Care & Repair Cardiff
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CARDIFF
CAERDYDD

Quarter 3 Report

Intermediate Care Fund 2014/15

City Of Cardiff Council

City of Cardiff Council - Intermediate Care Fund 2014/2015
Summary of Progress – Half Yearly Report

Ref	Project Description	Progress Update	RAG	Risks

1	**Establishing a Single point of Access**
	Gateway Service will provide a Single Assessment Gateway where all appropriate advice and services will be integrated.
		• The Gateway has visited just under 300 people since August 2014, 240 of those visits in Quarter 3. Evaluation of service provided has demonstrated that the 4 most popular service drivers are:
		  • Income Maximisation
		  • Social Isolation
		  • Preventative slips, trips and falls
		  • Assistive technology
		• 92% of clients Felt able to remain living at home independently in their own home, with many saying they would not have been able to find the support/guidance they had were it not for the Gateway.
		• A single financial assessment form is now in use, covering Disabled Facilities Grants, Targeted Elderly/Domiciliary and Residential Care Assessments.
		• Meeting the “One Council Approach” a shared Database has been developed and unified working practices are now in place with 50% of Visiting Officers being able to carry out multiple Assessments. Training for all Visiting Officers will be completed by the end of February.
		• Commencing in Quarter 3, Care Package Reviews
			Green	<u>Risk:</u>
				The Gateway service and deliverables are not sustainable after ICF funding ceases and project closure.
				
				<u>Control:</u>
				Services are being future proofed by bringing together existing visiting officer roles to create one generic visiting officer. Work is underway to determine the future state of the Independent Living service.

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		have taken place with a view to establish actual and preventative savings to negate the need for new or additional support. One element proving successful is partnership working with Occupational Therapists to provide support through technology, equipment or adaptations to prevent care • The Gateway Social Worker has been working on cases within the Social Work Review Team Identifying the following cost savings/ cost avoidance: • 6 people no longer require the Community Resource Team and are now supported by the implementation of adaptations saving £39,811 per year. • 2 Care Packages have been reduced and are now supported with the implementation of adaptations saving £11,144 per year. • Through new partnership working with Occupational Therapists it has been possible to negate the need for care with early of equipment/ adaptations estimating £64,000 of cost avoidance. Housing Resettlement Officers are now fully integrated in Whitchurch and Heath hospitals. A Database has been created to manage referrals and performance information and is now being fully utilised. Fortnightly meetings take place for work load updates to raise	Green	

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		issues and good practices to help develop the service. • In Quarter 3 Housing Resettlement Officers received 67 referrals and have assisted with 45 hospital discharges. • The discharges have estimated to have saved 127 bed days resulting in an estimated save of £29,210 based on £230 per bed day. The most common issues resolved have been based on housing issues and homelessness.	Green	
2	**Preventative Interventions** Provision of preventative and intervention services including work with care and repair to support integrated services for health, housing and social care needs in support of older people to maintain their independence and remain in their home.	• In Quarter 3, 68 Safety at Home referrals have been completed totalling 244 to date in an average of 20 days. Works include fitting hand rails, steps and lever taps. In Quarter 3, 2 Safety at Home referrals have assisted with safe hospital discharge totalling 11 for quarters 1, 2 & 3. It is estimated that this has saved 11 Hospital bed days. Estimated savings are £2,783 @ £253 per bed day. • In Quarter 3, 359 Rapid Response Adaptation Programme Referrals have been completed totalling 775 referrals to date in an average of 10 working days. Works included fitting grab rails, hand rails, smoke detectors and key safes. In Quarter 3, 80 completed referrals have assisted with safe hospital discharge totalling 101 for quarters 1, 2 & 3. It is estimated that this has saved 101 bed days. Estimated savings are £25,553 @ £253 per bed day.	Green	

Ref	Project Description	Progress Update	RAG	Risks
		Feed back from clients. • 96% of clients would recommend this service. • 98% of clients are satisfied with the standard of work completed. • 92% of clients felt more able to remain living in their homes with increased independence.	Green	
3	**Third Sector Partnership** Healthy and Active partnership to provide support to older people. Community volunteers to work across the city to ensure older people, keep active, stay healthy and avoid social isolation.	**Age Connects** • Age connects are now offering a volunteer support service to facilitate access to existing local based services with focus upon addressing social isolation. • Criteria for referral has been approved and clients have been referred since 1st December 2014. • A total of 43 referrals have been received during December 2014. • 41 out of 43 referrals have become clients. 2 being ineligible to receive a service. • 15% of clients have requested to be linked to activities in their communities to help reduce social isolation. • 85% of clients have requested a home visitor to reduce social isolation. • 75% of clients requesting a home visit considered themselves housebound. • 17 out of 41 clients are currently on the waiting list.	Amber	Risk: Services delivered by HAP require more investment than the identified grant. Control: Robust financial Monitoring and funding post march 2015 to be provided by Health.

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		• 56 Volunteers have been recruited and 17 in the process of recruitment. • On average each volunteer spends approximately 2 hours a week providing support. **<u>Citizen Driven Health</u>** ▪ Project brief has been finalised and Service Level Agreement ha been signed off. ▪ A Project Working group has been established with representatives from Cardiff Council, InQube, University Health Board, Social Service, Third Sector and Third Sector Housing meeting on a monthly basis ▪ Ely and Grangetown were selected as the target community groups based on risk factors associated with higher hospital admissions. ▪ A 'Design Studio' workshop was held with stakeholders to enable a better understanding of the co-production approach. And use the range of expertise to develop asset and experience maps within the target communities. ▪ 1 Kick Off Workshop with older people in Grangetown has been completed ▪ Ely Older Peoples Workshop has been postponed to January 2015 to allow the design of the event and Communities First to have fuller involvement.	Amber	<u>Risk</u> Citizens slow to engage with the Citizen Driven Health Initiative <u>Control</u> Co-production and working group established to maximise engagement and minimise risk

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4	**Interim Care Flats** The provision of interim care units which can be utilised as step down accommodation whilst a persons home is being adapted or enabling the person to be assessed fully in a home environment while allowing the person to adapt to support provision	• Six Properties have been approved for use as Step Down Accommodation. • Legal documentation has been arranged on the short term lettings policy of the flats including discussions with Health & Social Care. • A Step Down Coordinator has been employed to manage referrals, admissions, lettings and any issues relating to the accommodation. • A referral mechanism and criteria have been approved between Housing and Health and Social Care. Referrals will be received from Social Work Teams, Occupational Therapy and Housing Resettlement Officers. • All structural work to remodel the flats has been completed, the flats have been made accessible throughout with doors widened and threshold steps removed. • Two of the Flats are complete with the exception of a Gas Service and deep clean. Both will be available for referral by approximately the beginning of February. • The design and fit of the properties has been completed in conjunction with the Community Occupational Therapy Service and the Disable facilities Service. These properties have also been decorated to a specification agreed with the RNIB.	Amber	<u>Risk</u> Unable to identify Suitable Service Users who can be discharged from hospital into Step Down Accommodation. <u>Control</u> Robust referral criteria and mechanism in place to determine suitable Service users. All referrals screened by Step Down Coordinator to ensure Service users meet criteria and are suitable. <u>Risk</u> Service users move into Step Down Accommodation and do not want to move back to their own accommodation. <u>Control</u> Robust short term tenancy agreements have been created and approved. Clear guidance has been created for Service Users before entering Step Down Accommodation detailing terms and conditions. Step Down Coordinator in place to ensure no delays with Service Users returning to their own home.

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		• Adaptations installed in Lydstep Flats include: ▪ Level Access Shower ▪ Height Adjustable Kitchen ▪ Automatic Toilet ▪ Automated video door entry system ▪ Tele Health equipment ▪ Automated window openings ▪ Bed hoists ▪ "Altro" type vinyl flooring • Agreement has also been made for the flats to include "Just Checking" • The four remaining flats are expected to be completed by the end of Feb and match in specification where possible.	Amber	
5	**Smart House** A suitable property will be identified and adapted to include a range of equipment, assistive technology and Telecare/Telehealth packages. This is to encourage more independence and awareness of what can be done in the home without care.	• Meetings have taken place to discuss changes to the existing lease for the Joint Equipment Service which has been approved to incorporate the Smart House within the existing facility. • Plans for the construction of a Smart House within the Joint Equipment Service Warehouse have been approved. • A structural Engineers report has been commissioned and work plans approved. • Partnership working with Care and Repair to complete the construction works has been agreed. • A Fire Safety Consultant has provided a Fire	Amber	<u>Risk</u> Smart House was originally expected to be a refurbishment of an existing property. With the change to construction of a house within the Joint equipment service. it is forecasted that the Smart house may over spend <u>Control</u> Regular meetings taking place to monitor spend on the Smart House and consideration may be given to

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		Safety Report. • Structural work commenced on the Smart House in early December including the installation of additional supports to create a second floor to make the property look more like a house. • Specification for the Smart House has been agreed with involvement from Occupational Therapists and Disabled Facilities on equipment to be included in the Smart House.	Amber	the movement of Capital between Step Down and Smart House
6	**Visual and Hearing Impairment Project** Joint working with health, Social Care and Housing to support elderly citizens with sensory loss to stay in their own homes with greater independence.	• In Quarter 3, a Rehabilitation Support Worker and Social Work Assistant have been employed. • Work has been ongoing in quarter 3 to review and reassess existing users of day care centres to see if they have the reablement potential to have social isolation needs met within a community based setting. • Partnership working with Hearing Loss Wales, RNIB, Health and Social Care continues to work well with regular meetings and project updates. • Work has been done in a variety of wards to raise awareness of sensory loss and ensure sensory impairments are considered as part of the discharge process. • Working groups have been set up to pass the knowledge gained back to the wards. • Action on Hearing Loss Wales provided Sensory Loss Awareness Training to Gateway staff. • In Quarter 3, 74 clients that accessed Visual Impairment Services received equipment.	Green	<u>Risk:</u> Partner processes delay project activity. <u>Control:</u> Ongoing and regular communication with partners. Appreciation of partner's constraints within the scope of the project deliverables.

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		• The sensory Loss Support Worker met 17 Service Users during Quarter 3. Interventions included. ▪ Information Provision ▪ Hearing aid Maintenance ▪ Referral to Audiology ▪ Referral to Third Sector Organisations ▪ Referral to Social Workers • Evaluation is underway to estimate the impact of the rehabilitation service on quality of life outcomes for people with low vision.	Green	
7	**Promotion and delivery of Assisted Technology and Promote increased usage of community alarm** Reviewing and implementing innovative solutions as an intervention measure to aid independence and prevent crisis. Promotion and expansion of telecare / telehealth and alternate solutions to allow people to remain independent.	• Several awareness sessions have taken place with Key Stakeholders such as Occupational Therapists, Social Workers and The Gateway to raise awareness of services and Assistive Technology. • Meetings have taken place with the Step Down Coordinator to determine fitting Just Checking and Telecare in the Step Down Accommodation. • A review of the Assistive Technology referral process has been reviewed and new forms have been created to simplify the process which is now in use. • A new framework for the procurement of TeleCare has been approved making it simpler to purchase new equipment. • Assistive Technology Working Group continued to meet to discuss referrals.	Green	<u>Risk</u> Council Procurement mechanism delays sourcing technology solutions <u>Controls</u> Available frameworks reviewed to make procurement processes more efficient but also compliant with existing legislation. <u>Risk</u> Lack of Staff Engagement in the new model. <u>Controls</u> Regular meetings with partners and

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		• Several marketing and promotional activities have taken place which include. ▪ the production of a DVD ▪ Road shows in St David's 2 ▪ Adverts showcased on the Big Screen in The Hayes. ▪ Full page advert has been placed in the Cardiff Echo • 97.5 % of customers felt able to remain living in their own homes with increased independence as a result of Assistive Technology. • 97.3% of customers felt safer living in their own homes as a result of Assistive Technology.	Green	Briefings take place to maintain awareness.
8	**Developing Medicine Management** Supporting medicine management for those receiving domiciliary care to improve patient safety, promote independence and dignity	• Recruitment to post in Quarter 3 was mostly ongoing with difficulties due to the number of applications received and interested parties being offered other posts. • A Project Officer has been in post since Mid December to review and help identify methods to reduce polypharmacy. (Patients on Multiple Medications). • The Project Officer will identify patients where polypharmacy is a concern and make safe and sensible recommendations on prescribing in situations where extra consideration is needed due to the complexities of both the individual's conditions and their medication. This includes: ▪ when a patient is either on, or has indications to be on, multiple	Amber	<u>Risk:</u> Delay in recruitment of staff. <u>Control:</u> Recruitment issues have been escalated to hasten the recruitment process.

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		medications; ▪ when a patient is at risk of falling ▪ When a patient has multiple carer calls to supervise or administer medication • Reviews of the recommendations by the Project Officer will then be undertaken by a Pharmacist to determine their effectiveness.	Amber	
9	**Virtual Pool Fund** Creation of a virtual pool of funding to enable hospital discharge to take place prior to the requirement for decision making on the organisational responsibility	• Quarter 3 involved discussions between UHB, Health and Social Care on the provision of intermediate care beds to reduced Delayed Transfers of Care (DToC). • Processes and criteria have been developed to enable the transition from Hospital to Intermediate Care to reduce DToC. • Intermediate Care beds at The Court have been purchased to assist with discharge during the Winter Pressures period. • These beds have been available since Late October resulting in 10 Service Users Being discharged from hospital • The average time spent at The Court during Quarter 3, was just under 30 days. • During Quarter 3, Discussion took place between UHB, Health and Social Care on the provision of additional staffing to provide Domiciliary Care to improve Delayed Transfers of Care and support the transition from hospital to home.	Amber	<u>Risk:</u> Partner processes delay project activity. <u>Control:</u> Ongoing and regular communication. Appreciation of partner constraints and controlled within the scope of project deliverables.

Case Studies

The following case studies highlight the impact the ICF work streams are having:

Case Study 1: Gateway Service

Margaret's Story

Margaret is 80 years of age and lives with her husband who has recently been diagnosed with Alzheimer's. They are both new to the area and unsure who to seek advice from

Margaret contacted c2c to see if the local authority could help, and was passed to the gateway, Margaret was worried her husband would become isolated, as he loved to go out and about and walk the dog.

What did we did?

one our visiting officer called to meet Margaret to discuss their concerns, they were financial and the fact they would have to give up their car as her husband can no longer drive.

During the visit, the visiting officer discussed the benefits of a Vega watch to allow her husband to be independent, and walk the dog,

The Visiting officer also rang the dementia support groups and arranged they attend a local coffee morning.

During the home visit, the visiting officer identified that Margaret should be eligible for Attendance Allowance and completed and submitted the application on her behalf. She was later awarded AA at the higher rate.

How are they better off?

Margaret now has peace of mind when her husband goes out to walk the dog, as he has the Vega watch.

Financially, they are £81 better off each week, which equates to an extra £4,228 per annum. They now have the financial back up to be able to pay for taxis to take them to various appointments and family visits.

They are able now meeting new friends through the dementia friends coffee mornings.

What they said about the service

The Vega watch would be fantastic. As we're new to the area I was worried about him walking the dog, now he can go out and I know where he is.
Attendance allowance would be very helpful towards taxis as we're having to give up our car.
Thank you for all your help; I did not know where to turn before you called!

Case Study 2: Gateway Service

Mrs Clements Story

Mrs Clements is 64 and has been housebound for 2 years - as a result of severe arthritis which causes pain and mobility problems.

She is finding the lack of company difficult and she is starting to think about moving into Sheltered Accommodation. She and her family would like more advice on what options are available in this respect and how to go about it.

What did we do?

One our visiting officer's called to meet Mrs Clements to discuss her concerns, they were financial and feelings of isolation.

During the visit, the visiting officer established Mrs Clements was in receipt of low level DLA, so completed and submitted request for PIP

The Visiting officer also completed sheltered housing application

Referred to health active partnership "getting out there"

Arranged for community alarm to be fitted.

How are they better off?

Mrs Clements is now on the waiting list for sheltered housing, and in receipt of an additional £32.90pw as a result of the PIP application.

She feels more confident at home with the installation of a community alarm, and is considering attending some of the options offered to her under the Healthy Active Partnership.

What they said about the service

Thanks so much, I go to pieces when I have to deal with forms. I would never have applied without you helping me"

Case Study 3: Preventative Intervention

Colin and Hazel's Story

Colin is aged 75 and his wife, Hazel, is aged 68. Hazel had recently had a few falls in their home and her confidence was low. She was nervous using the stairs and the shower and was very concerned that she would have a further fall.

Colin had received a birthday card from his GP on his 75th birthday explaining about Care & Repair services and the Healthy@Home project and contacted us to see if there was anything we could do.

What did we do?

The Care & Repair Healthy@Home Caseworker visited Colin and Hazel in their home and discussed with them their concerns.

To reduce Hazel's risks of falls, the Caseworker arranged for a grab rail to be provided in the shower and for a hand rail to be provided on the stairs.

The Caseworker arranged for the Agency's Occupational Therapist to assess Hazel's needs which resulted in a perching stool being provide for Hazel to help her to continue to bake and cook in her kitchen

During the home visit, the Caseworker identified that Colin and Hazel did not have a carbon monoxide detector and so arranged for a CO detector to be provided to reduce the risk of carbon monoxide poisoning.

During the home visit, the Caseworker identified that Hazel should be eligible for Attendance Allowance and completed and submitted the application on her behalf. She was later awarded AA at the higher rate.

The Caseworker also completed and submitted a blue badge application on their behalf.

How are they better off?

Hazel is now safer in her home. Her risk of falling has been greatly reduced. She now feels more independent in their home. This is also huge relief to Colin who was extremely worried and nervous about his wife's wellbeing.

Financially, Colin and Hazel are £81 better off each week, which equates to an extra £4,228 per annum. They now have the financial back up to be able to pay for taxis to take them to various appointments and family visits.

They are really pleased with the support and help they have received from Care & Repair Cardiff

Case Study 4: Preventative Intervention

Ernest and Dilys' Story

Ernest is aged 76 and his wife, Dilys, is aged 75. The couple have significant medical issues. Ernest has arthritis, prostate cancer and is double incontinent. He had a heart attack 3 years ago and since had a pacemaker fitted. He is currently awaiting a knee replacement operation. Dilys has COPD, asthma, a stomach ulcer, osteoporosis and macular degeneration. She had a hip replacement 3 years ago.

Ernest and Dilys were advised about the Care & Repair Healthy@Homes Service by Llanrumney Medical Centre. They had not heard about Care & Repair before and were curious to find out more, so they contacted us to arrange a home visit by our Caseworker.

What did we do?

The Care & Repair Healthy@Home Caseworker visited Ernest and Dilys in their home and discussed with them their concerns.

During the home visit, the Caseworker identified that Ernest and Dilys should be eligible for Underlying Entitlement to 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, Ernest and Dilys were now 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, Ernest and Dilys were now eligible for assistance from ECO to fund the costs of a new central heating system as their existing boiler was over 20 years old and very energy inefficient and costly to operate, which the Caseworker successfully applied for on their behalf.

During the home visit, the Caseworker identified that Ernest and Dilys did not have a carbon monoxide detector and so arranged for two CO detectors to be provided to reduce the risk of carbon monoxide poisoning.

The Caseworker arranged for the Agency's Occupational Therapist to assess Ernest and Dilys' needs which resulted in a hand rail to be provided on the stairs, the bathroom door being repositioned to make it easier for them to open and a replacement shower cubicle with a drop down seat with arms.

How are they better off?

Ernest and Dilys are now safer in their home. Their risk of falling has been greatly reduced.

Financially, Ernest and Dilys 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.

Ernest and Dilys' home is more energy efficient having had the new boiler from the ECO scheme.

They are over the moon with the support and help they have received from Care & Repair Cardiff, and feel that their lives have been changed considerably for the better. They felt that the Caseworker was wonderful and nothing was too much trouble.

Case Study 5: Housing Resettlement

Background

Mr A is 65, and a below the knee amputee. He worked for many years, but had to take early retirement due to his health problems. Mr A is a wheelchair user. Mr A did have a package of care prior to his hospital admission and this was going to continue on discharge.

Mr A was referred to the Welfare Advisers in the Independent Living Service by his Social Worker, for assistance with filling out Housing Benefit/Council Tax Reduction form; but they were unable to see Mr A before discharge. The Housing Resettlement Officer (HRO) went to see Mr A, on his discharge day, and then found out that his discharge was delayed due to his poor health. He was expected to be discharged on the following Monday. Mr A was due to move into Sheltered Accommodation, into a self contained flat.

What did we do?

The HRO assisted Mr A in hospital with filling out the application for Housing Benefit and Council Tax Reduction.

Mr A in conversation with the HRO said that he had previously lived in a residential home so that he did not have any furniture or appliances to take to his new home. A hospital bed had already been delivered, but the flat that he was moving into did not have any carpets, curtains, furniture, kettle, cutlery, crockery or any appliances. Mr A did have some funds but these were very limited. Mr A bought curtains for his bedroom, and a sofa for his living room with his savings.

The HRO made a referral to Speakeasy for help with fund raising, the Cardiff Consortium, and also the BT benevolent fund to see who could help with his need.

How are they better off?

Mr A is now getting housing benefit and council tax reduction.

He was contacted by the Cardiff Consortium and Mr A decided to purchase dining table and chairs from them, which they were able to deliver.

Mr A received a fridge/freezer, microwave, dishwasher and cooker from the BT benevolent fund.

Clients Feedback

Mr A phoned up the HRO to thank them for their help with this, and was really happy in his new home.

Case Study 6: Housing Resettlement

Background

Mr B is 79, and was admitted to hospital with poor mobility, and poor health due to cancer. He had his one leg amputated and also had other medical problems due to his cancer. He was now mobile with a wheelchair, and had been fitted with a prosthesis. He had lived as a private tenant in a ground floor flat, for many years and has a small dog. Having a dog seemed to be causing a problem for finding alternative private rented accommodation.

Mr B had been ready for discharge since June this year, but it was deemed by the hospital Occupational Therapist (OT) that this would not be feasible unless Mr B had adapted accommodation as his current accommodation was not suitable. The ward staff said that Mr B's mood was getting quite low, and he was desperate to get out of hospital.

Mr B was on the housing list as a priority and Delayed Transfer of Care. Mr B had been offered a bungalow already and the Independent Living Service Occupational Therapist (ILS OT) had already been out with Mr B to view this; this however was not deemed suitable.

What did we do?

The Housing Resettlement Officer (HRO) noticed that Mr B was being considered for another property; and when she spoke to the allocations team they did not feel that this was suitable tenancy for Mr B. The HRO brought this to the attention of the ILS OT and together they went out to view the property. The OT thought that this was worth pursuing, and with a few adaptations would be suitable for Mr B.

Mr B was happy with the property and requested some support with his resettlement. A referral was made to the Council's Tenancy Support team.

How are they better off?

Mr B has signed his tenancy agreement, and will be moving into his new accommodation shortly; he will be able to take his dog with him.

Mr B also has support with his resettlement from Tenancy Support.

Client's Feedback

Mr B was very excited about his new property, even though he was feeling quite poorly at the time.

Case Study 7: Health and Active Partnership, Age Connects

Client Details

Mary 84, is registered blind, has high blood pressure, tendonitis and suffers from kidney failure. Even with these issues she doesn't consider herself housebound but tends not to go out without support.

Mary lives in Roath, alone and apart from friends who call twice a month does not have visitors, she employ's carers to help her around the house and with shopping. Mary rarely leaves the house and when she does it is by taxi because she cannot use public transport. Mary feels things have gotten considerably worse in the last 5 years she used to go out a lot but no longer does.

Source & Reason for the referral

Mary referred herself to the service because she was feeling isolated and was looking for support.

Actions taken

Mary phoned our referral line and after a brief chat to ensure we were the appropriate service was visited and assessed by a member of staff. When asked how would she most like the project to help her to reduce her isolation she replied.

"I would like regular transport; I can still get in and out of a car as my mobility is still reasonable. Specifically I need to go to Spectrum in fairwater, every Friday to a circle dance group from 10am till 1pm."

We explored this request with Mary and discussed various options to help.

Outcomes for the client

Mary's request from the project was

"I would like regular transport; I can still get in and out of a car as my mobility is still reasonable. Specifically I need to go to Spectrum in fairwater, every Friday to a circle dance group from 10am till 1pm."

- We resolved Marys issue and in the way that the client wanted.

With the pilot project having only just started and the volunteer recently placed with Mary it is too early to tell if Mary isolation has reduced because of attending the circle

dance group. We will be completing a survey with Mary at a later date to capture this information.

Service User Feedback: Visual and Hearing Impairment

After receiving the service the client made contact to express her satisfaction and gratitude. The service user said that the training, information and support received was 'The Best'. The Speed with which the service was received was graded 'The Next Day, very Satisfied'. The service user said they were now more optimistic about the future.

The service user was asked how things had improved since they had received the service. They advised 'I can come up stairs better now and do things to make life better for me, when I go out on foot or in a car. I can do my work on Tuesday afternoons. The new things I can have from Sight Cymru have been good. It's been a long time and it's sad that others did not help me as well as you did. I can dress better with the seat in my bedroom and this helps with doing things better. Now I aim to do things and I have things to hold onto and the light gives a warm and bright feeling in the rooms.

The service user was also very grateful for the help in filling out the forms.

The service user was more optimistic about the future and felt that the service was of an exceptionally high standard. The service user is now more mobile, can access work and feels that life is better.