more aware of where other agencies contribute to the wellbeing of older people and more aware of the difficulties that they have and the kind of information that they need and the things they struggle with. (Participant 9, community planning)

To the extent that BNSF was responsible for setting up the group, many of these benefits can be attributed to their influence. However, the contribution of BNSF was evidently much greater.

BNSF as 'Glue'

A theme that emerged from the focus group discussions was the role of BNSF in providing administrative support to the working group. The BNSF team took responsibility for various tasks such as completing funding bids and producing the Home Safety packs. By assuming this role the team freed up the other partners to focus solely on contributing their message to the road-shows.

I think the likes of Jan and Claire that are employed to do just this work, BNSF, if that wasn't there you'd have people trying to do that as part of their job. (Participant 4, community planning)
I think that's a good point; that the admin backup, just doing the road-shows – they put the home safety packs together, they record everything. We don't have to do that so we can stick to turning up on a specific day and delivering the message (Participant 5, community planning)

This administrative role goes some way to explaining how BNSF operates as "the 'glue' that attracts, holds together, and drives a wide range of preventative services for older people" (BNSF annual report, 2004; page 1). As a team that links in with various agencies and the older population, BNSF can be usefully conceived of as the hub of a network. Various partners and project managers described using BNSF as a connection to other agencies, as a source of advice, and as a point of referral.

The beauty of the arrangement with BNSF is that I quite often phone up Jan or Claire and say 'where do we take this?' and they'll come back or they'll take it on and take it to social services. We have found people who are disabled and couldn't escape their home in a fire. We've been able to pass it on to BNSF who then involve social services and get a ramp put in place for the person. That sort of thing wasn't happening before because you carried out your own role and then it came to an end (Home Fire Safety Checks project manager)

The above anecdote demonstrates how BNSF's position within the network of agencies enabled these agencies to augment their service. Through linking in with BNSF the agencies could respond to additional needs identified in their service users and refer to the appropriate service. There are clear benefits for older people in this approach. If services are able to respond to issues outwith their remit by appropriately referring on, then older people should be receiving much more of the assistance they require.

In funding such diverse projects, BNSF have created awareness between agencies of the work of others that has promoted inter-agency working. Moreover, the Lead Officer indicated that the team have intentionally promoted such working through their relationship with the projects funded. For example, the Podiatry Service was encouraged by BNSF to link in with the CAHTC to provide training for carers about foot care. Other partners, including fire, police, trading standards, and environmental health, have also inputted to the CAHTC training through their links with BNSF and the Home Safety for Older People Working Group. From the service-user perspective, BNSF projects such as Food Train and Richmond Fellowship have utilised the CAHTC training for their staff. Other links include the Podiatry service, who have had an article in the Food Train's newsletter, and have provided information about obtaining foot health products that appears in 'Guid Guidance for Older Folk'. Inter-agency working has occurred between Rapid Response and the Food Train, with all patients who were discharged from hospital being provided with information about the Food Train, in order to ensure that they would be able to get their shopping. The Food Train project manager said of BNSF:

It's a fantastic network across the region in that it's brought together people who would otherwise have not got together, and who would not see the relevance of each others organisation.

Similarly the Active Service project manager noted the unusual nature of BNSF in its funding of such diverse projects.

Where else would you get something that's funded a mental health service, a service about people's feet and a training service for care at home services, and all the other projects? If you go to a commissioner, they'll commission within their remit, whereas this is more expansive, this is across all of those remits, with the shared remit of older people.

The Food Train project manager further highlighted that even those organisations that were less relevant to the day to day work of the project could be utilised from a communications point of view. For example, if an organisation was having difficulty dealing with customers with dementia, the manager could point out Dementia Friendly Communities as a source of help. The Podiatry service reported that the association with BNSF had had the positive effect of raising awareness of their service in other agencies. Clearly BNSF has succeeded in both promoting and facilitating various partnerships that are unlikely to have occurred in its absence.

As the hub of this wide network, BNSF also provide an expanding knowledge base from which they can draw that includes a growing understanding/expertise on older people's issues. Moreover, the team are commended for not assuming knowledge but

rather showing a willingness to check with partners or older people to ensure they provide the best information. This was highlighted at the community planning focus group.

Because they're working for older people all the time, they understand older people, they're beginning to develop an expertise in that direction, and they don't think they know it all, they will quickly ring us up and say 'what do you think about this, can you canvas the views of so and so?' (Participant 3, community planning)

A characteristic of the team, that appears to have developed their position within the network of partners and facilitated their success in this role, is their particular communication and interpersonal skills. The team were described in the focus group discussions as being pro-active, dedicated and easy to approach.

I think a lot of credit has to go to all members of the team who all contribute something… They're all very approachable. (Participant 5, community planning)

I think the big thing is that they seem to care about what they do (Participant 1, community planning)

The can-do attitude, there's no problem insurmountable; they'll find an answer to the problem, a solution (Participant 8, community planning)

These qualities must be recognised as having an important role in ensuring the programme's success. An important dimension contributing to the team's effectiveness is also the direction provided by the Lead Officer. A key theme that emerged from the focus group discussions was the role of the team, but particularly the Lead Officer, in providing a driving influence. The Lead Officer is credited with vehemently focusing the programme on the needs of older people.

She made sure the older person was central to the whole thing. (Participant 3, community planning)

Discussion with the Lead Officer indicated that this focus on older people was achieved by challenging partners to include older people around the table, highlighting that their presence would advantage the group. She is also attributed with various qualities that have been critical to the success of the programme. Participants indicated that Lead Officer provided the 'vision', bringing ideas and enthusiasm for the work that motivated those around her.

A lot of credit has to go to Jean of course who has had the vision, because it's Jean that's had the vision and brought the team along with her. (Participant 3, community planning)

Moreover, partners were encouraged to become involved through the provision of information and active networking by the Lead Officer to ensure awareness of the work of BNSF.

Jean Elgar is the one person, if anything came in at all she ensured that everyone knew what was coming in and what was their part, getting everyone onto the plans.

And from then on it's taken off; everyone seems to be working well now. (Participant 6, community planning)

The term 'driver' is used because it effectively describes the various components that appeared to contribute to the overall effect. The Lead Officer brought vital group-working and leadership skills, was able to motivate partners, provided a focus on the older population, and catalysed and developed older people's involvement. The Lead Officer capitalised on the existing community planning framework to form the Home Safety for Older People Working Group partnership, shifting the focus of the work towards older people. In previous working groups, partners reported that there was motivation to achieve, but a lack of direction or guidance to translate this into action. Under the leadership of BNSF, the Home Safety for Older People Working Group was perceived as a driven group that shifted from a 'talking shop' to an effective partnership.

We were all in former community safety groups… We got no guidance whatsoever, knew what we wanted to do but had no clout to do it. So that group was going nowhere, but then we formed the sub-group of the same members but with the drive of Jean behind it as chair. (Participant 8, community planning)

The driving influence served to pull the partners together and focus the agenda. Moreover, it concentrated the group on achieving tangible outcomes. Partners indicated that the drive operated through an expectation to achieve whereby each partner was held accountable for their contribution.

What do you think is the difference between these ones that haven't worked – is it this driver? (Facilitator, community planning)
It's the driver and the focus (Participant 3, community planning)
Targets, deadlines you know you come and you find that you're expected to do it. In some groups its 'oh you haven't done that' and then it's passed over. You come to this group its 'oh you haven't done that, so when can we expect that'? And everybody knows that is the way the group works, and you take it on the chin. (Participant 5, community planning)

Clear from this discussion was that the 'drive' or leadership centred on encouraging each partner to contribute by providing clear aims and targets. What is also evident is that the partners responded well to this direction, understanding it to be part of the effectiveness of the group. The discussions indicated that the partnership of the Home Safety for Older People Working Group was viewed favourably by those involved. They also revealed a loyalty to BNSF, a commitment to the work of the partnership and to assisting BNSF. Part of this loyalty derived from a conviction that the work of BNSF was valuable.

Nobody ever feels they're getting their toes stepped on by BNSF; everybody's got a good word for them. Whatever BNSF delivers is assisting them. (Participant 6, community planning)

That's why we respond to all the requests from BNSF because we know that all the work they do is worthwhile (Participant 1, community planning)

Taken together, the evidence presented indicates that BNSF operates as more than just 'glue'. It is not simply holding together disparate services, but rather it has created and nurtured a culture of partnership working with older people placed at the centre. This important role for older people is explored in depth in the following section, Role of Communities.

SECTION 9: ROLE OF COMMUNITIES IN THE PROGRAMME

The following section explores the role of communities and older people in the selection, design and delivery of the BNSF projects, with consideration given to the methods of involvement used, and the achievements from this approach. The primary sources of evidence are the focus group discussions with OPSDG and community planning partners and discussions with the BNSF Lead Officer. The main ways in which communities have influenced the development and delivery of the BNSF programme have been via the community consultation exercise and through OPSDG.

Community Consultation

A clear theme running through focus group discussions with OPSDG and community planning partners concerned the 'bottom-up' approach taken by BNSF in the development and delivery of the programme. BNSF capitalised on the region's activist groups for older people, particularly Elderly Forum, to obtain the views of older people. A survey of older people was carried out by members of Elderly Forum on behalf of BNSF to discover the kind of services older people needed and wanted. The findings validated the focus of the programme on small preventative services and directed the funding towards projects with this remit. This consultation approach was grounded in research evidence and policy and received unanimous praise during the discussions.

They got it from the 'coal face', actually from the person who would be taking delivery of the service (Participant 6, community planning)

We're getting fed back the right things we should be doing, not saying to them "this is what we should do", rather they're telling us what we need (Participant 6, community planning)

Any kind of move to get the opinion of older people is praiseworthy. (Participant 9, community planning)

Evident from these quotes was a strong perception that the consultation with older people would focus the programme on the areas of greatest need. There was clearly a belief in the argument that older people know best what their own needs are and that they should therefore provide the direction for any work undertaken.

An important feature of the consultation exercise was the use of Elderly Forum members to conduct the survey. This approach was considered to be superior by making older people feel more comfortable about the survey and thereby enhancing the validity of the information obtained. Moreover, by employing older people to the role, BNSF ensured that older people were not only consulted but were involved.

This was older people going into other older people's homes and helping them fill in questionnaires in their own words. (Participant 7, community planning)

The participation of Elderly Forum in the conducting of these surveys made a huge difference to the results when people knew that the answer was confidential and that

they weren't being invigilated as it were by social workers who might have some kind of impact on the care they're getting or might hope to get. (Participant 4, OPSDG)

BNSF have endeavoured to achieve partnership working with the older population including all the groups and agencies concerned with older people. This early involvement of Elderly Forum indicates one way in which this was achieved.

OPSDG

The bottom-up approach of BNSF is particularly exemplified by OPSDG. The setting up of this group has provided older people with a direct and formal role in community planning; an initiative that is certainly innovative. OPSDG have a direct role in community planning through their decision-making powers over the spending of BNSF monies. The focus group discussions revealed a clear conviction that older people ought to be involved in decision-making, based on the principle that older people understand best what they need and want. BNSF was therefore respected for having provided older people with this role.

Part of BNSF's strength is involving their client base. There's no point in paid officials sitting around the table saying this is what you need when the people who know best what they need are Elderly Forum and the various organisations that represent the older people. (Participant 5, community planning)

Clear from the focus groups was a perception that the usual approach to service planning and delivery, with officials dominating the decision making, was one in need of revision. The OPSDG focus group indicated that the members highly valued their role. Moreover there was a suggestion that their input was serving to create a philosophy of involvement that would benefit older people.

I think the principal thing for me is the input of the forum, of OPSDG and the elderly people they represent. The decision was taken to fund the projects… decisions like that would be taken previously purely and simply by either elected members or by officials without any contribution from either the people who benefit from the scheme of the funding authorities themselves. I feel the input of OPSDG in the granting process was very important and that kind of philosophy is fundamental to the whole thinking that's emerging from OPSDG. (Participant 4, OPSDG)

The group members highlighted their understanding of older people's needs, derived from their experience of living as older people and their consequent recognition of what was important. Having this knowledge was considered a vital component to selecting appropriate services that would best serve the older population.

The older you get the more you realise what you need, so you will always need people like ourselves who know what people need, so you can address that and pass that on to the people who make the policy that think they know what older people need. Its people round the table here that know what older people need. (Participant 5, OPSDG)

That's been older people saying what money should go where because that's what we want, not what you all think we should have, but what we want. So that's what we do with the money (Participant 3, OPSDG)

In stressing their understanding of older people's needs, there was clearly a resistance within OPSDG to decisions regarding older people being made exclusively by officials. Underlying this resistance appeared to be a feeling of older people being 'acted upon' rather than 'worked with'. This was linked to an important theme concerning the running of the group. While they acknowledged the important role of professionals in providing them with a start, there was a desire for OPSDG not to be directed, but to develop and retain autonomy. Without this autonomy there was a sense that older people would lose their say in what happens to them.

I was very suspicious and I'm still slightly suspicious of OPSDG and certain aspects of OPSDG. I recall in the early meetings saying that I felt it had been set up by the system and the parameters for its activities would be dictated by the system. That is still true to a certain extent but not anything like as much as I anticipated it would. (Participant 4, OPSDG)

It still happens that professionals think that they know what's best for everybody. And it's up to us as people that are able to speak, able to contribute to say 'no, you don't know, ask us, ask the people'. If they're allowed they'll still do it. You have to be pro-active all the time, because if they were allowed, from the top right up to Edinburgh it would still go on. (Participant 6, OPSDG)

While these concerns were evidently important to the group, there was also a sense that they were achieving the kind of autonomy they felt was appropriate. The group emphasised the importance of speaking openly, highlighting that the members were each independent thinkers capable of voicing their concerns and 'holding their own'. Through this approach they felt able to avoid being driven by the authorities, but rather that they could work in partnership to achieve.

The authorities had to give us a starting point, we had to have that. And I think we've went on from that and developed on our own. (Participant 10, OPSDG)

Hopefully… they haven't taken over as much as they would like to because the people around this table are quite independent minded and if they see something is being taken over by one part or another they won't hesitate to say so. I think what we try to do is work hand in hand with the authorities but we won't be driven by them. We'll work with them but not for them. (Participant 8, OPSDG)

In order for the involvement and decision making of older people to be genuine, there is certainly a need for the kind of self-direction and independence highlighted. Were the group to be driven by the authorities it would be valid to assert that their participation was tokenistic. Moreover, their determination to be autonomous can clearly be understood within the context of their previous experience of such tokenistic involvement of older people. Members highlighted that prior to OPSDG there was little scope for older people to have an active role.

I think the most significant element of the BNSF involvement has been that they have actually involved older people. That is fundamental to the whole philosophy of this particular group and it's been taken on board by BNSF. Prior to the setting up of this group there were groups which purported to represent the interests of the elderly and other parts of society but the actual involvement of elderly people is minimal. (Participant 4, OPSDG)

It was apparent that the members perceived their involvement in this group to be genuine. As a result of this involvement, it was believed that older people's views were being represented.

It's not tokenism. The older people of Dumfries and Galloway are having a say in what services, and all aspects of their life, due to the funding. (Participant 6, OPSDG)

The benefits of involvement to the individuals in OPSDG and to older people more generally were highlighted in these discussions. This theme centred on having purpose and a role in society, underlying which was a sense that this involvement provided hope.

Not only are we involving older people but older people feel involved. They don't feel sidelined, they don't feel patronised, they don't feel as though everything is over and they just sit in their armchairs waiting for the funeral director to come (Participant 2, OPSDG)

You're giving them (older people) hope (Participant 6, OPSDG)

And it's parents, older parents once again who've got a role, whether you realise it or not, you're no longer the old biddy that sits there waiting to be fetched out, you've actually got something to contribute to family life again (Participant 3, OPSDG)

The extent to which this sense of hope or feeling of being involved reflects the feelings of the general older population is uncertain. Undoubtedly, OPSDG will not represent all older people and much of the population will remain outwith the reach of BNSF. What seems to be the case, however, is that the members themselves were benefiting greatly from being in the group. These benefits appear to have come from the feeling of purpose that membership of OPSDG provided. There was clearly a sense of responsibility that came from working on behalf of other older people that made the members feel they were making a contribution.

By developing OPSDG, BNSF is credited as having a critical role in allowing the voice of older people to be heard.

I think that's a great move for increasing the voice or clout of older people (NS community planning)

An important consideration for OPSDG relates to their effectiveness as representatives of the general older population. The assertiveness of the members, and the fact that they participate in the group, indicate that they are what is often described as 'activists'. In describing themselves as "*people that are able to speak,*

able to contribute" (participant 6, OPSDG) the group have demonstrated a cognisance of this role. Furthermore, they have indicated a desire to act on behalf of, and in the interest of, older people. What is questionable, however, is the strength of their claims to knowing what older people need and want. A limitation must be noted regarding how representative the group are of older people more generally. While they are certainly well placed to speak to the experience of being older, there needs also to be acknowledgement of the diversity of the older population and the limit to which this small group can voice such a broad range of views. As a group of activists they must be credited for lobbying for older people and promoting their welfare. However, without direct involvement of the more vulnerable and less active members of the older population, OPSDG's claims of representing all older people should be tempered. This assertion does not denigrate the achievements of the group, nor does it ignore the context from which they have evolved. Involvement of older people is a very recent concept and the existence of OPSDG is a prominent achievement. Moreover, there is evidence that the group members seek to obtain the views of the more vulnerable by reporting to, and from, their communities.

In exploring this issue of representation with the BNSF Lead Officer, the need for an incremental approach to older people's involvement was highlighted. The Lead Officer explained that in recruiting members to OPSDG the aim had been to promote representation. While acknowledging that the group membership was predominantly focused on 'activist' older people, the Lead Officer also highlighted that this is a difficult issue to address. Moreover, the role of such activists in making things happen was underlined.

We're always going to have some of the 'well kent faces'. It's very easy to talk them down, but without some of these well kent faces things just wouldn't happen'. (BNSF Lead Officer)

The Lead Officer explained that OPSDG represent other older people through their links with their local communities. Via a two-way communication process the work of OPSDG is reported back to the communities by OPSDG representatives, and the issues raised by the community are brought by the representatives to the attention of OPSDG. Representation is also promoted through the affiliate membership of various agencies related to older people, for example, Care and Repair.

SECTION 10: SUSTAINABILITY AND MAINSTREAMING

The purpose of the following section is to consider the potential for the BNSF programme and projects to be mainstreamed or sustained. Project-specific issues of sustainability and mainstreaming will be considered in turn based predominantly on evidence from interviews with project managers. The broader programme level issues will then be examined using evidence from discussions with the BNSF lead officer and the focus group discussions.

Active Service

The project manager indicated having some concerns about the continuation of the project's funding for the final year of BNSF. For this reason, the manager reported having approached commissioning managers in health and social services to make preliminary enquiries about obtaining mainstream funding. To mainstream the project would be to bring it into line with the original Active Service in Dumfries. It is likely in that case that the project would be linked in with Community Mental Health Teams. The project manager acknowledged that a limitation of that approach would be the cessation of the open-referral system currently in place that promotes the accessibility of the project. An advantage of having the project mainstreamed would be that the project would be funded, run, managed and monitored in a manner consistent with the Dumfries branch. The project manager asserted that the project should be rolled out to other areas to make it available across the region. Certainly the shortage of services for older people with functional mental health problems outlined in the Programme Impact section supports the argument for rolling out. Having already been rolled out from Dumfries, the project manager perceived no barrier to its being replicated elsewhere.

Dementia Friendly Communities

BNSF funding will cease in 2005, when the project manager's post will disappear. The project manager feels that the project is similar in approach to health education, in that it provides education and information, and as such, could be sustained. She has had a request to roll out the project into neighbouring Ayrshire, and several people who attended the Alzheimer Scotland AGM expressed an interest in having the project in their area.

Sustaining the project will almost certainly be a critical component of its success. As was indicated in the Programme Impact section, the aim of the project is to change the view of a community. This is a very long-term objective, and one that evidently requires ongoing work and repetition. The project manager indicted that in returning to communities after work had been done, it was clear the perceptions were shifting very gradually and that there was a need to capitalise on this. The funding to continue the project beyond BNSF had not yet been examined at the time of interviewing the project manager. It has been indicated, however, that the BNSF Lead Officer is planning to commit the final year of BNSF to obtaining mainstream funding for the BNSF projects. Should Dementia Friendly Communities secure this funding, the work will be continued. If funding were obtained, the project manager suggested that a full time post would be appropriate, given the large older population in Dumfries and Galloway, the large proportion of rural areas, necessitating a lot of travel, and the value of providing regular updates to information-giving events, as opposed to one-off.

Food Train

There was wide agreement from the OPSDG focus group that of all the projects, the Food Train had become indispensable, with such a large number of older people being dependent on the service. For this reason participants suggested this project would have the greatest chance of being mainstreamed.

I think of all the things that we fund at the moment the one that I would see that they would have to fund is the food train because they've become so established that people really do expect them to be there. I think it would have to carry on if we weren't there. (Participant 8, OPSDG)

This conviction was supported by discussions with the project manager and the BNSF Lead Officer who both expressed confidence that the project would receive mainstream funding from the council to enable its continuation after BNSF. The need for this project to be mainstreamed, and moreover to be rolled out to other areas, was beautifully summed up in a qualitative comment provided from a service user questionnaire.

I just hope the Food Train continues forever and that it can cover the whole country eventually.

The Food Train model has been replicated in a pilot of the project for the Dalkeith area, called the Midlothian Food Train. An older person from the area had seen the project covered on the Reporting Scotland programme and contacted his local council to find out whether they had a Food Train, which they did not. He went on to campaign with his local councillors and public health practitioners and single-handedly put a steering group together. In April 2004 they successfully launched their own Food Train and are being asked to deliver beyond Dalkeith and into the fringes of the city of Edinburgh. This project has the help of local Scotmid shops and the project manager in Dumfries and Galloway indicated that they are doing well. The Midlothian Food Train has received funding for one year from the Gorebridge Health Project regeneration fund. If successful, the project will be rolled out across the Midlothian area. The Dumfries and Galloway project manager strongly encouraged the Dalkeith project, providing all of the Food Train's practices as a model: policies, procedures, the delivery schedules, shopping lists and so on. This is an important example because it provides evidence that the project can work successfully in an urban area. The project manager indicated that older people in urban areas can be equally isolated by their location: for example living in high rise flats.

A recent development, which addresses the above point, is the establishment of a Food Train in an economically deprived area of Newcastle, which houses a high number of older people, many living in high rise accommodation. Funding was obtained through a Health Regeneration Project, and the project has the support of main supermarkets in the area. The project is run by paid development workers who are locally funded, who have access to a good pool of local volunteers. The project manager in Dumfries and Galloway has regular contact with the Newcastle initiative.

The manager believes that the project could be replicated in any area. She is currently endeavouring to procure funding from NHS in Dumfries and Galloway, who are benefiting directly and indirectly from the service provided by the Food Train, in the form of improved mental and physical health on the part of many of the service users..

A concern that must be considered is the sustainability of a service that is so heavily reliant on volunteer input. As was indicated in the Programme Impact section, the project is fortunate to have a core of very committed volunteers, however the project manager indicated that recruitment and retention of volunteers is an ongoing issue. The manager was of the opinion that the project certainly could be sustained on this basis. Moreover, if the project is successfully mainstreamed it will have the assurance of ongoing funding. Undoubtedly other services are successfully sustained on the basis of volunteer input, for example the Children's Panel (source: http://www.scotland.gov.uk/News/Releases).

An important issue for the sustainability of the Food Train concerns the work-load of the project manager. Much of the Food Train's success is undoubtedly owing to the commitment and dedication of its staff, and the tenacious work of its manager to promote and expand the service. The manager indicated, however, that through the expansion of the service the work involved had practically become more than was manageable for one person. She indicated one possibility was to bid for funding in the final year for an administrator to share the work-load. In order for the project to be sustainable, and not to become the victim of its own success, there is clearly a need to ensure that the staffing is adequate to meet the demands of the service.

Home Fire Safety Checks

As is indicated later in this section, the Home Fire Safety Checks Project manager indicated that BNSF had been integral to allowing the project to go forward, as funding does not exist in the mainstream budget for this particular work. However, an interview conducted with a Community Fire Safety Officer from the Strathclyde Fire Service revealed that the Home Fire Safety Checks project was considered an excellent model and was being promoted in the Community Fire Safety Forum. The forum is a nationwide collective of representatives from the fire brigades throughout Scotland that meets to discuss and share best practice. Promoting the model in this way may encourage rolling out of the service to other brigades, and increases the likelihood of the fire service making mainstream funding available. The model used by Dumfries and Galloway fire service has, for example, been replicated by the Tayside Fire Brigade. The Community Fire Safety Officer indicated however, that an impediment to the rolling out of this project was the structure of community planning in other areas. While Dumfries and Galloway have one local authority to deal with, other brigades such as Strathclyde have several. This creates a difficulty because the brigade would be required to present a business case for the project to every partnership in order to get agreement for funding. The officer indicated that this is a difficulty for community fire safety generally; the lack of a regional structure.

Podiatry

In the Annandale & Eskdale and Nithsdale component, the Podiatry service successfully bid for mainstream funding of the BNSF post to take over BNSF funding from March 2005. The project reported that having the BSNF post in place had enabled them to demonstrate what had been achieved with the additional funding,

which strengthened their bid. Due to the problems outlined in the Programme Impact section, the Wigtownshire and Stewartry component did not achieve their targets to the same extent, however the project indicated that the additional post had enabled them to sustain their service, and there were plans to use this evidence to bid for mainstream funding of this post also.

Rapid Response

The Rapid Response project manager explained that the BNSF funding for the Rapid Response project was ceased from August 2004. The decision had been taken by BNSF and OPSDG to cease funding of Rapid Response as this service was to be replaced and extended by the Short-term Augmented Response Service, STARS. STARS is mainstream funded by the council and the NHS. The success of the Rapid Response Services in Wigtownshire (BNSF and NHS funded) and Nithsdale (council and NHS funded) was highlighted as the reason for developing the STARS service (source: press release, www.dumgal.gov.uk). STARS incorporates the services provided by Rapid Response in Wigtownshire and Nithsdale as well as other services including the Dying at Home Scheme, and the Hospice at Home Scheme. Moreover, the service will be rolled out across Dumfries and Galloway.

A source of concern in the mainstreaming of the Rapid Response service was that the project manager had taken on staff with permanent contracts on the understanding from BNSF that the project would be funded for three years. When the project was mainstreamed the staff were not guaranteed to be employed under STARS and were required to be interviewed for these posts. All of the staff were successfully appointed to the new project. Had this not been the case, the Rapid Response project manager explained that this would have introduced a substantial cost pressure on the service to continue to employ these staff without funding.

The Care at Home Training Consortium

The CAHTC project manager explained that OPSDG had encouraged the project to consider running a membership consortium in order to generate income and reduce or remove the need for outside funding. This would require the care providers to pay a membership fee to be part of the CAHTC for which they would receive the training of their staff and other, as yet, undetermined benefits. Consequently, the project could continue to be funded following the cessation of BNSF. Currently only two care providers are members of the consortium. The BNSF Lead Officer indicated that the council's plan is to make membership of the CAHTC obligatory for care providers seeking employment and funding from the council. This would allow the council to ensure that the standard of care provided in the region is satisfactory while also sustaining the project over the long term. The impact of this project may well be sustained, and rolled out nation-wide, if the Home Care Practice Licence, currently being piloted, becomes a mainstream qualification. The implications for older people in terms of improved quality of care provision are vast.

The Community Regeneration Fund Replacement of BNSF

A clear theme emerged from both focus groups regarding the end of BNSF funding and its replacement with the Community Regeneration Fund (CRF). Concerns were unanimously voiced about this change of funding, about the suitability of the CRF to the Dumfries and Galloway area, and its implications for older people. Partners echoed the concern of BNSF that the CRF, with its focus on multiple indices of

deprivation, would disadvantage the rural authority by only being targeted at two areas. In particular, concerns were voiced about services being lost to older people that would have a detrimental effect on that population.

The big thing is that older people shouldn't be forgotten in this…the regeneration fund; I think it quite clearly stated it was to target areas of deprivation. Now you'll find in Dumfries and Galloway there are two places identified as areas of deprivation but collectively BNSF and ourselves are spreading this service in the areas that its needed, not identified as areas of deprivation. (Participant 1, community planning)
The Scottish Executive criteria for areas of deprivation don't take into account the rural communities. (Participant 3, community planning)

And if all this changes to another agency its going to leave a vacuum and lives are going to be lost. (Participant 7, community planning)

There was a clear perception that many of the projects funded by BNSF were reliant on its support to be sustainable. In particular community planning partners highlighted that there weren't funds within their own budgets to finance work such as that achieved by the Home Safety for Older People Working Group or the Home Fire Safety Checks project. The partners were able to incorporate such activities into their working hours, thereby providing officer time, but other expenses were outwith their budget. This argument suggests that such projects would have difficulty becoming mainstreamed.

What we couldn't do is provide the money for these projects from our budget. We can provide people but not money. (Participant 4, community planning)

I think the big thing with us, we're targeting 1000 elderly people for home safety checks, if we did not have the funding from BNSF if everything stops the question is will we be able to do 1000 next year? I very much doubt it unless somebody comes up with the additional funds… Working within our budgets, we just couldn't achieve it. Because of the rural area that Dumfries and Galloway is, we want to use, as we said earlier, local people, local fire fighters in the small towns around Dumfries and Galloway to deliver this service. As they're part time fire fighters we have to pay them to do that. Now through our normal budget we just couldn't do that. (Home Fire Safety Checks project manager)

Objections were raised in the focus groups to evaluating the BNSF programme when the fund was to be replaced by something else. Partners felt that the evaluation should determine whether the programme funding continues rather than being conducted after a decision had been made. Given that the CRF had already been set to replace BNSF, the partners asserted that the evaluation seemed to be futile. The contention of the participants was that the programme had worked well and that it should therefore be allowed to continue.

This has been doing a great job of work. Its funding stops next year. Now they're stopping the funding for BNSF before they even assess the programme. To me this is stupid… Of course they're now saying that the regeneration fund will take over from BNSF, but that can't deliver the service. So why did they actually withdraw the

funding before they actually assess the project on the job it's done? (Participant 6, community planning)
Don't fix it if it ain't broke. (Participant 5, community planning)
That's right, it's working. (Participant 3, community planning)

Continuing Involvement of Older People
Questions were also raised at the OPSDG focus group about the cessation of the BNSF programme and the impact this would have for older people's involvement. OPSDG members discussed their concern that the group could be disbanded. The perception was clear that such a change would set their progress back with negative consequences for the older population. In particular there was a concern that older people would lose their direct involvement into the community planning structure, whereby their voice and influence would be diminished.

If we didn't have BNSF though my fear is that the older people's view would be lost. We would lose the direct involvement into community planning that we feel we do have now. (Participant 3, OPSDG)

OPSDG has achieved so much and I just worry about when the funding finishes for it. What happens to OPSDG then because it would be a step backwards if this group had to disband? Because this is the way forward. Older people and the elderly should decide on what services they receive and any aspect of their life. This is what's happening now and I think we need to go forward without the threat of being disbanded. (Participant 6, OPSDG)

The BNSF Lead Officer explained that while the CRF was ostensibly introduced as a replacement for BNSF, in reality this was not the case. BNSF attempted to obtain CRF funding to ensure the sustainability of the BNSF projects but was generally unsuccessful in securing sufficient funding for most of them. The main reason cited was that the priority given by the CRF to areas of multiple deprivation meant that BNSF projects were competing with forty seven other projects for funding, many of which were focused on those areas. The Lead Officer was therefore focused on obtaining funding to secure the future of the projects in the final year of BNSF. A main source of funding that the officer will seek will be mainstream funding from the council. Assurance that funding could be found for some of these projects was indicated; however, the bigger challenge will be to continue to sustain the work of the BNSF team and way of working, and to continue to develop OPSDG. The focus of the BNSF team on older people and their success in operating as a hub is something the Lead Officer was desirous to continue. Evidently this way of working has been influential in supporting and advancing partnership and multi-agency work for older people. Having the alternative name of 'Guid Services for Older Folk' would provide a recognisable identity for the team following the cessation of BNSF. To sustain the work of OPSDG, the BNSF Lead Officer indicated certain priorities for advancing their role in community planning. One of these priorities was to promote their representativeness, a limitation of the group that was noted in the Role of Communities in the Programme section. As was highlighted in the Programme Impact section, change resulting from OPSDG will necessarily be incremental. The Lead Officer regards OPSDG as an 'infant organisation'. The aim for the group would be to progress their involvement, moving them into '*a higher strategic level'*.

Funding for the group would be sought from the council who currently provides funding and administrative support.

In addition to mainstreaming and sustaining the work of BNSF within Dumfries and Galloway, there is an argument for rolling it out to other areas as a model of good practice. However, the coterminous boundaries shared by the various community planning partners in Dumfries and Galloway is a factor that is likely to have facilitated the success of the BNSF programme. The earlier discussion regarding the rolling out of the Home Fire Safety Checks indicates the barriers that are created when a number of community planning structures have to be dealt with. This was highlighted at the focus group of community planning partners as an important factor that is also relevant to the rolling out of BNSF:

'Coterminous boundaries': we all work within the one area; we don't have half an agency working here and half working in another authority area. So we have established links within the council, and our bosses are all signed up to that through the community planning process and I think that that does make a difference, that we are getting support from our immediate line managers and above to support this system. That's not taking anything away from BNSF, that's adding on to it, I think that when you're saying about replicating it up and down the country, it can be replicated, but you've got to have similar criteria, mindsets. (Participant 1, community planning)

For areas that do not have these shared boundaries, it may be more difficult to achieve multi-agency or partnership working and this may present a barrier to the programme being replicated.

SECTION 11: DISCUSSION

The purpose of this section is to present some key evidence from the existing literature, with the aim of contextualising and explicating the impact of the BNSF programme.

There is a clear value in the kind of preventative services funded by BNSF as a means of improving older people's quality of life and ability to live independently. The decision taken by BNSF to fund preventative services was guided by research from the Joseph Rowntree Foundation. Research by Clark, Dyer and Horwood (1998) called for "a national strategy for the development of low level preventive services which takes on board the voices of older people themselves". The research noted the importance of low level preventive services in allowing older people to remain at home for longer and thus deferring the need for intensive and therefore more expensive services. The study stressed the importance to older people of remaining at home rather than having to go into a home. Moreover, a number of sites for intervention were highlighted which have directly or indirectly been addressed by the BNSF projects. For example, having access to assistance from 'reputable organisations' was found to be a salient factor in feeling safe and secure, particularly with regard to home maintenance and repairs. This highlights the importance of the Guid Guidance Directory in disseminating council approved contractors and providing other information and advice. It also supports the work of the Home Safety for Older People Working Group and the Home Fire Safety Checks projects as important preventative services that can promote feelings of safety and security in the home. Clark et al. (1998) indicated that older people also valued having options for help instead of relying solely on relatives. The respondents of many of the questionnaires, for example Food Train, Active Service, and Podiatry, highlighted the importance of the services in reducing the burden on relatives or friends to provide help. These projects are therefore providing this valued alternative to depending on relatives. Harding (1999) provides further evidence for the importance of these projects. She notes that respite care services help to sustain the relationship between carers and older people, which promotes older people's ability to remain at home. Moreover, respite services were noted to be highly valued by carers. This suggests that the added value from projects such as Food Train and Active Service in reducing the burden of care on relatives is making an important contribution to the BNSF headline outcome of keeping older people at home for longer.

Various other studies have also highlighted the importance of preventative services for older people in retaining and prolonging independent living. Harding (1999) noted that the quality of services provided to older people in terms of the reliability, consistency of staffing and choice in who provides care are important factors for older people. Given that the questionnaires indicated a high level of satisfaction with each of the projects, not just overall, but with specific reference to the amount of contact with project staff, and the accessibility and availability of the service, the findings from the evaluation support the quality of the services delivered. Harding emphasises that it is not enough to say that a service is delivered; the important point is also *how* it is delivered. The feedback from the evaluation questionnaires has strongly indicated that older people highly approve of the projects, suggesting the method of delivery is also satisfactory.

Research has also provided evidence to support the impact of the BNSF projects on quality of life. For example, Francis and Netten (2004) reported that the quality of life of vulnerable older people is "fundamentally dependent on the quality of the home-care service they receive, so raising standards of home care is clearly central" This research further highlights the importance of the provision of training by CAHTC to home carers to improve their standards of practice as a key component in the quality of life of older people. Other research has indicated the key areas that services for older people should address as a means of enhancing quality of life or promoting independence. Older people frequently prioritise information as a key aspect of enabling them to maintain control of their life and to make their own decisions (Harding, 1999). The Guid Guidance Directory has an important role in addressing this need for information. Raynes, Temple, Glenister, and Coulthard (2001) conducted a study to explore older people's view about what a quality home care service should look like. They found that older people defined quality according to eight key elements. These elements included the need for help with small tasks such as changing light bulbs, carers who are trained for the tasks that they do and who listen to their clients, aids and adaptations that facilitated independence and services which helped them to get out of their homes.

Godfrey, Townsend and Denby (2004) indicated the important factors required for older people to have a 'good' old age. Of these, safety in the home, opportunities for social engagement, and help with 'daily hassles' were highlighted. All of these elements or factors have been addressed by BNSF funded projects. Rapid Response has provided aids and adaptations to promote independent living. Food Train has considered extending its service to provide small-scale help such as changing light bulbs. Podiatry and Active Service, in different ways, have a key role in enabling people to get out of the house, while Active Service is integrally aimed at promoting opportunities for social engagement. CAHTC is addressing the need for adequately trained carers, which includes training in communication skills. Home Fire Safety Checks have addressed safety in the home issues, as has the Guid Guidance Directory which provides a section of information and advice on this area. Godfrey et al. (2004) also noted that a lack of knowledge amongst older people regarding what services and help are available acts as a barrier to gaining assistance. This highlights the importance of the Guid Guidance Directory in addressing older people's need for information and the value of the awareness-raising work of the Dementia Friendly Communities project. Finally, these authors indicated that many older people come to the notice of services having reached a crisis point. This further emphasises the need for preventative services and the importance of the BNSF approach.

Evidently the BNSF services are mainly aimed at providing low-level help with activities that may have become difficult with increasing age. A hypothesis in development by the Centre for the Older Person's Agenda at Queen Margaret University College, and at the University of Edinburgh, indicates a potential pathway by which the BNSF projects and other low-level preventative services may exert their positive effects. Hockey (1999; cited in Balaam, et al., 2001) argued that loss of independence in older people is not necessarily the result of a major life event or disruption to health, but may also occur as a consequence of accumulating, small, and seemingly trivial difficulties. What is suggested is that these small difficulties continuously erode coping resources and wellbeing over time until they result in crisis. Hockey termed this effect 'cumulative trivia'. Projects such as the Food Train,

Active Service, Podiatry or Home Fire Safety Checks, may serve as interventions that remove or reduce the impact of some of these 'trivial' difficulties, and in so doing, delay or prevent their accumulation in a crisis. The feedback from the questionnaire respondents provided examples of where this may be the case. For example, many Food Train respondents highlighted that, while possible, the exertion and stress involved in getting the shopping had become very demanding. The Food Train's intervention removed this hassle and was reported to have improved quality of life and promoted independence.

Cumulative Trivia echoes strongly a well-established concept in the social science literature called 'daily hassles': "irritating, frustrating demands and troubled relationships that plague us day in and day out" (Lazarus, 1983). The relationship between daily hassles as a source of stress, and troubled physical or mental health, is also well-established, although the existing research has predominantly focused on adults as opposed to older adults (Lazarus, 1999). A crucial difference between this concept and cumulative trivia is that the latter is specific to older people, and is suggested to accumulate until there is a loss of independence. This is not an argument that has been contended in the daily hassles literature (Balaam, et al., 1999).

An important point that Hockey emphasises regarding 'cumulative trivia' is that the trivial difficulties are not things that an older person would, for example, consult their GP about. Difficulties such as the aforementioned managing the shopping or changing light-bulbs are not things that older people may feel are worth bothering others for help with. Moreover, there may not be people from whom older people feel able to ask for help. Nonetheless, the difficulty of addressing these small problems has the potential to add up, and, over time, threaten independence. This indicates that services provided to address these difficulties are important as for some older people there may not be an alternative source of help. This has particular significance in the Dumfries and Galloway area because there are a large number of older people who retire to the area. These people may leave behind social networks and family who might otherwise be relied upon for this kind of help. This may be another reason why the BNSF approach has been particularly important to the Dumfries and Galloway area. What is also important to note regarding the interventions from BNSF projects is that their impact upon one area of an older person's life, such as their feeling of safety or the quality/quantity of their social contacts, does not occur within a vacuum. A positive or negative impact upon one area of quality of life is likely to impact upon other areas. Thus, by enhancing one area, an intervention may serve to free up coping resources and thus promote coping with other areas. For example, by providing a shopping service that reduces the exertion and stress for older people of shopping, Food Train may enable older people to put more energy into their social contacts or interests and activities they enjoy. It is this reasoning that provides strong support for the BNSF approach, and which strengthens the argument for both sustaining it, and rolling it out to other areas.

SECTION 12: ISSUES FOR CONSIDERATION

The purpose of this section is to consider some key issues and areas for development of the BNSF programme and some of the projects it has funded. It is important to note that these are predominantly suggestions for enhancing the impact of the programme or projects where potential areas have been identified; the evaluation has not found evidence that the programme is failing or having anything other than a positive effect upon older people.

The first suggestion concerns the work of the Dementia Friendly Communities project. In considering the groups to whom the project has delivered talks and workshops, it is evident that the majority have been with established groups such as workforces interested in older people or community groups such as WRIs. These are certainly important groups to target as they are likely to have interaction with older people who have dementia and to therefore be in a position to utilise the information obtained. In order for the project to more fully create a dementia friendly community, however, there is a need for more attention to be paid to other people living and working in the community. Whilst recognising that significant benefits would accrue from spreading the message to other community members, for example shopkeepers; without the connections of an established group, there is a difficulty in trying to bring people together for a talk/workshop. The drop-in talks held by the project manager were used to try to attract this section of the community and there would be value in developing and expanding this approach. The majority of the respondents to the questionnaire regarding this project indicated that their knowledge and understanding had been improved by attending the talks/workshops provided. It can be inferred from this feedback that there may be a gap in many people's knowledge regarding dementia that this project has gone some way to filling. If this is the case for workforces and community groups in Dumfries and Galloway, it follows that it may be the case in other areas. That being so, the Dementia Friendly Communities project could be used as a model for increasing knowledge and understanding of dementia in areas throughout the country.

The Food Train has clearly been a great success of the BNSF programme, having achieved full expansion, received outstanding reviews from its customers and been the recipient of two national awards. In terms of the development and continued success of the project, what is clear is that there must be sufficient staffing to meet the ongoing demands of managing the service. That it has grown so dramatically in its short period of BNSF funding indicates that the project is in need of additional staff. This same staffing issue is also one that may also apply to the CAHTC and which should be considered carefully. Both Food Train and CAHTC have benefited from diligent and dedicated management that has probably gone 'above and beyond the call of duty' to ensure the projects' success.

The sustainability of these projects should, however, be considered with regard to two potential limitations. Firstly, it may not be possible for managers to continue such a commitment indefinitely, as there is a risk that they will 'burn-out'. Secondly, the project managers should not be seen as irreplaceable. This point may also be applied to the BNSF programme and its Lead Officer. Clear structures and contingency plans need to be in place to support the projects in the absence of these managers to ensure the continuing success of the project. Time spent in reviewing and articulating the

day-to-day processes, and responsibilities undertaken by these managers, which could be presented in a written and accessible form, would assist in making clear the tasks undertaken and skills required to run the projects. This could facilitate projects being modelled and rolled out to other areas by explicitly identifying what is required for their successful implementation and management. This is particularly relevant where the success of projects is dependent to a large degree on the personality and motivation of one individual. For example, where possible, projects should try to ensure that various members of staff have lines of communication with other agencies, rather than networks relying predominantly on one individual member of staff. This would mean that if a manager or key individual within a project were to leave their post, or be absent for any period of time, the lines of communication would not be severed, or required to be rebuilt from scratch.

The feedback from questionnaires to users of the CAHTC training would indicate a significant demand for updates and refresher courses to be provided to sustain the benefits of the training over time. This is an area the project should consider for future development. There was also a call for all carers to be trained to ensure they were able to do their job, and for training to come sooner. The likelihood is that these latter points will be addressed if the plans for sustaining the service through paid membership by providers are progressed. The project should also consider the value of training informal carers. This is something that could be funded by mainstream services in recognition of the cost benefits of unpaid, informal carers and also as a preventative service with longer-term cost benefits. The benefits to the informal carer are obvious, for example through the protection of their physical health through manual handling training, or the reduction of stress and anxiety through confidence that caring duties are carried out appropriately. There are also many areas of added value such as the social support and social networks that might arise from bringing together a group of informal carers for training.

The Guid Guidance for Older Folk Directory of Services is providing valuable information in a format that greatly enhances the accessibility and availability of information for older people. In order that the directory continues to be provided and sustained it will require ongoing funding. The likelihood, based on discussions with the BNSF Lead Officer, is that the directory will be mainstreamed within the council and provided through such funding. A suggestion to further the use of this document is that it could be more widely promoted and advertised. Local media, such as press and radio that are particularly accessed by older people, may offer a means of promoting the directory and allowing it to reach a wider audience. Obviously this would introduce a cost pressure, and two suggestions are proposed to manage this. Firstly, a nominal charge to contribute to the expense could be made. It may be that people would perceive the directory as higher status if required to pay a small amount for it. Another method of covering cost would be to charge approved contractors to have their details included in the directory. There could be issues regarding excluding contractors who refuse to pay and thereby reducing consumer choice, and these would need to be considered. What is aimed at, however, is the means to promote the directory more widely and therefore facilitate its use by those older people who may thus far not have awareness of it.

The Directory has clear potential to be used as a model that could be replicated by other local authorities throughout the country. There are clear benefits in having

information collated and disseminated in this format. Promoting older people's access to information is an important way of allowing them to access services, particularly non-statutory and preventative services. Some older people may be uncomfortable seeking help from agencies such as social services or their GP if they fear that this will take away their control or independence. For example there may be fears about being placed in a home. The ability to self-refer to a wide range of services and thus retain control of what help is received can therefore promote help-seeking behaviour, and thus act as a preventative service.

As was indicated in the Value for Money section, communication between BNSF and the projects it funds has been a critical component of achieving a successful relationship. It was evident that BNSF strongly utilise their lines of communication with the projects as a key part of monitoring their progress. What has been demonstrated by the Podiatry project is that, where difficulties and the reasons for them have been timeously conveyed to BNSF, these have been accepted. Conversely, in the case of Active Service, a breakdown of the communication process resulted in misunderstandings and unnecessary complications. It is important therefore that all projects in receipt of BNSF funding are explicitly informed of the significance of this communication system and the potential consequences of failing to communicate.

A possibility for promoting the uptake of each of the projects by older people is through increased awareness-raising by the BNSF projects of each other's work. In the same way that BNSF has encouraged inter-agency working between projects, so this kind of awareness-raising could also be encouraged. Each of the projects has access to a different audience, and the questionnaire data indicated that the level of awareness by respondents of other BNSF projects had much room for improvement. For example, project staff could carry and distribute leaflets outlining the other BNSF projects to their service users, and advise them how to make contact if appropriate. In addition, there is potential for inter-agency referrals by project staff. Where needs are identified in service users that another BNSF project could address, this could be acted upon and a referral made.

An issue that arose from the questionnaires returned was that all of the respondents who reported their ethnicity indicated they were 'white European'. The sample from which these respondents were drawn was limited; therefore it is possible that a greater representation of different ethnic groups exists than was indicated. Statistics from the Scottish 2001 census show that 0.7 percent of the population of Dumfries and Galloway are minority ethnic (Office of Chief Statistician 2004), however there was no breakdown according to age to indicate the proportion that are older. There may be a call for projects to undertake activities aimed at promoting uptake of their service by minority ethnic groups. The projects should also consider whether there are any barriers to minority ethnic groups accessing their services, for example language barriers.

SECTION 13: KEY LESSONS AND CONCLUSIONS

A number of key lessons can be drawn from the evaluation of this programme. As was discussed in depth in the Partnership Working section of the report, BNSF has had an important role in creating and nurturing partnerships. The key elements that BNSF provided to that end were drive, support, and a common link between various different agencies. A lesson that can be drawn from this finding is that community planning could benefit from having this kind of supportive structure and leadership in place. Having a central hub that links agencies and which can focus and manage the agenda, provide administrative support, and direct activities may effectively 'grease the wheels' of community planning. Thus, the BNSF structure is more than 'glue', is it also 'grease'. As a part of sustaining the BNSF team in Dumfries and Galloway, and also in constructing a model for other areas, the team could be formalised in order that it may be utilised by any agency within community planning. Thus BNSF, or Guid Services for Older Folk as it would be known, could be a formal hub within the community planning network that specialises in promoting and supporting multi- and inter-agency working with a focus on older people. It should be noted, however, that the extent to which the programme can be replicated in other areas may be limited where these areas do not share coterminous boundaries. As was discussed in the Sustainability and Mainstreaming section, this is likely to have been an important factor in facilitating partnership working and one that has enhanced the success of the BNSF programme.

There is a clearly a lesson about the value of a unitary body that funds various different services across a wide range of remits. It is fundamentally this approach that has underlain much of the added value of the programme, through inter- and multi-agency working. As was noted in the Partnership Working section, without the connections to BNSF, many of these agencies would be comparatively unaware of the existence or role of each others' organisations. With their common link to the funding body, the different BNSF projects are not only conscious of each other, but they are able to engage in work together at various different levels. There may, therefore, be value in explicitly encouraging funding bodies to aim for this diverse approach in future, in which agencies with a variety of remits are intentionally selected. In so doing, channels of communication that had not previously existed between agencies may be created. As has been articulated, the benefits for the target population, in this case older people, are that they are more likely to come into contact with a variety of agencies that can provide them with support and assistance. Thus the programme creates its own added value in which the whole is greater than the sum of its parts.

The successful involvement of older people that BNSF has achieved through the creation and advancement of OPSDG is a very significant lesson that has been demonstrated by the programme. OPSDG provide clear evidence that older people can be involved in decision-making, partnership working and various other activities in the planning and delivery of services, and make a contribution that is valued and beneficial. They have an important role in challenging professionals and highlighting older people's issues. They also have the salient function of voicing the views and issues of communities and reporting to communities on the work of the group. As a group that surpasses much of the tokenism in older people's involvement, OPSDG contribute to the challenge that confronts other community planning partnerships,

both within and outwith Dumfries and Galloway; to enhance their own involvement mechanisms.

Perhaps the most important lesson from this programme is the importance of preventative services as a means of supporting older people. It cannot be over-stated that this value is not only important in terms of its potential long-term financial savings. It is also vitally important in that it helps to prevent older people from reaching a crisis point by improving their quality of life and prolonging their independence. The value to the individual is therefore immeasurable. The impact of the BNSF projects upon quality of life varied between service users; however the effect across-the-board was clearly evident. What was particularly significant was that many older people perceived a direct link between the project they were using and their ability to remain independent. As was considered in the previous Discussion section, the impact of these relatively small interventions may be to impede an accumulation of trivial difficulties, and in so doing, prevent an older person from reaching the crisis point that takes away their independence. That these services are provided at relatively low cost, and often with significant added value, for example to close friends/family, only enhances their worth. It is evident therefore that more investment into these kinds of services is warranted.

The available research evidence, as well as the evidence from this evaluation, provides a strong underpinning for the work undertaken and funded by BNSF as conducive to independent living in older people. Moreover, across all of this work there has been a demonstrable link with the social justice targets and milestones for older people. In particular, the programme has made important contributions to the proportion of older people able to live independently, through enhanced home care opportunities, through the provision of preventative services, and through the promotion of social inclusion.

SECTION 14: REFERENCES

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