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An Evaluation of the Gloucestershire POPP:

'Care Homes, Part of Our Community'

Final Report

May 2009

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Incorporating additional data and information collected by the Gloucestershire POPP Project Team

Gloucestershire
Care
Homes
part of our community

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EXECUTIVE SUMMARY

BACKGROUND

The Gloucestershire POPP, entitled 'Gloucestershire Care Homes – Part of our Community' was awarded £2,597,000 by the Department of Health to be spent between April 2007 and March 2009. The Gloucestershire POPP had three overarching aims:

- ⇨ To work with care homes to develop excellent services;
- ⇨ To encourage care homes to extend their services into the community and support communities to work with care homes in their area; and
- ⇨ To increase the opportunities for older people to participate in developing services.

The project plan outlined the following ways in which these aims were to be achieved. By :

- ⇨ Providing training and hands on support to care home staff from our care home support team of general and mental health nurses, pharmacists and therapy staff
- ⇨ Developing and providing training for care home staff
- ⇨ Providing care homes with small grants and advice to set up new services in the community
- ⇨ Recruiting older volunteers to work with care homes in a number of ways, including providing services or supporting care homes to work in the community

⇨ Supporting networks of older people to influence how services develop

This document provides a final report on the local evaluation of the Gloucestershire Partnerships for Older People Project (POPP) as carried out by a research team at the University of the West of England, Bristol (UWE). The evaluation, which was commissioned by Gloucestershire County Council, does not cover all aspects of the POPP. What it does provide is (1) a macro evaluation of the economic impact of the Gloucestershire POPP and (2) an in depth evaluation of the impact of specific initiatives within the Gloucestershire POPP. The report has two main sections: Section A presents the findings of the independent local evaluation carried out by the University of the West of England, while Section B contains additional information, evaluation and learning materials collected by members of the Gloucestershire Project Team. The report focuses on presenting findings from Section A but draws on data from both sections in order to reach conclusions about the success of the project.

KEY FINDINGS

- Interviews carried out with a range of project stakeholders towards the beginning and end of the project suggested that most aspects of the Gloucestershire POPP were thought to be very successful. These included improving the quality of care in care homes and improving joint working between statutory and independent sector agencies. However, progress was seen to be slower in the areas of changing public perceptions of care homes and engaging with older people around the development of services. While some elements of the project were thought to be sustainable, particularly the Care Home Support Team, there was a feeling that two years had not been long

enough to meet all of the project aims and as a result a similar level of sustainability had not yet been achieved in all areas.

- A national evaluation of all 29 POPPs has identified reductions in emergency bed days in hospital as a key indicator of the success of POPP funding and consequently the economic evaluation presented in this report focuses on this variable. Within the context of these provisos, the initial macroeconomic analysis suggests that the introduction of POPP funding has helped to maintain a reduction in emergency bed day use for the over 65 age group in Gloucestershire. The saving as a result of this reduction has been calculated at £967,000, which is equivalent to £1.20 saved for every £1 spent through the total POPP grant. Further analysis based on more recent data will be included in a future version of this report.
- In presenting this emergency bed data it is important to note that the methodology used by the national team and adopted by the local evaluators in relation to the Gloucestershire POPP does not aim to attribute any savings directly to the POPP, which is taking place at the same time as a number of other initiatives and changes in service configuration. What it does provide is a comparison of trends in emergency bed day use before and after the POPP interventions began. The national evaluation is able to build on this by comparing trends in levels of emergency bed day use in areas where there has been a POPP with those where there has been no POPP.
- Most of the focus and resource of the Gloucestershire POPP was directed towards the support of older people living in care homes through the creation of a care home support team and the provision of training for care home staff. A sub-macroeconomic analysis is currently being carried out using postcode data for admissions to Gloucestershire Hospitals NHS Trust from residents in Gloucestershire

care homes. Analysis of trend demonstrates a fall in payment by results (PbR) and the rehabilitation tariff for those known admissions. In addition, reductions in length of stay are seen from 14.8 days to 11.1 days, for a comparator 8 month period April to November 06/07;07/08;08/09, although numbers of admissions have increased in that time. This reduction is highly likely to be attributable to the care home support team, particularly in terms of enabling them to receive residents on return from hospital.

- The economic appraisal also includes an assessment of the cost effectiveness of the POPP funded pharmacy medicines management review that was carried out as part of the work of the Care Home Support Team. Data analysis suggests that this led to resource savings of £148,000. There are also indications that significant further savings are possible by extending this work across more care homes and taking into account the impact of reductions in medication side effects on, for example, the incidence of falls.

- The local evaluation included the use of a standard quality of life questionnaire, as provided by the national evaluation team, to evaluate the impact of two specific POPP interventions: the activity co-coordinator training initiative and the medicines review. Analysis found few changes in any of the indices of quality of life measured in this way and the small sample size meant that it was not possible to draw any firm conclusion regarding the effect of these specific interventions on quality of life.

- Fifty interviews were carried out by older people who were recruited as 'community researchers' in order to explore the impact of organised activities on the quality of life of care home residents. Although this part of the evaluation targeted homes where staff had received activity co-ordinator training through the POPP, it was not designed to directly assess the impact of that training. However, analysis of interviews did demonstrate that activities were highly valued by most residents and

made a major contribution to their quality of life. The quantity and range of activities provided varied considerably between care homes and several barriers to provision were identified, along with a widespread desire for more trips away from the care home. The involvement of older people as researchers in this part of the evaluation was very successful. It is hoped that they will be valued as an ongoing resource in Gloucestershire in relation to the evaluation of services.

- Performance exceeded targets for 8 of the 15 local and national indicators that were agreed with the Department of Health for the Gloucestershire POPP, as measured in December 2008. These include the number of delayed transfers of care from acute and community hospitals, the number of care homes receiving training through the project, the number of contacts between care homes and the CHST, the number using dementia care mapping and the number of additional older people involved in service planning and/or delivery.

- Performance was below target for 5 indicators, including the number of people taking up new services offered by care homes, the number of people benefitting from an outreach service and the number of older people helped to live at home.

- Project activity monitoring carried out by the Council Performance Team and the POPP Project Office highlighted the challenges of collecting performance data for a complex multi agency project. However, data collection systems were improved as a result of the project and a range of 'highlights' were identified. These included: over 1,000 older people have been involved in developing and evaluating the Project; 1,200 care home staff have received training as a result of the project; 126 contacts were made with the Care Homes Support Team in relation to behavioural problems, dementia, or mental health issues; and 14 different types of services were offered to the local community by care homes as a result of the Gloucestershire POPP.

- There is a strong case for continuing some of the data collection using the performance monitoring systems that have been established. This would enable tracking of those elements of the project that have been extended, inform decision making about service development and could also be used in future project applications.

CONCLUSIONS

The overarching aspiration of the Gloucestershire POPP was encapsulated in the title of the project: 'Gloucestershire care homes – part of our community'. This was driven by a widespread belief that care homes were perceived, by the professional community and the general public, as isolated from society and detached from other services for older people. A survey carried out to inform the original application for project funding found that older people had little faith in care homes, despite placing great value on some of the services they provide, such as convalescence and respite. The application therefore proposed to unlock the potential of care homes and the skills of their staff in order to enable them to provide services that were truly local and responsive. It was envisaged that this would lead to a range of benefits for care home residents and local communities, including fewer emergency hospital admissions, more people living in their own home, more involvement of older people in developing services, better partnership working and more trust in the services provided. Within this overall goal the project adopted three main aims:

- to work with care homes to develop excellent services;
- to encourage care homes to extend their services into the community and support communities to work with care homes in their area; and
- to increase the opportunities for older people to participate in developing services.

The local evaluation has demonstrated considerable progress towards achieving these aims. Some examples include the training that was delivered to over 1,000 care home staff in a range of areas including clinical skills, dementia care, nutrition, end of life care, enablement and activity provision; the belief among project stakeholders that the quality of care had increased during the course of the project; the areas of additional unmet need that were identified and initial scoping work was carried out; and the increased level of engagement between some care homes and their local communities. In addition, the economic evaluation has demonstrated the cost effectiveness of the project through reduced emergency bed day use and savings achieved through the pharmacy review.

Inevitably the project faced many unanticipated challenges, including recruitment problems and capacity building issues. As a result of these progress in some areas was slower than expected. For example, the development of new services by care homes was below target, as was the number of people benefitting from an outreach service provided by care homes. However, there were encouraging signs of improvement in many of these areas in the final months of the project and a strong belief that firm foundations had been built on which much could be achieved. For example, despite delays in establishing mechanisms for the engagement of older people in service development and planning, by the end of the project a comprehensive network of Hubs and Forums to support such involvement has been put in place.

The Gloucestershire POPP has also gone a long way towards meeting the Department of Health's aspirations for POPP on a national level. These were to provide person centred and integrated responses for older people, to encourage investment in approaches that promote health, well-being and independence for older people, and to prevent or delay the need for higher intensity or institutionalised care.

The long term success of the Gloucestershire POPP will largely depend on the extent to which its areas of success are supported to continue beyond the life of the project. The emphasis throughout the project on sustainability has been a major strength in this respect, and has led to continued commissioning of several elements, including the Care Home Support Team, an end of life care post, dementia link workers and the care home learning network. Also crucial will be the resourcing of the mechanisms that have been put in place to support engagement with older people across the county, particularly the hubs and forums. At the time of writing no decision had been taken on future funding of this central component of the POPP. A long term view also needs to be taken on the broader project aim to improve the image of Gloucestershire care homes. While there are already signs of change in the attitude of professionals, achieving similar change among the wider public will depend on continued resourcing of successful elements of the project and the implementation of effective dissemination of the achievements of the project, particularly through the mass media.

Finally, it is important to recognise the enormous amount of learning that has emerged from the project and the potential impact of this on service delivery. Much of this learning focuses on partnership working and the increased understanding, respect and engagement that has developed between statutory and independent agencies. Many additional examples can be found in Section B of this report.

SECTION A. AN EVALUATION OF THE GLOUCESTERSHIRE POPP: FINAL REPORT

INTRODUCTION

Partnerships for Older People Projects (POPPs) were a network of prevention pilots funded by central government and designed to encourage joint working between local authority councils with social services responsibilities, primary care trusts and the independent sector. Gloucestershire was successful in winning a POPP to focus on developing the role of Care Homes in the local community. A research team from the University of the West of England, Bristol, was commissioned to carry out the local evaluation of 'Care Homes, Part of Our Community' and this final report pulls together all the main strands of that evaluation.

The next section places the Gloucestershire POPP within its national context. The report then goes on to outline the main work packages of the POPP and the activities these generated before going on to explain how the local evaluation was designed to complement the work of the national evaluators. This is followed by three sections which present findings from the three main components of the local evaluation, namely (i) the impact of the POPP in terms of joint working and cultural change, (ii) an assessment of two specific interventions, and (iii) an overall economic appraisal. The report concludes by pulling together the main conclusions and specifying recommendations.

THE NATIONAL CONTEXT

There is a growing recognition from central government about the importance of targeted prevention services for older people. This agenda focuses on their capacity to both foster an improved quality of life and also their capacity to reduce the cost of health and social care services which have to be provided to those in crisis need. There is also an acceptance that this potential is often undermined by the lack of integrated partnership working at the local level (Means *et al*, 2008). A wide range of government reports have promoted the importance of meeting these twin challenges including the Green Paper on Adult Social Care (Department of Health, 2005), the White Paper on Community Services (Department of Health, 2006a), the Social Exclusion Unit report on **A Sure Start to Later Life** (Office of the Deputy Prime Minister, 2006) and the interdepartmental strategy review called **Opportunity Age** (HM Government, 2005). More recently, the whole thrust of adult social care policy has been on the need to transform provision by **Putting People First** (HM Government, 2008) a process seen as requiring an increased emphasis on prevention and partnership working.

Partnerships for Older People Projects (POPPs) fit into the centre of this government agenda. The 2004 Government Spending Review ring-fenced funding of £60 million for Councils with Social Services responsibilities to develop innovative prevention pilots as a collaboration with PCTs and the independent sector. Their overall aim was to achieve 'large scale system reform across health and care services to deliver improved outcomes for older people through greater investment in prevention' (Department of Health, 2006b, p. 1). More specifically, it was hoped that these partnerships for older people's projects would:

- provide person centred and integrated responses for older people
- encourage investment in approaches that promote health, well-being and independence for older people, and

- prevent or delay the need for higher intensity or institutionalised care.

  (Windle *et al*, 2007)

There have been two rounds of POPP funding in which each POPP is awarded money for a two-year period. Nineteen initiatives were funded in Round One (April 2006 to March 2008) and a further ten, including Gloucestershire, in Round Two (April 2007 to March 2009).

Since the 1970s, governments have often tried to achieve policy change through the use of such time limited monies which localities are asked to compete for. These monies are usually for innovative projects which are designed 'to shake up the system' with the hope that the agencies will continue with these initiatives once central government support has ended. These schemes have often been focused on prevention and frequently stressed the need to foster improved working relationships between health and social services. Sadly, sometimes the opposite has happened with disputes breaking out over who should 'pick up the bill' at the end of the initial grant. The end result has often been a failure to sustain such initiatives over the long term in the way originally intended (Glendinning *et al*, 2005).

A very important feature of the POPP initiative has been the emphasis on sustainability. POPP applicants were encouraged to submit an economic appraisal which would show how savings on acute services through prevention could be re-invested into service provision to ensure the long-term continuance of the POPP beyond the initial two year funding.

The national evaluation team for the whole POPP programme has already published two interim reports on progress (Windle *et al*, 2007; Windle *et al*, 2008). The first interim report underlined how each POPP tended to be

composed of a number of different initiatives and interventions with the 29 POPPs being responsible for a total of 245 different projects, which included:

- Community development to promote citizenship and volunteering
- Providing better access to information, navigation services and peer support for older people
- Health promotion activities to support healthy living
- Low-level or simple services for older people such as help with shopping, household repairs etc
- Specialist services for older people with chronic or complex conditions;
- Pro-active case finding of older people at most risk of losing their independence and of hospitalisation
- Integrated needs assessment and case management to prevent avoidable hospital admissions
- Better support for older people following discharge from hospital;
- Use of technology;
- Pathway design.

(Based on Windle *et al*, 2007, pp 2-3)

Finally, it needs to emphasised that the second interim report by Windle *et al* (2008) stressed how the POPP pilot sites were overall having a demonstrable effect on reducing hospital bed-day use in their localities while at the same time having a positive impact on the health related quality of life of older people using POPP initiatives. Such findings have given POPPs a high national profile which has included their heavy emphasis in a recent Department of Health (2008) report on **Making a Strategic Shift Towards Prevention and Early Intervention** which has been published as part of the

overall **Putting People First** agenda. The focus of this report is to explore and explain how such findings across all 29 sites relate to the particular focus and particular experiences of the Gloucestershire POPP.

THE GLOUCESTERSHIRE POPP

The Gloucestershire POPP was funded as one of the Round Two POPPs. The title of the successful project was 'Gloucestershire Care Homes – Part of our Community' with £2,597,000 to be spent on this initiative between April 2007 and March 2009 (Department of Health, 2007). The successful application had seven work streams, namely:

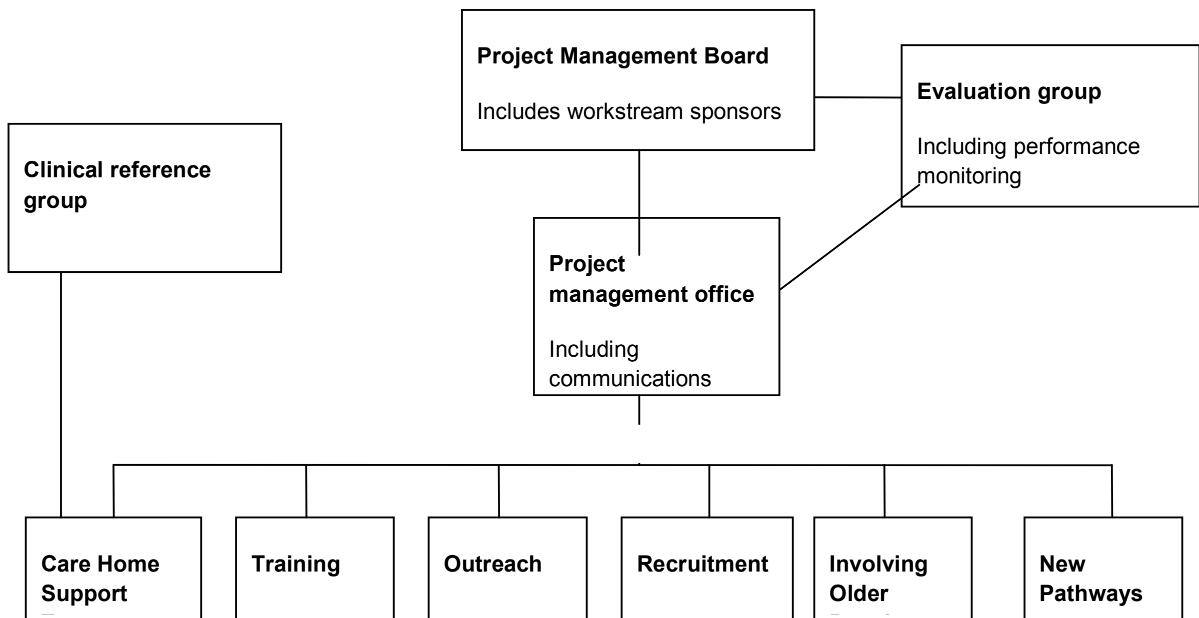
- The provision of Care Home Support Teams across the county to tackle such issues as medicines management, dementia care, falls reduction and the improved care of the dying.
- The development of outreach services to help Care Homes to provide different types of care and support to a greater number and wider range of older people and their carers in the community.
- The development of new care pathways such as step up (prevent admission) and step down (aid discharge) beds.
- Improved training for Care Home staff.
- The retraining and recruitment of older people for second careers.
- A local evaluation.
- A robust system of communication.

The work streams were of a very different scale with the Care Home Support Team costs accounting for over £1.5 million of the overall budget over 2 years. A summary of the project structure is shown in figure 1.

The overall logic of the Gloucestershire POPP was clearly set out in the application:

> The proposed project will unlock the potential that is presently dormant within Care Homes in Gloucestershire. Redesigning this element within the whole system of health and social care will bring about a sustainable shift from the focus on acute or long term care towards targeted earlier interventions aimed at improving care, well-being, choice, dignity and independence. This will result in more local responsive and person-centred care.

Figure One: Overall structure of the Gloucestershire POPP



The choice of focus for the Gloucestershire POPP was heavily influenced by a previous initiative. The care home support component was based upon an evaluated pilot in West Gloucestershire during 2003-2005. This pilot had been funded through a Social Services Access and Capacity Grant. The project was based upon a belief that support from the health community to care homes was often inadequate and fragmented. The grant enabled the establishment of a Care Home Support Team (CHST) which employed two full time nurses, a pharmacist for three days a week and input from two GPs. Important initiatives and developments included training for care home staff; improved communication between home and across sectors; medication reviews; active ageing initiatives; more coherent GP surgery and care home links; nurse support for residents with complex needs; and improved palliative care. The evaluation concluded that 'there is an obvious need for work to continue to support care homes' (Appendix 7 of the Gloucestershire POPP application).

The background as described above suggested that the Gloucestershire POPP would have strong roots in the local policy system. This was also reinforced by how the POPP was very much in line with performance indicators set down in the Gloucestershire Local Area Agreement relating to supporting independence, health and well-being for those over 75, namely:

- To reduce the number of people aged 75 or over admitted to hospital with fractured femur.
- To increase the proportion of older people supported to live in their own home by 8 per cent of the population by 2010 from a baseline of 61 per cent in 2006.
- To increase access to community based services, information and technology, including those delivered through health and well-being

partnership initiatives that contribute to feelings of security and physical and mental well-being of older people living at home.

The Gloucestershire POPP had three overarching aims:

- To work with care homes to develop excellent services;
- To encourage care homes to extend their services into the community and support communities to work with care homes in their area; and
- To increase the opportunities for older people to participate in developing services.

These aims were to be achieved via the workstreams in the following ways. By:

- Providing training and hands on support to care home staff from our care home support team of general and mental health nurses, pharmacists and therapy staff
- Developing and providing training
- Providing care homes with small grants and advice to set up new services in the community
- Recruiting older volunteers to work with care homes in a number of ways, including providing services or supporting care homes to work in the community
- Supporting networks of older people to influence how services develop

Table 1. The six POPP Workstreams

Workstream	Description
Care Home Support Team	Multi-disciplinary team including RGNs, RMNs, Physiotherapist, Occupational Therapist, Speech and Language Therapist, Medicines management team, administrator providing single point of access for care homes (dietician and podiatrist to be appointed). Workstream role includes training of care home staff, clinical referrals and case management and crisis response service.
Training	Led by GCC and works with skills for care, the NHS and others to develop training approaches for care homes, trialing different approaches e.g. elearning and developing new training pathways, linked to accredited learning and policy requirements. This workstream is also working with care homes to develop a "learning exchange".
Outreach	Led by Gloucestershire Care Providers Association with the primary purpose of encouraging care homes to provide services for older people outside the care home. Tasks include working with care homes who have been awarded small grants to develop outreach services and establishing an activity coordinator network.
Recruitment	Conceived as the workstream to encourage older people to volunteer or work within care homes and more widely as the project developed. Has been refocused to work on the recruitment of volunteers via CVS and fairshares/timebank, and the development of "hubs" to bring together community organisations and care homes within small communities in order to encourage them to work together, share resources and develop new services for older people.
Involving Older People	In addition to the representation of GOPA on the project and the small consultation done with older people to help define the project objectives, a dedicated workstream was funded to support involvement around POPP. The two main elements are 1. The recruitment and training of facilitators to engage with older people and to support care homes, and 2. Recruiting a forum coordinator to try to develop a sustainable level of engagement with older people.
New Pathways	The PCT has, so far, commissioned only 3 beds in Great Western Court for orthopedic recovery. There is still considerable "talk" about increased commissioning for the care home sector and the POPP project is seen as critical in making this possible.

BACKGROUND

The Gloucestershire bid for POPP monies placed a strong emphasis upon evaluation and the need to establish an evaluation stream of work. This has resulted in:

(i) An Evaluation Group chaired by the Performance and Information Manager at Gloucestershire County Council.

(ii) A strong emphasis upon using existing social care and health data, to be co-ordinated through Ivars.

(iii) The commissioning of an evaluation team (Robin Means, Simon Evans, Nikki Coghill and Jane Powell) from the University of the West of England, Bristol, to undertake the independent local evaluation.

(iv) The inclusion of Evaluation as a standing item on meetings of the Project Management Board.

All 29 POPPs have been evaluated at two levels. A research was commissioned by the Department of Health (DH) to carry out a national evaluation of all 29 projects. In addition, each POPP was required to commission a local evaluation. This section of the report describes the two evaluations and reports on the local evaluation.

1. <u>National Evaluation Requirements (Minimum Core Data Set)</u>

National evaluation requirements were comprised of the following:

(a) Meeting National Public Service Agreements (PSA)

- Reducing emergency bed days by 5 per cent by 2008.
- Increasing in the number of older people helped to live at home aged 65 or over per 1000 population.
- Increasing in the number of people supported intensively to live at home as a proportion of the total number of people being supported at home or in residential care.

The data needed for monitoring this component of the national evaluation were collected by the DH and the National Evaluation Team was able to draw upon this for Gloucestershire.

(b) Local Indicators (Core Data Set)

The National Evaluators recognised the diversity of the different POPP projects across the country and that because of this, reliance solely on a common national data set would be inappropriate. Hence, each POPP site was invited to self select a set of key local indicators (from 6

to 10) which were incorporated into the Minimum Data Set of the National Evaluators for each POPP. Each Gloucestershire POPP work-stream was invited to suggest indicators and the final decision was made by the Project Management Board. It was the primary responsibility of the local evaluation group lead to ensure that appropriate data was collated and then returned to the National Evaluation Team via the overall POPP Project Manager against the agreed indicators. The chosen indicators were:

- Numbers of Older People involved as a result of POPP
- Reduction in admissions to hospitals from care homes.
- Reduction in delayed transfers of care from acute & community hospitals
- Number of homes employing Preferred Priorities of care training
- Number of care homes who have received nutrition tool training.
- Number of contacts to CHST from care homes in relation to behavioural problems, dementia or mental health issues
- Numbers of care homes who have received basic dementia training
- Savings made as a result of medication reviews
- The number of care home staff receiving training directly as a result of POPP
- Range of new services offered by care homes directly as a result of POPP
- New services offered by care homes directly as a result of POPP – number of care homes taking them up
- Number of people befitting from an outreach service from a care home.

(c) Impact on Quality of Life

The National Evaluation Team provided a questionnaire that all POPPs were expected to use on a ‘before’ and ‘after’ basis for some of their

interventions. The UWE Evaluation Team administered these on behalf of the National Evaluation Team and applied them to the activity training coordinator initiative and the medicines review (see below for more detail).

(d) Cost Effectiveness

The National Evaluation Team also collected cost effectiveness data from a range of sources including the Public Service Agreement, local indicator data and Quality of Life data (see above). In addition, each POPP site was expected to provide data on all POPP income and expenditure.

2. <u>An Independent Local Evaluation</u>

It was also a requirement of project funding that each POPP would put in place a local evaluation component. Following a tender process, a research team at the University of the West of England, Bristol (UWE) was contracted to carry out the local evaluation of the Gloucestershire POPP. Rather than attempt to carry out an in depth assessment of performance across the whole range of project activity, it was agreed that it would be more useful and practical within the available resources to focus on the overall impact of the Gloucestershire POPP and the impact of specific initiatives on older people. The evaluation therefore focused on the following tasks:

- Exploring joint working and cultural change;
- Assessing the impact of specific interventions; and
- Carrying out an overall economic appraisal of the Gloucestershire POPP.

The UWE local evaluation adopted a mixed methods approach that incorporated qualitative and quantitative data across core elements of the evaluation as follows:

Stakeholder analysis: an exploration of joint working and cultural change

Semi-structured interviews were carried out with stakeholders who were identified as being best placed to provide diverse views and perspectives about the project. Interviews were carried out once soon after the project began and again during its last few months. Interviewees included Work Stream Sponsors and Leads, Care Home Managers, Commissioners of services involved with the POPP and those who were involved in developing the initial POPP bid.

Quality of Life questionnaire

Administered by the local evaluation team on behalf of the national evaluators. Designed by the national evaluation team as a before and after tool to measure impact of specific project interventions on the quality of life or service users.

Quality of Life interviews

These were designed to explore the importance of organised activities to care home residents and the potential of the POPP activity coordinator training initiative to improve their quality of life in a more in-depth way than possible through the quality of life questionnaire. Older people were recruited and trained as 'community researchers' as part of the project's aim to increase the involvement of older people in service evaluation.

Economic Evaluation

This strand of the evaluation aimed to assess whether the new interventions could be self sustaining beyond the POPP funding through savings made on acute services. This included identifying the actual resource saving to the

NHS that arose from the preventative role of the POPP in terms of promoting independent living and avoiding the hospitalisation of older people. The economic evaluation aimed to calculate (1) the potential impact of the POPP on levels of emergency bed day use (this measure was chosen by the local evaluators because it was used by the national POPP evaluation team) and (2) the savings achieved through a pharmacy review of care home prescribing. Data were for the economic evaluation were provided by the POPP project team and analysed by members of the UWE research team.

The local evaluation received ethical approval from the Gloucestershire NHS Research Ethics Committee.

Methodological Limitations and Challenges

As with any service evaluation the methodology adopted brought a number of limitations. These were largely due to the overall nature of the Gloucestershire POPP, the restricted availability of some data and the challenges of engaging with care homes. We now describe these limitations in more detail.

It made sense to adopt emergency bed day use as the main economic measure for the Gloucestershire POPP because it was also being used by the national evaluators. However, it is important to note that this measure and the methods of statistical analysis used do not aim to attribute any savings directly to the POPP. This is difficult to achieve because of the 'noise' created by other initiatives and changes in service configuration occurring at the same time. However, it is able to provide a comparison of trends in emergency bed day use before and after the POPP interventions began. It is also important to remember that although emergency bed day use was chosen as an indicator by the national evaluators of all 29 POPPs, a reduction in this indicator was not empahsised in the original application for the Gloucestershire POPP. Therefore any changes in levels of emergency bed day use do not necessarily indicate the success or otherwise of the project in achieving its specific

objectives, although it can be argued that a reduction in levels would contribute towards meeting its overall aim of maximising independence for older people while also reducing service costs.

The recruitment of care home residents as participants in the evaluation proved to be a particularly challenging aspect of the evaluation. The researchers encountered a high level of reluctance to take part among many care home managers, which led to a lower than anticipated response rate to the quality of life questionnaire. This, combined with a high level of unanswered questions, meant that the questionnaire analysis was not able to reach any significant conclusions. The low response rate was confounded by delays in completing one of the interventions that was being measured, the medicines review. With hindsight, more resources could have been sought in order to engage with care home managers on a face to face basis as a way of increasing participation. This approach was seen to work well for the quality of life interviews, where an initially slow recruitment rate was considerably improved by the use of additional community researcher time.

EVALUATION FINDINGS

1. JOINT WORKING AND CULTURAL CHANGE IN GLOUCESTERSHIRE: AN EXPLORATION

'Gloucestershire Care Homes: Part of our Community' incorporated a range of specific projects and initiatives which aimed to improve the lives of individual older people. However, it also included an objective to encourage more integrated, co-ordinated and mutually supportive inter-agency and inter-sectoral working. In order to evaluate this element of the project, the local evaluation team carried out semi-structured interviews with stakeholders who were identified as being best placed to provide diverse views and perspectives about the project. Interviews were carried out once soon after the project began and again during its last few months. Interviewees included Work Stream Sponsors and Leads, Care Home Managers, Commissioners of services involved with the POPP and those who were involved in developing the initial POPP bid.

Based on these interviews, this section provides a summary of the views of stakeholders in the Gloucestershire POPP and how those views changed during the course of the project. A full report can be found in Appendix A2.

An analysis of the first round of interviews with stakeholders that was carried out towards the beginning of the project identified five key messages:

- The Gloucestershire POPP is a complex project with ambitious goals. Two overarching aims are particularly important: changing the image of care homes and engaging with older people. Achieving these is crucial to the success of the overall project.
- Sustainability is the POPP's major challenge. The key elements of a strategy include promoting the benefits to a range of stakeholders, particularly the wider public, and linking with appropriate local decision

making bodies. There is widespread concern that the POPP will not have sufficient time to achieve sufficient 'real' savings

- There are major differences in the cultures of the statutory and independent partners involved in the POPP, particularly in terms of resources and ways of working. It is important that these differences continue to be understood and addressed in order to provide the independent organisations with the support that they require in order to carry out their roles within this initiative.
- Publicity has a major role to play and is key to changing perceptions of care homes, raising awareness of the project and spreading the message about its successes. There has been a delay in developing a comprehensive media strategy to promote a positive image of care homes but there is still time to do so.

To a large extent the follow up interviews carried out at the end of the project support the relevance of the themes that were identified towards the beginning. Two project aims in particular have proved to be major challenges and questions remained about the extent to which they will be achieved. Interviewees in round two felt that there had been good progress on the first of these, changing the image of care homes, among professionals but that it would take much longer to achieve similar progress in respect of the wider public. There were bigger questions about the extent to which the second aim, engaging with older people, had been achieved and a feeling that only with considerable commitment and resourcing would it be possible to build on the limited progress that had been made.

Round one interviews also identified concerns that two years wouldn't be long enough to demonstrate the economic benefits of the project. The findings from round two suggest that these concerns have only been partially realised.

To a large extent the developments that have occurred nationally through POPP have resulted in greater recognition of the value of preventative interventions by commissioners across health and social care services and beyond. This has reduced pressure on the Gloucestershire project to provide hard evidence of specific savings and has led to a commitment by commissioners to provide ongoing funding for some elements of the project, including the Care Home Support Team. Interviewees recognised this as a major success for the project. However, interviewees also felt that two years had not been long enough to meet all of the project aims and as a result a similar level of sustainability had not yet been achieved in all areas. This was felt to apply to two areas in particular: engaging with older people and changing public perceptions of care homes. In both these areas it was suggested by interviewees that some progress had started to be made but that further achievements depended on the allocation of sufficient resources.

The challenge of joint working between statutory and independent sector organisations is another theme that emerged as an issue in both first round and second round interviews. To a large extent the cross-sector differences in structure and culture have been recognised and addressed, leading to major improvements in both the level of understanding and the effectiveness of joint working. This has brought benefits not just for the POPP but also for many other existing and future initiatives in Gloucestershire. However, some round two interviewees also suggested that an initial lack of capacity among independent project partners led to some work streams taking a long time to get off the ground and may have affected their ability to meet targets.

2. IMPROVING THE QUALITY OF LIFE OF OLDER PEOPLE IN GLOUCESTERSHIRE CARE HOMES: ASSESSING THE IMPACT OF SELECTED INTERVENTIONS

One of the main challenges of the local evaluation has been the range and diversity of initiatives that were generated by the different work-streams. The evaluation has not aimed to deliver a detailed evaluation of each of these in terms of whether they met their objectives and the extent to which they fed through into improving the quality of life of individual older people. Instead, different work-streams and different elements within each work-stream received very different levels of evaluation input. More specifically, three different levels are detailed below:

(i) Profiling Activity

This part of the overall monitoring of the project was led by the POPP project manager with the aim of describing and measuring the core work areas of POPP in terms of the activities undertaken along with some of the learning that emerged. This work was not part of the formal evaluation of the project but an addendum to the formal evaluation and can be found in Section B of this report. It is hoped that this will be of use to those considering working with care homes in a similar way but also to partners within the project locally in considering the way forward once POPP has finished.

(ii) Local Indicators

Local indicators not only formed part of the national core minimum dataset but were also used to provide feedback on the progress of work-streams against their agreed objectives. A report on this element of project monitoring can be found in Section B1.

(iii) Assessing the Impact of the Project Interventions on the Quality of Life of Care Home Residents

Two of the key POPP initiatives were chosen within which to provide an evaluation of the direct impact on the quality of life of older people. These were the activity co-coordinator training programme and the medicines review. This section now presents the evaluation findings in these areas by

focusing upon the two main research instruments that were used, namely the quality of life questionnaire provided by the national evaluation team and the semi structured interviews carried out in collaboration with volunteer older people in the role of 'community researchers'.

2A. QUALITY OF LIFE QUESTIONNAIRE

Introduction and methods

The quality of life questionnaire was administered by the UWE local evaluation team as part of the national evaluation of all 29 POPPs. The questionnaire was developed by the national evaluators, based largely on a range of existing validated measures. It is designed to be used before and after specific interventions in order to demonstrate the impact of those interventions on the quality of life of participants across all of the POPPs. Guidance from the national evaluation team indicated that the questionnaire should be administered at least twice, once pre-intervention to obtain the base-line data and again following the cessation of the service. It was recognised that not all services planned by the pilot sites will be suitable and therefore decisions about which interventions it would be used with were left to individual projects in consultation with their local evaluators. In Gloucestershire two interventions delivered through the POPP were chosen: 1. The medicines review and 2. Activity coordinator training. A total of 160 questionnaires were distributed to 8 care homes, 4 of which had taken part in the medicines review and 4 in the activity co-ordinator training. Care homes were selected to provide a balance between rural and urban locations.

Findings

Seventy completed questionnaires were returned from 5 care homes at baseline (pre-intervention) and 31 at follow up (post intervention). There appeared to be two main reasons for this lower than expected response rate. Firstly, care home staff felt that the questionnaire design and content was not user-friendly and was not appropriate for some care home residents. This meant that residents required high levels of support from care home staff in order to complete the questionnaire. Secondly, where the questionnaire was being used to evaluate the medicines review the follow up administration needed to take place after the changes to medication had been approved by the appropriate GPs and implemented. As described elsewhere in this report, this process took much longer than anticipated and in some cases hadn't been completed within the timeframe of data collection for the evaluation.

The questionnaire was divided into four main sections:

1. Your Health Today
2. Your Quality of Life
3. Service use
4. About yourself

A full analysis can be found in the appendix, while here we highlight some findings from all sections apart from the 'Service use' section. Much of this section is not relevant to participants because it covers services that older people would only use in their own homes and not in a care home setting.

Profile of respondents

The age of residents ranged from 58 to 98 years, with a mean age of 85.

There were almost three times as many females as there were males.

Just over half of respondents had continued their education beyond the minimum school leaving age.

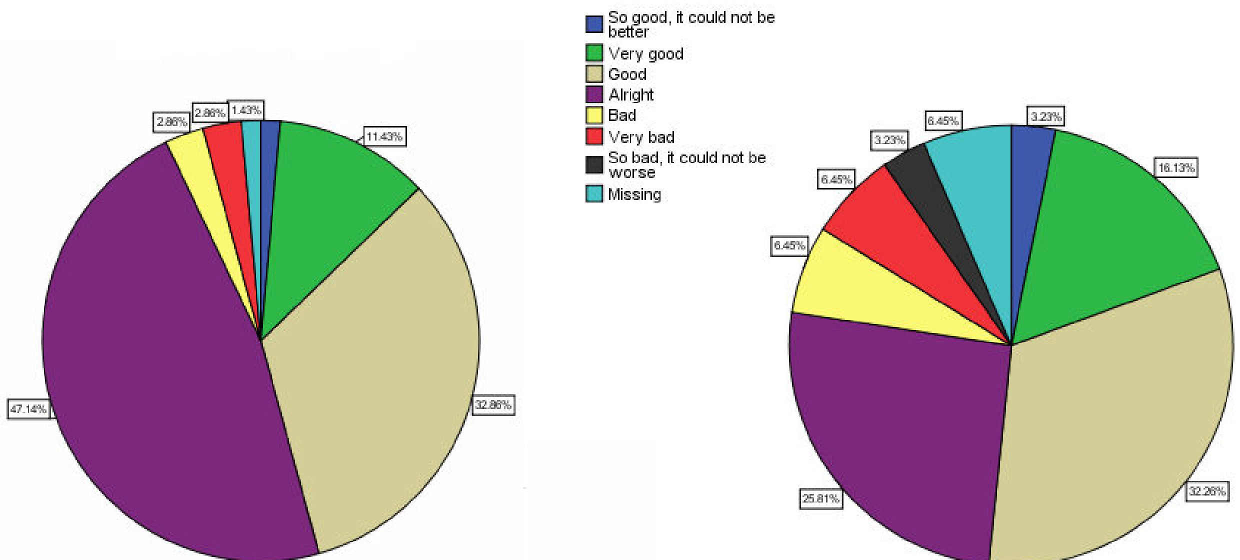
My Health Today

This subsection relates to participant's health status on the day that the questionnaire was administered. Higher scores indicate poorer health, with a possible maximum score of 15. There is an 11.5% decrease in reported health status between baseline and follow-up. However, limitations relating to sample size and differing population must be considered.

Quality of Life (figure one)

At follow-up 22.13% less reported their quality of life as being alright, but 4.7% more reported it as being very good. Additionally, there was an increase of 3.23% in those who reported that their health was so bad it couldn't be worse, and an increase of 3.59% each for those reporting their health as bad and very bad.

Figure one: Quality of life at baseline and follow-up by percentage response



Short Form Questionnaire Sub scales

The questionnaire included the Short Form Rhyff quality of life measure, which is made up of six subscales. Analysis suggests a reduction in feelings of autonomy, positive relations with others and feelings of personal growth from baseline to follow up, but an increase in purpose in life and environmental mastery. However, these changes are small and must be interpreted in light of the sample size which is too small to infer any real changes between baseline and follow-up.

Summary

The quality of life questionnaire was administered to 70 older people at baseline and 31 older people at follow up. The mean age of respondents at baseline was 85 years and 87 years at follow-up. More women than men responded at both baseline and follow-up.

There was little difference in the scores for ‘Health reported on the day’ and ‘my health today compared with general health over the past 12 months’. Although there were some changes between baseline and follow-up for the single enquiry into quality of life, the only changes of any magnitude related to a reduction in those reporting feeling alright at follow-up and an increase in those reporting their quality of life as good compared to baseline.

There was little difference in the scores between baseline and follow-up for the sub-scales of the short-form questionnaires or in the total score for this scale.

In summary, there were few changes in any of the indices of quality of life measured in this way. The quality of the data, particularly the small amount of post intervention responses, has affected the likelihood of detecting any

changes that may have resulted from interventions designed to affect the quality of life of older people. It is therefore not possible to draw any firm conclusion regarding the effect of these specific interventions on quality of life at this stage. However, there is evidence in the published literature to support the effect on quality of life of both medicines reviews and increasing both physical and mental activities in older people. To obtain a more accurate reflection of the effect of these aspects of POPPs on the quality of life of older people in care homes a larger sample size is required, which should be monitored over a longer time period, sufficient to detect any changes should they occur.

2B. QUALITY OF LIFE INTERVIEWS

Background

Research interviews were included in the local evaluation in order to explore in more depth the possible impact of the activity coordinator training on the quality of life of care home residents. A key feature of this part of the evaluation was the plan to recruit and train a group of older people from Gloucestershire to carry out the research interviews. This fitted in with one of the aims of the Gloucestershire POPP, to increase the involvement of older people in service evaluation and development. Approximately 30 people responded to advertisements and publicity about the opportunity for older people to take part in the evaluation. After initial meetings 6 of these individuals were keen to continue and they took part in a subsequent training session run by the UWE evaluation team on carrying out research interviews. This covered a range of issues including recruitment processes, research ethics, the development of an interview schedule and how to take interview notes. Additional ongoing support was provided to community researchers through regular meetings and telephone/email communication. Monies were provided by the Gloucestershire POPP in order to fund the time and expenses of this group. It is hoped that there will be further opportunities for this group

to continue to be involved in service evaluation in partnership with the Local Authority and/or Primary Care Trust in Gloucestershire. This element of the local evaluation has been disseminated by the Department of Health as an example of good practice in involving older people in the evaluation of POPPs.

About the interviews

The overall aim of the interviews was to evaluate the impact of the POPP activity co-ordinator training on the quality of life of residents. However, the methodology chosen, semi-structured interviews, reflects a recognition that this part of the evaluation would take the form of a broad exploration of the issues involved from a resident perspective, rather than an experimental study. This latter would have required a before and after methodology that was not possible within the evaluation design and the resources available.

Interviews were carried out with 50 residents from 10 care homes. Homes were chosen from a list of those where staff had been on activity training provided by the POPP. Within this population there was an overall aim to select the larger homes because these offered the greatest number of potential interviewees. There was also a geographical element to care home selection to meet the travel and mobility needs of the community researchers involved. Letters were sent to each of the care homes in order to introduce the evaluation and these were followed up by the community researchers in order to arrange interviews. It is important to note that the system of recruitment gave care home managers or other members of staff some influence in choosing participants from among their residents and that this could potentially impact on the findings.

Interview Findings

About the residents

Interviewers recorded some basic information about the health status of participants where appropriate. This indicated a wide range of conditions, including multiple sclerosis, rheumatoid arthritis, shortness of breath, impaired vision and strokes. Several interviewees regularly used mobility aids including Zimmer frames, wheelchairs and sticks. When asked what their main interests and hobbies were residents mentioned a wide range of activities. Those most frequently mentioned were reading (including Talking Books which were highly valued by residents with impaired sight), quizzes, puzzles, knitting, flower arranging, walks, bingo, gardening, radio/television and conversation. A few residents said that they had no particular hobbies.

Activity provision

38 of the residents interviewed knew who the activity co-ordinator was in their care home while the remaining 12 didn't know. All of the interviewees found out about what activities were available either via a weekly written programme or directly from staff. All 10 of the care homes offered some organised activities but the types and range of activities appeared to vary considerably. The overall list was comprehensive and included talks, singing sessions, exercises (dance, keep fit, music and movement), painting, crafts (making things out of paper, card, etc), knitting, music (organist, violin player guitarist), flower arranging, films, cooking, art group, trips out, games (bingo, quizzes, cards), television, on-site library, religious service. One person said that there was nothing offered in the way of organised activities, but it is important to note that this contradicted statements from other interviewees in the same home. Possible explanations for this include individual differences in awareness of what is on offer and memory problems.

There were also differences in reported frequencies of activities. For example, one resident said that there was something arranged for every day while

another was only aware of something happening once a week. There appeared to be considerable differences between homes in terms of the number of activities provided. Some of the organised activities were particularly enjoyed by residents. These included singing, bingo quizzes, arts and crafts and any activities that involved contact with other people. Many residents also mentioned how much they enjoyed going out, both into the care home garden or further afield on organised trips. Several interviewees expressed a preference for solitary activities such as reading, knitting and gardening and a few said that they didn't enjoy using the communal lounge at all because it was largely occupied by people doing nothing but watching television. One resident explained this by saying that 'I am quite happy in my own room whereas in the lounge they just sit around'. Another described the importance to her of the view from her room which looked out onto playing fields where she could watch the children playing hockey and tennis.

Only a few respondents mentioned specific activities that they didn't enjoy, those being bingo and painting. The majority appreciated the opportunity to take part in whatever was provided. There were, however, a range of barriers for some residents that prevented them from taking part in activities. Most of these were related to physical disabilities, particularly the use of a wheelchair and sensory impairments. For several residents, using a wheelchair limited their opportunities for activities away from the care home. This appeared to be largely because of transport difficulties. For example, one female resident had to take it in turns going out because the care home minibus only had room for one wheelchair, while another was told that her wheelchair wasn't safe enough to be taken out. Transport problems don't only affect residents with wheelchairs. One care home had stopped taking any residents very far because their minibus was very old and regularly broke down.

Several residents said that they couldn't take part in all of the activities they would like to because they were partially sighted, while another had stopped

doing exercise classes because he couldn’t keep up. Similarly, one resident said that she didn’t take part in any activities because she was incontinent.

Staff resources could also be a barrier, as indicated by one resident who said that that day’s outing had been cancelled because other residents needed to be taken to hospital. Almost half of the respondents said that there weren’t any additional activities they would like to take part in. Others did identify additional desired activities, including going out, poetry readings, exercises and using a computer. A few of the men who were interviewed expressed a desire for practical activities such as metal work, decorating and watch mending.

Activities and Quality of Life

Overall the interviewees gave a strong impression that activities were an important part of their lives. This is demonstrated by responses to a question about what life would be like without them. Replies included ‘I would be miserable, if I am left alone I am hopeless’, ‘It would make a huge difference; without them things would be very dull’, and ‘I would be bored stiff and somewhat cross with life’.

Several residents suggested that without activities they would spend their time watching TV and reading while a minority felt that it would make no difference, largely because they didn’t take part in them anyway. For example, one person said ‘If activities weren’t available it would make no difference because I stay in my room most of the time’. Participants were also asked what other factors were important to their quality of life. Their answers suggested that the staff were by far the most important, as indicated by comments such as ‘The staff here make all the difference’, ‘the staff here are golden’, ‘the friendly staff are the best thing here’ and ‘the kindness of the staff’. Two other factors were mentioned by several interviewees: the quality of the food and visits from

family and friends. One person found it difficult to answer this question because, as she put it, ‘this isn’t a good life’.

Conclusion

Organised activities in care homes are enjoyed by residents and play an important role in their quality of life, both as a form of social interaction and as a meaningful pastime. There is considerable variation between care homes in respect of the number and range of activities provided. It is therefore reasonable to conclude that the provision of good quality training for activity coordinators can improve the provision of activities and help to promote quality of life for residents.

To a large extent the provision of activities appeared to closely match residents’ hobbies and interests. However, it is difficult to know whether this indicates that care homes have tailored their activities to the needs of their residents as customers, or if it is more a case of residents viewing these activities as their main interests because they are the only things on offer. For example, few residents reported taking part in activities based on physical exercise and many said that they would like to go out more.

There appear to be several common barriers to the provision of varied activities, some of which are particularly problematic for certain groups. These barriers include the lack of accessible transport, insufficient facilities to support the needs of people with health problems and low levels of staffing. There were also indications of a need to take into account the large number of residents with dementia.

Finally, the evaluators suggest that it is important that this area of the quality of care provision continues to receive attention. Ongoing monitoring of activity provision would provide a useful measure of the continued impact of the POPP training.

2C. MEDICINES MANAGEMENT, PHARMACY REVIEW AND FALLS PREVENTION.

In addition to conducting an economic appraisal of the Gloucestershire POPP as a whole, the local evaluation has assessed the cost effectiveness of one specific POPP intervention, the pharmacy medicines management review.

The economic question for this element of the evaluation was:-

> What is the magnitude of resource savings to the NHS from POPP funded dedicated medicines management conducted by pharmacists on people aged 65+ in Gloucestershire care homes compared with routine medicines management?

In line with the agenda of the POPP project the medicines management team within the care home support team aimed to:

- achieve cost-effective prescribing
- reduce unnecessary and inappropriate hospital admissions
- improve the quality of life of residents in care homes
- increase the patient safety with processes designed to improve the administration and storage of medicines

Pharmacist recommendations for medications fell into three main categories:

- changes to improve chronic disease management for residents in care homes (to optimize current treatment) and allow the most recent and evidence-based guidelines to be used in care homes
- changes to reduce the risk to patients from medication-related problems (side effects, falls, prolonged use of non-steroidal anti-inflammatory drugs (NSAIDS))
- changes to medication to provide the most cost effective method of prescribing, for example, encouraging homes to restrict wound care dressings to the PCT dressings formulary.

The economic evaluation identified actual savings of £148,000 that were made through the pharmacy review compared with the scenario of an absence of POPP funding. Extrapolation suggests that further savings of over £2 million could be achieved by extending this work across all Gloucestershire care homes.

It is also likely that additonal savings can be achieved through the medicines review in a number of ways, including:

- reductions in the side effects of prescribed medicines, particularly in terms of falls;
- improved communication links between care homes and GPs and care homes and community pharmacies responsible for the supply of medication;
- better adherence to wound care formulary for all residents with wounds, appropriate use and documentation of catheters and a lessening of the inappropriate use of costly and largely unnecessary nutritional supplements.
- enhanced patient safety processes have all improved as a result of POPP funding and the work of pharmacists connected with the Gloucestershire POPP.

A full description and discussion of the economic analysis of the pharmacy medications review is included in the full economic analysis report (Appendix C).

3. ECONOMIC APPRAISAL

Introduction

One condition of the awarding of POPP grants was that an economic appraisal would be carried out locally. This aimed to show how the new interventions could be self sustaining beyond the POPP monies through savings made on acute services. There was an expectation from the DH that the Gloucestershire POPP would evaluate whether or not these savings have been made. The UWE Evaluation Team have taken a lead in this work, working closely with members of the core Gloucestershire POPP team. A summary of this aspect of the evaluation is presented below, while a full version is in Appendix A3.

The aim of economic evaluation is not to measure every single cost, benefit and resource change, but to quantify a number of ways of spending or investing resources and producing outcomes and resource savings from that investment and to compare this position with not making the investment. This assessment of the actual and potential cost-effectiveness of the Gloucestershire POPP aimed to explore the case for sustainability when POPP funding ceased in March 2009. Cost-effectiveness analysis was used to aid decision making about the most efficient use of scarce resources when more than one way of using resources is available and budgets are limited. An important part of the economic evaluation was to identify the actual resource saving to the NHS that arose from the preventative role of the POPP in terms of promoting independent living and avoiding the hospitalisation of

older people. For this reason the national POPP evaluation adopted reductions in emergency bed days in hospital as a key indicator of the success of POPP funding and consequently the economic evaluation also focused on this key variable. In addition, the local evaluation carried out an economic appraisal of the medicines review and describes the additional role of pharmacists from the CHST in falls prevention since that analysis was completed.

The Gloucestershire POPP commenced in May 2007 and monthly data was collected on emergency bed-day use between April 2004 and March 2009 for men and women over the age of 65. Our analysis makes a comparison between the actual level of emergency bed day use in this age group in Gloucestershire and an estimation/prediction of the levels of emergency bed day use that might have occurred in the absence of the POPP. A connected macroeconomic analysis of non-elective admissions from care homes to Gloucestershire Hospitals NHS Trust on a comparable eight month basis April-November in the years 2006/2007, 2007-2008 and 2008-2009 was also conducted. This aimed to explore the specific contribution of the care home support team that was a major part of the Gloucestershire POPP and its role in reducing the length of stay in hospital of residents from care homes.

The major resource savings of POPP at a national level have been stated as:-

1. reduced levels of health and social care dependency
2. reduced demand for health and social care
3. reduced support required for the independent living of older people aged 65 years and above.

In Gloucestershire the potential benefits of the POPP might include improvements in quality of life that older people experience from independent living at home. A resource saving connected with this outcome is a reduction in the inappropriate use of emergency hospital bed days, which could be estimated in the absence of outcome data. It could reasonably be expected that the POPP-funded care home support team in Gloucestershire would impact on the length of stay of residents from care homes admitted to hospital overnight for an acute episode through improved communication, partnership working and release planning.

The main question for this macroeconomic analysis was:

'What are the actual and potential resource savings associated with changes in the levels of emergency bed day use in older people aged 66 years and above in Gloucestershire that arise from POPP funding compared with levels that would have pertained without POPP funding?'

The secondary question for this macroeconomic analysis was:

'To what extent is the work of the POPP-funded care home support team apparent in postcode data for emergency bed days' admissions from Gloucestershire care homes to Gloucestershire Hospitals NHS Trust in people over 65 years?'

Data Collection

Historical data on the numbers of emergency bed days was provided for the period from April 2003 to March 2007. Subsequent data for comparison was collected from April 2007 to March 2009. All data refer to acute spells in Gloucestershire Hospitals NHS Foundation Trust, which accounts for around 90 per cent of the activity of Gloucestershire PCT. Out of county data has not been included as it is not available in the same format for all years and

community hospitals are not included as they have different costing arrangements.

Emergency bed day use data for Gloucestershire

Several limitations need to be considered when interpreting the outcomes from this aspect of the evaluation. These are detailed in the full economic report contained in Appendix A3. The analysis used here is based on the application of a statistical model to the emergency bed days' data for the POPP and a pre-POPP historical trend line calculated to predict emergency bed day use in the absence of POPP.

In line with the statistical methods used by the national evaluation team, a difference in difference technique was used to predict bed day use in the absence of POPP in Gloucestershire compared with the bed day use after the implementation of POPP. This was achieved by extrapolating trends in emergency bed-days prior to POPP implementation and comparing this to the bed day use after the implementation of POPP. The difference between these two provides the 'difference between difference' estimation. To date the initial macroeconomic analysis appears to demonstrate that the POPP investment has helped to maintain a reduction in emergency bed day use for the over 65 age group in Gloucestershire. This compares with a situation prior to POPP in which over 65s emergency bed days were increasing year-on-year. Gloucestershire has had an effect on emergency bed day use in the population of Gloucestershire over 65 years. The findings demonstrate reductions against trend from difference-in-difference analysis that produce potential resource savings to the NHS of the order of £1.20 saved for every £1 spent. [1]

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[1] This calculation is based on the full amount of the Gloucestershire POPP grant. It is important to consider that the costs of mainstreaming the service are likely to be less.

Difference-in-difference analysis of trends in the pre POPP data, compared with the same data in the presence of POPP interventions, suggests that the resource saving per annum from reductions in emergency bed day use in the population of Gloucestershire aged 65 years plus was £920K or just under £1 million.

A substantial challenge for the analysis applied in this macroeconomic evaluation, and indeed in the national evaluation, has been the attributional effect of the POPP. Difficulties in assigning the attributional effect of the POPP arise from the research design of the evaluation and the data limitations outlined in detail in preceding sections, both of which are beyond the control of the evaluation team.

However, firmer conclusions can be drawn about the success of the Gloucestershire POPP as a result of the macroeconomic analysis of non-elective admissions from care homes (PCT registered residents only) to Gloucestershire Hospitals NHS Trust. Difference-in-difference analysis (a technique to demonstrate a comparison of a POPP scenario with a non-POPP scenario) demonstrated that the number of these admissions fellby 2 per cent in March 2008 compared with the previous twelve months. This analysis suggest that theCHST has created substantial changes in the system for admittign residents/patients in care homes to Gloucestershire NHS Trust on an emergency basis.

CONCLUSIONS

The Gloucestershire POPP was a complex and ambitious project with the aim of bringing about major changes to the culture and quality of care homes throughout the county. This was to be achieved through the delivery of a broad range of interventions across 7 work streams. The project incorporated a set of performance targets against which the success of the project can be measured. In this section we summarise the findings of the local evaluation against these measures and against the broader aims and objectives of the project. We also draw on the performance and activity data and learning points that were collected by the POPP project team and are presented in full in Section B.

First we examine the success of the project in meeting its 3 overarching aims. We then consider the crucial issue of sustainability, the extent to which the successes of the project have been supported to continue once it ended.

Aim 1. To work with care homes to develop excellent services.

The main focus for achieving this aim was through the work of the Care Home Support Team and the Training work stream, which accounted for a large majority of the project's resources. There is good evidence to indicate considerable success in this area. For example, 1,200 care homes staff received training directly associated with the project. This covered a range of areas including clinical skills, dementia care, nutrition, end of life care, enablement and activity provision. Training was initially offered to 30 care homes but it soon became apparent that this would not meet demand and the service was extended to cover all 174 homes in the county on an 'on demand' basis. At the same time the need for additional training and support mechanisms was identified and addressed as appropriate. e.g. record keeping and accountability training, the learning exchange and the persons in charge of care network.

Additional evidence for success in meeting this aim comes from the interviews that were carried out with stakeholders during the course of the project and from an internal evaluation of the training programme. These demonstrated a widely held view that the overall quality of care had improved, and was continuing to do so. Care home managers placed particular value on the quality and affordability of the training which, without POPP, they felt they would have struggled to access. In addition, interviews with care home residents confirmed the importance of the provision of varied and meaningful activities to their quality of life. While this aspect of the evaluation did not aim to directly measure the impact of the POPP activity coordinator training, it does suggest that this training had the potential to improve the service provided by care homes. The findings from the quality of life questionnaire that was completed by care home residents before and after two POPP interventions, the activity coordinator training and the medicines review, were inconclusive due to the small sample size.

The project also identified additional areas of unmet need and carried out some scoping work, particularly in the areas of hearing impairment, visual impairment and dentistry, and POPP funding enabled GOPA to extend their Advocacy Scheme to include people in care homes.

Aim 2. To encourage care homes to extend their services into the community and support communities to work with care homes in their area.

Evidence of success in achieving this aim was mixed. Early progress in this area was limited and so a small grant scheme was set up to encourage care homes to develop new services, or extend ones, for use by the local community. This has included, for example, offering access to meals, activities and services. Take up was rather slow and although 14 different types of new services were recorded the number of people taking them up was below target, as was the number of people benefitting from an outreach service provided by care homes. To some extent this can be attributed to the

difficulties encountered in persuading care homes to experiment with new service provision. However, towards the end of the project there were signs of increased working between local communities and care homes, particularly through the newly created Hubs. These are described in more detail below.

Aim 3. To increase the opportunities for older people to participate in developing services.

Achieving this project aim has centred on the work stream led by GOPA. Initial progress was rather slow, largely due to the level of resources required for this kind of community development work. However, there were signs of considerable progress in the later stages of the project. For example, 6 locality Hubs were established across the county with the aim of bringing together care homes, voluntary and statutory agencies and local communities in order to enable the sharing of resources and the development of new services. Also, from April 2008 the POPP funded a full time Forum Coordinator post at GOPA to support the setting up of older peoples' forums across the county. As a result, 6 forums were established during the project with others in the pipeline. Additional work by GOPA included the production of a 'Guide to Good Practice' for consultation with older people. During the course of the project the number of older people in Gloucestershire involved with the POPP rose from 62 to almost 1,000. The project also included an objective to promote the development of second careers for older people. Several older people have been recruited and trained during the project, including facilitators for GOPA and community researchers as part of the local evaluation, but it is too early to say whether this has led to the development of 'sustainable' career opportunities.

Sustainability

Ensuring the continuation of the achievements of the project has always been central to the POPP, both nationally and locally, as demonstrated by the requirement for local POPPs to develop a comprehensive sustainability plan. The economic appraisal that formed part of the independent local evaluation was also important here because of its role in demonstrating the potential of the project to reduce service costs through reductions in emergency bed day use and through the savings identified by the pharmacy review. Many stakeholders in the project felt that the 2 year timescale for the project was not long enough to implement the project interventions and measure their effectiveness. To some extent this has proved to be true, with several aspects of the project only really beginning to take off towards the end. However, it is also the case that in Gloucestershire the commissioners were sufficiently convinced of the effectiveness of core elements of the project to provide some ongoing funding. This situation has also been helped by the emergence of wider evidence of the effectiveness of preventative approaches, particularly from the national POPP evaluation. As a result a range of services developed during the project were supported beyond the life of the project. These include the care home support team, the care home learning network, an end of life care post, dementia link workers, a single point of access for training, a managers network at GCPA and a post providing training, advice and support for activity coordinators. Sustainability of involvement of older people in service development and evaluation. GOPA have used POPP funding to create a solid basis for the involvement of older people across the county in service development and have identified several ways in which these can be built on beyond the life of the project. These include supporting existing and new hubs and forums to work with ongoing initiatives (e.g. Putting People First, the Local Area Agreement and the Local Strategic Partnership), coordinating older people's input to Gloucestershire LINk and providing training for older people who are working as volunteers in care homes. This type of community based approach to supporting the involvement of older people is in line with the Government's strategy for enabling a stronger voice

for older people [2]. Funding for GOPA to carry out activities such as these is due to end during the Summer of 2009. Therefore, the key question in terms of sustainability in this area is whether the necessary resources will be provided in order to continue and build on this work.

The project also included the longer term goals of improving the image of care homes and improving partnership working. There is much evidence to suggest that considerable progress has been made in terms of partnership working across Gloucestershire. For example, stakeholders interviewed as part of the local evaluation felt that the project had resulted in greater understanding and respect between statutory and independent sector agencies. Similarly, Section B of this report provides much anecdotal evidence of cross sector improvements in data management, organisational protocols and shared performance cultures. The evidence for improving the image of care homes is less compelling. While it can be argued that the overall profile of the project and the increased level of engagement with care homes is likely to have improved their image among professionals, there is as yet no indication of a similar change among the general public. However, although this ambitious aim was never likely to be achieved during the lifetime of the project there are signs that the first steps have been made, particularly through the engagement of older people in hubs and forums. Further progress in this area depends largely on continued resourcing of these initiatives and the implementation of effective dissemination of the achievements of the project, particularly through the mass media.

[2] Department of Work and Pensions 2009. Empowering engagement: a stronger voice for older people. The Stationery Office; London.

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The Gloucestershire Partnerships for Older People Project (POPP): Exploring Professional Perspectives and Early Experiences

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1. Introduction

This report explores the professional baseline inherited by the Gloucestershire Partnership for Older People Project (POPP). It starts by briefly outlining the national and local context to the Gloucestershire POPP before going on to present the key themes which emerged from interviews with eleven stakeholders.

2. The national context

There is a growing recognition from central government about the importance of targeted prevention services for older people. This focuses on their capacity to both foster an improved quality of life and also their capacity to reduce the cost of health and social care services which have to be provided to those in crisis need. There is also an acceptance that this potential is often undermined by the lack of integrated partnership working at the local level (Means *et al*, 2008). A wide range of government reports have promoted the importance of meeting these twin challenges including the Green Paper on Adult Social Care (Department of Health, 2005), the White Paper on Community Services (Department of Health, 2006a), the Social Exclusion Unit report on **A Sure Start to Later Life** (Office of the Deputy Prime Minister, 2006) and the interdepartmental strategy review called **Opportunity Age** (HM Government, 2005).

Partnerships for Older People Projects (POPPs) fit into the centre of this government agenda. The 2004 Government Spending Review ring-fenced funding of £60 million for Councils with Social Services responsibilities to develop innovative prevention pilots as a collaboration with PCTs and the independent sector. Their overall aim was to achieve 'large scale system reform across health and care services to deliver improved outcomes for older people through greater investment in prevention' (Department of Health,

2006b, p. 1). More specifically, it was hoped that these partnerships for older people's projects would:

- provide person centred and integrated responses for older people
- encourage investment in approaches that promote health, well-being and independence for older people, and
- prevent or delay the need for higher intensity or institutionalised care.

(Windle *et al*, 2007)

There have been two rounds of POPP funding in which each POPP is awarded money for a two-year period. Nineteen initiatives were funded in Round One (April 2006 to March 2008) and a further ten, including Gloucestershire, in Round Two (April 2007 to March 2009).

Since the 1970s, governments have often tried to achieve policy change through the use of such time limited monies which localities are asked to compete for. These monies are usually for innovative projects which are designed 'to shake up the system' with the hope that the agencies will continue with these initiatives once central government support has ended. These schemes have often been focussed on prevention and frequently stressed the need to foster improved working relationships between health and social services. Sadly, sometimes the opposite has happened with disputes breaking out over who should 'pick up the bill' at the end of the initial grant. The end result has often been a failure to sustain such initiatives over the long term in the way originally intended (Glendinning *et al*, 2005).

A very important feature of the POPP initiative has been the emphasis on sustainability. POPP applicants were encouraged to submit an economic appraisal which would show how savings on acute services through

prevention could be re-invested into service provision to ensure the long-term continuance of the POPP beyond the initial two year funding.

The national evaluation team for the whole POPP programme has already published an interim report on progress. This report underlines how each POPP tends to be composed of a number of different initiatives and interventions with the 29 POPPs being responsible for a total of 245 different projects, which included:

- Community development to promote citizenship and volunteering
- Providing better access to information, navigation services and peer support for older people
- Health promotion activities to support healthy living
- Low-level or simple services for older people such as help with shopping, household repairs etc
- Specialist services for older people with chronic or complex conditions;
- Pro-active case finding of older people at most risk of losing their independence and of hospitalisation
- Integrated needs assessment and case management to prevent avoidable hospital admissions
- Better support for older people following discharge from hospital;
- Use of technology;
- Pathway design.

(Based on Windle *et al*, 2007, pp 2-3)

3. The Gloucestershire POPP

The Gloucestershire POPP was funded as one of the Round Two POPPs. The title of the successful project was 'Gloucestershire Care Homes – Part of our Community' with £2,597,000 to be spent on this initiative between April

2007 and March 2009 (Department of Health, 2007). The successful application had seven work streams, namely:

- The provision of Care Home Support Teams across the county to tackle such issues as medicines management, falls reduction and the improved care of the dying.
- The development of outreach services to help Care Homes to provide different types of care and support to a greater number and wider range of older people and their carers in the community.
- The development of new care pathways such as step up (prevent admission) and step down (aid discharge) beds.
- Improved training for Care Home staff.
- The retraining and recruitment of older people from second careers.
- A local evaluation.
- A robust system of communication.

The work streams were of a very different scale with the Care Home Support Team costs accounting for over £1.5 million of the overall budget.

The overall logic of the Gloucestershire POPP was clearly set out in the application:

> The proposed project will unlock the potential that is presently dormant within Care Homes in Gloucestershire. Redesigning this element within the whole system of health and social care will bring about a sustainable shift from the focus on acute or long term care towards targeted earlier interventions aimed at improving care, well-being,

choice, dignity and independence. This will result in more local responsive and person-centred care.

The choice of focus for the Gloucestershire POPP was heavily influenced by a previous initiative. The care home support component was based upon an evaluated pilot in West Gloucestershire during 2003-2005. This pilot had been funded through a Social Services Access and Capacity Grant. The project was based upon a belief that support from the health community to care homes was often inadequate and fragmented. The grant enabled the establishment of a Care Home Support Team (CHST) which employed two full time nurses, a pharmacist for three days a week and input from two GPs. Important initiatives and developments included training for care home staff; improved communication between home and across sectors; medication reviews; active ageing initiatives; more coherent GP surgery and care home links; nurse support for residents with complex needs; and improved palliative care. The evaluation concluded that 'there is an obvious need for work to continue to support care homes' (Appendix 7 of the Gloucestershire POPP application).

The above situation suggested that the Gloucestershire POPP would have strong roots in the local policy system. This was also reinforced by how the POPP was very much in line with performance indicators set down in the Gloucestershire Local Area Agreement relating to supporting independence, health and well-being for those over 75, namely:

- To reduce the number of people aged 75 or over admitted to hospital with fractured femur.
- To increase the proportion of older people supported to live in their own home by 8 per cent of the population by 2010 from a baseline of 61 per cent in 2006.

- To increase access to community based services, information and technology, including those delivered through health and well-being partnership initiatives that contribute to feelings of security and physical and mental well-being of older people living at home.

4. The stakeholder interviews:

Professional perspectives and early experiences

The next section of this document reports on a strand of the evaluation that aims to explore professional attitudes towards the POPP within Gloucestershire. The original intention had been to present this in the form of a professional baseline which was inherited by the POPP when it came into operation in April/May 2007. However, a number of factors, including the time it took to meet NHS research ethics requirements, have meant that the interviews took place much later than originally intended. As such, the interviews have captured professional perspectives on POPP which were often influenced by early experiences of it. It will still be possible to compare these to perspectives at the end of POPP but we felt it was important not to mislead by presenting these as a baseline in the traditional understanding of that term. Despite the limitation, we still feel that this report generates important themes that can inform the project as it continues to develop.

4.1 Methodology

Following ethical approval from the Gloucestershire Research Ethics Committee, a

range of stakeholders was identified as being best placed to provide diverse views and perspectives about the project. These include Work stream Sponsors and Leads, Care Home Mangers, Commissioners of services involved with the POPP and those who were involved in developing the initial POPP bid. The POPP office sent emails to each of the 50 stakeholders involved in the project. These invited each of the stakeholders to participate in an interview that would explore their understanding and attitudes towards the POPP. The interviews were arranged at a suitable time and place for each stakeholder. Interviews were conducted by either one of two members of the evaluation team, both of who were trained in interviews of this nature. The interviews followed a semi structured format (Appendix one) and were noted by hand then typed up as soon as possible after each interview. Each interviewer conducted a thematic analysis of all the interview notes in order to identify the main themes. Both of the interviewers then triangulated their findings to agree a final list of key themes.

4.2 Response rate

Out of the 50 invitations sent to key stakeholders, 11 responded and agreed to be interviewed. This represented 22% of the total number of stakeholders invited to take part. Table one shows that the majority of the potential interviewees (60%) were care home managers/assistant managers and that only 6.7% of this population volunteered to be interviewed, making up 16.7% of the total number interviewed. Those who were part of the commissioners and others stakeholder group provided the greatest response, with 66.7% volunteering to be interviewed.

Stakeholders invited for interview	**% of total POPP stakeholders (*n*)**	**% of each group of stakeholders who were interviewed (*n*)**	**% of interviewees from each group of stakeholders (*n*)**
Care Home	60% (30)	6.7% (2)	16.7% (2)

Managers/assistant mangers			
Work stream sponsors	14% (7)	57.1% (4)	33.3% (4)
Work stream leads	14% (7)	28.6% (2)	16.7% (2)
Commissioners & others	12% (6)	66.7% (4)	33.3% (4)
Total	100% (50)	NA (12)	100% (12)

Table 1: Percentage (*number*) of potential and actual interviewees by key stakeholder group

Table two shows that there were nearly 17% more interviewees from statutory organisations than from non-statuary organisations.

Stakeholders invited for interview	% from statutory organisation (*n*)	% from independent organisation (*n*)
Care Home Managers/assistant mangers	0% (0)	2 (100%)
Work stream sponsors	50% (2)	50% (2)
Work stream leads	50% (1)	50% (1)
Commissioners & others	100% (4)	0% (0)
Total	**58.3% (7)**	**41.7% (5)**

Table 2: Percentage (*number*) of interviewees by statutory and independent organisation

It is important to note the relatively low response rate, which is a potential limitation of this part of the local evaluation. We suggest two possible reasons for this: firstly, the ethical review process placed some restrictions on this work in terms of who could be invited to take part and how many times they could be reminded of the invitation. Secondly, a large proportion (60%) of those invited to take part were care home managers. It has emerged from this piece of work that there are challenges in engaging with this group of stakeholders, partly because the project has stretched their resources considerably. It seems likely that this will have influenced their decision about giving up their time to take part in the evaluation.

4.3 Cross Cutting Themes

This section discusses the main cross-cutting themes which emerged from the analysis. The detailed responses to the interview questions are provided in appendix two. It is important to note that the LREC was concerned about 'a significant risk that the identities of the research participants and any contrary views they hold, will become evident to their employers, despite anonymisation' (letter dated 20th August 2007) and that as a result we agreed that our report would 'be analysed and presented in terms of general themes and issues and that no direct quotes will be used' (letter dated 18th September 2007).

4.3.1Resources

Overall those interviewed felt that the POPP was well resourced but some identified problems with how the resources had been distributed between work streams. Some work streams were felt to be struggling to get going and were therefore not spending the resources they had been allocated, while others had realised early on that they had insufficient resources to achieve their goals. A number of potential ways of addressing this had been proposed by project partners. Some but not all of these were agreed, but there was a

feeling that this was still an issue. Of most concern were the limited resources of the independent partners, two of which are run on a day to day basis by a single part time worker, and the impact that this might have on the success of the POPP. In particular, those interviewed identified two aims of the project where this might have an impact: engaging with older people and getting care homes signed up to the project.

Staffing was also identified as a resource issue, largely in terms of the difficulties that have been experienced in recruiting some staff. This had delayed the work of some work streams and contributed to an under-spend. However, some interviewees felt that the POPP management team had responded well in terms of dealing with this challenge.

4.3.2 Engaging with older people

Engagement with older people across Gloucestershire was identified as being of central importance to the successful implementation of the POPP. Key to this are the development of relationships with older people and the establishment of a range of mechanisms for user involvement that reach across the county. This was seen to include a range of activities, including eliciting views, encouraging participation in service evaluation and supporting their involvement in service development decisions. User engagement was also seen to be important as a way of putting professionals in touch with the views and needs of older people. Such engagement was a major element of the original bid for funding but some interviewees expressed doubts about whether it the reality would live up to this. The establishment of robust user involvement mechanisms from a relatively low starting point is a demanding task that involves a large amount of community development work, particularly across a large, rural county such as Gloucestershire. Several interviewees raised questions about the ability of the independent project partners to fulfil this agenda within the resources they have available.

4.3.3 *Care homes sign up.*

'Selling' POPP to care home managers and getting them to agree to take part are crucial to the success of the project. Some interviewees suggested that the challenge involved had been underestimated. It was felt by some that the amount of extra work that the POPP entailed for care homes hadn't been anticipated, leaving them with insufficient support. For example, there was no funding to provide cover for care home managers when attending project meetings. One interviewee said that care home managers were already 'up to their necks' in paperwork and were extremely reluctant to take on any extra work. These issues had been raised since the project began but some respondents felt that there was still insufficient understanding of the care home perspective and the problems remained. A lack of initial resources available to support communication and marketing was also mentioned as something that limited the extent to which awareness of the project had been raised among both the public and professionals.

4.3.4 Communication: between work streams, across services and with the public

Communication emerged as a strong theme across a number of interview questions. Interviewees identified three aspects of communication that they felt to be important. Firstly, excellent communication between project work streams and partners was felt to be fundamental in such a complex initiative and crucial to the integration of all work streams within the POPP overall. Some interviewees felt that not all work streams were fully informed and engaged with POPP in the early stages and that this had slowed down early progress. Secondly, interviewees talked about its impact on joint working, particularly across health and social care. There was a strong feeling that this was already fairly good in Gloucestershire, but that the POPP had great potential to make it even better, and was indeed already doing so. Joint working between the statutory and independent partners was singled out as an area where particular progress had been made from a relatively low

starting point. Communication and joint working with the medical professions was thought to be far less strong and was identified as one of the greatest challenges for the project.

Thirdly, interviewees identified communication via the media as an essential element of the project. There was widespread agreement that the image of care homes among the public and professionals is poor. One interviewee suggested that they are seen as 'somewhere that you go to die'. This has been exacerbated by the recent policy drive towards providing care to people in their own homes, which has led to an increasingly old and frail care home population. Challenging misconceptions is a central aim of the POPP and is essential to achieving many of the other objectives. For example, local people will only access services in care homes if stigma can be broken down. At the same time, the poor image of care homes among health professionals can be a barrier to recruiting staff to take on key roles in the POPP itself. Interviewees recognised the challenge of raising awareness of what care homes have to offer and what they are like to live in and some felt that changing such entrenched views within the timescale of the project was an impossible task. Engaging with the media was identified as a key way of improving the image of care homes. There was a recognition that this aspect of the POPP had been slow to take off, partly due to difficulties in identifying the necessary resources. However, it was felt that this was now being addressed and that communication still had a key role to play in 'selling' the benefits to both the public and professionals.

4.3.5 Sustainability

Section two of this report mentions how initiatives supported by time limited monies tend to struggle to continue as originally intended once central government funding has ended. This issue of sustainability emerged as a strong theme from the interviews. Respondents were very aware that this was a crucial issue and views were mixed. Some respondents felt that the project was sustainable because it would be shown to have reduced the amount

spent on acute services. There was, however, recognition that getting these savings transferred to community services would be a challenge. It was suggested that a range of national and local drivers would increase the chances of real change being sustained. These included the merger of the two Gloucestershire PCTs, the joint commissioning framework, the introduction of independent budgets, changing population demographics and the national prevention agenda.

Other interviewees were less optimistic about the sustainability of the POPP. One point that was made repeatedly was that the 2 years available for the project would probably not be long enough to achieve the broad range of changes necessary to achieve all of POPPs aims and objectives. Demonstrating the impact of those changes over a relatively short period was also seen as a major challenge. There was a strong feeling that some elements of the initiative would be sustainable but not others. For example, it was suggested that care homes will eventually deliver a good standard of care and reduce costs but that this is unlikely to be achieved within the timescale of the POPP.

4.3.6 Organisational cultures and systems

The Gloucestershire POPP is based on close partnerships between a range of partners and agencies. Independent organisations play an important role in the initiative and are particularly central to two of the main aims: recruiting care homes and engaging with older people. The stakeholder interviews suggest that there are considerable differences between some partner organisations that pose a significant challenge. Firstly, there are big differences in organisational structures. The smaller independent organisations involved tend to operate within a relatively straightforward and ‘flat’ model of working that produces decisions fairly quickly. In comparison, the ways in which Primary Care Trusts and Local Authorities work can seem

unfamiliar, bureaucratic and unnecessary. For example, some independent partners were surprised at the number of POPP generated meetings, the amount of paperwork and the level of reporting required. A second difference in organisational cultures is the availability and flexibility of resources. This has been highlighted by the extra workload that a complex initiative has placed on the extremely limited resources that the independent partners have at their disposal. There was recognition among some statutory partners that they had not been aware of the limited nature of these resources at the outset and that the independent organisations had struggled as a result. This appeared to have been exacerbated by the fact that the independent partners had not initially appreciated the size of the tasks that they had taken on.

It is clear that a good understanding of these organisational differences has developed as the POPP progresses and that the need for additional resources has been clearly identified. For example, the project plans to provide the independent sector with extra administrative support. However, recruitment problems caused delays which meant that this remained unavailable to one organisation at the time of writing.

In addition, proposals to use the under spend in ways that will support the role of the independent partners are currently under consideration. There was a feeling among interviewees that a mutual understanding has developed as a result of tackling these issues and that relationships between the statutory and non statutory partners are stronger as a result.

5. Key Messages

Overall, nearly all respondents were positive about the potential of POPP and recognised the considerable challenges it faced. Four main specific messages stood out for us from the cross cutting themes:

- The Gloucestershire POPP is a complex project with ambitious goals. Two overarching aims are particularly important: changing the image of care homes and engaging with older people. Achieving these is crucial to the success of the overall project.
- Sustainability is POPP's major challenge. The key elements of a strategy include promoting the benefits to a range of stakeholders, particularly the wider public, and linking with appropriate local decision making bodies. There is widespread concern that the POPP will not have sufficient time to achieve sufficient 'real' savings
- There are major differences in the cultures of the statutory and independent partners involved in the POPP, particularly in terms of resources and ways of working. It is important that these differences continue to be understood and addressed in order to provide the independent organisations with the support that they require in order carrying out their roles within this initiative.
- Publicity has a major role to play and is key to changing perceptions of care homes, raising awareness of the project and spreading the message about its successes. There has been a delay in developing a comprehensive media strategy to promote a positive image of care homes but there is still time to do so.

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Schedule for interviews with POPP stakeholders

1. Please describe you role in relation to the Gloucestershire POPP.
    a. (for work stream leads and sponsors only) How does your role link with that of work stream sponsor/lead?
    b. How does your role fit in with the overall POPP initiative?

2. What do you feel are the overall aims of the Gloucestershire POPP?
    a. What are the specific objectives? (e.g. quality of life, economic, joint working.)

3. Do you think that POPP will meet its objectives / aims

4. What are the potential benefits of the Gloucestershire POPP for older people?

5. What are the main challenges to successful implementation of the POPP?
    a. How sustainable are the POPP services and model of delivery beyond the life of the project?

6. How do you feel the POPP will impact on joint working? (for care home managers this will be about their links with statutory services)

7. Do you feel there are sufficient resources to implement the POPP as planned?

8. Is there anything you would like to change about the POPP and if so what?

9. Is there anything else you would like to say about the POPP?

Detailed responses to the interview questions

This section describes the main themes that emerged from each of the nine areas explored in the interview schedule.

1. What is your role in the Gloucestershire POPP?

The range of roles described by interviewees covered project management, commissioner, work stream lead, work stream sponsor, involvement in developing the initial bid for funding, statutory sector worker and care home manager. Respondents demonstrated a high level of awareness of their specific role and how it related to the overall project.

2. What are the main aims of the POPP?

Interviewees were asked what they thought were the main aims of the project. Their answers came into seven main categories:

- Improving how care homes are perceived. Raising awareness of what care homes have to offer and what they are like to live in; dispelling the myths about care homes among professionals and the public; integrating care homes with the local community.
- Improving quality of life for care home residents.
    - Promoting independence and increasing choice.
- Improving the quality of care delivered in care homes.
    - Better delivery of primary care services in care homes; more coordination between health and social care services.
- Increasing engagement with older people.
    - Enabling involvement in service evaluation and development.
- Up-skilling the workforce
    - More training, better job satisfaction, reduced staff turnover, lower costs.
- Building relationships.

- Improving joint working and communication within and between the statutory and independent sectors.

- Reducing the costs of service delivery.

  - Fewer admissions to hospital from care homes; better staff retention.

3. *To what extent can the project achieve these aims?*

Responses to this question produced a fairly even balance between those who thought the project would meet its aims and those who felt that it wouldn't. Analysis identified the following main themes.

- Overall it was seen as unlikely that all of the aims would be met within the lifetime of the project, but good progress would be made towards many of them.
- Care homes will all eventually deliver a good standard of care and reduce costs. However, this is unlikely to be achieved within the timescale of the POPP.
- Some respondents questioned how 'success' will be measured and felt that it will be very difficult to demonstrate that the aims have been achieved.
- Some project aims will be achieved but not all of them. Some respondents felt that their own work streams would meet their goals but that the broader project aims would be more difficult to achieve. In particular, it was felt that the poor image of care homes couldn't be changed in the lifetime of the project.
- Respondents from the independent sector appeared to have the most doubts about the aims of their works stream being achieved.

4. *What are the potential benefits of the project for older people?*

- A better image for care homes will reduce stigma and will therefore benefit care home residents.
- A better quality of life for care home residents due to improved services and better trained staff. Also reduced isolation, due to increased contact between care homes and the community
- A greater voice for older people across the county.

- Some respondents expressed concern as to whether the benefits for older people can be achieved by a short term project.

5. What are the main challenges to the success of the project?

- The limited time available: two years isn't long to make implement changes and demonstrate that they are having an effect. The fact that it has taken a long time to get things going makes it even more challenging.
- The difficulties of engaging with the wide range of partners in the project. In particular, establishing and developing links between statutory and independent partners was identified as problematic.
- Limited communication between work streams. It was felt that too much of the focus was on the Care Home Support Team while other work streams felt less central to the project.
- Cultural differences between partners. In particular, some respondents felt that there had initially been a lack of understanding about how independent organisations work and the limits of their capacity.
- Perceptions of care homes among professionals and public are deeply entrenched. Changing these is central to the success of the project but will take a long time.
- Financial uncertainties were also mentioned as a challenge. Concerns focused on continuing doubts about whether the under spend could be carried over and, is so, uncertainty about what it would be spent on.
- Several interviewees felt that the difficulties experienced in recruiting the necessary project personnel were a threat to the success of the project. This had led to delays in delivering interventions and also meant that for some time the independent sector partners lacked the necessary administrative.
- Many stakeholders felt that the project had a high level of bureaucracy, which put considerable pressure on their resources. Specifically, the number of meetings, the amount of paperwork and the level of reporting were identified as

problematic. The non statutory partners in particular found this difficult to manage within their resources.

6. *Do you think the POPP model is sustainable?*

There was a very mixed response to this question. About half of the interviewees felt that the project was sustainable for a range of reasons. Positive responses included:

- Yes, it will be sustainable because it will be shown to have saved money. However, this depends on resources being transferred from acute services to community settings;
- The prospects for sustainability are good because of other local and national drivers, including the merger of two PCTs, the introduction of independent budgets, changing population demographics and the national prevention agenda;
- Gloucestershire has a good record of pilot projects being successfully mainstreamed and the joint commissioning framework should help the POPP model to be sustainable.

A range of issues were raised by interviewees who were less optimistic about the sustainability of the POPP model.

- It will be difficult for the independent partners to sustain their role unless they are better resourced.
- There is insufficient time to demonstrate that it is effective and therefore make it sustainable.
- There were concerns about the financial viability of the model once the specific project funding runs out.

7. *What is the impact of POPP on joint working?*

Responses to this question were largely positive. The majority view was that joint working is already good in Gloucestershire but POPP has the potential to make it even better. Interviewees identified particular benefits in terms of joint working between statutory and independent partners, although cultural differences were seen by some as a challenge to this. Some concerns were raised about the extent of joint working between work streams and there were some doubts about the lack of shared budgets across health and social care. Links with the medical profession

were identified as the area where least joint working had taken place in relation to the project.

8. Does the POPP have sufficient resources?

Most respondents felt that there was sufficient funding for the project but some questioned how it was being spent. There was a widespread feeling that the independent partners were not initially sufficiently resourced to fulfil their role in the project, although attempts were being made to address this. In particular, the independent partners had not realised how much person time the project would require and were therefore struggling with the workload. Other resource issues raised include:

- Staff are a crucial resource and delays in recruiting professional and administrative staff have had a significant impact on the development of the project.
- Although there is sufficient money attached to the project it is not always being used effectively because some work streams have been struggling to get going.
- Time is an important resource and 2 years isn't long enough to implement a project of this complexity.
- The importance of marketing and communication wasn't fully appreciated in the early stages of the project and therefore they weren't allocated sufficient resources.

9. Is there anything about the project that you would change if you were doing it again?

- Improve the communication between partners and with the wider public.
- Create more engagement with GPs, care homes and older people.
- Provide more resources to the independent partners.
- Have fewer project meetings.
- Spend more time setting up the project and consulting with partners, particularly care homes, about what they want from the project.

Introduction

This section of the report assesses the actual and potential cost-effectiveness of the Partnership for Older People Projects in Gloucestershire. Cost-effectiveness analysis is used to aid decision making about the most efficient use of scarce resources when more than one way of using resources is available and budgets are limited. An important part of the macroeconomic evaluation of POPPs is the actual resource saving to the NHS that arises from the preventative role of POPPs in terms of promoting independent living and avoiding the hospitalisation of older people. For this reason the national POPP evaluation has identified reductions in emergency bed days in hospital as a key indicator of the success of POPP funding and consequently the economic evaluation presented here focuses on this variable. It has also been possible to supplement the macroeconomic analysis with an analysis of reductions in the number of emergency bed days from people registered with a GP in care homes and reductions in length of stay of emergency admissions in people over sixty-five years. Movements in all of these variables over the life of the Gloucestershire POPP support the focus on the care home support teams in terms of macroeconomic benefit.

In making a full economic case for a capital investment such as the POPP in Gloucestershire it is important that the potential for resource savings are made explicit as well as actual resource savings. In a large, diverse project of this nature it is crucial to discover the potential for resource savings and to explore how resources can be most efficiently targeted in order to release maximum savings. This is a major consideration for future sustainability of the outcomes of an initial capital investment.

The aim of economic evaluation is not to measure every single cost, benefit and resource change, but to quantify a number of ways of spending or investing resources and producing outcomes and resource savings from that investment and to compare this position with not making the investment. Gloucestershire POPP commenced in May 2007 and monthly data has been collected on emergency bed-day use between April 2004 and March 2008 for men and women over the age of 65. Our analysis makes a comparison between the actual level of emergency bed day use in this age group in Gloucestershire and an estimation/prediction of the levels of emergency bed day use that might have occurred in the absence of the POPP. The method for estimation has been made explicit and was discussed at POPP evaluation group meetings in advance of the final analysis.

The context for this macroeconomic evaluation

The vehicle and catalyst for the majority of the Gloucestershire POPP funding was the Care Home Support Team (CHST) and the rationale for this funding was a desire to create a less fragmented support to care homes from the health and social care community. The CHST was charged with developing solutions which would improve care in care homes and re-integrate care homes into the mainstream health community. The CHST employed 11 nurses, 4 RGNs, 5 RMNs at grade 5, 1 deputy RGN at grade 6 and 1 manager at grade 7.; 3 physiotherapists, 2 OTs, 1 SALT, a pharmacist and a pharmacy technician.

This macroeconomic evaluation has focused on the reduction in emergency bed days as one area of resource saving. Changes in this variable are indicative of the outcomes of the whole project, but this measure does not completely encapsulate the full range of potential improvements to outcome, which include improvements in working practices and policies, medicines management, staff training, and the wellbeing of older people. The time period for assessing the impact of the Gloucestershire POPP was relatively short and many of its benefits, for example, training to prevent falls, are not be visible in outcome data collected during the life of the project.

The Gloucestershire macroeconomic evaluation

The major resource savings of POPP at a national level have been stated as:-

- reduced levels of health and social care dependency
- reduced demand for health and social care
- reduced support required for the independent living of older people aged 65 years and above.

In Gloucestershire the potential benefits of the POPP centred on improved health and quality of life for older people living in care homes. A resource saving connected with this outcome was a reduction in the inappropriate use of emergency hospital bed days, which can be estimated in the absence of outcome data.

The main question for this macroeconomic analysis has been:

'What are the actual and potential resource savings associated with changes in the levels of emergency bed day use in older people aged 66 years and

above in Gloucestershire that arise from POPP funding compared with levels that would have pertained without POPP funding?'

Secondary Data

This section provides a summary of the main data collected in order to fulfill the macroeconomic evaluation requirements for this project. The data has a four year history (April 2003 – April 2007) and was collected at monthly intervals, from May 2007 to March 2009. All data refer to acute spells in Gloucestershire Hospitals NHS Foundation Trust, which accounts for around 90 per cent of the activity of Gloucestershire PCT. Out of county data has not been included, as it was not available in the same format for all years and community hospitals due to different costing arrangements.

The data fields provided by the evaluation team are presented in Table B:1.

Research design

Emergency bed day use in any given PCT at any given time varies for a great many reasons, some being seasonal factors (cold weather) a big factor in February 2009 when Gloucestershire suffered heavy snow, or local factors (local need), others being wider effects (national policy). In the absence of a randomized controlled trial research design it is possible that confounding factors have not been minimized within the research design and this creates challenges in comparing emergency bed day data before and after the POPP began in May 2007. Statistical techniques such as difference-in-difference analysis on emergency bed day data can reduce confounding issues but may not eliminate them completely. There is therefore a possibility that the deviation from trend in the emergency bed day data can be attributed to other causes as well as or instead of the POPP and this has to be borne in mind in considering the macroeconomic analysis below.

Table B:1. Emergency bed day data for Gloucestershire

1	Measure	The range of medical conditions and ages included in the analysis
2	Month of discharge	The month in which the patient was discharged from hospital in the format yyyymm
3	Number of spells	The number of hospital spells which ended in the corresponding month
4	Total bed days	The number of bed days relating to hospital spells ending in the corresponding month. This includes any period of rehabilitation
5	Average length of stay	The total bed days divided by the number of spells
6	Cost tariff year	The cost using the tariff applicable to the financial year in which the patient was discharged. Includes rehabilitation costs. Note that 2004/05 has no applicable tariff as Payment by Results (PbR) did not begin until 2005/05+
7	Cost 2005/06	The cost using the 2005/06 PbR tariff. This has been included to provide comparable costs across all years and includes rehabilitation costs.
+ Other combinations of tariff / data year were not available across all years.		

Emergency bed day use data for Gloucestershire

There are several limitations in interpreting this data. A reduction in bed days does NOT necessarily result in resource savings. Each admission, irrespective of length of stay, incurs a standard cost, which is payable up to a 'trim' point. That is, it includes a certain number of bed days. Beyond this 'trim' point, extra costs are incurred. Therefore, a reduction in bed days does not necessarily imply a saving, if that admission does not exceed the 'trim point'. The figures published relating to a reduction in emergency bed days agreed in the Public Service Agreement (PSA) used figures from data produced by the Department of Health from Hospital Episodes Statistics (HES). Gloucestershire does not have access to this data and has been unable to replicate the construction of the national data. The results reported here are

therefore based on data obtained from Gloucestershire Hospitals NHS Foundation Trust. This does account for 90 per cent of the activity within Gloucestershire PCT.

Approximately 8 per cent of emergency bed days in people aged 65 years and over are attributable to admissions from care homes. Other schemes in progress in Gloucestershire may have impacted on emergency admissions, but it is important to note that it has been possible to consider the potential impact of POPP on emergency bed days in people admitted to hospital from care homes in this macroeconomic evaluation. This is particularly pertinent for the financial years 2006/7 and 2007/8, when GP incentive schemes were put in place and case management and in reach services were instigated. The aim of all of these initiatives was to reduce emergency bed days.

Analysis

A statistical model was applied to the emergency bed days data for the POPP and a pre-POPP historical trend line calculated to predict emergency bed day use in the absence of POPP. A difference in difference estimation was used to predict bed day use with POPP funding after implementation and in the absence of POPP funding by extrapolating non-POPP trends in emergency bed-day data history prior to POPP implementation.

In other words, the trends in bed day use before POPP implementation in May 2007 were used to predict the bed day use that would have occurred in the absence of POPP and compared with the actual bed day use from May 2007 to June 2008 when POPP was operating. The difference in these two numbers can be attributed in general to POPP although some confounding may remain. (See section on data limitations above.)

Overarching trend and breakdown

Figure B:1 below demonstrates the trend in emergency bed days for those people over 65 years in Gloucestershire. The seasonality is evident, but over the whole period the trend is for a reduction in the level of emergency bed day use by this age group

Figure B:1. Monthly emergency bed day use for all conditions in men and women 66 years and above from April 2004 to March 2008.

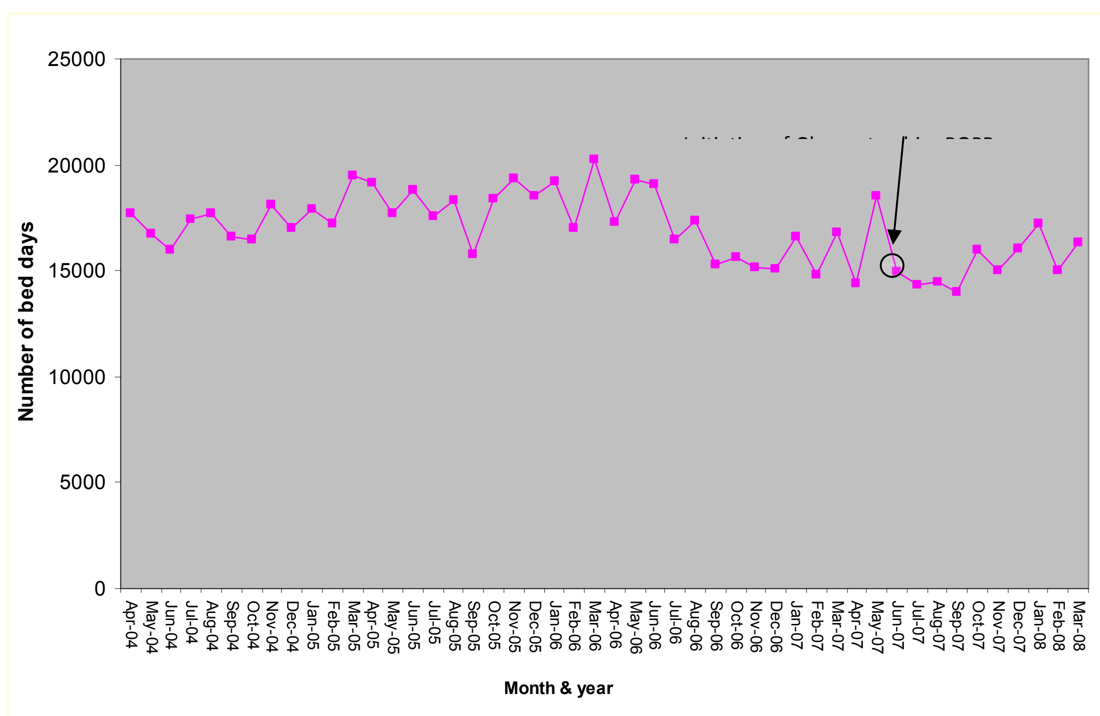

Table B:2 below demonstrates the total emergency bed days per month in Gloucestershire for people over 65 years averaged across the period. Column three indicates the average for each month of the change in the number of bed days between that month and the same month from the previous year. Table B:2 reports the average value of this change over the time series with May 2007 acting as a reference point. The difference is also listed as a percentage of the total average.

Table B:2 demonstrates that an average increase of 974 days per month in bed day use was apparent between April 2005 and March 2006. This subsequently improved through a reduction of 1775 days per month between April 2006 and March 2007. This reduction from baseline was further maintained at 1040 days per month for the year April 2007 to March 2008, and 434 days per month from April 2007 to March 2009 which encapsulated the time during which the POPP was operational in Gloucestershire.

The effect of the POPP on bed day use in the over 65s cannot be concluded directly from Table B:2. However, the numbers suggest that the introduction of POPP funding has helped to sustain a reduction in emergency bed day use for the over 65 age group in Gloucestershire. This compares with a situation prior to POPP in which over 65s emergency bed days were increasing year-on-year. The difference-in-difference approach is applied below to further confirm these effects.

Table B:2 Cost changes associated with average monthly emergency bed day use in people aged over 65 years and average monthly change over the previous 12 months Gloucestershire PCT

Gloucestershire bed days 65 years	**Total average bed days per month**	**Average monthly difference over previous 12 months average monthly difference**	**Average difference as a percentage of the total average**	**Cost changes based on £120* per bed day per month**
Apr2004–Mar2005 Without POPP	17363.58			
Apr2005-Mar2006 Without POPP	18337.08	973.50	+5.61%	+£116,820 Resource increase
Apr2006-Mar2007 Without POPP	16561.33	-1775.75	-9.68%	-£213,090 Resource saving
Apr2007-Mar2008 **With POPP**	15521.17	-1040.17	-6.28%	-£124,820 Resource saving
Apr2008-Mar2009 **With POPP**	16127.33	-434	-2.69%	-£52,080 Resource saving
Effect of	**Effect on**	**2007-08**	**2008-09**	
Average post-	Number of bed-	-630.97	-569.11	

POPP bed days compared with pre-POPP bed days	days per month			
Average post-POPP bed days compared with pre-POPP bed days	Cost per month of bed days £	-£75,717	-£68,293	
Every £1 spent on POPP project in Gloucestershire PCT	The Gloucestershire NHS Trusts	£1.20	£1.20	
* Source: Forder, J. (2008) Partnerships for Older People Projects – emergency bed day use analysis. Presentation at national evaluation event on 3rd April 2008, London.				

Difference-in-difference analysis

Any effect on bed days attributed to POPP funding can be valued according to the cost of an emergency bed day. The payment by results tariff gives a cost per admission and a per-day rate that applies if people are long stayers. The data in Table 7 does not at this stage distinguish specialties or healthcare resource groups (HRGs) of emergency bed days, nor the ages of the people admitted. Age profiles are important in this analysis as older people average longer lengths of stay than younger people, which translates into a higher total tariff payment (refer to explanation of the trim point in data limitations section above).

Analysis of the Gloucestershire emergency bed day data would have benefitted from more precise age profiling. However, data on length of stay were very revealing in terms of the success of the CHST in Gloucestershire, demonstrating a fall in average length of stay, total bed days and tariffs over time for bed days (PbR) and rehabilitation for those admissions from care homes we know about i.e. a non systematic subset of admissions (those we know of through postcode). There was a substantial fall in length of stay (los) for a comparator 8 months from April to November in 06/07;07/08;08/09 from 14.8 days to 11.1 days, even though admissions from care homes had increased in that time. These reductions were highly likely to be attributable to the work of the CHST in enabling care homes to receive residents back from hospital and improving communication about hospital to care home movements.

The cost of non-elective admissions from care homes (for residents with a GP) to Gloucestershire Hospitals NHS Trust fell substantially during the time of operation of the POPP. The figures in Table B:3 below are based on known hospital admissions from care homes i.e. where the patient's given address matches a care home address. It is not known what proportion of the total admissions from care homes this represents (as some patients will provide a home address different to that of the care home in which they are currently residing and so some admissions from care homes are not detectable). The figures are therefore not a precise reflection of the numbers and costs of admissions, but do provide an indication of trends over the past 3 years.

Table B:3 NonElective Admissions from Care Homes to Gloucestershire Hospitals NHS Trust April-November (8 months)

Year	Number of Admissions	Total Bed days	Average length of stay	Rehab Bed Days	Number of patients with rehab episode	Averag e length of rehab	Excess bed days	Excess bed days cost	PbR Cost (0809 tariff) £thousand	Rehab Cost (£141 per day)	PbR+rehab cost
2006/07	767	11368	14.8	5270	254	20.7	452	£93,447	£2,180	£743,070	£2,923
2007/08	852	10167	11.9	4955	274	18.1	300	£59,177	£2,164	£698,655	£2,863
2008/09	869	9635	11.1	4846	263	18.4	162	£34,309	£1,993	£683,286	£2,676

Review of emergency bed day rates

A per day payment of £120 has been applied within the difference-in-difference analysis of Table B:2. This is the same approach that was adopted in the national evaluation report of October 2007 and in the national evaluation day of April 3rd 2008 (Windle et al. 2007; Forder, 2008). The analysis that flows from Table B:2 is an estimation of the resource savings that have arisen after the implementation of the POPP in Gloucestershire as a result of a pre-POPP post-POPP difference-in-difference analysis in which the price of an emergency bed day is £120.

Historical data indicates that the annual change in average bed day use in people over 65 years over the previous twelve month average prior to the Gloucestershire POPP was a reduction of -2.03 per cent per month. After the implementation of the POPP this reduction was magnified to reflect a further average reduction in bed day use in people over 65 years of -6.28 per cent per month. Overall and in broad terms it could be argued that the Gloucestershire POPP investment has resulted in a further reduction of the pre-POPP emergency bed day use in the over 65 years age group by 4.25 percentage points.

Before the POPP was implemented there was a monthly mean reduction of 401.12 bed days. At £120 per day this equates to a saving of £48,134.40 (401.12 bed days x £120) per month or **£577,612.80** per annum.

In 2007-8 after the implementation of the POPP there was a mean reduction of 1040.17 beds days per month, which equates to a saving of £124,820.40 (1040.17days x £120) per month or **£1,497,844.80** per annum.

Applying the difference between difference approach in line with the national evaluation methods, this would result in an additional saving of £124,820.40 – £48,135 = £76,686.00 per month after implementation of POPPs, which equates to a saving of **£920,232.00** per annum for 2007-8.

In 2008-9 after the implementation of the POPP there was a mean reduction of 434 beds days per month, which equates to a saving of £52,080 (434 days x £120) per month or **£624, 960** per annum.

Applying the difference between difference approach in line with the national evaluation methods, this would result in an additional saving of £52,080 – £48,135 = £3945 per month two years after implementation of POPPs, which equates to a saving of **£47,340** per annum for 2008-9.

These findings indicate that resource savings from POPP investment persisted beyond the first twelve months of POPP at a reduced level of saving. This pattern is common in other POPPs in England.

Looking at the data in the lower part of Table B:2 demonstrates the size of the Gloucestershire POPP effect in another way. First, the effect of average POPP spending on bed day use is the (average) size of effect on bed days of having POPP investment in Gloucestershire PCT compared with its absence or not

having the POPP investment. To put the saving for 2007-8 in context, it represents 4.1 per cent of the total emergency bed days spending per month within Gloucestershire PCTs from April 2007 to March 2008. Second, every £1 spent on the Gloucestershire POPP creates a resource saving to Gloucestershire NHS Trusts of £1.20 on bed days which is a central estimate. The resource saving for Gloucestershire is just above the average for all POPP PCTs in England.

Discussion

Overall the macroeconomic analysis appears to demonstrate that the POPP investment in Gloucestershire has reduced emergency bed day use in the population of Gloucestershire over 65 years of age. The findings demonstrate reductions against trend from difference-in-difference analysis that produce potential resource savings to the NHS of the order of £1.20 saved for every £1 spent. The estimations underpinning this finding were robust and unbiased.

Evidence for positive resource savings in one area of the POPP were corroborated by the analysis of care home data on emergency beds in Table B:3. Emergency bed and rehabilitation tariffs have fallen over the life of POPP and reductions in length of stay in hospital for care home residents are directly attributable to POPP working.

Difference-in-difference analysis of trends in the post POPP data, compared with the same data in the absence of POPP investment, suggest that the resource saving per annum from reductions in emergency bed day use in the population of Gloucestershire aged 65 years plus was £920K or just under £1million for 2007-8 and an additional £47,340 in 2008-9.

A substantial challenge for the analysis applied in this macroeconomic evaluation, and indeed in the national evaluation, was the attributional effect of the POPP. Difficulties in assigning the attributional effect of the POPP arise from the research design of the evaluation and the data limitations outlined in detail in preceding sections, both of which were beyond the control of the evaluation team.

Introduction

The focus of local economic evaluations was to examine the elements of POPPs that were working well, to identify why this is so, to explain why some parts have not worked well and to examine these reasons too. The main objective of local evaluations was to put together a range of data and evidence to explore the difference that the POPP overall and the care home support team in particular made and to explore the potential for sustainability and further improved outcomes from POPP funding into the future. The specific focus of the Gloucestershire POPP local economic evaluations focused on two care home support team activities; namely the work of activity coordinators and pharmacy medicines management in improving the quality of life of the residents of Gloucestershire care homes.

The Gloucestershire medicines management was carried out by one pharmacist funded via POPP monies. Two types of data were collected by her in terms of POPP funded work. The first set of data was on medicines review up to September 2008 and this was economically evaluated for actual and potential savings. Since then medication review has also been conducted with a view to preventing falls in the elderly in care homes. The results of this work are described in the 'falls prevention' section below. The second set of data has not been economically analysed but describes the findings of extensive medication review over the last year to April 2009 in Gloucestershire care homes arising from POPP funding of a pharmacist. It is unclear how this data would translate into falls prevention rates and the impact of lower levels of falls on emergency bed day use and other health and social care services. However, the findings are described to highlight further potential for resource savings in the future that could arise from POPP funding.

The first section of the local economic evaluation demonstrates the magnitude of and potential for resource savings to the NHS from POPP funded dedicated medicines reviews conducted by pharmacists on people aged 65+ in Gloucestershire care homes, as compared with routine medicines management in the absence of the POPP up to September 2008.

Medicines management includes a whole array of activity including medication review, patient records, patient safety, collaborative working, service level agreements between providers and strategic monitoring of collaborative agreements and patient outcomes.

Background to Gloucestershire POPP inspired pharmacy medication review

Employment of a pharmacist for medication reviews

It is widely thought that care home patients do not receive the same level of medication review as older people in the community. Care home patients are also more likely than their counterparts in the community to suffer the consequences of poly pharmacy. In order to target these issues and improve the prescribing for care home patients in Gloucestershire the GPs working alongside the care home support team included medication review for patients within their workload. However, after a number of patients in several care homes had been reviewed it was decided that this method of medication review was ineffective and inefficient. POPP funding led to the employment of a pharmacist to target the poly pharmacy issues more effectively, but these reviews take time and have other resource implications if the results of medication review are to be put into practice and maintained.

The pharmacist developed a thorough methodology for medication review, which included a review of the resident's medical history as well as their prescriptions. Once these reviews had been completed the results were fed back to the resident's own GP in the form of recommendations. The POPP-funded pharmacist made a large number of recommendations and this led to a very high uptake of advice from GPs.

Pharmacist recommendations for economic activity in medicines management

Activity data demonstrates that pharmacy medication review initially undertaken within the care homes of West Gloucestershire PCT had an economic impact. The medication reviews were effective in terms of demonstrable resource savings as this economic evaluation will demonstrate. The same resource issues are still arising two years on, however, but some of the changes facilitated by pharmacy review should have a positive influence on future resource savings and sustainable culture changes into the future and the potential for resource savings is very great. Communication links between care homes and GPs and care homes and community pharmacies responsible for the supply of medication have improved.

Pharmacist recommendations for medications fell into three main categories:

- changes to improve chronic disease management for residents in care homes (to optimize current treatment) and allow the most recent and evidence-based guidelines to be used in care homes
- changes to reduce the risk to patients from medication-related problems (side effects, falls, prolonged use of non-steroidal anti-inflammatory drugs (NSAIDS))
- changes to medication to provide the most cost effective method of prescribing, for example, encouraging homes to restrict wound care dressings to the PCT dressings formulary.

Resource issues – medication reviews and the process of medicines management

In line with the agenda of the POPP project the medicines management team within the care home support team aimed to:

- achieve cost-effective prescribing
- reduce unnecessary and inappropriate hospital admissions
- improve the quality of life of residents in care homes
- increase the patient safety with processes designed to improve the administration and storage of medicines

Medication reviews can be expected to generate large resource savings in economic terms. Sometimes people are maintained on drug regimes after one incidence of prescription because of the difficulty in ascertaining a change in any health condition. As a result of the POPP funding and the GP contract some areas of healthcare for people in care homes have improved substantially, including greater consistency of approach to healthcare delivery within COPD, asthma, diabetes and cardiovascular disease than there was prior to POPP funding. This work has also extended to falls and fracture prevention with very good results.

The areas in which POPP resources have been able to release resource savings via medication review and healthcare management by pharmacists include pharmacy prescriptions, the use of equipment and other supplies, and improvements to process changes for medication review and adherence to patient safety protocols.

There has been an historical overuse of drugs for insomnia, depression and anti-psychotics that arises from infrequent, inconsistent patient review of 'mental health' conditions. In addition, inappropriate catheterization has been identified as one of the areas for review and agreement between care homes, medicine review and NHS staff. The repeat prescription of pain analgesic for 'previously acute, but now non acute conditions' has been another feature of prescribing behaviour that

is very costly and inappropriate. Inappropriate use of laxatives and steroids for older people in care homes was another key feature of prescription which POPP funding for pharmacy reviews has been able to tackle and reduce.

Everyday nursing care in Gloucestershire care homes has also experienced improvements as a result of POPP funding. Additional POPP resources have taken the pressure off everyday practice, thereby facilitating improvements in record keeping, documenting treatment and patient safety issues. POPP funding has facilitated the full documentation of adherence to wound care formulary for all residents with wounds, appropriate use and documentation of catheters and a lessening of the inappropriate use of costly and largely unnecessary nutritional supplements. Patient safety processes have all improved as a result of POPP funding and the work of pharmacists connected with the Gloucestershire POPP. This has been achieved by, for example, ensuring there are good standard operating procedures (SOPs), that are read and adhered to by staff, for ordering medication, safe storage, disposal of waste, homely remedies, recording of administered medication and safe storage use of monitored dosage systems (MDS). In addition, there has been an improvement in the recording and accessibility of patient information on individual residents. Poor and inaccessible record keeping has previously resulted in inappropriate hospital admission. This has high associated opportunity costs and leads to poor quality of discharge information from secondary care that often contributes to costly and unnecessary readmission to hospital overnight. There is a great deal of potential for more resource savings to be made in this area with additional investment in community pharmacy staff to undertake reviews and strategic managers to set up collaborative agreements. There is also a need to address patient confidentiality and consent issues and the process and managerial issues connected with sustained and large resource savings.

The level, standard and accessibility of patient records and information held within care homes is another important area of potential resource savings. Where there is poor or even no information on medical histories held in a care home, out-of-hours doctors err on the side of caution and admit sick patients overnight to hospital. The introduction of standard medical reports held at care homes for out-of-hours doctors, locum doctors and care home staff to share health information on residents might be expected to reduce hospital admissions from care homes and data on this will be examined in the sections below. The pharmacist within the care home support team has piloted and audited an admission/discharge pack (similar to antenatal packs) that is a patient or patient-agent held record. Strategically, health information sharing requires issues of confidentiality and consent to be agreed and understood by all parties.

Research design

The absence of a control group in the design of the national POPP evaluation meant that direct comparison of the cost-effectiveness of the Gloucestershire POPP and its local elements compared with routine health and social care has not been possible. The POPP research design creates an attributional issue for POPP outcomes that also extends to local economic evaluation. One of the main challenges created by the research design is the difficulty in capturing appropriate outcome measures that arise from the POPP funding. In this event, cost savings or resource savings are the next best economic data to estimate. The data currently available for pharmacy review has been assembled below in order to allow a coherent estimate of the resource savings arising from the POPP inspired medication review and patient management. Much of this data comes from an audit pilot conducted by the medicines management team.

The economic question for this element of the evaluation was:-

What is the magnitude of resource savings to the NHS from POPP funded dedicated medicines management conducted by pharmacists on people aged 65+ in Gloucestershire care homes compared with routine medicines management?

Resource savings are the product of resource use and the prices of that resource use and each of these elements has to be estimated separately. Presenting the economic evaluation question in this way allows a comparison to be drawn between the resource savings enabled by POPP funded pharmacy review activity and the pharmacy review activity that might have been expected in the absence of POPP funding. The economic estimates below also give an indication of the potential for resource savings once a full medicines management strategy is in place across Gloucestershire.

Resource savings – medicines management and pharmacy review

The Gloucestershire pharmacist working as part of the care home support team (CHST) collected data to support the estimation of the economic resource savings to the NHS that arise from medicines management and pharmacy review. In common with all economic evaluation approaches some assumptions have been made with regard to resource use, but these have been made explicit. Prices were applied to the time period in which they occured unless otherwise stated.

This economic evaluation is based upon audit data collected by the Gloucestershire PCT pharmacist. Actual and potential resource savings that have arisen from POPP funding have been estimated as well as strategic process development work vital to the future sustainability of the medicines management in care homes that has also been facilitated from POPP funding. Table C:1 presents data on the use of 'mental health' drugs. There is huge variation in prescription rates between GP practices for these drugs in the community and in care homes. Data has shown that even within low community prescribing GP practices the level of prescriptions of such drugs within care homes is ten-fold.

Table C:1 Antipsychotic prescribing in care homes (snapshot)*

Home:	**No. residents reviewed**	**No. on antipsychotic (%)**	**No. on typical (T) antipsychotic (%)**	**No. on atypical antipsychotic (A) (%)**	**No. on 2 or more***
1	27	10 (37%)	6 (60%)	3 (30%)	1 (T+T)
2	9	1 (11%)	1 (100%)	0 (0%)	0
3	38	18 (47%)	8 (44%)	10 (56%)	0
4	34	10 (29%)	2 (20%)	8 (80%)	0
5	21	5 (24%)	0 (0%)	4 (80%)	1 (T+A)**
Totals:	**129**	**44 (34%)**	**17 (39%)**	**25 (57%)**	**2 (4%)**

*None of the care homes were mental health homes, all were either residential or general nursing

**Note: Typicals and atypicals should NOT be prescribed together

There is considerable variation between practices regarding the prescribing of anti-psychotic drugs (both within care homes and within the community).

For example

Practice 1 (relatively low numbers of mental health drugs generally but also very low number of patients in nursing homes (0 patients in residential care)):

Community patients on antipsychotic medication (>65y)	1.2%
Nursing home residents on antipsychotic medication (>65y)	11.5%
Community patients on hypnotics (>65y)	2.3%
Nursing home residents on hypnotics (>65y)	3.8%

Practice 2 (relatively low numbers of mental health drugs generally and average nursing and residential patients):

Community patients on antipsychotic medication (>65y)	2.4%
Nursing home residents on antipsychotic medication (>65y)	14.2%

(no data yet on hypnotic prescribing)

Table C:2 presents actual data on the scope and range of medication review. Each review takes at least thirty minutes of computer time on the patient record. The follow-up work encompasses talking to the resident themselves about their feelings and views on a change in medication and liaison with residents' GPs in order to implement the results of the review. These processes are tremendously time consuming and require follow-up on a range of difficulties and issues.

Table C:2 Medication review actual activity to date and audit findings

Status of medication review	Total number of residents:	Number of homes:
Review completed awaiting GP implementation*	126	4
Started medication review, but not yet complete	152	4
Booked review, but not yet started	87	2
Request for review received (waiting list)	293	7
Totals:	**658**	**17**
*Some changes either did not require GP confirmation or confirmation was given on an individual basis		

Audit data demonstrated that of fifty three patients receiving a medication review in a residential home sixty two per cent (33 of 55) needed to have prescription reductions made at a rate of 1.73 items per person (57 individual items). This resulted in total savings of £5,798 per annum. Audit data demonstrated that of six patients receiving a medication review in a nursing home sixty six per cent (4 of 6) needed to have prescription reductions made at a rate of 3.5 items per person (14 individual items). This resulted in total savings of £1,570 per annum.

Table C:3 presents audit data which is also useful for this economic evaluation. It was assumed that of the 278 medication reviews (total of rows 2 and 3 in Table 7.22) completed in June 2008 they had all been or were very soon to be implemented. It was also assumed that these reviews resulted in reductions in medication for 65 per cent of those reviewed and that the average £ cost of this per patient per 28 day prescription cycle is the average of the cost of nursing home and residential care patients or (£74.12+ £51.69)/2 = £62.91 or £817.77 per resident prescribing cycle per annum.

Table C:3. Resource use and price profile of medication review in care homes in Gloucestershire

Activity	With POPP	Without POPP
Number of residential homes	97	97
Number of nursing homes	76	76
Number of nursing patients (>65years)	3246	3246
Number of residential patients (>65years)	1639	1639
Potential number of medication reviews resulting in a reduction in prescription if all residents could receive a medication review and have it implemented	3175	0
Number of medication reviews to June 08	278	0
Actual number of medication reviews resulting in a reduction in prescription to June 08	181	0
£ Average cost of medication per nursing home patient per 28 day prescribing cycle*	62.91	74.12
£ Average cost of medication per residential home patient per 28 day prescribing cycle^	62.91	51.69
£Total cost of medication for nursing care home patients (>65years) (per annum)+	817.77	£3,129,144
£Total cost of medication for residential care home patients (>65years) (per annum)+	817.77	£1,101,408
£ Actual resource saving from medication review compared with no POPPs scenario	148, 015	0
£ Potential resource savings per annum if POPP funding meant 65 per cent of all residents received medication reviews that resulting in	£2.6m	0

prescription change		
* Source Mayes (2008) An audit of 1,137 nursing home residents the average cost per patient was £74.12 per patient per 28 day prescribing cycle (£963.56 per nursing patient per annum) ^ Source Mayes (2008) Based on 133 residential patients the average cost per patient was £51.69 per patient per 28 day prescribing cycle (£671.97 per residential patient per annum) + Source Mayes (2008)		

Discussion

Based upon empirical data in section 1, the analysis above demonstrates that the medication review part of medicines management enabled by the POPP project has made actual resource savings of £148K compared with the scenario of an absence of POPP funding up to September 2008. This is a substantial saving, but as such does not represent the full range of mostly non-quantifiable resource savings that have been released by medicines management within the Gloucestershire POPP.

The potential savings from medication review across all Gloucestershire Care Homes are very large at least around £2.6m if enough resource could be devoted to extending this work. Section 2 of this work supports potentially a higher level of resource saving from falls prevention targeted medication review.

Section 2

Falls and fractures prevention

Medication reviews from Sept 2008 – April 2009 have concentrated on historical prescription responding to illness that no longer applies. This is expensive, but also potentially harmful in that it leads to residents taking unnecessary medication for blood pressure or mental health problems that might contribute to falls because of drowsiness and other undesirable effects. Another issue that medication reviews address, is the prescription of drugs, such as, bone remodelling agents, vitamin D and calcium in those at risk of falling as a result of various long term conditions.

About 2,114 residents in Gloucestershire care homes were reviewed using a falls and fractures questionnaire (Mayes, personal communication).

Data on 2,297 patients demonstrates that:-

- 34% were in residential care home 66% in nursing care home
- 61% were 85years+
- 25% were female, 75% were male
- virtually all residents were British
- 44 per cent of residents had had a fall in the last twelve months and of these of these 33% had had one fall and 67% two and two plus falls.
- 16 per cent of residents had had a fall that was bad enough to seek help from a GP or nurse or Outpatient Occupational Health in the last twelve months.

620 residents (27%) were taking calcium and vitamin D to help protect bones. It is recommended that all elderly care home residents should take these supplements to prevent falls and fractures. Very few would be exempt because they can't take these supplements, so with consent this figure should be nearer to 90 per cent of residents in care homes.

365 residents (16%) of those residents taking a bone remodelling agent were not also taking calcium and vitamin D. This has uncovered a big problem as all people prescribed a bone re-modelling agent should have a prescription for calcium and vitamin D.

67 residents (2%) were taking steroids (any dose for three months or longer). All of these residents should have been taking a bone remodeling agent, calcium and vitamin D, but only half of these and 39% were taking a bone remodeling agent calcium and vitamin D respectively.

Five residents had a diagnosis of Parkinson's disease and were taking medication likely to cause Parkinson's symptoms. At least one of these residents has since had the diagnosis of Parkinson's withdrawn.

Twenty five residents (1.2%) were taking an anti-dementia drug (ACI) and an antipsychotic drug, so increasing the risk of stroke.

459 residents (20%) had a last systolic blood pressure (SBP) reading less than 120mmHG and of these about half (46%) had also had a fall in the last twelve

months. 46 residents (5%) had a last systolic blood pressure (SBP) reading less than 100mmHG.

In residents with SBP lower than 120mmHG, about 60-70% were still taking medication for previous events of hypertension and hadn't had this anti-hypertensive medication stopped or dosages reduced recently.

551 residents (24%) were taking hypnotics or anxiolytics that cause drowsiness. 368 residents (16%) were taking an anti-psychotic drug, 230 residents (10%) were taking an antidepressant and a handful barbiturates/antihistamines. 413 residents (18%) were on "other drugs" likely to cause drowsiness (British National Formulary code 2).

In terms of more general areas things from this survey of note was the significant variation in the quality of record keeping as many residential homes had poor records and medical histories on residents.

Several residents had incomplete GP information on their medication charts, for example, date of birth was incorrect or the wrong GP/practice was listed. Correct notes are essential for emergency situations to be dealt with properly.

There was huge variation in monitoring blood pressure, as some homes measured it weekly, but then did not do anything with the information and some just didn't measure it at all.

Discussion

Medication review and medicine's management financed through POPP monies are very likely to make a significant difference to a range of costs. The budget for medication is a significant cost item and it is important to reduce the cost where ever possible, as it can lead to better outcomes for older people and release resources for other uses.

Areas of work on-going or in development in this area include:

- Development of Service Level Agreement (SLA) with community pharmacists to cover two levels of service:
    - Basic level – to look at processes and use of SOPs only
    - Advanced level – to begin more clinical reviews. Initially concentrating upon use of wound formulary dressings, NSAIDs and COX-IIs in pain control and catheter products

- Development of second (pilot) SLA with pharmacists to undertake medication reviews looking specifically at falls and fracture risk
- Audit of quality of discharge information from secondary care
- Audit of 35 homes considering: processes (storage, documentation, use of SOPs) and specific clinical areas (use of wound formulary products, documentation of catheterisation, use of mental health drugs, etc.)
- Continuing with medication reviews
- Use of independent prescribers within care homes
- GP zoning
- Inappropriate use of MDS (e.g. storage of controlled drugs within MDS, addition of "as required" medicines to MDS, addition of unstable medicines to MDS)
- Production of reports on significant history for use by homes (and OOH GPs) to reduce inappropriate hospital admissions.

Robust data collection of final outcomes in terms of reduction in falls, increased quality of life, reduced overnight beds from care homes and reduction in the medication budget are ongoing. However, one of the biggest issues in terms of economic resource savings is the large variability across care homes. Aggregate economic approaches to evaluation tend to mask this type of variability, but it is important and should be borne in mind.

References

Forder, J. (2008) Partnerships for Older People Projects – emergency bed day use analysis. Presentation at national evaluation event on 3rd April 2008, London.

Mayes, N. (2008) Care Home Support Team Report, June 2008.

Windle, K. Wagland, R. Lord, K. Dickinson, A. Knapp, M. Forder, J. Henderson, C. Wistow, G. Beech, R. Roe, B. Bowling, A. National Evaluation of Partnerships for Older People Projects: Interim Report of Progress. Hertfordshire: University of Hertfordshire.

Introduction and methods

The quality of life questionnaire was administered by the UWE local evaluation team as part of the national evaluation of all 29 POPPs. The questionnaire (which is included in the appendix) was developed by the national evaluators, based largely on a range of existing validated measures. It is designed to be used before and after specific interventions in order to demonstrate the impact of those interventions on the quality of life of participants across all of the POPPs. Guidance from the national evaluation team indicated that the questionnaire should be administered at least twice, once pre-intervention to obtain the base-line data and again following the cessation of the service. It was recognised that not all services planned by the pilot sites will be suitable and therefore decisions about which interventions it would be used with were left to individual projects in consultation with their local evaluators. In Gloucestershire two interventions delivered through the POPP were chosen: 1. The medicines review and 2. Activity coordinator training. It was hoped that a total of approximately 150 questionnaires would be completed and returned, 75 pre-intervention and 75 post intervention. In order to achieve this, and to allow for a 50% return rate, a total of 160 questionnaires were distributed to 8 care homes, 4 of which had taken part in the medicines review and 4 in the activity co-ordinator training. Care homes were selected to provide a balance between rural and urban locations.

Findings

Seventy completed questionnaires were completed and returned from 5 care homes at baseline (pre-intervention) and 30 at follow up (post intervention). There appeared to be two main reasons for this lower than expected response rate. Firstly, care home staff felt that the questionnaire design and content was not user-friendly and was not appropriate for some care home residents. This meant

that residents required high levels of support from care home staff in order to complete the questionnaire. Secondly, where the questionnaire was being used to evaluate the medicines review the follow up administration needed to take place after the changes to medication had been approved by the appropriate GPs and implemented. As described elsewhere in this report, this process took much longer than anticipated and in some cases this hadnt been completed within the timeframe of data collection for the evaluation.

Where responses to questions are presented as percentages, some of the these add up to less than 100%. This reflects the fact that some respondents didnt answer all of the questions.

The questionnaires were administered by residents themselves of with help from care home staff, friends or relatives (figure 1).

The questionnaire was divided into five main sections:

(i)Your Health Today

(iii) Your Quality of Life

(iv) Service use

(v)About yourself

This analysis now reports on each section separately, apart from the 'Service use' section. Much of this section is not relevant to participants because it covers services that older people would only use in their own homes and not in a care home setting.

Limitations in interpreting the responses from the quality of life questionnaire

The interpretation of this data has limitations. As described in the introduction, follow-up data was only obtained from three of the five care homes and this may bias the follow-up responses and confound the baseline responses; for example if the level of care required by residents differed in the different care homes It is possible that the respondents who completed the questionnaires at baseline were different to those who completed it at follow-up and or the method of completing was different. For example, figure one shows that at follow up more residents were helped to complete the questionnaire by family or friends, compared to at baseline. The influence of family or friends may affect the answers provided by the residents. A small sample size, particularly at follow-up limits the interpretation of all the data. Additionally, the time constraints of this project have restricted its ability to detect changes. This limits the likelihood of detecting changes as a results of any interventions , (e.g. medicines review and activity co-ordinators) which have been shown in the past to impact on quality of life and that may have been implemented in the care homes used for this evaluation. For example, we were only able to gain data from two care homes in which the medicines review had been completed and ratified by the relevant GP's . Any effects from changes in medication will take time before they manifest themselves and are measurable. The time between the change in medication and the administration of the follow-up questionnaire, was in some case only four weeks. This may not have been sufficient time to detect any resulting changes in quality of life. A further confounder to interpreting the results of this analysis relates to the interventions implemented in each of the five care homes. Only two of the care homes who had a medicine review had both baseline and follow-up data with one additional care home having baseline medicines review data only and only one care home had both baseline and follow-up data available after a trained activity coordinator had been involved with its residents, with one additional care home having baseline data only. Descriptive and comparative data are presented. It was not possible to explore associations between some of these results due to the large amount of missing data.

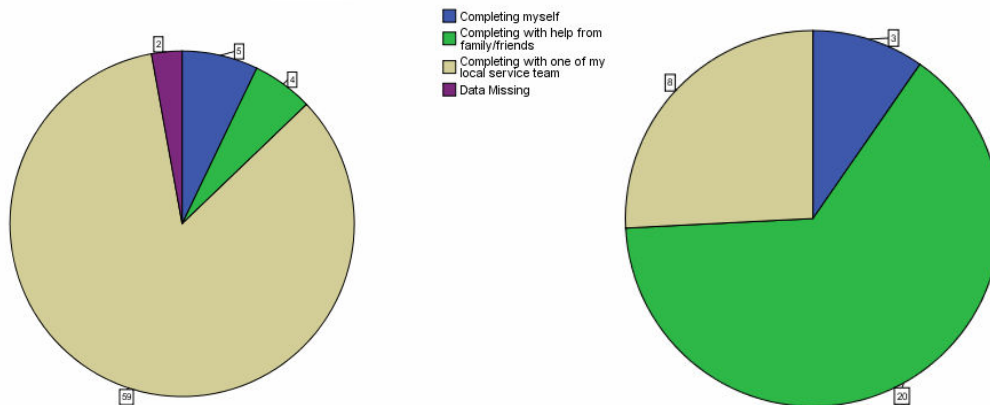

Figure one: Methods of completion of Quality of Life Questionnaire at baseline line(left) and at follow-up (right)

Profile of residents who completed the Quality of Life Questionnaire

Table 1 describes the residents who were asked to complete the questionnaire. There were no significant differences in age (p 0.25). There were almost three times as many females who completed the questionnaires as there were males. Just over half of respondents had continued their education beyond the minimum school leaving age. The minimum school leaving age may have varied cross age. At baseline around a fifth of respondents reported having either a university degree or professional qualification and at follow up this figure was around a third. Smoking status is closely related to socioeconomic status. Their was a higher proportion of non-smokers at follow up, which may relate to higher proportion of respondents who reported having a University degree and or professional qualification.

	Baseline	**Follow-up**
Total administrations	70	31
Age (mean)	84.89	86.90
Age range in years	58-97	68-98
Mean age	84.89	86.98
Age median	87	88
Gender	27.1% male, 71.4 %female	29% male, 71% female
Ethnicity (%)	95.7%	80.6%
Retired: yes or no (%)	Yes: 85.7; No: 10	Yes: 67.7; No: 12.9
Smoking status (%)	Current 2.9 Ex smoker 42.9 Never smoked 48.6	Ex smoker: 29 Never smoked: 71
Post code of residence: % of total responses	GL1 3PL: 17.1 GL52 8DP: 15.7 GL53 8DS: 11.4 GL6 OLS: 11.4 GL7 4AH: 28.6	GL1 3PL: 48.4 GL53 8DS: 22.6 GL6 OLS: 22.6
Continued education after minimum school leaving age	Yes : 32.9; No 65.7	Yes: 38.7; No 61.3

Do you have a degree or equivalent professional qualification	Yes: 17.1; No 81.4	Yes: 25.8; No: 74.2

Table 1: Profile of residents who completed the quality of life questionnaire

Marital status is shown in figure 2. There seems to be a difference in distribution of marital status between baseline and follow-up. It is unlikely that this has been caused by the time between when the measures were taken, and is more likely to be representative of differing populations being sampled at each time point.

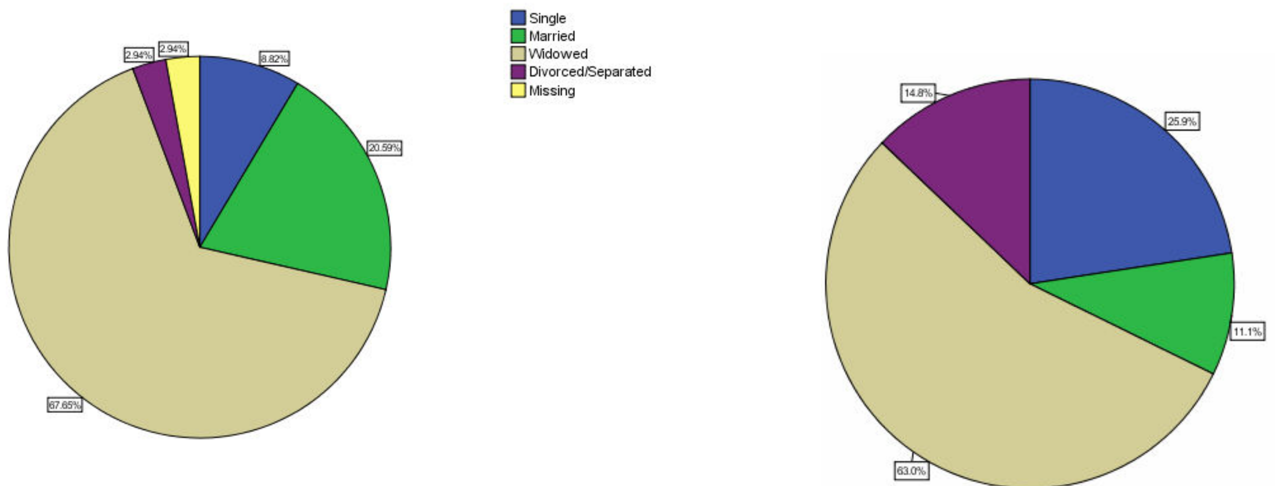

Figure 2: Marital status at baseline and at follow-up by percentage response at baseline line(left, *N* 68) and at follow-up (right, *N 27*)

My Health Today

This subsection relates to participant's health status on the day that the questionnaire was administered (table 2). Higher scored indicate poorer health, with the maximum score of 15. There is an 11.5% decrease in reported health status between baseline and follow-up. However, limitations relating to sample size and differing population must be considered.

Administration	*N*	Mean score (SD)
Baseline	69	9.38 (2.41)
Follow-up	30	10.60 (2.31)

Table 2: Mean scores (standard deviations) for health as reported on the day the questionnaire was administered

Table 3 shows the responses to the final question of this section which enquires about the participants health status today compared with the past 12 months.

Administration	Response	Percent response
Baseline *N=69*	Better	24.3
	Much the same	54.3
	Worse	20.0
Follow-up *N=31*	Better	19.4

	Much the same	51.6
	Worse	29.0

Table 3: My health state today compared with general health over past 12 months

Quality of Life

This sub-section consisted of only one question (appendix ?, will the questionnaire be an the appendix?) which asked participants to choose from seven possible responses, the results from which are shown in figure 3. There may be an issue here of how representative this one question is with reference to the multi -faceted issues that make up Quality fo Life. At follow-up 22.13% less reported their quality of life as being alright, but 4.7% more reported it as being very good. Additionally, there was an increase of 3.23% in those who reported that their health was so bad it couldn't be worse, and an increase of 3.59% each for those reporting their health as bad and very bad. This could be a reflection of the slightly older age range at follow-up compared to at baseline.

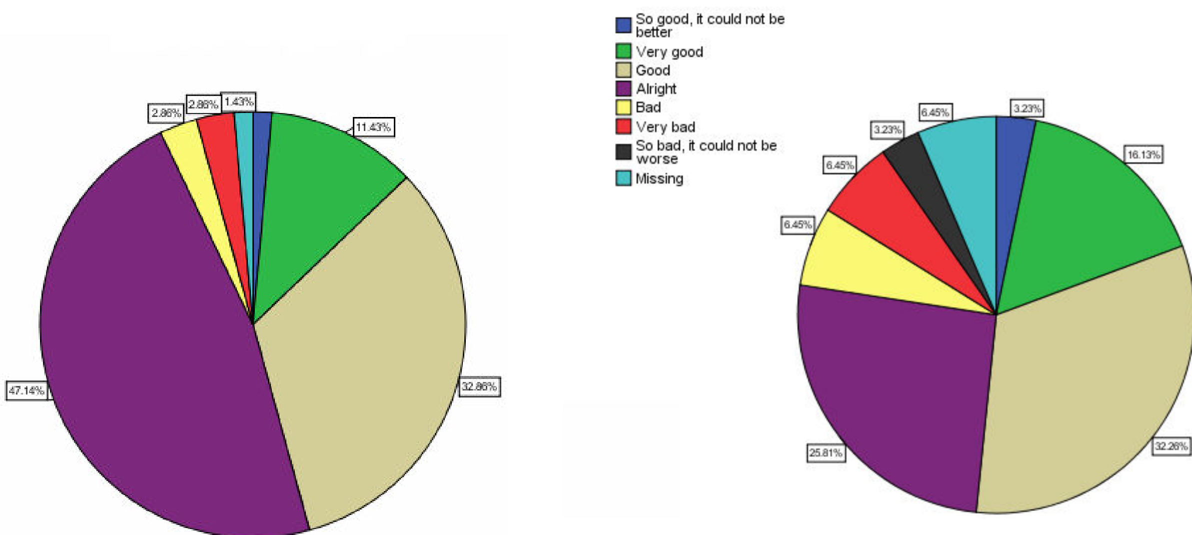

Figure three: Quality of life at baseline and follow-up by percentage response

Short Form Questionnaire and Sub scales

Total Short form questionnaire scores

These are shown in table 4. The maximum possible score is 108, with higher scores indicting better health. There were only five complete sets of data at follow-up, this prevents any further analysis being conducted on this sub-scale.

		N	Minimum	Maximum	Mean (SD)
Baseline	total short form questionnaire scores	52	54.00	104.00	76.04 (11.96)
Follow-up	total short form questionnaire scores	5	69.00	83.00	75.60 (6.10)

Table 4: Mean (standard deviations), maximum and minimum scores total short form questionnaire scores

Short Form Questionnaire Sub scales

Table five shows the responses to each of the six subscales that comprise the short form questionnaire section. Figure four provide a visual comparison of scores at baseline and follow-up.

		N	Minimum	Maximum	Mean (SD)
Baseline	Autonomy	55	5.00	18.00	13.22(3.78)

	Positive relations with others	55	6.00	18.00	13.22(3.78)
	Purpose in life	54	4.00	18.00	13.76(3.69)
	Self-acceptance	53	3.00	18.00	12.83(3.60)
	Environmental mastery	55	3.00	18.00	11.453.63)
	Personal growth	55	5.00	18.00	11.80(3.43)
Follow-up	Autonomy	9	10.00	18.00	12.89(2.71)
	Positive relations with others	9	12.00	18.00	12.89(2.71)
	Purpose in life	9	6.00	18.00	15.22(2.05)
	Self-acceptance	8	6.00	18.00	12.88(4.02)
	Environmental mastery	8	4.00	15.00	11.75(2.76)
	Personal growth	7	10.00	12.00	9.43(2.88)

Table 5: means (standard deviations) maximum and minimum scores for all 6 sub-scales of the short form questionnaire.

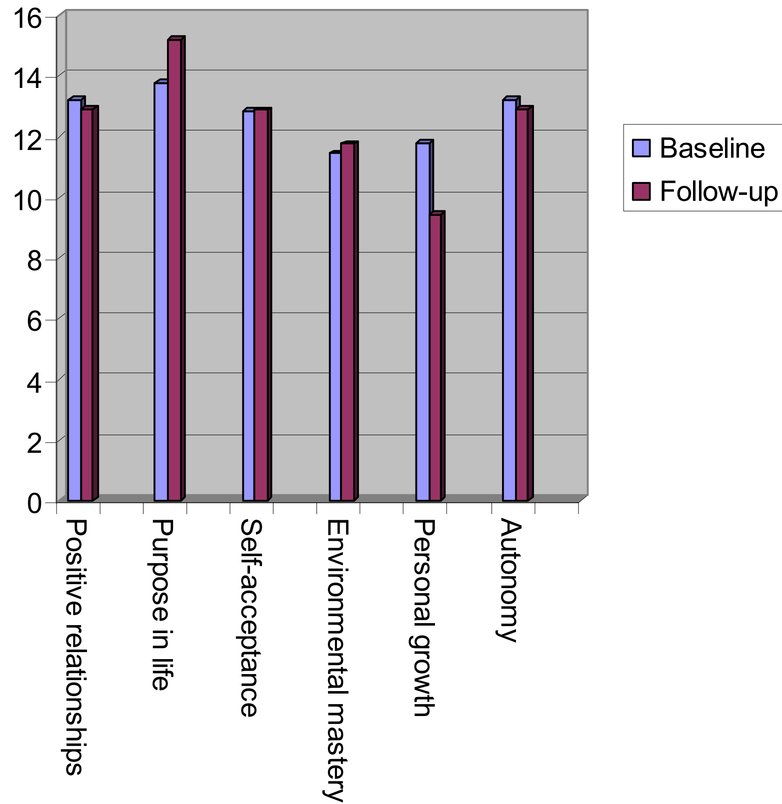

Figure Four: Scores for sub-scales of the short-form questionnaires at baseline and follow-up

The maximum score for each of these six aggregated sub-scales is 18. Higher scores indicate better health. There appears to be a reduction in feelings of autonomy, positive relations with others and feelings of personal growth from baseline to follow up, but an increase in purpose in life and environmental mastery. However, these changes are small, particularly at follow-up and must be interpreted in light of the sample size which is too small to infer any real changes between baseline and follow-up.

Summary

- The quality of life questionnaire was administered to 70 older people at baseline and 31 older people at follow up. The mean age of respondents at baseline was 85 years and 87 years at follow-up. More women than men responded at both baseline and follow-up.

- There was little difference in the scores for ‘Health reported on the day’ and ‘my health today compared with general health over the past 12 months’.

- Although there were some changes between baseline and follow-up for the single enquiry into quality of life, the only changes of any magnitude related to a reduction in those reporting feeling alright at follow-up and an increase in those reporting their quality of life as good compared to baseline.

- There was little difference in the scores between baseline and follow-up for the sub-scales of the short-form questionnaires or in the total score for this scale.

- In summary, there were few changes in any of the indices of quality of life measured in this way. Quality of the data including missing data and the time been administrations has affected the likelihood of detecting any changes that may have resulted from intervention designed to affect the quality of life in older people. It is therefore unrealistic to draw any firm conclusion regarding the effect of POPPS on quality of life at this stage.

- However, there is evidence in the published literature to support the effect on quality of life of both medicines reviews and increasing both physical and mental activities in older people. To obtain a more accurate reflection

of the effect of these aspects of POPPs on the quality of life of older people in care homes a larger sample size is required, which should be monitored over a longer time period, sufficient to detect any changes should they occur.

SECTION B. ADDITIONAL DATA AND INFORMATION COLLECTED BY THE PROJECT TEAM

B1. LOCAL PERFORMANCE INDICATORS

Introduction

The development and introduction of a set of Local Performance Indicators within the Project may be fairly unique in the national context; feedback from various conferences and events has suggested that this element provided an additional component to the overall evaluation. Attached, as Appendix 5 is a copy of the end of Project Local Performance Report, illustrating the additional information captured and used both to manage the developments but also to inform the overall evaluation. The following resume covers 2 main themes -

1. Context, Issues & Process
2. Performance measures considered against the objectives of the Project

1 Context & Issues

The contribution by various stakeholders to development of a POPP bid and the subsequent approval created an opportunity to introduce a core set of Local Performance Indicators. Initial work concentrated on the confirmation of the key objectives for the Project, which best reflected the priorities and proportionality of resources allocated. Participative consultation involving key stakeholders led to the production of the following Core Objectives of the project as shown in table 1 below.

The Project Evaluation Team agreed at an early stage that the development and introduction of Local Performance Indicators, specific to the work of this Project. It was agreed that the various components of the evaluation would benefit from the introduction and application of some quantifiable PI's which could also be used to track progress against targets.

Table 1 – Core Project Objectives

No.	Objective
1	Increase opportunities for older people to participate in developing and evaluating services
2	Work with providers to develop excellent services in care homes
3	Improve staff training and support care homes to be part of the care system
4	Deliver a more preventative approach by developing outreach services and encouraging greater community involvement
5	Offer training to older people so they have new opportunities for paid or voluntary work in the community
6	Demonstrate that the project is efficient

Subsequent work identified which workstreams would make significant contribution to the achievement of the objectives, and then what methods of evaluation could be used to provide evidence for the subsequent evaluation. The need to introduce quantifiable PI's which could then be aligned to other planned forms of qualitative evaluation – quality of life, case studies, became more apparent as Workstreams commenced their programmes. Using quantifiable PI's to illustrate progress on process was seen to have a useful purpose in monitoring developments and supported the various methods of governance being deployed.

Whilst we had confidence that the objectives would remain constant through the life of the Project we acknowledged at an early stage that further amendments or changes might be required to the Local PI's as work progressed. The Local PI's as shown in Table 2 below, represent the final set that were being monitored during the 2nd year of the Project.

Table 2 - Local Performance Indicators (2nd year)

Local PI No.	Local Performance Indicator
LI 1	Numbers of Older People involved as a result of POPP
LI 2	Reduction in admissions to hospitals from care homes.
LI 3	Reduction in delayed transfers of care from acute & community hospitals
LI 4	Number of homes employing Preferred Priorities of care training
LI 5	Number of care homes who have received nutrition tool training.
LI 6a	Number of contacts to CHST from care homes in relation to behavioural problems, dementia or mental health issues
LI 6b	Numbers of care homes who have received basic dementia training
LI 7	Savings made as a result of medication reviews
LI 8	The number of care home staff receiving training directly as a result of POPP
LI 9a	Range of new services offered by care homes directly as a result of POPP
LI 9b	New services offered by care homes directly as a result of POPP – number of care homes taking them up
LI 9c	Number of people befitting from an outreach service from a care home.

Most people will acknowledge that aligned to the service improvement agenda POPP also was intended to present stakeholders with the 'opportunity' to address some of the greater challenges associated with true partnership working. Sharing resources, knowledge, systems etc. and overcoming both formal (e.g. statutory fiscal duties) and informal (e.g. cultural) barriers as part of learning curve presented some interesting challenges. In this context a variety of themes emerged in planning and delivering on this POPP Project and the following four themes provided some interesting examples.

a. Resource variations

Initial work around the preparation, collection and collation of data for the PI's produced some interesting challenges, not surprising given the considerable variation in stakeholder resources, knowledge and skills. The Involving Older People Workstream led by Gloucestershire Older Peoples Assembly (GOPA) literally started from almost a zero base - few resources, limited IT, and yet rose well to the challenge to work to public service standards. Support was provided from the Council Performance & Information Team and the Project Team and thanks to shared positive attitudes and a strong will to achieve, good progress was realized.

b. Organisational protocols

Gloucestershire is probably similar to many other counties where in the space of two years significant internal re-organisations have been undertaken in both health and social care. e.g. three PCT's covering the county have merged into one, but main patient information systems were still based on a more historical two sites structure. Again goodwill and a desire to achieve have overcome many of the challenges, and whilst a certain number of constraints based more on issues around legal accountancy/audit requirments and governance variations continue, the experience of POPP should contribute to the objective of increasing the efficiency and effectiveness of partnership working.

c. Performance culture

All stakeholders started from where they were. Council adult social care understanding of performance management differs to that of colleagues in the PCT, and was interpreted differently again by people working in the independent and voluntary sector. Why and how we use performance reports and the importance of working with Local Performance Indicators was agreed in principle but detail around how monitoring and governance issues were addressed

remained as ‘opportunities for further development’. It may be that effective programme management will deliver performance improvements which cross service boundaries but these need to be clearly set out and subject to robust governance arrangements.

d. Language & terminology

Local Performance Indicators need to sit within some form of a performance management framework. Stakeholders worked together to understand requirements and common understanding around words describing concepts such as ‘objectives’, ‘targets’, and ‘user outcomes’; this was certainly advanced during the Project, but we need to acknowledge that such specialist language can be alienating to people who do not work in the more formal settings. Use of some initial workshops involving partner agencies could have led to reaching an agreement about ‘performance language’, the extent of its use and understanding but linked to a check that it actually would (or would not) serve a purpose.

Process

After initial set up, staff from the Council Performance & Information Team worked with Workstreams and the Project Team to deliver Performance Reports which were then reviewed by the Evaluation Team and sent on to the Project Management Board. Generally the reports were well-received and provided some measures of activity, mostly proving positive messages of progress. Where specific grants or budgets had been used it provided information on performance achievements or under-achievements which then provided a support or governance focus.

We found that the important stages of collection, collation and dissemination of information benefited from a performance reporting framework. The introduction and implementation of a reporting timetable even added some impetus to activities in the Project where stakeholders were keen to demonstrate improvement against targets and progress against achievements.

2 Performance measures considered against the objectives of the Project

The more detailed outputs and outcomes are evident in the end of year Local Performance Report (Appendix 5), however this paragraph provides the opportunity to demonstrate some quantifiable achievements against the objectives agreed at the start of the Project.

- At the end of the 2nd year over 1,000 older people will have been involved in developing and evaluating the Project. This success owes a great deal to the commitment of the full time Coordinator and her management of the team of Facilitators. *(LI 1)*

- Gloucestershire retains a National top quartile (best) ranking in terms of the PI which measures the number of delayed transfers of care from both acute and community hospitals. *(LI 3)*

- In the 2nd year 30 care homes undertook training using the Preferred Priorities of Care Pathway (PPC) which have a positive emphasis on managing end of life care situations. Gloucestershire PCT will continue to roll out the PPC pilot throughout the early part of 2009. *(LI 4)*

- By the end of the Project 50 care homes received nutrition tool training. This training has been well received with a high demand of uptake from care home staff. *(LI 5)*

- Over 2 years, 126 contacts were made with the Care Homes Support Team in relation to behavioural problems, dementia, or mental health issues. *(LI 6a)*

- By the end of the Project 51 care homes received training in the use of the Dementia Care Mapping Tool. *(LI 6b)*

- Over the 2years of the Project 1,200 care homes staff will have received training directly associated with the Project. *(LI 8)*

- 14 different types of services were offered by care homes directly as a result of the Project which were taken up by 35 different care homes. *(LI 9 a & b)*

- During year two 600 people in the community benefited from an outreach service from a care home. *(LI 9c)*

Other Local Performance Indicators provided information that could only be indirectly attributed to the Project but nevertheless proved helpful confirmation that intentions of objectives were being achieved.

The development, introduction and application of Local Performance Indicators provided a successful platform for the engagement of a wide variety of partners. We achieved a common understanding of the broader objectives of the project but more importantly how being able to measure performance would confirm progress and achievements. By adding the results of the quality of life evaluation it is possible to demonstrate that the many residents of care homes have positively benefited from the Project.

Ivars Reynolds

Chair of the Evaluation Group.

19th February 2009

PARTNERSHIP FOR OLDER PEOPLE PROJECTS

GLOUCESTERSHIRE CARE HOMES PART OF OUR COMMUNITY

END OF PROJECT REPORT

Compiled by Justine Rawlings, Project Manager, in conjunction with workstream leads

Distribution

18th February 2009 –	Workstream leads and relevant contributors v1
23rd February 2009 –	Helen Bown, Project Lead v1
3rd March 2009 –	POPP Project Management Board v2
31st March 2009 -	Handover to Helen Bown v3
30th April 2009	Sign off PMB

“The end of the project is in sight now - are you pleased overall with what the team has achieved? I think you should be -As an observer - it seems that, unlike a lot of government money, this short term intensive investment really does seem to have made a difference. So if you replicate our positive experience over the county and add in all the training /information and networking initiatives the project has initiated I think it really has been a good project and hopefully the older people in our community and the older people to come will continue to benefit from improved and more integrated services.”

Care Home Activity Coordinator

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1 INTRODUCTION

This project report aims to summarise the key work areas of POPP in terms of the activities undertaken. In addition, we have summarised some of what has been learned in delivering the project. This is not an exhaustive account and where there are supplementary documents that may provide more detail in a particular area, references will be provided. This document is not a formal evaluation of the project but sits alongside the formal evaluation. However, it is important to note, that the scope of the project was such that it was not possible to evaluate independently each intervention in detail and the formal evaluation of necessity focuses on the overall project impact, supplemented by detail on key areas such as medicines management. It was felt important, therefore, to draw out some key areas of learning from the point of view of those delivering the workstreams.

This report was compiled using direct contributions from workstream leads in partner organisations and feedback from various events and evaluation activities as specified, as well as reports and case studies records of which have been kept throughout the project. The report describes the activities and services undertaken and what has been learned, including work done on evaluative type activities such as case studies, surveys and monitoring of output. The report does not cover performance against the key indicators used by our evaluation team to measure the progress of the workstreams. We have also given some information about sustainability.

2 EXECUTIVE SUMMARY

The POPP project: Gloucestershire Care Homes Part of Our Community was designed to deliver the POPP agenda of promoting independence, health and well-being, working predominantly with the 174 care homes in the county. The project was hosted by Gloucestershire County Council, but was a partnership with Gloucestershire PCT, Gloucestershire Older Persons' Assembly, Gloucestershire

Care Providers Association and Gloucestershire Neighbourhood Projects (no longer in existence). Other key partners were the 2gether NHS foundation mental health trust. The project was informed by research into the views of older people, carried out by Gloucestershire Older Persons Assembly (GOPA) and by a previous very small pilot, delivering clinical support to a limited number of care homes.

The POPP activities ranged across a number of areas and were planned to be delivered via 6 workstreams:

- **Care Home Support Team** – To develop the model of clinical support to care homes
- **Training** – To develop skills of staff to deal with more challenging older people and enable more residents to have a choice of where they die
- **Outreach services** – To develop the capacity of care homes to provide different types of care and support to a greater number and wider range of older people
- **Involvement of older people** – to involve older people in the evaluation, planning and inspection of services
- **Recruitment** – to provide training and volunteering opportunities for older people and carers in the community
- **New care pathways** – to use different pathways to provide care e.g. step up step down beds involving care homes

The project was evaluated independently by the University of West of England and, in addition, each workstream was monitored against a set of Local Performance Indicators by the project evaluation group.

The project team and workstream leads also carried out a number of monitoring activities, including:

- Activity monitoring
- Surveys
- Feedback events
- Case studies
- Audits

These, together with a description of the work undertaken, form the basis of this report.

Overall delivery

The project largely delivered as planned, in terms of outputs. The economic appraisal work within the UWE report discusses the delivery of financial benefits as proposed within the bid. The largest workstreams, defined in terms of both funding and scope, ran largely to plan with some delays experienced early on in recruiting to the Care Home Support Team. The training workstream, in fact, delivered well beyond its initial planned scope.

The two smallest (in scope and funding) workstreams were not delivered:

- Recruitment
- New Pathways

The recruitment workstream failed when the lead partner organisation failed. The work done on involving older people, hubs and volunteer recruitment (see below) covered this to a degree but there was no substantial recruitment and training of older people within POPP for **paid** employment.

The New Pathways workstream did not have any funds attached to it and was assessed at the beginning as a risk, reliant as it was on predecessor PCTs' rehabilitation strategy. This risk materialised. A small amount of work was done which suggests that PCTs might realise savings by use of short-term beds in care homes but this was not picked up formally as part of POPP.

The underspend arising from delays in recruitment was used to deliver additional areas. These were agreed formally by the Project Board and, where a carry forward was required, the DH. They were in line with the overall aims of the project as follows:

- Hubs – communities working with care homes to develop inclusive services
- Mental health education nurses to develop dementia link workers in care homes (lead by the training workstream)
- Older persons forums
- Advocacy service to care home residents
- Further services (outreach hearing service, visual impairment outreach and dental needs assessment)
- Additional projects e.g. theatre, music, art, school partnership projects in care homes

The initial bid outputs were largely delivered and where this is not the case, the reasons are discussed in the report. The key areas that it was intended within the bid should be sustained were:

- A slimmed down care home support team
- Continued training

- Future support for older persons' engagement.

These have all been secured. The areas such as hubs which began later in the project have had less time to demonstrate success and further work may need ot be done to realise their potential.

Project activities and learning

Care Home Support Team

This was a multi-disciplinary clinical team with locality links to care homes. It delivered training based referrals, training, case management and crisis management. The areas covered included nutrition, dementia, end of life care, medicines management, falls and mobility, seating, swallowing and communication and care planning and record keeping.

Care homes were also provided with a best practice toolkit, linked to local and national NHS policies and procedures. In addition, the team provided links to community and primary care, leading to further work with GPs and District nursing to improve care home links. A clinical reference group of senior clinicians in the county provided clinical governance and advice to the team.

Referrals during the project were received from CSCI, GPs, DNs, social services and community mental health teams. The majority of homes accessed the service at some point. Feedback was gathered from care homes and was very positive, with negative remarks being made only about the wait for therapists on some occasions. Training by individual team members was rated by the care homes on average as 4.5 out of 5 (5 being excellent). Case studies indicated probable improvements in quality of life and prevented admissions. Feedback from local CSCI inspectors suggested that care homes valued the support, that

record keeping had improved within care homes, that access to services for residents had improved as a result of direct access to the MDT and that the specialist knowledge developed by the team was important. The team itself valued the ability to refer within the MDT and gain instant advice, providing a one-stop shop for complex problems.

Further services

Further services were provided to care homes via other agencies. The Gloucestershire Deaf Association provided a very successful outreach hearing aid service which visited care homes and demonstrated improvements in the quality of life of residents by making simple adjustments to hearing aids and raising awareness of care home staff. Gloucestershire County Association for the Blind carried out a limited needs assessment for a similar outreach service for the visually impaired. The community dental service looked at dental health needs in care homes. These are due to report at 31st March 2009.

Training

Training was delivered as planned in the areas of nutrition, dementia and end of life care. Further training was delivered in clinical skills in response to care home identified need and in the provision of activities in a care setting to support the outreach workstream. Training was provided to care staff, nurses, activity coordinators and cooks.

New approaches were tested using partnerships with a number of providers sourced and offered to care homes via a single point of access. A very successful dementia care training pathway was established and taken out to care homes by 2 care home education nurses who also established dementia link workers in homes and local forums. Learning networks were established to encourage development of learning environments, including greater use of elearning, and the independent sector also established a Persons in Charge Network.

The uptake for events and training was high. Impact evaluation work suggested that the areas most highly valued were dementia, clinical skills and cooks' training. Care home managers noted improvements in access to training, staff morale, staff and home performance and quality of care. The independent sector organisation, GCPA, was very positive and spoke highly of the service offered by the single point of access. CSCI inspectors noted a "huge" improvement in some homes as a result of the training. The PCT has developed an inclusive approach and care homes are represented in key areas of training and development e.g the end of life programme and the infection control group. Partnership approaches to developing training pathways across health and social care are now underway in nutrition and in end of life care, mirroring the very successful work done on the dementia care training pathway.

Outreach

This workstream struggled to deliver against initial targets and a limited number of care homes chose to work with the project in this area. However, those that did established services to the community in a variety of areas such as provision of meals, bathing and pampering, activities, advice and support, and footcare. The provision of small grants provided some with the set up costs required, including the costs of marketing their services. Those who did take part gave very positive feedback on the effect providing services had on the reputation of the care home in the community. Most felt that barriers had been broken down and a more positive view of the care home and sharing activities with residents had been developed. This was felt to also benefit care home residents. Some care homes felt that the horizons both of staff and residents as to what was possible had been expanded. CSCI inspectors reported that a number of homes were now signalling on AQAA returns, their intention of working more with the surrounding community.

The capacity of care homes to provide more for their surrounding community was increased by the setting up of an activity coordinators network which will extend after POPP to those working in day services etc. This is supported by training and a website giving useful information on standards, potential providers etc.

Involving Older People

Older people were involved in the project as part of the initial consultation, through governance and leadership roles, delivering programmes of activities, gaining the views of older people, evaluation of the project and through distribution of information about the project. In addition, care homes working on areas such as outreach were asked to ensure that residents were involved in expressing their views about new developments.

In so doing, they undertook a number of roles. GOPA trained older people to act as facilitators to seek the views of others, they also developed an advocacy service to care homes with older people taking on the role of advocates. The independent evaluators developed and trained older people in the role of community researcher who talked to care home residents about the importance of activities in their lives. In addition, GOPA have begun to work with local groups to establish a number of older persons' forums to secure engagement into the future. In a feedback event, older people were positive about the roles they had undertaken in support of the project and gave clear feedback and a particular perspective as to the services that would make a difference to the lives of local older people. This feedback was linked, wherever possible directly back to care homes and to hubs.

The involvement with care homes suggested a degree of nervousness initially on the part of care homes and a fear that this was another type of inspection. Some older people were nervous of the care home environment. However, the skills and training of the older volunteers, enabled links to be made and positive relationships to be built. The project demonstrated the need to involve older people from the beginning in the design of the project and to offer specific roles within the project. The input at board level influenced directly the direction of the project. Those who participated brought significant skills to the project and feedback from the event suggested they would like to continue to be involved in how services develop. The project also demonstrated the need to provide

recurring core capacity to enable organisational stability and, therefore, capacity for future engagement work

Recruitment - volunteers

As highlighted above, this workstream did not deliver as a result of the failure of a partner organisation. The volunteer recruitment carried out as part of the various workstreams, has however, been monitored and there has been limited success. The activity coordinator network will be promoting volunteers as a part of the increased capacity available to homes to enhance the quality of life of residents. Some particular homes have had great success in this area as part their small grant work and so have some community organisations working in hubs, suggesting that local approaches are likely to be most successful.

Hubs

Hubs were established in 7 areas. Community organisations and, in some cases, local older people, were given small budgets to work in very local areas to develop services and activities for older people, including care homes and care home residents. A variety of work was carried out in response to locally expressed need and resources. In many areas, it was simply a question of making resources available across organisational boundaries e.g. transport and providing information as to what is available for older people in an area (including services offered by care homes such as respite); in others running joint activities or training events; elsewhere the community began a programme of engagement with their local care home working with schools and other groups.

This work began very late on in the project but the leads believe there is great potential to develop more locally responsive services and resources. Paid coordination was seen as necessary to this as well as information and marketing. Some of the community groups involved have stated their intention to continue with the work after POPP.

Additional projects

A number of small additional projects were commissioned as a result of bids to the project, working with theatre groups, music events, schools and Gloucestershire Archives. Feedback from the care homes suggests that they value these types of activities. Whilst they may be "beyond their budget", some of the ideas are transferable and within the scope of the activities coordinators themselves to deliver. They also provide inspiration to activity coordinators and something a bit different to look forward to for residents. This will be taken forward by the activity coordinator network facilitator.

The groups report that they would also be more likely to work within the care home environment in the future. One group has just completed a further successful bid with Gloucestershire Archives for Heritage Lottery Funding for a project involving, amongst others, care homes and their residents in developing a touring play documenting the demise of the local "pub". This also demonstrates, as do the other projects outlined in this section, that care home residents have a contribution to make to their communities.

Quality outcome monitoring

The project was asked to look at areas in which outcomes might be better measured and data shared. The review identified a number of sources of information and a lack of joined up working, as well as a lack of data in some key areas. A number of recommendations have been made.

Project management

Issues regarding the overall project management were documented during the project. Overall the project structure and set up was felt to be sound. The project would have benefitted form additional recruitment and communication support right at the beginning. Recruitment became a major underspend area and

projects need a fast track HR process to deal with this. Communications are vital to gaining an understanding of key messages early on to enable sign up and involvement.

Sustainability

The POPP project has successfully sustained services and support beyond the lifetime of the project. These have largely been in the areas of training and support to care homes. Further work is needed to sustain the engagement of older people and the work within communities, as well as some of the smaller services which began towards the end of the project and have identified a potential area of need.

3 DESCRIPTION OF PROJECT

The POPP project in Gloucestershire, Gloucestershire Care Homes Part of our Community, set its aims as follows:

To

- Increase opportunities for older people to be involved in developing and evaluating services
- Work with providers to develop excellent services in care homes
- Improve staff training and support care homes to be a part of the care system
- Deliver a more preventative approach by developing outreach services from care homes and encouraging greater community involvement
- Offer training to older people so they have new opportunities for paid or voluntary work in the community

These were to be delivered via 6 workstreams[3]:

[3] Bid document

- **Care Home Support Team** – To develop the model of clinical support to care homes
- **Training** – To develop skills of staff to deal with more challenging older people and enable more residents to have a choice of where they die
- **Outreach services** – To develop the capacity of care homes to provide different types of care and support to a greater number and wider range of older people
- **Involvement of older people** – to involve older people in the evaluation, planning and inspection of services
- **Recruitment** – to provide training and volunteering opportunities for older people and carers in the community
- **New care pathways** – to use different pathways to provide care e.g. step up step down beds involving care homes

Originally evaluation and communications were defined as workstreams. It was felt that evaluation needed to stand a little more independently of the project and report direct to the Project Management Board. Communications were, in the end, handled directly through the project office.

The key partners in the project, responsible for delivering workstreams were:

Gloucestershire Older Persons Assembly	GOPA
Gloucestershire PCT	GCPT
Gloucestershire County Council	GCC
Gloucestershire Care Providers Association (independent sector)	GCPA
Gloucestershire Neighbourhood Project Network	GNPN[4]

Other key partners represented on the Project Management Board were 2gether NHS Foundation Trust (mental health), CSCI, and Gloucestershire Hospitals NHS Foundation Trust.

[4] The project ceased working with this organisation in June 2008

In addition, individual workstreams received support from a number of organisations and individuals. In particular, the Care Home Support Team enjoyed the support of a clinical reference group, drawn from senior clinicians in the Gloucestershire NHS organisations.

Project budget

The actual expenditure for the project is set out in Appendix 1. Money to support workstreams was grant funded to the relevant organisation. Original spending plans were adjusted as underspends arose e.g. in recruiting staff or as approaches were changed as the project learnt from delivery.

During the lifetime of the project, some services such as training courses for care homes were provided entirely free, to test approaches and outcomes,   that may in future have some charge against them. This and the costs associated with running a project, including evaluation costs, mean that the project costs do not represent the costs of providing the service into the future. The cost into the future can be seen in Appendix 2.

Care homes taking part and range of involvement

Gloucestershire POPP has measured its activity both through services delivered to individuals but also through services delivered to care homes and their staff, such as training. Our project was open to participation to all 173 (initially 174) homes for older people in Gloucestershire. Of these 33 are predominantly homes for those with learning disabilities who did not participate in all areas. Of the 173, 77 are nursing homes and 96 are residential. They range in size from small independent homes to large groups. They are home to approximately 4500 older people.

The uptake of training and referrals to the Care Home Support Team and Training, the most highly resourced workstreams, are outlined in Sections 1 and 2. In addition, the involvement of care homes in other project areas is mapped in appendix 3. Participation is greater in some areas of the project than others, this is discussed in the relevant sections.

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4 Sustainability

The Care Home Support Team

The care home support team was set up in order to deliver consistent support to care homes, and build on a small pilot, which had identified specific support and training needs within care homes. The expected outcomes were better medicines management, nutrition, care of the dying, dementia care, falls training and wound care. The team would provide case management. They were also expected to facilitate a culture change between agencies working with care home residents, including improved links to health and social care.

1 Workstream Description

The care home support team is a multi disciplinary team supporting care homes with on-site training, referrals – including case management and crisis support. The composition of the team and the core components of the training offered were based on a previous smaller pilot to identify needs. These were the gaps in knowledge and skills around:

- Mental health issues for older people
- Falls prevention
- Medicines management
- End of life care
- Mental health and well being
- Skills to manage potential unscheduled admissions
- Reinforcement of skills and training
- Building relationships between care homes and other disciplines e.g. physiotherapy

The team and the dates on which their service started is set out below. Elements of the team were difficult to recruit. This is discussed further on in the report.

	Start date	Clinical governance support	Base
Nurse manager, 5 RGNs and 5 RMNs based together in localities (one RGN acting as Deputy)	1/7/07 25/6/07 25/6/07	PCT PCT Mental health trust) (MHT	PCT MHT MHT
Pharmacist and pharmacy technician	1/10/07	PCT	MHT
Physiotherapy	1/10/07	PCT	MHT
Occupational therapy	5/11/07	PCT	PCT
Speech and Language therapy	1/4/08	PCT	PCT
Dietetics	3/1/08	Acute trust	Acute trust
Podiatry	1/2/09	PCT	PCT
CHST administrator	16/7/07	PCT	PCT

2 Workstream activity

The nursing team focussed initially on recruiting 30 care homes to undertake the initial training, whilst publicising their referral services to all care homes. The 30 care homes were chosen as representing a range of care homes – the objective being to have examples of a range of care homes using the services to enable the team to market their services further in future i.e. if the team had only targeted poor care homes, others may not have wished to be seen as part of the programme. A RGN and RMN were paired in each locality and based together to promote joint working and to build local relationships with a group of care homes. Physiotherapy and occupational therapy was locality based and took all care home referrals. The remainder of the team were not locality based and acted as the link to care homes but did not replace existing community services. Speech and Language Therapy (SLT) employed a therapist to lead in the CHST for 0.6 WTE hours embedding the remaining 0.4 WTE in the service within localities.

2.1 Training

The core training elements delivered by the nursing team, the dates on which delivery started and the training materials/approach used are detailed below. These are provided to care home staff designated by the care home to attend.

Training	**Materials/approach**
Dementia	Dementia Awareness
Nutrition	NAGE (including MUST tool
End of Life Care	Principles of palliative care

	Communication with patients and families at the end of life Caring and Nursing at the end of life LCP to be rolled out
Human Ageing	Part of the activities in a care setting module

Early on the team were contacted by care homes other than the original 30 and the decision was made to extend training to all care homes on demand and to be flexible in delivering to the care home's own identified need, as well as using referrals to suggest further opportunities for training e.g. a referral for confusion that identified a UTI as a cause might trigger training for all care home staff around dehydration as part of the NAGE training.

The end of life care training is not as advanced as we had hoped it would be at this stage. However, considerable progress has been made in identifying a cohort of homes who are interested in implementing the Liverpool Care Pathway and roll out has begun. The PCT is rolling out its own training and is involving the Care Home Support Team and the care home staff in the rest of the training which is being planned across the county to improve cross boundary working and equity of care.

Further key areas of training have been identified and developed in partnership with homes, and delivered by the CHST or centrally by the training workstream (see Section 2) e.g. record keeping and accountability and various clinical skills training. This is detailed in Appendix 4.

Further training delivered by the CHST is outlined below.

Training	**Source**
Care planning	Devised using PCT, CSCI and RCN documentation to meet the needs of care homes
Accountability and record keeping	As above
Wound management	PCT training
Physiotherapy: Falls and mobility	Devised by team
Occupational therapy Seating:	Under development
Speech and Language Therapy: SONAS	This was delivered by the team from SONAS, set up by SLT
Dietetics: MUST etc	NAGE
Podiatry	Not yet done
Medicines taking	Devised by medicines management
Medication for specific clinical areas	As above

Training devised by the team was done in response to information gathered from homes as to their perceived needs. Details of the training activity delivered by the CHST are outlined in Appendix 4.

2.2 Training based referrals

For the majority of the project, the team did not manage a caseload. Referrals were generally one off and the team members supported the care home to manage the problem. Referrals were also used to sign post to other services, deliver information or to promote training opportunities and or new ways of working e.g. GP zoning. Many homes required several visits to establish a relationship with the team, prior to any work being done.

The approach to referrals was designed initially to gain the trust of care homes in working with the project and to prevent care homes becoming deskilled or the CHST filling a gap in the skills and//or competencies that should be available in the home or provided via the existing District Nursing and community services. It later became apparent that there was a need in some cases to extend case management approaches to care homes and this is discussed below. It was also decided to take all physiotherapy and Occupational therapy referrals for care homes through the CHST to understand any unmet demand for these services. Physiotherapy referrals had a full caseload from the whole of the second year of the project and followed them up based on clinical need. The estimated referral rate for physiotherapy for one year was 1000 referrals. Prior to this it was 250 for one year.

The detail of the referral activity is in Appendix 5. Key areas were dementia care, physiotherapy, medication, falls and nutrition.

Referrals were open and received from a variety of areas. The majority were received from the care homes themselves (other than those between the CHST themselves, including follow ups). GPs are the next biggest referrers but some of these concern medication reviews, and the community mental health team have also referred more significantly. Reasons for referral recorded cover both clinical reason and the type e.g. advice and support. The latter took up much of the time as care homes became used to accessing services and sought the CHST advice on how to do this.

2.3 Case Management

The CHST are working closely with the case management team and have allocated link band 7 nurses to support them. The team also now have a dedicated District Nurse link to assist and provide support with case management in care homes. Both RGN and RMN continue to work together on a joint assessment process. The outcomes have been prevention of hospital admission, facilitation of early discharge as well as supporting the home in early recognition of symptoms with a resident with a long term condition. The team have demonstrated the benefits of co-location of the RMN and RGN and speedy referral to other members of the MDT.

The therapists worked with each other but also along their own discipline case management pathways with an overarching aim to prevent admission to the acute services and facilitate discharge. Below is an example of case management by the team.

"Mr X was a gentleman with end stage Parkinsons and dementia, and lacked capacity to make decisions for himself. He also lacked the ability to communicate. He had a wife who visited daily, and children who live away. Our team became involved because of a moving and handling issue, and the RGN case managed him for the last six months as he deteriorated. During that time, he

saw the OT, Dietician, Physiotherapist, Consultant GP and palliative care nurse, all as a direct result of the RGNs involvement and referrals.

The multidisciplinary approach helped us to give him an improved quality of life over those last few months, ensuring that he has nutrition appropriately, was moved correctly and given minor exercises by the home staff and his wife. As his disease progressed, we engaged with him and his family, to make decisions involving his end of life treatment and choices. Because of those discussions, when the point came recently where we met with the GP, the care home manager and Mr X's wife to make those decisions final, the process was less painful for his wife, and she was able to feel supported to make that choice. Mr X was not to be resuscitated, and this was documented in the care home notes, to avoid a situation where the gentleman, the family and staff had to go through that inappropriately. As a group, we collectively felt it would not be appropriate to actively treat any infection and this also was documented, with Mr X being moved onto an End of Life pathway. His medication was reviewed, and active treatments for Parkinsons were stopped. Pain control was changed to a patch to avoid disturbing him and ensure pain cover is appropriate. He was able to die quietly in the care home, with his wife and family present. With the planning, we prevented an inappropriate admission, and unnecessary trauma to both patient and family"

2.4 Crisis management

The approach of the team in this area took some time to evolve and it was important to retain the supportive nature of the team, in order to retain the trust of the care home, enabling real improvement to be made.

In 2007 following a CSCI referral the team supported a care home with training as well as working on the floor to improve standards. As a result standards were raised and the home received less intense support. In December 2008 there was a POVA referral to attend a meeting following a CSCI report. CHST were part of the action plan to raise standards and practice and the visits remain on-going. The

CHST do receive referrals from GPs D/Ns and CSCI to support homes with identified training needs. This is either with individuals or more general issues. Although not a crisis the referrer considers them urgent and our response is more rapid. Homes feel more supported. Specifically, medicines management have supported ensuring safe and good practice with processes associated with handling medication. The team audited and reviewed current practice then liaised with homes, GP practices, community pharmacists and CSCI to improve systems. Often this was something as simple as improving communications and understanding the problems faced in different organisations.

SLT have played an active role in reviewing the use of thickener and appropriate nutritional supplements by service users. Many swallow assessments have led to the reduction in the use of thickeners, the prescription of an appropriate dietary consistency and the education of carers and kitchen staff around what these consistency mean. They have also led to dietetic referrals for advice about the correct use of supplements.

2.5 Dementia Care Mapping

DCM is an observational tool, looking at people with dementia from their viewpoint. The results support person-centred care. DCM helps those planning care to maximise the well being of those with dementia. The results of the mapping, carried out by the CHST nurses was collated by the nurses leading the work with the dementia link workers and is covered in Section 2. The team members were drawn from a number of organisations. They have met regularly both to manage workload and to promote training, including opportunities for cross training between the team. Those disciplines without a locality presence receive referrals both through their colleagues within community teams but also from the locality based nurses. The team was, therefore, able, efficiently to provide support from the relevant discipline. The activities of the specialist elements of the team are outlined below.

2.6.1 Medicines Management

Initial work was based around individual medication reviews and a review of processes relating to handling of medicines within care homes. We targeted 4 homes (nursing and residential) and conducted full medication reviews. A concomitant piece of work was to also review recent CSCI reports and meet with the local CSCI pharmacist inspector to understand the more process orientated issues that he had concerns about. We also considered the paperwork generated by community pharmacists who had signed up to a locally agreed SLA (Service Level Agreement) to provide a review of care home procedures. The SLA had been in existence for some 2-3 years. Several “snapshot” audits were undertaken to assess the extent of various issues and to test whether our hunches for what wasn’t working were true. The audits included:

- Analysis of items most commonly prescribed to assess the usefulness of bulk prescribing in reducing prescription volume and hence workload and storage issues.
- Analysis of items added to monitored dosage systems to assess for appropriateness (e.g. “as required” medication, medication that may become unstable if not in original packs)
- Analysis of dosing frequencies to allow for a shift in workload from busier rounds to quieter ones.
- Review of prescription ordering processes to ensure homes view prescriptions prior to dispensing in line with CSCI good practice recommendations.

Results from each audit are available. It quickly became apparent that with such a small team we were not going to be able to deliver the number of individual medication reviews required in the homes. It was thus decided to try and concentrate upon some key areas and get as broad a coverage as possible – we wanted to consider high risk prescribing areas as well as quality of life and areas with cost implications. The areas it was decided to concentrate upon were:

- Falls and fracture prevention (quality of life and hospital admission rate issues)
- Prescribing of non-steroidals. A high risk area for elderly residents
- Catheter and bag usage (relatively low volumes but high cost)
- Co-prescribing of anti-dementia drugs and anti-psychotics (increased stroke risk)
- Diagnosis of Parkinson's and taking drugs likely to produce Parkinsonism (quality of life issues)
- Systolic blood pressure and falls risk.

In addition to these specific areas of work, the medicines management team were available as part of the overall multi-disciplinary team.

2.6.2 Physiotherapy

The physiotherapy team channelled all care home referrals through the CHST during the POPP project. This revealed a previously unmet demand from care homes represented by a dramatic increase (three times as many, see above activity) in referral levels once the team was in place. Key areas of work have been mobility assessments and provision of walking aids, such as frames, falls assessment and advice, rehabilitation e.g. post stroke, follow up following discharge, manual handling issues. There has also been some involvement of the physiotherapists in respite patients as the PCT has utilised short stays in care home beds to facilitate discharge from the acute hospital. There is no data from this available to the POPP project.

The physiotherapist also provided support initially to the orthopaedic recovery beds (see section 6).

2.6.3 Occupational Therapy

The OT service for the POPP project started in December 2007 with two Occupational Therapists covering the county of Gloucestershire. Initially, the work involved publicising the role. Discussion with staff soon highlighted the following areas of concern:

- Getting equipment to assist residents maintain independence with self care.
- Manual handling issues.
- Falls.
- Seating.

The team worked on these areas. We designed a falls presentation based around the falls awareness information developed and used by the Gloucestershire PCT falls clinic and the take up was very enthusiastic.

Examples of equipment issued to residents are:

- Specialist seating. Pressure cushions. Foam wedge, seating cushions. Chair raisers.
- Shower step. Shower chairs. Perch stools.
- Raised toilet seat. Commodes. Toilet frames.
- Bedlevers. Bed raisers. Pillowlifters. Overbed tables.
- Hoist slings. Slide sheets. Transfer boards. Patient turner. Handling belt. Arjo stedy.

2.6.4 Speech and Language Therapy

The key objectives for the SLT service working within the CHST were:

- Education to care staff in the home on swallowing and communication difficulties

- Improved timeliness of referrals and service provision (GP, hospital wards, homes)
- Proactively supported admissions to facilitate earlier discharge to care home
- Prevention of unnecessary admissions from nursing homes using information, improved referral, training on crisis prevention and onward referral e.g. dietician
- Improved communication environments in nursing homes.

Referrals to SLT have been high and work has focussed on achieving a good service standard. Audit measurements for training have been made and other outcome measures have been worked through to achieve the above goals. Whilst these goals have not been completed there has been considerable, measurable movement along each goal pathway. Each of these goals will continue to be progressed through as the service continues. The activity for SALT is recorded separately for the period to 31st December 2008 because of problems in local data recording systems.

SONAS

POPP has also enabled some care homes to be trained in SONAS. Sonas (a Gaelic term meaning contentment and joy) is a group communication therapeutic activity which activity support workers, funded by POPP have been trained to facilitate. This has enable access to communication therapy for over 200 people who severe dementia across Gloucestershire. It can now also be recommended as a therapeutic intervention following a communication assessment by SLT, where previously no service was available (as traditional SLT therapy is not effective in this client group). SONAS benefits the participants by improving communication, reducing challenging behaviour and increase participation in activities of daily living. All but one home where SONAS has been recommended have signed up for the training sessions and therefore these individuals will

benefit from therapy as well as those who will be recommended it in the future in those Nursing Homes who are running sessions.

2.6.5 Dietetics

The project struggled to recruit dietetic support and so the programme was delayed in this area. However, clear objectives have been set for this area of work and some progress has been made. The work of the nurses in training care homes also reinforced the need for a dietician to provide advice and expertise to the team, as well as to take direct referrals from care homes.

- Ensure malnutrition is detected and treated in all care homes in Gloucestershire

The dietician is auditing the use of the Malnutrition Universal Screening Tool (MUST) and the systems in place to treat malnutrition in a number of homes. The CHST best practice guidelines and training sessions can then be refined as required.

- Ensure appropriate use of prescribable and non-prescribable oral nutritional supplements in care homes.

PCT prescribing data is being used to assess the use of oral nutritional supplements and work carried out with medicines management to develop evidence based guidance for GPs on prescribing of SIP feeds

- Improve appropriateness and timeliness of referrals and service provision.

The dietician has developed CHST dietetic referral forms linked to CHST MUST best practice. By means of these referral forms and information on appropriate referral, GPs and Care Homes are made aware that a service to care homes is available to offer residents personalised specialist dietary advice when needed e.g. gluten free, diabetes, and osteoporosis.

- Give care home staff the knowledge/support to empower them to manage malnutrition effectively.

Develop nutrition champions within the care homes and peer support.

2.7 Clinical support to the CHST

2.7.1 Clinical reference group and clinical governance

The new ways of working, required support from local senior clinicians. The team was supported by a high level multi-disciplinary group, led by the Director of Clinical Development, including the PEC chair, consultants for elderly care medicine and palliative care, therapy leads, Skills for Care and the PCT community services.

The group provided clinical links into the partner organisations and clinical governance advice and support to development of materials, pathways and approaches, ensuring a unified approach and clinical “buy in” at the highest level.

The team, with support from all local NHS organisations, produced a number of materials, including a best practice toolkit for care homes. Available on disc and paper, this covered areas such as, elder abuse, measuring blood pressure, blood

glucose measurement and a hypoglycaemia record sheet for bloods taken, medication expiry dates, refrigeration, catheter guidelines, urinary symptoms, falls prevention, the MUST tool, wound management, dressings formulary, dementia and depression pathway, wandering, stroke and the 999 procedure. Other products include training materials, referral documentation etc

2.7.2 District nursing support

In response to the historical inconsistency in support across the county from the district nursing service, a short life working group commenced in January 2009 and will continue to meet for the next six months. The aim of the group is to identify the scope and practice of district nursing provision to nursing homes. They will also recommend key work streams to support this. Known tensions had been identified with some nursing homes. A skills gap analysis is being undertaken in nursing home provision. A referral form is to be considered for nursing homes to refer to district nurses when required.

2.7.3 GP zoning and Local Enhanced Services

Work was done by the team, and the consultant in elderly care, to identify the number of GP surgeries working with each care home. This demonstrated that in some localities care homes were dealing routinely with between 7 and 14 GP practices, with the resulting confusion in care planning and prescribing practice. The consultant visited PBC groups early on in the project in order to encourage GPs to slim down the number of GPs visiting each care home and consider "zoning" arrangements. A PEC paper outlined the need for this approach and was agreed on 8th May 2008. Further work demonstrated that there was a seeming correlation between care homes with higher than average admission rates per 10 beds and those with large numbers of GP practices working with them. One locality, where there are 8-14 GP practices going into care homes, accounts for 45% of homes with the higher admissions rates but has only 25% of all care home residents within that locality.

Medicines management work (see above) has highlighted potential for improvements in quality of life, falls prevention and cost-effectiveness. These cannot be delivered until GPs are able to prioritise signing off medication reviews so actual savings remain low.

GPs are now working with POPP in key areas and one PBC cluster will be piloting a Local enhanced service, which will include:

- Zoning to care homes
- Working with the CHST
- Identifying whether there is a need for an enhanced level of service
- Baselining information in key areas including Read coding patients' place of residence on movement I and out of a care home to ensure good outcome measurement is possible

Progress with this area after the POPP project has finished will need to be closely monitored.

3 Workstream learning

The Care Home Support Team accounted for the greatest proportion of funding and so it was decided to devote the majority of the independent evaluation resource to this area. Below are some further areas of learning that may not be picked up by the independent evaluation.

3.1 Care home views – acceptability of service

The CHST has carried out a number of surveys during the project to test the acceptability of its service to care homes. In addition, feedback has been collected at the end of all CHST training sessions, including scoring. For the most

part the comments were extremely positive. The majority of negative comments were to do with long waits, particularly for physiotherapy and OT where the project experienced capacity problems at various times. Care homes generally appreciated the accessibility of the team and the support given to staff to deal with the problem. Physiotherapy: “This service is very helpful it saves time as we can refer ourselves” . Many felt that the service had been needed for some time and were keen that it should continue after POPP: “The support, training and opportunities have been excellent. This needs to be a permanent scheme”.

The quality of the service was generally felt to be good: Occupational therapy: “Although it took a while for visit to be arranged after initial contact made the service provided was very good.” Many of the comments referred to the training and service being pitched correctly. “Clear, simple instructions for staff and client. Client communicated to directly.” Quite a few comments were extremely complimentary: “Really helpful team. Support for our care home has been the best I have ever encountered whilst working in care. It is good to be able to speak to professionals when you need to, not having to wait for appointments and referrals.”

Care homes directly related the support given to improvements in the quality of life of and care given to residents: “This is a service (physiotherapy) that is desperately needed in care homes to maximise independence and mobility for individual clients, if staff learn how to assist clients the clients quality of life will improve.” (Falls) “Training and both the trainers was (sic) excellent. A lot of information gained, things that we take for granted. I feel I should change my attitude towards them. (sic – residents)“

Training delivered by the team was evaluated and scored by participants. The average score across all questions was 4.5 (5 being excellent).

3.2 CSCI Feedback

A feedback session was held with local CSCI inspectors. They felt that the CHST support to poor or failing care homes had been "critical". They noted the "sheer relief" of managers who now had a point of access to pharmacy, physiotherapy and OT support. Record keeping had improved in some homes as a result of the team's work. They felt that the access to specialists had reduced the care homes' feelings of isolation and that the previous assumption that care homes had the resources to do everything themselves had needed to be changed and it was good to see this happening. In particular, they felt that the team had developed specialist skills e.g. in relation to pharmacy in care homes that could be shared in other areas.

3.3 Service delivery – CHST feedback

A session was held in January 2009 to understand the learning for the project from the point of view of the team.

3.3.1 Set up

Some service delivery issues were around set up. The team suggested in feedback that more time should have been spent initially getting GPs on board, although effort was put into this at the beginning with not much success. Simple things were not available as quickly as they should have been such as laptops and the project set up at the time of the merger of 3 PCTs did not facilitate this.

Recruitment had been a major issue. In part this was because the merger of the PCTs mean that HR resources were busy elsewhere and that there were a whole set of HR rules associated with the merger. This meant that there was also some tension in members of the team being seconded to the team on permanent contracts and other being on fixed term contracts. It was felt strongly by the team that the project should have operated in some way "outside" this so that it could

recruit speedily and that dedicated HR resource should have been available in the initial stages.

3.3.2 Roles

The expectations of partners e.g. CSCI as to the team's role needed constantly testing. There was a common misconception that the team had been set up to deal purely with poorly performing care homes, that they were a trouble-shooting team or that they would replace the functions of the district nursing service and this sometimes made for difficult relationships. The initial contacts with homes had been very difficult sometimes there had been a variety of acceptance. The team had sometimes been the "way in" for the whole POPP project, which had been quite hard. The RMN teams got the rest of the team in the door often and seemed to act more as tipping point. The team suggested this was because homes were aware of the need for support in this area.

The team felt that there had been real benefits from the multi-disciplinary team. The pairing of the RMN and RGN in localities linked to care homes was felt to be a good approach. The lack of a dietician from the beginning had been particularly missed. General nurses noted the need to look at the broader services and in particular "eyes, teeth, feet and ears". The team felt that there were a number of issues in the expectations for all the roles. They were required to be very flexible and responsive both to evolving project objectives and also working with care homes whose levels of skill and understanding were highly variable. In addition, the nurses, in particular, were required to develop and maintain relationships with care homes sometimes likening it to "cold calling". In fact, the team did extremely well at this but some of them felt that this was an unwelcome pressure and not commensurate with the grading of the role.

The volume of referrals in some areas was not predicted. This put pressure on some areas. This was not to be helped but meant staff needed skills in

prioritisation. Some of the proposed ways of working were quickly felt not to be appropriate e.g. carrying out medicines reviews in all care homes (see above). This impacted on the skills needed once a new approach had been decided upon. The therapists proved particularly difficult roles to which to recruit. The majority of therapy leads responded very well by adapting roles to provide flexibility, interest and support and clear career development. This meant that roles were often split so those carrying out the work could maintain their links with existing teams, say in the acute trust, and also input into the project. This probably benefited the team with better networks in the longer term.

3.4 Multi Disciplinary Team and ways of working

The team generally worked well and brought the benefits of multi-disciplinary team working to the care homes. A number of case studies demonstrate the value in this approach, an example is given below:

“Mrs B had developed erratic eating habits, leading to weight loss. The staff had tried a number of tactics to encourage her to eat. The GP was very concerned and contacted the general nurse on the team. She attended with her partner mental health nurse who identified that there were issues with the resident’s mental health and referred her to the consultant. That visit resulted in medication being prescribed to lift her mood. On review, the RMN discovered that the resident was now eating more consistently and gaining weight.”

The team was supported by a clinical reference group of senior clinicians in the primary, community and acute care. This worked well in assuring the quality of the team’s work e.g. signing off pathways or agreeing single approaches to documentation across NHS organisations and is likely to be continued in the guise of an older persons’ clinical reference group, reporting to the PEC. Support was offered via consultants linked to localities. It was felt that this had been much appreciated, but in the event, the support was at too high a level for the sort of

work that was being done and the interventions needed. The team felt very strongly that GP support either through the enhanced service approach or via specialist GP roles was needed. The team themselves felt that they had made a difference to the quality of life of residents and of staff. They felt that the "care homes have been great". They were very positive about the links to the training workstream and the support from the training office. They were really pleased that access to care for residents in some areas had improved and that homes were able to take responsibility to ensuring access to appropriate care now. The team felt that relationships were very important to the project and had largely worked. The next stage will need to include a review of the multi-disciplinary team, including understanding the interaction of different roles and the relative impact of different interventions.

3.5 Capacity and links to community teams

The original model had been to have smaller number of physiotherapists and occupational therapists on the central team with links out to the community teams. In the event both disciplines chose to have all care home referrals come through the CHST route. Benefits were felt to be simplified access to the teams and ensuring that care homes had equity of access, something that it was felt might be lost when the referrals came through community teams where it was felt those in care homes were in a "place of safety". The SALT and dietetics model, however, was to have the CHST therapist link to the normal network of therapists who would continue to work with homes. The CHST nurses are beginning to develop a good working model with the dietician, supporting and enabling care homes to use the MUST tool, so ensuring that they only need to contact the dietician when her expertise is required. Similar assessment models might be applicable for the other disciplines and be helpful, particularly where demand is particularly high or the resource scarce.

Medicines management has successfully involved community pharmacists effectively as part of the wider team in localities and this has potential to manage

demand and workload associated with this area. This has implications not only for the future specification of the CHST but for the equitable treatment of care home residents by community teams.

3.6 Specialist areas

Dementia Care Mapping

The CHST Dementia Care Mappers have provided comprehensive first reports based on the initial mapping, these will be incorporated into a full report. In summary; where mapping has occurred it is evident that the process has resulted in an examination of learning needs surrounding Person Centred Care and that the exercise has proven a valuable & powerful learning experience.

Results from the first mapping show many positive experiences for residents. The mapping is accompanied with constructive advice from the CHST dementia care mappers to enable person centred care to develop still further. These results have allowed the care homes education nurses (see section 2 Training) to support the CHST by developing their training focus with the Dementia Link Workers. Increasingly they are focussing on relationship centred care, this looks to build on the concept of Person Centred Care. Initial feedback from 2nd Mappings would appear to show a further increase in positive wellbeing scores for residents. This is a great credit to the participating care homes .Tom Kittwood the originator of DCM suggested that care staff can reach “a ceiling” in providing Person Centred Care, however DCM results appear to show significant developments.

A care home manager reported:

“The Dementia Care Mapping was a new concept to most members of staff but you were able to explain this in a teaching session and then attend to ‘Map’ the care given to our residents. Your feedback to us was excellent and your explanation helped staff to put the process into context. Although previously it

had been difficult to audit our care of people with dementia we now have a recognized tool that establishes the level of well being exhibited by residents.

Your follow-up session of Dementia Care Mapping was even more valuable to us as this proved that the lessons taught during dementia training and the previous mapping was utilised and that dementia care practices were improved. Without this we would have been unable to establish any increase in dementia awareness and well being for the residents "

From conversations with Dementia Link Workers (see Section 2: Training), where mapping has occurred it is evident that the process has resulted in an examination of learning needs surrounding Person Centred Care and that mapping has proven a valuable learning experience. Working towards training delivery that focuses on relationship centred care together with intensive in reach work within the care homes has resulted in DLWS who are expressing themselves as feeling more confident in effecting cultural change.

3.6.1 Occupational Therapy

Seating assessments were the most frequent referral. It became obvious that although the care homes provide various sized seating, many residents still experienced difficulties with transferring in/out of their easy chairs, mainly because they were in chairs that were too wide, too short or too high for them. These transfer problems could be easily sorted by raising chairs or at least changing chairs within the home environment so that residents were sat in a chair that was an appropriate size or height for them. Specialist seating was harder to come by, this involved a complex seating assessment and issues around equipment ordering, which improved as relationships developed. There is no equipment budget for anything non-stock or small aids such as cutlery or dressing aids and a problem with the availability of wheelchairs to residents in the care home community.

3.6.2 Physiotherapy

Whilst the CHST was not originally designed to replace existing community team support to care homes, the physiotherapy provision via the team has demonstrated that in the past, care home residents may not have received an equitable service as they were perceived to be in a less vulnerable environment. The bespoke physiotherapy support appears to be engendering more of a culture of enablement through the educational element of the team. The single point of access for care home physiotherapy has also been felt to be beneficial. Commissioners will need to be clear in setting the specification for the team and community teams as to how this is handled. It may be possible, for instance to retain the benefits of this approach by using posts that are joint between community and the CHST. The team would also benefit from rehabilitation support staff and this might be an option between the OT and physiotherapy provision, to carry out follow up rehabilitation support and assist with those clients needing 2 people, also taking first contact non-complex mobility assessments.

3.6.3 SALT

Prior to the introduction of the CHST and the SALT input, this service was available on an "as needed" basis. This was often ad hoc and dependent on the staff understanding within the home. The referral rate varied between one and 3 a week countrywide. Even without providing the targeted training, the SLT involvement in the CHST has increased the referral rate to 1-2 per day, because:

- The CHST recommend onward referral to SALT
- The referral is dealt with well and this encourages homes and gives them a better understanding of what SLT can offer
- Early support is being provided for discharges from hospital

From this, the learning points are:

- The importance of SLT inclusion in a specified and recognised MDT, understood by care homes
- Need for education on swallowing and communication problems in the MDT and on to the care homes
- Education provides more referrals but these are more appropriate
- The needs being met in care homes are wide and complex

Feedback from the SONAS training has been very positive so far with appreciation voiced for improved knowledge of communication and dementia. There have been no negative comments. Training is still being delivered at the time of writing.

3.6.4 Medicines management

Analysis of the medication review work demonstrated that there were common issues across homes. Also there remained considerable overlap with issues highlighted in a project, undertaken within the former West Gloucestershire PCT, some 2 years previously. Comparison with the former project demonstrated that although the quality of prescribing within most of the major clinical domains (e.g. cardiovascular, respiratory, diabetes) had improved – probably as a result of the nationally implemented Quality Outcomes Framework (QOF) in GP practices – the level of improvement within areas outside of QOF (e.g. pain management, mental health prescribing and osteoporosis management) was low.

Other issues that had improved little from the earlier project included the more "task based" orientated areas of prescribing such as:

- Use of wound care products (both choice of dressing and frequency of change);
- Use of catheters and appliances (including choice of product, frequency of ordering and documentation of indication for catheterisation, consent and formal care planning);
- Use of laxatives (with little well documented assessment of bowel function);
- Use of sip feeds (including documented assessments, choice of product, frequency of administration and little evidence of food fortification)

With respect to processes around handling of medicines the main issues appeared to involve:

- Understanding, and review, of protocols and guidance within the homes, including the need for relevant staff to have read the protocol and/or guidance.
- Communication between GP practices, homes and community pharmacies and a lack of understanding of the problems and barriers each faced when trying to supply prescriptions and/or medication
- Documentation within homes
- Complex prescription ordering processes
- Consistency in prescribing messages. This was particularly compounded by residents within a home being registered with different practices.

3.7 Admissions prevention, impact on length of stay

The independent evaluation conducted by UWE has focussed on this area, so this is not the focus of the project report. There were major problems for us in data collection, which are highlighted in their report. However, the team have also kept records of particular case studies in which they judged admissions may have been prevented or length of stay in the acute hospital reduced.

In addition an admissions audit is being conducted by the PCT, looking at records of those admitted from care homes. These are being reviewed independently by the PCT. A judgement will be made as to what might have prevented an admission and then a review will be conducted as to whether any of the CHST interventions might impact on this. A follow up audit with care homes around decision making on admission is also planned.

A review of admission rates, using postcode as a proxy, was conducted, looking at rates per 10 beds per care home. An initial analysis of the data does not clearly identify specific avoidable admissions. However, there appears to be a definite link between those care homes with higher rates of admission and the number of GP practices working with the home (see GP zoning above). The impact on admissions and length of stay within Gloucesterhsire Hospitals NHS Foundation Trust is measured within the UWE report. The mental health trust 2gether NHS Foundation Trust have reported overall decreases in admissions, length of stay and readmissions in those over 65. They identify POPP and the work of the CHST as a critical factor. They have also seen an increase in the referrals to community teams which they see as a positive measure in supporting prevention of admission and improvement in the quality of care. An elderly care psychiatrist has said:

"Following the POPP project input into care homes throughout the Cotswolds, I have seen an enormous increase in awareness of, and confidence in management of dementia in those care home which have engaged with the project to the improvement of care for their residents. Staff are far more aware of reasons for behavioural disturbance, less insistent that I remove the patient to hospital and happier to try non pharmacological interventions."

Partners in community pharmacy have also given positive feedback:

“I am delighted with the new falls and fractures review in Care Homes. This is an exciting new programme that enables pharmacists to become an active member of the clinical team in care homes. I have found the patient review to be professionally stimulating and has developed my CPD in this key area of care: the training was focused and of great help.

I am sure that this expertise will ensure that my MUR's in the pharmacy also benefit from this experience. I congratulate Nickki and Karen on a very well thought out programme. “

3.8 Impact on other providers

The impact on admissions and length of stay within Gloucesterhsire Hospitals NHS Foundation Trust is measured within the UWE report. The mental health trust 2gether NHS Foundation Trust have reported overall decreases in admissions, length of stay and readmissions in those over 65. They identify POPP and the work of the CHST as a critical factor. They have also seen an increase in the referrals to community teams which they see as a positive measure in supporting prevention of admission and improvement in the quality of care. An elderly care psychiatrist has said:

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I am sure that this expertise will ensure that my MUR's in the pharmacy also benefit from this experience. I congratulate Nickki and Karen on a very well thought out programme. "

3.9 The evaluation process

The team themselves had some thoughts on evaluation. They felt 2 years was not long enough to prove an impact and that the turnover of staff in care homes may impact on the success of the approach, until the training becomes more embedded. They felt that the quality of life work done was in danger of missing out on those with severe cognitive impairment or the bed bound and further work would be interesting in this area. The team, with hindsight would have had more input into the data collection required, benchmarking and thinking about what they would have liked to demonstrate but recognised the limitation on resources and the lack of research about the interventions in some areas.

4 Sustainability

The CHST has been jointly commissioned by the PCT and the County Council to continue after the project ends on 31st March 2009. At the time of writing, key performance measures are being agreed within the specification. Improved monitoring against these outcomes is expected also to improve longer term targeting of the team's work. This includes the proposal for all GPs to compile and maintain a register of those in care homes, using Read coding, to ensure that the impact of these interventions can be properly monitored.

The team felt that there were a few key areas that needed work in the future:

- Links with GPs – care planning at the home – GP zoning
- Developing a locality GP – older people specialist.
- Continuing to link care homes to key strategies
- Enabling a consistent District Nurse approach to care homes
- Enabling care homes to sign off competencies following training

- Ensuring the right therapy service given rising levels of referral
- Target training more closely now relationships had been built
- Better and more analysis of referrals
- Care homes and staff enabled rather than made dependent
- Core assessment and shared notes for the team
- Continued clinical skills training available to the homes
- Gather and publish data properly for the future
- Consider possible areas of academic work

A new SLA for community pharmacy has been devised. The community pharmacists visit homes and conduct reviews on a standard pro-forma. These forms are then returned to our team to review and contact the GPs with appropriate recommendations. In terms of process issues the original care home SLA has been revisited and the form simplified. Our team are currently writing sample protocols and guidelines for a variety of areas as well as collecting examples of good practice that may be shared and disseminated. The idea is for homes to be able to use these as examples to adapt to their individual working environment.

There are multiple prescribing issues within the care home environment. Broadly speaking these may be divided into one of two categories: (1) Clinical issues, or, (2) Process issues. Few of these issues can simply be resolved using a medicines management pharmacist to conduct medication reviews and undertake medication switching – a more strategic approach is required. The approach needs to support practices, care homes, secondary care and community pharmacies in adopting a more cohesive approach to the treatment of residents. There are no easy answers and it is possible that different approaches will need to be implemented in different areas. However, whilst the focus of the support may be different, what is clear is that it will take a multi-disciplinary approach to achieve the most benefits. The clinical reference group will be reconstituted as an

older people's clinical reference group with direct links to the PEC. GP zoning will need further development and continued monitoring.

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- 1.2 Activities
- 1.3 Evaluation and monitoring
- 1.4 Sustainability
- 1.5 The future

2 Dentistry

3 Visual impairment

As part of the project, we have identified additional service needs that were not part of the original bid but which contribute to delivery of excellent care. This includes services for those with hearing impairment, visual impairment and dentistry. In each of these areas, POPP has commissioned work to understand the needs of those within care homes and to look at different models of addressing those needs into the future. Each of these services has highlighted the need for good record keeping and it is clear that the presence of a strong MDT, and good GP links would also facilitate the work of others providing for the needs of residents.

1 Outreach Hearing-Aid Service into Care Homes

Provided by Gloucestershire Deaf Association (GDA)

1.1 Introduction

The GDA's hearing-aid service into care homes started in early 2008 and has been funded by POPP since October 2008. Our Hard of Hearing Outreach Worker made first visits to care homes and after each one left a feedback form for the care home manager to complete. Without exception the response was positive and, in many cases, outstanding, confirming that this is a needed service. We are now at the stage with many homes of doing second and third visits and there has been a noticeable increase in the number of residents our Hard of Hearing Outreach Worker now sees at each care home, suggesting the staff are recognising the value of the service and ensuring they are better prepared.

1.2 Activity

The Hearing-Aid Service provides a hearing-aid MOT, during which the GDA Outreach Worker carries out the sort of routine but essential maintenance to ensure aids function properly. In most cases this will involve replacing batteries and retubing. Hearing-aids are notoriously problematic and without such regular checks, will almost certainly start to dysfunction within weeks (certainly months) of being supplied. Elderly people in particular find hearing-aids fiddly and troublesome, and their carers may not have the knowledge or experience to help.

Over the year the GDA has made 68 visits to care homes, seeing 244 NHS hearing-aid wearers and 32 private hearing-aid users. It has replaced 199 hearing-aid tubes and 246 batteries. Our hard-of-hearing outreach worker has also identified 6 cases of badly fitting moulds, 8 broken moulds and 15 hearing-aids that require either more advanced repair or replacement: in each case our worker advised referral to hospital Audiology. When invited, our Hard-of Hearing Outreach Worker also talks informally with care home staff to increase their deaf awareness.

The Outreach Hearing-Aid Service into care homes is a valuable back-up to the repair service offered by Hospital Audiology: with the GDA able to focus on the basic maintenance work of the hearing-aid, it leaves more time availability for their highly trained technicians to concentrate on reprogramming or fixing the digital part of the aid, or making new moulds. They can also be confident that our outreach worker will make a referral to Hospital Audiology if this is necessary. This really is a case of working hand in hand with the NHS to improve the care currently available. Above all, however, the Outreach Hearing-Aid Service is valued by the care home residents and their staff. For a significant number of hearing-aid wearers the improvement to their quality of life is immediate and in some cases profound. The care home staff too report an enormous improvement in their ability to communicate with hard of hearing residents when their hearing-aids are working.

1.3 Evaluation/Monitoring

The GDA has monitored the effectiveness of its hearing aid service using feedback forms left after each visit for the Care Home manager to complete and send back. The response has been overwhelmingly positive. The service currently costs approximately £240 per care home visit. This includes follow up visits and any administration. The cost per case is, on average, £35, assuming an average of 7 residents seen per care home visit (again including follow up). In addition, anecdotally the staff and also the residents tell our Hard of Hearing Outreach Worker how much they value the service the GDA is providing. This is supported by the fact that in more recent visits she is seeing significantly more residents at each home during her visits. The staff are now making better preparation for the visits and ensuring all hearing-aid wearers are available to be seen.

1.4 Sustainability

The GDA would find it very difficult to continue funding its Hearing Aid Service into Care Homes without the financial support of the POPP Project. Initially the GDA

had hoped the service would eventually become an income generator for the charity, and early promotion of the service focussed on offering care homes an initial free visit followed by a £10 charge per visit to at least cover travel expenses. The care homes were clearly reluctant to pay for the service; and costs were generally passed on to the individual residents themselves. For a period this problem over how to pay for the service seriously hampered its growth.

Receiving money from the POPP Project has given the service sustainability at least until March 2009. Moreover, now that the care homes see it as free, the service has grown markedly. Over time, assuming the service continues to grow, the GDA will develop a team of volunteers to assist our Hard of Hearing Outreach Worker, although it is recognised that special training will need to be given.

1.5 The future

Provided the GDA can continue to obtain funding for this service, the hearing aid service into care homes has very clearly proved its worth and appears much appreciated. The GDA is now looking at how to extend this same service into Gloucestershire's rural communities, setting up drop-in clinics in village halls, etc. Work has begun with the Chipping Campden hub. We also hope to link up with other charities (specifically those for the elderly) and see if there is scope for offering the service at their luncheon clubs etc.

2 Dentistry

Need results here from Martin Brace.

This work began in February and is intended to review within care homes, the issues around oral health and dentistry. The review will include under any issues around accessing these services and maintenance of oral health. The objectives will be:

- To determine if the care home has access to dental treatment
- To determine if the care home has an oral care plan for its residents

- To assess unmet normative dental treatment need for residents of selected homes
- To determine whether treatment is to be provided on a domiciliary basis or if clients can or need to travel to a facility
- To categorise treatment into bandings using the current dental contract

The community dental service provides services for a number of care homes but not all and the care home support team have already identified areas where oral health is impeding other areas of care delivery.

3 Visual impairment

Need report here from Steve Martin.

The Gloucestershire County Association for the Blind has suggested that the quality of life of those in care homes with low vision might be substantially improved by training staff. It is expected that greater awareness of low vision and the products available for people with low vision, might enable care staff to improve daily living skills and quality of life. A small pilot is being conducted to review this in a sample of care homes. The project started in mid February 2009 to determine

- Could the quality of life for those with visual impairments in care homes be improved ?
- What is the best way to achieve this
    - The employment of a care home visitor?
    - Improved education of care home staff?

108 questionnaires have been sent out, so far 16 have been returned. Visits will also be conducted to look at the following:

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Communications: use of large print, tape, coloured paper for all printed materials – including care plans; telephones, free BT enquiries services

Assessments: frequency and by whom.

Monitoring: Staff – noticing signs or deteriorating vision in residents

Reporting back procedures

Staff visual awareness: As with monitoring – awareness of difficulties visual impairment causes.

Training: Any visual awareness and guiding training – providers.

Activities: choice and are they specialised for visual impairment

Premises: Contrasts in colour, lighting, equipment, décor, furnishings, outdoor spaces.

The study will be looking for results that will identify:

Good practice

Awareness of visual impairment

Training needs

Activities – or lack of them -

Other help and advice requested by care homes, eg for training (2 requests have come with returned questionnaires); availability of aids and equipment; assessment of indoor and outdoor spaces.

Possible introduction of a designated specialist in visual impairment for care homes – similar to those available for dementia

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- 5.5 Activities in a care setting

The training workstream was set up to provide training for care home staff to ensure they are skilled to deal with more challenging needs of older people and care of the dying. The areas it was proposed to cover were mental health, challenging behaviours, nutrition, care of the dying, elder abuse and enablement

1 The Care Homes workforce

Over 10,000 staff work in Gloucestershire's 174 Older People's Care Homes. Of these homes, 73 are nursing homes, employing over 400 RN's, 66 are residential care homes. 34 are registered dementia care providers. Staff turnover averages 19% and less than 25% of staff in residential homes are qualified to NVQ level 2. Statutory and regulatory training requirements are monitored by CSCI and supported with funding and training provision by Gloucestershire County Council via Gloucestershire's Care Sector Workforce Development Group (GCSWDG) on which the independent sector is represented.

2 Introduction

Since May 2007 the POPP training workstream has developed and funded a large and varied training programme for staff of all grades working in Gloucestershire's care homes. This builds upon the training provided through the GCSWDG. The POPP training programme is unique in that it provides care homes with a 'one stop shop' for staff to access training in clinical and care management subjects, social / personal care, and both basic and enhanced skills required to provide 'hotel style' services for older people, such as cooks training and food safety. At the start of the programme four main areas of need were identified from national priorities and local research:

- dementia
- nutrition
- end of life care
- enablement

It soon became apparent through feedback from managers, district nurses and the CHST that a further area of training needed to be addressed - clinical skills. Added to this was the recognition of the importance of training in “The Provision of Activities in a Care Setting”, to support the work of the outreach workstream (Section 3). All areas, with the exception of enablement, have been developed, delivered and evaluated, with excellent uptake and feedback. Enablement training has not been provided during the project due to changes in the original project plans for new pathways (see section 6) within care homes and subsequent resource issues within the training workstream. However, all training has been based on person centred approaches which promote enablement principles and a guide for care homes managers is being developed which aligns POPP training with the Personalisation agenda

3 Activity

POPP training examined ways of working closely with care home owners/managers to explore how a sustainable and resourced 'learning culture' could be developed within the care homes. As well as provision of training courses, we have developed, integrated and promoted the use of local learning resources, e-learning, bite size training, learning exchange groups, and train the trainer models as part of a blended learning approach. Training needs were identified and commissioned over and above training that was already on offer from other sources. However, invariably some courses such as the Provision of Activities in a Care Setting Course (PACS), Cooks Training and CIEH Level 2 in Food Safety overlapped with courses already offered through the Glos Care Sector Workforce Development Group (GCSWDG). It is important to note this training excludes any training delivered in the care home by the Care Home Support Team, although the 2 workstreams work together to deliver the best approach.

From October 2007 to December 2008, **1437** care home staff accessed training from the POPP training workstream. The detailed breakdown of numbers attending the courses are in Appendix 6. **UPDATED**

3.1 Clinical Skills

These included: early recognition of the sick & deteriorating resident, catheterisation skills, venepuncture, gastrostomy, faecal incontinence, syringe driver training, diabetes awareness, leg ulcer management, and stroke awareness. These were mostly attended by registered nurses. Care assistants also accessed early recognition and clinical observation training.

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3.2 End of Life Care

Seminars were accessed by both nurses and care assistants in support of this area, linking to the CHST identification of end of life care coordinators in 20 homes to pilot roll out of PCT pathways. A training and development pathway is being developed and a training post funded to ensure care homes are able to access this approach.

3.3 Nutrition

Training was provided via a foundation cookery course for care home cooks and Accredited CIEH level 2 Award in Food Safety and Accredited level 2 Award in Healthier food and special diets (209). The cooks' training was provided in a specially adapted kitchen in partnership with a local further education provider and proved very popular with 96 people attending.

3.4 Dementia

The workstream developed an innovative training pathway which includes on-site learning resources. To date, dementia e-learning has been accessed by over 100 staff and the regular one day dementia training has been attended by 98 staff. A 3 file learning resource pack was introduced into every care home. The dementia

pathway launch event was attended by 68 care home managers and as part of this work, POPP established the new role of Dementia Link Worker (DLW). To support the DLWs and implementation of the training pathway, the council worked jointly with the mental health trust to recruit two new specialist dementia education nurses. 88 DLWs are now fully trained and a further 52 DLW's are on the pathway. To support the care homes, best practice forums have been established and all DLW's are attending– 75% have attended all sessions and 43% of care homes in Gloucestershire now have a Dementia Link Worker.

3.5 Provision of Activities in a Care Setting

This training was provided in support of the outreach lead in developing the activity co-ordinator role and hence the possibility of interesting care homes more in provision of services to their community. 77 accredited co-ordinators trained and 10 staff trained in Active Ageing in Care Homes

3.6 Learning exchange

As part of this workstream, a number of care homes were supported to develop a learning culture in their own homes through the establishment of Learning Exchange groups, in conjunction with the GCSWDG. This has led to the provision of computers in care homes for staff development which were not generally available prior to POPP, and the greater use of e-learning tools

3.7 Persons in Charge Network

After meeting with a Network Co-ordinator for groups of care homes in Avon and Somerset and discussions with the Gloucestershire Care Sector Workforce Development Group about their plans to create a learning network it was decided that GCPA should promote the creation of network "run by managers for managers" to help engage with care homes and to provide a valuable information resource for care home managers and Persons in Charge.

This group has now held a total of 8 meetings and attracts an average of 40 – 45 managers. Those who attend are enthusiastic supporters of the value of the group and GCPA are committed to continue to organise the bi-monthly meetings after the POPP funding ends. The forum is supported by a dedicated website (which is currently being reshaped as a section with the GCPA website for reasons of economy). It has also proved a valuable aid to partnership working; the most recent meeting (Jan 08) invited the council's lead for older people to attend and gave his team within Adult Care an opportunity to discuss the transforming agenda with care providers.

4 Evaluation and learning

Course evaluation sheets, across the range of training & learning interventions, evidence a high degree of satisfaction and learning. 4.1 details the subsequent impact evaluation which sought to demonstrate whether POPP training has had an effect on working practice. It was undertaken with both staff and care home managers, with a 40% return rate from managers. A separate evaluation of the DLW role has been undertaken and a feedback and consultation session around training provided as part of POPP was held with the Gloucestershire Care Providers Association.

4.1 Impact evaluation

Staff responses evidence greater confidence, ability to challenge poor practice and increased understanding, leading to improved practice in the homes. Most highly valued, from the staff's perspective, were clinical skills, dementia and cooks training. It is apparent reading through the responses that the large majority of care home managers have found the POPP training invaluable, not only in relation to professional development of their staff and thereby the standards of care to their residents but because it has raised the profile of care homes. No directly negative responses were received.

It is important to note, however, there does appear to be a moderately high level of confusion in the evaluations with the care home managers as to who actually provides what training, which is possibly inevitable, given the high level of activity within the past 2 years. Managers seem to have credited POPP training with providing all dementia training and MCA and DOLs training which are actually run through the normal council training routes. There also appears to be a little confusion between the in-house training from the CHST and the generic / usually off-site training which has been commissioned by the Training workstream.

Themes arising from manager's comments:

"POPP training must continue- it will be a great shame if the training stops"

There were a number of key themes that could be discerned from the comments made by managers:

Access

Many comments related to the improved access care homes now had to training. Some suggested that the funding of training by POPP had substantially increased access, others pointed out the fact that POPP had enabled access to training previously unavailable such as clinical skills training. One commented "staff are more informed and training is more accessible". Another: "you know where to go to get the best training. Homes do not have to source training providers themselves". Small care homes, of whom there are several in Gloucestershire, felt they had benefited: " An opportunity for staff of small care homes (who can feel quite isolated) to meet training requirements, develop practices and become updated with new practices"

Staff morale and development

Managers felt they had seen an impact on their staff: "Staff are enthusiastic about training and growing in confidence and staff morale is much higher". The managers felt their work was more valued as a result and described a "sense of

care homes and staff now being recognised as professionals". Confidence of staff appeared to have improved "staff feel more confident to suggest things and initiate change" and "POPP training has allowed staff to venture out of the workplace and mix with other carers".

Quality of Care, Standards and performance

Clearly the objective in much of this is to deliver improved performance and we have tried to measure that impact elsewhere in our evaluation. In this survey, care home managers felt that standards had improved "a higher standard of care is being given in the care homes". This was also due to the resources provided "standardised best practice and resources have been made available – very helpful".

The managers pointed to improvements in skill levels around dementia care, nutrition and end of life care with managers able to "change attitudes, empower staff and thereby develop skills". "Cook's training has allowed food quality to improve….and has allowed care home cooks to be acknowledged".

A few comments related to impacts on the health and social care system as a whole as a result of this training in care homes: "(there is) less need to bring in outside agencies e.g. District nurses or practice nurses and GPs". Staff are more confident in caring for residents with Dementia. The training has allowed homes to register for beds for dementia care or to have more residents with dementia.

Constructive Criticism

Managers also offered some constructive criticism, which included:

- Not enough training sessions have been held in the Cotswold area
- Major problem with staff training remains the cost of back fill.

- Although attitudes of staff have changed in that they now see training as positive and would like to access, training managers can find it difficult to release them due to staff numbers.
- Training should be in the evening thereby allowing more staff to access sessions.
- Course on care planning for RNs needed. (the CHST carry out one to one training on care planning)
- Training for managers needed

For further detail, see Appendix 7.

4.2 Evaluation of Dementia Link Workers (DLW) development

The development of the DLW role is a critical component of the training pathway to ensure sustainable and embedded dementia learning. Increasing their confidence and competence is key to this and has been prioritised by the dementia education nurses.

There is an excellent take up of this new role and increased skills, knowledge and confidence as reported by the DLWs and the Dementia Education nurses. The high take up and continued attendance at the DLW best practice forums evidences a high degree of satisfaction and also that training alone is insufficient to bring about sustainable improvement in delivering quality dementia care. This evidence supports our original planning that there had to be on-site and in-reach support to ensure new learning was translated into improved person centred dementia care. We need to continue the specialist support roles in order to support the DLW's as they complete the pathway and begin supporting the training and development of colleagues in the home. Additionally, the model needs to be extended to all care homes.

"I have learnt how to use my knowledge to provide support and empathy to residents with dementia"

Being in a group to talk freely without being judged, building up my confidence"…..comments from DLW's

"Because I have more of an understanding of how dementia affects the brain, I am more aware of why residents express their needs through the behaviours that challenge"

There is a wide variation in care homes' approaches to person-centred dementia care with varying levels of commitment and support from senior care homes staff. Protected learning time for DLW's and other staff is recommended but not always available. The three file resource pack has proved a hugely valuable resource as it maintains an up to date record of staff's competency achievement to national standards via the progress logs; it assures standardised and quality assured learning resources are accessed in a variety of formats (Powerpoint presentations, workbooks, e-learning, research evidence) and it guides staff and DLW's through the staged pathway, facilitating a train the trainer model to cascade dementia awareness

Tools are being used to assess the staff's perception about their knowledge of dementia, their understanding of behaviour management, their leadership skills in the delivery of clinical care and confidence. This is done before and after their involvement in best practice forums. The team is also measuring the usage of the 3 file resource pack in support of their work. Case studies are also being collected. An example is given below:

"Recently I received a referral from the GP about a resident in a nursing home who was non compliant with medication and had behaviours that challenge.

Upon my arrival to the care home, I spoke with the nurse in charge who was also the dementia link worker. The nurse told me that whilst she had been waiting for the referral to be processed from primary to secondary care services. She had used the knowledge she had gained from the best practice forums and initiated the use of an ABC chart. The chart identifies potential triggers for a person responding to a particular situation or at a certain time.

Once the care home staff had identified the causes of the residents challenging, behaviours they were able to put together a care plan to support the residents mental health needs.

> The dementia link worker told me that her increased knowledge gained through the forums had increased her confidence to explore situations and behaviours arising from residents with a dementia.

The resident has now been accepting medication for a few days and this had increased her well-being. This only required one further follow-up visit from the CHST nurse to make sure that the care plan was successful and that staff were unilaterally using it."

4.3 Feedback from Gloucestershire Care Providers Association (GCPA)

At a formal consultation meeting on sustainability, GCPA reported very positive feedback on POPP training, with the following specific comments:

- The single point of access is key and an excellent service is provided by the post holder
- It is very important that the Registered Nurses in care homes access clinical skills training and engage with district nurses

- Inclusion of all levels of staff very important – valuing whole workforce in a care home
- The dementia training pathway is excellent
- Nutrition and end of life care training are so important and need to be rolled out / developed into a pathway along the lines of dementia
- GCPA will ask members to audit impact of training on staff turnover
- Learning Exchange and Persons In Charge networks currently need to stay separate as they are meeting different needs but some joint working / crossover is evident and there is a possibility of joining up in future. This should be reviewed in six months
- Recommend charging an administration fee for training rather than keeping it fully funded as this will enable the budget to go further and ensure providers value training
- DLWs support from the specialist dementia education nurses is "inspirational" – making a real difference to quality dementia care

4.4 CSCI Feedback

Local CSCI inspectors, in a feedback session, suggested that they had noticed a "huge" improvement in some homes as a result of the training they had accessed. They had particularly noticed an impact from both the cooks' training and the activity coordinators' training. They had heard from staff undertaking the link worker roles, that they felt empowered to be able to come back into the home and cascade training and knowledge. They also felt the Persons in Charge Network was a good development.

4.5 Early lessons learnt by POPP Training workstream

- Care homes are busy; on a typical day they may only have one opportunity (5 minutes) with which to book training; they do not have time to navigate the system

- Care homes need training to be easily accessible and within a bus ride or short drive of the business premises. Half days are popular
- POPP has provided a one stop shop where care homes telephone or e-mail their training needs and in most cases get an immediate booking confirmation which works well and is appreciated
- Care homes are keen to develop their IT capacity for e-learning, local learning resources and supported train the trainer models.

4.6 Generic outcomes

- Significant improvement in uptake and attendance on training courses, leading to increased knowledge, skills and confidence
- Greater skills base in nursing homes, creating enhanced nursing capacity for future commissioning
- Increased understanding within sector of relationship between training, best practice, quality of life for older people, staff morale, recruitment and retention, and compliance with CSCI requirements
- Excellent partnership working
- Nationally recognised best practice dementia training pathway
- Joint development of learning culture, more self sufficiency in meeting staff development needs

5 SUSTAINABILITY

A training sustainability plan is being consulted on to agree what needs to be sustained when the POPP project ends in April, how much can be used to support other sectors e.g. domiciliary care and how it could be resourced. The case to support a sustainability plan for POPP training is based on the following evidence:

- Workforce analysis, with particular regard to the size of the workforce, staff turnover and current knowledge, skills and competencies
- Local Commissioning strategies for Older People, particularly Dementia, Stroke, and End of Life Care
- The Personalisation agenda
- Stakeholder consultation
- Huge uptake and continued demand from staff and managers
- Training impact evaluation
- Correlation between workforce skills and CSCI star ratings
- Anecdotal and case study evidence of quality of life improvements and economic indicators regarding a reduction in referrals to NHS

The plan needs to be agreed as part of the wider workforce strategy and commissioners' advice is being sought on balancing priorities in line with commissioning needs across the breadth of care provision. We may want to target 'poorer' performing care homes and will need to agree the responsibility of care providers to financially contribute to this plan as well as the availability of commissioning resources, and split between GCC and PCT responsibilities. Monitoring and evaluation will need to be agreed

5.1 Clinical Skills

Historically nurses working in care homes have experienced funding and access difficulties when attempting to secure clinical skills training and updates for best practice and their PREP requirement. This problem was temporarily overcome by POPP funding to commission additional courses, bespoke courses and obtain placements on existing courses from the PCT, GHFNHST and other training providers. The courses were fully funded by POPP and made more accessible by being held around the county: Gloucester, Cheltenham, Forest of Dean, Cotswolds and Stroud. The uptake for clinical skills training was such that courses often exceeded the course quota - invariably leading to long waiting lists.

Increasingly care workers require clinical skills to support residents and the availability of training in this area is key. The PCT has agreed to include care home nurses in the clinical skills training offered to NHS nurses through the clinical skills training team. Additionally the PCT is working with the Council's training team to sustain clinical / specialist training for care staff. Currently there are capacity problems for all clinical skills training

5.2 Dementia

The centralised training will continue to be commissioned by the GCSWDG but the workstream is still currently seeking funding for the posts that have been used to develop the Dementia Link Workers and the delivery of the 3 file resources. Funding for 50% of this resource is available through the County Council. This is absolutely in line with the Dementia Care Strategy proposals and the support of the PCT is expected.

5.3 End of Life Care

The PCT are developing this area (see Section 1). It is expected that this will be done in partnership and use a similar approach to the development of the Dementia Care Pathway in terms of linking up courses and training materials that can be used across sectors, and aligning with national standards and qualifications

5.4 Nutrition

The training for cooks and in food safety etc will continue to be funded after POPP through the GCSWDG

Activity in a care setting

This training will continue to be provided in support of the project led by the Activity Coordinators' Network Facilitator post.

Led by Gloucestershire Providers' Association

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1 Workstream Objectives

At the start of the project the Outreach Workstream aims and objectives were defined as:

"To develop the capacity and role of Care Homes in order that they are able to provide different types of care and support to a greater number and wider range, of older people and their carers in the community."

2 Activity – new service provision

It is fair to say that we struggled in the early stages of this workstream and underestimated the barriers to achieving our objectives. These barriers to our initial efforts to persuade independent providers to trials of new services were:

- A concern that CSCI would not allow providers to deviate from their mainstream business;
- An issue of management time within the homes;
- Lack of business expertise, experience and interest in the development of new services;
- Some resistance to trying new ideas from both management and care staff;
- In many cases, no real interaction with the local community making it impossible to envisage what services may be relevant or how to structure a new service offering;

Strategies to overcome these barriers included:

- the development of peer networks, capacity and training opportunities to share experiences and to build capacity;

- agreeing with CSCI on a procedure to expressly permit the development of new services;
- offering pump-priming grants of up to £10,000 and the development of the hubs concept.
-

2.1 Building capacity

Networking

From an early stage in the project we identified the provision of activities as an area that not only had a real impact on the quality of life for residents of care homes but real potential as a service offering for non-residents too. To help foster an environment within the county that recognised the importance of this work and provided Activity Co-ordinators with practical support we set out to create a network.

The vision was to create a peer support network to enable Activity Co-ordinators to make best use of all the available resources within the county and to be able to share best practice and practical tips and hints. Mindful that many Activity Co-ordinators reported that it is difficult to attend off-site meetings and events, the workstream established an Activity Co-ordinators' website. The website is intended to be both a resource/information point and a "virtual meeting place" for Activity Co-ordinators. Eventually we hope this will allow activity coordinators to use their expertise to provide for older people in the community as well as for residents. To further support and develop the Activity Co-ordinators' Network we created a partnership based steering group. The membership of this group was representatives of Gloucestershire Care Providers Association; Gloucestershire PCT (Public Health); GCC (Adult Care and Lifelong Learning); and Gloucestershire Care Sector Workforce Development Group.

This steering group has secured post-POPP funding from GCC and GPCT for a full time Activity Co-ordinators' Network Facilitator who took up her post in December 2008. In addition, we used POPP funding to provide 21 Personal Computers with internet access to care homes to enable Activity Co-ordinators to use the Activity Co-ordinators website. By the end of January 2009 160 people had registered as users of the website. The official launch event for the website also attracted 77 delegates who enthusiastically endorsed the concept of a peer network for Activity Co-ordinators to share ideas and best practice.

Beyond the lifetime of this project we would like to see this network extending to include all those involved in organising and/or delivering activities for older people anywhere in our county.   Activity coordinators as a group could then be considered a resource for older people throughout the county.

Training

Our work in this arena should be seen alongside the excellent work of the Training Workstream. POPP has trained 80 Activity Co-ordinators in delivery of activities in a care setting; provided yet more Activity Co-ordinators with a comprehensive training in chair-based exercise and introduced a number of care homes to the concept of e-learning and the wider use of computers as a work tool. These programmes gave us a strong platform upon which to build this networking initiative. On the training front our workstream sought to add to the pool of skills available for activities through two initiatives:-

a) The delivery of reminiscence training to 23 volunteers (many of whom are also care home staff). This training is receiving on-going support from Gloucestershire Archives who have created a peer support network for those who have attended their training and will digitise their collection of memory boxes making them available to view on line via the Activity Co-ordinators website.

b) We also commissioned the charity MindSong to develop and deliver a training course in music as therapy. This trained 10 people who already had competent skills as musicians to be able to deliver music sessions for older people at approximately half the cost of music therapy delivered by a qualified music therapist (a service also offered by MindSong). MindSong will support these practitioners with an on-going network. As part of their efforts to make music more accessible to older people MindSong have also established a musical instrument lending library to be accessed through the main activity co-ordinators website.

Swapping Activity Co-ordinators

We hoped to encourage care homes to see their activity provision as a resource that could benefit older people in the wider community. The number of new service offerings that include activities suggests that we have been successful in this aim. We also hoped that this work with Activity Co-ordinators' environment would encourage them to "swap" their services; creating a money-free mechanism to transfer activity skills for the benefit of residents. This has not yet taken place, but there have been attempts to do. Those that have attempted have also highlighted the barriers to be overcome.

It may seem simply and mutually beneficial for two organisations to exchange their Activity Co-ordinators for a short period so that the respective residents can benefit from working with someone who has different skills and areas of expertise to bring to activities. However, in practice, this raises a range of questions from CRB clearance through to liability insurance and employment contracts.

Faced with these issues there was just one example of swapping during the period of the project (between Marina Court Sheltered Housing and the nearby Tewkesbury Nursing Home). This was not the simple swap that we had envisaged but was resolved directly between the two organisations by the Activity Co-ordinators becoming volunteer helpers at the other location (with associated CRB

clearance). We are indebted to NAPA (the National Association for Providers of Activities for Older People) for their assistance in trying to simplify swapping.

2.2 Outreach services to the community

2.2.1 Small Grants

- Helped 10 care homes develop and trial 14 services for 150 non-residents.
- Encouraged care homes to engage with community hubs and more formal local networks such as virtual teams and locality based health & wellbeing groups.

Details of the outreach services supported by POPP are in Appendix 8 and include:

- A short notice “sitting service” offering a safe and welcoming environment for someone whilst his or her carer attends something such as a doctor’s appointment.
- A drop in café including information service on benefits and services.
- Invitations to non-residents to join activities within the home.
- Offering use of the care homes facilities as a meeting place for a community-based older people’s group.
- Assisted bathing/spa sessions.
- Delivery of cooked meals from the care homes kitchen to the customers own home.
- Involvement in an Age Concern programme to establish a network of bases for the provision of a basic foot care service to older people in the community. Several care homes have been introduced to this

via POPP and are currently working with Age Concern on the development of this scheme.

Inviting non-residents to come in to the home to take part in activities has some part to play in more than 50% of the new service offerings being trialled through POPP.

Small grant business case approach

A cornerstone of the small grant process was the requirement that applications must demonstrate that the new service has been designed and costed to give the best chance that it will develop into a self-sustaining income stream or cost neutral added services. The intention is to secure long-term sustainability by encouraging the creation of a service that made business sense for the care provider. Some applications for small grants were refused on the grounds that the grant would be used to subsidise the cost of the service to such an extent that once the grant was exhausted the service would not be able to continue.

2.2.2 CSCI form for trying out new services

The Addendum to the Statement of Purpose was developed after discussion with the regulator and has created a simple yet valuable solution to a significant potential barrier to care providers reacting flexibility to demand/opportunities for the provision of new services to older people. The form not only clearly defines the new service but also allows any inspector to quickly see that the new service has been developed in consultation with existing residents and with thought applied to any impact on the provision of existing services. The POPP project has received requests from care homes for copies of the Addendum to the Statement of Purpose form for use in other initiatives not connected with this project. These requests have come from word of mouth recommendations via both CSCI inspectors and care home managers – clear evidence of the value of this simple tool.

GCPA will be writing to CSCI at the conclusion of the project to bring to their attention the important role this played in permitting care providers to respond to changes in the market and the needs of their client groups.

2.2.3 Hubs

There are 8 care homes actively engaged with their local communities through POPP hubs and the overlap between small grants to care providers and hub involvement is strong. The most significant barrier to initial engagement with local hubs by care homes is the capacity to release an appropriate member of staff/management to attend hub meetings. In the early stages, with no evidence of benefits to point to, this can depend entirely on the care provider having a key member of staff/management with the necessary vision.

It is probable that the introduction of greater client choice and personalised budgets will make the potential advantages of greater engagement with the local community more apparent. However, the issue of staffing levels within the independent sector and the associated capacity amongst appropriate staff/management members will remain a deterrent to this and other initiatives that are perceived as not central to their business.

3 Evaluation and Learning

3.1 Staff skills and capacity

Our experience throughout this workstream suggests that the key to new ways of working was appropriate human resources; in particular the time to devote to this non-core work and the skills and confidence to develop and execute the plan. Whether the focus is on the structured development of a new service offering or simply building links with the local community, the care homes that have been most active and most successful all share one characteristic: they have one member of staff with the time (often their own time), skills and confidence to take charge of their proposed initiative.

The offer of small grants allowed care homes to allocate some money to project management. This assisted greatly with take up of the grants. Analysis of the development of the services however suggests that in most cases this money did not buy extra management time. We assume that this is because such skills are difficult to purchase to meet such a short-term need. This difficulty within homes to allocate appropriate resources to their scheme is evidenced by the fact that we approved three grant applications that were subsequently not taken up because the care home was unable to proceed and a further one where we had to recall the grant for this reason. The success of the schemes therefore depended on the existing skills within the care home staff and the capacity of a key individual to find the time. In many cases this key individual was the Activity Co-ordinator rather than the Care Home Manager.

One Activity Co-ordinator had already demonstrated her entrepreneurial flair by working on behalf of residents to sell greeting cards they had designed and produced to raise funds for activities. With just a little encouragement from the POPP project and a small grant to help the home buy IT equipment she set about establishing strong links with local faith groups and schools, and opening up activities sessions to non-resident older people. As a result of her successes, the home is now planning a major garden redesign so that next summer they will be able to invite non-residents to come and enjoy their garden and extend the homes ability to offer a range of services to older people in the local area. The activity coordinator had the wholehearted backing of the home's owners but without her these initiatives would probably not have happened as the home had only recently been acquired by the owners and they were entirely focused on the core business and their refurbishment plans.

Even in cases where both the Work Stream Lead and/or the POPP Project staff visited the care home manager and offered direct assistance in setting up the initiative there were still instances of resistance to implement the new service(s)

with a degree of urgency. In one example, despite three visits and numerous follow-up calls, we were unable to proceed for this reason.

3.2 Consulting older people

How to consult older people in the local area was a real issue in the early stages of the project. A number of the care homes that came forward or were approached by us to discuss trialling a new service were clear that the development of a business plan – indeed the decision to invest time in preparing a proposal – depended upon detailed "market research" including reliable indicators on likely demand and costs people thought affordable. In the latter part of the project the Involving Older People Workstream, led by Gloucestershire Older Persons Assembly, had in place a network of Facilitators providing excellent data and with the capacity to respond to requests for market research in specific locations. This has been very useful to care homes.

In our judgement access to this kind of information is important to the development of new services by care homes not just because of the value to the business planning process but also because many care home managers have limited experience of developing a new venture and need as much reassurance as possible. We have learned that the perceived cost of a failed trial is not just financial; it is measured in the potential waste of staff/management time - a resource prized at least as highly as money by most managers.   Consultation need not be formalised or focused to be effective. The greater a care home's interaction with older people in their local community the more likely that care home is to identify and respond to opportunities to offer services to non-residents – as long as the home also feels that they have "permission" to change their service offerings.

3.3 The Addendum to the Statement of Purpose

In every case the Addendum to the Statement of Purpose was used by care homes developing a new service within the project. Care home managers

reported that the form was simple to complete. Its purpose as a means of demonstrating to CSCI Inspectors that the trial had been designed with proper consultation and the interests of the residents at its heart was acknowledged as essential by all parties locally.

3.4 Small grant process

The offer of pump-priming funds to help initiate a pilot service was very useful in encouraging care providers to come forward. Repeatedly these providers struggled to develop their business cases, or business plans or introduce the trial. In our judgement the difficulties they encountered were most commonly due to a lack of management/staff time and/or lack of the necessary skills and confidence to develop and execute a new service.

The indicators that we established to measure the progress in encouraging homes to provide "outreach" services were revised downwards early on from the bid, as it became apparent that we were unlikely to make the progress we would like. It is the revised targets to which we refer here.

- Number of new services offered by care homes directly as a result of POPP. Our target was 12 new services and 14 have been developed.
- New services offered by care homes directly as a result of POPP - number of care homes taking them up. Our target was to work with 35 homes but 10 have set up services. These are, however, in a wide range of areas and in different types of homes which should provide sufficient lessons learned to influence any future agenda
- Number of people benefiting from an outreach service from a care home. Our target was 400 and services were delivered to 150 people. Services only began in July 08 as a result of the early difficulties encountered in persuading homes to experiment with new service provision.

Our strategies have had some success but it has taken time to change the prevailing environment. As the project draws towards the close, we find ourselves in the frustrating position of refusing applications for grants on the grounds that the schemes will not be able to demonstrate any meaningful results before the end of the project.

Most of the homes that have trialled new services for non-residents have as a result built up far stronger links with their local communities – including voluntary groups, churches/faith groups, and local schools. In almost all cases these new links have had a positive impact on the lives of residents as well as on the home's ability to offer services and support to non-residents. One Activity Co-ordinator told us "From our perspective things have really changed - we had the local junior school in just before Christmas and they are keen to really build an ongoing relationship with us which is tremendous. We did some work with the local college's beauty students and that was a joy"

By inviting older people from the nearby villages to join them, one care home in the Forest of Dean has been able to bring together sufficient participants to make a viable group for a T'ai Chi instructor. They now host regular T'ai Chi sessions and the people who take part report improvements in mobility, balance and confidence as well as saying that they are having fun.

"My husband definitely benefits from the exercise sessions and I like the fact that if I am visiting I can join in – but that, if I'm not there he will get the session anyway. The Tai- Chi approach helps him with his brain /hand coordination – as he has Parkinson." (Wife of resident.)

As with all the homes offering new services to non-residents, the home is finding that this interaction with the local community is also helping change peoples attitudes towards residential care homes

“I was a bit reluctant to come to the T’ai Chi at first – I wondered how it would be – having the sessions in a nursing home – but I love it. I do my own exercises but also have the chance to help out with some of the residents – helping some of them who have strokes to move their poorly side a bit which makes it feel worthwhile”. (Non-resident T’ai Chi participant)

Another care home identified an initial attitude between clients and local people almost of suspicion. An “active ageing” session organised by the care home, broke down these barriers. The session was described by the care home organiser as “fun and vibrant”. The session was followed by afternoon tea and music and visitors lingered and mingled with the clients. The care home will now use these sessions to offer falls prevention screening and advice service, the podiatry service and other areas as villagers identify their needs. The organiser said: ”I feel it will become a drop in centre for older people”.

One care home has been trying to break down barriers with the local Black and minority ethnic community. Progress has been slow. Meetings with local communities, facilitated by GOPA and community organisations, and supported by local fieldworkers, identified a problem with some Asian communities feeling that accessing care for older relatives was an acceptable alternative to looking after them within the family. The care home has an ethnically diverse staff, is able to offer a variety of languages, appropriate food and activities. The barriers are slowly being broken down by individual introductions and recommendations, as well as visits to the homes by the community leaders, families and groups such as church groups. It is felt that 1-1 introductions and recommendations are most likely to succeed.

4 Sustainability

As a result of the success of this website additional funding has been secured for the creation of the post of Activity Co-ordinator Network Facilitator. The programme has been extended to include other initiatives and as originally

envisaged is being extended to include those involved in delivering activities for older people in a community setting. The partnership based steering group behind the role is also a positive step forward and has already helped the partners better understand the resources available within care homes .

4.1 Activity Co-ordinator Network

As a result of the success of this website additional funding has been secured for the creation of the post of Activity Co-ordinator Network Facilitator. The programme has been extended to include other initiatives and as originally envisaged is being extended to include those involved in delivering activities for older people in a community setting. The partnership based steering group behind the role is also a positive step forward and has already helped the partners better understand the resources available within care homes

4.2 Networks and developing role/profile of care homes

At the start of the project the Outreach Workstream held a series of 4 open meetings to consult with care homes: the Tewkesbury/Forest of Dean meeting was cancelled because there were no acceptances and in Cirencester the "no shows" were such that there were only 2 care homes represented. Today, the POPP funded Managers/Person in Charge Network now routinely gets 40 – 45 attendees (they meet every alternate month). This together with POPP's numerous investments in Activity Co-ordinators plus the general "atmosphere" generated from working with the Care Home Support Team, from participating in the additional training POPP has delivered and from simply hearing about the various initiatives surrounding POPP have helped to break down barriers. Care home managers and staff now have more positive evidence that it is worthwhile investing time in networking. One clear message from the project is how scarce a resource time is within the typical care home. One should not underestimate the significance of this barrier to participation in activities beyond the care home's own front gates.

It has taken a long time to achieve this change in outlook but there has been a measurable change. We now have an independent sector far more receptive to new ideas, ready to work with others, and that increasingly believes that they are seen by the statutory agencies as an integral part of the health and social care community. To maintain the networking momentum a meeting was be held in early March of all those care providers involved in hubs or in the small grants programme. This meeting is designed to share experiences and ideas and encourage individuals to establish personal contact with like-minded colleagues. GOPA have established a consultative network and an advocacy service, both of which are recognised by GCPA. The advocacy service is scheduled to attend a future GCPA meeting to discuss how they may work with care providers and their clients. We are hopeful that GCPA's members will recognise the value in the information available from the GOPA network and the business advantages that may be derived from reviewing this on-going consultation with older people. All of the hubs that have been created through this project have now established a local steering group (or invited the care home(s) to join the existing one). We are hopeful that these organisations will be self-sustaining and that the care homes will continue to be active within them.

The development of new services has also encouraged some of the care homes to seek to create links with local volunteers or strengthen existing links. In most cases these connections appear to work well and we would expect them to continue; for example one care now works with a group of around 20 volunteers from a local community based organisation.

4.3 Small grants

A central criterion applied to the award of a grant was the long-term viability. Therefore, we are hopeful that the majority of these will continue. From the outset we encouraged care providers to look at these pilots as the trialling of a new income stream – and to cost and charge for the service accordingly. Take up of the services offered has varied from home to home. Accessibility and particularly transport issues would seem to be a recurring issue in the cases where demand

has been below expectations. In some of these instances (e.g. the meals delivery service in Stroud) take up has been disappointing low. These services look unlikely to continue. However they are in a minority.

One learning point from this is the need to ensure that social workers and other health and social care professional are made aware of the provision of new services. Similarly, those homes or hubs who have successfully engaged with GPs have found that GPs surgeries are willing to signpost new service provision.

Advertising of services with the project has most often been by leaflet and/or poster in support of word of mouth promotion via health and social care professional and community leaders. Evaluation of the advertising suggests that there is resistance to advertising that directly or indirectly invites the prospective service user to think of themselves as an “older person”. We have no measurable data on advertising effectiveness but feel that there targeting carers, relatives and those working with older people is often the more effective route. All the care homes that reported increased interaction with their local community also reported that by the end of the project take up of their services by non-residents (including established services that the home has been offering for some time) had increased.

“As more people from the community join in with the care home activities there seems to be less anxiety for respite care should the community need it.” Care Home Manager

“From the business side there has not been a big impact financially (from the new services) but a much bigger impact with the village and the promotion of the care home itself.” Care Home Owner/Manager.

Workstream Lead Gloucestershire Older Persons Assembly

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3 Sustainability

The purpose of this workstream was to involve older people in the evaluation, planning and inspection of services. The key areas for this were thought to be consultation and planning, communication and gathering local intelligence. Older people were to be involved in the evaluation and inspection of services and to form a champions' network.

1 Activities

This workstream was led by Gloucestershire Older Persons' Assembly (GOPA). GOPA undertook a consultation with older people to support the bid. This told us that older people wanted:

- To see better training for care assistants in care homes
- To see better publicity for care homes
- To see more services provided in the community and "convalescence" services without the connotation of a "care home"

This consultation helped to set the framework for the POPP workstreams.

GOPA then became a partner in Gloucestershire POPP with a remit to engage older people in all areas of the project.

1.1 Governance and leadership

The GOPA Chair is a member of the POPP Project Management Board and leads the Involving Older People (IOP) workstream. IOP Workstream meetings have been held regularly throughout the project, bringing together representatives of local statutory and voluntary agencies, with older people, to guide developments. The GOPA committee has acted as a sounding board for much of POPP development as the members represent every locality in the county geographically and seldom heard groups such as those with sensory impairments and Black and Minority Ethnic Groups. Not all BME communities are represented

on the committee but there has been a commitment to gathering their views in other ways. For example GOPA directly supported three workshops which invited older persons' groups from BME communities to meet together and discuss what services they would like to see provided in their area. Committee members have promoted POPP in their communities and supported the strategic direction of older people's involvement. Two of the POPP Hubs are led by GOPA Committee members with a responsibility for managing programmes of activities and the associated budgets. '*I feel that we have been well-placed to take this lead because we are independent of the commissioners and providers and we know from local experience what is needed.* (GOPA member).

1.2 Consultation and involvement in support of POPP

1.2.1 Guide to Good Practice

Early on within POPP, the IOP workstream produced a Guide to Good Practice for consultation with older people which has been used in facilitation of further sessions as part of POPP. The basic principle of the guide was that a variety of methods should be used to engage with older people, reaching out to them in the homes and communities.

1.2.2 Facilitators

Eleven facilitators, themselves older people, have been trained to work with older peoples' groups to gain their views in support of the development of POPP Projects. Questions asked have related largely to the development of activities in support of independence, health and well-being. The need for facilitators was not identified initially in the Project Implementation Document but became clear as some of the other outreach projects within POPP struggled without direct feedback from older people.

GOPA significantly expanded its capacity through the volunteer workforce and started to deliver to the agreed targets for consultation in the second year (April

2008) when additional core funding was supplied from the POPP under spend to manage the delivery of this work.

By mid-March 2009, volunteer facilitators had visited around 60 older persons' groups across the county, bringing in well over 1200 responses. Facilitators visited some of the 26 library clubs for the housebound, and they discovered the extent to which these were appreciated by participants; indeed for many this was their only outing and/or point of social interaction with other people. For some older people the only outing is a trip to the hospital! Information events are being held around the county on a regular basis, organised by networks of organisations for older people, these serve as an additional method for the facilitators to gather views about local services. Parish newsletters have been very useful for reaching people in their own homes with information, but do not generate as much feedback as face-to-face discussion.

1.2.3 Examples of consultation

Feedback that has directly informed work within POPP includes the provision of assisted bathing, expansion of foot care in partnership with a care home, support to understand the activities that older people would be interested in seeing at specific care homes, supporting hubs to identify groups of older people with whom they can link - the information from consultation is fed via the database to local hubs within POPP helping potentially to inform the work of neighbourhood projects as well as care homes. The database information is also shared with our project partners at Gloucestershire Care Providers Association (GCPA) for circulation directly to care home managers.

The facilitators also gathered views about people's perceptions of care homes and local provision.

There is also potential for such work to uncover negatives e.g. about a poorly perceived local care home and it is not immediately clear how this can be dealt with. The new powers and remit of Gloucestershire LINk could perhaps benefit from this kind of local knowledge.

Whilst concerns over transport and foot care came up in all areas, closely followed by loss of facilities such as post office, bank, shops, NHS dentists, there were also positive comments about services that older people valued, such as gardening/domestic help, and the companionship provided by their social clubs. Some older people had concerns that were specific to prevailing conditions in their area, e.g. support during and after flooding episodes in Tewkesbury and basic shopping during times of heavy snow.

In a group setting, older people would, understandably, sometimes be reluctant to raise intimate concerns such as problems with bathing, but these comments were often later conveyed privately or by post, on the anonymous questionnaire left by facilitators for people to complete at their leisure. Interestingly, one respondent from a Cheltenham group had been told (incorrectly) by a local care home that they were unable to offer her bathing facilities because of insurance restrictions. This has since been taken up by the Gloucestershire Care Home Providers' Association and may, hopefully, lead to improved services to the local community.

Many older people were seeking increased opportunities for outings and leisure activities, with the emphasis on these being provided during daylight hours, as local as possible, with transport provided. Respondents were also seeking further learning opportunities, especially important in the light of recent government reductions in adult learning funding. One person from the Forest of Dean "would like computer lessons at a reasonable cost", indicating that they are happy to pay something towards the costs. This has been confirmed by older people in the Cotswolds, and one local Hub is proposing to set up Silver Surfers Clubs in two care homes, for residents and people living in the community. This also discounted a fairly common assumption that there was no demand from older people for access to IT and training in internet and email access.

Another common theme across all districts was the need for one single point of information where older people could find out what services, facilities and

entitlements were available to them. The Village Agents are highly valued amongst the communities they serve. Areas such as Stroud District and Cotswolds, which have the People For You schemes, were making a difference in this regard. An unlikely request, and a sign of the times, from a group in Cam was extra provision for Day Nurseries (to relieve pressure on grandparents with childcare responsibilities)! In Stroud there appeared to be an issue with lack of privacy at the reception of local GP surgeries and/or difficulties using the automated systems.

1.3 Database and newsletters

From the beginning of POPP, GOPA used its database of contacts to inform older people's groups about its activities. This database has been expanded under POPP and GOPA's network of members and organisations has increased by over 250% during the lifecycle of the project. Many of the new members are organisers of older people's groups, increasing access to information and help for more elderly frail people. An additional database was created for recording the views gathered by facilitators. The initial feedback from the tear-off slips used with the POPP leaflets was also collated and included in this database. It records the various services/needs that older people felt they needed in their respective areas, and was recorded by locality. This local intelligence was then distributed to workstream leads and, when Hubs and Small Grants were instigated, to those supporting these new initiatives. GOPA's Newsletter, sent out three times a year, has included information about POPP developments, resulting in more involvement of older people and participation in activities. Their website was relaunched in May 2008 with more opportunities to publicise POPP and GOPA's contribution to the Project. In addition surfers were able to make use of 'links to other websites' to learn more of the Project.

1.4 Care homes consultation

As part of the business cases for small grants, POPP has required care homes to consult with their residents over any changes. This has also been part of the form

used by care homes to inform CSCI inspectors of the new services they are piloting under POPP and give assurance as to the impact of those services. We estimate that care homes have spoken to approximately 330 residents to support their application for small grants.

1.5 Other workstreams

It is probably true to say that other workstreams have not always sufficiently involved older people. The six workstream leads have met together regularly to discuss interaction between them, and the Outreach workstream has taken most advantage of this. There is potential for these areas of work to consider this more in the future and it is part of the agenda in taking forward work around the quality commissioning framework for care homes.

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1.6 Delivery of services in support of POPP

1.6.1 Hubs

Older people have been involved to varying degrees in hubs. In some areas they have taken the lead, running the activities and managing the budgets. In others, where the neighbourhood project is already established, they have supported the work with feedback information from older people in the area.

The GL11 Hub brings together local agencies and the GPs. They have concentrated on an early-stage dementia project, recruiting older people as volunteer interviewers, and their feedback has enhanced the care given by the local agencies.

1.6.2 Advocacy

In the second year of POPP funding was provided to extend the existing GOPA advocacy scheme to include care home residents with an increase in the number of trained advocates.

Seven new volunteers were recruited and trained. The advocacy scheme developed links with 12 care homes in 2008 and handled 17 individual cases for care home residents.

The work of the advocacy service has largely been about trying to establish a model that works with care homes. The approaches tried were allocating an advocate to a care home to build up longer-term relationships or taking referrals for particular issues. Neither of these generated great numbers of referrals but time is needed to develop confidence in the service, particularly as care homes might anticipate feeling threatened by the issues raised. The Advocacy Co-ordinator has held advocacy awareness sessions in some care homes, which have produced very positive responses and should in the future generate more referrals. Towards the end of the project the number of enquiries from care homes had risen substantially compared to figures collated before the project began. Although the number of cases seems small, at 17, it should be noted that some of these cases involved substantial amounts of work for the volunteers concerned, over many months, and the advocacy service was working at full capacity throughout the project.

1.7 Evaluation of POPP interventions

As part of its delivery of our independent evaluation, UWE has employed and trained volunteer community researchers, all of whom are older people themselves. Their role and the outcomes of their work will be further described within the independent evaluation.

1.8 Development of forums and more sustainable forms of engagement for the future

The work done through POPP highlighted some of the limitations of the existing capacity for involvement of older people in the county. It became clear that issues such as the geography of urban/rural differences and local transport difficulties meant that the workstream needed improved mechanisms for increasing the

depth of engagement and participation. As a result, POPP funded GOPA to appoint a Forum Co-ordinator in April 2008, to work with Help the Aged and existing networks and groups within Gloucestershire to set up older people's forums in district, borough and city council areas. To date three older persons' forums have started work (Stroud, Cotswolds, Forest of Dean), one is launching in March (Tewkesbury) and discussions are underway in Gloucester and Cheltenham. These forums will be independent, and will aim to respond to requests for consultation from local authorities and engage local older people in setting agendas for change

2 Evaluation and learning

At an event to review and celebrate the involvement of older people, discussion groups considered what had been good about the POPP project, what had been learnt and what should be continued. (The comments in italics are direct quotes).

There was an emphasis on continuing quality services, and ensuring that enough time is given to development of these:

A permanency of POPP type work with a quality input/assessment.

The publishing of 'good practice'.

All projects need time to get established, to build trust and to develop.

More time was needed, to make a real difference.

Care homes

The changes in the care homes were seen as very beneficial, particularly with residents and older people from the community mixing together and sharing activities.

Good involvement of care home residents in community life and community clubs.

Further encouragement is needed for older people to interact with care homes.

Create befriending, especially for care homes.

The strengthening of Activities Co-ordinators, through networking and the new website, has led to

The breaking down of barriers and changing perceptions

Services

With regard to services, people were asking for the developments in footcare services to be continued, better planning for discharging hospital patients, expansion of community transport, as well as:

More understanding of dementia by families and care staff.

Information regarding support, transport, costs of care and knowing what is available, all of which needs to be communicated to people.

The need to treat everyone as an individual – choice, not prescribed services.

Local responses to local needs

The Forums and Hubs were seen to be important developments in enabling older people to have a say in the planning and delivery of local services and there was a strong feeling about support for their continuation:

Hubs are important and need to continue.

Forums need to be local but work together.

Ongoing support for local organisations because local knowledge is Key, which enables the response to be locally focused.

Ongoing support, particularly as we are in a 'contract culture'; big is not necessarily best.

Keep it local, but coordinate across the County - information exchange.

Each area is different – one size does not fit all and some areas need more support than others.

The need to reach out to older people who are house bound or not with OP groups and to other cultures.

Inspired, the use of schools, care homes and local history society.

Involvement of older people

There was an acknowledged value in older people taking on roles that support others in having a say in the care homes and in the community:

Older people having trained roles and being valued.

We have trained groups of researchers, we should use them.

People enjoyed being volunteers and it is important for rural areas and communities.

There is a greater need for volunteers and the management of them.

Asking empowering questions can expand possibilities rather reduce them.

Making sure older people are speaking and that we are not talking on their behalf is the right thing to do.

Older people need a voice outside of statutory bodies.

Older people do want to give their views.

Partnership working

This was seen to have been a real achievement, with agencies co-operating at county and local level:

Barriers can be broken down; however this can only be achieved by people and organisations working together.

Partnership working is the key as it prevents duplication and we have never had a group based on age before.

You can do a lot with limited resources, providing you have good partners and goodwill.

Gloucestershire Older Persons' Assembly (GOPA)

It will be a real loss if GOPA's input/work is lost through a lack of funding; it could be interpreted that Statutory Bodies do not see GOPA as an equal partner.

GOPA has something to offer. It fills a void for older people.

Advocacy, GOPA, Community Partnerships – all important to older people.

2.1 Capacity

The work in involving older people with POPP was not exclusively the work of GOPA; however, this organisation provided the leadership for the workstream Involving Older People and on the Project Board. The POPP project learned early on that, in order to enable GOPA to take a full part in the project and fulfil the demanding brief, time needed to be given in support. GOPA had to increase capacity rapidly to cope with the demands of the project, and the added support of the project officer from POPP enabled this to happen. It is important to recognise that smaller partners may not have the capacity to rapidly respond within Project timetables and it is sensible to support them to do this.

Since its inception in 2000 GOPA has not had core funding for engagement with older people across the county and this has meant that the funding for any project has also to cover core costs. This then limited its capacity to deliver on specific projects. POPP enabled GOPA to develop their back office functions and support new areas of work with specialist staff. In the longer term this had the added benefit of bringing in more volunteers and better support for them, which had a further positive effect in terms of capacity to deliver.

2.2 Involvement from the beginning

There have been benefits in having GOPA as a partner right from the start of the project. They have been partners in developing clarity as to how best to involve older people in developing the project. The nature of the project (i.e. piloting new approaches, partnerships and ways of working) has meant it is not always clear from the outset as to how older people can best play a part. GOPA's presence on

the initial consultation, the project board and in shaping the direction of project plans has been very valuable and enabled rapid adjustments to changes in direction where required.

GOPA quickly established a Workstream Advisory Group which met regularly throughout the project time, but attendance fluctuated as representatives from other organisations had their own priorities. There may be disadvantages in the approach taken by the project in having one older persons' organisation leading this workstream which meant that some of the other such organisations did not then choose to participate.

2.3 Approaches to consultation

The Involving Older People workstream has demonstrated that older people have a number of skills to contribute. The involvement has been at all levels and in service delivery as well as consultation. When older people are recruited carefully, given a clear brief and provided with appropriate training and support, they are willing and able to take up a number of roles.

GOPA invested in a range of methods to involve older people. The use of facilitators enabled the project to reach out to people in the community, and speaking to small groups was the best way to create an atmosphere conducive for conversations and to encourage feedback.

One could think, simplistically, that two age groups are being communicated with, one between 55 and 75. This age group is apt to be more mobile (both physically and with access to a vehicle) thus allowing them more time to respond, and more able to respond, and are a more balanced mix of male to female. Those over 75 can be less able physically, and there are more barriers for this age group to manage, which means they need more support and time, and they are also more likely to be predominantly female.

Access issues were significant factors: transport and relief care needed to be made available, and the arrangements for meetings had to take account of hearing loss, vision impairment and different languages. Most older people's groups plan their programmes far ahead and frequently the facilitators were only given a short slot to speak. The process of arranging meetings with groups was consequently more time consuming than originally expected.

There was a commitment to feeding back to groups the outcomes of their discussions, but there was not enough time to develop this as a regular dialogue and information exchange. The GOPA Newsletter and website are possibilities for maintaining contact with groups and the Forums, and parish newspapers reach out to the whole population.

2.4 Project requirements

The POPP project was not necessarily as clear as it could have been as to the brief for involving older people and, in future, a clearer specification for the work to be carried out might help organisations such as GOPA better understand the resource requirements. Initial workstream action plans overlapped, with a short lead-in time, resulting in pressure on GOPA to provide feedback from older people ahead of its own growth in capacity. This was further hindered by the loss of GNPN, which had the brief to recruit volunteers.

2.5 Care homes and older people

The care homes were mostly very good at consulting with their own residents regarding new activities. There was, for some, a certain amount of nervousness when it came to involving older people outside the care home in a variety of areas such as advocacy and community researchers. The perception could be that this was another form of inspection.

Similarly there was difficulty in getting the Outreach workstream off the ground and encouraging care homes to consider catering for those older people in the community. There are some notable successes but not in the numbers predicted and so the barriers identified in the initial consultation prior to the project still appear to exist in some areas (i.e. older people have a negative perception of care homes and some care homes do not see any need to interact more with the community).

Some care homes, in early meetings, initially rejected the idea that they could provide outreach services on the grounds that older people would want them for free and services such as IT were not suitable for older people. These misconceptions can only be dealt with by talking to the older people themselves and if care homes wish to provide outreach services in the future, they will need to continue this approach.

The title of Gloucestershire POPP - 'Care Homes – part of our community' sometimes made it difficult to involve older people, many of whom were keen to ignore the issues around care homes until such time as they needed them as they did not want to be associated with those whom they considered to be much older than them. In some cases this amounted to what can only be described as hostility to sharing spaces and/or activities with this much frailer, more vulnerable group, but in other areas, particularly where the Hubs are working, a successful start has been made on integrated activities.

2.6 Identification of local needs

The areas in which involvement were the most useful to the project were in undertaking "research" as to the potential activities that could be provided through hubs or by care homes in their community and the provision of time and expertise by older people in contributing to POPP activities.

Expressed needs can be very specific to an area and the earlier development of hubs and the role of facilitators would have enabled this local research to be undertaken.

The work done by this workstream, in trying to broaden involvement, may also be useful to future projects and areas of work in Gloucestershire who wish to understand both how they should deliver services now and how they should shape them for the future, engaging all older people in planning and the delivery of services whether or not they are currently service users.

3 Sustainability

The approaches to involvement piloted within POPP by GOPA may have useful learning for a number of areas including Putting People First and supporting the development of Gloucestershire LINk. GOPA is promoting their role for these developments and has presented its business case to the local councils and the Primary Care Trust. The County Council and PCT are reviewing the work done to understand how best to build on this area for the future. There is also interest in investigating the synergy between the GCC approach to service user involvement in evaluating services and the community researchers.

The Forums can be self-sustaining to a degree and there is some support available from Help the Aged but they may be at too early a stage to do this. The DWP document “Empowering Engagement: a stronger voice for older people” demonstrates the value placed on forums but county-wide development support is needed until they are firmly established locally.

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2 Activities

3 Evaluation

3.1 Capacity of the voluntary sector and monitoring

3.2 Capacity building

3.3 Volunteering in care homes

4 Sustainability

1 Introduction

The purpose of this workstream, as outlined in the bid, was to provide innovative retraining and recruitment of older people for second careers. The outcomes included developing opportunities for voluntary work, retraining for a new career, training for carers and for leadership and involvement. This workstream was designed to support other elements of the project with recruitment and training of older people to key roles within the project and also to care services generally. The organisation grant funded to deliver this work struggled with financial and organisational issues. This meant delivery was at first slow and then non-existent. A new management team drafted in began to turn it around but was prevented by the underlying financial problems. Remedial action was taken by the project but some project funds were lost and are currently subject to legal proceedings.

2. Activities

The remedial action included the following activities:

- The development of hubs lead by individual community organisations together with care homes and other providers to involve the community in care homes and older people's services, including the development of volunteering opportunities for older people (see section 7)
- Attendance at key events with partner organisations to promote working within care home environments
- Volunteers – creation and coordination of other volunteer opportunities within the POPP central office and via other workstreams.

The numbers and roles of volunteers within the project are as follows:

Role	Numbers and role	Organisation /workstream recruiting
Direct volunteers to care homes	12	POPP office
Small grants	23	Care Homes
Hubs	12	Hubs
Advocates	9	GOPA
Community researchers	8	UWE
Facilitators	11	GOPA

3 Evaluation and learning

3.1 Capacity of voluntary sector and monitoring

Gloucestershire Neighbourhood Projects Network was positioned to be able to provide this workstream in theory. Their training and community project networks meant they were ideally placed to recruit and potentially train older people. Earlier communication of the risks to the stability of this organisation within Gloucestershire County Council would have avoided the loss of so much time to the project. However, the project has been able to work with individual projects using the hub work programme.

3.2 Capacity building

Where community organisations have begun to take a role e.g. the neighbourhood projects within hubs, they have shown that they are able to develop the opportunities for older people to take up roles within the community and within the care environment. However, the lack of a coordinating workstream

lead meant that POPP struggled in this area. There was an existing project within the council to recruit older people to the care sector workforce. Some links were made but no additional paid opportunities were identified through POPP and the only training delivered to older people was in relation to the voluntary opportunities outlined above.

3.3 Volunteering within care homes

A number of care homes in Gloucestershire have well established volunteer programmes. POPP, therefore, was often dealing with homes that were rather less experienced. Initially, the project team found that there were a number of "inappropriate requests" for support from care homes e.g. for full-time care roles, as well as a lack of knowledge from some about the process and how to look after volunteers. There are still some care homes that are reluctant to involve people from outside the home and who do not see the benefits of so doing. Examples of the sorts of activities for which people have volunteered are: befriending, walking, manicure and pedicure, singing and music. Feedback from the GOPA event on 26th February and their advocacy work, has shown a real need for befriending services which a well organised volunteer programme either by individual care homes, another agency or GCPA might fill.

Neighbourhood networks working within hubs have provided some expertise on working with care homes. The Activity Coordinator Network will also promote good practice in working with volunteers and the benefits of bringing new skills or just a friendly face into the care home. This may also be a role for GCPA working with care homes.

4. Sustainability

This element of the project has not been very successful for a number of reasons and whilst elements such as individual volunteering opportunities, leadership and involvement through GOPA activities and some work in hubs, may have

opportunities for sustainability, there is no other strand of work going forward beyond the project.

In terms of volunteering within care homes, where this links to a specific scheme, e.g. advocacy, the sustainability is tied up with the sustainability of that scheme. Otherwise we will encourage care homes and the independent sector to continue to work with the community and with the opportunities available within volunteering.

Lead Organisation Gloucestershire PCT

1. Introduction

2. Activity

3. Evaluation and learning

4. Sustainability

1. New Pathways

This workstream was originally planned to encourage care homes to provide short-term beds to the PCT for rehabilitation, step up, step down type of care. It was in response to a programme at that time and the lack of such beds, particularly within the urban areas. By the time the project had started, the merger of the PCTs had led to a rethink of the strategy around bed provision and a review of capacity as well as pathways. As a result, it was only possible within the lifetime of POPP to carry out a small pilot of beds, specifically for orthopaedic recovery.

2. Activity

The orthopaedic recovery beds were piloted with one care home. The pathway was designed to enable non weight-bearing patients not yet able to receive rehabilitation to be looked after in a safe environment and avoid the use of a hospital bed for this purpose. The criteria were as follows:

- Currently an in patient in an acute hospital.
- Unable to cope at home due to immobilisation of limbs due to having sustained a fracture.
- Medically fit for discharge and not requiring continuing hospitalisation.
- Any nursing needs identified are within the scope of the district nursing service.
- Assessed as likely to be fit for rehab either at home or in an intermediate care bed within 6- 8 weeks.
- Not confused.
- Orthopaedic out patient review booked and transport identified.
- Meet Social Services criteria for a residential/high dependency residential care home bed.

Care homes were required to provide:

- Personal care
- Assistance to patients in mobilising, adhering to a therapy care plan
- Hotel services

The PCT provided:

- Physiotherapy
- Occupational therapy
- District nursing
- Equipment

This was thought to be possible initially by the reassurance of the CHST being in place, although in the end the support was provided by an inreach physiotherapist and the home with which this was piloted had on site intermediate care expertise.

The service saw 16 admissions; 7 male and 9 female over a period of 5 months. Of those, the majority (8) were over 85. The average length of stay was 23 days with bed occupancy of 73%. The discharge destinations were variously hospital, intermediate care and home. Further work needs to be done on the cost-effectiveness of this approach.

3 Evaluation/learning

Whilst the pilot was limited, feedback from care homes was that they appreciated the clear specification and the joined up approach between the County Council, the PCT and the independent sector in the shape of GCPA. The Council and PCT worked closely together to draw up a short list of possible homes that would not jeopardise the council's capacity requirements and would fulfil the PCT quality

requirements. The pilot made it clear that it was necessary to be very clear in any specification as to who does what in such a pathway between sectors and to ensure that the contribution of the care home was clearly understood.

Care homes also need guarantees as to contracted levels and longevity of arrangements to entice them away from the more dependable contracting with the county council or self funded residents.

The training programme had intended to provide enablement training to care homes wanting to work in this way with the PCT. As a result of the limited nature of this workstream that was not delivered.

4 Sustainability

The sustainability of such a service is dependent on the PCT strategy around bed capacity, which is currently under development. The PCT has extended the contract with this home but not to other homes. The cost-effectiveness has not yet been analysed by the PCT

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- 4.4 Leadership/coordination
- 4.5 Community capacity

5 Sustainability

1 Introduction

Hubs were initially developed within POPP to:

- Support interaction between communities and care homes
- To encourage volunteer and fairshare groups and other community organisations to work with older people in care homes as well as within the local community

Hubs are being developed in 7 areas. Most did not begin until September 2008 using underspend monies and partially to support the objectives of the recruitment and outreach workstreams and to strengthen the links between care homes and local communities. Hubs and outreach services overlap in some areas where the home and the community organisations have pooled their monies.

The 7 hubs are very different in their approach. The different projects undertaken by the hubs are explained in more detail in Appendix 9.

2 Partners

The partnerships formed in hubs have been very wide ranging, including: GP practice, social services, older people, care homes, sheltered accommodation, community organisations, theatre groups, village agents, day services, transport providers, schools. The lead organisation has varied from place to place. GOPA, a GP, neighbourhood projects etc have all been involved in leading work.

Community groups have begun to compare and network e.g. 3 hub areas have met to talk about how the community can support older people with dementia using innovative approaches they have tried out in their hubs.

3 Activities and services

The hubs and care homes have started to work on various activities. They are fairly free to pilot and be creative, looking at what might work in their local communities. There is no "brief" as to what we expect each hub to deliver other than that they should seek to involve care homes and care home residents in the community. Work so far has tended to be at the level of primary prevention/promoting well-being and on a very small scale.

They are services which "keep people going" and help maintain mental and physical well-being, such as reminiscence, early memory loss service, physical activity, volunteer visiting and befriending, sitting and respite services, bathing and pampering services, foot care, singing, computer classes, daytrips, general social activities, advice and information and intergenerational work. At least 2 areas have used the opportunity to research what is available for older people already within their area and to develop relationships that include the care homes and to provide clearer information to older people as to what support is available in their area and how to access it.

The hubs are flexible about what activity happens where, the aim being to share resources and to respond flexibly to the needs of local communities. Examples include a care home providing physical activity sessions via their trained coordinator to a day service and in return, care home residents attending the lunch club at the day service. Another might be one of the very few male residents of a care home being invited to get out to play cards at the local volunteer centre. Meetings of older people's groups can happen in a care home lounge and this enables the residents to be involved. Reminiscence sessions run at the local church hall, have older people taken there by the care home minibus and are facilitated by older, trained volunteers and supported by the local history club.

GOPA facilitators have begun working alongside the development of hubs and outreach services to ask older people what services they would like to see available locally.

GOPA have consulted directly with more than 1000 older people and have communicated with many more about POPP. The sorts of issues, services and activities identified have been; more social opportunities, pampering, toenail cutting/chiropody, respite, support for carers including sitting services, support and training for people with dementia and carers, activities such as crafts, films, days out, advice services, support with transport to get out, activities for the visually impaired, help in ensuring that older people in their own homes are eating properly.

4 Evaluation and learning

We have a number of Local Performance Indicators whose delivery we expect hubs to support:

LI 1 Involvement of older people

LI 9a, b, and c – developing outreach services.

We are also monitoring the number of volunteers working with POPP, some of who will be working with hubs. Hubs have been asked to monitor "activity"

Uplands & Stroud Hub – This was the first area to take on the challenge of working with care homes and POPP and coined the term "hub". The hub partnership encountered several obstacles in terms of losing key personnel, however, there was good cooperation between the GOPA lead and the care home. The district council is interested in the sustainability of this approach. .

There appeared to be a specific age group of 60 to 80 years that activities appealed to. Although several under 60s did attend initial sessions, none returned. Also, none of these activities appealed to the 80+ age group. The reasons for this are not apparent but suggestions have been made including location, conflicting activities taking place or that there is a general disinterest in what is being offered. No residents from care homes in the area attended any of the activities on offer at the Uplands Care Service through which the activities had been run. Some of the residents of the local care home struggled to become involved as they are within a high dependency unit and have significant needs Some of the sheltered housing residents were hostile to sharing activities of any kind with care home residents. It was felt that more publicity was needed to increase the numbers and to help with sustainability.

Pamela sending more of positive learning points

GL11 Dursley -"Try to Remember" – was a reminiscence project for older people experiencing memory loss including those with early stage dementia. It involved volunteers working with local residents who are experiencing the early stages of memory loss or dementia. Volunteers received training in reminiscence and gathered information from people who are experiencing early stages of memory loss to feed into future medical and care plans. The trainer, who works nationally, was not aware of another similar reminiscence based project in the country bringing together so many different sectors.

There have been many issues around the subject of reminiscence training raised throughout the latter part of the Hubs element of the POPP project and because of this a proposal for a county wide event "Early Stages of Dementia – The Community's Role" was been submitted to the POPP office and a pilot event was held in the North Cotswolds.

The community organisation has now developed an expertise in working with volunteers in this area and it has been suggested that social services may wish to refer people to this service.

Brockworth community project has learned a lot about the needs and wants of the residents and through the intergenerational work taking place between residents and the students from the school. The importance of a timely approach to the introduction of any activities offered to residents became apparent and the need to carry out any form of intervention in a sensitive manner. Transport has been an issue and Brockworth have been fortunate enough to access a Community Minibus provided by Tesco.

In Chipping Campden the need to take information and services out to surrounding villages and more isolated areas has been highlighted. The need for assertive outreach has been highlighted and once again issues around transport became apparent and the need to identify more opportunities for joint ventures also.

In Whaddon, it became apparent that some older people do not like to have to travel to events. Older people expressed concerns about going out in the evening but said they would have been interested if there had been transport.

Their experience showed that it takes times to break down the barriers between young and old and establish trust. For example, the sheltered housing residents turned down the offer of gardening help from the teenagers because they did not feel comfortable about it. It became apparent that it is important to take time to find out what their respective target audience likes and what their normal routine is and work within this.

In Podsmead , in Gloucester, two of the nursing homes that have been engaged have said that they have benefited greatly from the POPP input. Brunswick have taken training opportunities and been very happy with the input of the volunteers. One of the training courses that the activity co-ordinator undertook was related to music and therefore Podsmead were able to provide a resource pack linked to this with various percussion instruments, allowing her to put the training into practice. Westbourne said that attending the coffee morning and having the volunteers coming in with specialist skills has inspired them to resource more varied activities and given them new ideas. They are also going to receive a resource pack – this time linked to the volunteers who provide art and flower arranging.

More time and input from a worker would have been the biggest factor that would have raised the potential of this project. There is obviously a need to make links between care homes and the community, but a greater input and funding would be needed in order to fulfil the real potential of this role and this project.

4.1 Local services

A lot was learned about working in small localities. Services need to be accessible and by working together in small areas, organisations may be able to deliver more and provide more individualised services. Resources differ from area to area as do skills. It may be that a care home has expertise to share in supporting people with dementia but does not have space to run something like a dementia café/social support service. However, by working with other local providers, they might identify a community facility or sheltered accommodation that is suitable and all older people in residential care or in the community might benefit.

Lack of transport is frequently cited as the reason for local residents not accessing social groups and other services. Hub leads felt that local statutory authorities could do much to ease this situation by making their transport fleet (available for example to transport clients to day care centres) accessible by community groups

during the day. Offering subsidised training courses for local volunteer drivers would be an excellent start.

In some areas, anything provided needs to be very local - even a 10 minute walk across the estate can be too much for some elderly people. Ideally, activities need to target the elderly in the immediate vicinity of the care home

4.2 Care homes

Not all care homes are used to interacting with their local communities and in some areas this has been very hard to achieve. Sometimes a small initial step, such as providing somewhere to go to have a bath can begin the process.

4.3 Identifying local needs

Older people in specific localities are much better at identifying their specific needs for supporting a given area. In our model we have tried to work with local older people. In two areas, the hub budget is placed with the local GOPA facilitator to spend. GOPA facilitators are able to go out and talk through with people the services or issues they face locally, to record that information on a database and feed it to potential providers.

4.4 Leadership/coordination

Hubs have taken quite a lot of organisation and if the statutory agencies want to encourage the community to work with care homes and link together provision in small areas, it may be that there needs to be someone responsible for coordinating this work. At the very least, it would be a good outcome for POPP if care homes were linked in to any such developments in terms of promoting health and well-being of older people within the community.

4.5 Community capacity

Capacity in the community can be significantly increased if training in key areas such as nutrition and dementia could be extended into the community to provide a good level of general knowledge in working with older people, as well as training around the provision of specific activities. With the number of retired people rising nationally, and the current economic climate bringing more unemployed people towards the voluntary sector as they strive to retain active mind and bodies as well as make a positive contribution to the local community, there has never been a greater need to ensure that this valuable community human resource is supported.

Example at GL11: Six very keen and committed volunteers have been recruited – all over 50, with varying personal circumstances (one being a retired health professional). They have benefitted from basic Reminiscence Training which has helped their engagement with early dementia sufferers. Further relevant training to help the vulnerable clients with whom they work will relieve the pressure from the local health teams who struggle to find the 'time' that these clients need. Volunteers can be extra eyes and ears for clients, their families/carers and most importantly to the range of health professionals all working or living locally. There is such a willingness to do more for this client group, and to extend the support so that more can benefit. Our meeting with local Adult Care teams has left the question "when can we start referring clients to your volunteers?" ringing in our ears. The need and desire for statutory and voluntary sector to be working together is there – volunteers working through local community organisations with relevant training, can be the 'first tier' of engagement, offering befriending and much needed support which has the potential of delaying the more intensive health professional support.

Those working at a local level in the voluntary and statutory sectors are intensely keen to work together for the benefit of the most vulnerable in our communities. There is no resistance – there is a healthy respect and understanding that mutual benefits can be achieved through such partnership working.

Example at Whaddon: Capacity in the community. It isn't just that there is the need for specialized training. This particular Hub found that they needed to do preparation work with the young people before they could get them to work with the elderly. They needed to get them to think about basic mobility issues, problems experienced by someone with little vision or hearing loss so that they could understand what sort of support someone may need. This Hub identified a huge untapped resource in the young people of the community.

5 Sustainability

The national POPP pilots have several models for taking this kind of approach forward. In a number of areas, hub type approaches are being used, from active ageing centres or network centres that also reach out into the community to neighbourhood networks, to community development using the Sure Start to later life approach. The focus of the Gloucestershire POPP has been working with care homes and so hubs have only been a very small part of the project and need to be set alongside other similar work within the local health and social care services. However, if similar approaches were developed within Gloucestershire as part of the Putting People First agenda, the POPP project would encourage:

- inclusion of care homes and residents in local discussions,
- working at a very local level to identify needs and available provision
- the leadership of work by community and older persons' organisations and individuals
- use of the facilitators approach to understanding local older people's needs

One of the key themes that ran though all of the Hubs was that of the dependence of a small bank of well trained and supported volunteers to carry out the valuable work taking place in the various projects. It became apparent that without these volunteers the work would have been unable to take place and this is an area that needs further discussion and support.

Additional projects to encourage care homes to interact with the community

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1 Introduction

2 Home Front bulletins

2 Music for All Project

4 Sustainability

1 Introduction

The POPP project commissioned some additional work early on to provide care homes with new activities for their residents that involved interacting with community organisations. This was largely as a result of bids made independently to the project. Work with some arts organisations in the county, namely Artshape and Mindsong had already begun under the aegis of Lifelong Learning and these worked with the outreach workstream (see section 3).

In addition two other organisations' work is described below. These were required to produce reports, along with thoughts about how care homes might go about providing such activities themselves to support sustainability, and these are available to activity coordinators on the Activity Co-ordinators' Network website. We hope the new website will also provide information to care homes, looking for new organisations to work with their residents. The organisations themselves and those working with them on the projects all expressed how much they had enjoyed working with the older people. There was a real sense that the residents themselves made a huge contribution to the success or otherwise of these events. These reports are available and are summarised below.

2 "Home Front Bulletins"

This was a result of collaboration between the POPP project, a GP surgery, an arts centre, a care home, a theatre company and the local secondary school. The project aimed to use reminiscence theatre as a therapy for residents with early memory loss. Reminiscence sessions were run over an 8 week period, with residents and their stories, told in their own words, used to produce a piece of theatre. This is then performed back to residents, their relatives and people living in the community. The theatre company carried out the workshops at the care home. The play was then written from the transcribed stories. This was shared with the residents and their comments sought. Following this, the play was performed in the local arts centre to residents, relatives and the paying public and then, in the care home to residents, care staff and relatives. Sixty-six people,

including 53 members of the community, watched the performance at the Arts Centre. Thirty-nine residents watched the performance at the care home.

A questionnaire was completed by 14 residents, 6 relatives, 2 care staff, 1 GP and 2 members of the community. A more detailed analysis of the responses is available. The residents all found the reminiscence sessions enjoyable and they looked forward to them. "Until we got going I didn't think there was much to say. By the end I felt like I hadn't said enough." Relatives also felt the sessions had been beneficial: "I haven't seen my Mum so animated for years". Care staff felt the whole home had benefited: "There was an increase in social interaction after the sessions and there appeared to be an increase in self worth." The residents felt the play was of a good standard: "It was our play, our words, so of course it was good!" and some interesting points of accuracy raised: "They would never let a scrawny boy like him in the RAF!" Residents enjoyed getting out to the theatre: "It made it more special to be in a proper theatre"

It was not clear from the questionnaire whether the activity had improved the memory of those taking part. The majority felt the chief benefit was in quality of life. The comments also included the suggestion that more older people in the community could be involved with the care home residents and some of the partners in this activity went on to form a hub and do some work with small grants (see "Try to Remember" Section 3).

3 Musical Memories

This theatre group provided 5 Musical Memory Sessions to four care homes in different parts of Gloucestershire. The sessions were to provide entertainment and to explore memories. They were designed to benefit care staff by providing them with the opportunity to interact with residents in a different context and to learn new ideas for activities. A selection of music, chosen by the residents was produced on CD.

The project began with planning visits to the care homes and the following session plan developed:

Week 1	Introductions
Week2	Musical tastes/requests and visual stimulus e.g. album covers
Week3	Instruments
Week4	Desert Island Discs
Week5	Party!

The project found that they needed to move around the room and speak to people individually or in small groups. They brought with them a musician, able to source music on the spot or improvise as residents identified tunes they wanted to hear. The sing alongs proved particularly popular. Those who were hard of hearing appeared to enjoy live music more and a number of residents got up and danced when the spirit moved them.

A detailed analysis of the project is available, along with some very useful recommendations as to how to run something similar in the future. Each session was evaluated in detail and notes kept on each resident and in depth discussions held to ensure the project team would remember individuals and their tastes. This obviously impressed the residents and made for a really good atmosphere.

The feedback was overwhelmingly positive from residents and some comments were:

"I like all kinds of music. Dancing was my life"

"This is the highlight of our week"

"I'd love to keep it "(his kazoo)

The feedback from the staff was also very positive. The project team were clear that a good activities coordinator makes a huge difference within a home. Where

there was a lack of activities routinely available, the team felt that residents were not comfortable with each other and there was a lack of friendships between them. This made running an activity as an outside group harder.

As a result of this project, the group identified a follow up activity, involving music again. (see below)

4 Music for All Project

This was a follow up to the musical memories project. This time, care homes were linked to primary schools with each set of sessions ending with a concert for both the residents and the schools.

The proposed outcomes were:

- Young people to work collaboratively with care homes
- Young people to feel more confident with care home residents
- The "outside world" comes to the care home
- Local relationships are fostered with the school and the care home
- Song selections available on the website for cross-generational use.

The project is currently being delivered and evaluated via questionnaires to the staff, schools and residents.

5 Sustainability

Feedback form the care homes suggests that they value these types of activities. Whilst they may be "beyond their budget", some of the ideas are transferable and within the scope of the activities coordinators themselves to deliver. This will be taken forward by the activity coordinator network facilitator. The groups involved may also be more likely to work within the care home environment in the future.

One group has just completed a successful bid with Gloucestershire Archives for Heritage Lottery Funding for a project involving, amongst others, care homes and their residents in developing a touring play documenting the demise of the local "pub". This also demonstrates, as do the other projects outlined in this section, that care home residents have a contribution to make to their communities.

CONTENTS

1. Introduction
2. Information
3. Structures
4. Partnership
5. Outcomes and Performance Indicators
6. Recommendations

1 Introduction

As part of the POPP project, the evaluation group had the task of considering the development of data to support the future shared monitoring of quality within care homes and therefore supporting raised standards. The group, a partnership of GCC and GPCT, with advice from UWE (our independent evaluators), has worked on a set of limited local performance indicators to measure the progress of POPP.

Those managing workstreams, including representatives from the independent sector, have also identified information they would like to have in the future or standards they think are important and should be built into future contractual arrangements. For example, the project found early on that very few care homes could communicate electronically or allow their staff access to a computer, creating barriers to learning and participation in networks. Another finding of POPP is that there is a huge variation in the commitment to the role of an activity coordinator and this impacts greatly on the quality of life of residents. These two areas could be considered within the setting of new contractual standards.

In terms of developing further, more ambitious outcomes measures, the evaluation group has noted that, whilst there is scope for bringing information together, there needs to be a specific remit to use it, otherwise it is not appropriate to spend energy on its collection. The GCC contracts team have approached POPP to see what we have learned and other PCTs are talking to us about the sorts of quality commissioning standards that should be part of world class commissioning in relation to the health and social care needs of residents of care homes.

2 Information

Early on, the evaluation group established that key areas of information were not collected locally e.g. admissions from care homes. A further meeting of a wider group demonstrated that there are several possible sources and types of

information/data but they are not used systematically and across partnership agencies to support defined quality outcomes as yet, although this work is in progress in a number of areas.

Subsequent to that meeting, a key area – that of tracking residents through the healthcare system and being able to be report on the healthcare needs and usage of care home residents as a defined group - is being tackled. GPs will be encouraged by the PCT to "zone" to care homes and to code the fact that older people are resident in a care home on their practice systems.

Other information is collected and the advent of additional training and the role of the Care Home Support Team (CHST) within POPP has added more. The next stage is to use what is available; to ensure data considered critical e.g. admissions information is collected in the future and to use it to target the services commissioned after POPP and deliver an intelligent approach to quality outcomes. The data requirements should be reviewed in the light of the POPP evaluation and for all residents.

3 Structures

Currently the structures for monitoring do not appear to bring together outcomes for **all** residents of care homes with monitoring of those for whom GCC have a contract having the greatest scrutiny and those who are independently financed the least. At the very least, the structures do not enable all the relevant information to be brought together in a way that maximises its use and really focuses on the key issues. This has been noticeably improving e.g. in relation to homes in crisis where the information from CHST nurses about the training undertaken by homes has been used to good effect. This will be more important now that GCC and GPCT have jointly commissioned the CHST for an additional 2 years and are looking at how best to target their work and the support offered through the training partnership of Gloucestershire Workforce Development Group.

As a result of the issues raised by POPP, GCC is also working with GCPA (Gloucestershire Providers Association) to offer independent support to poorly performing care homes. In so doing, GCPA will need to work closely with the PCT and with GCC to ensure relevant training and CHST support is accessed by these homes. They will also have an interest in quality performance indicators and in fact will want to alert GCC and GPCT to any failures in health and/or social care support that might contribute to a home' poor performance. POPP has shown that health and social care data will need to be shared to support and monitor these quality improvements.

4 Partnership

POPP has benefited from a partnership approach and it would seem useful to maintain this and develop it still further. Any quality framework and monitoring should be developed in conjunction with homes and be seen as partnership approach to improvement and maintenance of standards. POPP (via UWE) has been measuring the impact on all stakeholders of this approach and we expect that it will demonstrate that the health and social care community can achieve much more if they work in partnership with older people and care homes in any approach to raising quality and/or identifying areas for improvement in the care of residents whether it is the care offered by the home or by health and social care inreaching into the home. The information partnership may need to be extended to relatives and residents but this was not covered within POPP.

5 Outcomes and or performance indicators

The areas/information identified currently as measuring the performance of care homes are (in no particular order):

- Admissions (using postcode as a proxy) and use of community teams (including mental health)
- Staff turnover

- Star ratings
- CRILL – inspection results for contracted homes
- Referrals to the CHST
- Long-term conditions and other health need – no specific information
- End of life care
- Dementia care and or training
- Staff training undertaken (CHST and GCC)
- National Minimum Data set (NMDS)
- ACIs (Adverse clinical incidents) including enabling care homes to report
- Complaints
- AQAA
- Service users views

Some of these overlap, some are reported confidentially and/or are only available to particular agencies. Some are not reported systematically at all or are only partially recorded.

6 Recommendations

POPP will not secure this work within it s life span and there are other agencies and departments already working on these areas. The project, based on experience is able to recommend the following actions:

- Develop quality outcome framework and structure to monitor jointly with the independent sector, relatives and residents
- Ensure one person is responsible for overall quality commissioning for outcomes for all care home residents, including the support to care homes and including working with other relevant commissioning or contracting bodies

- Map out the development of KPIs and other measures, being clear as to what information is available when
- Jointly develop format for KPI/quality outcome measurement
- Do not ask care homes to collect information in too many different formats or for too many different bodies
- Agree relevant information sharing protocols
- Complete GP zoning and as part of this code the care home as place of residence, keeping this information up to date
- Use the jointly agreed and accessible information across health and social care to target ongoing investments, including outcome monitoring in all relevant specifications whether in health, social care or the independent sector.

CONTENTS

1 Project governance

2 Learning points

2.1 Securing project support

2.2 Project management tools and set up

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2.4 HR and recruitment

2.5 Communications

2.6 Project outcomes and measurement

2.7 Project office support

2.8 Funding workstreams

2.9 Partnership working

2.10 Finance – joint working

1 Project governance

The project was run via a central project office with project management, administrative, financial and communications support. The Project Manager reported bi-monthly to a project board (structure Appendix 10), using project plans, risk management processes and documentation as per the GCC project framework. Significant changes to project plans or expenditure were signed off by this Board.

The evaluation group of external and internal evaluators met separately as an evaluation group, attended by the Project Manager. The independent evaluators were in attendance at the project board meetings. Key performance indicators were used to measure progress with workstreams in terms of key outputs. In addition the project reported directly to the DH within their POPP reporting framework. Retention and use of the underspend at the end of 2007/8 was agreed by the DH in relation to key project objectives and clear project plans.

2 Learning points

The points made here are based on a number of discussions recorded within the project team and with the project lead. They are clearly points that are made with the benefit of hindsight and so are not criticisms but we have used them to try to develop learning points that may support similar projects in the future. Many of the points arise as a result of trying to deliver a large project, to a short timescale, in a time of change. Future projects will have similar issues and no system can be perfect but, it is hoped, similar partnership projects might benefit from the POPP learning.

The project did put a lot of energy into project set up to try to ensure that the project was able to start on 1st May 2007. There were, however, some areas where lessons could be learned for the future.

2.1 Securing project support

The project benefited from a strong existing relationship and history of joint working between health and social care. In addition, the project board was constructed to secure high-level support to the project vision. Potential champions were identified early on and, whilst support to the PMB meetings was not always consistent, support for proposed sustainable outcomes was gained early within partner organisations in most, but not all, areas. Previous research had indicated the main areas in which care homes would value support. This meant that the project was able early on to secure care home participation with well-targeted practical services and support. This, in turn, was recognised by the rest of the project as providing the platform and goodwill for other areas of work.

2.2 Project management tools and set up

Early advice on set up was given to the group as a whole and PIDs and project management processes set in motion that the project office, employed later, were not then able to influence. The Project Manager should be one of the early appointees. The use of Microsoft Project Planner was strongly discouraged which was unhelpful in managing a project with so many dependencies and deprived the project team of the ability clearly to manage the critical path. This might have enabled some delays to have been avoided or at lease minimised.

2.3 Project data recording

The project was told they could not use MSAccess databases to record data. The subsequent attempt to use MSExcel spreadsheets to record the activity data was ill fated and made data production difficult. A more formal assessment of the project's data collection needs would have been helpful.

It was clear very early on that the data the bid suggested would be available for monitoring outcomes, would not be. This was made more problematic because health and social care also had to learn about each other's data systems and the

health organisations were merging. Data sources needed to be tracked and made clearer in setting performance indicators for the project in order to manage expectations but also to inform the cost-benefits of setting up project specific data collection systems.

2.4 HR and recruitment

The HR support at the beginning of the project was insufficient and the processes within the 2 key statutory organisations necessitate a lead-time for recruitment that is almost impossible to manage within the timeframe of a project. The initial stages of the project were almost entirely dependent on recruitment so this was critical. As the project went on, use was made of agency staff, shared posts, secondments and freelance workers to prevent delays. Projects need fast track HR processes.

2.5 Communications

The project tried to work with existing communications teams in the statutory sector but they did not have adequate resources to support the activity of the project, particularly in terms of marketing. Dedicated communications support would have been beneficial for the outset in order to support distillation of key messages, key audiences and enabling a broader "buy in". A formal communications assessment at the beginning of projects would be useful to assess the likely requirement and budget. Please see Appendix 11 for details of activity. The project work may be better disseminated once results are available from the evaluation.

2.6 Project outcomes and measurement

The project outputs and/or outcomes (the two were used interchangeably) outlined in the bid made it difficult to match project delivery to evaluation methods. Early on in the project, the aims and objectives were clarified but interventions were not necessarily targeted as expected by key stakeholders e.g. the reduction

of admissions was unlikely to be achieved within the project timescale, given the structure of the project. The economic evaluation should have been reviewed earlier on in the project in order to clarify expectations and measurables.

2.7 Project office support

In some areas this worked well and the project officers were able to support workstreams to deliver and provided a useful link between workstreams. In other areas, it was very difficult to gauge the workstream requirements. In one case the lack of a "base" for a workstream made it almost impossible to get the level of support right.

2.8 Funding workstreams

The failure of one organisation and loss of funding, as well as an unreported underspend in the first year of another demonstrated the need actively to manage funding against performance. Whilst it is recognised that up front funding for some smaller organisations is necessary, the project needed to be able to pay in recognition of work done. Quarterly payments would have been more appropriate and less risky.

2.9 Partnership working

The cultures and working arrangements of the organisations within the project were very different. In terms of project management, this had implications for delivery. The initial project management training helped with this but further follow up work to clarify ways of working also helped. These included meetings between the project manager and lead and individual workstream leads and their sponsors; workstream lead meetings and 3 joint meetings between the PMB, evaluation group and workstreams to ensure a shared understanding of the project. This area is covered in further in the independent evaluation.

2.10 Finance – joint working

Included within the original bid for the POPP for Gloucestershire was budget to fund a full time finance post to work jointly at the County Council and at the PCT. The post was filled in June 2007. Initially it was expected that the post holder would split her time between the two organisations and have access to financial and information systems in both. Gloucestershire County Council as administering body advertised and recruited to the post of POPP Accountant on a secondment basis. It was agreed that the Finance Manager would carry out day-to-day management of the post occupant for Community and Adult Care at Gloucestershire County Council, but that joint supervision meetings would be held every other month with the appropriate Finance Director at the PCT.

Although the largest and most heavily staffed workstream within the POPP was the Care Homes Support Team, it was the only cost centre managed by the PCT and the majority of the budget was staffing related. The budgets for all the remaining workstreams, the Project Team and for monitoring evaluation and finance were held at the County Council. During the first six months that the accountant was in post a new ledger system was introduced at the County Council and the Finance Team at the PCT underwent a review. The accountant raised concerns with her line manager that the amount of time being taken up in training on new systems, attending team briefs and development sessions in both organisations, added to the travelling between sites was impacting adversely on her ability to complete work to deadlines.

Into the second year of the project a member of the finance team at the PCT was given the specific task of providing the POPP accountant with the information required on a monthly basis and facilitating the management of the CHST cost centre by actioning journals and investigating issues arising. This arrangement has worked well, to a large extent, as a result of the relationship building process that occurred at the outset of the project.

1 Project budget

2 Budget for sustainability

3 Care Home Involvement spreadsheet

4 CHST training

5 CHST referral numbers

6 Training course numbers (inc DLW)

7 Training survey

8 Small grants summary table

9 Hubs summary table

10 PMB and other groups to manage project

11 Communications

12 Sustainability summary

APPENDIX B1: POPP BUDGET AND EXPENDITURE

The table below shows the budgets set in each area, including those agreed during the project to make use of the underspend. Agreement for each of these was secured through the project management board. Details can be found in the report.

Area of work	**Budget**	**Spend**	**Variance**
	£'000	**£'000**	**£'000**
Project team	261	261	0
CHST	1561	1178	-384
Further services	42	42	0
Outreach	150	177	27
Training	200	328	128
Mental health outreach	0	81	81
Involving older people	70	138	68
Recruiting older people	80	80	0
Hubs and small grants	0	80	80
Monitoring, evaluation and Finance	180	188	8
Communication	43	44	0
Contingency	9	0	-9
	2596	2597	0

	£'000
Care home support team	400
RMN support to CHST	175
Training	AW to confirm
Care home education nurses	81
GCPA capacity	MB to confirm
Activity coordinator network facilitator (1 year)	40
TOTAL	**>696**

Involving Older People

GOPA £tbc

APPENDIX B3: CARE HOME INVOLVEMENT SPREADSHEET .

See attached file ‘Appendix 3’

APPENDIX B4: CARE HOME TRAINING PROVIDED

See attached file ‘Appendix 4’

APPENDIX B5: CARE HOME SUPPORT TEAM REFERRAL NUMBERS

See attached file ‘Appendix 5’

APPENDIX B6: TRAINING COURSE NUMBERS

See attached file ‘Appendix 6’

Managers' impact evaluation

The POPP evaluation group agreed to the format of both training evaluation questionnaires. This report will cover the findings of the Managers Evaluation 'Has POPP funded training made a difference? So, where do we go from here?' The evaluations were sent out in early December 08 with a return deadline of the 16th January 09. 138 care home managers were sent evaluation questionnaires. 55 managers responded to the evaluation questionnaire - a 40% return rate of which 39 were from nursing homes (28%) and 16 (12%) from residential care homes. Some responses provided comprehensive feedback whilst others gave limited responses.

Method

Responses were collated in order to determine which training had had the biggest impact inside the care home, which areas of the care home had seen the biggest impact, what percentage increase in staff accessing training had occurred because the training had been fully funded and made more easily accessible, to determine how the care home measured the impact of POPP training on staff, to ascertain from the managers their expectations as to future training requirements.

Question 1 of the evaluation form refers to various training however, it is important to note each training heading relates to various related training courses. The following training headings relate to the corresponding training:

Clinical Skills training: Venepuncture Training for RNs, Gastrostomy Training for RNs, Early Recognition of the Sick and Deteriorating Resident Courses for RNs, Diabetic Awareness Training for all grades of care staff, Syringe Driver Training for RNs, Leg Ulcer Management Training for RNs, Stroke Awareness Training, Leg Ulcer Management Training for RNs, Catheterisation training for RNs and Catheter Care training for HCAs.

Dementia Care: Generic Dementia training courses on offer from GCC, Dementia Pathway, training from Band 7 nurses (Glos POPP and GCC) and formation of Dementia Link Workers

One day seminars: Dementia E-Learning launch and introduction of the Dementia Pathway, Parkinson's Disease Study Day for RNs, Stroke Awareness Study Day for RNs.

End of life seminars: 2 x End of Life seminars

Palliative Care Courses: Confirmation of Expected Death courses for RNs, Palliative Care Course for HCAs and pilot for Palliative Care Workers.

2 day Cooks Training, PACS, CIEH Level 2 Food Safety (the figures for this heading will also include the CIEH Level 2 award in Healthier Foods and Special Diets)**:**

Findings and analysis

Q1. Which types of POPP training have had the biggest impact inside your care home/ on the business?

The majority of responses initially indicated clinical skills training, dementia care, one day seminars and Activities had had the biggest impact inside care homes, however, the overall percentage of all the training appears to be evenly distributed throughout.

Comments made by the managers on the evaluations sheets indicated that the availability and funding of courses allowed more staff to access courses which would have been difficult to source otherwise especially in relation to clinical skills updating, one manager states 'it was a breath of fresh air finally being acknowledged as a professional sector with training needs which had long been ignored or priced beyond the average facility to pay for'

Q2. Which areas of the business have seen the biggest impact? The questionnaire offered five alternative responses – more than one response was allowed.

The majority of managers indicated POPP training had had a definite impact on improved standards and delivery of care within the care homes. Correspondingly, figures indicated staff morale, retention and recruitment had also been affected. One manager made a point of stating that POPP training had provided care homes with standardised practices, developing more competence in individual skills. As a manager she states 'this has eased my problems in staff development, this improvement has offered our service users better care if not the best.' Fewer managers stated the training had had an impact on the home star rating, market position and profile however, as the training has only been on offer for a relatively short period of time this is not surprising.

Q3. POPP training has been free of charge and conveniently provided in venues across the county. Approximately, what has been the percentage increase in your

staff accessing updates, refreshers and training days because they have been funded and have been easier to get to?

23 care home managers stated as POPP training had been fully funded and made more accessible to staff there had been a 100% increase in staff accessing training with 19 managers stating there had been a 50% increase and 9 showing a 25% increase. Only 2 managers stated that there had not been any increase. 2 evaluations showed no response to this question. Quite a few of the managers stated in the ‘additional comment’ section of the evaluation form that due to the courses being fully funded the homes were able to release more staff onto training courses and staff were more eager to attend training, refreshers and updates.

Q4. How are you currently measuring the impact of POPP training on your staff and the care they provide? (Resident/ Relative Feedback, Monthly Audit, AQAA and in house quality assurance framework, Staff Meetings, Supervisions and Appraisals).

The response to this question indicated strongly that managers are measuring the impact of POPP training via staff meetings, supervisions and appraisals. Quite a few of the managers stated staff were giving a lot of positive feedbacks re the POPP training stating that the training was of an excellent standard. One manager stated that staff who had previously been unwilling and reluctant to take training courses were now embracing the training with a ‘can do’ attitude and enthusiasm. A large number of managers stated staff were giving very positive feedback when coming back from training courses.

Q5.How do you think training for care home staff should be funded in the future?

25% of the managers felt that training for care home staff should be funded by the GPCT / GCC, with a contribution from the care home to cover administration costs. 22% felt some mandatory training should be fully funded by the care home but all other training (specialist / enhanced) should be funded via the GCC/ GPCT. 19% thought training should be fully funded by GPCT/GCC but linked in some way to contract monitoring, star rating, attainment of certain standards, agreement to adopt and demonstrate use of best practice and tools. 17% of managers felt that training should by fully funded by the GPCT/GCC with no conditions. 12% stated training should be funded by GPCT/GCC and the care homes as a 50:50 split and only 5% thought training should be made available through Learning Exchanges or Persons in Charge Network Group with some devolved budget responsibility.

Q6. What would be the most effective way to engage with care home businesses especially with regards to: meeting current and future workforce development needs, understanding new knowledge and skill requirements as the demand for new services grows, the allocation of available funds between mandatory and other types of training. Managers were given 8 responses to tick

Most of the responses from the managers stated the most effective way to engage with care home businesses would be through newsletters and emails.

Q7.Has the availability of POPP training allowed you to change/develop the care services you currently provide? Yes / No?

81% of all the responses said 'yes' with 19% stating 'no'. Most managers outlined a lot of positive comments 'POPP has contributed in so many ways','Improved staff knowledge and working practice',' improved clinical skills and staff are now up to date', 'staff have grown in confidence, knowledge and skills and put the nursing home standard as high', 'residents are able to receive certain aspects of care in house now with less need for the use of outside agencies eg. DNs or Practice Nurses'. 'Carers are much more informed about certain aspects of care and are able to cascade information to colleagues and deliver higher standards of care.' Two of the managers stated in the evaluation document that due to the dementia training and support their homes have now registered for dementia care beds.

Q8. Looking to the future, are there new services you would like to develop which are dependent on your staff acquiring additional knowledge and skills? A list of 8 examples were given for the managers to tick: reablement, hospital to care home to home service, falls screening, health and well being groups for older people in the community, out of hours emergency beds, homecare, meals delivery or other forms of outreach work, specialised day care – dementia/stroke etc, palliative care beds/end of life day and residential care.

Responses indicated care home managers would like services to be developed in the area of palliative care and specialised day care services

	CARE HOME	service	Partner(s)	sustainability
1	Brambles, Gloucester	Provision of activities including lunch	B&T Hub	This is charged at a rate to be both affordable and cover all costs for the home. This service will continue.
2	Brambles 2, Gloucester	Computer access	B&T Hub	This has effectively become a popular enhancement to the above service offering. This service will continue.
3	Four Seasons, Chipping' Campden	Assisted bathing	C/C Hub	Should be sustainable; again the services are charged at affordable rate that still offer the provider a return. Currently seeking to expand both these services into an Active Living Groups – posters presently being produced.
4		Sitting service	C/C Hub	
5	Mill House, Chipping Campden	Assisted bathing	C/C Hub	Good prospects for sustainability as this home is very active members of a strong POPP Chipping Campden Hub that will continue to flourish after the project.
6	Hazelhurst,	T'ai Chi		Very popular service

7	Ross-on-Wye	Activities & gardens	Local evergreen club St Vincent de Paul soc.(volunteers)	Definitely sustainable – they are seeking to expand the service further. The increasingly diverse offerings are supported by strong links with local community groups including c20 volunteers from a local church.
8		Beauty sessions	FoD College	
9	Henlow Court Dursley	Reminiscence	GL11 Hub	
10	Hill Ash House, Dymock	Film club		Limited take up to date; but forward costs are low so we are hopeful that this service will develop further. This home is in a very rural location and this service offers one opportunity to tackle the issue of isolation.
		Activities		
11	Kingswood, Wotton-u-Edge	Activities		Relatively late to start, but the owners are investing heavily in this and they also have 6 month contract with local arts group for the provision of activities (funded by family of one resident). Sustainability looks very strong.
		Hairdressing		
		Beauty sessions		
12	Northfield Stroud	Assisted bathing	Uplands Hub	Limited take up, but there are good prospects for continuation as forward costs involved in offering this facility are low.

13		Meals delivery	Uplands Hub	Limited take up. The future of this service looks in doubt
14	St Paul's Gloucester	Sitting service	B&T Hub	Sustainability is doubtful as response has been poor. These services have been targeted at BME groups (by a home with a very diverse and multi-lingual workforce) and despite significant efforts to publicise and advertise the services expressions of interest have not been reflected in levels of take up.
15		Activities	B&T Hub	
16		Hosting group meetings	the Afro-Caribbean Group and Asian Elders Women's Group	
17	The Manor House, Longhope	Advice 'drop-in' coffee mornings with Age Concern	Age Concern	Sustainability looks very strong. The home reports reasonable levels of take up. Perhaps more significantly, the home has noted an improvement in the image of the home in the local community and increased take up of the existing respite service. They also report that existing residents enjoy these new services.
18		Podiatry		
19		Active Ageing and other therapeutic activities		
20		Luncheon club		
21		Hair Salon		
22	Paternoster House Cirencester	Music as therapy	MindSong	

Appendix B9: Hubs summary table

HUB AREA	ACTIVITIES/SERVICES	LEAD PARTNERS	OUTCOMES/SUSTAINABILITY
Whaddon, Lynworth & Prior Oakley, Cheltenham	Young people offered gardening services for elderly residents and helped organise bingo sessions	Whaddon Lynworth and Priors Neighbourhood Project Whaddon Youth Centre, Winstonian Care Home Lynworth Sheltered Housing Lead Partner: WLPNP	Breakdown of barriers between young and old, the chance to participate in shared social activities, support for elderly people in their homes. The young people are fundraising to allow them to continue offering these activities and are working on a new project involving the elderly. The young people have taken ownership of this project and are looking at how it can continue. Whaddon Deputy Manager will continue to provide the link to the community.
Barton and Tredworth, Gloucester	**Guide to services for older people in B&T**, 2500 for distribution to groups and organisations. GUiDE and PALS (Chris Prosser) have confirmed they will integrate the information into their existing database. They will hold and distribute the booklets after the initial distribution. They will also respond to any requests for the booklet to be supplied in a different format/ language/etc.	Barton and Tredworth Community Trust - Bren McInerney GUiDE and PALS - Chris Prosser Bramble House - Julie McKinnon/Julie Seymour	Following the POPP small grant they are charging non-residents and so

	Bramble House continue to provide a **service for non-residents** including lunch, creative activities, reminiscence and basic IT access (internet/sending and receiving emails/creating greetings cards). They are working with local church groups and a local school. St Paul's Residential Home are continuing to **provide a respite service** but there has been a poor	St Paul's Residential Home - Mo Sayani	the service is self sustaining. They have three volunteers who help to provide the services. There is a small plot of land behind the care home which is being turned into a Sensory Garden. Although they have asked for a further grant towards the garden they were not successful as the garden would not be completed before the end of the POPP Project. Nevertheless the garden is going ahead and it will benefit both residents and non-residents. We will continue supporting this service until the end of the project but sustainability remains doubtful if there is not sufficient interest.

	response so far. Producing a new leaflet which highlights the ethnic diversity of both the service they can provide (e.g. culturally sensitive menus) and the staff providing the care service (e.g. multi-lingual staff). .		
Brockworth, Gloucester	Activities involving residents and volunteers including: **Reminiscence day** – the BES students ran a very successful day with singing and costumes from the 1940's **Singalongs** – these were advertised in the local community on the Parish noticeboards. Song sheets were provided, singing was led by Maureen Rowcliffe-Quarry from Brockworth Community Project, with a pianist from St George's Church and a volunteer singer also from St George's. Residents were consulted for the choice of songs with students from Brockworth Enterprise School (BES).Tea and cakes were served by the students who had also made some of the cakes and on one occasion they also decorated the room to celebrate a resident's 100th birthday. In addition volunteers from St George's organised a carol singing event in the home at Christmas.	Horsbere House Brockworth Community Project Brockworth Enterprise School St George's Church members	It is hoped to continue with the above activities on an on-going basis (subject to more funding and the health of volunteers)

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GL11 Community Project	**Recruitment of volunteers** – we actively and successfully recruited 6 volunteers. They have all been CRB checked and have now attended two Reminiscence Skills training sessions – a third one postponed due to bad weather.	The Hub started as a partnership of: GL11 Community Project	There is a growing demand for this work. The momentum gathered by the committed volunteers cannot be lost – they have learned new skills, engaged with local care homes and residents, met local vulnerable people trying desperately to live independent lives, met with carers

	Referrals from local surgeries/health professionals – we have received 15 referrals, and these 'clients' are at varying and wide ranging stages of memory loss. From those who do not accept they have a problem, and have chosen not to actively engage, through to a client who rings us 3 days a week and cannot recall a conversation 30 mins earlier – and who, worryingly, is living alone and extremely vulnerable. **Reminiscence Writer/Poet** – Five sessions with clients have been held, three are scheduled before the end of March, and 1 scheduled visit unable to take place due to sudden death of client **Engagement of volunteers with care homes** – three clients are in a care home (The Hollies), so volunteers have made several visits into the home where they have been made very welcome; one volunteer visited Henlow Care Home where staff, who also benefitted from the Reminiscence training, are already working well with residents	The Learning Community (TLC) Henlow Court Care Home Walnut Tree Practice (May Lane Surgery) Prema Arts Centre Gloucestershire Archives. Attracted new partnerships with: The Hollies Care Home where volunteers regularly visit residents. In addition, as knowledge of work has grown have been approached by: Barchester Care Group	who are struggling tremendously, not knowing who or where to go for support. To allow this successful pilot project to continue and to grow to meet the identified need, **core funding must be secured.** This will enable professional co-ordination, support and enhanced recruitment and monitoring of volunteers; it will enable transport costs to be covered. GL11 aims to maintain the links between volunteers and clients and to develop a Friendship or Befriending Club from this pilot – the social interaction which stimulates physical and mental well being can be achieved very cost-effectively by supporting a regular club of this type, and through our engagement with this vulnerable group, we now have a core group of people who would be our first members. GL11 has engaged with health professionals who are queuing up to refer clients, but GL11 can only offer support through the use of volunteers and a regular group activity with solid financial investment – not just a one-off grant, but 3-year agreed funding from which real benefits could be seen to individuals, families, the community – and to reduce the demand of local health services.

		Blanchworth Care Group Health Professionals in the Adult Care Team based in Dursley	
Campden Hub	**Developing a Local Network** The area of interest was defined as Chipping Campden and surrounding villages of Ebrington and Paxford, Mickleton, Willersey and Blockley. During the year the Hub has looked at local need (through members' experience and asking older people in the area) and has developed activities that begin to address these needs. **Campden Information Event** This was held in October 2008 at the Baptist Church weekly Coffee Drop-In. Fifteen organisations were present, offering a range of information and help for older people. Around forty older people attended.	2 care home managers 2 community nurse visitors to the elderly Adult Care manager Bromford Care Support Worker Village Agent CDC Health Policy Officer 3 representatives of local community groups – all older people Care home resident	The Group is interested in continuing to meet but this will be dependent on members feeling that something is being achieved. The accommodation for meetings is free, but there are some ongoing printing costs and to ensure real success funding would be needed for some limited Co-ordinator hours. New activities in Campden could be funded by the Community Trust, but other funding wold be needed for the other villages. Cotswold District Council is very supportive. The events cost very little and although they do not reach a large number of people they can be useful, particularly if linked with other events. The regular information column in the parish newsletters takes time and effort to sustain but it hoped that this

	Another Information Event is being planned for Mickleton on 16 March. Also aiming to have a regular column in the parish newsletters which will disseminate information on current issues to a wider audience including family carers. **Reminiscence sessions** A series of six monthly reminiscence sessions is taking place, organised by CDC Corinium Museum and CADHAS (Campden and District Historical and Archaeological Society). They are also held at the weekly Coffee Drop-In, in hopes that more people will used this opportunity for a chat. There have also been three photo shows at Mill House for residents and older people in the community, given by CADHAS volunteers. **Early-stage dementia care** Concerns were expressed by one of the community group members about some people they visit who are not coping, partly due to increasing confusion. They are not people who have received a diagnosis. This was discussed and confirmed by others in the Hub. As a result a session was held with Penny Garner, from SPECAL, who explained her approach. The interest has resulted in a training session being arranged in March for practitioners in different	Library Manager Representatives from GOPA and POPP.	can be done. It will also be valuable to maintain the information flow to local group leaders who see the most vulnerable on a regular basis. The cost of the Corinium Museum involvement has come from the Campden Hub budget. This could not be covered another time. The CADHAS volunteers are keen to continue to visit the care home and will do so, as the contributions add to their Community Archive. The cost of the SPECAL training is covered by the Campden Hub budget. This will not be repeated, but should provide a valuable understanding of a particular approach to dementia care in the community. The half-day event, in March, will hopefully result in improved multi-agency and community working together. CDC is very keen to support this development.

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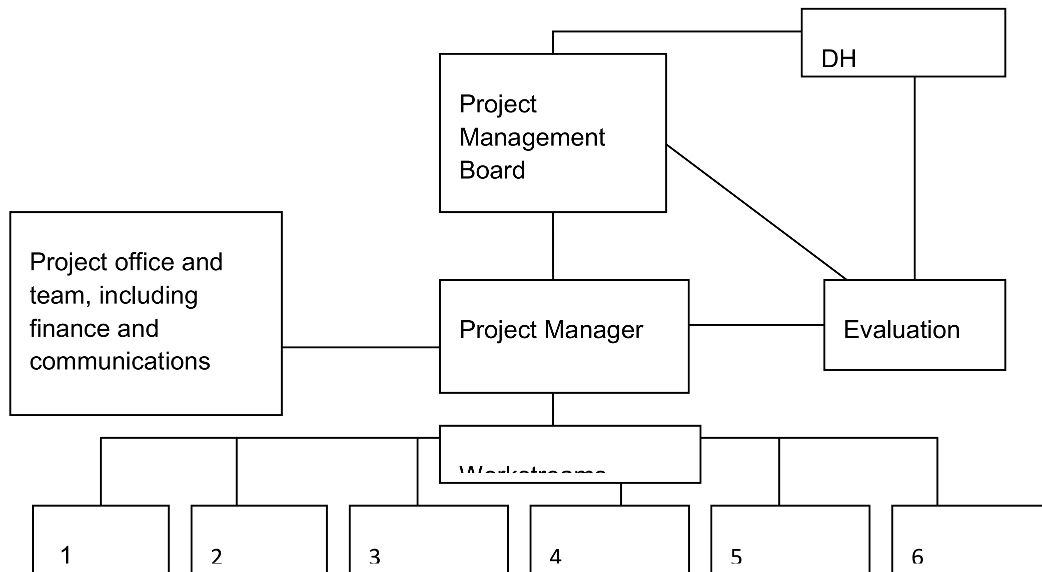
This paper is intended to outline to the Project Management Board, the proposed project management structure and to clarify membership of key groups, reporting arrangements and the expected agenda for these groups. The Board is asked to agree these project arrangements.

1 Project structure



2 Project members

The key members of each group are as follows:

Workstream leads

	Workstream	Lead organisation
1	Care Home Support Team	GPCT
2	Outreach	GCPA

3	**Training**	**GCC**
4	**Involving older people**	**GOPA**
5	**Recruitment**	**GNPN**
6	**New Pathways**	**GPCT/GCC**

Project Team

Project manager

Project officers

Finance

Communications

3 Reporting to the Project Management Board

The project manager will report to the Board using the project monitoring report standard report (Gloucestershire County Council) amended to include details of key milestones achieved. It is expected that the Board will identify the agreed tolerances. Any changes to plan in terms of resources(including costs), timescales or quality will only be reported to the Board if they are outside these agreed tolerances. A budget report will also be provided. Notes from all project meetings will be action focused around delivery of the plan.

4 Agenda for the meetings.

Standard core agenda are proposed for the Project Management Board and workstream leads meetings as follows:

Project Management Board

- Review of actions from the previous meetings
- Project Monitoring Report, including risks and issues
- Budget Report

- Key communications issues
- Evaluation update
- Equality Impact assessment

Workstream leads

- Review of actions from previous meetings and PMB
- Update on progress against plan agree any changes
- Review of key issues and risks
- Significant communications issues
- Budget update
- Shared issues/learning
- Agree report to PMB

POPP Communications

Over the course of the project there have been several strands to the communications process, consisting of press releases, web promotions and printed publicity including posters, flyers and newsletters.

The project branding has developed and become more cohesive across all the strands as the project has progressed. This has helped enable the brand to have a clearer, stronger identity thus allowing it to get its message across more powerfully and effectively.

Press Releases

Gaining publicity through this channel has been one of the hardest things to achieve. It has been difficult to get stories out into the news for a variety of reasons. There have been bigger stories out in the media at the current time of which we had no control over, and therefore some of our items didn't get picked up. Another problem we encountered was journalists sometimes didn't see POPP stories as being 'news worthy'. Care homes have a negative image in the eyes of the public and the media, so getting the press to follow up on our small but positive stories was difficult. The table below shows the successful press releases – ones that were 'picked up' by the press. Many more had been written but were unsuccessful.

Outsourcing press releases to a media communications company has been a very worthwhile exercise as they have the time and expertise to push the stories through their contacts.

Internal Communications

Date	**Where**	**What**
25-Apr-08	This Week in Community & Adult Care Directorate	'*Remember back when …*' Theatre piece on reminiscence Workshops with the Memory Lane Theatre and residents of Henlow Court residential home in Dursley (Prema Arts Centre on Friday 18th and Saturday 19th April.)

2-May 08	This Week in Community & Adult Care Directorate	*Care Homes get online for e-learning opportunities* – PC's out to care homes
2-May 08	Friday Feeling	*Care Homes get online for e-learning opportunities* – PC's out to care homes
30-May-08	Friday Feeling	Dementia Training Launch
30-May-08	This Week in Community & Adult Care Directorate	Dementia Training Launch
02-Jun-08	This Week in Community & Adult Care Directorate	Dementia Training Launch 23 May – *'Carers trained free'*
02-Jun-08	Friday Feeling	Dementia Training Launch 23 May – *'Carers trained free'*
04-Jun-08	This Week in Community & Adult Care Directorate	Stroud & Uplands Hub Launch – 11 June *'Keep Young & Beautiful'*
	Friday Feeling	Journal of Community Nursing & Care Management Matters
	This Week in Community & Adult Care Directorate	Journal of Community Nursing & Care Management Matters

External Communications

Date	**Where**	**What**
07-May-08	Stroud Life	'*Remember back when …'* Theatre piece on reminiscence Workshops with the Memory Lane Theatre and residents of Henlow Court residential home in Dursley (Prema Arts Centre on Friday 18th and Saturday

		19th April.)
02-Jun-08	Citizen – Stroud & City edition	Dementia Training Launch – 23 May – *'Training helps sharpen up skills in training'*
02-Jun-08	The Gloucestershire Echo	Dementia Training Launch 23 May – *'Carers trained free'*
04-Jun-08	Stroud Life	Stroud & Uplands Hub Launch – 11 June *'Keep Young & Beautiful'*
04-Jun-08	Stroud News & Journal	Stroud & Uplands Hub Launch – 11 June *'Keep Young & Beautiful'*
25-Jun-08	Stroud Life	Stroud & Uplands Hub – *'Over 50's given class in health and well being'*
May 2008	Journal of Nursing - Vol 22/Issue 5	Part of 'Healthcare in care homes:' article – *'Developing on best practice'* (pg 12)
July/Aug 08	Care Management Matters – May 2008	Article – *'Integrated health team – POPPing in'* (pg 40)
26-Sept-08	Citizen	Activity Co-ordinators network launched - *'Ideas given to care staff'*
Nov 08	Quedgeley News	Editorial on recruiting volunteer recruitment for Project
	Forest & Wye Valley Review	Launch of Forest Hub to represent elderly residents
Autumn 08	The Relatives & Residents Association Newsletter	Page 5 – '*Workshop on Gloucestershire POPP'*

Printed publicity

This consisted of POPP quarterly newsletters, posters and flyers to promote a care home's services and partner publicity.

Newsletters

The newsletters acted as a good way of getting across to all audiences what was happening across the project. They were also a useful tool in sign posting people to correct contacts. Positive feedback was received on these items.

Activity	Objective
A4 newsletters informing audience of progress work under taken by POPP. Newsletters sent out in: • Autumn 07 • January 08 • Spring 08 • Summer 08 • Autumn 08 • Christmas 08 • March 09	• To build the awareness of the project • To offer a clear signposting service so readers know who to contact for further information • To keep readers updated with the latest news in the project

Care Home Posters and Flyers

These were provided to care homes who wanted to promote a new or existing service to the older residents of the local community. These were displayed at appropriate places throughout the community, such as GP surgeries, day care centres and libraries. These posters and flyers acted as a useful tool in building closer links and relationships with the surrounding community and also help to build a more positive image of care homes. Printed material was the medium to use when trying to reach the older residents of Gloucestershire, as many of these people do not have the access or knowledge to use the online resources.

Printed publicity worked well when promoting information to care homes as it could be displayed on notice boards for staff to view, so not relying on care workers to use the internet.

Activity	Objective
A4 Posters to promote the care homes new service offered to older people in the surrounding local community. Posters provided	To build the awareness of the services the Manor offers To build closer links between care homes

to the following care homes: St Paul's Residential care home Mill House The Manor Nursing Home	and the wider community
A5 leaflet to accompany posters providing specific dates and information: The Manor Nursing Home	To build the awareness of the services and provide further information.
St Paul's Residential Home specialist services flyer promotes the services that are available to local residents who may be of an ethnic minority. The flyer will ultimately be translated into various different languages so it can reach people whose first language is not English.	To build awareness of the specialist services available to residents of the local community who may be of an ethnic minority whose first language may not be English. To build closer links between the care homes and the wider community

Other Printed Publicity

Training Posters

Posters were produced to help with certain areas of training. A poster was produced for the Speech and Language Therapist to help promote the SONAS training that was being provided to Activity Co-ordinators. This poster was sent out to all care homes to raise awareness.

The Dementia Training Pathway poster was developed to help with the training of the Dementia Link Workers. It outlined all the sections of the training and was a useful tool in explaining how all the elements of the course linked together.

Activity	**Objective**
Dementia Training Pathway Poster. To display in pictorial form the different components of the training programme and how they all link together.	To allow people to understand in a simple visual format how the training programme works. To encourage people to want to undertake the training programme

	To improve care home staff's knowledge and expertise in the field of Dementia
SONAS poster to advertise the new training available for this therapy.	To recruit care home staff to sign up to training To advertise that this new therapy is being offered in Gloucestershire and that it is free.

Partner publicity

Activity	Objective
GOPA Members Leaflet	• To explain what GOPA does • To encourage people to become involved with the charity
GOPA Forum leaflet. Explains what forums are and encourages people to get involved	To promote the forums so older people realise they can get involved in issues that affect them. To encourage volunteers to sign up
Volunteer Recruitment Flyer. To attract and recruit volunteers who are willing to offer their time/skills to care homes and their residents.	To build the number of volunteers who are willing to work on the POPP project To build closer links between care homes and the wider community To encourage volunteers to offer their time/skills – thereby giving residents of care homes a more stimulating environment to live in

Activity Co-ordinator Network Guide leaflet. Aimed at providing Co-ordinators with a step-by-step guide on how to use the website www.gcpaactivitynetwork.co.uk	• To make Co-ordinators aware of the new site and promote the site and its benefits • To provide clear instructions on how to access the site and its contents
A5 Barton & Tredworth Hub Booklet. Aimed at the elderly residents of the Barton & Tredworth area of Gloucester so they can find out about their local services and facilities. Produced in conjunction with GUiDE and PALS	• To build the awareness of the services available in the area • To promote GUiDE and PALS as the place to contact for further information once the POPP project ceases.
Camden Hub flyer to promote the activities that are being run by the Hub	• To promote the activities and talks being run in the local community

Web

The dedicated POPP pages on the GCC site (www.gloucestershire.gov.uk/POPP) provide a useful guide to the project, the partners involved and displays all the publicity that the project has accumulated. It is also a useful tool in signposting visitors off to other sites for further information.

The Primary Care Trust website provides information on the CHST and how to contact them. This is useful as care homes will still be able to contact this team and take advantage of their help and once the project ceases. (www.glospct.nhs.uk/content/services/services_popp.html)

www.gcpaactivitynetwork.co.uk

A web promotion was undertaken to launch the new Activity Co-ordinators website on the GCPA website (www.gcpaactivitynetwork.co.uk). This promotion offered an incentive to encourage Activity Co-ordinators to visit the site and discover what help and advice was available to them to help them improve the activities that they could offer their residents by sharing ideas and information with one another.

Since the initial launch the site has had over 150 new users register (Data correct 28 Jan 09).

Activity	Date of mailing	Objective	No: of visits/ new users
Postcard mailing to Activity Co-ordinators in all care homes	August 08	• To promote the launch of the new Activity Co-ordinators website	
Follow-up postcard mailing to Activity Co-ordinators in all care homes	Nov 08	• Offer incentive to visit site and so increase number of new accounts	

Other Activities

'Full of Life' Event

This took place on the 25th September. The event was well attended by older people and other professionals. The POPP stand was in the main hall where all the workshops and meetings were held, so ensuring we received as much of the footfall of visitors as possible. The only drawback was that it was right under one of the large monitors making noise levels an issue when sessions were being run. We were not aware of the position of the monitor when the stand was allocated.

There was a steady stream of visitors to the site, a mixture of older people and other professionals and business in the health and social fields. We had some visitors to the stand offering their services to help with events when creating hubs e.g. a reflexologist.

Overall the event has raised the profile of what POPP is working towards, in both the professional sector and also has helped to improve older peoples' perceptions of care homes and the services and activities they can offer

Summary of sustained outcomes and outcomes identified within bid

A Summary of services provided as part of POPP which have been sustained

Workstream	**£'000**	**Commissioner**
Care Home Support Team		
Care Home Support Team	400	GPCT/GCC
Care Home Support Team (RMN component)	175	GPCT
Community pharmacy contracting	None in addition, refinement of existing contract	GPCT
GP zoning and potential LES for additional care home support (above GMS requirements)	Zoning no additional cost but LES in one area 40	PBC cluster where LES in one area
Training (other than CHST delivered)		
Dementia care pathway and dementia link workers	81	GCC/GPCT
End of life	£30 000	GCC/GPCT

Nutrition	Tbc	GCC
Clinical skills	Tbc	GPCT
Social care training including activity coordinator (see also outreach), cooks training etc	Tbc	GCC
Learning exchange/network (and or PiCNet)	None	
Training coordinator	Tbc	GCC
Other project services		
Small grants/outreach services from care homes, including services provided within hubs by care homes	intended to be self sustaining	
Activity coordinator network (see also training) Sitting within GCC but managed via a partnership steering group to 31st March 2010	40 for one year	LAA
Older People forum network	tbc	GCC/GPCT
Advocacy	tbc	Part of an overall advocacy tender: GCC
Hubs	No identified funding stream	
PCT beds in care homes (currently orthopaedic recovery beds)	tbc	Not achieved

B Summary of additional outcomes that are not services

Partnership working around care homes	tbc GCPA capacity building	GCC
CSCI addendum to statement of purpose	none	n/a
Improved perception of care homes	Difficult to measure	n/a
Improved integrated data	Tbc and GP zoning arrangements	n/a
Contractual changes? (Use of IT)	tbc	n/a

C Summary of services identified within the initial bid but not provided

Output in bid	Reason not pursued
A training programme including expert patient, expert carer and elder abuse will be developed.	Recruitment workstream discontinued
Older people will become expert assessors of services in conjunction with CSCI.	Investigation showed role now fulfilled by Help the Aged “Experts by Experience” programme
Care Homes will provide more outreach schemes involving rehabilitation and intermediate care. These will support the present reconfiguration of care away from acute hospitals and long-term care, and be closer to the older person’s own home.	The PCT strategy was not sufficiently clear to commission services from care homes at this stage

Care Homes will be commissioned to link to other initiatives such as Telecare.	Telecare is available to care home residents
Crisis intervention services will be developed, including Out of Hours, that are both residential and outreach.	
There will be a culture change within Care Homes and the statutory sector that focuses on enablement.	Enablement now part of person-centred care (see training plan) Huge demand for physiotherapy by care homes suggests enablement now much better understood
A Champions network for Care Homes will be developed. Care Home Champions will link to the already established PCT and Local Authority Champions Network, to support the NSF for Older People, and Next Steps.	GOPA action but existing PCT champions network disbanded. Advocacy and evaluators cover some of this. Excesive given these roles established