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"We'll meet again - don't know where, don't know when"

Supporting Community Visiting in Essex Care Homes

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1. Introduction

Essex County Council is working to support community engagement in care homes. Alongside the developments described in the companion paper “It’s a Lovely Thing”: Commissioning Relationship-Centred Care in Essex (Granville, G., 2013) the Council has fostered the development of a Community Visitor (CV) pilot, operated by the My Home Life Community Association (MHLECA)

This report describes the results of a year-long evaluation of the Community Visitor pilot, conducted by researchers at the University of Essex. It was funded by the Joseph Rowntree Foundation (JRF), and forms part of a wider programme of work by JRF in the field of risk and relationship in the care sector.

The report describes how the CV pilot was established and its impact on the lives of older people, the culture of the care home, and on the volunteers themselves. It goes on to discuss wider learning from the pilot and makes a number of recommendations to inform future planning.

Part I: Establishing the Community Visitor Pilot

2. The Context

The evaluation of the US Long Term Care Ombudsman Programme (LTCOP) (Owen, 2006), acted as a spur to the Essex scheme. However, LTCOP differs from the Essex pilot in several significant ways. Firstly, it was established by statute, with a requirement under the Older Americans Act, 1978, that every US state appoints a State Ombudsman, who in turn establishes a team of volunteer ombudsmen. Secondly, the focus of the role is more squarely on advocacy and the assertion of rights. And thirdly, the programme is well established, with a national reach, and is now into its fifth decade.

The evaluation, cited in Owen, by the Institute of Medicine was strikingly positive:

“Every year the LTC ombudsman helps many thousands of residents . . . The regular presence of persons from outside of facilities has been identified as an important factor in improving quality of care and quality of life in facilities” (IOM 1995)

In response to his survey of the US experience, Owen describes the following requirements in establishing a UK system:

1. A clear, well developed framework of powers and duties established in law
2. Placement of the programme at a high level within central government, within the jurisdiction of a minister for older people, and at a high level within local government
3. Investment in staff and certified volunteers
4. Clarity of role of ombudsmen and a clear remit for the volunteers
5. Ongoing training and comprehensive professional support provided to volunteers and local co-ordinators
6. A reasonable ratio of local ombudsman to care homes
7. Good leadership within the programme and support from the state as a whole, including additional state funding.
8. Sufficient independence from the state to be able to advocate for improvements to activities run or co-ordinated by the state.
9. Good co-ordination and recognition within the CSCI (predecessor to CQC), where inspectors contact the local advocate for information
10. Access to legal and quality care support, which can assist the ombudsmen in ascertaining their own powers and also in establishing whether the care a resident is receiving is satisfactory.

3. The Community Visitor Pilot - what is it?

The Essex CC Quality Monitoring Team, had, for many years, worked alongside lay visitors, as part of the LA inspection team. With the evolution to the Essex Quality Improvement Team, the lay visitor role ended. MHLECA was then supported to develop the Community Visitor pilot. The total funding for the CV pilot was £15.5k, with the major contribution coming from Essex CC, in addition to specific grants from Essex Community Foundation and Age UK.

The outline of the CV scheme was simple. MHLECA would recruit volunteer CVs for care homes. The CVs would visit the home every week for at least a couple of hours. The intention was that the CVs would befriend members of the care home community, act both as critical friends and informal advocates, and witness the evolving culture of the care homes.

4. Our Evaluation - what did we do?

We carried out our fieldwork in three stages. Stage one included in-depth qualitative interviews with care home managers, CVs and MHLECA members, about their hopes and expectations for the scheme, how they saw the CV role developing, and why and how they became involved with it.

The second stage included focus-group discussion with staff members in each of the homes, care home observations alongside staff and CVs, as well as holding informal discussions with residents. Where possible, we also held more in-depth, focused interviews with older people and with relatives in each of the homes. We also undertook follow-up interviews with each of the CVs

In the third stage we asked CVs to help us by bringing together their evidence about the impact of the role. We looked at documentary evidence of impact via care plans and reflective diaries. Throughout the course of the pilot we also regularly attended and observed the six-weekly CV meetings which were designed to support and develop the CVs.

In summary the data collected included:

- 7 observations of care homes
- 1 observation of MHLECA/ home managers meeting
- 9 interviews and discussions with older people
- 12 interviews with Community Visitors
- 5 observations of Community Visitor meetings.
- 5 interviews with care home managers
- 3 interviews with MHLECA staff
- 1 interview with Essex QI Lead
- 3 focus groups with 6 staff in each care home
- 3 interviews with friends and relatives.

Anonymised quotes from interviews and focus groups are used to illustrate key points throughout the report. Where names are used, these are pseudonyms.

The process of analysis was based on a series of discussions across the evaluation. We fully immersed ourselves in the data at regular intervals, reflecting upon our experiences, thought about what we had learnt and free-associated on ideas and observations (Clarke, S, Hoggett, P, 2006). We also discussed our ideas more widely in regular multi - disciplinary university advisory committee meetings.

5. Aims of the Pilot

The original project plan defines the aim of the CV pilot as follows:

“To help older people considering or living in residential care, their families and friends and the providers of the services they use, to work together to maximise residents’ quality of life according to their individual needs and wishes.”

A consistent thread in successive MHLECA documents is the description of the CV as someone who stimulates:

“better and more accurate communication and mutual understanding between residents and their families and staff, in order to help improve the quality of life for all members of the care home community, and particularly residents”

At the outset of the pilot we asked people involved in the design of the pilot to comment on what they saw as the key purposes of the scheme, and this is what they said:

“Hopefully the CVs will be acting as the eyes and ears of the community, in a sensitive and not in a judgemental way. Bringing the community into the Home and getting the older people out, if that’s seen to be appropriate. Nothing must be imposed. The whole idea of people coming in to support the resident and the home in a structured way is great” Essex QI Lead

“The key thing is the communication with the home [...] the staff however good they are [...] simply cannot spend time sitting and chatting to people and [...] we know also that very often (older) people find it very difficult to raise issues..So we hope that that there will be people to spend time with the residents ,with the families, with the staff, get to know people, be able to just sit and spend time with people” MHLECA member

“I’m hoping that they’re really going to get involved with family members of the residents within the home, because I think family members are left out an awful lot ...and my hopes are that they’re going to really take on board when new residents come into the homes and link with the family members.....the guilt (of family members) is unbelievable, so I think it’s good if there is somebody there who is used to the home that can support them through that..” MHLECA member

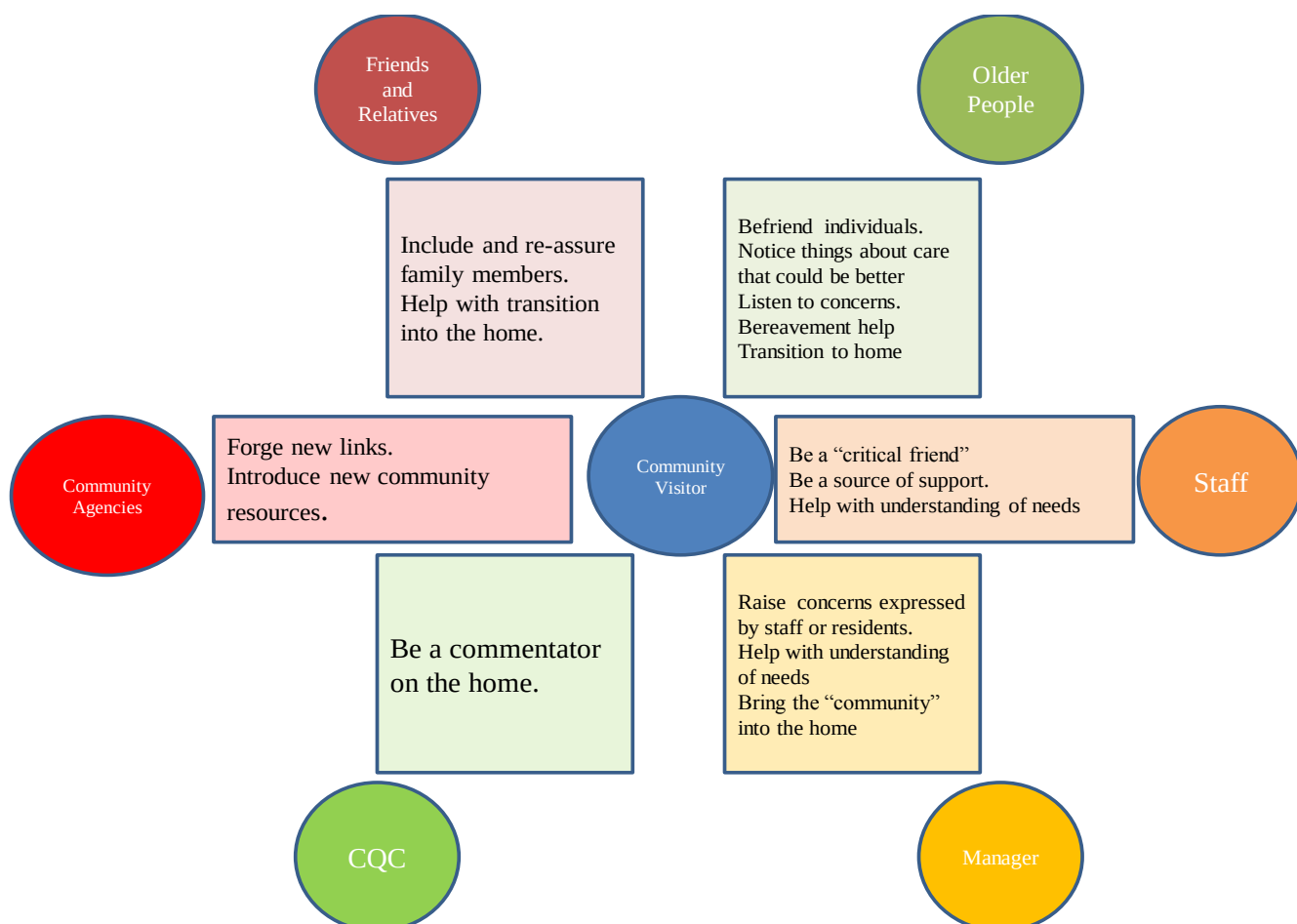
“People from the outside who are not relatives having good relations with our residents, and improving the quality of their lives. I think it’s really important for older people to have diverse relationships and also to have relationships with people who do not see them undressed.” Home Manager

“If you’ve got someone coming in to help, and to be able to improve that quality of life for the residents, and also understand the staff, you can’t really turn away from that, it’s a good thing.” Home Manager

“What we wanted to develop was somebody who is part of the team who actually became pivotal in the home, become if you like a critical observer..... if people are coming to look around a home you get a snapshot” Home Manager

What is striking about this sampling of views is the broad reach of ideas about what the CV role was meant to achieve. These are illustrated below.

Figure 1. The Role of the Community Visitor



We were aware, at this initial stage of the project, of an apparent tension between those aspects of the role to do with being seen as an “integral part of the home” (befriending, supporting, reassuring), and those aspects to do with being “external to the home” (critical friend, transition, making links to external organisations). These two positions require quite different levels of authority and autonomy. They also require diverging skills sets. However, MHLECA were clear that they did not expect any single individual to be able to undertake all the possible tasks

6. Identifying Participating Homes

A number of Essex care home managers were already participating in the My Home Life Essex Leadership Development Programme. MHLECA used this network to promote the concept of the CV and invite expressions of interest to participate in the pilot. Each of the care homes that responded to this invitation subsequently became participants.

The benefit to the pilot was that this meant that from the outset the care home managers shared an understanding and vision, informed by the eight My Home Life best practice themes. Equally, given the connections between MHLECA and My Home Life Essex, selecting homes from this pre-existing network meant that there was a degree of shared understanding and indeed friendship between the pilot organisers and the homes.

This facilitated the dialogue between the pilot organisers and the homes; it meant that there was a reservoir of mutual goodwill; and it provided the necessary space for co-construction of the pilot. However it raises the question of whether a “fair test” is being offered here: how valid are the lessons from the pilot for contexts which are not so closely integrated?

It is equally true that new and innovative practice will often require special environments in which they can be nurtured, before dissemination to a wider community of practice, through the snowball effect (Lave and Wenger 1991, Van Avermaet, 1996). MHLECA members were clear that CVs schemes could not be “imposed” on homes.

It follows that the homes that put themselves forward for the pilot were predisposed to developing community networks, whereas the homes that declined were not.

“When it was all put forward, you had to remember, the documentary was on Castlemead, ... and all the abuse there, so I think a lot of the managers at that time thought, actually, I don’t want anybody telling me that somebody is not doing the job right and then taking it outside the home, ... it wasn’t a good time to be putting yourself forward, if I’m honest” Home Manager

Three homes participated in the pilot – two homes with 38 residents, and one with 18 residents. The three homes represented a degree of diversity: one was owned by a charitable trust, one was family owned, and one was owned by a regional private provider. All three homes had a mixture of privately funded and public-funded residents from across the social spectrum. Two were located in a large town (population: 170,000), with the third in a rural village (population: 5,000).

7. Recruitment of Community Visitors

7.1 The selection process

“ We need to be looking for people who have a broad vision and intelligent appreciation for all the different aspects that need to be covered, those who have a real sensitivity and ability to engage with others, maybe retired professionals, such as nurses, social workers, teachers. I mean we’re asking an awful lot of our CVs” Essex QI Lead

Volunteers were recruited initially through informal MHLECA networks. The Association also undertook local advertising, and partnered with Colchester CVS to identify possible recruits.

MHLECA had a history of recruiting volunteers for its other programmes. This enabled it to bring both experience and a policy framework to the task. This included existing policies in the area of training, supervision and support. A volunteer “charter” set out core expectations and entitlements.

Selection did not appear to be against closely defined criteria. The recruitment documentation asks for general personal information. Responding to questions on the special qualities of a CV, the MHLECA member responsible for recruitment stated:

“I think it’s their enthusiasm, definitely, because I think all the volunteers we’ve got are very enthusiastic about what they’re going to do...one has said to me, ‘I just feel really proud that I’m part of this’, which is brilliant, you know, that is really good...their time is purely to look and watch and talk to people.”

The shape of the recruitment process inevitably shapes how the role is understood and taken up. Selecting against broad criteria implies that what mattered most was the ideal of “bringing the community into the care home”, with all its diversity and richness, but inevitably, in the absence of a clear template, this can leave the role open to different role holder’s interpretations.

The final decision to appoint lay with the home managers. This was seen as necessary to avoid a “personality clash”. However this would seem to compromise a necessary independence and “otherness” that the CV may require in relation to the culture of the home.

7.2 Numbers

A total of eight volunteers were recruited during the first year of the pilot, although three departed after a few months. Hence two homes benefitted from a pair of allocated CVs, with a solo CV at the third home. The original project plan forecast 4-6 homes with a minimum of two volunteers per participating home, which suggests an original anticipated number of 8-18 CVs.

In the same time period, other similar initiatives have attracted a large number of volunteers, albeit to roles that do not require the same level of ongoing weekly commitment. In 2013 The Alzheimer Society recruited over 30,000 Dementia Friend volunteers, to befriend people with Dementia. (Dementia Friends, 2013) In this case a national initiative, supported by the government, appears to have been able to develop sufficient profile to boost recruitment. As a further example there are currently on average 240 volunteers working in each hospice in England (Tickell, C, 2012).

We asked the question “what is the ideal number of CVs for a care home?” We were interested that both MHLECA members and CVs confirmed a number of 2-3 people. Presumably a high number of volunteers would support greater levels of individual befriending, whereas a low number of volunteers would give more of a sense of uniqueness to the role.

7.3 Backgrounds and motivations of the volunteers

We asked the CVs to describe what attracted them to the role:

“I started thinking about doing medicine and I started looking around in care homes where I could possibly volunteer and I tried GP surgeries and none of them would have me and I have tried lots of care homes and none of them would have me I have been involved with St John Ambulance for the past year and a half”

"I think as my elderly father had been ill and recently passed away and I knew that he had our love and support I thought I could give this to someone else and help other families cope with their parents being in hospital and moving into a care home."

"I was assistant chief nurse of a health authority ... and part of that role was to actually inspect and oversee nursing homes in that area"

"I am a mum of two, housewife and I have worked at home for many years and I just felt like I wanted to do something. Just something voluntary rather than going out to work and having to you know work full time and be beholden to someone else. I kind of just really wanted to give something back to be honest, just to help out."

"I used to work at a doctors' surgery every day after school. So I have always sort of been around a caring background. "

"I haven't worked for like nearly four years now 'cos I had (daughter) and then I got made redundant. It was really hard to get back into work so I was just looking online and I saw things like volunteering, and I thought volunteering gets me out of the house"

"I had been looking for about four or five months for a way of visiting care homes...I had approached a couple of care homes direct and that didn't work really...I went to a home where I had actually been a visitor to a friend very briefly and she died and about six months later I went back "

"Well I live round the corner, and I have been a volunteer here for exactly three years, the reason I became a volunteer was because I had been made redundant from my job and I was looking for another job but it was taking quite a long time"

Of the five volunteers who sustained a commitment for the year of the project, three had preceding links to MHLECA members, or to the care homes they worked in, and the remaining two had long histories of volunteer or nursing roles.

We were in no doubt that the project succeeded in identifying sensitive caring people. However it is also important to be realistic about the demands of the role and the qualities required to thrive in it. In this case we sense that the histories of those who sustained the role acted both as a source of personal resilience for the CV, and also a source of reassurance for the home.

8. Induction and Support

8.1 Induction Processes

There was evidence of a collaborative approach between the contributing agencies, with several joint meetings between care home managers, MHLECA members and the Essex QI lead to jointly discuss expectations, recruitment and induction and training, before the pilot officially began.

The induction process was described by CVs as supportive. CVs received copies of key policies, including safeguarding, and the MHLECA Code of Practice. A formal introduction to safeguarding was given by MHLECA members who were qualified trainers. However, given the open-ended nature of the CV task, it appeared difficult to provide detailed preparation on all aspects of the evolving role.

“We have had a few meetings with all of us before we even went into homes to get to know each other to assign us to homes..I started before the Christmas break because I went and had my introduction. I went and looked round the house and so I went and talked to each of the residents and that was my official first day” CV

“Initially... it was a little bit difficult getting in here. I was just sort of left to my own devices. One person did take me round and introduce me to everybody altogether which was nice”. CV

8.2 Philosophy

A feature of the pilot, from the outset, was the passion for it, expressed most clearly by the volunteers, MHLECA members, and home managers.

We understood this passion in several ways. Firstly, it was the necessary counter to the themes of isolation and loneliness that are present in the culture of care homes. Secondly, it offered the promise that “we can make it better”. Thirdly, as we have described, the pilot carried no automatic authority in the individual care homes. It had to win its way. So we can see passion as the necessary systemic glue that was required for the required relationships to be built and sustained.

A fourth theme that underpinned the passion was a philosophy of appreciative inquiry (AI) that was used in the pilot. This is the approach that advocates collective inquiry into the best of what is, in order to imagine what could be. Tom Owen, the Director of My Home Life, has described how the philosophy is integral to the wider My Home Life movement. Too often there has been a top down “things need to be

done to care homes” message from politicians, and other lead organisations in the field.

This can be precisely the wrong message to send out. It allows distancing from care homes, doesn’t consider the challenges care home face, focuses on the negative and doesn’t look at the good practice that is going on. By contrast, the CV is seen as someone who can witness, and celebrate, the good.

We were impressed by the culture of learning from experience that we witnessed amongst the CVs. CVs received a brief introduction to the concept of AI but it wasn’t always clear how the philosophy was adopted by all participants. We also wondered about the impact of AI in a context where it may be the burying of difficult emotions which can lead to difficulties in care homes. To the extent that the way care homes are viewed by society is driven by guilt and anxiety, leading to a distancing from death, illness, and the experience of loss, it must surely be equally important to fully face the emotional experiences in the home, to grasp how these emotions are defended against, and to understand the distortions to practice that these can result in. There is some research evidence that AI approaches can lead to difficult interpersonal dynamics not being addressed (Holte H, Gjerberg E, Johansen M, 2010). The challenge for the CV pilot then would seem to be how to do both: how to appreciate and celebrate good practice, but to be clear-eyed about more problematic aspects of the working culture of care homes.

8.3 Supervision

There was a consistent message from the CVs of feeling very supported by MHLECA members. Every CV talked of the instant phone support they knew they could access. Over time, each of the CVs also developed supportive relationships with the home managers. CVs used supervisions with the MHLECA project lead to talk about how they felt in the role, and what they felt their training needs were.

Home managers also provided the CVs with supervision, though it was not clear how the structure and frequency of supervision meetings was monitored. These arrangements would appear to support the sense of the CV as part of the home structure, but again make it difficult for the CV role to retain sufficient independence.

“The support is that I contact MHLECA if I need to, if I’ve got any problems, I know that if there’s anything that I’m unsure about, well anything, I’ll just contact them and it’s never a problem. I know I feel very valued, I really do, so that’s great.” CV

“So when I come in the manager updates me if there’ve been any particular illnesses or if somebody’s unwell or if there’s been a death or anything like that so that support’s there. If I’ve got any questions that’s not a problem to speak to the manager” CV

“Seriously, I think they’re (MHLECA) marvellous.... I think they are great, absolutely fabulous. But (I use) my ideas and I don’t think they’ve sort of given us ideas particularly, I can’t remember any meetings where they’ve had that” CV

8.4 Training

MHLECA members gave substantial thought as to how to provide a good enough training framework. We were realistic about the limits of what was possible here. The call on the volunteers’ time was already substantial, so there was not much additional space for training. However, we judged that the original proposal for a six weekly gathering for training and an action learning set was reasonable. It is important for projects such as the Community Visitor pilot to strike the right balance between targeted role–focussed learning (e.g. tuition), and broader reflective learning (e.g. action learning sets). Interestingly, the CVs view was that the focus should be on the latter.

The project was successful in negotiating with homes so that CVs could access all the training undertaken by home staff. This served to support the relationships between staff and the CVs. The CVs conveyed the wish for more training, but at the same time they valued the space for open discussion, and acknowledged the fact that, given that it was a new pilot, then it would be difficult to stipulate from the outset what training was required.

“I think if it does continue I do think there does need to be some element of essential skills maybe.” CV

“We haven’t had training, we do have bits and pieces when we have our meetings, but the My Home Life group are so passionate about wanting this to work I think it’s very very much needed and I’m aware of that so I’m totally supported” CV

“We did talk about if we wanted some bereavement training, we felt that we got more out of us sitting and chatting about our experience and pulling on MHLECA members’ experiences, we found we got more out of that” CV

“I first of all felt that there wasn’t enough of a manual to follow. But at the same time I understand that that can’t really be done because it’s a pilot scheme anyway and we’re all kind of finding our way, that’s how I look at it.” CV

“Yes, well I had some training last week, which was to do with, I don’t think I would have been invited in, I just happen to be here and so was Kim and she said do you want to come in on this training?” CV

Part II: What changed as a result of the Community Visitors Pilot?

9. The Impact on Older People

9.1 Getting Started

For many of us, making new friendships is a matter of personal choice, shared interests, and gradual evolution. Thus, in building friendships between older people and CVs there are a number of potential barriers to overcome.

Emma described how, initially, some older people would turn their heads away when she entered the room. Lynn described her uncertainty as she was left to get on with it. Bill described how some people weren’t interested and didn’t want anything to do with him. For some older people a change to the daily pattern could induce anxiety - one person asked the home manager to ask the CV not to speak to her.

CVs developed their own personal strategies. Lucy decided to “mill around” as though she wasn’t doing anything. She sensed that people could feel threatened if she just appeared. Rita realised that older people were often unaware of her specific role. Later she commented that she wasn’t convinced many actually could grasp the concept, though at the same time they valued her visits. She developed a habit of accompanying the tea round, as a way of starting conversations.

At one care home it was more usual for residents to spend time in their own rooms. The CV described how, “even for me, to knock on the door, and introduce oneself can be quite difficult. [I] don’t like standing over them and you can’t sit down because their chairs been occupied by loads of equipment, and I’m loath to sit on beds, it’s an infection point”. She said it was about treading gently and letting people get to know you.

9.2 Making Connections

Over time a range of connections developed. Lucy talked about how delightful the people were that she met. Emma said how much she loved the residents. Rita described how, “they’ve all become my friends”. After spending time with a blind and non-communicative resident, the CV said, “she really squeezed my hand - it showed we’d connected”

This was reciprocated by the residents. Edith, describing the impact of her relationships with the CVs, said “I feel like a person again”. She said it showed that she hadn’t been forgotten. For her, knowing that the CV would keep coming back was important.

The CVs’ first impressions were significant. Anna talked of the cycles in the week, and how weekends were particular low spots, with low levels of engagement and activity. Rita was frequently curious about how quiet the place was. She also reflected on how daunting it must be for older people to come into the home. Emma was concerned about the overall lack of stimulation in the lives of the people she met. Lynn was simply struck by how unwell so many of the residents were. Lucy talked of the feeling of grief that she felt lay beneath a lot of the older people’s conversations.

The other challenge to befriending older people was the fleeting nature of the relationships. One CV compared it to ‘speed dating’ because:

“you have to get to know that person very quickly really well in a very short space of time because they might lose their mind or they might die, or they might be ill, or something might happen...then the whole kaleidoscope changes”.

Other relationships in the home were also temporary in nature. The staff were often busy and the conversations brief; the relatives may visit infrequently and for short periods. The CVs also faced the challenge of building a relationship with a particular person on one visit, only for it to be completely forgotten by the next. This was initially quite painful for some CVs. It can be seen as a challenge to the omnipotent hope we each may have of being the one who will make the difference.

Despite these difficulties, we witnessed the developing impact of CVs making contact with older people, witnessing what mattered to them, and taking action that was supportive:

A resident complained to a CV that things were going missing from her room (which proved not to be the case). By careful communication between the CV and the home manager, the lady was able to get the counselling help she needed: the fear that things were being taken from her linked to past experiences, and were potentially linked to fears of losing independence.

An older person came to stay at the home for respite care. The CV spent some time with her, and through this, the lady decided to become a permanent resident.

A man's daughter was away for ten weeks in New Zealand and unable to visit. The CV made a point of visiting the man. Afterwards the daughter remarked to the manager that what the CV had done had been very valuable. Later, as the rapport between CV and the older person developed, he told her about his various medical problems. The CV sensed his growing depression, and a sense that he was giving up on life. She was able to talk to the manager about this, which enabled them to develop approaches to build his resilience.

9.3 Older People's Lives

It was evident that many residents valued having autonomy, having good company and conversation, and being involved in a rich range of activities. It was important that each older person was recognised as an individual with distinct needs, wishes, and hopes. This is such a basic human need, and yet in the care home setting it is a need that can conflict with processes of homogenisation and routinisation that can creep in when a few busy people are looking after people who need a lot of help.

Through our own observations and conversations with older people in the homes, we constructed a picture of some of the lives being led. There sometimes seemed to be a certain dignity in the quiet work of sitting, often in the same chair, watching passing events. In one home, old people often sat in the hallway, a place where there was more movement, more life passing by. Mabel told us she liked to imagine she was in the Bennetts' house in *Pride and Prejudice*, with all the girls swooping down the spiral staircase.

In interviews, many older people spoke well of their care homes. We observed that, for many people, small signs of being recognised made a big difference. Memories of previous years, when one was in one's own home, and with one's own friends, made frequent interruptions into the dialogue.

Hannah said, "This knocks spots off the other homes - I can go to bed at any time I like- It's quite homely, but it isn't home you see". Beverley told us about how lovely the care home is, how much she enjoys it, and then talked wistfully of how she's lost

her house, and her independence. A manager talked about how by the time you are in your nineties many of your friends have pre-deceased you.

Susan said, “There are things I’d like to do with my husband”, and Eric, her husband who was visiting, added that the previous day Susan had said to the carers, “Take me up to bed, I’m going to make love now”. There was laughter at this story, but Susan wasn’t laughing. She said to us, “I’m just a bit sad....I’m very sad”

Mary, a resident, explained how it can be difficult to talk with other residents, many of whom have hearing difficulties, or difficulties in comprehension. She wistfully commented that the occupational therapist visited regularly, “making us do things we don’t want to do”. Anna perceived that the people in the home had nothing naturally in common with each other than their frailty.

Joyce was glad she’d uprooted from Northampton, to be in a care home nearer her family because now they would visit her. But Edna saw being at the care home as a way of not being a burden on her family. Many of the older people we talked to were quick to tell how they’d come to be here, and what they’d lost in the process. Viv told of the serious stroke she’d had when she was on holiday with a friend, and how she was discharged from hospital straight to the home.

Some people told us they saw the CV in a different light to staff. Margaret and Sue said they liked Kim visiting because she just sits down and chats. Managers felt that the CVs allowed residents an opportunity to show a different side of themselves. Ethel valued that she could open up to CVs in a way that she couldn’t do with staff. Viv, an older person, said simply that when you see Emma, the CV, you smile: “it’s nice having a younger person in the place. A group of residents said they valued Lucy, “because she knows about ordinary things”.

Several times the view was expressed by staff that it was good that, through the CV scheme, older people had an opportunity to have relationships with people who were not involved in their intimate physical care.

A CV noticed that a person had what seemed like a tooth complaint and the CV persuaded her to have it checked out at the dentists. It emerged that she was coughing blood, and she ended up having a chest x-ray, which led to a diagnosis of lung cancer. The manager stated that if it wasn’t for the CV’s friendship and persuasion, the diagnosis would have been very delayed.

9.4 Initiating Activities

Each CV brought their own ideas and their own personalities to a range of activities that they introduced to the home.

Emma described how she brought in audio books for residents who were losing their sight, and how with other residents she was working on life story books. She talked about her travels. When a resident had talked about how much she liked “Joseph”, the musical, she was able to get hold of a CD. And when a resident talked of his love of the singer Kathryn Jenkins, she got hold of her autograph. She felt she spent a lot of time chatting about wartimes and other memories. Residents had valued when her daughter came in as well.

Kim’s preference was to “work her way round the room”, and spend a little bit of time with everybody, often reminiscing, or reading the newspaper together. We observed Kim being quick to notice when a resident was upset, and seeking to make connection with her.

Anna talked about the importance of a “prop”, and had witnessed the amount of interest and attention her dog had elicited. She regularly played bingo with the residents and organised quizzes. A major project was to start a residents’ choir, which now had 26 members, and which she aimed to take to sing at other care homes. She saw a main aim of the work was to help people have a “normal” life, and the choir was part of this: “we were all part of the choir together” she reflected. Anna used what she described as “her house full of rubbish” to initiate reminiscence work with older people.

CVs obtained reminiscence boxes from the local museum of items to show and pass around the group. The residents recalled memories which these items evoked and shared stories, for example, of life in the thirties. A group of Brownies came to visit a home and following their visit the CV brought up pictures of Brownie uniforms across the years to show residents, and those who had been Brownies were able to share their experiences.

Rita described how she had brought Mrs Blyth a tape recorder to capture all her stories, and how she had listened to Mrs. Croft’s memories of how Head Street used to be. A CV’s reputation as a scrabble player went before her, and now a small group of people had a board ready for her when she arrived.

One CV said she felt a significant thing she did was “helping the resident feel worthy”. This particular CV had encountered an old lady who wouldn’t speak to her much (due to dementia) but she recognised this lady needed company. She went through a photo album with her and this helped the lady start communicating. The CV felt this was a major achievement.

In a conversation with a resident, the older person said to the CV, “No, I haven’t got a quality of life, and in four years time, when the money runs out, I’m going to want euthanasia”. The CV was able to help the staff team put in some more support, but also initiated some practical measures to give her more of a sense of control of her day to day life.

9.5 Doing the Little Things

It was in addressing the ‘little things’ that CVs often seemed to make a big difference. Residents could be upset by things that are easily remedied by a short conversation or action such as moving the flowers, making a tea instead of a coffee, having an address read out to them on a letter, letting them know the day of the week, making sure a bell is pressed and a staff member comes quickly, holding a hand, passing a tissue.

Anxieties are raised quickly when little things go unaddressed and here the CV played an important role. When observing we noticed the little things that were done which could have caused residents stress had they been missed by a member of staff.

‘It is the small things that are so important to the quality of care. Things like having your tea made right. Residents often don’t like to say anything so little things like that often go unnoticed. The CVs may make a big difference in that respect’. Home manager

We witnessed a litany of “small things” that the CVs were engaged in: posting Christmas postcards, reading the paper to residents, doing up the zip on a handbag which had got stuck, asking the staff for some grapes for a resident who really wanted some. The ability to notice was key. Rita tried to think through the boundaries between her previous clinical knowledge and the “lay” CV role. She had spotted the signs of a resident being in pain, but wondered whether a CV with no medical background would pick that up.

A CV noticed that a resident seemed sad. When she asked what was wrong the lady said that she had an upsetting letter informing her of the death of someone she knew but she couldn't read who it was and who had written the letter. The CV was able to read the letter and address out loud to her. This reassured the resident. Although the news was indeed sad, it wasn't the death of the person she initially thought it was.

9.6 Providing Company

Despite residents often being surrounded by many other people there are many potential restrictions which inhibit conversations between residents. We found that often you had to get close to the ear or face of a resident to talk to them or hear what they are saying. This, and the separation by individual wing backed chairs means that many are left unable to talk to each other. For example, they also can't easily move to spots to sit with someone else. There are breaks in conversation because someone can't hear her or cannot remember what they have said or what you have said, and this leads to conversations spiralling in different directions.

An older person was unable to speak loudly so couldn't make herself heard to other residents. Her head was bent low into her chest and she spoke with a low, soft voice. The CV had to put her face almost touching her to hear and be heard. This physical inability to move her head or speak so she can be heard meant that this resident was getting increasingly lonely. She said:

"I don't talk to anyone. I keep myself to myself...If I had a fish in a bag and it could talk I would talk back to it".

Often residents got frustrated with one another and were sometimes unable to comprehend why a fellow resident might not remember a conversation. Most residents suffered some degree of dementia or deafness or a combination of the two, which made fluid and intelligent conversation difficult.

We witnessed the CVs take a role in re-linking the threads of these conversations. One resident said 'I feel she is one of us as well, you are not up there you are down here with us and that's how I feel'. Residents often didn't want to disturb the work of the care staff and thought them to be 'too busy'.

A resident had recently suffered a mini stroke and had spent some time in hospital. She was depressed and had talked earlier of euthanasia. The CV was empathic with the resident and spoke at length with the lady about her experience of having the stroke. The CV, who had a medical background, was able to explain some of the

side effects of the stroke and why the lady was feeling like she was. The lady explained that in hospital she had been neglected. She showed the CV a bruise she had caused by banging her hand on her commode so she could get the nurses attention. The CV asked did you report it? To which she replied tearfully 'no I was scared'. The CV said, "Oh darling never, ever be scared", and put a comforting arm around her. The CV promised to raise it with the hospital in her role as the hospital governor.

A resident, who had been a primary teacher, was lonely. On the CVs' first visit she wanted an intelligent conversation, about education and travel. On the second visit, she had a mild form of dementia, and didn't recognise the CV. The CV was about to go away but the resident said she needed to talk. This helped her communicate how much pain she was in. She initially didn't want the CV to communicate this to staff ("I mustn't be any trouble"), but subsequently relented, so she could get more of the help she needed

9.7 Liaising with relatives and friends

"The families are very vulnerable... and you are just a friend; they might cry, or they might be cross or furious or guilty, there's a lot of guilt, and you can just sort of be there. I'm quite useful, just to be there."

"Mum was a bit apprehensive, but it's much better than her staying at home---the CV was here when I brought her in and she was here the following day...so Mum's seen her....The CV puts me in the picture"

There was evidence that for some families, the CV did play a significant linking role. They placed value on the fact that the CV wasn't part of the system, and wasn't paid, so could be seen as a kind of insurance that things were OK in the home.

Since the CVs go in on set days and times, often during the week, this doesn't always match up with times in which relatives visit. We were aware of the comparative absence of discussions about relatives from the interview transcripts. In one home this appeared to be linked to relatives' actual absence- the CV here could identify just 2 regular visiting relatives. But the CV role is potentially significant in providing support for relatives. One CV put it like this:

'It's like a role reversal. The children become the parents. It's tough for them, the families, really tough, the families are very vulnerable, and I actually like it that there's no social niceties, you are just a friend, and they might cry or they might be cross, or furious or guilty, there's a lot of guilt, and you can just sort of be there'.

A resident wanted to attend her grandson's wedding but the family were not sure how they would manage to get her there or manage her care once there. The CV drove the resident and a carer to the wedding. The resident had advanced dementia and couldn't remember much when in the home, but once out she suddenly remembered just where she was and exclaimed 'just stunning isn't it?'

10.The Impact on Care Staff.

A theme which keeps arising is that CVs are a 'fresh pair of eyes'. One manager said "I think somebody coming in with a fresh pair of eyes will say, why are you doing that?" but the issue here is how to keep those eyes fresh, particularly when the CV themselves may wish to feel fully accepted by the staff team.

10.1 Context

Staff teams could describe warm working relationships with the older people:

"It's everything, you're the mum, you advise them, you look out for them, you're their friend and I think like we're in a family"

"As we've been here such a long time you can joke and have a laugh with them, they don't mind you messing with them, what you say. They like to have a little go back at you"

But this was in the context of tight staff to resident ratios. In one home this was 7 staff for 38 older people; in another 4 staff for 16 older people; and in the third, 9 staff for 38 older people. This leads to a regular tug on time:

"It's like at lunchtime they say "pull up a chair and have some lunch", but our role is to serve everybody. We always try to have a conversation, but I think if they had their way. they'd have you for ages".

"They constantly ring all day and you go in, you go back in again and say "we've just been to you"....they ring and ring and ring and say "I don't care about anybody else. It's me, I'm here".

"It's quite hard sometimes, it's a juggling act."

We observed the sheer labour involved in the care task, the constant round of emptying commodes, helping with dressing, serving tea, lifting people in hoists, keeping the laundry ticking over. Staff teams explained that they tried to order things to a routine, but it rarely worked out. We saw evidence of how tiring the work feels, with a sense of little respite, and being on the go all the time. In this context, stopping, sitting and talking to residents could seem taboo, and anti-task. The work involves remembering what everyone needs, and being constantly alert. A member of staff recalled ringing back to work at midnight, because she had forgotten to take someone's teeth out.

There was also evidence of some close connections between individual staff and residents:

"My particular lady hasn't been very well at all of late and she just likes you to sit with her when she has her meal, and she likes you to sit there on a chair, she wants you right by the side of her, on the bed and she'll sit and hold your hand, the whole time she'll squeeze your hands just like you're here and she don't want you to go, till she's had her lunch"

A member of staff stated that it was unfair for residents to "move on" because "they're used to us, and we're used to them".

There was also a sense of keeping a distance in the relationship. One member of staff explained that sometimes the residents got too close, and it was necessary to have a line, because the staff member could get too attached, and then the resident might "pass away", and that would mean the staff member would get upset. There seemed to be a real tension between this sense of a distance had to maintained, but at the same time a sense that "they're family"

Staff members talked about how they sometimes felt the connection between resident and staff member, was closer than with the older people's natural families, and how they had witnessed older people put a front on for their relatives. They talked of a resident who was so annoyed because her family no longer seemed to understand her, but just told her what she had to do.

In a case where a lady was suffering from dementia, the staff had to help the family get used to the fact that the lady's personal habits of always looking "presentable" were falling by the wayside:

"the family found that really, really hard to accept. They wanted her mother to put her make up on still, and they wanted their mother to be the way she had always been".

The staff had to broker the changing relationship and the feelings of guilt and blame that accompanied this.

Staff teams talked of the rewards of the work, the pleasure of meeting the needs of the older people, and helping to make them happy, how it made them feel good when they got a spontaneous thank you or hug or kiss from a resident.

“It’s a job you don’t want to do but you get pulled to it. Sometimes you’re so tired, I think I really can’t do this anymore...but can’t pull away from it. It’s got you”

It came across as a job with small but intense moments of satisfaction. Staff talked about “the little moments everyday” that are priceless. There was pride expressed in the work as well. In various conversations the staff relayed what the home, and the team could provide that was special.

10.2 Staff perspectives

Staff teams appeared to see the CVs as being mainly there for the residents:

“A lady comes round with a dog, she goes from room to room”

“The CVs come in and talk to residents”

“She does puzzles and quiz books”

“She spreads herself out as much as she can”

In contrast to what the CVs anticipated, the comments by staff about CVs tended to be appreciative of the CV role. CVs were described as genuine, observant, and caring. There were positive statements about the intentions of the role. Again, these tended to focus directly on the benefit to residents. CVs were seen as a “third party platform” for residents to talk to, if they couldn’t talk to anybody else, as someone to offload worries to. To the extent that the CVs were there for the staff, this was seen in terms of practical help they could offer, such as accompanying residents to appointments, or investing in the quality time with residents that they felt they couldn’t offer themselves. It would free up the staff to get on with the things they needed to do, and leave the staff more able to make sure the residents were “comfortable”.

Most staff interviewed hadn’t talked to the CVs. An occasional misattribution was that staff had originally thought that CVs were family members of the residents. The staff interviewed could not recall specific suggestions or feedback made by CVs. A common sentiment was that the CVs would “get used to how we do things here”.

Home managers perceived the staff and CVs as more involved with each other than the self-reports by the respective teams, with the CVs described as being engaged in

being critical observers, and querying staff. There was sensitivity to maintaining the link between staff and CVs so that a triangle of resident - CV- staff member could be maintained.

“I’m going to have to do much more work with staff group and the CV: she can’t have met everyone yet, the whole relationship could break in some way...” Home Manager

10.3 CV perspectives

CVs were more prone to describe the relationship with staff as distant, and therefore lacking in trust, and marked by a fear on the part of the staff members, that the CVs were in the role of spies. This left the CVs feeling uncomfortable, and pondering how they were meant to fulfil their role of being there “for the whole home”. One CV talked of a profound sense of feeling unrecognised, and that the staff were unaware of her different skills and abilities. Another talked of getting her information about what was going on from the residents, and not from the staff. A further observation by CVs was about the “rotten image” of care staff, and how, in a climate of regulatory criticism, the staff were seen as “too frightened to do anything”. All of these perceptions served to inhibit the CV’s sense of relationship with staff.

Over time, there appeared to be a growing relief from CVs that they felt they were increasingly seen as “part of the furniture”. They identified a number of signs of this: for example, the staff more readily greeting them, or through being incorporated in more training activities. The CVs felt they needed to be careful “not to rock the boat” in terms of what they said about the home or the staff. This was at least in part out of respect for the knowledge and length of service of the staff. The CVs didn’t want to be perceived as newcomers who didn’t know what they were talking about.

CVs believed that an important part of their role was to show staff that the staff were valued and noticed. They saw themselves as doing the relationship building that the staff didn’t have time to do. They could “go off on tangents” that staff couldn’t allow themselves.

The CVs offered a number of comments on how staff undertook their role. They were aware that they didn’t make these comments from a position of objective knowledge of the structure and functioning of the home, but from a subjective position of how the staff role felt to them. They were able to recognise and comment on times when the staff responded sensitively and with kindness to older people. They witnessed the sheer busyness of the role, and how this limited the time for relating. One CV made the observation that in some cases staff were prone to do too much for residents, and thus removed the space for choice and independent activity. There

were longer reflections on how staff at one particular home tended to put the shutters down on conflict (A CV witnessed a resident being sent to their room because they'd been shouting). There was also concern that there didn't appear to be much in place to help staff deal with the reality of frequent deaths in the home of people they had cared for. These matters were readily talked about in interviews with us. We sensed that what was missing was a space where these matters could be thought about with the staff teams themselves.

11. The Impact on Home Managers

The home manager held great significance for each of the CVs. This was partly due the leader's influence in shaping the culture of the home. One manager was described as a "lioness" who was ready to fight for each of the residents; another was credited with transforming the culture on return from a long absence. A corollary of this was that in some homes the working culture suffered when the manager was absent.

We reflected that the manager had a particular significance for the CV. With no formal intrinsic authority, the CVs relied on "borrowed authority" from the manager. However, this authority could be both given and withheld. In one home the leader acted symbolically to convey the importance of the role. The CV proudly recalled how in a fire drill the manager had said, "Rita, come on, you're a member of staff, stand here' and she said that in front of everybody". This same manager took steps to meet the CV at the beginning of every visit, and to set up a communication system so that the CV was aware of key information about the residents, and that also the staff team were aware of any key conversations the CV had had. The day to day reality of the CV role was effectively shaped by the manager's stance.

Elsewhere, CVs found it difficult to influence the manager. They either felt that they didn't have sufficient access, or if they did have access that ideas weren't taken on.

"I think I may have slightly overstepped the mark and said things that were a bit too close to the bone, and I think that why's she's sort of lost the plot with me....I think others have found this, the managers – they like the idea (of the CV project), but they don't really want to see you too much" (CV)

Of course this kind of observation cuts both ways. In making decisions about practice, the manager is accountable to residents, families, regulators, owners, and others for practices in the home. By contrast the CV is freed of formal accountabilities, so is authorised to say anything, but can't expect that these perceptions will automatically hold sway.

MHLECA members sought to support the process of influencing, by asking all parties to sign up to an agreement which would clarify how matters raised by the CV would be tackled. Although this was drafted at the outset of the project, homes did not sign this until the CV had “bedded down”. This certainly helped the dialogue, but there were still views expressed that in some homes the agreement wasn’t adhered to.

CVs demonstrated that they were able to notice and think about the care culture in the home. Anna observed that she didn’t think staff listened to the bells quick enough—leaving residents’ needs unattended to. She felt that, several months into the project that care was still too task - based, and that a staff member sitting down to chat with residents would be met with disapproval by other staff who would see it as lazy. Emma queried why the dining room was in the conservatory, which in the summer was unpleasantly hot. A CV was unhappy with how a member of staff spoke to one of the residents. Lucy observed the lack of sustained interaction with the residents, apart from a, “Hi, how are you?”

The project developed a space, outside the home system, where these issues could be thought about - the six weekly CV meeting. MHLECA members also facilitated occasional meetings of all the home managers, where observations of this sort could be discussed. Again, what appears to have been missing was an accepted space within the home, where CVs, staff, managers and residents could think about the CV observations together.

The home managers talked about finding the right balance in their relationship with the CV. Managers appeared to be navigating a path between maintaining the motivation of the volunteer, maintaining the motivation of the staff, and retaining their ability to do what is right for the home- this could mean either adopting new ideas, delaying them in the interests of stability and continuity, or refuting them.

“The CV initially saw it as her job to tell me everything that was wrong ... I was concerned it might alienate staff because they come in for a lot of criticism anyhow...they come in with some brilliant ideas, and if I’m honest I’ve told them to put some of them on hold. Anna, she pulls the rug from under you....you have to let her feel like she’s in control, but you’ve got to hold onto the reins to a certain degree without her realising it...as the manager my job was to give the CVs confidence in their own abilities and their beliefs where they wanted to take it and for, me to support it, but also to allow them to have their own personality without me stifling that, but without me feeling challenged.”

12.The Impact on Community Visitors

“For me volunteering gives you a purpose; I’m just achieving something; I can go away from here and think I have actually made a difference to someone’s life” CV

“I feel really proud of the role, it gives me a lot of pleasure to come in and feel that I’m giving other people pleasure and time, and trying to bring ideas in” CV

CVs valued the opportunity the role gave them to use their personalities to directly help someone. There was something exciting, and also a little disruptive about this role. CVs saw the role as very much shaped by their own interests and insights. They could fully “bring themselves in”, but by the same token they didn’t always do as they were told, they saw themselves as a little bit of grit in the system.

The CVs found the role rewarding. It built their confidence and sense of purpose; it enhanced their appreciation of lives of older people; and it gave them a greater understanding of the life of the care home.

“I think it’s given me more confidence and it’s just making me feel like I am doing something worthwhile and worthy. And it’s something to look forward to really.”

‘It was a complete surprise to me that I loved it. I love being with the old people and I just love finding out about them about their lives and I love the feeling of going home and feeling that I have cheered somebody up or I have made a difference to their lives’.

‘I don’t think it’s easy being in a care home although several of them say that they feel safe and secure, they are happy, it’s a lovely place, the food’s wonderful and all the rest of it. I think quite a few of them have quite an underlying feeling of grief really and one or two maybe a bit of frustration but they seem to rise above it all. And another lady who has got quite a lot of physical problems - She says this has gone wrong and that’s gone wrong and I am all over the place but isn’t it wonderful. And I think what courage; it’s all those sort of qualities that come out, really quite inspiring’.

13. The Learning Process

A consistent element of the pilot has been the structured support for volunteers provided via six-weekly CV meetings. This has embodied an important principle, articulated at the first CV meeting:

“All of us will be learning all the way through’. Reflection will be part of that. Thinking about ‘what would I do differently?’ ‘What are someone else’s perspectives?’ You don’t notice things until you reflect on them” MHLECA member

The CV meetings, and the availability of individual support via MHLECA was designed to help CVs process some of their own responses to their work. The meetings were informed by the philosophy of action learning sets (Kramer, R. 2007) .

We observed five of the action learning sets, and witnessed the ways in which the group functioned to support the CVs. To illustrate this we look below at examples of group themes:

Dealing with Death

Some of the CVs were deeply affected both by the fact that older people that they had befriended would die, and the fact that this may appear to be insufficiently acknowledged in the home. Anna stated:

‘I don’t like it when they die, I hate it. One’s friends do die, and older people you know do die, of course, but they don’t die at the speed they die here, you don’t lose ... how many people have I lost here, how many friends, I don’t know, sixteen, it must be, who I’ve known really quite well, and it’s odd, it’s different’.

To us, this appeared to be a clear example of how the CV can act as an “emotional antenna” for experiences that may be too difficult for others to give voice to in the home. Staff, managers, and residents, are living and working in an environment in which death is frequent, and therefore it would be unsurprising if they distanced themselves from the experience. The CV spoke about how she found each loss profoundly painful, and how unbearable it was that the deceased resident’s room was quickly painted over and re-occupied. She said:

‘People don’t tell me for example if somebody’s died, and that’s quite hard. I find it really, really quite difficult when people die because I get very fond of them, and then, it almost, somebody else is in their room, and I find that really hard’

Sybil, an MHLECA member, responded that when she had worked as a care home manager she hadn't had much awareness of how others might view the room. As a manager all she had is the pressure to fill the room and the bed so she was straight on the phone trying to fill it. There were diverging responses in the group from a view that "You don't want to put up a great big sign saying someone has died" to a view of "Why are we hiding this away?" A third source of advice encouraged discreet acknowledgement: a bereavement book, a photo in a frame, some flowers, in a prominent spot so everyone can reflect on it.

The group was trying to think about, and work through a way of responding to death. The meeting was important as it allowed a constant aspect of care home life to be faced and not denied. In this sense the meeting was doing some work on behalf of the care homes. It led to a number of conversations in the care homes on these matters.

Bruising and Falls

A CV observed that 7 of the residents in her care home had substantial bruising. The group asked her if she had raised it with the manager, but she said she hadn't, as she felt she may just get fobbed off with an all too plausible "reason". There had been a recent example of this, she said, where when the CV had asked staff about bruising, a staff member said the older person had had a fall. The CV then questioned the older person who said, "Apparently, I had a fall"- she had no independent memory of what had happened.

There was then a discussion amongst the group about how they would know when bruising was a cause for concern.. There were suggestions about making comparisons with other homes, and about checking whether or not referrals had been made for the older people to see doctors. The CV asked whether it was her role to look at this.

For us this highlighted both the dilemmas about the open-endedness of the CV role. If a fundamental concern that drove the inception of the CV scheme was whether or not older people were safe in care homes, then having an informed approach to how to tackle potential signs of abuse is essential. What was evident in the meeting was that beyond sharing the observation with other CVs, the CV was not aware of what her role was in this respect.

This is satisfactory if CVs are simply members of the community invited into care homes, but it becomes difficult territory if any assumption is made that the presence of the CV in some way underscores a level of safe practice. Safeguarding requires, arguably, both a willingness to stay curious and observant about all aspects of

practice, but also a clear-sighted knowledge-in-practice of local protocols so that appropriate notification can occur.

The meeting was an essential space for an important issue to be thought about. It allowed learning about the CV role. One of the outcomes of this discussion was an agreement for a meeting between CVs, MHLECA and the home at which the CVs observations were addressed.

Discussion

We concluded that the CV meeting was an important, and in many ways primary means of sustaining the energy, insight and focus of the CV pilot. The meetings were well facilitated, and were a space where difficult and problematic issues could be surfaced. This allowed the CVs to develop as a functioning team, with a deepening appreciation of each other's contributions. However, any group is prone to stray from its task, and substitute other tasks or defences, in an effect to dissipate tension. Ensuring skilled facilitation in future CV schemes will be very important

This draws attention to the fact that there was not an equivalent space created inside the homes. We would anticipate that a design that allowed CVs, older people, staff, and the home manager to reflect together on how the culture of each home is developing would be a promising innovation.

Part III: Conclusions

14. Summary of Findings

We found that the CV pilot has enhanced the capacity of homes to offer something simple, necessary, life supporting, and affirmative. This capacity has been described in various ways: compassion, relationship-based care, intelligent kindness (Gilbert 2009, Youngson 2012, Ballatt and Campling 2013). It is essential to our sense of being human, but in the institutional setting it is potentially elusive.

CVs are engaged in regular acts of witnessing, caring, noticing and acting, to support older people. We have attempted to describe these in terms of making connections, initiating activities, doing the little things, providing company, and liaising with friends and relatives.

We found that MHLECA evolved an effective means to support CVs in undertaking these roles. This included readily available phone and face-to-face support, regular CV discussion meetings, and an ongoing dialogue between the home managers and MHLECA.

These are important achievements. What has been crafted is a sustainable means to ensure that motivated and supported volunteers can take up this important role in the care homes connected to the pilot. Significantly, all three care homes are maintaining the CV role following the end of the pilot.

We found some evidence, though not as compelling, that CVs could influence the culture of the home. Limitations in this area were partly a consequence of the design of the pilot, and partly a consequence of the reality of dynamics in the care home.

A diversity of expected aims for the CV role led to recruitment against a very broad range of requirements. We argue that the task of befriending and connecting with individual residents requires quite different skills from being able to observe existing practice in the care home, and connect with the staff team in a way to influence, or celebrate, this practice. And equally this is different again from community networking - the CVs very successfully brought their own personalities into the care homes, but this is different from making new links with a range of other different community groups.

We also found that the reality of the preoccupations, skills, priorities and authority of both the home manager and the staff makes the process of influencing care home culture complex. It would be ambitious for any external volunteer to expect to be able to impact on this, especially when each CV is present for 2-3 hrs of a care homes' 168 hour week.

This is not to say that positive culture change did not take place. We were able to observe discreet examples of concerns, originally flagged up in CV meetings, being subsequently raised with staff and managers successfully. MHLECA members were instrumental in driving this process. This was then augmented by the weekly act of CVs role modelling personal and involved care.

We were sympathetic, though, to the substantial pressures that care homes and their staff are under. We were able to observe not only the heavy load of the care staff's daily round, but also the important threads of continuity and connection that linked the staff teams and older people.

The challenge then for any CV scheme is how exactly to establish a collaborative, mutually understanding link across the boundary between volunteers and employees in the home. We saw a start being made with this, in, for example, the involvement of the CVs in care home training events. But we have argued that more could be done.

Replicating the CV meeting, as a periodic event in each home, including the home manager, staff, older people and the CV, would be a good first step.

We believe that the CV role could be helpfully developed by creating a clearer template of what the role does and does not involve. This should clarify what specific skills role holders need to possess, and hence what additional training needs to be provided. This will also inform the recruitment strategy.

We have highlighted the role continuum that ranges on the one hand from a broad role definition, focussed largely on befriending, which would lead to a diverse range and large number of CVs; towards on the other hand a narrow role definition, focussed on more professionally skilled CVs, smaller in number, with a focus on “critical friend”, advocacy, and/or community connecting functions.

This would also clarify whether or not the CV can be regarded as validating practice in the home. We have highlighted pitfalls, if untrained volunteers are expected to provide re-assurance (for example to relatives) or raise the alarm when they do not always have the expertise to discern the prevailing nature of culture in the home.

There is a view that volunteer initiatives in the social care field can serve to mask the need for long term structural solutions, and compromise the work of staff teams. Naylor et. al. (2013) argue that that these pitfalls can be avoided if there is a clear vision on how volunteers contribute to project objectives, if there a focus on improving quality rather than reducing short term costs, if the infrastructure for supporting volunteers is sufficient, and if the boundaries between professional and volunteer roles are kept clear.

The Community Visitor pilot has been invaluable in highlighting the role of committed, supported volunteers in augmenting the work of the home. We applaud this. We have also described the impressive momentum that the pilot has generated. As the work on vision, structure and boundaries continues to evolve, we commend the Community Visitor model for wider dissemination

Older people

- a) Older people were less isolated and had greater opportunities to develop friendships, and have company (*substantial evidence*).
- b) Older people had access to, and took part in a greater range of activities (*substantial evidence*).
- c) Older people had more opportunities to take part in activities beyond the home (*substantial evidence*).
- d) Older people received support and guidance when joining the home (*substantial evidence*).

- e) Older people's personal choices and preferences were given greater priority (*substantial evidence*).
- f) Older people's physical care improved (*substantial evidence*).
- g) Older people had access to an informal advocate when things were not as they wished (*substantial evidence*).

Relatives and Friends

- a) Relatives and Friends had additional information about the quality of care in the home (*some evidence*).
- b) Relatives and Friends had a point of contact, beyond the staff team, who could tell them about the home. (*some evidence*).
- c) Relatives and Friends were assisted in maintaining relationships with care home residents (*some evidence*).

Staff

- a) Staff were supported in their task of providing relationship-based care, through the additional resource of Community Visitors (*some evidence*).
- b) Staff were able to reflect and learn about a focus on person - centred and relationship - based care, through observing the role of Community Visitors (*some evidence*).
- c) Staff received feedback from Community Visitors about their practice, and how it impacted on older people (*some evidence*).
- d) Staff were able to develop their care practices as a result of this feedback (*some evidence*).

Home Managers

- a) Home managers received additional information about the quality of care in the home, from the Community Visitors (*substantial evidence*).
- b) Home managers were able to address issues of personal care for older people, of which they otherwise would have been unaware (*substantial evidence*).
- c) Home managers received feedback on how their actions and behaviours impacted on the culture of the home (*some evidence*).
- d) Home managers were able to adjust their actions and behaviours as a result of this feedback. (*some evidence*).

Other stakeholders

- a) Community representatives and organisations were more aware of the needs and attributes of people in the care home, and how they could make mutually beneficial connections.(*some evidence*).
- b) Community Visitors themselves benefitted through taking up a role where they were able to directly contribute to the wellbeing of older people, and learn about their lives (*substantial evidence*).

15. What things helped?

- a) The recruitment of volunteers with good interpersonal, and caring skills, who were able to make a sustained commitment to the project.
- b) The availability of on - demand phone support and face to face support from MHLECA members.
- c) The availability of a well facilitated six weekly meeting for Community Visitors which allowed issues and emotions to be surfaced in a way that helped the project develop.
- d) The enthusiasm and support of the home managers for the project.
- e) The willingness of the home staff and members to welcome Community Visitors.
- f) The collective passion for the project, as demonstrated by members of the Essex QI team, MHLECA representatives, home managers, and Community Visitors.
- g) The space for Community Visitors to influence the role so that their personal interests and skills were made best use of.

16. Recommendations

In the light of the experience and learning from the pilot, we make the following recommendations:

16.1 Role Clarity

Clearer role descriptions and person specifications should now be created, defining the different aspects of the role, and the desirable skills of applicants

We have highlighted a role continuum with three aspects: aspects of the role that focus on befriending, aspects of the role that focus on being an ambassador for older people and the home, and aspects of the role that focus on informal advocacy.

These three aspects each require different skills, with areas of overlap. Each aspect also suggests different optimum CV levels, and different levels of support. So for example “befrienders” should capture a wide diversity of interests, could be relatively

numerous, and offer varying levels of commitment. “Advocates” would need a higher level of experience or familiarity with caring roles, specific skills in representing the best interests of others, with each home maybe only having one or two CVs in this role. No single person would need to undertake all three of these different aspects of the role.

16.2 Recruitment

In the light of the above comments about role clarity, the recruitment strategy should now be reviewed.

We have highlighted the potential for high levels of volunteer recruitment in related fields (dementia befriending, hospices). Community Visitors have found the role life enhancing. Care homes are too small a business unit to sustain long term recruitment of volunteers, and value the role of MHLECA in this area.

16.3 Supervision and Support

The system of oversight and supervision should now be further developed by the CV provider, which is independent of the care home. The frequency of this will depend on the aspects of the role which are emphasised.

16.4 Community Visitor Meeting Facilitation

The facilitator of the Community Visitor meeting is an essential role. New iterations of the CV schemes should now consider what skills/ qualifications are required to ensure that the meetings provide sufficient support for volunteers.

16.5 CV provider/ Care Home Liaison

Liaison between the CV provider and the care home should occur so that both parties are aware of the levels and quality of support and supervision that has actually been provided for each CV.

16.6 Care Home Induction

Induction routines should now be developed to include all in the home so that all staff, and as far as possible older people, are aware of the CV role.

16.7 CV Induction

Induction for Community Visitors should include any additional training required to enable CVs to take up relevant aspects of the CV role.

16.8 Training Programme

The valuable Community Visitor meetings should now be augmented by a training programme specific to the role of Community Visitor.

16.9 Certification

The training programme should be certificated by a recognised education provider.

16.10 Care Home Learning

Participating homes should establish their own facilitated meeting, equivalent to the community visitor meeting. We recommend that this is attended by representatives of all the members of the care home's community, so that there is a place for the CV and others to think together about the evolving culture of the home.

16.11 Care Homes' Community of Practice

Opportunities for sharing practice between participating care homes, such as periodic managers meetings, should be sustained and developed.

16.12 A statutory role?

Future work should consider the benefits of whether the Community Visitor role should be statutory. We are mindful of precedents in other sectors (e.g. Prison Visitor, Reg.33 Visitor), and indeed international Community Visitor precedents in Australia and the US.

16.13 Further research

We believe our findings raise further research questions that merit exploration. For example:

- a) Beyond the pilot: do these findings translate to a regional/ national context? We recommend a larger scale evaluation of the CV intervention over a larger geographical area
- b) The volunteer and social care. We recommend further work on who becomes a volunteer. How do we understand the disparities in volunteering between different sectors (e.g. hospices, hospitals, care homes)? What are the rewards and what are the inhibitors for the volunteer? And how can this be used to develop the take up of the CV role?

References

Ballatt, J and Campling, P (2011); "Intelligent Kindness" London, RCPsych.

Borwick, I (2006); "Organisational Role Analysis- managing strategic change in business settings" in Newton,J et.al " Coaching in depth- the organisational role analysis approach" London, Karnac.

Bowers, H et al.(2011) "Not a one way street: Research into older people's experiences of support based on mutuality and reciprocity" , JRF programme paper

Clarke,S. and Hoggett, P.(2006), "Researching beneath the surface", London, Karnac.

Dementia Friends newsletter November 2013. Accessed 30/12/2013

<http://www.dementiafriends.org.uk/news/category/dementia/dementia-friends-newsletter-15-november#.UsGrKbTyHJk>

Department of Health (Australia) (2013), "The Community Visitors Scheme"

Accessed 30/12/2013:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-cvs-cvs.htm>

Estes, C et al.(1995) Real People, Real problems: An evaluation of the Long Term Care Ombudsman Programs of the Older American Act. Institute of Medicine.

Estes,C. et al.(2006) Enhancing the performance of local long term care ombudsman programs, Institute for Health and Aging, University of California

Gilbert,P (2009) " The Compassionate Mind" London, Constable.

Granville . G (2013) "'It's a lovely thing': commissioning relationship-centred care in Essex" National Development Team for Inclusion

Guttman,D and Pierre R (2000), " Consultation and Transformation: Between shared management and generative leadership" in Klein, E,B; Gabelnick,F; and Herr,P (2000) " Dynamic Consultation in a Changing Workplace", Connecticut, Psychosocial Press.

Holte H, Gjerberg E, Johansen M.(2010) "Effect of the organisational development tool, Appreciative Inquiry" Oslo: Norwegian Knowledge Centre for the Health Services (NOKC, 06 - 2010.)

Institute of Medicine (1995). Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act.

Kramer, R.(2007).” Leading Change Through Action Learning”. *The Public Manager*, 36 (3):38-44

Meyer, J. et al. (2007) “My Home Life: Quality of Life in Care Homes.” National Care Homes Research and Development Forum , London, Help the Aged paper.

Naylor, C.; Mundle, C.; Weeks, L;Buck, D; (2013) “ Volunteering in health and care: securing a sustainable future” London, Kings Fund.

Lave, J. and Wenger, E (1991). “Situated Learning: Legitimate Peripheral Participation”. Cambridge: Cambridge University Press.

O’Shaughnessy C.V. (2009) The role of Ombudsmen in assuring quality for residents of long-term care facilities, Washington , National Health Policy Forum

Owen, T. (2006), “A proposal for the development of a long-term care advocacy programme in the UK”, Help the Aged working paper.

Tickell, C et. al. (2012), “Volunteers: Vital to the future of hospice care” Commission into the Future of Hospice Care

Van Avermaet, E. (1996). “Social influence in small groups “ London,.Blackwell.

Youngson,R (2012). “ Time to Care” NZ, Rebelheart.