

Improving homes, Changing lives



Care & Repair
Gofal a Thrsio



Bridgend County Care & Repair

Managing Better

A Critical Prevention Study

October 2018



Making a case for doing it differently

Managing Better (a Critical Prevention Service) is a three year, 2016-19, funded programme by Welsh Government under the Social Services, Third Sector Grant framework. £1.25m was provided for a service co-produced by Care & Repair Cymru, RNIB Cymru and Action on Hearing Loss Cymru meeting the ambitions of the Social Services and Wellbeing (Wales) Act 2014.

The experiences on the ground, from our three-way partnership, were that in approaching preventative intervention, none of us were able to deliver to the high standards of our ambition, if we did it alone. We could, through working together, offer more to our NHS and Social Services partners, if we provided a greater investment into independent living, through combining more understanding of what personal challenges make life difficult to manage as we grow older, and how we could improve opportunities by making the home a better place to live.

Our *what matters* conversations have consistently highlighted a desire to manage better as being a top priority for older people...to live in a house that meets their needs and to live a happy, healthy life in the community of their choice.

Our new service has allowed us to explore together, through collaboration, how we can do things differently and put our clients at the heart of our service.

Through the direct experience of delivering our services in a new way we find we are more relevant to NHS and Social Care partners; intervening earlier and through making new connections, preventing smaller problems becoming significant barriers to independence. Making lives more manageable is helping to reduce demand pressures on our acute and statutory service partners.

Managing Better 2017-18



302
People Helped
and
32% over 85

299 (99%)
of people helped had
a sensory loss



Health Referral
77 Direct
(Hospital & GP)
46 Indirect
(ECLOs & ROVIs)

ENABLE grants
Works Completed
102
and value of works
£34,460

Healthy Homes
Assessments completed

230 (76%)



Falls Prevention

157



Works Completed

235

at a value of **£180,000**



Home Safety

230

Welfare Benefits

116

Clients Helped
and increased benefits **£242,284**



Speed of service

88% seen within
30 working days and
52% within **15 working days**



94%
of clients would
recommend the service



Improved Independence
& Wellbeing

94%
can Manage Better at home



Care & Repair – What we do?

Care & Repair's mainstream services are based on a 'needs-led, person-centred' approach:

- led by a Caseworker who assesses the declining independence and self confidence of an individual and the potential risks in their home;
- combined with professional advice & support from a Technical Officer that is linked to specification for home improvement/adaptation and includes supervision of the works

The outcomes are clearly supporting independent living and are a combination of:

- Measures addressing fuel poverty and general poverty
- Prudent Healthcare advice and health promotion
- Person-centred support
- Falls Prevention
- Home Safety
- Dry and Warm homes
- Personal Safety & Security

Referrals are made up from 'Self', 'Housing', 'Social Services', 'Health' (Acute Hospital) and 'Third Sector'

What does Managing Better do differently?

Whilst the Managing Better service builds on the basic strengths of the mainstream Care & Repair service it differs in a number of ways. Greater understanding of the levels of vulnerability with clients, i.e. the level of sensory loss, provides a specific reference point for both our introduction into the service and our assessment approach.

Working with our national partners, who have delivered essential training packages, has assisted us to develop our service offers differently. We have been far more informed around communication and ensuring effective access to our services. This gives clients confidence in our service and provides a positive experience. Confidence is key to getting the service right for the client.

The focus of the Managing Better Caseworker training has also assisted us in terms of what we deliver to our clients. There are specific approaches that we have considered to make home improvements more relevant to our client group. i.e. colours, tones, contrasts, lighting, brightness, sound pitch, amplification, etc. We routinely, employ low-level techniques to make the home more manageable and work closely with increased referral protocols and joint-visits with the Rehabilitation Officers from Social Services and the third sector to get it right for the client. We negotiate with our Local Authority Private Sector Housing colleagues, when delivering

a Disabled Facilities Grant or ENABLE grant to ensure RNIB's 'Visibly Better' standards are incorporated into our standard approach to home adaptations.

Critically, there are also significant benefits in terms of identifying clients. The service is far more confident in dealing directly with people with sensory loss. It has also used that 'confidence' to gain referral protocols with community-based and hospital-based sight and hearing support, e.g. Audiology, Eye Health Clinics, Sensory Teams, etc. There are innovative partnerships between Housing and Health that have forged new partnerships through the development of this service. In terms of preventative action, it has picked up vulnerable clients that had other (*other than sensory loss) environmental challenges, causing/ exacerbating poor health and providing threats of increased dependency on statutory services. Sensory loss services and housing services can now offer far more through collaboration.

Reflecting on Client Case Studies

Partners have indicated how operationally the joint-working agreements forged locally have ensured not only good outcomes for the vulnerable clients, but also a reduction of pressures on statutory services. The clear gain for clients is the speed of the services offered and the avoidance of delays caused by unnecessary bureaucracy that leaves the client at risk.

Hospital-based Clinics (Outpatients)

The links with Audiology, Eye Health and Falls, are all preventative innovations. New partnerships and new referrals from these sources, reflect a growing awareness of the need for greater health promotion and a growing understanding that the environment and poor housing is an underlying cause of poor health.

Acute Hospital (Inpatients)

Having far more confidence in communicating and engaging with vulnerable patients that have a sensory loss, assists us to get things right for the outcomes of safe discharge. It also helps us intervene in a way that is relevant and effective for the patient returning home. Where there is further complexity from Dementia or Stroke this confidence and expertise is particularly important.

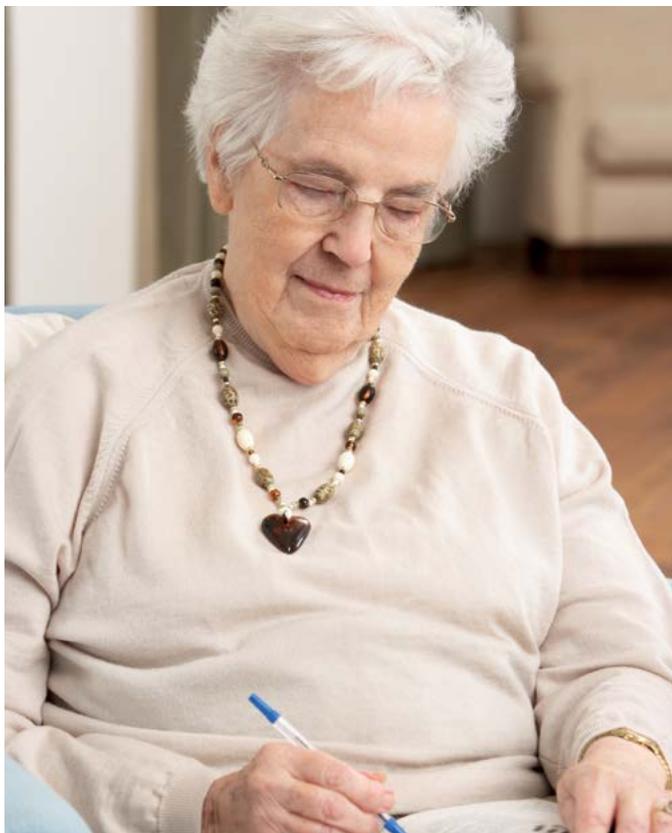
Social Care (Rehabilitation)

Statutory services are under enormous pressure and there are often waiting lists that are more difficult to manage given high demands for low level interventions and more intense demands from complex cases where underlying housing risk is a factor in independence. The joint-working arrangements between Managing Better and Rehabilitation Officer Visual Impairment (ROVI) in Bridgend are exemplary, based on trust and problem-solving to put the client first, and identified risk priorities.

Making the Case for Prevention

From an analysis of how the Managing Better service works in Bridgend and understanding how it is integrated with other service partnerships; i.e. including ROVI, Primary Care services and Acute Hospital services, this service can also claim to make preventative savings. Apart from more sophisticated computation for Social Return On Investment (SROI) related to keeping people economically active in the community, free from the need of more complex health and counselling support, and rehabilitation, there are some more basic cost avoidance benefits.

We have calculated our preventative savings on only 30% of the total clients for Managing Better, receiving services in Bridgend for 2017-18.



The areas we have calculated preventative cost benefits against are:

1. Additional ROVI costs at 3 days for just the complex cases
2. Safe Discharge costs (at an average 7-day bed day saving) for Hospital to Home patients
3. Hospital Admissions prevented for that group highlighted as at risk through formal referral
4. Primary Care, additional costs likely for those complex cases referred from ROVIs
5. Hip Replacement surgery for those likely from reference to Public Health Wales (PHW) epidemiology
6. Residential Care costs for only 1 year referenced to PHW epidemiology

On modest assumptions it is likely that **£4** is saved for every **£1** invested in Managing Better.

This amounts to **£700,000** cost avoidance; and at a unit cost average of **£688** per vulnerable client there is an average **£2,390** preventative saving to the state.

This is based on dividing total service costs by modest cost assumptions for only thirty percent of clients, with a likely adverse life outcome extrapolated from the case study scenarios.

Case study - Hospital to Home



Mrs B was referred to the Managing Better Service because a Caseworker was present at Accident & Emergency during a Winter Pressures Project. Mrs B reported several falls at home within the last few months and presented with several illnesses; sleep apnoea, oedema, hearing loss, arthritis and balance problems.

Mrs B was visited initially by the Hospital to Home's Home Safety Officer within 3 working days where an on-the-job assessment was completed and the following installed:

- Fixed shower seat
- Grab rail to the front door
- Grab rail to the toilet

A visit was also completed by the Managing Better Caseworker who established the following:

- Draughty window in the living room next to Mrs B's chair
- Cold house with reports that the boiler wasn't working correctly
- Family were concerned about leaving Mrs B alone, and as a result daughter has had to leave employment
- Mrs B wasn't claiming all the welfare benefits she was entitled to
- Hearing loss has worsened
- Mrs B had not had a sight test for over 2 years
- Fall hazards identified in the porch area
- Concerns over security

The issues were addressed as follows:

- Healthy Homes Assistance Grant successfully applied for to cover the cost of repairs to the draughty window
- Warm Homes on Prescription successfully applied for to replace the central heating boiler
- Telecare equipment installed to promote independence and reduce worry and anxiety for Mrs B and her family
- Application for Personal Independence Payment to be submitted
- Letter of support to assist with Blue Badge application
- Signposted to GP for hearing check
- Signposted to optician and provided advice on the importance of having an eye test every 2 years even if Mrs B reports her sight as 'ok', and advice provided on the possible link between varifocal glasses and falls
- Rapid Response Adaptations Grant (RRAP) processed for grab rail to porch area and for security light to be installed for added security
- Advice was also given on appropriate footwear

What would have happened without Managing Better

It is likely Mrs B would continue falling and become a cyclical attendee at A&E, possibly requiring more substantial medical intervention.

She would not have accessed all the services she was entitled to and her sensory loss issues would have been overlooked.

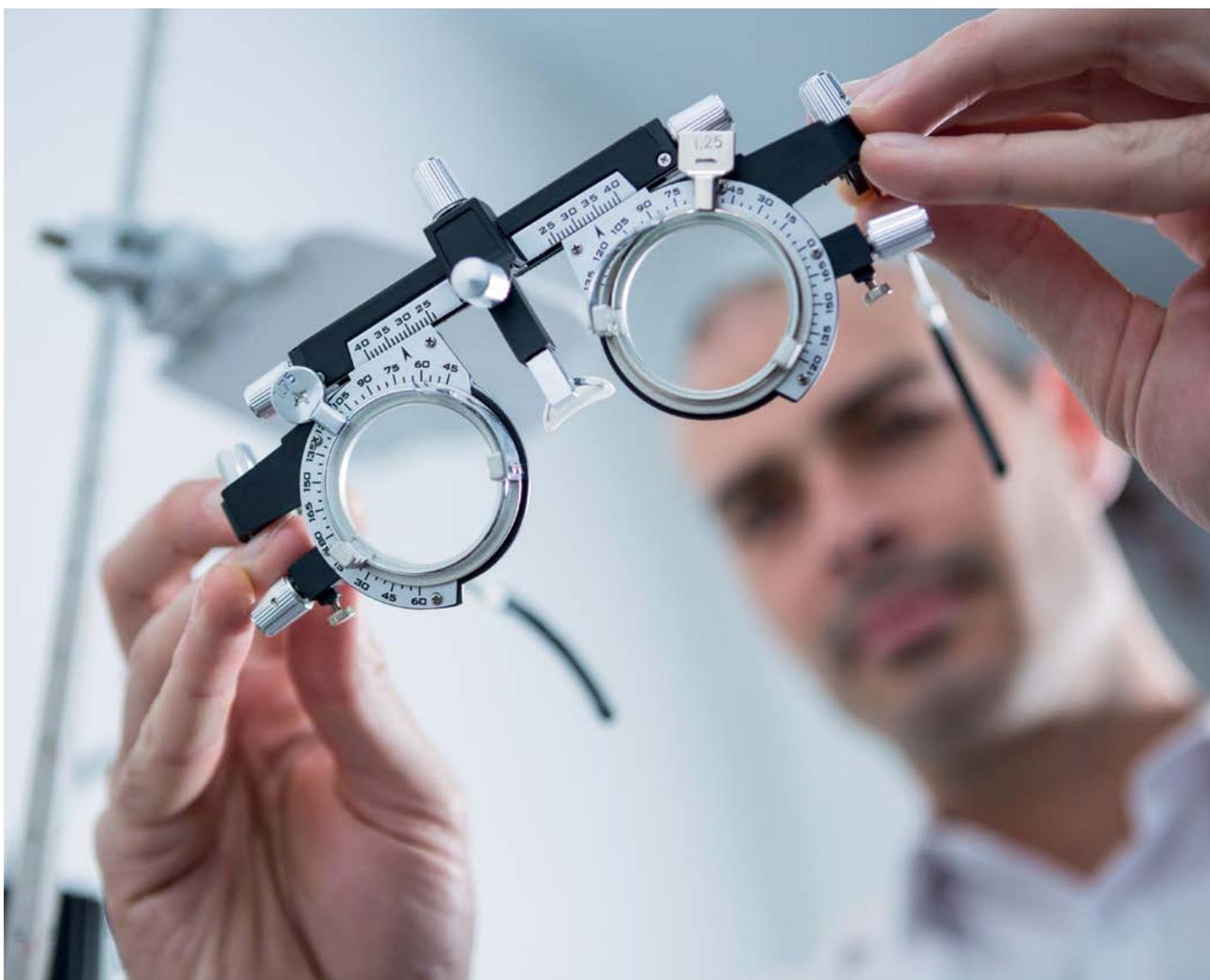
She would have continued to live in a cold, hazardous home with poor health outcomes.

Preventative Savings

The average preventative savings for Hospital to Home patients is £2,900 avoiding post-discharge costs, with £2,000 being saved due to early safe Hospital Discharge and an average of up to 6 bed days saved, if she had been admitted into hospital.

Evidence suggests:

Visual impairment increases the risk of falls by **170%** and the incidence of a hip fracture is **130%** higher with this group (Royal College of Optometry)



Case study Hospital - Audiology



Personal Circumstance

Mrs R, an owner occupier, was referred into the Managing Better Service by the Audiology Department within Princess of Wales Hospital for a general assessment. She presented with dual sensory loss, wearing bilateral aids, and sight being affected by Age Related Macular Degeneration (ARMD). Mrs R also presented with poor mobility and a greater risk of falling.

Living Circumstance

On visiting Mrs R it was quickly established that her home was becoming increasingly inaccessible and not meeting her needs. The home was warm and the central heating system was found to be in good working order however, there were no smoke alarms or carbon monoxide detectors fitted in the property.

Challenges to Independent Living

Mrs R's challenges to independent living were identified as follows:

- Risk of falls around the home due to sight loss and unsteadiness on feet
- Unable to access shower/bath safely with risk of falls due to the step into shower and shower controls being extremely high. Mrs R is under 5ft.
- Poor lighting
- Benefits advice – low income
- Rushing to the door as Mrs R keeps missing people – increased risk of falls
- Security at front of house – poor lighting and secluded area
- Fire and carbon monoxide risks
- Inaccessible kitchen

Services Provided

- Referral to in-house Occupational Therapist (OT) for assessment in the kitchen
- Referral to the Fire Service
- Working with Wales & West Utilities added Mrs R to their Priority Services Register and issued a free CO detector
- Letter sent to Mrs R's GP with regard to risk of falls
- Accessed ENABLE grant for grab rail to bath, install a new shower (high contrast buttons to aid sight loss and reduce scalds), lowered shower electrical unit, concealed lighting to bathroom, amplified doorbell, external light to front door, step to rear door
- Accessed a Healthy Homes Assistance grant for drop-down shower seat and grab rails to the shower (inside and outside), front door and back door, lower pull cords in bathroom
- Benefits advice and support with Attendance Allowance forms and Welsh Water Help U forms

Outcomes

Having a Managing Better Caseworker with Trusted Assessor status has allowed Mrs R to manage better at home with the risk of falls being reduced. Mrs R is able to safely access all areas of her home with greater confidence. Without intervention, Mrs R would have waited several months for a Community Assessment from Social Services.



What would have happened without Managing Better

Had Managing Better not intervened Mrs R's confidence would have continued to deteriorate. She may well have fallen and had to visit a hospital.

Preventative Savings

The average preventative savings for Secondary and Primary Care could be as high as £67,430 if we assume for a high-risk scenario, the combination of Hospital Admission, Hip Replacement and a transfer into Residential Care.

Evidence suggests:

Visual impairment increases the risk of falls by **170%** and the incidence of a hip fracture is **130%** higher with this group (Royal College of Optometry).





Case study - Healthy at Home

GP Partnership

Personal Circumstance:

Mrs S, aged 55, was referred into Bridgend County Care & Repair and the Managing Better Service via a GP Practice. On the GP referral, Mrs S was reported to have sensory loss, was managing a number of chronic conditions and needed general safety advice. Mrs S lived in her own home with her husband.

Living Circumstance

The Managing Better Caseworker visited Mrs S at home and found she suffered from the following: macular degeneration, diabetic retinopathy, epilepsy, diabetes, arthritis, diverticulitis, high blood pressures, angina, cellulitis and stroke which resulted in short term memory loss and right sided weakness. After using the Falls Risk Assessment Tool we identified Mrs S had recently had several falls.

During the visit, Mrs S mentioned the central heating worked intermittently and she was having to top-up the boiler with water regularly. The house felt cold and draughty and there was damp in some rooms.

Mrs S was alone most of the day as her husband was employed full-time. This concerned Mrs S as she felt anxious about security. Challenges to independent living identified during the visit:

- Fear of being alone
- Cold, damp and draughty house (may increase risk of falls)
- Welfare benefits advice needed

- Accessing boiler to top it up (increased risk of falls)
- Difficulties using the stairs
- Mrs S was very nervous about answering the door due to sight and memory loss
- Difficulties with cooking / making a cup of tea/coffee
- Difficulties using the telephone to communicate with family/friends

Services Provided and Outcomes

Full Caseworker visit was undertaken and the following was completed:

- Advice on avoiding slips and falls - remove loose mats and rugs
- The Caseworker completed a Falls Risk Assessment - Letter sent to GP highlighting the risk of falls
- Successful application for a Winter Pressures Grant which paid for stair rail, Security door chains to front and back door, Door lock intercom, PIR Sensor light to front of house

- Highlighted front steps
- Large button telephone
- A welfare benefits check was carried out - Application for Council Tax Disabled Reduction complete
- Successful application for a Warm Homes Prescription Grant which paid for a new central heating boiler
- Referral to the local Sensory team who supplied Liquid level indicator, One-cup demonstration, Bump-ons
- RNIB Talking Books Service
- Referral to ECLO for emotional support
- Discussed Telecare



Total value of works £5,397.30.

What would have happened without Managing Better

It is highly likely that Mrs S would have fallen as her circumstance indicated many risks, and she would have continued to live with greater anxiety, little day time support, increasing loneliness and the likelihood of a serious injury.

Combined this might have required increased GP visits, a hospital stay, home care and possible therapeutic intervention.

Preventative Savings

After analysing the previous evaluation of Bridgend County Care & Repairs Primary Care Service it is likely that there could be up to a 60% reduction in visits to GP surgeries when a comprehensive housing intervention, including safe, warm and well approaches, is provided, equal to £684.

Preventable hospital admission costed at £4,027. Home Care costs at £13,200 p.a. For a service intervention cost of £5,489 (including Casework time) the intervention could avoid costs of £17,921: a net preventable saving of £12,432.



Case study - Living Independently in the Community

ROVI Partnership

Personal Circumstance

Mrs J is 58 and lives alone in a privately owned 3 bedrooed terraced property. Her husband died last year and she has a daughter and 2 sons living locally. Mrs J has been diagnosed with Corneal Dystrophy and Cataracts and registered sight impaired/partially sighted. She has been waiting for cataract surgery on both eyes, to be followed by laser treatment and corneal transplants.

Since her husband's death Mrs J's health has deteriorated significantly. She has recently had a fall and broken her left leg and toes on her right foot. An X-ray on her knees has shown she has osteoarthritis.

Living Circumstance

On visiting Mrs J it was quickly established that her home was becoming increasingly inaccessible and not meeting her needs. The home was cold and heating was poor, she had low income and there were numerous falls risks around the house.

Challenges to Independent Living

The Healthy Home assessment highlighted, in addition to ROVI assessment:

- Hazards on stairs
- Risk of falling at both the front and back door
- Welfare Benefit opportunity to address low income and fuel poverty
- Cold home

- Risk from inappropriate lighting in kitchen
- High risk of falling

Services Provided:

The following help was provided to ensure a safe home prior to ROVI interventions:

- RNIB grant application for an accessible tablet
- Provided advice and support with Employment Support Allowance forms
- Processed a grant for a new boiler
- Advised on refuse assistance
- Galvanised rail and grab rails to the back door

- Supported with a claim for Welsh Water HelpU
- Warm Home Discount
- ENABLE grant for lighting in the kitchen
- A new concrete path
- Stair rails
- Key Safe



What would have happened without Managing Better

There is a high risk that Mrs J would have continued falling, with increasing threats linked to the likelihood of escalating medical intervention. From the ROVI perspective, due to the complexity of the case, there would have been a serious delay in ROVI interventions until the home had been made safer. This would have required a series of complex referrals rather than just one referral to the Managing Better service.

Preventative Savings

Likely costs avoided are	
Hospital Admission	£4,027
Primary Care Support	£114
ROVI additional time	£117
Total:	£4,318





Case study - Living Independently in the Community

Identified by Deaf Community

Personal Circumstance

Mr & Mrs S, owner occupiers, were referred to Managing Better from a D/deaf club. Mr & Mrs S were referred for falls prevention as both have falls history. They are both in their 80's, are both Deaf British Sign Language (BSL) users and required use of an interpreter for any visit. Mr S suffers from swollen legs and arthritis in his hands which is now affecting his ability to communicate effectively through means of BSL.

Living Circumstance

The Managing Better Caseworker visited Mr & Mrs S with a BSL interpreter where it was established that Mr S was a frequent faller due to increasing balance problems. A healthy home check confirmed no issues with heating/damp, but challenges to independent living:

- Difficulties in using the following
 - Bath
 - Toilet
 - Stairs
 - Front door
 - Bed
 - Chair
- Anxiety to family of Mr S being left alone due to falls.
- Inability to hear smoke/CO alarms

Services Provided

- BSL interpreters used when visiting the clients
- ENABLE grant processed for rails to bath, toilet, stairs and front access
- Referral to Fire Service for assessment for aids
- Referral to Occupational Therapy for assessment of chair
- Telecare assessment



What would have happened without Managing Better

Clearly this is a high-risk scenario with two vulnerable older people living independently at home. This could double the costs of any interventions and heightens the sense of urgency as conditions deteriorate.

Without these combinations of service, a slide to lengthy medical intervention and long-term dependency is inevitable. The personal costs of vulnerability, where the need to support confidence and build up resilience is ignored, would be significant.

Preventative Savings

The average preventative savings for Secondary and Primary Care could be as high as £67,430 if we assume for a high-risk scenario, the combination of Hospital Admission, Hip Replacement and a transfer into Residential Care. These costs could be doubled.





Case study - Living Independently in the Community

Eye Clinic Liaison Officers (ECLO)

Mrs P has no sight in her left eye and premature retinopathy in her right eye, acute glaucoma and stigmatism. She is registered as severely sight impaired. The lighting in her home was so dark that she was struggling to live safely due to her sight loss. She was not using several rooms in her home due to the poor lighting and fear of falling. She was also finding it hard to go out on her own due to the deterioration in her eyesight because she was worried about falling and ending up in hospital. Mrs P was referred to Managing Better by an Eye Clinic Liaison Officer (ECLO).

The Managing Better caseworker visited to find out what was important to Mrs P and to carry out a Healthy Home Assessment, which identified a wide range of poor lighting issues which made the home unsafe.

The caseworker arranged a joint visit with an electrician to complete a lighting assessment and the Managing Better Caseworker was able to access an ENABLE grant to provide:

- All new LED bulbs in the kitchen, downstairs toilet, lounge, dining room, hallway, landing, stairs, bedrooms and bathroom.
- Under-unit LED strip lights fitted in the kitchen.
- New LED fluorescent light fitted in the utility room.
- 2 Passive Infrared (PIR) sensor lights fitted in the garden and existing bulbs replaced.

- Edgings and nosings highlighted on the steps in the garden.

The caseworker also provided advice and information about local support groups, social groups and activities. Now Mrs P's home is safe she is due to start orientation & mobility training with a ROVI.

Mrs P said "When you haven't got a lot of sight you think well, how can good lighting make that much difference? But it certainly has for me. It's changed my life. It means I don't need to rely on anyone and I can be independent and do the things I want to do, when I want to do them."

What would have happened without Managing Better

The likely scenarios for Mrs P, had Managing Better not intervened, would have been increasing lack of confidence and decreasing independence. She may well have fallen and had to visit a hospital.

Preventative Savings

Royal College of Optometry commissioned research estimates Visual impairment increases the risk of falls by 170% and a hospital-related falls incident would cost £4,027 as a bare cost and as GP visits are indicated to rise by with associated poor health the cost of increasing Primary and Social Care would be £291. A total of £4,318.



Working with Sensory Services

‘We’ve been involved with the Care & Repair Managing Better service for two and a half years. It’s had a positive impact on Service Users by preventing falls, minimising risks and complements the Rehab/Sensory Team. Evidence suggests through collaborative working and joint visits the Service Users are seen in a timely manner and are provided with a holistic assessment covering all aspects of a person’s life.’

Kath Greenwood
(Assistant Manager Sensory Services, Bridgend CBC)

Working with Rehabilitation Officers – reducing pressures on Social Services

‘Joint working with Managing Better Caseworkers is vital with ROVI’s and Sensory Teams across Wales. As a practising ROVI I feel we work very well together providing our service users/clients with a full holistic and comprehensive assessment. The Managing Better service can also act as a safety net for people who may not know about what services are available to them in their local area.

The work carried out by the Managing Better Caseworker can reduce time a person is waiting, especially in areas where ROVI’s can’t always get out quickly, where there are long waiting lists and massive demands on Sensory Teams. Adaptations to the home can prevent an individual from falling. Lighting assessments can be done quickly by the Managing Better Caseworkers allowing a ROVI to undertake training with the older person, such as preparing a hot meal safely, making a hot drink safely and moving safely around their home. Support given to help older people apply for Welfare Benefits, to which they are entitled, can make such a difference to their daily living expenses.

The Welsh Rehabilitation Officers Forum (WROF) will continue to work alongside the Managing Better service. We are currently looking at more joint training and networking opportunities to develop our roles further. Care & Repair and other third sector organisations take some of the huge pressures off Health and Social Care by collaboratively working. We are all cogs in a wheel and if the Managing Better service wasn’t there it would have a massive impact on what services can be put in place.

Managing Better makes a big difference to the safety and wellbeing of people who have sight and hearing loss.’

Sandy Davies
(Rehabilitation Officer for the Visually Impaired, Bridgend CBC)

Working with the Hospital to Home Service (Princess of Wales Hospital)

“Our Managing Better Caseworker (Kelly) is a huge asset to our Hospital to Home service. Kelly is able to provide an additional resource to the Casework role, in terms of her expertise in dealing with patients with sensory loss.

Her role is invaluable especially for patients who have been newly diagnosed with sensory loss, for example, on the stroke ward at the hospital. Patients are anxious regarding a life changing condition and how they will manage at home, Kelly is able to reduce their worries with the specialised advice she is able to provide.”

Meinir Woodgates
(Senior Hospital to Home Caseworker)



Julie's Story

A Managing Better Digital Story

Summary

The principal achievement of Managing Better is **working together** across sectors to upstream interventions and prevent avoidable pressures on public services escalating. It is clearly focussed on increasing independence and reducing dependency: improving personal resilience.

The focus on how Managing Better has operated in Bridgend, across Primary, Secondary, and Social Care, provides some demonstrable examples of critical prevention. Rooted in the ambitions of the Social Services & Wellbeing Act, i.e. *‘contributing towards preventing or delaying the development of people’s needs for care and support’*, and contributing to the evolving agenda of the Wellbeing of Future Generations Act, i.e. *‘how acting to prevent problems occurring or getting worse may help public bodies meet their objectives’*, Managing Better has much to offer.

Managing Better provides significant learning for public service integration as well as providing innovative templates for prevention. Most of all it casts a bright light on some of the darker corners of service delivery, ensuring how less included, isolated and hard-to-reach older people, can be genuinely helped to manage better in terms of daily living and quality of life.



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The cost avoidance assumptions are not derived from local NHS partners but uses research by NICE, Personal Social Services Research Unit (PSSRU), Chartered Society of Physiotherapy (CSP) and Age UK.

Every effort has been made to ensure that the information in this document is accurate. However, Care & Repair Cymru does not accept any responsibility for errors or omissions.

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