WIRRAL

An evaluation of the Wirral Community Trust Care Home Pilot

July 2013

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Applied Health and Wellbeing Partnership

The Applied Health and Wellbeing Partnership
The Applied Health and Wellbeing Partnership supports the development, delivery and evaluation of the Wirral Health and Wellbeing Strategy, through the innovative generation and application of evidence for effective and sustainable health and wellbeing commissioning.

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Executive Summary

The number of older people within society is increasing; locally it is estimated that by 2032, 27% of the Wirral population will be aged 65 or above. Older people are the main users of NHS health and social care services, and are more likely to have an emergency admission to hospital than any other group in the population. Adults aged over 65 occupy more than two-thirds of acute hospital in-patient beds, and a large proportion of emergency hospital admissions who stay for more than two weeks are patients aged over 65. The need to understand and prevent avoidable hospital admissions within this population is therefore paramount.

In Wirral, a pilot project has been delivered in ten care homes, with the ultimate aim of reducing avoidable hospital admissions amongst residents. The project involved a Community Multi-Disciplinary Team visiting each care home for half a day per week to support residents who had been identified as requiring specific support. The project also involved contact from an Out-of-Hours GP, who telephoned care homes at weekends, to determine whether any support was required for residents.

A process and impact evaluation was undertaken to understand the perceived impact of the pilot project on care home managers, staff and health professionals. One-to-one semi-structured interviews were held with care home managers and healthcare professionals involved in the delivery of the pilot. In addition, case study interviews were undertaken with staff from the care homes, to explore whether the issues raised by the care home managers and healthcare professionals were also reflected by the care home staff.

The evaluation findings revealed that the purpose of the pilot was well understood by the majority of the healthcare professionals. There was some ambiguity regarding the purpose amongst a small number of professionals, who felt that the purpose of the pilot were vague or had changed during the implementation of the project. Some care home managers were aware of the reasons they had been selected to participate in the pilot, and the majority understood the purpose and objectives of the project. Care home managers and staff felt that the pilot had not affected their day-to-day role.

Healthcare professionals and care home managers felt that the pilot resulted in improved working relationships with others, and both stakeholders agreed that this facilitated successful collaboration and integrated working, as well as knowledge sharing.

All healthcare professionals and care home staff felt that the pilot had provided support for care home residents, and had a positive impact on their care. Examples provided included referrals being made more promptly, assessments being completed, and advice and equipment being provided. The stakeholders described how they felt that they pilot had contributed to a reduction in hospital admissions.

1. Introduction

Older people are the main adult users of NHS health and social care services (Philp, 2007; Age UK, 2012) and are more likely to have an emergency admission to hospital than any other group in the population (Blunt, Bardsley & Dixon, 2010). The number of older people within society is set to increase; by 2032, it is estimated that 27% of the Wirral population will be aged 65 or above. With an increasing ageing population, the number of older people presenting with health related problems also increases (Department of Health, 2008; Wirral JSNA, 2012) which has significant implications for the NHS.

The Government's vision for Adult Social Care (*Communities and Active Citizens* and the White Paper *Equity and Excellence: Liberating the NHS*) documents the intended drive towards the personalisation of public services in health and social care, in order for as many people as possible to be able to stay healthy and actively involved in their community for longer. This in turn should potentially delay or avoid the need for targeted services (Department of Health, 2010).

Over 70% of hospital bed days are occupied by emergency admissions, and over 80% of emergency admissions who stay for more than two weeks are patients aged over 65. Older people are the main adult users of NHS health and social care services, at any one time occupying more than two-thirds of acute hospital in-patient beds. Understanding and preventing avoidable admissions is a pressing issue, especially with NHS budget restraints, an increasing ageing population, and the demand for care closer to home (Mytton et al., 2012).

Research highlights current issues in the care of the elderly in acute settings such as the high rates of admissions that could be avoided, the exposure to harmful risks in hospital settings, the high rates of readmissions that could have been avoided, delays in hospital discharges, and an overall lack of integrated care for the elderly. These factors have a large impact upon hospital admission rates and length of stay, and can also impact the elderly patient adversely. Research illustrates that there is a significant need for services that provide effective interventions for the elderly that prevent hospital admission, readmission and reduce length of stay.

Alternative settings, such as care within the community, have been found to be more appropriate than an acute setting for some elderly patients; yielding similar outcomes to hospital stays at a reduced cost, whilst enabling individuals to maintain their independence and remain in a familiar environment. Timely and appropriate interventions can reduce risk and also maintain independent living. Integrated care approaches have been found to reduce the utilisation of hospital based services and result in lower readmission rates for both elderly patients and those with long term conditions.

In Wirral, an intervention has been piloted by the Community Trust, with the aim of reducing avoidable hospital admissions in care home residents. Wirral Community Trust secured funding for the project from the NHS Strategic Health Authority, who had advertised for providers to submit applications to deliver support to care homes to help reduce hospital admissions. One of the stipulations of the project was that the funding had to spent by the end of March 2013, meaning that the length of the project would be three months.

The pilot project involved two strands:
- A Community Multi-Disciplinary Team visiting care homes for half a day per week. The team visited those care homes which requested support for specific residents;
- Contact from a GP from Out of hours at the weekends who telephoned care homes on Saturday and Sunday and enquired as to whether they needed them to visit or offer advice about any of the residents.

The intervention was piloted in ten Wirral care homes, between January and March 2013. The size of the project was restricted to ten care homes to ensure that the pilot intervention could be feasibly delivered within the designated three month time period, and with the short lead in preparation time.

The ten care homes were selected on the basis of analysis provided by Paul Wormald, the Strategic Data Analyst from the Cheshire Warrington and Wirral Commissioning Support Primary Care Information Team (PCIT), which identified care homes according to fall rates, diagnostics, and hospital admissions. Specifically, the analyst extracted data from the top ten admissions to hospitals from Wirral care homes within a year, the top ten admissions to hospital from care homes with a secondary diagnosis of falls, and the top ten care homes that had admissions to hospital that could have possibly been treated in the community. These were then cross referenced to create the final list of ten care homes.

Each of the care homes involved in the pilot was sent a letter by the project manager, informing them of the project aims and objectives, and of the timescales involved. This letter was followed up by a telephone call, which provided opportunity for care home managers to ask any questions and obtain further information about the project.

A variety of healthcare professionals were involved in the delivery of the pilot, including a Senior Continence Nurse, a Specialist Continence Nurse, an Occupational Therapist, a Community Matron, a Physiotherapist, Pharmacy representatives, and an Out of Hours GP. Recruitment of health professionals to the project was via an expression of interest, which was distributed to healthcare professionals in Wirral.

1.2. Evaluation

The Applied Health and Wellbeing Partnership (AHWP) were requested to undertake a qualitative evaluation to explore the process and impact of a pilot project on care home residents, managers, staff and healthcare professionals. This supplemented the quantitative data collected by the project, and enabled a holistic understanding of the impact of the initiative. The evaluation framework included triangulation of the qualitative and quantitative tools to provide an understanding of the impact of the pilot project on care home residents, managers, staff and healthcare professional. Here, we present the evaluation findings and recommendations.

2. Methodology

Qualitative methods were used to assess the process and impact of the pilot project on care home residents, managers, care home staff and healthcare professionals. The data collection and analyses took place between April 2013 and June 2013. The evaluation design, selection of participants and topics for the interview guide have been developed in collaboration with the NHS Wirral Transformation Programme Manager. Secondary data collected by healthcare professionals were also included in the evaluation.

An application was made to Liverpool John Moores University Research Ethics Committee prior to the commencement of the evaluation to review the ethical implications of the proposed participant recruitment and data collection. The evaluation design and methods were approved as being ethically sound in March 2013 (ethical approval reference number 13/HEA/055).

2.1 Methods

One-to-one semi-structured interviews were undertaken with care home managers and health care professionals involved in the development and delivery of the care home pilot. The interviews were undertaken via telephone or face to face and lasted between 11 and 35 minutes. Case study interviews were undertaken with care home staff involved in the delivery of the pilot. The interviews were undertaken via telephone and lasted between 10 and 25 minutes.

The programme manager had designed a data collection sheet to capture a range of interventions they were required to provide in each care home, and any recommendations they made to care home staff. In addition, the healthcare professionals also designed a data collection sheet to capture more qualitative data regarding the type of intervention they believed was needed at each care home visit.

2.2 Participants

Care Home Managers

All care home managers from the ten homes involved in the pilot were invited to participate in a telephone interview; seven agreed to participate. These interviews enabled identification of both process and impact of the intervention within each home. Care home managers were initially contacted by the NHS Wirral Evaluation Commissioner who informed each manager that the evaluation team would be telephoning them to invite them to participate in the evaluation. Permission for the researcher to contact them regarding the evaluation was requested. Once permission was agreed the researcher contacted them to introduce themselves and provided a participant information sheet, and a convenient time and date was arranged for those who agreed to take part.

Following this, participating care home managers were informed that the next element of the evaluation would involve case study explorations with some homes, and made aware that they may be invited to further participate in this phase. The case study explorations aimed to collect additional information to support care home staff experiences of the pilot. Six homes were selected to participate in a case study, and it was initially hoped that face-to-face interviews would be conducted. However, four care homes declined to participate, explaining that they did not have capacity. Where homes were not able to participate due to capacity issues, a telephone interview was offered. Two care homes took part in a telephone case study interview.

Healthcare professionals

Telephone and face-to-face interviews were undertaken with eight healthcare professionals who were involved in the development and delivery of the pilot. The evaluation commissioner

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initially identified the following healthcare professionals to be invited to take part in a semi-structured interview: Senior Continence Nurse, Specialist Continence Nurse, Occupational Therapist, Community Matron, Physiotherapist, Pharmacy representatives, an Out of Hours GP, and the Project Support Manager. Representatives from Pharmacy were involved in the evaluation in March only, and interviewed once the pilot was completed, to enable a full understanding of experience and impact. However due to several locum General Practitioners being involved in the Out of Hours service no single practitioner could be contacted. All healthcare professionals involved in the delivery of this intervention were aware of the evaluation and the researcher subsequently made contact to introduce themselves and provided a participant information sheet. A convenient time and date was then arranged for those who agreed to take part. Consent was obtained from all healthcare professionals who agreed to be interviewed.

Care home residents
It is important to highlight that care home residents were not be included within the case studies as, due to the nature of the setting, patients may have been too unwell to consent to inclusion. Furthermore, care home residents may not have been aware that the service they received as a part of the pilot was different to usual care. The option to select only those patients well enough to take part was considered, however including only those patients who are well enough to participate would have limited the research findings and may not have provided a full reflection of service experiences. Exploring the experiences of care home staff provided important insight into the impact of the pilot.

2.3 Location
Interviews with care home managers and staff members were undertaken over the telephone. The case study interviews were undertaken over the telephone.
The semi-structured interviews were undertaken either at their place of work or over the telephone if preferred.

2.4 Materials
Care home staff
Semi-structured interviews with care home managers, and case study interviews with care home staff, explored their experiences of delivering this pilot intervention, and the perceived impact that they felt this service had on healthcare professionals, patients, and their families.

Healthcare professionals
Participants were asked about how and why they were involved in the care home pilot, and their experiences of being involved in the project. Participants were also asked about the perceived impact they felt this service had on healthcare professionals, patients, and their families.

2.5 Analysis
Each interview was transcribed verbatim and data analysed thematically. Researchers reviewed the transcripts and determined the key themes arising from the care home manager interviews and healthcare professionals' interviews. The researchers then discussed the key themes to highlight any differences, and a final list of themes for each participant group was determined and presented separately for the care home managers and healthcare professionals. The last process of analysis was to triangulate the findings from the care home staff interviews and healthcare professional's interviews, alongside the case study interviews, to determine common themes and conflicting findings, and consider any recommendations that the research team felt may be important to highlight for the future development and delivery of this service. Case studies were described descriptively and

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analysed in the context of the interview findings. The secondary data were analysed descriptively.

3. Results

3.1 Interviews with Care Home Managers

Care home managers from all ten care homes were invited to participate in a semi-structured telephone interview. A total of seven care home managers took part, with three care home managers opting not to participate. The interviews lasted between 11 and 35 minutes, and were transcribed verbatim.

3.1.1 Impact of the pilot on care home staff

When managers were asked how they had been involved in the pilot, the responses were varied. Some care home managers stated they had worked closely with the multidisciplinary team throughout the whole of the pilot, whilst others stated they had had a general project manager overview or delegated the pilot to a deputy.

In terms of delivering the pilot, managers tended to identify residents who they had concerns about and who they thought would benefit from the service and this information was then passed onto the multidisciplinary team. In one case, their deputy then had contact with the team until the end of the pilot in another the care home manager passed the pilot over to the care home staff who then took an oversight of the pilot. Recommendations were then forwarded onto the care home manager and a meeting held with the multidisciplinary team to discuss these.

In terms of the purpose and understanding the aims and objectives of the pilot, some care home managers were aware that the purpose was to reduce hospital admissions for care home residents, and thought that their home had been selected due to high rates of falls and hospital admissions, whereas as others described that they did not know why their care home had been selected. One manager stated they were selected as they had been highlighted as having a high number of patients having falls and being admitted to hospital within one year. This manager was aware that the NHS were delivering a pilot to try and reduce hospital admissions and were keen to become involved so they could continue to receive their Gold Standard Framework accreditation. The majority of care home managers who were interviewed stated that they understood the aims and objectives of the pilot; only a few managers stated otherwise. One manager stated that although they understood the aims and objectives of the pilot they felt they were a little vague.

> *"So we were very keen to be a part of that and for it to have a measurable benefit for our residents so I could then use that then as evidence for my Gold Standard Framework then as well",*

> *"Yes I did, I knew they were here to reduce hospital admissions, trying to prevent people going to hospital that didn't really need to go",*

> *Yes, although I found them a bit vague…how they were actually going to put that in place, how they were going to make a difference to that [reducing hospital admissions] really"*

When care home managers were asked what they initially thought when they learnt that the pilot would be taking place in their care home, the majority of responses were positive. Managers stated that they thought it would be a good opportunity for them to be involved, and highlighted the benefits of working in collaboration with other healthcare professionals. One care home manager described how they would have liked to have more notice of when the pilot was going to be delivered, and more information about the pilot before it commenced. Whilst the need for notice and preparation was recognised by the project manager, the amount and type of delivery information was limited due to the short

preparation time between the Community Trust receiving funding and needing to implement the project.

> *"Extremely, extremely pleased",*

> *"We want to be part of every pilot and anything that is going on in the Wirral",*
> *"I was quite pleased. I like to be involved in any new services that are out there to see if there is anything that can benefit our residents",*

> *"My only concerns were, I think we could have done with a little more perhaps, notice and preparation and a bit more information on the pilot, not just obviously for me but for my nursing staff who are more involved really"*

The majority of the care home managers felt that the pilot had not affected their day-to-day role. The predominant reason for this was that the care home managers had involved their care home staff instead so they did not have much involvement in the pilot.

> *"It didn't affect my day to day role in any shape or form",*

> *"My team, my staff have teams of patients that they look after and they are responsible entirely for their care"*

The care home managers were generally very positive about the pilot, and described their gratitude and the value they felt the pilot had provided.

> *"I thought the whole team were doing an extremely good job, they were receptive to what we said",*

> *"I was hoping they would stay longer, I want them back! Can we have them back please as soon as?!",*

> *"I think it's just been a positive experience and we would welcome it back again",*

> *"I am very sad it's ended because it played a huge part here especially the way we were at the time in December when they started",*

> *"I think I expected it to be definitely more of definite plans that we would have to put in place sort of like action plans for the future"*

Improvements in practice
Care home managers described how the pilot had resulted in improvements in practice, in terms of both multidisciplinary working, and policies and procedures.

> *"Well obviously the up to date information that the team had and obviously the correct policies and procedures that they used they implemented in our home",*

> *"Directed staff to the correct procedures",*

> *"Certainly having access to that broad range of professionals to look at wide range of issues"*

Care home managers' experiences of implementing the pilot
When managers were asked about their experience of implementing the pilot both positives and challenges of the service were provided by care home managers. Managers spoke of the positives of their experience of implementing the pilot. These included how effective the

service was, for example in gaining equipment for residents. The multidisciplinary team were also deemed as flexible and positive to work with. Managers also stated how they initially thought the service would be more challenging than it actually was.

> *"It was a very effective programme whilst it was here…one area in particular was the impact for the equipment that we needed here in the home to help obviously with the clients",*

> *"It was a lot less challenging than I thought really. I thought there would be a lot more actions for us to complete, get involved with, a lot more influence over the carers the residents, different types of assessments ye"*

Care home managers described some of the challenges they experienced during the implementation of the pilot. One care home manager felt that the multidisciplinary team made too many recommendations to one care home manager, who described feeling overwhelmed with the workload. Another manager described that they felt that the pilot had been 'rushed', however, this is likely to be due to the limited time period that the pilot had to be delivered within. This participant went on to suggest that it would have been beneficial for discussions to have been held between the care home manager and the multidisciplinary team on what residents they thought needed to be seen. This manager also described how the list of residents needed to be regularly updated as resident's health changed on a daily basis. Another care home manager stated that on one occasion they had requested for a resident to be seen and this did not happen.

> *"I think we found it difficult at the beginning because they were recommending a lot of different things, a lot of equipment as a home we had to address the things that were needing addressing immediately ; health and safety issues and various other bits and bobs",*

> *"The ethos, the thoughts behind it were extremely good, being completely honest and I have been honest with the team as well, it was ill-conceived to begin with and rushed",*

> *"If they would have actually sat down and planned it and talked to the homes that were involved with it to begin with, before they actually implemented it on any ideas on how to choose patients, how to communicate with the staff that sort of thing",*

> *"A brand new set of patients with a whole new set of risks would have been admitted but they seemed to only go on the first set of patients that I gave them",*

> *"I believe there were a few difficulties with a couple of residents. We had asked the team to take a look at them for us, they weren't actually assessed, so they were missed somehow",*

Improved relationships
The majority of care home managers spoke about the positive relationships that had developed with other healthcare professionals, as result of the pilot. One manager stated that the multidisciplinary team provided support; another manager stated that the pilot had enabled relationships to be built with other healthcare professionals. A further manager stated that they were now able to share knowledge with other healthcare professionals.

> *"Window of opportunity to tap into other health professionals which we never had before or was more difficult",*

"For an OT and Physio to come knocking on my door every week and saying 'hello, who can we see and who can we help?' was a breath of fresh air because we never usually get to see a Physio year on, year in",

"Every care home needs access to these people",

"We've had a very good relationship with them and were getting to know those people that work in the community and they were actually a very friendly bunch, very happy to share their knowledge and do the best for the residents"

One manager stated that they initially struggled with relationships with other healthcare professionals but this later improved. One manager stated that they did not think the pilot had affected how they worked with other healthcare professionals.

"At the beginning the rapport with the other professionals back in December wasn't very good and I think when the multidisciplinary team came in in December the team were very vary of them because of the things that had gone on in the home"

3.1.2 Perceived impact of the service on care home residents

All care home managers spoke positively of the support they thought the pilot provided for care home residents. The managers felt that the pilot enabled staff within their home to complete assessments more promptly than usual, which was felt to have subsequently resulted in advice and equipment being provided to residents in a timely manner. One manager stated that these assessments had identified those residents who were at high risk of hospital admissions, and understood this would aim to prevent future hospital admissions. Other positive impacts included care home residents receiving a referral in two to three weeks rather than waiting for up to six weeks without the pilot.

"It has had some benefits for some of the residents so there has been an easier access to getting some of the assessments done rather than waiting you know for an OT or a referral from a GP or a physic referral",

Care home managers identified a number of different impacts that the pilot had on care home residents. Managers felt that the care homes now undertook activities differently, following advice from the multidisciplinary team, and that residents' health had improved. They felt that hospital admissions had reduced, and that hospital re-admissions had been prevented. One manager felt that the pilot did not immediately impact on the level of hospital admissions, and their reasons for this included the day of the week the patient became ill (Saturday and Sunday, out of hours GP, hospital admission). Furthermore this care home manager thought that the pilot was too short and it was not possible to identify whether there had been an impact on hospital admissions. However, this care home manager stated that the new equipment provided as a result of the pilot, such as the higher backed chairs, may prevent future hospital admissions. One manager stated that they did not think that the pilot affected hospital admissions.

"Well yes it has because we are now doing things differently from their recommendations",

"All the residents sort of improved as well and it was most beneficial to them",

"There was a gentleman that was on the residential floor and he had numerous hospital admissions because of hospital admissions because of catheter problems but because the continence nurse was on the team she was able to

sort the problems out and eventually had his catheter removed and she monitored that and that reduced his hospital admissions",

"Definitely prevented hospital admissions",

"By putting higher chairs in place it may prevent hospital admissions in the future because maybe the patient can get out the chair easier so they won't fall over",

"The pilot was far too short, there's no way anybody could glean any, well certainly not in X home. You know by sheer chance you might have helped one admission if someone was in the right place at the right time"

Care home managers were asked what they thought would have happened to residents if the pilot was not available. Managers stated that they would have just carried on as they had done before the pilot was introduced. One manager felt that there would be no equipment for residents, if the pilot had not been undertaken. Another manager described how they felt that some residents may still have catheters in place if the pilot had not been implemented. Another stated that if the pilot was not available then residents would have been admitted to hospital.

"Well they would still be waiting, we would just be getting on with it"

3.1.3 Perceived impact of the service on families and carers
Care home managers felt that the pilot had had a positive impact on the residents' family/carer. Only one manager felt that they did not think the pilot service had much contact with the family/carers, which was described as being due to the short timescale over which the pilot service was ran.

Positive impacts described by care home managers included the family member/carer seeing the resident with new equipment, and the reassurance that their relative was being cared for. Another care home manager stated that the pilot had a positive impact for the family/carer due to things being done in a more timely manner. One manager felt that if the pilot service could be offered on a more permanent basis that it would make the family/carer happy.

"They want to put their relative in a home where they know they are not going to get ignored by other healthcare professionals",

"They were pleased that there was another aspect of care being provided for their relatives",

"As a whole it's been positive because they can see that things are being done quicker rather than us just referring them to the community team which can take a few weeks. They've seen things get done quicker so there quite happy with those things",

"If this [the pilot] was a continuing thing and I could say that were part of this project and every week a Physio, and OT and a Community Matron and a Pharmacist come in to review your mother they would be delighted"

3.1.4 Suggested changes to the pilot
Care home managers were asked whether they felt that any changes could be made to improve the pilot, if it were to be delivered again. Some managers could not think of any changes. Other managers suggested that the service would benefit by organising their paperwork in a more efficient manner. Others felt that they would benefit from closer working relationships between the care home staff and the multidisciplinary team, so they could set

goals together and ultimately identify reasons for hospital admissions with the aim of preventing these in the future. One manager felt that the service should allow the multidisciplinary team to visit more often.

> *"Yes I think I would like to see more of a definite structure of meetings with the care home staff you know before and after they have done an assessment on somebody so we can set specific goals you know we can identify specifically the problems that are perhaps leading to the admissions to hospital",*

> *"A bit like you know a strategy meeting, a before and after sort of thing",*

> *"Maybe if they can came more often rather than once a week, ye that would be good. Two or three times a week would be ideal wouldn't it? Or one day on the nursing floor and one day on the residential floor or maybe half a day"*

3.2 Interviews with Healthcare Professionals
All eight healthcare professionals involved in the delivery of the pilot were interviewed, including; the Commissioning Manager, Project Support Manager, Community Matron, Senior Continence Nurses (n=2), Occupational Therapist, Physiotherapist and Trust Pharmacist. The evaluation initially aimed to interview the Out of Hours General Practitioner who was involved in the pilot by telephoning care homes at the weekends and enquired as to whether they needed them to visit or offer advice about any of their residents. However this was not possible due to several locum General Practitioners being involved in the Out of Hours service and no single practitioner could be contacted.

3.2.1 Impact on healthcare professionals
Practitioners described how they became involved in the pilot which included a number of reasons; some had been seconded to work on the pilot, with one participant stating that they were seconded as the pilot needed additional support after it had begun. Other reasons provided for how participants became involved included that they had been asked by a senior if they would like to take part in the pilot because they knew this participant had an interest in this area. One participant stated that they had an interest in the care that is delivered in care homes and felt that participating in the project was a developmental opportunity.

The majority of the healthcare professionals felt that the purpose of the pilot was admission prevention, with one participant stating it was to see if having a multidisciplinary team working in care homes had an impact on hospital admissions. One participant stated that the reason they thought they were involved was due to the high number of admissions for Urinary Tract Infection's (UTIs) and catheter issues.

Five of the eight healthcare professionals felt that they understood the aims and objectives of the pilot. When participants were asked what they understood those aims and objectives to be, their responses included; reducing, presenting and avoiding hospital admissions. One healthcare professional went onto say that although they did understand that the initial remit was to prevent hospital admissions, they felt it was unclear for quite a long period how much involvement they were supposed to have. One healthcare professional also added that in addition to the prevention of hospital admissions the pilot also aimed to prevent falls and UTIs. Furthermore, one person stated that they felt the purpose of the pilot was also about the education of care home staff as well as a reduction in hospital admissions. This participant went onto state that although they understood the aims and objectives of the pilot, they felt the multidisciplinary team struggled to understand these.

> *"It was very simple and that was to reduce admissions to hospital",*

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"This is a difficulty question to answer. Initially the remit was to prevent hospital admission. It was unclear for a long time how much involvement we were able to give",

"The education of the staff and the homes about who do they go to? Ok they don't want to send them to the hospital but is it only the GP who can deal with this? No we've got service that will help and support you",

The three healthcare professionals who stated that they did not understand the pilot's aims and objectives, or were unclear of what they were, said that felt they were not clearly expressed. One participant stated that they thought the aims and objectives changed during the period in which the pilot was run.

"We kind of knew there was something to do with prevention of hospital admissions but how to do that and how to go about it we were not clearly told",

"That all seemed to me a little bit, I was repeatedly trying to ask myself what is the aim of this [pilot] is it to care, and I think the goal posts in that sort of shifted in that it was initially admission prevention and that it kind of changed to improving the quality of care"

Healthcare professionals felt that the pilot had supported their work with other healthcare professionals. All healthcare professionals felt that the pilot had enabled providers to establish close working relationships through collaboration and integrated working and education. This enabled the healthcare providers and care home staff to work successfully as a team, collaborating and creating links, sharing education and advice. According to one healthcare professional, this prevented a GP from visiting the care home, and a subsequent hospital admission, as the team were able to deal with the issue. Furthermore, one participant stated how it had made them more aware of the roles of other healthcare professionals. Healthcare professional described how they thought the pilot had value and would help improve the quality of care of elderly residents requiring long term care and support.

"I think that it is definitely a service that would have value, it would definitely improve the quality of care for the older person living in long term care and it would help support the nursing staff in their role really"

"We did develop very close working relationships which was really good",

"As a team we worked so well, we supported each other so well because we were able to kind of do joint visits or",

"The fact that we established working relationships with care homes they were more now free to ring us and ask for advice on the phone or even just visit us when needed",

"I think it has provided those links now because my normal day job is in the community I now have links to those services really, I feel more confident to be able to link with them to discuss patients or refer patients",

"It's given me links in with the OT"s, and physiotherapist",

"Whilst we were able to stop hospital admissions we were able to prevent GPs from visiting because we are able to sort out patients"

One healthcare professional did describe how they felt the pilot affected the working relationship with care home staff negatively as they felt patronised. One participant felt that there had not been enough time to establish a routine with the care home staff.

"Because it was such a short time frame you just couldn't develop any routine or ingrain any practice really",

"We felt like we were just starting to get a handle on it all and then the project ended you know"

3.2.3 Perceived impact of the pilot on care home staff

All healthcare professionals described the positive ways in which the pilot offered support to care home staff. Healthcare professionals felt that care home staff were subsequently more aware of the services in the community and that there were alternative ways in which tasks could be completed in an improved manner to improve service provision. Others felt that care home staff were now able to approach the multidisciplinary team as a point of contact regarding any concerns they had over residents. Healthcare professionals also stated that they felt the pilot had provided care home staff with reassurance and an element of confidence in their decisions, giving them confidence to not be afraid to raise their concerns. One healthcare professional felt that the support that the care home staff received came from a wide range of staff, and another felt that care home staff were supported through training throughout the pilot from the multidisciplinary team. Furthermore, one healthcare professional stated that care home staff had also been supported in that they now knew how to access equipment. This healthcare professional then considered whether this was an issue related to training or awareness in informing care homes how they access the appropriate equipment.

"It has allowed them [care home staff] to see that there are other ways of doing a task and they should not be afraid to raise their concerns",

"It has alerted the care homes to some areas of poor practice and highlighted room for improvement",

"It gave them [care home staff] a contact so if they had any queries they could ring and speak to any member of the team [multidisciplinary team] with whatever the query was and then we could refer them onto other people if we felt that we couldn't deal with the problem",

"I would like to think in terms of staff it's about knowing where those points of contact are should they need them and not just ringing the ambulance service or the GP",

"I think it was really, really, really beneficial for them [care home staff]. You know if they had any concerns about patients they could ask us about them you know we could see them",

"It was things like just saying to the [care home] staff yes you are right to be worried or not don't worry we will look at the patient for you, we will reassure you",

"It helped their confidence levels because we were able to tell them in a lot of cases you are doing lots of the right things but in other ways small improvements can help and I think it gave them the confidence to make those changes",

"It was good as well because we had such a full range of skills",

"I think one of the homes said to me 'oh now I know how to access equipment, I didn't know how to do that'",

"Are we making it clear how people can access that? As a community trust do we need to do some work on that? Do we need to get better at advertising what we have got?"

3.2.4 Perceived impact of the service on care home residents

Support
Healthcare professionals felt that the pilot had provided care home residents with a full and holistic assessment regarding often complex care need, which enabled recommendations to be put into place. Furthermore, the support received by care home residents was described by one participant as 'proactive' and by another as 'continuing'. Healthcare professionals also felt that the pilot had stopped the dissemination of inappropriate or excessive medication and felt that residents were able to have access to necessary equipment with ease. Two healthcare professionals stated that the support the participant should receive should be at the right time, at the right place for residents. Some healthcare professionals felt that the pilot had promoted what the organisation (NHS) can do, and an additional participant stated that residents experience a more prompt service.

"They [patient] gets a better and a faster service"

"It really gives them a chance to have a full assessment really…the clients are really having a thorough assessment",

"We were going in with a fresh set of eyes, we were doing a full assessment on the patients and getting a more holistic assessment so it wasn't one group of professionals going in and looking at one aspect of their care…and looking at all of their needs and how one may impact on another you know that sort of thing",

"We were able to go beyond, we were able to go deeper, we are not superficial… to kind of provide more complex care for patients",

"Their care had improved in terms of identifying risks of pressure sores, risk of falls, you know so there was proactive care for those patients that we particularly identified",

"We were able to commence new medication for patient; we were able to stop other medication",

"Ensuring that patients and clients have the right equipment for moving and handling",

"Hopefully that their care is tailored towards their individual needs, they get what they need and when they need it by the right person",

"Making it easy for them, if they need something then you know it should be provided there and then for them not for them to be chasing us around the system"

Perceived impact on hospital admissions
Six of the healthcare professionals that were interviewed stated that they thought the impact of the pilot on residents included avoiding hospital admissions. One described that the pilot had helped care home staff realise that residents did not always need to be admitted to

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hospital, which then helped to avoid hospital admissions. One healthcare professional stated that they did not think that the impact of the pilot on the residents affected hospital admissions. Two other participants thought that the impact of the pilot was that it had improved the quality of life for some residents. Furthermore, one participant stated that the residents now received better care plans as result of the pilot.

> *"I know a couple of times I have prevented admissions",*

> *"So there certainly have been cases were we have prevented an admission",*

> *"What I do know at the minute and we haven't delved into it lots is that we have looked at the NWAS activity and has looked at 2 or 3 care homes and it has shown reduced activity…this should not be taken in isolation as there are an awful lots of people working on different initiatives to try and target this type of group",*

> *"It brings to light any issues, any risk factors that might be there that might lead them to a hospital admission or lead them to a deterioration in their condition or welfare",*

> *"It means we can put recommendations in place to prove the care they are having and ultimately prevent the hospital admission",*

> *"Started to make the care home managers and staff realise that some patients don't necessarily to go to hospital they can be managed within the care home",*

> *"We feel that it's got to have a positive effect on trying to prevent the hospital admission and also provide the patient with better care plan",*

> *"I think it did that [improve quality of life] with the people that we saw",*

> *"It allowed them [care home residents] to realise that they had a voice and were able to speak out if they wanted and should not feel they were a nuisance"*

Four out of eight healthcare professionals thought that if the pilot service was not available then residents would be admitted to hospital. One participant felt that this would be due to care home resident's lack of education, with care home staff reverting back to the 'old system'. One participant felt that without the pilot, the care home residents would not be treated in the correct manner, for example having catheters when they did not need one. Another participant stated that the care homes would lose their contact with the Community Trust. One participant felt that, without the pilot, care home residents would have longer waiting times for referrals.

> *"Would have had, I mean definitely a number of admissions. All those people we saw, quite a number of them would have in a way ended up in hospital",*

> *"I think they [care home staff] would revert back to the old system which is in a panic and in a state and put them into hospital, they would just phone 999, they would phone the GP",*

> *"And they didn't know who to call on so their initial reaction was 'this patient is very well, we've got this and this and this symptom therefore we better get him into hospital",*

"The care that was been given by staff because of poor training and education wasn't as good as it could have been so therefore they didn't know how to handle certain situations",

"Patients who had catheters that didn't need them",

"They would lose that contact to a certain extent with the community trust again"

3.2.5 Perceived impact of the service on families and carers

The healthcare professionals who worked with care home resident's families and carers experience all spoke positively about how the pilot had impacted on these people. Healthcare professionals felt that families/carers were grateful, reassured, supported and pleased that their family member was being appropriately looked after. One healthcare professional stated that the pilot provided carers with support and encouraged them to communicate with the team if they had concerns for example. This participant stated they felt it had made carers more aware of the services available.

"From what I have experienced from the relatives they were very grateful for us",

"Also reassure the family member that actually the home were actually providing good care",

Hopefully that they would feel that their family member was looked after in an appropriate way and that they could see the benefit of that you know them becoming better and to some degree and independent individual",

"That they were been truly cared about not just being dealt with",

"I am not sure there was an impact on the family members but carers were provided with good support and encouraged to communicate with the team if they had concerns. It made them more aware of the services available"

3.2.6 Experiences of implementing the pilot

Before the pilot commenced, all healthcare professionals were briefed about the purpose, objectives and delivery of the project. Despite this, two healthcare professionals described feeling that they lacked understanding about the pilot which initially caused confusion about their role in the pilot, and resulted in another healthcare professional seeking clarification from their senior. Two participants described feeling that they did not receive enough guidance or direction, and one participant described how they subsequently began to set up the pilot by themselves. One participant stated that, during the planning stages, they had the role of instigating the paperwork and supporting the team. Although the project manager had contacted care homes to provide information about the project, one of the healthcare professionals felt that it may have been beneficial during the planning stages of the pilot to meet with the care home staff and residents. A further participant felt that there was a lack of administrative support during the planning stages of the pilot.

"Very, very confusing initially because we didn't know what we were supposed to be doing",

"We didn't know if whether we were supposed to be doing treatment or were supposed to provide health education",

"Discussions were held around just advising following assessment and not treating the residents. As time progressed there were times when treatment was carried out",

"Well there was no guidance it was a question of going and seeing what you could do to the best of your ability really so we were not following a plan of any kind",

"It was a difficult experience in terms of we hadn't really been given any real directives and how to set it up and not all the members were actually where there right from the start",

"We actually had to set up the whole process ourselves really and we actually had to get a lot of information from the care homes and introduce ourselves to them before they could actually get patient contact",

"As the first person involved with the team I instigated the paperwork and how the team should run",

"There could have been better consultation processes before the programme started and then these challenges probably wouldn't have happened",

"I initially went out to visit the homes and explain what the pilot was about"

Half of healthcare professionals who were interviewed stated that not all the healthcare professionals had been involved from the start of the pilot, and this was felt to have created inconsistencies and challenges.

"The people who were supposed to be involved in the project were kind of tricking in along the way. Which made things very difficult, like the Pharmacist came towards the end of the project",

"I know that I was coming into a team that was established anyway so that was a challenge in itself"

Due to the funding arrangements, the pilot was constricted to being delivered within a three month period. This limited time period was raised throughout the evaluation, with participants describing the challenges brought about by the short timescale. Two healthcare professionals felt that there was not enough time to see all the residents, as the pilot had ended after healthcare professionals had just started. One healthcare professional felt that there needed to be more staff available to provide the service. One participant felt that the three-month time period was not long enough for the pilot to prove the worth of the service.

"We did not have adequate time",

"We did not have time to do the pilot as it should be",

"Why can't we take 5 care homes and do some really good work instead of 10 care homes and we do very little work or kind of spread ourselves so thin",

"It was like opening a Pandora's Box. You went in there and you were just so aware with such a small team you were only hitting the tip of the ice berg",

"The time constraints on the pilot – 3 months was not long enough to prove the worth of the service",

"I personally would have liked to have seen things last a lot longer",

One healthcare professional described how they felt that there was a lack of communication between the multidisciplinary team and the out of hours GP. This participant stated that it was important to have a good and open relationship with the GP, but this was often difficult in the pilot due to the large number of GPs from different care homes. Furthermore this participant stated that they often struggled to get the information they required regarding residents and their medical background history. One participant felt that there was an issue with the communication between the healthcare professionals and the care home staff.

> *"Completely no communication between us and the out of hours GP",*

> *"I think I would probably think I was just getting that contact right, and that relationship right and being able to help and its finished and gone",*

> *"Because care homes have so many GPs it was very difficult to establish a relationship with all those GPs",*

> *"You couldn't get the information that you need…especially their [residents] background information was very inaccurate, it was very difficult to find information",*

> *"We were actually spending more time searching for information in patients files so we would know what to do with them which was really using clinical time",*

> *"Communication with some of the staff in the care homes – they did not seem to mind if we were there or not"*

One healthcare professional described that there was not the direction that the multidisciplinary team were looking for; it was felt that some people relished the autonomy, whereas others required a more detailed management approach. One healthcare professional stated that they felt the care home staff had lacked confidence when looking after residents due, to a lack of information at the beginning of the pilot. However, they felt that the pilot subsequently did boost their confidence. One healthcare professional stated that they felt it would have been beneficial to train care home staff and support them to develop their skills.

> *"There maybe was not the direction that they may be looking for … we made it very clear at the beginning that it was about them going into the homes and making of it what they felt was the right thing to do",*

> *"Some people quite relished that and they were quite happy to be given that autonomy and freedom and other people don't, they want a lot more detail and guidance and management and that wasn't provided",*

> *"You could feel like they don't have the confidence to look after these patients, particularly around COPD, diabetes, you can just tell they don't have the correct up to date information on patients",*

> *"But it did build their confidence and they are able to now make decisions that probably they couldn't have done before"*

One healthcare professional stated that they felt the inclusion and exclusion criteria for visiting residents was not robust enough and that they would have liked more flexibility in which residents they visited. Furthermore, one stated that regular monitoring of care home residents equipment and medication reviews was important as this sometimes meant that equipment gave inaccurate readings for example regarding diabetic patients. Some

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healthcare professionals felt that residents were often on medication that they did not need to be on.

"For me I just didn't think the inclusion and exclusion criteria was robust enough",

"The care homes had one B machine, the one that checks the blood sugar being used for all the patients and they were not being quality controlled…and therefore probably the readings were not accurate",

"We identified patients on medication that they shouldn't actually be having or taking or some of them taking or some of them taking suboptimal therapies",

"That need of reviewing patients medication when in care homes"

One healthcare professional felt that care homes and their residents would still have the expectation of a service that was no longer running. Furthermore this participant stated that there was also the disadvantage that team expertise had been brought together for the pilot and then this may be dispersed. One participant felt it was a disadvantage that the team did not have a name and this caused additional problems.

"They [care home staff] now may be expecting to receive a similar service, same type of service and it's not there",

"You've lost that team expertise if you like; it's now been diluted again",

"No proper management really from the multidisciplinary team…I mean if you actually rolled it out there would be a management structure, there would be admin support you know there would be all that there in place and then there would be a plan",

"We didn't have a name initially and that was part of the set up as well and another problem really because we didn't actually have a name"

Healthcare professionals were asked if there was anything they would change about the pilot, if it were to be delivered again. Participants suggested that involving more healthcare professionals. Despite healthcare professionals being recruited to the project by responding to an expression of interest, some of the healthcare professionals were not aware that this had happened, and suggested that creating an expression of interest in recruiting healthcare professionals would avoid motivation issues. One healthcare professional stated that they would have liked to have seen the pilot being advertised as an 'admissions prevention service', as they stated that some people were a little confused as to what the service was about and what it was aiming to do

"I just think you need greater numbers there really and more of a mix of staff",

"I would change the number if clinicians on board, people who are able to prescribe you know like community matron we need people to prescribe",

"When you get a team together you need to make sure that the personalities are going to get on and that they are going to complement each other both in terms of personality and skill",

"It [name change] took away from them the fact that we were actually admission prevention team"

3.3 Case Study Findings

Care home staff from six care homes were invited to participate in a case study telephone or face-to-face interview. A total of two care home managers took part, with three care home managers opting not to participate due to time constraints. One care home manager agreed a staff member would take part but when the researcher arrived at the care home ahead of a previously agreed interview, the care home staff member was unaware of the interview. The care home staff member stated that they would be able to take part in the telephone interview at a later date. However when the interview was arranged for a later date the care home member of staff withdrew their participation mid-way through the interview. The remaining participants could not be contacted by telephone or email. The interviews lasted between 10 and 5 minutes, and were transcribed verbatim.

3.3.1. Impact on care home staff

Care home staff in one case study were unsure why their care home had been selected to participate in the pilot. These same care home staff did however understand the aims and objectives of the pilot and felt that these were to prevent falls to subsequently prevent hospital admissions. Two care homes spoke positively about the pilot taking place in their home stating that they welcomed the possibility of new ideas and advice. One care home did not feel that the pilot had affected their day to day role too much only requiring a little more time than usual in their working day.

> *"I mean the aims and objectives for us falls prevention it was a big thing, stopping people falling and getting them admitted to hospital. So if they were at risk of falls try and make it as best for them as we could",*

> *"We were quite open to it, we always welcome any ideas from people coming in like that",*

> *"We did benefit from it and we did get some good advice out of it",*

> *"We found it helped because obviously they were the experts",*

> *"We might have spent time with people that's all, only time"*

One care home highlighted that their home had a form which was used to record details about resident's health. The multidisciplinary team completed this form when they attended after visiting residents and subsequently provided the care home staff with the recommendations they had made. One care home felt that some of the recommendations were beneficial and others were not. The recommendations the care home staff thought were beneficial included gaining seating for a resident very quickly rather than having to wait for several weeks (which is what happened previous to the pilot). Other recommendations, such as lowering the level of a wash basin, were felt to be impractical.

> *"If we request anything like that, it takes weeks and weeks they were able to do it in quite a short space of time",*

> *"She [resident] finds it hard to reach the wash basin so she has a bowl but they said if you alter the wash basin she will be able to use the wash basin. That's not practical for us"*

Experience for care home staff
One care home spoke positively about their experiences of implementing the pilot and stated that they took advice from the multidisciplinary team on board as appropriate. Two care homes felt that, as a result of the pilot, they knew which healthcare

professional to contact if they needed to. One care home felt that the multidisciplinary team had been a good support.

"We followed the advice that was given as best that we could. I mean if we felt that something was appropriate like altering things then explained why we didn't think that was appropriate",

"So we have met them (OT, Physiotherapist), we know who they are we know we know that they are there so if we need to get in touch with them",

"We could ask them questions rather than ringing GP's and one thing or another so it was quite good",

"We found them a good support because we are not nurses we're carers so it was quite handy"

3.3.2 Impact on residents

One care home staff member stated they did felt the pilot had a small impact on residents. Reasons provided for the small impact included that the care home staff felt they knew the basics, and that this was just being reiterated to them. Other care home talked positively about residents benefitting from receiving equipment and referrals that they would not have received in the pilot had not been running, which they felt made the residents life more comfortable.

"I mean it wasn't a big impact but there was some impact",

"Well I think we knew the basics anyway and we knew our residents quite well and some of the suggestions I think we thought well we know that",

"Well we got referrals quicker and the equipment came quicker than we normally would have done",

"It's got them [care home resident] some equipment that they would not have had otherwise so it's made their life more comfortable and easier"

Care home staff did not think the pilot had affected hospital admissions but did feel that if the pilot had not run residents would not have received the necessary equipment.

"I mean the chairs now on the blocks are now more comfortable but I don't think its prevented them going into hospital"

3.3.3 Suggestions for the future

One care home felt that because they were quite a large home, they already had the knowledge and skill set through talking to one another and suggested that maybe smaller care homes would benefit from the pilot.

"I think because we are quite a large home we have a lot of staff who have quite a lot of different ideas coming in and we do sort of talk things out with each other, it might be more beneficial for a smaller home that doesn't have that"

3.4 Triangulation of Qualitative Findings

Following analysis of the qualitative data obtained through the interviews with the care home staff and the healthcare professionals, an overall thematic analysis was carried out across both sets of data. Here, the data were interrogated to determine any similarities in terms of

impacts of the pilot service on residents, families/carers, healthcare professionals and relationships with healthcare professionals. The advantages and disadvantages of the service and any changes to the service suggested were also descriptively analysed.

- Both the healthcare professionals and the care home staff largely understood the pilot's aims and objectives.

- Both the healthcare professionals and the care home staff felt that there could have been more thorough and robust planning during the development stage; and these stakeholders felt that this would have allowed clarification of roles and expectations, as well as clarity surrounding how they thought the pilot would be best carried out.

- Both the healthcare professionals and the care home staff highlighted the benefits of working with other healthcare professionals as this allowed close working relationships to be established. This relationship also allowed a support network for care home staff. Furthermore, the healthcare professionals were able to share their knowledge and experience and educate one another through the idea of peer support.

- Healthcare professionals and care home staff both described the positive impact the pilot had had on care home residents. They stated that the pilot enabled a full assessment on residents and appropriate equipment being provided. The impact of this pilot was felt to be the prevention of hospital admissions and care home staff changing their behaviour to help assist in the prevention of hospital admissions.

- Both the care home staff and healthcare professionals stated that some care home residents would have ended up being admitted to hospital if the pilot had not had been delivered. One reason given for this was due to care home staff having to resort back to the way of working before the pilot commenced, such as due to a lack of equipment, for example.

- Healthcare and care home staff felt that the pilot had a positive impact on the families/carers, with stakeholders describing how families/carers felt reassured that their family member was being appropriately looked after.

- The healthcare professionals and care home staff highlighted several similar advantages of the pilot service. Advantages for the care home residents included thorough assessments being completed, access to a broad range of healthcare professionals and appropriate medication for that resident. Advantages for the healthcare professionals included collaboration through team working and the knowledge and support through peer links to be able to confidently make appropriate decisions regarding care home residents health care.

- Some healthcare professionals and care home staff described similar challenges that they felt they faced during the implementation and delivery of the service. These included more planning at the development stages of the project and the issue of time constraints with the pilot only running for a certain period of time.

3.5 Analysis of Secondary Data
In order to monitor the progress and impact of the care home pilot, data were collected by healthcare professionals from the ten care homes they visited during the pilot. Data included the frequency and type of visit made to care homes. Initially, the project lead designed a data collection sheet (known as data A) comprising of open-questions for healthcare professionals

to take to visits and record data regarding care home name, health professional role, and professional input required. Data A recorded 351 visits by healthcare professionals. Once complete, these data were inputted in Excel by the project manager. The data were then exported into SPSS by the researcher.

In an effort to identify the number of repeat visits per resident, the number of visits for each resident were then coded and expressed as a single input in SPSS using date of birth. However it was not possible to code all visits made by healthcare professionals due to missing information such as date of birth and date visited (n= 329 visits).

Once the pilot had commenced, the healthcare professionals implemented an additional method of collecting data (known as data B) using coded outcome fields. Data collected here included several additional categories to those designed by the project lead, such as risks identified, advice provided and treatment given to care home residents. Data B recorded 376 visits by healthcare professionals. Data were inputted by the healthcare professionals themselves after attending a visit to the care home. The data set was then converted into an SPSS file. Both data were then categorised for ease of analysis and descriptive statistics were carried out on each of the datasets.

3.5.1 Frequency of visits to care homes
The frequency of visits by health professionals to each care home was explored. Quantitative data A highlighted that the care home with the highest number of visits from healthcare professionals was Edgeworth House, with a total number of 51 visits. This care home also had the highest number of multiple visits (residents requiring more than one visit by a healthcare professional) for each resident (n=44). This may be due to Edgeworth House being the second largest care home housing 103 residents (Table 1). The average number of residents in each care home was 71. The care home with the least number of visits from healthcare professionals was County Homes, with a total of 21 visits (with 82 residents) (Table 1). Data A also highlighted County Homes care home alongside with St George's care home as having the least number of multiple visits (n=12). The average number of visits recorded by healthcare professionals to care homes was 33 with 55% (n=102) of residents being visited just once (n=43, 23% twice). Table 1 shows the number of visits to each care home, including repeat visits, and provides a percentage of total visits compared to number of residents in the home.

Table 1 Number of visits per care home and size of home - Data A

Care home	Number of visits by team						Total n visits	Visits/ resident number (%)
	1	2	3	4	5	6		
Elderholme	15	5	3	1	0	0	**38**	60
Edgeworth House	7	6	6	2	0	1	**51**	103
Bebington Care Home	13	4	1	2	0	1	**38**	87
Safe Harbour	14	4	3	0	0	0	**31**	45
Park House	10	8	2	0	0	0	**32**	111
Mother Redcaps	11	5	2	1	0	0	**31**	51
County Homes	9	3	6	0	0	0	**21**	82
St Georges	13	1	2	1	0	0	**25**	77
Benham	6	4	3	1	2	0	**37**	43
Nazareth House	4	3	0	1	1	1	**25**	50
Total	**102**	**86**	**72**	**36**	**15**	**18**	**329**	

The data collected by the health professionals themselves (Data B), reported a slightly higher number of visits to the care homes (total n = 376). The total number of visits per care home was also different (Table 2).

Table 2 Number of visits per care home and size of home - Data B

Care Home	Total number of care home visits by team	
	Data A	Data B
Park House	32	35
Edgeworth House	51	41
Bebington	38	48
County Homes	21	21
St Georges	25	36
Elderholme	38	41
Mother Redcaps	31	42
Nazareth House	25	41
Safe Harbour	31	35
Benham	37	34
Missing		2
Total	**329**	**376**

Quantitative data A and data B showed the number of visits to each care home was not necessarily proportionate to the size of the home. Often, the care homes with the least number of patients requested more visits from the healthcare professionals, than those larger care homes (Figure 1).

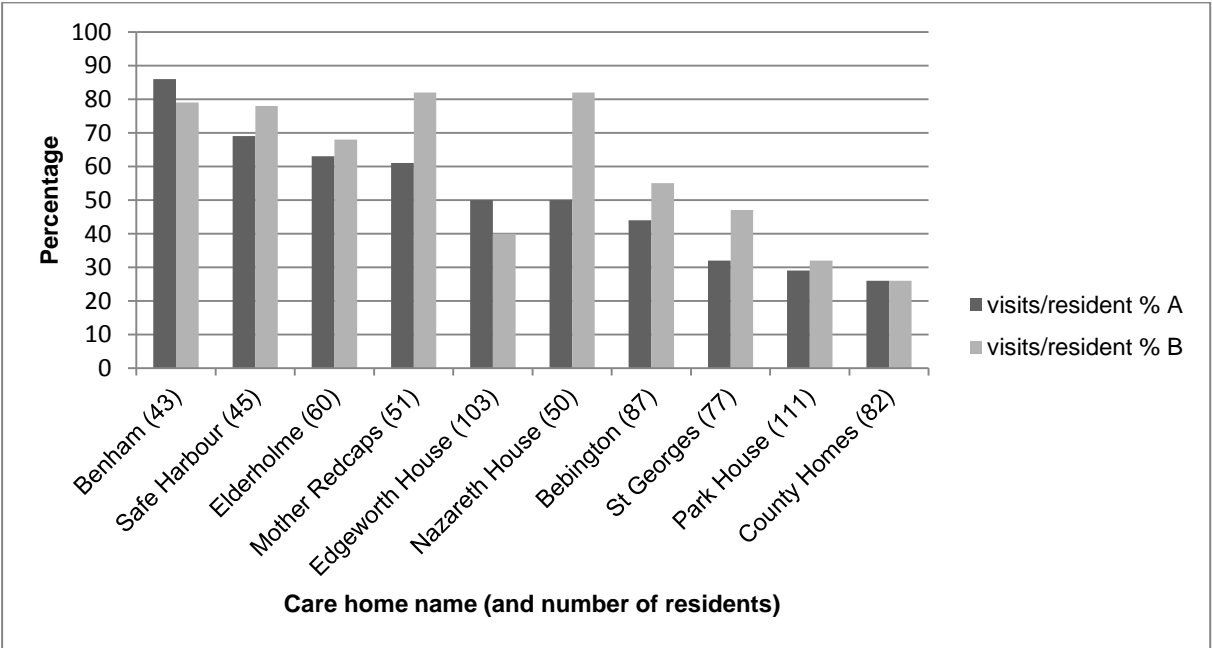Figure 1 Number of visits per care home, by size of home (in brackets) (Data A)

3.5.2 Purpose of visit
Data A recorded the reasons why healthcare professionals were requested to attend care homes. On the data collection form, to be completed by healthcare professionals, these reasons had been categorised by the healthcare professional into: therapies, continence issues, Community Matron and other.

For healthcare professionals that completed this section, data A demonstrated that the most popular reason for healthcare professionals visiting care homes was for therapies (106/183, 57.9%), followed by continence (79/183, 43.2%), Community Matron (58/183, 31.7%), and other (25/183, 13.7%).

Data A were analysed to identify how many repeat visits were for the same reasons, a total of 16 (8.4%) visits were recorded here as being for the same reason (Table 3).

Table 3 Number and percentage of visits made for the same reason (Data A)

	n	%
Yes	16	8.4
No	20	10.5
Partially	29	15.3
Total	**65**	**34.2**

The data collection sheet designed by the project manager of the pilot (data A) provided healthcare professionals with the opportunity to reflect on the problems and/or risks that they identified when visiting the care home. The problems/risks identified by healthcare professionals were categorised for ease of analysis by the researcher. Out of the 24 problems that were identified there were four that were most frequently raised: risk of falls, UTI, respiratory and continence issues (Figure 2).
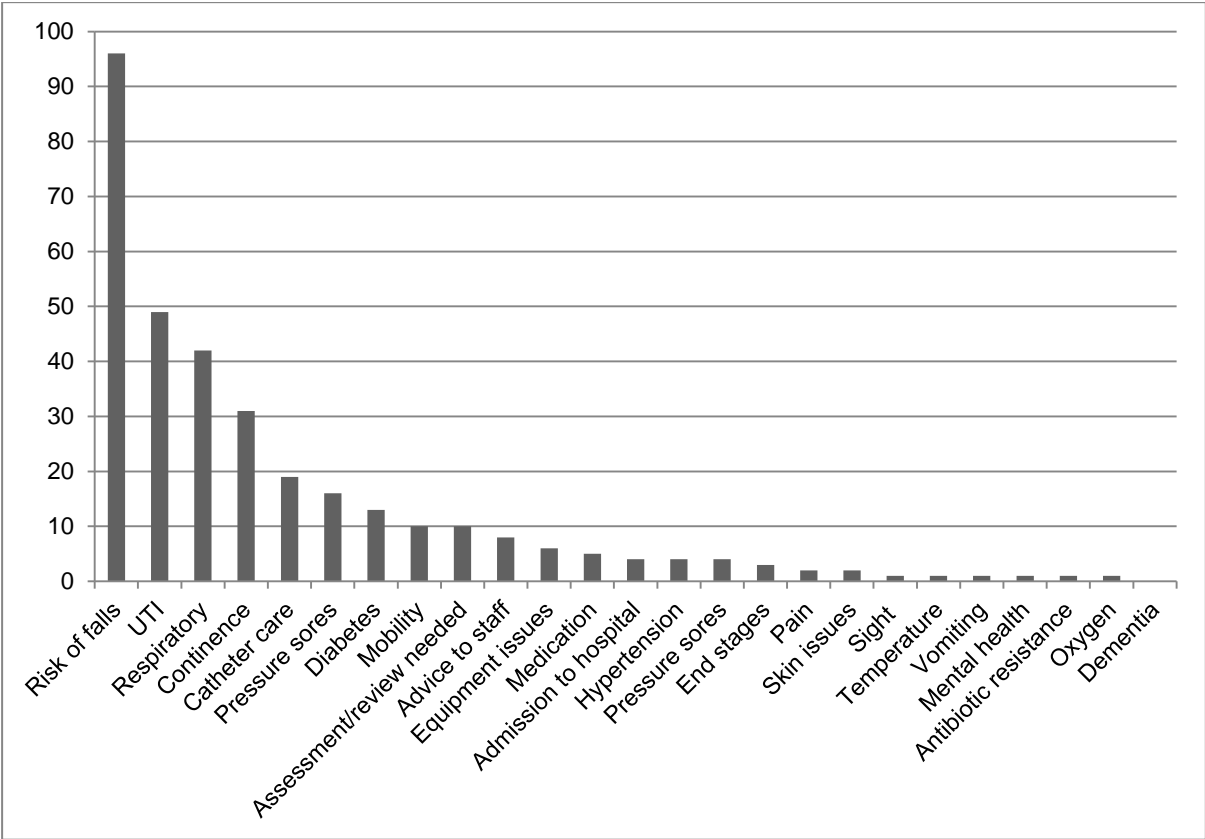
Figure 2 Problems/risks identified by healthcare professionals (Data A)

The data collection sheet designed by the healthcare professionals of the pilot (data B) enabled healthcare professionals to reflect on the problems and/or risks that they identified when visiting the care home. The problems/risks identified by healthcare professionals were categorised for ease of analysis by the researcher. Out of the 35 problems that were identified there were three that were most frequently raised: referral/discussion with other agency, risk of falls, and advice on transfer methods (Figure 3).

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The data sets A and B both highlighted pressure sores and the issue of mobility in the top ten identified problems and risks. Both figures 2 and 3 illustrate the differences in the types of information collected when health professionals visited the care homes. Where data A identified issues in terms of health requirements, data B identified where advice was required, and the type of advice that was sought.
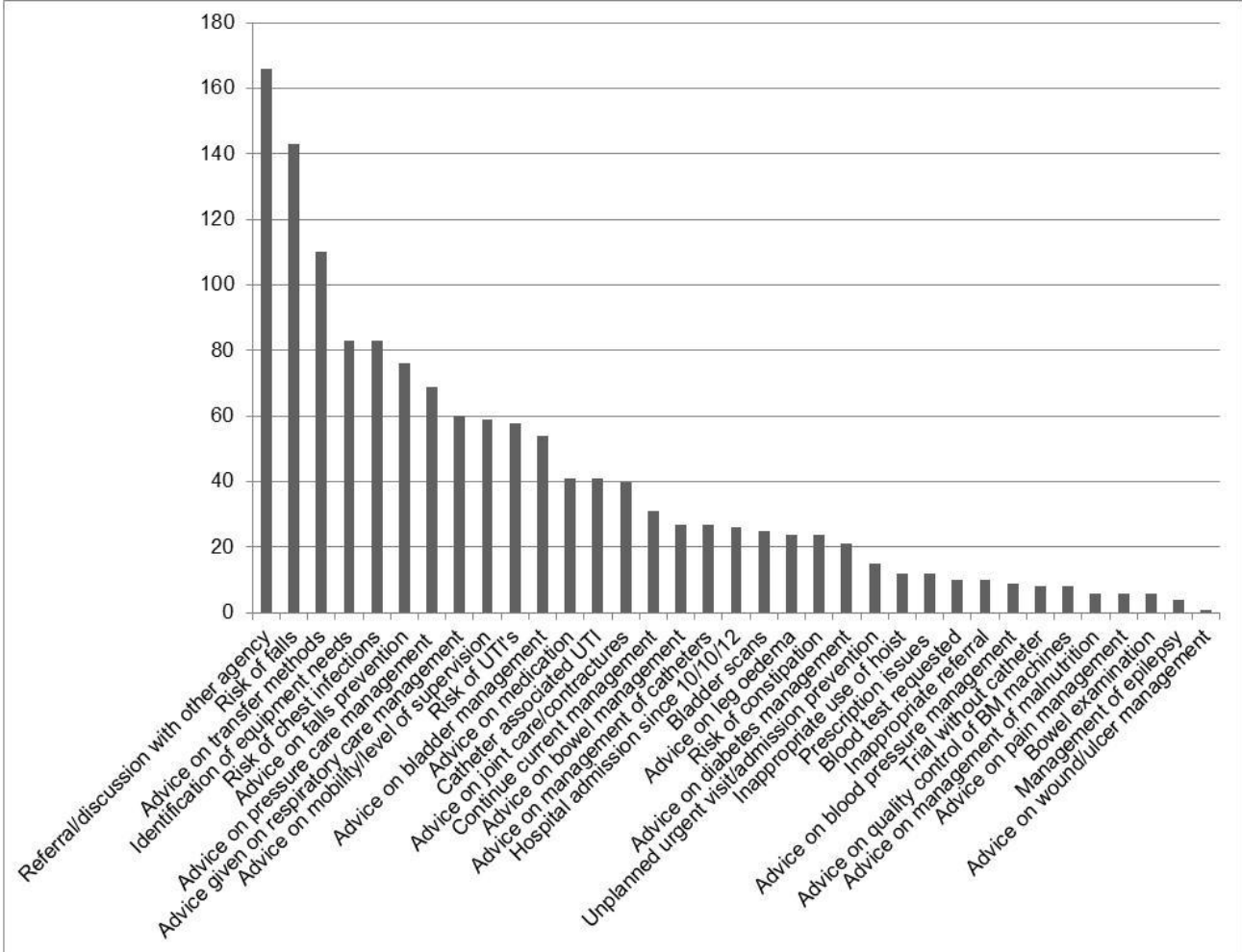
Figure 3 Problems/risks identified by healthcare professionals (Data B)

Both data sets recorded which care home the resident was from, their date of birth, and the date they were seen, which healthcare professional they were seen by and risks and problems identified by the healthcare professional. Data A however recorded the reason the healthcare professional had been requested to attend the care home whereas data B did not. This additional information gave context to the problems and risks identified. Furthermore data A had separate categories for recording problems and risks identified and advice, treatment, intervention provided, where data B had these in a single category.

Data A were analysed to identify how many of the same problems had been identified by health professionals during these repeated visits. The same problems were identified at 6.8% of all repeat visits, with some of the same problems being identified at 15.3% of the repeat visits (Table 6).

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Table 6 Number and percentage of issues identified at repeat visits – Data A

	n	%
Yes	13	6.8
No	19	10.0
Partially	30	15.8
Total	**62**	**32.6**

The most frequently identified problems (risk of falls, UTI issues, respiratory issues and continence issues) required up to six repeat visits (Figure 4).
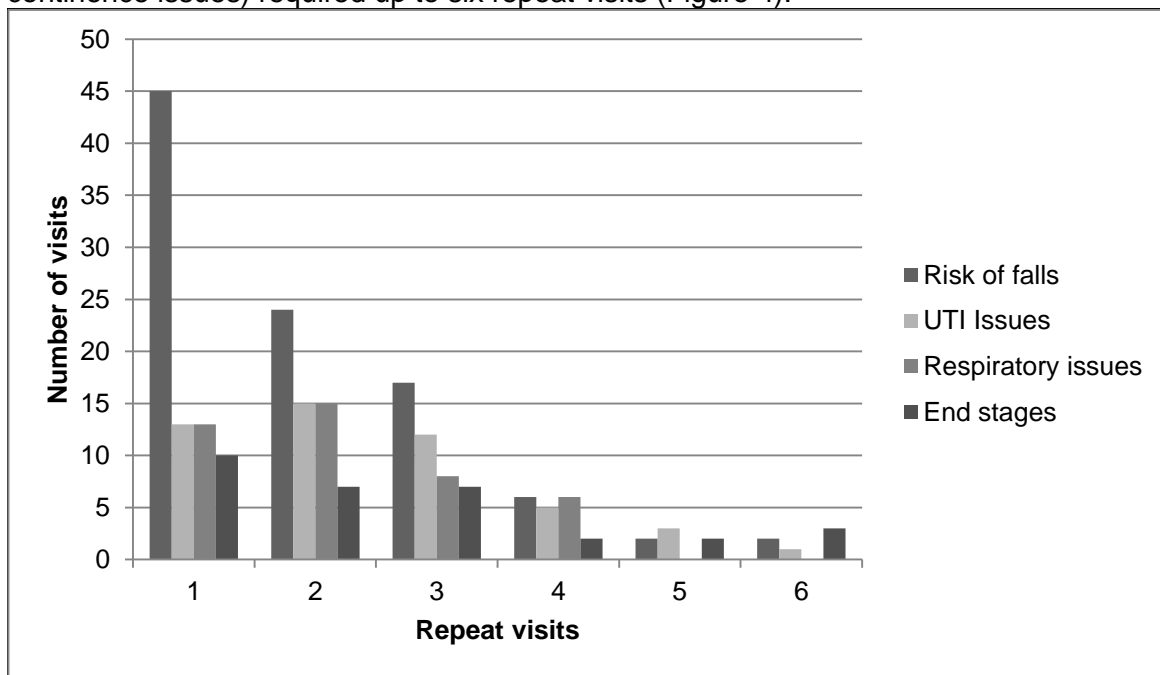
Figure 4 Problem and risks identified by healthcare professionals (Data A)

3.5.3 Hospital admissions
Data A identified that, out of 181 visits to care homes, admission to hospital was identified for four patients. Data B identified that 15 visits to care homes had been for an unplanned urgent visit/admission prevention (Figure 6), and that 26 hospital admissions had been seen over the period of the pilot (since 10/12/2012) (Table 7). Dataset B does not provide any unique identifiers, therefore it is not possible to identify how many of these admissions were for the same patient.
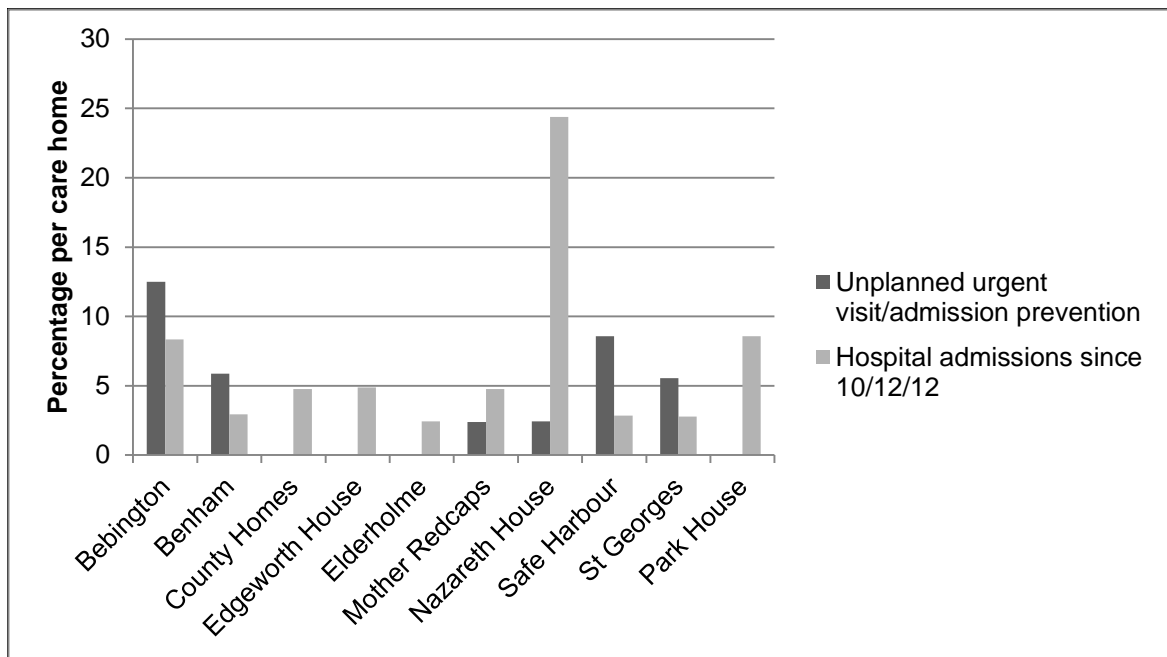
Figure 5 Unplanned urgent visits and hospital admissions per home (Data B)

The North West Ambulance Service (NWAS) collate data regarding call-outs, and the programme support manager provided analysed data to add further context to the potential impact of the care home pilot. The NWAS data suggested that there had been a reduction in the total number of call outs in the majority of care homes since the pilot commenced in December 2012, with the exception in the anomaly in February 2013 where the majority of the care homes experienced an increase in hospital admissions (Figure 6).
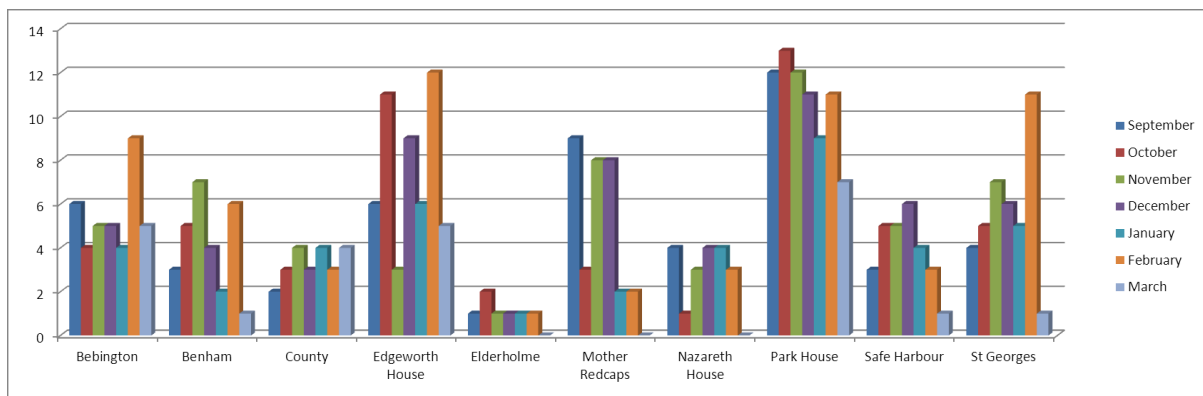
Figure 6 North West Ambulance Service Data

County Homes care home was the only care home that appeared to have experienced an increase in the number of hospital admissions since the pilot commenced, with Elderhome care home's hospital admissions appearing to remain stable throughout the period of the pilot. Elderholme had the lowest number of hospital admissions since the pilot began (n=4). The care home with the greatest number of hospital admissions since the pilot was implemented was Park House (n=38) however this home has the largest number of residents (n=111). It is unclear from the data how many of these call outs were repeats for a single resident.

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4. Discussion

4.1 Implementation of the pilot
The majority of healthcare professionals understood the purpose, as well as the aims and objectives of the pilot. When participants were asked what they understood those aims and objectives to be, responses included reducing, presenting and avoiding hospital admissions. However, some healthcare professionals did not understand what the purpose and aims of the pilot were as they felt these were unclear, vague or changed as the pilot was ran.

Some managers knew why their care home had been selected (high rates of falls and hospital admissions) whereas others, including care home staff did not. The managers that tended to know why their care home had been selected were more aware of the purpose of the pilot. The majority of care home managers and care home staff did understand the pilot's aims and objectives. Care home managers highlighted that the pilot had not affected their day to day role; however this may be in part due to some care home managers delegating the pilot tasks to care home staff such as nurses. Care home staff felt that although their day to role did not change too much the pilot required a little more time than usual.

4.2 Impact working with other healthcare professionals
As a result of the pilot, healthcare professionals and care home managers felt they had improved relationships with other healthcare professionals. Healthcare professionals felt that the pilot had supported their work with other healthcare professionals. Both healthcare professionals and care managers felt this enabled successful collaboration and integrated working as well as knowledge sharing and education. According to one healthcare professional, this prevented a GP from visiting the care home, and a subsequent hospital admission, as the team were able to deal with the issue. Furthermore, one participant stated how it had made them more aware of the roles of other healthcare professionals.

One healthcare professional did say that they felt the pilot affected the working relationship with care home staff negatively as they felt patronised. Another healthcare professional felt that there had not been enough time to establish a routine with the care home staff.

4.3 Experiences of the pilot
Care home managers and staff generally spoke positively about the pilot describing their gratitude for the support and advice they had received from the multidisciplinary team. The majority of healthcare professionals felt that care home staff were able to approach the multidisciplinary team as a point of contact regarding any concerns they had over residents and this had provided reassurance as well an element of confidence in their decisions. This was reiterated by care home staff. However one healthcare professional stated that they felt the care home staff had lacked confidence when looking after residents due, to a lack of information at the beginning of the pilot. However, they felt that the pilot subsequently did boost their confidence.

Care home managers felt that the pilot had resulted in improvements in practice, in terms of both multidisciplinary working, and policies and procedures. This was also felt by healthcare professionals. The flexibility of the multidisciplinary team was felt by care home staff as good with regard to the residents. These impacts could be seen to positively impact on the care home staff through improved working practices and having a point of contact for any concerns they may have. In addition through new knowledge and training from collaboration may also then impact on the quality of care residents received.

Two healthcare professionals felt that they had not received enough guidance or direction during the pilot. In addition, some healthcare professionals talked about having more staff to

provide the service and felt that there was a lack of communication between the multidisciplinary team and the out of hours GP due to the large number of GPs from different care homes. One healthcare professional felt that care homes and their residents would still have the expectation of a service that was no longer running. Furthermore this participant stated that there was also the disadvantage that team expertise that had been brought together for the pilot and then this may be dispersed.

Care home managers spoke of feeling overwhelmed at times regarding recommendations made by the multidisciplinary team with care home staff describing how the recommendations were not always practical to implement. One care home manager also described feeling 'rushed' in ensuring that discussions took place between the team and the staff about which residents they felt needed to be seen. Care home managers went on to say that the residents who they felt needed to be seen by the multidisciplinary team changed on a daily basis, and it was important that this was regularly updated and communicated.

4.4 Perceived impact on care home residents

All care home managers, staff and the majority of healthcare professionals spoke positively about the support the pilot provided for residents. Some of the support mentioned by healthcare professionals and care home managers included full and holistic assessments and referrals being completed more promptly than usual resulting in helpful advice and equipment being provided. One care home manager felt that the assessments completed by the multidisciplinary team identified patients who were at high risk of hospital admissions and described how this would aim to prevent future admissions. The care residents received as a result of the pilot was described by one healthcare professional as 'proactive' and by another as 'continuing'.

The impact on care home residents described by care home managers included activities been undertaken differently following advice from the multidisciplinary team. For example, healthcare professionals felt that the pilot had stopped the dissemination of inappropriate or excessive medication. Some care home managers felt that this improved the resident's health. Two healthcare professionals thought that the impact of the pilot was that it had improved the quality of life for some residents.

Healthcare professionals and care home managers felt that hospital admissions had reduced, and that hospital re-admissions had been prevented. One healthcare professional described that the pilot had helped care home staff realise that residents did not always need to be admitted to hospital, which then helped to avoid hospital admissions

Some healthcare professionals and care home managers and staff however thought that the pilot was too short and it was not possible to identify whether there had been an impact on hospital admissions. One care home manager highlighted that the new equipment provided as a result of the pilot may prevent future hospital admissions.

If the pilot had not been available healthcare professionals and care home managers felt that they would have just continued as they had been doing. Healthcare professionals felt that this would result in hospital admissions and that the care homes would lose their contact with the Community Trust.

4.5 Perceived impact of the service on families and carers

Healthcare professionals and care home managers felt that the pilot had a positive impact on the residents' family/carers, such as reassurance that their relative was being cared for and assessments, referrals and equipment sourced being done in a more timely manner. One healthcare professional felt that the pilot provided carers with support and encouraged them

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to communicate with the team if they had concerns for example and that the pilot had made carers more aware of the services available.

5. Transferable Learning

This three month project has provided opportunity to pilot and evaluate the impact of a designated Community multi-disciplinary team support to residential care homes. This project has highlighted a number of key findings integral to the delivery of future care home projects.

- Although this project only had a short lead in time between the preparation and implementation stages, future projects could provide opportunity for all healthcare professionals involved in delivering and implementing projects to meet one another during the planning stages, to avoid inconsistencies in service delivery.

- Clear and concise communication to all involved in the delivery of implementation of the project would help avoid ambiguity and uncertainty; including details about project aims, objectives, roles, responsibilities and anticipated impact on day-to-day working. If a project is only to be delivered for a restricted period of time, ensure all staff are aware of this, in order to manage expectations of what will happen once the project finishes. This is to ensure collaboration and communication links still remain.

- Although not applicable to the current project but important for future projects, a number of evaluation participants felt that service name and advertisement would raise awareness and increase clarity about the service.

- The current project invited healthcare professionals to become involved by providing an expression of interest. Despite this, some of the professionals were unaware that this had happened. Future projects should ensure that all involved are aware of the recruitment processes that took place to secure their involvement.

- Administrative support was important for the delivery of this pilot, and should be provided consistently throughout future projects. This would help coordinate paperwork as well as monitor visits from the multidisciplinary team, resident visits and health issues, assessments, referrals, equipment requests, and hospital admissions.

- During the implementation stage of projects similar to this, ensure regular meetings and communication between care home staff and the multidisciplinary team to discuss residents they feel need to be seen, including any updates on new residents entering the home, and improving and deteriorating health of current residents. This will help identify reasons for hospital admissions with the aim of ultimately preventing these in the future. Ensure that the lines of communication between the multidisciplinary team and the care home staff remain open if advice or support is needed in the future. Consider regular medication reviews for care home residents.

5.1 Key messages

This project has highlighted that even within a short timescale there can be positive outcomes from a small project, particularly in terms of improvements in communications and relationships amongst health professionals. All staff involved in the delivery and implementation of the project described key outcomes in terms of working relationships and increased awareness of available services. Although the pilot has finished, these methods of working should be advocated as routine amongst relevant services.

- Evaluation participants reported that the pilot had improved relationships with other healthcare professionals, which had enabled successful collaboration and integrated working, in addition to knowledge sharing and education.

- Evaluation participants felt that the pilot had improved practice in terms of multidisciplinary working, and better understanding of policies and processes.

- Healthcare professionals and care home staff felt that they were able to approach the multidisciplinary team as a point of contact, providing reassurance and confidence amongst care home staff, and supporting decision making.

- Awareness of the multidisciplinary team, their roles, and the support available helped care home staff to realise that residents did not always need to be admitted into hospital, and that support was available to help them within the community.

- All healthcare professionals and care home staff described the positive impact that multidisciplinary working had on residents' family members and carers, in terms of providing reassurance that their relative was being well cared for, and that equipment was being sourced in a timely manner.

- Out of the 24 problems that were identified there were four that were most frequently raised; risk of falls, UTI, respiratory and continence issues.

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Healthcare Professional Interviews
Participant Information Sheet

A qualitative evaluation of a pilot intervention which aims to reduce avoidable hospital admissions in care home residents

Dr Hannah Timpson, Miss Lisa Hughes
Applied Health and Wellbeing Partnership, Centre for Public Health

You are being invited to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not.

What is the purpose of the study?
The Wirral Community NHS Trust is piloting an intervention which aims to reduce avoidable hospital admissions in care home residents. The intervention is being piloted in ten Wirral care homes, between January and March 2013.

You are being asked to take part in a study to explore your experiences and perceptions of this service, and your perceptions of the impact that this service has had on falls, diagnostics and admissions. You are being asked to take part in this study because you are involved in delivering this service.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights.

What will happen to me if I take part?
You will be given at least one week to read the information on this sheet and decide whether you would like to take part in this study. You can contact the Commissioning Manager, or the research team, if you know you would like to take part. If you have not done so after at least one week, the research team will contact you to ask if you would like to take part.

If you do decide to take part then one of the research team members will then contact you to arrange a suitable time to meet for an interview. It is anticipated this will be a private room in your place of work or over the telephone if preferred.

At the start of the meeting, I will explain the study to you; if you agree to take part you will be asked to sign a consent form. During the interview I will ask you about how and why they are involved in the care home pilot, and their experiences of being involved in the project. Participants will also be asked about their perceptions of the impact that this service has on healthcare professionals, patients, and their families. The conversation will last around 30 minutes to one hour.

Are there any risks / benefits involved?
There are no direct risks or benefits for you being involved in the study, but the information you give will provide an understanding of the impact of this pilot, and will be used to inform the future development and delivery of the pilot intervention, and possible commissioning intentions.

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It is not expected that there will be any risks to being involved; however, you do not have to answer any questions that make you feel uncomfortable.

Will my taking part in the study be kept confidential?
Yes, we take confidentiality very seriously. If you do decide to take part in the study your contact details will be saved to a password protected file and passed from NHS Wirral to the Applied Health and Wellbeing Partnership research team via an encrypted email. Your contact information will only be stored electronically on LJMU password protected computers, and only the research team will have access to this data.

The interview may be tape recorded, this is because I want to give you my full attention and cannot write fast enough to take notes. The tape recording will not be shared with anyone else and a copy of it will be saved on a password protected computer. After I have written out the interview, the original recording will be deleted (a copy of it will remain on the password protected computer until the study has finished). I may use quotes from the interview in the study report, but they will be anonymised (no-one will know it is you who has said it). No-one has to know you have taken part and the interview will not be shared with anyone beyond the people named above.

Contact Details
If you have any questions or would like to discuss the study, you can contact the study team directly:

Hannah Timpson
Email: H.Smith@ljmu.ac.uk
Telephone: (0151) 231 4382

Lisa Hughes
Email: l.j.hughes@ljmu.ac.uk
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Appendix 2 – Care home participant information sheet

Care home staff Interviews
Participant Information Sheet

A qualitative evaluation of a pilot intervention which aims to reduce avoidable hospital admissions in care home residents

Miss Lisa Hughes, Dr Hannah Timpson
Applied Health and Wellbeing Partnership, Centre for Public Health

You are being invited to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not.

What is the purpose of the study?
The Wirral Community NHS Trust is piloting an intervention which aims to reduce avoidable hospital admissions in care home residents. The intervention is being piloted in ten Wirral care homes, between January and March 2013.

You are being asked to take part in a study to explore your experiences and perceptions of this service, and your perceptions of the impact that this service has had on falls, diagnostics and admissions. You are being asked to take part in this study because the care home you work at is one of ten care homes that have been selected to evaluate the pilot.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights.

What will happen to me if I take part?
You will be given at least one week to read the information on this sheet and decide whether you would like to take part in this study. You can contact the Commissioning Manager, or the research team, if you know you would like to take part. If you have not done so after at least one week, the research team will contact you to ask if you would like to take part.

If you do decide to take part then one of the research team members will then contact you to arrange a suitable time to meet for an interview. It is anticipated this will be a private room in your place of work or over the telephone if preferred.

At the start of the meeting, I will explain the study to you; if you agree to take part you will be asked to sign a consent form. During the interview I will ask you about your experiences of the delivery of the pilot intervention, and their perceptions of the impact that this service has on healthcare professionals, care home residents, and their families. The conversation will last around 30 minutes to one hour.

Are there any risks / benefits involved?
There are no direct risks or benefits for you being involved in the study, but the information you give will provide an understanding of the impact of this pilot, and will be used to inform the future development and delivery of the pilot intervention, and possible commissioning intentions.

It is not expected that there will be any risks to being involved; however, you do not have to answer any questions that make you feel uncomfortable.

Will my taking part in the study be kept confidential?
Yes, we take confidentiality very seriously. If you do decide to take part in the study your contact details will be saved to a password protected file and passed from NHS Wirral to the Applied Health and Wellbeing Partnership research team via an encrypted email. Your contact information will only be stored electronically on LJMU password protected computers, and only the research team will have access to this data.

The interview may be tape recorded, this is because I want to give you my full attention and cannot write fast enough to take notes. The tape recording will not be shared with anyone else and a copy of it will be saved on a password protected computer. After I have written out the interview, the original recording will be deleted (a copy of it will remain on the password protected computer until the study has finished). I may use quotes from the interview in the study report, but they will be anonymised (no-one will know it is you who has said it). No-one has to know you have taken part and the interview will not be shared with anyone beyond the people named above.

Contact Details
If you have any questions or would like to discuss the study, you can contact the study team directly:

Hannah Timpson
Email: H.Smith@ljmu.ac.uk
Telephone: (0151) 231 4382

Lisa Hughes
Email: l.j.hughes@ljmu.ac.uk
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Appendix 3 – Healthcare professional consent form

Healthcare Professional Interviews
Consent Form

A qualitative evaluation on *a pilot intervention* which aims to reduce avoidable hospital admissions in care home residents *(ethics reference number)*

Dr Hannah Timpson, Miss Lisa Hughes

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.

3. I understand that any personal information collected during the study will be anonymised and remain confidential

4. I agree to take part in the above study

5. I understand that the interview will be audio recorded and I am happy to proceed

6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

Name of Person taking consent | Date | Signature
(if different from researcher)

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Care home staff Interviews
Consent Form

A qualitative evaluation on a pilot intervention which aims to reduce avoidable hospital admissions in care home residents *(ethics reference number)*

Miss Lisa Hughes, Dr Hannah Timpson

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.

3. I understand that any personal information collected during the study will be anonymised and remain confidential

4. I agree to take part in the above study

5. I understand that the interview will be audio recorded and I am happy to proceed

6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.

Name of Participant   Date   Signature

Name of Researcher   Date   Signature

Name of Person taking consent   Date   Signature
(if different from researcher)

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Healthcare Professionals Interview Guide

***A qualitative evaluation of a pilot intervention* which aims to reduce avoidable hospital admissions in care home residents**

Purpose: Evidence regarding the experience and perceptions of the pilot will be elicited through interviews with healthcare professionals involved in delivering the service. Healthcare professionals will have been informed by the Commissioning Manager about the evaluation, and subsequently researchers will have made contact with these individuals to provide them with information (including the Participant Information Sheet) about the research, and invite them to participate. Participants will have had at least one week to read the Participant Information Sheets and decide whether to take part. Interviews will be undertaken either face-to-face or via the telephone depending on the preference of the participant.

Interviewer script at the beginning of the interview: "Hi [name of participant], my name is [name of interviewer]. I am a researcher from the Centre for Public Health at Liverpool John Moores University. First of all thank you for agreeing to meet/speak to me; I really appreciate the time you have given. We have been asked to assess the experiences and perceptions of healthcare professionals to inform the future development and delivery of the pilot intervention.
You've been invited to take part as you are either involved in the delivery of the service, or because you refer patients through to the service, and we'd like to hear about your experiences of this. I would like to ask your views on the service, the advantages and disadvantages of the service and how you think it could be improved. Would that be okay?"

If the participant agrees, continue with: "*Thank you, that's great. If you are not comfortable answering a question, please let me know and I shall move on. If you would like to stop the interview at any time, this is OK. You can withdraw from the study and it will not affect your rights. What we discuss and anything you say is in confidence, I will not take any personal information and no-one will know what you have said. If it is OK I would like to tape record the conversation because I would like to give you my full attention and I cannot write fast enough to take notes. After the interview I shall summarise our conversation using notes, this will be saved on a password protected computer, no-one but the research team will have access to it. After this I shall delete the original recording. I may use the odd quote from our conversation in the report, but your name will not appear next to it. Would you still like to participate in the study?"* If participant agrees, ask them to sign a consent form, give them a copy of this along with the participant information sheet pointing out the contact information.

Interview guide

Impact on the healthcare professionals

- Can you tell me how you are involved with the pilot?
  - What is your role?

- Can you tell me why you are involved with the pilot?

- Do you understand the aims and objectives of the pilot?

- What is your experience of implementing the pilot intervention?
  - Was it more or less challenging than you expected?

- - Were there any difficulties you faced?
    - If yes, please explain

- Has the pilot supported how you work with other healthcare professionals?
  - If so how
  - If not, why not
  - Has it affected working relationships?

Impact of the service on care home staff

- In your perception what support does the pilot service provide for care home staff?
  - How does it offer this support?

Impact of the service on the care home residents

- In your perception what support does the pilot service provide for care home residents?
  - How does it offer this support?

- What impact do you think the pilot has on care home residents
  - Why?
  - Do you think this affects the prevention of hospital admissions?
    - How and why?

- What do you think would happen to care home residents if the pilot service was not available?

Impact of the service on families/carers

- Do you think the pilot impacts on the experience of family members/carers?
  - How / why?

General questions about the service

- What do you think are the advantages of this service?

- Do you think there are any disadvantages of this service?

- Is there anything you would change about the service?

- Is there anything else you would like to say about the service?

Care home staff Interview Guide

A qualitative evaluation of a pilot intervention which aims to reduce avoidable hospital admissions in care home residents

Purpose: Evidence regarding the experience and perceptions of the pilot will be elicited through interviews with care home staff involved in the service. Care home staff will have been informed by the Commissioning Manager about the evaluation, and subsequently researchers will have made contact with these individuals to provide them with information (including the Participant Information Sheet) about the research, and invite them to participate. Participants will have had at least one week to read the Participant Information Sheets and decide whether to take part. Interviews will be undertaken either face-to-face or via the telephone depending on the preference of the participant.

Interviewer script at the beginning of the interview: "Hi [name of participant], my name is [name of interviewer]. I am a researcher from the Centre for Public Health at Liverpool John Moores University. First of all thank you for agreeing to meet/speak to me; I really appreciate the time you have given. We have been asked to assess the experiences and perceptions of care home staff to inform the future development and delivery of the pilot intervention.

You've been invited to take part as you are either involved in the delivery of the service, and we'd like to hear about your experiences of this. I would like to ask your views on the service, the advantages and disadvantages of the service and how you think it could be improved. Would that be okay?"

If the participant agrees, continue with: "*Thank you, that's great. If you are not comfortable answering a question, please let me know and I shall move on. If you would like to stop the interview at any time, this is OK. You can withdraw from the study and it will not affect your rights. What we discuss and anything you say is in confidence, I will not take any personal information and no-one will know what you have said. If it is OK I would like to tape record the conversation because I would like to give you my full attention and I cannot write fast enough to take notes. After the interview I shall summarise our conversation using notes, this will be saved on a password protected computer, no-one but the research team will have access to it. After this I shall delete the original recording. I may use the odd quote from our conversation in the report, but your name will not appear next to it. Would you still like to participate in the study?"* If participant agrees, ask them to sign a consent form, give them a copy of this along with the participant information sheet pointing out the contact information.

Interview guide

Impact on the care home staff

- Can you tell me how you have been involved with the pilot?
    - What is your role?

- Do you know why your care home was selected to participate in the pilot?
    - Explore reasons for this
    - Explore views
    - What were your thoughts when you learnt that the pilot would take place in your care home?
        - Positive aspects

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- ▪ Explore any reservations
- Do you understand the aims and objectives of the pilot?

- Has the pilot affected your day-to-day role?
  - o If so, how
  - o If not, why not

- What is your experience of implementing the pilot intervention?
  - o Was it more or less challenging than you expected?
  - o Were there any difficulties you faced?
    - ▪ If yes, please explain

- Has the pilot supported how you work with other healthcare professionals?
  - o If so how
  - o If not, why not
  - o Has it affected working relationships?

Perceived impact of the service on the care home residents

- What support does the pilot service provide for care home residents?
  - o How does it offer this support?

- What is the impact of this support?
  - o Why?
  - o Does it affect the prevention of hospital admissions?
    - ▪ How and why?

- What do you think would happen to care home residents if the pilot service was not available?

Impact of the service on families/carers

- Do you think the pilot impacts on the experience of family members/carers?
  - o How / why?

General questions about the service

- What do you think are the advantages of this service?

- Do you think there are any disadvantages of this service?

- Is there anything you would change about the service?

- Is there anything else you would like to say about the service?
  - o Your experience or that of the care home resident?

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An evaluation of the Wirral Community Trust Care Home Pilot

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