“Keeping People Connected”

A Partnership Project: London Borough of Southwark, Age UK Lewisham and Southwark and My Home Life

Final Report: December, 2014

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"A sense of autonomy, control or ownership over one's life; the importance of focused activity and purpose (or perhaps learning) and community engagement; prioritising meaningful relationships; an active home life and having the right support if one is frail or near the end of life are all vital to people's quality of life."

The Commission on Residential Care (2014) p163

BACKGROUND

The London Borough of Southwark supports a policy of speedy hospital discharge. This policy ensures that older people, in particular, do not spend unnecessarily long periods on hospital wards (placing them at more risk) and that beds are freed up for others who urgently need them.

In 2012, the Head of Older People's Services in the Borough, Ray Boyce, was concerned that the success of the discharge policy might adversely affect those older people who, having entered hospital unexpectedly in crisis, were then too quickly discharged into a residential or nursing home. He also believed that older people in this situation, together with others who moved suddenly into residential care from their own homes, might feel bereft and disconnected from their former lifestyles and communities. He worried that these older people might be faced with spending the rest of their lives with people they had not met before, in completely different locations and surroundings; particularly if they were without the support of relatives and friends.

The "Keeping People Connected" Project was conceived to identify the needs of older people in this situation and to determine what was currently being done and what more could be done to support them.

In January, 2014, when Ray Boyce retired, Vanessa Pugh became Interim Head of Older People's Services in Southwark, giving her support to the Project. John Howard, Head of Operational Services and Chair of the Care Home Quality Improvement Group, also endorsed and supported the Project's work with care home staff.

A PARTNERSHIP PROJECT

The "Keeping People Connected" (KPC) Project began on 5th August, 2013 as an 18 month partnership project between Southwark Local Authority, Age UK Lewisham and Southwark and *My* Home Life.

Southwark Local Authority (Southwark LA) funded the KPC Project and provided information about and access to Hospital Discharge and Adult Social Care Teams. It was also able to identify, introduce and link the Project Manager, Geraldine Matthews, to care homes in the Borough (http://www.southwark.gov.uk). A Social Worker, Sue Eldred, provided considerable help with this process at the beginning of the Project.

Age UK Lewisham and Southwark (AgeUKLandS) hosted the Project and Jennifer Werner, Independent Living Manager, provided supervision on its behalf. The Charity (http://www.ageuk.org.uk/lewishamandsouthwark) runs innovative projects for older people in the Borough which provided opportunities for shared learning. Additionally, it has good links with and knowledge of other groups and projects working with older people in the area, specifically its COPSINS (Consortium of Older Peoples Services in Southwark) partners.

***My* Home Life** (MHL) The work was part of the *My* Home Life Southwark Care Home Quality Improvement Strategy 2013-2015. MHL is a values-led approach that is appreciative, evidence-based and relationship-centred (www.myhomelife.org.uk). It is focused on making a difference to quality of life for those living, dying, visiting and working in care homes. Julienne Meyer, Professor of Nursing: Care for Older People at City University, Executive Director of *My* Home Life, provided

academic supervision and conceptual support for the Project. The Project Manager, Geraldine Matthews, is a member of the *My* Home Life Team.

STRATEGIC FIT

Residential care is an important part of the health and social care offer to frail older people, particularly for those who can no longer be cared for in their own homes. This Project has strategic fit both nationally and locally.

For instance, nationally, the recent Demos Commission on Residential Care (http://www.demos.co.uk/projects/corc) highlighted:

"Over 450,000 older and working-age disabled people live in residential care, yet the many acts of hospitality, human kindness and great care are drowned out by stories of shocking abuse. This report starts with a simple proposition: residential care has a future; it is an essential part of our health and social care system … Unloved, even feared, for most people residential care is not a positive choice. Linked in the public mind to a loss of independence, residential care is seen as a place of last resort … During the course of our inquiry we have witnessed great care: we have seen what the future can look like, because it already exists in the present."

Rt Hon Paul Burstow MP, Chair of Commission on Residential Care (2014) p9

Locally, the London Borough of Southwark has also made a strategic commitment to work with care homes in an evidence-based, appreciative way. The Forward from Cabinet Member for health, social care and equalities, Catherine McDonald, in the *My Home Life Southwark: Care Home Quality Improvement Strategy* 2013-2015 states:

"We are committed to treating every resident the way we would wish members of our own families to be treated, and for every care home resident to have the kind of high quality care each of us would want for our own relatives. The council's fairer future promises underline our strong commitment to high quality personalised services and this is why I am pleased to present *My* Home Life Southwark, which sets out our strategy on how we will work together to improve the quality of care in our local homes.

Care homes in Southwark provide essential support to people who are no longer able to live in their own homes. Our vision is that each individual is supported to live their lives in accordance with their own beliefs, preferences and culture so they feel comfortable and 'at home'. High quality of life is made possible when it is grounded in the relationships between the people who receive, provide or support care and this in turn fosters a culture of respect, dignity and compassion. I recognise that delivering high quality care to a wide range of individuals is complex as each person has their own individual needs, values, aspirations and preferences. This strategy recognises that sustained quality improvement will only be achieved if we re-orient the whole system and all play our part to ensure local homes are not 'islands of the old' but actively supported and open to the community. At the heart of this is ensuring our residents get the best possible care and experience good quality of life. *My* Home Life Southwark brings together the Council, NHS colleagues, providers and the voluntary and community sector around a joint vision for the highest possible

standards of care and a practical set of actions that will help to deliver this. I am pleased to be able to present this strategy and look forward to an update on progress in 6 months."

AIMS OF THE PROJECT

The project had a number of aims:

- to ascertain what is already known, from the research based literature, about supporting older people making the transition into care homes
- to identify the needs of and provide support for a small number of older people in Southwark who are making the transition directly from their homes/hospital to a care home setting
- to help older people making such transitions stay better connected with their communities and maintain their identities, interests and social connections
- to explore the possibility of a sustainable model for continued support based, on the learning from this exploratory study
- to produce a report, in partnership with City University, to share the lessons learnt (from the variety of perspectives of all those involved) within the context of the wider body of knowledge
- to disseminate the findings, with permission of the funder and those involved, so that others can benefit from the lessons learnt (newsletters, academic and professional articles, bulletins)

METHOD: WHAT HAS BEEN DONE?

From the outset, it was envisaged that the Project Manager (PM) would work with the 3 main care home provider organisations in the Borough. The Project Manager worked as a broker throughout the project using appreciative action research[1] to talk and listen to people about "What works well?" and "What needs to happen in order to offer greater support to older people making the transition from hospital/home to live in a care home?" The approach involved working positively with and for all parties involved across the whole system, trying to encourage and facilitate learning as change took place.

Detailed field notes were kept throughout the process and this Report is based on an analysis of these field notes reflecting what has been learned from the issues raised. Southwark LA might wish to reflect on these issues in order to take forward and build upon the work of the Project.

An appreciative, action research approach was used throughout in seeking the views, challenges and perspectives of older people and representatives of the provider services, groups and organisations that work with and for them. Data collection was in the form of field notes which

[1] Dewar B and Sharp C (2013) Appreciative dialogue for co-facilitation in action research and practice development, International Practice Development journal, 3, 12, 1-7.
Register via http://www.fons.org/login-zone/registration-form.aspx and then once that's done, your paper is http://www.fons.org/library/journal/volume3-issue2/article7

recorded the substance of conversations, interviews and meetings. People and organisations consulted are recorded below in each strand of action.

Ascertaining what is known

Research was undertaken to ascertain what information already exists in Southwark about older people's transitions from hospitals to care homes; the numbers involved and about what is known in the literature about managing this transition.

Local perspectives on older person's journey from hospital to care home

Information was gathered from: Southwark LA; Age UK Lewisham and Southwark and its partner organisations in Southwark; Southwark and Lewisham Integrated Care (SLIC); Southwark care homes; King's College Hospital NHS Foundation Trust; Guy's and St Thomas' NHS Foundation Trust and other organisations/clubs working with and for older people in the Borough.

Numbers of older people discharged from hospital to Southwark care homes each month

Information was sought from: Southwark LA (Community Support Team and Southwark LA Commissioning Manager, (All age) Long Term Conditions); King's College Hospital NHS Foundation Trust and Guy's and St Thomas's NHS Foundation Trust.

Broader perspectives from the literature

The literature was selectively explored to ascertain what is known about older people in their transition from hospital to care home and about support for this transition. This included articles that seemed pertinent to the subject from general reading of E Journals in The Adult Nursing and Heath and Society Subject Guides at City University and websites of organisations working with and on behalf of older people.

Views of older people

The views of older people living in the community and in care homes were explored in relation to maintaining their connection with their local community following admission to a care home

Living in the community

Obtained in the course of individual and group discussions at 5 Clubs for older people in the Borough: Southwark Pensioners' Association, Southwark Irish Pensioners' Project, Blackfriars Settlement, Golden Oldies and Time and Talents. Groups ranged from 6-30 members of both sexes.

Living in care homes

Obtained in the course of individual interviews with 5 women and 3 men living in 3 care homes in the Borough and 1 outside the Borough. Residents were identified by the Community Support Team and care home managers.

A further 4 men and 5 women who had gone to live in care homes during the previous 6 months were consulted. These older people were referred by care home managers and were visited by the Project Manager on a number of occasions with a view to offering them support in maintaining their connections should they wish.

Views of professionals

Information about procedure for older people making the transition from hospital to care home and the perspectives of those involved was sought in a series of meetings with: Southwark LA Adult

Social Care Team and Hospital Discharge Teams North and South; Southwark LA Sheltered Housing Services Manager, Voids and Lettings Manager and Housing Area Manager South; Head of Nursing, Trauma, Emergency and Medicine, Kings College Hospital NHS Foundation Trust and Head of Nursing, Acute Medicine, Guy's and St Thomas' NHS Foundation Trust; Discharge Coordinator, Consultant Nurse for Older People, Matrons of Health and Ageing Units and Manager, Delivering Dignity Project, King's College Hospital NHS Foundation Trust; managers of day centres (2 run by Age UKLandS and 2 run by Southwark LA), Service Manager AP Southwark LA day centres and managers of befriending organisations in Southwark (Time and Talents, Southwark Irish Pensioners' Project, Blackfriars Settlement and Dulwich Helpline & Southwark Churches).

Views of care home staff

Information and perspectives on how to enable residents to stay connected to former lives and lifestyles were sought in a series of meetings with: care home managers, carers and activity co-ordinators in 8 care homes (run by 4 providers) in the Borough, 2 care homes outside the Borough and senior management representatives of 2 major care home providers in the Borough.

Views of others

Views were sought from volunteering and other initiatives which might offer possible support to care homes to help maintain their community links including: *My* Home Life (MHL); MHL care home managers; Essex "Fans" Project; Attend Project (Innovation Fund, LB Southwark and HC-One); King's Volunteers; St Christopher's Hospice and befriending organisations in the Borough.

FINDINGS

The next section of the Report focuses on "What has been learned?" in the course of the Project. A number of exciting linked initiatives have also spiralled off from the Project and these follow and are noted as "Outcomes: Ongoing Work". It should be noted that any report only captures a moment in time. The "Outcomes: Ongoing work" has been informed by "What has been done?" and "What has been learnt?" and the picture of "Keeping People Connected" in Southwark today is likely to have moved on again from what is reported here. Change is ongoing, but reflecting on the lessons learnt at any one time, is helpful not only to those who are involved in the work, but also to others who might wish to follow a similar path. The work clearly demonstrates the good will and determination – apparent throughout the Project - of all those working with and for older people in the Borough to reflect on what they do and to strive to do better still.

What has been learned?

The gathering of information locally on the older person's journey from hospital to care home suggested that there was lack of a local road map. Further, information gathered on the numbers of older people discharged from hospital to Southwark care homes each month showed that it was unclear how many people were affected. A number of issues were raised from the literature that might be worthy of further reflection.

Lack of a local road map

Southwark LA does not seem to have a "road map" available which details what services are available in the Borough to help the older person's journey between independent living, hospital care and residential care. The PM found it hard to glean this information and found that it depended on conversations with people from a wide variety of services and organisations in the Borough. Mapping out this journey is important in order for all those involved in offering support to be identified, responsibilities clarified and for continuity of support to be achieved. Such a map would also enable evaluation of the effectiveness and quality of the whole service.

Unclear how many people are affected

Approximately 12 older people per month are discharged from hospital into care homes in Southwark. Hospital Discharge Teams originally suggested that around 16 older people per month are discharged from hospital into Southwark care homes but it has not been possible to obtain data to support this. King's College Hospital NHS Foundation Trust has, however, provided figures for numbers of older people discharged from hospital into care homes from Dec 2103 –May 2014. Additionally, Andy Loxton, Commissioning Manager, Older People Southwark LA, has provided numbers for older people entering care homes on a temporary and permanent basis throughout 2013. Assuming that discharge numbers from Guy's and St Thomas' NHS Foundation Trust (numbers currently unavailable) would match those from King's College Hospital NHS Foundation Trust, it would seem that approximately 12 older people are discharged from hospital into Southwark care homes each month.

Additional lessons from the literature

Transition is stressful

The literature tell us that moving into a care home is a stressful transition for older people and especially so when there is no alternative. In 2007 *My* Home Life[2] conducted a Review of the Literature in which it was noted that:

"There is no doubt that the move from one's own home to a care home is a major, and often final, life transition....It can be particularly difficult when it is triggered by necessity rather than by desire."

Need for support

The importance of support in managing this stressful transition to produce a positive outcome was also highlighted in the Review:

"With appropriate planning and support, the transition can be managed so that it produces benefits, including improved quality of life."

Support is patchy and loneliness is an issue

Research into later life transitions undertaken for the Calouste Gulbenkian Foundation[3] suggests, however, that there is "significant variation in the adequacy of interventions to support people" and that:

[2] NCHR&D (2007) *My* Home Life: quality of life in care homes – Literature review, London: Help the Aged, 42

"the loneliness that older people can often experience as a result of the transition into institutional care warrants much more attention."

Important co-ordination role for the nurse

Coordinated and continuous health care is clearly important in supporting older people's transitions. This is recognised in an article on Transitional Care of the Long-Term Care Patient in Clinics in Clinics in Geriatric Medicine Journal[4], where transitional care is defined as:

"a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations".

The important coordination role of the nurse in coordinating this process was highlighted in Department of Health Guidance, 2010[5]. The Guidance suggested that smooth transitions of care in hospital discharge can be as important as the clinical interventions received. The role of the nurse was seen as central in achieving effective discharge and transfer of care and his/her assessment should note "the individual's experiences, lifestyle, priorities and, importantly, concerns".

Interestingly, the details to be included in the nurse's assessment suggest that managing older people's transitions from one location to another – and this surely also includes hospital to care home - is not solely about ensuring continuity of clinical care; it is also about recognising "experiences, lifestyles and priorities", the very elements that keep older people connected to their former lives, to *who they are*.

Important supportive role for care home staff

Care home staff clearly also have a key role to play in offering support to residents traumatised by a crisis entry from hospitals into their care. Guidelines to assist them in supporting adjustment for residents (and relatives/carers) were developed by Oleson and Shadick (1993, cited in Davies 2001, p82, cited in 2007 MHL Review). These Guidelines suggest that:

"staff should assist residents to sustain relationships with family and friends, as well as other individuals who may be helpful in resolving the crisis and its aftermath"

Value of knowing the person

Life history work supports older people to maintain connections and enhances their care. Learning about what matters to older people, their lives and lifestyles – life history work - is identified in the literature as key in providing support for the transition from hospital to care home.

The Life Story Network[6] sees life story work as being at the heart of excellent care and support:

"Excellent care and support is based on building relationships. This involves recognising the uniqueness of the person and their life experiences, which influence not only who they are and how they behave, but also their hopes and wishes for the future. Life story work enables us to see people as individuals in the

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[3] Robertson G (2014)Transitions in Later Life, Calouste Gulbenkian Foundation, 163-166

[4] Oakes Liliana S, Gillespie Suzanne M, Ye Yanping, Finlay Margaret, Russell Matthew, Patel Neela K, Espino D (2011) Transitional Care of the Long Term Patient, Clinics in Geriatric Medicine 27,2,259-271

[5] Sturdy D and Heath H (2010) Guidance that offers a fresh perspective on transitions, Nursing Older People, 22, 4, 6

[6] http://www.lifestorynetwork.org.uk/

context of their relationships with others, thus preserving their unique identity and enabling their rights to be respected."

Key organisations working for and on behalf of older people support and value this work:

Dementia UK [7] sees life story work as "a tool to enhance the care provided to older people".

The Altzeimer's Society[8] sees life story work as "often enjoyable" and an activity which may enable" greater interaction or open up communication."

The Social Care Institute for Excellence,(SCIE)[9] notes the importance of life story work when someone is being transferred between environments:

"On a practical level, a record of experiences, likes and dislikes is very useful when someone is moving between environments such as respite, day or residential care. "

Organisations working with older people therefore agree that life history work enhances older people's care by offering a starting point from which connections can be maintained and meaningful activities devised. The Keeping People Connected Project has sought to establish what life history work is carried out in the Borough to support older people's transition into care homes.

Mixed views from older people

There were mixed views from older people; in particular, there was a difference in view between those living independently in the community and those who had been admitted into a care home.

Views from those in the community

Those living independently in the community agree that they want to maintain friendships and continue to attend clubs should they live in a care home. They are concerned about communication difficulties with hospitals and care homes.

Maintain important friendships

Those living independently agree that they would want to maintain important friendships. Many older people stressed how important their friends are to them. If they, or their friends, were to go to live in a care home, they would want to keep in touch:

"I visited my friend in a care home yesterday: it was a day out for me and my friend loved seeing me."

"We've known each other since we were little girls."

Continue to attend clubs in the community

They wish to continue to attend clubs in the community

"We have a laugh and I've got a lot of friends here."

"It's good to get out after a long weekend indoors."

[7] http://www.dementiauk.org/information-support/life-story-work
[8] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1671
[9] http://www.scie.org.uk/publications/ictfordementia/lifestoryactivities.asp

Several people spoke of the pleasure of attending clubs or day centres where they felt known and where they enjoyed the activities available and the friendship bonds.

It is currently impossible for care home residents to continue to go to day centres which they have previously attended due to the difficulty of providing transport and of finding the funding that is required for attendance of a day centre such as Stones End. (A care home resident's personal budget is generally fully used to finance their stay in the home.)

Maintaining connection with a previously-attended day centre would make a new resident in a care home feel that they were still very much in touch with his/her previous life and friends. Additionally, their friends in the day centre would not experience the sudden bereavement that managers of these centres say comes from the unexplained "disappearance" of a previously familiar face. It is, however, possible for a care home resident to continue to attend some clubs in the Borough such as those at Time and Talents and the Irish Pensioners Project, for example. Here the costs of attendance are minimal and the organisations themselves provide transport.

Difficulty keeping track of friends

Those in the community had difficulty in keeping track of friends who entered a hospital or care home suddenly. Several people spoke of not being able to get through to hospital switchboards in order to locate friends; others spoke of not knowing how to find which care home a friend had gone to.

"People didn't know what home she was in. Next thing I knew she'd died and I'd known her for so long…"

"I didn't even know my friend was in a care home and she moved out of the area. Her daughter didn't tell us. It was so sad."

Hospital Discharge Teams confirmed they were not able to release information about older people they were transferring to care homes without the consent of the person involved although they would contact people if their client asked them to do so. Unfortunately, older people in this situation may be too ill or confused to provide the relevant information and consent.

Views from those living in care homes

Views from those living in care homes were different to those living in the community and include missing former habits and occupations to not missing or even remembering former lifestyles. Family support is important and friendships developed before entry into the care home seem less important than those formed within the care home.

Missing aspects of former lifestyle

Some missed aspects of their former lifestyles which it ought to be possible to maintain or restore

For instance, Ann had artistic talent and missed being part of a group in the community with similar skill and enthusiasm:

"Surely I could be picked up and taken to a class!"

Copying drawings produced by the home's activity coordinator did not meet Ann's need and, although she was not able to go out to join a group, the care home eventually arranged for a talented amateur artist to come in weekly to give Ann lessons, paint alongside her and talk.

Another resident, upset by the loss of control of her finances – taken over by the Borough when she first entered the home - continually expressed her frustration:

"I want to know where all the money is and what has happened to my home: no one will tell me."

An Irishwoman desperately missed links with her heritage and homeland. A regular trip to the Borough's vibrant and warm Irish Pensioners' Settlement would have enabled her to meet other Irish people but its the care home was unable to make this happen.

Two residents missed having a daily newspaper:

"I like having a go at the crossword."

"(The paper) keeps getting pinched so my son has cancelled it."

Case study: Margaret

Margaret, in her 70s, suffered a stroke and went from living independently to hospital and thence to a care home where she remained mentally alert but mostly confined to a wheelchair. She missed many aspects of her independence, including her weekly trips to a local day centre where she played cards and draughts with her friends.

"I used to have a good time there: no one can play draughts or cards here. They're all too far gone."

The PM worked with the care home to flag up Margaret's need for someone who could engage in these activities with her and a carer was identified who could play draughts with Margaret. The PM also contacted the day centre she had attended and the local representative of The Stroke Association. Margaret was delighted when former friends from the day centre visited as well as the manager – *"It was really nice seeing her".*

A trip back to the day centre was arranged and the Stroke Association representative offered to accompany Margaret. The day centre staff liaised with care home staff to help them set up appropriate transport using a taxi service with which Margaret was familiar.

The visit to the day centre was a great success, reconnecting Margaret with an important element of her previous life. A link was established between the day centre and the care home which ensured that Margaret could return to the day centre whenever she wished.

Case study: Joe

Joe, in his late 80s, explained that an important part of his weekly routine when he lived independently was to visit the local market – "The Blue" – where he would banter with stallholders, have a drink in his local and buy jellied eels. He wasn't fond of meals in the care home.

"They're nice here but the food's diabolical."

The PM discussed with care home staff the possibility of taking Joe to the weekly market in his wheelchair. Unfortunately, staff and/or volunteers were not available to do this. However, the home did arrange for jellied eels to be bought for Joe each week which he much enjoyed.

"I've got a supply of eels in the fridge. I can have 'em when I like!"

Care homes do try to learn their residents' likes, dislikes, talents and interests in addition to their medical needs. This is evidenced in regularly updated care and activity plans. They also often capture life histories of new residents. However, the findings above suggest that, in spite of these efforts, significant information about meaningful friendships, lifestyles and habits may be missed. When such information is known, limited resources may mean that it cannot always be acted upon.

Not missing aspects of former lifestyle

Some residents did not seem to miss or remember their former lives and lifestyles. Residents who had been in a care home for at least a few months were often unwilling or unable to look back to the time when they entered a home or before: they looked "inwards" to their current life and not "outwards" to their former lifestyles. Whilst happy to reminisce about their lives before they entered the home, an acceptance of their current lot and/or loss of memory, made them disinclined or unable to remember any difficulties or losses associated with moving into the home.

They expressed the following views:

"I don't know where I lived before."

"You have to pick up the pieces and get on with it."

"I just accept being here; I don't think about home."

"I feel more secure now and I like having people around."

"I don't really have any friends who visit but I've got a good pal downstairs- we meet up every day."

and even…

"It's not a bad place to be incarcerated!"

For these residents, talking about previous lives and other reminiscence work is satisfying: most homes run reminiscence activities and some work on a one to one basis. This is valuable and important work and is an area in which volunteers/befrienders can be of great support to the care home.

Sense of loss

Some older people living in care homes experience a sense of loss arising from feeling useless and being a burden to relatives which is not likely to be remedied by maintaining connections to former lifestyles.

One woman, whilst utterly accepting her need to be in a home in which she experienced kind and sensitive care, nevertheless evinced a deep sense of loss of her former life– its activity, mobility and the sense of being of use and not a burden to relatives. She enjoyed the activities provided within the home and continued to knit and read as she had done throughout her life.

It follows, then, that the sense of grief and loss felt by some residents is not able to be remedied by meaningful activity or connections to former lifestyles.

Some good work by social workers and hospitals is already happening, but a number of issues

Both social workers and hospitals are likely to be involved in offering support to older people as they make the transition from home to hospital to care home. Befriending organisations and day centres may also be involved as well as, ultimately, care homes. However, a number of issues were raised by the professionals consulted.

Lack of quality, consistency and co-ordination

Quality and consistency of support offered may be compromised because, in spite of best intentions those involved, there are difficulties with communication between groups/services involved. Information, which could be used to keep people connected to their former lifestyles, is not passed on or may not be sufficiently well-captured.

Social workers

Not always allocated a social worker

Older people "known" to social services before they enter hospital and care home are likely to receive ongoing support from social workers through the transition and until they are settled in their care home. Those not previously known may receive little support from the Borough's social workers during the time they are in hospital. Hospital Discharge Teams – consisting of Southwark social workers - recognise the importance of time spent talking to older people in hospital about going to live in a care home, about capturing former lifestyles and connections and the collection of treasured possessions. In reality, they are usually unable to do these things because of pressure from heavy workloads and sometimes very tight time schedules.

Unable to collect treasured belongings

Some older people are well-supported emotionally by relatives or friends when they fall ill, enter hospital and go to live in a care home Where nearest and dearest are not involved, if support of the older person is to be holistic, it necessarily falls to those who *are* involved - the Borough's health and social care services and, sometimes, befriending organisations - to deliver emotional as well as medical and practical support during the transition. The Borough's Adult Social Care Team is able to offer good support. It is, however, unequal and may be compromised by workload and communication difficulties with other people/services. This may result in some older people entering care homes without subsequently having the chance to collect, or have collected, their treasured possessions.

Difficult to access treasured possessions

The Adult Social Care Team take over once an older person enters a care home and their Community Support Team conduct a Review after 6 weeks. At this point, there is an opportunity for the Team to offer the support of collecting treasured possessions if they have not been collected by anyone else to date. (Those with complex needs will have been supported in this and other aspects by the Team from the outset.) This task can be made difficult for the social workers involved because of the following challenges:

- tracking down responsible relatives or obtaining their support;
- making contact with the Housing Officer in charge of closing down the tenancy (in the case of those who were former Council housing tenants) in order to make arrangements to

collect possessions and lack of awareness of a protocol between Social Care/Housing Department over this;

- identifying, in the case of some older, frail people with dementia who may have become "inward-looking" since moving into a care home, precisely what their treasured possessions are.

Issues compounded by lack of review

Sometimes, pressure of work means that a Review does not take place until much later than 6 weeks. Furthermore, those residents admitted for "respite" may remain on this unsettling and disconnecting status for several months. This means that the above difficulties experienced by social workers are compounded. The outcome in either case is the same: some, though probably only a few, older people do not have their treasured possessions collected, a situation distressing for anyone but particularly unhelpful in the case of those with dementia whose links to previous lives and lifestyles are increasingly tenuous…

Hospitals

Both Hospital Trusts in the Borough offer support to older people (and their relatives) with the discharge process in the form of ward-based discharge nurses/coordinators but this support is largely of a practical nature. Older people's community and lifestyle connections may be weakened or lost because of a number of issues including the need for an advocate, life history not being passed on and poor links with care homes.

Need for an advocate

Unless an older person has mental health issues, they are not likely to have an advocate whilst they stay in hospital. Whilst it is the case that nursing staff are increasingly person-centred and that supportive relationships may well be formed between nurse and patient, hospitals may do well to give consideration to patients having "named nurses" who would have a greater responsibility for the holistic care of their patient. These nurses could also play a useful part in the pre-assessment of an older person conducted by care home managers on the wards prior to a patient transferring to a care home.

Life history not being passed on

Information about an older person's connections and lifestyle (captured in person-centred profiles made in day centres) is not collected by the hospitals when an older person is admitted. Instead, they put together their own profiles of each patient using the "This is Me" template. Hospitals are working to improve the quality of information collected in this profile and more work needs to be done to capture important connections and preferences and to act upon these. However, when completed, this profile is not passed on to the care home when an older person is discharged to live there. This results in a loss of key information which is unlikely to be regained in the case of an older person with dementia.

Links with care homes not strong

Good links with care homes are an important part in improving older people's care during this transition and, indeed, if/when older people need to return to hospital from care homes. Effective links have been made through SLIC's Care Home Interface Project in which health professionals work proactively with care homes to ensure prevention and good management of some health issues and good end of life care. However, there is still work to be done to build on this good work

and improve links between ward sisters on older people's wards and senior care home staff in all care homes in the Borough.

Good relationships between hospital and care home staff can only have a positive impact of the quality and consistency of support and care offered to older people in the Borough who leave hospital to live in care homes.

Befriending organisations offering support, but not universally available

Befriending organisations offer good support to older people known to them. Their finite resources and restricted geographical reach within the Borough mean that this support is not universally available.

Many older people in Borough attend groups run by or at the Blackfriars Settlement, Time and Talents, Dulwich Helpline and Southwark Churches Care and the Irish Pensioners' Project. These organisations additionally have befriending services. Befrienders continue to support older people with whom they have links as they go through the system and in the care home.

Support from befrienders can be extensive, even, in some cases, including looking after treasured possessions when an older person is in transition from hospital to care home. By their very nature of being linked before, during and after this transition, befrienders are themselves keeping older people connected to former lifestyles.

However, befriending organisations speak of the difficulties they have in tracking down older people who suddenly go into hospital and of getting precise information about what is happening from Hospital Discharge Teams. They overcome these difficulties by dogged determination which an unexperienced other friends of the older person concerned may not possess.

Unfortunately, the excellent, connective support offered by befriending organisations does not– and is not likely to - extend to those not previously known to these organisations when they fall ill or to those outside their geographical reach.

Important role of Day Centres

Day centres support closely a number of older people in the Borough who are living independently: their knowledge of and the information they collect about older people can play a key role in keeping older people connected but this is not passed on when members go into hospital or care homes. Former members are rarely able to return to day centres once they have entered care homes to live.

The Borough's 4 day centres– 2 run by the Council and 2 operated by Age UK Lambeth and Southwark - offer person-centred care to a number of older people in the Borough on a daily and regular basis. Some older people attend a day centre for a number of years and have particularly strong relationships with staff and volunteers.

Day centres put together person centred profiles (PCPs) for each of their members which are based on the Helen Sanderson model. They are typically one page in length and may have three sections: an appreciation of the person; who/what is important to that person from their perspective; and how to support them well. The day centre is not officially informed about what has happened to a member who suddenly stops attending although it may find out some information from friends,

relatives or neighbours. This means that it may not be able to maintain any contact with the older person so affected and equally cannot pass on the valuable PCP or any additional knowledge accumulated by their staff over time.

Furthermore, older people who are friends of the day centre member who has "disappeared" are often themselves left bereft or confused:

"People here don't get a chance to say goodbye, have a party or acknowledge their leaving in any way and so there's no closure."

Unfortunately, it is not often possible for a day centre member who has entered a care home to return to their day centre on a regular basis because of cost implications. A notable exception to this existed in the case of an older person who attended Southwark Park Resource Centre and then went to live in Bluegrove Care Home. As the care home is next door to the Centre, staff from the Centre were able to collect their member so that the routine of attendance could be maintained.

Both Stones End and Yalding Day Centres have also collected or facilitated the return of members from a care home for a one-off visit to offer closure. Such visits have clearly meant a great deal to all concerned but they remain the exception rather than the rule.

Care homes recognise the importance of supporting residents, but number of issues

Care homes recognise the importance of supporting residents to stay connected to their former lives and lifestyles; they appoint activity coordinators to provide meaningful and relevant activity. This work can be very effective. Quality and extent of work may, however, be limited in some homes by narrow vision and insufficient staff to deliver it; limited training; insufficient support for those isolated in the Activity Co-ordinator (AC) role; increasing difficulty in providing meaningful activity to a very frail and demented care home population and a lack of useful information passed on to the homes about residents' former lives and life

Insufficient meaningful activities

Activity Coordinators (ACs) are employed in the 8 main care homes in the Borough: their vision of the work varies and there are not enough hours devoted to activity provision in the Borough's care homes. ACs in the Borough's homes are very committed to their work. However, several work alone and/or on a part-time basis and their vision for the provision of activity varies greatly:

"I like to give back; I want to make them happy."

"I am passionate about what I do; I want to get deeper into what residents care about."

"It's a wonderful job: if you spend time with them you'll get something from them and a relationship develops."

and:

"I see my role as offering activities that are person-centred to feed what makes residents individuals and give them the opportunity to express themselves; to bridge the gap between the care home and the community."

Working within a team and access to good training offers an AC the potential to develop a wider vision of his/her work but, whatever that vision may be, there needs to be enough time and staff to deliver it. "*We need more manpower!"* was a cry frequently uttered by ACs in the Borough.

None of the of the Borough's homes currently meets NAPA's recommended ratio of AC time available to each resident (1 hour per resident per week or l½ hours per week in the case of those with dementia). Some homes fall very far short. This places unfair expectancies on the ACs concerned and is it likely to mean that some residents will have little opportunity to engage in meaningful activity.

Inadequate training

Training available to ACs is given in house by the Borough's providers and is not of consistent quality.

Each provider organisation offers some in-house training to ACs when they are appointed and also on an ongoing – largely online – basis. This training is likely to reflect the induction course undertaken by all new employees with some additional and specific training, in one case lasting 6 months, mostly consisting of specifics of how the provider company goes about delivering activity in their homes and what that should look like.

In other cases, the "training" is simply based on a "what has been done before" basis with the new AC expected to maintain and build on this.

None of the providers insist upon AC applicants having particular qualifications for the post:

"I got the job because my sister used to do it."

"I've done a lot of volunteering with older people."

Some providers do encourage external training when ACs are in post. This may be in the form of NAPA's Level 2 "Supporting Activities" Award - which NAPA considers to be the minimum requirement for those undertaking this work - or their Level 3 Award, "The Provision of Activities". Both of these are distance learning courses.

None of the ACs in the Borough has, at the time of writing this Report, undertaken either of these courses or an equivalent BTec course being explored by one provider. There is indeed no financial gain or available career path which might motivate ACs to do so.

This lack of training from outside the provider organisation means that some of those undertaking this role are not able to have a vision of their work beyond what was done before/always done within the organisation.

Insufficient support

There is insufficient support offered to ACs in what is often an isolated position within the care home

Support offered to ACs in the Borough varies. Whilst all the ACs spoke of the support and encouragement of their home managers, for some, little other support is available. Occasionally,

the AC may feel he/she is an "ad on" rather than an integral part of the staff team. This, and the shortage of colleagues doing the same work, can make some ACs feel very isolated.

Some providers offer online support in the form of ideas and prompts and one notably holds 3 monthly meetings of ACs from its homes in Southwark and annually with those across London. This excellent practice offers an opportunity for networking and exchange of ideas and support although there is still no chance to benefit from learning of good practice outside the provider organisation.

ACs in the remaining homes in the Borough said that they would like more support. Some admitted to being unaware of many organisations and resources in the Borough, such as Potted Histories, which could come, without charge, to the home and engage in meaningful activity with residents thereby adding to the offer.

Challenge of frailty, including dementia

Activity coordinators spoke of the difficulty they experienced in providing meaningful activity for those in the home who were very frail and demented. Those going to live in care homes are older, more frail and likely to be suffering from varying degrees of dementia than ever before. This clearly means that group activities that have long taken place in care homes: bingo, reading groups etc. may have less relevance with the need for one to one work increasing. All of this work falls to ACs who usually begin with what they can learn of the life history of residents. From this work they may be able to devise meaningful activities or make connections between their residents and people or things that have been important in their lives. Nevertheless, several ACs in the Borough spoke of the difficulty in finding meaningful activity for those in their care who are very frail. There is clearly a need for discussion, exploration and training around this topic to support those delivering activity in the Borough's care homes.

Useful information not passed on

Useful information, which may help ACs in their work to connect new residents, is not passed on to the care home.

There is currently no protocol or mechanism for day centres and hospitals in the Borough to pass on person centred profiles which are compiled before an older person enters a care home.

These profiles may contain information about important people and activities which a new resident may no longer be able to articulate to staff in the care home. Effectively recording and passing this on plays an important role in keeping older people connected when they go to live in care homes.

Others can support staff in offering activity and in befriending

Volunteering and other initiatives offer potential for support to care homes to maintain their community links and those of their residents.

Value of volunteers

Volunteers can support staff in offering activity and in befriending residents in the Borough's care homes. Care homes find it difficult to attract, support or sustain local volunteers.

The engagement of local people to help with the activity offer or with time to talk to residents would clearly improve residents' wellbeing and their connection to the surrounding community.

Whilst a few care homes in the Borough have some long-standing volunteers, there is nevertheless a sense amongst homes that they will just not be able to attract or keep volunteers and this is the case in reality. A lack of expertise in framing attractive advertisements, of money to do so and of time on the part of care home managers means that volunteers remain a rich resource which is largely untapped.

Local hospitals and hospices can provide volunteers

King's College Hospital NHS Foundation Trust and St Christopher's Hospice have tried and tested large volunteer schemes from which lessons may be learned.

Both these organisations in the Borough each attract and keep hundreds of volunteers of all ages which proves that there is a rich fount of people within the Borough prepared to volunteer.

Obtaining volunteers is, in the case of in both organisations, a well-developed art. Considerable time and work has been done not only on recruitment but on training, using volunteers effectively and keeping in good touch with them. These are aspects that are all generally poorly handled in care homes if tackled at all. There is clearly potential for transfer of understanding about volunteer recruitment from these successful organisations to care homes.

Successful models can be drawn on

My Home Life has drawn together the thinking around community engagement with care homes and the Essex FaNS Project provides a successful model for community engagement, both of which may be of use to Southwark.

Southwark is keen to support volunteering and community engagement with care homes. The *My* Home Life paper: An Emerging Model of Community Engagement in Care Homes (Appendix 1) draws together the current thinking about this and is a useful starting point for exploration of the subject. Additionally the Friends and Neighbours (FaNS) Project in Essex -www.mhlec.org/FaNs -is proving an effective model for enhancing community engagement with care homes.

Outcomes: ongoing work

A number of outcomes, direct results of the Project, can be identified through ongoing work: other outcomes result from concurrent, relevant work elsewhere with which the Project has engaged. All this work is therefore collated here and is best described as ongoing work. It includes: creation of road map for older person's journey; social workers linking to care homes; development of new Housing Department procedures; hospital trusts improving support to older patients and improving links with day centres and care homes; day centres passing on key information about members to hospitals and keeping in touch with members who move on and care home activity coordinators being supported to deliver meaningful activity to their residents.

Creation of road map of older person's journey:

At the time of writing this Report, it is understood, though not confirmed, that Southwark Older People's Services is working to create such a road map; Southwark and Lambeth Integration of Care (SLIC) has also been doing some mapping as part of the First Phase of its work and both Hospital Trusts are engaged in work which looks closely at the patient's journey whilst in their care.

Social workers linking to care homes:

A pilot scheme to improve links and joint working with care homes has meant the placement of Linked Social Workers at 3 of the Borough's larger care homes. Although staff in these roles are likely to be very busy, their existence on site more frequently offers the potential for improved communication between all agencies; the opportunity for closer tracking of new residents; more timely Reviews and the prompt collection of residents' treasured possessions.

New procedures being considered

It is understood that the Housing Department is about to reframe its procedures. This provides a good opportunity for consideration of improving information gathering about older people and lines of communication with social workers. For instance, the Sheltered Housing Unit has agreed to consider:

- ways of including a note important people in older people's lives, in addition to next of kin, in information collected from residents in sheltered housing
- how older people's most treasured possessions, especially photographs, might be "protected" from disappearing into storage and
- how lines of communication between Housing and Social Services and vice versa might be further improved so that even if treasured possessions are not ultimately collected by social services, it might be possible to track down and contact the care home into which a former resident has gone to live to pass on things to him/her there

It is to be hoped that General Housing will also be prepared to consider amending their procedures similarly, especially with respect to finding out, early on in a tenancy, who, addition to next of kin, older people regard as their special friends and connections.

Hospital trusts improving support offered and creating better links

Hospital Trusts are improving support offered to older patients and are creating better links to day centres and care homes. Both Hospital Trusts are engaged in a number of initiatives which reflect a strong determination to improve the quality of support offered to older people in their care. These initiatives are driven by Heads of Nursing and other senior staff who are passionate about improving patient care.

- They continue to work with SLIC to improve the discharge process and communication with care homes;
- They have established communication links with day centre managers and are amending admission procedures to ensure that managers are contacted when one of their members enters hospital. This will mean that important information can be collected about medication and lifestyle and that day centres have the opportunity to enact their own protocols to keep in touch with their members;
- King's College Hospital NHS Foundation Trust is exploring having named nurses and linking some senior nurses to care homes to provide advocacy and continuity of support to older people on their wards; they are including visits to care homes and day centres in their induction training for new nurses;
- Both Trusts are sharing ideas for the better support of older people in their care.

Day centres working with hospitals

Day centres are working with hospitals to pass on key information and develop a protocol to keep in contact with members entering hospitals and care homes. For instance:

- The Borough's day centre managers have met with representatives of both hospitals in order to make links and ensure that their information is passed on;
- Day centre mangers are working with staff to ensure that they understand the importance of capturing key information about important people and connections when compiling members' person centred profiles;
- They have begun developing a protocol to ensure that contact is maintained for a while with a member who goes into hospital and/or a care home and that those "left behind" are given an opportunity to keep in touch, pass on a message or meet for a final time.

Care home activity coordinators being better supported

Care home activity coordinators are being better supported to deliver meaningful activity to their residents. For instance, Southwark's Care Home Quality Improvement Group, working with the Project's PM, is sponsoring a Forum for all the activity coordinators in the Borough in January 2015. The aims of this Forum are:

- to facilitate discussion and provide training to ACs about what constitutes meaningful activity in care homes today;
- to encourage sharing of good practice and increase awareness of useful resources within the Borough;
- to offer support and networking opportunities to ACs who feel isolated in their work.

CONCLUSION

The concluding section of this report focuses on "What helped in the project?", "What did not help in the project?" and goes on to suggest "What needs to happen next?" The conclusion largely represents the reflections of the Project Manager and Southwark LA might usefully share a draft copy of this report with key stakeholders and invite them to comment on the resonance and relevance of the findings and explore whether there are any perceived gaps. By doing this, key stakeholders could be invited to consider "What needs to happen next?" from their own perspective and this might help them to further engage in the work and continue to take it forward.

What helped in the project?

The bringing together of Partners who were able to contribute overarching expertise together with local knowledge and contacts has been crucial to the Project as has the support of key people within Southwark Council. The Project Partners, and the forensic and brokerage skills of the Project Manager, have driven the work and enabled encouragement of change.

Elements which have assisted the Project are:

- The specific contribution of each of the Partnership organisations including:

    - The expertise, experience, academic support and contacts afforded by *My* Home Life;
    - the support of a few key "fixer" personnel within Southwark LA and the cooperation of their social care, discharge and housing teams and
    - experience gained from other projects working with local older people locally and contacts afforded by Age UK Lewisham and Southwark. The provision of a base in the Borough at Age UKLandS Stone's End Day Centre, provided a convenient, supportive and grounding environment for the Project Manager.
- Inclusion of the PM in Southwark's Care Home Quality Improvement Group and the practical support of its Chair, John Howard, in forwarding work with activity coordinators;
- Support and a commitment to ongoing work from Heads of Nursing and other senior staff in both hospital trusts in the Borough and the setting up of a Forum to take work forward at King's College Hospital NHS Foundation Trust;
- Unreserved support from managers, activity coordinators and other staff in all the Borough's care homes and from key senior managers in two care home provider organisations in particular;
- The engagement and frankness of the managers and their members of a number of befriending groups and other organisations working with and for older people - including day centres - in the Borough;
- The warmth, openness and willingness to share experiences of the older people of Southwark.

What did not help in the project?

Poor or no response to emails and other communication attempts was the biggest single difficulty experienced by the PM in the course of this Project. A great deal of persistence was required in order to elicit responses even, sometimes, from those already closely associated with the Project. There were, of course, notable exceptions to this generalisation but, given that many of those with whom the PM attempted to make contact are, themselves, in positions necessitating communication with others, it has to be concluded that this is an area which all those involved could seek to improve.

The lack of information about those involved in the older person's journey from hospital to care home made initial progress slow; nevertheless, it has to be said that there was some value in learning about this afresh: the PM was able to approach the task with no preconceptions.

What needs to happen next?

In order to carry forward its commitment to improving quality in the Borough's care homes and to maintaining the former lifestyles and connections of residents in these homes, it is suggested that Southwark LA gives consideration to the following strands of action:

- Continue to encourage training and support of activity coordinators. This may be done through:
    - ongoing sponsorship of a 6 monthly Forum such as the one begun in January 2015;
    - exploring the embodiment in commissioning of a requirement for every care home in the Borough to match the NAPA suggested ratio of activity coordinator time per resident;

- exploring with care home providers and NAPA, a requirement for all of the Borough' s activity coordinators to undertake NAPA Level 2 as a minimum training requirement.

- Take forward work to improve volunteering and community engagement with care homes in the Borough by:
  - extrapolating useful lessons from current thinking and the work done by others in this area such as that drawn together by *My* Home Life;
  - working with King's Volunteers and St Christopher's Hospice to learn from their expertise in recruiting, training and sustaining volunteers;
  - working with an individual care home, ideally in partnership with or with support from either King's Volunteers or St Christopher's, to pilot a scheme to foster community engagement which trials some of the lessons learned above.

- Make permanent and extend the Linked Social Worker scheme to all 8 of the Borough's main care homes to improve links with care home staff; to ensure that all Reviews for new residents are conducted within 6 weeks and that those on the unsettling and disconnecting "respite" status do not remain so for an unacceptably long time.

- Maintain and build upon the links established with the 2 hospital Trusts in the course of the Project to promote good communication and exchange of information about older people and their connections between, on admission, the hospitals and day centres and, on discharge, the hospitals and care homes by:
  - producing a clear road map of the older person's "journey" through the system which enables responsibilities to be defined, especially at crossing points from one service to another;
  - encouraging the newly-formed links between day centres and hospitals to be maintained by arranging, through the offices of the Line Manager for Southwark LA day centres, regular review meetings with all those involved;
  - determining who, within Southwark LA staff, should have overall responsibility for liaising with the hospital Trusts, day centres and care homes to ensure that good channels of communication, exchange of useful information and the momentum of the work with activity coordinators are maintained.

- Encourage the Adult Social Care Team and the Housing Department to create together or clarify a protocol for dealing with the treasured possessions of older people who were formerly the Council's tenants when they go into care homes. As part of this protocol, thought needs to be given to the creation of clear guidelines about management of communication between the 2 Teams and their respective responsibilities in the process.

- Encourage the Housing Department, when reviewing its procedures, to give consideration to capturing useful information about their older tenants' connections at an early stage in the tenancy so that nominated special friends, in addition to next of kin, could be contacted when an older person falls ill.

My **Home Life** is a UK-wide initiative promoting quality of life and delivering positive change in care homes for older people

IDENTIFYING AND SHARING BEST PRACTICE

In 2006, more than 60 academics worked together to develop a vision for best practice in care homes for older people based upon what older people, relatives and staff want and what works in care homes. We help care homes to deliver this vision through local and national networks of support and by creating and distributing materials and useful Top Tips on best practice.

WE BROKER POSITIVE RELATIONSHIPS

MHL works locally to support positive relationships between residents, relatives and staff. MHL also broker better partnership-working between care homes, the local community and the wider health and social care system. Through listening to different views, these stakeholders can work together to solve problems.

WE FOCUS ON BEING APPRECIATIVE

MHL focuses on the positive, valuing and acknowledging the good work care homes do now and supporting them to become the best that they can possibly be. We encourage the public to view care homes as a positive option.

WE MAKE A DIFFERENCE

The MHL approach is tried and tested. It is a proven model widely heralded across care homes, commissioners, regulators and government. Our influence and uptake is spreading across the UK.

IMPACT

- ✓ Significant evidence of positive outcomes of leadership support delivered to a substantive and growing number of care home managers across England, Scotland and Northern Ireland and other positive outcomes of work in Wales.
- ✓ Positively evaluated by external research (e.g. NDTi, University of Essex)
- ✓ Identified as playing a significant role in turning round failing care homes
- ✓ Actively engaged in research to share the lessons learnt from attempts to improve practice
- ✓ Improving partnership-working between care homes and wider statutory agencies
- ✓ The Government has highlighted MHL as a "recognised quality scheme" (https://www.gov.uk/government/news/new-online-tool-to-search-and-compare-local-care-providers).
- ✓ Endorsement for MHL is given in the Government White Paper *Caring for our future*[1] and the LGA/NHS Confed/Age UK Commission on Dignity[2], the Centre for Social Justice Older Age Review[3], and the Welsh Assembly's Review of Residential Care[4]

[1] HM Government (2012) *Caring for our future: reforming care and support,* White Paper presented to Parliament by the Secretary of State for Health and by Command of Her Majesty, The Stationery Office Limited (available at: www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support

Community engagement (CE) is anything that connects care homes (CH) with local people, charitable groups, businesses and clubs. Neighbourhoods can be a great supply of volunteers and other types of resource for CHs and, equally, CHs have a wealth of knowledge and experience to share with their local community (expertise in caring for frail older people, including dementia at the end stage of life). CE should enable all CH residents (even the most frail) to be part of civic and community life.

Value of Community Engagement

Strong Community Engagement (CE) in care homes has many benefits:

- Given tighter funding allocation, the need for active Community Engagement to support quality of life in CHs has never been greater
- Residents feel less isolated and lonely, which impacts positively on their health and well-being
- Relatives and Staff feel more supported, valued and appreciated – this enhances quality of care for residents
- Staff have more time to engage when supported by the community – helping them focus on the "little things" that make a "big difference" to residents
- The public is helped to feel less fearful of care homes and more comfortable being alongside dementia, frailty, end of life

Ways forward

Many care homes are doing great work in CE. However, much more can be done to strengthen impact:

- Challenge societal attitudes towards CHs and what they represent (partly fuelled by negative media portrayal)
- Encourage CHs to be at the heart of their local community – an integral part of intergenerational life
- Identify meaningful activity and creative resources for CHs and help them access these more easily
- Prepare volunteers and staff to work collaboratively on CE to make CHs great places to live, die, visit and work
- Pilot and test new CE initiatives and share lessons learnt from working across the whole system

What is already known

MHL has already developed significant learning about what works in CE:

- Enhancing CE Project (DH) – identified what is understood by CE and developed resources on how to do it
- Spots of Time Project (CBT) – created a website to help CHs access volunteers
- Keeping People Connected Project (Southwark CC) – Identifying ways in which care home residents can stay better connected to their previous lives and lifestyles
- MHL Essex Community Visitors Evaluation (JRF) and MHL Essex Friends and Neighbours scheme (FANs)

Key principles that should underpin a CE approach

Based on significant learning about 'what works' in relation to CE in care homes, MHL has

developed a model which embeds the MHL values and the following additional principles:

- CE does not happen on its own – it needs to be nurtured and helped to embed
- There is not just one way of doing CE – it is complex work that requires flexibility and "out of the box" thinking
- Community Engagement Projects should build upon what is already known but should co-create new approaches with care homes and the community in order to reflect the local context
- Projects should seek to nurture positive relationships across care homes and the wider community: facilitating a sense of security, belonging, continuity, purpose, achievement and significance for all
- Projects should recognise the importance of a supportive, trusting and appreciative approach towards care homes, rather than starting from a position of blame, mistrust and suspicion. This positive approach will result in more positive outcomes
- Projects should seek to gain the buy-in and support from public and private organisations to support implementation
- Care Homes need to be in a state of readiness to engage with their local communities and may need support to enable this to happen (possibly through their involvement in the MHL Leadership Support and Community Development Programme)
- Volunteers need to understand the context of CHs and be supported to work well with residents, relatives and staff

An emergent design – "Care Home Community Brokers"

Following these principles, our learning indicates a staged approach is required to support the development of a local **'Community Engagement Broker'**:

- MHL acts to stimulate the development of CE across the 4 nations (England, Wales, Scotland, Northern Ireland)
- Local MHL events will be hosted to invite a range of stakeholders to consider taking forward CE, to help understand what works and design a community engagement programme that acknowledges the local context of CE and CHs: What's currently happening? What are the local drivers? Who are the key individuals?
- A local third sector organisation will be identified and supported to take on the role of fostering positive and trusting relationships between care homes and their local communities and to act as broker
- The broker would work alongside a named individual in each care home (preferably the activities co-ordinator with the support of the manager/provider) to:

- Help them understand how they can encourage and support better community engagement
- Help map the individual and collective needs for community engagement of older people, staff and relatives in care homes
- Help businesses and the local community to better understand the value/ relevance of engaging with CHs
- Prepare the local community to engage, helping them understand context of CH and nature of work they are doing
- Act as a 'match-maker' between care homes and the wider community where it is needed
- Act as a source of information for care homes to help them link to other local initiatives in the area (including the wider health and social care system)

- Act as an advocate in helping tackle some of the other barriers to CE and inclusion
- Provide practical support where necessary (i.e. DBS checks, volunteer inductions)
- Share the lessons learnt with MHL to create resources that inspire others to take forward CE activities.

Some examples of outcomes to date from work in MHL Essex:

Greater engagement of public/ businesses, who in return get named as a 'fan' of their local care home.

- Local community visitors who support care homes deliver quality of life (positively evaluated by JRF/Essex University)
- Bakery providing free cakes to residents for 100th birthdays
- Paint shop providing free paint to support students to create art/murals in a care home
- Florist donating flowers to care homes
- Essex University Students Union are engaging with 3 local homes

Greater engagement from wider health and social care agencies

- The local council monitoring team playing a more positive supportive role to help care homes to deliver quality (positively evaluated by JRF/Essex University)
- The local fire brigade agreeing to send local fire cadets to care homes on Remembrance Sunday to take residents out
- The local hospice agreeing to 'share' their volunteers to support older people in care homes at the end of life

"Our quality of life everyday is determined by the presence or absence of things that are important to us - our choices, our routines."

Michael Smull[10]

[10] Smull M and Sanderson H (2005) Essential Lifestyle Planning for Everyone, HAS Press, 64 (Available at: http://www.helensandersonassociates.co.uk/reading-room/how/person-centred-planning/essential-lifestyle-planning-.aspx)