Cardiff & Vale of Glamorgan – Regional Collaboration Fund Grant 2014/2015

Summary of Progress – Quarter 3

General Update

Programme status = **GREEN**

The robust programme and project management introduced in May 2014 is continuing with monthly reports to the Programme Board focus ensuring that the Programme delivers the following outcomes in line with the criteria set out in the grant bid:

- **Be collaborative** – all projects should include at least two partner organisations.
- **Result in integrated working** – be that between the two councils or one/both councils with the Health Board.
- **Result in people focused outcomes and benefits** – for example, enhancing wellbeing, health, independence and do so more efficiently and effectively.
- **Generate demonstrable benefits for partner organisations** – for example, reduced costs, improved performance indicators, enhanced staff development opportunities or improved operational efficiency.
- **Result in no direct long-term increase in revenue spending** commitments for the partner organisations.

This is the second year of a three year Programme, which is currently funded until April 2015. The Programme has focussed on 4 Projects in 2014/15. These projects are trialling new models of working ensuring that these are delivered collaboratively across two or more of the partner organisations. All projects are on track to deliver identified outputs within timescales and budget and will set in place some of the essential elements required to take forward the Social Services and Well Being Act 2014.

We are continuing to develop performance measures and provide the baseline information required to evidence the benefits being realised. This report contains data for the Effective Community Resources Team project which shows the progress that has been made since the co- location of Health and Social Care staff into 3 locations in Cardiff and the Vale of Glamorgan. This data clearly evidences the benefits from this co – location and although there is still much to do, progress is being made to deliver fully integrated pathways for health and social care. This report also includes performance data for the Streamlined Integrated Assessments, the Enhanced Occupational Therapy and the Enhanced Learning Disabilities Projects. The development of these performance measures is on going and will include outcomes where it is possible to do this within the Programme timescales.

Case study evidence is also being collated and some examples including service user's feedback are appended to this report.

Programme Risks and Issues

1. Unable to recruit and retain suitable staff because of the short term funding of the Programme.
   Mitigation - Working closely with HR to identify fast track processes to recruit individuals.

2. Failure to spend grant allocation within deadline
   Mitigation – Robust project and programme management in place with monthly monitoring of progress to the Programme Board.

Effective Community Resource Teams

Project status = **GREEN**

This project has established three Community Resource Teams (CRT's), two in Cardiff (Whitchurch and Llanrumney) and one in the Vale of Glamorgan (Barry hospital), bringing together University Health Board (UHB) and Local Authority staff to deliver a more joined up service, improving response times and reablement capacity. Each CRT is managed by a Locality Manager and in the Vale of Glamorgan this post is a joint appointment between the Council and the Health Board. Each CRT is also working closely with a third sector organisation, also based in the CRT providing voluntary sector support to the in – reach service.

Achievements

- Following the successful co- location of Health and Social care staff, work is on going to fully integrate processes to deliver an integrated pathway for service users.
- Mobile devices have been issued to Home Care reablement in the Vale and these are already improving efficiency as carers are now able to receive information via their mobiles, receiving accurate up to date information and respond more quickly.
- In Cardiff the Mobile Working and Scheduling project is being delivered under an internal Programme and linkages have been made between the two Local Authorities to ensure best practice is shared to maximise benefits.
- The third sector partners, Age Connects and the British Red Cross, are continuing to work with the CRT's to provide additional resources to accelerate the reablement of service users.
- In the Vale of Glamorgan, referrals are now being managed through the Contact Centre (there are strong links with the Improving Access to Health and Social Care Project which is funded through the Intermediate Care Fund Project)
- In Cardiff the In reach home care team has continued to develop and now provides support to all wards in UHW. The team's presence on the wards has increased as the ward staff gain a better understanding of their role in helping to accelerate discharge and provide better outcomes for service users and fewer re-admittances.
- The availability of staff from the In reach team on wards has improved communication with the service user, therapists and family members enabling a more specific and informative screening of the patients service needs and social background which assists with the assessment prior to

discharge. There have been a reduction in the number of unnecessary visits to service users who do not need/want packages of care.

- Performance data is collated and shared with the team on a weekly basis to support discussions on the numbers of service users who are discharged following the In reach team's intervention and to consider ways that the service can be improved.
- The co- location of third sector staff in the CRT's is proving effective in identifying ways the third sector can support service users to maintain and regain independence. The co-location has created a "walk- in" easy referral process for service users. Staff from the British Red Cross and Age Connects have developed close working relationships with the staff in the CRT's and are included in team meetings and Multi - disciplinary meetings to explore how best to support individual service users. For the period 1 April 2014 to 31 Dec 2014, British Red Cross have received 99 referrals in the Vale of Glamorgan and provided support. For example, they have carried out joint visits with physiotherapists and occupational therapists and been shown what was required. Third sector staff have then been able to maintain the momentum of exercise with the service user, freeing up the therapist to move on to new cases.

Project Risks and Issues

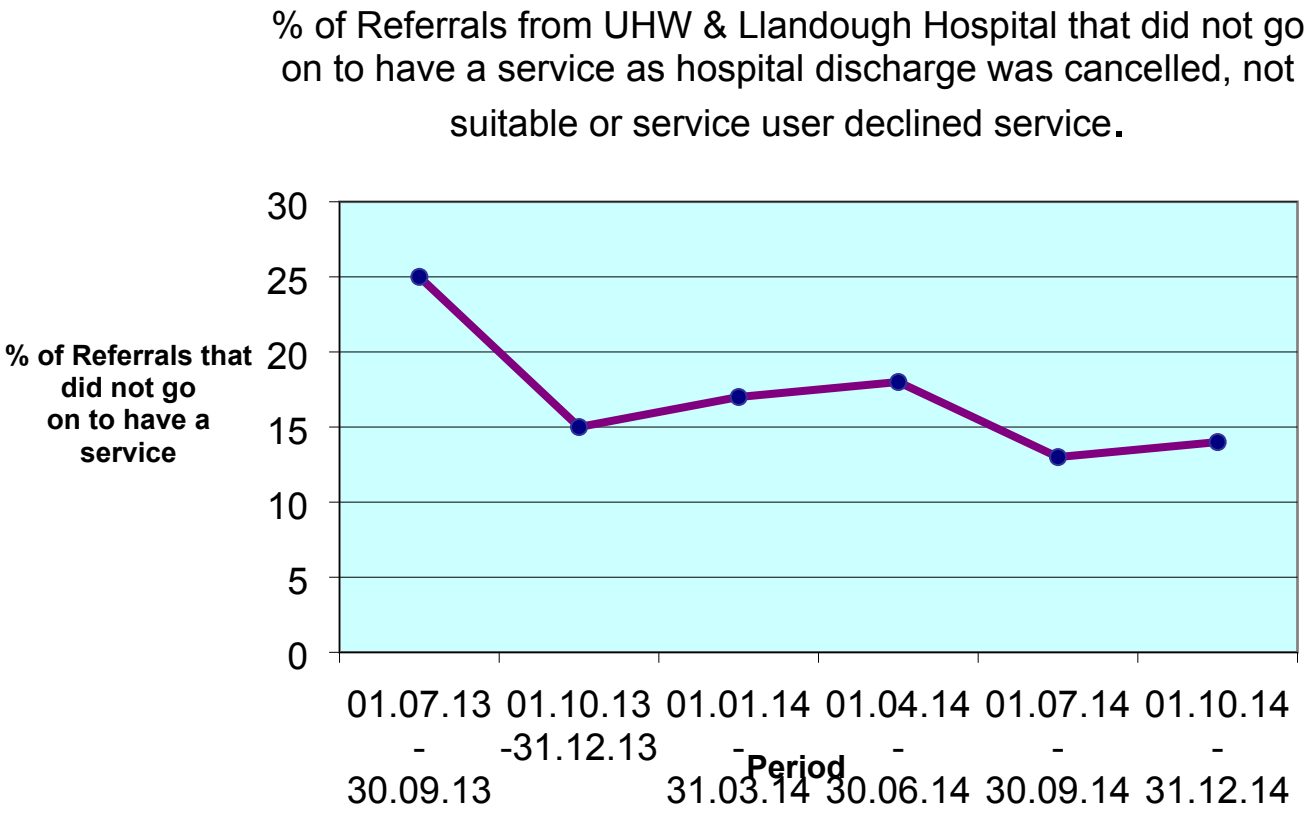
1. Increased demand is placed on the Community Resource Teams to reable service users to full independence before they are ready
   Mitigation – Health and Social Care staff are fully engaged in the reablement process.

2. The short term nature of the funding for this project will impact on the recruitment and retention of staff.
   Mitigation – Working closely with HR to identify fast track processes to recruit individuals.

Effective CRT's Performance Measures

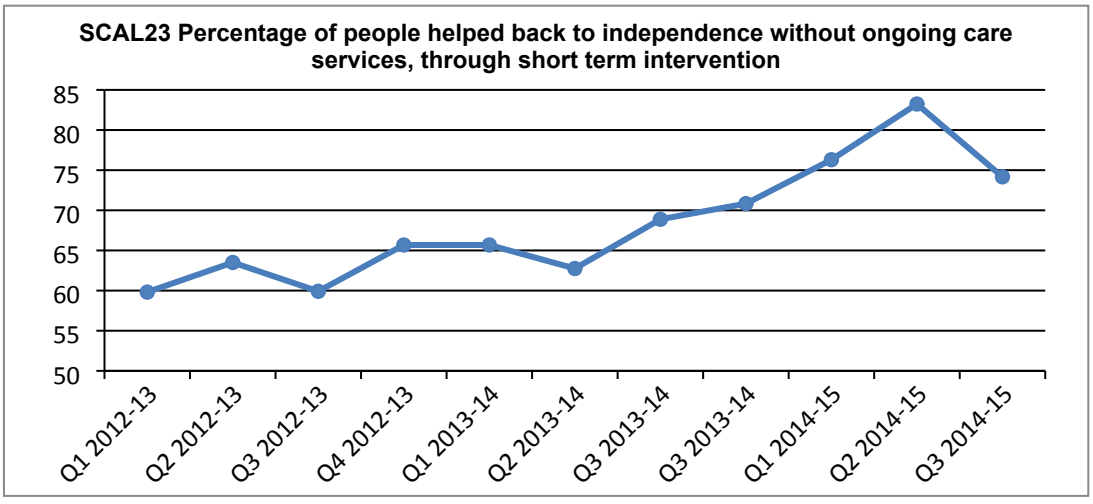
Graph 1 shows the benefit of having in reach Home care staff based in the hospital wards. Theses posts are wholly funded through the RCF Grant. Health and Social care staff were co-located into the CRT's in April 2013 and since this time the percentage of unnecessary calls has been reducing, although there is a small increase from Quarter 2 to Quarter 3. The trend for decrease is as a direct consequence of the Home Care staff engaging with health staff in the CRT and with the service user prior to hospital discharge. This has resulted in a better outcome for service users. Further monitoring of this indicator is required to determine whether further interventions will result in sustaining a further decrease in unnecessary callouts.

Graph 1



Graph 2 shows the improvements in percentage of people helped back to independence in the Cardiff CRT's. Since the co -location of Health and Social Care staff in the CRTs in Q1 2013/14. It can be seen that there was an initial dip in performance during the bedding in process but that rates have been increasing each quarter to end of Quarter 2, 2014. There has been a decrease for Quarter 3 from 83% to 74 %, further monitoring is required to see if this is a short term blip or whether this is a continuing trend.

Graph 2



Assistive Technologies

Project status = Closed GREEN

The RCF Grant supported a review of the current operating models in Cardiff and the Vale of Glamorgan using assistive technologies i.e Telecare. Independent advisers worked with officers to develop a future target operating model that could be applied in both Authorities.

Achievements

- There is no further funding for this project under the RCF grant. Funding has been allocated under the ICF Grant for both Cardiff and the Vale. Both Authorities are delivering projects which will take forward the recommendations in the independent review commissioned as part of this RCF Programme.

Project Risks and Issues

None

Streamlined Integrated Assessments

Project status = GREEN

This project has delivered a streamlined integrated assessment (IA) process which will be used across the three partner organisations. It is also funding a process of culture change for staff completing the assessments, moving from a culture of dependency to one of independent living where this is appropriate.

Achievements

- The final draft of the IA Nursing Inpatient Assessment Form was taken to the Clinical Standards and Innovation Board on the 19th November and has been given the final approval by the IA Project Board. The form will now be taken to the Nursing Midwifery Board with a proposal to pilot it for six months. The form will be used in paper form in a hospital setting, and arrangements will be made for the form to be built in PARIS to enable use in the community. Significant work was undertaken in Quarter 3 to fully integrate this process across the UHB and to combine the nursing assessment document with social care Integrated Assessment documentation.
- The Intermediate Care Liaison Manager, in the UHB is preparing a discharge checklist which will be included in this process.
- A Cardiff and the Vale of Glamorgan Health and Social Care Partnership 'Integrated Assessment In-patient Assessment' document has been developed, and a rigorous consultation process carried with health care practitioners.
- A training and communication plan for implementation across the LHB is being developed to support this in 2015 (the Integrated Discharge Service will be included in the development of this).
- Initial work commenced with OT's from Cardiff and a draft form has been developed to link their assessment with IA. The scope has now been widened to include representatives from the Vale of Glamorgan and the LHB to consider the development of a shared IA OT Assessment tool. After an initial meeting in November, a further two have been planned for January 2015.

- The proposed tool was taken to the UHB Management Team in November. Meetings are planned for January 2015 to enable its implementation within PARIS.
- A review of the CRT process in Cardiff Health & Social Care took place, resulting in the front end of IA (Core Data and Promoting Well Being, Advice and Information) being utilised from 24th November.
- The IA Assessment tool was presented to staff at Marie Curie with a view to the assessment and referral forms being used by this sector.
- An audit of all referral forms has commenced, the findings of which will be analysed with a view to streamlining and improving the process further across all areas in line with IA in 2015.
- The IA Development Group has met twice in the last quarter. It continues to meet to further develop and improve the forms, supporting guidance and, to inform changes to our electronic case file recording and business processes. From this, the first IA Development News Letter was circulated to staff to keep them updated about changes and improvements. A second is planned for the next quarter: http://cmsweb.cardiff.gov.uk/cardiff/ObjView.asp?Object_ID=15178
- Work has commenced to update and review the assessment information on the Internet. In addition, a section for staff has been developed on the Intranet to keep them informed about IA and associated performance indicators and business processes:
- Work has continued to review and update our Case File Audit Tool in Line with Integrated Assessment.
- Throughout the quarter, advice and guidance continues to be provided to practitioners, Performance Information and CareFirst staff in relation to IA.
- The UHB have also developed an educational package to support roll out of the Integrated Assessment document across the UHB and will be training Integrated Assessment trainers for all clinical areas in February 2015.
- Four Outcome-focused practice training sessions have been delivered for Social worker and Social Work Assistants to ensure that the integrated assessment process focuses on outcomes and the problems that can arise if a clear focus on outcomes is lost. The course has adopted an interactive approach, with participants encouraged to join in discussions. Feedback on the sessions has been positive.

Project Risks and Issues

1. The training does not deliver the required shift in culture change
   Mitigation – Operational Managers involved in developing the training specification.

Streamlined Integrated Assessments Performance Measures

Indicator Title	Previous Year	Quarter 1	Quarter 2	Quarter 3
The average number of working days between initial enquiry and completion of the care plan.	31	26	26	24

Table 1 shows the reduction in the length of time from the start of the Integrated Assessment process to the completion of a care plan. The new streamlined process has resulted in the process being improved by 7 days which is better for service users and enables the team to undertake more assessments.

Enhanced Occupational Therapy

Project status = **GREEN**

This project has increased the current Occupational Therapy and equipment capacity to review current high cost packages/double handling cases with a view to ensuring that all necessary equipment and enablement opportunities have been provided. This will result in service users and carers maximising their independence, achieve better outcomes and make savings in the cost of packages of care. It is also trialling a new model of working which is reducing duplication of visits for home care staff and Occupational therapists. There are different approaches in Cardiff and the Vale of Glamorgan which reflect the local demography. Regular project team meetings take place across the two Authorities to ensure best practice is shared and benefits are maximised.

Achievements

- The additional review OT has been working collaboratively with case managers undertaking timely reviews of people with a Physical Disability. This work includes review of high cost packages or double handed packages of care or situations where there is a potential "failure" in the community service. This work has delivered the following benefits:
    - Safeguarding – through assessment and task analysis, the OT takes an 'alerter' role highlighting potential or actual problems, which can be worked on jointly with a Social Worker to prevent, reduce or end abuse.
    - Good Practice to ensure outcome measures and goals have efficacy, efficiency and are still effective for both the Service User and the Authority.
    - The reviews take account of the individual's circumstances to promote awareness and change as normalisation of and part of the reablement process. Single handed packages of care give the service user more privacy and better promotes their dignity.
    - Increased communication and the provision of additional information for the service user from the outset to inform people how the process works and to manage expectations, emphasising that reviews of care packages are ongoing and will need to reflect current needs and recovery.
    - Closer working with Physiotherapists to support and encourage service users to redefine goal planning, as part of reviews, where appropriate
- Delivery of savings, alongside improved outcomes for service users, with more outcome focussed packages of care
- A new model of working has been established and being piloting using the Occupational Therapists (OT's) to undertake initial assessments. This has delivered savings and improved outcomes for service users by reducing the number of assessments carried out by different specialists (See performance measures)

- In the Vale of Glamorgan the review of high cost care packages is continuing and is reducing packages through the provision of equipment or advice to carers on appropriate methods of manual handling.
- With the opening of the new Extra Care facility locally (Project funded through the ICF), working closely with service users as they move in to ensure appropriate equipment for safe care and possibly reduced care levels.
- Joint visit with Social Worker in newly set up Intake Team based at C1V to review need of care package for newly referred service user.
- Referring on to other services such as VCRS where rehab may improve function and independence in some tasks.
- Education to family and carers around improving function either by rehab or provision of equipment- to help decrease or maintain a safely delivered care package.
- Review of high cost care packages with a view to reducing the package with provision of equipment or advise to carers on appropriate methods of manual handling.
- Review of cases where a new request has been made by the Care Agency to increase care as they are struggling to manage with one carer or within the time allocated to visits.
- Referring on to other services such as VCRS where rehab may improve function and independence in some tasks.
- Education to family and carers around improving function either by rehab or provision of equipment- to help decrease or maintain a safely delivered care package.
- Review of care packages and equipment provided following hospital discharge.

Project Risks and Issues

1. Unable to recruit specialist staff which could result in a failure to spend budget on time and not deliver maximum benefits

   Mitigation – Close working with HR to identify fast track processes to recruit processes to recruit specialist individuals. Doubling up of resources for Q3 and Q4 to maximise benefits

Enhanced Occupational Therapy Performance Measures

In Cardiff the Review OT has reviewed 6 new service users during Q3 with the following potential weekly savings:

1 confirmed as a saving £115.95 per week, 1 with the potential of being reduced, saving £399.10 per week, 4 prevented increased packages of care costs. The total amount prevented being - £535.30

The additional OT's recruited to carry out initial assessment and prevent duplicate visits.

24 service users have been supported, all of who were visited either before, or at the same time as the Home Care Manager (HCM), therefore preventing duplicate visits for the service user. Of these, 6 did not receive / require a visit from the HCM.

Of these 24 service users, 14 received care from the CRT, 8 declined care, 1 person did not require any care, and 1 person was staying with family members and had equipment provided via OT's to assist.

Of the 24 case:

- 4 people are independent with no ongoing package of care required (saving £291.41)
- 2 people were admitted to hospital or deceased
- 9 people have declined care, either at the outset or during the process (saving £798.21)
- 4 people have an ongoing care package, including 1 person who is set up for direct payments (saving £79.18)

OT equipment or advice was provided in 17 of the 24 cases improving outcomes for service users.

30 cases have been reviewed:

In the Vale of Glamorgan:
During the 3rd quarter, 31 new cases were seen. Some remain ongoing. For this quarter weekly savings of £840 have been achieved through the work of the review OT's through the

- Review of high cost care packages with a view to reducing the package with provision of equipment or advise to carers on appropriate methods of manual handling.
- Review of cases where a new request has been made by the Care Agency to increase care as they are struggling to manage with one carer or within the time allocated to visits.
- Referring on to other services such as VCRS where rehab may improve function and independence in some tasks.
- Education to family and carers around improving function either by rehab or provision of equipment- to help decrease or maintain a safely delivered care package.
- Review of care packages and equipment provided following hospital discharge.

Enhanced Learning Disability Services

Project status = GREEN

This project is providing a temporary resource to review care packages for people with learning disabilities ensuring that appropriate and cost effective care packages are provided and developing a modernised, integrated Learning Disability day service across Cardiff and the Vale of Glamorgan which will deliver better outcomes for people with Learning Disabilities that are sustainable in cost terms.

Achievements

- The effectiveness of the project continues to be evidenced in a variety of ways. It is important to note that while savings have been made, reviews have now been completed in a timely manner. This has enabled work to progress regarding the Day Opportunities Strategy and identifying people for the Closer to Home project. As a result we can now ensure we are delivering the better value and outcomes for service users.
- A review function has been established within the Cardiff and Vale Learning Disability teams and this requires time to bed in and strengthen. It has already started to challenge the rather paternalistic

culture/practice of Learning Disability Services (which is a national issue) to ensure people are supported at appropriate levels and are eligible for services.

- Review of people using the internal day service and detailed plans for signposting to alternative provision is on track with case managers.
- The structure for new internal day service in Cardiff is currently being mapped.
- A number of new models of working i.e. social enterprise and cooperative in the Vale have opened or re-established including YMCA HUB café, TRACK and Positive Images. There is already provision in Cardiff to signpost people.
- The savings tracking tool for both Cardiff and the Vale continues to evidence the effectiveness of the project and the work undertaken by the four RCF workers. (See performance measures below)
- Significant savings have been identified through review of third sector day provision and this will be independently verified by Financial Services
- Closer to Home - 14 individuals who have been identified as wanting and are able to return from out of county placements. The first property will come on line in November 2014 and 4 people will return. This will improve outcomes for individuals alongside, £49,000 savings which have already been achieved through this work in Quarter 2.
- Handover for 2 properties imminent within Cardiff to start to return individuals back to the locality. This will include some Closer to Home service users. Compatibility exercise already underway by operational teams

Project Risks and Issues

1. Insufficient time for the review function to be embedded within business as usual

Mitigation – Case made to Joint Local Service Board and Welsh Government relating to the Year 3 funding for the project

2. Council approval required for the Day Opportunities Strategy 2014-17 so it can fully commence

Mitigation – Cabinet Members in Cardiff and the Vale briefed and reports for both Scrutiny and Cabinet are approved.

3. Availability of suitable properties that can be adapted to enable service users to return closer to home

Mitigation – Actively working with the Housing Departments in Cardiff and the Vale and also with RSL's to source appropriate accommodation.

Enhanced Learning Disabilities Performance Measures

The performance measures for this project relate to improved service user outcomes in addition to delivering potential savings. A service user outcome survey will be included in the final evaluation of the Programme.

Vale of Glamorgan

- Over 100k of savings has been delivered through the use of assistive technologies in Supported Accommodation.
- Over 50k savings identified in residential spend and 25k in domiciliary spend to date. This has led to a projected underspend of the LD budget of 13k and is verified by Finance.
- The review function will be further developed within the team, this will then need time to bed in to ensure project outcomes continued to be delivered.

Cardiff

- 112k savings has been delivered on review of high costs residential placements with further savings identified that are yet to be verified by the Finance Team
- Review of domiciliary care packages has achieved a savings of 120k subject to further verification.
- Closer to Home - 14 individuals who have been identified as able to return from out of county placements. The first property will be handed over in next 2 weeks and will then facilitate the return of 4 people following movement of other placements. This will improve outcomes for individuals and a 49k savings for this year has already been identified.

Improved Commissioning

Project status = Closed **GREEN**

This project commissioned an external adviser to undertake work to explore the development of a joint brokerage system across Cardiff and the Vale of Glamorgan. A report was completed within time scale and work is now on-going between the two Local authorities on the potential for joint commissioning. There is no further funding for this work under the RCF grant.

Project Risks and Issues

None

Nichola Poole - Programme Manager Remodelling Social Care and Integration with Health across Cardiff and the Vale of Glamorgan. 29th January 2015

Appendix 1 Regional Collaboration Fund Case Studies

Case Study 1 - Enhanced Occupational Therapy Services Project

Background

Mrs S is a 90 year old lady who lives with her husband in a semi- detached privately owned house. Mr S has been her principal carer who has assisted her in all aspects of personal care and activities of daily living since she became immobile following a fall seventeen years ago, where it was determined that she had fractured her hip and had developed spinal compression at sacral level. Mrs S did not receive rehabilitation on her husband's directive, consequently, finding that he needed to take on all roles pertaining to Mrs S's need including household chores

Mrs S was admitted to hospital in October 2014 where she was diagnosed as suffering from a urinary tract infection, further complicated by the discovery of kidney calculi (stones). She was treated and maintained in bed until medically stable, then discharged home. In this interim, Mr S became unwell having injured his shoulder and was unable to take on the previous role in caring for Mrs S. A profiling bed with integral side rails, mattress, commode and patient turner (to assist with chair/bed/commode transfers) were provided at discharge and a double handed package of care consisting of 4 x 30 minute calls over a 7 day period was instated.

On discharge from hospital, Mrs S remained unwell and her GP was notified, He diagnosed a chest infection and advised that Mrs S remained in bed until well enough to be transferred. Following a further period in bed, she recovered, and transfers with care staff commenced, a referral was made to the community occupational therapy team, as carers were now experiencing difficulties using the patient turner with Mrs S which necessitated that they adopt unsafe modes of practice.

Mrs S suffers spinal cord compression at sacral level, has suffered a cerebral vascular accident in 2011with residual effects being a left sided hemiplegia and dysphagia, which have resolved to a greater extent. She suffers from recurrent urinary tract infections and has bilateral cataracts for which there is not surgical intervention planned.

What we did

An assessment was undertaken where it was determined that use of the patient turner was unsafe and an alternative was provided, in the form of an electric stand hoist and transfer sling, further assessment ensued however, Mrs S was very nervous and agitated and could not tolerate the transfer sling! Further discussion between Mr and Mrs S occurred where it was put to them that a full hoist and sling would now be required if transfers from bed to chair were to go ahead. A hoist, and universal sling, was provided and a re- assessment carried out. The outcome of this assessment was favourable, however on transfer to a chair, Mrs S could not tolerate sitting without feeling nauseated and distressed, she was also much weaker and requested that she be returned to bed and to remain in bed for future care.

Outcome of assessment and actions

Mrs S had been in receipt of four thirty minute calls of double handed care each day, over 7 days each week, these were for personal care and toileting needs.

The cost of the care package was £420 per week, the care agency hourly rate being £15 per hour.

Given her change in her circumstances, the package of care was changed to increase the morning call to 45 minutes, for personal care, with a reduction to 15 minutes for the lunch, teatime and evening calls which were for incontinence pad change, the calls would still be double handed.

In total, a saving of 7 man hours each week was made, with a yearly saving of 364 man hours.

The new package of care was reduced to 21 hours each week at £15 per hour equating to a total cost of £315 each week. An overall saving of £105 per week was made.

How the person is better off:

Constitutionally, it would have been more beneficial if Mrs S could have been transferred from her bed into her chair, in terms of psychological and physical welfare. However, due to her frail condition and her inability to tolerate sitting in her chair (even for a short period of time) and considering the fact that a profiling bed with backrest and knee brake was in use, this could be positioned to provide Mrs S with comfort and the ability to sit up whilst supported, so that she could interact with her environment. The distress of sitting out in her chair outweighed the benefits for Mrs S.

Mrs S is contented and agrees that staying in bed is the best option for her.

Benefits for service user /carer

Mrs S is very frail and her condition has deteriorated to a level where bed care is the only option. She can be cared for in bed, without being unduly moved and handled and can sit supported in her own bed, with access to the same environment as had been the case when she could sit out in her chair. Being in bed, the specialist bed offers her better body positioning and supports her posture, unlike her own chair. Mr S does not have to struggle to support his wife as had, been the case prior to her hospital stay, so he conserves his own body strength and prevents further injury to himself. With the reduction in time spent in toilet calls, carers are less intrusive and the visits quicker, which allows both Mr and Mrs S to resume a more private family life.

Case Study 2 - Enhanced Occupational Therapy Services Project

Background

Mrs S is an 80 year old lady who lives alone in a privately owned house. Her daughter lives locally and supports with shopping and cleaning tasks.

Mrs S has Lewy Body Dementia and has a right sided weakness. She is able to mobilise with a zimmer frame or a kitchen trolley with supervision of another person.

What we did

On assessing Mrs S, there was a care package in situ of 3 calls daily, double handling.

There was an old manual recliner chair in situ which client did not find comfortable. OT observed client being assisted to transfer from the chair by 1 carer. There is also a static commode in situ next to the chair which client needs assistance of 1 person to use. OT discussed with Mrs S' daughter regarding her chair. Daughter was planning to buy a riser recliner chair for Mrs S. OT agreed that this would benefit chair transfers.

The bed in situ was a ¾ size bed. Carers reported that at times they are required to slide client back in the bed but that in order to do so, one of them has to climb onto the bed to access the slide sheet in order to manage sliding. There were already wendylet sheets in situ but carers report that they were not being used due to client sliding down in bed when positioned slightly upright with pillows.

Daughter purchased a riser recliner chair and OT ordered a profiling bed.

How the person is better off:

Mrs S can now have the wendylet sheets in situ at all times on the profiling bed for repositioning as necessary.

With the profiling bed in situ, Mrs S needs only the assistance of 1 person to assist her in and out of bed, as the controls can be used to aid the transfer. The wendylet sheets can be used by 1 person to reposition Mrs S in the bed as necessary.

The riser recliner chair also aids clients transfer although she only needs assistance of 1 to transfer on and off the chair without the riser function.

The package of care has now been reduced to single handling calls, from 28.5 hours weekly to 18 hours weekly, a reduction overall of 10.5 hours per week.

This is a yearly reduction of 546 hours per year.

The cost of the bed and mattress provided was £410.

Case Study 3 - Enhanced Occupational Therapy Project

Background

Mr J is aged 64. He was admitted to hospital in November 2013 with nausea, vomiting, jaundice, decreased oral intake, poor liver function and at that time he was in heart failure and had shortness of breath and extreme fatigue.

On discharge a package of care was set up for him to return home. This consisted of 4 calls daily (total 2.5 hours), to help with personal care, transfers in the morning and supervision when mobilising. Plus 1.5 hours domestic call and 6 hours floating support for respite for wife to allow her to go out during the week.
A hospital bed was provided for use downstairs with commode in living area.
An extended period of rehab had taken place and this had improved Mr J's function.

What We Did

A referral was received to OT from the Social Worker. A joint visit took place and OT undertook functional assessment at the home.
Mr J had improved and was now able to perform all his personal care independently. He had no problems with transfers and was walking independently. Carers continued to attend and carried out more domestic work and meal preparation in their call times.
Recommendation was made to finish care plan completely. Mrs J was referred for a carer assessment to look at services that she could access to allow her to go out. She remained very anxious about leaving her husband at home alone.
Mr J had an appointment with his consultant coming up and OT recommended that they discuss with him his current medical condition and how he could progress and improve mobility. The couple had become very anxious about his condition from the previous year and Mrs J was fearful about leaving him on his own in case he died. With re-assurance from the Consultant and possible Physiotherapy intervention it is hoped that Mr J will continue to improve and start to do the stairs at home, so being able to sleep upstairs again and access bathroom and bedroom. Equipment supplied for hospital discharge can then also be returned to Joint Equipment Store.

How the person is better off:

Mr J and his wife have been re-assured about his independence and mobility through the intervention of the OT. He should be able to return to using the upstairs which will improve quality of life as the equipment that intrudes on their life downstairs will no longer be required. Mrs J will have a carer's assessment that will give her access to respite services for when she wishes to go out.

Case Study 4 - Enhanced Occupational Therapy Services Project

Background

Mr T is a 90 year old gentleman who lives in a privately owned house. His Grand- daughter and her partner live in the vicinity and have been calling daily to assist him with his personal care and activities of daily living. Mr T had received intervention from the community occupational therapy service in the past and minor adaptations and equipment had been provided. Hand rails had been fitted to the stairway; items of equipment provided to assist him meet toileting needs. Mr T was admitted to hospital in October 2014 having suffered a chest infection and exacerbation of his illness, he was hospitalised for two months and discharged under the supervision of his Grand-daughters partner, who had agreed to become a full- time carer, who, consequently moved in with him.

Mr T suffers from "Lewy" body dementia and is prone to urinary and chest infections. He is able to mobilise and gain access to all aspects of his home. Mr T has been able to prepare hot drinks for himself, and can with minor assistance attend to his own hygiene. Mr T's ability fluctuates due to changes in his cognition, however, Mr T is reported to be lucid for a greater proportion of the time.

What we did

Assessment of Mr T and his circumstances determined that since his discharge from hospital, that he has been in receipt of a care package, consisting of an hour each morning of double handed care for personal hygiene and a sitter service of three, three hour calls each week to enable his carer to visit with family. Equipment has been provided for hospital discharge consisting of a profiling bed with mattress and integral side rails, a commode, and walking caddy mobility aid. The bed was placed in the lounge with the commode in the vicinity. The walking aid was placed in an adjacent room. Mr T's chair had been raised on chair raiser units, with a pressure relieving cushion placed on the seat. The ground floor toilet had a raised toilet seat in place with integral hand rails. Lifeline is on site and can be used in an emergency

Observation of Mr T physical and cognitive ability determined that he was able to mobilise without walking aids around his home and locate all areas of his home without prompting, he was able to transfer on the stairs using the handrails that were fitted, without difficulty and could ascend and descend the stairs without causing undue concerns. Mr T could transfer to his armchair, double bed (in his bedroom on the first floor) and toilet independently and without difficulty. He presented lucidly, his carer advised that since discharge from hospital, he had not experienced any episodes of confusion or hallucinatory episodes. Mr T had been provided with a bath-board by his family which was removed from the bath, having been fitted inappropriately, the item being too wide for the bath and the fitting ledge too narrow. A perching stool with armrests was available to enable Mr T to sit to strip wash. Mr T's carer advised that he carried out all personal care with Mr T. Mr T requested that he return to sleep in his own bedroom on the first floor.

Outcome of assessment

Based upon Mr T's level of ability and his carer's availability and willingness to support Mr T he was allowed to return to sleeping in his own bedroom on the first floor. Mr T's carer being aware, that if Mr T became confused or disorientated that he return to sleep on the ground floor. Mr T's carer felt that he managed Mr T without excessive intervention from external agencies. Mr T's carer is also aware that lifeline can provide a bed occupancy sensor and door contact alarm should concerns arise in respect of Mr T getting up at night.

Mr T was being provided with an hour of agency care for personal hygiene needs, His carer advised that the agency did not carry out personal care and that carer was happy to meet this need, the a.m. call was withdrawn.

Mr T's carer advised that he did require three sitter calls each week to cover the times that he visited his family on the basis of maintaining safety for Mr T these were maintained

Based upon the assessment the double handed, hour call for personal care, was withdrawn reducing the hours of care from 14 hours to 9 a saving of 5 hours each week, which over a year equates to 468 man hours

Previous cost of care provision being £175 per week reduced to £108

Equipment was returned to stores total cost of equipment - bed £330 side rails £103, mattress £140 mobility aid £11.99, commode £16.82 total cost saved £601.81

Benefits to service user

Mr T is able to return to sleep in his own bed, as desired, and not constrained to living on the ground floor. The carer is happy to support Mr T in all aspect of care, however finds the sitter service beneficial as it gives him time out to visit his family without any worries about Mr T falling or having an accident.

Case Study 5 - Effective Community Resource Teams Project

Background

Mrs X was admitted for a second time after a fall at home which resulted in her receiving a fractured neck of femur and the need to have a hemiarthroplasty.

Mrs X lived alone in a two story house and was previously independent with her activities of daily living although she had had a number of recent falls with worsening mobility and also some slight memory problems.

What we did

The CRT In Reach officer funded through the RCF grant visited on ward and screened Mrs X's notes and identified a possible need for equipment to be provided prior to discharge. She discussed this with the ward OT. Mrs X's son was present whilst the In Reach officer assessed her on the ward and was able to give information to them both regarding community alarm and key safes. During the conversation Mrs X's son, expressed his concerns about his mother's discharge as she had previously been very independent and due to having hip precautions in place for her discharge, she now needed time and support to fully recover. Both were very concerned about a permanent potential loss of independence.

The In Reach officer was able to explain that the CRT team is a short term service, with the emphasis on the role of the carers to work with Mrs X promoting her independence and dignity and ensured them both that the aim of the CRT team was to maintain and retain independence throughout. Mrs X's son lived away and was unable to provide much practical support. In Reach were able to give information for Age Connect to assist with shopping until she was back to her pre admission levels of independence with regards to her mobility. In Reach identified that CRT full team input was needed in the short term.

Whilst the home therapist identified that Mrs X was not safe to bath she was able to strip wash with carer support and an assessment for a level assess shower was requested. Due to Mrs X memory

problems it was arranged for her medication to be put into blister packs. Mrs X progressed very well with carers who helped her to establish a routine at home and she recovered to regain her full independence.

How the person is better off:

Mrs X was very grateful for support and the family are very pleased with the outcome.

Had it not been for the information and support provided through screening by the In Reach service supported by the RCF grant and the Effective Community Resource Team project, Mrs X would not have received any information until she was at home, In Reach enabled a safe discharge from hospital and alleviated family concerns. In contrast had the officers from the CRT not had contact prior to date of discharge this could have resulted in re admission back into hospital as Mrs X was fiercely independent and very likely to have declined care support.

Case Study 6 - Enhanced Occupational Therapy Services Project

Background

Mr P, a 92 year old was discharged from an out of county hospital with a fractured right hip, and dynamic hip screw in place. Mr P had been in hospital for 5 weeks, but was described as mobile, independent in all transfers, and experiencing some urine incontinence on discharge. Mr P had previously been supported by his spouse, but on discharge the hospital had requested four calls a day to assist with personal care, dressing, meal preparation and to assist in incontinence management.

What We Did

On the initial joint visit, Mr P was advised of the service, and what the service could provide to support his transition home. On discussion Mr P wished to try to be independent without the support from carers. All options were discussed with Mr P, it was then agreed that carers would not be put in place initially to allow Mr P time to adjust at home. After some discussion Mr P noted that the main issues were his incontinence and PC, Mrs P agreed, and stated that she would provide all meals. Mr P noted that he became tired standing in the shower, and had a history of falls. The shower was assessed and it was suggested that a wheeled shower chair may be suitable due to the shower environment and Mr P's transfer needs. It was agreed that the OT would revisit in two working days, and complete a shower assessment with equipment. If carers were required, home care services would be notified.
OT agreed to contact District nurse service, and advised on transfer techniques out of the bed, and when putting on incontinence pads.

How the person is better off:

After the follow up visit, the shower equipment was deemed suitable, and Mr P was able to wash independently and safely. Mrs P no longer needed to supervise Mr P, but was able to wheel Mr P in and out of the shower. Carers were put in for morning calls only to assist Mr P and Mrs P and build confidence. After five days carer calls were no longer required.

This joint visit ensured that the service users was safely discharged and risk of readmittance was reduced. Joint working allowed for care needs to be addressed straight away, and independence to be regained. Joint visiting reduced requested care calls of 4 a day to one call a day for five days.

Service user/citizen feed back

They were very happy with the service, but felt with the equipment in place, and support from the DN service, they were able to manage independently

Case Study 7 - Effective Community Resources Teams Project

Third Sector Partnership - Age Connects Community Liaison Officer

Miss A, a 94 year old who lady lived alone was well known to the CRT following numerous hospital admissions as a result of falls due to decreasing mobility.

Miss A was hugely perceptive and feeling isolated in her home, her only sibling was unable to visit due to poor health, she said that the only "outings she had were to hospital" Miss A realized that regrettably it was time to consider moving to residential care. This was an very emotive undertaking for her.

Miss A received considerable input from the teams OT's and Physiotherapists as she progressed from using a stick to a walking frame and then a wheelchair- there was a collective concern from the team as to her deteriorating health and mobility and her re referrals into the team.

The Community Liaison Officer (CLO) was asked to visit Miss A to look at ways of increasing social interactions.

During the visit, her physical and emotional pain became quickly apparent, Miss A was very upset and said she did not want to sell her home and move into a residential nursing home but also recognized that this was possibly her only option. The C.L.O subsequently visited Miss A twice at home to discuss at length various future housing options and provided emotional support and advocacy regarding provision of residential care settings in the Cardiff area. Brochures of homes were made available and several followed up or discarded.

Although still emotional, Miss A accepted that selling her home and moving into a supported environment with a community of older people was the way forward. From this, the C.L.O was able to work efficiently with the Occupational therapist in the team to make an appointment for the client to visit her preferred option and it was arranged that both CLO and OT would accompany the lady by taxi to her first visit.

As Miss A required the use of a wheel chair, the O.T was able to provide both practical and emotional support alongside the C.L.O when the two hour familiarisation appointment took place.

Although, the first home visited was not the right practical or emotional fit for Miss A, several more appointments followed whereupon the O.T met the client at an arranged time at her house, in order to help her into a wheelchair adapted taxi and the Nursing Home representative was able to meet Miss A

to show her around, and discuss queries. Another member of the team met Miss A on her return home to help her mobilise into her property.

Following three more potential viewings and within a six week time frame Miss A found “a suitable homely home that is perfect “ and she is currently preparing for her move .

Working collaboratively and efficiently as a team has enabled Miss A to live in a secure, safe , caring environment with a community of residents and staff she feels at ease with, the Team are delighted Miss A is comfortable with her choice and will be cared for in a long term, homely setting.