Reset

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Planning and Delivering Resilience-Affirming Community Support for Older People

Participatory Action Research Report

September 2024

Cyrenians

Queen Margaret University
EDINBURGH

Edinburgh **Health and Social Care** Partnership

Contents

Reset
Resilience • Relationships • Resources

Reset
Resilience • Relationships • Resources

Acknowledgements

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To our Advisory Group – thank you for your guidance through the first stage of the Reset Programme.

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Our Learning Journey

In this report we share our learning from Reset - Edinburgh Community Resilience Programme, which we hope can inform future planning and delivery of resilience-affirming, community-based support for older adults.

As part of this learning, we engaged in conversations with relevant people and with each other; we observed practice – ours and others; we collected and explored data. We made changes to our initial ideas and 'practice as usual'. Some of these worked, some did not. Often, we had to make further changes, on other occasions we chose to return to where we started. We had 'ups', we had 'downs'. We reflected upon and learned from it all.

We are limited by the sequential nature of written reporting. So, while we are attempting to share the outcomes of our iterative and dynamic learning journey that we embarked upon in May 2022, we ask that you bear with us as we communicate what we found about the resilience of older people and our existing systems of community support, until we arrive at the essence of our journey.

Our Key Learning Points

Services should understand the complex and contextual nature of resilience needs

Organisations should develop a work culture that supports the resilience of community support staff and populations served

Services should adopt a person-centred, comprehensive approach to assessing resilience needs

Services should apply flexible, holistic, person-centred and relationship-based approach to community support

Organisations should nurture a skilful workforce

Service providers and commissioners should work towards change within existing systems of community support

Thank you,
Reset Partnership

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Introduction

This report summarises learning from Reset - Edinburgh Community Resilience Programme. It provides evidence-based information about actions to consider when planning and delivering resilience-affirming, community-based support for older adults. The ultimate aim is to enable them to have more good days. Our findings are informed by the views of older people and the programme and community partners we collaborated with, who have experience and expertise of working with and supporting older people.

Older adults experience inequalities across several domains of life (Public Health Scotland, 2021; Alliance, 2021; World Health Organisation [WHO], 2022), with many living in relative poverty (Centre for Ageing Better, 2023; United Nations, 2015), experiencing loneliness and isolation (Laindeiro et al., 2016; WHO, 2021) and limited access to adequate health and social care (United Nations, 2018; Care Quality Commission, 2022). These outcomes are associated with decreased health, wellbeing and quality of life, and increased mortality (Molony and Duncan, 2016; Organisation for Economic Co-operation and Development, 2019).

The situation has been exacerbated by the COVID-19 pandemic and the current cost of living crisis (Blundell et al., 2020; Iacobucci, 2022; Mental Health Foundation, 2020; Office for National Statistics, 2022; The Lancet Public Health, 2022; Scottish Government, 2020), with statutory and third sector services struggling to meet the needs of community-living older adults.

> Public services should be *"built around **people and communities,** their **needs, aspirations, capacities** and **skills,** and work to build up their **autonomy** and **resilience.**"*
>
> Christie Commission, 2011

Thus, the provision of community services designed to enhance the resilience of older people became a global, national and local policy imperative (Department of Health and Social Care, 2021; Irvine Fitzpatrick, 2021; Scottish Government, 2022; WHO, 2016, 2020). But there is limited research examining such community-based, resilience-focussed approaches.

These policy priorities led to the formation of the Reset - an intersectoral partnership between Edinburgh Health and Social Care Partnership (EHSCP), Queen Margaret University (QMU) and Cyrenians.

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The partnership was established with the primary aim **to enhance** the health and wellbeing of older people through promoting **resilience**. By developing trusted **relationships** and **resources** that are important to individuals, we have learned what should be considered when planning and providing this kind of support.

The main objective was to develop and optimise the evidence-based, resilience-affirming approach to community support, merging three innovations contributed by the Programme partners: community navigation (Leśniewska, 2021), the resilience framework (Górska et al., 2021; Whitehall et al., 2021) and the Incite model of intersectoral working (Irvine Fitzpatrick et al., 2021).

We define **resilience** as **the process of adapting to adversity experienced across the lifespan** (Windle, 2011), **shaped by complex interplay between multiple personal and environmental factors** (Górska et al., 2021).

Throughout the report, we present direct quotations obtained through interviews and group discussions with older people, representatives of referring agencies, community partners, informal carers and the Reset team. Some of the quotes were collected by Reset Community Resilience Workers (CRWs) as part of their one-to-one key work. The language used by the participants remains unedited.

Given the diversity of older people living in Scotland (Cohen et al., 2014), we adopted a broad definition of older people as those of age 50 plus, and used needs-led, rather than age-led, approach to facilitate access to resilience-affirming community support.

Our Approach to Learning

What we did

We applied principles of Participatory Action Research (PAR) as an approach to learning. PAR was chosen because it facilitates involvement of relevant people in knowledge development and co-production and increases shared ownership of both processes and outcomes (Reason and Bradbury, 2008; Kemmis and McTaggart, 2008; Uggerhøj et al., 2018), thus supporting sustainability.

Figure 1. Participatory Action Research

Where the research happened

Research was embedded within Reset's daily practice across four geographical localities in the city of Edinburgh: North West, North East, South West and South East.

We wanted to better understand the needs of older people across the city, as it is known that social and economic circumstances may vary, depending on where people live (City of Edinburgh Council, 2022). This increases the importance of better understanding of resilience needs at a local level and designing community support capable of responding to specific needs.

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Who took part

Overall, 41 people took part in individual interviews or group discussions. This included:

- 21 older people (including 8 supported by Reset and 13 members of community),
- 5 Community Resilience Workers,
- 2 informal carers,
- 5 referrers,
- 8 representatives of partner organisations.

Ethics

Favourable opinion was provided by the Health and Social Care Research Ethics Committee A (23/NI/0049).

Informed consent was sought from all participants (see Appendix 1 for Reset Information Sheet and Appendix 2 for Reset Consent Form).

General Data Protection Regulation (GDPR) requirements, as per the Data Protection Act (2018), were applied to manage data and to ensure its security.

Report Overview

When working on this report, we were guided by two main objectives. First was to address research questions set at the outset of the Reset Programme. Second was to do justice to a complex learning process that we engaged in.

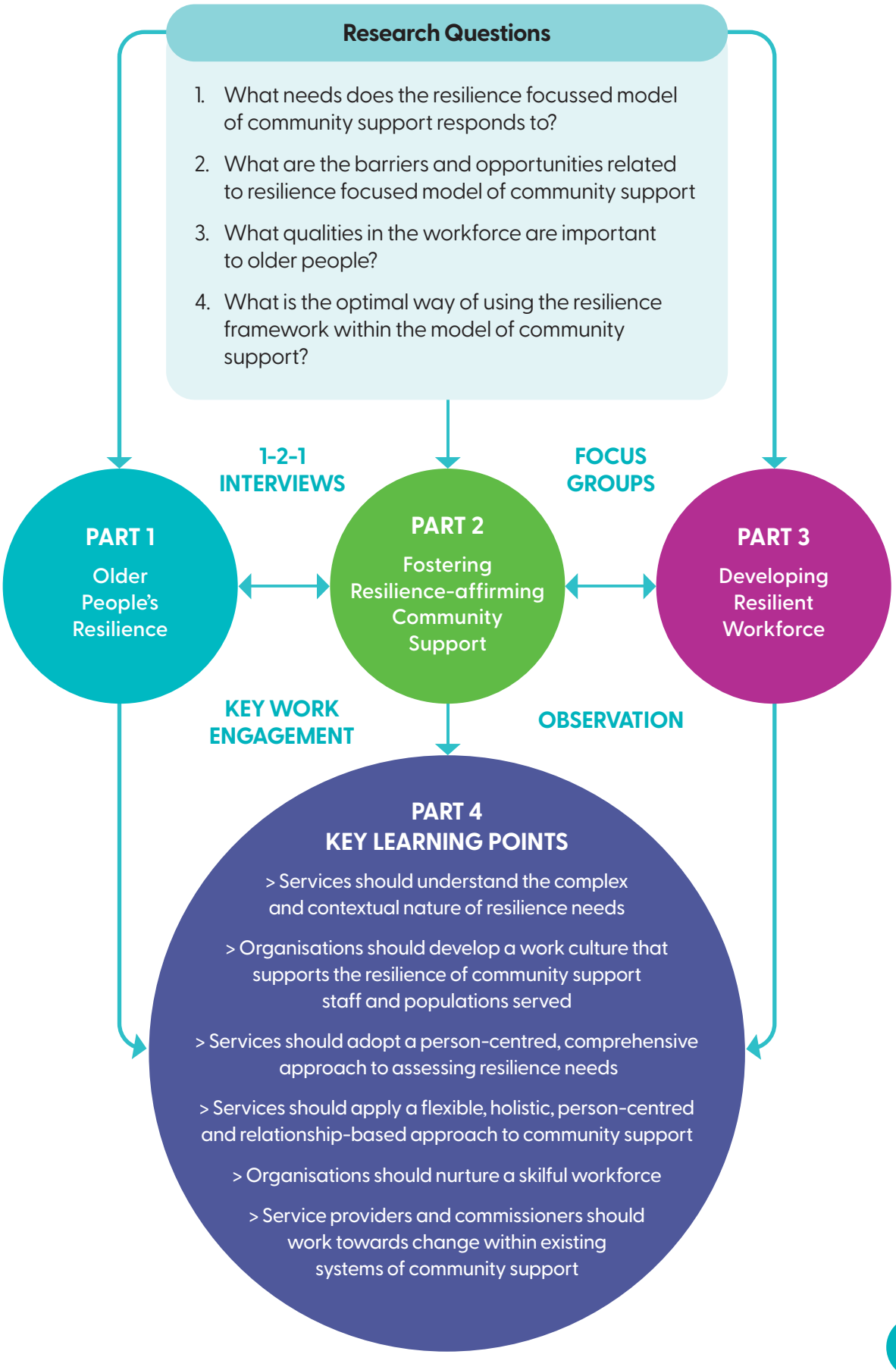
Through our research we learned that to enhance resilience of older people, we need resilient communities and services. This is consistent with our understanding of resilience as resulting from interplay between the person and the environment (Górska et al., 2021).

As a result, while acknowledging that there are overlaps between identified themes, we present our learning in four parts:

- **Part 1: Older People's Resilience** – explains our understanding of resilience and explores specific factors within the person and within environment that were important to older people in the communities we worked with.
- **Part 2: Fostering Resilience-affirming Community Support** – explores the impact of the Reset Programme. As part of this, we share its key features, how they were applied in practice, and what we have learned through the process. We present a selection of anonymised case studies to illustrate both the complexity of resilience needs and support provided. We also explore barriers and opportunities we encountered.
- **Part 3: Developing Resilient Workforce** – considers skills and characteristics within workforce that were important to older people. It also explores cultural factors within the health and social care system.
- **Part 4: Key Learning Points** – identifies and expands upon our main learning relative to planning and delivering resilience-affirming community support for older adults.

Figure 2 signposts through the report's structure, while offering insight into relationships between our research process and key findings.

Figure 2. Report structure in the context of research process and findings



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Part 1. Older People's Resilience

Our Understanding of Resilience

Recent research (Clark et al., 2018; Górska et al., 2021; Whitehall et al., 2021) supports understanding of resilience as the ability to adapt to adversity, determined by dynamic, complex interplay and fit between personal resilience needs and support available within the environment.

Contrary to traditional view of resilience as a fixed personality trait (Wagnild and Young, 1993), these recent developments recognise its evolving nature, which means that **resilience changes over time** in response to adverse events (Clark et al., 2018; Górska et al., 2021). Research identifies **many factors, both within the person and within the environment, that impact resilience** (Hicks and Conner, 2014; Fontes and Neri, 2015; MacLeod et al., 2016; Madsen et al., 2019; Górska et al., 2021). These characteristics mean that **resilience is contextual**, supporting the importance of understanding factors affecting resilience at individual and community levels.

Through engagement with older people and community partners, we identified a range of factors impacting resilience of older people in Edinburgh, including:

- **Personal resilience factors:** self-efficacy, mental and physical health, loneliness / sense of social connection.
- **Environmental resilience factors:** access to and quality of social networks, safety, information about and access to relevant services and resources, access to meaningful activity, material resources and assets.

The outcome of support was determined by **fit between personal resilience needs and environmental resources**. For example, if a person with reduced mobility experienced challenges due to unsuitable housing, the ability of resilience support staff to address these needs had potential to enhance the person's overall resilience by improving access to community resources, reducing loneliness, increasing sense of safety, facilitating engagement in meaningful activity or community participation and strengthening overall mental health.

Figure 3 illustrates our learning about older people's resilience in the context of Edinburgh communities.

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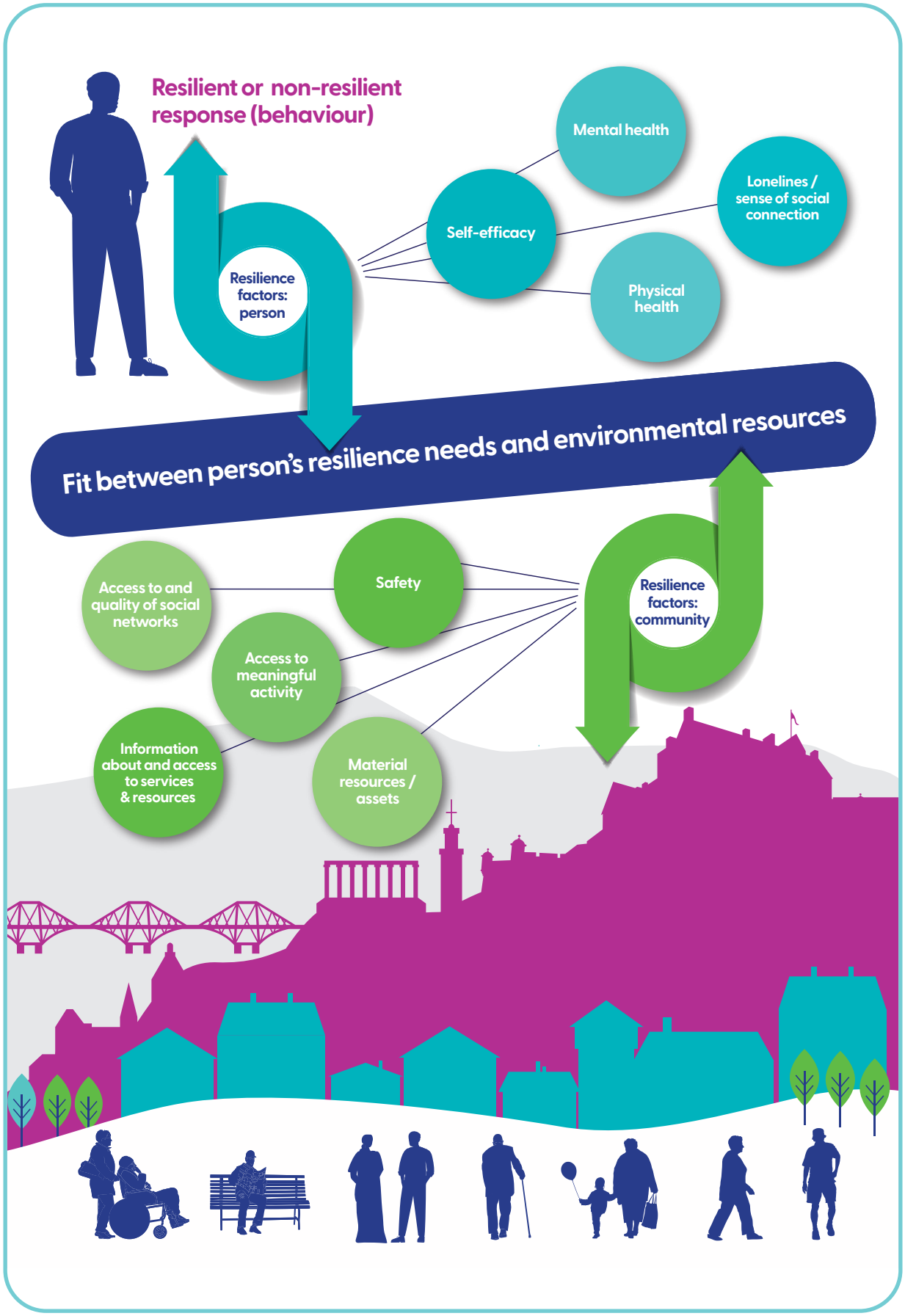
Figure 3. Resilience in older people: impact factors



It is important to keep in mind that, due to its contextual nature, factors affecting resilience may vary, depending on time, geographical location, socioeconomic and political circumstances (Górska et al., 2021). Hence, the list of factors identified through our research is not exhaustive. It is representative of the resilience needs of, and environmental support / resources available to, older people within communities participating in the Reset Programme and across its duration.

Personal Resilience Factors

Self-efficacy

Self-efficacy is a person's belief that they have skills necessary to do well in tasks they undertake and to reach their goals (Bandura, 1977). It encompasses the sense of confidence, sense of control and agency over own behaviour and over the environment.

Older people often have a strong sense of self-efficacy and are determined to maintain their independence for as long as possible. They express a deep sense of pride, dignity, and self-reliance.

> *"I'm pretty resilient most of the time. I look after myself. I deal with everything, and I like a challenge... I am the most determined person you'll ever meet in your life and absolutely nothing will keep me down... But what's been happening recently is the illnesses and the health problems. And I can usually cope with most of that. I'm getting older now, although I dinnae think I am. And I keep thinking that I'm a lot younger than I really am, and I still try to do what I used to do and I cannae do it."*
> (Older Person, Reset)

> *"I do my own cooking; I do my own washing... I'd like to think that I can do a lot of things myself because I've never asked for help in my life until this [recent hospitalisation] happened to me."*
> (Older Person, Reset)

As illustrated above, older people acknowledge that, with age, they experience, and need to adapt to, changes in their health, both physical and mental. These changes can affect their sense of efficacy, making it necessary to re-evaluate what they can and cannot do and, at times, accept assistance. This, itself, is an adaptive process that older people may need support with.

"I'm trying to be independent, I'm trying, but some things I can't manage... It's my balance and my mobility, and I can't walk very far. My legs are away... I like to think I can do things for myself, but there are things I have to realise I can't do. Some things I can't do I have to get help with."

(Older Person, Reset)

This is where the resilience-focussed community support has a role to play in supporting older people through helping them to maintain, or regain, self-efficacy, a sense of control and self-confidence.

"When people who are elderly are losing a bit of control because their health is deteriorating, and their mobility is a bit poorer than what it was before, maybe their cognition isn't as great as what it was... Reset come in and just make them feel included and empowered to actually keep that control for a bit longer."

(Referrer)

"You [Community Resilience Worker] have made me start trying to be more independent. You have given me the confidence to make phone calls. I explain at the start of the calls my situation and that it will take me some time to respond, and I don't worry about taking my time with things as much as I used to. I now make phone calls, and I have spoken to my housing team about arrears and sorted that myself."

(Older Person, Reset)

Mental and Physical Health

Older people experience changes to their physical and mental health to which they need to, sometimes rapidly, adapt. For some, it is a natural process of accepting age-related changes.

"I think what helps to be resilient is when you accept, 'It is what it is.' ... As you get older, you have to do a bit of accepting about people [helping]."

(Older Person, Community)

For others, the adaptation is difficult, uncomfortable, and can lead to a sense of loss.

> *"My health has deteriorated so badly in the last two-three years... There's so much turmoil in my head, all these things are happening, and it's totally alien to me... This is personal stress that's come upon me like a plague, and I just don't know how to get rid of it."*
>
> (Older Person, Reset)

Supporting older people's resilience needs that relate to deteriorating health may mean providing practical support, or technological solutions, that enable them to do things that they are no longer able to do independently.

> *"Practical stuff like being able to manage their own home and their own garden. Being able to move around their own home and their own garden... They might be trying to navigate life with new limitations with regards to their health."*
>
> (Community Partner)

It may involve assistance identifying, accessing or navigating through health and social care or other relevant community services that older people may benefit from.

> *"You get a specific [Community Resilience] Worker who's very knowledgeable about the area that they work in. I've worked in [the community] for a number of years but my job isn't necessarily to look for opportunities for people all the time. Whereas [the Reset team] seem to know really specific information in the area that they can direct people to, which is massively helpful." (Referrer)*

Loneliness and Sense of Social Connection

Experience of loneliness is common among older people (Laindeiro et al., 2016; WHO, 2021). Research points to age-related changes and losses such as the death of a partner and/or friends, deteriorating health, and loss of social roles through retirement as contributing factors (Cohen-Mansfield et al., 2016). COVID-19 pandemic further exacerbated this experience through physical isolation, health anxieties, ceased activities, reduced social connections, and poor motivation (Patulny and Bower, 2022). This was also the case for older people who participated in our research.

"There's a higher level of social isolation, certainly since COVID. I think people have spent more time in their houses and become perhaps more unsteady on their feet or they're just not using their bodies like they used to."

(Community Partner)

There is a recognition that technological solutions, such as phone calls or video calls help, but cannot replace direct human contact relative to supporting resilience.

"I don't think telephone calls are enough. I mean, they go some way, but I think if you really want to build somebody's resilience, it's about human connection at the very heart of it."

(Community Partner)

Although older people are often used to being alone, and some embrace it, many express the need to get out, connect socially and interact with others. For those who find this difficult, home based support services provide essential links with others.

"Company would be nice... I am a bit of a loner, so I'm quite happy with on my own anyway. But I've actually noticed quite a bit recently since I got out the hospital with the likes of the physio coming up, somebody like yourself [interviewer], or [Community Resilience Worker], whatever. It's nice just to know that somebody's coming to your house today, even if they're only here for 10 minutes, it doesn't matter. Somebody's coming in my door for something."

(Older Person, Reset)

"I have no family with me. They're very far away unfortunately... Although I have good neighbours I am very much always on my own, and happily on my own... Unfortunately, I did lose my husband to death 6 years ago, and that has taken away a lot of my confidence in self. However, I have lived with that. I have managed with it... I'm very glad to get any support at all that will come to me. Very glad."

(Older Person, Reset)

Some older people connect with other seniors, who they perceive as being in more need for social contact, in a way of 'peer-support'.

"I have neighbours who are housebound. They cannae get out and they get lonely. I see them a couple of days, I hand a paper in... The woman likes to blether."
(Older Person, Community)

Environmental Resilience Factors

Access to and Quality of Social Networks

The importance of social networks, including family, friends, neighbours, professionals, and members of the community (such as bus drivers or shop assistants), relative to enhancing resilience was emphasised in our research. This related to access to support and, of equal importance, opportunities for social interactions.

"A lot of the times it's being able to talk to somebody [...], it's just to share what's going on inside of me with somebody else. I know they canny help me, but I've said it to somebody else and they know what's going on. So, that is a big help with being able to have somebody to talk to and just to talk about ordinary things that's just happening in life. What's on the news, or what's wrong with me, or just having a general blether to somebody really. Because otherwise I'm just sitting here looking at the walls."
(Older Person, Reset)

"I like going out. My daughter, she always wants me to go in the car, but I like to get out myself [...]. It's giving me a wee bit of air to get out not always in a car all the time. If I need [my daughter] anytime I just phone, but I can manage myself, they're going, 'You alright? Mind and phone me.' They're busy... but still that's good they're like that anyway."
(Older Person, Community)

Older people reflected on eroded community connections which limit opportunities for social interactions and support.

> *"In the olden days if you lived in a street, you knew your neighbours, they were friendly. Not now, because a lot them, the young people are out working, they're away all day... They don't know their neighbours... They know nothing about you, so there's a different atmosphere from community feeling."*
>
> (Older Person, Community)

But they also recognise the value of such networks, especially when they have limited support from family and friends.

> *"I worked abroad for about 17 years, so most of the people I know have either died, or moved away, or gone somewhere else... The neighbours are quite friendly, so that's ok, they've offered to take me shopping and stuff like that, but I tend to go shopping on my own just to get out the house."*
>
> (Older Person, Reset)

Information About and Access to Services and Resources

Access to information, technology, services, and resources was recognised as an important factor relative to supporting older people's resilience. Participants reflected that often, older people are not aware of support that may be available to them. Therefore, providing information, raising awareness, and facilitating access to services and resources available within communities and through statutory means is crucial.

> *"There are things [available], but if you don't come here [community group] you don't know about them. It's when you come here that you can learn about things like that [support with shopping]."*
>
> (Older Person, Community)

Often, this lack of awareness of the available support, services and resources is compounded by growing reliance on technology relative to providing information about, promoting and facilitating access to services.

"I think not knowing about what's there to help them and not being able to find out about it themselves... If older people don't have the access to technology, it's harder for them to find things out. They don't just Google things like we would on their smartphones."

(Community Resilience Worker)

Older people often lack skills to search for and navigate through technology-based information. Many express the desire and willingness to learn, but others may not have confidence to engage with technology and therefore require support to use it.

"I think you should have classes to teach us how to do that for oldies, how to work a computer. Are there any classes on that?"

(Older Person, Reset)

"Everything is online. If you're looking for information you get it online. It's quite difficult if you're older and don't have those skills. People can show you, but the trouble is if you're not using what you've been shown, you forget it."

(Older Person Community)

Growing reliance on technology was seen as one of the risk factors relative to older people's ability to access the support required.

"I think if services are restricted just to being available on the phone... that digital exclusion aspect comes up, then we're not gonna see action. You're not gonna get everyone the help they need. So, as a service, having the resources to be able to send someone out in person can sometimes make the difference."

(Community Partner)

Safety

Two aspects of safety were identified as important for maintaining older people's resilience. Firstly, the need to feel safe and comfortable in their neighbourhood:

> *"[In my previous house] I couldn't cope with all the noise that was going on up above. And that was one of the main reasons I took this place here because you don't hear a soul. It's really quiet. And that was my number one thing that I wanted more than anything, was peace and quiet, because of what I had to listen to in my old house."*
> (Older Person, Reset)

> *"I really want out of here... It's because of [my neighbour] next door... I'm getting a sort of anxious feeling every time I even think about her..."*
> (Older Person, Reset)

Secondly, financial security in relation to online banking and transactions, which many older people do not feel comfortable with, was identified as a common source of anxiety and concern. Having alternative options in place, ensures that services and/or resources are available for all.

> *"Financial vulnerability is a massive thing that we respond to because a lot of services now are Direct Debit... The amount of people that have lost out on services, i.e., the Food Train, or other ones, because they refuse: 'No, no, no I'm not signing up for anything cause I'm not having them take it out my bank'."*
> (Community Resilience Worker)

Material Resources and Assets

Unsuitable housing, energy and food security concerns, and financial needs were consistently highlighted as impacting older people's resilience.

> *"A lot of the situations are quite urgent needs. So, things like clothing, food, or energy issues at home... Getting those things to people when they need them is really important... Housing and environmental is a big one for us. So, bidding on properties, filling in EdIndex forms, because there's no other services that provide that kind of support on a longer-term basis."*
> (Referrer)

Assistance meeting these needs, particularly in the context of their complexity and, often, technology-based access to relevant resources and services, was one of the key requirements relative to community-based support.

"It took quite a while to get [a suitable] place fit for me to live in because I've got a lot of health problems. But [Community Resilience Worker's] been a great help, she's done everything... She helped with my moving, she got the removal van, she organised everything so I can move in. The only thing I didn't have when I moved in was furniture, so she got a chair from the centre there, she brought over here. That was a great help."
(Older Person, Reset)

"[Community Resilience Worker] also put me onto the fact that I'm eligible for the Attendance Allowance... [The extra money] supports obvious things like the cost of heating, I mean all my food, my groceries are delivered, so I probably spend more on groceries than I ever did."
(Older Person, Reset)

Access to Meaningful Activity

The ability to engage in meaningful activities i.e., activities that are important to individuals, in which they want or need to engage in (World Federation of Occupational Therapists, 2024), were identified as important to older people. Older people particularly valued activities that provide opportunities for social connection, as well as meet their need for routine and purpose.

"I quite like a sudoku and a crossword, plus they keep your brain ticking sometimes too, even if you cannae get them, you're still thinking."
(Older Person, Community)

"I'm out every day now. I have a routine to go out, I'll be going out this afternoon. I send books up to my sister-in-law, so I'll be going to the post office and doing that."
(Older Person, Reset)

But, as health deteriorates with age, affecting mobility and various areas of function, this was frequently identified as an unmet need.

> *"I used to watch football. I used to go to the pub now and again, but these things have stopped... They've got a wee community centre just as you come in. They've got a pool table and television, but I can't manage that. I find that when I go and I walk, I can't walk very far. I have to take a rest."*
> (Older Person, Reset)

Limited provision of community-based activities that recognise the diversity of older people, their levels of ability and range of interests, was also highlighted as restricting opportunities for meaningful engagement.

> *"A lot of people will say 'Oh they're all old. I dinnae want to get mixed up with old folk', and I think 'Well you're old yourself.' ...If they came here [community club], seen the activities, there's plenty of activities for people."*
> (Older Person, Community)

> *"They have a tea morning, but I'm not into that kind of thing... When I get better, I might actually go down and start a wee club of some sort [with other residents] ... I'll show them how to do a bit of drawing and painting and stuff... Older people like myself would enjoy doing things like that... I've got experience with guitars, drums, painting and drawing, building models. So, I've got a lot of things to offer."*
> (Older Person, Reset)

Indeed, social activities were perceived as an opportunity for older people to support others and to contribute as community members.

> *"I was befriending a lady, and I did it for about just over a year. And I used to see her every week for coffee and things like that."*
> (Older Person, Community)

Part 2. Fostering Resilience-Affirming Community Support

Reset Programme

The Reset Partnership was established with the primary aim to implement the Edinburgh Wellbeing Pact's (Irvine Fitzpatrick 2021, p.9) commitment to **maximise wellbeing of older people** through a programme of community support designed to enhance **resilience, relationships and resources**, that are important to individuals, and to **learn what should be considered when planning and providing this kind of support.**

> *"[Reset] provides practical stuff and that contact with people. And just a person-centred approach really starting where the person is at and helping them identify what they think they need... GPs or hospitals can only see the medical side of it, whereas with time we can sit with people and we can work with them holistically to just identify those other social emotional issues in their life to build resilience as opposed to just coming at it from a medical perspective."*
>
> (Community Partner)

Across the duration of the Reset Programme, four dedicated Reset Community Resilience Workers (CRWs) assessed resilience needs and provided individualised, relationship-based support to 291 older people across Edinburgh communities.

This involved the CRW visiting the person at home or in hospital to get an understanding of their needs within their current circumstances. The initial visit would take around 90 minutes and focus on listening to what matters most to the person and discussing the support that may be beneficial. The CRW took a person-centred approach to understand the individual's needs and how best they can assist them to live more independently. Their visits would recur weekly or fortnightly depending on the complexity of support required and the initial goals. The CRW would be contactable in between visits, should any issues arise. When necessary, intersectoral visits took place with Social Workers, GPs and other relevant service providers. Support periods would range from a few visits to several months, depending on requirements. This reflected our recognition

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that needs can evolve and the fact that often, as we would tackle one area of concern, other difficulties would become apparent. CRWs had the autonomy to manage their caseload and adapt the support they offer to fit changing needs. They also had the flexibility to maintain the support for as long as needed, whilst being mindful of boundaries and dependency forming.

Assessing resilience needs

At the onset of the Reset Programme, we tested the use of the Reset Questionnaire, a self-report tool, validated to assess resilience needs in a reliable and comprehensive manner (Whitehall et al., 2021). The questionnaire consists of 34 items related to personal and environmental determinants of resilience. We identified that, in the context of communities like those supported by Reset, assessment of older people's needs requires sensitivity as, often, people are referred for support at the time of crisis and increased vulnerability, with many basic needs unmet. We therefore adapted the tool in line with Maslow's Hierarchy of Needs (Maslow, 1971; Appendix 3) to facilitate a comprehensive assessment of resilience needs through person-centred, sensitive conversations. This allowed exploration of, and focus on, basic needs i.e., these related to health and wellbeing, access to essential resources, safety and comfort; before considering higher level of needs, including social connection, belonging, self-esteem, personal growth and fulfilment. Additionally, we set out to capture and monitor a range of demographic and health factors, as research suggests that at least some of them (e.g., gender, education, marital status, income, access to social support and size and quality of support networks, depressive symptoms; general health) are directly associated with resilience (Górska et al., 2021).

CRWs were provided with training in using the questionnaire to identify resilience needs, support personal goal setting and to inform planning of support to achieve these. When doing so, they were encouraged to apply their professional judgement relative to person-centred, sensitive consideration of when to introduce the questionnaire, and whether it was appropriate to complete it in stages or in a single attempt.

However, from the onset of the service, the uptake of the questionnaire was low, with CRWs reporting barriers to implementation.

Although the role of the Reset Questionnaire in capturing the person's own perspective on their resilience needs was recognised, CRWs noted that the self-reported status often misaligned with their observation of people's needs, which could lead to missed opportunities relative to identifying and addressing many unmet needs.

"The people that we work with are very stoic so we could really miss something there that is a big issue... [The questionnaire is] not going to give us a true reflection of what is happening... because people are gonna say, 'Oh everything's fine.' ... We could potentially miss a lot of work that needs to be done if we took the questionnaire at face value."

(Community Resilience Worker)

"As much as it's great that [the questionnaire is] person-centred and self-reported, maybe it is risking being a bit one sided."

(Community Resilience Worker)

Community support staff also reported difficulties introducing the questionnaire at an appropriate time. They often met people when they experienced crisis and increased vulnerability, when asking them to complete the questionnaire is not appropriate and stands in a way of building rapport and trust. However, completing it at a later stage, when the person's basic, immediate needs were addressed, was seen as missed opportunity relative to capturing the level of need and extent of support provided.

"The whole point of the questionnaire is that it would be done at the start of your relationship with the person... We're dealing with people that are in hospital, they're in crisis, they don't have food, they need their energy bill paid... So, if you're really going to measure something, you would do it right at the start when they're in the crisis... We're not able to do that because it's totally inappropriate to introduce this questionnaire when a person you meet is in crisis."

(Community Resilience Worker)

CRWs argued that the questionnaire format of assessment does not fit well with the ethos of Reset as it could feel transactional and create a power imbalance between support staff and older person.

"We are the person who'll go and have a cup of tea when somebody's feeling lonely. A listening ear with no agenda... The questionnaire becomes an agenda and that then creates a different relationship dynamic."

(Community Resilience Worker)

Instead, they emphasised the importance of identifying older people's needs using a conversational, relationship-based approach. This was supported by older people who stressed the importance of conversation and face-to-face interaction as part of a person-centred, comprehensive assessment of their resilience needs.

> *"I'd rather speak to you and tell you how, you know [rather than filling out a questionnaire] because that's not a day-to-day thing is it really? [...] I'd rather tell you, ask me and I would give you the feedback that way. [...] I'm reading them [questionnaire items] but they mean nothing to me."*
> (Older Person, Reset)

> *"I prefer talking because I can talk to somebody face to face, or whatever, but if it's written down on paper, or something like that, that makes things a lot harder for me."*
> (Older Person, Reset)

Subsequently, the Reset team adopted a face-to-face, conversational, relationship-based approach to assessment of resilience needs. To ensure consideration of relevant range of personal and environmental resilience factors, CRWs used findings presented in Part 1 of this report, to guide the assessment process. However, we do acknowledge that, to facilitate consistent and equitable approach to assessment, further work is needed to develop a format of assessment that allows consideration of a broader range of personal and environmental factors, facilitated through person-centred conversations, while reducing reliance on skills, competencies and understanding of resilience factors by individual practitioners. Such approach should incorporate consistent and accurate recording and monitoring of relevant demographic and health characteristics (Górska et al., 2021), to inform more targeted, effective, bio-psycho-social support.

People's Stories

Older people are a diverse group (WHO, 2022). Although many live active and healthy lives, a large proportion, particularly those from disadvantaged backgrounds, experience poverty as well as complex, multiple health and social care needs which affect their health outcomes (Age UK, 2019; WHO, 2022). We know that most of the variation in these outcomes is due to people's physical and social environments – including their homes, neighbourhoods, and communities, as well as their personal characteristics – such as their sex, ethnicity, or socioeconomic status (British Medical Association, 2017; WHO, 2022).

As illustrated above, this is also the experience of older people within communities that this research focused on. With the consent of individuals concerned, we collected four case studies, representing experiences of older people across these communities to illustrate the diversity of their experiences and complexity of needs, as well as the kind of care and support offered by the resilience workers to meet these needs.

All names have been changed to protect identities.

Bill, South West Edinburgh

Resilience needs addressed: physical health, mental health, physical environment, income, safety, material assets, social isolation, access to information, services and resources, feeling valued.

Bill, 65 years old, was living in temporary accommodation. A historic work injury had left him with back pain and poor mobility. He had a severe visual impairment and was awaiting a double cataract operation.

Despite his health issues, Bill was still managing the stairs within his second floor flat until he was hit by a car which fled the scene leaving him with a serious neck injury and broken bones in his hands and feet. His daughter and son in law were supportive. However, both work full time and were feeling the stress of caring for Bill. This had led to tension in their relationship, and they were struggling financially to continue to support him.

The Royal Infirmary of Edinburgh (RIE) referred Bill for support to aid his discharge from hospital. He needed help with shopping and cleaning services.

When Jane, the Reset CRW, met with Bill at his home, he informed her that his Personal Independent Payment (PIP) had been stopped suddenly without any notice. This had resulted in a significant reduction in his income, extreme financial hardship and rent arrears. English being Bill's second language made dealing with this matter over the phone more challenging and he was no longer able to get out of his flat.

Bill's flat was cold, and the faulty smoke alarm would sound whenever the carers used the oven. He had an energy debt of £5K as this had never been paid during his 5 years of occupancy as he believed this was included in his rent payment. Jane's initial assessment determined that, as well as access to emergency food, he needed urgent help to claim emergency benefits.

Jane submitted a referral to The Advice Shop for a benefits check to ensure Bill was getting assistance he was entitled to. This is ongoing, with a current claim for Adult Disability Payment (ADP) pending four months while awaiting a medical review scheduled for September 2024. An application for a Limited Capability for Work Related Activity (LCWRA) for Universal Credit (U.C) has also been submitted which, if awarded, will be backdated to November 2023. Additionally, an application was submitted to the Scottish Welfare Fund for financial assistance.

Numerous other referrals were sent:

- **Changeworks** - Bill awaits an appointment with an Energy Support Advisor to discuss the best way forward in dealing the large energy debt.
- **Golden Years** - to reduce Bill's social isolation, Jane sent a referral for befriending. He is currently on the waiting list due to a shortage of volunteers and high current demand for this service.
- **Community Fire Safety Team** – Jane liaised with Private Sector Leasing (PSL) to arrange for the smoke alarm to be replaced and for oil heaters for Bill's cold bathroom.

Jane worked with the care agency and district nurses to arrange an increased care package which now includes time for changing the bed and light housework.

Replacement pillows and bed linen which had been disposed of when Bill was taken into hospital were purchased through the Reset client fund and Jane arranged a home visit from Bill's GP to get a backdated sick note for his benefit application and ADP claim.

Where Bill is now

With more care package hours Bill has more support at home with practical tasks. The new bedding means he is more comfortable. His home environment is safer and his debt more manageable. Bill's family members who care for him are less stressed and there is less tension. Primarily, Bill is safer, more comfortable at home, has increased financial security and improved living conditions.

Below is feedback provided by Bill's son-in-law in relation to his support:

"The Reset team, especially Jane, have been hugely influential in Bill's care and forward planning...myself and the family 100% do not know how we would have managed without this valuable input....everything from arranging appointments to home visits have made such a huge difference....Jane's ability to reassure Bill has been a major part of his recovery....She is a credit to the Reset group"

"The Reset program and all the team are honestly worth their weight in gold and should be commended for their work"

"Please continue making a difference"

Janine, North East Edinburgh

Resilience needs addressed: physical health, mental health, self-efficacy, safety - physical environment, income maximisation, availability of information, access to services and resources.

When Janine was referred, she was 77 years old and living alone in a sheltered housing complex. Her physical health and mobility had deteriorated since suffering a stroke and was causing her challenges moving around her home. This was exacerbated by the cables and electronic equipment cluttering the floor, increasing her risks of falling.

Janine was actively involved in the art world but when her husband passed away in 2021, she withdrew from all social activity. Janine's daughter had died some years earlier so other than the occasional visits from her son she had no regular support network. This sequence of events had caused a decline in her mental health, and she had become very isolated.

The Reset referral was for support with de-cluttering and to re-organise items around her home. She had fallen numerous times, causing a further dip in her health so the aim was to create a safer living space.

CRW, Lisa, visited Janine at her home and completed a needs and risk assessment. She discovered that Janine was struggling to manage her finances and had accrued £10,609 of debt including credit cards and personal loans as well as her energy bills and council tax falling into arrears. She had been avoiding any letters, calls or correspondence relating to this.

No payment method had ever been set up for Janine's council tax, CAS alarm or energy bills. Lisa submitted a referral to the Advice Shop and worked alongside Janine's Money Adviser to gather information on further accrued debt, Janine's current income, expenditures and they completed a Debt Pack.

Together, they conducted a benefit check and determined that Janine had been receiving an increased amount of housing benefits as well as a reduction of council tax which she was not entitled to. Lisa discussed this with Janine and encouraged her to be transparent as, although it would reduce her income, in the long-term it would make her situation significantly better. Janine agreed, so Lisa updated the revenues and benefits team with her most current details, reducing her total debts to £7,059 (difference of £3,640).

Lisa assisted Janine to call British Gas, ATEC24 (CAS team) and ChangeWorks to start looking at the resources available to her and set up repayment plans.

Janine and Lisa have also been working together on a weekly basis to pack up and organise items into boxes. They are gradually working through the clutter, making the space safer to navigate.

By taking a holistic approach to the referral and assessment of need, Lisa could tackle additional issues which were of high importance to Janine.

Janine was placed on the Priority Services Register and vulnerable client list for ChangeWorks to receive relevant grants and financial support relating to the energy fuel debt. As Janine retired from the Armed Forces, she was also connected with Soldiers', Sailors' & Airmen's Families Association, the armed forces charity, for future financial support.

Janine's mental health has been deteriorating and resulting in serious functional impairment. A Severely Mentally Impaired (SMI) form was requested and signed by her GP and as a result her council tax arrears has been cleared and she was exempt of any future payments. The Money Advisor will continue to share this with the other creditors and request a consideration of debt write-off or reduction.

During the four-month period of support, Janine's relationship with Lisa developed considerably and she shared more about the negative impact of this situation on her mental health and wellbeing. Initially overwhelmed by the idea of decluttering, she 'did not want to start something she couldn't finish', she gradually engaged with this process.

By taking the time to listen to her worries and provide reassurance that she was not going to have to do this alone, the pair agreed on a plan to split the work into manageable tasks. They have now reached the point where Janine goes through her belongings and sorts through her items between visits, independently.

Where Janine is now

Janine has re-gained her confidence and found the motivation to take ownership of daily tasks. She has been more honest with her GP about her mental health struggles and been able to budget and set payment dates. She is also more aware of the resources available to her and who to contact if she needs help in the future. All in all, her environment is safer, finances more manageable and she is seeking the support she needs to have more recurrent better days.

Mary, North West Edinburgh

Resilience needs addressed: physical health, physical environment, availability of support networks, self-efficacy, quality of support, safety, technology, access to services and resources, material assets, quality of life.

At 73 years old, Mary was unable to be discharged from hospital. Her first floor flat with no lift access was no longer suitable for her needs as she was unable to walk and confined to a wheelchair.

Mary was very capable mentally but because she had been in hospital for several months, she had forgotten a lot of her passwords and could not retrieve her emails on her laptop. She had a couple of friends and a brother who visited her in hospital but none of them were able to support her to get home.

The Western General Hospital referred Mary to Reset for support with discharge by securing a suitable property, and for help with benefits. When the CRW, Marie, met with her, Janine advised that she already had an EdIndex account but needed help accessing and using it to bid for properties. She also needed help to organize the move and to resolve an issue with a previous application for Attendance Allowance which she had sent but it had never progressed as the form was not fully completed.

Marie worked along with the Home First Coordinator, the hospital Occupational Therapist (OT) and Home Accessibility Referral Team to manage the move from hospital and secure suitable housing. She re-set the EdIndex account and found that the person had gold priority, making her needs urgent. Once a suitable place was secured, she dealt with the tenancy paperwork, arranged for a removal firm and assisted Mary to pack her belongings.

Marie contacted Mary's internet provider to transfer the service and finalised her Attendance Allowance application, applying for the higher rate, now that her care needs had changed.

Once home, Marie and the OT worked together to arrange an appointment with the Southeast Scotland Mobility and Rehabilitation Technology (SMART) centre so that she could be assessed for an electric wheelchair. Mary no longer had enough strength in her hands to operate a manual chair, meaning that for the time-being she was housebound.

Where Mary is now

With the additional income Mary was now able to pay for her electric wheelchair, taxi costs to get around and private companionship support. She felt she was able to manage independently with the support of the carers.

Mary received backdated Attendance Allowance of £1500.40 (£68.10 a week) and backdated higher rate of £538.40 (£101.75 a week), a total increase of £33.65 a week.

Below is feedback provided by Mary and the Home First Coordinator:

"The support from Reset was invaluable." **(Mary)**

"Working collaboratively has reduced my workload." **(Home First Coordinator)**

Paddy, South East Edinburgh

Resilience needs addressed: physical health, mental health, sense of coherence, optimism, social isolation, quality of support, safety, perceived stressfulness of an event, meaningful activity, feeling valued.

Paddy was 69 years old and had been living in Edinburgh social housing for the past 20 years. His home was in an area of multiple deprivation with high levels of poverty and anti-social behaviour. The main entrance was heavily littered and there were often people using drugs in the stairwell.

Paddy struggled with traumatic and depressing memories. He had no social circle, no hobbies, and his neighbours who helped him had their own challenges.

Unable to read or write, Paddy relied on others, mainly the neighbours, to keep tabs on how much money he had and on his mail. This made Paddy vulnerable to exploitation and abuse, and he seemed to place a high level of trust in individuals whose intentions were unclear.

Paddy was referred by the Home First team at RIE. There was minimal information, but the main request was to assist with a house move so that he could be discharged. His admission to RIE followed a serious fall at home three months earlier which had resulted in a head injury.

When the CRW, Donna, met with Paddy, he was considered to have very ill-health due to his end stage COPD, low body weight and increasing inability to manage the second floor flat. The process to apply for a place in sheltered housing had already begun and Social Work were looking for Reset to take over. Donna supported Paddy with all aspects of the tenancy transition, including terminating his lease, liaising heavily with City of Edinburgh Council (CEC) housing regarding his new tenancy, any repairs required and carpet fitting.

Donna's initial assessment of Paddy was that he would benefit immensely from Reset support but that co-productive working with other services was vital. She asked Social Work to arrange for a mental health assessment as this had not been done despite Paddy 's suicidal ideations at their first meeting. He repeatedly said, "I've just had enough of it all now" and was refusing food on the ward.

To improve Paddy's emotional wellbeing Donna made frequent hospital visits, to get to know him and build trust and familiarity. He quickly felt more comfortable and began to express his hopes and fears about being alone and coping with his complex health.

Donna helped Paddy to purchase a portable radio and headphones, enabling him to have a home comfort and a source of distraction from the noise on the ward that he found both exhausting and overwhelming.

Donna terminated his social housing tenancy and managed all arrangements for the move, including booking movers, discussing options for storage, helping Paddy to choose, order and pay for carpets from his bedside, arranging the uplift of his hospital bed from his tenancy, and liaising extensively with CEC housing officers. She also liaised with RIE Social Work, around the ongoing plan for Paddy's care, including the move into a community hospital.

In addition, Donna liaised with the RIE hospital Benefits Worker to manage overpayments of PIP for while he was still in hospital and to begin an application for Discretionary Housing Benefit to cover the cost of potential duplicate rental charges.

Paddy discussed funeral wishes with Donna and she made enquiries about the options available with a local Funeral Director.

Donna invested time and energy into getting to know Paddy on his terms, chatting to him about his family and his past, his former career, pet peeves, favourite foods, what was important to him for the remainder of his life. When visiting the ward, Donna would bring his favourite Gregg's chicken bake and borrowed a hospital wheelchair to take Paddy on visits to the canteen and out into the green space surrounding the hospital. Paddy loved having fresh air and a change of scenery. Donna would read out letters and helped him count his money and manage correspondence around his existing and new tenancy.

An update on Paddy

Donna supported Paddy's move from RIE to a community hospital and helped him to unpack and settle, arranging his clothes and furniture to make him feel more at home. Sadly, he died shortly after the move.

Donna continued to work on the case, notifying all parties involved, providing updates and cancelling planned work. She submitted an Adult Protection concern to Social Care Direct as Paddy's neighbours had signed out his belongings including bank cards and PIN. As Donna had discussed Paddy's wishes with him, she was committed to respecting these.

Having no contact with family or close friends, there was no-one to attend the funeral, celebrate Paddy's life, his experiences and the things he had loved and cherished. Donna took the time to go for a walk to manage her own resilience. She lit a candle, read some poetry and made some reflections on him as a person to provide a sense of dignity and closure to a "sweet man" who was very alone and vulnerable in the final days of his life.

Below is feedback provided by Paddy:

"I call it the hell hole this ward (laughs)... I can't thank you enough for going to get that radio for me... I'm going to drift off listening to programmes...I might listen all night... aww I'm so grateful."

"Aww it's so good to go outside and it isnae that cold pal...I love it...the fresh air is magic."

"I'm so relieved, I can get well here now...so happy to be here pal (said to Donna as she held his hand, while he cried during his first day at the community hospital)."

Barriers

Societal attitudes

Older people in this research reflected on the impact the societal attitudes towards ageing, acceptance and inclusion of older people has on their experience.

> *"I realise how important it is to walk into a shop and not be treated as somebody who is odd... That's something that has improved enormously over the many years that I've been an adult... Before my wife died, she was in a wheelchair in the last year or two and you'd go to a restaurant, and nobody would look up and stare at you... You were just another person and I find that now myself and I realise how important it is."*
>
> (Older Person, Reset)

It was suggested that older people are often negatively viewed and marginalised, and that these perceptions may be reflected in insufficient funding for services to address the needs of this group.

> *"Other cultures perhaps respect older people, I think in our culture, in Britain, we tend to think you've done your 35 years' service. You're getting older and maybe there's an element of, like, people feel forgotten."*
>
> (Community Partner)

Digital exclusion

The experience of being marginalised is partially reflected in the digital exclusion affecting older people. Many services are now only available through digital means (e.g., energy or welfare benefit providers, increasingly banking), limiting accessibility for groups with reduced resources or skills to use or navigate through complex telephone or internet-based systems.

> *"Access to technology and the ability to use it is a really big one. I would say 99% of the people I work with cannot use the computer or smart phones for different reasons. It's a huge thing and it's getting worse."*
>
> (Community Resilience Worker)

"Trying to access cash is tricky, parking your car is tricky because they don't want you to use coins anymore... It doesn't worry me too much because I can cope but I can see myself in 5 years' time being completely perplexed by all the new technology coming in."

(Older Person, Community)

Growing reliance on technology to identify and access services and resources and older people difficulty coping with this demand, was identified as underscoring the risk of older people missing out on the available help and, consequently, the need to provide face-to-face, home based assistance using technology and navigating through digital systems.

Navigating through automated systems to speak to a real person can be difficult for older people. Even if they are successful in getting through the automated stage of the call without being cut off for selecting an incorrect option, they may still have a long wait to connect with someone.

Repetitive questioning for data protection, being passed between departments, waiting in further queues and having to repeat the reason for the call and data protection again, can cause anxiety, stress and frustration. At times, there is an option for a call back which often does not happen.

"I think if services are restricted just to being available on the phone... when digital exclusion aspect comes up, then we're not gonna see action. You're not gonna get everyone the help they need. So, as a service, having the resources to be able to send someone out in person can sometimes make the difference as well."

(Community Partner)

The assumption by service providers that everyone has confidence and ability to engage with technology has been identified as limiting accessibility for older people. It highlights the need for a better design of digital platforms and more digital literacy awareness training of staff handling technology-based services, to promote better inclusion and accessibility for all.

"The interventions or information being accessible and geared towards the person that is receiving it [is important], because it's not good enough to say 'Well there's your information about whatever'... That happens a lot... I've worked with gentleman, and I think the housing officer meant really well, he sent him detailed screenshot instructions of how to set up an account on EdIndex... [but] it's not accessible to the person, so I think it's one thing to give information and another thing to make sure [it's accessible]."

(Community Resilience Worker)

Governance

Establishing a governance board at the implementation stage to steer services is beneficial in helping them to meet strategic aims and outcomes. Direction and strategic leadership from a governance board would ensure alignment with service specification, contract requirements and research protocol from the onset.

Partnership working

Although the value of Edinburgh Health and Social Care Partnership, relative to promoting integrated care for older people was acknowledged, people in this research reflected on the lack of consistency in partnership working across services, particularly between sectors. This often was exacerbated by incompatibility of digital platforms used by different organisations.

"Some of the hospitals will quite happily use their online referral system and pop it through so we can deal with it as quickly as possible whereas others are like, 'Oh no, we're not allowed to give you that information, you have to phone us.' So, then you phone them and then you've got to leave a message, so you're constantly chasing things up. We're all part of the Edinburgh Health and Social Care Partnership, everything's secure. You can give us that information and we can get it dealt with so the person can get home."

(Community Partner)

Information sharing between agencies is not always straightforward and referral forms are often submitted with limited information. Many Social Workers expect the third sector to have access to their systems and ability to access crucial information about a referred person's health and social circumstances.

Working alongside the NHS often presents similar challenges, as the third sector does not have access to the NHS portal to request e.g., movement of hospital equipment, instead having to go through occupational and physical therapists. There are instances of inappropriate data sharing and a lack of concern for privacy that could be addressed through better use of a shared platform. In one case a person's possessions, including banks cards and PIN, were released by hospital staff to a neighbour who became subject to an adult protection inquiry following the person's death.

> ***"At times, I come across somebody who actually comes back as a re-admission, and I can see on our [care management] system, on AIS, that I actually did the referral for the Reset worker. But then because you guys don't have access to AIS, I don't know what was actually done."***
> **(Referrer)**

> ***"The housing associations deal differently with the people that we pick up... The [housing] system is so broken. It's not linked in with the hospitals and the Home Accessibility Referral Team, and the EdIndex team."***
> **(Community Resilience Worker)**

It is a-typical for the same GP to support a patient on an ongoing basis. Older people routinely engage with a range of GPs within their medical practice, and this can create challenges for consistent care, particularly when supporting people with complex health circumstances and often in the absence of extended family. With advocacy services operating under growing pressures and with higher thresholds for referrals, people find it increasingly challenging to receive the required assistance. Therefore, services such as Reset play a crucial role in advocating for clients to specific health and social care professionals about needed improvements in personalised and person-centred care.

Services often work beyond capacity, which leads to pressures on front line staff who do not have the time to invest in effective person-centred partnership working. Such pressures lead to narrowing of focus and limit opportunities to address complex health and social care needs in a timely, person-centred, holistic way. Partnership work is not always prioritised as it can be perceived as requiring too much time and resource.

Communication and responsiveness

On occasion, when liaising with statutory partners, CRWs experienced difficulties obtaining a response to emails enquiring about support for older people. Some departments do not provide a telephone number to call, making it challenging to follow up. When support is unavailable, there is often no alternative signpost.

Such challenges with communication can be distressing and frustrating for older people. Reset engaged with a person unable to contact a service for several months, resulting in deterioration of their property. In another case, the CRW requested a welfare check as they were concerned someone had fallen at home. When following up 24 hours later the CRW was advised this had not taken place but informed they could contact the police directly to request this.

Resources

Service capacity and resource provision within community services was also identified as a barrier. This related to limited funding which affected availability of both financial and human resources.

> *"I think that there's maybe not the services to meet the demand [...]. And that is across Edinburgh, across Scotland, across the world."*
> (Community Partner)

> *"[Within Reset] there's only one worker per locality... The two [people] that I was referring from that locality were very complex and would've really benefited from the support. And because they don't have that support, they're just left and there's that gap... So, I would say that in some of the bigger localities, it would be good to have more workers so that they can take on more cases."*
> *(Referrer)*

One person was visited at home by a health practitioner to assess leg swelling, the deconditioning of a client's skin, and to order a pair of Ted Stockings, advising a two-week delivery period. Six weeks later the stockings had not arrived, and the skin condition had significantly worsened. When the CRW called the clinic, a recorded message informed them that the service was operating at reduced capacity and would return the call within 28 days

Many services such as befriending are at full capacity. Many older people still feel lonely and isolated despite the increased focus on reducing this in recent years. They can often wait for months for a match with a volunteer.

Age related deterioration in health often leads to increased social isolation and difficulties attending to daily tasks independently. Services that enable social connection and provide assistance with activities such as shopping or cleaning are limited, often exacerbating ill health. People also describe not being able to get to health or hospital appointments due to a lack of transport service or an inability to use transport without assistance.

A person supported by Reset was unable to be discharged from hospital due to a two-month delay in fitting radiator covers in their sheltered housing tenancy. This delay prevented them signing new tenancy agreement, being able to progress the fitting of carpets and installation of white goods to the new allocated tenancy. The person never left hospital and died whilst waiting for this to be completed.

Opportunities

Focus on resilience

Working in the way that reflects and supports understanding of resilience as a process of adapting to adversity, shaped by complex interplay between multiple personal and environmental factors (Górska et al., 2021) affords opportunity to deliver community-based assistance which is both person-centred and holistic. It facilitates a comprehensive assessment of people's needs and their strengths, as well as assets, resources and challenges within the environment, enabling the support that allows "[being] *solution focused as opposed to looking at everything as a problem.*" (Community Resilience Worker).

> *"We work holistically, we're not focused on one area... it increases our positive outcomes because, for one person we can achieve so much... And we're constantly building on our knowledge as well... we're a one-stop shop for some people... we're given the freedom and the autonomy to do that and learn and improve... what we are doing is creating a small team of people who are multi-skilled and so you're not having to pass people from pillar to post, which often happens."*
>
> (Community Resilience Worker)

> *"Workers focus on what is important for the person. And they also provide knowledge, information, and links with the community, so people can feel empowered and in control."*
>
> (Referrer)

It was acknowledged that the understanding of resilience applied in this research should be promoted, further developed and clarified among community support staff to facilitate such positive outcomes and to help both staff and older people to better understand what resilience-focused support means in practice.

> *"We need to revisit what resilience means because we've all got our own perception of it... I think we need to be more informed as to what that looks like... We talk about it a lot and we're Community Resilience Workers but revisiting what resilience actually looks like, and what other people's perceptions are of resilience... I think it's something that we should revisit quite often (...) because it gives us confidence and a solid base."*
>
> (Community Resilience Worker)

Reset
Resilience • Relationships • Resources

Supporting resilience may take different forms. For some people it may mean encouragement, motivation, reassurance and physical support when working to improve mobility; for some creating opportunity for social interaction; for others help with income maximisation and ensuring fulfilment of basic needs such as access to food, energy, safe, suitable housing and relevant health care. For most, it means supporting their sense of self-efficacy and control, which may have been affected by e.g., prolonged hospitalisation, experience of bereavement, living in unsuitable environment, insufficient financial resources. Many older people may experience multiple resilience needs at the same time.

"I'm a determined person and I would've attempted to do all this myself, and some of it I wouldn't have been able to do, and some of it I would've been able to do. But it would've took me an awful lot longer. So, like going out and walking to the end of this road, I probably wouldn't even have attempted that until last week or something, whereas I've been doing it now right from the start because of the help that I got. So, that makes a big difference because I'm a lot better now being able to do these things. I'm a bit better now than I would've been if I'd been left to try and do it myself. The other thing is just being able to talk to somebody, that is a massive part of it. It's- they do help obviously, but it's not just the help that they're actually physically doing, it's being able to talk to somebody because otherwise you're just sitting here looking at walls."

(Older Person, Reset)

"All these things, they've all snowballed from her just coming here to fill in a form.... It's made a big difference with a lot of things. I've got the electricity on, that's a big massive worry off my mind now. I'm getting to the shops, I'm actually starting to get a life back, which I didn't have."

(Older Person, Reset)

Seeing the person and the context

Being able to assess older people's needs and to support them within the context that is most relevant to the person, was crucial to effectively support their resilience. This was regardless of where the initial contact with the CRW took place – whether at hospital or at the place that the person calls home.

The ability to provide face-to-face, rather than technology based, contact and interaction was seen as more appropriate when working with older people. It afforded opportunities to develop relationship and trust and to engage in a more systematic, thorough and comprehensive assessment of needs, as well as exploration and use of most relevant support and resources.

"Being able to go to somebody's house rather than trying to do phone calls and other things that other services provide, is a really good thing. Because a lot of people struggle on the phone, or they don't want phone calls. Or they don't really want services until people go into their house, speak to them, and make that connection. A lot of the time [the Community Resilience Worker] will come in as well and identify needs or support needs that we haven't asked for. So, they're looking at the whole situation at home, and thinking about things that maybe we haven't thought of through that discussion that they're able to have, through the time that they're able to spend with people. So, we ask for one thing and often get a lot more, which is great."

(Referrer)

[Community Resilience Worker] usually got an answer for most stuff. So, she's been able to help me quite a bit... She seems to know who to ask for what, things I've never heard of, or people I've never heard of... It's putting people like me in touch with the right people... and giving us knowledge of the people that actually exist, because I was in hospital, I wouldn't have known... I wasn't expecting any help from anyone."

(Older Person, Reset)

"A lot of the services a person engages with, they've got a time and a place. So, you work with them in the hospital, you work with them to get discharged, you work with them when you're at home, but we're able to fit into every single piece, and we can."

(Community Resilience Worker)

Enabling community living and participation

Community-based, resilience-focused support was described as enabling independence and community participation and allowing older people to live at home for as long as they can.

"Reset is a resource for people to continue to live in the community, live where they would like to live, be listened to and supported to do the things that they would like to do. There are some things that prevent them from being able to do their shopping, or accessing social activities, and the role of the Reset worker is to provide that link to those things, and support them to be at home"

(Referrer)

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For those older people, for whom this support was initiated while in hospital, the involvement of CRW was seen as providing the link and continuity between hospital and community care, facilitating the process of discharge and providing a safety net afterwards. Once home, the focus shifted towards enhancing resilience, developing community connections, boosting sense of self-efficacy and control.

> *"[Staff] in the hospital, they fill in all the paperwork, they tick the boxes, the person goes home, and that's their involvement ended. We have an opportunity to meet [people] from earlier on in their hospital stay, and form that relationship so that when they go home... they've got a trusted relationship there. Because a lot of people are discharged into total isolation... There is an opportunity [for Reset] to be part of the process rather than just an afterthought when things aren't going to plan."*
> (Community Resilience Worker)

> *"If there is that availability most of time for the [Reset] worker to come onto the ward and meet the person before they actually go home, that then builds up that little bit of consistency for them. That starts that relationship building and then they follow that through by visiting them at home. And I think that's really, really important."*
> (Referrer)

Supporting housing needs

Supporting older people with a complex process of securing safe and suitable housing was identified as one of the major needs addressed by CRWs. This was often part of hospital discharge and involved assessment of housing needs, supporting or completing complex housing applications on behalf of a person, facilitating and supporting the process of moving between properties and settling in a new environment.

This support often was related to changing needs of older people, often reflecting deteriorating health, problems with mobility, general difficulty coping independently and reduced social support available within current housing. It was also frequently required due to older people's lack of confidence and skills negotiating complicated, technology-based applications and liaising with relevant services. For some older people the support involved de-cluttering their current environment.

In most cases, addressing housing needs led to enhanced mental health, sense of self-efficacy and control, as well as improved social connections and participation, general wellbeing and ability to cope, supporting the emphasis we place on the relationship between environmental factors and resilience.

"The Reset team [are] able to keep involved for as long as possible, or as long as needed to get that need met. To do the bidding on the housing and then give them support through with moving and organising removals, and new furniture and just everything into the new property. That's a really big one, certainly for my referrals."
(Referrer)

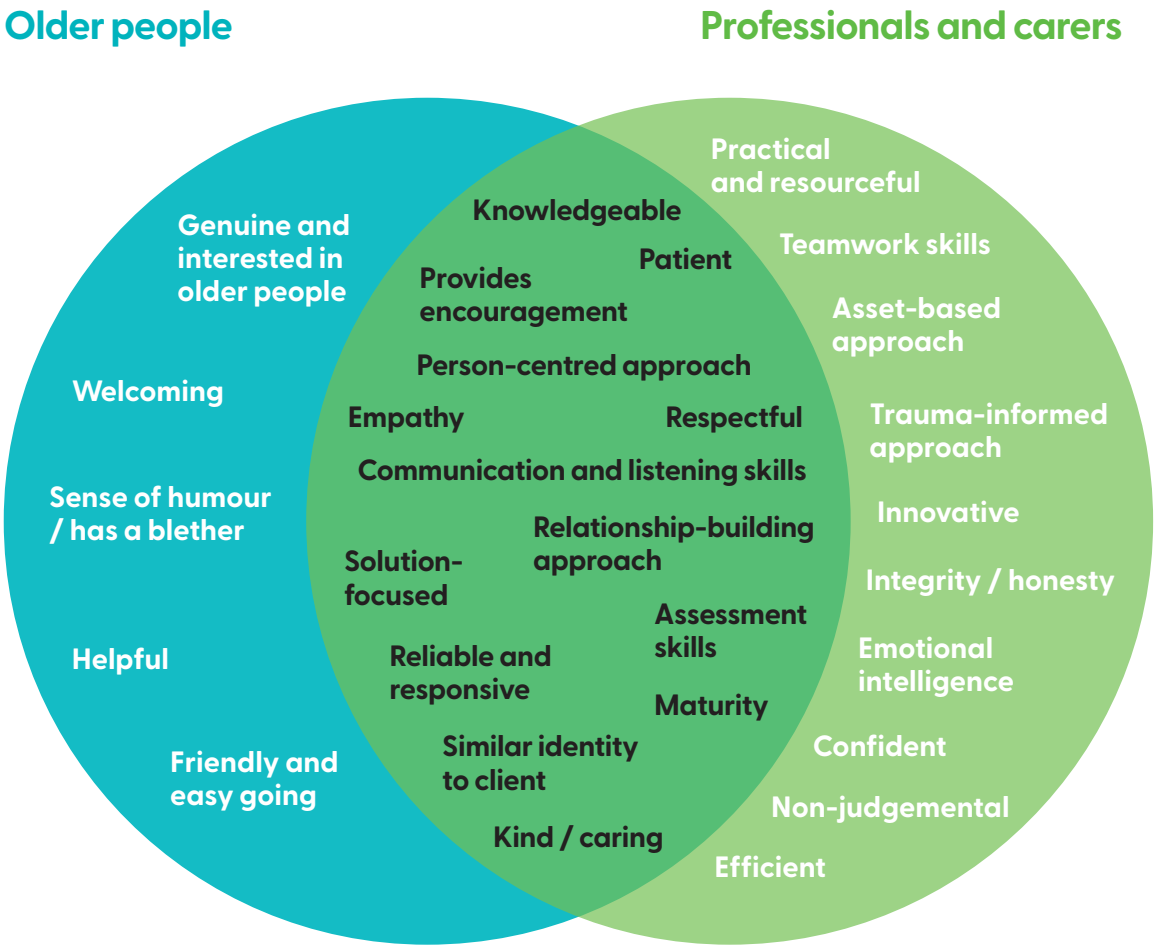
"We go to the door with an EdIndex form. We will fill it in with the person. We will then post it off. We will then follow up... We're the only people that are actually doing that. Then when it comes to viewing, we're accompanying people, picking people up and taking them to the viewing, and being there when they sign leases."
(Community Resilience Worker)

Part 3. Developing Resilient Workforce

Ensuring the Right Set of Skills

Addressing complex needs of older people requires skilful and knowledgeable workforce. Both older people and community stakeholders identified a broad range of skills and personal qualities as important in staff working with older generation. These are summarised in Figure 4.

Figure 4. Staff skills and personal qualities identified as important to older people receiving resilience-focused support



These do not only include professional skills such as those required for e.g., assessment of needs and strengths, goal setting, case management, advocacy, hospital discharge planning and support, facilitating complex welfare applications or addressing housing needs. They also involve the ability to understand needs specific to the older population, to develop and maintain rapport and build respectful relationships with people. Older people stressed the importance of people's skills in community support staff, including empathy, sense of humour and "being a blether". They also valued practical support provided by staff e.g., with food shopping or assistance when moving to more suitable housing; as well as their knowledge of, and the ability to facilitate access to, a broad range of services and resources which older people often are unaware of and / or do not have skills or confidence to pursue.

"You can't pick and choose your clients, so you have to pick and choose the people that you are employing. And so, I think there's a degree of maturity and the skill in handling people, skill in understanding and assessing people without making it apparent that that's what you're doing... Some of it comes with, not just training, but with maturity, just developing and getting it wrong a few times."

(Older Person, Reset)

"I like to think that if I'm going to someone in the workforce that they could be knowledgeable enough to be like a gateway to make suggestions of where you might get support you're really needing. So, I'd want them to be part of a network and if they didn't know, they would find out for you. That sort of thing; a gateway."

(Older Person, Community)

"[Community Resilience Worker] got things done. Normally people, they listen and then they get nothing done but she acted on my feelings immediately."

(Older Person, Reset)

"Community Resilience Worker's] been great. She's down to earth, and she's really friendly. She blethers away, she's my kind of person because she understands what I'm saying to her, and she's really helpful with everything... It's good to know there's somebody there that you can ask [for help] if you need them... It's a bit of chat there and a bit of a laugh and a joke and whatever. What a difference that makes."

(Older Person, Reset)

Ensuring that staff are equipped to effectively support older people may involve:

- Recruitment strategies that incorporate relevant skills, knowledge and experience as additional role requirements.
- Providing staff with ongoing supervision and training opportunities to identify and address gaps in their skill set.
- Building a network of community partnerships to facilitate access to the most appropriate and effective support and resources.

Peer Support and Reflective Practice

The ability of community support staff to benefit from peer and team support was identified as important by CRWs. As well as expanding and enhancing their toolkit for working with older people and community partners, this also supports their own resilience at work by allowing them to share knowledge and resources. In turn this increases their confidence through mutual understanding and emotional support.

"Being able to rely on colleagues and sort of bouncing off each other, I suppose, and information sharing, and knowledge sharing, and I think that's what makes a strong team."
(Community Resilience Worker)

"Peer support, definitely... It gives you that wee chance to be that bit vulnerable... with your colleagues... It forms stronger relationships... We're all human beings, we're all a bit vulnerable... It opens us up to supporting each other more."
(Community Resilience Worker)

"I think it's important for workers to have the opportunity to get together. I think working in isolation can be dangerous. You know, there's a certain level of lone working or home working, so coming together with your peers. Good supervision so that you're accountable for what you're doing so that you're met regularly with the manager, maybe clinical supervision for more complex cases."
(Community Partner)

This includes engagement in individual and team-based reflective practice, which facilitates learning from successes and challenges, but also identification of strengths and limitations. Being aware of these, forms the basis for honest communication and managing expectations from the employer and community partners, including older people, relative to support available and service / staff capacity.

> *"Usually in health and social care, you have a care plan, or you document your work in a day and then you turn the page... and it's never reflected back upon, so the way that we can reflect on the work that we're doing by having research by our side is very unique and very positive..."*
> **(Community Resilience Worker)**

> *"I think being honest with people about what you're able to provide, and what support is available to them... A lot of the time people have high expectations of the services that they can receive, or that are available... Letting them know that you'll do your best to support them with what they want but actually, there's probably a limitation to what you can provide."*
> **(Referrer)**

This may involve developing work culture where:

- Staff are encouraged and supported to engage in formal (e.g., as part of regular team meetings) and informal (e.g., through team WhatsApp group) peer support.
- Staff are provided with opportunities and structures to facilitate regular reflective practice, both as part of a team and individually.

Resilience-Affirming Work Culture

In line with our understanding of resilience as a process of adapting to adversity, shaped by complex interplay between personal and environmental factors (Górska et al., 2021); an ongoing, conscious effort needs to be made within the workplace to support staff resilience.

This should be done by creating work environment and culture which values staff, providing access to relevant support and guidance (beyond training aimed at skill enhancement), optimal funding and resourcing, and opportunities for intersectoral working to support complex needs of older people.

Organisations which embrace a learning rather than blame culture, will develop valuable awareness of what works well and what does not.

Valuing staff

Although community resilience staff have been consistently appreciated by the people they work with, the view by Reset team and other community partners representing staff working with older people was that community health and social care personnel is not valued within the broader society.

> *"[Community Resilience Worker's] been a great help, she's done everything... She helped with my moving, she got the removal van, she organised everything so I can move in. [...] That was a great help."*
> (Older Person, Reset)

> *"It's a real societal failure we've got there, and we just don't value caring in any shape or form in the way we ought to."*
> (Community Partner)

There was a perception that this is reflected in funding of community-based services for older people, including staff numbers and their remuneration.

> *"There's a lot of funds getting cut back from all sorts of things nowadays. And to me, if they take too much money away from these things people like yourself, or other people that's coming to help, aren't gonna be able to do it. And then what's going to happen to people like me that get out of hospital and cannae do these things? We're getting left sitting here with nobody. And that's gonna be even worse."*
> (Older Person, Reset)

Based on this, efforts should be made to:

- Highlight and promote the value of community health and social care within communities and broader society.
- Advocate for funding reflective of needs of communities served by health and social care services.

Supporting staff's emotional wellbeing

Staff within older people services, both community and hospital-based, experience high levels of bereavement at work. This is related to demographic profile and types of needs of the population served. It was observed that, due to long-term, relationship-based nature of support provided, particularly by community support staff, experience of bereavement at work may have profound emotional impact on individuals. This impact is not always recognised within workplace, resulting in limited access to appropriate support.

Staff reported that acknowledgement of the impact that bereavement may have on them by the employers, providing access to emotional support and creating space to allow dealing with the impact, would enhance their experience and wellbeing at work. The form of support should be the individual's choice and may involve e.g., reflective practice which gives them permission to take the time to process and reflect on the experience. Providing access to peer or more formal support, if needed, is also important.

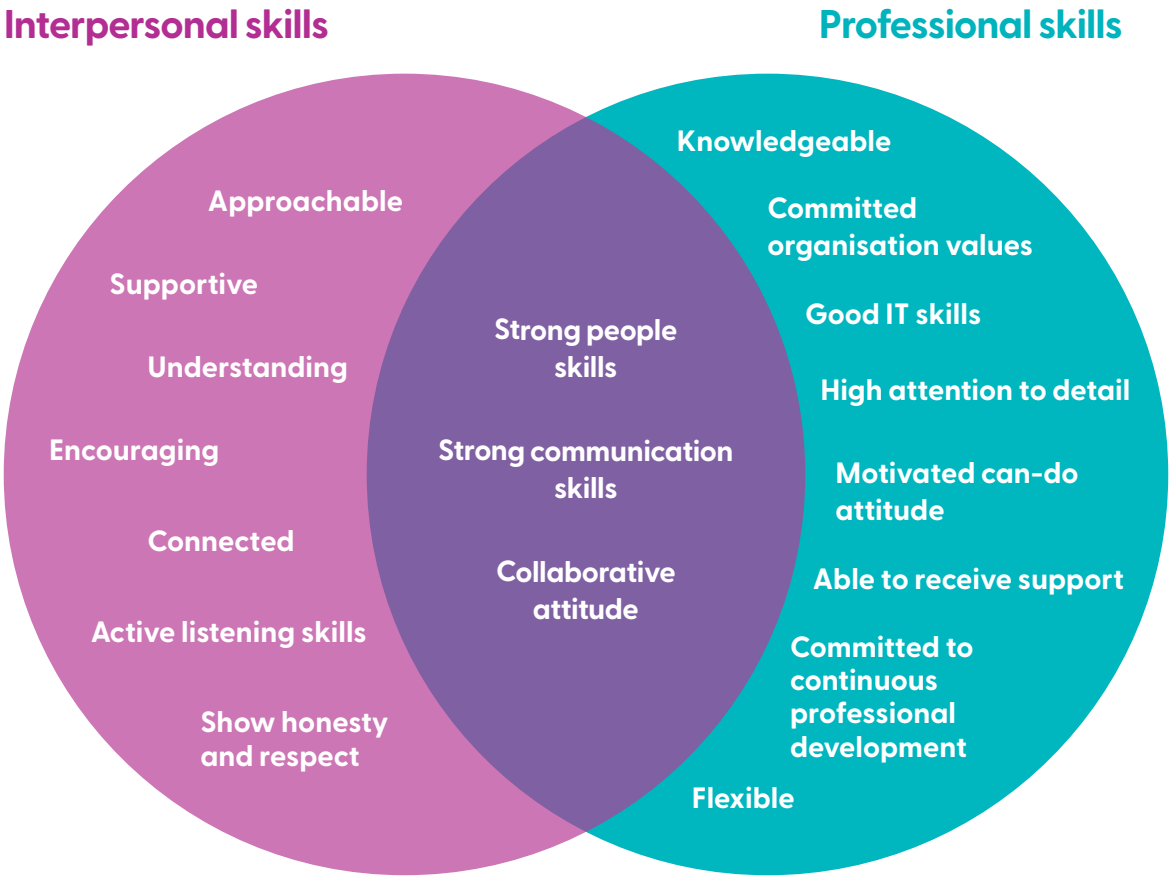
> *"We've all experienced [bereavement at work] more than once... I think just having it acknowledged and it's something that's going to happen to us a lot, and it has happened. I think it needs to be acknowledged."*
> (Community Resilience Worker)

> *"I think that group with the psychologist is good. But in this context, it's not going to work because I'm not going to go online with colleagues who I probably don't know and say that somebody I know really well has just died. I'm not going to do that. Maybe some people would, but I wouldn't find that helpful."*
> (Community Resilience Worker)

Supportive leadership

Organisations and managers who prioritise their team's well-being can foster a culture of mutual respect and motivation, which is essential for the high demands placed on community support staff. Figure 5 on the following page presents a range of skills and qualities desirable in line management of a community support team, as identified by the Reset CRWs.

Figure 5. Leadership skills and personal qualities identified as important to reset staff members delivering resilience-focused support.



"I am very happy with my role here at Reset, I enjoy the work, I enjoy the team and feel valued and not pressured into working until I drop"
(Community Resilience Worker)

"I really do appreciate [my manager's] encouragement and support. It feels great working in a team where you are appreciated, supported, and encouraged to reach your potential"
(Community Resilience Worker)

"I am enjoying the job a great deal. Colleagues are very supportive... and generally, feel my home-life balance is good... I find the general culture at [my organisation] incredibly friendly and supportive. I like the team a huge amount. We have a good diverse range of skills that complement each other in a very positive way and are willing and open to learning from and with each other – which I appreciate a lot."
(Community Resilience Worker)

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Funding for older people's services

The report by the Health Foundation and Nuffield Trust (2023) shows that provision of social care for older people across the UK has become fragile and fragmented, with limited resources and workforce shortages limiting access to care. A similar picture emerged from conversations with older people and stakeholders involved in the provision of community care involved in this research. This suggests the need for better resourcing, both in terms of funding to ensure access to relevant resources and workforce.

> *"[Within Reset] there's only one worker per locality... The two [people] that I was referring from that locality were very complex and would've really benefited from the support. And because they don't have that support, they're just left and there's that gap... So, I would say that in some of the bigger localities, it would be good to have more workers so that they can take on more cases."*
> (Referrer)

> *"I think in reality [we need] more staff and more resources. That's the bottom line."*
> (Community Partner)

Work systems supportive of intersectoral working

> *"[Edinburgh] Health and Social Care Partnership have really been working very hard [...] to become way more flexible, innovative, and open to partnership."*
> (Community Resilience Worker)

Although the importance of, and progress towards, practice enabling partnership working within the local Health and Social Care Partnership was recognised in this research, we also identified several gaps and areas that require improvements. This related particularly, but not exclusively, to partnership work between statutory and non-statutory sectors, which are often affected by incompatibility of administrative and digital systems and broader service cultures.

Our research suggests that the following adjustments would have the potential to improve experiences of staff across services and, ultimately, outcomes for older people supported by these services:

- **Communication**

  Enhanced communication between older people services, both statutory and non-statutory, facilitated by shared access to digital case management platforms.

- **Complex needs require complex support**

  Recognition, across sectors, that complex needs of older people and other populations served should be addressed through complex approaches to support delivered through partnership, intersectoral, interdisciplinary work and that contributions of all staff involved is of equal value.

  We refer to 'complex support' because, to address varying and complex health and social needs of older people, CRWs frequently deliver support that reflects the UK Medical Research Council's definition of complex interventions (Skivington et al., 2021). This involves:

  – number of components e.g., crisis management to ensure people have food on their tables and utilities to keep their home warm; facilitating applications for income maximisation; addressing housing needs; enabling social connections or access to social or health care,

  – targeting a range of behaviours e.g., hoarding; social isolation / withdrawal; substance use; debt management avoidance,

  – specialist expertise and skills required, often beyond expertise within the single service, making partnership, interdisciplinary, intersectoral working essential to ensure effectiveness of support,

  – number of groups e.g., older people, families, carers; various services and professionals,

  – flexibility of support in terms of its focus (e.g., self-efficacy, housing needs, income maximisation, family liaison) and duration.

- **Transparency and accountability**

  Organisations across sectors ought to own responsibility for outcomes of populations served. There is a need for clear and transparent governance to enable, monitor and ensure service-specific and joint areas of responsibility. There is also a need for authentic commitment to ongoing learning and evidence-based service development. This requires consistent and accurate recording and monitoring of a range of relevant data, to better understand resilience needs within the communities served and to enable more targeted service development.

- **Culture change**

  To recognise equal value of statutory and non-statutory services and personnel across sector in terms of contributions to health and wellbeing of populations served.

Part 4: Key Learning Points

Services should understand complex and contextual nature of resilience needs

As demonstrated throughout this report and illustrated through the included case studies, older people have multiple and complex resilience needs, which are influenced by a broad range of personal and environmental factors. This makes resilience needs unique to the individual. Older people also have a history of coping with adversity. They have abilities and strengths that should be recognised and supported to enhance outcomes while boosting or maintaining their sense of autonomy and control.

> ***"I've never asked for help in my life until this [hospitalisation] happened to me. So, I like to think I can do things for myself. But there are things I can't do - I have to realise I can't do. Some things I can't do I have to get help with."***
>
> **(Older Person, Reset)**

Ongoing interaction and 'fit' between the personal and environmental factors affecting resilience, determine older people's health and wellbeing outcomes.

Resilience needs may vary over time and should be monitored to allow adjustments to changing needs and circumstances.

This means:

- Meeting the person and assessing their needs at the place that reflects their current circumstances. This may be in their own home or while they are still in hospital.
- Dedicating time to listen to people to identify their individual resilience needs.
- Exploring resilience needs through relational conversations with the person in a way that facilitates comprehensive consideration of a broad range of personal and environmental factors, including a range of relevant demographic and health characteristics.
- Recognising that a person may have a range of resilience needs, which may change over time, and working with them to set person-centred goals that are regularly reviewed and monitored to meet evolving needs.
- Recognising that complex needs may require complex support (Skivington et al., 2021), involving partnership working between multiple agencies, including intersectoral approaches.

Organisations should develop work culture that supports resilience of community support staff and populations served

A survey facilitated by the Scottish Government (2023) showed that health and social care staff working within communities felt less valued than their counterparts within statutory health service. This is significant, as feeling valued at work is linked to better physical and mental health, as well as higher levels of engagement, satisfaction, and motivation (American Psychological Association, 2012).

This perception of community-based health and social care staff being less valued was echoed in our findings, with the following requirements being highlighted as important relative to improving work culture and, consequently, staff experience:

- More adequate resourcing and funding allocation for community support services to address heavy workloads and issues with staff retention.
- Access to training and investment in skills' development to enable staff to effectively meet complex resilience needs of older people.
- Regular clinical supervision and availability of peer support.
- Access to pastoral care to support staff dealing with the impact of psychological stressors at work e.g., experience of bereavement.

The importance of having a skilled manager/leadership cannot be understated when developing positive work culture. This research identified that effective managers are crucial in creating a supportive and appreciative work environment. They play a key role in ensuring that staff feel valued, recognised, and adequately supported and can directly impact staff morale and retention.

Additionally, as previously identified by the Scottish Government (2023), our findings emphasise the importance of services working together to more effectively meet the complex needs of older people. Specifically, the following conditions were considered as required to facilitate a better working culture:

- Routine inter-agency, intersectoral working.
- Better communication between services / agencies / sectors, including improved information sharing and better alignment of systems supporting this.

This means:

- Adequate funding and resourcing of community health and social care services that is reflective of complex casework and capable of supporting heavy workloads and issues with staff retention.
- Highlighting and promoting the value of community health and social care within communities and broader society.
- Promoting a culture of ongoing learning. It should involve commitment to consistently and accurately record and monitor a range of relevant data, to better understand resilience needs within the communities served and to enable more targeted service development. This should be supported by intentional, continuous reflective practice, by individual staff as well as broader teams and organisations.
- Promoting a style of line management that prioritises staff well-being, is person-centred and can foster a culture of mutual respect and motivation.
- Supporting emotional wellbeing of all staff, and particularly those experiencing high levels of bereavement at work. This should be based on individual needs and include options such as time to process the experience, or access to peer or more formal support, if needed.
- Routine partnership work between statutory and non-statutory sectors characterised by:
  - Enhanced communication between services, facilitated by shared access to digital case management platforms.
  - Recognition, across sectors, that complex needs of older people and other populations served should be addressed through complex support (Skivington et al., 2021) delivered through partnership, intersectoral, interdisciplinary work.
  - Clear and transparent governance to enable, monitor and ensure service-specific and partnership-level areas of responsibility.
  - Recognition of equal value of statutory and non-statutory services and personnel across sectors in terms of contributions to health and wellbeing of populations served.

Services should adopt a person-centred, comprehensive approach to assessing resilience needs

Recent theoretical developments and research findings support the understanding of resilience as a process of adapting to adversity experienced across the lifespan, shaped by complex interplay between multiple personal and environmental factors (Windle, 2011; Clark et al., 2018; Górska et al., 2021). Regrettably, common approaches to assessment and practice reflect traditional thinking about resilience as a psychological trait, focusing on personal resilience factors (Cosco et al., 2016; Windle et al., 2011). Additionally, most assessment tools have a questionnaire format which, although a very useful survey tool, can be lengthy, lack sensitivity, be non-personal, and off-putting (NHS Evaluation Toolkit, 2024).

These limitations of using questionnaire format to facilitate assessment of resilience needs were emphasised by practitioners and older people who participated in this research, indicating that it may not be the most appropriate approach. Instead, stakeholders stressed the importance of using a **face-to-face, conversational, relationship-based** approach to support a **person-centred, comprehensive** assessment of resilience needs.

Accordingly, during the initial visit, the CRW would carry out a risk assessment and complete an evaluation of need based on the conversation with the client. CRWs are skilled in observing areas of concern which people they work with may not be aware of themselves. Many older people do not want to be a "burden" and would say that they can 'manage', but when informed of the options available, they would often welcome the additional help. The focus of the initial visit is to start building a relationship, providing reassurance that the support will be tailored to the person's needs and available for as long as necessary. The assessment of needs would take place throughout the engagement, as the relationship and trust develop. The support would be adjusted to reflect the evolving needs of the person.

> *"OP: [to assess people's needs] you need to go and meet them in their house, I think you absolutely do, because that gives you, I think, some idea of the lifestyle they either had or have had, what they've been accustomed to [...], and so you need people to be able to talk to other people. I: What do you think is the best way of going about finding out what somebody needs? OP: Well, human discussion, so coming to [someone's house] like one-to-ones. [...] I: Do it in person? OP: Yes it has to be that, because other than that, trying to do it by email, or text, or phone calls, it doesn't work."*
>
> (Older Person)

This means:

- Developing trusting, secure relationships to form the basis of the assessment process.
- Adopting a comprehensive format of exploring resilience needs, that reflects the relational conversations with the person and allows consideration of a broad range of personal and environmental factors that may affect resilience, while facilitating a needs-led, person-centred approach. This should incorporate recording and monitoring of relevant demographic and health characteristics, recognised through previous research as directly associated with resilience.
- Implementing conversational, rather than 'checklist', style of assessment to identify protective and resilience factors, to inform and guide the care and support offered.
- Supporting Community Resilience Workers to use their professional judgement, based on their observations, skills, expertise and knowledge of the person they are working with, to form the basis of assessment, while ensuring that workers are aware of the wider social ana environmental factors which impede or promote resilience.

Services should apply a flexible, holistic, person-centred and relationship-based approach to community support

Our research identified the need for community support that focuses on person's needs, identified through a comprehensive assessment, and is based on trusted relationship between the person and support staff. It also showed that older people value support which is provided at the place they call home.

The needs-led, long-term support offered by Reset, allowed for the development of strong connections and trusted relationships. By getting to know the individual in their own home, CRWs found that older people tend to be more at ease and that issues they initially consider 'trivial' but may become significant, are often uncovered through conversation. This allowed the CRW to encourage action and to assist them to manage challenges independently at an earlier stage, avoiding the need for statutory support further down the line. Working in a person-centred way empowers older people to build skills and confidence required to manage future tasks on their own, developing competence and promoting a sense of self-efficacy. The CRW offers advice and information on community services and sustainable links to support older people's needs and to allow them to remain independent at home for as long as possible.

This means:

- Whenever possible, providing support at the place people call home.
- Developing and maintaining trusted relationships so the person can feel safe and valued.
- Encouraging individuals to recognise their own strengths and ability to adapt to challenges with the right type of support.
- Promoting independence through flexible, skilled key-work which supports complex resilience needs in a person-centred manner.
- Identifying, accessing and utilising available community resources and relevant existing services to do so.
- Where required, applying inter-disciplinary, inter-agency or intersectoral approaches to support, and advocating on behalf of older people.

Organisations should nurture a skilful workforce

Supporting complex resilience needs of older people requires skilful workforce.

A range of skills and personal qualities desirable in community support and care staff working with older adults, identified through this research, is reported in "Ensuring the Right Set of Skills" section (Part 3, p.46).

Importantly, community support staff needs to have an excellent understanding of older people, including appreciation of their strengths and the range of needs they may experience. Older people emphasised the importance of personal values and people skills, including empathy, respect, kindness and sense of humour.

All stakeholders recognised the ability to develop and utilise a broad range of relationships and to engage in joint working with relevant services and community partners to address complex needs.

This means:

- Developing recruitment strategies that incorporate relevant skills, knowledge and experience as additional role requirements. These include professional skills for assessment, goal setting, and complex case management as well as competences required to develop and maintain respectful, trusted relationships.
- Providing staff with ongoing supervision and training opportunities to identify and address gaps in their skill set.

- Encouraging and supporting staff to engage in formal and informal peer support
- Providing staff with opportunities and structures to facilitate regular reflective practice, both individually and as part of a team.
- Building a network of community partnerships to facilitate access to the most appropriate and effective support and resources.

Service providers and commissioners should work towards change within existing systems of community support

We identified the need to create a culture where older people are included, feel safe and are valued. This may involve challenging the broader societal attitudes towards older people which assume a decreased level of ability; as well as working towards communities were accessing services through digital, automated systems does not disadvantage them.

> *"I think the wider culture is set up in a way that older people are maybe being slightly sidelined in a wider context... They feel their needs are not important."*
>
> (Community Resilience Worker)

Many older people wish, and continue, to actively participate and contribute to their communities. However, many experience barriers. This may relate to physical accessibility of buildings and infrastructure or limited transport options.

> *"I feel that in Edinburgh the people are getting older, and it's getting worse walking on the streets. They've extended the stops between buses and there doesn't seem to be much help for pedestrians. I use public transport all the time, it's the only way I can get around [...]. I can't walk so far, so it sort of puts you off going out to try and get transport to take you places."*
>
> (Older Person, Community)

It may also reflect stereotypical perceptions of older people's needs and the mismatch between design of community services and diversity within the older population. This can lead to limited opportunities for engagement in meaningful activities and social participation.

> *"Everything is online, [...] and it's quite difficult if you're older and don't have those skills. And people can show you, but the trouble is if you're not using what you've been shown, you forget it. [...] I see it getting worse, I mean just like trying to access cash is tricky, parking your car is tricky because they don't want you to use coins anymore, and you know, there's so many things. It doesn't worry me too much cause I can cope but, I think, I can see myself in 5 years time being completely perplexed by all the new technology coming in."*
>
> (Older Person, Community)

Digital, and often automated, access to services such as health care, energy provision, housing support or income maximisation, has become the norm. Older people are often disproportionately affected by the barriers caused by digitalisation. Where, traditionally, services would have a shop front, direct telephone line to a real person and / or agents who could do a home call, the modern way of working can be restrictive and lead to long-term issues. Reset referrals are often for vulnerable individuals who have significant difficulties leaving their homes to pay bills or access services such as shopping, utilities etc. Some lack skills or confidence navigating through complex technology-based systems and rely on support from others to access services and resources. In such cases the CRW would spend a lot of time on the phone to call centres, navigating automated systems or completing online forms on behalf of customers. Many older people are unable to keep up with changes to the digital world and feel left behind. Although more profitable and efficient in the business world, digitisation fosters a sense of isolation among older people. There is therefore a moral obligation on the expanding world of business to provide more inclusive and equitable options.

> *"I'm no good with that internet, [...] people my age group didnae ken about computers, ken what I mean. I mean we grew up at school with just chalk boards *laughs* [...]. I'm one of the people of older generations. [...] it's all got to be on the phoneline, it's all done online, what am I gonna do if I didn't have [daughter's name], what would I do?"*
>
> (Older Person, Reset)

This means:

- Considering the diversity of older people and their diverse needs and interests when developing opportunities for engagement in meaningful activities.
- A requirement for local authorities and city planners to provide transport options and infrastructure that enhances accessibility and supports different levels of mobility e.g., reduced distances between bus stops or, where this is not possible, providing sheltered places to rest between stops; more frequent and diverse bus routes.
- An obligation by statutory and non-statutory services, including business and industry, to design services that are accessible to people lacking the skills and confidence to engage with and use digital and / or automated services. This should include an option for accessing services through direct, face-to-face contact.

Conclusions

This report provides evidence-based information about actions that should be considered when planning and delivering resilience-affirming, community-based support. It was informed by the views of older people and community partners with experience and expertise working with and supporting older people, but our findings can be transferable to different groups and services.

Building upon strengths of resilience-affirming approach to community-based support identified by the participants of this research, while considering changes to practice as suggested in this report, can lead to better health and well-being outcomes, and more good days experienced by people living within our communities as well as community support staff.

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Appendices

Appendix 1. Reset Information Sheet

Appendix 2. Reset Consent Form

Appendix 3. Reset Questionnaire

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Participant Information Sheet: Community

Version 2.0, 14/04/2023

We would like to invite you to take part in our research project. Before you decide whether to get involved, we would like you to understand why the project is being done and what will happen if you take part. One of our team will go through this information leaflet with you and answer any questions you may have. Ask us if there is anything that is not clear.

What is the purpose of the research?

The study will allow us to inform development of Reset: a new city-wide community resilience model of support for older adults in Edinburgh.
The research is a collaboration between Cyrenians, Edinburgh Health and Social Care Partnership and researchers at Queen Margaret University (QMU). Reset support will be delivered by a community support team at Cyrenians, who will work with people to enable them to remain independent at home, and to improve their health and wellbeing through supporting their community resilience.

Who is responsible for research?

The Reset service will be developed using Participatory Action Research facilitated by researchers at Queen Margaret University (referred to within this document as 'we'). We will invite people within Edinburgh communities and health and social care staff working with people to contribute their views and experiences to shape Reset to ensure it meets the needs of the people using it.

Resilience is the ability to bounce back after a difficult time in your life

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Summary information

In this research, with your permission, we will use information from you and from your medical records. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study we will save some of the data in case we need to check it and for future research.

We will make sure no-one can work out who you are from the reports we write.

This information pack tells you more about this.

The **Reset questionnaire** helps us to understand how people feel about their resilience. It was developed by researchers at QMU and asks about your general health and wellbeing, where you live, your local community, your social support, and the type of person you are. We will be using the questionnaire in this study to understand how people feel about their resilience.

The questions reflect the needs all humans have (represented below by the Reset tree icon), including basic needs, such as health and wellbeing, access to resources, safety and comfort (the roots); the need for belonging and self-esteem (the tree trunk); and the need for self-fulfilment (the tree crown).

Self-fulfilment needs

Belonging & self-esteem needs

Basic needs

Why have I been asked to take part?

You have been asked to take part because you have been referred to Reset for support.

Do I have to take part?

It is up to you whether you decide to take part. If you agree to join the study, we will ask you to sign a consent form. You are free to withdraw from the study at any time, without giving a reason.

What will happen if I take part?

We will ask you to complete the Reset questionnaire to help us understand your needs and identify ways of supporting your community resilience. We will also ask you to provide some information about yourself.

Additionally, we may ask you if you wish to share your views and experiences of the Reset service through other research activities, such as interviews or focus groups, facilitated by the researchers. You may also be asked to help us analyse and interpret the information we collect. This will be used to inform decisions about how to develop the service. With your permission, the information you provide will be recorded (e.g. audio / video recording / written information).

What are the possible benefits of taking part?

There are no direct medical or health benefits to be gained from taking part. However, the information we gather during this research will help to develop community services for older adults in your local area.

What are the possible risks and disadvantages of taking part?

We do not think there are any risks or disadvantages if you take part in this research. The research will be co-ordinated by experienced researchers and will be carried out in a compassionate way. Research activities will be carried out in a relaxed environment. You will be encouraged to chat about your views and experiences openly; there are no wrong or right answers. You will be free to withdraw from the project at any time if you decide you no longer wish to be involved. Your decision to withdraw will not affect the standard of support and care you receive – the support from the Reset team will continue as normal.

What happens when the research project stops?

After you have completed the questionnaire and, if applicable, taken part in the Participatory Action Research, you will not be required to do anything else. You will continue engaging with your Community Resilience Worker as normal.

What if there is a problem?

If you have a complaint about the research or the way you have been treated during the study, or if something happens during or following the research that you wish to complain about, please contact Dr Sylwia Górska at Queen Margaret University (the lead researcher) on **07724 141 939**. For independent advice and support you can also contact Patient Advice and Support Service on **0800 917 2127**. Full information about this service can be accessed via: **https://www.cas.org.uk/pass**

How will we use information about you?

With your permission, we will need to use information from you and from your medical records for this research project. This information will include your NHS number (CHI number), name, and contact details. We will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

The only time we would break confidentiality is if we were worried about your safety or someone else's (e.g. protection of children or vulnerable adults). Such information would be forwarded to Rebecca Simpson (Cyrenians Senior Manager - Health and Wellbeing) who would address the disclosure with adherence to relevant legal procedures. We would aim to discuss this with you first.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What will happen to the results of the research?

The results of the research will be used to inform development of the city-wide Reset model of support in line with the needs of the people who use it.
The findings may be published in academic journals, reports, and other publications accessed by audiences with interest in health and social care.
You will not be named in any publication without explicit permission.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to change the data we hold about you. If you agree to take part, you will have the option for your data saved from this study to be used in future research or for educational purposes.

Where can you find out more about how your information is used?

You can find out more about how we use your information from:

- patient information on health and care research at **www.hra.nhs.uk/information-about-patients/**
- patient data and research leaflet at **http://www.hra.nhs.uk/patientdataandresearch or QMU data protection information at https://www.qmu.ac.uk/footer/foi-and-data-protection/data-protection/**
- by asking one of the research team
- by sending an email to Cara Dickson (Queen Margaret University Data Protection Officer / Legal Adviser, Governance & Quality Enhancement) at **CDickson1@qmu.ac.uk**

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Who is organising and funding the research?

The research is funded by the National Health Service. The research will be co-ordinated by researchers at Queen Margaret University in collaboration with Cyrenians and Edinburgh Health and Social Care Partnership.

Who has reviewed the research?

The research project has been reviewed by Health and Social Care Research Ethics Committee A.

If you have read and understood this information sheet, any questions you had have been answered, and you would like to take part in this study, please now see the consent form.

Thank you for reading this information leaflet.

If you have any further questions about this research, please contact:

Dr Sylwia Górska
Queen Margaret University
Tel: 07724 141 939
Email: SGorska@qmu.ac.uk

For independent advice about taking part in research, please contact:

Patient Advice and Support Service
Tel: 0800 917 2127
https://www.cas.org.uk/pass

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Edinburgh Health and Social Care Partnership

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Privacy and Consent Statement: Community

Version 1.0, 07/03/2023

The Reset Team is committed to protecting and respecting the privacy of people who access our support, and everyone who deals with us. The Reset Team comprises staff from Cyrenians and Queen Margaret University. We abide by the confidentiality policy as per data sharing agreement between Cyrenians, NHS Lothian, and Queen Margaret University. The only time we would break confidentiality is if we were worried about your safety or someone else's (e.g., protection of children or vulnerable adults) but we would aim to discuss this with you first.

With your consent the Reset Team may use your personal data to:

- provide you with support
- send you information about this project
- link you with one or more of support services
- notify you of changes to the support we provide
- seek your views on how we support your community resilience needs
- perform data analysis to understand who is accessing our support
- perform data analysis to understand the impact of our support

If you are happy with the above, please confirm that:

☐ I have read and understand the information sheet (07.03.2023, v. 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my support and/or legal rights being affected

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- [ ] I give permission for the Reset team to access my medical records for the purposes of this research study

- [ ] I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Queen Margaret University, Cyrenians and from the NHS. I give permission for these individuals to have access to my data and/or medical records

- [ ] I give permission for my personal information (including name, postcode, and consent form) to be passed to Queen Margaret University for administration of the study

- [ ] I give permission for my Community Health Index (CHI) number to be collected and passed to Queen Margaret University

- [ ] I give my consent for any audio, visual or video data collected as part of this project to be reproduced for educational and/or non-commercial purposes, in reports, presentations, publications, websites and exhibitions connected to the Reset project. I understand that real names will NOT be used with such data

- [ ] I give permission for the Reset team to inform the referring service about my participation in this research

- [ ] I agree to my anonymised data being used in future studies and for educational purposes

- [ ] I agree to take part in this study

Please print your name: .....

Your signature: ..... Date: .....

Staff signature: ..... Date: .....

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Questionnaire

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This is a questionnaire about some of the things that may affect your resilience. To better understand what affects your resilience, we will ask you about your general health and wellbeing, where you live, your local community, your social support, and the type of person you are.

The questions reflect the needs all humans have (represented below by the Reset tree icon), including basic needs, such as health and wellbeing, access to resources, safety and comfort (the roots); the need for belonging and self-esteem (the tree trunk); and the need for self-fulfilment (the tree crown).

Self-fulfilment needs

Belonging & self-esteem needs

Basic needs

The questionnaire can be completed over a few sessions, or it can be completed in one sitting depending on your needs. The questionnaire has been designed for you to complete on your own. However, you may complete it with help if needed. The answers you give should reflect your own views.

For each question, **please circle one of the four choices** to let us know if you strongly disagree, disagree, agree, or strongly agree.

Please select one answer for each question.

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YOUR CONTACT DETAILS

Date of birth: .....

Address: .....

.....

.....

Postcode: .....

Preferred method of contact (telephone / email): .....

Telephone number / email address: .....

.....

Participant ID: .....

NEXT OF KIN CONTACT DETAILS

Name of next of kin: .....

Preferred method of contact (telephone / email): .....

Telephone number / email address: .....

.....

BASIC NEEDS

The first section asks about your overall health and wellbeing, your access to resources, and your safety and comfort. These things provide the foundation for a good life.

		Strongly Disagree	Disagree	Agree	Strongly Agree
1	I see myself as a healthy person	0	1	2	3
2	I am physically able to do the things I need and want to	0	1	2	3
3	I always have enough energy to do the things I need and want to	0	1	2	3
4	I am able to do things on my own	0	1	2	3
5	I can always make myself understood to others (e.g. over the phone, in new social situations)	0	1	2	3
6	I can always keep my mind on what I'm doing (e.g. planning a meal, doing a crossword)	0	1	2	3
7	I can always think of ways to solve my problems (e.g. reorganising appointments, retracing steps to find lost keys)	0	1	2	3
8	I live in safe and suitable housing	0	1	2	3
9	I have no problems getting around my home and neighbourhood (e.g. getting up and down stairs, reaching cupboards, getting to the shops)	0	1	2	3
10	I have no problems taking care of the place where I live (e.g. vacuuming, changing bed sheets)	0	1	2	3
11	I can afford the things that I need	0	1	2	3
12	I can find and use the community services I need (e.g. voluntary agencies, carer support, social work services)	0	1	2	3
13	I have no problems organising my routine so that I can do the things that are important to me (e.g. making time to meet friends)	0	1	2	3
14	I am always satisfied with my daily routine	0	1	2	3

BELONGING & SELF-ESTEEM NEEDS

The next section asks about your need for connection, belonging, and self-esteem. These things help you build a good life and see your full potential.

		Strongly Disagree	Disagree	Agree	Strongly Agree
15	I have family who support me	0	1	2	3
16	I am part of a circle of friends (e.g. have regular contact with friends, neighbours and/or support groups)	0	1	2	3
17	My circle of friends helps me get through through life's demands	0	1	2	3
18	I can take part in the social activities that I want (e.g. meeting friends, family events)	0	1	2	3
19	I have no problems getting along with others and making new friends	0	1	2	3
20	I have additional roles in my community/society (e.g. volunteer/unpaid work, member of an organisation)	0	1	2	3
21	I am happy to help my friends and family	0	1	2	3
22	I find it easy to accept whatever life throws at me	0	1	2	3
23	I feel in control of my life	0	1	2	3
24	I have principles that I live my life by	0	1	2	3
25	I am a patient person	0	1	2	3
26	I can forgive myself and others	0	1	2	3
27	I can always present myself in the way I want to (e.g. doing my hair, wearing clean clothes)	0	1	2	3

SELF-FULFILMENT NEEDS

The final section asks about your need for personal growth and fulfilment. These things help you achieve your potential and live the life you wish to live.

		Strongly Disagree	Disagree	Agree	Strongly Agree
28	I am generally happy	0	1	2	3
29	My past experiences have helped me learn about life	0	1	2	3
30	I understand the realities of life	0	1	2	3
31	I can see the funny side of life	0	1	2	3
32	I have things to look forward to	0	1	2	3
33	I can find and use the learning/training resources that I want (e.g. library services, further education, interest groups)	0	1	2	3
34	I can take part in the leisure activities that I want (e.g. hobbies, gardening, swimming)	0	1	2	3

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ABOUT YOU

Please tell us more about you.

Which of the following describes your gender identity?

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ I prefer not to say

Other .....

What is your marital status?

- ☐ Civil Partnership
- ☐ Divorced
- ☐ In a relationship
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ I prefer not to say

Other .....

Which of the following best describes you?

- ☐ Buddhist
- ☐ Christian, including Church of Scotland, Catholic, Protestant and all other denominations
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ No religion
- ☐ Sikh
- ☐ I prefer not to say

Other .....

What is your employment status?

- ☐ Employed for wages
- ☐ Homemaker
- ☐ Military
- ☐ Out of work and looking for work
- ☐ Out of work but not currently looking for work
- ☐ Retired
- ☐ Self-employed
- ☐ Student
- ☐ Unable to work
- ☐ Unpaid carer
- ☐ Volunteer
- ☐ I prefer not to say

Other .....

Do you live alone?

- ☐ No
- ☐ Yes
- ☐ I prefer not to say

Which of the following describes where you live?

- ☐ Private residence - own home
- ☐ Rented from a housing association or local authority
- ☐ Rented from private landlord
- ☐ Sheltered housing
- ☐ Supported accommodation
- ☐ Temporary accommodation
- ☐ I prefer not to say

Other .....

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What type of residence describes where you live?

- ☐ Basement with lift
- ☐ Basement with stairs
- ☐ First floor or above stairs only
- ☐ First floor or above with lift
- ☐ Ground floor no stairs
- ☐ Ground floor with stairs
- ☐ I prefer not to say

Other .....

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay man
- ☐ Gay woman/ lesbian
- ☐ Heterosexual
- ☐ I prefer not to say

Other .....

Do you have any health conditions or disabilities?

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

If you have any health conditions or disabilities, can you tell us what they are?

.....

.....

.....

.....

.....

.....

How would you describe your ethnic background?

- ☐ Asian / Asian British - Bangladeshi
- ☐ Asian / Asian British - Chinese
- ☐ Asian / Asian British - Indian
- ☐ Asian / Asian British - Pakistani
- ☐ Asian / Asian British - Any other Asian background
- ☐ Black / African / Caribbean / Black British - African
- ☐ Black / African / Caribbean / Black British - Any other Black / African / Caribbean background
- ☐ Mixed / Multiple ethnic groups – White and Asian
- ☐ Mixed / Multiple ethnic groups - White and Black African
- ☐ Mixed / Multiple ethnic groups - Any other Mixed / Multiple ethnic background
- ☐ White - English / Welsh / Scottish / Northern Irish / British
- ☐ White - Gypsy or Irish Traveller
- ☐ White - Irish
- ☐ White - Any other White background
- ☐ Other ethnic group - Arab
- ☐ Other ethnic group - Any other ethnic group
- ☐ I prefer not to say

What is your highest completed level of education?

- ☐ Primary (i.e., 4-11 years)
- ☐ Secondary (i.e., 11-18 years)
- ☐ University/college
- ☐ Trade/technical/vocational
- ☐ I prefer not to say

Other .....

Thank you for filling in this questionnaire

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