

Partnerships for Older People Projects (POPP)

Round 2 Pilots

Project Profiles

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
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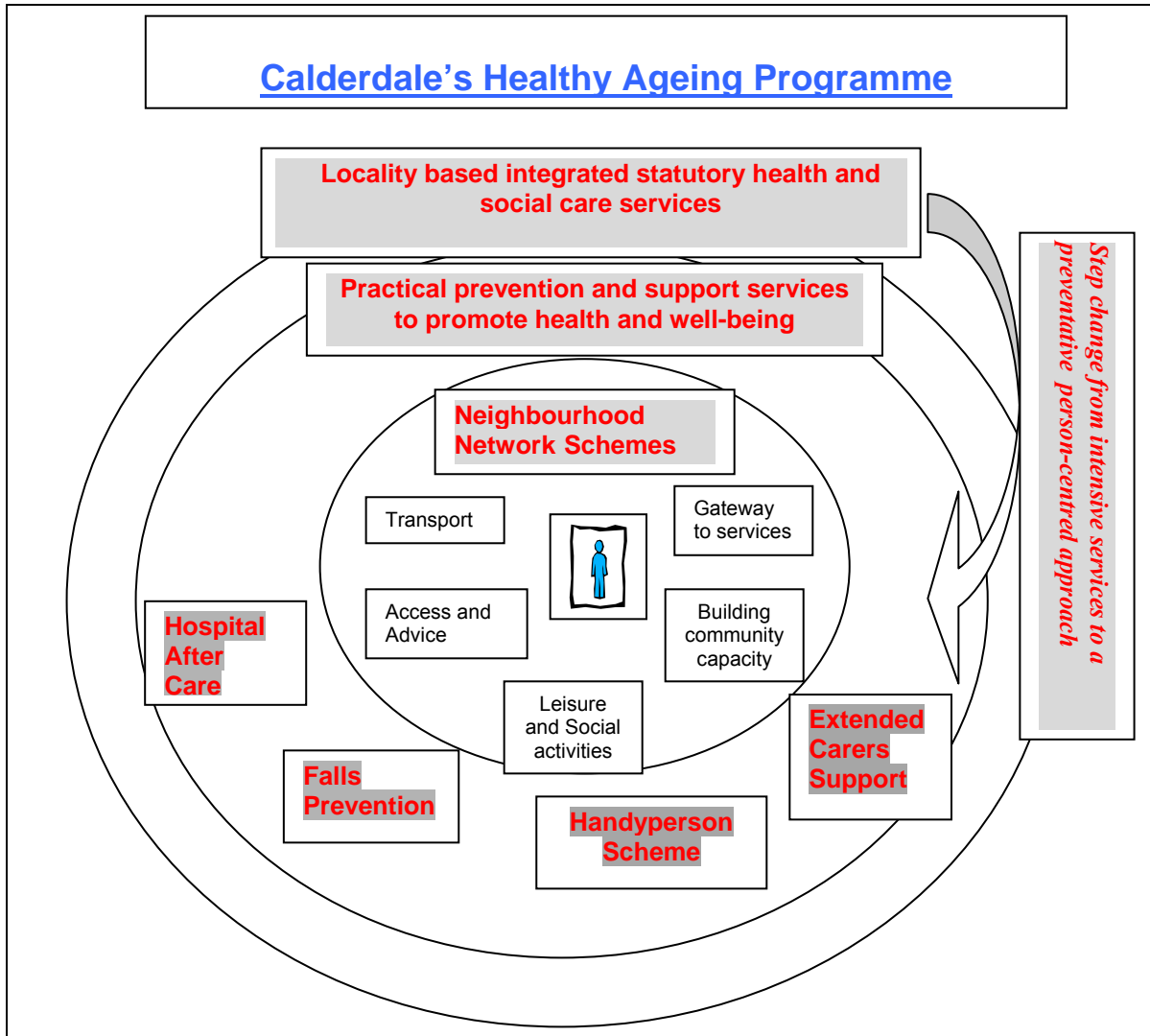
Introduction

All of the successful POPP projects have the following factors in common:

- They are two year projects driven by Local-Authority-led partnerships (including at least one lead PCT partner), which will receive ring-fenced funding (a share of £18.5m) over the financial year 2007-08.
- All the Round 2 POPP sites will be established from 1st May 2007.
- They bring together a range of interventions, which have been chosen because of their combined potential to provide a sustainable shift of resources and culture towards 'prevention' across the whole health and care system. It is this overarching strategic approach and the scale of the projects that makes POPP an innovative programme both locally and nationally.
- Partnership arrangements are innovative locally as they are either extending existing partnerships or creating completely new partnerships. The partnerships are underpinned by a range of delivery mechanisms including as pooled budgets, joint commissioning, Local Area Agreement etc.
- They represent different circumstances and challenges such as differing levels of deprivation, rural and urban environments etc which will enable us to test what works under which conditions.
- They have involved and have made a commitment to continue to involve older people, carers and staff in the delivery and evaluation of services.
- The service delivery models represented in the projects contribute to the delivery of some or all of the following four priority areas, which are key themes within the White Paper 'Our Health, our care, our say':
 - addressing the needs of carers
 - earlier targeted interventions including case management approaches for older people with long term progressive conditions
 - broader quality of life interventions
 - greater involvement of the third sector to extend the market and to provide greater choice.
- *Together with the Round 1 POPP sites, the 10 new sites will provide coverage across all nine regions.*

Calderdale

Healthy Ageing Programme



Main Elements

Calderdale's Healthy Ageing Programme comprises the following main elements that are inter-linked and key to developing a whole systems approach.

- **Engaging, enabling and empowering older people**
 - Neighbourhood Network Schemes
- **Improving the management of long-term conditions**
 - Improving the health & well-being of carers
 - Locality integration
 - Home From Hospital
 - Falls prevention
 - Handyperson service

Each element is outlined in more detail below.

Engaging, Enabling and Empowering Older People

Project 1: Neighbourhood Network Schemes (NNS)	
Description of Initiative	<p>Two pilot NNS will be set up and run by local older people for older people. They will meet local needs in a flexible way to provide the services, activities and opportunities that older people want and need. The NNS will offer a range of activities that promote health, well-being and independence. This will include a mix of:</p> <ul style="list-style-type: none"> • advice and information – eg information days, drop in clinics, leaflets, signposting and referral on to appropriate services • social, recreational and learning opportunities – eg coffee mornings, outings, arts and crafts, volunteering opportunities, inter-generational activities • healthy living activities – eg T'ai Chi, Falls Prevention and other physical activity classes, smoking cessation sessions • practical help and support provided by volunteers – eg decorating, gardening, handyperson, befriending, carers support, telecare etc • possibly transport • reaching out to isolated older people in the local community
Staffing	<p>1 (35 hours) NNS Co-ordinators per scheme. Main tasks are to:</p> <ul style="list-style-type: none"> • Undertake community development work by liaising with local older people about their needs, identifying buildings and other resources available and developing the NNS services, activities and opportunities alongside older people. • Support the Management Committee in their work - eg supporting them to fundraise, assisting with publicity & organising training • Locate and support isolated, hard to reach older people and those with long-term conditions locally, undertake assessment visits to identify needs and help them to link into services • Take referrals from and signpost older people to statutory and voluntary organisations • Work with the Development Support Worker to develop services to meet the identified needs • Monitor activity and assist in evaluation of the pilot • Explore whether a social enterprise model is feasible <p>1 (30 hour) Development Support Worker per scheme. Main tasks are to:</p> <ul style="list-style-type: none"> • Recruit, train and support volunteers to meet needs • Support the co-ordinator
Older People's Involvement	<ul style="list-style-type: none"> • At least 50% of people on each site's management committee will be older people from the locality • Older people will run, develop and evaluate the pilots with support from the Co-ordinators, Voluntary Action Calderdale, Age Concern Calderdale and Calderdale Council – this will include updating local older people on progress via newsletters, leaflets etc • The NNS will offer employment and volunteering opportunities

Improving the Management of Long-Term Conditions: Preventing Admissions and Improving Well-being

Project 2: Improving the Health & Wellbeing of Carers	
Description of Initiative	<p>Our Carer Support Project has several elements with the aim of reducing the number of situations where care breaks down by supporting carers to self care and manage their situation more effectively, increasing the economic well-being of carers and meeting carers needs in a more effective way.</p> <p>Carer Support A part time support worker will be employed to offer time limited support focused on specific outcomes agreed at the outset. The Support Worker will also offer assistance with Carers Assessment so that:</p> <ul style="list-style-type: none"> • more assessments will be undertaken and • carer needs will be identified and met more quickly. This can sometimes alleviate the need for more expensive respite services <p>Expert Carers Programme POPPs funding will help us to provide “Looking After Me” courses. These are expert carers programmes that will be led by trained volunteer tutors who themselves have experience of caring for a relative. The course runs over 6 weekly half day sessions and helps carers to:</p> <ul style="list-style-type: none"> • Learn new skills to manage their caring situation more effectively • Develop the confidence to take more control of their life • Develop more effective relationships with health and care professionals • Use their skills and knowledge to lead a fuller life • Meet with others who share similar experiences <p>Remodelled Service Provision Respite service provision will be remodelled in the light of the results of research. It is likely that a home based respite care service will be developed to help carers in crisis or emergency situations.</p>
Staffing	<p>1 PT Carer Support Worker – to provide support as outlined above 1 PT Expert Carer Programme Administrator - to recruit volunteer trainers, arrange the courses, develop promotional material, administer and evaluate the courses and provide administration and telephone support to the case worker. Volunteer trainers - to deliver the Expert Carers Programme Staffing for remodelled respite services (in the voluntary sector)</p>
Management & delivery	<ul style="list-style-type: none"> • The Carer Support Worker and Programme Administrator will be employed by a local carers voluntary organisation under a service level agreement with the Council and PCT. • The remodelled respite service will be provided by a voluntary or independent sector agency via a service contract

Project 3: Locality Integration	
Description of Initiative	<p>Our POPP project is geared towards moving to an integrated model of service delivery.</p> <p>The key features of the model of integration we are exploring include:</p> <ul style="list-style-type: none"> • How services can be co-located within localities to improve communication and decision making • The feasibility of pooled commissioning and provider budgets • How locality integration will fit with Practice Based Commissioning • How we can test our local system for misaligned incentives • Arrangements for managing staff in localities • How we can use IT more effectively • How patients/service users can be involved in service review and

	<p>development resulting in clearly articulated outcome measures</p> <ul style="list-style-type: none"> • Mechanisms for jointly identifying and delivering key targets • The feasibility of a single point of access into services for clients/patients • Implementation of one set of assessment documentation • Implementing case management particularly for people with long-term and complex conditions <p>Once the model has been agreed it will be rolled out across Calderdale in a phased programme</p>
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Project 4: Home From Hospital	
Description of Initiative	<p>The Home from Hospital support service will contribute to achieving a safe and efficient discharge by offering a flexible person-centred service including:</p> <ul style="list-style-type: none"> • Providing practical support, including preparing the house prior to the person coming home, making sure the house is warm and food provided • If required, escorting a person back home and settling them in, also following up with a phone call or visit a couple of days after discharge • Carrying out a simple home safety check and referring any concerns to appropriate agencies and services • Providing or co-ordinating arrangements for transport home if necessary • Offering appropriate reassurance visits • Offering short-term practical assistance with cleaning and other non-personal tasks • Encouraging access to other services including benefits/income checks <p>The service will be:</p> <ul style="list-style-type: none"> • Offered for a maximum of 6 weeks – continuing needs after 6 weeks will be assessed separately • Work closely with the Rapid Response Team • Be provided by paid staff complemented by trained volunteers where reassurance and confidence building is needed • Provide continuity of worker whenever possible
Staffing	1 FTE Co-ordinator and a small pool of PT support staff
Management & delivery	The service will be provided by a local voluntary organisation working alongside existing services to ensure a whole system approach that develops a comprehensive discharge planning, co-ordination and after care service in partnership with acute hospital trusts and social services. The Service Co-ordinator will be based and work closely with the Rapid Response Team. The Project will be overseen by a multi-agency delivery team.

Project 5: Falls Prevention	
Description of Initiative	<p>The project will employ assistant falls practitioners to support the work of the Falls Practitioner. The specific difference they will make is:</p> <ul style="list-style-type: none"> • Increasing the capacity in the system to provide targeted evidence based interventions cost effectively eg chair based exercise for those in nursing and residential homes. • Supporting the implementation of multi-factorial falls prevention work to include physical activity, sight/hearing checks, environmental checks and repairs, training/awareness raising, lifestyle change and peer mentors
Staffing	2 FTE Assistant Falls Practitioners
Management & delivery	These staff will be employed by the PCT and managed by the Falls Practitioner. The Project will be overseen by a multi-agency Falls Prevention Group.

Project 6: Handyperson Service	
Description of Initiative	<p>This service will provide:</p> <ul style="list-style-type: none"> • Low cost repairs • The installation of additional security fixtures, grab rails & telecare installations that need fixing to a wall • Carry out small home improvements (eg putting up shelves, re-hanging doors) to assist older people to maintain their homes
Staffing	At least 1FTE additional handyperson (this depends on the type of service contracted)
Management & delivery	The handyperson service will be managed or subcontracted out by the Home Improvement Agency. There will be a HIA/Handyperson Project Board led by the Supporting People Team.

Croydon

POP STOP - Bringing Services to Older People in Croydon

POP STOP is a mobile unit available 7 days a week with a flexible timetable including evenings. The unit will deliver information, services and support to older people and their carers in ordinary everyday settings right to the doorstep. Staff and volunteers from statutory, voluntary and the independent sector will provide:

- ❑ Health MOT's and medicines management
- ❑ Keeping Well in Old Age
- ❑ Advice on What's On?
- ❑ Falls Prevention
- ❑ Equipment, Adaptations and Assistive Technologies
- ❑ Caring for Carers
- ❑ Staying Safe and Secure
- ❑ Benefits Advice
- ❑ Housing Advice
- ❑ Nail Cutting Service



POP STOP, using wireless technology, will provide a single accessible gateway to other health, social care, housing, leisure, safety, benefits and voluntary sector services. Skills sharing and training will take place between the various staff, volunteers and agencies staffing POP STOP to ensure that knowledge and support to older people provided on board is maximised.

As POP STOP moves around the Borough, information and services will be targeted and adapted to local need. Using public health data and predictive modelling, developed in partnership with the King's Fund, we will identify and focus on older people who will most benefit from POP STOP. We will take POP STOP to communities that traditionally have had difficulty accessing services and those at high risk of long term illness, addressing health inequalities and social exclusion. **POP STOP** will support people in making informed choices to promote their health, independence and well being.

The POP STOP Mobile Unit

The mobile unit is based on research and design used by the Metropolitan Police to create accessible mobile offices. It will be a low floor chassis vehicle built on modern front wheel drive vans. It offers flexible space that can be used in different ways to meet different needs. It supports good access to the public including wheelchair users and people with limited mobility. It is based on a medium size van, so no special driving licence is required, so can be driven by operational staff after limited training and familiarisation. It has a power supply supported by the base vehicle engine. Fitted with a hearing loop, the mobile unit includes space for individual consultations, the display of material, access to computers and printers, supporting the provision of information, assessment, referral and the services the make up POP STOP. It will provide a number of services:-

Health MOT

POP STOP will provide health checks, advice and support to identify risk factors for diseases such as coronary heart disease, stroke and diabetes. Loss of hearing and vision increase the risk of social isolation, depression and increase the risk of accident and falls. In addition to providing blood pressure and blood sugar monitoring, we will provide an initial hearing and vision screening service and information, support, and treatment advice. It will also be possible to offer flu and pneumonia immunisation on POP STOP in areas of low uptake.

With the Service Development Officer for Black and Ethnic Minority Communities we will ensure that communities know about the service, when it is available and that culturally

sensitive services are taken to communities with the appropriate interpreters available. POP STOP will be available in places where older people from BME communities come together, such as at places of worship, luncheon clubs and day centres.

Supporting People with Long Term Conditions

POP STOP will support people with long-term conditions by linking to Croydon's Virtual Ward initiative. People with long term conditions and at risk of having frequent admission to hospital are identified, using a predictive modelling algorithm developed in partnership with the King's Fund, and cared for in virtual wards in the community. POP STOP will take additional services and advice to patients on the virtual ward supporting the case management model delivered by community matrons and health visitors for older people. The service will be designed in a flexible way to meet the needs of patients.

A pharmacist will offer a medicine management and medication review service on POP STOP in addition to providing the service to patients with long term conditions on the virtual ward. Medication reviews will focus on reducing risks associated with coronary heart disease, diabetes, stroke and medication related falls. POP STOP will contain examples of compliance aids available to support older people to manage their medicines and remain independent for longer. POP STOP will promote the Medicine Use Review service provided by community pharmacists.

POP STOP will support the Expert Patient and Carers Programme by ensuring information about the service is taken to communities and that people can be booked directly onto courses.

Keeping Well in Old Age

Croydon Voluntary Association's Health Champion Project supports the development of health champions from within communities. Forty-five health champions will be recruited over the next three years. POP STOP will link with health champions to ensure that it supports the health needs identified within communities.

POP STOP will provide an assessment, information and advice services to support people in making healthy choices and to access the care and support they need to maintain their health and well-being. In line with "Choosing Health" advice on stopping smoking, improving diet and nutrition, increasing exercise, encouraging and supporting sensible drinking, and improving mental health will be provided on POP STOP and refer people to other initiatives, including exercise classes and healthy eating programmes, provided throughout Croydon.

POP STOP will also work to prevent cold-related illness. Health Through Warmth (HTW) is a scheme to help tackle the issue of fuel poverty, associated cold-related illnesses and excess winter deaths. Working with Croydon Energy Network POP STOP will ensure that "Health through Warmth" advice is taken to communities particularly to areas of high deprivation.

Befriending Services aim to reach older people who may be lonely or living in isolated circumstances. Volunteers visit people in their own homes, to chat, reminisce and enjoy a cup of tea together in a relaxed environment. POP STOP will support access to this service provided by Age Concern and community and Neighbourhood Care Associations.

What's On- Information and Advice

The Voluntary Sector Service Providers for Older People (VoSSPOP), are an organisation that represents the voice of voluntary organisations for older people. They will have a vital role on POP STOP in informing older people and carers about the many and varied activities they can take part in. Information will be provided about tea dances, the University of the Third Age, day care, luncheon clubs, shopping trips, gardening help, and many other events, excursions and activities that take place throughout Croydon.

No Slips and Trips - Falls Prevention

The Falls Co-ordinator will ensure that POP STOP is equipped to take out the message of falls prevention, to provide falls screening and using the falls pathway refer people to appropriate falls services including medical workup, therapists, the handyman service, staying put service, equipment and assistive technologies as appropriate.

Get Equipped- Equipment, Adaptations and Technologies to support independence in old age

POP STOP will support access for older people and their carers to the equipment and assistive technologies they require to live safely and independently in the community. Croydon is one of the eleven local authorities that have been successful in obtaining funding for a self-assessment pilot project. The project focus is for the development of a fully accessible self assessment tool and procedure for people to be able to independently determine their need for equipment and minor adaptations, and to enable them, if they choose, to self refer for further council services as appropriate. Self-assessment on board POP STOP will enable people to self assess for equipment and services in addition to being advised by people on board.

Caring for Carers

POP STOP will support carers by providing the information needed to support their caring role by enabling them to directly access services. POP STOP will make sure that carers are informed and have access to services to prevent crises developing resulting in the person cared for go into hospital or long term care.

POP STOP will provide advice on benefits, such as the attendance and carers allowance, and help carers to claim the benefits to which they are entitled.

Croydon has a prize winning Memory Service developed in partnership with South London and Maudsley Trust. POP STOP will enable this service to go out into communities and provide carers with advice, information and access to the mental health assessment and treatment for those with cognitive impairment.

Safe and Secure

We will work with the local Crime Prevention Officers, to identify ways that POP STOP can support older people to be and feel safer. This will include taking the Staying Put SAFE service to older people in the community providing free home safety and security service and access to Home Security Officers, who carry out surveys, offer advice on accident prevention and home security and supply and fit a variety of equipment including smoke alarms.

Don't Lose Out- Benefits Advice

Working with the Benefits Agency we will ensure that advice about benefits for older people and their carers is taken into the most deprived communities. Benefit Advisors will deliver advice about benefits to older people on POP STOP. We will improve access to this service by taking it into communities in highest need.

Homes Fit to Live In - Housing Advice and Support

POP STOP will provide a service to older people and their carers who want advice about housing, sheltered and extra care sheltered housing. Working with the Housing Department we will ensure that housing officers are available on POP STOP to provide advice to vulnerable older people.

Best Foot Forward - Nail Cutting Service

Age Concern Croydon, in collaboration with the PCT podiatry service have established a nail cutting service. Volunteers are trained to safely cut older peoples nails for a reasonable price. POP STOP will enable the service to be taken to people and communities were it is currently not provided.

Devon

My Life, My Choice – Feeling Good at Home in Devon

There are three elements:-

- Multi-disciplinary teams at cluster level
- Community mentors
- Footcare service

Multi-disciplinary teams

The service will work with adults and their carers to promote their independence and choice in their own homes or close to home across the full spectrum of needs from low level to intensive urgent care needs.

This proposal involves current Devon PCT “in-house” provider staff, Devon Adult and Community services care management staff and Devon Partnership Trust community staff (OPMH) and Voluntary Sector staff working as part of a coherent integrated service across the whole of Devon closely aligned with primary care. The proposed model creates a seamless care pathway across services that are currently provided by primary, social and community care.

The overall Devon-wide service and approach is delivered via integrated health and social care “clusters” organised alongside groups of primary care practices and related to the coastal and market towns, and Exeter.

The Voluntary and Community Sector will be integrated into this service as equal partners to support the identification of people at risk of loss of independence and/or experiencing a downturn in their lives and in co-ordinating access to community based, (wherever possible mainstream services) to support people to maintain the level of well-being and independence achieved through the integrated service interventions.

A core service of integrated health and social care front-line practitioners aligned to a grouping of primary care practices to include staff with specialist roles “dedicated” to the cluster with named other specialist staff who are linked with more than one cluster. Each cluster has an integrated central co-ordination function for inter-professional co-ordination across ACS / PCT / PC and the Voluntary Sector. The population served would likely to be in the region of 35,000 in line with the national evidence base re: Managing Long Term Conditions.

This service delivers an integrated service in relation to an individual’s needs:

- Case finding
- Case management
- Assessment
- Care planning
- Monitoring
- Reviewing
- Direct treatment / support and rehabilitation
- The arrangement of care / treatment / support from other providers as appropriate
- Health promotion activities

Additionally, the model provides a platform for the further development of self care and self assessment strategies and will use the eSAP business process.

The ACS broker service will further support staff from both health and social care in the “micro-commissioning” of care services for individuals. Following assessment, the broker service will make all the necessary arrangements for service delivery.

Community Mentors

Community mentors are part-time, paid staff, usually with creative or teaching skills, working within clear management structures and governance. They are an integral part of the GP based MDT's.

What they do

- Working within local GP Practice and / or with communities (geographical / identity / faith), they outreach to early identify participants
- Encourage and support isolated people to become as independent as possible, supported by, and contributing to, their own communities
- Stimulate and facilitate individuals and community groups to become free-standing
- Work across generations

Who they support

- Older people who are becoming isolated or losing confidence as well as people who have had a serious health issue and are recovering from treatment and support of the MDT
- Hard to reach groups - very rural areas,
- Minority ethnic elders - Chinese, Muslim, Polish in particular
- Carers of older people

During the course of the POPP project there will be 72 Community Mentors with at least three based in each cluster MDT.

Foot Care Service

We will establish the service in four pilot areas to test the service model and establish its potential for supporting continuing independence. The service would be under the supervision of a qualified podiatrist and would be delivered by a team of trained volunteers in each of the areas.

Our target is to reach 800 people in the first year and 1200 by year two. This will be achieved by recruiting and training 4 teams of 6 volunteers (24 in total).

System change

The core innovation is a whole system redesign at primary care level incorporating in one team, health (including GP Practice staff and mental health workers), social care and voluntary sector staff, drawing on common resources according to agreed protocols.

This proposal is underpinned by workforce and learning plans to support the new ways of working, new roles and new partnerships. The services will use common SAP tools and eSAP to join processes and systems. We are on track to be the first fully functioning integrated electronic SAP community by June 07.

Innovative aspects of the partnership arrangements are as follows:

- Integrates and rolls out across Devon an innovative model of multi disciplinary working that incorporates the major service improvements tested by “early adopter” enthusiasts in primary, social care and VCS
- Builds and releases community social capital through the involvement of the voluntary sector community mentors
- Locates the drivers for change with users and carers, front line health and social care staff (including critically GPs) and the Voluntary Sector recognising that the factors that help individuals maintain independence, confidence and motivation include the ability to regain control of their health and lives, and to have satisfying, self-designed and sustainable solutions to problems
- Creates opportunities for to take forward agreements to create additional operating efficiencies through deeper integration of the workforce at all levels across Devon
- GPs will be engaged directly (for the first time outside the pilot sites in Mid Devon and Exeter) on their own agenda of reducing inappropriate demands on their time and payments for emergency admissions to hospital
- The development of integrated commissioning with the Devon PCT, and joint capacity for policy / planning / management information work
- A consortium framework for voluntary agencies to deliver efficiencies and a co-ordinated service delivery response has been agreed in principle by representatives of Devon’s voluntary sector
- The establishment of both the Devon wide carers’ partnership board, and the Devon Senior Council will add to the robustness of the partnership

Financially, the partnerships will continue to draw on a locally tested model of informal pooling of resources which has delivered well and met Audit requirements while avoiding additional bureaucracy. The agreement to meet voluntary sector costs for MDT representatives, and to include planning for services to be provided by the voluntary sector (footcare, mentoring) within core planning represents a step change for the community, insofar as this has previously happened only a) for carers services; or b) very locally.

**A CLUSTER SERVICE – INTEGRATED HEALTH AND SOCIAL CARE ALIGNED
WITH PRIMARY CARE**

Level 1

“Core” staff/roles dedicated to a given cluster population. Core staff may also have specialisms

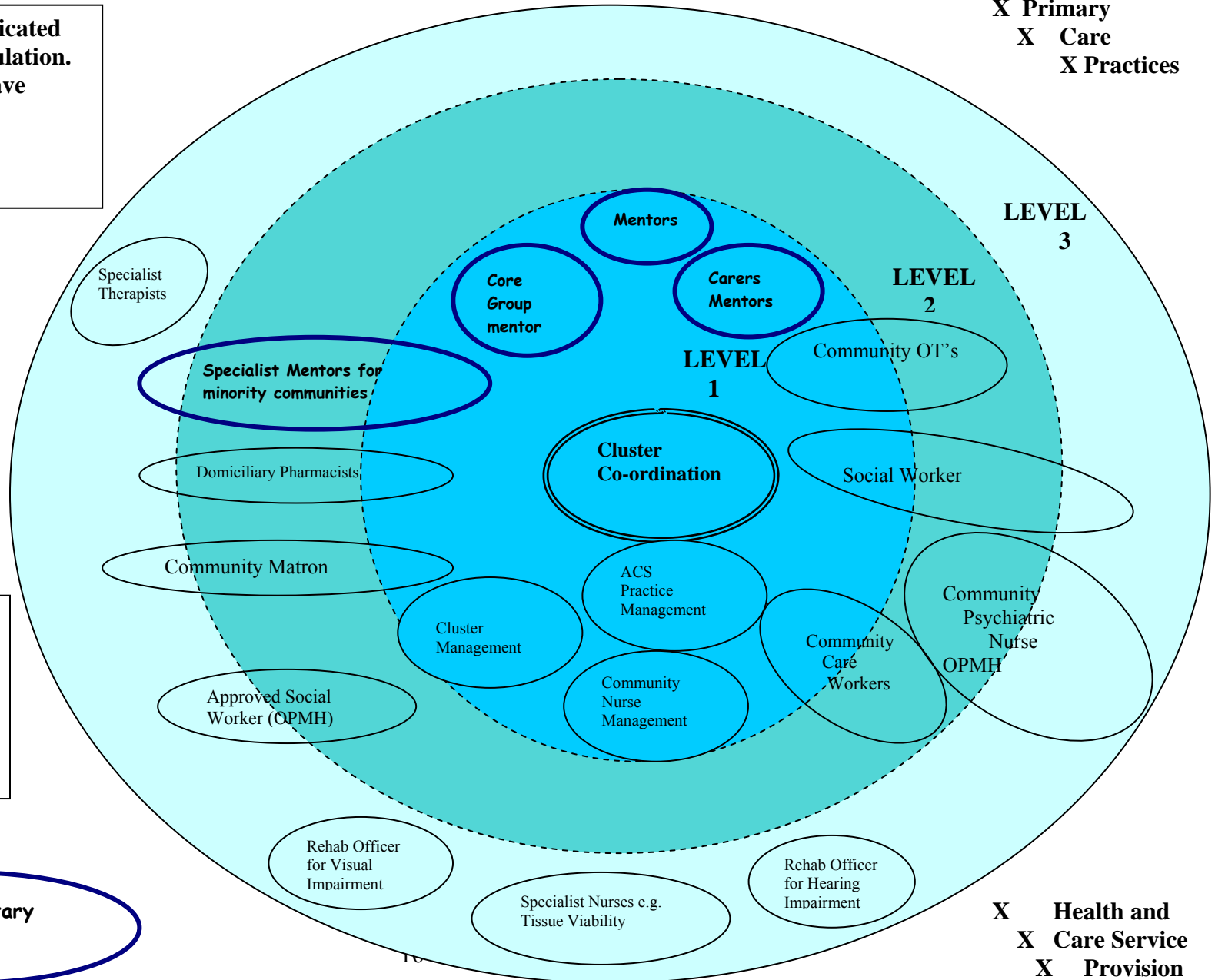
Level 2

“Aligned” staff, likely to have a specialist role but who work closely with the “core” staff

Level 3

Highly specialist staff who work across and link with more than one cluster

X Primary
X Care
X Practices



Gloucestershire

This project focuses on service redesign, and service change, working with Care Homes across Gloucestershire. Redesigning this element within the whole system of health and social care will bring about a sustainable shift from the focus on acute or institutionalised care towards targeted earlier interventions aimed at improving care, well-being, choice, dignity and independence.

Gloucestershire Care Homes could provide a wider range of services to a wider range and greater number of people. These services would be more local and more responsive than present services. This would include a variety of services within the Homes and an assortment of outreach services. These services would also provide opportunities for the local population (including older people) to help with the promotion of health and well-being via voluntary or paid employment.

With Care Homes in the centre of such a hub, older people will be able to play a full and active part in their communities. This will result in healthier and self-sustaining communities.

The project aims to promote a healthier older age, improved care pathways and better whole system working. To do this it seeks to have 8 work streams:

- Provide **Care Homes Support Teams**. To use and develop further the West Gloucestershire model;
- **Develop Outreach Services**. Develop the capacity of Care Homes to provide different types of care and support to a greater number and wider range of older people and carers in the community;
- **Develop new Care Pathways**. These should seek to inform, involve and provide care for older people using different pathways e.g. step up and step down beds.
- **Provide Training for Care Home staff**. In order that staff are skilled to deal with more challenging older people and with care of the dying, enabling more residents a choice of where they should die;
- **Involve** older people in the evaluation, planning and inspection of services;
- Provide innovative **retraining and recruitment of older people** for second careers;
- Seek to have robust **evaluation** so that the legacy of POPPs is rich and fruitful; and,
- Provide a robust system of **communication** so that all, particularly older people, are informed about the Project and its progress

Care Homes Support Teams

- Medicines Management
- Nutrition
- Care of dying
- Care of older people with MH Needs
- Falls
- Skin integrity / wound care
- Provide links to health and Social Care
- Facilitate culture change within Care Homes, Primary and Secondary Health Care and Social Care
- Ensure case management for those with long-term conditions
- Advise re work flows e.g. response to increase in hospital admissions
- Access to psychological therapies
- Use of telecare and telemedicine

Outreach

- Planning for older age e.g. finance, housing, care, healthy aging, preventative technology etc
- Use of Information Technology e.g. for residents and those in the community
- Welfare rights advice
- Provide sign posting and information
- Develop reciprocity schemes e.g. leisure vouchers for providing care
- Change perception of community's view of Care Homes i.e. to be seen community resource

Training of staff from Care Homes, Acute and Primary Health care and Social Care

- Mental Health
- Challenging behaviours
- Nutrition
- Medicines management
- Elder abuse
- Production of training packs
- Enablement

Involving Older People

- Consultation and planning
- Communication
- Gathering local intelligence
- Older people to evaluate and inspect services
- Formation of a champions network

Recruitment and Training of Older People

- Identify older people in the local community, including hard to reach older people
- Provide links to scheme
- Voluntary work
- Retraining for new career
- Training for carers
- Training for expert patient
- Leadership and involvement
- Lifelong learning

New Pathways

- Rehabilitation / promoting independence
- Intermediate care
- Step up (prevent admission)
- Step down (aid discharge)
- Link to ISIP initiatives

North Somerset

In summary the project includes the following elements:-

- Project Management to develop integrated teams
- The Community Development Workers engaged by Age Concern Somerset
- The Community Development Worker engaged by SREC
- Improving pavements in a specific area where there has been a cluster of falls
- New services for Carers

Integrated teams

The redesign of North Somerset's community health and social care services will involve joining up the Council's Adult Care Services, the PCT's District Nursing Services and the Avon and Wiltshire Partnership's Mental Health Services for Older People into four, fully integrated, co-located and jointly managed teams. These teams will be based around four clusters of GP practices.

We will have a single point of access for these teams, building upon the Adult Social Services Single Point of Access already in place, and will develop shared assessment processes and information systems. We will have a joint case management and self-management approach. Working closely with the GPs, the teams will be able to offer a holistic approach to preventative and long-term care. They will be able to target people who are frequent and substantial users of services, intervening to prevent the complications of diseases such as COPD and diabetes and the deterioration of social circumstances. Cost savings from emergency admissions will enable us to sustain our investments in preventative care.

Our shared knowledge will enable us to identify people with emerging needs and offer preventative care, signposting to other support networks. Early intervention will enable the introduction of assistive technology to prevent deterioration.

We already share the responsibility of reducing delayed discharges and excess bed days regardless of whether they are considered to be a 'health' or 'social' care responsibility. For instance, we have 'stretched' the systems put in place under the Delayed Discharge Act to include patients in non-acute as well as acute beds. All patients are therefore assessed and discharged within timescales set out in the Act regardless of whether they would become 'reimbursable' delays. Our joint teams will improve our performance in this area too. Enabling people to leave hospital at the earliest opportunity will speed up their return to independence and reduce the risk of hospital acquired infection. A joined up approach to discharges will reduce the likelihood of readmission.

Community development

Our four new locality teams will each include a new post of Community Development Worker (CDW) for Older People. They will be located within the teams but employed and managed by Age Concern Somerset.

The role of the CDWs will be to reach out to older people, encouraging participation in volunteer schemes, including local befriending initiatives and practical self-help. They will develop and train older people to be included in the planning, development and monitoring of services. The CDWs will target some of the hard to reach older people who are isolated because of poverty, bereavement or because they live in rural areas.

Through Somerset Race Equality Council (SREC), we will be recruiting another CDW Worker with a specific remit to engage the older BME population. Older people from the Black and Minority Ethnic (BME) population tend to be less likely to use health and social care services than other members of the population. However when services are eventually accessed they are likely to be substantial and costly. We will find out how we can develop services that meet the needs of the whole population and encourage involvement in their design and evaluation. The Community Worker will complement an exiting project being undertaken by SREC to develop a BME forum in North Somerset.

This initiative will result in more people from our BME population accessing services at an earlier stage, preventing complications arising from long term conditions and reducing the likelihood of crisis intervention. Linking our project to SREC's ongoing activities will reduce social exclusion for these older people.

Carers services

Carers have told us that they would like to redesign the way that respite care is delivered in North Somerset. They would like to take control and manage their own care when and where they want it. Through our local voluntary organisation, Crossroads, funds will be made available to invest in a range of services, eg, weekend breaks, home respite (or sitting) services, access to training opportunities, eg financial management, domestic skills, stress management. Crossroads will manage this budget. Approximately 100 carers will be able to choose from a menu of services, arranged by their own organisation, as and when they want them.

Improved pavements

Our Senior Citizens' Forum has campaigned long and hard for an improvement in the condition of pavements. Uneven pavements create problems for carers pushing wheelchairs and older people may find it difficult to mobilise and be put off going out. Where pavements are broken or uneven there is an increased likelihood that people will trip and fall. We will invest money in an area where there have been a high number of falls. This will reduce the number of falls, emergency admissions, the need for home care services and the amount of money paid out in compensation.

Leicestershire

DALE PROJECT (Decisions at Life's End)

The DALE project aims to reverse the increasing number of older people who die in hospital often separated from family and friends as a consequence of the general trend of increased unscheduled admissions. It intends to do this by putting the older person at the centre of services and providing an integrated, holistic and supportive service, which enables as many people as possible to be given the choice of having a dignified death in their own home.

The objective of the DALE project is to provide an estimated 1,869 people from Leicestershire and Rutland who are currently admitted to hospital and subsequently die, to choose either not to be admitted or to be discharged early to die at home. It will do this by providing intensive care and support services along a pathway that starts at the point when an older person is identified as dying and ends when that person dies at home.

The DALE project will be established across all the county areas of Leicestershire and Rutland, and will provide locality-based services, consisting of additional nurses and generic health and social care workers, integrated within an existing intermediate care team, and supported by other local mainstream services and other mainstream community support. An essential element of this service will be locally-based GP cover at home.

The service model will build on existing services, many of which, particularly those developed for patients with cancer, are already well established. These services are now being extended to people with non-cancer palliative care conditions, many of whom are elderly, frail and vulnerable. The DALE project will not replace any current end of life services but instead, will innovatively complement and integrate services in the community, enabling them to become seamless, comprehensive and fully co-ordinated.

Project Manager

The DALE project will be managed by a project manager and a four-phased approach over two years will be taken to implementing it:

1. Care homes and extra care schemes
2. People living in sheltered schemes with warden services
3. Older people living in the community at home with family/carer support
4. Older people living alone with support from agencies.

'Closer to home' options will be provided by care homes and community hospitals.

Early key responsibilities for the project manager will include:

- Promoting through publicity, training and education a major shift in culture amongst all participants that hospital care is better than home care
- Facilitating a process by which older people's wishes about their death can be recorded and acted upon
- Establishing local directories of support services identifying the full range of services that can be called upon to support the dying person.

The Dale Pathway

1. Medical assessment is undertaken when death of an older person is predicted
2. Care at home is requested (or has been stated in an signed directive)
3. Single call made to the DALE service to activate the immediate nursing and practical care required to support both the person and their carer/s at home
4. Personalised package of care for each person will be co-ordinated by the local district nurse team working closely with the DALE service
5. Essential medical and care equipment will be delivered within hours
6. Families or friends can be actively involved in the direct care if they so wish
7. Continuity is maintained if a person's situation is stable enough to transfer them to mainstream services eg district nursing teams, hospice at home

People dying at home receiving services from the DALE service, will include those where an admission to hospital has been deflected, and those who were in hospital but where a hospital to home discharge has been facilitated.

Involvement of Users and Carers

Older people have continued to be key influencers in developing the DALE project with extensive consultation and discussion taking place regularly between them and a network of local partnerships representing the health, social and voluntary sectors. Their involvement will continue through the project's implementation and evaluation. Leicestershire and Rutland is a large rural area which spans a radius of 50 miles. Populations are diverse and often isolated. Hard to reach groups are represented.

Financial Shifts

The DALE project will promote a sustainable shift towards prevention and improved well-being for older people through releasing funding currently being used to support emergency admissions and bed days, to support community services that reflect patient choice.

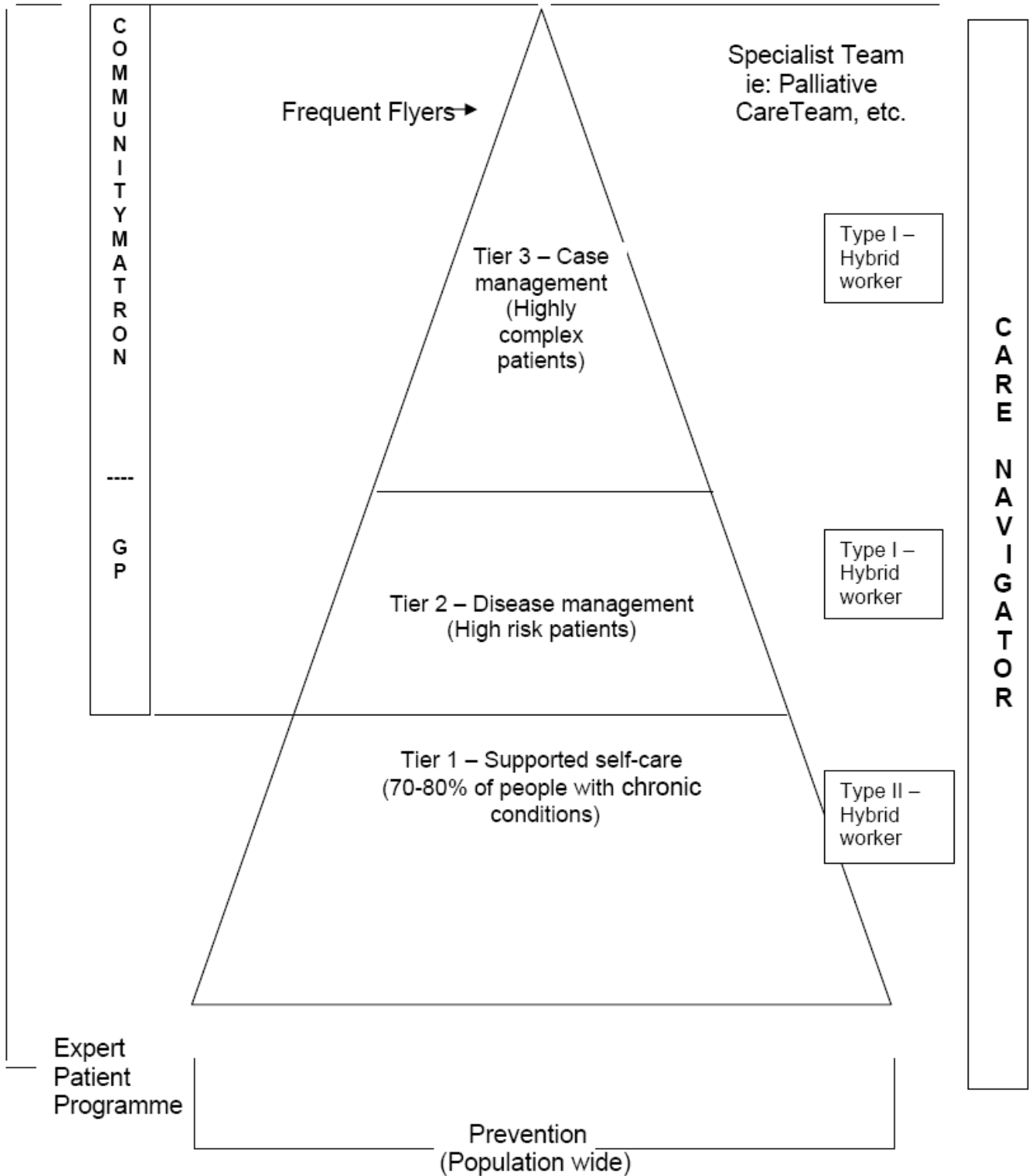
Kent

The INVOKE (Independence through Voluntary Action for Kent's Elders) is an innovative partnership which will develop new support arrangements for older people. The new types of services will include:-

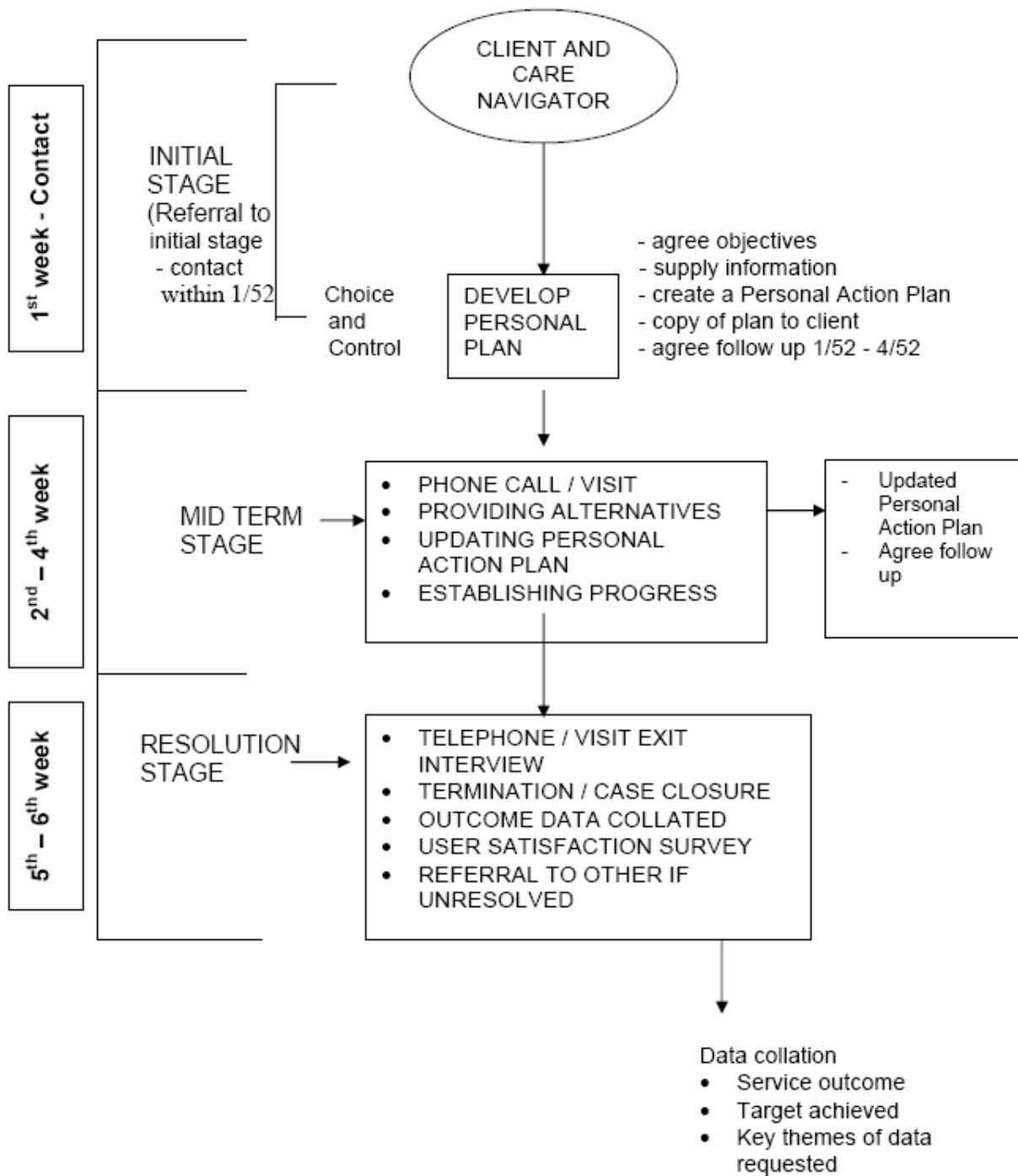
- **Hybrid Worker (Type I)** - This person will work with the Community Matron or Case Manager. They will focus on older people with long term conditions (– e.g. heart disease, diabetes etc) who at risk of deterioration/unstable (Tire 2/Tier 3). Providing personal nursing and social care, following stabilisation this continued link will provide the support for the individual to remain in the community – combating isolation and improving a person’s well being
- **Hybrid Worker (Type II)** - The Hybrid Worker would be working with working with older people in the community (Tier I - chronic conditions) supporting those who are able to self manage and enhancing their role through education, health promotion etc. Working at local community level employed by the voluntary and community sector
- **Care Navigator** - Will provide the support that is needed during life changes by providing a directory of services and support that the individual can choose and control. They would manage a “Transition Plan” – not just providing information and signposting but advising older people to help them make informed choices about the options for care and the routes to that they should take. Based within the voluntary and community sector.

The following diagrammes illustrate how these new services will intervene and operate.

POPPS Interface



CARE NAVIGATOR
BROKERAGE DIAGRAM



Rochdale

The project will deliver a major transformation through **community empowerment** in how change will be delivered. This will be based on:

- **Partnerships with older people at a Township level:** an Older People's Partnership in each of Rochdale's four Townships would be a partnership between older people, the Borough Council and local organisations;
- **Devolving commissioning and funding:** the Township Older People's Partnership will be given responsibility for a development budget for commissioning local activities and promoting older people led/supported initiatives, and leading to independent organisations of older people.
- **Capacity building:**
 - ☞ Dedicated capacity building and training for the local Partnerships and other older people in the community to provide them with the confidence and skills for commissioning and development;
 - ☞ Building a volunteer and resource base within each of the Townships to provide helper and volunteer capacity both as deliverers of services and participants in the local Partnerships;
 - ☞ Supporting further capacity building within the Carers Association.
- **Enterprise initiatives and business start up:** developing opportunities for carers and older people to start new businesses, linked to the "BIZ 50+" initiative, which provides long-term support to businesses with an emphasis on the 50+ age group.

Partnerships with Older People at a Township Level – TOPP of the POPPs!

We are entering into an ambitious new partnership with older people within Rochdale's Townships. The POPPs project will be delivered on a Township basis, and new service developments commissioned and led by a Township Older Peoples Partnership (TOPP) in each of the four Townships – Rochdale, Middleton, Heywood and Pennines.

TOPPs will be made up of representatives from Pensioners Associations and other older people's organisations. They will be supported by the Council for Voluntary Services Rochdale (CVSR) who will be funded to provide dedicated capacity building and training to the Partnership to enable it to become constituted as an independent organisation. This will enable the organisations to take on the management and coordination of the Building Healthy Communities project beyond the life of the POPPs pilot.

The CVSR will bring together older people's associations within each Township to establish the TOPPs. CVSR will work with the Partnership to develop representative membership, inclusivity, and terms of reference. They will identify training needs and advise on constitutional structure.

There will be links into the Township structures through the local Councillors and through membership of the Township Area Partnerships which have a wide range of interests

and sub structures which in turn feed into the Health, Environment and Safer Communities agenda.

TOPPs will give older people a stronger profile and voice within Townships, and help them directly influence service development within the community.

How we will measure success

- Evidence of representative membership of Township Committees;
- Numbers of new attendees at community meetings;
- Programme of capacity building training developed and delivered.

Devolving Commissioning and Funding

Through TOPPs we will create an entirely new financial partnership with older people in the Borough, giving them greater control over resources to develop local activities. TOPPs will have access to an indicative commissioning and development budget for preventative services and local activities eg healthy living, leisure and learning, and the associated transport needed. Around 40% of the total POPPs funding will be devolved in this way, allocated to TOPPs to reflect demographic distribution of people over 65 across Townships. They will determine their local priorities within the agreed project criteria, but also in direct response to the choices and needs identified by older people through outreach work in the community.

TOPPs will access customised training and support to continue to grow and develop during the term of the project, to gain independent status to enable them to raise continued funding from external, charitable or mainstream sources.

We believe that the development budget will attract other resources and sources of match funding to continue to expand the range of new preventative services for older people within the locality.

How we will measure success

- Evidence of effective decision making on POPPs development budget;
- Successful bids for development monies submitted to POPPs Project Board;
- Training on preparing funding bids provided to each TOPP;
- Business plan developed for external funding bids and fund raising activities.

Capacity Building

Our Building Healthy Communities for Older People project will be a catalyst for generating local informal support services and activities for older people and carers, by releasing the skills and capacity of older people themselves, and other members of the community to take an active role.

Alongside the development of commissioning capability, this initiative will build up **helper and volunteer capacity** within each of the Townships, to support the expansion of new activities and services within the locality. Many people first approach volunteering through involvement as informal helpers to gain confidence.

CVSR has a well established and successful Volunteer Development Agency (VDA) as part of its portfolio. Last year over 70 older people – aged over 60 – were placed into a variety of different organisations and groups. The VDA will be commissioned to work in the Townships with the existing volunteer networks and to encourage new volunteers to

participate in identified activities eg assisted shopping, gardening and transport. Activities may be delivered within the home or in a variety of local venues including community centres, civic centres and sheltered accommodation.

Training for volunteers will be an essential part of the project. This includes helping volunteers access training in for example minibus driving (MiDAS), form filling and advice, physical activities, Expert Patient programmes and Walk Leader courses. In addition to the positive benefits derived from volunteering, many volunteers are looking to extend their skills for future employment, by gaining experience and confidence. A training element will be included in the criteria for use of the TOPPs development budget, to ensure that these objectives are met.

How we will measure success

- Increase in numbers of helpers and volunteers;
- Numbers of volunteers receiving training and skills development;
- Increase in sense of confidence & wellbeing through volunteering;
- Increase in diversity of services offered by volunteers.

Enterprise Initiatives and Business Start Up for Older People and Carers

The Carers Enterprise Development worker will support the development of new business enterprises set up by carers, which will expand the range of local services and opportunities available to older people as well as developing potential sustainable income streams for the Carers Association.

The programme will link with the “BIZ 50+” initiative, which aims to provide long term support to any businesses, but with particular emphasis on the 50+ age group. This initiative goes live in November 2006, backed by Lloyds Bank and SAGA. This will be a web based programme providing easy to use information taking the mystique out of various aspects of running a business as well as a web forum and a weekly web cast.

Under the “BIZ 50+” scheme there will also be a networking self help group geared around the needs identified by the members, the emphasis being to keep up the momentum of new businesses to carry them over the first difficult hurdles. If successful, the Council’s bid under the Local Enterprise Growth Initiative (LEGI) will also support these developments. LEGI will provide wide ranging support to new businesses including Business Advisors, Talent Scouts, a Business One-Stop Shop, Enterprise Hubs and Social Enterprise Support. It is anticipated that some of these businesses may indeed be started by older people themselves thus having a double benefit to this project.

How we will measure success

- Increase in the number of older people and carers supported with advice and set up costs to start small businesses;
- Further development of local Carers Association;
- Increase in number of small businesses providing affordable Criminal Records Bureau checked and registered services;
- Increase in the number of older people provided with services by small businesses/enterprise

Tameside

Tameside Older People's Project (TOPP)

THE 'OPEN DOOR'

We propose to use our existing experience to introduce the 'Open Door', a borough-wide model of early intervention for older people and their Carers, to ensure that those most at risk of losing their independence, but who do not yet need institutional support, can stay at home for longer. This includes older people coping with long-term conditions that may lead to complex health and social care needs.

Early intervention will be achieved through a volunteer workforce, eventually to number 100 over the life of the project, which will make contact with older people in their homes, and provide a conduit for that individual to access support. The Open Door can be accessed via GPs, Registered Social Landlords, family, friends, Carers, community groups, or people may register directly with the scheme themselves.

The range of support available for older people through the Open Door will take the following forms:

- 'Check Up' – following registration on the scheme by an individual, one of the Open Door volunteer team will arrange to visit the older person in their home, and carry out a home-based 'Check Up' based on an adapted version of the Staywell or Evercare Connections technology. All those registered with or invited to join the Open Door will be offered a regular six-monthly 'Check Up', to identify changing needs.
- 'Take Up' – the 'Check Up' and any further visits by the Open Door volunteer can be used to provide older people with advice (for example, on Benefits entitlement, Housing, Community Transport) or information about relevant services, education or leisure activities. Any appropriate action will be recommended, for example information will be provided on low-level support available, or a referral will be made to existing health and social care services, or other services such as the Joint Benefits team with DWP or voluntary sector sub-threshold services. If necessary the volunteer may act as a personal navigator through the range of services available. Through their web-enabled laptop, the volunteer will be able to draw upon a wide range of information, for example from Tameside's OWL website for older people or the Lust for Life guide to services for older people, tailoring it specifically to the individual's needs and interests.
- 'Speak Up' – contact with the Open Door volunteer is a two-way process. In addition to providing tailored information and advice to older people, it is intended that the 'Check Up' will capture information that can be used to inform commissioning decisions, and to provide feedback to partners on service quality and impact. Opportunities will also be offered for people to become more actively involved in developing services for older people in Tameside, for example via the 'Really Important Questions' process.

Information gathered in this way will be used to monitor progress towards locally developed Performance Indicators and outcomes. It will also be used by Tameside Third Sector Coalition (T3SC) our Council for Voluntary Services (a major partner within the

OPP) to inform work to develop the capacity of community groups and voluntary organisations to meet the needs of older people revealed.

Figure. 9 The TOPP transformation

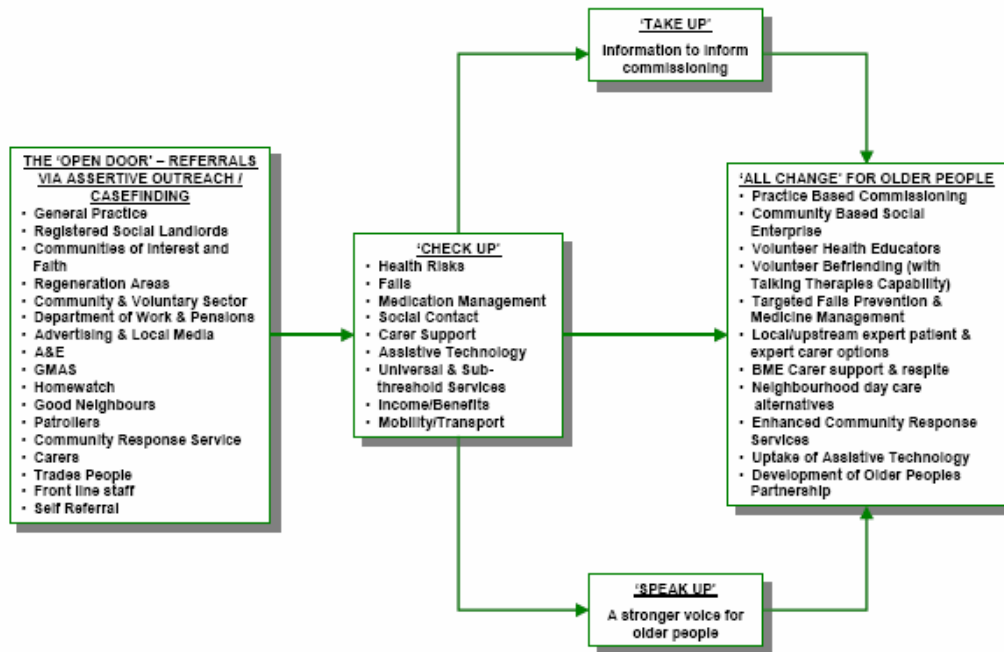
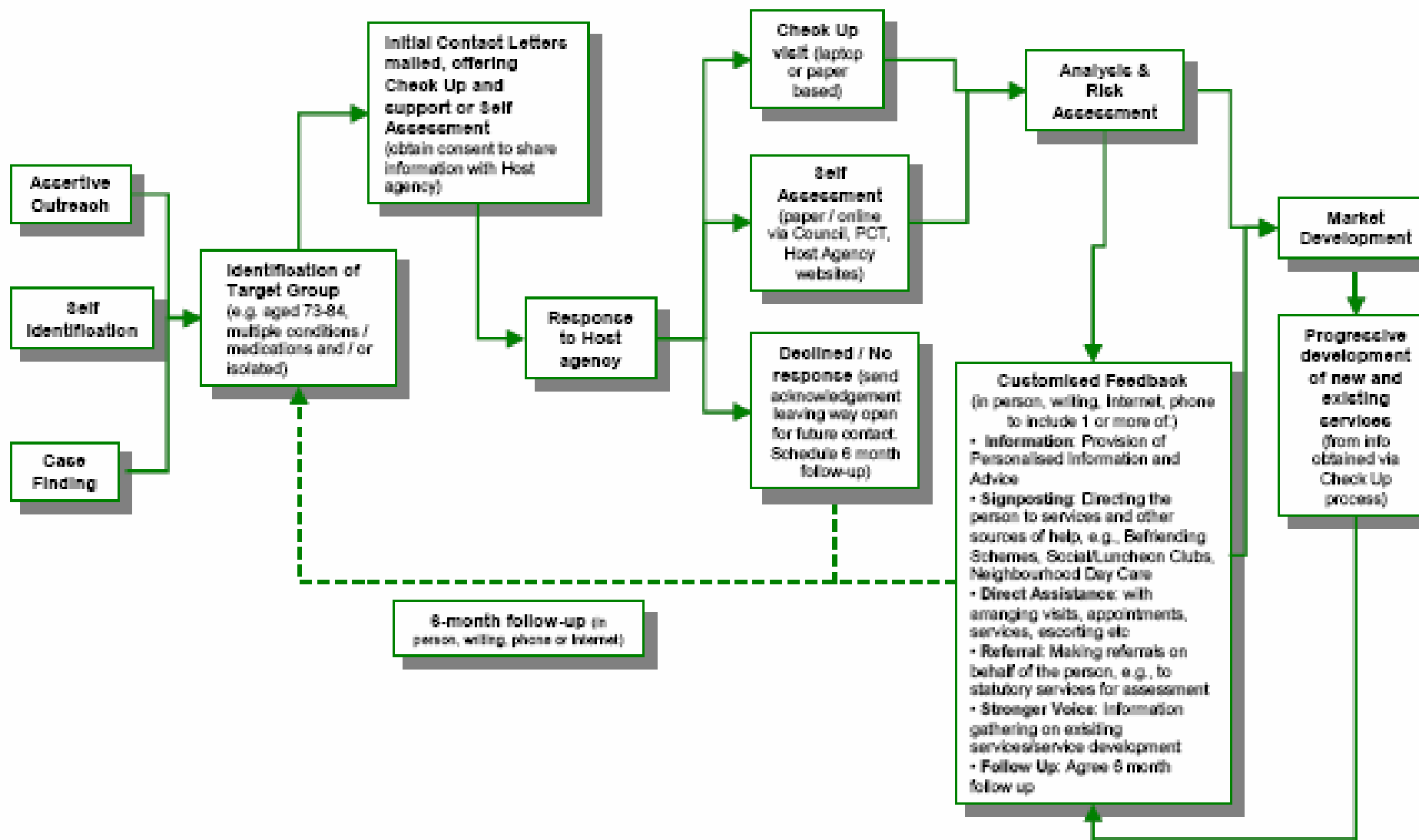


Figure. 10 The Open Door pathway



West Sussex

WELL Being Pathway

Our structure will support an integrated pathway for an individual requiring well-being services; it will ensure that an individual, or someone on their behalf, can access a wider network of community services through a single accessible gateway. Older people and carers will be able to connect or re-connect to a wide range of community services, activities or support. This will be a co-ordinated approach to preventive action throughout the well-being pathway

Project Scope

Initially the project will cover 3-5 of the 12 localities in West Sussex. These early starters will as far as possible be aligned with the 5 areas of deprivation in West Sussex. The intention is to roll out across the county by March 2009. The project will have the potential to reach all adults 55+ years, or younger if they are carers of older people. Although the project will focus on older people there is potential for some elements e.g. the Community Resources database, to be extended to all adults in local communities.

Key Elements of the Service Model

- Joint Prevention Teams – single point of access in each locality
- Co-ordinated local community networks of well-being services
- Community links, engagers, developers and capacity builders
- Local Information/Resources Data-base

Joint Prevention Teams (JPT) Health and Well-Being

To support the shift towards prevention, a Joint Prevention Team (JPT) will be established in each locality across the county. The team will comprise these core members:-

Health Advisers (HEPOP)	F/T	
Health Trainers	F/T	
Social Care Workers	F/T	
Carers Link Workers	Sessional	
Prevention Link Workers	Sessional	
Team Co-ordinator – Data and information support	F/T	
Volunteers – to support above staff	Sessional	

Older people will be encouraged to work as Prevention Link Workers, Carers Link Workers, and Volunteers for mentoring, way-finding and visiting support.

The Pension Service, though not part of the core team, has expressed its commitment to support the JPT, for example by receiving direct referrals to carry out benefit entitlement checks or to react quickly to life events (e.g. bereavement, deteriorating health indicating potential entitlement to benefits).

Daily Activities/Resource Centre Outreach staff have committed to providing a service response as required.

The role of the JPT is:

- (i) To improve access to low-level preventive services through a single point of contact for the service, for the older person, their relatives/carers and professionals in the partner agencies, including primary care and hospitals
- (ii) To sign-post those with complex health and/or social care needs including mental health support needs to the appropriate health and social care agencies
- (iii) With the older person, to identify how their health and quality of life can be improved using a self assessment tool.
- (iv) To identify relevant community resources and link the older person to those resources/preventive services which could be of benefit, including follow-up on outcome and further support that may be required including support to sustain access in the short term
- (v) To be a focus for information on gaps in local preventive services and a source of intelligence for future commissioning of those services, including for practice-based commissioning groups, through Prevention Link Workers and Community Engagement Workers (see below)
- (vi) To 'case-find' using successful HEPOP methods and Sure Start 'characteristics of excluded people'. Through a Programme of outreach to health centres, faith meeting places and voluntary groups to identify people at risk from health or social care needs, isolation or loss of independence, including excluded groups such as older people with mental health difficulties and black minority elders. A programme of targeted outreach and follow-up will be offered to those older people identified through case-finding.

Local Community Preventive Networks - co-ordinated to support capacity building in the voluntary sector and to achieve the preventive shift

We will build on an existing successful community network pilot project – the Worthing Neighbourhood Care Alliance (NCA). We will extend and roll this model out across all localities in the county if our POPP bid is successful.

The role of the **NCA Co-ordinator** would include:

- Co-ordination for a preventive services audit
- Consultancy and co-ordination for collaborative community fund-raising bids to fill service gaps
- Co-ordinating community participation in neighbourhood care activity
- Information management through a new data-base accessed via the web

- Improving the well-being pathway from one VSO to another
- Managing the Community Engagement Workers and Publicity Officer and co-ordinating their activity

The NCA Co-ordinators will be based in the voluntary sector, managed by the local Community Voluntary Services (CVS), reporting to a new **locality Partnership and Prevention Steering Group**. This will be part of POPP governance arrangements.

Community Links and Engagers (new posts – temporary)

In order to achieve a sustainable 'preventive shift', and embed this new culture of prevention in local neighbourhood communities each locality NCA will engineer a major increase of community participation and involvement by the general public and older people in design, planning, delivery and monitoring of preventative neighbourhood care. To support enhanced community engagement a **Community Engagement Worker** (CEW) will be employed in each geographic area recognised as a community/neighbourhood by local people. Initial focus will be on the 5 Areas of Deprivation identified in the Needs Analysis and on excluded groups, for example, Black Minority Elders. Core functions of the role will be to identify existing volunteers and neighbourhood care support resources and gaps:-

- Identify existing 'care' volunteers and activity as appropriate
- Initiate new volunteer recruitment techniques
- Support local residents' neighbourhood care groups to set up
- Support local groups' functions and events e.g. street lunch clubs
- Organise open days with the community
- Support community newsletters
- Establish links with housing association Tenant Participation Groups and other neighbourhood care groups
- Establish links with neighbourhood watch schemes/coordinators, 'community workers', housing wardens, and development workers from voluntary organisations
- Establish links with Parish Councils and County Local Committees
- Establish links with community development teams in local Councils and the PCT where they exist
- Develop Sixth Form College and local business volunteer recruitment drives
- Through the above work in their communities, case-finding and sign-posting of vulnerable older people to Joint Prevention Team
- Identify gaps in local resources/services and develop local response to these gaps where possible
- Work in collaboration with Local Strategic Partnerships (LSPs)

The CLWs will be supported in their role by volunteers and together they will be the 'eyes' and 'ears' of the Project ensuring that all development activity and service response is firmly rooted in the needs and builds on the existing strengths, of local communities.

It is expected that CLWs will be placed within the communities they will be working with through a number of smaller VSOs providing office space and support. In Worthing, for example, there is already support for this approach from the Mile Project (working in Castle Ward) and the Salvation Army (based in Central Ward). This local placement and additional proximity to local or ward-focused VSOs would assist with achieving local knowledge and credibility.

For reasons of efficiency and effective management support, and accountability, we intend to commission a key VSO in each locality to employ and manage the CLWs in a given locality.

It is anticipated that CLWs would only be employed for the duration of the POPP project and that they would seek to make their efforts sustainable by recruiting lead volunteers or '**Community Champions**' to maintain a visible role in their immediate neighbourhoods after the project dates.

Participation and engagement with local Councillors and decision-makers will improve as neighbourhoods become more active in prevention. CLWs will promote community participation generally, focusing on engaging older people and supporting links with elected representatives and County Local Committees helping to enhance the community leadership in health, social care and support.

Community Fundraisers

As gaps and then solutions for improved services at neighbourhood level are identified by older people themselves, neighbourhood support groups, Community Link Workers and other regular consultative arrangements (e.g. Older People's Forum), support mechanisms for fund-raising to develop these services will be required. This collaborative approach linked to the local Neighbourhood Care Alliance arrangements – and agreed priorities – will support a more cost-effective approach to meeting local need at local level and minimise risk of duplication of effort or lost opportunity for smaller voluntary providers. Community Fundraisers will develop links with the local business community through its representative bodies. Local businesses would benefit from their funding of neighbourhood care schemes which seek to enhance older people's ability to shop, and purchase goods and services from local traders and contribute to their community's economic well-being.

Social Enterprise Development Worker

It is anticipated that whilst some of the preventative services required to make up a working 'preventative landscape' already exist, there will be other areas in one or more of the localities which need intensive development and application in order to put new services onto a long-term, sustainable footing.

The Social Enterprise Development Worker will work with the NCA constituent organisations and Community Fundraisers to take on these more intractable gaps, applying specialist skills and knowledge to find social enterprise solutions in areas such as Community Transport. This will be a vitally necessary addition to the 'preventative landscape' if older people are to be enabled to take advantage of the opportunities, social and otherwise, which will no doubt arise. This person will link closely with the WSCC Economic Development Unit which has a support role for social enterprise developments in West Sussex and is currently leading on a Social Enterprise Pilot Pathway bid for a health and social care project in the county.

Publicity and Communications Officer

Function:-

- To raise awareness of preventive services and POPP Project with all stakeholders
- To publicise preventive initiatives, progress and learning
- Develop a range of communications and delivery mechanisms
- Support and co-ordinate publicity and communication across the NCAs
- Manage POPP Preventive Resources and Services Database

Resources/Information Database

An online database will be developed for access through a website. We will work in partnership with a voluntary sector information service provider ICIS (West Sussex Independent Combined Information Service) in order that information will be managed and updated within their online databases. The front-end website – the general pages explaining the POPP project locally and, amongst other things, inviting local involvement and volunteering - will be managed in each locality by the NCA Coordinator supported by Publicity Manager.

The website will:

- Publicise all preventative services
- Publicise the Joint Prevention Team
- Publicise the Neighbourhood Care Alliance
- Promote volunteering in Preventive Services through a local URL
- Provide regular news updates
- Provide an online channel for volunteer recruitment
- Provide a protected database of volunteers, skills and availability

In order to support neighbourhood volunteer activity, we will develop, where these do not exist already, a Volunteers Database which is neighbourhood specific. Here volunteers' interests, abilities, particular skills and availability would be recorded along with contact details so that they could be matched with neighbourhood care providers, or be registered as a 'good neighbour' willing to be called upon by the Joint Prevention Team to make initial face-to-face or telephone contact with older people in their immediate community, provide a lift to the local health centre, or perhaps accompany and introduce someone to a lunch club for the first time.

Volunteers

Volunteers will have a key role both within the Joint Prevention Teams and the local community networks as:- mentors, way-finders, and community champions, linking older people to services, befriending, or offering immediate support and practical help following discharge from hospital, for example.

In order to assist with capacity building in the Third Sector, innovative ways will have to be found to recruit and support a larger number of volunteers. This will form part of the role of the Neighbourhood Care Co-ordinators and the Community Engagement Workers.

An existing 'Supported volunteering' programme in Worthing would be used to encourage and facilitate volunteering from people who are often excluded, for example, people, including older people, from BME and LBGT communities or those with mental health problems. Lessons from this experience may well be applicable across other localities.

The permanent nature of the post of NCAs together with the identification of lead volunteers/Community Champions will assist in sustaining on-going capacity building for volunteering.