National Institute for Health and Clinical Excellence

# Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care

**Fieldwork report**

**March 2008**

dr foster intelligence

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## MANAGEMENT SUMMARY

### 1. Background and objectives

This report presents the findings of qualitative fieldwork:

- To evaluate the relevance and utility to practitioners and service providers (and their clients, patients or service users) of NICE draft recommendations on occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care

### 2. Our approach

We adopted a qualitative approach to the fieldwork, which included both group discussions and depth interviews. In total, 69 professionals took part in the research, including the following:

- Domiciliary care and social care managers and their staff
- PCT Public health advisers with responsibility for older people
- Local Authority leisure services managers and their staff
- PCT and Local Authority commissioners of services for older people
- Occupational therapists working with older people
- Local Authority Directors of Older People's Services
- Residential care managers and their staff
- Voluntary sector workers who provide services to older people or who represent the views of older people and their carers
- Health promotion specialists with responsibility for older people
- GPs
- Practice nurse
- Community pharmacist

Fieldwork also included a group discussion with older people and their carers.

Fieldwork was conducted in Wakefield, Derbyshire, Leeds, Cheshire, Staffordshire, Barking & Dagenham and Redbridge between 19 February and 18 March 2008. All fieldwork was audio-taped and transcribed verbatim.

## 3. Summary of main findings

*3.1 General response*

- All welcomed the development of these recommendations and thought older people would benefit from their implementation:
    - Many hoped that these recommendations would lead to sustained funding for health promotion and physical activity programs for older people
    - Some professionals said past schemes had failed due to loss of funding, while others said low levels of uptake of the schemes provided had resulted in the loss of funding
- All consider NICE a credible source of such guidance and recommendations and thought that they could be cost effective depending on the perceived target population
- There was some confusion over whether the target population was all people over 65 for recommendations 1 to 3 (if this was the case, there was some concern that the cost of implementing the recommendations would be prohibitive), or only the most disadvantaged (if more targeted, the recommendations were generally considered more feasible)
- Those with existing health promotion and physical activity schemes for older people were more confident they could implement the recommendations than whose without such schemes (or who were not aware of any local provision)
- Many also wanted to see greater coverage of increasing opportunities for social interaction and tackling poor mental wellbeing (e.g. anxiety, depression, and nerves) which they thought was commonplace among older people, especially isolated older people
- Older people themselves welcomed the recommendations, but thought many would not be sufficiently motivated to take part in the activities outlined

***3.2 Recommendation 1: health promotion and occupational therapy***

- Some professionals wanted clarification whether or not the target audience was all people over 65 or just those who are most disadvantaged
- All thought older people would benefit from regular group or individual sessions on health and wellbeing (including information, advice and support on benefits, home and community safety, local transport, nutrition, exercise, and basic health needs), but were concerned about the cost implications of having to provide health promotion sessions to all people over 65
- Occupational therapists (OTs) were concerned that they did not have the capacity to deliver the interventions outlined. They were also concerned that they would be

expected to provide the full range of information, advice and support details, when they themselves did not think that their role covered all these areas. E.g. they were concerned that people would expect them to provide benefits advice but they did not consider it their role to provide benefits advice (although they would signpost older people to relevant sources).

- Many thought other professionals should also take action, e.g.:
    - Several thought commissioners should be listed to make sure that funds were made available locally
    - Several thought GPs and GP primary care team members should be cited specifically as a potential provider of the kinds of interventions listed
    - Some thought community matrons would be a good provider of the kinds of activities listed
- In terms of the actions that should be taken, some professionals wanted more detail on the kinds of nutritional advice that they should offer; others wanted the list to be extended to include information, advice and support to increase social interaction and to tackle poor mental wellbeing
- All welcomed the suggestion to obtain regular feedback from service users and thought this would lead to effective service design
- In terms of improvements, some wanted greater coverage of:
    - How to raise awareness of the services on offer to older people
    - How to recruit and retain older people to such programmes
    - Guidance on how to tackle barriers to access (including transport, language and cultural barriers)
    - How to ensure schemes and programmes are accessible, and how to tackle barriers to access (including transport, cultural, and language barriers)
    - How to measure the impact and effectiveness of such interventions (e.g. to prove to commissioners the value of such schemes, e.g. in terms of reduced number of bed days)

### *3.3 Recommendation 2: provision and promotion of physical activity*

- Again, several professionals queried the target population (i.e. all over 65s or those who are most disadvantaged)
- There were two key concerns about who should take action
    - First, many professionals were concerned about the lack of appropriately trained exercise instructors locally (i.e. trained to deliver exercise programmes to people over 65)

  - Second, many professionals think other professionals should be listed, including:

    - Occupational therapists and physiotherapists as potential providers of information, advice, and support on physical activity for people over 65, especially in relation to rehabilitation services

    - Commissioners to make sure funds are made available to support such activities

    - GP primary care team members as potential gatekeepers and referrers to such programmes

- In terms of what action should be taken, participants wanted clarification about precisely what physical activity advice should be given to which populations, and why (i.e. who should be doing moderate intensity exercise, strength and resistance training, and toning and stretching exercises. They thought activities needed to be tailored to the individual, and changing needs and abilities of people as they age (both in terms of physical health and mental wellbeing). Residential and social care providers had concerns that their population would not be able to take part in such activity (e.g. due to severely restricted mobility, dementia, etc)

- Some professionals were confused by recommendations to encourage physical activity once or twice a week, and also 30-minutes of moderate physical activity per day on five or more days a week

- In terms of improvements, some suggestions were made including:

  - Direct references to giving older people information, advice, and support specifically on discharge from hospital

  - Guidance on how to tackle barriers to access (including transport, language and cultural barriers)

  - Specific coverage of interventions to improve social interaction and tackle poor mental wellbeing among older people

  - Guidance on how to engage and involve older people with severely restricted mobility, dementia, etc

  - Guidance on how to measure impact and effectiveness to prove the value of the interventions to commissioners

### *3.4 Recommendation 3: walking schemes*

- Again, there was some confusion about whether recommendation three targeted all over 65s or those who are most disadvantaged

- All thought it was clear who should take action; again, some thought commissioners should be cited specifically to ensure funds are made available to support such programmes

- All thought they could implement the recommendations cost effectively; GP primary care team members thought they could refer older people to a walking programme

- All thought older people who were sufficiently mobile to walk for the recommended period would benefit from the implementation of the recommendation; however, social and residential care providers had concerns that their target population would not be able to take part in such activities (due to severely restricted mobility, dementia, etc)

- In terms of improvements, professionals wanted further guidance on:

    - Raising awareness of any walking programme, including how to reach isolated older people (in both rural and urban areas)

    - How to motivate uptake of a walking programme and how to tackle any barriers to access

    - How to engage and involve older people with severely restricted mobility, dementia, etc

    - The level of staffing that was appropriate for a walking programme, e.g. to ensure adequate support for anyone with restricted mobility or limited fitness

### *3.5 Recommendation 4: training*

- Professionals thought everyone should be trained to deliver a brief intervention to promote physical activity among older people

- All welcomed the recommendation to promote training to provide information, advice and support to older people

- Several wanted training to cover how to assess the risk of frail older people taking increased levels of activity (e.g. through increased risk of falls)

- There was some confusion about what occupational therapists were being asked to do (i.e. where they be asked to develop and implement training programmes, which they thought they would not have time to do; or were training bodies being encouraged to consult them on the design and delivery of training in their area)

- Few were aware of any specific training programmes that would give a professional the skills to deliver these recommendations

- In terms of improvements, some thought the recommendations should be amended to include coverage of:

    - How to design and implement a training programme

    - How to identify and tackle any access barriers

    - How to train private sector staff involved in the delivery of public services to older people (e.g. domiciliary care)

- How to engage and involve older people with severely restricted mobility, dementia, etc

- How to monitor the standards of training and subsequent service delivery (a particular concern for OTs)

## 4. Summary of conclusions and recommendations

1. The extent to which health promotion and physical activity programmes have been implemented locally appears to vary between PCTs; levels of awareness of the schemes and programmes on offer also varies between professional groups

2. Professionals do not link physical activity programmes with mental wellbeing

    a. They tend to associate schemes that promote social interaction with improved mental wellbeing

    b. They assume the recommendations will focus on tackling poor mental wellbeing and want to see greater emphasis on tackling anxiety, nerves and depression which they believe is commonplace among isolated older people

3. Professionals may benefit from making the relationship more explicit between the interventions involved and the mental wellbeing of older people

4. Overall, professionals welcome the draft NICE recommendations on occupational therapy and physical activity to promote the mental wellbeing of older people in primary care

5. There is consensus that the recommendations would help to enhance the health and wellbeing of older people

6. However, there is some concern that the recommendations do not adequately reflect the changing physical and mental ability of older people as they age

7. Against this backdrop, the target population for recommendations 1 to 3 needs to be clarified, i.e. it needs to be made clear whether the recommendations target all people over 65 or just those living with the most disadvantage

    a. Professionals are generally more confident they will be able to implement interventions targeting those who are most disadvantaged

    b. They have concerns about the cost implications of targetting all over 65s, albeit they accept that such interventions may be cost effective (e.g. in terms of the reduction in bed days achieved, etc)

8. A wide range of professionals wanted to be included in terms of who should take action in relation to recommendations to 1 to 3, including:

    a. PCT commissioners (recommendations 1 to 3) to make sure funding is made available to support schemes

b. Occupational therapists (recommendations 2) who could deliver some of the activities outlined

c. Physiotherapists (recommendations 2 and 3) who could deliver the activities outlined

d. GP primary care teams (recommendations 1 to 3) who are likely to promote and refer into the programmes outlined

e. Community matrons (recommendation 1) who often work with particularly disadvantaged older people

9. A number of professionals wanted to clarity around exactly what occupational therapists are expected to do in relation to both recommendations 1 and 4. As they are currently worded, the recommendations caused concern about increased workload among this professional group

10. Greater specificity would be welcomed in relation to the specific action that should be taken in a number of places (or cross referenced with other NICE guidance that covers relevant topics), including:

    a. What advice should be given on nutrition, exercise, and basic health needs (recommendation 1)

    b. Exactly what level and frequency of physical activity is recommended for specific populations of older people and how to assess any risks associated with increased physical activity, e.g. for frail elderly (recommendation 2)

11. All welcome the fact that your recommendations are evidence-based; we understand you would reference the evidence base in your final document and this is likely to be welcomed by the professionals implementing them

12. There is consensus that it is important that professionals are trained to deliver the interventions outlined, and that schemes are more likely to be effective if older people are actively involved in their design and performance appraisal

13. In addition to the recommendations made, professionals would like further guidance on:

    a. How to promote interventions among the target populations

    b. How to ensure older people have effective access to interventions

    c. How to measure the impact and effectiveness of interventions to prove their value to commissioners

    d. How to engage and involve older people with severely restricted mobility, dementia, etc

## A. BACKGROUND

Mental health problems become more common as people get older and England's population is ageing. The number of people over 65 will increase by 15 per cent in the next ten years and the number of people over 90 is expected to double in the next 30 years. It is estimated that 40 per cent of older people attending GP surgeries, 50 per cent of general hospital patients and 60 per cent of care home residents have mental health needs.

Mental wellbeing has important consequences for the quality of life for older people and the social fabric of society. Positive mental wellbeing can also help to promote positive physical health and help defer and diminish the costs of care for older people.

Reviews of national service frameworks (NSFs) for mental health and older people have highlighted challenges in delivering mental health services for older people. The *Everybody's Business* report has been recognised by the Healthcare Commission and CSCI as a benchmark for mental health services and focuses on:

- Ensuring age equality in mental health care (i.e. making sure that mental health care is provided on the basis of need , not age)
- Improving detection of mental illness in non-specialist settings by improving the skills and competencies of staff
- Securing comprehensive specialist mental health services for older people with a strong emphasis on community mental health teams, memory assessment clinics and liaison services
- Promoting mental health as part of active aging

*The promotion of mental health and well-being in later life* highlights the substantial evidence that there are five core factors influencing mental wellbeing amongst older people:

- Discrimination
- Participation in meaningful activity
- Relationships
- Physical health
- Poverty

Against this backdrop, the Department of Health has asked NICE to:

> *'Prepare guidance on public health interventions aimed at promoting mental health in older people.'*

The guidance will concentrate on interventions and activities that promote mental wellbeing in people aged over 65, especially those identified in vulnerable and at risk groups. The guidance is primarily for public health commissioners, policy makers,

professionals and practitioners who work with, or who have some responsibility for, older people living at home or in a care setting. The outcomes of the guidance will cover activities and interventions that seek to promote:

- Quality of life
- Psychological wellbeing
- Self-esteem

This report presents the findings of qualitative fieldwork to test the draft recommendations, within the draft guidance, among commissioners, managers, and staff involved in the delivery of services to older people.

## B. OBJECTIVES

NICE CPHE commissioned Dr Foster Intelligence to conduct fieldwork to test the draft guidance recommendations. Fieldwork is one of the final stages of testing of the recommendations and therefore robust feedback was required on the views of diverse professionals involved.

The stated objective was as follows:

- To evaluate the relevance and utility to practitioners and service providers (and their clients, patients or service users) of NICE draft recommendations on occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care

The main research questions were as follows:

- What are the views of practitioners, carers or other providers on the relevance and usefulness of these recommendations to their current work or practice?
- What impact might the recommendations have on current policy, service provision or practice?
- What factors (e.g. service configuration, training) could impact – positively or negatively - on the implementation and delivery of the guidance?
- Do practitioners know of any evidence, either from their own experience and practice or elsewhere, not currently taken into account by the recommendations?
- What factors could either help or hinder the effective implementation and delivery of the intervention guidance as part of current practice?
- Do practitioners know of any evidence, either from their own experience and practice or elsewhere, not currently taken into account by the recommendations?
- To identify, collate, appraise and synthesise any additional evidence based on grey literature relating to issues of implementation of interventions to promote mental wellbeing among older people through primary care and residential care services.

We wanted to give the frontline staff who will have to implement the recommendations, but who would not normally take part in a consultation exercise, an effective voice in the development of the recommendations.

## C. OUR APPROACH

### 1. Qualitative methods

Qualitative methods were selected as most appropriate for this study. The iterative nature of qualitative enquiry enables researchers to scope out in depth and detail the response across audiences to the main research questions. We wanted to understand what people thought of the recommendations and why they will contribute to implementing particular views, rather than count how many people held particular views. We also wanted to make sure that participants were clear about the role of the CPHE and the status of the draft guidance and associated recommendations. Care was taken to check comprehension of the draft recommendations (e.g. in consultation with CPHE team observers), and consider their detail, complexity, and implications thoroughly.

### 2. Group discussions and depth interviews

Where possible, group discussions were convened. Group interaction enables participants to trade views and experience, and to formulate more informed viewpoints in the process. It enables them to explore any positive and / or negative issues associated with the draft recommendations and their implementation. It also enables them to work more creatively, e.g. to develop solutions to any issues identified.

A group discussion would usually comprise 4 to 8 participants and would last for 90 minutes. Group discussions would usually comprise homogenous participants (e.g. in terms of professional group, role and responsibilities) to ensure a group dynamic develops. Therefore, we generally aimed to convene group discussions with participants from similar professional backgrounds. In summary, we conducted 8 group discussions, 4 paired depth interviews and 9 individual depth interviews (see *Sample* below).

Of course, busy professionals can find it difficult to attend a group discussion at a fixed venue and time. However, given tight timescales for recruitment it was not always possible to conduct group discussions. Where it proved impossible to recruit a group we aimed to conduct individual depth interviews in its place. Depth interviews can be arranged at a time and venue of the participants' choosing. Depth interviews usually lasted around one hour.

Where possible, NICE CPHE team members attended fieldwork to enable them to hear participants' views first hand.

### 3. Sample

Fieldwork was conducted in Wakefield, Derbyshire, Leeds, Cheshire, Staffordshire, Barking & Dagenham and Redbridge between 19 February and 18 March 2008. We generated lists of key contacts in organisations in the areas selected to take part in the fieldwork. We wrote to potential participants in advance to notify them that the research was taking place (see Approach Letter in the appendix). We used a screening questionnaire to ensure we achieved diverse participation in the study (see Recruitment questionnaires). For fieldwork with GP primary care team members and

older people living in residential care and their carers were recruited using our freelance recruiter network.

We preplaced the draft recommendations with participants in advance to give them time to consider their views on the contents of each. A detailed discussion guide was used to structure interviews and ensure themes were explored in detail and depth (the draft recommendations are included in the body of the report and are appended. The discussions guide is also included in the appendix).

Below we outline the final sample achieved. Note: we consider if we have 12 participants per sample cell before we generalise about the response across that group. If the sample is below 12 we generally consider findings indicative for that group. Therefore, we have robust data for occupational therapists and for the sample as a whole. As other sample sizes fall below 12, findings from other professional groups are indicative only.

The findings reported below are based on 21 fieldwork units. In total, 69 participants took part across the fieldwork units. The table below details the response.

| | No. of Focus Groups | No. of Paired Depth Interviews | No. of Individual Depth Interviews | Total No. of Interviewees |
|---|---|---|---|---|
| PCT/ LA Commissioners of Services for Older People | 1 | | | 8 |
| LA Directors of Older People's Services | | | 1 | 1 |
| Public health advisers with responsibility for older people | | | 1 | 1 |
| Health promotion specialists with responsibility for older people | | | 2 | 2 |
| Health improvement | 1 | | 1 | 9 |

| | | | | |
|---|---|---|---|---|
| staff/ community outreach staff | | | | |
| Domiciliary care/ social care managers & staff | 1 | | | 8 |
| Residential care managers and & staff | 3 | | | 14 |
| LA Leisure Services managers & staff | | 2 | | 4 |
| Occupational therapists working with older people | 2 | | | 14 |
| Voluntary sector workers who provide services to/ represent the views of older people | 1 | | | 7 |
| GPs | | | 2 | 2 |
| Practice nurses | | | 1 | 1 |
| Community pharmacists | | | 1 | 1 |

**4. Data collection and analysis**

All qualitative fieldwork was audio-taped and transcribed verbatim. Transcripts have been anonymised and stored securely. Researchers also completed fieldnotes to supplement transcripts.

We used Grid Analysis to ensure openness and transparency. In summary, Grid Analysis plots the response from each group in a specific row and groups the main themes in an individual column on the grid. Themes are grouped by objective to

ensure the analysis can prove delivery against the original brief. Findings recorded in the grid are referred back to the transcript to ensure transparency.

Points of consensus and difference between the groups would be identified via the analytical process. Analysis would be conducted throughout the fieldwork process to enable us to test the validity of any consensus identified, etc.

Two researchers interpreted the data separately to ensure credibility and validity of the subsequent outputs. Where a difference in interpretation occurs, the research services director reviews the data and both interpretations with the researchers and acts as arbiter to decide the final interpretation.

Verbatim quotes have been selected to illustrate key points made in the body of this report. Care has been taken to make sure they are anonymised.

## D. MAIN FINDINGS

### 1. General response

All welcomed the fact that NICE CPHE was developing recommendations on occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care. All thought it was important to provide information, advice and support for older people to help them remain active and maintain independent living. Many were aware that encouraging older people to remain physically active was more cost effective than providing expensive health and social care (including residential care) in the future. As such, many thought these recommendations outlined cost-effective interventions and could help to reduce demand for expensive (e.g. by improving health and wellbeing, contributing to improvements in the management of long-term diseases, and reducing use of urgent care services, including hospital admissions).

> *"It might prevent a few admissions to hospital, because we do get a lot of people who are in because they're low in motivation, and they're depressed so they're not looking after themselves properly."*
> **Group discussion, Occupational Therapists, Cheshire**

> *"Even though a lot of this is common sense, I think there probably is a bit of an iceberg out there of people who are living in isolation, who perhaps could have a much better quality of life in every sense of the word, physically and mentally."*
> **Depth interview, GP, Leeds**

> *"The daughter said to her mum, why are you walking around? She said, oh well they told me at day care I'm not to sit there for too long, I'm just to walk around. And that's the first time she'd left her, we call, her nest. And actually her wellbeing is much better because she now realises that she shouldn't be sitting there."*
> **Focus group, Voluntary Sector Organisations for Older People, Cheshire**

Professionals who commissioned, managed, or delivered services to older people wanted to make sure any information, advice, and support they gave to promote physical activity and good mental wellbeing worked. Therefore, they welcomed the fact that NICE's recommendations were based on the best available evidence of effectiveness. Some wanted explicit references made through the recommendations to the evidence that underpinned them.

> *"…if there was access to evidence about the impact that some of these steps can have, organisations are more likely to grasp them and say 'we want to develop some of this'."*
> **Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

All thought the recommendations would benefit older people. All thought NICE was a credible source of recommendations on this important topic. However, perceptions of the perceived implementability and usefulness of the recommendations varied.

Participants who were aware of, or involved in, health promotion or physical activity schemes for older people in their area were confident they could implement such programmes. Professionals who were not aware of any current measures in place to encourage older people to be physically active were more concerned about their feasibility and usefulness.

Perceptions of the target audience also influenced the perceived implementability of the recommendations. If participants perceived recommendations 1 to 3 to target all older people over 65, they were more likely to consider the cost of implementing the recommendations prohibitive. If they perceived recommendation 1 to 3 to target older people living with disadvantage, they were more likely to consider the recommendations feasible.

> *"It's very important that you get good evidence on which you base decisions, in terms of certainly not just on a global scale, but also you're looking at local communities and what works for that community. Because one community can be very different to another so you can't say this will work everywhere, it's actually getting there and having a clearer picture."*
> **Mini-group, Social Services managers and staff, Cheshire**

The extent to which physical activity and walking schemes had been developed specifically for older people varied between areas. Some said their local PCT was aiming to get all older people more active. Many targeted all adults over 55. However, few actively evaluated their activities to determine their impact.

> *"We have an ageing population. We're aiming to get to people who are 55 plus, and getting into that group of people earlier with the promotion of preventative strategy."*
> **Depth interview, PCT Public Health Manager for Older People, Yorkshire & Humber**

Others provided physical activity programmes as part of their intermediate care services (e.g. cardiac rehabilitation, post-operative rehabilitation, etc). As such, their programmes were more targeted. They were generally provided by occupational therapists and physiotherapists. As such, many participants were surprised to see no direct mention of physiotherapy in the recommendations given their content. The extent to which such interventions were evaluated was unclear.

Some professionals (including GPs and GP primary care team members) were unaware of any health promotion or physical activity schemes in their area. This included professionals working in areas with programmes reportedly in place.

None appeared to provide health promotion and physical activity schemes for older people with the express intention of promoting mental wellbeing. Consequently, many linked improving mental wellbeing with schemes intended to increase social contact (e.g. lunch clubs, reminiscence sessions, etc).

All hoped that these recommendations would lead to the development of effective programmes to promote mental wellbeing among older people through physical activity and health promotion. Several professionals said they had had schemes locally, but that funding had been short-lived. Others said that schemes had generated limited

interest among older people locally. Several were aware this could have been due to difficulties gaining access to services, e.g. poor transport links in both urban and rural areas, language and cultural barriers in areas with large black and minority ethnic populations, etc. None were aware of any specific measures to tackle these obstacles.

Many also wanted to see the recommendations expanded to include social contact. They believed many isolated older people benefited from contact with other people of a similar age and from a similar cultural background, designing programs around social contact was also viewed as an essential element to attract program participants.

> *"...the team promoted across the district 42 free opportunities to physical activity. Not just training sessions but also bowls and dance sessions, t'ai chi, and things like that. The sessions that were far and away the most successful were the ones where there was a more social element to them."*
> **Depth interview, PCT Public Health Manager for Older People, Yorkshire & Humber**

> *"A recognised programme that people are adopting. We just do the British Heart Foundation one. The other thing we've found very successful is people like doing exercise to music, and that's not mentioned and that seems a shame not to mention that. There is no mention of t'ai chi which is also very popular, but I think it's important whatever exercise programme is put on, we can put on t'ai chi programmes anywhere, everywhere and everybody comes, what we can't find is enough t'ai chi tutors. But you if you called it something else, people won't come because they think t'ai chi is good and friendly. So you've got to reflect the passions, if you like. And line dancing is fashionable, isn't it, but ballroom dancing isn't particularly. In Middlewich, we just closed a tea dancing group, but it's reborn as line dancing."*
> **Focus group, Voluntary Sector Organisations for Older People, Cheshire**

Many also wanted to see more specific reference to tackling anxiety, nerves and depression among older people. They thought poor mental wellbeing was commonplace, especially among isolated older people. They were concerned that it was accepted by many health and social and residential care professionals as a normal part of ageing. Consequently, they were concerned that very little was done to tackle it.

> *"I would add something more specific on mental health promotion because I know exercises could help mental health but there are other more specific things that I think people, everybody, all of us, need more. So, information and training on that like how to combat anxiety, depression, dementia and delirium, as they call it now."*
> **Mini-group, Social Services managers and staff, Cheshire**

> *"It doesn't mention anything about mental health"*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

Older people living in residential care and their carers welcomed the recommendations, but thought that many older people might lack the motivation to get involved in physical activity schemes (e.g. if they have not taken regular exercise during their lives, why start now?). They also thought that older people in residential care might have too restricted mobility to get involved, or many find it difficult to take part due to dementia, etc. Those who had some experience of physical activity schemes associated them with physiotherapists rather than occupational therapists.

> *"I do think the words 'physical activity' is an alien word to the older people Group"*
> **Focus group, Voluntary Sector Organisations for Older People, Cheshire**

## 2. Recommendation 1: Health promotion and occupational therapy

*Who is the target population?*

Adults aged 65 and older living independently, with or without support, or in residential care who are most disadvantaged. This includes, for example, people living in isolation or in rural areas, people with restricted physical abilities or learning disabilities, and people from black and ethnic minority groups.

*Who should take action?*

- Registered occupational therapists, and health, social and residential care, or voluntary sector practitioners.

*What action should they take?*

- Offer regular group and/or individual health promotion sessions that follow the principles and methods of occupational therapy and health promotion. Sessions should be delivered in a setting and style that best meets the needs of the older person or group (for example, with particular attention to physical access, communication, and informality). The length of time for each session should be negotiated with the individuals involved. Sessions should aim to cover a broad range of topics and encourage people to identify and construct daily routines that help to maintain or improve their health and wellbeing, including information and advice on:
    - Access to services and benefits
    - Home and community safety
    - Best use of local transport schemes
    - Nutrition (for example health eating on a budget)
    - Exercise
    - Ensuring basic health needs are met or maintained (e.g. eyesight and hearing tests)
- Invite regular feedback from participants and use to inform the content of the service and to gauge levels of motivation

### *2.1 Who is the target population?*

There was some confusion over who the target population was. Several wanted clarification whether or not the recommends referred to all older people over 65 or only those who are most disadvantaged (similar comments were made in relation to recommendations 2 and 3).

> *"Who determines what the disadvantage is? I think that isn't a very clear criteria. Is that socio-economic disadvantage? Is it a health disadvantage? I think that's a little dangerous. I know it goes on to talk about, for example people living in isolation, or in rural areas, but I think there needs to be some clarity about what it is you're getting to. If you're aiming to get to the very frail person living alone, isolated in their own home, you're going to need to be careful how you do it."*
> **Depth interview, PCT Public Health Manager for Older People, Yorkshire & Humber**

> *"We're talking about three different categories: adults aged 65 who are either living independently, or have support, or are in residential care?"*
> **Focus group, Occupational Therapists, Newham**

They thought all older people would benefit from the activities outlined.

> *"Anything that promotes the improvement of health and well being for older people is always positive."*
> **Depth interview, PCT Public Health Manager for Older People, Yorkshire & Humber**

However, they thought that the resource implications of providing health promotion to all older people over 65 would be prohibitive.

*2.2. Who should take action?*

In terms of who should take action, occupational therapists (OTs) were concerned that the explicit reference to them would mean that local authority and PCT commissioners would think that this was exclusively the domain of OTs.

> *"And maybe somebody in social and residential care is going to say, 'Well, that's an OT thing!'."*
> **Group discussion, Occupational Therapists, Cheshire**

Several local authority professionals were not clear what occupational therapists were and what they did. They thought that the recommendations were more relevant to other health and social and residential care professionals.

GPs and GP primary care team members were surprised there was no mention of them here or elsewhere in the recommendations. They thought they could be actively involved in implementing this recommendation.

> *"I was looking for the word GP, but I can't see the word GP, or the mention of GPs anywhere, so that would suggest that we're not going to be involved directly. We tend to get roped into all sorts of stuff. It wouldn't surprise me if we get roped into this."*
> **Depth interview, GP, Leeds**

Some thought community matrons would be well placed to deliver such interventions and should, as such, be explicitly mentioned.

> *"I was thinking about the role of the community matrons, who at the moment target vulnerable elderly patients who've mostly got medical problems, but there's no reason why she couldn't expand her role, or you could have extra community matrons going into elderly people's homes, and assessing them in a more structured way."*
> **Depth interview, GP, Leeds**

A few thought a longer and more specific list of professionals should be included. They thought a general reference to health, social and residential care, and voluntary sector practitioners was too vague.

> *"If I was to run these groups and go away and run it now, I would actually get probably a dietician and a physio at least with me, because there are sections here about exercise, there are sections in here about healthy diet, and I would probably run an NPB group programme, and one day have two rooms, a multiple session, and one day have physio doing more about exercise, one day a dietician doing more about healthy diet. So I can see how OTs would, while being independent activity, I can see how it fits, but I also think there are other professions that could have a full role."*
> **Focus group, Occupational Therapists, Newham**

> *"When we first read through, people said there were certain areas here that I don't yet feel qualified to go into detail, or I thought that other people would be more qualified."*
> **Focus group, Occupational Therapists, Newham**

> *"I think one of those who should take action, I think it really ought to be a lot wider. The danger of course is that nobody takes any notice."*
> **Mini-group, Social Services managers and staff, Cheshire**

Others thought that the broad categories cited here meant that all professionals working with older people were covered by this recommendation.

> *"Well, you've covered health, social and residential care and voluntary practitioners which is everybody."*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

*2.3 What action should be taken?*

In terms of what action should be taken, except for those actively involved in the fields, many were not clear what the 'principles and methods of occupational therapy and health promotion were' and wanted guidance on what precisely was meant by this phrase.

All agreed that older people would benefit from the range of information, advice, and support outlined. Some thought the list should be extended to include information, advice, and support specifically on maintaining mental wellbeing and tackling poor mental health, especially anxiety, nerves and depression.

Some also thought that greater detail was required on the nutritional information, advice and support to be given. For example, they thought that coverage of hydration

was required. One PCT manager thought that poor hydration could lead to older people getting disorientated.

Occupational therapists were concerned that they would be expected to deliver all the information, advice, and support mentioned. They had two key concerns. First, they did not think all the activities listed were their responsibility (e.g. access to benefits). They suggested that they could only signpost people to other sources of information, advice, and support with access to benefits. Second, they had concerns that they would be expected to deliver such information, advice, and support within existing resources. They were concerned they would not have capacity to do so. They thought other professionals, including social and residential care would need to be actively involved in delivering the recommendations.

Again, some were concerned about the resource implications of the recommendations. For example, some queries whether the funds were available to support increased demand for eye and hearing tests. All welcomed the suggestion to invite regular feedback from participants and use this to inform the content of the service and to gauge levels of motivation. They thought user involvement was an important part of effective service design.

> *"There's some things on there that OT shouldn't be able to do, like access to benefits. I mean, we can point them in the right direction, but I wouldn't have a clue about what benefits are available."*
> *"…It would have to be something separate. It's not going to happen in the hospital. We do not have time to do all this."*
> **Group discussion, Occupational Therapists, Cheshire**

*2.4 Improvements*

In terms of improvements to the recommendations, some thought greater emphasis needed to be given to raising awareness among older people of the schemes and programmes currently available. Several would welcome more guidance on how to recruit and retain participants in older people's groups, especially those living with multiple disadvantage.

> *"We had an event recently. It's very difficult to attract people in because they need to feel confident and almost safe to approach you, where as if you are approaching them within their own venue, within in their own group, within their own environment, then they have more confidence in that."*
> **Depth interview, PCT Public Health Manager for Older People, Yorkshire & Humber**

> *"…it is almost like a course, I don't know whether you'd get them in the door. You'd have to really sell it differently. And there is nothing here about providing transport so that people can get to wherever it is they're doing this, and that's a serious omission."*
> **Focus group, Voluntary Sector Organisations for Older People, Cheshire**

> *"We did start more of an information-type group on the Stroke Unit, which was run once a month, and it was for all patients and carers and family members to come along, and it was more, a talk was given by one of the MBT on stroke prevention, and generally answering all their questions about things that might help them following a stroke or anything else that they wanted to know. That has fallen by the way a little bit at the moment, but it was planned for a once a month thing, which we started doing."*
> ***Focus group, Occupational Therapists, Newham***

> *"Why would I bother going to listen to somebody boring talking... I'd rather go out." "So if you're going to do this you've got to make it fun".*
> **Focus group, Occupational Therapists, Newham**

Several professionals wanted recommendations included on how to ensure effective access to such programmes. They were aware that some older people might have difficulties getting to sessions due to poor transport links, mobility problems, language or cultural barriers (especially those working in areas with large and aging black and minority ethnic populations). A few also suggested lack of appropriate space in healthcare settings could be a challenge, e.g. to run group sessions.

Finally, some professionals wanted guidance on how to measure the effectiveness of such programmes. They thought that commissioners were increasingly interested in measuring outcomes.

> *"People are going to say, 'Yes, that's all good, but how are you going to see the outcome'."*
> **Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

Older people and their carers living in residential care also thought older people would benefit from such activity. However, several did not think they would be interested in receiving such information, advice, and support. They thought district nurses would be a good provider of such a service.

## 3. Recommendation 2: provision and promotion of physical activity

***Who is the target population?***

Adults aged 65 and older living independently, with or without support or in residential care who are most disadvantaged. This includes, for example, people living in isolation or in rural areas, people with restricted physical abilities or learning disabilities, and people from black and ethnic minority groups.

***Who should take action?***

Trained exercise instructors.

***What action should they take?***

- In collaboration with older people and their carers, organise, plan and offer tailored exercise programmes in the community, focussing on:
    - Mixed exercise programmes of moderate intensity (including cardiovascular and resistance training)
    - Strength and resistance exercise, especially for frail older people
    - Toning and stretching exercise.
- Ensure that exercise programmes reflect the preferences of participants
- Encourage participants to attend sessions at least once or twice a week
- Offer a range of activities of moderate intensity (such as dancing, swimming, walking), particularly activities that promote strength, coordination and balance, aiming to achieve 30 minutes of moderate physical activity per day on 5 or more days each week
- Invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation

*3.1 Who is the target population?*

Again there was some confusion over whether or not the target audience was all older people over 65 or those living with disadvantage. Some social and residential care professionals challenged the target population specified. They did not think that their service users would be able to take part in the activities specified, because their mobility or cognitive ability was too severely restricted. They thought they would be unable to perform the types of physical activity that were being described under the 'what action should be taken?'.

*"Is the target population really the right one for these interventions? Maybe they'd suit people better who are not in our services and we need specially designed schemes for more disabled people."*
**Mini-group, Social Services managers and staff, Cheshire**

*"….although you're talking about tailoring it to how much the person would like to do. Even so, the people that we tend to work with are usually struggling to get up out of the chair or are walking a few metres in walking frames…"*
**Mini-group, Social Services managers and staff, Cheshire**

*"…most are in too much pain to walk…the majority need assistance."*
**Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

*"…some residents struggle getting into and out of a chair."*
**Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

*"Well, that one specifically I don't think is particularly [relevant] given that the action should be taken by trained exercise instructors. That's only relevant to me if we broaden that to include chair-based exercise."*
**Depth interview, Physical Activity and Older People project worker, County Health Promotion Service, Derbyshire**

*3.2 Who should take action?*

All thought it was clear who should take action. Some local authority leisure services managers thought clarification was needed that exercise instructors should be trained to deliver programmes to older people aged 65 and over (including people with restricted physical abilities or learning disabilities). Some local authority physical activity coordinators and managers thought the recommendations were aimed at high level policy makers and it was unlikely that exercise instructors delivering the programs would ever see the recommendations. They saw it as their job to make sure the information was cascaded down to relevant staff.

*"I think, first of all, the 'who should take action', trained exercise instructors, exercise instructors aren't going to be reading this. So, it needs to be PCT who will then employ exercise instructors to deliver this or a local authority like ourselves to employ exercise instructors to deliver this."*
**Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

Many professionals from across the different sample groups were concerned about the lack of any appropriately trained exercise instructors in their area. They were concerned about the lack of any funding to pay for any specialist training for exercise instructors. They wanted NICE to make recommendations specifically about the commissioning and funding of appropriate training for exercise instructors (see also Recommendation 4).

OTs thought they should be included under the heading who 'should take action?'. They felt that advising older people on physical activity was a core part of their job. As such, they felt they were well placed to deliver such information, advice, and support.

Many thought PCT commissioners and directors of adult services should be included under the heading 'who should take action?'. They thought this would make sure that funds were made available to support such activity, e.g. to make sure specific plans were included in commissioning strategies and operational plans.

> *"If this came out as good practice guidance…to health and wellbeing partnerships, we could take that on board and look at how we could commission these services and ensure that we had universal coverage within this area."*
> **Depth interview, Strategic Director for Adult Social Services, Derbyshire**

> *"If the PCT (commissioners) led on it, then they can either get the local authority in, private firms, or community groups. They can then decide how they want this to be delivered."*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

Some social and residential care workers and managers thought that GPs should be included under who should take action, e.g. as the gatekeeper to exercise on prescription programmes.

> *"I think that [GPs prescribing exercise] would be a good way because most people go to the doctor don't they? And old people go to the doctor more than the rest of us."*
> **Mini-group, Social Services managers and staff, Cheshire**

GPs and practice nurses acknowledged that they could potentially have a role in promoting exercise programmes and referring older people to them. Some GPs and practice nurses were concerned that they were not aware of any specially trained exercise instructors in their area or any specific programmes for older people. They were also concerned about the cost of any such referral.

> *"I think it's not something that is particularly one of our priorities, and I'm not aware of any schemes that would enable patients to do that, and, of course, money always comes into it…the cost issues as well as everything else."*
> **Depth interview, GP, Leeds**

However, some PCT commissioners thought that GPs, practice nurses, and community physiotherapists should be identified specifically. They thought they should be involved in assessing older people's physical activity needs and risks, and then referring them into specific programmes.

*3.3 What action should be taken?*

All thought that it was fairly clear what action should be taken. All welcomed the fact that exercise programmes should be organised and planned with older people and their carers. All welcomed the fact that exercise programmes should reflect the preferences of participants. All thought encouraging participants to attend sessions at least once or twice a week was about right. Some wanted clarification of exactly what was meant by each of the following:

- Mixed exercise programmes of moderate intensity (including cardiovascular and resistance training)

- Strength and resistance exercise, especially for frail older people

- Toning and stretching exercise.

Some social and residential care professionals were concerned that the type of exercise suggested, e.g. strength and resistance exercise, was too vigorous for frail older people

All welcomed the fact that regular feedback should be sought. Many welcomed the references to everyday physical activity (*such as dancing, swimming, walking*). They thought older people were less likely to be put off by such activities (e.g. compared to going to the gym, which older people might consider prohibitively expensive). Some wanted a longer list of activities to be included to help them give direction to older people about the kinds of activity that is recommended (e.g. gardening, walking to the shops, etc). Some older people felt that their peers attended programs for a variety of reasons (e.g. exercise, social interaction, to have a laugh, or for something to do) and that a variety of programs should be provided to cater for and attract people with different interests.

> *"…one might like one thing one might like another."*
> **Group discussion, Older People in Residential Care and their Carers, Staffordshire**

Some GPs and GP primary supported group exercise sessions as a cost effective solution, however some Care Home Managers noted that their clients would need one to one care to perform such activity. GPs and Care Home Managers also thought older people would prefer the social aspects of group sessions and benefit from improved social capital as a result.

> *"…every single person living in your home getting 30 minutes exercise per day on five or more days a week is unrealistic. In order to do that, it's a fabulous idea, you'd need 24 volunteers. I'd need 24 volunteers working here, and that comes with its own pitfalls because, one, you've got to get 24, two, you've got to train them and then put them all through CRB checks and all the rest of it, three, they're going to have to have moving and handling training and first aid training, and four, you're going to have to do 24 risk assessments every time you leave the building"*
> **Focus Group, Residential Care Home Managers and Staff, Derbyshire**

A few participants were confused that the recommendation asked them to encourage physical activity once or twice a week in one bullet point and *30 minutes of moderate physical activity per day on 5 or more days each week* in another bullet. They wanted clarification about what they should recommend for which group of older people.

> *"Once or twice a week and then later on it says five or more days each week."*
> **Depth interview, Borough Physical Activity Coordinator, Greater London**

*3.4 Improvements*

Overall, most participants considered this recommendation relevant, and thought older people would benefit from it (e.g. if part of a wider programme of healthy living).

> *"It would improve the general health, along with the things that we talked about in recommendation one like better nutrition, things like that."*
> **Depth interview, GP, Leeds**

Some wanted greater specificity in the recommendations, i.e. exactly who is expected to do what, and with whom?

> *"It's all very woolly! It says, 'Organise, plan and offer tailored exercise programmes in the community', but there's no details about how and where and how often, and when. It does actually say once or twice a week, but there's no practicalities here about the resources and facilities."*
> **Depth interview, GP, Leeds**

Some thought it would be useful to recommend that all older people should be given an exercise programme following discharge from hospital. They thought this would help to promote independent living.

Some social and residential care professionals working with older people with critical and substantial needs were concerned that this recommendation would not benefit their service users, who they thought would be unable to perform the kinds of physical activity identified because their mobility or cognitive ability was too severely restricted. They wanted additional recommendations that sort to promote social interaction in it is own right. They thought this benefited their services users and enhanced their mental wellbeing. None offered any evidence to substantiate this view. Some also felt that the low level of motivation of some older people in high care situations also needs to be taken into account.

> *"…and the level of dementia of the clients that we've got at the moment is quite severe. So, the ones that can't really do any of the activities. Time is spent on a one-to-one basis, maybe doing hand massage, manicures, just sitting holding their hands."*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

Some wanted guidance on how to tackle barriers to access of such programmes, including transport, language and cultural barriers to access. Others wanted guidance on how to raise awareness of the availability of such programmes among isolated older people as well as the awareness of health professionals as to what is actually available

> *"Leeds is notorious, I think, for having a lousy transport system. It hasn't got a metro. It hasn't got trolley buses. It's pretty poor really, and it gets pretty congested at times….I suppose, you know, you've got to think about localities, I mean I'm thinking about the locality where I work. There's one or two leisure centres, but I'm not sure that elderly people can easily get to them and you wonder about cost issues and all the rest of it."*
> **Depth interview, GP, Leeds**

*"I think…if we increase the range of activities which are available for people to select from, which have a positive pay off in terms of engagement and continuation of independence, then that will have a positive impact on people's sense of community belonging and social networking and things like that."*
**Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

*"I think transportation always seems to be a bit of an issue for patients living alone at home, getting to and from activities and groups and things. It always seems to be a big one for them, because they don't have the transport"*
*"…possibly patients are in rural areas, they may not care for that if it means travelling extensively each session, so transportation is going to cost."*
***Focus group, Occupational Therapists, Newham***

Again, some commissioners wanted guidance on how to measure the impact of such interventions.

Participants identified a number of barriers to implementing these recommendations. Many were concerned that there were no appropriately trained exercise instructors locally or programmes to which they could refer older people, as well as a lack of 'awareness raising' resources or systems. However, GP primary care team staff were willing to promote schemes and refer older people to them.

*"If they come down to the surgery, we can put posters up, we can talk about it. I don't think our organisation would actually lay on any exercise programmes…"*
**Depth interview, practice nurse, Staffordshire**

*"Again, it's a matter of making people who are involved in the care of the elderly like GPs, district nurses, and people like that, aware of where they can refer people to. So, again, letting me know where I can point people in that direction"*
**Depth interview, GP, Leeds**

*"This is trained exercise instructors. Well, we certainly haven't got any of those"*
**Depth interview, Strategic Director for Adult Social Services, Derbyshire**

A few also suggested lack of appropriate space in healthcare settings could be a challenge, e.g. to run group sessions. Overall, participants thought that lack of funding could prevent them implementing these recommendations.

*"…comprehensive coverage of that against that target population, which is a pretty broad target population, would require a significant resource input"*
**Depth interview, Strategic Director for Adult Social Services, Derbyshire**

*"I think the problem would be more a case of availability, and the finances, so you know, again, it encourages things like swimming, or dancing, you know, where are people going to get these opportunities do these sort of activities? Who's going to provide the costs of transport for them, and who is going to provide the actual facilities for them, and will they have to pay for it, etc? So, I think there's more practical issues involved."*
**Depth interview, GP, Leeds**

There were also concerns about the success of short programs designed at increasing exercise activity in the long term.

*"One of the things we find is that people will come to a five-week programme and never do it the day they finish, and physios have got a real problem about people maintaining exercise, and if they don't maintain it you're losing the benefit. We talked about making videos for older people so they come to a course for five weeks and then they go home with the video and have the video every day"*
**Focus group, Voluntary Sector Organisations for Older People, Cheshire**

Based on the implementation of previous strategy some thought that the recommendations would lead to increased workload of existing staff.

*"…they'll look at this and they'll say to our training department, right, you've got to now provide exercise instructors. Where are we going to get these from? Oh, I know, we'll get some of the care assistants on these courses but we won't give them any money and we won't give them any extra hours; it'll be part of their duty alongside… and that's what'll happen, because I don't think there'll be anybody that is given that job, even if [overtalking] that'd be great but you know that's not going to happen, and that's how our department will look at that39 guidance on the assessment of prevention of falls in elderly people, 2004…when we started to do chair-based exercises… the way they met that guidance was by training our care assistants to do chair-based exercises, without any extra resources, and extra money"*
**Focus Group, Residential Care Home Managers and Staff, Derbyshire**

*"You've got to put that training within the context of an operational structure where people can actually deliver it. But in a carer situation there's got to be time allowed for somebody, you know. Rather than everybody sleeping after lunch, the more the carers go and have their dinner or go home or whatever, but there's actually some time set aside and that it's seen as valid and not just you're just here to do all the tasks that are required"*
**Focus Group, Residential Care Home Managers and Staff, Derbyshire**

Several thought a number of national charities provided funding to support such programmes. They would welcome guidance from NICE about how they could gain access to any such funding to support local programmes.

## 4. Recommendation 3: walking schemes

***Who is the target population?***

Adults aged 65 and older living independently with or without support or in residential care who are most disadvantaged. This includes, for example, people living in isolation or in rural areas, people with restricted physical abilities or learning disabilities and people from black and ethnic minority groups.

***Who should take action?***

Local authorities working in partnership with leisure services, community development groups and voluntary sector organisations.

***What action should they take?***

- In collaboration with older people and their carers, offer walking schemes of low to moderate intensity.
    - Walking schemes should be organised and led by trained workers or volunteers.
    - Walks should last about 1 hour and include at least 30-40 minutes of walking plus stretching and warm-up/ cool down exercises (depending on people's mobility and capacity)
- Arrange a group meeting at the outset of a neighbourhood walking scheme that includes:
    - Introducing the walk leader and participants
    - Offering opportunities for local walks at least three times a week, with timing and location to be agreed with participants and consideration given to differences in mobility and capacity.
    - Providing health advice and information no the benefits of walking and stretching and warm-up/cool-down exercises
- Recruit walk leaders from the local community and provide them with training in first aid and creating appropriate walking routes.

*4.1 Who is the target population?*

Again, there was some confusion whether the target population was all people over 65 or those who are most disadvantaged. *4.2 Who should take action?*

All thought that it was clear who should take action, i.e. 'local authorities working in partnership with leisure services, community development groups, and voluntary sector organisations'. Local authority staff agreed that the recommendations were relevant to

them and their strategic partners. However, several thought that PCT commissioners should also be included to ensure that funds were identified to support such activities and to make sure that referrals from GP primary care teams were made into such schemes.

> *"If, for all of these, it said local authorities and primary care trusts working in partnership, that would cover it."*
> **Depth interview, Strategic Director for Adult Social Services, Derbyshire**

> *"We'll help fund them and I'm actually helping to fund one locally already. But it's not us who's doing it. The joint funding initiative comes through the PCT, the social services and the district council leisure services development."*
> **Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

*4.3 What action should be taken?*

All thought it was clear what action should be taken. Professionals working in areas with walking schemes in place were particularly confident that they could implement these recommendations. Several said the already had such measures in place.

> *"We do that already, but again, actually we nearly got that one right."*
> **Depth interview, Strategic Director for Adult Social Services, Derbyshire**

GPs and the practice nurse saw their role as raising awareness of such schemes and programs and referring older people to them.

> *"One thing I'm thinking now, from just thinking while we're talking, is if we had knowledge of it, and thinking about that lady I saw yesterday, and how I felt then, it might be a nice idea to integrate with them. If you know there's a walk on, to actually go and have a walk with them…"*
> **Depth interview, practice nurse, Staffordshire**

Many thought that this recommendation would be cost-effective to implement, especially if volunteers were recruited to run the walking schemes.

> *"…They [walking schemes] have…got resource implications but there's nothing in there which couldn't be brought together within the existing structure."*
> **Depth interview, Strategic Director for Adult Social Services, Derbyshire**

> *"I think that within resources, you could definitely look at running more programmes specifically for that age group and extend what we've got going on as well. It always comes down to resources, though, doesn't it?"*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

> *"The structures are in place, and this should actually come out as guidance to those who are commissioning the service."*
> **Depth interview, Strategic Director for Adult Social Services, Derbyshire**

All agreed that walking was low to moderate intensity exercise. All agreed it was important that group leaders were appropriately trained, including training in first aid

and creating appropriate walking routes. All thought the amount of walking recommended (i.e. about one hour and include at least 30-40 minutes of walking plus stretching and warm-up/cool down exercises, depending on people's mobility and capacity) was about right, albeit some older people would need to build up to this amount of physical activity. All welcomed recommendations to hold group meetings at the outset of any neighbourhood walking scheme, and things to cover in the meeting. None asked for any additional information or clarification on how to run such sessions.

All thought that older people who were sufficiently mobile and active enough to take this level of physical activity would benefit from enhanced mental wellbeing as a result of taking part, including increased opportunity for social interaction and enhanced social capital as a result.

> *"…it is just about this general health promotion message, without making people think that they're doing it because it's promoting their health. It's activity based services which will have that indirect and long-term pay-off, but in the short term have a much more direct impact because people feel the benefit of being part of a group, having an activity they can focus on and plan around, on perhaps a weekly or monthly basis, or whatever…"*
> **Depth Interview, Older People's Services Manager, Derbyshire**

> *"I understand the contribution that is hoped and could make to improving people's general health and wellbeing and therefore reduce the demand on my services. It's maintaining people's mental health as well as their physical health."*
> **Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

*4.4 Improvements*

Some thought that isolated older people living in both urban and rural areas might have difficulty getting to hear about such programmes, e.g. if they were not in regular contact with services. Some thought isolated older people might have difficulty physically getting to any organised activity due to poor transport links in both urban and rural areas. Some thought it might be difficult to motivate some older people to attend walking groups, e.g. if they did not like walking.

> *"I'm not quite sure how they propose to do this so it would encourage people to come out of the…sheltered homes or come away from the television and this sort of thing"*
> **Depth interview, GP, Leeds**

> *"She said, I don't like walking, I'll live with it. That's it".*
> **Focus group, Occupational Therapists, Newham**

Consequently, they wanted guidance on how to promote such schemes and make sure older people had access to them. Some suggested that the recommendations should suggest that additional support should be provided for frail elderly attending any such schemes to make sure they are always attended to by a trained professionals, e.g. if they have to stop during the walk or need to support to attend the walk.

Several thought a number of national charities provided funding to support such programmes. They would welcome guidance from NICE about how they could gain access to any such funding to support local programmes.

## 5. Recommendation 4: Training

*Who is the target population?*

Professional bodies, skills councils and others responsible for developing training programmes and setting competencies, and continuing professional development (CPD) schemes for those working with older people. This includes health and social and residential care professionals, domiciliary care staff, residential care home managers and staff, and support workers, including the voluntary sector.

*Who should take action?*

Professional bodies, skills councils, and other organisation responsible for developing training programmes and setting competencies, standards, and CPD schemes.

*What action should they take?*

- Involve registered occupational therapists and health promotion practitioners in the design and development of locally relevant training schemes for those working with older people. Training schemes should include:
  - Essential knowledge of the principles and methods of occupational therapy and health promotion
  - Effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)
- Enable practitioners to:
  - Help older people to identify and construct daily routines that help to maintain or improve their wellbeing
  - Promote exercise routines and other activities that help older people develop and maintain their physical and mental wellbeing according to individuals preference
  - Improve, maintain or support older people's ability to carry out daily activities and promote independence

*5.1 Who the target audience is? And who should take action?*

Most thought it was clear who the target audience was and who should take action. Most did not query either of these two sections. However, some thought that it should be made clearer which professional skills bodies were intended to be targeted. Some professionals thought everyone working with older people should be trained to deliver brief interventions and refer into relevant programmes and schemes to improve their mental wellbeing and increase their levels of physical activity. They suggested this recommendation should be expanded to include this, especially risks associated with key health conditions (e.g. heart disease, osteoarthritis, osteoporosis, etc).

All agreed that professionals would need training to deliver health promotion and physical activity programmes to older people, especially frail elderly. There was some concern about the risks associated with frail elderly taking more physical activity (e.g. perceived increased risk of falls and fractures, etc). They thought the recommendation should be expanded to cover assessment and identification of potential risks.

> *"If you get somebody who's well-qualified, well-skilled, you're going to get a range of different things. If you get somebody who doesn't feel they're competent to do it, you'll have a team that doesn't do it, and you just get one-to-one. So I think it depends on the skill of the team leaders out there."*
> ***Focus group, Occupational Therapists, Newham***

> *"We didn't used to have paid leaders but frailty of the people that come to us now is such that we feel we need to have a paid leader so they've got the first aid certificate and all that."*
> ***Focus group, Voluntary Sector Organisations for Older People, Cheshire***

> "I've got two members of staff that have done training on exercise and we try and use chair-based exercises weekly."
> **Focus Group, Residential Care Home Managers and Staff, Derbyshire**

*5.2 What action should be taken?*

Many queried the action that should be taken. There was concern that the recommendation asked occupational therapists and health promotion staff to deliver training to other professionals, rather than involving them in the design of training delivered by others. They were concerned that such staff would not have capacity to undertake such training activities. As such, they thought the recommendation was unrealistic.

> *"The recommendation is targeted on registered occupational therapists and health promotion practitioners. So, they've got the responsibility for devising relevant training schemes for those working with older people. So, they take the lead. Most of these initiatives would come through the relevant organisations training services, rather than registered therapists. I'm not saying that there's anything wrong with it; I'm just thinking how could they find the space to do that sort of activity on top of their day job?"*
> **Depth interview, District Authority Area Manager for Services to Older People, Derbyshire**

Few participants were aware of any specific training or continuing professional development courses that would fulfil the details outlined in the recommendations.

*5.3 Improvements?*

Some thought the list of issues covered by the recommendations should be further expanded to include how to design programs for older people, including tackling any difficult older people might have gaining access to health promotion and physical activity, especially older people from black and minority ethnic groups (e.g. language and cultural barriers). Some also suggested recommendations could be made about *training the trainers* / *co-ordinators* to ensure quality standards, other suggested the

inclusion of skills to assess the risks and capabilities associated with working with older people.

> *"So, we could have like a training the trainer, so getting the trainers, but also training the health professionals to deliver the messages that we want. So, a GP sees a person, sees they're overweight, says you should be doing this, here is a contact for them, go ring them and they'll give you their Healthy Lifestyles programme."*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

> *"An awareness training course would be good - what signs to look out for* [risk assessment for older people referred to a physical activity programme], *that type of thing!"*
> **Group discussion, Residential Care Home Staff Activity Coordinators, Wakefield**

Some thought that training subject area should move beyond just clinical aspects pertaining to physical exercise

> *"For me it lacks something in the training about providing meaningful social activities. It's a bit clinical again. And, if you want to improve people's mental health basically they need to have fun, feel needed, and do something useful. To me those are the principles and I'm sure there are some learned people have got the right jargon for that, but that doesn't seem to come through that. It's got a bit lost, that bi.t"*
> **Focus group, Voluntary Sector Organisations for Older People, Cheshire**

Some thought direct reference should be made to the provision of training to private sector employers and their employees that deliver older people's services commissioned by PCTs or local authorities, including domiciliary social and residential care, residential care and nursing care services.

> *"We can't train home carers from private agencies, can we? We can demonstrate how something's done, but we can't train, because they're not our staff and we're not responsible for them."*
> **Group discussion, Occupational Therapists, Cheshire**

OTs expressed some concerns that other professionals will be delivering OT-based care. They thought it would be important to monitor the standard of care delivered and have concerns that the recommendation will result in a reduction in the quality of OT care currently delivered (i.e. if other professionals are asked to deliver elements of their work).

Some felt that a wider approach should be taken with program material being available through a central agency.

> *"Looking at consistent framework and materials that could be used across a wider area that individuals could fit into and use. And I suppose it goes back to the bit about strategy for the management and so on, if somebody, like in public health, was made responsible for trying to ensure that materials were available*

*and that there was a programme that people could pick up or add into, that would be more likely to make it happen. Because as it is it's a bit laissez faire, isn't it? It's a bit like, pick this up if you want."*
**Focus Group, Local Authority and PCT Commissioners for Older People's Services, Staffordshire**

Some participations were aware a range of recognised professional qualifications and continuing professional development courses were available. They would welcome NICE providing such a list to enable them to use locally.

## 6. Implementation

- Several participants had direct experience of setting up and running health promotion and physical activity programmes for older people; their key insights for successful implementation were as follows:

  - Include health promotion and physical as part of a comprehensive older people's health and wellbeing strategy (e.g. which includes nutrition, quitting smoking, safer drinking, etc)

  - Make sure one local agency leads the development and delivery of the strategy

  - Make sure your strategy builds on the services already provided locally across the NHS, local authority, and voluntary sectors (e.g. audit what is currently available and develop a directory of available services; a number of national charities like the British Heart Foundation were said to be providing walking and training for scheme leaders)

  - Make sure your strategy is develop and delivered via a strong strategic partnership across the NHS, local authority, and voluntary sector services

  - Ensure all strategic partners are involved in the strategy's development to ensure ownership

  - Make sure all strategic partners are aware of their roles and responsibilities in the delivery of the strategy and any associated action plan

  - Engage and involve older people and their carers in strategy development to make sure it meets their needs, expectations, and aspirations

  - Make sure you identify sufficient resources to deliver the programme (including funds and staffing), including any targeted activity

  - Offer both group and one-to-one interventions / make sure your programme design is flexible and responds to local need

  - Offer both group and one-to-one interventions / make sure your programme design is flexible and responds to local need

  - Make sure you identify and tackle any barriers to access (e.g. public transport links, language barriers, etc)

- Set clear outcome or performance measures to ensure you track changes in performance over time

- Identify a co-ordinator to lead the programmes development and delivery and a maintain relationships across strategic partners and providers

- Train all providers and update their skills regularly (via CPD) and where possible make sure they are recognised training qualifications to motivate uptake (e.g. NVQ)

- Brief them regularly on changes in the programme's development and delivery to ensure their knowledge is up-to-date

- Make sure you have clear referral mechanisms identified and information to support referrals; make sure other programmes cross refer (e.g. expert patient programmes)

- Develop materials to promote the programme and market test them with your end-point users

In general, participants thought the guidance identified most of these issues. They though information, advice and support from NICE on the implementation of the recommendations would be welcomed locally.

## E. CONCLUSIONS

1. The extent to which health promotion and physical activity programmes have been implemented locally appears to vary between PCTs; levels of awareness of the schemes and programmes on offer also varies between professional groups

2. Professionals do not link physical activity programmes with mental wellbeing

    a. They tend to associate schemes that promote social interaction with improved mental wellbeing and

    b. They assume the recommendations will focus on tackling poor mental wellbeing and want to see greater emphasis on tackling anxiety, nerves and depression which they believe is commonplace among isolated older people

    c. You may want to make the links more explicit in the guidance to ensure professionals appreciate the close relationship between the interventions involved and the

3. Overall, professionals welcome the draft NICE recommendations on occupational therapy and physical activity to promote the mental wellbeing of older people in primary care

4. There is consensus that the recommendations would help to enhance the health and wellbeing of older people

5. However, there is some concern that the recommendations do not adequately reflect the changing physical and mental ability of older people as they age

6. Against this backdrop, the target population for recommendations 1 to 3 needs clarifying, i.e. whether the recommendations target all people over 65 or just those living with the most disadvantage

    a. Professionals are generally more confident they will be able to implement interventions targeting those who are most disadvantaged

    b. They have concerns about the cost implications of targeted all over 65s, albeit they accept that such interventions may be cost effective (e.g. in terms of the reduction in bed days achieved, etc)

7. Many think a wide range of professionals should be included in terms of who should take action in relation to recommendations to 1 to 3, including:

    a. PCT commissioners (recommendations 1 to 3) to make sure funding is made available to support schemes

    b. Occupational therapists (recommendations 2) would could deliver some of the activities outlined

    c. Physiotherapists (recommendations 2 and 3) who could deliver the activities outlined

   d. GP primary care teams (recommendations 1 to 3) who are likely to promote and refer into the programmes outlined

   e. Community matrons (recommendation 1) who often work with particularly disadvantaged older people

8. A number of professionals wanted to clarity exactly what occupational therapists are expected to do in relation to both recommendations 1 and 4; as they are currently worded, the recommendations may cause concern about increased workload among this professional group

9. Greater specificity would be welcomed in relation to the specific action that should be taken in a number of places (or cross referenced with other NICE guidance that covers relevant topics), including:

   a. What advice should be given on nutrition, exercise, and basic health needs (recommendation 1)

   b. Exactly what level and frequency of physical activity is recommended for specific populations of older people and how to assess any risks associated with increased physical activity, e.g. for frail elderly (recommendation 2)

10. All welcome the fact that your recommendations are evidence-based; we understand you would reference the evidence base in your final document and this is likely to be welcomed by the professionals implementing them

11. There is consensus that it is important that professionals are trained to deliver the interventions outlined, and that schemes are more likely to be effective if older people are actively involved in their design and performance appraisal

12. In addition to the recommendations made, professionals would like further guidance on:

   a. How to promote interventions among the target populations

   b. How to ensure older people have effective access to interventions

   c. How to measure impact and effectiveness of interventions to prove their value to commissioners

## APPENDICES

1. Approach letter
2. Recruitment questionnaire
3. Discussion guide
4. Recommendations

## 1. Approach Letter

NHS
National Institute for
Health and Clinical Excellence

71 High Holborn

London

WC1V 6NA

Tel: 020 7067 5800

Fax: 020 7067 5801

**www.nice.org.uk**

**MENTAL WELLBEING OF OLDER PEOPLE:**
**DRAFT NICE PUBLIC HEALTH INTERVENTION GUIDANCE: FIELDWORK**

I am writing to ask for your help with a very important stage in the development of NICE Public Health Guidance on Interventions to promote the Mental Wellbeing of Older People. We want to invite professionals working with older people to consider our draft recommendations. We have asked Dr Foster Intelligence to manage this process.

We need your input to help us make sure our recommendations are relevant, useful, feasible, and implementable. Therefore, your feedback is extremely important to us. We are especially keen to involve; volunteers, frontline staff, managers and commissioners of services who work directly with older people to make sure our recommendations work for you. Anything you tell us will be treated in the strictest confidence with any comments we use in the final report anonymised.

NICE is the body responsible for providing national public health guidance on promoting good health and preventing and treating ill health. The objective of NICE's public health guidance is to bring about social, economic, organisational, community and individual change to improve health and reduce inequalities in health.
I do hope you will be able to take part in this important project. If you have any queries about the research, please contact Nigel Jackson at Dr Foster Intelligence on 020 7332 8866 or Dr Linda Sheppard at NICE on 0161 870 3119.

Yours faithfully

Tricia Younger
Associate Director
Centre for Public Health Excellence

National Institute for Health and Clinical Excellence

## 2. Recruitment Questionnaire

**RECRUITMENT QUESTIONNAIRE**

**NICE CPHE MENTAL WELLBEING OF OLDER PEOPLE**
**DRAFT INTERVENTION GUIDANCE**

Hello, my name is …….. and I am conducting research for Dr Foster Intelligence on behalf of NICE.

NICE (National Institute for Health and Clinical Excellence) is the arm's length organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE have produced draft recommendations for their forthcoming intervention guidance on the mental wellbeing of older people. They have commissioned us to conduct fieldwork to test these recommendations with frontline staff, managers, and commissioners of services who work with older people. We want to get your views on their relevance, appropriateness, feasiblity and implementablity.

Note: no incentives, but locum fees and travel expenses can be reimbursed.

The session will be held at……..

…….

on……..

the start time will be……..

I have just a few short questions to ask you to make sure we are getting the right mix of professionals on the day.

---

Q1a. Do you:

| | | |
|---|---|---|
| Work with/care for older people (65 and over) | | Recruit to quota |
| Manage services for older people (65 and over) | | Recruit to quota |
| Commission services for older people (65 and over) | | Recruit to quota |
| None of the above close (65 and over) | | **Close** |

Q1b. Are you involved in activities to ensure the mental wellbeing of older people?

| | | |
|---|---|---|
| Yes | | Recruit to quota |
| No | | Recruit to quota |

Q2 Do you work for:

| | | |
|---|---|---|
| Primary Care Trust | | Recruit to quota |
| Local authority | | Recruit to quota |
| A voluntary sector organisation | | Recruit to quota |
| A private sector organisation | | Recruit to quota |

Q3 Do you work with, manage or commission services for, older people aged:

| | | |
|---|---|---|
| 65-74 | | Recruit a mix |
| 75-84 | | Recruit a mix |
| 85-94 | | Recruit a mix |
| 95 and over | | Recruit a mix |
| 65 and above (across age range) | | Recruit a mix |
| None of the above | | **Close** |

Q4 Do you work with, manage or commission services for, older people:

| | | |
|---|---|---|
| From socially deprived backgrounds (e.g. very low income groups) | | Recruit a mix |
| Living with a disability or long-term limiting illness (e.g. mobility, sensory impairment) | | Recruit a mix |
| From black and minority ethnic groups | | Recruit a mix |
| Who are lesbian, gay, bisexual or transgender | | Recruit a mix |
| Who live in inner city areas | | Recruit to quota |
| Who live in isolated rural areas | | Recruit to quota |
| Who are travellers | | Recruit a mix |
| Who are homeless | | Recruit a mix |
| For whom English is not their first language | | Recruit a mix |
| Who are asylum seekers or refugees | | Recruit a mix |
| Other socially excluded group (write in below) | | Recruit a mix |

Q5 Which of the following best describes your occupation / role:

| | | |
|---|---|---|
| GP | | |
| Practice nurse | | |
| Other community nurse (e.g. district nurse, health visitor) | | |
| Occupational therapist | | |
| Physiotherapist | | |
| Chiropodist | | |
| Community pharmacists | | |
| Social / domiciliary carer | | |
| Social / domiciliary care services manager | | |
| Adult social services care manager | | |
| Adult social services director | | |
| PCT director of public health | | |
| PCT public health adviser | | |
| PCT health promotion staff | | |
| Sheltered and/or supported housing manager | | |
| Sheltered and/or supported housing staff | | |
| Residential and/or nursing care home manager | | |
| Residential and/or nursing care home staff | | |
| Voluntary sector organisations that represent older people and their carers | | |
| Other (write in below) | | |
| | | |

**CHECK QUOTAS AND RECRUIT AS APPROPRIATE:**

| |
|---|
| **Name:** |

| |
|---|
| **Address:** |

| |
|---|
| **Telephone number:** |

| |
|---|
| **Mobile number:** |

| |
|---|
| **Email address** |

## 3. Discussion Guide

**National Institute for Health and Clinical Excellence (NICE)**

**Centre For Public Health Excellence (CPHE)**

**Fieldwork on draft recommendations on: occupational therapy and physical activity to promote the mental wellbeing of older people in primary and residential care**

### A. Introduction (10 mins)

1. Welcome: introduce Dr Foster Intelligence, moderator and any observers

**2.** NICE have produced draft public health guidance for consultation with stakeholders and professionals from the private, public and voluntary sector on **occupational therapy and physical activity to promote the mental wellbeing of older people in primary and residential care**

- This draft guidance is aimed at a wide variety of people, including decision-makers, commissioners, managers, and frontline staff from a range of backgrounds (including occupational therapy, community development, leisure services, and a range health and social care professionals)

- During this consultation period NICE wants to test the draft recommendations within the guidance with the professionals who will have responsibility for implementing them and the older people and their carers affected by them. They want to see how relevant, useful, feasible and credible people find them.

Reassure them: this is a very important stage in the development of the guidance. NICE takes the views of professionals and the public very seriously and will consider them very carefully when revising the draft guidance. This is your opportunity to influence what the final guidance.

3. Please be open and honest – all views will be strictly anonymous

4. Ask permission to audio-tape fieldwork. Explain confidentiality and anonymity.

### B. Warm up (10 mins)

Introduce self, role, responsibilities

### C. Context (20 mins)

*Researchers note and explore what organisations do now and how different this is to what the guidance is asking them to do:*

1. Does your organisation have a strategy that covers the promotion of mental wellbeing and / or health promotion sessions and / or physical activity (including walking programmes) for older people (65 and over)? What / who does it cover and why?

2. Does you organisation offer / provide access to any kinds of group or individual health promotion sessions (that follow the principles and methods of occupational therapy and health promotion)?

    - What do you think *the principles and methods of occupational therapy and health promotion* are?

3. Does your organisation offer / provide access to any kinds of group or individual physical activities among older people (65 and over)?

    - Does this include tailored exercise programmes and / or walking programmes?

4. If yes to either of the above:

    - What is on offer (type, location, duration, frequency of activities)?
    - Who provides it?
    - How and why was it set up (was any evidence used to decide what was best to do? Any evidence generated about the effectiveness of your activities – get examples if possible)?
    - How do people know it is available?
    - Which older people (if any) do you target activities at and why (gender; health and disability status; socio-economic background; ethnicity; location, e.g. areas of deprivation; housing status, e.g. independent living, living in supported housing / in receipt of domiciliary care, living in residential care, etc; or, age, e.g. over 65, over 75, over 85, etc;? And which actually take part / who turns up?
    - How do older people gain access to such activities?
    - What help and support is provided to enable older people to attend?
    - How well attended are activities?
    - What is your role personally in the activities offered?
    - What training have you had specifically to fulfil your role in providing access to such activities for older people (65+)?
        - What training, if any, is available?
        - What exactly is involved (e.g. in particular, does it cover the principles/methods of occupational therapy)?
        - Who is eligible for such training?
        - How useful / relevant did you find the training?
        - How could training be improved? What other training in this area would you like and why?

- How do you think the activities you / your organisation provides could be improved? What barriers if any? What needs to change to make improvements happen?

**D. Exploring the response to the NICE draft recommendations (40 mins; 10 mins on each)**

*Work through each of the draft recommendations individually. Work through each element of the draft recommendations in detail and in order. Read out for the tape.*

- How clear is each of the draft recommendations, in terms of:
  - Who the target population is? Does this cover population groups within whom you work?
  - Who should take action? Is it asking you to take action (i.e. is it relevant to you)? Should it be?
  - What action should be taken? What do you think the draft recommendation is asking you to do and why?
- What difference, if any, do you think the recommendation will make to your work / to the mental wellbeing of older people in your area? Do you think the recommendation will work to improve mental wellbeing of older people in your area and why?
- How will each element of the draft recommendations help or hinder your work to promote mental wellbeing among older people through the occupational therapy-oriented initiatives identified in the recommendations?
- Overall, what impacts (positive and negative) do you think each element of the draft recommendations would have on your / your organisations / your population and why?
- How do you think each element of the draft recommendations could be made:
  - More relevant to you and your organisation / your population and why?
  - More feasible (or do-able) and why?
  - More useful and why?
- Would you / your organisation be able to implement the draft recommendations?Would you encounter any barriers to implementing the draft recommendations and why? What would need to happen to tackle such barriers effectively?

**D. Overview (10 mins)**

- Overall, which of the draft recommendations will have the most / least impact locally and why?

- Which of the draft recommendations do you think should take highest priority and why?

- What three things could NICE CPHE do to make sure you / your organisation implements the recommendations and why?

- Any other thoughts on how the draft recommendations can be improved? Why?

## 4. Recommendations

Focus groups identified a number of factors and strategies for implementing physical activity and health promotion programs that are currently or could be utilised.

**Form a local strategy and look long term:**

- Successful local authorities have conducted stakeholder meetings, defined actions and responsibilities as a group.
- Successful local authorities have combined all relevant strategies and plans for older people into one coherent local plan of action.
- Successful areas are developing an early intervention strategy for the 'aging population' aimed at the 55 plus age group and are focused on; health promotion, education and developing good health practices (e.g. diet, and physical activity). Successful authorities identified that raising the health of communities is a long term outcome
- Successful implementers will consult communities to clearly identify what programs are available and what programs are needed.
- Successful implementers have identified that research needs to be conducted to construct 'performance indicators' and 'models of change' that will enable the value of programs to be accurately assessed.
- Successful implementers will encourage all stakeholders to commit to the local strategy. *"Yes, have clear guidelines on what you want people to do and people should really pledge, I would say have a pledge that they're actually going to commit to doing these things, from the different organizations. Because otherwise it's like these draft white papers, whatever you like, you get it printed out, people look at another copy of it and we're supposed to be working to that and that and it gets forgotten about"* **Physical activity and older people project worker, County Health Promotion Service, Derbyshire**

**Raise program awareness – network, network, network:**

- Successful implementers will identify a local lead organisation to act as a coordinator to raise program awareness as well as manage the dissemination

of program information between program providers, healthcare professionals and the community.

- Successful implementers are ensuring organisations and healthcare professionals who have contact with older people are identified, informed and kept up to date with the programs available. Some areas are producing a 'directory' of programs, program resource packs and leaflets, as well as having program coordinators visit organisations and professionals to raise awareness provide information and training sessions about specific programs.

- Successful implementers will establish signposting referral systems at possible access points (e.g. GP practice, pharmacies and care homes). One possible system for GP practices might be a "Prescription for Exercise" scheme where GPs promote physical activity amongst patients by prescribing older people an exercise programme. *"… a way of encouraging patients to do exercise rather than giving them pills. So somebody might come in with a little bit of high blood pressure and then, rather than prescribing a pill, they would be told to go away and do a bit of exercise and given a prescription for it…like a referral to a gym or a local sports centre or something like that"* **Depth Interview, GP, Leeds**

- Successful implementers will recognise that they are competing against a vast range of health messages and programs. Successful implementers will design their message and program to fulfil the needs and motivations of the organisations and professions that will be promoting their programs. For example, some pharmacists noted that they are more likely to refer or promote activities if a link is made to products they can sell, similar to the stop smoking campaign being directly linkable to stop smoking products.

**Develop Voluntary Sector Programs :**

- Successful implementers have recognised that the volunteer sector is already providing a wide range of physical activity programs for older people and have chosen to work closely with the voluntary sector to develop, train, and find funding opportunities. Successful authorities are working with community groups to break down barriers (e.g. community groups are providing course translators).

- Successful implementers are developing partnerships between the voluntary sector and the social care sector

- Successful implementers will realise that targeting the disadvantaged will require access to significant resources (e.g. transport, housebound, rural, don't see the advertising etc)

- Successful voluntary sector physical activity programs have developed a number of management processes and structures. Some program leaders are paid and receive 'formal' training, in turn the leaders manage a group of unpaid volunteers, and are successfully passing on formal training to volunteers either 'on the job' or through volunteer training days. To ensure actual needs are being met some programs are also including older people as part of program management teams.

- Successful programs have identified to attract and maintain program participation, social interaction needs to be an essential element of program activities. The underlying structure of voluntary sector programs appears to be better at incorporating the informality of social elements, as volunteer run programs are not allocated tight time and outcome constraints (in contract to heath care professionals who are expected to maximise time and outputs.

- Government social services are presently funding some volunteer activity programs such as "get active".

- Successful implementers will realise that focusing on funding, supporting or empowering established programs will be more effective than establishing new programs or training. Successful implementers have found a range of benefits to implementing through established community and health groups, such as not having to advertise or setup a group, access to a range of resources (e.g. venues and transport) and better participation as participants are familiar with each other, feel safer, and are more comfortable and confident.

- Successful implementers will use current infrastructures to host/ run physical activity or health promotion classes *"I think maybe the new polyclinics could do that. Lord Darcy might be able to get involved in this. I think it's a political thing and I'd be very happy if the polyclinics wanted to take it over. I think we've probably got enough to do thank you".* **Depth Interview, GP, Leeds**

**Offer a range of activities:**

- Successful programs operate a mix of group and one to one programs based on a needs assessment approach. One to one and group work are viewed as different roles. Some organisations are employing community workers to work with community groups, and health trainers working on a one to one basis.
- Successful programs present a range of activities for different interests and motivations. One local authority present community organisations with a 'menu' of possible activities they have instructors to deliver. A taster session of each program is delivered and the group chooses the activity that best suits their needs, motivations and interests.
- Successful authorities will identify ethnic culture groups as specific targets.

**Develop training based on actual needs that delivers organisational impact**

- Successful implementers will realise that implementing new training schemes may actually create barriers to developing programs (such as organisations needing to be certified or needing funding to send staff on training).
- Successful implementers will make use of established training resources and expertise. Successful implementers are using healthcare professionals to train and update program staff. Nurses and OTs are already playing a more consultative role rather than a delivery role to volunteer organisations. The OT College has also published guidelines for physical activity programs conducted in care homes. Successful implementers will maximise and build current expertise in running health activities. *"I was reading this, I was thinking about the role of community matrons, who at the moment target vulnerable elderly patients who've mostly got medical problems, but there's no reason why she couldn't expand her role, or you could have extra community matrons going into elderly people's homes, and assessing them in a more structured way"* **Depth Interview, GP, Leeds**

- Successful implementers will build modules onto existing healthcare training programs (such as the NVQ training for Care Home Staff) rather than create new programs.

- Successful implementers will realise that not all training programs are effective or viewed as worthwhile. Training needs to be seen as beneficial to achieving the organisations goals for organisations to be motivated to train staff. *"And what did they teach you on that course?" "Not much. He just repeated everything… I wouldn't do it again"* **Focus Group, Residential Care Home Staff Activity Coordinators, Birmingham**

**Some examples of successful programs already in operation:**

- "Extend" is a successful volunteer based exercise program operating in Wakefield.

- British Heart Foundation is currently running a successful national level walking program that incorporates training for leaders.

- The diabetes relatives association is currently organising walking programs.

- A wide variety of funding bodies are interested in the health of older people. Funding is currently being provided to programs by helped the age, sport relief, city councils and PCTs.

- Successful implementers are also using patient led health promotion initiatives such as the "expert patient" program, where patients who have had a health issue for a period of time teach newly diagnosed people how to deal and cope with the health issue.