
# Pathfinder East
# Making a Difference

Annual Report 2019/20

CHESHIRE COMMUNITY ACTION

PATHFINDER
Your Path To Wellbeing

Cheshire East Council

# Contents

01

# Introduction

This Annual report focuses on two key questions:



**Contractually, the agreed outcomes of Pathfinder East are:**

- Isolated, older and vulnerable people have increased access to services thereby reducing their isolation;
- Older and vulnerable adults in deprived areas develop: increased sense of self-worth, improved mental-health, well-being, independence and community involvement;
- Our interventions will prevent escalation to costlier service interventions.

**Secondary objectives of Pathfinder East are:**

- To help older and vulnerable people live independently and safely in their own homes;
- To reduce social isolation and loneliness;
- To improve the financial status of older and vulnerable people by supporting appropriate access to benefits;
- To engineer a more appropriate use of health and social care services;
- To encourage cost savings in health and social care;
- To increase community capacity.

**In order to provide a robust SROI (Social Return on Investment) analysis, we have followed the main principles for producing an SROI analysis. These include:**

- Focusing on what changes;
- Valuing the things that matter;
- Avoiding over claiming;
- Being transparent;
- Verifying results using a valid and tested calculator.

It is acknowledged that there is always an element of subjectivity within any SROI analysis. However, we have used conservative estimates as a way of avoiding over claiming and have clearly shown how and where such assumptions have been made to ensure transparency.

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# About Cheshire Community Action (CCA)

**This Section provides information about the lead agency responsible for managing Pathfinder East.**

CCA is one of 38 Rural Community Councils operating to support rural communities in England. CCA operates across the whole of Cheshire and Warrington.

CCA is involved in a wide range of projects. These include:

- Pathfinder West Early Intervention Service;
- Community Buildings Advice Service;
- Information, Advice and Support for Rural Groups;
- Neighbourhood Planning/Consultancy;
- Consultations.

CCA were interested in developing a project based on the "Village Agent" model in rural communities, and this was piloted in Cheshire West and Chester in 2010/11. From here CCA developed the service further and delivered a full Community Agents Service across Cheshire East from 2012-2018.

CCA secured funding for the initial Community Agent proposal (2012–2018) through support from Cheshire East Council, Cheshire East Clinical Commissioning Group and the BIG Lottery Fund. For Pathfinder East funding has been through Cheshire East Council.

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# The Context

**This Section provides the rationale as to how Pathfinder East emerged, who it was aimed at and why it was needed.**

In 2018 there were 86,680 older people aged 65+ in Cheshire East (Office for National Statistics indicative population estimates 2018). Estimates suggest that in 2018 5,200 (6%) older people were living with dementia and 34,672 (40%) with a limiting long term illness.

The age structure of the population is forecast to change significantly with an 8% reduction in young people (0-15), a 12% reduction in working age people (16-59 female, 16-64 male) and a 42% increase in people of retirement age (60/65+), with the number of older people (85+) increasing by around 92%.

Social isolation is a key determinant in people requiring social care support and it is estimated that 37% of those aged 65+ and 50% of those aged 75+ are living alone.

There is ample evidence that people want a single community point of contact to deal with agencies, provide information and ensure consistent messages. Poor access to medical care leads to increase in hospitalisation from chronic diseases, especially for disabled people, older people, low income groups, and those living in rural communities. This point is accentuated by the Government push for Digital by Default. Many of the services that beneficiaries have difficulty with are web-based. Latest figures still highlight the 55+ age group as being the largest group that have yet to access the internet.

Loneliness & Well-being: Almost 17% of pensioners in the target areas live alone and many go for long periods without any form of social interaction. This project has attempted to address all of these issues.

**17%** of pensioners in the target areas **live alone**

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# About the Pathfinder East Project

**This Section provides information about Pathfinder East, its design, how it has been implemented and what we have learned so far.**

Pathfinder East is an innovative approach to meeting the social needs of the older and vulnerable population in the area. Local community health and adult social care professionals had identified that older and vulnerable adults were being exposed to higher levels of social, physical and digital isolation than the population norm.

The original Village Agents Project was primarily designed as a signposting service but also to solve practical challenges experienced by people in the community and those being discharged from hospital. It was established to build relationships across the sectors, to provide up-to-date information and link clients to existing services and activities in order to better meet the needs of these clients.

Following on from the pilot Village Agent project, then onto a successful 6-year Community Agent service, the project evolved to Pathfinder East, where there is much more of a focus on tackling social, physical and digital isolation.

Pathfinder East are now recognised as a first point of contact for any person presenting with low level social needs across the area. They are often described as "a conduit" across the sectors; they are bridging that gap in services that arose as a result of changes to access to services, and they continually track existing services and activities. The team don't just track and refer, the bulk of their work is practical, in supporting people through a myriad of issues, all with the overall outcomes of improving the health and wellbeing of the beneficiary.

Referrals into the service are primarily from adult social care. Self-referrals are continuing to increase and referrals from some teams of community health professionals continue, although they are lower than originally anticipated.

The Pathfinder East team assess the needs of clients referred into the service through triage. Our team then discuss options and either take on specific issues to resolve or/and then refer to relevant activities or services. They help people to access the services to which they signpost. In addition, they have been trained in completing financial assessment and benefit claim forms, and also help clients with other forms as appropriate.

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# Analysis of Monitoring Data

**This section provides an analysis of the monitoring data collected throughout the lifetime of the project.**

## Referrals in

A total of 1293 referrals were received from across the borough of Cheshire East for the period April 2019 through to March 2020.

Figure 1 shows the pattern of referrals for each six-month period over the middle twelve months of operation. There was an increase in the numbers referred in the second six-month period compared to the first.

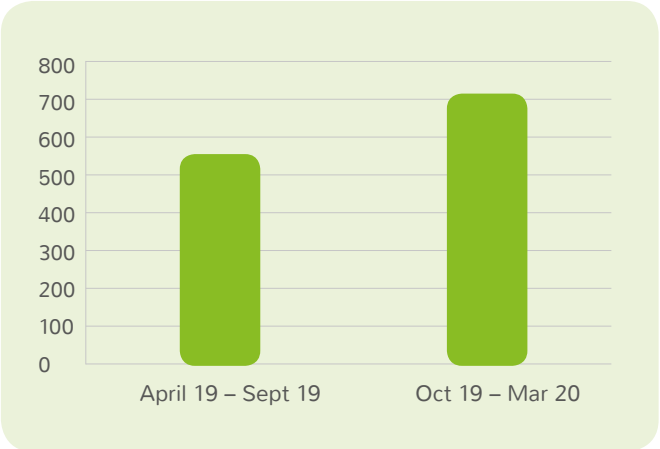
As the project has continued, the total number of referrals has increased.

## Referrals by age and gender

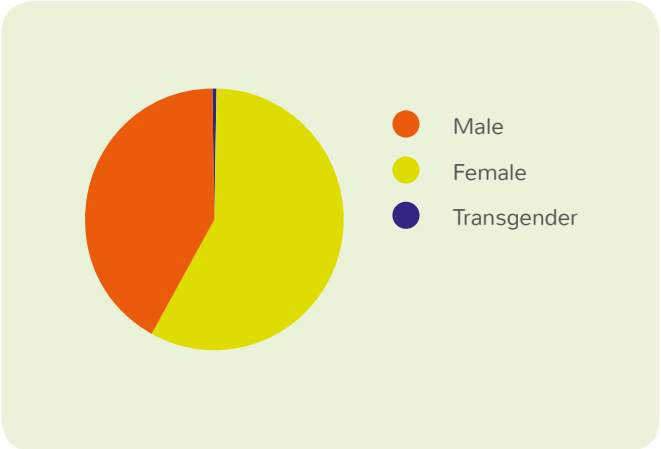
Of all of those referred into the service 58% were female and 42% were male; in four instances gender information was not captured on the database. The higher proportion of female service users is unsurprising, given that women live longer and are known to be more likely to engage with support services. However, typically older males are considered the most isolated group who will often be reluctant to seek help and engage with the services, but with this service there is a higher proportion of men seeking support than other interventions. There were 0.1% transgender beneficiaries.

Service users are aged between 20 years and 100 years, with the most prominent age of service user being 69 years. The average age is slightly higher for female service users (71 years) compared to males (70 years).

### Figure 1: **Referrals over time**




### Figure 2: **Gender Breakdown**



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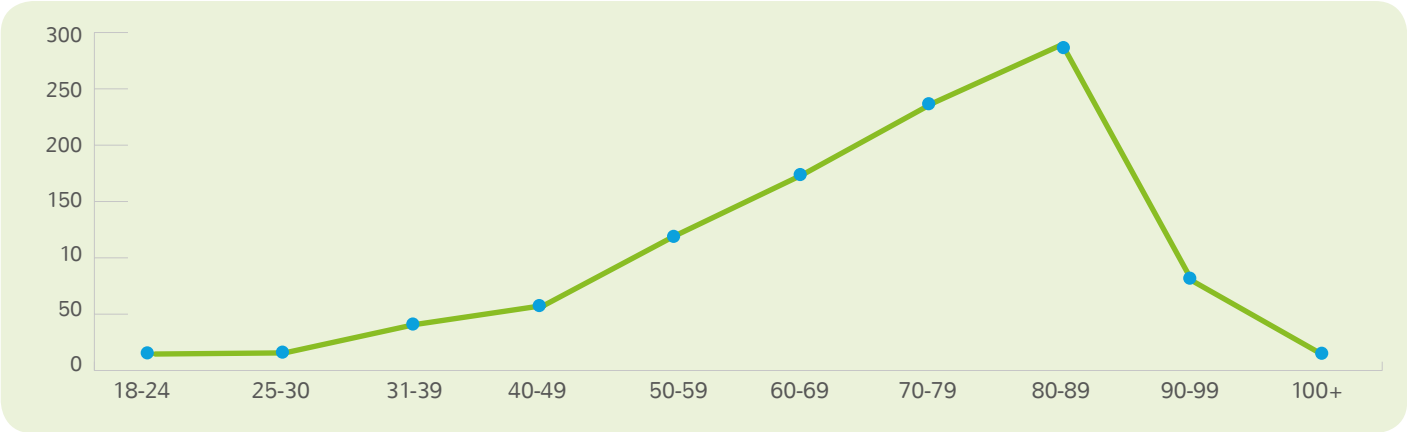
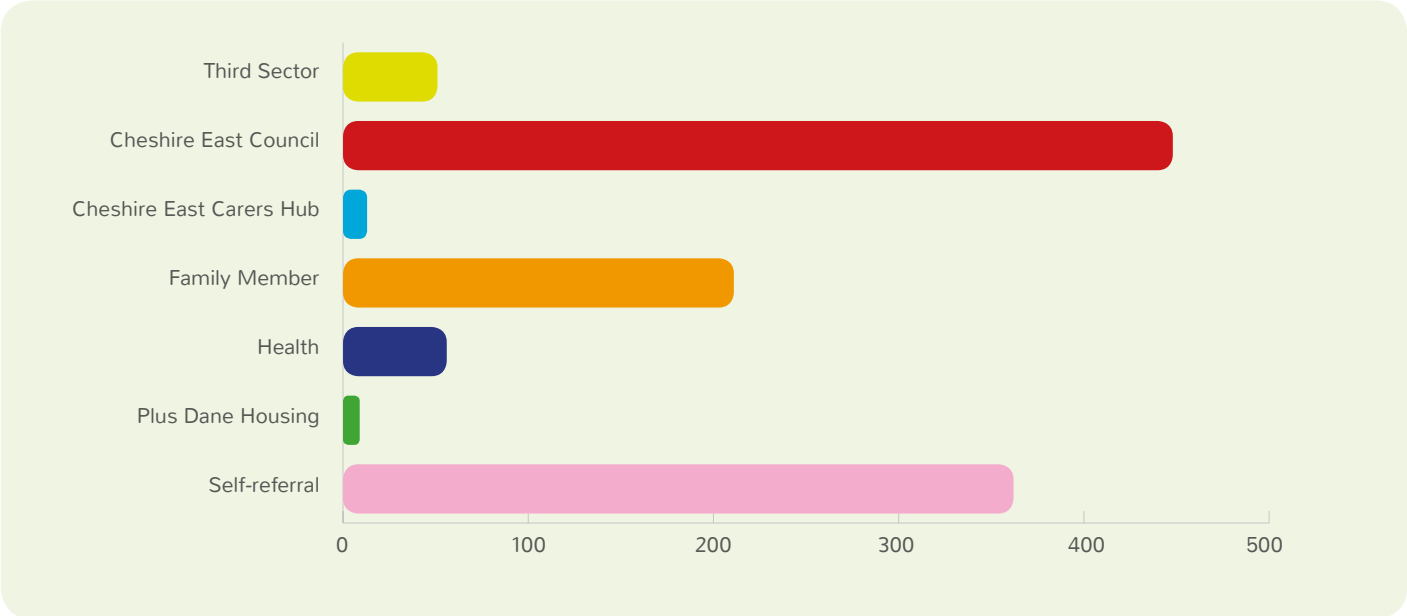
Service users are most likely to be referred into the scheme when they are over 60 years of age, with almost sixty percent (59%) of total referrals being made for service users aged over 70. An astonishing 36% of service users are aged 80+.

From previous contracts there has been a significant reduction in the number of service users under the age of 50. It is unclear why this is the case, but could be related to tighter referral pathways.

## Figure 3: **Breakdown by Age**




## Figure 4: **Referral Organisations**



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## Referral Organisations

Referral data clearly demonstrates that the greatest proportion of referrals are made from the Local Authority services, accounting for 35% of referrals to March 2020. Referrals made by family members and self-referrals are at 31% and 18% respectively, see Fig 4.

When looking at the referral data for each area, it is clear that Local Authority services in Cheshire East continue to make the most referrals to Pathfinder East. One reason for this is likely to be the pre-existing relationships between the Pathfinder East and key Local Authority workers. Feedback in relation to referral processes has been positive.

Self-referrals have continued to increase steadily throughout the lifetime of the project. This is likely to be due to raised awareness and word of mouth. It is also acknowledged that a proportion of the self-referrals is made as a result of voluntary sector, health and/or social care staff providing information about Pathfinder East service to their patients/clients.

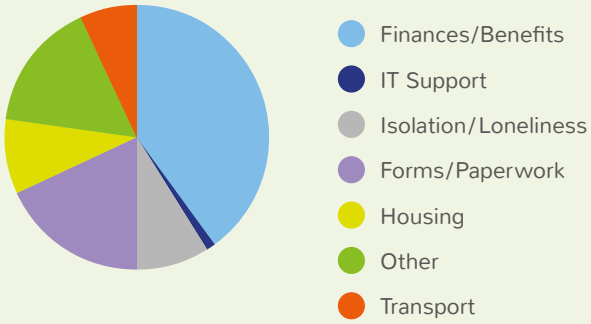
A further breakdown of local authority referrals shows that Adult Social Care is the main referrer and social work teams are the predominant users of the service.

## Referral reasons

The most popular services that are being provided are benefits/financial advice and help with completing forms or accessing services. From our perspective these fall under the category of access to services.

The Pathfinder East team are dealing with an increasing range of needs that are being presented to them. Property maintenance, including gardening, decorating and other domestic services have all increased over the past 12 months.

## Figure 5: Initial reason for referral




Access to other services such as food delivery and support to access food banks has also increased. Service users are increasingly likely to be referred to Pathfinder East for general advice and support relating to financial, legal and health/care needs.

Requests for assistance with transport (7%) and information about availability of social activities (9%) continue to provide service users with the means of 'getting out of the house' whether to attend medical appointments or access other services, visit relatives in hospital or to reduce their social isolation. These are the key needs regularly addressed by Pathfinder East, see Fig 5.

Previously the results presented here related solely to the initial referrals where a single need was identified at the outset. However, we are now able to capture additional needs through working with an individual, and these are reflected in the data above.

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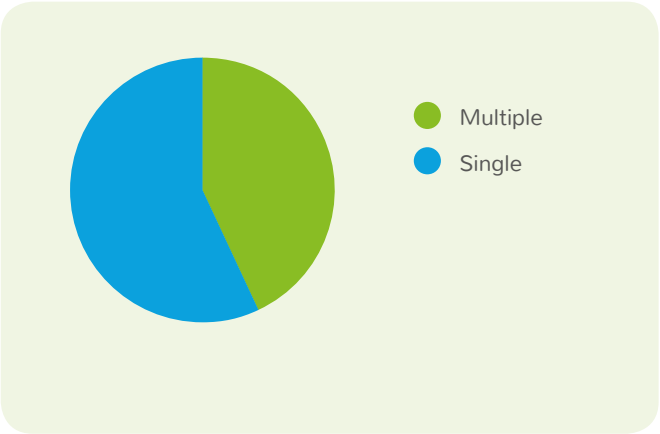
43% of the total relates to multiple needs that were identified after contact had been made with the client; see figure 6 below.

## Figure 6: Single needs versus multiple needs




## Other notable demographic data

The Pathfinder East team have noted that almost 57% of service users have some sort of care. Indeed, to this end the service has discovered many hidden carers and taken the necessary steps in trying to ensure that these carers are supported by the relevant agencies.

Almost three quarters (74%) of service users have long-term conditions. Many of these long-term conditions exasperate the service user's ability to access services, again underlining why the 1-2-1 home visits of the Pathfinder East team are so valuable.

## Direct or indirect referrals

The Pathfinder East team continue to respond to service user referrals in two ways – either making direct contact with the client or by providing information to the referring agent who would pass on this information back to the service user (indirect contact). The majority of referrals (98%) continue to involve direct contact between the Pathfinder East team and the client.

Pathfinder workers also liaise closely with family members when the need arises, and support with other presenting issues. For example, many hidden carers are identified through this holistic approach.

## Service Providers

Once the team have assessed the needs of those people referred to them, they then either provide the service themselves or identify a relevant service and pass the referral on to them. The majority of these referrals are to the voluntary sector. Public sector services include Welfare Rights and housing, while the private sector referrals include requests to private care companies and social housing providers. There are also clients who require referrals to multiple agencies in order to meet a series of needs not provided by one single organisation.

To date the Pathfinder team have referred clients to over 30 specialist organisations to access services.

The time the team spent on each referral varied from 10 minutes for providing information to 600 minutes to deal with more complex needs requiring multiple agency involvement.

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# Project Inputs

**This section describes the inputs of all of the stakeholders to Pathfinder East and we examine the inputs for the main stakeholders.**

## Cheshire East Council

CEC provided £108,280 to CCA for implementation of Pathfinder East per annum. This is currently a two year fixed term contract, to run until December 2020.

## Voluntary Sector

Voluntary and community sector organisations have no financial input to the project. However, as a result of referrals made to Pathfinder East, many experienced an increase in workload which has not been funded through the project. For the purposes of the SROI, we have not been able to calculate this figure accurately. Therefore, no monetary value has been attached to the provision of services or activities as these costs are currently covered within the core funding of these agencies/organisations.

## Cheshire Community Action

It is also acknowledged that CCA have provided an in-kind contribution in terms of management and support time for the project. While management costs were included in the funding proposal, there is clear evidence to suggest that CCA have added considerable value to the project by contributing a substantial amount of time not covered within the budget. However, given the difficulties in accurately estimating the amount of time provided, no monetary value has been placed on this in-kind contribution and it is not included in the SROI.

## Overall Input

For SROI purposes, the total inputs to Pathfinder East have been valued at £114,280. This includes direct funding and in-kind contributions from stakeholders.

## Table 4: Breakdown of inputs 2019-20

| | Financial Contribution | In-kind Contribution | Total |
|---|---|---|---|
| **CEC** | £108,280 | £2,500 | £110,780 |
| **CCA** | _ | £3,500 | £3,500 |

Total Inputs
£114,280

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# Outcomes and Evidence

**This section will describe the projected outcomes of Pathfinder East.**

## Outcomes

The model adopted for the Pathfinder East has continued to develop and evolve. There have also been some staff changes in terms of project staffing, governance and operational membership. However, the project has continued to adapt to these changes and move forward.

The intended outcomes of Pathfinder East are:

- Isolated, older and vulnerable people have increased access to services thereby reducing their isolation;
- Older and vulnerable adults in deprived areas develop: increased sense of self-worth, improved mental-health, well-being, independence and community involvement;
- Our interventions will prevent escalation to costlier service interventions.

It is accepted that these are very broad aims. However, the project team have worked steadily toward achieving these aims, and it allows for a holistic approach to the support provided.

Overall, the evidence gathered supports the view that the work of Pathfinder East has resulted in a range of positive outcomes for both service users and the statutory services, which are unable to provide the low level support to the clients that is often needed.

We will now examine in further detail the outcomes achieved as a result of Pathfinder East for each stakeholder group.

## Outcomes for stakeholder groups

### Outcome 1

**Isolated, older and vulnerable people have increased access to services thereby reducing their social isolation.**

One of the primary aims of Pathfinder East is for isolated, older and vulnerable people to have increased access to services, thereby reducing their isolation and helping people retain their independence in their own homes for longer, thus reducing the numbers accessing residential care services. The ability to cope and manage daily tasks such as shopping, cleaning, and generally looking after themselves is very important if older people are to stay at home longer.

Evidence from Social workers reports that older people want to stay in their own homes and are more likely to need placing into residential care at a time of crisis. Social workers also report that support with more social needs can delay such crises and hold a view that some of their clients would in fact have required some form of residential care without the support of external interventions like Pathfinder East.

### Outcome 2

**Older and vulnerable adults in deprived areas develop: increased sense of self-worth, improved mental-health, well-being, independence and community involvement.**

Throughout the life of the project we have carried out surveys with service users to ascertain the effectiveness of the interventions. We have used the Short Warwick-Edinburgh Mental Well Being Scale (SWEMWBS). The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

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"Thank you so very much for all you are doing. My life appears to be one big rush at the moment whilst my husband is in the nursing home. It's very comforting knowing you are there."

Our findings show that 89% of those surveyed score higher than the population norm. Therefore, these validated surveys with this stakeholder group clearly highlighted that their perceptions of their own health and wellbeing had improved dramatically.

Managing long term conditions has been made easier and people are feeling much less anxious and desperate. Also, just knowing that there is someone there who they can reach out to for help should they need it, are all factors that have led to this stakeholder group feeling more secure. As a consequence of this people are engaging better with services.

## Outcome 3

**Our interventions will prevent escalation to costlier service interventions.**

From the outset of the project it had been recognised that people were not accessing wider council services. It was felt that much of this was due to lack of awareness. The Pathfinder East team serve to raise awareness of those services with the wider client population.

Adult social care teams have been shown to be the main referrers to the Pathfinder East. Prior to Pathfinder East, a huge problem for the adult social care teams had been the fact that, increasingly, they were unable to provide the lower level support people were requesting. Pathfinder East frees up time for social workers and other statutory partner staff, this then means that these professionals can focus their time and resource on those with more acute needs.

It is readily accepted that many older and vulnerable people do not claim all of the benefits to which they are entitled. Reasons for this vary and much effort has been made to ensure that this changes. Older and vulnerable clients also reported substantial increases in their finances due to either additional benefits or subsidised or free care and equipment.

In some cases, clients found it difficult to cover care costs e.g. day centre use and personal care packages. Also some had been told that they were not eligible for subsidised care. The Pathfinder East team have been involved in a number of resubmissions which have resulted in people no longer having to pay for their care.

Improved financial status also has an effect on "peace of mind". Many service users told us that increasing their income meant that they were feeling less pressured and worried about paying their way. This in turn helped them feel better, enabled them to pay for non-funded services such as cleaners or transport where needed.

Social isolation is the pre-eminent need referred to Pathfinder East. While some clients present with specific health and social care needs there is also a large element of the vulnerable and older population who are simply lonely. Many of them have outlived or lost contact with friends, are housebound, have family living at a distance and often lack the confidence or ability to go out and make new friends.

There is clear research evidence that links the effects of loneliness to older people's health. The link between loneliness and depression is also well evidenced. As a result, lonely and isolated people use more healthcare resources and are more likely to need long term care, have a poorer quality of life, be at a greater risk of dementia and are also at greater risk of dying prematurely.

Both health and social care professionals are now adopting a more holistic approach to care, and are regularly identifying that clients are lonely and isolated. As a result, they are referring them to Pathfinder East, which they see as one way of preventing the more extreme effects of loneliness and isolation on clients' health and wellbeing.

Some clients are also engaging more with community events and groups, which in turn results in increasing their social networks and links them with other activities and services.

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While lack of such practical support would not be a major cause for people moving into residential care, it is regarded as a serious contributory factor. If people are not able to manage and maintain their property or access equipment they need, their houses are more likely to become unsafe and people will suffer more falls.

There have been a number of instances whereby homes have become unsafe due to older people developing hoarding tendencies, or the upkeep of properties has generally been poor, with damp, leaking pipes etc. This has created conditions which have often resulted in falls.

Pathfinder East have actively supported clients in removing clutter to enable tradesmen access to rooms to repair central heating which, in turn, meant the property could be heated so clients were not living in the cold. Feeling comfortable and safe in their own homes is very important and relevant in clients staying in their homes for longer. Patient/client safety is a prime concern for both health and social care staff. We have also referred to Occupational Therapy for assessments, where needed.

## Quality of outcomes

From the monitoring data collected by the project and ongoing input from the Pathfinder East team and other service providers, we have examined each of the outcomes in detail and attached the numbers of those people reporting benefits from these outcomes. In some cases, this is the actual numerical value recorded; however, in some cases these are conservative averages based on the data collected. We have then analysed this data with a popular and validated SROI tool.

## Table 7: Outcomes

| Stakeholder | Outcomes |
|---|---|
| **Older and vulnerable adults** | Isolated, older and vulnerable people have increased access to services thereby reducing their isolation; |
| | Older and vulnerable adults in deprived areas develop: increased sense of self-worth, improved mental-health, well-being, independence and community involvement; |
| **Cheshire East Council** | Our interventions will prevent escalation to more costly service interventions. |

89%
of those surveyed state improved outcomes

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# Programme Impact and Social Return on Investment

**This section examines the overall impact and SROI of the project.**

A key objective of the evaluation was to show the full impact of this project using the SROI toolkit. However, Pathfinder East does not operate effectively as a stand-alone project and is often dependent on others to provide services. Alongside this, the older and vulnerable clients are also likely to be receiving some support from other agencies and services.

In order to ensure that the SROI evaluation is accurate (avoiding over claiming), it is necessary to apply the effects of attribution, displacement, deadweight and drop-off and incorporate them into the final calculation. This annual review will not go into detail on these points. The software we have utilised does take into account these effects.

The impact of Pathfinder East has been assessed by calculating the quantity of each of the outcomes multiplied by the value of the financial proxies used and then minus the attribution and deadweight.

Analysis of the data for Pathfinder East has resulted in an SROI ratio of £8.25 per £1 invested. This means that for every £1 of investment in Pathfinder East, £8.25 social value has been created.

"Just to let you know both mum and dad have received Attendance Allowance. I would never have got round to doing it so thank you again.
My parents asked me to send their thanks too. They are both over the moon."

09

# Discussion

**Pathfinder East has continued to evolve throughout the period under review, and has successfully forged a place for its services within the wider community.**

There is little doubt that Pathfinder East has adopted the role of "link person" or bridge between the statutory and voluntary services. In doing so the team are successfully ensuring that older and/or vulnerable people are able to navigate and access a range of services on which they would otherwise have been likely to miss out. At the same time, they have continued to develop their networks within both sectors as well as establishing good relationships with a wide range of smaller community organisations across the Borough. The Pathfinder East team appear to have created a niche for themselves that complements health and social care services and at the same time provides an additional level of care to clients that was largely inaccessible before.

There is also little doubt that the role of Pathfinder East has impacted on the way both health and social care professionals carry out their own roles. Dealing with requests for low-level, non-clinical interventions has meant that health and social care professionals are no longer required to source such interventions in which in itself is saving them a lot of time. It also means they are less concerned about patients/clients at discharge, as the Pathfinder East team are trusted to refer back if this is needed. The relationships between the Pathfinder East and health and social care professionals have developed over time and remain positive. The numbers of people referring patients/clients to Pathfinder East for services continues to increase.

Pathfinder East are approached to deal with a diverse range of social and low level needs, all of which are likely to have impact on health and wellbeing and clients' ability to maintain independence. Reducing social isolation is the core aim of the project and the Pathfinder East team have ensured positive outcomes for clients in this area. Support with finances and accessing both social and medical activities have all served to improve clients' perception of their own health and wellbeing, increased their income, led to many of them becoming more socially active, having increased self-confidence and generally feeling well supported, thus reducing levels of stress, depression and anxiety.

Many of those referred to the scheme do have a long term condition or continuing health needs, the results of which often bring about depression, anxiety and social isolation. However, Pathfinder East are having an impact by promoting a more positive approach to dealing with such conditions by increasing clients' social networks, reducing their worries and concerns (particularly finance related ones) and improving access to practical services to ensure they are able to maintain and feel safe and secure in their own homes.

It is clear that Pathfinder East are also providing services. The majority of these services are supporting by form-filling, helping clients respond to letters etc., and they are increasingly providing such practical support to clients. The role of the Pathfinder East appears to have developed over time and they are increasingly called upon to deal with complex needs requiring a wide range of services. A number of these are illustrated in the case studies at the back of this document.

Pathfinder East has managed to become a conduit for both health and social care. The team offer an extensive knowledge of available services across all sectors, have developed and maintained positive relationships and have shown their capability for meeting demands on services across the past 18 months, but more importantly at peak times such as the winter periods. Service provision was maintained even at peak times. Client satisfaction with the project continues to be high, and key referrers' satisfaction has also been consistently high throughout the period of operation.

# 09

"I can't thank you enough for your visit to us. Your time must be valuable and I am very grateful that you helped us so much on that day. I can honestly say that if the world were filled with more people like you, it would be a much better place."

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# Conclusions

**This section presents conclusions from this evaluation.**

The social isolation of older and vulnerable people and the impact of that on their health and wellbeing is well documented elsewhere. CCA had begun by exploring this concept further with regard to rural communities. However, due to severe budget cuts, health and social care professionals also identified the need for a more widespread effort to sustain the independence of older and vulnerable people for longer, and to reduce hospital admissions and bed blocking by older people not being able to return home. They also pointed to the need to improve the general health and wellbeing of this client group by reducing social isolation, expanding social networks and increasing social activity. For many years CCA have attempted to provide support to those people who are socially, physically and digitally isolated by giving them 1-2-1 access to qualified staff that can support them through a wide range of problems.

This SROI evaluation shows that Pathfinder East has created a significant social value of £8.25 for every pound invested into the project. This is based on a robust evaluation process to ensure that any assumptions and estimates used are realistic and based on information provided by the data at hand.

Our validated survey work has demonstrated that people using the services clearly gained the most value from project activities and outcomes. This further highlights the effectiveness of the service in reaching, providing services and linking services to this group of people and its importance in improving their health and well-being in general.

Overall the quantitative and qualitative evidence supports the view that Pathfinder East has been successful in meeting its aims, has achieved some significant outcomes for stakeholders and particularly for service beneficiaries and can show that it has successfully created social value for all the stakeholders concerned, with an SROI of at least £8.25 for every £1 invested in the project.

For every
**£1**
of investment in the
Pathfinder East project,
**£8.25**
social value has
been created.

# 10

"Thank you so much for listening and helping I have been trying for months and months and you are like a breath of fresh air. Thank you for understanding."

# Appendices

## Case Study One

**Steven (not his real name) a 77 year old man, was originally referred by his social worker mainly because he was very isolated, although this was a complex case. We spoke to the Local Area Coordinator and District Nurse who were also involved. There was initially some difficulty making contact with Steven, so we also spoke to the GP who visited him at home in order to make the initial contact.**

At the initial visit the following tasks were completed:

- Attendance Allowance application process started;
- Referral made to the OTs to assess his late mothers walking frame which he used to mobilise;
- Steven's back door would not shut or lock properly. Orbitas were contacted, who managed to book an appointment to see the door the next day;
- Our team member took Steven around the corner so that he could get his hair cut;
- Referral made to Extra Help to go and see Steven for cleaning, companionship, possibly a few errands here and there and to tidy his garden;
- Steven was getting overwhelmed by what tablets he needed to reorder and so the pharmacy was contacted and his doctors and it was requested that blister packs were made up for him to be delivered to his door.

It was clear from initial assessment, and from talking to Steven that not much was working well for him at all (although he did speak highly of the District nurses and GP surgery). He expressed a preference to want to move into independent living

accommodation. He had a poor living situation and was very lonely and isolated, and struggled with basic daily tasks so his situation would have been rated at no higher than 1 or 2/10.

### What we did that worked well

Our team member helped Steven to complete the Attendance Allowance application, which included having to request his NI number from the DWP. She also supported him with the entire process of

# Appendices

moving from his property into Saint Clements Court in Macclesfield; she completed the application with him, attended a visit there and helped to facilitate the move as well. She worked closely with the Development Manager of St Clements Court to achieve this. Our team member supported Steven in signing for his keys. Steven also requested help in purchasing a new bed, chairs for the lounge and a new fridge as he wanted to move in with all new furniture. On Steven's request she also sourced an Estate Agent (Northwoods) to complete a valuation with a view to selling his property. Our team member helped with notifying current suppliers of the move and requesting final bills and readings and setting up direct debits with new suppliers as well as transferring Steven's current landline number over to his new address.

## What the impact was on the client/family (try and include scaling within your response)

On a scale of 0 – 10, where would you now assess the situation as being at?

The new situation should be rated at a 10/10; Steven was previously living alone and would go for days at a time without speaking to anyone. The property was in disrepair and his health and hygiene were suffering. He moved into supported accommodation in November and spent Christmas with other people enjoying sharing a meal in the communal area; he is financially much better off and his mental and physical health have improved dramatically. Previously he didn't know who to ask for support apart from his GP (not always the most suitable) and now there are staff on site whenever he needs help, he now attends social groups within St Clements.

## What impact did the client/family feel it had? And what lessons were learned?

The move impacted a lot of aspects of Steven's life, but he mostly expressed his gratitude at not having to spend Christmas alone. He is much less lonely and more sociable; apart from what he has told us himself, he is much easier to get in touch with now as he doesn't ignore phone calls and seems much happier.

Steven was originally supported by medical staff, but they were not always the most appropriate people to be helping with the issues he was having (such as housing, finances, social isolation etc.); the impact on Steven's quality of life was much bigger as soon as a more appropriate service was involved.

It is also worth noting that, although difficult to measure, the impact of early intervention and prevention of potential crisis point on not only Steven's health but the workload of the associated service providers, must also be substantial. If he hadn't moved into supported accommodation he would have a poorer quality of life still, with a lot more people and expense involved in ongoing support.

# Appendices

## Case Study Two

**In July 2019, we received a referral for Mr L, a 70 year old man, who had recently moved to Crewe and was living in a shared house (6 people) which was unsuitable for his needs. He had had a stroke and was struggling to get transport to appointments. He had no friends in the area, was extremely socially isolated and low in mood. He only received a small State Pension and no other income, so a benefits check was required. It was clear from the initial contact that it was a complex case and a lot of support was needed.**

The actions taken are outlined below;

- **July 2019**: Initial contact made and drop in session attended to complete Attendance Allowance (AA) form, discuss housing and social opportunities. Advised to request a Housing Needs Assessment from Cheshire Home Choice to try and get a higher priority banding. Also considering extra care homes at this stage. Mr. L said he would not be able to afford to socialise until AA in place. Discussed low cost social opportunities and transport options to access these. Initial Benefits check done with limited information. Advised to apply for Pension Credit, and the application process explained.

- **Aug 2019**: Further benefits check completed, drop in session attended and housing benefit claim processed. Reminded to progress pension credit application. Details of new Flexilink transport service provided. Further social opportunities discussed including suitable exercise classes and Men in Sheds.

- **Sep 2019**: Housing benefit application successful. New housing options so far unsuitable and delay at extra care homes due to Beechmere fire. Using Flexilink bus and considering trying some social activities soon. Unfortunately, AA application declined as he had been living abroad. Advised he can reapply in Nov 2020 when eligible.

- **Jan 2020:** Mr L secured a new property. Attended drop in session - supported to report change of circumstances for council tax / housing benefit and claim a Discretionary Housing Payment for overlapping tenancies.

- **Feb 2020:** Rang Mr L to check how he had settled into his new house. Still needed some curtains, furniture, bedding etc. Signposted to St Pauls Friday sale. Informed him of social support in his local area - neighbours' network, lunch club and other local activities. Housing benefit and council tax reduction applications successful.

- **April 2020:** Rang Mr. L to see how he was getting on in lockdown. Can access local shop and has had help from a neighbour. Advised we can refer to Goodgym to help with the garden once lockdown ends. Needs more furniture for lounge (didn't get to St Paul's before lockdown). Informed him of potential

# Appendices

FOTE grants (although applications currently closed until 1st June due to covid-19) if he is receiving pension credit. Rang him again to discuss progress and possibility of applying for Cheshire East emergency assistance which he declined. Also considering grants from Wavelength for a TV and a Stroke Association grant.

**May 2020:** Support from Pathfinder East and Age UK to process Stroke Association grant application - received a TV and stand. Mr. L also agreed to apply for emergency assistance – we completed online application and he has now received a 2 seater sofa and a cooker.

## What we did that worked well

Our team member supported Mr. L to navigate the system; giving him the basic information may not have been sufficient in this situation as his circumstances were very complex. For example, he went from not knowing about the existence of Attendance Allowance to knowing exactly how to apply and when he will be eligible due to his living abroad. Our team member also managed to get him suitably housed in a relatively short space of time, due to their knowledge of Cheshire Homechoice and the priority banding system, which was key to his wellbeing as he was in a very desperate situation. It was also key to Mr. L's enthusiasm to engage with other services and social groups; he went from extreme isolation and low mood to getting support from Age UK, Stroke Association, Cheshire East Council, Goodgym and other local social activities. This was largely due to an improvement in quality of life and renewed confidence in the support available. Our team member has even managed to make his new home even more suitable by sourcing furniture and increasing his income.

## What the impact was on the client/ family (try and include scaling within your response)

On a scale of 0 – 10, where would you now assess the situation as being at?

The new situation should be rated at a 10/10; Mr. L was previously very isolated but also isolating himself due to his circumstances contributing to a very low mood. His home was totally unsuitable and his physical and mental health were suffering as a result. Now he is financially much better off and his mental and physical health have improved dramatically. He has used the Flexilink bus to get out and about and to appointments, therefore reducing social isolation. He now has friendly neighbours, likes the area where he is living and is getting support from the neighbour's network with shopping, travel to hospital etc. We have stayed in touch during the Covid-19 lockdown and Mr. L is happy to ring us for further support as required, whereas previously he didn't even know who to contact if he needed support.

## What impact did the client/family feel it had? And what lessons were learned?

Mr. L's physical and mental health have improved, as a direct result of our intervention, as has his confidence to go out and access other services. He has people locally who he can talk to, whereas previously he would go for a few days at a time without speaking to anyone even though he was in shared accommodation. He now realises his own quality of life and has more confidence in trying to tackle any arising issues, even if this just means giving us another call for support.

It is also worth noting that, although difficult to measure, the impact of early intervention and prevention of potential crisis point on not only Mr. L's health but the workload of the associated service providers, must also be substantial. Without support to turn things around, it would only have ended in a crisis situation. Now he is living happily and independently.


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CHESHIRE COMMUNITY ACTION

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