

Welcome...



Professor Ian Philp

Dear colleagues and friends,

I am delighted to contribute to the POPP newsletter. I have been getting to know more about some of the fantastic work being done, and have seen the very positive findings in the interim independent evaluation of the projects as a whole.

It is very heartening to read about the extent of involvement of older people in the projects and the benefits this has brought about. I am also pleased to see how the projects have focused on improving the wellbeing and quality of life of older people as much as on achieving efficiency gains from reducing the need for acute hospital beds.

POPP is generating extremely valuable lessons about

how to achieve effective partnerships. These partnerships amongst commissioners and providers of health and care services are essential to delivering the key ingredients for improving the system of care for older people with complex needs: early intervention for old age conditions; streaming to specialist care in crisis; early supported discharge from hospital to community; and comprehensive assessment prior to care home placement. Partnership with older people and organisations representing their interests is essential to promoting health, independence and wellbeing for all older citizens.

Although I am stepping down as National Clinical Director for Older People, the work of POPPS takes forward the values and approach I have sought to provide. I look forward to seeing how the hard work and skill of all those involved in POPPs continues to bear fruit, is sustained, shared and spread. The end results of the POPP programme could be a transformation of the culture and system of care that truly meets the needs of older people in 21st Century England.

Professor Ian Philp is National Director for Older People's Services and Neurological Conditions

Transforming adult social services

The White Paper *Our health, our care, our say* confirmed that people want adult social care services to have a greater focus on increasing independence, and promoting well-being and inclusion in communities through early intervention, rather than at the point of crisis.

These aims lie at the heart of the POPP programme and have a new significance following the recent announcement by Health Secretary Alan Johnson of [Putting People First – A shared vision and commitment to the transformation of adult social care](#)¹. This groundbreaking concordat sets out a cross-sector commitment to transform social care over the next three years, based on a shared vision of integrated and personalised systems. There are five key elements:

- ◆ A new relationship between government, local authorities, the NHS, independent sector providers and the regulator.
- ◆ A major shift of resources and practice to prevention, early intervention and re-enablement.
- ◆ High quality accessible information and advice available to all irrespective of financial means

- ◆ A commitment to treating carers as partners.
- ◆ Maximum power, control and choice in the hands of the people who use these services and their carers.

Significantly, this revenue grant includes money from resources secured in the Comprehensive Spending Review 2007 from the NHS, in recognition of the positive impact investing in social care through early intervention and re-ablement can have in people's health and the demand for healthcare as highlighted by the initial findings from the National POPP Programme through the work of the POPP pilots.

The contribution of the POPP pilots and related initiatives such as LinkAge Plus pilots to building the evidence base of what works, as well as identifying challenges has never been more important. [Local Authority Circular \(DH 2008\) \(1\)](#)² explains that by 2011 all 150 councils will be expected to have made significant steps towards reshaping their adult social care services.

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Transforming adult social services (continued)

The circular confirms the detail of a new ring-fenced Social Care Reform Grant, which will provide an extra £520 million funding to all councils with social services responsibilities over the next three years (2008/09 to 2010/11) to support councils to redesign and reshape their local systems. A core element of the funding as detailed in the associated grant conditions (p23, 9ii) is to support all councils to create a strategic shift in resources and culture from intervention at the point of crisis towards early intervention.

This includes joint working with the NHS and wider local government partners, to harness resources from across the whole system to shift the focus of care and support away from intervention to a more holistic, proactive and preventative model. This work should be part of a commissioning strategy developed with partners and informed by the Joint Strategic Needs Assessment.

Health Secretary Alan Johnson explains: "Personalisation means local government, Health Trusts, other statutory agencies like DWP, the pensions service, housing authorities and the Learning and Skills Councils coming together with the third and private sectors to focus their shared resources and expertise on improving health and well-being in every community".

"This concordat together with the Next Stage Review of the NHS led by Lord Darzi, will demonstrate our determination to create a single health and well-being system in every community," Johnson adds.

Councils will be supported to make substantial progress on transforming their services over the next three years, with performance across health and social care measured against relevant indicators in the National Indicator Set (and any relevant LAA improvement



Personalisation targets resources in every community

targets). This information will inform the joint performance assessment across health and social care undertaken by the new joint inspectorate, the Care Quality Commission, and the Comprehensive Area Assessment (CAA).

The Department of Health will be working with a range of partners including a consortium of the LGA, IDEA and ADASS to support councils to make substantial progress on transforming their systems over the next three years. We will also ensure an information loop back from work being led by councils across the regions with respect to early intervention and prevention, with the aim of capturing good practice for national dissemination.

We are delighted to bring you this second edition of the POPP newsletter at what is an exciting time of opportunity and challenge for all councils to either initiate or build on existing work to redesign their local systems to ensure a greater focus on promoting independence, early intervention and prevention. In this newsletter we present examples of locally innovative work being taken forward across the country to provide low level or 'simple' services to older people whose needs are below or borderline for eligibility of care provided via Social Services

Interim report on progress

The [National Evaluation of Partnerships for Older People Projects: Interim Report of Progress](#)³ provides findings and key lessons learnt to date from the POPP programme. The evaluation is due to present further findings in October 2008.

- ◆ With some caveats, when compared with non-POPP sites, there are indications that POPP pilot sites appear to have a significant effect on hospital emergency bed-day use. The results show reductions against trend that would produce an average potential cost saving in the order of; for every £1 spent on POPP, £1 will be saved on hospital bed-days. Future cost analysis will explore older people's reported levels of quality of life alongside any data on cost effectiveness. However, without a full randomised control trial, there are questions about the attribution of POPP effects. Statistical techniques reduce but do not remove the possibility that some other cause explained the deviation from trend rather than POPP.
- ◆ Pilot sites are reporting improved access for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
- ◆ Partnerships between statutory organisations and the community and voluntary sectors have improved if compared with the perceived quality of partnerships prior to the initiation of POPP. Greater recognition of the necessity of including the voluntary sector within service provision. Increased recognition across statutory services of the need for low-level services to sit within the overall health and social care economy.
- ◆ POPP projects have led to improved multi-agency staff working and the development of shared procedures and protocols for cross-boundary services.

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3. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079422

Interim report on progress (continued)

- ◆ Pilot sites are reporting that older people's involvement has increased within steering groups, commissioning, recruitment, provision and evaluation.
- ◆ Older people's health (including mental health) and wellbeing needs are becoming better integrated within the wider strategic agenda. There has been re-branding of services away from being seen as 'welfare' to health and wellbeing.

Cost-effectiveness

The data exploring the cost-effectiveness of POPP uses emergency bed-day use on a monthly basis between April 2004 and December 2006. Analysis between POPP pilot sites and non-POPP sites enables measurement of the differences of activity and subsequent costs around emergency bed days prior to and after, the start of the POPP programme (May 2006).

Further analysis can be found on the [POPPs website](#).⁴

Early intervention under the microscope



POPP projects are helping people every day

As part of our work to extract and make available learning from the POPP programme and related initiatives, this newsletter provides examples of some of the many projects underway across the country which concentrate on finding older people whose needs are below or borderline for eligibility for care provided via Social Services as defined by FACS. These projects include:

- ◆ Bristol Promoting Independence Team (Invest to Save budget)
- ◆ East Sussex Navigator Service (POPP)
- ◆ Gloucestershire 'LinkAge' project (LinkAge Plus)
- ◆ Knowsley IKAN (POPP)
- ◆ Nottinghamshire Community Outreach Advisors (LinkAge Plus)
- ◆ Tameside Open Door (POPP)
- ◆ Wigan Time Limited Contact (POPP)
- ◆ Worcestershire Wellcheck (POPP)

The logic behind the work of these projects is that if you can find and help people before their needs reach crisis level you can improve their wellbeing and help to delay or avoid dependence on more intensive services.

But how do projects find older people for whom that vital bit of help or information will support them to manage better at home? Who are these people? And once found, what help can they be offered? And when can they expect that help to arrive? Individual projects have set about tackling these key questions in different ways.

Identifying people who may be on the borderline of needing help is never easy. An older woman who is

struggling to cope alone in an upstairs flat may not know who to ask for help, may not want 'to be a nuisance', and may not realise that there are numerous services available in the community to help her. But she might mention her worries to a neighbour who has heard of a local project, so word of mouth is vital.

The recently bereaved lonely 90-year-old man may not know how to find social activities which will help him find some pleasure in life again, but his GP may know about projects in his area.

POPP projects are helping people every day and they use a variety of methods to seek them out. They may talk about their services at lunch clubs, community groups or in local newspaper articles.

Many employ people with local knowledge and networks, who become known and trusted in their communities. Neighbours and friends pass on information, social workers and district nurses too; there are many ways of getting the message out.

Handyperson schemes have been found to be a good way of attracting people to whom services do not traditionally reach out, as such schemes are seen as independent and 'non-stigmatising'. Older people are usually then willing to talk about other problems and the Handyperson staff can make suggestions and referrals.

Once 'found', people are offered a home visit during which they can discuss their problems and wishes in complete confidence, and receive an assessment of their needs.

Referrals are then made – for fire safety advice, for equipment to help with daily living, for benefits advice, for befriending, for social activities – the list of help available is long. People receive the help they need within usually one to two weeks, and they are followed up after first contact to check that actions have been completed.

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4. www.dh.gov.uk/en/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/DH_4099198



Individuals can self-refer to projects

Early intervention under the microscope (continued)

The projects studied fall broadly into two main categories:

1. **Signposting** – where people who have been identified as needing help, or self refer, have a conversation with a worker, a brief 'assessment', receive information about which organisation(s) might be able to help and are either referred by the worker, or the individual accesses services directly from information provided.
2. **Case management** - where people with higher-level needs are identified as being at risk of ill health or functional decline, receive a formal assessment and referral for services, and ongoing, regular input and support from a designated worker or team.

For all projects it is necessary to undertake some form of 'case finding' – a means of using agreed and validated criteria to target older people who may require help, and thus to ensure that resources are focused on those in need.

Some of the most important features for successful projects are:

- ◆ Involvement of older people at all stages of planning, development, operating and monitoring/evaluating services.
- ◆ Committed, enthusiastic, well trained and supported teams. Overall, commitment and personal qualities of team members – such as the ability to listen and a 'can do' approach to solving problems - are vital factors.
- ◆ Simple, clear documents which record personal details in a manner that is easily transferred (with permission) to other organisations. All projects are keeping good records of individual case involvement.
- ◆ Being linked to a wide range of services to help ensure that no one 'falls through the net'.

Projects in Action

Knowsley IKAN

The IKAN scheme uses multi-agency team to target people aged 55-plus living in most deprived area of Knowsley.

Launch events, mail drops and Community Wardens are all used to publicise the service.

Third party and self-referrals, are followed by a home visit and a comprehensive assessment is carried out by paid workers.

People are signposted to services, for example, there is a fast track into handyperson, befriending and health visitor services, and other networks are well developed.

IKAN demonstrates ease of access into a potentially complex system.

The handyperson service is a very valuable in providing 'foot in the door' with people who would otherwise not access services. This in turn enables engagement with other services.

Attending 'flu clinics' was found to be a good way of targeting older people in need.

IKAN has a strong focus on falls prevention and there is evidence that this has already had an impact on reducing the number of falls and fractures.

Projects in Action

Tameside Open Door

The Tameside Open Door programme is a borough-wide model of early intervention, that targets people aged 60-plus who do not receive social care services or who would like information, advice or support at home to help them retain their independence and wellbeing.

A Personalised Information Service is delivered by charity Age Concern.

It uses volunteers, who make contact with people in their own homes. They complete a 38 point weighted questionnaire called the Community Options for Remaining Active (CORA) then, depending on scoring, they refer on, signpost to services or act as navigators.

Referrals come from GPs, community groups, families and self-referrals, with some targeting of specific communities.

The Tameside Open Door programme has good links across a wide range of organisations, both statutory and voluntary.

There is already evidence that the project is picking up people who are eligible for services.

Key learning from the projects

◆ Interlocking care pathways and services

Services must fit together closely, enabling referral within and between them, down as well as up. A good example of an interlocking care pathway is Tameside's Opening Doors for Older People project, which uses a structured questionnaire - the Community Options for Remaining Active (CORA) - to determine needs. Based on answers provided, a personalised profile is produced, with clear contact details for organisations across the system that can provide help.

◆ Handyperson schemes

These are often a good way of attracting people to whom services traditionally do not reach out, as they are seen as independent and 'non-stigmatising'.

◆ Fast tracking and links with other agencies

Projects which have well-developed 'fast tracks' into other organisations offer a comprehensive and effective service to older people.

◆ Occupational Therapy services

OT services continue to be important to this type of early intervention. However, they can also often be the source of delays due to long waiting lists. Several projects have faced this challenge and reorganised services to meet demand.

◆ Opportunistic involvement

There are benefits from 'opportunistic' assessment, for example, seeing a person for a minor, simple query, and using the opportunity of the conversation to gently probe and uncover further needs.



Hard-to-reach communities benefit

◆ Individual follow-up and review

Some form of review, follow-up or feedback from agencies about individual cases is desirable, to ensure that suggested actions have been completed and to gain some impression of progress/outcomes.

◆ Qualities of team members

Several projects noted the importance of the personal qualities of team members – whether paid or unpaid. Key qualities mentioned by service users and team leaders alike include listening skills, respect, can-do approach, friendly manner and the ability to build trust.

◆ And remember . . .

POPP and similar projects do not operate within a 'closed system' – they are vulnerable to and influenced by whatever is happening in the wider whole system, and even within other parts of their own organisations.

Top tips

◆ Costs and benefits

It is extremely important to be accurate about project costs when trying to calculate savings and demonstrate benefits. What is costed in, what is not? What are the overheads and how are they charged? Are accommodation charges part of the calculation? How are costs apportioned between partners, and what of telephones, travel?

◆ Tools used

For highly specified, data driven case finding tools such as PARR to work, total sign-up from all partners to ongoing data collection is essential.

◆ Interconnectedness of services

Projects should look carefully at how services



Personal qualities are important for POPP workers, whether paid or voluntary

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Top tips (continued)

interconnect: are there gaps? Does everyone who needs to know about the service actually know about it? Has there been adequate 'marketing' of the service, in a range of ways, and is there sufficient publicity? Are the care pathways agreed and clearly defined? These and other questions need to be constantly asked and the answers reviewed in the context of improved service delivery.

◆ Staff training

Staff training is important and can be provided effectively in many different ways. For example, university-led programmes over weeks to in-house provision lasting just a day or two.



Marketing of services is vital



Projects in Action

Nottinghamshire Community Outreach Advisors

Nottinghamshire Link Age Plus scheme targets people aged 50-plus in hard-to-reach groups, such as travellers, mental health users, rurally isolated people and those from black and ethnic minority communities.

Seven community outreach advisers work with community groups, GPs, faith groups and health providers to organise displays, events and publicity, for example, in supermarkets and on local radio.

An assessment and referral form showing designated referral pathways is used.

Ten simple questions offer effective means of 'opportunistic' case finding. People are signposted to services and receive a written 'receipt' telling them which services they have been referred to. A Contact Centre phones after four weeks to check actions and outcomes. If these are satisfactory there is no further contact.

A supported employment scheme also offers gardening/home handy person employment to people with learning disabilities. Older people themselves act as 'mystery shoppers' to check the quality of the Link Age Plus service.

Projects in Action

Somali Elders' lunch club

The Bristol Promoting Independence Team has a community development function which has helped launch a lunch club for Somali elders. Each meeting involves a hot meal, socialising and advice or help with issues ranging from benefits, health, social care and housing. A range of partners has helped get the club up and running for a trial period. These include the Easton Jubilee Trust, a local charity experienced in working with the Somali community, and Servicelinks, a Somali advice service. Attendance varies week-to-week and has peaked at around twenty. Some diners have lived in the UK since the 1950s and others have arrived as recently as six months ago.

Setting up the club has meant learning some cultural lessons, for example the need for separate male and female dining groups, and the limited value of letters and written material in a community that has only had a written language since the 1970s.

Sue Cheasley, Promoting Independence Team Manager, said: "Identifying and where possible meeting gaps in community resources is part of our remit. This lunch club is a good example of where we've done that. It's also about creating an environment where we can build a relationship with people, identify needs and overcome cultural misapprehensions."



The Somali Elders' lunch club

Projects in Action

East Sussex Independence First's Navigator Service

The East Sussex Independence First project is a partnership venture supported by POPP encompassing a range of preventive services targeted at older people at risk of hospitalisation and institutionalisation, referred through health channels.

One of its component services, the Navigator Service, was set up to trial a 'signposting' model and to gauge its effectiveness in helping to maintain independence in a wide subsection of older people, rather than concentrating on those at highest risk.

A partnership project between East Sussex County Council and Anchor Staying Put, the service employs trained community workers to visit older people aged 60+ in their own homes. They talk through problems with older people, using the structured Background Information and Contact Assessment (part of the FACE suite of data recording tools) tool to record personal details and likely needs.

East Sussex sought an appropriately selective 'case finding' tool to enable accurate identification of the target group. After careful consideration the decision was taken to use Adult Social Care 'Fair Access to Care Services' criteria, at the 'moderate' level, to screen people for eligibility. The service has also started to take self-referrals.

The Navigator Service is part of a wider group of partners contributing to a new initiative 'County

Connect'. This service gives citizens of East Sussex another way to access information and services, following a single visit from one of the partner agencies - the Fire and Rescue Service, for example.

Aimed at people at FACS level 'low' County Connect dovetails neatly with the Navigator Service (aimed at FACS level 'moderate'), and provides a further piece of the jigsaw helping to ensure that no one falls through the net. This interconnectivity is fundamental in the matrix of services helping older people maintain health and independence.

Navigators receive in-house training tailored to their needs. This includes Single Assessment Process (SAP), 'trusted assessor' training for low-level equipment needs, FACS criteria and how to apply them, confidentiality and record keeping. In addition, they have training on equality issues and how to work with people to whom services do not traditionally reach out.

As would be expected with a new service, most people had no previous knowledge of the Navigator Service prior to initial contact, and some expressed concern about being contacted by telephone.

One person mentioned being contacted by a 'stranger' but all agreed to a visit "because we needed all the help we could get". Others were uneasy about cold calling, because of "everything you read in the newspapers or see on television". Apprehension was short-lived as service users felt that Navigators acted as a lifeline for often isolated and vulnerable people.

The holistic nature of the service was also valued. One person commented: "they took a picture of how my day existed".

The fact that Navigators have direct access to grants for handyperson services, aids and adaptations, transport, carers and exercise and well-being was a valued

feature, strongly supporting the concept of direct commissioning of low level services to help people remain independent at home. Rapid access to handyperson schemes is important not only for practical help, but for a non-stigmatised 'foot in the door' which can lead to identification of other needs.

The impact on carers was positive in identifying carers specific needs, which might have been missed in a more clinical or functional assessment. These included renovation of a garden,

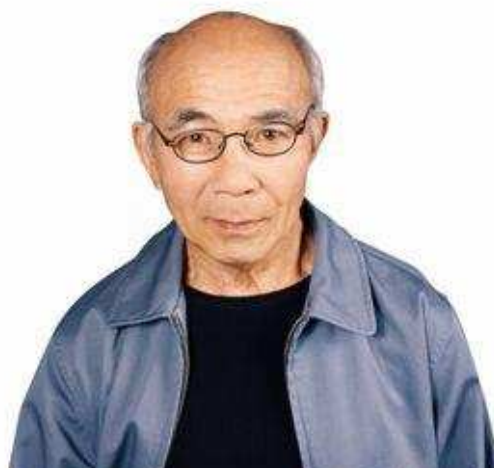
assistance with a heating grant, home insulation and improved income support.

The following were identified by service's users and carers as positive results:

- ◆ maintenance of independence signposting to services
- ◆ practical help
- ◆ reduction in social isolation
- ◆ maximisation of welfare benefits

A recent quality of life survey revealed:

- ◆ 51% said their quality of life was good before Navigator intervention, rising to 75% after intervention;



Projects help people maintain independence

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East Sussex Independence First's Navigator Service (continued)



The Navigator service means people know who to ask for help

- ◆ To the question "I know who to ask for help", 82% answered 'yes' before Navigator intervention, and 94% after; and
- ◆ 55% felt they could manage their own conditions before Navigator intervention, compared with 84% after.

Personal history – Mrs X

Mrs X was not coping with management of her husband's long-term conditions, whilst also ill herself.

A Navigator applied for a massage course to improve Mrs X's wellbeing, obtained a wellbeing/exercise grant for Mr X to get out of the house and have time away from his carer, arranged for the garden to be renovated and made secure, enabling improved safety and access and its use as a place 'outside the four walls', and for a fire and home safety check to be carried out, with key-safe and smoke alarms fitted.

Personal history – Mrs B

Mrs B had a fall in the supermarket and was taken to hospital. On returning home she was visited by an occupational therapist who found she was having problems adjusting. The occupational therapist referred her to the Navigators.

A Navigator visited Mrs B at home. Her neighbours were helping with shopping and housework, but she was anxious and lonely. The service provided signposting to the Pensions Service for an attendance allowance claim, the Fire Brigade for a home safety check and smoke alarm, the Handyerson Service for grab rails and a second stair banister. The Navigator prescribed chair raisers, a perch stool and a raised toilet seat from the small equipment budget and arranged for Mrs B to visit a local social club to see if it would be suitable.

Six weeks later the Navigator followed up. The Pensions Service had visited and had submitted an attendance allowance claim and maximised Mrs B's other benefits. Her income was tripled. The new equipment from the Navigators had led Mrs B to feel more secure in her home and she had joined the club suggested, so felt less socially excluded.



Wellbeing and exercise help promote independence



Niggling worries can be dealt with

"We screen in, rather than screen out."

Worcestershire Wellcheck offers assessment and signposting services aimed at people aged 50+ experiencing difficulties because of ageing, but who would not be eligible for services.

Worcestershire Wellcheck has been widely advertised. Third party and self-referrals are taken. Paid Wellcheck

Officers employed by Age Concern visit older people and complete an assessment using Single Assessment Process (SAP) documentation.

All the older people contacted are given a personalised checklist detailing suggested services. This is held in the person's home in what is referred to as a 'red folder'.

If people cannot make contact with the suggested services themselves Wellcheck staff will do this and follow up. There is also periodic follow-up to check outcomes and the individual's current situation.

Wellcheck also has the use of a mobile assessment vehicle for low level Occupational Therapy needs in the Evesham and Worcester area. To ensure universally high professional standards all staff complete a two-day assessment course run by the University of Worcester.

Quotes regarding the Wellcheck Service show the impact on real lives:

"I get comfort from knowing that someone cares."

"I would have just given up without your ongoing support."

"On the dark days when loneliness sets in, kindness and someone to talk to about problems means everything."

"I picked up a Wellcheck leaflet at my doctors' surgery and I'm so pleased I did because all the niggling worries have been dealt with."

"Age Concern have really been very kind and caring and to think that the Occupational Therapist has now agreed to let me have the work done is wonderful."

Worcestershire Wellcheck: A personal case history

A referral was made to the Wellcheck team by Mr and Mrs X's daughter in April 2007. She was concerned that her parents were starting to struggle to maintain their independence. She was also worried about their wellbeing, safety and overall quality of life. They have no children living nearby and although their family are supportive, they are not on hand to provide practical assistance.

Problems faced

The couple live in a bungalow in a semi rural location. They are both 80 years of age.

Mr X's health had deteriorated since Christmas 2006 and prior to this he had been supporting his wife, whose mobility had declined following a fall when she broke her hip. They were experiencing difficulties with shopping, cooking, managing finances, transport and medication. They had also found that socially they were becoming increasingly isolated and did not feel confident enough to go away on holiday or become involved in local social groups.

A home visit was arranged within seven days of contact.

Mrs X was clearly anxious that life was becoming more difficult for them and they did not know how to access

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Worcestershire Wellcheck: A personal case history (continued)

help. She also wished to know of services that would assist her husband in the event of her own hospitalisation.

Mrs X was also concerned that her husband would be unable to summon assistance if she had another fall. Mr and Mrs X also had no working smoke alarms.

Having completed the Wellcheck assessment, it was suggested that Mr X apply for Attendance Allowance to provide additional money so that they could pay for help.

Information was also provided on the Frozen Meals service to ease the problem of shopping and meal preparation.

Advice on Pendant alarms was also provided to overcome the problem of Mr X being unable to summon help in an emergency. A data link was completed for both clients to ensure all medical and next of kin details would be available to the emergency services if needed.

A fire safety check was arranged to ensure provision of smoke alarms and a referral was also made to the Occupational Therapist for provision of appropriate equipment.

Suggestions on accessible holidays were also provided and assistance was given on applying for a disabled parking badge. Information about local social groups was also made available.

The issue relating to medication was addressed by advising about an electronic pill dispenser with alarm, while to address the financial concerns it was suggested that they sought legal advice to set up an Enduring Power of Attorney.



Occupational therapists provide appropriate equipment



Worcestershire Wellcheck promotes social contact

Following the assessment, when asked whether the Wellcheck service had helped them, they said: "We greatly appreciate the information and help you have offered and fully intend to follow the suggestions to ease our difficulties."

Six months later

When Mr and Mrs X were contacted again in six months to review their situation, they had had a fire safety check and smoke alarms fitted. They both had pendant alarms and were receiving frozen meals from the Community Meals service. The Occupational Therapist had supplied the appropriate equipment to assist them in the bathroom. Enduring Power of Attorney had been set up and Mr X had been awarded the higher rate of Attendance Allowance.

They had employed a carer to help them with shopping and cleaning. They were also reassured that she could provide additional support if Mrs X was admitted to hospital.

Mr and Mrs X had also been away on holiday with a company who specialised in holidays for people over 60 so their needs could be met.

They will continue to be reviewed annually to ensure that they remain independent for as long as possible and they are also aware that they can contact us at any time should any problems arise.

Projects in Action

Gloucestershire Village Agents



Village Agents meet to discuss the project



Personal choice and control are enhanced

Gloucestershire County Council, in partnership with the Gloucester Rural Community Council, has successfully set up the Village Agent Project, covering nearly 150 parishes in some of the most isolated areas of the county.

Thirty Village Agents work within clusters of communities that have limited or no access to services locally. Each individual parish cluster contains a 50-plus population of between 331 and 1125 people. Village Agents are paid a small weekly retainer to work 10 hours per week within the local community, targeting people aged 50-plus providing information, promoting access to a wide range of services, carrying out practical checks and identifying unmet need.

Between January and the end of July 2007 there were over 11,000 contacts with the service. The target for April 2007 to June 2007 (according to the University of Birmingham's Inlogov report) has been more than exceeded with the total number of contacts amounting to 4,344 and the total number of meetings reaching 744.

A Gateway Referral Form has been designed to identify monitoring information such as the demographic characteristics of people accessing the service, how and

where they make contact, and the resulting actions. Organisations referred to feed back following referral and action; if there has been no feedback the project manager chases.

Up to June 2007, the top ten topics or concerns for people aged 50-plus in the defined parish clusters, which prompted them to contact a Village Agent, were:

Topic	Gateways
Support – family/neighbour concerns	148
Support general	78
Fire and safety – smoke alarms	67
DWP – assessment	61
Helpdesk Occupational Therapy	57
Energy – home heating/insulation	44
Home Improvements Agency - minor work	35
Age Concern Service	24
Council	24
Healthy lifestyle	24

One measure of the successful impact Village Agents have had on their local communities comes from the Fire Service. From June 2006 to June 2007, the Fire Service fitted 2,000 smoke alarms across the county; between December and June 2007, there were 60 Village Agent requests for smoke alarms. This has produced an increase of 6% since the Village Agents became operational.

Personal history - Mr and Mrs F

Demonstrates award of benefits, improved financial security and self-confidence, choice and control, improved health and wellbeing, enhanced safety and security.

Mr F phoned to ask for help with benefits entitlement. Visited at home and query referred to Pensions Service. Following several visits from them, the couple now receive Carers Allowance and Pension Credit of up to £96/week. They also receive Attendance Allowance of £107 per week between them. The Pensions Service is investigating Council Tax and rent allowances.

Mr F owns a car but finds it increasingly difficult to get to the garage some distance from the bungalow, so rarely

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Gloucestershire Village Agents (continued)

uses it. This left him feeling frustrated and confined to his home. He asked to investigate the purchase of a lightweight wheelchair to fit into his car and advice sought advice from Cirencester Disability Information Service (DISC). Information was passed to Mr F who has been to try chairs for himself, is now buying one and researching holidays for himself and his wife – their first in years.

He now has regular home visits from a chiropodist and 'employs' a gardener and window cleaner. He is currently awaiting results of an OT assessment to make his bungalow more accessible. He needs access ramp new wheelchair and housing provider is looking into providing a new path to the rear of his property. County Highways were contacted to get them to clarify the road markings in front of the wheelchair access point on the pavement. Mr and Mrs F have mobility problems and the most appropriate type of alarm system for them is being investigated.

Projects in Action

Bristol Promoting Independence Team



A&E and GP practices are used to identify those at risk



Cases are co-ordinated by Bristol Promoting Independence Team

Some FACS projects – Brent, Bristol and Devon for example - employ a case management approach to supporting older people in the community. This model requires a structured commitment with individual service users and the development of an association, over time, in which trust, respect and continuity are established. Small changes in overall circumstances or health status are easier to detect, due to the ongoing nature of the involvement. These projects aim to demonstrate impact on health service usage – prevention of unnecessary hospital admissions, for example - and employ multi-professional teams to work closely with older people deemed to be 'at risk'. One such scheme – in Bristol – is described in more detail below.

Bristol Promoting Independence Team

The Bristol Promoting Independence Team was established in December 2005 to pilot a new approach to prevention. It aims to reduce the number of older people experiencing a crisis, for example, emergency admission or admission to long-term care, to promote community engagement in supporting older people and to promote integration and service alliance within health and social care.

The project is led by Bristol City Council in partnership with Bristol Primary Care Trust, Avon & Wiltshire Mental Health Partnership Trust, Bristol City Council Neighbourhood and Housing Services, Bristol Care and Repair and Age Concern Bristol.

It is organised into two neighbourhood multi-agency teams based in areas of deprivation in Bristol. The teams use proactive identification of those 'at risk' by case finding in A&E, via Ambulance Services, GP practices and within the community, undertaking holistic assessment, carrying out time limited case management to improve independence and wellbeing, co-ordinating the care and support required to address their needs.

Case finding in A&E operates in the following way: two hospital districts – one in the south and one in the north of the area – pass details each month of people aged 65+ attending A&E but not admitted, to the Promoting Independence Team. This amounts to 30-50 people per district, per month. All names are checked with GPs and letters introducing the team and offering help are sent, together with a short, weighted questionnaire.

Response rates of up to 85% are achieved. Based on the answers and scores, people are either offered a visit or sent a further letter offering help if required.

An evaluation, by the University of the West of England in 2007, found that for quality of life measures there were improvements in self-reported happiness for 37 of 111 people.

Another indicator is the extent to which the service can reduce the number of admissions to hospital and long-term care. This is evaluated using a Prevention of Hospital Admission form. The interim evaluation

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Bristol Promoting Independence Team (continued)

identified 12 instances where hospital admission had been prevented and five where admission to long-term care had been prevented. The final evaluation is due in February 2008.

The Bristol teams hold a small care budget. This can be used to set up packages to support carers and to introduce people to care (if FACS eligible, through the normal social care channels, if not FACS eligible, via use of Attendance Allowance). Nurses are trained to order low level OT equipment. The teams also hold a small pump priming budget to help start new community services; this has been used to support a lunch club for Somali elders and carers groups.

This 'fast tracking' of funds is helpful to individuals and small organisations alike, in that it can help tackle problems by putting in services quickly, helping to avert crises and boosting morale.

Older people simply do not know how to pick their way through myriad organisations, schemes, services and agencies. Problems often come in threes and fours when health, independence, housing matters, bereavement or financial worries all conspire to overwhelm and leave them feeling alone in a complex world.

A common theme, from the service users studied is: "I wouldn't have known where to go if it hadn't been for you".

Personal history – Mr A

Mr A felt unsafe in his home, partly because his flat had been targeted by vandals. He was referred by a



Cases are regularly reviewed by the team

neighbour who had heard about the Promoting Independence Team. An assessment revealed that he was not eating properly, partly due to a low income.

Following intervention by the team Mr A moved into sheltered accommodation, his son took responsibility for monitoring his diet and he was put in touch with the pensions service. A subsequent case review concluded that, had these risks not been identified, he could have become increasingly socially isolated and would probably have experienced a rapid deterioration in his health.

Projects in Action

Wigan Time Limited Contact (TLC) scheme



Home visits are part of the service

This scheme is coordinated by Wigan and Leigh Pensioners Link and aims 'to prevent changing times escalating into crisis situations for older people'. It provides a range of services including regular telephone contact, home visits, information, help with transport arrangements, practical assistance and help in becoming more involved in social and community activities. The scheme has recently been expanded to include domestic help for people recently discharged from hospital following surgery. Help with cleaning, shopping and practical support in the home are provided on a short-term basis.

This element is geared to provide low level pro-active support that will provide a friendly voice and face, information, advocacy and companionship and, in some circumstances, practical assistance, help the older person maintain their independence and manage the situation themselves.

The project lead and part-time administrator are paid posts, and the services are provided by 20 volunteers. Volunteers receive in-house training that covers confidentiality, boundaries, health and safety and advocacy.

Most referrals are taken from Primary Care, Social Services, Intermediate Care services, Carers Helpline, the 'Starting point' telephone line and from the hospital. People are able to access the service directly through Pensioners Link. Access is available during the evenings and weekends. Volunteers will receive training as to when appropriate to refer an individual on for mainstream services.