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To promote the better health of older people through encouraging inter-disciplinary training, research and excellence in practice and services.

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A note from the editor

Welcome to the latest edition of the Journal of the Institute of Ageing and Health. There has been a real focus on utilising the experience and expertise of older people to support and improve society and the Institute of Ageing and Health have been involved with the Ageing Better in Birmingham project bid.

As ever, we would like to thank all the contributions to the journal. We have some interesting papers to share with you including; interesting statistics on dementia, the use of poetry to enhance the quality of life of people suffering with dementia, questions about the best way to train nurses, an international study that explores and compares the concerns of growing older in different societies and an article on social isolation. These articles are presented first and are followed by some more informal papers, one by David Jolley which clearly outlines the huge amount of work done by Wolverhampton to become a dementia friendly city. Another article outlines the contribution of the NIHR in developing research and finally an informal evaluation of a rehabilitation unit in South Worcestershire.

Without these contributions we would not be able to share research, reflections and stories to improve ageing and health in the West Midlands. At the back of the journal are guidelines on how to submit your contribution so please join us and keep sending in any research or scholarly articles to continue to promote a network of shared expertise and interest around ageing and health.

Dr Ruth Pearce

Contributions for publication must be typewritten with double space. Contributors should check personally the accuracy of any references which are to be quoted by name and date. Photographs (black and white) should be written on an accompanying sheet of paper and not on the back of photographs. Photographs, diagrams and drawings submitted for publication should where possible be no smaller than 3 1/4" x 4 1/4". The Publications Committee retains the right to edit letters and does not necessarily share opinions expressed by contributors.

Challenges faced by healthcare professionals in the provision of compression hosiery to enhance compliance in the prevention of venous leg ulceration

Suzanne Tandler, Community Staff Nurse and Leg Ulcer Clinic Nurse, Tenbury Wells.

Venous leg ulceration affects 1 in 500 people in the United Kingdom (UK), with an annual cost of treatment to the National Health Service (NHS) reported to be at least £198 million[1]. The prevalence of venous leg ulceration is acknowledged to increase with age and has a high recurrence rate[2] with 1 in 50 patients over the age of 80 having experienced an ulcer[3]. The UK has an increasingly aging population that places pressure on health care services, coupled with national savings of of £14 billion by 2014 is signified[4] and a local efficiency of £15 million is required according to local data[5].

This study explores the reasons for non-compliance with compression hosiery, which aims to prevent the recurrence of ulceration and reduce the symptoms of venous disease experienced by patients thus improving quality of life[2]. The emergent themes from the literature informed the development of a questionnaire which was administered to members of a Tissue Viability County Team involved in the assessment, treatment and management of patients in the provision of compression hosiery. The questionnaire aimed to examine professional knowledge and opinion as to the factors they consider affect patient compliance with prescribed compression hosiery. Participants were asked to contemplate and identify possible changes to current practice that would address non-compliance. The findings are considered in relation to the literature with the aim of enhancing the current local delivery of leg ulcer aftercare.

Background

Chronic venous hypertension occurs as a result of superficial or deep vein valve incompetence or damage caused by Deep Vein Thrombosis (DVT), this results in blood being able to flow backwards, leading to an increase in blood volume and pressure that causes damage to neighbouring valves which can cause veins to become varicosed[2]. Venous hypertension causes capillaries to become swollen and leak blood products into tissues that surround them, causing damage, visible skin changes and an increased risk of the development of ulceration. Skin changes associated with venous hypertension ranges from; oedema from the accumulation of fluid in the tissues, discolouration (hemosiderin staining) as a result of deposits of red blood cells, distension of tiny blood capillaries in the foot (ankle flare and the formation of scar tissue in the gaiter and foot region) which is at an increased risk of breakdown.

Patients can often present with only one of the above skin changes which signifies the importance of a holistic assessment and the accurate diagnosis of the underlying cause[2]. This is achieved by the use of a Doppler ultra sound that measures arterial blood supply to the feet which can eliminate the presence of arterial disease, combined with a positive clinical assessment of venous hypertension by a suitably qualified health care professional, an accurate diagnosis can be made followed by a treatment plan devised by both the patient and healthcare professional[6].

Compression therapy in the form of bandages and hosiery affects all circulatory systems reversing the physiological changes that result from venous hypertension, improving the healing rates of venous leg ulcers and preventing the recurrence of further ulceration, by the re-absorption of fluid into the veins reducing oedema significantly[2].

Literature Review

A literature search was conducted using the key words "ulcers and recurrence", "venous ulcer and hosiery", "compression stockings/hosiery" and "compliance/ adherence/concordance", "ulcers and prevention". To ensure that all relevant literature was identified the terms "compliance", "concordance" and "adherence" were used interchangeably. Reference sources that were utilised in the literature search were; CINAHL, Medline, Academic Search Complete, and Sciencedirect.

Recurrence of venous leg ulceration

A study was conducted in which 300 participants with newly healed venous leg ulcers were allocated to receive either class 2 or class 3 compression hosiery[7]. Over a quarter of all participants did not comply with the allocated treatment, although no statistically significant difference was recorded between the two classes' of compression hosiery[7]. It was suggested that this was an anomaly in the data due to the higher rate of non-compliance in the class 3 group compared to that of the class 2 group. It is acknowledged that patients should be measured and fitted with the highest grade of compression hosiery that they can apply and tolerate[2, 6, 8]. Although it also recognised that it

is important to remember that if patients cannot tolerate a high grade of compression, a low class of compression is better than none[9].

Similarly in an earlier study, the aim was to assess leg ulcer recurrence and participant compliance; no statistical difference was noted between the two brands of hosiery[10]. The cumulative recurrence rate was 26% after 12 months which is comparable to the recurrence rate of those who did not receive compression due to unsuitability (57%). No recurrence rates by the level of compliance were provided despite being part of the aim of the two studies[7, 10].

It is suggested that the risk factors for recurrence on univariate analysis were; history of previous ulceration, deep vein thrombosis (DVT) and intolerance of compression hosiery[10]. However, it is unclear whether the total numbers of participants were included in the final analysis, as the data is presented in percentage format.

In a systematic review, it was suggested that the prevention of venous leg ulceration is hindered by non-concordance, despite a limitation in the availability of more recent research; the articles that have been reviewed provide sufficiently valid evidence that non-concordance with compression hosiery is significantly associated with recurrence of venous leg ulceration[11]. It was recognised the potential of the true extent to which non-concordance and non-compliance influences not only the effectiveness of treatment outcomes and patient quality of life, but the economic burden on the NHS[11, 12].

It was reported that 90% of the participants had previously been prescribed compression hosiery of which; 29% class 1, 64% class 2 and 7% class 3. However, only 56% of the 90% said that they wore their hosiery on a regular basis, which was deemed to be a minimum of 5 days a week[13]. The conclusions identified that when class 2 compression hosiery was worn on a regular basis (5 days a week) it significantly reduced recurrence rates; in comparison to participants who wore class 1 hosiery or no hosiery at all[13].

Participants with cardiac disease had higher recurrence rates when compared to participants' without cardiac disease; this however has not been widely recognised by other studies[13]. Furthermore it has been recognised that participants' who have previously had a Deep Vein Thrombosis (DVT) and a previously large ulcer are at an increased risk of ulcer recurrence[10, 11, 14]. A history of a DVT causes damage to the structure of the vein, predisposing them to ulceration[8].

Application difficulties

Compression hosiery is the "mainstay" of the preventative therapeutic treatment of venous leg ulceration and recurrence, although many patients experience some element of difficulty with application. The effective use of hosiery aids that are widely available on prescription are recommended to allow for easier application and helps prevent trauma to new epithelial tissue that can easily be damaged[16]. It is recommended that following healing patients should be advised to continue wearing compression bandaging for a "few weeks" before using hosiery; nevertheless it is acknowledged that it can take up to 12 months for tensile strength to improve[2]. It has been suggested that approximately only 80% of total tensile strength is regained[17].

It is suggested that district nurses stereotype leg ulcer patients who are non-compliant with compression hosiery, also they are keen to delegate after care to more junior members of staff and carers[18]. Due to the limited amount of time they have to meet the needs of their clients they feel that if they are required to give skin care they won't be able to do tasks that they might otherwise do[18]. Moreover, the social services carers in this study recognised the role of leg ulcer aftercare and compression hosiery in preventing recurrence; however the majority received no formal training and felt that it should be the responsibility of the healthcare staff to deliver the care. This demonstrates the presence of discrepancies in opinion as to who should be the provider of leg ulcer after care[19], as care provided by social services is means tested. Another compelling factor is that the role of the community nurse has significantly developed in the last decade with a focus upon reducing hospital stay and admissions. District nurses are key in the delivery of complex care and the supportive role in the drive for high quality care by improving and extending services provided to meet the health and care needs of an increasingly older population by respecting the wishes and choices of patients[4].

Resentment was also expressed by patients' for the need to fund their own leg ulcer aftercare due to social care being means tested. The patients expressed similar opinions to the carers; that skin care and the application of compression hosiery should be the responsibility of the health service. Daily hosiery application and removal is no longer considered a nursing role and therefore is no longer resourced as such yet to meet the needs of the individual patient, this would enhance the health and wellbeing of both patients and carers[20]. This ideology is reinforced by the recent drive to improve the delivery of health care in the community; through the publication of the new vision for district nursing[4].

Discomfort

Despite discomfort being given as a reason for discontinuation of compression hosiery use, there is little discussion given to determine the underlying causes of discomfort experienced by participants. Although it is suggested that it may be due to poor application techniques arising from a lack of guidance from knowledgeable clinicians. Participants

were unwilling to tolerate the restrictive feeling of wearing compression hosiery daily, as they were deemed binding, poor fitting and uncomfortable[21]. Participants commented on the way in which the compression hosiery affected their quality of life and that they would prefer to endure the worsening symptoms of venous hypertension and increased risk of ulcer recurrence; these participants were deemed in this study as non-compliant. This leads onto question the accuracy of participant limb measurement that was carried out, whether the fit of the hosiery was assessed and whether the selection of hosiery was appropriate. If patients find their compression hosiery uncomfortable it is vital for practitioners to act promptly to check measurements and suggest alternative brands, styles or made to measure garments[8]. For compression hosiery to be effective correct fitting is vital.

The best practice statement for compression hosiery[22] supports the use of compression hosiery in the prevention of venous leg ulcers. It calls for the appropriate assessment, selection and fitting of hosiery to be carried out by competent clinicians. A range of hosiery designs and options are available with varying materials and elastic components, which can affect ease of application and patient comfort[2]. In their systematic review they go further to explain that it is vital that clinicians have the training and competence in understanding the differences in hosiery knit, as below knee circular knit compression hosiery can cause a tourniquet effect that can lead to a build- up of oedema and cause pain. Whilst flat knit hosiery is stiffer due to the way it is produced and is considered to be more effective in the treatment of chronic oedema which is likely to be more comfortable, although it is appreciated that they are often more difficult to apply[2]. It is a process that requires patience and understanding from the patient and clinician to find the most suitable hosiery for individuals and is worth it if concordance and quality of life is achieved as a result[20].

In an audit of compression hosiery use in two NHS Trusts, it was found evidence to support good practice with regard to the use of compression hosiery to prevent further progression of venous disease[23]. In addition, this study has highlighted the educational and practice developments that are required as it has raised questions whether hosiery selection in practice has become ritualistic despite guidance available in the form of manufacturer guidance, national guidance and Trust guidelines[6, 8, 23.]

Healthcare professionals should have an awareness and understanding of the emotional turmoil experienced by patients who suffer from recurrent leg ulceration[20]. This awareness would enable the clinician to show empathy and actively work alongside the patient to alleviate symptoms that can affect concordance with compression hosiery. Pain although not identified in this study as a standalone reason for non-compliance is a significant cause in practice for patients to decline the use of compression hosiery.

Health promotion

Patients are often perceived to have little knowledge and understanding of their condition and the role of compression hosiery in the treatment and management of chronic venous insufficiency[24, 25]. Patient's level of compliance with treatment is influenced by a lack of understanding and knowledge of the complexity of their condition[14]. It is imperative that the healthcare professional is competent and confident in completing a thorough assessment to establish the patient's level of understanding, to enable the nurse and patient to work in partnership towards identifying goals of care and appropriate treatment regimens[6, 26].

Providing patients with information in a range of formats is vital, including advice on lifestyle changes such as limb elevation, diet, ankle exercises and skin care. Equally important is the consistency of information provided, as it is evident that patients' often feel confused from conflicting advice given and inconsistent care provided which can lead to distrust in healthcare professionals[11, 14, 18, 20.] Furthermore, the need for patients to have confidence in their nurses' ability to prevent patients feeling powerless and negative about their condition is important[27].

Healthcare professionals are encouraged to follow a recognised process of leg ulcer after care management, the best practice statement identifies the requirements that professionals need to ensure that they select the most appropriate hosiery, based upon the individual needs and preferences of the patient[28]. In addition to appropriate selection, the World Union of Wound Healing Societies[29] provide possible solutions to complications that may occur, including that of staged introduction to compression hosiery which may improve concordance. Although it is important that patients are aware that their symptoms (of chronic venous insufficiency) may not be immediately alleviated, with the need to carefully consider the effect of pain, pressure damage and skin problems and act promptly to minimise risk.

Nurses raised concern that they felt unable to give priority to health promotion due to time constraints and a lack of resources, indicating that there are deeper organisational challenges that exist, that need to be addressed if there is to be an improvement in leg ulcer after care services provided and in turn reduced recurrence rates[14, 18].

Self-Efficacy

Parse's theory of human becoming compares traditional nursing paradigms in which the nurse is considered to be the expert on a patients' health rather than the patient themselves30. The theory embraces the value of an individual's lived experiences and the role of nurses to enhance the quality of life, which empowers the patient as

an expert in their own condition.

More recently the Expert Patient Programme was designed to reduce the escalating cost of managing long term conditions by providing patients' with the skills they require to manage their condition more effectively thus reducing the amount of medical/nursing intervention needed[31.] With the vision of improving their self- confidence and intern their quality of life, which is underpinned by the behavioural change theory self-efficacy[32].

Self-efficacy is defined as individuals' thoughts, feelings and beliefs concerning their level of capability of completing a given task, or reaching a set goal[33]. Perceived self-efficacy will also determine a persons' persistence to achieve despite barriers that are encountered such as difficulties with application of compression hosiery. Bandura identifies that those who have a higher self-efficacy are more empowered to succeed with the more challenges that they are faced[32]. This compares to those with low self-efficacy who can be enhanced through the utilisation of reflection and goal setting to adopt a more beneficial health behaviour which can be achieved in a group setting by witnessing people in a similar situation to themselves overcome difficulties[32]. An example of this is the Lindsay Leg Club model of leg ulcer management which aims to improve both healing outcomes and the psychological impact of living with leg ulceration and frequent recurrences[34].

Self-efficacy underpins many interventions with the intention to modify behaviour in health care, such as weight loss programmes and smoking cessation[35]. Such interventions are currently being researched to address patients' non-compliance due to non-adherent behaviour with leg ulcer aftercare and lifestyle advice[14]. However, due to the professional skill and time required to implement the intervention; the feasibility of using such intervention is unclear due to the financial burden faced by the NHS, an ageing population and a reduction in the number of district nurses[36].

Patients who wore compression hosiery as prescribed were notably associated with being knowledgeable about the causes of their condition, low depression scores and high self-efficacy scores with regard to lifestyle recommendations[24]. Despite this, it is recognised that improved knowledge alone may not improve adherent behaviour; as through the analysis of the data it was shown that 32% of participants held the belief that compression hosiery would not help prevent recurrence of ulceration which was given as a primary reason for non-compliance with hosiery[24].

This is a common theme signifying the extent to which self-efficacy and leg ulcer aftercare are intertwined[14, 24]. This demonstrates the challenges encountered by nurses in the delivery of beneficial outcomes, through the provision of holistic care that not only meets the increased expectations and needs of patients' but also to provide healthcare commissioners the measurement outcomes that they are readily seeking[35].

Patients' have their own individual needs and personal health belief model. Within this they set their own risk budget with regard to the health related actions that they are prepared to take depending on the perceived severity of their susceptibility of having ulcer recurrence and the impact of the changes that they make on their current lifestyle and quality of life.

Overall

Compression hosiery is recognised as the mainstay for treatment in the prevention of venous leg ulceration recurrence and reduction in the symptoms of venous hypertension. Possible solutions to complications experienced by patients and healthcare professionals have been highlighted in the literature; these include a staged introduction to compression hosiery[29], effective use of compression hosiery application aids[16] and clear and consistent health promotion using verbal and written information[38] including lifestyle advice that incorporates the facilitation of self-efficacy improvement techniques[32]. These possible solutions aim to improve patient concordance with compression hosiery and leg ulcer aftercare which intern could ultimately see an improvement not only in patient's quality of life, but the financial burden faced by the NHS[12].

Research design

The aim of this study is to work towards the enhancement of the current delivery of patient information and staff training on the management of compression hosiery alongside the Tissue Viability Team. To enable achievement of this aim and to compare and relate the findings to practice, it was important to gather data based upon the main themes of the literature review to explore the views, knowledge and practice of registered healthcare professionals who deliver leg ulcer after care services in a local Trust. Ethical approval was sought from the local Trust and the study was deemed a service evaluation and permission for the study was granted.

This study is a survey that utilises a self-report questionnaire to generate data. The questionnaire was distributed to a purposive sample of 26 registered healthcare professionals (n=26) who are members of a County Tissue Viability Team.

The questionnaire aimed to establish whether respondents considered non-compliance to be an issue in the provision of compression hosiery, questions were included to discover what information is commonly provided to patients when prescribed hosiery. Respondents were asked to identify the reasons they considered to be behind non-compliance and what they felt could be done to address compliance.

Analysis

The data collected was manually entered into a web-based online programme (surveymonkey.com) to generate the findings using descriptive statistics in the form of frequencies that are reported into percentage format and presented using bar charts and pie charts.

Findings

The findings indicate the reasons for patient's non-concordance with compression hosiery from the perspective of healthcare professionals, application difficulties and discomfort accounted for the majority of responses.

From the respondents (n=26), 67% had completed an accredited leg ulcer management course.

Figure 1 outlines the advice currently given to patients when prescribed compression hosiery.

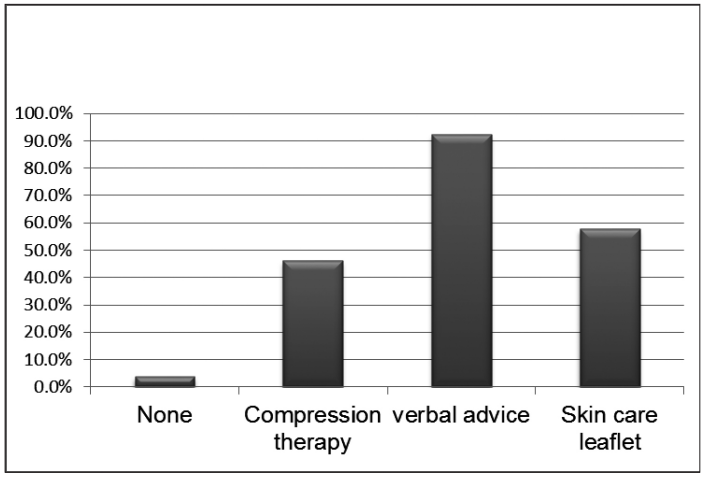

Figure 1: Advice given to patients when prescribed compression hosiery.

Sixty percent of the respondents felt patients received sufficient information. The respondents considered non-concordance an issue in 25-50% of patients.

Figure 2 outlines the main reasons the respondents thought patients were non-concordant with compression hosiery.

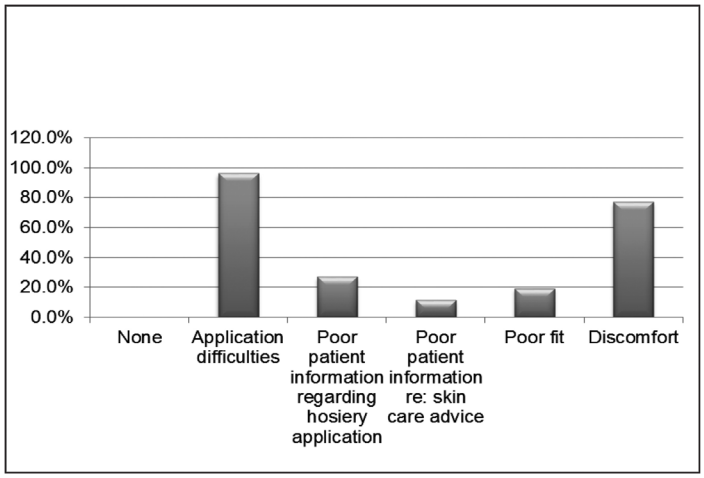

Figure 2: Reasons for non-concordance.

Respondents were asked whether they consider that patients understand the importance of compression hosiery and opinion was divided at 50% as to whether patients were considered to understand the role of compression hosiery. However, 72% of respondents considered that patients did not take sufficient self-responsibility for their own compression hosiery application and care.

Alongside this perceived lack of responsibility, 72% of respondents were contacted by patients with concerns about their treatment. Whilst respondents also attributed non-concordance as an issue it indicates the significance and need for the topic of non-compliance/non-concordance/ non-adherence with compression hosiery to be explored to reduce the burden on patients' quality of life.

Figure 3 considers what respondents considered could be done to improve compliance.

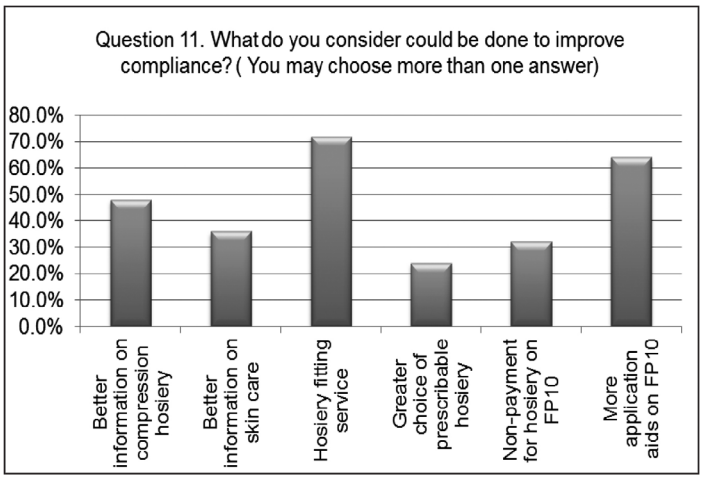

Figure 3: What can be done to improve compliance?

There was a mixed response as to how often respondents review patients with compression hosiery, this included Doppler assessment, skin care and hosiery measuring and fitting. Only 25% of respondents reviewed treatment before 12 weeks, 50% reviewed between 12-24 weeks and 25% reviewed after 24 weeks.

Discussion

Sixty percent of respondents considered that patients were supplied with sufficient information when prescribed compression hosiery, information which consisted of verbal advice in 90% of responses. These findings relate to the literature whereby nurses provided, in most cases only verbal advice, clinicians therefore may not be providing adequate information and support[18]. Although 60% of respondents felt that they had supplied sufficient information, only half of the respondents considered that patients understood the importance of the role of compression hosiery in their treatment. It is acknowledged that patients need to be provided with the facts about their condition and treatment

options available to enable the patient to make an informed decision on whether to comply with treatment. Non-compliance with treatment is positively associated with a lack of knowledge and understanding of their condition and treatment with compression hosiery[13, 14]. It is the responsibility and role of the health care professional to ensure that patients are supplied with sufficient information in an appropriate format[2]. The majority of respondents in this study, 62%, held an accredited leg ulcer course. Health professionals involved in the provision of compression hosiery should be competent to do so[22].

Respondents considered that non-concordance was an issue in up to 50% of their patients and when respondents were asked what they considered could be done to improve compliance, 48% selected better information on compression therapy. Unfortunately, respondents were unable to expand on their responses limiting the insight gained into whether it was of the opinion of respondents that existing information is considered inadequate.

Comparably to the literature[11, 15, 18, 21], application difficulties were reported as the single most common reason for non-compliance with compression hosiery. Whilst the use of application aids is recommended and a selection is available on FP10 prescription, their usage has not been established; 64% respondents felt that a wider variety would enhance compliance. Future research comparing the effectiveness of individual aids may be useful in determining whether current aids available on FP10 are prescribed and demonstrated when a prescription for compression hosiery is provided. This may in turn affect the opinions of respondents with 72% considering the implementation of a hosiery fitting service justifiable to aid application. Although such a service might be difficult to deliver and would be means tested due to the £20bn efficiency savings required by the year 2014/1539.

The concepts of application technique or inaccurate sizing of compression hosiery causing it to be uncomfortable and the reasons why patients do not wear hosiery that has been prescribed[18] relate to the findings within this study with 77% of respondents giving discomfort and 19% giving poor fit as reasons for patients' non-compliance with compression hosiery. The accurate measurement and selection of the appropriate type of compression hosiery with regard to flat or circular knit garments is key to ensure that a patient's comfort is promoted at all times[2], with health care professionals who are equipped to provide problem solving solution when complications occur[8].

In an audit of the use of compression hosiery 92% of nurses reported selecting hosiery based upon concordance, although the selection process was questioned and a query was raised as to whether selection had become ritualistic[23]. Nurses are accountable for their practice and therefore need to ensure that they are not only competent to provide the care needed but also work towards a patient centred approach that delivers evidence based outcomes[4, 40].

Compliance is a shared responsibility between the healthcare professional and the patient26. Patients should be encouraged to take an active role in their treatment through the utilisation of the nurse-patient therapeutic relationship which is based upon trust, empathy and empowerment to promote patients to take control of their health[2, 16, 26]. Seventy-three percent of respondents in this study felt that patients did not take sufficient responsibility for their own application of hosiery and care therefore; consideration must be given as to what can facilitate this in practice.

Conclusion

Twenty-six health care professionals who are members of a tissue viability county team took part in a small-scale survey. The questionnaire explored the challenges faced by healthcare professionals and patients in enhancing compliance in the provision of compression hosiery. The main findings concur with the literature that application difficulties and discomfort are the most common reasons given for non-compliance with compression hosiery and this needs to be addressed to improve the provision of care delivery, which intern should ideally improve patient concordance.

It is vital that the assessment, measurement and selection process by which hosiery is prescribed is holistic ensuring that patients are involved and play an active part in their care to promote compliance. A therapeutic nurse-patient relationship based on trust to empower patients to take control of their health can benefit holistic care and therefore, enhance compliance health[2, 16, 26].
Healthcare professionals are accountable for the care they provide and must ensure they are competent and confident in providing patients with sufficient information in an appropriate format as non-compliance is linked to patients who have a lack of knowledge and information regarding their condition and treatment[6, 8].

Future recommendations

Further research from a larger representative sample focussing on the frequency and effectiveness of application aids used in practice to consider whether improvements can be made to increase their usage would be useful.

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Poetry with people with dementia: An evaluation of a two year project engaging in poetry activities with older people in residential and nursing homes.

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Abstract
This paper is a summary of an evaluation of the first two years of a three year poetry project for older people with dementia. The project was set up with a poet in residence who mentored six poets to deliver poetry activities to older people and those with dementia in residential and care homes in Herefordshire.
The project was developed and run by the Courtyards Hereford. The evaluation was undertake through the use of questionnaires that were given to staff and carers undertaking training workshops and the poets, staff and carers in the homes who facilitated the activities and finally by the residents who took part in the project.
The main findings were that participants that responded to the questionnaire for staff and carers it had increased confidence and assisted them in gaining more knowledge about the residents, whilst for residents it had a number of positive effects including enhanced communication, increased self-esteem and enhanced self-worth whilst making them feel less isolated.

Key words: Dementia, poetry, creative writing, wellbeing, self-esteem.

Introduction.
Maintaining an active mind and a good level of physical activity is important for an individual's physiological health and wellbeing [1,2] and there has been emerging evidence and debate around the use of poetry and creative writing in community settings to improve mental health and patient self-esteem [3]. Although the therapeutic effect of arts on wellbeing has been recognised for many centuries studies are only recently being undertaken to identify their effects [3] and Mooney [2] reported that primary research has found that there may be some physiological responses to certain types of poetry in the brain. However the current evidence in the literature does not necessarily review this in relation to increased quality of life, improved orientation, medication use, and the retention and recruitment of staff. Poetry is used for people with dementia for a variety of reasons and can be for the person with dementia, the carer/ family and/or staff. For the person with dementia claims are made that it; stimulates memory [4,2,1], helps people make sense of their lived experiences [5,6], can be a catharsis of negative emotions and validation of positive emotions to evoke feelings [2,6,7] as a form of communication [7,8,] enhance personhood and self-esteem [9] and help them to express distressing feeling states [8]. For the carer/staff it can; help them gain an insight into the whole person 10, provide a greater insight for the carer in relation to self-affirmation and release of emotional baggage 6 as well as form a connection between the persons world and the caring professional [7].
However when engaging with this activity it is essential that specialists are trained to develop interpersonal skills in order to gain the confidence of the patient and be aware of potential dangers of these activities [11,12.] It is also important to justify resources allocated to creative production based on theory and sound evaluation [13].

Background to the project
The Courtyard Hereford has been involved in several arts and older people projects since 2010. One of these projects has involved creative writing and reading poetry activities for people with dementia in Herefordshire under the guidance of a poet in residence.
In order to address the issues of working with people with dementia the project included eight poetry reading and creative writing training study days aimed at examining ways of helping people with dementia to create their own poems within a group or one to one sessions. There were a further two 'reflective writing for carers workshops' where poetic techniques for self-expression was delivered to enhance reflective practice for family, carers and staff.
Four poets were initially employed to deliver the poetry programmes within the homes. These poets had received further training from the poet in residence and there was a continual mentoring process from the poet in residence. Two further poets were employed later in the project and also received training and mentoring from the poet in residence.
The poetry project evaluated involved poets providing time for the residents from three residential care homes to talk and allowed time for them to be listened to. The poets recorded, in a written format, particularly interesting or poetic elements of the conversation which they were then able to form into poems. These poems then returned to the residents for editing and agreement on the content using

only the residents own words. The residents were then given their poems to share with a group, keep as private memoir or, if they wished be published.

Aims of the project

The projects aims were to assist older people to feel less isolated, improve their personal independence and create a stronger local community.

Methodology

An evaluation was undertaken following the training days from carers and staff who attended them, from residents and staff/carers engaged in the activities carried out in the homes and from the poets who were responsible for the delivery of the activity. The evaluation was conducted through the use of questionnaires with a mixture of closed and open ended questions asking the participants to comment on their views on the project from their perspective in line with the projects aims.

From the training days, sixty-three questionnaires were completed from a total of ten workshops. Eight questionnaires were completed from the placements which were completed by a daughter of a resident, friend of resident, day care coordinator, occupational support worker, two care mangers and two poets. Poets also kept diaries, although these have not been used in this evaluation, and ten questionnaires were completed by the residents who took part in the activities.

Evaluation of the workshops from carers and staff

A total of ten workshops were carried out over a period of two years where sixty three participants were involved in the evaluation. Participants were asked to complete a questionnaire at the end of the study day. The following themes were identified.

Application to practice: Thirteen of the responses included that they would now apply this into their practice and comments included *'… gave me ideas as to how to facilitate poetry workshops…', .. 'I can't wait to start using some of these ideas' and 'looking forward to apply what I've learnt in the home'.* One participant had answered positively but noted that they currently did not work in this area but felt it would be useful for the future.

Self-development: Nine of the participants noted that this had helped them with their own development with comments such as *' .. for my own self-awareness', 'I will take away a lot from this session' and ' learning how to preserve the important emotional content for a speaker ….'.*

Development of new skills: forty five participants noted that they had developed new skills from the workshop. Comments included *'gave me tools to use with people with dementia…', 'informed my approach when working 1-1 with residents', 'enlarged my horizon about dementia', 'taking tips back to help with activities' and 'improved knowledge of writing for reflection'.*

Increased confidence: seven people noted that this workshop had increased their confidence especially in being creative.

Insight into working with people with dementia: Ten participants had referred directly to working with people with dementia and comments included; *'I have learnt a little more about dementia' and 'insights into working with people with dementia and into the condition'.*

Resident's evaluation form the activities in the homes

Ten residents completed questionnaires from three homes. The questionnaire encouraged the residents to identify how the project had worked for them. The themes noted from the questionnaires were as follows:

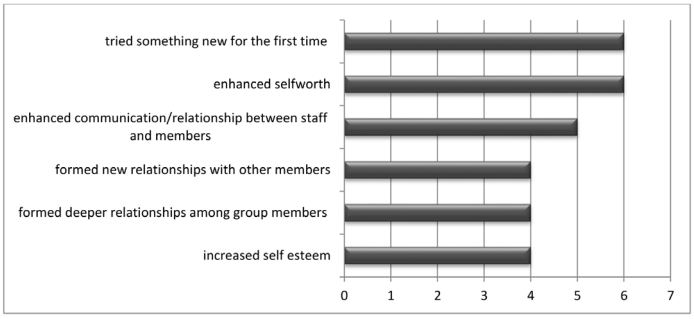
Aspects of the project that worked particularly well: all the residents had enjoyed the experience with three noting how they enjoyed chatting, two identified meeting people and three included the bringing back of fond memories.

Feeling less isolated: seven felt that the project had helped them feel less isolated. Three stated that this project had not had any effect although two noted that they were already very active with their relatives, family and within the community.

Promotion of wellbeing and quality of life: seven answered yes and one resident stated that they had *'learnt how others lifted their lives and how difficult their lives were'*

Benefits from taking part: eight made positive comments with how they have enjoyed the social interaction, stimulating, evoked memories and one realised how hard people work. One had not answered and one stated that there was no benefit but had not made any further comment.

Table 1 – statements that applied to the resident from taking part in the activity.



Evaluation of placements from the poets, carers and staff

These included three care and residential homes with a total of eight participants who answered questionnaires in relation to their placements. Of these two were residential care staff, one a friend of resident, one a daughter of resident, one day care coordinator, two poet students and one occupational support worker.

The following themes were noted from the respondents:

Encouraging residents to be creative: All eight participants were positive that the project had encouraged residents to

be creative. They identified areas of thinking about happy memories and were able to use their imagination to create stories or scenarios relating to different objects or topics. They suggested that the playfulness was where people were able to be creative.

Encouraging people to engage: again all eight suggested that residents that would not previously have engaged in this kind of activity had engaged well and suggested that it had opened up more conversations for relatives/friend to discuss when visiting, they also noted that some residents appeared more confident, continued to participate in events even when the project was over and that it had assisted one resident with limited language as a result of their stroke and also one with hearing difficulties to engage with others.

Benefits to physical health: only five answered positively as several noted the difficulty in measuring change through observation. Only one answered that this was not the case but did not add any comment as to why they felt that way. For those who noted some change they suggested that this was in relation to overall wellbeing, *'shifting in mood from being shut down and unhappy to being communicative and engaged'* and one respondent noted that this change had lasted for several hours following the activity.

Increased self-esteem; again all participants answered positively. They noted that this appeared to improve the feelings of self-worth, this was evidenced through the participants highlighting how the residents were now talking among themselves outside of the actual group meetings, how they had stated that they were looking forward to the next session, surprised at their own ability and stated that they felt valued, that they had noticed an increased pride at showing their work and increased enthusiasm to participate within activities.

Decreasing feeling of loneliness: again all participants had answered positively with comments such as how it had helped one resident to settle into the home, how some residents had joined in when normally they would not take part in group activities, the supportive and encouraging atmosphere during the activities had been very inclusive and how this activity had, by its very nature, been about intimacy and human connection.

Reduction in anxiety and depression: again only six were able to identify positively and two stated they could not comment. The positive responses were evidenced with comments such as 'seemed to have a calming and cheerful influence', one resident felt uplifted that she could talk about her feelings and express them on paper, they identified how some residents actually appeared more relaxed and animated during and after the sessions. Some noted how they had witnessed residents mood shifting and how one resident who had been diagnosed with depression had improved enough to go home. Those who did not give an answer again noted the difficulty in measuring change.

Empowered: Again seven were positive and one did not answer. They included comments such as: '*it gave them self-worth', they appeared to feel appreciated and listened to' and 'I would judge that they felt empowered by being able to say whatever they wanted'.*

Limitations of the evaluation

This was a small scale evaluation of a larger project and was not able to measure benefits such as increased physical health, improvements in depression, quality of life or improved orientation. Questionnaires were given to participants that were willing to complete them following the session although there was no systematic format for collection of the questionnaires.

Summary

The evaluation aimed to identify areas of: isolation, independence and creation of a stronger local community through the delivery of creative and poetry activities within residential care homes. Evaluations of the project were completed through questionnaires primarily to carers and staff undertaking creative writing and poetry workshops delivered by a poet in residence. These were then followed up with evaluations from staff, carers and poets who engaged in the activities within the residential care homes and finally from the residents themselves.

The evaluations highlighted areas of self-development, development of new skills, networking, increased confidence and insight into working with people with dementia for the carer, staff and poets. Residents reported a feeling of being less isolated, had formed new relationships and affected their wellbeing. Social interaction, enhanced communication/relationship between staff and members and improved feeling of self-worth were also highlighted. The training and mentorship form the poet in residence had also helped to develop the interpersonal skills and create an awareness of the potential dangers as noted previously by Dobson [11] and Mottram [12].

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Social isolation in older adults and its impact on health

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Introduction

Social isolation is a complex phenomenon that is increasingly being compared to high risk health behaviours such as smoking and obesity[1,2]. Over recent years, increasing amounts of studies consider how social isolation can affect health[2,3,4,5,6]. Older adults who express feelings of social isolation or loneliness experience higher rates of cognitive decline3,4, clinical depression4, cardiovascular disease[5,6] all leading to an increased risk of morbidity and mortality[5,6,7.]

Background

In the UK, 10 million people are over 65 years old which is predicted to rise by over 50% in 20 years time and the number will have nearly doubled to around 19 million by 2050. Included within this total is 3 million people aged 80 years and over, and this is projected to double by 2030 reaching 8 million by 20508. Given the predicted rise in the population of older adults and increasing longevity alongside the increasing numbers of older adults without spouses or children, it is forecast that social isolation will escalate[9,10.]

Social isolation impacts on quality of life and wellbeing with demonstrable negative health effects[1,2,3,4,5,6,7,9,10,11.] Loneliness is associated with being either a cause or consequence of depression and has higher rates of mortality[12]. This negative impact on individuals' health can lead to increased health and social care service use, while lonely and socially isolated individuals are more likely to have early admission to residential or nursing care[12,13.]

Literature Search

A search for relevant literature accessed three library databases Summon, CINAHL and Medline to gain understanding of what factors cause social isolation and how this impacts on health. Five published research studies were analysed to enable illustration of the key factors that lead to social isolation and loneliness and the resultant impact on health.

To differentiate between social isolation and loneliness the following definitions enable clarification: social isolation is described as the objective lack of relationships and social interaction whereas loneliness is expressed as a subjective, distressing feeling[9]. There is an important distinction between objective isolation and perceived isolation with some arguing that loneliness is the colloquial term for perceived social isolation whereas objective isolation is due to social disconnectedness[7,9].

Review

The first study by Coyle and Dugan[11] examined social isolation and loneliness and their relationship to health outcomes. With a sample of 11,825 they used data from the Leave Behind Questionnaire of the Health and Retirement Study. They examined self-related health and mental health conditions using logistic regression. The results showed that social isolation and loneliness did not correlate, and indicated that social isolation led to self-reporting physical health as fair to poor whereas loneliness led to an increased probability of experiencing mental health problems. The study suggests that global measures of social isolation that do not distinguish between social isolation and loneliness may not reveal the impact on physical and mental health.

These findings relate to the second study by Cornwell and Waite[9] who used population-based data from the National Social Life, Health and Aging Project. They interviewed 3005 individuals aged between 57-85 yrs old and received 2910 questionnaires. They combined multiple indicators of social isolation into scales assessing social disconnectedness (social network characteristics, number of friends and social participation) and perceived isolation (loneliness and perceived social support). On examining the extent to which social disconnectedness and perceived isolation are experienced they considered associations with physical and mental health among older adults[9]. Results indicated that social disconnectedness and perceived isolation are independently associated with lower levels of self-rated physical health. The findings indicate that social disconnectedness and perceived isolation have separate and distinct links with mental and physical health suggesting they are not interchangeable indicators[9].

The third study by Shankar et al[2] considered the impact of social isolation and loneliness individually concurrent with health-related behaviour (e.g. smoking and physical activity) and biological factors. They analysed data from over 5,000 participants who were eligible for a nurse visit and blood sampling including data such as blood pressure, cholesterol and inflammatory markers. They measured loneliness using the short form of the revised UCLA scale

and an index of social isolation was calculated combining marital status; frequency of contact with friends, family and children and participation in social activities[2].

Their findings indicated that fewer than 2% of participants reported being lonely all the time, while nearly 7% had the highest possible scores on social isolation[2]. Both social isolation and loneliness were associated with a greater risk of being inactive as well as reporting multiple health-risk behaviours, including smoking. Social isolation was also positively associated with blood pressure, C-reactive protein and fibrinogen levels[2]. In their discussion they recognise that loneliness and social isolation may affect health due to the impact these factors can have on health behaviour. Also, social isolation may be linked to biological processes that are associated with the development of cardiovascular disease.

The fourth study by Cacioppa et al[7] was selected as Cacioppa and Hawkley are known authors in the field. Whilst this paper is not an empirical study it considers experimental, cross-sectional and longitudinal studies and discusses the various ways social isolation is related to, and in some cases affects, human neural, hormonal, cellular and genetic processes. The study gives a biological rationale for the human reaction to social isolation. They argue that humans are a social species so naturally form societies that extend beyond the individual. These social processes developed to ensure survival and genetic legacy and involved the development of behavioural, neural, hormonal, cellular and genetic mechanisms to support them.

They argue that the effects of perceived isolation in humans are comparable to studies conducted that involved experimental control of isolation in non-human social species. These experiments demonstrated increased tonic sympathetic tonus and hypothalamic pituitary adrenocortical (HPA) activation alongside decreased inflammatory control, immunity, sleep and expression of genes regulating glucocorticoid responses. The paper claims these effects contribute to higher rates of morbidity and mortality in older adults.

In the final study selected, by Kobayashi et al[3], they aimed to develop a profile of socially isolated older adults (SIOA) in British Columbia based on socio-demographic and health characteristics to examine the impact of SIOA on healthcare services. The study sampled 1064 over 65 yrs olds who were identified using the Lubben Social Network Scale which asks questions about contact with family and friends. Data was gathered by telephone interview. The results indicated that 17% of the sample were socially isolated. The study identified that the strongest predictors of social isolation were income, gender, marital status, self-rated health, length of residence and home ownership[3].

Further analysis indicates that SIOA did not overuse health services. The findings underscore the importance of understanding differential profiles of need and service use for SIOA within broader social contexts, and are discussed in terms of their implications for health care policy and program planning for this vulnerable population.

Discussion

The articles were selected due to the comprehensive analysis of the multiple factors that impact on social isolation, therefore health. Coyle and Dugan[11] and Cornwell and Waite9 differentiate between the effects of perceived social isolation or loneliness and social disconnectedness and how they link to health. Older adults who perceive they are socially isolated or lonely experience more mental health problems in comparison to those who are socially disconnected who rate their own physical health as poor[11]. It is recognised that research into social isolation can be blurred by the multiple aspects that contribute to it however, both perceived isolation and social disconnectedness are associated with worse physical and mental health[9].

Social isolation can be linked to depression although there is a need to recognise that a depressive affect may precede increased social isolation[4]. The health risks associated with loneliness and social disconnectedness are more apparent in the older adult community due to changes in circumstances experienced including retirement, decreases in mobility, low income, increases in illness and disability as well as the loss of spouse and other social network members[9,11].

Many social factors such as stress, negative life events and poor social support may influence an older adult's perception of social isolation and ability to cope with such events3. Loneliness involves the perception of the quality of the individual's social relationships which induces feelings of distress[11]. A key point to raise is the word perception, meaning that individuals can live solitary lives and not feel lonely, contrasting with individuals who have many social relationships and yet still experience feelings of loneliness[11.] This emphasises the importance of the perceived quality of the individuals' relationships. Older adults may experience more impact on their social network due to bereavement however, it is worth noting that many older adults are not lonely and a dwindling social network may contribute to enhanced fulfilment with their social relationships[10].

However, these impacting factors are believed to affect health behaviours due to changes in social support or social prompts guiding behaviour choices[1,2]. Loneliness is associated with an increased probability of being physically inactive and smoking (or both) however, the effects of social isolation are greater with a 23% increase in odds of being inactive (compared to 13% for loneliness) and a 32% chance of being a smoker (compared to 10% for loneliness)[2]. Social isolation is also associated with increased blood pressure and inflammatory markers[2,7].

These findings link with models of health behaviours and suggest that those who are isolated are less likely to be influenced by others[2]. This may account for elements of social isolation as less acceptable behaviour becomes socially isolating[14]. An individual who experiences isolation which results from an imbalance between their actual level of connectedness and their perceived level of connectedness can experience distress. It is argued that this distressing psychological process combined with behavioural, neural, hormonal, cellular and genetic evolution impacts on the body's response to stress caused by social isolation which can result in negative health outcomes for older adults[7,9].

The pain associated with social isolation can be regarded as a biological construct which progresses into an aversive signal that motivates behaviour changes[7]. This signal alerts social threat, which in turn means the older adult perceives their social environment as threatening[4,7]. As a result, lonely individuals withdraw from society which prompts behaviour perceived as self-preserving but is ultimately destructive[4,7]. The interaction of social isolation leading to social threat can initiate neurobiological mechanisms which increase mental load leading to diminished cognitive abilities[4].

Conclusion

The findings suggest that older adults, who can manage changes within their social circumstances and stay connected socially, may experience less physical and mental health issues[9]. However, for those older adults who struggle to cope with changes in their social circumstances, there needs to be a process of identification to recognise those who are reluctant to engage in social activities and illness preventative measures. For healthcare professionals this could mean screening through home visits, hospital discharge planning or annual health screening programmes in primary care clinics[12]. These could be proactive for determining which older persons have health behaviours or coping skills that place them at-risk for social isolation[12.]

Research, policy and age friendly actions to address social isolation are already at the forefront of government policy and more needs to be done as the population ages especially in light of the fact social isolation is an everyday yet preventable problem affecting older adults.

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Is it time to rekindle the debate about training and educating a generic RN practitioner?

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It is important to recognise the need to educate nurses for care in the twenty-first century, and we need to be cognisant of the fact that there is a changing demographic in the West. Nearly two thirds (65%) of people admitted to hospital in the UK are over 65 years old. People over 65 occupy more than 51,000 acute care beds at any one time, and people over 85 years old account for 25% of bed days – which demonstrates an increase from 22% over the past 10 years[1]. At any one time, a significant number of people in the above category will be experiencing some form of delirium, dementia or depression. Sixty per cent of older people admitted to general hospitals will have, or will acquire, a mental disorder during that admission according to the Department of Health[2]. Mental disorder in older adults is a predictor of increased length of stay and poorer outcomes[3]. Likewise service users who have mental health issues may be finding that some of their physical symptoms are being managed less than optimally[4].

In tandem with this, people with intellectual disabilities face a changing demographic, which includes increased longevity and changing patterns of morbidity and mortality[5]. The Disability Rights Commission report[4] revealed an insufficient response from the health services and governments in England and Wales to the major physical health inequalities experienced by some of the most socially excluded people: those with learning disabilities and/or mental health problems. Statistically, this includes 1,000,000 people with learning disabilities, 200,000 people with schizophrenia or bipolar disorder and 6,000,000 people with depression in England and Wales. This issue is not confined to the UK. A study shows that cancer patients with comorbid mental illness in the USA die of their malignant disease about 10 years earlier than do cancer patients who did not have comorbid depression, bipolar disorder, anxiety, or other serious mental illnesses such as schizophrenia[6]. A literature review of suicide in cancer patients[7] concluded that suicide in someone with a cancer diagnosis is approximately double that of suicide in the general population, and that early detection of depression may be of benefit. Older people are more likely to have a completed suicide attempt than are their younger counterparts[8]. On the basis of all of the above points, it would be safe to say that physical and mental health is intertwined. Indeed the Department of Health strategy No Health Without Mental Health[9] highlights this issue, so we need to produce practitioners who can identify, integrate and act upon care needs whoever the client or patient may be, and we need to work on the assumption that many of those who need nursing care will have complex physical and mental health needs.

There is much variety around the point at which specialist qualifications are gained. Information about first level pre-registration education in eighteen countries, reviewed a few years ago[10] showed that four models existed, forming a range from an entirely specialist course to an entirely generic one, with variants in between. This is represented in Table 1 over:

This provides a useful basis for discussion because there is considerable debate in many countries about the possible advantages and disadvantages of the move from specialist to generic nurse education at initial qualification level. The situation is not stagnant, as some countries that moved to generic courses without specialist options (Model 4) have subsequently introduced options in certain specialties (Model 3)[10]. Our situation is that current EU directives[11] explicitly require adult nurses to have a range of nursing experiences that are deemed to be essential to the achievement of the professional qualification as RN, and it enables Adult Nurses to work as a nurse within any European Union member state. There is not the same requirement for Mental Health or Children's Nurses. Interestingly learning disability is not included in the range of experiences required, despite the wide scope of health needs within this population.

We already have argument and debate about clarifying the difference between advanced and specialist practice post qualification. The consensus from workshops undertaken with post qualified staff, was that nurses working at an advanced level required a minimum period of broad experience to consolidate their nursing skills and knowledge, before moving into an advanced practice role, and that practitioners working at an advanced level required a formal qualification to support and underpin their clinical practice[12]. This could fit well with the argument that nurses need broad experience with specialisation after

Table 1: International profiles and perspectives	
Model 1 Specialist qualification at first level	The German system is direct entry to general nursing, paediatric or geriatric nursing. Ireland, with a 4-year degree course, offers 5 direct entry routes to general, children and general integrated, intellectual disability, psychiatric nursing and midwifery. Some Canadian provinces offer direct entry to psychiatric nursing and in Italy, there has been a contested move to introduce direct entry to paediatric nursing.
Model 2 Specialist qualification at first level after a core plus branch course	The UK system has been that of a core programme followed by a branch in which a specialist qualification is gained (adult, child, mental health or learning disability). This appears to be unique. **This has now changed with the new NMC guidelines which require field specific (adult, child, mental health) qualification at pre registration level.**
Model 3 and 4 Generalist qualification following a generic course with specialist options and without specialist options	The majority (14) of countries provide a generic nurse training with no specialist qualification at preregistration level. Specialist qualifications are obtained at post-registration level. In many countries, the move from specialist, direct entry courses to a generic education accompanied the transition of nursing education to the higher education sector. These countries differ as to whether specialist options are offered towards the latter part of the course or all students follow the same programme throughout.
Adapted and taken from Robinson and Griffiths[10]	

qualification. This is mainly because ***any*** aspect of nursing can be viewed as a speciality.

Some key points that we may need to consider in this debate are centred on the current economic climate: The Royal College of Nursing[13] points out that a critical factor in determining NHS policy on staffing and training will be the decision concerning how NHS funding is allocated. The target to find efficiency savings in England of up to £20 billion by the end of the financial year 2015 (equivalent to 4% of England's NHS budget each year) will have implications. Latest reports indicate a 12.6 % reduction in intakes to pre-registration nurse education between 2010 and 2013 (RCN 2013) in tandem with increasing demand on care services.

Nurse education and the quality of care provided has been the subject of public and professional commentary[13,14,15.] In the UK, the Nursing and Midwifery Council (2010) has produced standards for pre registration nursing education, which provide child, adult and mental health field specific requirements, and competencies, which are separate. The Willis Commission on Nursing Education[16] has stated that it is essential that the nursing workforce adapts to meet the challenges faced by healthcare and the changing demographics, and the Commission believes that examining pre-registration education is fundamental to this. We have a new Professional Standards Authority for Health and Social Care[17] and we need to work with this organisation to consider all of the issues discussed here.

The Royal College of Physicians1 has made the following statement:

"Transforming the care that patients receive can only be achieved by challenging existing practice …We must consider whether the way we educate, train and deploy physicians ensures the right balance of general and specialist skills to deliver expert, holistic care for current and future patients. It is vital that all medical professionals have the skills and knowledge they need to care for older patients with complex conditions, frailty and dementia" (RCP p 8).

The same statement applies equally to nursing: if we are to provide expert, holistic care for the growing numbers of older adults, we need nurse education to be fit for purpose.

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Preliminary results of an international study exploring and comparing positive aspects and concerns of growing older in different societies.

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With the demographic changes experienced worldwide of an increasingly ageing society the number of people now living well into their eighties is also increasing. Globally the population of 60 and older years of age is projected to reach 22% by 20501 with the oldest old age group (over 80 years plus) growing at the fastest rate[2]. Although Europe has the highest proportion of 65 plus age group, Asia, Caribbean, East and North Africa and South are also set to triple by 20502. However this is a new phenomenon for many developing countries where 63% of the over 60 year olds live[3]. For this reason the countries included in this study were from developing countries.

With this ageing population there is a need to understand and gain an insight into the older person's experiences and perceptions of growing older within their own societies in relation to their independence, choice and decision making. These in turn can help to inform government agendas and policies and help demystify some of the myths surrounding growing older.

As Watson[4] noted ageing can be easily observed. However it is harder to explain and understand. Therefore, in an attempt to identify what is happening in different countries and cultures and to share these experiences, attitudes and perceptions from older people, this study asked people from three developing countries, from three different continents, to take part in this study. The aim was to gain an insight into the lives and perceptions of older people in relation to ageing and identify similarities and differences in different countries and cultures across the globe.

The objectives included:

- To explore the lived experiences of older people living in a variety of cultures and countries
- To identify the perception of growing older within their own cultural environment.
- To explore and contrast the views of older people within each country and across the boarders
- To identify any areas where we can share cultural perspectives and good practice in the global community.

Methodology;

The study was undertaken using a qualitative phenomenological design[5] which included questionnaires and interviews to achieve the study aims. An interpretive descriptive approach was used to explore older people's perceptions of the positive aspects of ageing and their concerns about growing older. This interpretation was undertaken using a content analysis through coding the results in order to organise the data prior to further in-depth interpretation and theming[6].

The total sample consisted of fifty four older people who were interviewed or given a questionnaire to complete. Of these participants ten older people were from three villages in Indonesia, fifteen were from the Northern region of Tanzania, fifteen were from Iquitos in the Amazon Jungle of Peru and fourteen were from the capital city of Lima in Peru. Peru's results were spilt in relation to location as Iquitos is a remote Amazon Jungle town where there is limited work and participants tended to be manual workers such as farmers, whereas, those from Lima tended to be wealthier and the majority had retired from professional occupations. The reasons for identifying these as two cohorts was, as Demakakos et al[7] found, that wealthier participants tend to report more positively in relation to ageing experiences than those from poorer parts.

All participants were aged over 60 years, and where required, local translators were used to translate the questions during the interviews. The participants, where ages were known, were aged between 60 and 89 with an average age of 72.9 years. The lower age of 60 was used rather than the usual agreed 65 plus years' criterion[8] as Mitchell[9] notes this mile stone of 65 plus years does not serve well for these developing countries and as seen in this study their combined average life expectancy is currently 69.6 years.

Of these participants 22 were male and 28 females, however not all data was available from Indonesia in relation to gender. The participants were asked two questions that required three answers. These were:

- To name three things that they were looking forward to, or now enjoying, in their later life.
- To name three things that concerned them about getting older within their society.

These questions were asked in order to identify the older

person's perceptions and experiences of growing older within their culture and environment.

Introduction

Ageing as we know is an inevitable part of life, however, as Abrams et al[10] noted attitudes can affect people of all ages in relation to their perceptions of that process. This they suggest can have important implications for individual's wellbeing, age equity and social cohesion. They also note that understanding these attitudes to age is essential if we are to develop appropriate strategies and policies for an ageing population. As Watson[4] noted that although ageing is inevitable it is not in itself debilitating but can be accompanied by mental and physical conditions that are age related which can have an effect on the individual's perceptions and experiences as they grow older.

Some older people, according to Walker[11], seek to gain mastery over aspects of growing older, embracing it as a friend whilst others transcend them and view them as a foe. As Schar et al[12] and Yen and Anderson[13] also noted ageing can be associated with feelings about locality and space and contribute significantly to a person's quality of life. They all also note that the locality should be taken into account when exploring quality of life issues when reviewing old age as Barrett[2] also suggested the complexities of the relationships between individuals, communities and their environments can in turn be shaped by one another. Therefore there is a need to understand how older people perceive ageing within their own society and include positive aspects as well as identifying their concerns in order to assist them to engage in their experience of transforming the ageing process and help us gain an insight in to this area.

Abrams et al[10] noted that people often delay in preparing for later life and that there are huge divergences in perceptions of age boundaries with individuals psychologically delaying the category 'old' as they advance in years. Therefore, by reviewing some of these perceptions from an older person's experience we can help to dismiss some of the preconceived ideas and myths surrounding older age and help people prepare for a more positive experience.

In relation to the age range chosen for this study the countries that were included have a lower than many average age life expectancy of developed countries. With the overall global average life expectancy age of females at 79 years and males at 75 years of age[14] all three countries still have a lower life expectancy of 77 years in Peru , 71 years in Indonesia and 61 years in Tanzania[14]. The country with the lowest life expectancy being Tanzania with an average life expectancy of 59 for males and the highest in Peru for females at 79 years.

Another factor to take into consideration for this age group is the health and functional status of older people which, although is improving in many countries[2], currently stands at 61 for males and 64 for females in Indonesia, 66 for males and 68 for females in Peru and 51 for males and 53 for females in Tanzania. Interestingly the relative proportion of females to males is smaller in less developed countries to those in the developed countries which may be due to the female's lower social status, combined with a preference for male children which may also have a negative impact on female life expectancy[9]. As seen in this study all three countries have a four year difference rather than the average of 7 years difference in the developed countries[9].
As many governments' agendas review their ageing population the social and economic impact, as never seen before, will result in many challenges that are unknown and unseen. These include areas such as Sub-Saharan Africa which is expected to experience the smallest increase in the older population in the next 30 years due mainly the HIV/AIDs epidemic[9].

This subpopulation then, according to Barrett[2], represents some of the most vulnerable people in the world who need to be given a voice to highlight their personal perceptions and experiences of ageing.

Older people in Indonesia, Tanzania and Peru.

All three countries are classed as emerging and developing economies therefore referred to as 'developing countries' according to the World Bank[15] and includes some of the most older vulnerable people in the world.
Indonesia, according to Arifin et al[16], is the most populous country in the world and were the first to gather information from older people aged 60 and above. The older population, of 60 plus years of age, are also the fastest growing segment of the population within Indonesia. Arifin found there was a good self-related health status and functional ability, they participated within home-centred leisure activities and their economic security varies by sex.

Tanzania does not use the same common terms for ageing as other developing countries but views it in relation to declining biological process where 60 years of age is also seen as the beginning of old age and the majority of older people belong to the poorest and most vulnerable groups within the country. Their 60 years and older age group is estimated to triple between 2020 and 2050[17].

Peru's population is also rising with an increase in their older population, which according to Nunez[18], will, by 2025, be estimated to be 8.6% of the country's total population having an impact on the health care services and pensions for this age group.

Findings.

Flowing the initial coding of the data from all the questionnaires and interviews the following themes were found: positive aspects of ageing and concerns related to growing older within the different cultures.

Positive aspects of ageing

Demakakos et a[l7] in their study of English adults found that in general, ageing is viewed as a positive experience for the majority of older people. This positive perception and experience was also evidenced in this study when participants were asked to discuss positive aspects of ageing. However six respondents stated there was nothing to look forward to; of these, five of were from Tanzania and one from Indonesia.

Through the analysis of the data collected, the following themes were identified in relation to positive aspects of growing older. Firstly, people could spend more time with their family (n= 30) and secondly, time for hobbies with eighteen responses (see table 1). However, the majority of people in Lima, Peru identified hobbies as their most positive aspect (n =11) with respondents from Tanzania not including hobbies in their top five (see table 2). Seeing their children grow and develop was also an important aspect across all the countries. Work was split between those who were glad to give up work and others who wanted to continue with their own work, which also appeared in all countries but related more towards continuing work in Indonesia whereas in Lima, Peru it was to pursue their own form of work. The last top positive aspect included 'health' with six respondents identifying that that they were still in good health which was related by two respondents to their ability to still be able to work.

Other aspects identified included: saving money, building their own homes, having a partner looking after them, living within a community, not caring about other people's opinions and aspects that related to their faith.

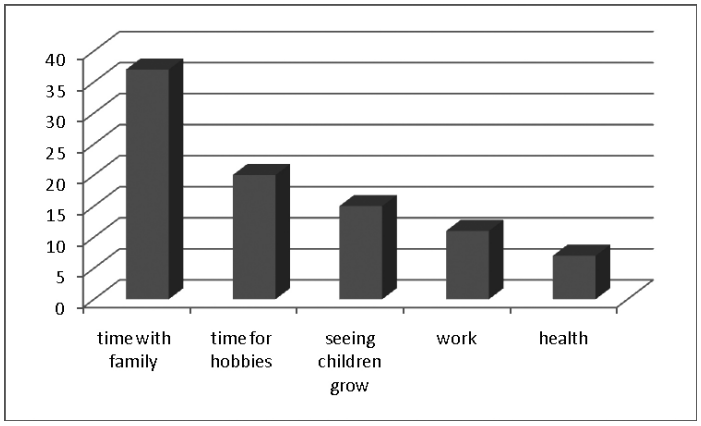

Table 1 top five positive aspects of growing older

Concerns about ageing

As noted earlier Demakakos et al7 found that for some ageing is not an unpleasant experience and suggests that this often contradicts the lay belief that the ageing is a process that leads to physical, mental, social and economic deterioration. They go onto note that the association of age with experience of ageing is not linear. Often they suggest that the experience depends on the person's age as to their concerns and experiences at that time. Donorfio

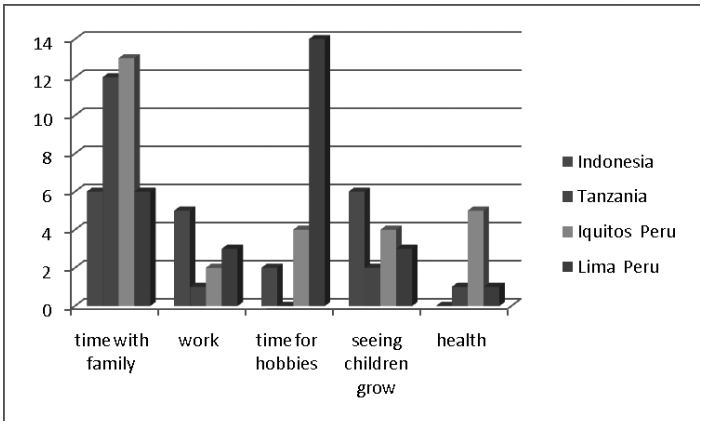

Table 2 : top five positive aspects of growing older relating to each country

and Chapman[19] also highlighted that some of the attitudes to ageing has changed over the years and that today's old person is more vibrant, confident, and able to remain more active and still contribute to society.

In this study, to identify these changing attitudes the participants were also asked to identify any concerns they had in relation to ageing. The highest comments related to their health and fear of deterioration (see table 3), this is in line with Donorfio and Chapman[19] and Demakakos et al[7] who also suggest that the main fears are associated with dealing with limitations in relation to physical or mental health. Bowling's[20] study also found that having and maintaining health was the most common concern for older people and Demakakos et al[7] found that two thirds of older people worry that their health will worsen. This was in the highest for all three of the countries and was noted as the top concern top for Tanzania and Lima, Peru but came a close second for Indonesia (see table 4) who identified death and dying as their top concern and Iquitos, Peru who identified living alone as their top concern. Loneliness, being a burden, loss of independence and death and dying were the other main concerns for this study (see table 4).

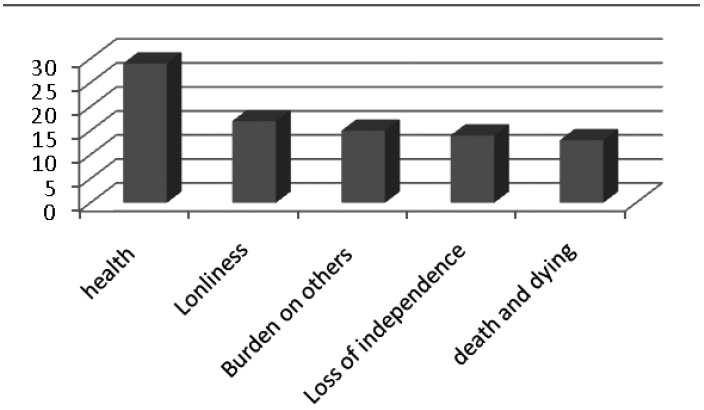

Table 3, Top five concerns of growing older

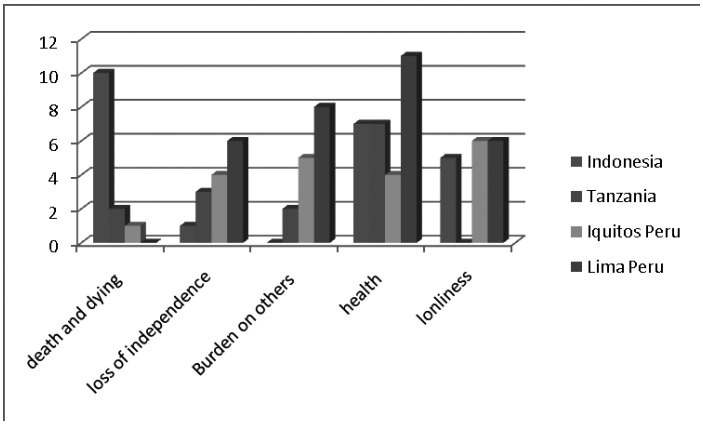

Table 4: top five concerns in relation to growing older in each country

Conclusions.

The ageing population is a reality across the globe and understanding ageing and explaining ageing is still difficult[21]. Fee et al[21] also points out that often older people are seen as a homogenous group which does not take into consideration geographical location which can affect life and work experiences which in turn can affect health and behaviours and attitudes. This was evidenced in some of the findings of this study.

For the three developing countries included within this study the main positive aspects of ageing identified included: being able to spend time with their families, time for their hobbies or personal time, seeing their children, being able to work and health. Their concerns related to health concerns, becoming lonely, being a burden on others, loss of independence and the fear of death and dying.

The top positive aspects identified by the participants in the study were fairly constant across the countries with the exception of Tanzania where five did not have anything that they felt was positive about ageing and one in Indonesia expressed the same concern.

Limitations

This study only reviewed older people from three developing countries. As noted with the Peruvian cohorts there can also be a great diversity in the perceptions depending on location within the same country and therefore it is difficult to generalise these results across the globe or, at times, within the same country. Each country has its own unique culture and societies with their own attitudes towards their ageing population and even within each country these are different depending on the individual's personal health, social and economic situation. All these aspects will affect the older person's perceptions of growing older.

This paper is a report of the preliminary finding of the study and further in-depth analysis is required to identify the possible differences between the perceptions of growing order within the three countries.

Acknowledgements

Primarily our thanks go to the older people who were so willing to share their personal feelings about ageing with us. Thanks also go to the people who helped with data collection and interpretation with whom the study would not have been possible who include Irma Alcazar, Cesar Alcazar Wong, Ysabel Utia Pineo and Elizabeth Chigua.

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Vulgar Fractions

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Can you trust these vulgar fractions?

In the traditional opening presentation at the 8th UK Dementia Congress at Nottingham, Jeremy Hughes of the Alzheimer's Society shared the numbers which challenge him and the Society:

- Less than 50% of people who have dementia receive a diagnosis during their life time.
- 35% of people with dementia are housebound.
- The majority of visits made to people with dementia for care sponsored by Local Authorities are of 15 minutes duration.

There could be problems with hanging too much on the detail of these numbers which are used to describe populations and their need for help on the one hand or their cost and burden to society on the other.

The 'less than 50%' tag depends upon estimates of the prevalence of dementia. Serial estimates have predicted rising numbers of people with dementia in this country and in other parts of the globe[1,2]. A recent survey updating actual prevalence in three cities of England has found decreased prevalence of dementia at every age-band[3]. This finding is in keeping with studies of actual prevalence and incidence in other countries[4,5,6.] The denominator is subject to change, so the certainty of the challenge is weaker.

A reconsideration of the 'Age Time Bomb' has introduced an alternative statistic the 'Old Age Dependency Ratio' which has for long influenced fears and policies with its message that fewer and fewer working age people are being expected to support more and more non-productive, dependent old people. This assumes that the same proportion of people of working age are working generation to generation and that all generations of old people are as prone to dependency as previous generations. Neither of these assumptions is true. More women remain in the workforce than was the case, increasing the denominator, whilst successive generations have displaced dependency into later decades and most people in the 60s and 70s make very positive contributions to the economy7.

The 35% housebound statistic comes from a recently released Alzheimer's Society document8. Which is splendid in itself but does not clarify the sample of 500 people with dementia who contributed and they may not be representative of the dementia population. Thirty-five percent of them went out of the house no more than once a week which is not a common definition of housebound. There is reference to a study which found people who were housebound were twice as likely to have cognitive impairment as controls who were out and about[9]. This is not all that surprising and does have implications for services and voluntary organisations but is does not mean that one in three people with dementia living in private households never leave home although nearly 40% of people with dementia are living in a Care Home[2].

Fifteen minutes per visit, including travel time is a cold, hard fact. Leonard Cheshire's survey[10] obtained responses from 132 of 152 English Local Authorities: 60% now countenance such visits in response to austerity measures. For some authorities they account for three quarters of all contacts with disabled or elderly clients. In 20 of the 132 authorities, such brutally short versions of personal care were all that was available to more than a quarter of clients: hardly a dementia friendly fraction.

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Developing the evidence base for social care – the contribution of the NIHR School for Social Care Research

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The National Institute for Health Research established the School for Social Care Research in 2009 to undertake and commission world-class research to develop the evidence base for improving adult social care in England. The School has a portfolio of 55 projects, spanning all client groups (e.g. older people, people with mental health problems, carers, and people with learning and physical health disabilities), diverse care settings (e.g. communities, people's homes, and care homes), and major practice issues (e.g. prevention, personalisation and safeguarding). Each project will report with a summary of findings, designed to be easily accessible (free on our website, short and easy to understand) and to be relevant to practitioners, managers, commissioners, and the interested lay reader.

In addition to these projects, we have published 12 methods reviews, with more in process. These are to help new and existing researchers to better understand certain research matters (e.g. mathematical modelling or observational method), or what it is like to research in certain social care settings (e.g. in care homes or in end of life care), or working with specific groups (such as deaf or visually impaired people). There are also 5 scoping reviews published, and more coming, which take an overview of a topic (e.g. the role of the third sector, or economic evidence for community capacity building) to set out clearly and comprehensively what is known, the implications of this and what are the research gaps. All our review papers are available as free pdf files on our web site.

As the largest client group for social care, the needs and preferences of older people, and how best to support them are central issues to the School and its work. Examples of relevant projects are:

- John Woolham, University of Coventry, is examining whether personal budgets are always the best way to deliver personalised support for older people (further information at http://www.sscr.nihr.ac.uk/PDF/Insights/IN19.pdf;

- Jon Glasby, University of Birmingham, has examined what local authorities consider to be their top investments in prevention in social care, with reablement being a priority (read the findings at http://sscr.nihr.ac.uk/PDF/Findings_17_prevention-initiatives_web.pdf);

- Nan Greenwood, of Kingston University, is examining how do older Black and Minority Ethnic carers of stroke survivors assess and report their satisfaction with social care services (read more at http://www.sscr.nihr.ac.uk/PDF/PO36.pdf)?

- Robert Jones, University of Nottingham, is exploring a fidelity index to help improve effective integrated home support for people with dementia and their carers (read more at http://www.sscr.nihr.ac.uk/PDF/Insights/IN7.pdf).

Our great challenge now is to begin to turn the results of our activity in to improvements in social care. We look forward to working with colleagues in the network of the Institute of Ageing and Health – West Midlands to do this. If you have any queries about our work, or would like to be added to the circulation list for our newsletter (for updates on projects/findings, our conferences and seminars), please get in touch.

Wolverhampton: Dementia-Friendly City – from roots to blossom and seeds

David Jolley, PSSRU, The University of Manchester,
Susan Mary Benbow, Visiting Professor of Mental Health & Ageing, Staffordshire University
Kate Read, Senior Lecturer Association for Dementia Studies, The University of Worcester

On June 5th 2013 the University of Worcester and the Journal of Dementia Care hosted a conference on Dementia Care in the Community, the fourteenth in a series, which began in 2000.

It was wonderful to find this launched with a showcase and discussion of current work being undertaken to make Wolverhampton a dementia-friendly community (see http://www2.wolverhampton.gov.uk/council/news/2012/august/280812d.htm). Santosh Kumari (the Commissioning Officer for Wolverhampton Council) fronted the meeting with live contributions from others on the day and video contributions from colleagues and partners in the traditional health and social care sectors as well as the retail sector, schools and other agencies.

For those who have travelled with Wolverhampton in its trials and triumphs, we looked back to the creation of the Wolverhampton Branch of the Alzheimer's Society through the efforts and passionate commitment of Moira Low its first Chairman in the early 1990s. Moira received great support from the Council and the Director of Social Services at that time, Martin Shreeve. They would be proud to see the massive changes and improvements in knowledge and understanding of people with dementia, their needs and the needs of their families, which are being realised in the City and shared with other leaders in the field.

Having seen Alzheimer's disease in her grandmother, Moira then saw it emerge in her mother and began to share with her father the task of caring for her. They wanted to learn as much as they could about dementia and to be sure that mum, and other people with the condition, could receive the best of assessment, treatment and support. There was no branch of the Alzheimer's Society in the town at that time and formal health and social services had not given it high priority. Moira turned to the Dudley Branch of the Society and received generous support, which she reciprocated several fold. Her efforts were rewarded by enthusiastic responses particularly from Wolverhampton Social Services through Martin Shreeve. Moira met Tom Kitwood of Bradford University and became deeply influenced by his work on person centred care. She was involved in helping to set up the first residential-respite care for people with dementia, the Kinver Unit at the Mandela Residential Home. She was honoured Citizen of the Year for Wolverhampton, 1996.

Moira knew about dementia, cared about it and did as much as she could to improve services and support for people with dementia, their family carers, and professionals working in the field. Her impact was greatest in Wolverhampton, but she became known throughout the country. She was a very spiritual person and a regular member of St Jude's Church on the Tettenhall Road. She recruited and inspired support from other carers and colleagues in Social Services and health care, most notable amongst whom is Moni Grizzell, a dedicated nurse who continues to lead the Memory Clinic in Wolverhampton and has represented safety and sense to generations of people with dementia, their family carers and professionals and trainees of every discipline. Together they encouraged others to join them; to have a vision for better services; and to deliver it[1, 2, 3, 4, 5].

When Moira died in 1999, she left substantial legacies for continued work in Wolverhampton through the Alzheimer's Society Branch, Social Services and research. A fund, which had its origins in Wolverhampton Health Care NHS Trust, was renamed in her honour. It has sponsored training, education and research in dementia for and by people working with people with dementia in the City. Monies to the fund came from donations and proxies for lecture and training fees and averaged one to two thousand pounds per annum. Additional money came from modest research grants.

Education and training:
The fund provided financial support for staff of the PCT (and its predecessor) and Local Authority employees to attend courses. These have included half day and full day release events. Larger sums have supported training in Horticultural Therapy and Social Work and a commitment was made from 2004 to support one candidate per annum to enrol on an MSc course relevant to the care of older people with dementia or other mental health problems at a local university. Wolverhampton University, Staffordshire University and Birmingham University all initiated such courses during this period with contributions from practitioners and academics from Wolverhampton. Five individuals have been supported on full Masters courses and others have attended targeted modules.

Research outputs, presentations and publications

An initial survey of dementia in Wolverhampton: An analysis of the characteristics and needs of people known to have dementia and their carers in North East Wolverhampton: the work was presented at the Science Park Wolverhampton December 1996.

Studies of spirituality and faith in dementia: This study of faith and stresses amongst people with dementia and their carers attending the Memory Clinic at Penn Hospital[6] culminated in presentations to the College of Psychiatrists (RCPsych)[7] to the British Society of Gerontology (BSG)[8] plus the John Young Lecture (Stafford) 2006, and talks to local groups. Further collaborations were generated with groups of similar interest in Bradford, Manchester, London and Hull and from these publications have followed[9, 10, 11.]

Studies of dementia amongst the South Asian and African Caribbean communities of Wolverhampton: These studies included the Twice a Child series and a collaborative venture with colleagues in Bradford. Presentations have been made at the BSG, RCPsych and several other centres. Karan Jutlla (now of The University of Worcester) has obtained her PhD in extending these studies and there have been several publications[12, 13, 14, 15, 16, 17.]

Studies of Memory Clinic clients and outcomes: Moira's close friend, Moni Grizzell, led this work. Presentations have been made at the Royal College of Nursing, National Memory Clinic conferences and in several other settings. Sarah Lyle presented findings in her MSc dissertation for Keele University. Others of the team established the West Midlands Memory Clinic Network, produced reviews of Memory Services and extended the concept to create a Memory Clinic in Primary Care[18, 19, 20, 21, 22, 23].

Care of people surviving into late life with chronic mental illness: Whilst dementia has been the biggest issue for mental health services addressing the needs of older people, it is important to recognise that other groups may experience even greater neglect. Pioneering studies of the circumstances of people 'graduating' into old age with chronic or relapsing serious mental illness may lead to better services by greater understanding[24, 25, 26, 27, 28.]

People with Learning Disabilities: Two projects were carried out relating to dementia and people with learning disability. One was a national project carried out for the Faculties of Old Age Psychiatry and Learning Disability Psychiatry, Royal College of Psychiatrists, which resulted in several presentations, a report[29] and a paper[30]. Alongside this a psychology assistant was employed and carried out a local project to establish a database of people with Down syndrome in Wolverhampton who were at increased risk of developing Alzheimer's disease later in life: this also resulted in presentations and a published paper31.

Reflection

So the inspiration stemming from Moira Low, including the activities of a small fund which has carried her name, has yielded blossoms and seeds of hope and possibilities where there appeared to be very little. This tradition goes on and is celebrated in the work described at Worcester. It is wonderful to reflect that the determination and love of one small person can lead to such sustained benefit.

The Moira Low fund has recently been closed with the remaining monies diverted to support new ventures: evaluation of tea dances at the Blakenhall Resource Centre, Alz Café, the Dementia Carers Support Group in Wolverhampton and Dementia Pathfinders http://dementiapathfinders.org/. Dementia Pathfinders is a newly formed enterprise aiming to deliver therapeutic care and support for people with dementia and their families, and programmes of education and learning for people working in the dementia care field. It will have a base in the City.

So well done Wolverhampton for taking up the challenge via Moira and Moni 20 years ago, for growing and nurturing understanding and better services through listening and teaching, and well done for laying seeds for more improvements in these years to come.

Well done and thanks too to the Journal of Dementia Care and Dementia UK (previously fordementia) for the series of annual study days on Dementia in the Community, based in the West Midlands.

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A Unique Venture in South Worcestershire: Community "Rehabilitation" at the Timberdine Unit: Service Evaluation and Observations a Year on

Background:
Between 2011 and 2015 the population of Worcestershire is expected to grow by 8,500 (1.5%) (from 560,300 to 568,000), including an expected rise of over 14% in the >65. Across the health and social care economy there is a commitment to extend care out of hospital by developing a range of community based services that will improve quality and provide more care closer to home. The NHS Worcestershire QIPP plans and the existing Strategic Plan aim to ***re-design services so that there is a reduction in the amount of care delivered in secondary care with a greater emphasis and investment in services which support the people of Worcestershire to improve their own health, with increased levels of support and care within primary and community care sector.*** Thus, the aim of the service reconfiguration was to redesign the provision of stroke and rehabilitation services for patients from Worcester, Droitwich and Ombersley. The Geriatrician –lead rehabilitation service previously situated on a hospital ward in the old block of Worcestershire Royal Hospital was closed and a unique Unit was formed under the ownership of the Local Authority with the newly integrated health and social care community resources of circa £2.5m.This replaced a former social care resource centre in Worcester city and is called Timberdine Nursing and Rehabilitation Unit .

It was envisaged by Commissioners that there would be three groups of patients admitted: rehabilitation, stroke and step-down and was staffed accordingly. The model came into effect from 1 August 2011 and now provides nursing care, residential care and rehabilitation for patients who continue to need 24 hour care and rehabilitation following admission to the acute hospital. It seems relatively unique in design and delivery in so much as there is limited evidence of similar community models elsewhere in the country. There are many examples of nursing home provision, community stroke units, community hospitals, rehabilitation units for specialised conditions individually; but no single facility offering services to this broad range of patients in one place in the community.

The Unit employs 15.74 WTE registered nurses, 24.97 WTE care staff, 2 WTE Occupational Therapists, 2 WTE Physiotherapists and a social worker. Amongst this is a dedicated stroke team, consisting of a 'core team' of 3.56 WTE registered nurses and 1.93 WTE senior care staff; and 3.61 WTE intermediate Care Support Workers. There is an extended team of staff able to work across both units to cover annual leave and sickness etc. The Clinical Lead is by a Matron who is the only Prescriber. Nurses and are in charge of the wellbeing of patients in their wing when on shift. Their normal nursing duties include regular observations, transcribing and giving out the medication and writing the discharge summaries. The nurses are a contented and professional team, who are developing a training matrix to ensure a wide range of competency and skill mix is available. In addition there are links to various other multidisciplinary team members. There are regular sessions provided by the Hospitals's Orthoptist, Stroke Consultant and Geriatric Consultant and from Community Dietician, Speech and Language Therapist, Community Stroke Matron, GP and Chiropodist. Input is available from specialist nurses (PD, Palliative Care, Tissue Viability ,) Stroke association ,Carers association , Palliative Care support team ,Continence Nurse, CPN ,Spiritual support , Community Matrons, Care Managers and District Nurses.

Documentation is all in the SAP (Single Assessment process) folders that stay with the patient.
There is an ECG machine, phlebotomy and bladder scanner and staff are competent in their use. Other equipment used includes catheters, parenteral fluids, prescribed oxygen. There are IT links with the Acute Trust to access radiology images and investigation results as well as their outpatient letters and Electronic discharge summaries. Policies have had to be written for near-patient testing for anticoagulation, simple medications, oxygen and emergency medication, and the falls policy is still being written. Any incidents are reported quarterly to the quality and safety review board.

Medical cover: G.P's visit for 2 hours daily. Initially this was by Rota from the local walk in Centre, but they now have two permanent G.P's covering Timberdine with much more consistency. G.P's visit the new patients within 24 hours. Consultant cover is from Dr. Ruma Dutta, a Geriatrician with Special Interests in falls and Palliative Care, who covers two sessions per week. Her role is to be consulted by various members of the MDT including the GPs, on a range of issues. This includes performing CGA and medication reviews, writing prescriptions, liaising with the Acute, reporting to the Coroner, requesting and obtaining

radiology and blood results, talking to patients and relatives, estimating prognosis and providing clinical supervision to the Matron as well as maintaining email and telephonic input. Some of the patients are well known to many of the staff including Dr Dutta. The Acute Trust's then Medical Director cum Geriatrician, who oversees the County's two other stroke rehab wards (based in Community Hospitals) provides weekly Stroke Medical input.

Despite initial apprehension, there is now a complete acceptance of each other's roles, and excellent individual relationships are established. Staff has worked hard to overcome early teething problems and developing the culture needed across health and social care to deliver the rehabilitation model required. Access to intravenous fluids, oxygen, medication, NHS supply chain delivery, agency staffing without access to NHSP, insufficient social work hours have all been hurdles that have been overcome. Staffing levels and skill mix have been maintained. There has been some difficulty providing sickness cover for the therapy team, who are not managed by the Unit, unlike the nursing and care staff who report to the nurse manager. In general there are good systems in place to cover the skills and competencies required each day, a team member takes the lead each day to release the Matron from tasks that can be performed by others.

The unit has been registered as a nursing home by the Care Quality Commission (CQC), however they have yet to perform an inspection of the new service

Key performance Indicators routinely collected are: Reduction in delays in discharge, Reduction in readmissions. Outcomes included reduction in institutionalization, Providing care closer to home, Admission within same day as referral, Promoting independent living, Positive patient experience, Length of stay for Stroke patients within 30 days, Length of stay for rehabilitation patients within 21 days, Length of stay for Step-Down to Nursing Home Patients within 21 days, Reduction in delayed discharges. 7 measurable outcomes identified by National guidance and service frameworks (NSFs) for those living with long term conditions and particularly stroke patients are improved health and emotional well-being, improved quality of life, making a positive contribution, choice and control, freedom from discrimination, Economic well-being, Personal dignity.

Progress/evaluation:
Of the 198 patients admitted in the first 5 months, over half (109) were discharged home, the majority receiving some level of additional support (from the intermediate care team, the hospital at home team, stroke team or required ongoing care package). 30 were readmitted to the Acute. Almost a quarter of the discharges have been to long-term nursing home placement.
There have been approximately two deaths per month. The Commissioners had not expected to be providing a significant End Of Life service. The total number of deaths in the first 15 months was 22. Of the first 14 of these, 10 were expected deaths on the Liverpool Care Pathway and 4 were unexpected deaths not on the Liverpool Care Pathway but with DNAR orders in place. This has lead to building close links with St. Richards Hospice and good support from a Palliative Care Consultant, Simon Challand.

Mean LOS for 5 months was 21.3days (range: 13.5-51days for step down patients; for "rehab" patients 21.2-28.1days, stroke ranged 20-40.1days). The delays in discharge have been substantial at times. At the beginning of March 2012, 54% of the beds were taken by patients that no longer met the minimum requirements for care. Many of these patients have required 3 members of staff for adequate nursing care during their stay. When considered together with the increased length of stay, in excess of 30 days, it would seem that the unit is receiving a far more complex case mix of patients than originally anticipated by the Commissioners. The unit has responded well to this complex demand, but commissioners feel there may be alternative patients who could be sent from the Acute instead, a view not shared by the Consultants.

Other difficulties include ability to discharge older patients in time for admissions, inappropriate referrals of patients still requiring acute care, and lack of appropriate information on discharge summaries. The staff try to deal with these sensitively.

Feedback: The staff at the Unit have been awarded the Customer Service Excellence Standard for maintaining high levels of customer service, by EMQC. The inspector was very complementary about the services provided saying that they ***"really understand the needs of our service users"*** and that the "managers within the service, together with external line managers, promote a customer-focused culture and encourage staff to participate in this. This is shown in the training and support offered to staff and in the 'hands on' style of leadership. A 15 question patient and carer feedback form distributed on discharge, received overwhelmingly positive feedback. Over 92% of the 70 surveys returned said that patients had a positive experience. Privacy, dignity, autonomy, choice, care, comfort, knowledge and goal-setting all received high praise. " Other feedback comments include "*I just wanted to drop you an email to say thank you to all the staff at Timberdine who helped the family care for my nan in her final days. As a family we were really impressed with the quality of the care she received and how lovely and accommodating all the staff were. Please extend this to your staff team and keep doing such a good job." "I think the organisation of the Timberdine Unit was excellent. The staff could not have helped more. They were the kindest and caring. I found that my stay there was equal to a 5* nursing home. Thanks to everyone concerned. Considering my age (100 in July) your staff looked after me wonderfully." "Quite the most pleasant*

nursing home or hospital I have ever been in. From the nursing staff to the décor, to the choice of food and I was quite sorry when it was time to come home!! This nursing home is really outstanding and I wish it all the very best" " Felt it was the best place to go, after arriving via hospital; I was unable to get out of bed, after 6 weeks with the help of all the staff. I am doing really well, walking, talking and getting my life back. Can't rate Timberdine high enough"

Individual patient outcomes have been assessed by using assess the case study approach. An unannounced quality and safety visit by NHS Worcestershire noted 8 areas of good practice including food, drinks, privacy, kindness and enthusiasm. Their recommended included the revision of Care Plans, and better documentation of falls, manual handling and pressure ulcer prevention, as well as submission of a falls report.

Risks : Falls is the greatest risk. In the first 15 months three patients sustained a fractured neck of femur and one fractured a clavicle. These will be difficult to tackle by environmental modification; from October 2012 fallers are reviewed by the Falls specialist Consultant Geriatrician. In 15 months the Unit have received 5 informal complaints related to communication issues (from GP, relatives etc), and one formal complaint related to nursing home respite care funding directed towards a social worker.

Cost

The unit is receives an annual income of circa £2.5m from NHS Worcestershire Health and Social Care. Although Timberdine is registered by the CQC as a nursing home, it is providing the level and intensity of nursing care that would normally be delivered in a hospital setting. For comparison purposed therefore, financial benchmarking has been undertaken using a similar sized rural acute hospital, elderly care unit with a dedicated stroke unit. The cost comparison assumes that the average length of stay is consistent for both providers at 21 days. Both units have the same number of beds and an average cost of prescribing per patient of £132.00 - £135.00 based on 5 months available data pro rata. The analysis shows that Timberdine is 8% (£191k) more expensive than the benchmark provider unit and supports the same number of beds with 15% (n10 WTE) less staff. The unit costs £5k more per bed to run each year; however the cost per patient, including prescribing costs is comparable to a hospital ward.

Since the Unit began functioning however, there has been an overall increase in acute admissions to Worcester Acute and Community Hospitals for the local population within the Timberdine catchment area. There have been 514 more emergency admissions and 216 planned admissions to hospital in the over 75s. This age group is likely to make up the largest proportion of those referred to Timberdine. The average length of stay for both categories has fallen by 1 day during the period. The rise in cost to commissioners of this increased activity as £1.6m. During the same period, the cost of excess bed days to the commissioners for this activity has fallen by approximately £267k. Thus the Unit has saved 4,213 bed days, reducing the cost of excess bed days by £267k.

New audits that are about to begin internally include pressure ulcer audit and an adverse reaction to anticoagulant therapy audit. These will be monitored quarterly internally and there will be a regular permanent audit plan developed .The EOL service will be monitored. To the Commissioners its future success will depend upon building in resilience within the integrated teams to maintain the level of support required to a growing population. In summary, It is a well run and forward thinking organization, achieving a patient satisfaction rate of over 92% and taking patients out of secondary care, which is what it was set up to do.

Discussion:

Compared with the hospital ward that it replaced (from which a large number of staff were recruited), the Unit weighs on both sides of the scales. The ambience, beautiful environment, single rooms, better food and better staffing ratios are a marked improvement on the old. On the other hand, the lack of on-site radiology and intravenous drugs, availability of junior medical staff round the clock have lead to readmissions (e.g. sepsis, LVF). Patients have to be transported to outpatient appointments and for specialist review whereas these would have come to the patient on the old ward. Again, all admitted patients are not seen and assessed by the Geriatrician and so all have not had Comprehensive Geriatric Assessment including a medication review, whereas they would have had on the previous ward. However, there is improved and timely discharge due to documentation being written by the nurse in charge of that unit, whereas on the old ward this was often delayed due to and lack of junior medical staff lost to the EWTD, on call rotas ,clinics or leave and to nurses not leading the process.

Commissioners feel that the unit has demonstrated benefits in terms of improved quality of patient experience and successfully reduced costs, notably the reduction in excess bed days. Its success is in no small part down to the input, determination and tenacity of its staff. It has fulfilled its aim of successfully moving services from the Acute to the Community and created a unique integrated Unit under the auspices of the County Council which is highly appreciated and allows patients to return to the Community.

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Poem composed by the Poet Laureate of Worcestershire:

TRUST IN TIMBERDINE

A beacon in the darkness when nightmares rule your life
Timberdine is waiting, helping you survive
The atmosphere is different, positive, serene
A place to stay and heal awhile
Gill and Julie's dream.

Here, broken people are welcomed through the doors
Met by willing, caring staff whose commitment will ensure
That skill and dedication are the order of the day
As they nurse you back to health again
Then send you on your way

There is no shame in illness, it happens to us all
Some of us lose memory and are unable to recall
The simplest things that filled our lives
Our families and friends
Sadly, some must leave this world, they've reached their journey's end

The arm that now won't move at all, the legs that cease to walk
The hidden smile that indicates unwillingness to talk
Are gently coaxed, cajoled, coerced
With tenderness, like kin
Revealing the much stronger you that still exists within

The newest of equipment, the positivity of staff
Magic happens daily, again a patient laughs
The future's looking hopeful
It's radiating, bright
The darkness lifts a little bit letting in the light

Wherever next you travel, whatever road awaits
The strength from help and kindness never underestimate
Your spirit will grow stronger, loved ones will be calm
For everyone is touched by
Timberdine's healing balm

Worcestershire Poet Laureate
September 2012

INSTITUTE OF
IAH
AGEING & HEALTH
West Midlands

Contributors' Guidelines

The Journal of the Institute of Ageing and Health (West Midlands):

A well written appropriately constructed paper makes the editors' job simpler and hastens publication. To this end the following should be considered, but where doubts remain enquires, prior to submission, as to suitability, styles etc. are welcomed. Submissions can cover any topic related to ageing or health in later life. Preferably manuscripts should be submitted electronically via email to Jeanette.lane@bhamcommunity.nhs.uk or post to the Institute of Ageing and Health - West Midlands at the address below.

The journal welcomes original articles relating to health care from carers, older people and any health care worker involved with caring for older people.

Presentation of articles:

- Manuscripts should be prepared using Microsoft word in double spaced format with ample margins.
- Title page should include: title of the article to include authors name, qualifications, designations and place of work
- The format should include an introduction, main body and conclusion.
- Any references, if used, should also follow the Vancouver system of referencing as set out below.
- There is no minimum word limit for these articles however they should not exceed 4,000 words.

For original research include:

Key words - Up to six essential key words

Abstract - No more than 200 words to include a short resume of the research aims, major findings and conclusions.

Main text - To include an introduction, methodology used, results, discussion, any related limitations and future recommendations, ethical considerations and conclusion.

Length of article -This should be between 3-4,000 words in length (minus references)

References

These should be numbered in the order in which they appear in the text. At the end of the article the full list of references should follow the Vancouver style (see examples below).

Please give the names and initials of all authors (unless there are more than seven, when only the first seven should be given followed with et al.)

Examples:

Book references

Sheldon JH. *The Social Medicine of Old Age: Report of an inquiry in Wolverhampton.* Oxford University Press, 1948.

Chapters in books

Mountain G *Assessment and dementia* In Downs M and Bowers B (eds) Excellence in Dementia Care Research into Practice. Berkshire. Open University Press. 2010

Journal references

The authors' names are followed by the title of the article; the title of the journal abbreviated according to the style of Index Medicus; the year of the publication; the volume number; and the first and last page numbers.

Holmes C, Hopkins V, Hensford C, MacLaughlin V, Wilkinson D, Rosenvinge H. Lavender oil as a treatment for agitated behaviour in severe dementia: a placebo controlled study. *Int J Geriatr Psychiatry* 2002; 17: 305-308

Electronic references

British Geriatric Society. Population and Projections. 2012 http//www.bgs.org.uk/index.php [accessed on 3 /3/12]

Authors should get permission from the source to cite personal communications. Authors must verify references against the original documents before submission.

Illustrations

Clinical photographs of people or their lesions must be accompanied by written consent from the subject. Tables should be short, plain and should not repeat information contained in the body of the text.

If printed charts are included these should be original figures, diagrams and tables. These should all be referred to in the text. If using already published figures, tables, diagrams and/or tables these must be acknowledged and it is the authors responsibly to gain permission for their use.

Publication is at the discretion of the editor who may seek external peer review.

Proofs maybe sent for consideration to:

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