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Title: Quality improvement through the paradigm of learning

Abstract

Purpose: If we are to achieve meaningful participation and co-production for older people using care, then more radical approaches are required. This project explores an innovation where older people using social care were matched to community based learning mentors to develop partnerships within which learning interventions were facilitated. We explore how the concept of learning underpinning this innovation might be used as a paradigm to raise the quality of care in institutionalised settings using a co-productive and relationship based approach to promote wellbeing in later life.

Design/methodology/approach: A structured evaluation drew on qualitative data captured from individual interviews with older people (n=25) and their learning mentors (n=22) to reflect on the potential benefits and challenges involved when introducing learning interventions in care settings. The data was contextualised alongside interviews with relevant stakeholders (n=10) including a care home manager, social care and education commissioners, Trustees and project staff to assess the interdisciplinary contribution of lifelong learning to quality improvement.

Findings: Introducing learning interventions to older people within care settings promoted participation, advocacy and relationship-based care which in turn helped to create a positive culture. Given the current challenges to improve quality in care services, we suggest that a paradigm of learning offers an innovative framework for encouraging older people to retain their independence as care homes strive towards a person-centred approach. Promoting social activities and leisure through the mechanism of learning was found to foster closer working relationships between older people and the wider community. These had a levelling effect through the reciprocity generated and by using an asset based approach. There were benefits for care provider as the partnerships formed enabled people to raise both individual and collective concerns about care and support.

Originality/Value: Raising and sustaining the quality of support for older people requires input from the wider public sector beyond health and social care. Purposeful engagement with other disciplines such as learning and leisure offers the potential to realise a more sustainable model of user choice, person-centred support and user involvement. Engagement in learning activities can help to nourish and sustain membership of the community which is significant for marginalised populations such as older people living in care homes.

Keywords: Older people, Care Homes, Quality, Learning opportunities, Social care, Participation, Co-production, Reciprocity

Paper Type: Research evaluation

Background

There are an estimated 5,153 nursing homes and 12,525 residential homes in the UK providing care and support for 426,000 older people (Laing and Buisson, 2014) from which 59.2% are aged 85 years and over (ONS, 2014). Whilst only 16% of people aged 85+ in the

UK live in institutional care (ONS, 2014), this group constitutes one of the most medically and socially complex groups of people in the community (Scourfield, 2007; Finbarr et al, 2011). The number of care homes has remained almost stable since 2001, despite a dramatic growth in the overall ageing population. Institutionalised care is however, predicted to remain a key provider of support for older people in the immediate future so improving the quality of provision and person-centred care remains significant (Fotaki, 2011). Improving public confidence in the safety and wellbeing of vulnerable older people living in care homes (Katz et al, 2011; DEMOS, 2014) is also poised against a background of austere measures which have significantly reduced funding for the public and community services impacting on social care (Age UK, 2012).

Despite making some good progress, two major reports commissioned by the government (Abraham, 2011; Francis, 2013) documented that older people continue to experience unmet needs, poor quality support and unacceptable variation of standards in care settings resulting in a call for national action. A range of research findings have highlighted widespread systemic problems within the care home sector such as; lack of equality in health provision (Victor, 2010); the lack of diversity within the services that support older people (Knocker, 2012; author 1, 2013); restricted access to community-based services (Edwards, 2014); inequity for self-funders and overly complex funding arrangements (Institute of Public Care, 2011); poor working conditions and lack of support for the social care workforce (Immison and Bohmer, 2013); the disenfranchisement of older people living in institutions from the political system ,(Scourfield, 2007) and continuing widespread ageism in society (Kennedy, 2014). In response to this bleak picture, a strong movement towards co-production (Needham and Carr, 2011) has looked to older people and their representatives to collaborate with commissioners and providers and to work together for improvement of quality at a transformative level. ‘Co-production’ describes a relationship where professionals and

citizens recognise each other's vital contributions to improving the quality of life for individuals and their communities. By sharing power, co-production draws on the expectation and rights of service users and recognises their strengths and expertise in order to promote genuine involvement (Butterworth and Campbell, 2014). A diverse range of campaigns and initiatives have given rise to the accessibility of rich resources to support person-centred quality initiatives in older people's care (Think Local, Act Personal, 2013; Lupton and Croft-White,, 2014). More work is needed however to sustain and expand the mandate for *all* public services impacting on older people's support beyond the role of health and social care. We suggest that purposeful engagement with other disciplines such as education and leisure offers the potential to nourish membership and citizenship for a marginalised population living in care homes and forms part of a systems approach to promoting choice and user involvement (Mayo, 2009; Hafford-Letchfield, 2010).

Paradigms for improving support for older people living in care homes

There are limitations in the structures within which care services to older people are expected to improve. For example, evolving changes to statutory regulation has an important role to play in making sure that services provide safe, effective, compassionate and high quality care (Care Quality Commission, 2014). Inspection and regulation however can only provide a snapshot of improvement. This needs to be countered with a more balanced approach which positively channels older people and their carers' own skills and self-knowledge into improvement particularly when managing personal risks.

At an organisational level, care homes that actively interact with the local community are more likely to demonstrate transparency and reciprocity (Blood, 2013, 2010). This might involve increasing the activity of local volunteers (Tanner and Morgan-Brett, 2014) and/or introducing digital and social media into the lives of older people (Bowers et al, 2013), both

of which have been shown to make a positive difference. Positive research findings on quality improvement stress the importance of service providers supporting and mediating meaningful and rewarding relationships between service users with high support needs and members of the local community. Using a range of approaches that actively facilitate both the individual *and* collective voices of older people living in institutional settings play a part in combatting stereotypes about their abilities (Hare and Hazelwood, 2013: Hafford-Letchfield, 2014). Whether the aspiration for increased participation and co-production in care homes is policy or user-led, the aim should be to create opportunities that enable older people to both give *and* receive support (Blood, 2013).

A commission into the future of residential care (DEMOS, 2014) identified that parallel developments in government policy with reduced resources, present a significant challenge for the care sector . Inflationary pressures on weekly fees for individuals have not let up on expectations of what has to be achieved within that financial envelope (ADASS, 2014). The Care Act, 2014 introduced new responsibilities to local government to provide preventative services and to promote 'wellbeing' going beyond a narrow definition of 'care' to maintain people's health. Kümpers et al., (2013) note that efficient coordination and communication in and between the different settings in which care is provided needs. Care needs to go beyond one-dimensional – mostly medical measures and its components be matched with an individual's complex life circumstances. This can be achieved by building collaborative leadership between health and social care; the care home sectors with statutory regulators and older people's advocacy groups to form new and effective partnerships that are willing to embrace innovation and find new solutions.

Improving quality through the paradigm of learning

Connecting with pedagogy in social care is not yet well established given that older people are a relatively marginalised group within the theoretical and practice aspects of lifelong learning (Hafford-Letchfield:2013;2014). Whilst the promotion of education and learning in later life and the emerging evidence on its benefits for wellbeing have started to attract attention over the last decade (DBUIS, 2009; Jenkins and Mostafa. 2013), this has not yet been effectively collated requiring further cross analysis, interrogation and critique (Soulsby, 2014). Within some European countries, social pedagogy has been applied to work with people in many formal or informal institutional settings. Its principles include holistic approaches and the valuing of service users' rights as a foundation for practice. Social pedagogy places its emphasis on teamwork and sharing in aspects of service users' daily lives and activities. It also recognises relationships as being central to care and allied to this, the importance of listening and communicating (Eichsteller and Holthoff, 2012). The application of social pedagogy to residential childcare is one of the few models externally evaluated in the UK with favourable findings (Cameron, 2012) and suggests that a 'lifecourse' model could fit well with person-centred care. Building on these concepts, the remainder of this paper reports on findings from an independent evaluation of an innovation which utilised principles from social pedagogy and lifelong learning in order promote participation of older people in care settings and to improve the quality of care provided.

Learning for the Fourth Age

Learning for the Fourth Age (L4A) is a social enterprise providing learning opportunities to older people in care settings in England, UK. L4A recruits, trains, places and matches volunteers ('learning mentors') to older people. A partnerships is formed which focuses on a common area of interest to inform individualised interventions using the principles of learning. L4A works across approximately 15 residential homes and to a lesser extent, in domiciliary settings. An independent externally funded evaluation was commissioned to

evaluate the impact of older people in care settings when engaging with L4A learning and development activity. The evaluation sought to:

- evaluate what learning and development interventions work and under what conditions by identifying factors which help and hinder individual learning.
- critically appraise the systems and processes of L4A as an organisation to improve and modify the support to provide the effective learning of older people in care settings;
- provide an informed external perspective on the financial model underpinning L4A operations.

This paper reports specifically on the aspects of the evaluation which tell us about how an emphasis on learning impacted on the micro perspectives of those who participated, namely older people and learning mentors. We will also comment on the impact of engaging with learning from a meso (organisational) level and finally on the implications for the macro level in relation to quality improvement.

Design/methodology/approach

We initially considered identifying baseline measures for older people entering new learning partnerships by completing a wellbeing questionnaire which could be repeated after a set period of interventions. However, due to complications with access, tracking residents and the complexity of information required within the resources available, this was not feasible. The diverse variables and circumstances impacting on an individual's health within the care setting alone would not allow any such data to be stabilised and meaningfully interpreted. The literature demonstrates that it can be very difficult to disentangle the respective roles of multiple factors in a qualitative study (Jenkins and Mostafa, 2012).

Given the above challenges, the evaluation incorporated a qualitative methods design. Qualitative data through individual semi-structured interviews was captured from older people (n=25), 15 of whom were living in three types of care home (*see Table 1*) and 10 of whom were living in their own homes with the support of domiciliary care. Interviews with learning mentors (n=22) involved a mixture of face-to-face and telephone interviews using a broad topic guide and some learning mentors were involved with more than one partnership. All interviews were digitally recorded and lasted between 20-60 minutes relative to the length and depth of experience individuals had with L4A at the time. The interview questions were designed to gain the participants' unique in-depth perspectives on the meaning and value of formal/informal, structured/unstructured learning within their partnership and on the concept of learning as a support mechanism. There was a focus on how 'learning' is specifically conceptualised, recognised and acted upon in order to make exploratory connections between these and any self-reported wellbeing as a result of the service. The sampling strategy combined purposive (i.e those in active partnerships) as well as snowballing (by being present in the homes and using leaflets and posters). We were dependent on gatekeepers such as L4A and care home managers to access participants. The age of older people participating ranged from 68 – 94years and for the learning mentors from 18-72 years although the majority of these were in a younger age range and comprised a number of local university student volunteers.

Ethical approval was granted by Middleses University. Careful consideration was given throughout the process to minimise intrusion and to feedback formative assessment so that those participating experienced any early benefits from the findings and that any issues arising could be dealt with.

Table 1: Characteristics of Care Home

Site	**Sector**	**Noted relevant characteristics**
Site 1	Independent (Charity)	Fees: Higher Residents: from more privileged backgrounds (education and professional) Activities: activities co-ordinator. Funding: L4A paid through care homes own budget Contextual challenges including recent expansion/ restructuring of services and change in staff profile and roles.
Site 2	Charitable Trust – Dual provision including sheltered housing	Fees: average Residents: mixed Activities: no activities co-ordinator, led by L4A with residents Funding: L4A paid directly from Trusts budget Context: Amenable to outside input, without active leadership.
Site 3	Private Sector – National chain	Fees: average Residents: less advantaged

		Activities: no activities co-ordinator Funding: L4A paid by individual residents through the care home systems rather than its budget. Context: Challenging to outside input with minimal internal leadership.

Data analysis

This was undertaken within the resources available. The recorded interview data was listened to by each author and a written note taken of key issues and themes independently using an aural method of coding. Each author made notes for comparison using interpretative phenomenology (Reid et al, 2005). We then subjected a sample of all of the interviews to a cross-check with each other to compare findings and to establish validity. Interpretation of participants own self-reported changes provided the main source of the data we collected around 'wellbeing'. Grouping the codes resulted in the identification of themes within and across each group of participants; i.e., older learners and learning mentors. Findings were complemented by desk research through examination of the documentation, policies, procedures and systems used by L4A to support its day-to-day operations. 'Expert'

interviews with the Care Quality Commission and local commissioners (n=3), L4A staff and Trustees (n=6) and Care Home Managers (n=1) helped to contextualise findings and throw light on how any recommendations might be developed and taken forward. The remainder of this paper reports on selected themes found to be particularly relevant to considering the relationship between learning interventions, user participation and enhancing the quality of care. These were: learning as a leveller in unequal relationships; the benefits of giving and reciprocity in learning exchange; learning as a tool for reflecting on later life and building resilience. We conclude with some key messages for future practice.

Findings from the data: articulating experiences at the micro level

Learning as a 'leveller' in unequal relationships

The provision of 'learning' as a concept was seen as of vital importance and distinct from 'activities', commonly associated with just joining a pre-arranged activity or 'befriending'. These latter activities can be perceived as unequal in terms of how people come to participate in them. What made the difference was the intention and the framework of 'learning' used which appealed to some older people, particularly those with more substantial educational experience. Whilst the operationalizing of, or recognition of 'learning', was not always a conscious process, it was clearly embedded in individual's reflections:

"*If I get the hang of it, anyone else can then learn from me…..It's enjoyment, knowledge, I think it's more than passing the time, yes it's not just about passing the time*" (person learning to use an i-pad).

Reaching out to those less inclined towards learning is a challenge particularly in relation to equality of access for many marginalised group (Soulsby, 2014). The literature documents that both prior qualifications and wealth are strong determinants of learning in later life

(Jenkins and Mostafa, 2012). This was evidenced in the backgrounds of those older people who more readily took up opportunities with L4A. We found L4A very successful however in generating learning partnerships with people experiencing substantial issues with health and disability including cognitive decline. This may be explained by the approach offered which provided greater flexibility by tailoring learning from the starting point determined by each individual's needs and abilities. This is significant given that participation in learning tends to reduce with age (Jenkins and Mostafa, 2012; Hughes and Aldridge, 2013).

Learning mentors were trained to use a reflective model in their approach which facilitated a more person centred intervention and encouraged the potential for deeper learning. Learning mentors were also able to work flexibly when there was a 'crisis' – when perhaps the older person wasn't able to engage in a planned activity because of illness or a family matter. This was not seen as a barrier but often resulted in the learning mentor adjusting their interventions and being proactive in responding to the older person's situation. This illustrated another difference between 'learning' and 'activities'. This opportunity to share personal circumstances was particularly valued and enhanced the relationship between the older person and their learning mentor which Carr (2012) has described as being central to relationship based practice, continuity and dignity in care.

We drew out some powerful examples of how individual participants responded or perceived their learning experiences by drilling down to the impact of the activities they were involved with, with their learning mentors. There was evidence that 'learning' was going on, that 'learners' were making progress and clear identification of not only new skills and knowledge gained but a growing sense of confidence alongside these. Table 2 illustrates how we were able to categorise different experiences that could be conceptualised as 'learning' from the data using broad descriptors:

Table 2 Emergent categories of 'learning'

Learning types	**Examples**
Acquired learning	New skills for painting, navigating the internet, using an iPad
Application of learning	Investigating health conditions, trying out new knowledge to promote own activity and health or mental wellbeing
Motivational learning	Discussing current affairs; Sharing views with external world; connecting own experiences with others coming in
Cognitive stimulation (also seen as prevention)	Exploring new literature; structured reading; structured discussion;
Affective learning	The process of engaging in arts based activities and feeling good as a result
Reflective and self-learning	Reflecting on life events through reminiscence, using films, biography and storytelling. Learning about 'self' in later life and how to navigate, understand transitions.
Learning to support independence or survival	Making new relationships; maintaining social contacts; doing online shopping; digital inclusion
Cultural learning and 'generativity' (Erikson, 1950)	Building relationships about different cultures; connecting with people from diverse backgrounds such as age, culture and ethnicity.

Older people made many references to how these types of interventions made a significant difference echoing research findings that informal types of learning have a positive impact on wellbeing (Soulsby, 2014). Individuals particularly expressed intrinsic enjoyment of learning by being exposed to different subjects, and the 'feel-good' factors stimulated by opportunities for interacting with others similarly motivated. People often appreciated 'learning' because it helped them to be receptive to new ideas, to improve understanding and maintain a positive outlook as well as give expression to other discontents. There was overwhelming evidence on how the interventions they experience enhanced and enriched their everyday lives:

"*I look forward all week to her coming. Life here is unstimulating...I call her 'my sanity'; it saves me from being down in the dumps a lot or thinking am I going to get like everybody else. I'm very, very fortunate that I've got V.*" (Care home resident)

"[the learning mentor] is going to help me with the computer but first he wants to get to know me... The getting to know you business is going really well. He's most excellent. It's a lot of fun". (Male care home resident)

An unrecognised benefit of the partnership to the older person was being able to confide in someone not directly involved in their care or situation. Individuals also sometimes relied on the learning mentor for informal support and advice given that they were not directly involved in any decision making processes. Both sides of the partnership described situations where having a non-judgemental listening ear within the context of a personal relationship, brought a more person-centred perspective to their experiences of living in care. Francis (2013) recognised safeguarding and alerting as an important function of the Third Sector particularly in relation to how advocacy and the promotion of dignity and safety for users of care services are supported. We found that where there was a quality issue that concerned the older person, the learning mentor demonstrated potential for greater tenacity in getting it

sorted (whereas this was not always the case with care staff). This had a positive effect on the potential success of local safeguarding policies.

The benefits of giving: reciprocity in learning exchange

Within the learning partnerships, opportunities for co-learning were also illustrated (see case study 1 below)

Scenario 1

Florence is 89 and losing her sight. Frustrated by this she thought L4A would offer a chance for stimulating conversation. She is not local but came to look after her mother and remained in the area. A strong teaching career in higher education had left her with a love of working with young people. With almost no other family and her friends limited to ex colleagues and a church group, the care home seemed ideal as it provided activities. Shocked at the level of care other residents required, Florence realised that she missed intellectual conversation about culture and the social and political world which she had been used to. Florence received befriending help from a retired nurse, who gave her regular company and trips out, and she took part in group activities led by the enthusiastic young woman in charge of 'activities'. Something was missing in her life, though, and talking it over with the L4A staff she realised it was the company of young people engaged in learning, particularly young people from other cultures and countries. L4A found Florence a learning mentor who was a shy Korean student, 'Annie', who was studying international development at the university. The student was missing her family and she needed to improve her English. When they first met Florence realised how shy Annie was so immediately adopted her old teaching style, asking many questions about Annie herself and her country, her family and her studies. Annie blossomed in the relationship and began bringing Japanese artefacts for Florence to feel, telling her about her homesickness

and her studies. Florence describes their relationship as very special and uplifting. 'I look forward to Annie's visits all week' she says. Annie has never missed a session in a year of visits and although both know the sessions will end, Annie is delighted to have found someone she can talk to 'like my grandmother, who I miss'. Each is learning about the other, their work, their world and their everyday activities.

In the work of L4A, participants described their sense of wellbeing through expressions of reciprocity, which was more pronounced where the older person experienced some sort of exchange in their relationships with learning mentors. Learning mentors similarly identified mutual benefits gained from the relationship. Many commented on how generativity in learning partnerships diverted the older person's preoccupation away from their own personal needs, comforts and concerns. Both the learning mentors and the older person actively reflected on how working with someone from a different generation had given them a new perspective on the other person's experience, expertise and to feel they each brought something different and made an active contribution to what was a new relationship which also required effort. We noted that the concept of 'youth' was particularly emphasised by older people, as this is noticeably missing in their experience of living in care homes – or, if they are socially isolated, in their own homes. Dealing with loss, an often unacknowledged undercurrent in care settings, came up regularly as an issue for discussion in both sides of the learning partnership. For example, learning mentors referred to the 'payback' they felt where the older person's situation connected with their own personal story. Younger learning mentors also referred to achieving feelings of empathy and personal growth, all of which contributed to their motivation and thus their own wellbeing and how these themes could be exploited further.

The benefits to learning mentors were an unintended consequence of L4A's work. Learning mentors reported making new life choices, gaining employability skills and particularly

described the relationship between motives for volunteering and satisfaction with some examples of longer term relationships and benefits after they moved on. They described changes in career intentions, course intentions, changed family behaviours, changed work behaviours, and made reflective comments on end of life experiences that were clearly life changing thus making direct links between altruism and reciprocity.

Learning as a tool for reflecting and building resilience

L4A was found likely to have greater impact; where there was a positive and supportive culture that recognised the need for organised activities. In Site 1, some of the residents interviewed actually said they were too busy to fit the evaluation team in, which is a striking contrast to the stereotype of older people living in care. There were some examples where residents played a more active role in challenging the system from within the home and articulated strong desires for autonomy and decision making. For example, in order to overcome what were seen as 'dull days' and to generate some more enthusiasm from less active or motivated peers, two residents set themselves up as a resource for learning by initiating a discussion group about their lives in a care home.

It is conceptually difficult to measure both the impact of a learning intervention and to be sure of its quality. Matching with the right learning mentor was crucial to facilitate rapport but if done carefully can bring out a dormant or latent interest in the older person as well as a sense of fulfilling an ambition not yet achieved or desired in order to explore an interest. Examples of informal learning included exploring Chinese history for one woman who had had relatives in Hong Kong but regretted never being able to visit. 'Keeping the mind active' was often cited as a preventative measure against dementia which most participants feared. Where the older person did not always 'feel up to it' (learning) – or felt frustrated about being able to get back to an activity previously enjoyed before they became unwell,

they talked about feeling tense. This however stimulated motivation. Mastering something was also associated with giving a 'boost' to physical health as well as a psychologically. In a couple of situations, this was seen as an opportunity to optimise health so that health was seen as a fuel for learning and vice versa:

"I'm convinced that if I can master this, it will give me a boost, a boost I need to get better again……I've got in my head the idea, if I attack something like this, and if you are successful in doing it, it will encourage other people in doing things. If you can get people to have a go where they don't think they can do it…" (learner living in a care home and confronting life-threatening illness).

This older man articulated what we understood to be a 'dose' effect of learning where the strength of his perceived wellbeing was perceived to be commensurate with the number of learning activities he was still able to do.

Within domiciliary partnerships, one of the most striking findings was the value that older people place on the benefits and independence of learning IT skills We observed particular tenacity in trying to remain digitally connected and frustration with the many obstacles associated with 'keeping up' with technology in the face of changes in physical or cognitive abilities. Support in using technology made the availability of help and support a factor of paramount importance to sustaining digital connection; a vehicle to challenge or impress the younger people in their networks with their abilities to keep in touch via technology. Being IT literate was therefore another great leveller between generations in this respect. For three people, L4A bridged gaps and provided continuity when the individual's mobility was affected and they were no longer able to get to IT sessions at their local library or voluntary organisation. Referrals for domiciliary learning partnerships mostly resulted from L4A's outreach work as well as direct referrals from social workers and sheltered schemes. For one

couple described in the case study below, learning activities offered a real alternative to traditional carer relief, with added benefits for both of them and illustrates the potential of what is known as 'social prescribing'.

Scenario 2

Mary and Patrick, an Irish couple, live in their own home. Mary had had a career as a factory machinist and purposely took up a lot of new activities and interests when she retired to compensate for her lack of time for these in her working life. In the last year, Mary developed problems with her short term memory and general physical co-ordination. Having a good insight into her situation has resulted in poor mood with frequent tearful episodes and expressions of feelings of uselessness. This is contributing to an increasing underlying depression as she becomes more anxious about her future. Mary was referred to social services by her GP and they put her in touch with L4A. Through the last few weeks, Mary has enjoyed the opportunity to refocus on those skills and activities that she had previously enjoyed but had not been able to motivate herself to. After gaining her confidence and trust, the L4A worker was able to get Mary to spend some quality time on painting and exploring new areas of craft work in order to think about what would be the best match between her interests and that of a learning mentor. Observing this process has generated trust from Patrick, Mary's main carer. These opportunities have also helped her concentrate on improving her fine motor skills and her frequent bouts of tearfulness are gradually subsiding. Mary pays £8 a session which can last between 30 minutes and 2 hours depending on how Mary is feeling on the day. This is considered to be good value not only for the activity itself but the opportunity given to Patrick to go out and play bowls with his friends with peace of mind, "it's lightened the burden on me as such". Mary particularly commented on the feel good factor that she got from knowing that she wasn't stopping Patrick from being stuck with her and was particularly focused on the importance

for her to be able to "being able to be with another woman", which she thought was important for her own identity and sense of agency.

Findings from the data informing quality at the meso level

Integrating learning into a care pathway, such as in dementia care, by primary care or social work highlights how different types of provision can strengthen the links between community-based providers around wellbeing. Social prescribing (CSIP, undated) has been described as:

"…primary care-based projects that refer at-risk or vulnerable patients to a specific programme: for example, exercise, learning, and arts on prescription. However, it also includes a very wide range of initiatives in which primary or secondary care provide a signposting or gateway service, linking patients with sources of information and support within the community and voluntary sector".

In relation to the above example; the broader, holistic framework evident in social prescribing with its emphasis on personal experiences, relationships and social conditions is well illustrated. GPs' commissioning of more holistic approaches in dementia care are now well documented in the literature (Acton et al, 2007). Social prescribing or referral schemes are often reliant on a worker based in primary care to facilitate referrals and joint working, a process developed by NIACE in 2000 (James, 2001). Connecting learning opportunities with domiciliary support at an earlier stage can support transitions where the older person is struggling to cope with change.

Whilst the relationship between learning interventions and wellbeing in this evaluation was self-reported, the unique way in which these were tailored for an individual, combined with the relationship and subsequent support offered, all provided tangible evidence of this

association. Definitions of wellbeing often emphasise physical health rather than feel good or more subjective factors (Maynard et al, 2008). One care home manager listed a number of organisational benefits, such as securing a Royal visit, improving reputation; encouragement to go in for recognition awards in the care sector; attention by the local press; enhanced profile in their group of care homes; use of equipment provided; the benefits of older people being able to connect to their relatives through technology; something different to be able to put in the brochure; a way to get something more from their commissioners contract; improved CQC ratings; always having someone there to respond to queries and commitment from L4A staff and volunteers. Another manager stated:

"They get the chance to learn a skill, it's like the bucket list, it's probably something they wanted to do for most of their lives and never got round to doing it, like for K-, you've only got to speak to K-, the benefit he's got from learning……"

The funding of learning interventions within care homes was not something that older participants were aware of as most did not pay directly. This raised the problematic issue of top ups and limitations when thinking about how to fund additional interventions. As illustrated here, it also highlights growing division between self-funders and those reliant on state funding within residential care in relation to how far they can access opportunities such as those offered by L4A essential to quality support, wellbeing and being heard. Costing of different methods for how learning activities could be funded are important given that access to additional resources in the context of rising cost of residential/nursing care and the means testing of personal income affects accessibility and equity. Overall the learning interventions were potentially low-cost, high impact interventions subsidised by the residential settings. However in Site 3, where there was hardly any activities going on, L4A were managing to "keep their foot in the door" even where their costs were not always completely covered as it was recognised by the home staff and its managers that they provided a lifeline for some

residents where the owners of the care home were reluctant to resource activities adequately. When asked to give their activities a monetary value, older individuals drew on comparators; indicated willingness to fund themselves where possible; or referred to trade-offs where their craftwork could be sold within the care homes fundraising activities in a quid pro quo arrangement. L4A also operated a voucher scheme where a set of learning activities could be gifted by relatives and friends for special occasions. This helped them feel that they could contribute something tangible and this eased their sense of helplessness when their loved one went into care. Within domiciliary settings older people also pooled their resources by making an individual contribution to the overall fee for a regular group activity in shared arrangement such as sheltered accommodation, or through advanced purchase using the voucher scheme to fund a set group of individual sessions with a specific goal in mind.

Recommendations from the evaluation were made about supporting mentors to improve the quality of what they do through improved team work, peer supervision, more reflective co-recording of outcomes and a tailored training programme. Some learning mentors found themselves in the role of 'alerter' in their relationships with older people and needed the opportunity to talk about matters which would not necessarily be immediately shared with care staff whilst visiting the care settings. The importance of having a visible co-ordinator that visited the care home regularly and able to develop a relationship with the care home manager to give formal feedback and respond to the homes priorities through the service proved very powerful. In short learning mentors formed potentially significant safety-nets for safeguarding practice given their 'independent authority'.

Reflecting on the overall findings from a macro perspective

This paper makes a case for introducing learning interventions within care settings to promote participation, advocacy and relationship base care which in turn helps to create a

positive organisational culture (Burtney et al, 2014). Given current challenges to quality improvement, using a learning paradigm may encourage the retention of independence, as care homes move towards a person-centred approach. This evaluation identified that whilst regulation and inspection are important to promote quality, some processes can create tension in the workplace and stifle creativity. Building opportunities for participation and advocacy into daily life provides both an individual and collective voice for groups of people with shared interests. It also helps to express issues around poor practice through a trusted relationship. Working closely with the wider community to address collective as well as individual concerns can support an asset based approach and a more egalitarian view of care spaces away from hierarchical domains and towards a 'work-with' rather than a 'work-for' attitude.

Co-learning experiences were able to facilitate accessible, appropriate and high quality information which older people used to make decisions and play a part in the community or network which can be virtual, physical, intellectual as well as practical. The role of learning mentors provided a circle of support where reciprocity and mutual interests promoted wellbeing and which promoted service user literacy in different areas, fundamental to their fuller engagement. Further, care homes need to diversify in cultural and operational changes in the face of significant financial and social pressures and the approach of L4A is one which not only raised expectations but addressed standards set by stakeholders – (commissioners; regulators and providers of support services). Further, at a local level the involvement of outsiders as potential alerters of safeguarding provided the organisation with evidence to identify good practice and to address difficult issues which were raised through the vehicle of the learning partnership, in a more proactive way.

There are limitations around the funding and resourcing of learning opportunities for both commissioners and providers within their mission to achieving more integrated experience of

person-centred care. It was also acknowledged by the regulator that incentives for such schemes are challenging given that care homes are required to be compliant rather than meeting stretch criteria and the development of any accreditation schemes which incentivise examples of quality improvement such as this one are still difficult to achieve and measure. There is also a need to train the workforce in a socio-health-social care integrated model of practice with older people so that a more sustainable approach is achieved, given its low status and churn. This evaluation helps to clarify what we mean by interprofessional collaboration by recognising the value of learning in different care contexts. Creative use of the environment to bring forming groups to reflect interests, creating common links that start conversations in more diverse areas, support self-determination, fun and community bonding between employees, service users and the community can promote social connectedness in low cost ways. Given that L4A worked in 15 care homes which were diverse in their funding, structure and CQC ratings, the potential for developing a model which can adapt to individual care homes was considered to be highly probable if leadership is present both in the community and care settings concerned.

Recommendations

We have pulled out some tentative recommendations to consider in a strategy to improve quality improvement in care settings using a learning approach:

- It may be useful to build into the process of assessment of care needs and during the admissions to care, the taking of a learning history. This will help to focus on the strengths and needs of the older people who are making a key transition in later life. The knowledge from these histories can then be drawn upon to develop strategies around promoting formal and informal learning which aim at helping people to have

more control in their care environments and to develop or maintain their skills and knowledge or use these for the benefit of others.

- Care home managers can develop partnerships with the local community which involve volunteer learners or recruit people with particular skills, so that they can come into the care environment feeling they have a skill to offer and exchange. This provides a stronger basis for developing more reciprocal relationships and providing extra stimulation to the day-to-day environment.
- Care home managers can also revisit programmes of activities in care settings and refocus on more purposeful learning activities that reflect the genuine interests and needs of residents.
- For those responsible for commissioning care, giving attention to how interdisciplinary partnerships might feature learning in assessment, interventions or the development of future care provision will help to recognise and embed more co-productive approaches to community support. There may be merit in commissioning some cost-benefit analysis of any new ways of working such as by evaluating the outcomes of social prescribing or service user education programmes. The introduction of voucher schemes to share and control costs of learning interventions or to offer short programmes which target particular issues is one way of funding these activities and to provide frameworks where the outcomes can be measured and evaluated. This can also build an evidence base to inform future commissioning plans and to stimulate the sector to develop person-centred approaches.

- Finally, being inclusive in any approach that considers learning opportunities for those people with conditions who on the surface may not seem amenable to learning such as those with cognitive decline or sensory impairments. Utilising the evidence of approaches which use informal learning or an arts based approach can provide stimulation

to develop more supportive and more sustainable relationships between those working to provide a high quality of care.

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