Lorn and Oban Healthy Options Ltd

Helping people live healthier lives

Who are we & Why are we here?

Charitable organisation established in 2011 by community activators, health & exercise professionals.

Committed to improving health & wellbeing by providing education, advice and interventions from experienced exercise professionals.

40% of our community live with one or more chronic medical condition

Strong ethos of collaboration from the start, collaboration at the heart;

if the problem is in the community the solution is in the community

Demographic projections from 2010 – 2035 suggest75% more people aged 75+

- **Run by an experienced, committed, knowledgeable Board of 7 voluntary directors. Backgrounds in NHS, education, housing, industry, commerce and social enterprise.**

- **LOHO employs 6 staff, 3 f/t, 3p/t which equates to 4.5 FTE**

Health Improvement activities and education through social prescription.

Delivered by highly qualified professional staff.

Mainstream Service

1:1 Consultation

Tailored exercise & activity programme

Move well classes

Health & Wellbeing education sessions

Re-wild walking group

Strength & Balance Classes

Tai Chi

Self Management Courses

Advice, Support, Signposting

Smoking cessation guidance & support

Reablement service:

Partnership working with Physiotherapy as part of the Oban Living Well Project

1:1 sessions delivering a tailored programme at home or in the community.

Clinical supervision from Senior Physiotherapist

Oban Living Well Support Services

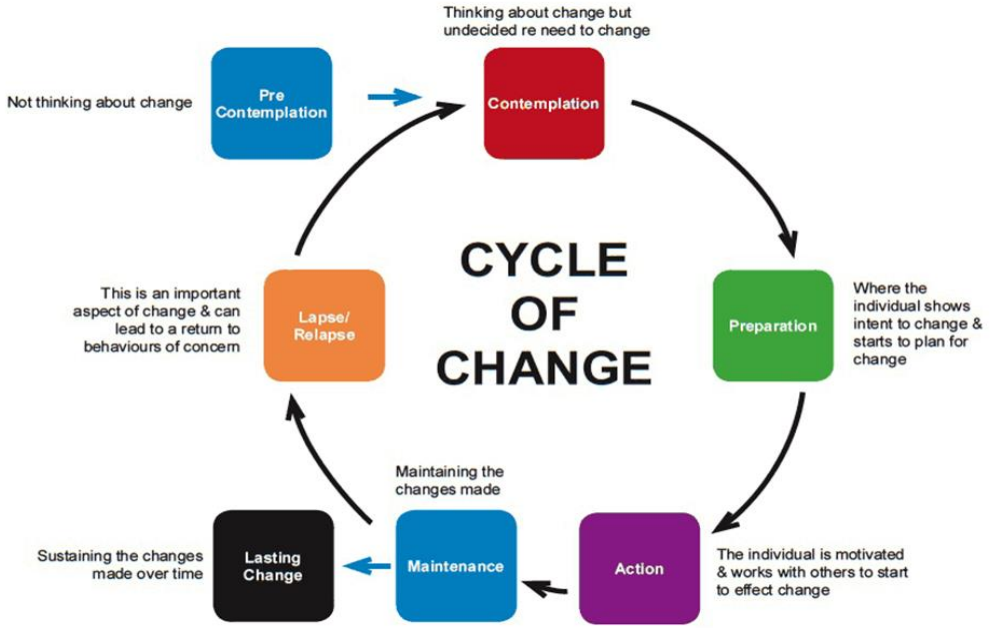
A collaboration between NHS, 3rd Sector and the community

HEALTH FOCUS	LEAD & DELIVERY PARTNERS	BENEFICIARIES	ACCESS ROUTE	SERVICE PROVIDED	POTENTIAL NUMBER OF BENEFICIARIES
PREVENTION *Creating health in our communities.* **Edmonton Frailty Scale Not Frail**	**Healthy Options (HO) Led** Using existing local community resources and organisations.	People of all ages, all abilities.	Self-referral (opt-in), community referral (family, neighbours, friends, colleagues)	Providing opportunities locally to exercise, take part in activities, eat healthily.	**Everyone**
CONTROL MANAGE OR IMPROVE CONDITION *Helping those with chronic medical conditions to improve their health and wellbeing.* **Edmonton Frailty Scale 0-5 Not Frail**	**Healthy Options (HO) led with NHS advice and influence** Using existing (and new) resources in the community.	Patients with chronic medical conditions or at risk of developing long term condition which could be improved by adopting an **active** healthy lifestyle.	Well established patient referral route using HO referral form via Health Professionals – GP surgeries, Physiotherapy, Cardiac, Dietitian, Mental Health, Pulmonary, OT, etc.	HO qualified exercise professionals, with input from health professionals co-design with the patient a programme of exercise based social prescriptions resulting in the client self-managing their health.	**4,500**
REABLEMENT *Helping patients, with new or at risk of needing social care packages.* **Edmonton Frailty Scale 6-7 Vulnerable 8-9 Mild Frailty**	**NHS Physiotherapy** led with Healthy Options delivering.	Patients likely to have at least one chronic condition starting to impact on their ability to fully self-care – starting to need increased social or family support for activities such as shopping, housework or activities requiring a degree of balance and/or strength.	Patients assessed by physio and/or OT (prior to and following intervention) are referred to HO exercise professional.	HO Exercise Professional who works 1-2-1 in patients home and depending on progress the patient is encouraged to engage in existing community classes / referred to HO mainstream programme / referred to Oban Frailty team.	**600+**
SUPPORTING FRAIL PATIENTS TO LIVE WELL AT HOME *Providing holistic care to patients with complex conditions.* **Edmonton Frailty Scale 10-11 Moderate Frailty**	**Oban Frailty Team (NHS – Lorn Medical Centre (LMC)).**	Patients from LMC with more than 1 chronic condition starting to impacting on simple ADL's likely to be already in receipt of social care and at risk of recurrent hospital admissions / increased dependence on health and social care services.	Self-generated referrals from interrogation of practice data electronic Frailty Index (eFI). Referrals from other health and social care professionals via Multi Disciplinary Team (MDT) meetings.	Lorn Medical Centre (LMC) patients only. Practice led MDT service aimed at regular review and holistic management of complex patients presenting with significant issues due to frailty. Using an anticipatory and person centred approach.	**400+**

Access Criteria (to LOHO mainstream programme)

The individual is:

- **Independently mobile with / or without mobility aids.**
- **Independently able to transfer sit to stand.**
- **Motivated to engage / actively in the preparation stage of the change cycle.**

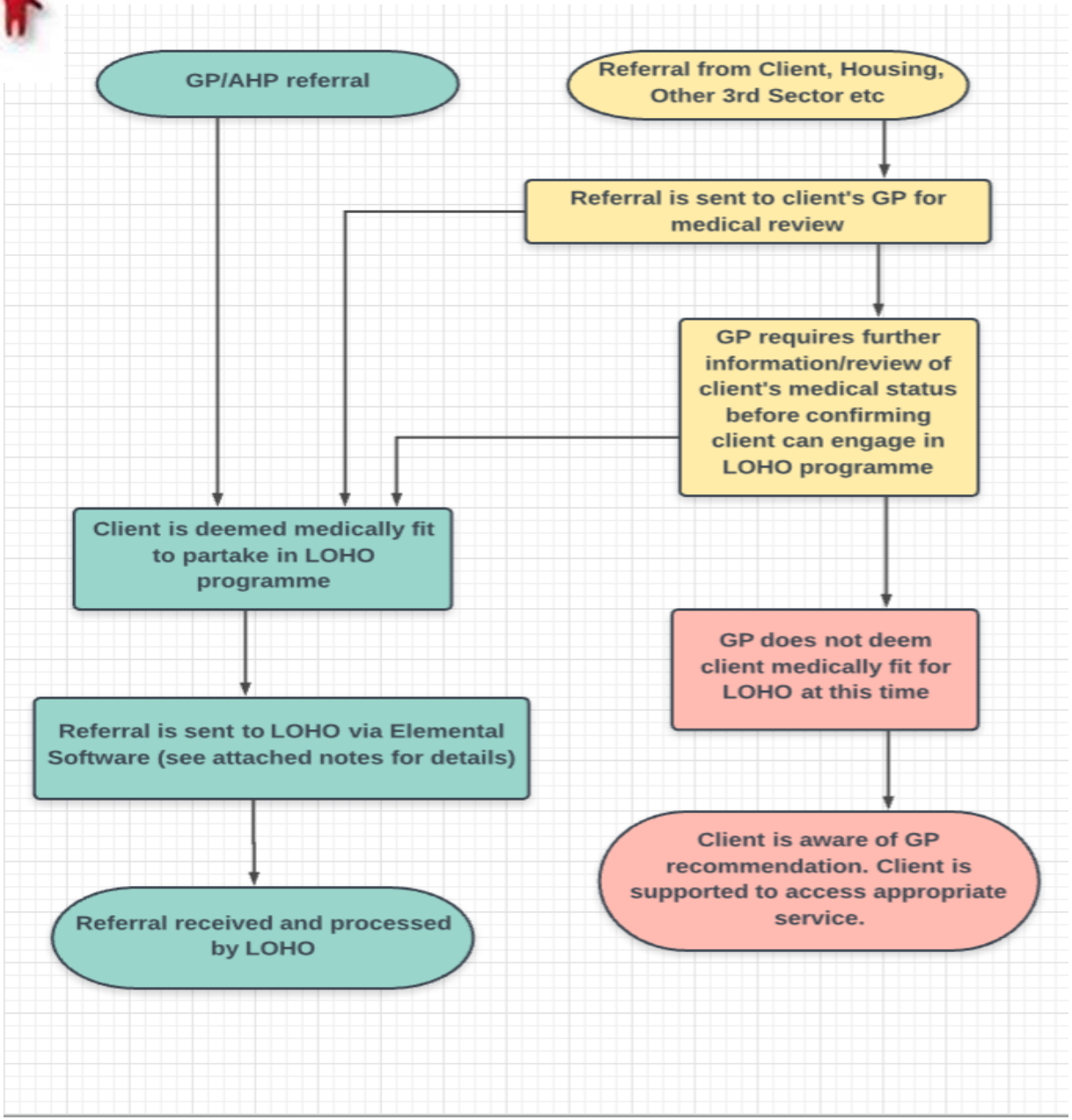


Exclusion Criteria *(to LOHO mainstream programme)*

The individual:

- **has a BP of 180/100 and/or a resting heart rate of 100+ *(see attached guidance notes regarding LOHO risk assessment)***
- **requires assistance to transfer sit to stand**
- **is experiencing exacerbation of symptoms of a severe/enduring mental health condition**
- **has significantly impaired cognitive/perceptual ability**
- **remains in the contemplation stage of change**

Referral Pathway



The LOHO Model

Individual

- Person at risk of developing, or living with chronic physical and/or mental health and wellbeing issues.
- Person socially isolated and/ or at risk of / or already living with health related issues.

Referral

- GP, AHP, nursing
- Other 3rd sector organisations,
- Self Referrals
- Housing etc

Consultation

- 1 to 1 consultation
- Wemwebs, ParQ & Wellbeing outcome star forms basis of assessment, discussion, goal setting & generation of social prescription
- Rapport established with named exercise professional.

Tailored Programme

- Education
- Tailored 1 to 1's
- Move Well
- Gym/swim
- Re-wild walk
- Tai Chi

Education Programme consists of:

Wk 1: **Benefits of physical activity**	Wk 2: **Eat well guide**	Wk3: **Food labels**
Wk4: **Portion sizes**	Wk5:**Fat, salt, sugar**	Wk6: **Energy balance**
Wk 7: **Mood and food**	Wk8: **Behaviour change**	Wk9: **Takeaway food**
Wk10: **Sleep improvement**	Wk11: **Self management**	Wk12: **Self management**

Review

- 1 to 1 meeting with named exercise professional. Progress reviewed and joint decision made whether ready to graduate or if extending time with tailored programme is appropriate.

Graduation

- Successful completion of LOHO programme, (or appropriate time to finish programme as discussed with exercise professional).
- Transition to ongoing activities / clubs / groups within the community. (ie health town / health village activities)
- Self sustaining health behaviours / condition management.

ELEMENTAL
The social prescribing people

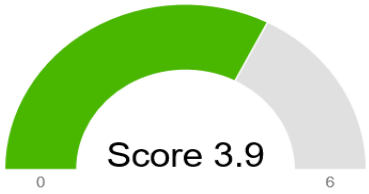
BMI

tell me more...

Obese Class I

Resting Heart Rate

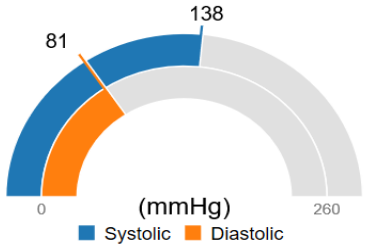
tell me more...



Above Average

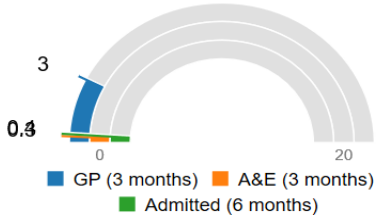
Blood Pressure

tell me more...

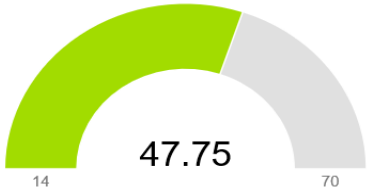


High (Hypertension Stage 1)

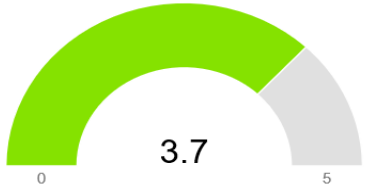
GP Attendance



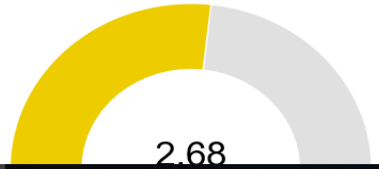
Well Being (WEMWBS)



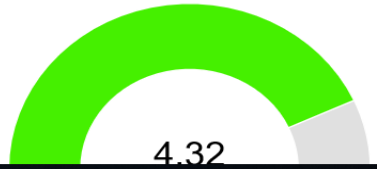
Wellbeing Star (Overview)



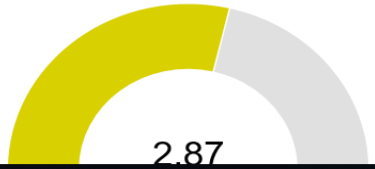
Wellbeing Star - 1. Lifestyle



Wellbeing Star - 2. Looking after yourself



Wellbeing Star - 3. Managing your symptoms




healthy options
• Improve Your Health & Change Your Life
• Supporting People to Manage & Improve Chronic Medical Conditions
• Personalised Exercise & Activity Programmes
Healthy Options + Health Professionals + Community Resources = your Path to a Healthier & Fitter Future
Lorn & Oban Healthy Options Ltd.
Top Floor, St Moluag's Centre, Croft Avenue, Oban, Argyll, PA34 5JJ
Office: 01631 565113 | info@lornhealthyoptions.co.uk
www.lornhealthyoptions.co.uk
Registered Charity: SC041998

Success stories so far……

- Young client with long standing mental health issues
- Referred by GP to LOHO,
- Outcome:
  - ✓ **Marked improvement in mental health**
  - ✓ **39Kg weight loss and reversal of weight related liver damage.**
  - ✓ **Reduction in number of annual GP visits from 19 down to 5.**
  - ✓ **Reduction in medication with annual saving of £2700 in drug costs.**
  - ✓ **Engagement as volunteer in local organisation, with progression to starting an apprenticeship**.

LOHO are on target to work with 400+ individual clients and deliver over 8000 interventions in 2019

Questions / Open Discussion