

## Aged Care Reform Series - Wellness

*The National Aged Care Alliance (the Alliance) developed this paper to provide additional advice to Government, through The Hon Mark Butler, MP Minister for Mental Health and Ageing, as it considers the proposed aged care reforms from the Productivity Commission's Caring for Older Australians report which was released in August 2011. Wellness is one in a series of six papers available on the Alliance website ([www.naca.asn.au](http://www.naca.asn.au)), other papers in the series include: Assessment and entitlement (including the Gateway), Financing aged care in Australia, Palliative Care, Quality of care and Workforce.*

### Fitting existing prevention, early intervention and wellness programs and initiatives together

- Within a national framework of active ageing where a wellness philosophy is a central pillar of public policy and government departments are required to review policies to ensure they do not run counter to the philosophy but rather actively promote it.
- Specific programs and initiatives to be the responsibility of the Australian National Preventive Health Agency. This responsibility to be accompanied by a specific active ageing/wellness funding stream and resourcing for the Agency to take on this role.
- Strategies to be across the life-course and targeted at critical times for intervention where evidence to this effect exists.
- Strategies to include public campaigns to inform and change attitudes and expectations about ageing as well as encourage adoption by individuals of healthy lifestyles and other behaviours that are known to be associated with ageing well.
- Wellness philosophy to be adopted across the health and aged care system and care pathways developed that ensure whenever individuals experience a significant change in function that is not associated with a properly diagnosed advanced terminal or degenerative condition that they are given the opportunity to be reassessed and offered a service that is focused on rehabilitation/restoration/reablement.
- That, as discussed in more detail in relation to reablement, a national framework be developed for how the existing different 'restorative' programs (TCP, GEM, Rehabilitation, homecare reablement) be brought together into coherent regional service networks in which the target groups for each service and the reasons for referral to other services are clearly defined. Ongoing research examining the cost effectiveness of different service models with different target groups, is however essential, as there is a significant and important gap in the evidence in this regard.
- All health and aged care professional and worker training to be framed within an active ageing/wellness paradigm.

### Initiatives to promote positive ageing

- Need a range of initiatives (such as those found in the quick literature search done for the Alliance – see appendix) that target lifestyle and other factors such as social connectedness and forward planning that have been shown to be related to health/functional/social/quality of life outcomes.
- Adoption of these initiatives should be based on evidence of their effectiveness but there needs to

be funding for their development and trialling as well as further funding for ongoing provision if demonstrated to be effective (too often programs are piloted, found to work but then are discontinued as the money was only for the pilot).

- Initiatives at the early stage of ageing should just be elements within a range of active ageing initiatives that, as identified in response to the first question, are planned to be throughout the life course focusing on different elements at different times depending on what is most critical at different stages.
- Need research examining when in the life course initiatives are most effective in terms of take up rate and impact eg. Advanced care planning, appointing an enduring Power of Attorney. In addition to this research, there needs to be education and mechanisms that encourage and support people to do this planning and appointing at the time they are diagnosed with a chronic or degenerative condition, rather than during the final stages of their life/conditions. The Alliance will consider these issues further.
- While the Australian National Preventive Health Agency could be responsible for development of the national framework (KPIs etc) it could possibly be Medicare Locals who act as regional purchaser and co-ordinator of these types of services/initiatives and take responsibility for ensuring that there is an appropriate range (to match their population profile) of programs operating within their region. Medicare Locals could also be responsible for identifying service needs and filling the gaps, and for coordinating what is on offer given that not all programs are government funded eg. disease specific groups who raise money to be able to deliver programs or implement initiatives.

## Positive Ageing and the Economic Potential of Seniors

- The Minister's Advisory Panel for the Economic Potential of Senior Australians (EPSA) is likely to recommend the development and adoption across government of a Wellness/Active ageing framework. In line with this concept, EPSA is recommending looking at ageing across the life course.
- Development of a national program of wellness/active ageing initiatives would need to be done in partnership with the specific diseases agencies, many of whom are already taking a life course approach.

## Connections and Opportunities with Primary Health Care

- The establishment of Medicare Locals (MLs) and Local Hospital Networks (LHNs) as new regional infrastructure with coordination responsibilities provides opportunity to support greater collaboration between the health and aged care systems to overcome existing service gaps and limitations, and help ensure better access to well-coordinated, and comprehensive, health care, within a framework that promotes wellbeing.
- It is expected that as regional coordinators of health care services, core business for MLs and LHNs will include working:
  - in close partnership with any future regional aged care coordination body (i.e. the Gateway) that may be established, to ensure greater integration of health care and aged care services at a regional level. This would include collaboration to determine local service needs and locally relevant service models, including service mapping and identifying and addressing service gaps; and

- to ensure strong integration at a local *service level* between health care services, aged care providers, and other relevant health and aged care sector agencies. For example, this may include supporting GPs to participate in RACF’s Medication Advisory Groups to support quality use of medicines within the facility.
- MLs, working in partnership with the local aged care sector, can also perform a broader scope of functions to enhance the quality of care and quality of life, for aged care recipients. These include:
  - Ensuring timely access to comprehensive GP and other primary health care services, by establishing locally-appropriate solutions to address barriers to timely access to care.
  - Providing care coordination support for older Australians with chronic conditions and complex care needs living in the community to assist them to access a range of community based health services.
  - Supporting the effective use of information technology, and the uptake of the ePCHR, to enable information sharing between service providers, including hospitals, pharmacies, primary care providers, RACFs, community care providers and, as appropriate, aged care coordinating/assessment bodies (currently ACATs, potentially the Gateway).

## Reablement services

- Reablement is the use of timely assessment and targeted interventions to: assist people to maximise their independence, choice and quality of life; appropriately minimise support required; thereby maximise the cost effectiveness of care and ensure people continue to actively participate and remain engaged in their local communities. The term reablement is currently only used to describe home care programs that take a restorative approach. However, the definition could equally well be applied to other programs or services that focus on restoration (e.g. transition care, restorative care, rehabilitation and GEM) as the principles and objectives appear to be essentially the same. The differences between the services appear to be mainly in the level and type of need of the target group, the staff mix and their level of specialisation, and, in the case of GEM, their location, as currently GEM is only an in-patient service whereas the other three types of service are delivered in both community and hospital settings.
- In England, where there has been a Government funded initiative to assist councils (who are responsible for home care services) to develop these services, almost all councils are planning, implementing or running a reablement service. Most often these services target either individuals referred for home care from hospitals or from the community, less often both. The reablement service (including the assessment) is delivered by non-health professionals who have been trained in reablement, with allied health professionals (most commonly Occupational Therapists) available for advice and referral.
- In Australia, the Home Independence Program, the longest running home care reablement service in the country, is delivered by a multidisciplinary allied health team working in an interdisciplinary way (i.e. only one care manager works with the client and delivers all interventions unless specialist referral required). However, other Australian reablement programs do not necessarily have health professionals as the Care Managers and last year Silver Chain was funded by Health Workforce Australia to develop training for non-health professionals to be able to deliver the program with the health professionals being available for mentoring, support and specialist referral.

- Home care reablement has been shown in both the UK and in Australia to improve clients' functioning and quality of life and reduce the need for ongoing home care services. Its effectiveness in terms of reducing service use and hence the cost of care has been found to last for up to five years so far.
- Homecare reablement can generally be said to be appropriate for older people such as those:
  - living in the community who are beginning to find daily tasks more difficult or who experience an increase in the difficulty with which they perform everyday activities;
  - who have been in hospital and have been discharged and need to regain confidence and need assistance to regain functional abilities and get back to their usual routines
  - have had an injury or illness
  - needing support to regain social connections
  - needing to learn daily living skills that they have never previously needed (eg. when a man is widowed and does not know how to cook and housekeep)

On the other hand it may not be appropriate for older people who:

  - are terminally ill (unless they have asked for assistance to remain as independent as possible when aids and equipment and exercise can be appropriate)
  - have an advanced neurodegenerative disorder.
- As regards implementation of reablement services, it was agreed that assessing for reablement would be an integral part of the Gateway assessment for people seeking an entitlement to aged care. The assessment would identify why they were having difficulties and then discuss their options as to how these might be overcome through a reablement service which would be provided free of charge.

Individuals may elect not to accept a reablement service and receive other services as part of their aged care entitlement. Accepting a reablement service is not a pre requisite to receiving ongoing aged care services and support but should be encouraged.

## Effectively meeting short term needs

- Timely, comprehensive assessment that focuses on what has precipitated the request for assistance, the nature and origin of the difficulty being experienced, and the potential to improve, is considered the key to being able to initiate the appropriate service response and set up the right expectations with the individual and their family.
- A restorative approach being recognised as the appropriate service response unless specifically contra-indicated.
- The type of restorative service provided would depend on the level and type of need of the individual, and what is currently available. As already described, each region needs a comprehensive network of restorative programs to ensure that the appropriate service response is available locally. These could be accessed through the Gateway.
- Research is needed that specifically looks at what type of program/service is most cost effective for individuals with different care needs; there is evidence for the effectiveness of various programs and their components - e.g. comprehensive geriatric assessment (when accompanied by targeted interventions) has been shown to result in reduced hospital readmissions, maintaining optimal cognitive and physical function and possibly reduction in mortality;

transition care was found to improve patient functioning and reduce hospital readmissions and transfer to residential care; rehabilitation programs in a range of settings have been found to be associated with improvements in functioning; and, home care reablement has been found to improve functional independence and reduce the need for ongoing care.

## Provision of short term care in residential aged care facilities

- Short term care in residential facilities needs to be provided in separate, appropriately designed and staffed accommodation, where staff have a restorative ‘transition’ mindset.
- The sub-acute care types of Rehabilitation and GEM would have similar accommodation requirements, basically being as ‘domestic’ as possible to support self sufficiency, but may require different therapy spaces and equipment depending on the type of rehabilitation specialist service required. This type of accommodation would also be appropriate for Transition Care and Respite clients.
- This accommodation may be a separate wing within an existing aged care service which would share some facilities with the rest of the building.
- The similarities in philosophy and care models of rehabilitation, GEM and Transition Care could mean that the services were co-located, given that the staffing requirements of the different models do not compete and can all be adequately met. It would also be an appropriate setting for respite clients who may then be more likely to maintain function, or even improve, when in respite.
- Being able to be flexible in staffing models depending on the case mix of residents at any particular time would be the key. As regards respite clients this could include involvement of the individual’s usual home support workers.
- Another key element of ensuring that the system is two way is setting up the expectation with the individual and their family that they are only there for a defined period before going back to live in the community.
- This mindset also needs to be applied to the requirements for admission and discharge processes and paperwork. New procedures, paperwork and service agreements would need to be developed to ensure the short term nature is clearly understood by all parties. Changes to these requirements will also make this type of service delivery more efficient for aged care providers to administer.

## Effective use of HACC, sub acute and short term care

- On the basis of current knowledge regarding service effectiveness, develop a range of care pathways to be recommended to individuals with different care needs based on a comprehensive assessment and understanding of their goals.
- These pathways would need to be developed at a regional level given the different service offerings in different regions and should integrate health and social care. As already described this would involve MLs, LHNs and aged care working together.
- At an individual level, whatever the funded program, the service offering would need to be flexible and individually tailored, provided by well trained and remunerated staff working in a wellness model.
- Conduct research to better understand what service options achieve the best outcomes for clients with different care needs, including people from a CALD background, GLBTI people, Indigenous peoples and others.

- Given the current gap in the evidence-base regarding what short term care can most effectively be provided in a residential care setting, create a new program to fund the development, piloting, evaluation and translation, if cost effective, into ongoing services of appropriate service models.

## Barriers and disincentives for provision of short term care

- Lack of flexibility in service provision and poor communication between service providers.
- Lack of information and education of, and understanding by, individuals and families about the potential of these approaches to improve health and independence and the concern that if services cease they won't be able to get them back if needed.
- Funding disincentives for short term episodes including the fact that short term episodes are more expensive for providers.
- Lack of a coordinated community awareness raising/education campaign on ageing well and healthy active ageing.

## Broader use of the GEM model

- GEM models of care could be delivered in a short term residential care setting or home-based setting, given staff availability and an understanding of who would benefit more from this type of model than transition care, rehabilitation or reablement.
- Given this understanding, it could well also be appropriate in certain circumstances for individuals to be referred from the community to GEM units (this happens rarely at present).
- Refer to Appendix 1 for further information.

## Reform recommendations

To ensure a wellness approach is adopted and integrated in the aged care reform process, NACA has identified the following recommendations:

- Develop a national wellness policy and framework that is applied to all health and aged care services;
- Make the Australian National Preventive Health Agency responsible for overseeing the policy and framework, as well as responsible for an active ageing/wellness funding stream, in which ageing well strategies are recognised as requiring a life course approach that affects individuals and communities;
- Create older persons' restorative service regional networks which take responsibility for ensuring that appropriate services are available across the care continuum and accessible through the Gateway when appropriate. This would involve the development of explicit aims, objectives, target groups, service models and referral pathways for each service, the identification of service gaps and the development of strategies to fill these gaps. These networks could be facilitated/convened by Medicare Locals and LHNs and would include hospitals and residential and community aged care providers as service deliverers. The involvement of residential aged care providers in the provision of restorative services would require changes to aged care funding and paperwork to enable more efficient and effective short term service provision;

- Fund rigorously evaluated pilot studies of different short-term restorative service models that include an economic analysis to better understand what programs/service options achieve the best outcomes for older people with different care needs, and what the costs of providing these services on an ongoing basis would be. This would lead to aged care resources being utilised more effectively and efficiently, thereby maximising the cost-effectiveness of care;
- Develop a community education program/awareness campaign on healthy active ageing, accompanied by initiatives (refer to the literature search at appendix 2) that target lifestyle and other factors related to health and quality of life outcomes; and
- Ensure that the Gateway assessments are based on a wellness model that results in reablement approaches being offered to consumers as an alternative and/or adjunct to ongoing service delivery.

# GEM

## Definition

Geriatric Evaluation and Management (GEM) is a model of care under the umbrella of sub-acute care, sub-classified according to the AN-SNAP Casemix Model as distinct from acute beds funded under the casemix model via a DRG. GEM provides a short term rehabilitation option of specialised high quality care for older Australians for problems unique to old age, which typically consist of multifactorial or undifferentiated problems such as one or more of the geriatric syndromes commonly associated with frailty such as falls, incontinence, confusion, failure to thrive or failed social support systems. The goal of a GEM Service is to intervene earlier in the older person's acute care journey to minimise functional decline, assess the issues, establish an accurate multidimensional diagnosis and rehabilitation program, to restore function, facilitate return home and reduce the need to seek residential care.

GEM Services are staffed by a Multidisciplinary Team (MT) and Specialist Geriatrician and promote a wellness and restorative model of care. GEM differs from Geriatric Rehabilitation (GR) and has thus led to the establishment of GEM Units separate from GR, although GEM patients may require more formal GR. GR will usually have a specific and readily recognised cause for a recent change in functional status such as acute stroke, amputation, orthopaedic procedure or deconditioning following an acute illness and requires a period of increased nursing and allied health support, under geriatrician medical surveillance, until sufficient recovery of function to permit independence. The establishment of GEM units has evidence base for reducing functional decline, mortality, need for long term care, hospital lengths of stay and readmission rates. GEM models of care can also be provided as an outpatient or consultancy service, but the evidence is not as strong.

## Issues

All tertiary referral Level 6 and most Level 5 hospitals around Australia at present have GEM models of care although may not be designated as a GEM Unit, but are conducted within a designated geriatric unit. The principles of GEM are applied to elderly persons, admitted after comprehensive geriatric assessment either from acute hospital beds or less likely the community. The final disposition of GEM patients is uncertain at the onset of the GEM episode hence discharge planning for this group is more problematic. The ability to provide this type of ideal management depends on geography and availability of Geriatric Specialist man power. The value of GEM is particularly pertinent if directed to those most able to benefit ie those with a moderate amount of disability compared to those who are severely disabled or the relatively fit. GEM principles could be offered in the home or low level care, before hospital care is precipitated but monitoring for maintenance of function, screening for and prevention of functional decline in the aged person's place of residence in the setting of disability and multiple co-morbidities has not been well studied nor proven successful so far. Equitable service provision for regional, rural and remote as well as CALD and ATSI is needed.

## Potential solutions

- Ensure entry points of aged persons to hospital care have firm GEM principles applied to the environment and culture of nursing and medical/surgical care eg in emergency departments, Medical Assessment and Planning units (MAPU) and acute medical/surgical units.

- Establish expertise if not in a designated unit, in a rehabilitation environment designed and staffed by those abiding by and dedicated to GEM principles of care provision.
- Ongoing education and training for this service delivery model needs support including involvement of carers and family.
- Ongoing Geriatric Specialty Training is vital to address manpower issues.
- Community day therapy centres attached to residential aged care facilities and delivering care via the MT could be used to provide more rehabilitation in the home, low level care, and residential Transition Care Packages (TCP) based on GEM principles.
- Regional, rural and remote centres could gain access to GEM expertise via such programs as Inter-RAI Comprehensive Geriatric Assessment (CGA) via video-conferencing.
- Adequate technological support and provision with commensurate funding support will facilitate e-health access.
- Nurse practitioners in remote locations could be trained in GEM principles especially in gathering data for CGA to access geriatric expertise on line.
- General practitioners could also be supported via e-health.

## Recommendations

GEM Units have the potential for early intervention in those most at risk of functional decline during a hospital admission and need support in establishment and continuation. Ongoing GEM principles should be enabled to be delivered after hospital acute care, GEM and GR in the aged person's place of residence via rehabilitation in the home, supported by domestic and personal care as well as promoting the use of TCP. Residential TCP needs promotion and encouragement to serve a wider geographical area, to support carers and family. General practitioners and nurse practitioners need support and training to conduct CGA in the home and low level care, with consultation support of geriatrician specialist services. CGA could be offered at entry point to residential care to complement ACAT assessments, facilitate appropriate ACFI funding and accreditation so wellbeing is optimised along GEM principles.

Telehealth has the opportunity of delivering GEM Services to residential care, rural and remote communities such that this type of care is not limited to tertiary referral hospitals in major cities around Australia. E-health needs funding and technological support with Medicare item provision. Provision of these services will promote healthy ageing, quality of life and wellbeing including independence and self management in the face of disability and multiple co-morbidities and support caregivers and families, as well as residential care providers.

## Active ageing literature review

This literature review has been split into three areas; (1) interventions aimed at improving physical health, (2) interventions aimed at community participation and (3) interventions related to planning for old age.

### Physical health

It is well established that maintaining good physical health through appropriate exercise and nutrition is a vital aspect of successful ageing and preventing disease, preventing falls, and preventing functional limitation in older people (Baruth, 2011; Conn, 2003; Davies, 2010; Yan, 2009). Interventions to improve physical health among older people can take a number of forms. A few interventions that have shown benefits in terms of the physical health of older people are presented here.

#### Active living every day initiative

Baruth et al (2011) assessed the impact of the Active Living Every Day program on physical functioning and functional limitations in older adults. The Active Living Every Day program is a 20 week physical activity intervention that teaches older people the skills needed to become or remain physically active. Participants in this intervention attended a 60 minute group class each week which focused on cognitive and behavioural strategies. Participants also received a book which covered weekly class materials and included assignments. The aim of this program was to encourage participants to carry out 30 minutes of aerobic activity on most days of the week. Participants in this intervention were assessed by four tests of physical function (assessing movement, agility and flexibility). Participants showed significant improvement in all four tests. The study also found a significant reduction in the number of participants classified as 'impaired' (Baruth, 2011).

#### Eat better and move more

the Eat Better and Move More program is an integrated nutrition and exercise program aimed at older Americans. This program is aimed specifically at older Americans who participate in the Older Americans Act Nutrition Program, which aims to promote health, decrease malnutrition and prevent physical and mental deterioration, in particular among low-income individuals and members of minority groups. The Eat Better Move More program aims to encourage older adults to increase physical activity by providing them with step counters and a log book to keep track of the number of steps taken. The program also aims to improve nutrition by having weekly sessions for participants involving talks and group activities on nutrition, i.e. emphasising eating more fruit and vegetables, calcium and dietary fibre. The program was carried out from several different sites, each of which were encouraged to offer group walking sessions and other activities. Evaluation of this program found that over seventy per cent of participants showed significant improvements in both nutrition and physical activity. The authors attributed the success of this program to the ease of use by participants, inexpensive implementation, tailoring to older adults and being geared to simultaneously improve physical activity and nutrition. Enthusiasm of local staff and facilitators was also seen as an ingredient for success (Wellman, 2007).

## Active choices

Wilcox et al (2006) reviewed the impact of a physical activity program for older people in community settings, 'Active Choices'. Active Choices is aimed at helping participants develop the behavioural skills needed to incorporate moderate physical activity into their daily lives. It is a six month program delivered through one face-to-face meeting followed by one-on-one telephone counselling. Participants receive biweekly telephone calls for the first two months and monthly telephone calls for the last four months (up to eight calls total). Counselling is tailored to the person's readiness for change and emphasises key social cognitive theory constructs (e.g. social support, self-regulation, self-efficacy). The authors of this study found that the Active Choices program led to significant increases in physical activity, decreases in depressive symptoms and stress, increased satisfaction with body appearance and function, and decreases in Body Mass Index. The benefits were seen across a diverse sample of the US population (Wilcox, 2006).

## Healthy moves for ageing well program

healthy Moves for Ageing Well is a strength training program, aimed at frailer older adults and designed to be delivered in the home. The intervention consists only of low-intensity exercises, which are performed while seated using only light weights. Participants in this program were encouraged to complete these exercises three to five times a week, in the morning and afternoon. The program also involves feedback and social supports for participants, and assistance with setting simple goals for participants relating to everyday tasks, to improve adherence. Volunteer peer mentor coaches were recruited as part of the program, and these coaches contacted participants regularly to monitor progress, assist with goal setting and building confidence. The outcomes of this study included a statistically significant reduction in the number of falls and level of pain experienced by participants (Yan, 2009).

## SeniorWISE

The SeniorWISE (Wisdom is Simply Exploration) study examined the outcomes of an intervention that tested whether health training could improve health and functional ability in elderly people residing in the community. The intervention being tested consisted of eight 90-minute classes, involving lectures and discussions, conducted twice weekly for a month. An additional four classes were held three months later, giving participants a total of 20 hours of health training. Topics covered in classes included exercise, spirituality and health, alternative medicine, weight management and more. The authors of this study concluded that the educational program contributed to successful ageing by participants. This was supported by results which showed significant improvements in participant's functional status (McDougall, 2010).

## Senior Health Mentors

A number of interventions include the use of peer mentors in encouraging seniors to make healthy lifestyle changes. Senior Health Mentors are specially trained seniors who can offer support and advice to their peers and encourage them to make healthier changes to their life. They can also offer information about local services that may be relevant to older individuals (Greengross, 1997; Ndegwa, 2011).

Dorgo et al (2011) assessed the effectiveness of peer mentoring in a fitness program aimed at older adults. The authors of this paper noted that previous reports had shown interventions including

social support such as mentors or buddies had the potential to increase older adult's participation in physical activity and overall fitness, and increase program enjoyment. In this study 30 older adults were recruited in order to train participants in a physical activity intervention. The 30 mentors took part in a 30 week program which covered topics of ageing, health and fitness, training, exercise safety etc in order to prepare them for the role. The study found that intervention participants trained by peer mentors improved in all measures of physical fitness (including measures of flexibility, strength, endurance and agility). The authors suggest that the use of peer mentors in this program may have led to a high retention rate among participants (Dorgo, 2011).

Another study by Coull et al (2004) assessed the use of volunteer lay health mentors as an intervention in older people with ischaemic heart disease. In this study participants attended monthly meetings with a mentor-led group over a one year period. The groups discussed a range of issues relating to cardio-vascular disease such as lifestyle risk factors, blood pressure, cholesterol, understanding of the disease and other topics. The mentors were recruited from the local community and were given thirty hours of training by a nurse, dietician, physician and others. The study showed that mentored patients had significant improvements in exercise levels, beneficial changes to diet, improved compliance with medication and improved physical functioning when compared to controls. The authors of this study concluded that the success of the mentoring program was based on well-motivated lay mentors, well structured training from healthcare professionals and the use of a coordinator with a community education background (Coull, 2004).

## Participation

Participation in the community is known to have positive effects on the wellbeing of older people (Skingley, 2010). Social engagement is recognised as being vital to healthy ageing (Hutchinson, 2007). Social engagement can allow older adults to maintain independence and prevent disability (McDougall, 2010). Research by Warburton et al (2006) found that older Australians consider that passing wisdom on through participation in the family or community forms a positive role identity, important to psychological wellbeing and successful ageing (Warburton, 2006). There are a range of different interventions or programs that can assist older people in being engaged with the community, a few of these are summarised here.

### Arts clubs

Silver Song Clubs are community based groups which provide opportunities for older people to join together and sing. Skingley et al (2010) evaluated the impact of Silver Song Clubs on the health of older people in the UK. The Silver Song Clubs outlined in this paper were facilitated by experienced musicians and supported by other volunteers. These Silver Song Clubs took place in community venues with the older people who attended provided with transport to and from the venue as necessary. Participants sung familiar songs and used percussion instruments or hand chimes. Although this study only took a basic qualitative view of the impact of the program, the researchers found evidence for a number of potential benefits for the people attending the clubs. These included the benefit of enjoyment, which can be positive for health, improved mental health and wellbeing, social interaction, physical improvement (i.e. breathing), cognitive improvement and improved memory (Skingley, 2010).

A similar study by Murray et al (2010) assessed the impact of a community arts intervention aimed at older adults in a disadvantaged community. The authors suggested that community arts can give individual pleasure through providing opportunities for self-expression and skill development, while creating an opportunity for people to come together and share ideas. The intervention assessed here

involved weekly meetings of the participants. Meetings lasted about two hours and in each meeting participants took part in arts activities such as pottery, painting, writing and engraving. Participants in this intervention identified several benefits, including a sense of achievement, a feeling of creativity, increased social interaction and new friendships, a sense of identity and belonging (Murray, 2010).

## Raging Grannies

The Raging Grannies is a voluntary activist organisation operating across Canada and the United States, in which older women dress up in stereotypical granny costumes and perform songs around topics of social injustice. The Raging Grannies were started with the aim of giving older women a sense of empowerment through social activism (Hutchinson, 2007). Hutchinson et al (2007) examined the impact that being a member of the Raging Grannies had on the individuals involved, and in particular examined the link between social activism, empowerment and healthy ageing. The authors found that membership was linked to a number of positive outcomes, including an expanded sense of self and personal worth and a sense of purpose in life, which in turn are linked to positive health and well-being in older women (Hutchinson, 2007). Members viewed their membership of the Raging Grannies as making a difference to society as well as providing them with personal benefits (Hutchinson, 2007).

## Men's Sheds

Golding et al (2011) carried out a study examining the impact that Men's Sheds have on the lives of older men. The authors outline that if men are out of work, have limited education, live alone and/or have poor literacy they are at an increased risk of social exclusion. This lack of connectedness with the community can impact on individual's health and wellbeing. The authors suggest that Men's Sheds may have the ability to reach men who are no longer working; who may be in poor health or disconnected from society. Community participation can have significant health benefits for older men. The paper suggests that Men's Sheds may be an effective context for enhancing older men's health and well-being, as in this setting older men are co-participants who participate in hands-on, shared group activities in familiar social and community settings. The wellbeing benefits of this type of organisation are particularly powerful as in this setting there is an active consideration of the changing needs, wants and interests of the men involved as they age (Golding, 2011).

## Planning for ageing

Noone et al (2009) carried out a study to examine the relationship between pre-retirement planning and well-being in later life. According to Noone, pre-retirement planning could be undertaken through attending seminars on the topic, discussing retirement with partners or friends, or reading about retirement. Planning for retirement should include both financial planning and planning for the psychosocial and physical changes which accompany ageing, including changes in social status, health, identity, leisure time and relationships. This study found that individuals who plan for their retirement, both financially and psychosocially, report greater satisfaction with their retirement, and greater physical and psychological health (Noone, 2009).

In the paper "Mapping Your Future – A Proactive Approach to Aging", Spira (2006) describes a tool that older adults can use in planning their futures. Spira mentions that planning for ageing is important as planning can help to offset crises and provide support structures for people to utilise as their position in the community changes. This tool covers health, work/leisure, finances, housing and relationships. This tool aims to encourage people to start conversations about life choices and maintaining a sense of empowerment and well-being. The tool also intends to create linkages with resources to assure security and well-being (Spira, 2006).

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