Age Alliance Wales
Intermediate Care Fund
Identifying Outcomes

In December 2013, the Welsh Government announced the establishment of the Intermediate Care Fund (ICF) which aimed to provide *"a real opportunity to build on effective working across health, social services and housing to improve the planning and provision of more integrated services."*[1]

Age Alliance Wales (AAW) has carried out a review and collated evidence that clearly shows that ICF projects are making a difference. Between August 2014 and December 2015, 7 Age Alliance Wales organisations worked with partners to support 13,054 older people across Wales to access preventative services. The projects operated in 19 local authorities, all 6 health boards, and actively involved 44 public and voluntary organisations. This does not include any organisations that become involved via referral or signposting.

All the projects cited in this report involve collaborative working between voluntary and public sectors and illustrate how well designed, tailored interventions can have a big impact on the quality of life of older people. They also demonstrate a shift away from working in silos towards achieving the goal of a seamless, integrated service that works with individuals to identify their own goals and ultimately to empower them to manage their own care.

Perceptions of the third sector are changing; local authorities and local health boards are becoming increasingly aware that the third sector is key a partner in supporting people to age well, cope better with illness and remain independent. Age Cymru Swansea Bay and Care & Repair Cymru have noticed an increase in referrals to their services as a result of the ICF.

All projects cited in this report can be termed preventative even though they provide support for older people at different stages of their lives or illness. For example, Stroke Cafés and Sensory Loss Workers provide support for older people in hospital settings or who are recovering from a serious illness. In contrast, Age Cymru Gwynedd's Living Well Centres provide a flexible community based service for older people to access preventative services at an earlier stage and thereby delay the onset of illness of depression.

In the face of current public sector cuts, enabling citizens to take advantage of and capitalise on available community assets is vital. Age Alliance Wales organisations deliver services that are agile and responsive to need and are well placed to support older people to identify and achieve their personal goals by capitalising on community assets. The value of this approach should not be underestimated.

Creating a more joined up approach between housing, health and social care is vital to ensure that any gaps in the provision of care do not lead to the worsening of a condition or

[1] Welsh Government Written Statement on Intermediate Care Fund. Available @ http://wales.gov.uk/about/cabinet/cabinetstatements/2013/8284299/?lang=en

illness. Older people must be able to access a seamless service that ensures relevant information and advice is easily available when needed. Collectively AAW organisations are very well placed to provide community-based, integrated services tailored to meet an older person's health, housing and social care needs.

AAW was pleased to hear that the Welsh Government is to make additional funding available to take forward projects funded by the ICF. We believe that mainstreaming successful ICF projects will have a tangible and measurable effect, most importantly on the lives of older people, but ultimately, will reduce pressure on hospital wards and A&E departments across Wales.

Age Alliance Wales is currently working to develop sustainable partnerships within the third sector and across statutory services to ensure the successful delivery of ICF projects.

Age Connects Wales

Voluntary Sector Broker Service - Vale of Glamorgan's Contact Centre.

The ICF funded a full time post to further develop a successful pilot in 2014/15 with the primary aim of keeping older people independent, engaged with community support and prevent unnecessary admissions to hospital. The Service works proactively with the Vale Contact Centre and the Glamorgan Voluntary Service (GVS) team to ensure that information on Third Sector provision is readily accessible to relevant professionals and to broker the service provision in response to identified needs.

Outcomes

There were 101 referrals between June & November 2015 with 65% originating from the Vale Information Service (C1V, Social Services and integrated daily triage). Of the 101 referrals 64 were successfully passed on to for Third Sector support including other Age Connects services. In a survey of stakeholders from C1V and GVS 50% said they had been able to divert demand for statutory services to voluntary sector and 100% said it was a "valuable service".

Hospital Discharge Service – Community Resource Team/FOPAL

This short term pilot, January to March 2016, will see the Liaison Officer in the Emergency Unit at UHW post increase to 5 days a week building on the existing relationship with health professionals in the EU particularly the FOPAL team. By having direct access to the additional resource within the main HDS it is anticipated that at least 1 patient a day could be escorted home before a referral to the main service or CRT is made depending on individual need.

Outcomes

Data not yet available as project is still in pilot stage.

Hospital Discharge Service – Discharge Support Officers

The Age Connects Discharge Support Officers are part of the Integrated Discharge Service located in both the University Hospital of Wales (UHB) and University Hospital Llandough. They can assist older people and their families needing additional support on discharge from hospital to any setting including care homes. This short term pilot, January to March 2016, will see an increase in capacity by 21 hours.

Outcomes

Data not yet available as project is still in pilot stage.

Community Navigator Corwen

The Denbighshire Community Navigator Pilot running in Corwen through Age Connects North Wales Central is currently in its final phase. Initially funding through the ICF stream and then later by Denbighshire County Council, the project provided a platform to work with older people in Corwen and the surrounding area so that they will receive the support they need and want to allow them to remain in their own homes, living independently, with the right levels of natural and statutory support, for as long as possible. We aimed to do this by:

- Working with local older people to map out the support available to support them to achieve their aspirations and goals for remaining independent and for being fully involved in their communities, (including recognising the assets they may bring to their community).
- Fully exploring the use of natural forms of local support and resources available within communities such as a person's own family, friends and local community groups.
- Providing routes to access for specific health and social care provision that are required by the individual to complete their rehabilitation / reablement journey.
- Promoting a personal staying healthy agenda.
- Being person centred, tailored and holistic.

To date 40 residents have accessed the service with a range of issues from money matters to social isolation. The project clearly encapsulates the ICF focus on prevention, rehabilitation, reablement and recovery.

Age Cymru Gwynedd

Living Well

The aim of the project is to create a flexible community based service for older people to access early preventative services. Key to this approach is the provision of socialising opportunities to reduce the impact of loneliness and isolation which research has linked to the

onset of ill health and depression. The project also acts as a practical model of Public Health Wales' 5 Ways to Wellbeing.

The centres also provide the following:

- Community based hospital discharge support.
- A community based Information, advice and advocacy service to improve local access.
- An opportunity to empower older people to shape and develop the local services that they access.
- Support for carers and older people's families.

Outcomes

Centres have opened in 4 rural locations and during the three months the scheme has been in operation, the centres have been accessed by 113 older people.

Age Cymru Gwent

Project 1: Extended Hospital Service (EHS) in Newport, Caerphilly, Torfaen, Monmouthshire, Blaenau Gwent

The Extended Hospital Discharge Support Services (EHS) enable older people to fully recover from their illness by providing them with appropriate support to re-engage with their community. The services are designed to follow on from the six week hospital discharge support service.

Outcomes

Older people have been supported in their homes to rebuild their strength and gain confidence. Primarily support was provided for tasks such as preparing meals, undertaking light household duties and shopping until the older person felt able to continue themselves.

Initially some people were also escorted to appointments with GPs, dentists, hospital consultants and opticians. Others were assisted to organise transport for themselves.

Referrals were made to Care & Repair, the Alzheimer's Society, Newport City Council, community occupational therapists and various community groups. A few people were introduced to dancing classes, gym sessions and voluntary work.

The service has had a positive impact on the lives of the people who were referred during this short period. They have been supported to gain confidence and achieve their goals. This has not only improved their mental and physical wellbeing but enhanced their quality of life.

Between October – January 2015, 170 older people have received intensive support to enable them to remain independent at home.

Monmouthshire Extended Hospital Discharge Service

Mr D, 73, was referred to the EHS by the hospital's discharge service (HDS) following total hip replacement surgery. Age Cymru Monmouthshire was asked to assist with shopping support, bill paying and a benefit check. The HDS had found

that Mr D's home was very cluttered with papers, food and other various discarded items; there was only one chair that he could sit on.

The support worker soon discovered that this was a great embarrassment to Mr D and that it was also a major health and safety hazard as he was not able to use his zimmer frame or even a walking stick safely.

Mr D's partner had died two years previously and he felt that nothing was worthwhile anymore, so had stopped cleaning and left rubbish where it fell. Previously, Mr D had been active in the local church and friends would come and visit him, but since his home had become so dirty and cluttered he decided that he could not let his friends see how he was living. Consequently he decided to cut all ties with the church and his friends.

When the HDS support worker had completed his support plan, it was evident that he did have realistic goals that he wanted to achieve. He was transferred to the EHS service for a comprehensive risk assessment of the home environment. Following this a number of realistic goals were identified:

1. To de clutter home and to be able to manage his home independently.
2. To drive car again.
3. To shop independently.
4. To re engage with the local community.

All goals were achieved in the following ways:

- **Goal 1 -** following an intense period of support, the client slowly began to discard rubbish himself and began to take an interest in his home; when the support worker pulled out he was still having help with the clutter and was becoming more independent.
- **Goal 2 –** Mr D owned a car that he had not used for a very long time; the support worker helped him to ensure that the car was made roadworthy and then accompanied him on his drive to the local shops. Following this Mr D's confidence improved and he became independent with his shopping.
- **Goal 3 -** the client then informed the support worker that he was confident enough to drive and be independent.
- **Goal 4 -** the next goal was to re engage with the community so the support worker informed him of local clubs that may be suitable. The support worker accompanied Mr D to the first club meeting to offer him support; he enjoyed the club and has continued to attend each week.

On the 6 week review the support worker advised the client of a local businessman who was hosting a Christmas Day lunch with entertainment for people with no family. Mr D attended and really enjoyed the day. This case study demonstrates that with intense support and confidence building this client achieved all his goals and became independent.

Re established Hospital Discharge Service to people 50+ who do not meet the criteria for Intermediate Care Services in Torfaen.

This service was designed for people aged over 50 who did not meet the criteria for Intermediate Care Services in Torfaen. These people would have received no other support at home without this service. Support provided included shopping; referrals for personal care and occupational therapy; assistance to establish lifelines, telecare and smoke alarms; escorts to GP/hospital appointments; assistance with bill payments, referrals to Care & Repair for adaptations to the home and referrals to advocacy and befriending services.

Outcomes

These measures enabled people to regain their independence and prevented them from being readmitted to hospital due to a lack of support at home. Support workers also successfully applied for Attendance Allowance for 7 people, pension credit for 1 and Blue Badges for 4.

Between October 2014 - January 2015, 93 older people received support in their homes following discharge from hospital.

Older Persons Pathway Pilot

Age Cymru Gwent worked as part of an integrated team focussing on one GP surgery in Newport in order to identify older people in the 85+ age group who may require assistance at home. Some people were then contacted by the Age Cymru Gwent Care Facilitator who noted any issues or care needs. If an individual required medical intervention or personal care, a referral was made to the Intermediate Care Team and a relevant professional such as a nurse, occupational therapist or physiotherapist was allocated.

If the person's needs were of a social nature, support workers from the Extended Hospital Service would visit and provide a range of interventions, such as referrals to Care & Repair for aids and adaptations, assistance with shopping, welfare benefit checks, and referrals to the Alzheimers Society.

Outcomes

During the period August 2014 – January 2015, over 344 visits have been made to the patients in this surgery and feedback has been positive.

The amount of income generated for these patients by welfare benefit applications is £77,600.

Age Cymru Swansea Bay

Extension of service supporting older people aged 50+ upon discharge from hospital – established 2001

This existing service works closely with the Swansea Community Resource Team, and until November 2014 was based within their service. Age Cymru Swansea Bay provided low level support for this team by providing a meal preparation visit during the week. The ICF funding has enabled this service to be extended to operate 7 days a week. This has been of particular

use across the winter period. The hours of some staff have also increased during the 5 day working week to allow more support to be given to those at risk clients or those who visit their GP or A&E regularly.

Outcomes

Age Cymru Swansea Bay has noticed an increase in referrals into the service as a result of the ICF monies coming into Health and Social Services within Swansea. This has enabled different models to be set up and as a result, more work is being allocated the third sector, who are viewed by the ABMU as a very important partner in this work.

Age Cymru Pembrokeshire

Pivot Pembrokeshire

This is a collaborative project involving the following 6 third sector organisations: Age Cymru Pembrokeshire, British Red Cross, Pembrokeshire Association of Community Transport Organisations, Pembrokeshire Association of Voluntary Services, Pembrokeshire Care & Repair and Royal Voluntary Service

The project aims to achieve the following:

- To develop a more collaborative model to harness the potential of the third sector and integrate current services to support statutory rehabilitation and reablement services.
- To build on the services already in place in order to provide a more integrated, flexible and responsive service.
- To provide safe and well type initiatives following a period of reablement.
- To connect and develop community transport schemes.

Outcomes

- The PIVOT project has brought together a range of voluntary organisations to provide an integrated service that reduces statutory input within the hospital and community setting. Unscheduled admissions have been avoided through the provision of an enhanced transport and assessment / low level service facilitation / provision service.
- Demand for existing services such as the Age Cymru Pembrokeshire Hospital Discharge Service (ACP HDS) has increased with referrers using the PIVOT number for a range of enquiries that have then been passed to the relevant organisation.
- The Care & Repair Rapid Response Handyman Service has reduced the risk of falls; British Red Cross has provided confidence building support; Age Cymru Pembrokeshire has provided information and advice, befriending, carers' support and welfare benefits advice.
- The community transport service has ensured that service users are settled within their home following discharge from hospital and have essential groceries. The older person has then been linked to a home visiting support service which has greatly reduced the risk of unscheduled admissions and immediate readmissions.

Between July 2014 – 31 December 2014, **155 referrals for people aged 50+ have been received**. **Of these, 27 people have been provided with transport only; 111 people have been provided with assessment only; 17 people have been provided with transport and**

assessment and 4 safeguarding referrals have been passed to the Adult Protection team.

British Red Cross in Wales

Torfaen Telecare Project

Working alongside the existing Torfaen Assistive Technology Department, the assistive technology support assessor (ATSA) employed by Red Cross, takes referrals for the 'just checking' kits from the lead Telecare/Telehealth Assessor. Following referral, the ATSA completes an initial assessment before fitting the equipment and providing on-going monitoring to measure the impact of the equipment fitted. The findings are then reported back to the lead Telecare/Telehealth Assessor. The main intended outcomes of the project are:

- To build Assistive Technology into the Frailty Tool Kit by using equipment that is put in place for time bound intervention, easy to put in place and to take out and which can provide information to care professionals and to families
- To use Telehealth and Telecare equipment as a mechanism whereby an individual's care needs can be monitored. Telecare can be very useful in assessment to determine patterns of behaviour and to help target when care intervention may be best.

Outcomes

Between October and December 2014, 76 service users have been assessed and had 'Just Checking Kits' installed into their homes. Monitoring the kits has enabled the care needs of these individuals to be assessed thereby ensuring that the most relevant and effective package of care is put in place.

RCT Community Support Service

The community support service aims to help people aged over 65 and living in RCT to cope with the challenges of aging and reduce levels of loneliness and isolation. Individuals are supported to identify their personal goals and the areas of daily living that they find challenging. The older person receives person centred support from a dedicated volunteer/support worker for a period of up to 12 weeks to work towards realising the goals set out in their action plan.

Outcomes:

- Reduced social isolation.
- Improved health/wellbeing and quality of life.
- Improved awareness and confidence to access local support services.
- Improved community cohesion through individuals being assisted to become more involved in their local communities.
- Improved engagement and participation of vulnerable individuals within RCT.
- Increased numbers of individuals supported to be discharged from hospital.

- Increased numbers of individuals prevented from unnecessary hospital admission.
- Volunteering and skills/learning opportunities offered to 4 individuals residing within RCT.

The service, which became operational in October 2014, had a target number of 50 older people to be supported by the end of March 2015. Up to the end of December, 34 individuals have already been assisted by the service.

Gwynedd Arfon

The Red Cross Gwynedd (Arfon area) project offers an integrated package of support for up to six weeks that encompasses practical and emotional support, confidence building, the provision of information and signposting and onward referral to other agencies where the need for long term support is identified. Transport and mobility aids are provided to assist with the resettlement and rehabilitation of the older person.

Outcomes

Since November 2014, the service has delivered the following outcomes:

- Facilitated earlier hospital discharge and enabled individuals to return to their own home setting safely once clinical needs have been met.
- Reduced the risk of readmission by identifying the support needs of the individual and assisting them to put support services in place that will enable them to maintain their independence and live safely at home.

The scheme became operational in November 2014 and in its first month provided support to six individuals enabling them to be discharged in a timely manner.

Flintshire Reablement Service

A Red Cross reablement support worker is based in the Flintshire Multi-disciplinary Reablement Team and coordinates referrals from the team to Red Cross. Red Cross then provide a six week package of support which is aligned with the six week programme of support provided by the hospital reablement team.

The support provided is tailored to the specific needs of the individual but the goal is to enable them to be able to maintain their independence, live safely at home and have an improved quality of life.

Outcomes

- To avoid older people being admitted to hospital for social rather than medical reasons.
- To reduce the number of 'revolving door' service users that present to the reablement team by working with these individuals to identify the main reasons why they regularly present and support them to find solutions for those reasons.

PIVOT Service

PIVOT is a collaborative initiative delivered by Red Cross, Age Cymru Pembrokeshire, RVS and PACTO and Care & Repair. The service runs seven days a week from 9am to 10pm and

aims to prevent unnecessary hospital admission for individuals who have presented at A&E and for whom hospital admission would be more for social rather than medical reasons.

PIVOT comprises of three elements; transport home from hospital (provided by PACTO and RVS); out of hours small adaptations and home safety checks (provided by Care & Repair); rapid assessment and provision of low level support to resettle the older person back into their home environment (provided by Red Cross & Age Cymru Pembrokeshire).

PIVOT support can be provided for up to six weeks. Where on-going needs are identified, the older person is assisted to access other support services available within their local community.

Outcomes

- To prevent unnecessary and unscheduled hospital admission for older individuals attending A&E.
- To reduce the risk of readmission for individuals who have returned home following attendance at A&E through the provision of low level support, information, signposting and onward referral to other agencies

Between August 2014 and December 2014, the Red Cross PIVOT support workers have provided support to 111 individuals and in doing so avoided their unnecessary admission into hospital.

Morriston A&E Supported Discharge Service

£20,000 of ICF funding was secured to fund the Red Cross Morriston A&E Supported Discharge Service from July to September 2014. Red Cross has a presence within the A&E department at Morriston Hospital seven days a week to provide emotional and practical support to patients who are awaiting and or receiving treatment within the department.

The service provides transport and resettlement support at home for individuals whose clinical needs have been met but who have been identified as having low level support needs that, if unmet, may lead to unnecessary hospital admission.

For individuals receiving resettlement support at home, a full assessment is undertaken and, where on-going support needs are identified, the individual is referred onto other community services.

Outcomes

- To provide a positive patient experience at Morriston Emergency Department. For those patients who receive clinical care, to improve the likelihood of a swift recovery and improved well being.
- To provide transport and resettlement support at home; improve patient flow through A&E; facilitate safer discharge and reduce time as an inpatient.
- To reduce the number of patients that regularly attend A&E by working with these individuals to address the issues that cause this level of attendance.

Neath Port Talbot Home from Hospital Service

ICF funding enabled the existing Red Cross home from hospital service to extend its hours of operation from 9-5, five days a week to 9-9, seven days a week.

This service, which is registered with CSSIW, provides practical, emotional and personal care support, confidence building and information provision with the aim of supporting the service user to address their physical and emotional needs while recuperating at home following a stay in hospital.

The main outcomes achieved for individuals supported to date include:

- Rapid short term support has enabled the older people assisted to be discharged from hospital and convalesce at home.
- Short term support has ensured a safe hospital discharge while other intermediate care services are put in place.
- Reduced risk of readmission to hospital for people assisted with personal care, practical and emotional support.
- Greater resilience to remain living independently within their own homes through the provision of Red Cross tenancy support.

Between October and December 2014, 43 individuals, many of whom had higher level support needs and required evening and weekend visits, have been supported to be safely discharged from hospital.

Wrexham Third Sector Broker

The Red Cross third sector broker role was created in August 2014 and was designed to enhance and create opportunities for the Wrexham Intermediate Care Older Persons team to utilise third sector services for statutory service users.

The aim of embedding a third sector specialist into the team is to ensure that vulnerable individuals who go through the brokerage service are made aware of and supported to access the complete suite of services available within their local communities, many of which are provided by the third sector, in order to help maintain their independence.

The role ensures that knowledge of third sector services is provided to older people in order to empower them to better maintain their own independence. The role is also having a positive impact by helping brokerage staff to better utilise and engage third sector provision to ensure the best possible outcomes are achieved for older people.

Outcomes

- To ensure that older people are supported to maintain their own independence and able to live safely at home by being provided with comprehensive and accurate information on support services and recreational/social activities available within their local community.

- Improved care co-ordination and a reduction in the number of service users admitted into care through being effectively supported in their own home setting.

The Red Cross third sector broker role has been very successful since being introduced in August and discussions are currently underway to transfer this function into the SPoA Project in Wrexham.

The table below shows the range of ICF funded projects that the British Red Cross has been involved in or led and the project outcomes:

Project	Service Users	Support Hours	Visits	Telephone calls	When Scheme Became Operational
Flintshire Reablement Service	4	26	14	18	End of November
PIVOT (Pembrokeshire)	111	422	157	310	Beginning of August
Telecare (Torfaen)	76	220	88	304	October
RCT Community Support Service	34	188	129	52	October
ICF Gwynedd Arfon	6	35	20	34	
Morriston A&E Service	1247	23	86	47	
Third Sector Broker Wrexham	32	33	33	67	August
Single Point of Access Denbighshire	54	15	10	102	June
Neath Port Talbot HFH	43	748	1341	630	
TOTAL	**1607**	**1710**	**1878**	**1564**	

Care & Repair Cymru

Rapid Response Adaptations Programme (RRAP) and RRAP Plus

The Rapid Response Adaptations Programme (RRAP) allows Care & Repair agencies to carry out minor adaptations such as ramps and handrails, to enable people to return safely to their own homes following hospital discharge. RRAP adaptations can also be used to prevent the need for admissions to hospital or subsequent transfers to residential care. The programme requires adaptations to be completed within 15 working days, although jobs can be carried out immediately, if in response to a crisis. The RRAP grant can only be used to fund minor adaptations for older homeowners or private tenants.

RRAP Plus is an extension of RRAP as it allows agencies to complete works on a cross tenure basis, therefore allowing them to provide minor adaptations in social housing properties. RRAP Plus covers works up to £500, in comparison to RRAP which is £350. Care & Repair have argued for a number of years to be able to provide RRAP on a cross tenure basis**,** as agencies support homeowners and private tenants to return home from hospital quickly and safely through the RRAP grant, however are unable to do so for social housing tenants under the current remit of funding. ICF funding has made the traditional RRAP service available to a greater number of clients and improved its capacity to respond to need.

Independent Living Grant extension (ILG)

The Independent Living Grant was piloted in 2011-12 and was managed by Care & Repair agencies across Wales. The programme helped reduce waiting lists for Disabled Facilities Grants (DFG) and the additional resources freed up authorities funding for DFG's enabling more people to be helped and sooner. A number of Care & Repair Agencies received ICF funding to continue providing ILG type works.

Working directly with hospital staff Care & Repair Caseworkers are able to coordinate home safety works and grants like ILG have provided an ability to apply the same flexibility and targeting for mid-level adaptations as that provided through RRAP. Hospital discharge services have helped prevent discharge being delayed and has therefore supported improved ward management; whilst guaranteeing older people greater safety in the home.

RRAP, RRAP Plus and ILG have all contributed to maximising independence for older people, enabling clients to remain in their own homes, safely, for longer. Carers are supported to maintain their caring role with reduced risk in terms of moving and handling. People with palliative conditions receive a quick response to their changing and urgent needs allowing them the best option for comfort and well-being during an extremely stressful time.

Hoarding service

Flintshire Care & Repair piloted a Hoarding Service in response to need from the Local Authority, Social Services and the Local Health Board. A specialist Caseworker was appointed to fully engage with all partners to assist individuals with hoarding tendencies and to provide practical help and support to redress the balance in their lives and put choice back into their control. The initiative sought to engage with health and social services in order to provide further support for people to overcome the causes of their hoarding issues and tackle the problems identified through this process.

As this project has developed it has become an example of best practice in terms of innovation, engagement with cross sector partners and the demand is evident. Benefits to clients include harm reduction, prevention of slips, trips and falls, improved mental health and well-being and reduction of demand on other local service providers. This service is another example of a Care & Repair agency providing a value for money service which maximises on relatively small investment and provides maximum outcomes for clients.

Hospital to Home

Care & Repair provides direct assistance for clients in preparation for their return home from hospital, helping to relieve pressures on hospital bed shortages and providing relief to hospital staff. Principally offering continued support for the patient/client and a better environment in which to recuperate. The Hospital to Home service facilitates partnership working with departments in the broader Health Service and referring partners, enabling the speedier facilitation of safe hospital discharge. The funding received for the Hospital to Home service has enabled Caseworkers to identify clients suitable for adaptations and housing interventions more quickly (at best from ward rounds) expediting hospital discharge, promoting prolonged independence at home and reducing the likeliness of re-admission to hospital through assessing and managing housing risks.

Outcomes

In **Conwy & Denbighshire** the number of patients supported through the discharge planning process was 59. In **Bridgend** the Hospital to Home scheme helped facilitate 428 hospital discharges and a further 46 people were supported after being discharged. In Bridgend a further 168 people were supported to be discharged through the installation of telecare equipment. In **Cardiff & Vale** 551 referrals were completed that assisted older people to safely return home from hospital and 296 were completed that assisted older people to reduce the hazards in their home that could lead to hospital admission. **RCT & Merthyr Tydfil** reported that 44% of clients were visited on the same day or the next day after the referral.

In terms of the value of outcomes against investment, Hospital to Home has proved to be a cost effective measure which relieves some of the systems pressure on the Health Service, and provides notional financial benefits to Health Boards that can redirect investment potential.

In terms of partnership working it is a valued and endorsed service and in terms of client experience older people are able to return to their homes with the peace of mind that their environment is fit for their changing needs. The service proactively supports the independence and safety of older people in their own homes and helps to reduce the need for social care services.

Healthy @ Home Project (Cardiff and the Vale)

The Healthy @ Home Casework service is a partnership project funded by ICF, working with GP surgeries to offer the Care & Repair Casework service to patients on their 75th birthday. During the visit the Caseworker can offer a range of services that may be of interest to the client now or in the future. Any work completed would then support the client to stay living at home longer and with increased safety, thus having a long term positive impact on their health and well-being.

The aim is to encourage Primary Health partners to identify older people that are presenting at GP surgeries, often with complex health needs or vulnerable through frailty, to enable early preventative intervention. Allowing the Agency the opportunity to facilitate access to older people who may benefit from the service quickly reduces the risk from home hazards and prevents small problems growing into unmanageable crises. Focussing in on some low cost works to address falls, wider safety, home security, cold homes, reduction of damp and fuel poverty, clearly remove some of the underlying environmental issues that cause poor health. This improves well-being, encourages prudent health and supports independent living.

Outcomes

During the ICF funding period the Agency successfully engaged with 46 out of the 58 GP surgeries initially visited. The agency received 262 referrals of which 212 older people had initial home visits incorporating a healthy homes check.

The Healthy @ Home service was piloted using ICF monies and has been dependent on the work done by the Agencies involved to foster positive and successful working relationship with each of the GP surgeries who are involved in the project. In Cardiff the ICF funding for Healthy @ Home ended on 31st March 2015 and the Agency has been self-funding continuation of this work since.

Occupational Therapy

Denbighshire Care & Repair have received funding for an occupational therapist based within the Agency to support their work.

Handyperson service

Pembrokeshire Care & Repair have utilised the funding to support their Handyperson service. The majority of Care & Repair agencies manage handyperson services, which are hugely popular services for older people as they provide small repairs and adaptations, and allow people to maintain their independence at home.

Care & Safety First (Dementia project)

Bridgend Care & Repair have created a service for both younger and older people diagnosed with dementia. The agency provides urgent minor adaptations to support people to return from hospital to a safer home environment.

Outcomes between April 2014 to March 2015

- **11,034 requests for a service from Care & Repair can be attributed to projects funded through ICF grants, during the nine month period.**

- **10,274 older people assisted to support their independence, health and wellbeing.**

ICF funding has led to an increase in referrals from health and social services to Care & Repair Agencies. This increase demonstrates how successful relationships have been developed between sectors. ICF has led to a greater understanding of the role of the third sector, particularly Care & Repair Cymru and how we can support the work of health and social services to the benefit of their clients.

Partnership Outcomes

Through ICF funding Care & Repair agencies have been able to support health, housing and social care partners in the following ways:

Intended Outcome	Number of Clients
Taken off an adaptations 'waiting list'	854
To facilitate hospital discharge	1318
To maximise independence	6955

Case study – Care & Repair Cymru

Mr and Mrs Evans were advised about the Care & Repair Healthy@Homes Service by their GP surgery and contacted us to arrange a home visit from our Caseworker.

The Care & Repair Healthy@Home Caseworker visited the couple in their home to assess their circumstances. During the home visit, the Caseworker identified that Mr and Mrs Evans should be eligible for Carer's Allowance and completed and submitted the application on their behalf. They were awarded this allowance which raised their threshold for other eligible benefits such as Guaranteed Pension Credit, full Council Tax Benefit and carers premiums.

Because of the Guaranteed Pension Credit award, Mr and Mrs Evans became eligible for a Home Warm Discount of £140 per annum, which the Caseworker successfully applied for on their behalf.

Because of the Guaranteed Pension Credit award, the couple became eligible for assistance from ECO to fund the costs of a new central heating system as their existing boiler was over 20 years old, very energy inefficient and costly to operate. The Caseworker successfully applied for this on their behalf.

During the home visit, the Caseworker identified that Mr and Mrs Evans did not have a carbon monoxide detector and so arranged for two detectors to be provided

to reduce the risk of carbon monoxide poisoning.

The Caseworker arranged for the Agency's occupational therapist to assess their needs. Care & Repair arranged for installation of a handrail on the stairs and a replacement shower cubicle with a drop down seat with arms. The bathroom door was also repositioned to make it easier for them to open.

The Care & Repair agency supported the couple through all of the works being completed, ensuring the works which were completed by contractors were to an acceptable standard and that the couple understood how to manage the new equipment which had been installed, including the new boiler.

Mr and Mrs Evans are now safer in their home. Their risk of falling has been greatly reduced. Financially, the couple are £138 better off each week, which equates to an extra £7,176 per annum. They also had a back payment in Council Tax benefit amounting to £1,200.

RNIB Cymru and Action on Hearing Loss Cymru

Sensory Loss Workers

Action on Hearing Loss and RNIB, working in partnership, secured ICF funding in 3 Local Health Board areas until March 2015. The funding was used to put in place Sensory Loss Workers in each health board area.

The role of the Sensory Loss Worker is to support people with sensory loss (hearing loss or sight loss, or both) who are in hospital, so that they return home able to manage their sensory loss better and live more independently as a result.

Although ICF monies were made available to local authorities and health boards from early 2014/15, the process of commissioning services from the third sector meant that confirmation of the available funding was not received until May/June 2014. From July – September Sensory Loss Workers were recruited and trained, who began actively working in the hospital setting between October and November 2014.

Outcomes

Between November 2014 – December 2014, the project across all 3 Health Board areas saw 61 patients.

The significant majority (76%) were over the age of 80, and 30% were aged 90 or over.

The significant majority of service users benefitted from provision of information (22 people), and many also benefitted from receiving hearing aid maintenance at the bedside (17). Service users also received direct links into audiology services, referrals to third sector organisations and/or social work teams; in addition, recommendations were made to ward-based staff.

Service users reported a real impact on their quality of life through engaging with the Sensory Loss Workers. In order to report this impact, workers were asked to accurately record the feedback they have been given verbatim. This was because most people lacked the capacity or the wellbeing to write. The most striking findings from the written stories is how the lack of understanding by health professionals is impacting significantly on patients' ability to engage with their care:

People were asked (On a scale of 1-10, where 1 is 'totally disagree' and 10 is 'totally agree):

1. 'I can live independently at home with my sensory loss'
2. 'I feel able to deal with the challenges that my sensory loss presents'
3. 'I am able to do the things that are important to me'

Of the patients who could rate their own progress, all 4 showed improvements on all 3 measures. Of the total 27 patients who were measured (either by themselves or by their Sensory Loss Worker), most patients showed an improvement pre- and post- intervention, and others remained the same on a couple of measures; no patient measured lower post-intervention than pre-intervention.

Other significant impacts of having a sensory loss worker in post

As well as individual patient contacts, the Sensory Loss Workers have been aiming to leave a legacy of increased awareness amongst those who they are working with in relation to sensory loss. They have made a wide variety of links with different professionals and the impact of this work will be felt after the current funding period ends. Some of these impacts include:

- The Gateway Team and the Contact & Assessment Team in Cardiff trained in understanding and identifying sensory loss.
- 2 separate wards have scheduled training from their colleagues in Audiology by end March 2015 (Cardiff).
- Colour tonal contrast of patient cutlery and glasses on wards, as well as large print menus/more pictorially based menu selection now being trialled in Newport.
- Physiotherapy team in Newport trained in understanding hearing loss, using hearing aid settings and personal listening devices.
- Staff signposted to relevant support (RNIB and Action on Hearing Loss) for improving the built environment in the hospital for those with sensory loss (Newport and Cardiff).
- 'Sonido' listening devices purchased by visiting officers from the Contact and Assessment team – this will enable them to communicate properly with people who otherwise would not be able to hear them (Cardiff).
- Information and signposting advice given to professionals in health and social care (both in the hospital and community based), on how to support their patients/clients

with sensory loss. They otherwise would not have known how to support these patients/clients effectively.

Case study RNIB Cymru/ Action on Hearing Loss

Patients have reported a real impact on their quality of life through engaging with the Sensory Loss Workers. As most patients lacked the capacity or the wellbeing to write, the most striking findings come from the stories written by a Sensory Loss Worker about the lack of understanding by health professionals and how this impacts on patients' ability to engage with their care:

Mr A, who has hearing loss

> *"No one was looking for this patient's hearing aid, which he was without. He was being spoken to about life changing decisions without the help of an aid or listener and was assumed not to have capacity."*

Mr C, who has hearing loss and sight loss

> *"Whilst on the ward I overheard a doctor talking loudly to a patient. The doctor was telling him that he was fit to be discharged and had to choose where to go. I heard the patient saying he didn't know and the doctor saying that he could not stay in hospital as he was fit and was walking around. The doctor said that he knew the patient's wife was also in hospital but she wasn't going to be leaving and he was. The doctor said that he could go home with a care package. The Dr was walking around the room during parts of this conversation. "*

Mrs D, who is registered blind

> "*Mrs D has been registered blind for most of her life and has adapted completely at home. However she has had a very negative experience during her time in hospital. She states that in the time she has been there only two members of staff have introduced themselves to her. She often doesn't know who is talking to her or what role they have and people are constantly moving her belongings around. Staff will walk away leaving her talking to herself and she misses food and drink that is left for her. She stressed that being in hospital was having a substantial adverse effect on her wellbeing and her confidence. She was therefore desperate to be discharged as soon as possible.*"

We also found that in a great many cases, patients' hearing aids are not being used, despite the fact they can make a significant impact on communication with professionals:

> *"The patient asked me to look in her handbag for her mobile phone as she has not spoken to family for a long time. When I opened her bag I found a hearing aid. I cleaned this and changed the battery and fitted the aid. She*

was instantly happy and shocked stating to me that she could hear what was going on around her. She was quite emotional at the change and excited that she could hear people talking in the ward."

We found that patients benefitted hugely from using a personal listening device (a Sonido) to amplify things for them:

"It made her feel human again and as if she did not have a hearing loss…. It was the best Christmas present she could have had"

"He was amazed at the difference it made and seemed to relish being able to communicate with me"

Stroke Association

Stroke Cafés

The aim of this project was to expand current life after stroke services across Gwynedd to increase opportunities for stroke survivors and carers to meet and socialise in local cafés. The project also aimed to:

- Provide peer support opportunities.
- Increase stroke survivors' confidence in public places.
- Assist the stroke survivor to communicate their order thereby increasing independence.
- Reduce isolation by accessing community venues.

Stroke cafés were piloted in the rural areas of Ynys Mon and Ceredigion, with much success. For people who do not wish to attend a formal 'group' setting, the cafes provide an informal yet structured place to meet. For people with aphasia, the cafés provide an opportunity to practise supported conversation skills and ultimately, to regain the use of spoken language. Research shows that stroke has a social impact on both the stroke survivor and carer. Stroke cafés address the need for more interaction by using both social and therapeutic means.

Similar projects have demonstrated the following outcomes:

1. Brought the service closer to the person, thereby overcoming transport issues.
2. Increased confidence of stroke survivors, especially those with communication issues, to order their beverage and interact with other customers.
3. Increased the café owner's awareness of stroke and its effects and improve accessibility.
4. Raised awareness with the general public and reintegrated stroke survivors and their carers back into their community.

Outcomes

Between October 2014 – December 2014, venues were sourced in Blaenau Festiniog and Pwllheli to hold fortnightly café meets for stroke survivors, their families and friends. The first café was attended by 11 people; 6 stroke survivors and 5 carers/family members.

Posters have been distributed to local community centres, libraries, community hospitals and GP practices to ensure this service is advertised widely. We are in the early stages in terms of evaluation, however some comments from cafés set up in other locations include:

> *"The stroke cafe has been brilliant. I have met many people who are in the same situation as me and it's great to sit down over coffee to listen and learn from their experiences. The volunteers who give their time to us are fantastic and the café owners can't do enough for us."*
>
> *"I've only been to four and it's great to have a jangle. You could say it was a "stroke of luck" that I found the café and I look forward to it every fortnight."*

Other comments fed to staff and volunteers have been:

- The ability to discuss stroke and the impact of the stroke, in an informal setting.
- Stroke survivors have informed us of the benefits of peer support but also the carers have been able to use this time to meet other carers too.
- The positive impact of returning to daily activities – arranging transport, ordering and paying for coffee.

Therefore, we are seeing an increase in social interaction and people feeling more confident and independent in their life after stroke, all leading to improved health and well-being.

With the continuation of this funding we would be able to develop the cafes further for stroke survivors, carers, family and volunteers.

For more details of members of Age Alliance Wales, visit the website:
www.agealliancewales.org.uk/Age_Alliance_Members/

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