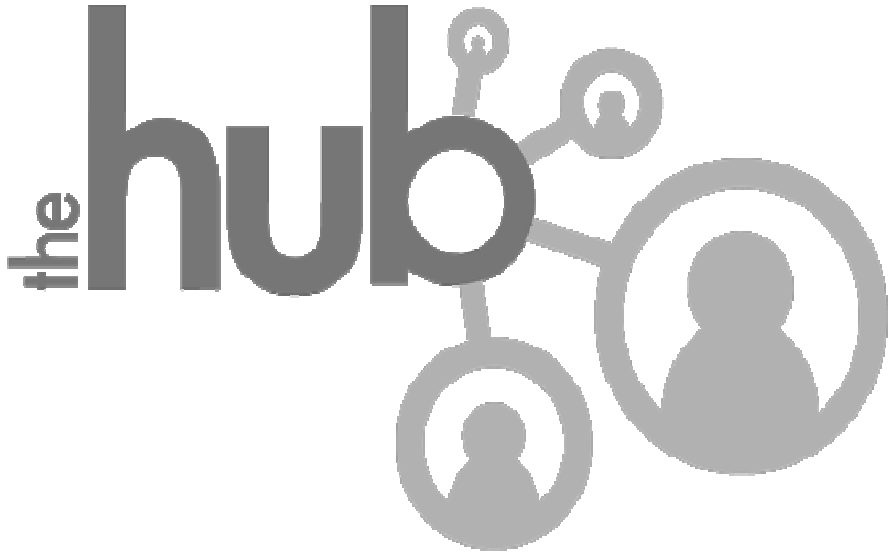
strachur



A COMMUNITY PROJECT SUPPORTED BY THE INTEGRATED CARE FUND

THE STRACHUR HUB WAS THE IDEA OF KATE PATON, THE PRACTICE NURSE OF THE STRACHUR MEDICAL PRACTICE.
(SMP)

Kate's objective was to bring something into the community to:

- **Ensure that older people had the opportunity to live independent lives in their own home for as long as possible**
- **Reduce social isolation**
- **Improve their quality of life**
- **Provide some respite to carers and family members**
- **Improve mobility**
- **Prevent falls.**

In June 2015 an application for funding was submitted by the SMP's Patient Participation Group to the Integrated Care Fund of the Health and Social Care Partnership (HSCP).

In February 2016 we were granted the funding of £12.8kpa.

Together with Heather Grier, Ian Asher and a group of very dedicated volunteers, the Hub started on its journey at the beginning of March 2016.

SETTING UP

- **Between the date of our application and granting of the funding we :**
- **Planned how we would implement our ideas.**
- **Received support from TSI in this set up.**

- **During this time we sought to:**
- **Employ a qualified Otago trained instructor**
- **Seek a deputy to be locally trained.**

- **We originally envisaged around 16 people attending each week, based on Kate's 'sounding out' of patients.**

- **A problem however: Transport. People had expressed an interest to come but could not get there.**

- **A solution: We entered into a co-production with Cowal Elderly Befrienders from whom we hire a specially adapted vehicle.**

WHAT ARE WE TRYING TO ACHIEVE?

As well as Kate's 'local' goals, we seek to have positive impact on some of the criteria laid down by the Scottish Government on improving health and well-being in Scotland.

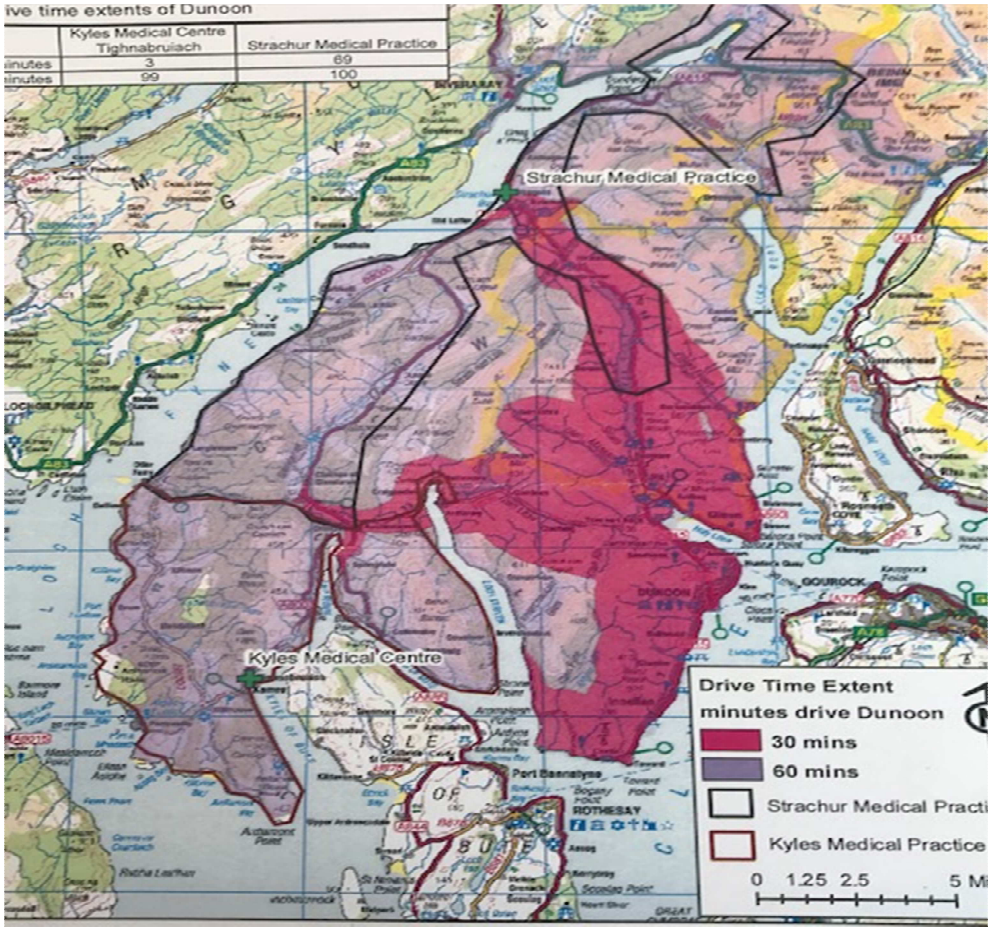
- **Healthier Living**
- **Independent Living**
- **Positive Experience and Outcomes**
- **Maintained and Improvement Quality of Life**
- **A reduction in Health Inequalities**
- **Carers are supported**
- **People are safe in their environment**

These remain our target areas

THE STRACHUR MEDICAL PRACTICE

- **Covers a large geographical area**
- **Has 892 patients.**
- **269 of them are over 65 years of age**
- **121 of over 65's have long term conditions**
- **87 of them live alone**
- **Limited access to transport, so the expectation that older people travel to Dunoon is just not working for them.**
- **Older people were becoming isolated, less mobile, and prone to falls.**
- **Cairndow to Dunoon: 28 miles, so a 56 mile round trip**
- **From Dunans, nr Glendaruel to Dunoon: 32 miles so an 64 mile round trip**

COVERAGE – KYLES AND STRACHUR PRACTICES



WHAT HAVE WE ACHIEVED?

- **The continued co-production with Cowal Elderly Befrienders.**
- **An Involvement with Interloch Transport**
- **Support and encouragement from Dr Coull and the Strachur Medical Practice**
- **A Hub running every Thursday 10.30 to 1.30 for our 'older' community members**
- **An average attendance each Thursday of 37**
- **4148 attendees to end of May 18 since the start.**
- **A maximum in any one week was 48**
- **Regular Strength/Balance and Tai Chi Classes**
- **Less mobile attendees enjoy playing the ball game 'Boccia'**
- **Purchased the equipment required to undertake all activities**

CONTINUED

- **Supplying a lunch for all our attendees each week, with soup provided by the Bay Cottage Tea Room as a contribution to our community and sandwiches and baking from our group of supportive volunteers**
- **Not charging but asking for donations instead**

As well as our regular Thursday daily activities we have organised:

- **Diabetes Management Courses**
- **Chronic Pain Management Courses**
- **Falls Prevention through Exercise, Strength and Balance**
- **Mindfulness classes - on-going**
- **Counterweight classes - on-going**
- **Conversational French Class – working with 'Takeaway Creative'**
- **Defibrillator Training and CPR Course**
- **First Aid Class – on-going**
- **Choir for Lauder Memorial Concert**
- **Country Dancing**

Country Dancing at the Hub – 26th July 2018

Continued

- **Co- production also with the Creggans Hotel, and Manse Gardens' common room. We also use the Sports Pavilion and the Strathlachlan Hall when necessary.**

- **Our locally trained instructor also carries out an exercise programme monthly in the local ' Friendship Club' another group of elderly people.**

- **Instrumental in the installation of a defibrillator at the Village Hall, supported by the SMP, available 24/7.**

- **New loading and unloading bay at the Village Hall car park leading to easier access for more frail participants.**

- **Acquired equipment for the local primary school 5 aside football teams**

- **Preventative fitness class for a 'younger age' group – on-going, together with an outside walking group.**

Continued

- **We made a dvd with the story of the Hub, with film of activities and interviews with participants,**
- **On the 30th June 2018 we ran a successful 'Roadshow' to showcase our activities with 'taster' sessions for visitors to participate in all our activities.**
- **Part of the roadshow included a display to explain to our community and visitors the difficulties currently being encountered at our HSCP and Council with cost and budget issues.**
- **We have had many visitors to both the Hub and the Roadshow and these include:**
- **Brendan O'Hara, MP**
- **Michael Russell, MSP**
- **Cleland Sneddon, CEO, Argyll and Bute Council**
- **Councillors Audrey Forrest, Jim Anderson and Alan Reid**
- **Elizabeth Higgins, Lead Nurse from the HSCP**
- **Alison McGrory, Lead Public Health from the HSCP**
- **Dr Christine McArthur, Lead on Falls Prevention from the HSCP**
- **Jayne Lawrence-Winch, Local Area Manager from the HSCP**

We have had excellent publicity and support from the local press.

All visitors have endorsed the Hub's success.

A recent Independent Assessment for
the strachur hub

By Student Doctor Fiona McKirdy.

Fiona carried out an assessment in July 2018 on 24 of the participants who attend the Hub. They were given a questionnaire on their experiences, how they felt about the Hub, and permission to look at their medical records with the objective of seeing what direct health benefits could be evidenced.

The outcomes are as follows:

OUTCOMES

- **15% of responders live alone.**
- **80% of those responded who attend the Hub said it had given them more confidence.**
- **79% of the responders reported having long term conditions including COPD, heart problems and hypertension. Of this subset 79% felt their health condition had improved since joining the Hub.**
- **87.5% felt that their overall health had improved since joining the Hub**

Continued

83.3% felt they were stronger since joining the Hub

16.6% admitted to previously feeling lonely and isolated. 75% of this subset felt that attending the Hub has improved this. 25% of the overall group reported previous low mood with 66.6% reporting an improvement since joining the Hub.

100% of the group reported and increased quality of life since joining the Hub and all (100%) would recommend friends to join.

Continued

Falls: 34 patient records were accessible. A filtered search on the EMIS system indicated 14 of the 34 patients had a history of falls, with 37 falls amongst them.

Since each member had joined the group, the overall numbers of falls had dropped from 34 to 3, a reduction of 91%. The number of patients falling pre and post joining the Hub fell from 14 to 3, a reduction of 79%. Whilst other factors need to be taken into account, this indicates the work at the Hub is very likely to be a positive contributor to this reduction.

In 2010, falls in the 65 + was estimated to cost the NHS UK wide £4.6 million per day, equating to more that £1.7b pa. This is about the same amount required to fill the funding gap in councils for adult social care by 2020.

OBAN TIMES – 26 JULY 2018

Bid to reduce number of falls in Argyll

Health chiefs are aiming to help older Argyll and Bute residents to Move and Improve, according to a new report.

Plans are in place to provide exercise programmes in the community which will help elderly people reduce the risk of being hospitalised due to a fall.

These will take place under the Move and Improve project launched by the NHS last year, which consists of three levels of standing and balancing exercises.

The document, which went before a meeting on Tuesday, revealed that the area has a quarter of the population aged over 65 – far higher than the Scottish average.

The report was delivered on Tuesday at a meeting of NHS Highland, which runs Argyll and Bute Health and Social Care Partnership (HSCP) together with the council.

Stephen Whiston, head of strategic planning and performance with the HSCP, said: 'It has been identified by the HSCP that we require falls admission data at a hospital and locality level to understand who is being admitted, where and why.

'We have work starting this year with the national falls programme, the Information Services Division and Active and Independent Living and Improvement Programme to develop a quality dashboard for falls for incidences of admissions due to hip fracture and falls.

'Argyll and Bute is taking action to reduce falls and each locality has an action plan based on the national minimum standards.

'We are working with partners to provide evidence-based exercise programmes in our communities for older people to improve strength and balance which reduces the risk of falls.'

Continued

100% also felt that this should be used as a template for setting up similar groups in other rural areas.

The last question asked was about their favourite things about the Hub with no pre-printed answers. 96% reported that the socialisation, exercise or both were the most enjoyable aspect. The remaining respondent answered that what they enjoy most is the ability to watch fitness improve week to week.

All participants in this audit responded positively towards all aspects of the Hub. Enabling 80% of those living alone to feel more confident in their own homes by meeting once a week and having the support of the GP practice is invaluable in the community. This could lead to further benefits to health and social care but was outwith the scope of this audit.

In her conclusion Fiona said that the evidence gained from her audit supports the use of this model to provide further health services tailored to the elderly where access to such services can be problematic and limited.

The Annual Report of the **Director of Public Health**

NHS Highland

2016

Loneliness and Health

Public Health

Daily Mail
27/03/18

You can die of loneliness

Social isolation could raise chance of a premature death by 50%, study warns

By **Kate Pickles**
Health Reporter

LONELINESS may raise the risk of a heart attack by more than 40 per cent.

A major study published today also suggests that social isolation can increase the chance of a stroke by 39 per cent and premature death by up to 50 per cent.

The analysis is based on the health records of 480,000 Britons – making it the largest study of its kind. Those who already had cardiovascular problems were far more likely to die early if they were isolated, suggesting the importance of family and friends in aiding recovery.

The research team, which included British academics, said lonely people had a higher rates of chronic diseases and smoking and showed more symptoms of depression.

Christian Hakulinen, the University of Helsinki expert who led the study, concluded that having few social contacts was a risk factor for early death, particularly among those with pre-existing cardiovascular disease.

'The message is that if we target the conventional risk factors then we could perhaps reduce the cardiovascular disease among those who are isolated or lonely,' said Dr Hakulinen. 'It is also important we show that those who are socially isolated might have a worse prognosis after a heart attack or stroke.'

Scientists from University College London and Finland tracked the 480,000 Britons, aged 40 to 69, for seven years.

Social isolation was associated with a 43 per cent higher risk of first-time heart attack when age, gender and ethnicity were factored in.

Once lifestyle and socio-economic factors were taken into account, this explained 84 per cent of the increased risk, suggesting the lonely and isolated were most vulnerable to well-known risks.

Similarly, social isolation was associated with a 39 per cent heightened chance of a first-time stroke, but the other conventional risk factors accounted for 83 percent of it.

The results were similar for loneliness and risk of first-time heart attack or stroke, according to the study in the medical journal Heart. Those who already had cardiovascular problems were 50 per cent more likely to die if socially isolated and still a quarter more likely to die once known risks had been accounted for.

More than half of all people aged 75 in Britain live alone and more than a million are believed to be suffering from chronic loneliness. Helen Stokes-Lampard, who chairs the Royal College of GPs, said loneliness could have a devastating impact on long-term health.

'Facing intense pressure'

The professor said: 'The reality is that loneliness and social isolation, particularly for older people, can be on a par in terms of its impact on health with suffering from a chronic long-term condition and, as this study shows, increase the likelihood of developing serious conditions, such as heart attacks and strokes.

'On the front line, GPs and our teams report seeing patients on a daily basis whose underlying problems are not primarily medical, but who are feeling socially isolated or lonely.

'As well as being distressing for patients, loneliness can also have a real impact on general practice and the wider NHS, at a time when the whole system is facing intense resource and workload pressures.'

The college said it was working with charities, community and voluntary groups to draw up a manifesto to present to Government to tackle loneliness.

FUNDING

Our total budget for a year has been in place since February 2016. The amount is £12,827 pa and this does not allow for any cost and demand pressures or inflation. Running for 51 weeks per annum, that's a weekly cost of £251.50, with the average attendance per week of 45 (including the preventative class) is £5.58 per session per person. With each session lasting 3 hours (plus 1 hour for the preventative class), that is a cost per hour of £1.40 per person.

This project is certainly delivering value for money in our view.

AND FOR THE FUTURE?

- **We are now drawing up plans to seek alternative funding as there is no guarantee that the HSCP Cowal Locality will continue to support this project beyond March 2019, the end date for the current ICF grant funding.**
- **It is our belief this project has been a success and should continue to be HSCP 'core' funded.**

If funding discontinues and we are unable to raise adequate alternative inflow, the project may have to cease. This will have a substantial negative impact on this rural community, and the health and wellbeing outcomes would not be met unless services were supplied from Dunoon up to our community at a substantial increase cost per person per week. Many participants would be unlikely to attend a similar venture in Dunoon, for some due to age and frailty, and others transport issues.

CHRISTMAS PARTY 2017

strachur hub

THANK YOU FOR THIS OPPORTUNITY TO SHOW CASE

OUR ACHIEVEMENTS TO DATE AND HOPE YOU ENJOYED OUR PRESENTATION