An action research evaluation of Northumberland FISHNETS

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Acknowledgements

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# Table of Contents

## Contents

<table>
<thead>
<tr>
<th>Section/Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION 1: Introduction to the evaluation</td>
<td></td>
</tr>
<tr>
<td>Chapter 1: Introduction and background to the evaluation</td>
<td>8</td>
</tr>
<tr>
<td>The FISHNETS Partnership</td>
<td>8</td>
</tr>
<tr>
<td>Policy background to the Partnerships for Older People</td>
<td>12</td>
</tr>
<tr>
<td>Projects Programme</td>
<td></td>
</tr>
<tr>
<td>Review of literature underpinning FISHNETS interventions</td>
<td>13</td>
</tr>
<tr>
<td>Chapter 2: Methodology</td>
<td>16</td>
</tr>
<tr>
<td>Introduction</td>
<td>16</td>
</tr>
<tr>
<td>Action research evaluation method</td>
<td>16</td>
</tr>
<tr>
<td>Older people’s participation in the evaluative process</td>
<td>17</td>
</tr>
<tr>
<td>Aims of the evaluation</td>
<td>18</td>
</tr>
<tr>
<td>Action research design</td>
<td>18</td>
</tr>
<tr>
<td>Strand 1: Well-being and quality of life of older people</td>
<td>19</td>
</tr>
<tr>
<td>Strand 2. Building and sharing knowledge and learning through Collaborative Learning Events</td>
<td>20</td>
</tr>
<tr>
<td>Strand 3: Exploring service targets</td>
<td>21</td>
</tr>
<tr>
<td>Governance and ethical considerations</td>
<td>25</td>
</tr>
<tr>
<td>SECTION 2: Findings</td>
<td></td>
</tr>
<tr>
<td>Chapter 3: The FISHNETS partnership</td>
<td>27</td>
</tr>
<tr>
<td>Introduction</td>
<td>27</td>
</tr>
<tr>
<td>Analytic framework</td>
<td>27</td>
</tr>
<tr>
<td>Findings from the process analysis of the FISHNETS partnership</td>
<td>28</td>
</tr>
<tr>
<td>Good reasons for the partnership</td>
<td>28</td>
</tr>
<tr>
<td>High stakes</td>
<td>28</td>
</tr>
<tr>
<td>Right people</td>
<td>29</td>
</tr>
<tr>
<td>Right leadership</td>
<td>30</td>
</tr>
<tr>
<td>Strong balanced relationships</td>
<td>31</td>
</tr>
<tr>
<td>Trust and respect</td>
<td>31</td>
</tr>
<tr>
<td>Good communication</td>
<td>32</td>
</tr>
<tr>
<td>Formalisation</td>
<td>32</td>
</tr>
<tr>
<td>Discussion</td>
<td>33</td>
</tr>
<tr>
<td>Chapter 4: Community Involvement</td>
<td>34</td>
</tr>
<tr>
<td>Introduction</td>
<td>34</td>
</tr>
<tr>
<td>Older people and community involvement</td>
<td>34</td>
</tr>
<tr>
<td>Analytic framework</td>
<td>36</td>
</tr>
<tr>
<td>Involvement of older people through participation in the Partnership Board</td>
<td>36</td>
</tr>
<tr>
<td>Type of involvement</td>
<td>36</td>
</tr>
<tr>
<td>Level and range of involvement</td>
<td>37</td>
</tr>
<tr>
<td>Representation</td>
<td>38</td>
</tr>
<tr>
<td>Support</td>
<td>38</td>
</tr>
</tbody>
</table>
Impact of OPPB on service planning in Northumberland 39
Involvement of older people through the Community Chest 40
Type and range of involvement 40
Level of involvement 41
Impact of the Community activity and interest based groups 41
Contribution of groups supported by the Community Chest to the involvement strategy 42
Discussion 42

Chapter 5: Intermediate care and physical activities 45
Introduction 45
Service development: Intermediate Care 45
Service uptake 46
Intermediate Care and physical activities evaluation findings 47
Real time tracking of the service user journey through the Falls Pathway 47
Sample 48
Community Rehabilitation Team intervention 51
Leisure centre based exercise group intervention 52
Attendance at classes 55
Impact on quality of life 55
SEIQoL Quality of life scores 55
Qualitative data relating to quality of life 55
Positive changes in physical abilities 55
Achieving personal goals 56
Improvement in confidence 56
Summary 57
Discussion 57

Chapter 6: Home environment 59
Introduction 59
Service development 59
Northumberland County handyperson services: 59
Northumberland STARS 59
Northumberland County telecare services 61
Findings 62
Views and experience of using the handyperson service 62
The need for accessible, acceptable handyman services 62
Contributing to the prevention of falls in the home environment 63
Make homes safer 64
Enables older people to improve their homes 64
Enhancing quality of life 65
Views and experience of using telecare services 65
An acceptable, appropriate, individualized service 65
Enabling older people to continue to live in their own home 66
Reducing risk(s) associated with living alone 67
Enhancing quality of life 67
Implementation issues 68
Discussion 69

Chapter 7: Accreditation and education 71
Introduction 71
Service activities 71
Education 71
Accreditation 72
Findings 72
Impact on practice 72
A need for targeted education for the prevention of falls 72
Increased knowledge and understanding of falls and problems that contribute to falls 73
Developing practice 73
Risk assessment and risk modification 74
Challenges to implementing change in practice 75
Impact on service provision 76
Falls audit in sheltered housing schemes 76
Time and location of falls 77
What was involved in falls 77
Injuries sustained as a consequence of a fall 77
Reacting to and preventing falls 77
Discussion 78

Chapter 8: Information, publicity and communications 80
Introduction 80
Service activities 80
Healthy active living 81
Safe and healthy living 81
Falls prevention 81
Findings 82
Getting the information out 82
Engagement with information 83
Getting information to ‘hard to reach groups of older people’ 84
The information strategy is a vehicle to inform service development and service planning 85
Discussion 85

SECTION 3: Added value of Northumberland FISHNETS

Chapter 9: Discussion 87
Introduction 87
What was achieved through Northumberland FISHNETS 87
more than the sum of the individual parts 88
Far reaching involvement of older people in service development and delivery 88
The service culture: moving towards primary falls prevention 89
Impact of FISHNETS on physical ability and quality of life 89
A whole-system response to falls prevention 90
CHAPTER 1: INTRODUCTION and BACKGROUND to the EVALUATION

The FISHNETS Partnership

Northumberland FISHNETS partnership was led by Northumberland Care Trust1 and comprised of organisations within the public, not-for-profit and for-profit sectors. The partners came together to develop a proposal for an older peoples' falls prevention programme in Northumberland in response to an opportunity for funding from a government initiative, the Partnerships for Older People Programme (POPPs). The FISHNETS mission - to keep older people fit, involved, safe and healthy through sustainable community networks - was pursued through a joined up strategy of evidence based falls prevention and community level preventative activities. Key FISHNETS partners included Northumberland Care Trust, Northumberland District and County Councils, Northumberland Age Concern, RoSPA, Council for Voluntary Services, Independent Sector Providers, Supporting People, Home Improvement Agency, Blyth Valley Care, North Country Leisure, Castle Morpeth Leisure, Northumbria University and Newcastle University.

When the bid for funding was successfully achieved, the Older People’s Partnership Board (OPPB) was formed, which provided strategic direction and governance for FISHNETS; and operational task groups were developed to manage the FISHNETS programme of work. The links between partners, the OPPB and task groups are illustrated in Figure 1. The FISHNETS funding enabled existing services to be enhanced or extended, as well as new initiatives to be implemented, thus creating a distinctive whole system development, which aspired to balance the strategic driver of universal primary prevention with the need for targeted secondary falls management services, in order to provide a framework for the efforts of the FISHNETS task groups (see Figure 2).

The partners represented on OPPB included Northumberland Care Trust, the FISHNETS project manager and older people, who brought with them the experience of living later life in Northumberland and a wealth of skills derived from occupational and voluntary work throughout their lives. OPPB convened monthly and provided a forum for regular communication, ongoing scrutiny of service delivery and decision-making, in order to progress the ambitious targets that were predetermined in the FISHNETS proposal.

Operationally, FISHNETS was delivered through six linked task groups. Each task group was representative of partner organisations that were committed to achievement of the particular goals of that group. For example, the home environment task group included representatives from Blyth Valley Care (Northumberland Stars - handyperson provider), Home Improvement Agency, District Council members, Supporting People managers and members of the OPPB with a particular interest in the development of home improvement services.

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1 Northumberland Care Trust was set up on 1 April 2002 and was the first ever primary and community based Care Trust in England and Wales. It serves over 310,000 people in four localities with nearly 3,000 health and social care staff. The Care Trust has a budget of more than £430 million to provide social services for adults as well as GP services and community health services. The Care Trust employs around 1,100 staff directly, including 350 who have transferred from Northumberland Social Services department and 580 from Northumbria Healthcare NHS Trust.
The wide ranging partnerships that existed within FISHNETS are represented in Figure 1 and the explicit whole system configuration is modelled in Figure 2. By structuring partnerships around operational imperatives, individual task group members were mutually interdependent and functioned in collaboration to meet service targets. Working together to achieve a shared vision for the older population ensured a strategic commitment to the partnership. In keeping with the POPPs drivers (see policy background, p.) the intention was to use the FISHNETS funding to pump-prime a sustainable model of population-level preventative services, rather than to provide a short-term fix for gaps in provision.
The FISHNETS task groups were:

Community involvement

In addition to older people membership of OPPB, community development work focused on engaging older people in FISHNETS programmes. There was a particular emphasis on ‘hard to reach groups’ to reduce social exclusion and enhance awareness of and access to the range of preventative services across health, social care and housing agencies. A key strand of this programme of activities was the implementation of the ‘Community Chest’ which was a fund for the establishment of community activities that aimed to promote and enhance inclusion of the older population in social and community activities.

Picture 1: The community benefiting from the Community Chest fund
Accreditation and Education

This group focused on raising levels of knowledge and skill of fitness, involvement, safety and health and access to networks of support and information. It also worked to raise awareness of falls, fractures and osteoporosis through targeted training. Different aspects of the programme were geared to meeting the varying requirements of older people, their carers and those who supported or worked with them. A key objective was training older people to undertake peer support and mentoring roles within physical activities and lifestyle programmes. The Accreditation scheme aimed to establish good practice across the whole system of community health services, housing and support providers, care homes, home care and day care in regular contact with older people.

Home Environment

The Home Improvement Agency coordinated home environment assessment service to assess risks, with advice and interventions linked to falls prevention, fire prevention, crime prevention, fuel economy, heating and insulation, aids and minor work. The existing handyperson scheme was expanded county wide, and tailored packages of equipment and assistive technology were made available to augment care.

Physical activity and lifestyle

Exercise and lifestyle initiatives were implemented to provide a range of programmes that aimed to sustain personally relevant exercise, including Tai Chi, and modify fall risk factors such as poor balance, weak muscle strength and impaired gait. Resources were mobilized to assist the most at risk groups of older people to participate in physical activity with the aim of improving overall safe mobility and personal fitness.

Intermediate care

This group focused on the development of integrated case management systems, based on the Unique Care Model, which has been used to proactively seek out and refer those at risk. Services have been enhanced and expanded to address the rehabilitative aspects of prevention and the development of a county wide Falls Pathway.
Information, publicity and communication

Communication and events were adopted to ensure the projects whole system impact on falls prevention and to facilitate awareness of and access to programmes across communities. This was achieved through an educative, awareness raising communication strategy that involved use of multi-media resources, older people’s networks, and intergenerational activities.

Policy background to the Partnerships for Older People Projects Programme

Supporting older people to live independently in the community has been a central plank of Government health and social care policy throughout the 1990s and beyond (Department of Health, 1989; 1990a; 1990b; 1997; 1998a; 2000a; 2001a). Clark, Dyer and Horwood (1998), in their study of the priorities of older people living in the community, were critical of the community care reforms that failed to set a preventative agenda to address low level need. Whilst community care policy emphasised independence, choice and dignity, the focus remained on those with the greatest need. Their study pointed to the importance of establishing low-level supportive services, such as handyperson, house maintenance, housework and gardening services, to promote quality of life and well-being in later life. It also emphasised the importance of social engagement in determining quality of life. Low level services were viewed as essential to enable older people to remain in their own homes, and, where needed, extra-care housing, and to prevent or delay the need for higher intensity and more costly care.

The White Paper ‘Modernising Social Services’ (DH, 1998a) gave explicit recognition to the importance of preventive approaches as a response to the needs, problems and concerns of later life. Measures such as ‘prevention grants’ were made available to Authorities to support strategies to promote the quality of life of older citizens and prevent or delay dependency. The evidence from an evaluative study by Lewis et al (1999) indicated that Authorities were beginning to promote a preventative agenda, with some taking a strategic approach to prevention and identifying resources to fund preventative services.

Throughout UK policy and guidance documents concerning the development of preventative strategies there is an emphasis on minimizing the use of high intensity care and on the cost benefits inherent in preventative strategies in the planning of old age services. Lewis et al (1999) stated:

“the value of investing in prevention needs to be judged not only by quantifiable reductions in expenditure on other services, but also in improvements in quality of life and independent living, as perceived by older people themselves and service professionals,’ and ‘preventative approaches need to draw upon a range of organizations, professionals, communities and older people. They should promote quality of life in general, not simply focus on preventing admission to hospitals or institutions.”

The emphasis on quality of life is a key component of the powers of Local Strategic Partnerships to promote the social, as well as economic, well-being of their population. It is also a fundamental tenet of the Office of the Deputy Prime Minister’s proposals for sustainable communities and neighbourhoods and of the Home Office proposals for
community cohesion. The critical assumptions in all these initiatives are that actions by all agencies are inter-dependent; that action by one produces an impact for others; and that, by working in partnership, much improved outcomes for older people can be delivered overall.

The Government has for a number of years been promoting partnership working between agencies as key to delivering better outcomes for older people. In addition, the Better Government for Older People programme (Hayden and Boaz, 2000) kick started the development of more formal engagement between older people and local authorities/Local Strategic Partnerships. A growing number of areas have been setting up Older People’s Forums to bring together different networks of older people, together with Partnership Board type structures which link these older people’s networks with the Local Strategic Partnerships. The aim is to enable older people to have a real say as partners in decision making around planning for an ageing population. This theme of engagement and partnership with older people is particularly important in the planning and delivery of preventative old age services to ensure that services address the needs and priorities of older people.

Review of literature underpinning FISHNETS interventions

Falling in older people is widely accepted as a major public health issue: 40% of home accidents amongst people aged 65 years and over are due to a fall (Health Education Authority, 2001). The Cochrane Review of interventions for preventing falls in older people (Gillespie et al, 2003) concludes that approximately 30 per cent of people over 65 years of age and living in the community fall each year. Falls are the leading cause of injury-related hospitalisation in persons aged 65 years and over and up to 10% of falls in community dwelling older people result in significant injury (Campbell et al, 1990). Recurrent falls lead to loss of confidence in everyday activities (Cwikel, 1992), social isolation, increased admissions to hospital (Tinetti and Williams, 1997) and a greater probability of early admission to institutional care (Donald and Bulpitt, 1999). Not only do falls contribute to the mortality rate in the older population, but fractures sustained from falls can seriously impact on the long term prognosis of the faller. Many older fallers never regain mobility following fractures, especially of the hip (Marottoli et al, 1992) and prevention of fractures from falls that result in hip fracture was a key element of the economic evaluation of the impact of FISHNETS.

The problem of falls was placed high on the health and social care agenda by Standard 6 of the NSF for older people (Department of Health, 2001a), which specified that older people who have fallen should receive advice and intervention from specialised falls prevention services. Three years later the National Institute for Clinical Excellence (NICE) Falls Prevention Guideline (NICE, 2004) was published, which sets standards and aims to remove inequalities in falls prevention service provision. At the time of the FISHNETS project, the county of Northumberland did not have equality in falls prevention services or the integrated pathways that were recommended by policy and guidelines. In the preparation of the FISHNETS bid, a focussed approach was taken to develop services, whilst at the same time appraising the evidence to support planned FISHNETS initiatives.

The majority of high level evidence from randomised controlled trials suggests that falls are caused by an interaction of multiple risk factors, such as gait and balance abnormality, environmental hazards, visual impairment, multiple medications, other medical problems and fear of falling. An individualised multi-factorial approach to intervention has been
shown to be the most effective in reducing fall rates. For example, although home hazards contribute to fall risk, the effectiveness of home hazard modification is limited unless offered as part of a multi-factorial package of intervention (Gillespie et al, 2003).

However, there is robust evidence from several trials to show that tailored, specific exercise, as a single intervention, does improve gait and balance and reduce other risk factors for falls and injuries, including osteoporotic fracture (Gillespie et al, 2003; NICE 2004). Whilst the majority of studies focus on prescribed home-based exercise, evidence from more recent randomised controlled trials has shown that once weekly supervised group exercise programmes conducted in community settings, with at risk older people, are also effective in reducing falls (Day et al, 2002; Barnett et al, 2003; Skelton et al, 2005).

Skelton et al (2005) have shown that a 36 week individualised balance and strength retraining group combined with a home exercise programme reduced falls in a group of high risk community dwelling older women. A randomised controlled trial by Barnett et al (2003) tested an intervention programme designed to improve balance, coordination, aerobic capacity, function and muscle strength coupled with educational information regarding strategies for falls prevention. A control group received only the educational information. The intervention group performed better in some of the balance measures and fell 40% less than the control group during the 12-month trial period. Day et al (2002) investigated the individual and combined effects of three interventions; home hazard management, vision assessment and group exercise on balance, strength and frequency of falls in people aged 70 years and over. The strongest effect was found in the groups receiving a combination of the interventions, but when analysed in isolation, the group exercise program demonstrated the greatest improvement in outcome. Success of any falls prevention programme depends as much on participants’ compliance as on the effectiveness of the intervention. Barnett et al (2003) reported a mean compliance rate of 23/37 sessions, with 33% attending 30 or more sessions.

Fear of falling is often overlooked both as a problem for older people and a risk factor for further falls. Prevalence rates between 26% and 55% for fear of falling in community-dwelling older adults have been reported (Lach, 2005). Self-imposed activity restriction, due to loss of confidence in the ability to move around competently, can lead to accelerated physical decline, social isolation and loss of independence (Vellas et al, 1997, Cheal and Clemson, 2001). Research has shown that older people may not restrict their activities simply to avoid the physical consequences of falling, such as injury and loss of independence, but because they are concerned about the social implications of being seen to ‘lose control’ (Yardley and Smith, 2003). It is clear that falling and fear of falling has a significant effect on quality of life (Salkeld et al, 2000), which is a key outcome studied at both local and national evaluation level.

The compelling evidence for falls prevention programmes has now provoked a shift from individualised to ‘whole community’ public health strategies around the world. A Cochrane systematic review of population-based falls prevention (McClure et al, 2005) included six studies from Australia (Kempton et al, 2000), Denmark (Poustrup et al, 2000), Sweden (Lindqvist et al, 2001; Svanstrom et al, 1996), Taiwan (Lin et al, 2006) and Norway (Ytterstad et al 1996). These studies all encompassed an approach to population-based intervention described by Moller (1991) as a shared ownership between experts and community members for determining appropriate priorities and interventions, with an emphasis on community involvement. Interventions included tai chi (Lin et al, 2006) and multi-faceted programmes encompassing educational packages (Poustrup et al, 2000;
Kempton et al, 2000). In Norway (Ytterstad et al, 1996) the study period was eight years, with the first three devoted to baseline data collection, before introducing a whole system multi-factorial approach, not dissimilar to FISHNETS, designed to improve co-ordination between existing services. Although none of the six studies reviewed by McClure et al (2005) were randomised controlled trials, they were all robust evaluations with matched control communities and they consistently reported reductions in fall related injuries, thus providing a strong evidence base to support the partnership, population-level approach adopted by FISHNETS.

The Cochrane systematic review concludes with a number of recommendations, including the need for randomised controlled trials at population, rather than individual level. Such studies, whilst useful, would be highly resource intensive and require funding on a scale beyond that available in Northumberland. However, a further strong recommendation from McClure et al (2005) is the need for a better understanding of factors that influence the effectiveness of whole community approaches tofalls prevention. Elucidation of barriers and facilitators to service delivery, uptake and sustainability was lacking in the six studies reviewed, which impedes efficient replication of the successful population outcomes that were reported.

Organisational learning through evaluation

The local action research evaluation of FISHNETS (see Methods chapter 2) was designed to test out the implementation of evidence-based whole system falls prevention strategies in a way that would promote organisational learning for sustainable change. Collaborative learning groups were set up to ensure that the partnership knew and understood any emerging barriers to achieving task group goals, so that remedial action could be taken where appropriate. By the same token, sharing learning throughout the project enabled the whole system to replicate, where applicable, the facilitating actions and behaviours that appeared to promote successful service development and uptake. Through a cyclical approach, with continuous feedback, the evidence-based falls prevention services were studied both within the unique Northumberland context and against the national imperative created by the needs of an ageing population.
CHAPTER 2: METHODOLOGY

Introduction

The national Partnerships for Older People’s Projects programme created multiple levels and layers of evaluation to optimize the opportunity to learn about the approaches developed by the 29 pilots. One of the key features of the POPPs programme was the way that pilot sites were introduced in settings where complex changes were taking place across the social and health care statutory sector, as well in the independent and voluntary sectors, and these were likely to impact on provision in a number of ways. It was anticipated from the outset of POPPs that the initiatives developed in the programme would constantly evolve and continue to do so throughout the life of POPP and beyond.

At a national level the POPP evaluation strategy specifically aimed to identify the approaches that could most successfully be repeated across England in different health and social care communities and at a local level the strategy focused on supporting innovation to address local need. Consequently, each pilot site was subject to evaluation by the national team and a local team. The local evaluation of Northumberland FISHNETS was carried out by two research teams. Northumbria University was responsible for an action research evaluation that aimed to ascertain the impact of FISHNETS initiatives and through exploration of that knowledge contribute to organizational learning and redesign of service delivery as the pilot developed. Newcastle University carried out an economic evaluation on the impact of FISHNETS in Northumberland.

Action research evaluation method

The broad framework of collaborative action research allowed us to capture outcomes and embed local learning and ongoing service development within the approach to evaluation. For the purposes of this project, action research was defined as:

“A period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future oriented.” (Waterman et al, 2001 Chapter 3, p11.)

The collaborative action orientated approach was flexible and capable of interfacing with the requirements of the National Evaluation Strategy. At a local level the approach facilitated integration of evaluation with organizational goals, and as these shifted the evaluation process was reviewed and revised.

The design of the evaluation was grounded in the initial service baselines that were established for each of the interventions that were part of the FISHNETS development: community involvement, education and accreditation, home environment, physical activity and lifestyle, intermediate care, communication and events. Each service initiative specified its own objectives and outcomes for measuring success. Prior to implementation of the evaluation these outcomes were agreed with the Department of Health as part of the process for securing POPPs funding. As the project progressed the methodological framework was operationalised into a cyclical process of problem identification, planning, action and evaluation as depicted in figure 3.
Older people’s participation in the evaluative process

The evaluation was designed as a participatory activity; inclusive of all stakeholders and participants involved in Northumberland FISHNETS. A unique feature of the evaluation process was the involvement of older people as active partners throughout all stages of the process. All too often research investigating the impact and the effectiveness of services for older people has addressed service, professional and academic concerns and the involvement of older people has been little more than as subjects that provide data (Bright, Hollands and Smith, 1998; Carter and Beresford, 2000; Peace, 2000; Reed et al, 2006). By including older people in the development of the evaluation strategy, the project was underpinned by a strong service user involvement strategy.

Seven older people were recruited to the evaluation team. Five of the seven team members agreed to take an extended role in the evaluation. One 94 year old woman agreed to act in an advisory capacity, commenting on documentation and interview schedules and the other member’s health deteriorated soon after joining the team and this prevented her from continuing her involvement. The team members had diverse backgrounds (e.g. farmer, manager, teacher), an in-depth knowledge of living in Northumberland, good links to their local community, and different motivations for participating in the project, such as enhancing the image of older people and improving services for older people.

Team members became honorary researchers with the Care Trust in accordance with Trust processes, and participated in a training programme that included both formal and on-the-job learning. Their extended roles in the project included involvement in data collection, analysis and report writing. They participated in research activities across different localities and different services in order to facilitate dissemination and promote cross-fertilisation of ideas. This was the first opportunity for these older people to participate in service evaluation. The following quotations capture some of their thoughts about this experience (further discussion is presented in Appendix 1).
“This has been a tremendous learning curve for me.”

“I have met some great people and have been very humbled when hearing about the way that they live and how they manage their daily lives.”

The aims of the action research evaluation were

1. To contribute to organizational learning and redesign of service delivery through the evaluation strategy
2. To map service and community developments arising through Northumberland FISHNETS
3. To ascertain the impact of Northumberland FISHNETS initiatives on the health and quality of life of the older population in the locality
4. To ascertain the impact of Northumberland FISHNETS initiatives on service design and delivery

Action research design

The aims of the evaluation were addressed through 3 interrelated strands that were:

1. Impact of Northumberland FISHNETS on physical health and quality of life (addressing aim 3)
2. Building and sharing knowledge and learning through Collaborative Learning Events (addressing aim 1)
3. Exploring service targets (addressing aim 2,3,4)

These strands were conceptually interconnected in the way that they examined a specific element of Northumberland FISHNETS and developed understandings of prevention, well-being and quality of life through service development and delivery. These strands are represented diagrammatically (fig 4).
### Northumberland FISHNETS programmes

<table>
<thead>
<tr>
<th>Strand 1: Well-being and quality of life of older people</th>
<th>Strand 2: Collaborative Learning Events</th>
<th>Strand 3: Exploring service targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohorts of older people through the programme – examining their experience and the impact on their quality of life through SEIQoL-DW assessment and semi-structured interview</td>
<td>Learning groups focusing on selected topics and issues</td>
<td>Community involvement</td>
</tr>
<tr>
<td>Community involvement</td>
<td>Community involvement</td>
<td>Education and Accreditation</td>
</tr>
<tr>
<td>Accreditation and Education</td>
<td>Accreditation and Education</td>
<td>Home improvement</td>
</tr>
<tr>
<td>Home environment</td>
<td>Home environment</td>
<td>Physical activity and lifestyle</td>
</tr>
<tr>
<td>Physical activity and lifestyle</td>
<td>Physical activity and lifestyle</td>
<td>Intermediate care</td>
</tr>
<tr>
<td>Intermediate care</td>
<td>Intermediate care</td>
<td>Communication and events</td>
</tr>
<tr>
<td>Information, publicity and communication</td>
<td>Information, publicity and communication</td>
<td>Ongoing data collection and analysis of the service targets</td>
</tr>
</tbody>
</table>

Figure 4: Diagrammatic representation of the design of the action research strand of the evaluation

### Strand 1: Well-being and quality of life of older people

**Assessing well-being and quality of life**

With respect to defining quality of life, definitions that focus on physical well-being and optimum functional ability are problematic in later life, particularly in advanced old age. Estimates of the prevalence of disease, illness and disability through official surveys suggest that these rise in the older population. For example, the Health Survey for England 2000 (2002) indicates that serious disability features with approximately 16 percent of men and women over 65 living in private households. Many clinical diagnoses, including stroke, cardio-respiratory, endocrine and musculoskeletal disease, depression and dementia feature among older people. Also many functional diagnoses are prevalent, such as incontinence, confusion, and immobility, and impairments such as visual and hearing deficits exist. Defining quality of life on the basis of physical well-being alone is limited in this population group.

When using ‘quality of life’ (QoL) as a measure of the outcome of health/social care services, therefore, careful consideration needs to be given to which elements of QoL the intervention or service might target and whether the chosen outcome measure is sensitive to specific effects. According to Lhussier et al (2005) there is a tension between the current policy driver of ‘person centeredness’ and QoL measures that are driven by the
concerns of the service. Standardised scales used to measure quality of life (QoL) impose an external value system, with weightings derived from grouped data. Although these measures may be reliable, they are not necessarily relevant to an individual's present life situation. Seemingly comparable activities or issues do not have the same relevance or importance for all individuals and this relevance may change over time or over the course of illness or disability (O'Boyle et al 1992).

To address the concerns highlighted above the Schedule for the Evaluation of Individual Quality of Life –Direct Weighting (SEIQoL-DW) (Hickey et al 1996) was adopted as the measurement tool in this study. SEIQoL allows respondents to nominate the areas of life which are most important, rate their level of functioning or satisfaction with each, and indicate the relative importance of each to their overall quality of life. The SEIQoL-DW leads to a score on a continuous scale of 1-100, higher scores indicating better quality of life.

Sample
Cohorts of older people who used the home improvement (telecare [n=9] and handyperson [n=14]) and physical activity and lifestyle (leisure-centre falls prevention exercise programme [n=50]) services were invited to participate in data collection concerning quality of life. The SEIQoL-DW tool was administered prior to and following interventions to assess the impact of the activity of the older person’s perception of their quality of life. Further discussion of the administration, and data analysis of the quality of life measurement is given under strand 3– investigating service targets (p.21).

Strand 2. Building and sharing knowledge and learning through Collaborative Learning Events

Collaborative action learning is a continuous process of learning and reflection supported by those involved in an initiative, with an intention of getting things done. Through action learning, individuals learn with and from each other by working on real problems and reflecting on their own experiences.

Five Collaborative Learning Events were held throughout the evaluation. These were:

- **The FISHNETS partnership: Relationships, Integration and Outcomes** - the 12 participants were members of OPPB and task group leads
- **Integration and decision making** - the 6 participants were members of OPPB and task group leads
- **Impact and sustainability of the falls pathway** - the 20 participants were members of OPPB, physical activities and lifestyle task group members, intermediate task group members, community rehabilitation team
- **Education, training and accreditation** - the 16 participants Members of OPPB, education, training and accreditation task group members, education providers and sheltered housing service managers
- **Home environment** - the 20 participants were members OPPB, home improvement task group members, handyperson service staff older people’s research group, researchers from Northumbria and Newcastle Universities

Reports were written following each learning event and distributed to participants to promote further reflection on the discussions that had taken place. These reports have been regarded as a data source and have been drawn from in this final report.
Strand 3: Exploring service targets

Mapping service activities

In line with the contractual agreement with the Policy Research Programme, targets were established for each of the FISHNETS programmes. Hence, service level data was routinely collected to establish performance against those agreed targets and this was monitored through quarterly reports from FISHNETS to the POPPs programme. The following discussion details data collection and analysis that was undertaken in each programme area for the purposes of the local action research evaluation. This involved examination of specified service activities that were identified and agreed with the FISHNETS project Manager and with members of the FISHNETS task groups (see table 1 for a summary of data collection and sampling for part 3 of the action research evaluation).

<table>
<thead>
<tr>
<th>FISHNETS programme area and brief summary of activity</th>
<th>Data collection and sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community involvement</td>
<td>Individual and small group interviews with 18 co-ordinators/providers and 26 participants of community chest activities (n=44)</td>
</tr>
<tr>
<td>Education and accreditation</td>
<td>Audit of falls in sheltered housing schemes (n=13 schemes) Group interviews with home care staff (n=12) Individual interviews with care home managers within the accreditation scheme (n=8)</td>
</tr>
<tr>
<td>Home improvement</td>
<td>SEIQoL assessment before and after home improvement service provision 9 telecare service users and 14 handyperson service users (n=23)</td>
</tr>
<tr>
<td>Physical activity and lifestyle</td>
<td>SEIQoL assessment, Tinetti balance and gait; and Falls Efficacy Scale Before leisure centre based Falls prevention programme, ½ week following completion of programme and 3 months following completion Participants of the Falls Prevention Programme (n=50)</td>
</tr>
<tr>
<td>Intermediate care</td>
<td>Real time tracking of the journey of 9 service users throughout the Falls pathway (n=9) Pre and post rehabilitation team falls prevention intervention using the Tinetti balance and gait assessment (n=41)</td>
</tr>
<tr>
<td>Communication and events</td>
<td>Individual interviews of Leisure service managers and staff, and physical activities task group members (n=7)</td>
</tr>
</tbody>
</table>

Table 1: Data collection summary for Part 3 of the action research evaluation

Community involvement

There were three strands to this aspect of data collection:

- Generating field notes and theoretical sensitivity from participant observation of the Older People’s Partnership Board and FISHNETS task groups throughout the project.
- Collation of project documentation including minutes of meetings, project documents and verified reports derived from collaborative learning events.
- Fifteen interviews were undertaken at the end of year 2 with 18 Community Chest activity co-ordinators/providers and with 26 participants to explore the need for the activities that had been established with Community Chest funding, how the activity
addressed that need, their views about the activity, personal impact resulting from their participation in the activity, the added benefits to the local community, and plans for sustainability.

Analysis: The interviews were tape-recorded and transcribed verbatim. The transcripts were read and reread to identify the issues and topics that the participants discussed. This formed the foundation for open coding and thematic analysis.

Accreditation and education

There were three strands to this aspect of data collection:

- An audit of falls and approaches to falls prevention in sheltered housing schemes. 13 Anchor housing schemes were invited to complete a monthly audit report from February 2007. The audit was a tool for developing a robust system for falls recording, reporting number of falls, number of tenants falling, location, time and injury resulting from the fall. The audit included collation of falls prevention related activity such as risk analysis, change in service (e.g. exercise group in the Scheme) and practice (e.g. falls prevention talks with tenants). A total of 86 audits were completed within the data collection period Feb 2007 – March 2008.
- Group interviews with 12 home care staff who had undertaken FISHNETS training. The topics that were explored included their views of FISHNETS training, relevance of the training to their role, impact on their practice, and examples of ways that they applied the training in their own practice.
- Individual interviews with 8 care home managers who participated in the falls accreditation process. The managers were asked about their views of the accreditation process and the impact that the process had had on the prevention of falls in their care home.

Analysis: Quantitative data was inputted and processed using SPSS software. The data was descriptively analysed to identify trends with respect to falls over the data collection period.

The interviews were tape-recorded and transcribed verbatim. The transcripts were read and reread to identify the issues and topics that the participants discussed. This formed the foundation for open coding and thematic analysis. Initial findings were discussed during service provider meetings and in the fourth collaborative learning event. These discussions resulted in review and refinement of the codes and further development of the themes.

Home environment

Data collection
The impact of telecare and handyperson services was assessed through strand 1 data collection, as described above. It was anticipated at the outset of the project that it would be possible to interview older people who used a range of simple to complex home environment services prior to and following up take of the service. It quickly became apparent that this was not feasible, as many of the service users repeatedly accessed the service, and others used the service long after data collection was completed. In recognition of the diversity of service use (simple interventions, such as fitting a light bulb, to complex home adaptations to change the environment as a response to the assessed
need of the older person) a matrix sampling technique process (Reed and Proctor, 1996) was utilized to ensure that a diverse sample was generated.

In the case of telecare services 9 people were selected that met the following criteria: users of a range of telecare interventions, located in urban and rural areas, old and advanced old age service users, able to participate in an in-depth discussion of their experiences. The selected individuals had use of a range of interventions including lifeline 4000+ with pendant, fall detector, smoke detector, carbon dioxide detector, temperature extreme detector. These individuals agreed to participate in a SEIQoL-DW assessment and a semi-structured interview that explored the type of telecare service that they received, their experiences of that service and the impact that the service had had on their life.

For the handyperson service, 14 people that met the following criteria were selected: new/repeat users of the service, simple/complex interventions, urban/rural location. The selected individuals had a range of interventions in their homes including re-fitting of doors, change of light bulbs, grab rails fitted to exterior doors, fittings in the bathroom, curtains re-hung and furniture moved. These individuals participated in a SEIQoL-DW assessment and a semi-structured interview that explored the type of handyperson service that they received, their experiences of that service and the impact that the service had had on their life, prior to the intervention and 1/2 weeks following the intervention.

**Analysis:** Quantitative data were inputted and processed using SPSS software. Within-subject comparisons were made to explore the impact of the home environment intervention.

The SEIQoL-DW assessment interview was audio-recorded and transcribed verbatim. This qualitative data was thematically analysed to identify the issues and topics that individuals discussed and the themes that were discussed by all of the participants. The global quality of life scores derived from SEIQoL-DW before and after the intervention (in the case of handyperson service users) was inputted and processed using SPSS software. Changes were juxtaposed with qualitative interview data to enable suppositions to be made about how the home environment intervention had impacted on quality of life.

**Physical activity and lifestyle**

**Data collection**

The impact of physical activity and lifestyle programmes was addressed through 3 measures from individuals participating in the leisure-centre based falls prevention exercise programme - before the intervention commenced, soon after participation in the programme and at follow-up 6 months later.

First, programme participants were asked to undertake a SEIQoL-DW assessment and semi-structured interview prior to the Falls prevention exercise programme to explore why people take part in the programme, the cultural acceptability of the physical activity programme, life-style changes and the impact of the activity on their health and well-being.

Second, standardised assessment of balance and gait was determined by a validated outcome measure, the Tinetti performance orientated assessment of gait and balance (Tinetti 1986), which was undertaken by qualified physiotherapists from Northumberland
Care Trust and researchers. A training event was held, hosted by the action research team, to make sure the assessments were carried out in a reliable manner. The assessments took place either in FISHNETS services venue or in the participants own home. Wherever possible the same assessor completed the 3 assessments. In line with recommended best practice all of the participants were asked by the assessor, at every meeting during data collection if they had fallen.

Third, standarised assessment of falls related confidence and self efficacy was assessed by a self-completion questionnaire known as the falls efficacy scale (FES). We used the anglicised version of the FES, which has been tested for reliability and validity (Parry et al 2001).

Sample: All participants who commenced the leisure centre based falls prevention programme from January 2007 were invited to participate in the evaluation and recruitment continued until a sample of 50 participants had been achieved. As the project progressed there was an attrition of 9 people from this aspect of data collection, leaving 41 complete data sets.

Analysis: Quantitative data was inputted and processed using SPSS software. The data were analysed using descriptive statistics to measure change in gait, balance, falls related confidence and quality of life outcomes, in order to measure levels of improvement or deterioration as people moved through the service. Within groups non-parametric (Wilcoxon signed ranks) and parametric (paired t tests) were used where appropriate to test for statistical significance. In the absence of a control group, cause and effect can not be reliably attributed.

Intermediate care

Data collection
The focus of initial activities was on the development of a standardised Falls Pathway across the County. The Falls Pathway that was developed was a schematic diagram of the services that were available to people in Northumberland who were at risk of falling and those who experienced falls and how these linked with each other. As the project progressed the focus shifted to the delivery of the service. To reflect this data collection involved 2 strands: 1) exploring the effectiveness of the pathway through real time tracking and 2) examining the impact of the rehabilitation team intervention on gait and balance.

Strand 1: The NHS Institute for Innovation and Improvement (2005) has supported and developed a ‘process mapping’ that is now a key component for service improvement. The Institute considers that process mapping is one of the most powerful ways for multidisciplinary teams to understand real life problems from the patient’s perspective and to identify opportunities for service development. In contrast to the methodology advocated by the Institute mapping of the real life journeys of patients through the Falls pathway was undertaken. Older people moving up the pathway and people moving down the pathway were tracked. The Falls Pathway includes basic low level services that are funded by FISHNETS through to falls medical and therapy interventions in a hospital based clinic. Movement up the Pathway referred to patients who entered low level services and were referred to more specialist interventions. Movement down the Pathway occurred when someone was discharged from medical specialist and therapy services into a lower level service such as the Falls Prevention Exercise programme in order to prevent falls or deterioration. Real time tracking of 9 service user journeys through the Pathway involved a
member of the research team making weekly contact with the participants (i.e. telephone call or visit) to discuss what services they had received during the week, and what was planned. Tracking service users throughout their patient journey informed the review and development of the Falls Pathway by highlighting gaps and delays in existing services.

**Analysis:** Research notes that were made of the patients' journey were examined and translated into a journey profile. A profile was developed for each service user, detailing service interventions, when these occurred, when these should have occurred, and referral to other services, interventions or exercise programmes. The profiles were analysed to identify how these corresponded to the developing Falls Pathway.

Strand 2: Many of the older people who entered the Falls pathway accessed a range of interventions by the Community Rehabilitation Teams, including a rehabilitation team-based 12 week falls prevention exercise programme. Some of these individuals then moved onto the leisure-centre based exercise programmes. Prior to and following each programme, standardised assessment of balance and gait were undertaken in the rehabilitation centres by the qualified physiotherapist who was providing the exercise intervention from Northumberland Care Trust. A total of 39 anonymised data sets were provided to the action research team for secondary analysis. 29 of these individuals had gone on to access leisure centre falls prevention programmes.

**Analysis:** The data for strand 2 was provided to us and we transferred it into SPSS and performed a secondary descriptive analysis.

**Information, publicity and communications**

There were four strands to this aspect of data collection:

- Documentary analysis of project documents and related media
- Participant observation of FISHNETS events and activities
- Secondary analysis of interviews that were undertaken with task group members and users of FISHNETS services throughout the evaluation
- As a way of assessing the added-value of FISHNETS to enhancing the range of physical activities and life-style groups and community based preventative initiatives, interviews were undertaken with 4 managers of leisure centres within Northumberland district and 3 physical activity task group members. They were asked about what has changed as a result of FISHNETS, and in particular how the Young at Hearts Events, which were a key aspect of the FISHNETS Communication and activities programme, influenced these changes.

**Analysis:** The interviews were tape-recorded and transcribed verbatim. The transcripts were read and reread to identify the issues and topics that the participants discussed. This formed the foundation for open coding and thematic analysis.

**Governance and ethical considerations**

As this study involved service users, community dwelling elders, NHS, social services and local government staff, and voluntary/independent sector staff in Northumberland County, the project was reviewed and approved by Northumberland LREC. In addition approval was sought and gained from Northumberland Care Trust R & D department.
Since this study involved informants who represented organisations or agencies with an interest in prevention for older people and promoting well-being in later life it was important that the participants were fully informed about the concerns, aims, scope, relevance and intended dissemination of findings relating to the study to attain informed consent. The researchers developed strategies to maintain anonymity of the respondents and to respect their confidentiality throughout all aspects of the evaluation.

Informed consent in the project was regarded as a process that was continually negotiated and this supplemented the more conventional formal consenting process (Dewing, 2002). Process consent was one of continual renegotiation and was particularly appropriate in this evaluation because there were considerable lapses of time between data collection points and it was possible that the participants may have changed their mind about taking part or indeed forgotten that they had agreed to participate in the evaluation. The researchers wanted to ensure that the rights of the participants were upheld, therefore at every meeting informed consent was revisited with the participants and they were reassured that declining to participate in the project would not affect the care that they received, and that data collection was of no harm to them.
SECTION TWO: FINDINGS

CHAPTER 3: THE FISHNETS PARTNERSHIP

Introduction

In the UK, health and social care policy rhetoric and guidance has been predicated on concepts of multi-professional working, collaborative, and multi-agency approaches to service provision, greater consumer involvement, and statutory responsibilities to work in partnership (National Audit Office, 2001; Dowling et al, 2004; DoH 1997; 1998b; 2000a; 2000b; 2005a; 2006). Consequently, Northumberland FISHNETS was developed as a multiagency, multi sector, multidisciplinary partnership that focused on the core objective of reducing serious injury in the older population through prevention of falls. Unlike many partnerships in the field of health that fail to complete their aims and do not survive the first year (Lasker et al, 2001), the FISHNETS partnership has flourished and met the majority of the targets that were established in the POPPs proposal. The findings presented in this chapter were generated from analysis and triangulation of the following data:

- Field notes from participant observation of the Older People’s Partnership Board and FISHNETS task groups
- Minutes of meetings and project documents
- Previously circulated and verified reports derived from collaborative learning events.

This chapter commences with a description of the analytic framework adopted to explore key dimensions of the FISHNETS partnership and moves on to present an account of the partnership that is both grounded in data and discussed in relation to established generalisable theory.

Analytic framework

Though there are many ways of evaluating the processes that contributed to the functioning of Northumberland FISHNETS, the Warnwarth partnership conceptual model (Warne and Howarth, 2008) was adopted as an analytic framework, as it acknowledged the complexity, interrelatedness and messiness of partnership working, which were characteristic features of the FISHNETS partnership. What we observed was driven by top-down Department of Health policy and guidance, yet operationalised by a local impetus to acquire new funding to support existing services and develop new ones for Northumberland.

In the Warnwarth framework the notion of the ‘good enough partnership’ sits at the core of the conceptual model; that is ‘is a partnership good enough to do the job and achieve its aim(s)’. In this model a partnership is seen as being influenced by eight interrelated dimensions, which are – good reasons for the partnership, high stakes, right people, right leadership, strong balanced relationships, trust and respect, good communication and formalisation. Each of these dimensions were used to analyse data related to different aspects of the FISHNETS partnership in order to shed light on the factors that may have led to FISHNETS developing in the way that it has. The following discussion does not intend to examine the underpinning assumptions inherent in Warnwarth’s model, rather the
model is accepted as a given. The discussion does present a synthesis of data analysis relating to each of the dimensions of the Good Enough Partnership.

Findings from the analysis of the FISHNETS partnership

Good reasons for the partnership

When the POPPs programme was announced, there was immediate impetus for older people, agencies and organisations across statutory, voluntary and independent sectors in Northumberland to develop a partnership. This was a unique opportunity for older people, managers and service staff to work in a collaborative way to realize a shared vision of service provision for the older population of Northumberland. A key issue was the desire to deliver falls prevention services that all of the stakeholders considered older people needed across the entire County to enhance their quality of life, in contrast to the inequality of service provision that had previously existed in Northumberland. The external driver of bidding for competitive funding may have brought the partnership together, but the shared vision for the future was a strong positive underpinning and once the partnership was successful in securing funding, the external impetus was quickly replaced by an internal imperative to work collaboratively to meet the requirements and conditions of the grant.

High stakes

The stakes were high within the FISHNETS partnership in varying contexts. For the Care Trust and Local Authority, success in achieving the aims and objectives of this project had local and national implications. The reputation of these organisations with key government departments and inspection bodies could have been negatively affected by failure to achieve service targets or perceived lack of commitment to a new and developing policy agenda.

Indeed, a case was made in the bidding process for POPPs funding to support the development of a countywide falls pathway, which had the potential to draw attention to Northumberland’s health and social care organisations’ slowness to meet National Service Framework targets. There were also potentially negative consequences for those with managerial responsibilities for the relevant adult services. Some key players realised they would have to champion this project within their own organisation and the efforts invested to prioritise FISHNETS alongside competing demands were shared in discussions at task group meetings.

During the operationalisation period the financial arrangements of the POPPs programme involved financial risks for all partners and required discussions about how the sharing of these risks could be managed within the larger partnership arrangement for the Care Trust.

There were also important positive outcomes for health and social care organisations that were part of the FISHNETS partnership. The project provided a vehicle for the delivery of unachieved milestones and targets in important older people’s policy areas, such as The National Service Framework for Older People (DH 2001). As the project developed, some organisations were able to point to FISHNETS as an exemplar of innovative service
development in the Comprehensive Performance Assessment (CPA). Therefore FISHNETS was instrumental in supporting organisations’ star ratings.

For voluntary organisations and independent service providers, involvement in FISHNETS carried risks of a different kind. Future contracts and work awarded by commissioning arms of the statutory partners may have been influenced by their performance in this high profile project. Equally, becoming a FISHNETS partner had the potential to create new, unplanned opportunities to further their work with the growing older population in Northumberland.

What was unanticipated at the outset of Northumberland FISHNETS was the extent of the profile of the overarching POPPs programme at the highest level of government. This realisation has, in turn, risen what were initially viewed as high stakes across the whole of the FISHNETS partnership. The ongoing reporting to the national project and evaluation team highlighted all areas of activity and partners has not realised how visible service level outcomes would be.

Right people

The FISHNETS vision was generated by individuals who came together as a group in their commitment to developing innovative, high quality preventative services for older people. These individuals were sufficiently empowered to make decisions on behalf of the organisation and the older Northumberland County population that they represented within the FISHNETS partnership. This culminated in a successful bid for Department of Health funding. Through collaborative learning, they attributed their success to the diverse perspectives, experience and knowledge of the needs of the older population that they brought to the partnership, and their ability to make timely decisions within this context. During the initial phase of FISHNETS, organisational structures were developed to facilitate the translation of the FISHNETS strategy into operational processes and deliverable services. The individuals who had been instrumental in developing FISHNETS maintained their commitment to the project and agreed to take on new roles and responsibilities within this structure. For example, older people community representatives became members of the Older People’s Partnership Board, who worked in collaboration with service partners to undertake governance and financial accountability for the project. Organisational representatives also agreed to undertake new roles as task group leads or task group members to make operational decisions and oversee the day-to-day implementation of the project. This was a complex undertaking in a situation where services were being delivered across service and sector boundaries and by staff who did not necessarily have a history of working together. Partners identified a great need for staff development to enhance their capacity to fulfil new responsibilities. For example, older people board members completed ‘Stronger Voice’ training to develop skills and knowledge for their expanding role within FISHNETS.

Implementation of the project required the recruitment of staff to new posts, which was somewhat problematic in a climate where there was a freeze on new appointments within

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2 Stronger Voice is part of the National Consumer Council’s response to increasing demands for consumer involvement. Stronger Voice training will ensure that organisations have meaningful representation and will help demonstrate that they take representation seriously. For involvement to work effectively, representatives need the right skills. Stronger Voice trains representatives to put forward the consumer point of view more clearly and to base their input on well-researched, realistic and relevant information.
the host organisation. At times this led to slippage in meeting predetermined targets and frustration within existing staffing, as individuals talked of their struggle to meet the demands of ever increasing workloads.

Significant changes have occurred throughout the FISHNETS experience with regard to the people involved with this initiative. Toward the beginning of the second year of the project the host organisation, Northumberland Care Trust and key external partner organisations such as Northumberland County Council, went through a process of structural reorganisation. These reorganisations resulted in changes to the people within the partnership, when key individuals were made redundant or realigned in their organisations with new responsibilities. This had a considerable influence on the leadership and management within FISHNETS. Whilst this was a time of considerable uncertainty for those who remained, these changes also created the opportunity for new people to join the partnership. By the end of the project, new relationships had developed within the FISHNETS partnership and this enabled the integration of FISHNETS services into the new organisational structures.

**Right leadership**

Leadership operated at several different levels within FISHNETS. At the National level, the project was one of 19 first wave pilots in the Department of Health POPPs programme. It was clear from the initial prospectus inviting applications that the DoH was looking for local innovation which it could support rather than intending to lead the process itself. As the projects got underway there was increased performance management from the centre with a particular emphasis on economic parameters of service development. This was sometimes at odds with the local philosophies of partnership and older people centred care, where quality of life and service development were key priorities for the OPPB and the task groups.

At the local level, strong leadership was apparent in the FISHNETS partnership. The OPPB had a high profile and strong decision making power (see chapter 4: Community involvement). Information was fed up to the Board and decisions were cascaded back to the task groups through the project manager. Effective strategies, such as devolved task group decision making, empowered service providers to take things forward. It was clear from collaborative learning events that all of the partners involved in FISHNETS had a high degree of ownership of the project and shared its aspirations. Effective communication channels were observed and were used to ‘join up’ the thinking across and between task groups. The strong role and presence of OPPB co-ordinated activities provided a point of reference for all task group activities.

As in any leadership position, the personal qualities of the individual leader were pivotal. The initial project manager and the successor’s personal strengths and effective communication skills, were crucial in forming effective relationships, trouble shooting across the project task groups and generally facilitating the process of making things happen. FISHNETS had clear aspirations and the shared vision evident in the initiative could not have been achieved without the ‘right leadership’. As the FISHNETS project funding drew to an end, the continuation of effective leadership became an issue that was more important than ever to secure the sustainability of the partnerships and the service developments that had been achieved.
Strong balanced relationships

The partnership was forged in a collective effort that was focused on securing the funding for the project. Everyone worked to this common objective with less attention being devoted to ‘getting to know each other.’ A consequence of this was the development of linkages between agencies and organisations that enabled commitment to the FISHNETS vision. These linkages did not always translate into interdependent operational processes when the project moved into the implementation phases. In some sections of the project, such as development of handyperson services across the County, independent working practices within the home improvement task group facilitated service development and meeting service targets in a timely manner. In other sections of the project organisational cultures that existed prior to the partnership overshadowed relationships during the initial developments. This resulted in suspicion between partners concerning organisational agendas, and misunderstandings of the imperatives underpinning the FISHNETS project. Working within task groups enabled the project team to nurture their relationships and during the first year of implementation, differences in organisational culture and decision making processes were identified and worked through, resulting in a valuing of the different contributions that partners brought to the project and the development of new ways of working.

From the commencement of the project, attention was given to reducing the power differential between the older people board members and professionals. Board members, for example, received an honorarium for their commitment to the management and governance of FISHNETS. Whilst the payment was an attempt to introduce equality into the relationship, in no way did it represent the many hours of work that board members devoted to the project. An effort to establish equality in this relationship was also evident in the way that Board members were able to influence decisions about appointment of the project team and in service planning.

With the reorganisation of the Care Trust came changes in relationships between the partners. For example, older people members of the Partnership Board had been central to decisions about staff appointments and they had considerable autonomy in decisions about the FISHNETS budget. The reorganisation, which coincided with acute pressures on the Care Trust’s budget, resulted in some key decisions about staffing and resources being taken by service managers as part of the wider agendas. Reflection on this situation by Board members and the host organisation stimulated the development of strategies that forged new relationships and partnerships that moved the project into a new operational context where Local Area Agreements and Local Delivery Plans were significant to its future. The relationship changes that took place with the FISHNETS initiative highlight the temporal nature of partnership interactions and the need to continually reflect on and manage relationships that are critical to the effective working of the partnership.

Trust and respect

People with diverse backgrounds were brought together in FISHNETS and professionals from health, social care and the third sector came together in a partnership with older people and service users. Trust and respect was evident from the early bid development meetings through to the operation of the OPPB.

Respect for each other’s points of view has been crucial to the success of the partnership in the visioning of FISHNETS and bringing to fruition its respective service developments.
Partnership members did not shy away from the ‘big issues.’ Strong values were evident in action as challenges were encountered and dealt with. Opinions were openly exchanged between partnership members and, even where compromise was required, there was a transparent process leading up to final decision making. Most players behaved with integrity, had faith in consensus decision making and trusted each other’s judgements and were observed to have participated in a culture where mutual respect was apparent. Learning and development were high priorities across all aspects of the project and people and their services moved forward together in a collaborative manner. The respect, trust and confidence between stakeholders has been a project success. Whatever FISHNETS becomes beyond the project funding, the core values and beliefs that it has fostered will be critical to future success.

**Good communication**

The organisational structure within FISHNETS provided formal links between older people, service managers and service personnel; partner agencies and organisations; and the commissioner and provider of services. This structure provided the foundation for communication processes that enabled the partners to openly share information that was required to make the relationship work, including their objectives and goals, knowledge of statutory and non-statutory services for older people in Northumberland County, service data, potential areas of conflicts and changing situations.

Individual members of the partnership exchanged their ideas and communicated their concerns with other members through formal structures (OPPB, task group meetings, and supervision sessions) and informal conversations. Face-to-face informal conversations were particularly valued by members as a way of sharing ideas and developing creative ways to ‘think outside the box’ in order to move the FISHNETS agenda forward.

Developing open and effective communication structures and processes was not straightforward. For example, some partners relied heavily on e-mail communication as a quick and accurate method of communication, whereas other partners did not have access to or did not regularly use e-mail. Hence, methods of communication that were acceptable to everyone in the partnership had to be developed and this challenged the partnership. A change in the membership of the partnership disrupted relationships and this had an impact on communication flows.

**Formalisation**

From the inception of the FISHNETS proposal, the OPPB provided a strategic structure for organisation representatives to maintain regular communication with each other and it provided a vehicle for decision making during the implementation phase of the project. Importantly the organisational representation on the Board (e.g. Director of Social Care and County Wide Services, Head of Provider services – Older People Services) ensured that decision making processes resulted in timely and effective decisions that enabled the project team to meet the demanding service deliverable targets that were predetermined in the FISHNETS project proposal.

From the commencement of the implementation phase of the project, OPPB linked with middle and operational managers through the FISHNETS task groups. In the main, the leaders of these task groups held key roles within their respective organisations; therefore
they were able to translate the FISHNETS strategy into operational processes and deliverable services. This provided a structure for strong vertical linkages within the FISHNETS organisation and between the partnership organisations.

With the reorganisation of the Northumberland Care Trust, during the second year of implementation, came a new structure in the FISHNETS host organisation, which resulted in the development of new posts and new people fulfilling the posts. This had a major impact on FISHNETS because some of the individuals who had championed the development and implementation of FISHNETS within the Care trust, including the Director of Social Care and the Head of Older People’s Services were no longer with the organisation. There were also changes in the staffing of FISHNETS (e.g. the project lead was appointed to a senior manager position in the Care Trust), which resulted in the need to appoint new staff to the project.

The combined effect of these changes resulted in partners working in relationships that fell somewhere along a continuum between 'permanence' and 'transition.' The FISHNETS partnership is not unique in this respect, as changes in government policy and organisation restructuring has influenced such changes across the country. At its best, periods of ‘permanence’ in relationships in the partnership facilitated shared decision making that recognised the authority, accountability and responsibilities of individual partner members. Whereas phases of ‘transition’ disrupted decision making processes and made it harder to sustain mutual understanding that was so important to partnership arrangements. In recognition of the potential detrimental impact of ‘transition’ phases, the FISHNETS project team sought ways to continuously review relationships and decision making processes, and actively worked to grasp opportunities that arose (e.g. new people, new ideas, new possibilities for funding) to realise the FISHNETS vision for the County.

**Discussion**

Partnership working was not an option for Northumberland FISHNETS, it was an eligibility requirement in the application process for POPPs funding. The successful bid for project funding provided a banner around which all the FISHNETS partners were able to rally and was undoubtedly a catalyst in developing the partnership that existed. This chapter has explored the processes and the complexities that have been inherent in establishing and sustaining the partnership, which has not been without its challenges. Yet the partnership has been sustained, with plans for mainstreaming elements of FISHNETS in order to further develop the vision for preventative services for older people beyond the completion of the POPPs pilot project in Northumberland.
CHAPTER 4: COMMUNITY INVOLVEMENT

Introduction

A central tenet of POPPs was the involvement of older people in service planning. Inherent to this was the assumption that the participation of older people in decision making processes would ensure that the services that were developed would be responsive to the needs of older people in the local community and bring about a culture change in service delivery organizations. Traditionally health and social care services for older people across the UK were illness-focused, service-led and medically-driven. POPPs aimed to facilitate the development of old age preventative services that provide the right support and care at the right time and closer to home to enable older people to be supported to live independent, healthy and active lives in the community. In keeping with this agenda FISHNETS aimed to bring older people to the decision making arena at multiple levels. In order to explore these issues the following data sources were collated and analysed:

- Participant observation of the Older People’s Partnership Board and FISHNETS task groups
- Interviews with Community Chest activity co-ordinators/providers and activity participants
- Reports derived from collaborative learning events.

This chapter commences with a discussion of the structures and processes for involvement that were implemented in Northumberland. The discussion moves onto explore the impact of this strategy on the governance of service planning for preventative services for older people, decisions about service delivery, and involvement of older people in providing services in the County.

Older people and community involvement

Older people’s engagement with the POPPs initiative commenced in Northumberland with their participation in consultation events and workshops that led to the development of the FISHNETS proposal. They were active members of the working groups that created the FISHNETS vision. It was at this early stage that the partnership of 37 statutory, private, voluntary and community organizations, which was coordinated by the Northumberland Care Trust on behalf of Northumberland County Council deliberated about the type and level of community participation in the initiative. In the proposal that was put forward to the Department of Health it was proposed that older people who had interest in the FISHNETS outcomes would be invited to participate in service planning and the governance of the project through membership of the Older People’s Partnership Board (OPPB) and the task groups that directed the operationalisation of the project.

Widespread publicity for the recruitment of older people to serve as Board members began as soon as the bid was approved in principle by the Department of Health and continued over several months, in the press and through the partner organizations. Two applications were received from this process, and five other individuals, who were previously involved with the development of the FISHNETS proposal, were approached directly by Northumberland Care Trust to formally invite them to membership of OPPB in its first year, commencing April 2006. The agreement being that recruitment for permanent members of
the Board would continue under the direction of the Community Development Workers when they had been appointed to FISHNETS. These plans were delayed when structural reorganization of the Care Trust and County Council led to a freezing of community posts. When it became clear that the freezing of posts would impact on recruitment to the Board, in December 2006 existing members agreed to continue to function as Board members. During the latter part of year 1 and in year 2 of the project two members resigned due to ill health and other personal commitments. One new member was recruited to OPPB following an election in the West of the County.

The majority of OPPB members had experienced long-term engagement with officers in the Local Authority and Care Trust in different capacities. Hence when they came to the FISHNETS partnership board they saw familiar faces across the board room table. This provided a foundation for a working relationship that took FISHNETS from the ideas that they had been instrumental in shaping into a service. Those involved at the commencement of the project had previous experience of committee work, which was invaluable to enable them to participate in decision making processes. Early recognition of the importance of this experience led OPPB members to agree to mentor other older people when they were recruited to the Board.

Broadening older people’s participation in FISHNETS was planned to be addressed through local reference groups. These groups were to be established in each locality and be comprised of people that had an interest in the different elements of the project. This was intended to provide a mechanism for the Board to seek information from the local communities in Northumberland and to channel information from the Board back into the communities. Throughout the first year of implementation the delays in appointment of the community development workers, who were to be charged with the responsibility of establishing the Reference Groups, led to the decision by the project team to change this proposal. The outcome being that the wider community participation in FISHNETS would be aligned to the work of the Community Chest. This was a fund that was made available to support the establishment of community activities that aimed to promote and enhance inclusion of the older population in social and community activities. It was explicit in the application process for this funding that the recipients would agree to participate in involvement and consultation activities led by the Board.

Throughout the project 134 organisations/groups received funding from the Community Chest Fund. Grants in total of £72,955.75, ranging from £110 - £3,894.56 were approved by OPPB. The groups that were supported included church hall committees, friendship clubs, skills centres and activity groups (such as gardening). These provided a range of physical activities, social engagement programmes, social interest groups, skills development opportunities, access and information points for local communities, health improvement classes, intergenerational activities (such as rugby training for older men), and training of older people to enhance community capacity building.

In addition to older people being involved in governance and decision making processes they participated in the implementation of the initiative. Sixty-four older people were trained as exercise trainers. Following the training these individuals ran EXTEND classes in their own local communities. Seven older people were also recruited to the action research evaluation team and they participated in data collection, data analysis and dissemination of the project outcomes. Older people who provide informal care across the County participated in the training programs that were provided under the auspices of FISHNETS. This involved 573 older people taking part in, for example, Falls Prevention and Low Vision
Training. In summary the involvement strategy ensured that older people participated in governance, operational decision making and implementation of the project.

Analytic framework

This involved a general analysis of collaborative learning reports, project documentation and observational data, identifying central themes. The general analysis used two frameworks that were developed by Sherry Arstein (1969) and David Wilcox (1994) concerning types and level of public involvement in decision making processes. Arstein (1969) introduced the idea that involvement can be conceptualized as a ladder of participation. The lower rungs of the ladder represent tokenistic forms of participation such as information provision, and the higher rungs represent citizen power whereby those involved control decision making processes. There is an implicit assumption within this model that the forms of involvement further up the ladder are better than those at the lower levels. Wilcox (1994) challenged this notion, and argued that the type of involvement that is employed within service organizations should be appropriate to meet the aims and context of the involvement initiative. The analytic framework adopted both of these theories. The range and level of involvement in 2 streams of activity, participation in OPPB and the community chest, were explored. As the analysis developed the context and power relationships for participation was examined providing insight to the changes that were witnessed as FISHNETS was implemented.

Involvement of older people through participation in the Partnership Board

Type of involvement

The vision for Northumberland FISHNETS, which was articulated in the proposal to the Department of Health, had older people at the heart of governance and service planning. They were to be partners with senior service managers:

“Community representatives and service users will be in the majority on OPPB and the chair of the Board will be recruited annually from them. The Board will include a representative of the Care Trust at Director level. This will allow the budget management for the project to be devolved to the Board and ensure high-level communication and consultation with executives and senior manager in the partnership organization.”

(FISHNETS funded proposal through the POPPs programme)

The terms of reference for OPPB affirmed the centrality of the Board to the governance of the project. It was charged with the responsibility for approving and monitoring income and expenditure, development of governance systems, reviewing program development, receiving and reviewing reports from task groups, participating and deciding on staff appointments, receiving requests for and granting funding for community chest being consulted about new strategies and policies in the Health Care Trust, and reporting back progress to the Department of Health. As the project was implemented it became clear that the older people members of the Board shared the responsibility for these roles with the professional members of the Board. They were active participants in decisions about service planning, service monitoring and reporting.
**Level and range of involvement**

As they developed their role through experiential learning and formal skills development such as Stronger Voice training the members began to extend the scope of their sphere of influence in Board processes. They began to challenge systems within the Trust (for example the financial reports did not include appropriate headings for Board members to monitor expenditure and these were changed following requests from the Board). They also critically examined decisions made by professionals (such as the service contract for the handyman scheme that the Board suggested needed a business plan to sustain the service into the future) and they made recommendations for service development through their involvement in the operational task groups. Thus their involvement in decision making processes in the project evolved from decisions made FOR older people BY professionals to a situation where decisions were made WITH and in some instances BY older people for older people. In this way the services that were planned to be developed in the FISHNETS proposal were tailored to the needs of older people. This is illustrated by the way the older people members of the Board championed the development of podiatry skills training for informal carers as well as professional care staff to optimize access to these skills within the whole economy of care. This was grounded in their understanding of the difficulties that older people have in undertaking their own foot care and the impact that this has on mobility and enhanced risk of falls.

This illustration indicates that the level of involvement in service planning and governance, in this instance equated to what Arnstein described as the highest level of participation. The professionals in the project team and the Board supported the shift in power from professionals to older people. The transition in power was supported by ensuring that the Chair controlled the agenda by meeting with the project manager to set the agenda prior to Board meetings; members had access to information to make informed decisions; and they were empowered to postpone requests from professionals and organizations if they felt that the timing of such requests were really rubber stamping exercises rather than true consultation where they were able to influence the outcome.

The shift from face-to-face interaction with decision makers part way throughout the project, to less direct forms of communication, or through a third party was perceived by the older people as a shift in power from the Board. They continued to have a say in what happened, but the outcome was determined by other people, the professionals. Fluctuations in the balance of power occurred in response to changes in the external environment within which FISHNETS operated. Such changes impacted on the accountability and responsibilities of Board members and the older people perceived that they were less involved in from key decisions about the project, such as changes in the staffing and the management of the project. This was in contrast to their previous experience in the earlier stages of the project of making decisions about recruitment and appointment of staff. Another key indicator that the power relationship had changed to one where older people’s influence over decisions was reduced concerned service planning. Rather than making decisions about service planning at the stage of determining the services that were to be funded beyond the project, the older people were informed about decisions that had been taken by managers. This was a frustrating experience for the older people when this transition occurred. Their level of involvement in the project had evolved into one where professionals held the power to control decisions and influence the shape of preventative services for falls in the older population in Northumberland.
Representation

The strategy that was developed for community involvement aimed to promote the inclusion of older people with diverse backgrounds, who lived in different areas of the County (including rural and densely population urban localities), and had different experiences of health, social care and housing services. The implementation of this strategy was not entirely straightforward. The FISHNETS implementation group gave considerable effort to think through the interests, skills and experience that were needed to engage with older people to meet the aims of the service. This resulted in a publicity campaign to inform community dwelling older people of what the service was trying to achieve. The aim of this approach was to identify relevant individuals that could bring different perspectives on what older people need to enable them to continue to live in Northumberland communities rather than relying on the same older people that were already known to the statutory services. There was, however, little response to the publicity campaign and this led to a revision of the strategy.

This was a frustrating situation for those older people who had been involved in the development of the FISHNETS proposal. They had envisaged that older people from across the County would have grasped the opportunity to influence the development of preventative services and in particular falls prevention services. Rather than perpetuate what appeared to be apathy within the older population they responded to this situation by agreeing to continue their participation in FISHNETS as Board members. Consequently this led to the development of a Board that included older people who were community dwelling, lived in a wide range of localities across the County and were all white. A notable characteristic of this group of people was that they all were involved in a wide range of community, voluntary groups such as Age Concern Northumberland, Woman’s Institute, Alzheimers Society, sporting and recreational groups, to name but a few of their organizational associations. Their links to organizations within Northumberland was certainly a strength in that they were able to draw on this knowledge and bring it to decisions made within OPPB. The difficulty for these people was that prior to FISHNETS they were very busy people and with this new commitment they had to balance multiple activities and fulfill what turned out to be a very demanding additional activity.

The issue of the representation of older people through OPPB was continuously debated throughout the life of the project. There were concerns raised by professionals questioning whether the views of this group of people represented that of the wider population of older people. In response the older people members recognized that they brought their particular view of the world to the Board in their desire to tailor services to what they perceived to be the needs of older people. This was a world view that did challenge professional decision making in the County and ensured that the preventative agenda was recognized at the end of the project as an important aspect of service provision to promote the health and well-being of the older community.

Support

The above discussion has highlighted that those older people who agreed to participate as Board members were committed to realize the FISHNETS vision. From the commencement of the project their participation in the Board was given recognition in the Care Trust through the payment of an honorarium in addition to personal expenses. The project team facilitated involvement by ensuring that meetings were scheduled in advance, at a time convenient to members, and transport was available. Importantly the meetings
were conducive to an open and honest exchange of ideas. The atmosphere was comfortable and relaxed which enabled the members to bring their different experiences, talents and skills to the decision-making arena. This was achieved by the chair who ensured that everyone could have their say thereby contributing to decision making processes.

As well as the social situation having an influence on an individual’s ability to participate in decision making, the environmental features were significant. Some of the Board meetings were held in rooms adjacent to other meeting rooms. When this occurred the noise was detrimental to participation. In response every effort was made to schedule meetings in rooms with minimal background noise.

The availability of administrative support ensured that members were able to plan and control the agenda and receive minutes and other information that informed their decisions. The team did however experience delays in the receipt of some of the project information such as budget reports as a direct consequence of the pace of service development and communication between the FISHNETS task groups. This had a direct influence reducing the time that members had to analyse the information to inform their decisions.

The support and training that members received during the early stages fostered the development of a team of people who grew in confidence and skill to influence service planning. This was particularly evident toward the end of the project when difficult decisions were being made within the Care Trust about future funding of services beyond the life of the FISHNETS project. Although the older people Board members were not empowered at this stage of the project to make long term decisions they did challenge decisions made by professionals and successfully championed sustaining of the prevention agenda in the Care Trust.

**Impact of OPPB on service planning in Northumberland**

The FISHNETS governance arrangement that was executed through OPPB ensured the fullest range of involvement of older people in decision-making. This included commenting on plans, consultation, instigating activities, taking responsibility for carrying out tasks and leading service planning groups. Wilcox’s (1994) model of involvement stressed the importance of adopting different levels and types of participation in different circumstances, and in keeping with this the FISHNETS organisation enabled older people Board members to continue to extend their roles as their skills and expertise developed.

OPPB has been instrumental in giving voice to older people to influence service planning in Northumberland’s health and social care organisations. As the external, organisational context continued to evolve and change throughout the implementation of FISHNETS, OPPB sought to develop the older person’s agenda in relevant agencies/organisations. Notably, they worked to influence the Northumberland Strategic Partnership (NSP). This partnership was developed in response to recent policy that led to the creation of Local Strategic Partnerships (LSPs) across the country. When OPPB members were invited to participate in the NSP Older People’s Strategy group (OPSG), the subpartnership

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3 The Older People’s Strategy Group is the sub partnership representing older people in Northumberland Strategic Partnership. The Partnership is comprised of a wide range of
representing older people in Northumberland they grasped this challenge, recognizing the importance of influencing the Community Strategy, Local Area Agreements and Local Delivery Plans through Northumberland LSP. Undoubtedly this created new possibilities for older people to continue to influence service planning in Northumberland beyond the life of FISHNETS.

**Involvement of older people through the Community Chest**

The Community Chest was a fund that was devised by OPPB. It was intended to facilitate the organic development of community activities that were led by older people living in local communities to address unmet need. The range and scale of these projects provides evidence of the added value of older people’s involvement in the Board. The following discussion focuses on the views and experiences of the co-ordinators and users of the projects that were developed with this fund.

**Type and range of involvement**

Throughout Northumberland older people volunteers have identified need within their communities and sought ways to respond:

“He started the bowls club. He wanted to get the village together more………. We’re an ageing population and you tend to shut yourself behind your door. So we needed something to bring them out of their house. And it worked. Because it’s an easy game to play, although there’s a lot of skill involved. But it doesn’t take a lot of effort to get there and play it.”

(Community Chest co-ordinator)

Hence, the Community Chest activities that now exist reflect the interests and skills of the organizers and the unique characteristics of local communities. These include a range of physical activities, social engagement programmes, social interest groups, skills development opportunities, access and information points for local communities, and health improvement classes.

The organic development of these activities has resulted in a rich tapestry of older peoples’ involvement in service planning and service delivery. They have fulfilled roles as Trustees, project managers, committee members, treasurers, fund generators, resource managers, administrators, recruiting officers and publicity officers. What these projects organizations, which represent most sectors and interests in Northumberland undertaking the following roles: encouraging collaboration to secure the economic, social and environmental well being of the communities of Northumberland; facilitating the preparation and implementation of a countywide Community Strategy; acting as the strategic sub-regional partnership for Northumberland in the context of the Regional Economic Strategy; securing and managing strategic external funding; influencing the distribution of NSP partners' mainstream resources; lobbying or presenting a common voice for Northumberland; improving the integration of partner strategies/plans, mainstream programmes, resources and actions; and supporting the development of LSPs in the six District areas of Northumberland.
have in common is the way that those who are involved have drawn on their skills and talents to develop local services activities and interest groups that contribute to the enhancement of life in that community.

**Level of involvement**

The Community Chest funding was made available to extend the range of activities provided through older people’s groups and the development of new activities in Northumberland. Applicants for this funding were supported by community development workers to develop their proposals, however they remained in control of decisions about the priorities, scope of the groups’ activities, and the intended outcomes. Thus decisions were made BY older people about the needs that existed within their communities and FOR older people in the way that group activities were developed:

“We want to be part of the community and add to the community. That is my whole aim – to reach out to local people. We want to bring our community into the community rooms. We want to keep older people active. Stop them vegetating at night in the winter. Even an activity like card making can improve dexterity. It can keep hands and fingers active and get people to use their eyes…. That’s what it’s all about – keeping people active.”

(Community Chest co-ordinator)

Decisions about requests for funding from the Community Chest were made by OPPB. This strategy ensured that OPPB executed governance over the development of community based groups under the auspices of FISHNETS. It also ensured that older people extended their decision making power to that described by Arnstein as the highest level of control.

**Impact of the Community activity and interest based groups**

Service users and community chest organizers described in detail the range of activities and interest groups that provided opportunities for older people to participate in creative arts, performing arts, physical activities and interest groups. Being able to participate in these activities was greatly valued. It was a way for them to maintain their interests, develop new skills and knowledge and do something that enhanced their sense of purpose, which was so important to their health and well-being. For some people the activities were a way for them to keep socially and physically active:

“Well when you think of our neighbour. I mean he never did anything. Now he gets into his car and goes to the snooker club. It’s the only thing he does. He would not have come to do anything else in the hall. Now he comes and meets other people.”

(Community Chest service user)

Playing carpet bowls, new age curling, or participating Salsa-size or a tea dance were “fun” and “enjoyable” ways to engage in exercise:

“Well it’s good exercise and good company…I look forward to it and it cheers me up…I mean there's people here that I would never have known if I hadn’t come here. The music is good. I go home and I feel as if I’ve achieved something.”

(Community Chest service user)
The above quotations are illustrative of the views of many people. Whilst the activities were inherently valuable, they also provided the means for older people to extend their social networks with the possibility of developing new social relationships. In a society where loneliness is a growing problem for older people the social aspect of being with other people and enjoying their company was so important.

As well as being active and having opportunity to be with others participation in these activities provided a means for older people to experience inclusion in their communities. This was as important to the organizers as well as the participants of the activities. The organizers, volunteered their time and expertise, and in this way contributed to the fabric of their community. This was personally satisfying and contributed to their sense of belonging. In this respect participation in community chest activities had the potential to contribute to health and well being to everyone involved with the activity.

**Contribution of groups supported by the Community Chest to the involvement strategy**

In addition to enhancing the range of interest and activity groups for older people in Northumberland a secondary function of the Community Chest fund was to contribute to the development of the involvement strategy. In return for securing funding for their activities those associated with interest and activity groups agreed to participate in consultation activities, thereby acting as local reference groups. This strategy had the potential to extend access to the views of a large number of local people to inform decision making about service planning beyond the representation of older people that existed within OPPB.

The strategy was also intended to form the platform for succession planning of the membership of OPPB. It was anticipated that members of local reference groups would develop their skills through taking part in consultation events, hence their interest in service planning and policy development would be fostered. Over time this would result in a critical mass of people who were willing to extend their participation in service planning processes in Northumberland and would put themselves forward for election to OPPB.

The anticipated development of the older population to participate in service planning decision making was not realized throughout the FISHNETS project. There was, for example, little participation by community dwelling older people in election to the Board in the second year of the project. In response the Care Trust persisted in its endeavour to foster the development of the older population to participate in decision making. However, when those associated with community chest activities were approached to take part in Stronger Voice training to develop their understanding of involvement of the public in service planning decision making and their skills to enable them to take part there was a minimal response.

**Discussion**

Through the FISHNETS partnership older people have been brought to the heart of preventative service planning, decision making and service delivery for older people in Northumberland. Such involvement has been encouraged in the UK by the government through recent policy developments (for example, DoH 1989b, 1997, 1998a, 1998b, 1998c
OPPB provided a vehicle for the Care Trust to meet the requirements of Section 242, National Health Service Act 2006 in the Care Trust. This Act placed a duty on health care organisations to make arrangements to involve and consult patients, carers and the public in:

- Planning: Not just when major change is proposed, but in ongoing planning of services
- Proposal for development / change: Not just in considering proposals but in developing them
- Decision making: In any decision that may affect the operation of services.

Prior to this Act coming into being the Care Trust were compliant with these statutory duties with respect to its POPPs submission, FISHNETS, in 2005. Older people were partners from the origin of the FISHNETS idea and have continued to work in partnership with organisations in statutory, for-profit and not-for-profit sectors. It could therefore be argued that the Care Trust did not merely react to legislative and policy developments, it was visionary in aspiring to bring older people to the centre of decision-making structures within FISHNETS. These were devised at a time when older people generally faced exclusion from service planning and policy development, as reported by the Social Care Institute for Excellence (SCIE):

“Older people are excluded simply because they were old and it was assumed that they could not perform certain tasks and activities.”

(SCIE, 2004, p. 5).

Social exclusion has been a widely recognized aspect of life for many older people, yet the Care Trust implemented a strategy to overcome the social and economic mechanisms that constrained the involvement of this population in order to change the social conditions of later life in Northumberland. FISHNETS raised levels of awareness and opportunities for older people to get involved. Older people were viewed as part of the citizenry, and by providing supportive approaches that enabled them to participate in decision making processes, they developed the capacity to get involved much more effectively than previously thought possible. This strategy upheld the legitimate right of older citizens to have a say in decisions that affected them and provided opportunities for older people to exercise their moral duty to take part in the construction and maintenance of their community.

The future success of involvement of older people in service planning and policy will depend on developing capacity from the wider community. It is clear from the approaches that were adopted during FISHNETS, to enhance the level and range of participation of older people across Northumberland, that this is not straightforward. Future models of involvement need to build on what worked during FISHNETS and effort should continue to develop innovative ways of involving the public in decision making.

The future success of involvement of older people will also be dependant on the continued support from Authorities to share decision making responsibilities with older people. Structures have been developed to support involvement and it could be argued from the findings reported here that there has been a cultural change in Northumberland where there is now a willingness to listen to the voice of older people. This could all too easily be undermined if involvement is not supported and older people are not enabled to influence decisions about service planning and delivery. Across all service sectors there is
uncertainty about medium and long term funding and pressure to work within tight budgetary restraints. This will undoubtedly influence the way Authorities will involve older people in service planning and local policy development in the future. Whatever the future, Northumberland FISHNETS has created a demonstration model that partnership working between older people and service providers could bring new insights and innovative responses to preventative services that had not previously existed.
CHAPTER 5: INTERMEDIATE CARE AND PHYSICAL ACTIVITIES

Introduction

A specific objective of the FISHNETS initiative was to reduce falls and the associated problems of hip fractures in the older population. Modification of physical risk factors for falls, through targeted physical activity interventions and specialist rehabilitation, was provided pre-FISHNETS via unevenly distributed community services across the County. Existing services were therefore at different stages of development. With FISHNETS came the opportunity to develop and enhance community rehabilitation teams to provide an equitable countywide integrated falls service compliant with NSF and NICE guidelines. At the same time, community-based falls prevention exercise classes were developed using FISHNETS funding to train instructors and cover costs of venues. In order to explore service users’ experiences and impact of these services the following data was collected:

- Real time tracking of service user journeys through the Falls Pathway
- Community Rehabilitation Intervention cohort: Standardised assessment of balance and gait was determined (Tinetti performance orientated assessment) pre and post intervention
- Leisure centre based exercise group cohort:
  - Standardised assessment of balance and gait was determined (Tinetti performance orientated assessment) pre intervention, post and 6 month follow-up
  - Individual interviews, including a quality of life (SEIQoL-DW) assessment pre intervention, post and 6 month follow-up
  - Assessment of falls related confidence and self efficacy (Falls Efficacy Scale) pre intervention, post and 6 month follow-up

This chapter will provide an overview of the services that were developed under the auspices of the FISHNETS Intermediate Care and Physical Activities task groups; the service uptake during the first two years of implementation; and finally the findings from the action research evaluation.

Service development: Intermediate Care

Community Rehabilitation Teams (CRT) were established incrementally across the County. The appointment of new FISHNETS funded staff was somewhat delayed due a freeze on establishing new posts within the Care Trust until the requirement to redeploy existing staff had been fulfilled. Following appointments the function of the CRTs was expanded to take on the rehabilitative aspects of prevention, including:

- Supporting the identification and registration of those at highest risk of falls and chronic disease in primary care
- Conducting multi-factorial assessments and interventions, including intensive rehabilitation programs
- Ensuring education and training programs were in place for those at medium and high risk of fall fracture
• Promoting links with community-based exercise programs and home improvement services in the County.

The development of the CRTs occurred alongside the work of the FISHNETS Intermediate Care task group, which focused its initial attention on the development of the Falls Pathway in response to Standard 6 of the NSF for older people (Department of Health 2001), which specified that older people who have fallen should receive advice and intervention from specialized falls prevention services. The NICE Falls Prevention Guideline (NICE 2004) demanded equality in falls prevention service provision and highlighted the evidence to show that tailored, specific exercise can improve gait and balance and reduce other risk factors for falls and injuries.

![Figure 5: The Northumberland Falls Pathway](image)

The Falls Pathway shown above represents the relationship between different services across the economy of care, including the independent, statutory and voluntary sectors. The Pathway was integrated across health, social care, leisure and housing. For the first time in Northumberland there were explicit links between low level preventative services and specialist diagnostic, treatment and rehabilitation interventions for falls and the intention was for service users to be able to move through the Pathway in a seamless manner.

**Service uptake**

We were provided with data collected from the Falls Pathway by the Intermediate Care team, indicating the uptake and referral routes into services. We have performed a secondary analysis of this data, to indicate broad trends, although it should be noted that this is for information and descriptive purposes only.

A self-completion assessment (the Cryer Tool) was used to determine risk of falls and to direct individuals towards interventions and services most appropriate to their needs. In
the first year of FISHNETS data were available for only Central and Blyth Valley, whereas in year two, all areas were up and running and collecting service level data.

Across the two years, a total of 1,131 people either contacted or were referred in to the pathway (n=803 (71%) women and n=328 (29%) men). The majority of people referred were aged 65 years and over (n=1078, 95%), with a striking n=420 (37%) aged 85 years and over. In the first year, referral from hospital was the most common route into the pathway, followed by Social Services, GPs, CRTs and self referral. As the services spread out over the County in year two, referral patterns were similar but with a noticeable rise in the percentage of self referrals (year one 15/329, 5%; compared to year two 141/755, 19%), perhaps indicating the impact of widespread FISHNETS publicity campaigns as the project progressed.

Intermediate Care and Physical Activities Evaluation Findings

The main aim of evaluating the Falls Pathway and associated services was to understand the service user journey and, from a service user perspective, explore the experience of receiving falls prevention services. We used a real time tracking approach, which is explained in the Methods Chapter.

Real time tracking of the service user journey through the falls pathway

A unique feature of the Northumberland FISHNETS Falls Pathway was the attempt to integrate services across a whole system of falls prevention and treatment. Understanding the workings of a system from the perspective of service users is a key part of describing a whole system. The NHS Modernisation Agency has supported and developed a methodology for ‘process mapping’, which is now a key component of service improvement projects across the UK. The Modernisation Agency considers process mapping to be one of the most powerful ways for multi-disciplinary teams to understand the real problems from the patients’ perspective and to identify opportunities for improvement.

A map of the service user’s journey provides:

- a key starting-point to any improvement project, large or small – tailored to suit the organisation or individual style.
- the opportunity to bring together multi-disciplinary teams from primary, secondary, tertiary and social care of all roles and professions and to create a culture of ownership, responsibility and accountability.
- an overview of the complete process – helping staff to understand, often for the first time, how complicated the systems can be for patients. For example, how many times the patient has to wait, how many visits they make to hospital and how many different people they meet.
- an aid to help plan effectively where to test ideas for improvements that are likely to have the most impact on the project aims.
- brilliant ideas – especially from staff who don't normally have the opportunity to contribute to service organisation, but who really know how things work.
- an event that is interactive, that gets people involved and talking.
- an end product – the map – which is easy to understand and highly visual (http://www.modern.nhs.uk/improvementguides/process/4.htm)
We used process mapping to both track the service user journey and to feed into collaborative learning for service providers.

**Sample**

Nine service users agreed to participate in the mapping activity. There were 3 males and 6 females, age range 70-91 years, all were community dwelling elders (1 rural location and 8 urban locations) living in the South East, West and North of the County. Their journeys through the Falls Pathway are illustrated below under pseudonyms:

- **Anne (91)** had repeated falls that resulted in a range of small and significant injuries. She entered the falls pathway when she presented at Accident and Emergency.

  - Fall – injury treated by emergency services
  - Medical assessment
  - South Community Rehabilitation team
  - Physiotherapy at home x 2 wkly
  - Falls prevention exercise program – hospital based

  Falls prevention exercise program - leisure centre based. At the end of the first program she continued to take part in a second and third class and intends to continue as long as the classes run.

- **Betty (85)** experienced a fall 2 years ago and when she recently presented with facial bruising and an injury to her right shoulder following a fall she was referred by her GP to the community rehabilitation team.

  - Fall – injury treated by GP
  - Medical assessment
  - South Community Rehabilitation team
  - Physiotherapy at home x 2 wkly for shoulder injury
  - Falls prevention exercise program – hospital based

  Referred to falls prevention exercise program - leisure centre based
  Four weeks following referral she uncertain about the date to commence the class. Intended to contact the community rehabilitation team to discuss continuing in a physical activity programme at the end of data collection.
Charles (70) had Parkinsonism and recently experienced repeated falls that resulting in a range of small and significant injuries. He was referred by his care manager to the Community Rehabilitation team.

- **Assessment by care manager**
- **South Community Rehabilitation team**
- **Physiotherapy at home x 2 wkly**
- **Falls prevention exercise program – hospital based**

  Falls prevention exercise program - leisure centre based. At the end of the first program he continued and took part in a second class. Following this he was uncertain about whether he would continue to a third program.

Doris (89) had experienced repeated falls and was referred to the community rehabilitation team by the district nurse who visited weekly to change the dressings to her leg injury.

- **Repeated falls identified by district nurse**
- **Medical assessment by specialist falls consultant**
- **North Community Rehabilitation team**
- **Falls prevention exercise program – hospital based**

  Falls prevention exercise program - leisure centre based. No further participation in exercise programs when the exercise class was completed.

Edward (84) had fallen repeatedly. This was identified by his chiropodist during a regular appointment, who made a referral to his GP.

- **Repeated falls identified by Chiropodist**
- **Medical assessment by specialist falls consultant**
- **North Community Rehabilitation team**
- **Physiotherapy at home x 2 wkly**

  Referred to falls prevention exercise program - leisure centre based
  Eleven weeks following referral he was uncertain about the date when the class would commence. At this point he had not had contact with the rehabilitation team for 6 weeks.
Florence (79) had fallen repeatedly. Following a recent fall that resulted in injury to her hand and foot her warden advised her to go to accident and emergency for assessment. Subsequent discussion with her GP led to a referral to the community rehabilitation team.

Assessment by warden, following a fall, highlighted the need for further physical assessment. Medical assessment by specialist falls consultant

Advised to go to accident and emergency for assessment and treatment

North Community Rehabilitation team

Physiotherapy at home x 2 wkly

Referred to falls prevention exercise program - leisure centre based

Seventeen weeks following referral she was uncertain about the date when the class would commence.

Florence (79) had fallen repeatedly. Following a recent fall that resulted in injury to her hand and foot her warden advised her to go to accident and emergency for assessment. Subsequent discussion with her GP led to a referral to the community rehabilitation team.

Assessment by warden, following a fall, highlighted the need for further physical assessment. Medical assessment by specialist falls consultant

Advised to go to accident and emergency for assessment and treatment

North Community Rehabilitation team

Physiotherapy at home x 2 wkly

Referred to falls prevention exercise program - leisure centre based

Seventeen weeks following referral she was uncertain about the date when the class would commence.

Gloria (75) tripped in the street and resulted in a fractured pelvis. During rehabilitation from this injury her GP suggested that a referral to the community rehabilitation team may be helpful to her.

Fall –injury treated by emergency services

Inpatient treatment in acute trust

Following discharge ongoing review and treatment by GP - ongoing

West Community Rehabilitation team

Physiotherapy at home x 2 wkly

Falls prevention exercise program - leisure centre based.

Leisure centre later life exercise class

These case studies illustrate movement through the Falls Pathway in Northumberland and demonstrate integration of services across the Pathway. The mapping reflects users’ experience and their understanding of the service and has been used primarily to promote discussion and collaborative learning with FISHNETS staff involved in the Falls Pathway. The essence of this learning has been captured through earlier collaborative learning reports and will not be repeated here. In summary, the real time tracking appears to show effective movement up the pathway, i.e. GP to CRT to specialist assessment by a consultant when indicated. The links between health and leisure exercise programs did result in continuous access to falls prevention exercise programmes in the cases of Anne, Charles, Doris and Gloria. However, in the cases of Betty, Edward and Florence, there were gaps in the service user journey between health and leisure centre programmes, which have been fed back to staff. The case of Ian demonstrates that individuals can use self referral effectively to influence decision-making regarding care and service use, which promotes control, independence and quality of life in later life.
Community Rehabilitation Team intervention

We were provided with a database of clinical outcomes on the Tinetti gait and balance scores for a cohort of 38 individuals who had received Community Rehabilitation Intervention. The aim in presenting this data is to give an indication of the progression of an opportunistic sample of service users who entered the Falls Pathway and to be able to compare the gait and balance scores of those accessing CRTs with those entering leisure centre exercise classes. The baseline data shown in the following tables relates to assessments done by therapists at the beginning of intervention and at a follow up between 11 and 26 weeks (median 13 weeks) later.

<table>
<thead>
<tr>
<th></th>
<th>Baseline week 1</th>
<th>Follow up week 11 – 26 (median 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>22.5</td>
<td>29</td>
</tr>
<tr>
<td>Min</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Max</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Inter-quartile range</td>
<td>16-25.25</td>
<td>25-33</td>
</tr>
</tbody>
</table>

Wilcoxon signed ranks test, p=0.0001

Table 2: Tinetti gait and balance performance (total score) for n=38 patients referred to CRTs

<table>
<thead>
<tr>
<th></th>
<th>Baseline Tinetti gait score</th>
<th>Follow up Tinetti gait score</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Median</td>
<td>5.00</td>
<td>8.00</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Maximum</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Percentiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>4.00</td>
<td>6.75</td>
</tr>
<tr>
<td>50</td>
<td>5.00</td>
<td>8.00</td>
</tr>
<tr>
<td>75</td>
<td>6.25</td>
<td>9.00</td>
</tr>
</tbody>
</table>

Table 3: Tinetti gait scores at baseline and follow up for n=38 patients referred to CRTs

<table>
<thead>
<tr>
<th></th>
<th>Baseline Tinetti balance score</th>
<th>Follow up Tinetti balance score</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Median</td>
<td>18.00</td>
<td>21.50</td>
</tr>
<tr>
<td>Minimum</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Maximum</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Percentiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>14.00</td>
<td>18.75</td>
</tr>
<tr>
<td>50</td>
<td>18.00</td>
<td>21.50</td>
</tr>
<tr>
<td>75</td>
<td>20.00</td>
<td>24.00</td>
</tr>
</tbody>
</table>

Table 4: Tinetti balance scores at baseline and follow up for n=38 patients referred to CRTs
The data show an improvement in Tinetti scores following rehabilitation team intervention. The increase in the cohort median total score of 6.5 points (Table 2) represents a meaningful and statistically significant clinical change, although cause and effect cannot be attributed. The lowest score has shifted from 6 to 16 points at the follow up assessment, indicating that, in this small group, the ‘worst’ cases have improved considerably. Improvement in both balance and gait has occurred (see median scores, tables 3 and 4). In the absence of a control group, these changes cannot be reliably attributed solely to the rehabilitation intervention; however the clinical outcome improvement is noteworthy.

**Leisure centre based exercise group intervention**

A cohort of 50 people who were attending leisure centre exercise classes were recruited to participate in a study of outcomes of gait, balance and falls efficacy before and after the classes and at a follow up 6 months later. These individuals were also interviewed about their quality of life and SEIQoL scores were obtained. Complete data sets were obtained for 41 out of the 50, representing an attrition rate of 18%. There were 31 (76%) women and half the participants were aged 80 years and over. The age band and gender of participants is tabulated below:

<table>
<thead>
<tr>
<th>Age band in years</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70-74</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>75-79</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>80-84</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>85-90</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>&gt;90</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Table 5: Age band and gender of leisure centre based exercise group cohort

Most participants lived in their own home (92%) and more than half of these lived alone. The remaining 8% lived in sheltered housing or in the home of their child. Self reported data indicated that more than 80% had fallen in the past 6 months.

The following tables show the outcomes for Tinetti gait and balance and Falls Efficacy Scores.
<table>
<thead>
<tr>
<th></th>
<th>Before exercise classes (week 1)</th>
<th>After exercise classes (week 11 – 21 median 15)</th>
<th>After 6 months (week 26 – 35 median 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>28</td>
<td>32</td>
<td>31.5</td>
</tr>
<tr>
<td>Min</td>
<td>5</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Max</td>
<td>35</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Inter-quartile range</td>
<td>22.75-31.75</td>
<td>24.25-33</td>
<td>22.5-34.75</td>
</tr>
</tbody>
</table>

Wilcoxon signed ranks test, p=0.034 (First Tinetti-Second Tinetti)
Wilcoxon signed ranks test, p=0.016 (First Tinetti-Third Tinetti)

**Table 6: Tinetti gait and balance total scores for n=41 attending leisure centre exercise classes**

<table>
<thead>
<tr>
<th></th>
<th>Before exercise classes (week 1)</th>
<th>After exercise classes (week 11 – 21 median 15)</th>
<th>After 6 months (week 26 – 35 median 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>8</td>
<td>8</td>
<td>8.5</td>
</tr>
<tr>
<td>Min</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Max</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Inter-quartile range</td>
<td>6-9</td>
<td>7-9</td>
<td>6-9</td>
</tr>
</tbody>
</table>

**Table 7: Tinetti gait scores for n=41 attending leisure centre exercise classes**
Table 8: Tinetti balance scores for n=41 attending leisure centre exercise classes

<table>
<thead>
<tr>
<th></th>
<th>Before exercise classes (week 1)</th>
<th>After exercise classes (week 11 – 21 median 15)</th>
<th>After 6 months (week 26 – 35 median 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>21</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Min</td>
<td>5</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Max</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Inter-quartile range</td>
<td>17.75-23</td>
<td>18-24.25</td>
<td>18.75-26</td>
</tr>
</tbody>
</table>

Wilcoxon signed ranks test, p=0.0001(FES1-FES2; FES1-FES3)

Table 9: Falls Efficacy Scores for n=41 attending leisure centre exercise classes

<table>
<thead>
<tr>
<th></th>
<th>Before exercise classes (week 1)</th>
<th>After exercise classes (week 11 – 21 median 15)</th>
<th>After 6 months (week 26 – 35 median 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>25</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Min</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Max</td>
<td>65</td>
<td>52</td>
<td>57</td>
</tr>
<tr>
<td>Inter-quartile range</td>
<td>18.25-39.25</td>
<td>10-28.5</td>
<td>10-23.25</td>
</tr>
</tbody>
</table>

The leisure centre exercise class participants were more able than those who received rehabilitation team intervention, indicated by a 6 point advantage in median Tinetti total score at baseline. This advantage is accounted for largely by gait performance, where the median score at baseline is only one point short of the maximum and stays at this level for both follow up assessments. The implication of this is that the ceiling effect of the gait scale prevents any major improvement in gait being measured. Improvements in the balance score account for most of the net increase of 3.5 points in the median total score. Whilst this is clinically and statistically significant, the decrease in Falls Efficacy Score is more striking (Table 9), indicating an 11 point improvement overall. We can not attribute
these improvements solely to leisure centre classes, but these findings do indicate that meaningful improvement was achieved by participants who attended.

**Attendance at classes**

Uptake of exercise interventions in the community may be as low as 10% (Day et al 2002) and compliance with exercise is a major factor in success of the intervention. In the case of FISHNETS leisure centre classes, attendance was excellent, with a mean attendance of 7 out of a possible 12 classes. This high level of attendance undoubtedly enhanced the group outcomes and is an important finding in its own right in relation to maintenance of participants’ motivation. People who attended 7 or more classes (n=30/41, 73%) were therefore treated as a ‘good attendance’ group and the Tinetti and FES data re-analysed. This revealed that the good attenders were slightly more able in terms of Tinetti and FES scores but the pattern of improvement in the short term and at follow up was not significantly different in comparison with the whole cohort findings.

**Impact on quality of life**

**SEIQed Quality of life scores**

Quality of life was measured using the SEIQed instrument for the same cohort of 41 and tested at the same time points as gait, balance and FES. It is possible to score a maximum of 100 and minimum of 0 and we found that the mean score was 83 (SD 14) at baseline, rising to 86 (SD 9.4) after the exercise class intervention and then to 87 (SD 11.2) at 6 months. This change is small on a continuous scale of 0-100 and was not significant using a paired t-test. A score of 83 indicates a high quality of life in relation to individual domains that were chosen by participants as important to them.

**Qualitative data relating to quality of life**

Although the SEIQed was not sensitive to measurable changes in quality of life, the qualitative data did reveal important findings related to how older people related the benefits gained from the falls prevention exercise classes to their daily lives. An overview is presented below under themes of ‘positive changes in physical abilities’, ‘achieving personal goals’ and ‘improvement in self confidence’

**Positive changes in physical abilities**

Physical health has been shown to be very important to older people and the ability to move around is often the key to enabling independence and maintaining relationships with others. Participants noticed tangible physical changes:

“It helped to strengthen my shoulder….. Lots of the exercises include the use of both arms….doing all sorts of stretching”  
(Service user)

Improvements in strength and balance, shown through improved Tinetti scores were articulated by participants in terms of meaningful enhancement of physical ability:

“I hadn’t been able to walk up the stairs for about 18 months, and now I am able to do that.”  
(Service user)
General body conditioning effects were noticed:

“Well they keep your old bones going. I felt when I went to the class that my legs were more supple.” (Service user)

Improvements in stamina and function can reduce the need for care, which is an important outcome at both an individual and population level:

“Well the first two weeks that I came back, it was much the same, you know and I used to get achy legs. Then as it went on I did without my stick. I had always had a stick. I now I can do without the stick… I can make my own bed… They (the carers) helped me out and now I can do that for myself.” (Service user)

Although the preceding quote represents only one person’s experience, it does point to potential far reaching benefits of community-based exercise classes.

**Achieving personal goals**

Setting personal goals is part of the approach to class-based falls prevention and this had been taken on board by participants:

“My goal was to be able to get out to the shops…and now I do shop and I have been to Newcastle….So yes I have achieved what I wanted to do.” (Service user)

Personal care was a key focus for some participants:

“I can now make my own bed, I can dress and I can do all of the buttons up. I can do all sorts of things and that is great.” (Service user)

Recognition of the link between exercising and resumption of physical activity and may be a key motivating factor for continuing to exercise regularly:

“I was gardening right up to the time that I had this happen with my back that I had to stop, I thought that I would never get back to it and I’ve planted seeds in plant pots and put them into the ground…I’ve done it and I can lift things, not heavy things. I can’t say enough good about this.” (Service user)

**Improvement in confidence**

The striking improvements in Falls Efficacy scores, presented earlier in this chapter (table 9) are verified by comments from participants about how their confidence grew:

“If you have had a fall you are worried about walking, you know, you are watching the pavements and everything. At least I am……In case you trip or fall. So I think that the exercises are good. They help you get over that and build your confidence up again.” (Service user)

Low self confidence and self efficacy are important risk factors for falls and are strongly linked to fear of falling and reduced quality of life. The role of exercise groups in building confidence should not be underestimated.
Summary

Whilst the qualitative data presented here are not supported by quantitative findings, using SEIQoL, there are some important insights from the perspective of older people about how attendance at community-based falls prevention exercise classes impacted on their quality of life, in terms of ability to function and look after themselves, as well as being able to get out of the house, resume hobbies and fulfil personal goals.

Discussion

The outcomes presented in this chapter confirm the applicability of an evidence-based approach to community falls prevention classes in Northumberland. Expected improvements in gait, balance and falls efficacy have been demonstrated alongside powerful personal stories from individuals about how their lives have changed. Situated within an integrated Falls Pathway further strengthens the role of such classes in being able to fulfil the needs of individuals moving ‘up’ or ‘down’ the escalator of provision for older people at risk of falls.

Understanding why participants comply (or don’t comply) with exercise requires an awareness of the processes involved in changing or modifying behaviour and maintaining that change. When reviewing factors affecting compliance with exercise (Robinson, Dawson and Newton 2008) the Transtheoretical Model, often referred to as ‘stages of change’, developed by Prochaska and DiClemente (1983) emerges as a logical explanation of intentional behaviour change. The model is based on the principle that an individual will

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Figure 6: Stages of Change applied to exercise behaviour. Adapted from Prochaska and DiClemente (1983)
move through a series of stages when attempting to change behaviour. These stages range from pre contemplation, where there is no intent to change, or denial of the need to change, through to maintenance of long term exercise behaviour. Movement through these stages may occur in a linear fashion and the falls pathway aims to facilitate people at risk of falls into the action stage of exercise and/or intervention. However, without motivation and social support, such as that provided by the exercise instructors and by the peer support of fellow group members, individuals are more likely to move through the stages repeatedly in a cyclical manner, as shown in the figure below, often with lapses in exercise behaviour before maintenance is achieved.

The FISHNETS model of an integrated Falls Pathway with full access into low level basic services and community based exercise classes has developed incrementally throughout the project. We have described its development and evaluated its impact through a mixed method qualitative and quantitative approach. Experimental cause–effect relationships are not suggested from the data presented but we are confident that the interventions, which were evidence based, have produced a local impact that can be measured, mapped and articulated by service users. The evaluation data presented in this chapter has had a core purpose in influencing service development and sustainability strategies and is not intended as a one-off end point judgement. In many ways, what has been achieved represents a starting point for the future and the action research experience has hopefully left behind a familiarity with cyclical evaluation, which is a powerful way to develop service capacity in the longer term.
CHAPTER 6: HOME ENVIRONMENT

Introduction

A central dimension of Northumberland FISHNETS was to improve the home dwellings of the older population. Two core objectives underpinned this element of the project. First, to enable older people to remain in their own homes for as long as possible and, second to make homes safer places to live in later life. This is in keeping with the widely accepted view that older people value their homes and want to live there in later life. Current public policy promotes the development of services to support older people to age in place. Through FISHNETS there has been enhancement of the handyman service that existed in Berwick and in the South-East of the County prior to FISHNETS and development of Telecare technology in the County. The experience of service users was explored through the following data collection strategies:

- Individual interviews with handyperson service users, prior to and 1/2 weeks following receipt of the service. This included a quality of life (SEIQoL-DW) assessment
- Individual interviews with telecare service users following receipt of the service, which included a quality of life (SEIQoL-DW) assessment

This chapter commences with an overview of the services that were developed under the auspices of the FISHNETS Home Environment task group and the service uptake during the first two years of implementation, and then the focus changes to present findings from the evaluation.

Service development

Northumberland County handyperson services: Northumberland STARS

With FISHNETS funding came the opportunity to expand existing handyman services in Berwick and in the South-East to Countywide provision. The service responds to the needs identified by community dwelling older people. Some of the jobs are small home maintenance activities (such as changing a light bulb, fitting curtain rails, changing curtains), whereas other jobs require expertise to complete complex tasks (e.g. fitting grabs rails to tiles in a bathroom, repairing and replacing frayed carpets) (see table 10). All of these jobs, regardless of scale or complexity are negotiated with the occupant to ensure that the outcome is both desired and acceptable.
Table 10: Types of jobs undertaken within Northumberland STARS Handyman services

Countywide service provision was achieved by November 2006. Analysis of service data between April 2006 – end of September 2008 indicated that 17,284 jobs had been completed by the service. There was a steady increase in the number of new service users as well as continued use by existing service users (see table 11).

Table 11: Number of new and existing service users

Individuals across all ages have used the service, with the group aged 75 – 85 having the highest service usage. There was also a gender difference in service usage, with older women, who lived alone, tending to use the service more than men or couples. Ensuring equality of service provision across the County was not without its difficulties. Northumberland is a diverse county with large areas of rural countryside, small villages/hamlets, sea-side towns and semi-urban districts in the South East where more than half of the County’s population lives. Providing the handyperson service to these...
different localities involved the recognition of geographic differences and developing strategies to enable delivery of the service. For example, in the rural western and northern area of the County the handyman travels long distances between jobs that required careful attention to travel, route planning and scheduling of jobs. Added to this there is the spiralling cost of fuel and wear on vehicles from driving long distances that posed additional challenges to the delivery of the County wide service.

Northumberland County telecare services

The level of interest in assistive technologies has grown in recent years alongside the awareness of the potential of assistive technologies to manage risk arising from problems associated with ageing, namely frailty and chronic illness and disease. Within England influential reports by the Audit Commission (2004 b– Assistive technology, independence and wellbeing) and I&DeA (2003) have raised the profile of the possibilities that technologies may bring to aged care service provision. Emerging Department of Health policy (DoH 2005a, 2005 c) also emphasises a key role for technology in providing support to all users of social care services. It was in this context that the telecare service in Northumberland has developed. By August 2008, 267 telecare packages were allocated which include telephone support lines, alarms, falls pendant, surveillance and sensor devices such as tilt and mattress sensors, telephone reminder for administration of medication, pills dispenser units, safety devices such as smoke alarms and carbon monoxide detection, and automated lighting fitted to community dwellings (see table 14. The technology that is fitted to a particular dwelling is based on assessment of need and in negotiation with the service user, hence an individual may have anything from a telephone support line to an extensive range of technologies fitted to their home.
There were considerable difficulties in developing the system to respond to emergency calls from service users in different parts of the County and this impeded the implementation of telecare services during the initial stages of development. Now that this has been addressed telecare services are available county wide.

**Findings**

Whilst the handyperson and telecare services were both developed to enable older people to age in place by improving the home environment, they are qualitatively different services. For this reason the findings arising from interviews with service uses are discussed separately.

**Views and experience of using the handyperson service**

*The need for accessible, acceptable handyman services*

The majority of the participants who took part in interviews about the handyman service spoke of the importance of having access to services that enabled them to maintain their home and make adaptations to change their environment in the service of their needs. Many spoke of the worries that they had experienced about not being able to do this.

Some had contacted local tradesmen to do small repairs to their home and had difficulty in getting small jobs seen to.

“The fitting on the light on the landing was broken. So we didn’t have light at the top of the stairs. It’s a bit dangerous for him to do that, particularly with all of the falls that he has recently had….if we asked an electrician to come – I mean we have been retired years and the workmen that we used are now retired themselves. Then you don’t know who to ring to come. We tried and rang a chap and he thought it was a tiny job and he wouldn’t be able to come for ages. They are busy people and they have bigger jobs and bigger fish to fry, rather than just propping up a couple of elderly folk.”

(Service user)

Maintaining and repairing homes was a worry not only for their immediate circumstances but also about how they would manage in their home in the future. This was viewed a problem for all older people. Those who lived alone may have experienced a loss of D.I.Y. skills in their household following illness or death of their partner. Couples, in contrast, may no longer be able to fulfill their customary lifetime roles. As people age and their abilities deteriorate, they do worry about the implications of undertaking risky activities. This can be a very sensitive issue for individuals who want to continue to live in their own homes and to do so safely. For example, a couple in their 80’s were first time service users of the Handyperson service. The husband had severe osteoporosis and arthritis which limited his mobility and range of movement in his back. He had experienced frequent falls in the past year, however these had not resulted in injuries. Two light bulbs had blown, one in a high stairwell and the other an external light overlooking the front door steps. Whilst he had always been proficient doing a range of DIY activities in the home, his wife was particularly worried about his desire to attend to the light bulbs. He did agree to contacting the Handyperson service and arranging for them to attend to these jobs. He was, however
concerned about his changing role in the household and felt that this type of support could be embarrassing and reduce his self-esteem. His fears were unmet. The handyman was very sensitive when he met the couple and involved the husband in the activity, willing to be advised and supported by him. The wife was so relieved when her husband agreed to the continued support by the service. Her concern about the hazards that her husband was willing to tolerate were minimized and she felt that she once again could experience “peace of mind.”

Older people are also anxious about letting strangers into their home. Their home is a place described as “my safe haven,” hence it a place where they experience safety and security. It was therefore important that people using this service felt secure in the knowledge that the handymen were approved by “an authority” and that they could trust these people. This perception was reinforced following their first contact with the service. They were also impressed with the friendliness, promptness, efficiency of the handymen and the high quality of their work:

“I would recommend this service to other older people and I truly believe that the handyperson service will enable us to live in our own homes for as long as we want to live there. I am one satisfied customer.”

(Service user)

**Contributing to the prevention of falls in the home environment**

Older people fear the possibility of falling and sustaining serious injury and they balance this fear with the desire to continue to live in their own home:

“I’m terrified of falling. I live alone and I have had accidents in the past that led me to consider moving from the home that I love. I want to stay here, but I am terrified of falling.”

(Service user)

This 73 year old woman lived alone in an isolated cottage in rural Northumberland. She had severe arthritis, which affected her mobility in such a way that she frequently fell and injured herself. The above quotation highlights her concern about falling, and pointed to her desire to remain in the home that she relocated to following retirement. She was acutely aware of the need to modify her home to minimize the risk of falling and the Handyman Service was extremely helpful in making changes to her home environment. For example, the section of carpet at the entrance to the living room had become frayed through constant usage. This was a hazard that had caused her to trip and nearly fall on many occasions. Although she wanted to replace the carpet this was very difficult because she lived on a fixed low income. When the handyman was fitting a rail in the living room he broached the subject of the hazardous worn carpet. He suggested that a section of carpet could be taken from under the settee and used to replace the doorway carpet. The service user agreed and was delighted with the outcome – the appearance of her room was improved and it was a safer environment.

The handyperson service continues to provide a means of changing homes to reduce the risk of falling. In the above examples, the older man did no longer need to change light bulbs in a somewhat dangerous situation and the changes to the carpet minimized potential risks of falling in the home environment. In other situations homes have been changed to modify risks – rails fitted to steps, grab rails attached in bathrooms, garden paving stone replaced, and worn carpets repaired. Through these interventions potential hazards are minimized with the aim of preventing falls.
Make homes safer

In addition to the handyman interventions discussed above, the interviewees highlighted the importance of the safety check that the handyman conducts. This was viewed as an important part of the service:

“I suppose we’ve been aware of safety in the home for quite a long time. And there will be the odd point perhaps, detail, which might need sorting, but generally we knew that our house was okay at this point in time. But things can go wrong. They can go loose (pointing to the stair carpets). You get used to them and you know ‘I’ll just step over that.’ And then one day you don’t. You know, we all have things in our home that might need attended to.” 

(Service user)

In another situation the interviewee spoke of the way that the handyman identified that the electrical cable of her iron had frayed. This was a particularly dangerous situation, exposing her and her neighbours to the risk of an electrical short circuit or at worst a fire. Inappropriate locks, missing cables, non-functioning security systems, dead batteries in fire alarms are some of the hazards detected through this service. Through this type of intervention hazards in the home are identified and appropriate action to make the home safer is negotiated with the older person.

Enables older people to improve their homes

Whilst improving safety is undoubtedly important to older people, being able to continue to maintain and/or improve the aesthetic quality of the home environment is also greatly valued. This is highlighted in the following quotation from a single woman who lives on a fixed income in rural Northumberland:

“I mean it is wonderful. And the best thing, from my point of view, is that if I go out shopping and I see something – like I saw that chandelier in a charity shop – I know that I could buy it. Now, before the Handyman Service was here, I would have thought to myself that I like the light but I could not buy it because I have nobody to put it up for me. It is really important to me to be able to keep my house looking good. It just makes be feel happy and that is so important now that I am living on my own.” 

(Service user)

This quotation highlights the way that the service enabled older people to continue to enjoy the experience of making improvements to ones home environment. Changing furnishings, moving furniture, fixing new fitting to a home are important aspects of making home improvements, which contribute to a sense of well-being, thereby quality of life in later life.

Another key feature of improving homes is maintaining and developing the functionality of this environment. Moving furniture, for example, may improve the aesthetic appeal of a room and it may enhance the older person’s ability to move around in that environment. Without ongoing maintenance homes can quickly move into a state of disrepair and its functional quality may deteriorate. Dripping taps and loose fittings, for example, may not be hazards requiring immediate attention however the accumulated impact of these individual issues may contribute to the creation of an unfit environment. In the worst scenario living in a house that is in a state of disrepair resulting from an older person’s
ability to attend to maintenance and repair may be the key factor that prompts their decision to move from that environment.

**Enhancing quality of life**

**SEIQoL quality of life scores**

It is possible to score a maximum of 100 and minimum of 0 and we found that the mean score was 84 (SD 9.9) before intervention and 83 (SD 11.1) after intervention. This change is negligible on a continuous scale of 0-100 and was not significant using a paired t-test. A score of 84 indicates a high quality of life in relation to individual domains that were chosen by participants as important to them.

**Qualitative data relating to quality of life**

Although SEIQoL was not sensitive to measurable changes in quality of life, the qualitative data did reveal important findings related to how older people related the benefits of the handyman service to their daily lives. The previous discussion has highlighted the way that the handyman service improved the quality of life of community dwelling older people by enabling them to maintain and repair their homes, and make adaptations to modify the environment to their changing needs. In addition to the points that have previously been discussed it is important to highlight the way that this service also enables people to maintain their personal routines. Throughout life people develop behaviours and routines that define who they are and through the execution of activities shape their temporal boundaries. The act of changing curtains, for example, in springtime and autumn may appear to be a simplistic activity that maintains the cleanliness of the environment. This same act, however, is symbolic of the maintenance of the older person’s ability to engage in customary annual activities. Hanging of flower baskets ensures that they continue to contribute to the communities effort to enhance the quality of the lived environment.

There is a wealth of evidence that has been gained through these interviews with older people that the handyman service enables service users to continue to experience quality of life in later life. This is a positive contribution, enabling them to do what they want to do when they want to do it, as well as a negative contribution through the reduction of risk and exposure to hazards in the home environment.

**Views and experience of using telecare services**

**An acceptable, appropriate, individualized service**

All of the telecare service users that participated in the evaluation were very positive about the service. They indicated that it was an acceptable service that was not perceived to be an invasion of their privacy:

“There are lots of additional thing to the heat sensor that I have in the kitchen. They are not there to be intrusive. It’s like that thing that hidden on top of there. You forget that it’s there. It is there for your own protection.”

(Service user)
They expressed the view that the service provided a solution to their problems, namely, fear that they would be unable to continue to live in their home and its neighbourhood, the perceived threat of disruption to their sense of self if relocated from the place that was meaning-making in the context of their life-course, and anxiety about loss of independence and reduced autonomy in how they lived the latter part of their life.

They indicated that they valued the personalized service that they received – they were able to negotiate the type and range of telecare provision and adjust this as their needs changed. This enabled them to continue to live their preferred lifestyle and when things went wrong, through ill-health or accident, they felt reassured that they had direct access to the call centre to raise an alert that would generate a prompt response from their family/keyholder(s)/contact person or community responder.

“it makes me feel happier. I have my independence and I know that there’s somebody there, close by.”

(Service user)

**Enabling older people to continue to live in their own home**

Increasing frailty, deteriorating health, acute illness, hospitalization, illness/death of a spouse/carer, time of crisis are key triggers that prompt an older person to make the decision to give up their home and move to a supported living environment. Families and professionals are also more likely in these situations to encourage the older person to come to this decision, or indeed make the decision for the older person and override their preferences.

The evidence from the evaluation points to the way that telecare services can provide an alternative service to support older to remain at home:

“Without this (medicine prompt) I probably wouldn’t be able to stay in my own home. It reminds me to take my medication and then I don’t have to worry about that.”

(Service user)

This quotation highlights the important role that telecare can provide prompts and reminders that would otherwise not be available to them in the home environment. These services can also provide a back up system that enhances the individual’s sense of safety and security:

“Over Easter, mother was ill. And needed to be admitted to hospital. And when she came out I came here to live with her and my husband as well. And we would still have been living here with mum without the telecare system. That’s the biggest advantage - It means that I can live in my own house overnight and for the rest of the time, I’m here. Tuesdays, Thursday, Saturdays and Sundays. Mum’s at…..the other three days. And so I… I’ve been living in my own home, and it means that mum can live in her own home because without the telecare system I don’t know that… I don’t think mum would have been sufficiently confident to stay on her own. And I don’t that I would have been very happy with that either.”

(Daughter of a telecare service user)

The latter quotation highlights the improved quality of life for the whole family. The older person was able to continue to live in her own home and younger members of the family
were able to “to have a life now,” by recreating their own lifestyle in the knowledge that their mother had access to monitoring services and could have additional support whenever necessary. This story and other evidence point to the influence of telecare on decisions that older people make about continuing to live in their own home. This daughter was convinced that her mother would have not have been able to continue to live alone and would have faced the decision to move to a supported living environment. This was a choice that did not reflect the values of the family nor their preferences.

The older people in this evaluation wanted to experience independent living for as long as possible and they viewed the provision of telecare services as one way to achieve this goal:

“it’s given mum a lot more confidence because she doesn’t feel that I have to live here and get her everything. It makes her feel good about herself and about everything.” (Service user)

“Telecare is here 7 days per week. It is Telecare that actually keeps me here in my house.” (Service user)

Reducing risk(s) associated with living alone

People tend to access telecare services when they perceive that their exposure to hazards and potential harms in the home environment exceeds their tolerance of those risks. Older people themselves may identify the problem and seek a solution through telecare:

“It prompts me for my medication. When I get busy I just totally forget the meds..........when they (community care services) cut back my carers there were 3/4 times when I completely forgot to take my meds and when my carers next came they found that there was Warfarin and stuff from the night before just left which I should have taken. So now I have my prompt.” (Service user)

“I get a call at night about 9.00pm to see if I’ve taken my medication. That’s smashing.” (Service user)

Younger members of a family worry about the increased exposure to risk of ageing relatives when they have experienced falls, or have problems remembering to turn the gas off on the cooker or take their medications as prescribed. It is in these situations that they explore the potential of telecare to provide a “back-up service.” This strategy modifies the risk that the older person is exposed to by putting in place an “early warning system” that things require further assessment and possible intervention.

Enhancing quality of life

The previous discussion has highlighted the way that telecare services have improved the quality of life of community dwelling older people and their families through enhancing their sense of security and safety. Service users describe telecare services as their ‘life-line,’ and as their ‘back-up.’ When they have access to the service they know that they can raise an alarm and get people around to address the problem when the need arises:
"When any of these (falls pendant, heat sensor, pills dispenser, smoke alarm) are used a voice immediately contacts me. You can hear the dialling tone then there’s the voice answering on the other end which says….. “Hello Mary, your smoke alarm is indicating…is everything alright.”

(Service user)

“He(son) was very keen for me to get it after I had this carry on here. And he also had a thing put on the wall outside with my keys on. You know so that people could get in if there was a problem.”

(Service user)

It is not only the older person who considers telecare to be an important back-up service, relatives and carers also reported decreased anxiety - “peace of mind” - knowing that the devices and sensors provided an early warning system or provided a response when things went wrong. This is illustrated in the quotation from a daughter of a telecare service user:

“And I don’t that I would have been very happy with mum living on her own without some type of support - knowing that there wasn’t a system in place that would at least partially take over and give someone an indication that something wasn’t right. I think it’s very important to have this type of input. We were in the situation of living in with my mother and now she is happy, safe and able to live on her own. This means that we actually have a life as well now. And so that… I think that is the biggest benefit there’s been.”

(Service user)

By enhancing their sense of security and enabling older people to stay in their own home they can continue experience the dimensions of their own personal life that give it quality. This may include experiencing comfort, enjoyment, dignity, autonomy, privacy, individuality, being able to continue to engage in meaningful activity and maintaining their personal, social relationships that are particularly dependant on locality such as living as partners and neighbours. Some of these points are highlighted in the following quotations:

“They wouldn’t allow him (husband) to come out of hospital if we didn’t have a carbon monoxide detector fitted in our home.”

“I have wonderful neighbours….they come in and visit. I so much enjoy having a chat with them. I would really miss them if I had to leave here.”

“I’m a research historian, I’ve had stuff published. I’m 70 but the mind is still activity and I’m keeping the mind active. As far as I’m concerned I haven’t got time to kick the bucket yet…..I’m that busy and then I’ve got to write up after that. I’, quite occupied and this is how I forget about taking my medication at time.”

(Service users)

**Implementation issues**

Most of the participants were unfamiliar with telecare prior to engagement with the service. Consequently they felt that they required time and support by service staff to build their confidence with the system. Invariably the participants spoke with high regard about the way that the staff were patient with them and responsive to their inquiries.

They had to learn how the systems worked, particularly when things did go
wrong. For example, the shapes of some medication resulted in tablets being stuck in the pill dispenser and this resulted in the need to develop a strategy to overcome the problem:

“Because, you see, that's the shape of it (the tablet). I'll show you from the other side and you'll see better. I'm going to fill it this afternoon. But you see the shape of them. And you see that kind of tablet. If you have a capsule, the capsule can get wedged under this part of the dispenser. Now I have worked out a system to avoid that type of problem. But apart from that, I can't fault it.”

(Service user)

Older people and their families required support to develop the confidence to adjust the system to suit personal needs otherwise this created the potential for the very telecare technologies that were used to enhance their independence and quality of life could place restrictions on an individual's personal routines.

“At first I was getting up to avoid the alarm going off. I couldn't have a lie in. but with their help (staff) I have learnt to adjust the system and now it is working just fine.”

(Service user)

The issues discussed here highlight the importance of ensuring that the implementation of telecare in an individual’s home is well supported by a team that can support the older person and their families to make changes to the devices and develop the skill and knowledge to optimise their use of these technologies.

**Discussion**

Supporting older people to live in a safe environment was one of the central objectives of the home improvement dimension of the FISHNETS initiative. Whilst the evidence gained through the evaluation cannot measure the extent to which this particular facet of the service development has contributed to achieving the Older people's PSA targets of improving quality of life and independence of vulnerable older people, there is overwhelming evidence that the home improvement services have made a contribution.

Older people want to age in a place of their choice and there is now recognition of this in housing, health and social care policy in the UK. They have a deep attachment to their home (Cooper, 1974; Saunders 1989; Gurney and Means, 1993; Golant, 1998; Heywood, Oldman and Means, 2002), which is influenced by many interrelated factors. These include the observation that a home is more than a building, it has both existential and experiential dimensions, with physical (objects, spaces, boundaries), social (involving people, relationships and interactions) and metaphysical (significance ascribed by individuals and communities dwelling in the home) elements. There is also a temporal and historical aspect to every home that gives rise to a sense of continuity in life to the occupant. Hence every feature of a home confers a set of memories - decor, furnishings and objects - that are both symbolic and representative of self and a lifetime’s achievement. The importance of home to an older person and the disruption to their life-course when they are compelled to move to another environment can not be underestimated.

Older people who have fallen, or who feel at risk of falls, frequently seek to restrict their activities and may confine themselves not only to their own home but to a decreasing
space within that home, in order to feel safe (Vellas et al 1997, Cheal and Clemson 2001). Interventions to improve the safety of the home and to help older people adapt their environment in ways that are acceptable to them are very important, as evidenced by our data. Self-imposed activity restriction can lead to accelerated physical decline, social isolation, loss of independence and ultimately increased fall risk.

The older people who participated in interviews concerning the home improvement service highlighted the importance of their home to their quality of life and sense of wellbeing. They also spoke of the anxieties that they had experienced over the possibility that they may not be able to remain at home. At the worst, these older people were anxious about continuing to live in environments that were not fit to meet their needs. At the minimum they were concerned about their ability to continue to make changes to their home, as their physical ability declined, and the risks that they were exposed to when they tried to perform home improvement tasks. The introduction of the handyman and the telecare services have been welcomed by the older population in Northumberland. These services have provided a means that enabled older people to modify their homes according to their needs. The services also provided an additional layer of support to create a comfort zone substantial enough to give older people and their families the confidence to continue to live in the place of their choice.
CHAPTER 7: ACCREDITATION and EDUCATION

Introduction

A core aim of FISHNETS was to improve practice amongst those whose work brought them into regular contact with older people, with a particular emphasis on falls prevention. ‘Work’ in this context being the management and provision of services, and formal and informal care for older people. Therefore a key element of FISHNETS was sustaining and extending training programs that existed in Northumberland prior to the implementation of FISHNETS and to develop new programs that the Accreditation and Education task group and OPPB considered to be relevant to the prevention of falls.

The impact of educational and training programs can be wide ranging, from changing the understanding and skills of the individual participant, their practice, the service received by the service user and the service. In this case the focus of the evaluation was on the impact of the FISHNETS education and accreditation programs on preventing falls in the older population and developing approaches to falls prevention. In order to explore these issues data collection involved:

- Group interviews with home care staff who have undertaken FISHNETS training
- An audit of falls and approaches to falls prevention in sheltered housing schemes
- Individual interviews with care home managers who participated in the falls accreditation process.

This chapter commences with an overview of the training and accreditation that was developed, and the discussion that follows is grounded in an analysis of the data that was generated from the audit and interviews.

Service activities

Education: Since the implementation of FISNETS the education program has developed and by the end of the project the Falls education program included:

- Falls Prevention
- Low Vision
- Introduction to Dementia
- Dementia Person Centred Care
- Podiatry training
- Train the Trainer Seated Armchair Training
- NVQ Level 2 in Exercise & Fitness
- Nutrition and Assessment in Older People
- Medication in Older People
- BTEC Level 2 in Dementia

A unique feature of this program has been the emphasis on the inclusion of older people. By October 2008, 573 older people had completed programs including Falls Prevention and Low Vision Training. These individuals make a major contribution to the provision of informal care across the County, therefore it is important that their skills are developed to enhance the care that they provide. Home care, day centre, sheltered housing, care home
staff, handyman and rehabilitation officers across statutory, voluntary, for-profit and not-for-profit organizations have participated in training (n = 3,171 by October 2008).

Accreditation: As service providers engage with the process of staff training, relating to the prevention and management of falls, they can register with Northumberland Care Trust to progress toward accreditation. The accreditation process was devised to act as a stimulus to enhance the quality of service provision and thereby facilitating organisational development.

The programme involves a multi factorial approach with organisations undertaking self assessment against predetermined standards in 8 areas, concerning raising awareness of falls, assessment and review of older people, falls recording, optimum vision, foot checks, medication reviews, mobility/transfer and environment. This assessment creates a baseline data set. An action plan is then negotiated with the service provider and support is given to improve practice. Following attainment of accreditation a 6 monthly falls audit is completed, which provides ongoing feedback to the organisation concerning falls and falls prevention. Since April 2006, 215 home services across Northumberland County have been engaged in the accreditation programme against a potential 266. By October 2008 162 organisations (78 care homes, 33 sheltered housing schemes, 34 day centres and 17 home care services) had been accredited.

Findings

Impact on practice

This first section reports on the views and experiences of individuals who participated in FISHNETS training and accreditation scheme. All of these individuals were formal paid carers. The majority of trainees indicated that their knowledge had changed as a result of their training and this had a direct impact on how they interacted with their clients and their approach to care.

A need for targeted education for the prevention of falls

“I think that a client falling is one of your worst fears. You know, a client falling when you are there. Or even when you are not there and going to a client who’s fallen. So it is one of the things that you are very, very careful of when your are hoisting people or when you are helping people move form a wheelchair to a toilet for example. You seem to be very careful…..We are very aware that it could happen to anybody at any time.”

(Home carer)

Although this quotation captures the views of the home care staff it also epitomized the views of formal and informal carers of older people across the whole economy of care who participated in different aspects of the evaluation. Staff were concerned about the possibility that clients could fall and be injured. Equally they were aware that their roles were changing and expanding and with this came a responsibility to undertake risk assessment and implement management plans to minimize their clients’ exposure to risk. Hence care staff have become increasingly concerned about acquiring the necessary skills and knowledge to enable them to undertake their role.
**Increased knowledge and understanding of falls and problems that contribute to falls**

Whilst care staff and managers were aware that falls are a problem with serious consequences in the older population, the training raised their awareness of the scale of the problem:

“I never realized that so many people suffered from broken hips in a year, or broken legs….and then how long it takes from first going into hospital to aftercare, and then the cost of all of this…it brings it home.”

(Home carer)

The courses were valued by the interviewees as a way to increase their understanding of later life and living with problems such as low or impaired vision. Experimental learning enabled them to gain insight to the issues that affected the quality of life of their clients:

“The low vision course was excellent….I’d never worn a blindfold or done anything like that before and it was really scary and you realized just how vulnerable people are….and it makes you realize what people have to go through on a day-to-day basis. And we also tried on glasses that helped you to understand what people with different types of blindness experience. There were ones with lace in front and the ones with the little holes. We had to walk around and do all of the exercises with those on. And it just makes you realize how horrific it can be….And there was a lecture from a partially sighted person and she talked about her experiences and explained what it was like for her.”

(Home carer)

This focused their attention on the need to be sensitive to the particular difficulties that individuals encounter in their daily life. For example, they spoke of the understanding that they gained of the importance of not moving furniture when visiting a client with visual impairment:

“we had a lady who’s 94 and she had an accident because the carer had moved furniture to a different place and she wasn’t expecting it to be there. I always tell people now ‘don’t ever move her furniture, for example don’t move her stool.’. You know the course makes you realize what they are going through.”

(Home carer)

Combining an understanding of the problems older people experience with the intimate knowledge of an individual’s preferences, needs and idiosyncrasies .the interviewees suggested that they were able to make fine adjustments to care packages as illustrated in the above quotation.

**Developing practice**

The majority of the interviewees spoke of the way that FISHNETS education provided achievable and practical ways for them to develop their practice. Strategies such as those described below enabled them to support a service user to be as independent as possible:
“Fold the notes (paper money) in different ways so the client can work out the
difference between the five and the ten pound. And in that way they can manage in
the shops by themselves.”

(Home carer)

“They felt that it was all too easy in the course of a busy work life to become less attentive
to the little things that had the potential to contribute to falls. The FISHNETS courses
raised the participants’ awareness of the need for them to take preventative action in daily
practice, and to never get ‘blasé about the potential for falls’ in any practice setting. They
recognized the value in taking simple measures to minimize hazards:

“After the course – I mean you do it anyway- but whenever you go into somebody’s
house your eyes are everywhere for even just a carpet that is turned up a little bit and
you are thinking that somebody could trip…There again if we pick up on something
like that we could suggest a little bit of double sided sticky tape or just move it or turn
it the other way.”

(Home carer)

“We now pay attention to residents’ slippers, we make sure that they fit properly…we
make sure that shoes are fastened…we now pay particular attention to people’s
medications….It made people very aware.”

(Care assistant)

Whilst staff may encourage residents to wear good fitting shoes and slippers, this does not
always change the behaviour of residents. In one care home residents participated in falls
awareness training sessions with care staff and the outcome was quite noticeable to staff.
They witnessed residents advising their fellow residents to change their footwear, and
discussing the benefits of falls prevention strategies, such as participating in exercise
groups, with their relatives.

In care home settings the managers indicated that such simple changes in practice had
had a cumulative effect on the incidence of falls:

“We have very few falls now…They are looking at the environment
differently…everybody is aware of the importance of keeping the corridors clear, not
having obstacles in the corridors. We don’t move furniture around now, so it doesn’t
disorientate anyone…this all helps to reduce falls.”

(Care home manager)

**Risk assessment and risk modification**

The discussion in the previous section highlighted the way that practice had changed in
care settings. Many of practices concerned changes to the way that risk and hazards in
the care environment were identified and evaluated. Staff developed a heightened
awareness of the individual, environmental and organizational factors that had the potential to contribute to falls:

“This program has extremely beneficial to the way in which myself and my care team assess the risks of residents falling and how to minimise these risks and identify potential risk factors.”

(Care home manager)

Importantly the approach to falls changed from reacting to falls and treating injury and loss of confidence to an approach that actively sought to prevent falls:

“You can advise. I’ve been out to a lady today doing a risk assessment and now we will send out information on falls awareness and the actions that they can take to reduce the risks that they face in their own home.”

(Home carer)

Risks that were identified through the assessment of individuals were addressed through care planning processes that attempted to modify or eliminate the identified hazards.

Following completion of staff training, care settings throughout the County were able to apply for accreditation of their organization. This involved a process of ensuring best practice that aimed to prevent falls was implemented across the organization. Additionally, systematic approaches to identify and modify risks were developed. This resulted in some organizations developing documentation that tracked the incidence of falls and when regular patterns were identified or the incidence exceeded predetermined targets alerts were triggered:

“The most positive thing for me is knowing I have all the right documents in place and I was able to use some of the information in residents care plans. For example, the monthly falls record gives a visual display of all of the falls that occur, the time and location. We recorded falls in individual care plans prior to the accreditation but with the new system we can identify patterns quickly and act accordingly.”

(Care home manager)

When a pattern was recognised or an alert triggered this led to further analysis of the data and practice in the care setting. If risks or hazards were identified an action plan was developed to prevent further falls. In addition the accreditation and verification process required organisations to complete a six month audit of fall incidents. This system for recording falls is now in place and represents a robust audit tool for evaluation of future fall rates and any interventions implemented on a home-by-home or across-home basis.

**Challenges to implementing change in practice**

Those who participated in the educational programs wanted to transfer what they learnt in the classroom to the practice setting, however this was not always straightforward. Some of the interventions that were described in the previous section were easily replicable in the care environment, such as keeping corridors clear of clutter. Though these interventions may be simple; they had the potential to reduce potential hazards. Other interventions, however, required specialized equipment or adaptations made to the care environment. In these situations additional resources are required, and arranging this may
be beyond the home carers or care assistant’s decision making capacity within their service:

“It is all about prevention…..you come back from the course and you go to a lady’s house, now I see the need for some grab rails here so you report this to your line manager, and they report it to the care manager and then you are waiting for weeks and weeks for them to come….My feeling is that that is too long, the time span, because that person could fall next week and that could have been prevented.”

(Home carer)

This outcome is frustrating for the individual who has undertaken training to enhance the quality of service that they provide, when the reality is that they are limited in the extent that they can change their practice.

**Impact on service provision**

Northumberland FISHNETS was implemented in the County as a vehicle to transform the service culture to a whole system approach to the prevention of falls in the older population. The previous section of this chapter pointed to the changes in practice that were experienced by individuals who were known to have engaged in the FISHNETS programs. This level of analysis gives little indication whether the impact of the training and accreditation programs extended beyond these targeted individuals. The evaluation strategy, therefore included a strand of data collection in environments that had minimal engagement with FISHNETS training and accreditation to observe activity in relation to falls during throughout the second year of the evaluation. This involved an audit of falls in sheltered housing schemes. The second part of the discussion presents selective findings from the audit that is an implicit part of the FISHNETS accreditation scheme.

**Falls audit in sheltered housing schemes in Northumberland**

During the period February 2007 – March 2008, 86 audit reports were completed by 13 sheltered housing schemes. The number of audits that were returned from the participating schemes did vary. Four of the schemes returned 1 or 2 audits, and the other schemes returned between 4 and 13 audits (mode: 3 schemes returning 7 audits).

41% of audit reports indicated that no falls had occurred within the scheme during the reporting month. 20% of audits reported 1 fall during the month, 17% reported 2 falls, 22% reported more than 2 falls (see figure 7). The total number of older people who were reported to have fallen during the audit was 83, with 26% of these individuals experiencing more than one fall (now referred to as repeat fallers). Repeat fallers accounted for 52% of all reported falls. This data highlights the large number of falls that involved repeat fallers. The most extreme case was a report of 11 falls by the same tenant.

![Figure 7: Proportion of audits reporting falls Feb 07 – March 08](image-url)
Time and location of falls: The findings indicate that falls were more likely to occur in the morning, before midday (43%), followed by the period midday to going to bed (34%), and the least number of falls were reported for the period after going to bed at night (23%). The majority (80%) of all falls occurred within the tenants own flat, and in that location the living area (38%) of the flat. Tenants also frequently fell in the kitchen (19%) and bedroom areas (18%). Fewer tenants (14%) were reported to have fallen in the communal areas of the scheme and this was more likely to have occurred in the communal rooms (5%) or hallways (3%). Only 7% of falls occurred outside of the scheme, in the street or when the tenants took part in organized bus trips.

What was involved in falls: Only 51 of the 86 (59%) audit reports indicated that the falls involved furniture, aids, equipment, or footwear. Chairs/sofas accounted for 27% of these items, mobility aids a further 27% (which included wheelchairs/electric scooters 6% and walking frames 21%), and beds 18%. Other items such as rugs, slippers, commode, toilet, rubbish bin, washbasin and table were reported within 1 or 2 audit documents.

Injuries sustained as a consequence of a fall: Of the 83 people who fell, 33 (40%) were reported as suffering one or more injuries. These included injuries to knee and lower leg (35%), head (22%), hip and thigh (12%), wrist and hand (10%), elbow and forearm (10%), shoulder and upper arm (5%), abdomen (3%), rib (1.5%) and ankle and foot (1.5%). Further scrutiny of the audits of the repeat fallers indicated that injury was slightly more likely to accompany one or more of the falls that occurred.

Reacting to and preventing falls: Importantly the audits have provided feedback on falls prevention activity that is taking place within the schemes. In those situations where a tenant has fallen immediate action has taken place to treat injury or minimise harm. Following this action is taken to identify and address the causative factors, such as repair of furniture, or removal of hazards within the tenants flat. Future orientated actions are also taken in order to prevent further falls such as completion of the Cryer tool and referral to the Northumberland Falls team.

The audits that were completed during the earlier part of the audit year highlighted the importance of routine safety checks and making changes to the scheme following the reporting of a fall. Audit reports from the later stage of data collection included details of a range of falls prevention activities within the schemes. These included:

- Falls prevention talks with groups of tenants
- Falls prevention advice given to individual tenants by the scheme manager
- Tai Chi lessons within schemes (funded through the Community Chest)
- Chair based exercise classes within schemes (funded through the Community Chest)
- Group exercise sessions within schemes/ Extend classes
- Craft classes that encourage tenant participation, which have an emphasis on falls prevention
- Referral to the Community Rehabilitation Team
- Referral to leisure centre based falls prevention exercise programs

These findings indicate that there has been a shift in emphasis from safety checks and actions following a fall that was observed in the earlier audit reports to the implementation of falls prevention activities that was report in the latter audit data. This represents a shift from a reactive approach to falls in the older population to a preventative approach. Whilst some of the Scheme managers had engaged in FISHNETS training, there were clear
indications that they had also accessed the exercise and lifestyle programs provided through FISHNETS, Community Chest resources and services across the falls pathway that was developed by the Intermediate care task group.

Discussion

In all fields of practice there is an increasing emphasis on preparation for practice that involves formal and accredited training. This is a significant change for some parts of the care workforce, such as home care services, where the emphasis has been on on-the-job training and peer teaching as preparation for the role.

The move toward establishing mandatory and optional training as a norm across the care sector is predicated on the notion that participation in training results in enhanced practice and an improved service. This is a restricted view of practice and service development – known as Technical practice development - where it is assumed that knowing the evidence and developing relevant skills will bring about change. It is quite a simplistic view of the way people engage with training and its outcomes. They may be provided with appropriate information and acquire a particular competency, however, this does not necessarily result in a change in the way that they undertake their role. There may be many barriers to an individual implementing what they have learnt through a training program in their practice, none-the-least being organisational restrictions on what they can do, lack of resources and resistance from other staff and service users.

FISHNETS provided a vision throughout the partnership that investment in training would bring about change. This vision, however was not grounded in the narrow restricted notion of Technical practice and service development that is discussed above. It was envisaged that training was part of and contributed to a service transformation across the County. FISHNETS brought with it a vision for a cultural change, and training was part of the fabric of this change in much the same way that Kemmis conceived such change:

“… the transformation of practice understands that changing practices is not just a matter of changing the ideas of individual practitioners alone, but also discovering, analysing and transforming the social, cultural, discursive and material conditions under which their practice occurs …” (Kemmis, 2006)

This is akin to Rob Garbett and Brendan McCormack’s idea of Emancipatory Practice Development. In this model practice development is viewed as a continuous process of improvement towards increased effectiveness in services and care. This is brought about by enabling health care teams to develop their knowledge and skills and to transform the culture and context of care. (Garbett & McCormack 2002 & 2004). Hence training is instrumental to transforming the workforce but for change to be achieved training needs to be set within a systematic approach to the transformation of the whole system of care.

When these ideas are related to what is taking place within the FISHNETS project it can be argued that training is not necessarily an outcome in itself it is part of the process in bringing about the cultural change of a preventative approach to the challenges of later life. The findings presented in this chapter provide evidence of cultural changes at a number of levels throughout the implementation of FISHNETS. At the individual level practice changed, with individual care staff and managers assessing risk of fall and implementing relevant approaches to prevent falls or minimise the impact of falls. At the organisational level systems were developed to address system failures and provide early
warning alerts that triggered a heightened approach to modify risk factors within the organisation. At a policy level the prevention of falls became a key priority for service development.

The findings presented in this chapter point to the way that front-line practice development has been achieved through accreditation and training, which has raised awareness at the individual level and promoted an important system enhancement to ‘basic care’, as set out in the Department of Health POPPs vision. There is clear potential for this training to continue and to become a benchmark for service level quality assurance.
CHAPTER 8: INFORMATION, PUBLICITY and COMMUNICATIONS

Introduction

Information, and the ability to act on it, is vitally important for older people in maintaining their independence and quality of life. Information is the means whereby older people develop knowledge about the services and the support that is available to them in their locality. Access to services and community based activities can be very complex and through the provision of information and advocacy older people can be supported to ‘navigate’ their way round the system. In recognition of this the FISHNETS information, publicity and communications group sought to distribute information relating to healthy active life-styles in later life to promote social inclusion for elders in Northumberland communities. There was also a specific focus on disseminating falls prevention information to those most at risk of falls but also to the wider community to promote the adoption of preventative strategies as part of normal routine and life style activities.

Our aim in the evaluation was not to judge the effectiveness of the publicity strategy, but to gain an insight into how information was disseminated and subsequently accessed directly and indirectly by older people living in Northumberland. The findings that are reported here were generated from an analysis of the following data:

- Documentary analysis of project documents and related media
- Participant observation of FISHNETS events and activities
- Interviews with leisure service managers and staff, and physical activities task group members
- Secondary analysis of interviews that were undertaken with task group members and users of FISHNETS services throughout the evaluation.

This chapter commences with an overview of the information, publicity and communications strategy that was implemented under the auspices of FISHNETS and then moves on to explore what was achieved through that strategy.

Service activities

Prior to the implementation of FISHNETS getting information out to the older population had moved to centre stage for many organizations across Northumberland. This had led to the development of a Countywide group known as Opportunities for older people, which aimed to co-ordinate the dissemination of information. With FISHNETS came a further opportunity to enhance access to information for older people. To optimize access to information and use of the resources made available to older people a strategic decision was made in the early stages of the implementation of the project to integrate FISHNETS publicity and communications with existing systems and to build on them. It was anticipated that this would also contribute to the sustainability of the old age preventative information agenda.

The information strategy that developed involved use of multi-media resources, older people’s networks, and intergenerational activities. A rich program of information dissemination, events and activities emerged from the older people’s information strategy.
and these can be broadly categorized as relating to Healthy active living; Safe and healthy living, and Falls prevention. Examples of information and activities include:

Healthy active living;

**Young at Heart events:** 14 Young at Heart events took place across the County of Northumberland with more than 1400 older people attending and receiving information on subjects as diverse as falls prevention, oral hygiene and cavity wall insulation. These events provided the opportunity for older people to participate in taster sessions of a wide range of activities including Tai Chi, carpet bowls, salsa dancing and kick boxing. This program will be sustained beyond the FISHNETS project through partnerships with leisure providers.

**A Northumberland school competition:** This project was an intergenerational initiative that involved school age children in the production of the FISHNETS’ logo and project posters. The posters highlighted key aspects of healthy lifestyles in later life. The FISHNETS’ Board selected the winning entries, and the two winning posters received prizes. Five hundred copies were printed and distributed throughout the County.

Safe and healthy living

Older people’s issues are now embedded into relevant Northumberland strategies and action plans including Physical Activity, Mental Well Being, Food, Nutrition and Alcohol.

**Distribution of health related booklets:** 20,000 medicines leaflets concerning safe and effective administration of medication, and 20,000 over 50’s healthcare packs concerning information about the handyman scheme, home safety, energy efficiency, health information, and accessing benefits/grants were distributed via GP surgeries, pharmacies and Young at Heart events.

**Establishment of website:** [www.northumberlandFISHNETS.org](http://www.northumberlandFISHNETS.org).

was established and is incorporated into the county’s Northumberland-Together site and linked to the Northumberland Life site. A volunteer is actively involved in its ongoing development. An innovative publicity strategy was developed to promote the site through the distribution of 500 mousemats. The web site provided FISHNETS related information and importantly sign posted older people to events and services in Northumberland.

Falls prevention

**Falls awareness and prevention booklets:** A wide range of literature, including the distribution of 30,000 falls prevention booklets, was provided to the older population as sources of information concerning the strategies that they can implement to prevent falls and to encourage them to make contact with the falls prevention services in Northumberland. This literature also provided information relating to accessing services, sources of help, advice and if necessary advocacy.

**FALLS Fayres:** 8 Falls fayres, with more than 850 participants were held throughout the County to raise awareness of falls and enhance older people’s knowledge of what they could do to minimize their risk of falling. During these events activities such as ‘Slipper exchanges’ were organized to promote the participants engagement with falls prevention activities.
Findings

Throughout the project service providers reported that they strived to disseminate the FISHNETS message to older people across the County, in particular disseminating relevant information to those most at risk of falls. This included targeting carers and informal carers in an attempt to access isolated older people especially those who lived at home. In the context of falls prevention in the older population this was highly complex. Falls in the older population is inappropriately and widely considered by the general public to be a normal part of the ageing process, hence it is perceived to be a condition that is not amenable to prevention. There is also the added difficulty that older people may not tell others that they fall to hide frailty and prevent others from making decisions that their living arrangements ought to change to enhance their safety.

These difficulties needed to be addressed in the information strategy in order for individuals to perceive that they have an information need or that aspects of their current lifestyle could be improved. Older people, family and carers do not necessarily know what they don’t know or what is available in their locality, and this was reinforced in the interviews with older people during the study. The information strategy, therefore, was developed to address these issues. This was achieved through an approach that included both universal distribution of health related information and targeted distribution to those most at risk of falls that is described in the previous section concerning service activities. The following discussion explores the impact of this strategy from different stakeholder perspectives.

Getting the information out

The information strategy included a range of communication media to facilitate distribution of information. The single largest vehicle for distribution of information was through mass media communication such as newspapers and television, and postal distribution of health and falls related information. Added to this voluntary sector agencies/groups such as Northumberland Age Concern, Haltwhistle partnership and the Women Institute included information about FISHNETS activities and services in their literature. This information was also relevant to the younger old population (50 years and over), hence specific strategies were developed to ensure that this population was targeted. For example, Falls awareness and prevention booklets were distributed through 60 businesses, identified via the Healthy Workplace Award, which had the potential to reach 3,000 employees. More generally Safe and healthy living and Falls prevention type information was distributed through GP surgeries, pharmacies, chiropodists and leisure centres to ensure that it was made available to members of the public (see case study 1 as an illustration of the impact of this distribution process).

Case study 1

Edward is an 84 year old man who lives in the North of Northumberland County. During his regular chiropody appointment his practitioner noticed that he stumbled when walking along a corridor. He inquired whether Edward had had problems with falls and subsequently provided him with information about the FISHNETS services. He contacted his GP and was referred to the North Community rehabilitation team and falls specialist services. Edward stated “I am so pleased that my chiropodist was so well informed and knew how to direct me to the right help. I am now getting the right type of help.”
It is not possible to quantify the numbers of people receiving information in this way through the data collected for the evaluation. The scale of this activity, however, in a population of approximately 57,500 people 65 and over it is likely that a large proportion of this population received health related information. Self referral (36% of total referrals) to the leisure centre based falls prevention programs is indicative that older people were aware of this service. Similarly the up take of the Extend classes (n = 1537) suggests that people were informed that these programs existed and knew how to access them.

Older people generally prefer to have information either in hardcopy or face-to-face. The information strategy embraced the distribution of hard copy materials as discussed previously and provided opportunities for face-to-face information transfer through Young at Heart events and Falls Fayres. In total 2,250 older people had direct face-to-face information concerning falls and falls prevention. They were informed of the actions that they could take to minimize their risk of fall in their own home and the range of community activities that they could access to enhance their well-being. They were also provided with information about the falls related services within the County and how they could access those services.

Engagement with information

Action is not always a direct consequence of receiving information. A recent report by the Department of Works and Pensions (2008) highlighted the importance of services recognizing that age is a factor in determining the attitude of the person seeking information, which may affect how likely they are to access the information and then in turn to act upon it. A unique feature of the FISHNETS information strategy was the way that the combination of multi media and information provision events through organizations and groups across the whole economy of care provided an integrated message concerning Healthy active living, Safe and healthy living, and Falls prevention. This had the effect that individuals were exposed to the same information in different environments, in different ways and at different points in their life. It was anticipated that the accumulative effect of multiple messages would enhance the recipients’ engagement with the information.

Importantly older people were exposed to the information at times when they were most likely to make behavioural changes such as immediately following a fall. For example following contact with the ambulance emergency service, in addition to treatment of any injuries that were sustained as a consequence of the fall, they were referred to falls rehabilitation services. This was the point where the individual entered the Falls Pathway and received an in-depth assessment and gained access to other falls prevention services. During the assessment process the individual was informed of the range of services, aids and adaptations that was available to them to prevent the future likelihood of falls and to improve their quality of life. This was a critical opportunity for information services as this is the stage when individuals are likely to be most receptive to acting on the basis of information that was imparted.

In contrast, the provision of information through the Young at Heart events and Falls Fayres was with individuals who had demonstrated their interest in active healthy life styles and falls prevention through their attendance. Whilst these were individuals who were motivated to participate in the event they could be at any stage along a continuum of having no intent to change their life style, in denial of the need to change or ready to make changes. It was therefore important that participants had opportunities for direct exposure to interact with new ways to try out new physical activities and engage in falls prevention.
activities. These were fun events that were safe spaces for the less confident to try out something new.

Numerous stories were captured throughout the interviews with older people that indicated how much they enjoyed the face-to-face events, which had been the trigger for them joining for example a salsa dancing or kick boxing class in their local leisure centre or community hall. In addition to being the stimulus to participate in a new physical activity, these events were important in sign posting people to services that existed in the County and pointing to ways to access them. For example, individuals spoke of the way that they had received information about the handyman service but thought that it ‘was too good to be true. It must therefore be a con.’ The Young at Heart events provided a forum to allay such anxieties and encourage older people to make use of services to enable them to live independent healthy and safe lives.

**Getting information to ‘hard to reach groups of older people’**

Northumberland has the lowest population density of any area in England. In the more rural areas of the County there are older people who do live in relative isolation, cut off from services. In contrast the urban South East area is densely populated, with high levels of poverty and deprivation. This is a factor marginalizing older people from services in Northumberland. Hence a specific aim of the FISHNETS initiative was to widen knowledge of and improve access to services through outreach. This was achieved by the distribution of information through the formalized information infrastructure in the County. FISHNETS information was widely distributed through grassroots networks such as the 103 Northumberland Women’s Institutes and the community groups that were supported with Community Chest funding (see p 35). This strategy did have the effect of information reaching the heart of small villages and settlements. Interviewees, for example, highlighted that users of the handyman service had first heard of the STARS service (handyman service) in a Woman’s Institute meeting.

There was also evidence that there were community dwelling older people who remained marginalized from Healthy active living; Safe and healthy living, and Falls prevention information throughout the FISHNETS initiative. In some localities those individuals who were linked to services received falls related information whereas the message did not reach other individuals:

“In our area the Young at Heart events were largely attended by people who were already attending falls prevention and exercise activities. So I think that there was a problem that really there wasn't enough promotion done.”

(Service provider)

Some of the participants who took part in interviews concerning the leisure centre based falls prevention program and handyman scheme also indicated that they knew of older people in their communities who had not had access to FISHNETS related information. Service providers were aware that the information gap persisted despite the concerted effort to ensure that older people, despite their circumstances, had access to information. Adopting innovative approaches such as the Northumberland Schools competition and Young at Heart events were partly successful in reaching out to communities of older people that were not the traditional audience of active healthy and falls prevention information. There was a commitment toward the end of the project to build on what had worked and to continue to develop innovative approaches that enabled access to and
engagement of older people with Healthy active living; Safe and healthy living, and Falls prevention information.

The information strategy is a vehicle to inform service development and service planning

Service providers across all sectors in Northumberland were acutely aware that the County’s population is ageing and in some areas such as Berwick upon Tweed and Alnwick this is occurring more rapidly. The FISHNETS initiative was viewed as an opportunity to test out new services and new ways of delivering services with this rapidly ageing population. This was important because large numbers of very old people had not previously existed and service providers wanted to ground service development and service planning in the knowledge of what older people felt that they wanted and needed, and their expectation of those services.

The information strategy was effective in accessing knowledge about what older people liked to do as leisure and exercise activity, which would contribute to active healthy ageing lifestyles and the prevention of falls in the older population. Importantly the strategy elicited information relating to gaps in current service provision and issues in service delivery that created a barrier to participation.

“we’ve now got information about what older people would like to do as a leisure, exercise activity and what we are not providing at the minute. A lot of people have asked for afternoon sessions. Exercise classes that we don’t really run because traditionally we have done these classes in the morning But actually they can’t get here in the morning and they don’t want to come out at night, in the dark by themselves. So we’ll now look to change our programmes so that these options are there.”

(Service provider)

This quotation highlights the importance of understanding issues relating to delivery of leisure services that could so easily be a barrier to older people’s participation. Knowledge was also gained throughout FISHNETS about the way that older people engage with information. There were numerous accounts from service users indicating that they knew of some FISHNETS services, such as the falls prevention exercise programs, and not others, such as the handyman service. At one level this points to the ongoing need for information to be shared across organizational and service boundaries. When this was investigated further it became clear that some service users had received information about other services and had fully engaged with this information. This suggest that there is a need to continue to develop information services that are sensitive to the cognitive, sensory and communication problems that can accompany old age.

Discussion

The findings reported in this chapter reveal a complex canvas of messages. Notably, FISHNETS partners recognized the importance of older people having access to information to help them make the necessary choices for an active healthy lifestyle and the prevention of falls. This is perhaps unsurprising given the emphasis on knowledge transfer in the UKs modern information society. In response, however, the partners actively
developed innovative strategies to get information out to older people, which is one of the strengths of FISHNETS.

It has been widely reported that older people have difficulty in accessing information and when they do access information acting on it. This culminated in a national program funded by the Department of Works and Pensions that commenced in 2006 - the LinkAge pilot program. This program aimed to develop innovative information resources for older people in 8 Local Authority areas (Ritters and Davis, 2008) and develop knowledge of approaches that facilitated information transfer and information utilization. The information strategies that were adopted by FISHNETS were in keeping with the models that have emerged from this major program. Multi media and multi method approaches were endorsed by the LinkAge program, and in FISHNETS these were a vehicle that did reach out to older people. These approaches ensured mass distribution of information to the older population in Northumberland and more focused distribution through grassroots networks. The combination of these methods reached into communities in different ways, thus optimizing the potential of the information strategy to access older people living in different circumstances.

Toward the end of the pilot project evidence that older people were unaware of FISHNETS services persisted. This is not suggesting a failure in the program, but a signal that there is an ongoing need to build on the successes of FISHNETS and to continue to develop alternative approaches that reach into communities to ensure that older people whatever their circumstances receive healthy active ageing, safe and healthy living and falls prevention information.

Importantly the information strategy empowered older people to develop the confidence to ask for information and access services. This is evidenced by the number of older people that self-referred to the Falls Pathway and exercise groups as the project progressed. Those strategies, such as the Young at Heart events, that were enjoyable, based in local leisure centers and community halls, and included opportunities to try out new activities were particularly valued by older people as a way to build confidence. Public Service Agreement 17 (HM Treasury, 2007) endorsed efforts by service providers to develop approaches to delivery that overcome the social exclusion that so many older people experience. The innovative information provision events that were developed throughout the FISHNETS project provided service providers with insight to ways of working toward this and greater understanding of the lifestyle needs and preferences of older people.
CHAPTER 9: DISCUSSION

Introduction

The POPPs programme provided a unique opportunity for the development of a whole-system preventative strategy in Northumberland, which aimed to keep older people fit, involved, safe and healthy through sustainable community networks. This was pursued through an integrated approach to the development of services that focused on evidence based falls prevention and community level preventative activities. The preceding chapters have explored the complexities that were inherent in establishing and sustaining the partnership and the involvement of older people at all levels of decision making. The outcomes that were achieved by the FISHNETS partnership in terms of service deliverables have been detailed in each of the findings chapters with respect to intermediate care, lifestyle and physical activities, home improvement, accreditation and education, information, publicity and communications and community involvement. From the presentation of this data the scale of service development that has occurred throughout the implementation of FISHNETS and the impact of this initiative on services users is readily apparent. Each findings chapter concluded with a discussion that explicated how the activities emerging from the task group contributed to the vision and aims of FISHNETS. The focus in this final chapter moves away from discussion of the individual parts to exploring the impact of the whole system development.

What was achieved through Northumberland FISHNETS: more than the sum of the individual parts?

In its most simplistic form the outcomes of the FISHNETS project could be measured in terms of performance targets. These were explicit from the outset of the project and were regularly monitored by the national project team. Service statistics indicate that the FISHNETS partnership met the majority of the targets and milestones that were established in the POPPs proposal (see the previous findings chapters for further details of service outcomes). Therefore it could be concluded that FISHNETS was successful in delivering service outcomes and, in some areas, deliverables exceeded expectation. However, simple auditing does not capture all aspects of what was achieved by the FISHNETS partnership.

The individual developments were evidence based and grounded in current guidance and best practice for falls prevention; therefore it could be argued that they might have come on stream eventually without the POPPs funding. However, the distinctiveness of the FISHNETS initiative was not only what was developed but how the services were developed and the added-value of this whole-system approach.

Permanent Secretary Sir Richard Mottram stated that the ultimate test, to be applied with particular rigour, is what works:

“Those keen like me for partnership working of various kinds and for more freedom of manoeuvre for those on the ground must show that it delivers more than the alternative.” (Newman, 2001. p.11).

This reflects the emphasis in public policy on outcomes and points to the importance of creating alternative methods of service delivery where context and mechanisms interact to
produce outcomes that are more than the sum of the parts of the partnerships represented in any initiative (Dowling et al, 2004). The following sections of this chapter examine outcomes that were achieved as a consequence of the partnership and not merely those that could have been achieved by the various partners working alone. Key outcomes were: supporting the far reaching involvement of older people in service development and delivery; a movement of the service culture towards falls prevention for older people as well as treatment within a whole system response; and an explicit focus on those services that are often deemed to be low level that make a big difference and matter to older people. We have observed these outcomes through an action research lens and draw our conclusions from practical and contextual data. The interaction between systematic reflection and service development, facilitated through collaborative learning, typifies the power of action research to both evaluate and stimulate local development and innovation (Waterman et al 2005).

Far reaching involvement of older people in service development and delivery

The population of Northumberland County is rapidly ageing, reflecting the regional and national picture. Such demographic change is unprecedented. Whilst there is generalisable knowledge about the issues and problems of older age, there remains a need to develop a locally contextualised evidence base to inform service delivery. The FISHNETS project provided an opportunity for service providers to develop knowledge of the types and levels of services that really matter to older people, their families and carers, to enable them to continue to live at home in the County.

The range and scale of involvement of older people was unique in this project. Older people influenced service planning directly through the OPPB and community chest activities or, indirectly, for example, through participation in Young at Heart events. In this way, the sphere of influence of older people in service planning was extended beyond governance bodies. There were opportunities for engagement with services at all levels in provider organisations across the whole economy of care, which provided a vehicle to encourage and enable older people with different skills (committee work, co-ordinating community based older people’s groups), living in different circumstances, to influence service planning. Current government policy supports such wide scale involvement, yet few organisations achieve such participation (ODPM, 2003; DH, 2004; Reed and Cook, 2007). Often involvement is limited to a few people who participate in decision making arenas, replicating their input across provider organisations including housing, transport, health and social care. This limits representation, as the voice of only a few people can be heard in these situations. What was achieved through FISHNETS, in reducing duplication of effort and creating structures that supported different types of involvement, could act as a good model for other localities.

Older people were instrumental in shaping the FISHNETS vision at its inception and in reshaping this vision as knowledge was gained about what worked and what didn’t work as the project unfolded. Being able to respond flexibly to the needs of a population, as those needs are identified, contributes to the building of capacity within the community. The use of the community chest as a vehicle to address need, as perceived by older people and for older people in local communities, was illustrative of such capacity building.

The structural changes for involvement at the end of the FISHNETS project has ensured that older people continue to have a voice at the highest level of decision making in the County, through Northumberland Strategic Partnership. The FISHNETS experience points
to the need for power sharing, a willingness to engage on equal terms in decision-making and careful ongoing negotiation of intended outcomes involving all stakeholder perspectives. Whatever the future, Northumberland FISHNETS created a legacy of partnership working with older people that transcended organisational boundaries.

The service culture: moving towards primary falls prevention

The FISHNETS initiative laid the foundation for an important cultural shift in service provision in Northumberland, whereby the maintenance of good physical and emotional health in later life is viewed as positively as the treatment of poor health. This is evidenced in the NSP strategy for the older population of Northumberland (NSP, 2007) that seeks to support older people to remain in the first two phases of later life (older workers and third agers) whilst limiting the time in the stage of needing care. The development of the falls pathway, and the commitment from the Trust for its sustainability, represents a tangible shift from a disparate picture of falls prevention and treatment provision across the County to a connected set of services through which a patient journey can be mapped and successfully travelled. Enhanced basic low level services, such as the home handyman service and EXTEND physical activities classes, were a requirement of the POPPs programme and, in Northumberland, they now operate successfully at primary prevention level and underpin the specialist secondary diagnostic and therapy interventions, which were partly funded by FISHNETS.

Many factors came together to prepare the ground for the impact that FISHNETS had on service culture in Northumberland. The project was implemented at a time when there was increasing acknowledgement of demographic change in the County. Challenging PSA targets, which were key POPPs drivers, had provided a strong impetus for development. The later life PSA (PSA 17) was published towards the end of FISHNETS and raised the bar further in terms of ensuring that Local Authorities make older people a priority as they develop local Area Agreements and wider service provision. Therefore FISHNETS became a central focus for not only its original targets but also a wider agenda, as the partnership prepared its sustainability strategy.

As a POPP pilot, Northumberland FISHNETS had aimed to support independent living of older people in the community and promote healthy and active ageing through a falls prevention programme. Integration of prevention and early intervention alongside improved service delivery across health, social care, housing and independent sector partners enabled FISHNETS to champion an approach that:

- supports independence and interdependence in later life
- provides integrated, holistic and flexible packages of care and support for the prevention and treatment of falls in the older population
- focuses on prevention of ill-health and promotion of well-being to enable older people to live full, healthy and independent lives as they grow older.

Impact of FISHNETS on physical ability and quality of life

The findings from the cohort study of people who attended exercise classes demonstrated that physical attributes of gait and balance were improved to a significant level and self efficacy was enhanced. Becoming more physically able and having greater self confidence
represents reduced fall risk, which was the aim of introducing evidence-based exercise classes. We examined quality of life using a system of individualised measurement, alongside in-depth interviews about the effect of FISHNETS services on the lives of older people. Although the SEIQoL scores did not significantly change, the interview data clearly indicates the impact of enhanced physical ability on being able to achieve personal goals and greater independence. Similarly, the SEIQoL scores did not significantly change for those who received intervention from the home handyman service. The qualitative data, however did illuminate the impact of these services in enabling older people to experience a sense of security and safety in their home and in enhancing their comfort in that environment.

People spoke of the value of FISHNETS services in attending to the minor irritants in life which can inhibit independence and feelings of wellbeing. Low level basic services impacted on quality of life in ways that older people could clearly identify and articulate. The combined effects of the whole system approach have created opportunities for simple interventions to make important differences to quality of daily life.

A whole-system response to falls prevention

Older people, particularly those of an advanced old age, require support from a whole-system of agencies across a number of services, including primary/secondary health and social care, housing, transport, leisure, and education in statutory and independent sectors to promote well being and prevent the health, social and personal challenges of later life. The FISHNETS approach has many of the features of a whole-system community based intervention, defined by Moller (1991) as:

“An explicit approach to achieving reductions in the incidence of injury at the population level by application of multiple countermeasures, and multiple strategies in the context of community-defined problems, and community-owned solutions.”

FISHNETS interventions were implemented in relation to the problems that were identified at the bid development stage and in the context of specific cultural, political and local service delivery networks in Northumberland. According to Moller (2004) the fundamental question for community based prevention is “does it work in the real world?” and, if so, how can we develop evidence about what factors should be replicated. This action research report has offered detailed analysis of principles upon which FISHNETS was based and offered a perspective on perceived benefits and clinical level outcomes that have been achieved by purposeful integration of services and systems. Risk modification emerges as a unifying theme for FISHNETS and the overall aim of preventing falls and injuries has been pursued by a joined up synergistic approach across the county of Northumberland. The involvement of older people and the commitment to basic low level services alongside specialist interventions stands out as the uniqueness of FISHNETS and warrants on-going audit and evaluation. The POPPs funding has facilitated development of data gathering and outcome measurement systems that were previously unavailable, for example standardisation of gait and balance assessment across services and geographical boundaries and falls recording in residential homes. Governance and monitoring by the OPPB has spearheaded a service user led philosophy, which has the potential to keep the needs and perspectives of older people at the heart of future developments.
Sustainability of any novel community based intervention requires policy change as well as guidelines for services (Barnett et al. (2004). Therefore to assume that the best features of FISHNETS will continue without attention to structural and organisational issues would be imprudent. Furthermore, ‘programme sustainability’ on its own may be only a short-term solution, as long-term ‘effect sustainability’ is the desirable public health outcome. Decision makers often rely on simplistic explanatory models for determining funding priorities but, in the case of preventative community based programmes, the complex relationships between targeted individual level interventions (e.g. exercise classes), social and environmental conditions and the agencies tasked with delivering services, requires consideration in order to achieve sustainable population level outcomes (Swerissen and Crisp 2004).

In the case of FISHNETS, the end of the POPP project may represent the beginning of an approach to risk modification that involves not only individual risk factor interventions but also attention to risk conditions through promotion of equality of access to services and effective infrastructures for good social relationships and strong support networks. The adoption of the falls pathway represents a significant achievement for FISHNETS partner organisations, who have begun to develop sound understanding of their relative contributions to the falls prevention strategy. We have also seen evidence of comprehensive efforts to improve competence of the workforce through well planned education and accreditation and a willingness of low level staff to undertake preventative work. The historical and spatial influences that enabled or inhibited partners working together has been explicitly addressed and patterns of power, authority and hierarchy are better understood in order to progress the strong service user led approach which is so fundamental to the ‘community owned solutions’ mentioned by Moller (1991).

Conclusion

Northumberland FISHNETS has been the ‘good enough partnership’ and responded to the opportunities that were made available for development of falls prevention services through the POPP initiative. It has achieved its aims, as evidenced by target-based criteria. A comprehensive whole-system falls prevention programme for older people is now available across Northumberland County including campaigns to raise public awareness of the benefits of exercise and falls prevention, community rehabilitation team intervention, falls prevention exercise programmes in leisure centres, community based exercise and interest programmes, and home improvement through handyman and telecare services.

The legacy of FISHNETS will be determined by sustainability strategies and future investment. The partnership approach, which has been so evident throughout the project, is central to continued whole system service improvement. The older person’s voice has been strong and influential in service design and development and must remain so in order to sustain the Northumberland approach to falls prevention. Now that national imperatives for falls prevention have been met, the future challenges revolve around maintaining the distinctive and effective whole-system community-owned evidence based programme, with a preventative philosophy at the core and capacity for multi-agency partnership working.
References


Health Education Authority (2001) Older people in the population. London HMSO.


Appendix 1: Older people researchers’ views of participation in the evaluation of Northumberland FISHNETS

**Background to older people’s involvement in the evaluation team**

Older people were actively recruited to participate in the action research strand of the Northumberland FISHNETS evaluation as members of the research team. This decision was grounded in the premise that older people have a moral right to participate in research that affects their lives, which is consistent with the wider movement in Western society to involve the public in key decisions about policy formation, organisational structures, service provision, service delivery, and research. In this evaluation, older people were involved in the development of the POPPS pilot proposal for Northumberland FISHNETS and were instrumental in shaping the overarching evaluation strategy that was part of the submission. When the initiative commenced, older people were invited to participate in various roles in the evaluation process, which included:

- Membership of the Partnership Board (OPPB) that oversaw the evaluation
- Membership of the FISHNETS evaluation steering group
- Members of the action research evaluation team undertaking the following roles:
  - Data collection & making notes of interviews and observations
  - Analysing and interpreting findings
  - Contributing to research reports
  - Presenting findings at conferences and meetings
- Sources of information and data

**Recruitment**

Recruitment strategies to the action research evaluation team included invitation to join the research team were included on the FISHNETS website, approaching the Woman’s Institute, Parish Councils, Bell View Belford and participants attending tea dances that included a FISHNETS presentation, and following up initial introductions from OPPB members. Seven older people, one man and six women were recruited to the older people’s evaluation team through this strategy.

**FISHNETS older person evaluation team members**

Five of the seven team members agreed to take an extended role in the evaluation. Of the other two members, one 94 year old woman agreed to act in an advisory capacity, commenting on documentation and interview schedules; the other member’s health deteriorated soon after joining the team, however she indicated that she would rejoin the team when her health improved.

The team included older citizens of Northumberland County who had with diverse backgrounds (farming, teaching, management, social work, nursing, and community development). They all brought knowledge of what it is like to live as an older person in Northumberland County, and they had strong links with their local communities. Their motivations for taking part in the evaluation team did vary, and this included a desire to enhance the image of older people; to contribute to the improvement of services for older people in the County; and to facilitate change in local communities to make them better places to grow older in.
Preparation for the role

Team members completed processes within Northumberland Care Trust (including CRB check, occupational health screening) to secure honorary researcher status with the Trust. The team also completed processes within Northumbria University to acquire a library card and access to resources.

An important aspect of preparation for the role was participating in a training program. Team members had little or no previous experience of research and evaluation. The training program, therefore explored the following subjects:

- An introduction to the concepts and practicalities of service evaluation
- The application of ethical principles when conducting evaluation studies
- Principles and practice of interviewing as an approach to data collection
- Introduction to SeiQoL as the interviewing method used within the evaluation
- Opportunities for group members to role play the SeiQoL interview as an interviewer and interviewee.

Following this initial training the development of interviewing and observational skills was facilitated through a program of on-the-job training. Prior to service user interviews researchers have met with field researcher to explore issues associated with the evaluation and to negotiate roles within the data collection process. Importantly opportunities were made available following the interview for reflection on the interview process to explore ways to enhance questioning and listening skills. Regular team meetings provided further formal opportunities to reflect on the interview process and to explore emergent understandings of FISHNETS. By capturing the discussions during these meetings and reflecting on the knowledge and understanding that team members have of FISHNETS team gradually move toward participation in analysis.

The team engaged in a two day “Stronger Voice” course to develop skills for participation in service planning, policy development as well as research. The researchers felt

“that really helpful and it made me realise that a lot of elderly people probably do not realise that they could speak up about things that are not working well for them.”

(Older people research team member)

Another aspect of the training was ongoing sensitization to the research field. Therefore, opportunities were created for team members to take part in FISHNETS events and activities. These included: participation in the Younge at Heart Event, which included the launch of the Falls pathway in the central locality, Woodhorn Colliery, Ashington; observation of OPPB meetings; meetings with FISHNETS staff and personnel associated with FISHNETS; site visits to FISHNETS services will take place as the project progressed.

Views and experiences of participation in the evaluation team

This was a new experience for all of the team members. At first team members lacked confidence in the data collection methods, however their confidence quickly grew as they developed competence with interviewing techniques:

“This has been a tremendous learning curve for me.”
They readily drew on their life experience and newly acquired skills and knowledge to generate a rich data source for the evaluation. They gained great insight into the need and problems of older people:

“I have met some great people and have been very humbled when hearing about the way that they live and how they manage their daily lives.”

**What was learnt from involvement in the evaluation team**

“Small things make a BIG difference to the lives of older people living in Northumberland County”

“The message needs to get out that FISHNETS services make a difference to people’s lives.”

Their involvement in the evaluation team enabled them to learn more about older people themselves, and how important it is to older people to be supported to enable them to remain in their own homes. To remain in their own homes they need services that support them to manage their problems. They recognised that the provision of services is not the only solution – older people are reticent to ask for and accept help, therefore they need to be encouraged and empowered to accept the services that are available in the County. They became acutely aware of the risks that older people take in their daily lives such as standing on stools to make minor but necessary repairs such as changing a light bulb. As the team member’s knowledge increased they became more motivated to campaign in the networks that they were associated with in their own communities to promote the prevention agenda that FISHNETS was introducing to the County.

They also gained knowledge about the FISHNETS service. The following points summarise what was learnt:

- FISHNETS is a service that is valued by older people
- FISHNETS enables older people to achieve their personal goals – e.g. stay in their own home, improve their mobility and therefore increase independence, prevent social exclusion
- People have difficulties and do not always know what services are available in their communities
- There is a need for multidisciplinary teams and different agencies to work together and this has been achieved through FISHNETS
- Much has been achieved by FISHNETS
- New services (e.g. leisure centre based falls prevention programs, handyperson services county-wide)
- Much needs to happen in Northumberland
- Need to communicate the message to older people about what is available
- Need to improve co-ordination between services
What older people contributed to the evaluation team

The older member of the team brought new insights to the project. They indicated that their unique contribution was:

“We have been able to recognise gaps in services based on our knowledge of FISHNETS and Northumberland County.”

“We have been able to bring our insights about the preferences and needs of older people to the project.”

Research team as of October 2008

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