ADULT SERVICES COMMITTEE

AGENDA

Friday 12 January 2018

at 10.00am

in Committee Room B
Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Hamilton, Hind, Loynes, McLaughlin, Richardson, and Thomas.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 14 December 2017 *(for information as previously circulated)*

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   6.1 Service User Experience – *Director of Adult and Community Based Services*

7. ITEMS FOR INFORMATION

7.1 Care Quality Commission: Local System Review – *Director of Adult and Community Based Services*

7.2 Care and Support for Deafblind Adults – *Director of Adult and Community Based Services*

8. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

FOR INFORMATION: -

Date of next meeting – Thursday 1 February 2018 at 10.00am in the Civic Centre, Hartlepool

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

14 December 2017

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Stephen Thomas (In the Chair)

Councillors: Paul Beck, Lesley Hamilton and Mike McLaughlin

In accordance with Council Procedure Rule 5.2 (ii), Councillor Katie Trueman was in attendance as substitute for Councillor Carl Richardson

Also present: Frank Harrison, Judy Gray, Sue Little, Gordon and Stella Johnston
Ann Baxter, Chair of the Teeswide Safeguarding Adults Board
Donna Owens, Hartlepool and Stockton on Tees Clinical Commissioning Group

Officers: Jill Harrison, Director of Adult and Community Based Services
Jeanette Willis, Head of Strategic Commissioning – Adult Services
David Ward, Head of Finance, Child and Adult Services
Angela Armstrong, Principal Democratic Services Officer

48. Apologies for Absence

Apologies for absence were received from Councillors Brenda Loynes and Carl Richardson and Evelyn Leck.

49. Declarations of Interest

Councillor Stephen Thomas reiterated a personal interest as an employee of Healthwatch and a personal interest in minute 52 as a local authority representative on Teesswide Safeguarding Adults Board.

50. Minutes of the meeting held on 23 November 2017

Received.

51. Matters arising from the Minutes

(1) Minute 44 – Independent Living Fund Update

The Director of Adult and Community Based Services confirmed that the Assistant Director, Finance and Customer Services had provided the clarification requested by Councillor Paul Beck in relation to the financial support available to veterans. It was noted that this clarification would be forwarded to all Members of the Committee. The Chair suggested that any further queries should be directed to the Assistant Director, Finance and Customer Services and fed into the Finance and Policy Committee.

Decision

(1) That the clarification provided in relation to the financial support available for veterans be circulated to all Members of the Committee.
(2) That any further queries be forwarded to the Assistant Director, Finance and Customer Services and fed in the Finance and Policy Committee.

(2) Minute 43 – Transforming Care – North East and Cumbria

A representative from Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) had been invited to provide clarification on a number of issues raised. The representative provided a detailed and comprehensive presentation which recapped the Transforming Care Agenda, outlined progress to date and identified the priorities for the future. The Chair requested that copies of the presentation be forwarded to all Members of the Committee.

In response to a number of questions, the representative from the CCG indicated that one of the aims of the Transforming Care Agenda was to ensure providers were working together to provide care across all localities through the further development of the workforce. A Member requested a list of all the providers involved in the provision of care through the Transforming Care Programme. The representative from the CCG responded to a number of questions from Members of the Committee and members of the public.

The Chair concluded that a number of good points had been raised during the discussions and reiterated the commitment of the Council to the general principles of the Transforming Care agenda. The Council recognises the importance of Hartlepool residents having the opportunity to return to the area, with appropriate support, however did have some concerns around the resources available to sustain the Transforming Care Programme and the timescales. The representative from the CCG was thanked for her attendance and for answering questions and it was requested that regular updates be provided to the Committee as the Transforming Care Programme was developed.

Decision

(1) That representative(s) from the CCG are invited to future meetings of the Adult Services Committee to provide updates on the development of the Transforming Care Programme, particularly in relation to provision for people in Hartlepool.
(2) That a list of all providers involved in the provision of care through the Transforming Care Model be forwarded to Members of the Committee.

52. Teeswide Safeguarding Adults Board Annual Report 2016/17 and Strategic Business Plan 2017/18

(*Director of Adult and Community Based Services and Independent Chair of Teeswide Safeguarding Adults Board*)

Type of decision

Non key.

Purpose of report

To present the Teeswide Safeguarding Adults Board Annual Report 2016/17 and Strategic Business Plan 2017/18.

Issue(s) for consideration

The Independent Chair of the Teeswide Safeguarding Adults Board (TSAB) presented the Teeswide Safeguarding Adults Board Annual Report 2016/17 and Strategic Business Plan 2017/18.

A report had been submitted to the Committee which highlighted that the TSAB had been established in order to meet the requirements of the Care Act 2014, which created a legal framework for adult safeguarding, requiring all Local Authorities to set up Safeguarding Adults Boards (SABs) for their areas. The four Tees Local Authorities had worked together for a number of years along with strategic partners to promote cooperation and consistency in relation to safeguarding adults work, and this collaborative working had continued, with the statutory responsibility now resting with the TSAB. It was a requirement of the Care Act 2014 that a SAB publishes an annual report. The Teeswide Safeguarding Adults Board Annual Report for 2016/17 was appended to the report.

It was noted that it was also required under the Care Act 2014 that SABs publish an annual strategic plan setting out its strategy for achieving its objective and what members would do to implement the strategy. The Teeswide Safeguarding Adults Board Strategic Business Plan for 2017/18 was appended to the report.

The Independent Chair highlighted the salient issues included in the report and responded to questions from the Committee in relation to a Safeguarding Adult Review, care homes within Hartlepool, training to providers and other agencies and the increase in referrals. It was highlighted that the Board consisted of members from multi-agencies who all worked together to ensure a joined up approach was in place.

Decision

The report was noted, the Teeswide Safeguarding Adults Board Annual Report 2017/17 was endorsed and the Chair of the Teeswide Safeguarding Adults' Board was thanked for attending and for answering questions.

53. Access to Short Breaks for Working Age Adults with Physical Disabilities (*Director of Adult and Community Based Services)*

Type of decision

For information.

Purpose of report

To provide the Committee with an update on access to short breaks for working age adults with physical disabilities.

Issue(s) for consideration

It was noted that there were currently approximately 180 individuals aged 18-65 with a physical disability and an assessed need receiving services in Hartlepool. Further detailed analysis of the services accessed by these individuals was included within the report. The Head of Strategic Commissioning highlighted that the potential of a short break flat to be provided within a new development in Seaton Carew was currently being explored. In addition to this, work would be undertaken to review current service provision at the Council's Centre for Independent Living with the aim of maximising the benefits of this state of the art new facility.

A discussion ensued during which the Head of Strategic Commissioning provided responses to a number of questions. In response to a question from a member of the public, the Chair indicated that the Committee would be looking at support for carers at a future meeting. A Member sought clarification on whether there were any discussion forums where people with disabilities could meet up. The Chair confirmed that this would be explored as part of the discussions which were ongoing around refreshing the overall engagement strategy within Adult Services.

Decision

The report was noted.

54. Support for People Living with Dementia (*Director of Adult and Community Based Services*)

Type of decision

For information.

Purpose of report

The report provided a further update regarding support for people living with dementia in Hartlepool following a report in November 2015.

Issue(s) for consideration

The Head of Strategic Commissioning presented a very detailed and comprehensive report which provided a summary of national developments along with the Hartlepool position in supporting people living with dementia and their carers. It was noted that there had been significant improvements in raising awareness of dementia within the community and local businesses. This had included a joint event which was held involving Hartlepool Borough Council, Healthwatch Hartlepool and the Dementia Collaborative to highlight the issues surrounding dementia and also celebrate how, as a community, people and organisations had come together to improve the lives of those living with dementia.

It was highlighted that following the successful accreditation as a Dementia Friendly Community (DFC) in September 2015, Hartlepool as a DFC had gone from strength to strength helped by the focal point at The Bridge within the town centre. Further details of the pledges by local organisations to be Dementia Friendly were included in the report.

The Head of Strategic Commissioning informed the Committee that in recognition of all the work carried out by the DFH in the community, Hartlepool was shortlisted to the last three in the Dementia Friendly Community of the Year Award hosted by the Alzheimer’s Society in recognition of the commitment to the agenda in Hartlepool and the work undertaken to date.

There were a number of further developments being undertaken including family leadership; dementia research; and care homes and further details were included within the report. It was noted that there was training available to become a dementia friend and then go onto become a dementia champion and the next training session would be held in Durham in January 2018.

The Chair noted on behalf of the Committee the tremendous achievement to be shortlisted to the last three for the Dementia Friendly Community of the Year Award. This reflected the amount of hard work and dedication from the Local Authority, local businesses and carers to raise awareness of dementia across the town and thanks were passed onto everyone involved.

It was noted that the Ceremonial Mayor had invited the High Sheriff of County Durham to visit Hartlepool as she had asked to see the good work being undertaken in Hartlepool and would be visiting a number of venues.

Decision

(1) The report and the developments in relation to support for people with dementia and their carers with further reports to be received by the Committee as appropriate..

(2) That the thanks of the Committee be passed on to everyone involved in the submission to the Dementia Friendly Community of the Year Award.

55. Commitment to Unison Ethical Care Charter (*Director of Adult and Community Based Services*)

Type of decision

For information.

Purpose of report

To provide an update on progress regarding the Council's commitment to the Unison Ethical Care Charter.

Issue(s) for consideration

The Director of Adult and Community Based Services confirmed that on Friday 25 November 2017 the Hartlepool Borough Council had signed the Unison Ethical Charter and a copy of this document was attached at Appendix 2.

The Chair commented that it was a significant achievement as Hartlepool was only the 2nd local authority in the region to sign up, and 35th on a national basis which demonstrated a tremendous commitment to provide high quality domiciliary care and commitment to those providing care. A Member commended the Chair on his hard work and commitment in progressing this commitment with the Chair adding that former Councillor Sylvia Tempest had been instrumental in driving forward this issue since 2012.

Decision

It was noted that the Council had formally signed up to the Unison Ethical Care Charter.

56. Strategic Financial Management Report – as at 30 September 2017 (*Director of Adult and Community Based Services and Director of Finance and Policy)*

Type of decision

For information.

Purpose of report

To inform Members of the 2017/18 Forecast General Fund Outturn, 2017/18 Capital Programme Monitoring and provide details for the specific budget areas that this Committee was responsible for.

Issue(s) for consideration

The report provided the background and financial reporting arrangements for 2017/18 as well as a summary of the overall Council financial position and General Fund outturn information in relation to the areas this Committee has responsibility for.

Details of the overall budget position for the Adult and Community Based Services Department was summarised in a table included in the report together with the reasons for the forecast outturn. Further details of specific budget areas were outlined at Appendix A. The report included details of recommended reserves together with planned capital expenditure.

The Director of Adult and Community Based Services responded to a number of questions raised during the discussion that followed. Significant concerns were expressed by Members at the medium to longer term funding of adult social care from 2019/20 onwards, especially as a significant element of work within adult social care was underpinned by the Better Care Fund.

Decision

The report was noted.

57. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

58. Any Other Business – Respite Services for People with Learning Disabilities/Complex Needs - Consultation

The Director of Adult and Community Based Services informed the Committee that the Committee’s initial response to the consultation was based on information provided by the Clinical Commissioning Group (CCG) at the meeting of the Committee in October. However, Officers had subsequently been made aware of the views of families and carers had not had the opportunity to express their views as part of the consultation process. With this in mind, a second response had been prepared and would be forwarded to the North East Commissioning Support Unit expressing concerns that the consultation had not been robust and requesting that further opportunities be made available for people to share their views. In addition to this, the response reiterated the previous concerns expressed by the Committee at the availability of provision and funding for people with learning disabilities and/or complex needs. It was noted that the Audit and Governance Committee was working alongside the Tees Valley Joint Health Scrutiny Committee and would also be forwarding a response to this consultation. The response from this Committee would be forwarded to all Members of the Committee.

Decision

It was noted that a second response to the consultation on Respite Services for People with Learning Disabilities and/or Complex Needs would be forwarded to the North East Commissioning Support Unit and circulated to Members of the Committee.

The meeting concluded at 11.55am.

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 21 December 2017

ADULT SERVICES COMMITTEE

11 January 2018

Report of: Director of Adult and Community Based Services

Subject: SERVICE USER EXPERIENCE

---

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Non Key Decision.

2. PURPOSE OF REPORT

2.1 To present the Service User Experience report for Adult Social Care 2017, which is attached at **Appendix 1**.

3. BACKGROUND

3.1 Understanding how people experience adult social care services and knowing what works well for people helps shape services.

3.2. The attached report draws on work that has been done to check that people who use adult services are having choice in the support they get and that they feel safe and secure with that support.

3.3. The department also produces a Child and Adult Services Complaints, Compliments and Representations Annual Report that is presented to Adult Services Committee.

3.4. This report looks at the other methods that are used to talk to people who use adult social care services. These are:

- The Annual Social Care Survey
- The Bi-Annual Carers Survey
- Practice Week / Month
- Feedback as part of the Assessed and Support Year in Employment (ASYE) Programme

3.5 These methods form part of the Department's strategy for engaging with people who use services and carers, which also involves:

- regular consultation and engagement through established groups such as the Learning Disability Partnership Board, Mental Health Forum and Carers Strategy Group;
- engagement on an individual level through regular reviews;
- information and advice provided via Hartlepool Now; and
- consultation on specific themes or topics.

3.6 The wider Engagement Strategy will be reviewed in 2018 with the outcome reported to Adult Services Committee.

4. SERVICE USER EXPERIENCE

4.1 It is proposed that Adult Services Committee review the attached report and consider the feedback provided from people who use services and carers.

4.2 The report is based on feedback from over 1,400 people who use adult social care services and carers. Feedback in relation to how services improve quality of life and help people to feel safe, as well as people feeling they have control over their lives is excellent.

4.3 Data from the national surveys of people who use services and their carers is published and it should be noted that the outcomes in Hartlepool are all above the national and regional averages. For the user survey results, Hartlepool has the best rates in the region for four of the seven measures. In relation to the carer survey, Hartlepool has the highest rating in the country for one measure and for all five measures is ranked in the top 4 of all authorities in the country.

5. RISK IMPLICATIONS

5.1 No risk implications have been identified.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations associated with this report.

8. CONSULTATION

8.1 The consultation arrangements are outlined in the report at **Appendix 1**.

9. CHILD AND FAMILY POVERTY

9.1. There are no child and family poverty implications associated with this report.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1. There are no identified equality and diversity considerations.

11. STAFF CONSIDERATIONS

11.1 There are no staff considerations associated with this report.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There are no asset management considerations associated with this report.

13. RECOMMENDATION

13.1 It is recommended that Adult Services Committee;

- note the work that has been undertaken to understand the views of people who use services;
- note the feedback that has been provided;
- recognise the dedication and commitment of staff in adult services to delivering high quality services; and
- approve the publication of the report.

14. REASONS FOR RECOMMENDATIONS

14.1 This report demonstrates that the Department listens to the views of people who use services and provides evidence that people using services are generally very positive about the support they receive.

15. CONTACT OFFICER

Sarah Ward
Principal Social Worker
Email: sarah.ward@hartlepool.gov.uk.

What is it like to get Adult Social Care Services from Hartlepool Borough Council?

Introduction

Understanding how people experience Adult Social Care services is really important to us.
We want to know what works well for people, we want to check they are having choice in the support they get and that they feel safe and secure with that support.

We use a range of methods to help us understand how people experience our services and this includes the monitoring of Complaints, Compliments and Concerns. Our annual complaints report is available at www.hartlepool.gov.uk/complaintsandcomplimentsannualreport

How do we know how we are doing?

We do not just rely on complaints or compliments to tell us what people are thinking about our services. We also use a number of other ways of asking people what they think. We use questionnaires and we talk to people face to face. The different ways we find out what people think are described in Appendix 1.

1,443	This report includes responses from 1,443 questionnaires and 30 face to face interviews.

People received a broad range of support including:

Home Care

Personal Assistants

Day Care and Residential

What are we doing well?

Most people said that the care and support services they received helped them to:

- Have a better quality of life (94%)
- Have control over their daily life (93%)
- Feel safe (91%)

People were generally positive about the quality of support they received:

- 67% said that the support they received was good or very good.
- 67% said the amount of support they received was good or very good.
- 68% said that the dignity with which they were supported was good or very good.

... I really am most grateful for the wonderful care we enjoyed from all the carers

"I would like to thank everyone involved for the services they provided. It has given me my life back."

People feel they are listened to:

- 95% said their views were taken into account in support planning.
- 95% said their support plan reflected their wishes.
- 64% could decide how their personal budget was spent.

... She explored in-depth what I feel was needed for my personal

...she was very attentive to the client and willingly listened to others. She had a sensitive approach.

What have carers told us?

78% were satisfied with the support or services they and the person they care for receive from social services.

Because of the support carers get:

- 90% can spend some their time doing things they want to do.
- 90% get social contact with people they liked.
- 91% had some control over their daily lives.

...it's good to know the social worker is there. Knowing someone is there makes me feel less anxious

...Everything is fine at the moment but it might get where we need more help and I wouldn't worry about talking about that to her.

In conclusion

People’s experience of social services is generally very positive. The report highlights where things are going really well for people.

We will continue to make sure that people get the opportunity to tell us what they think about the services that they receive by looking at all the information we collect from surveys and from talking face to face to service users and their carers.

...we would like it to be recorded of the superb service we have had by Social Services...this service was top class.”

Appendix 1

Annual Social Care Survey

The Annual Social Care survey is designed to help all adult social services departments understand more about how services are affecting lives. A random sample of service users is selected from caseloads across adult services and a questionnaire designed by the Department of Health is sent out. The survey takes place between January and February of each year. Support to complete the questionnaire is given to service users who request it.

The findings discussed in the report are from the Annual Social survey conducted in 2017. The data is reported to the Department of Health who then use some of the data for a number of measures in the Adult Social Care Outcomes Framework.

In 2017 a total of 1043 questionnaires were sent out with 411 returns. This represents a return rate of 39% which is high for this type of survey so it is possible to say that the findings can be treated as being representative of people's experience of using adult social care in Hartlepool.

Bi-Annual Carers Survey

The Personal Social Services Survey of Adult Carers is a bi-annual national survey developed by the Department of Health. The survey is used to find out more about whether or not services received by carers are helping them in their caring role and in their life outside of caring.

The aim of the survey is to collect information about carers' experiences of social care service and support that feeds into monitoring of the impact of the National Carers Strategy.

The data used in this report is drawn from the last survey that was conducted in 2016. 801 questionnaires were sent out with 354 completed returns, a return rate of 44% which is high for this type of survey suggesting that the findings can be treated as being representative of carers experience in Hartlepool.

The Personal Outcomes Evaluation Tool (POET)

Hartlepool has taken part in Lancaster University and in-Control's POET research since 2015. The POET research measures people's experience of accessing support and featuring outcomes structured around the Care Acts domains of wellbeing. POET provides local authorities with a clear and simple framework to measure how well they are meeting the requirements of the Care Act and to demonstrate the impact they are having on the lives of local people who need support.

The first part of the research involved the sending of questionnaires to personal budget holders in Hartlepool. 99 people responded to the survey and returned completed questionnaires.

After having established the benchmarking data from the POET survey, questions and now asked as part of the review process. This allows us to track progress over a period of time.

The findings discussed in this report are from the original data collected in 2015 and the most recent set of POET data based on 579 reviews from April to September 2017.

ASYE Feedback

All Newly Qualified Social Workers (NQSWs) who come to work in Hartlepool Borough Council are registered with Skills for Care to take part in the Assessed and Supported Year of Employment (ASYE). As part of that year social workers have to ensure that they gather service user feedback that discusses their practice and the impact of services on the person's wellbeing. This feedback is collated as part of the NQSWs ASYE portfolio and is used to assist the social worker to reflect on their practice.

Practice Month

Adult Social Services has in place a quality assurance framework that includes Practice Month. Practice month is where a number of auditors complete a range of audit activities across the month which includes case file audits, observations and service user feedback.

During the last practice month in March 2017 46 case file audits took place with social workers, 8 observations, and 17 phone calls with service user and/or carers.

ADULT SERVICES COMMITTEE

12 January 2018

Report of: Director of Adult and Community Based Services

Subject: CARE QUALITY COMMISSION: LOCAL SYSTEM REVIEW

---

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required: for information.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with an update regarding the Care Quality Commission's Local System Review for Hartlepool, which was published in December 2017.

3. BACKGROUND

3.1 Following the announcement of additional funding for social care in the Spring 2017 budget, work was undertaken nationally to develop performance measures associated with this allocation, which will form part of the Improved Better Care Fund.

3.2 The measures, which include Delayed Transfers of Care, aim to assess patient flow and how the interface between health and social care services is managed.

3.3 Based on an assessment of these indicators, the Department of Health identified areas that they perceived to be experiencing particular challenges, where there had not been any other form of intensive support initiated, and asked the Care Quality Commission to undertake local system reviews in those areas. Twenty areas will be reviewed, with the first twelve areas announced in July 2017 and a further eight announced in December 2017.

3.4 A notification was received on 4 July 2017 advising that Hartlepool had been identified as one of the first twelve areas to be reviewed.

3.5 The review process focused on over 65s and specifically considered how health and social care services work together to:

- support people to remain independent in their normal place of residence;
- support people in a crisis such as a hospital admission; and
- support people to return to their normal place of residence following a crisis.

3.6 The review process involved submission of a Local System Overview Report, a two day on-site visit from members of the review team in September 2017 and a five day on-site visit from the whole review team in October 2017.

3.7 A wide range of system leaders and partners were involved in the review process including health and social care commissioners and providers, Healthwatch and voluntary sector organisations. The review also involved case tracking and focus groups with people who use services and carers.

3.8 The draft report was shared with system leaders in late November to provide an opportunity for any factual accuracy issues to be addressed.

3.9 A Local Summit was held on Thursday 7 December 2017 where the Care Quality Commission presented the report and work began to develop an action plan is response to the areas for improvement that had been identified.

3.10 The final report was published on the Care Quality Commission 2017 website on Friday 8 December 2017, and a copy is attached as Appendix 1.

3.11 A system action plan is currently being developed for submission to the Department of Health. Implementation and monitoring of the action plan will be overseen by the Health & Wellbeing Board, which involves representatives from all of the key partners.

4. OUTCOME OF THE REVIEW

4.1 The attached report summarises the outcome of the review and identifies a wide range of areas of good practice, and areas where new initiatives are having a positive impact. The report also acknowledges that there are areas where performance has improved significantly, such as Delayed Transfers of care.

4.2 The report also identifies areas for improvement which will be the subject of an action plan, and addressed through targeted work to deliver or sustain improvements.

5. RISK IMPLICATIONS

5.1 There are no risk implications identified.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this issue.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no identified child and family poverty considerations.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations identified.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations identified.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations identified.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee notes the outcome of the Care Quality Commission local system review for Hartlepool and notes that the action plan developed in response to the review findings will be monitored through the health & Wellbeing Board.

13. REASONS FOR RECOMMENDATIONS

13.1 The Adult Services Committee has oversight of adult social care services that will be the subject of the review by the CQC.

14. CONTACT OFFICER

Jill Harrison
Director of Adult and Community Based Services
Tel: 01429 523911
Email: jill.harrison@hartlepool.gov.uk

Hartlepool

Local system review report

Health and wellbeing board

Date of review:
09 -13 October 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that will bring together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Delivery lead: Ann Ford, CQC
- Lead reviewer: Karmon Hawley, CQC

The team included:

- Two CQC reviewers
- One CQC analyst
- One CQC strategy lead
- One CQC Expert by Experience
- Three specialist advisors: one former local government director, one with a background in clinical nurse governance and one with a general practice background.

How we carried out the review

The local system review considered system performance along a number of ‘pressure points’ on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings. Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

- Maintaining the wellbeing of a person in their usual place of residence
- Crisis management
- Step down, return to usual place of residence and/or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive?**

We have then looked across the system to ask:

- **Is it well led?**

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC’s own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Hartlepool Borough Council (the local authority), NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (the CCG), North Tees and Hartlepool NHS Foundation Trust (NTHFT), Tees Esk & Wear Valleys NHS Foundation Trust (TEWV)

members of the Hartlepool health and wellbeing board
- Health and social care staff including social workers, GPs, discharge teams, reablement teams and the integrated discharge team
- Healthwatch Hartlepool and voluntary and community sector (VCS) representatives
- Health and social care provider representatives
- People using services, their families and carers during our visits to day centres and support groups and in focus groups

We also met people using services from North Tees and Hartlepool NHS Foundation Trust in both A&E and the discharge lounge as well as at the urgent care centre.

We reviewed 16 care and treatment records and visited 11 services in the local area including Hartlepool and North Tees Foundation Trust, intermediate care facilities, care homes, domiciliary care agencies, GP practices, an extra care housing scheme, out-of-hours services and the urgent care centre.

Hartlepool context

Demographics

- 17% of the population is aged 65 and over.
- 98% of the population is categorised as White.
- Hartlepool is in the most deprived 20% of local authorities in England.

Adult Social Care

- 18 active residential care homes:
    - 11 rated Good
    - 6 rated Requires improvement
    - 1 currently unrated
- 8 active nursing care homes:
    - 4 rated Good
    - 2 rated Requires improvement
    - 2 currently unrated
- 13 active domiciliary care agencies:
    - 9 rated Good
    - 3 rated Requires improvement
    - 1 currently unrated

GP Practices

- 17 active locations
- 13 rated Good
- 4 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people living in Hartlepool LA are almost entirely at one NHS acute hospital trust:

North Tees and Hartlepool NHS Foundation Trust (RVW)

- Receives 76% of admissions of people living in Hartlepool LA.
- Admissions from Hartlepool make up 28% of the trust's total admission activity
- Rated Requires Improvement overall

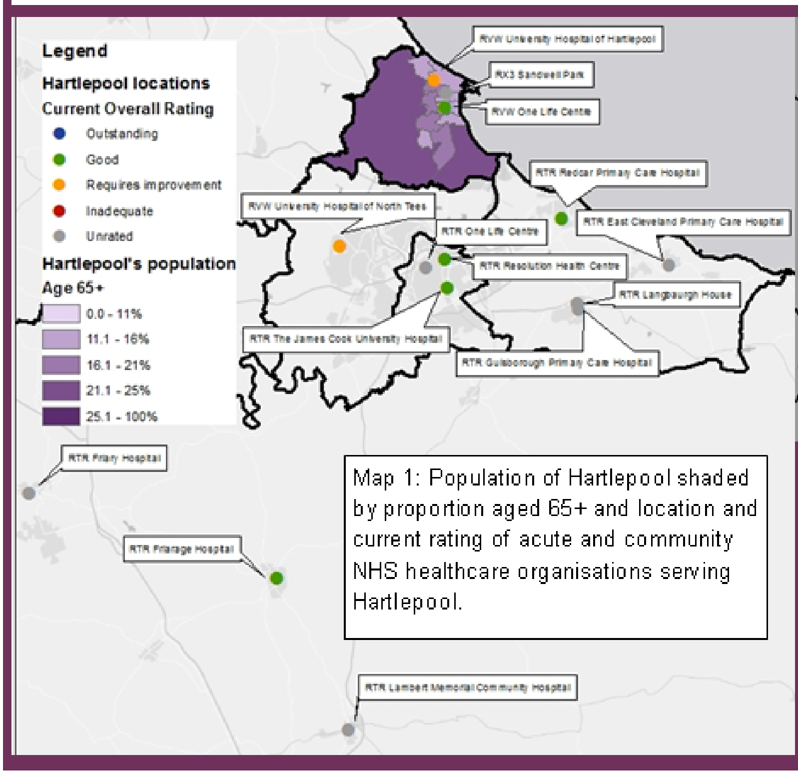
The second main trust is South Tees Hospitals NHS Foundation Trust (RTR)

- Receives 15% of admissions of people living in Hartlepool LA.
- Admissions from Hartlepool make up 3% of the trust's total admission activity
- Rated Good overall

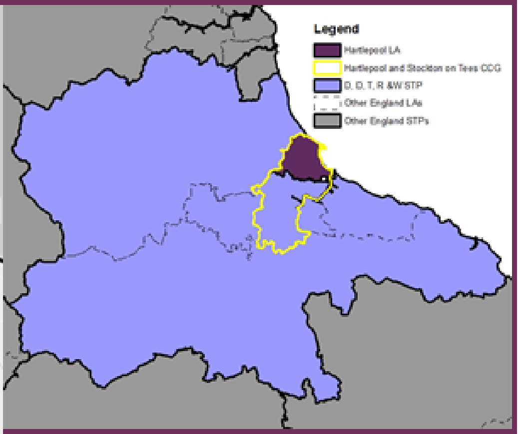
Community services are provided by:

- Tees, Esk and Wear Valleys NHS Foundation Trust (RX3) - currently rated Good overall.

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of Hartlepool shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Hartlepool.



Map 2: Location of Hartlepool LA within Durham, Darlington, Teesside, Richmondshire and Whitby STP. Hartlepool and Stockton-on-Tees CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- The sustainability and transformation plan (STP) ‘Working together to improve health and care’ for Durham Dales Easington and Sedgefield, Darlington, Teesside, Hambleton, Richmondshire & Whitby was undergoing restructure and realignment for the geographical area. The plan provided a comprehensive account that had potential to be a driving force for change across the wider system and support integrated working at a local level within Hartlepool. The Hartlepool Matters report, which describes a model for the integration of health and social care services in Hartlepool, was incorporated within the STP vision and delivery plan and would support the STP being translated at local level.

- Historically relationships across the STP footprint had been compromised. System leaders in Hartlepool acknowledged that in the past relationships across the wider system had been poor and there had not been a high level of trust but more recently this had begun to improve. There was an acceptance among system leaders that a shared vision was required with leaders working collaboratively to improve and develop sustainable services across the STP footprint.

- Relationships had improved between system leaders from Hartlepool Borough Council (the local authority), NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (the CCG), North Tees and Hartlepool NHS Foundation Trust (NTHFT) and Tees Esk & Wear Valleys NHS Foundation Trust (TEWV). Aligned with the jointly developed health and wellbeing strategy there was a strong commitment from the local authority, the CCG and NTHFT to serve the people of Hartlepool well. The health and wellbeing board (HWB) was recognised as the vehicle for progressing this, and work was underway to strengthen its challenge and support functions.

- There was a shared understanding across system partners of the challenges that each organisation faced and a willingness to work together with a solution-driven approach without compromising their own organisational responsibilities. There was evidence of joint working in respect of the Better Care Fund (BCF) initiatives which were supported by system partners.

- The BCF had resulted in positive outcomes for people in terms of social inclusion, hospital admission avoidance and timely discharge.

- Local priorities were focussed on keeping people well in their normal place of residence by providing them with preventive services and support and also enhancing the capacity within the care home sector and extra care housing schemes.

Is there a clear framework for interagency collaboration?

- The Joint Strategic Needs Assessment (JSNA) was robust, well considered and underpinned by clear delivery plans and outcomes. This had been translated into the Hartlepool Matters report and the Hartlepool Matters implementation plan 2017 as a joint local strategy overseen by the health and wellbeing board. All partners were sighted on what was important to older people, their families and carers.

- The BCF plan built on the early integration between the local authority and the CCG and had interdependencies with the JSNA and the Hartlepool Matters report. The BCF plan was facilitating elements of risk sharing between partner organisations. For example both the CCG and the local authority had agreed plans set out in the BCF that needed full investment to pooled budgets in order to achieve the desired outcomes. Both parties agreed to manage the risk of increased emergency admissions to hospital and increased admissions into residential services. It was encouraging to see that there was an acceptance of the challenges ahead and a willingness to work together to improve people’s experiences and the quality of services.

- Governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight of the various strategies, including the joint commissioning strategy for intermediate care and the joint commissioning strategy, The Great North Care Record (API).

- There were positive examples of shared approaches and initiatives that supported people in Hartlepool to have timely access to services and support that met their needs in a person-centred way. The joint approach for people living with dementia had positive outcomes in terms of diagnosis and longer term support. Cross-system collaborative plans for the anticipated increase in demand due to winter had been submitted and there was evidence of a system-wide approach to winter planning.

- Care home closures locally had resulted in a substantial loss of long-term care beds in Hartlepool and the lack of capacity had led to increased numbers of delayed transfers of care (DTOC).

- There had been proactive attempts to stabilise and improve capacity in the care market. The local authority had worked well with local providers to encourage the development of new care facilities and improve availability to good effect. Recently there had been a significant increase in care home bed numbers that was supporting improved patient flow and a reduction in DTOC.

- Additionally, a joint and collaborative approach had been adopted to improve the quality of long-term adult social care services following poor CQC service ratings. The majority of providers that we spoke with said that they felt well supported by the local authority and the CCG to secure service improvement.

How are interagency processes delivered?

- Partnership working across the system was supported through defined governance, and there was involvement and representation of a wide membership on a variety of partnership boards such as the North of Tees Partnership Board, BCF Pooled Budget Partnership Board, BCF Delivery Group and BCF Project Implementation Group. Within these forums, key issues were discussed and actions agreed for implementation and performance monitored.

- Frameworks for interagency collaboration across the health and social care interface were developing positively, an example being the integrated discharge team.

- System leaders and frontline staff across the systems reported good integrated working between health and social care professionals. However, social care providers expressed a desire to work more collaboratively with the local authority. Partnership working could be further improved by ensuring all partners and stakeholders were kept informed of pilot projects and initiatives so these could be utilised to their full potential.

- Frontline staff were clearly focused on the strategic direction, needs and welfare of people who lived in Hartlepool and they expressed a desire to improve outcomes for people through collaborative working. Some community based teams felt systems and processes could be streamlined to enable this further.

- A self-assessment against the high impact change model undertaken and provided to the Local A&E Delivery Board (LADB) in June 2017, identified that significant progress had been made in relation to early discharge planning, monitoring of patient flow, multi-agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes.

- Frontline interagency and multidisciplinary teams were supporting people to move through the system smoothly and seamlessly; there was good support placed at ‘front of house’ in

A&E to help to prevent avoidable admissions. Once people were admitted to hospital their journey was tracked via the patient flow coordinators and the integrated discharge team. This was having a positive impact and reducing DTOC. Our analysis showed that the percentage of older people staying in hospital for 7 days or longer reduced in 2016/17 to be more consistent with national and comparator averages.

- System leaders had developed winter plans covering the resilience of the system to support increased demand. Frontline staff were aware of the plans across primary and secondary care.

- There was an active voluntary and community sector (VCS) that played a positive role in supporting older people to remain at home and to be socially included.

- A number of support services were commissioned through the BCF including carers support, day services for people living with dementia, a dementia advisory service, advice and signposting, and a handyperson service.

- Further work was being undertaken to improve the coordination of services and to ensure the voluntary sector felt engaged and included in service design and delivery.

- Thirteen Housing Association was a willing partner to improve the experiences of older people and there had been some positive work around the development of extra care housing schemes.

What are the experiences of frontline staff?

- Health and social care professionals in Hartlepool were highly dedicated to supporting people using services, their family and carers. Staff that we spoke with felt that leaders were visible, responsive and inclusive. Frontline health and social care staff reported that staff generally communicated well across agencies. However, some social care staff reported that they were not always kept informed when people in their care had been admitted to, or discharged from hospital.

- We found that a collaborative multi-agency approach was establishing well as a result of new initiatives that supported networking and the building of relationships. Social care staff welcomed the opportunity to be more involved in people’s care when in hospital and in the discharge assessment process.

- Feedback from frontline staff was, in the main, very positive, although they identified issues about workforce; particularly about the recruitment and retention of nurses in nursing homes and paramedics. There were system-wide plans in place to mitigate risks associated with these issues and new models of care, which would promote integrated working and best use of resources, were being considered.

- In the main, staff felt supported with their professional development and career opportunities; however some specific concerns were expressed with regard to the lack of opportunity for ambulance staff to undertake the advanced practitioners training due to waiting times for places.

What are the experiences of people receiving services?

- Most older people living in Hartlepool received health and social care services in a timely way. However some concerns were expressed in respect of access to GP services. Most people using services told us they felt included in decision making about their care, treatment and support. However, some people had to tell their story more than once due to duplication of assessments as they moved through the system.

- There were a number of extra care housing schemes which supported people to remain independent in their own homes for longer. People living at these schemes were extremely positive about their experiences and the benefits this brought.

- Local people benefitted from access to direct payments and data for Q1 2017/18 showed the rate of direct payments per 50,000 people was 8.13 in Hartlepool and Stockton-on-Tees, above the regional average of 4.73 per 50,000 and above the national average of 3.63 per 50,000. While continuing healthcare (CHC) data for Q1 17/18 showed that the number of standard CHC referrals exceeding 28 days was 0.64 per 50,000 in Hartlepool and Stockton-on-Tees CCG (far below the England average of 10.27), we did speak with some people who reported long waiting times for their direct payments. Where applications had been successful, we heard positive feedback about the impact of this in respect of the person having control and involvement in their care planning.

- We found a multidisciplinary, integrated approach to delivering a number of key services including the single point of access, which provided a proactive and solution-focused service that improved people’s experiences.

- There was effective involvement of people using services, their families and carers, who were engaged in developing and improving health and social care. People living with dementia were being identified earlier and they, their families and carers were well supported. There was a range of community support groups that provided advice, support and guidance.

- Reported levels of overall satisfaction with adult social care and support were above national and comparator averages in 2015/16 (ASCOF) and in our more recent analysis of 2016/17 data, at 64% for Hartlepool in 2016/17 compared to the comparator average of 63% and England average of 62%.

Are services in Hartlepool well led?

Is there a shared clear vision and credible strategy which is understood across the health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, inter-agency and multidisciplinary working and the involvement of people who use services, their families and carers.

There was a collaborative leadership approach between system leaders and a coherent vision and strategy that could be articulated by people across the system. System leaders were committed to working together and further developing strategies for working more collaboratively with the STP. There was evidence that people who used services, their families and carers were engaged by partners in developing and improving the health and social care interface.

Strategy, vision and partnership working

- We found there was a strong commitment from local partners to serve the population of Hartlepool well. Historically there had been tensions between system leaders following the closure of the A&E at University Hospital of Hartlepool in 2011. Following the recommissioning of the urgent care service in the town and a change in senior leadership, local system-wide relationships had improved. Over the last 12 months there had been a recognition that leaders needed to work together to provide sustainable high quality services for the people of Hartlepool.

- Local leaders worked well together and the Hartlepool Matters report had been jointly developed and published. The Hartlepool Matters report and the subsequent implementation plan was informed by the JSNA and aligned to the local vision, the health and wellbeing strategy and the BCF plan. The alignment of these strategies and plans resulted in a cohesive vision and implementation plan for the area.

- The Hartlepool BCF plan set out a system-wide approach to provide solutions to local issues. There was an acceptance that a shared vision and approach was crucial for the provision of sustainable services and to address associated risks.

- The STP for Durham Dales Easington and Sedgefield, Darlington, Teesside, Hambleton, Richmondshire & Whitby had been established following the merger of two smaller STPs. Local systems leader felt disconnected from the STP and felt unable to influence decisions made by the STP that would impact on Hartlepool. Local leaders acknowledged that more productive engagement with the STP was needed.

- Partnership working between the CCG, the local authority, NTHFT and TEWV was supported by good governance; partnership boards held organisations to account and enabled innovative and collaborative working.

- Partnership working between CCG, the local authority, NTHFT and TEWV had continued within the past 12 months. The urgent care centre (UCC) had been established as well as collaborative working initiatives such as the Integrated Discharge Team and integrated discharge pathways, a discharge to assess and trusted assessor pilot project for the elective orthopaedic pathway, and development of the Home from Hospital service (the latter had impacted positively on DTOC).

- There was a joined up approach to winter planning, using lessons learned from the previous year’s performance to inform the plan for 2017/18. Primary and secondary care providers had been able to input into plans through workshops facilitated by the CCG.

- Adult social care providers told us they were not always able to influence the strategic direction and the implementation of plans. Many adult social care providers were under-represented at some fora; however, we found that a domiciliary care provider attended a A&E Delivery Board event in October 2017 which meant that they could feed provider perspectives into planning. The local authority acknowledged engagement with providers had reduced and they told us they had plans to improve this.

- The voluntary sector felt engaged by the health and wellbeing board and the CCG’s locality board meetings and were able to represent the views of communities and contribute to the wider strategy.

Involvement of service users, families and carers in the development of strategy and services

- We found there were many opportunities for local people to be engaged in the development of services. Local people were involved in the Hartlepool Matters report and implementation plan through local fora and engagement events to influence and participate in service design and delivery. The health overview and scrutiny committee indicated that there should be even more public consultation in respect of local changes to health and social care services. People living in Hartlepool were encouraged to take an active role in influencing service design and delivery through groups such as the 50+ Forum, Hartlepool Carers Strategy Group and Dementia Friendly Hartlepool. There was targeted engagement during Dementia Awareness Week, Carers Week and World Mental Health Day, and people had strong links with Healthwatch.

- Healthwatch Hartlepool was represented on executive committees across ten themed areas that spanned all dimensions of health and social care. It was also a member of the locality meetings and was represented on the CCG's primary care co-commissioning joint committee.

- In developing the Hartlepool Matters report and implementation plan an engagement event with older people was held to gain feedback on what worked well, how services could be improved and what they felt were the priorities for the future. The feedback from this event had been incorporated in BCF plans, and had influenced developments across the system. For example, to address reducing social isolation, there had been investment in a 'Befriending Network' and a home library service for people who were housebound.

- A 'Family Leadership' course for people living with dementia and their carers was delivered in 2016. This course, delivered in partnership with In Control, drew on the Partners in Policymaking model and created shared understanding of dementia alongside offering people information and support.

- There was regular engagement and co-production with older people. The CCG had developed Community Health Ambassadors and had led a range of engagement projects and formal public consultations including a frail elderly summit and ongoing engagement regarding the regarding the Better Health Programme.

- Qualitative feedback from people who use services, their families and carers was gathered by system leaders and Healthwatch through public consultation and surveys and this information was used to improve services.

Promoting a culture of inter-agency and multi-disciplinary working

- Frontline staff we met were consistently focused on the needs and welfare of people who lived in Hartlepool and expressed a desire to improve outcomes for people through collaborative working. Some community based teams felt systems could be streamlined to enable this further as they described duplication in assessments that created unnecessary workloads and meant that people had to tell their story more than once.

- There were good examples of interagency and multidisciplinary working. A multiagency group consisting of the CCG, NTHFT, TEWV, Hartlepool Borough Council and Stockton-on-Tees Borough Council had been successfully working together to promote dementia awareness. The integrated discharge team won the Best Integration Project of the Year at the North East, Cumbria, Yorkshire and Humberside Commissioning Awards facilitated by the NHS North of England Commissioning Support Unit.

- Frameworks for interagency collaboration were developing to improve outcomes for people; an example of this working well was the collaborative dementia strategy. Health and social care organisations in Stockton-on-Tees and Hartlepool were collaborating to improve the experiences of people living with dementia, their families and carers.

- In addition, the integrated discharge team was working effectively to reduce DTOC and a single point of access worked to reduce the multiple points of entry in to the system for people who required care and support and enable timely access to services.

- All GP practices in Hartlepool were members of the GP federation. The GP federation had a well-established relationship with the CCG and undertook joint working with them, for example in the development of the care coordinators role. The Local Medical Committee (LMC) and the GP federation described how this had improved joint working across GPs and told us that the federation was now looking to develop cluster working strategies. Responses about the impact of this care coordinator role from people using services was extremely positive; all 20 people who received the service in the previous six weeks had provided very positive feedback, including describing the service as making a “vast difference” and “life-changing”.

- A self-assessment against the high impact change model had been undertaken and provided to the LADB in June 2017. This identified that significant progress had been made in relation to early discharge planning, monitoring of patient flow, multi-agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes. However, it was acknowledged in the response to the system overview information request that further work was needed to develop and embed trusted assessor models.

- The Hartlepool BCF Delivery Group was reviewing the high impact change model in light of the new BCF plan for 2017-2019, highlighting areas of good practice and agreeing actions for areas that required further improvements.

Learning and improvement across the system

- System leaders and frontline health and social care staff told us there was openness to being innovative and to trying new approaches to enable learning and improvement. An annual review of the Hartlepool Matters report had taken place to understand what was working well locally and to share learning. The Hartlepool Matters implementation plan followed this to secure future improvements.

- There were various fora to share best practice at an organisational level, including:
    - A recent “practice month” in adult services in the local authority, gave managers the opportunity to strengthen links with frontline staff and people using services. During practice month, case audits and observations were completed alongside the social worker. There were observations of social work interaction with other relevant professionals as well as the service user and/or carer (where achievable). The approach provided assurances that services were person centred and well-coordinated.
    - The GP federation and the LMC had been exploring cascading learning to get practices to share good practice and protocols to save time and effort. They told us this was starting to work and practice managers had regular meetings to network and share good practice.
    - The ambulance trust director told us there was a forum for sharing important messages with frontline staff. However social care providers told us that whilst there had been fora for them to share good practice, these were not taking place as frequently.

- However, it was less clear how learning and sharing of best practice was fostered across the system. Some social care providers told us that they felt opportunities for them to be involved in sharing good practice and learning new skills had diminished recently.

- Following a Healthwatch investigation about the hospital discharge process, a system wide action plan was put into place. This resulted in changes such as establishing daily huddles and the development of an integrated discharge team. System leaders told us that as well as excellent feedback from patients and staff, recent performance data had shown that the number of delayed days had reduced by 41% between Q3 and Q4 2016/17. This fed into the BCF plan and was monitored through the local authority’s Adult Services Committee. Our analysis indicated these changes had resulted in reduced delays with the average daily delayed days in July 2017 below the national average.

- Quality monitoring and evaluation of impact was undertaken by the CCG through several audits. The CCG Operational Plan outlined the care and quality gaps across the STP area and also outlined the health and wellbeing, funding and finance gaps for the system overall. The local authority's Local Account of Adult Social Care Services in Hartlepool 2016/17 outlined areas where they were doing well and areas where there was room for improvement and plans for the future.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

There was effective board leadership and information sharing so that senior teams were held to account for the delivery of their strategies and the management of risk to quality service delivery. Strong relationships between partners supported the effective interface between health and social care systems.

Overarching governance arrangements

- The STP lead told us that governance arrangements of the STP were currently being reviewed due to the restructure and realignment to the geographical areas. There was good engagement between the CCG, the local authority, NTHFT and TEWV but not all partners felt engaged with the STP.

- The BCF board had oversight of the BCF Delivery Group and the BCF Project Implementation Group which oversaw delivery of the BCF plans and development of new pathways and models of care. It also ensured that decisions were made using correct processes so that each organisation was accountable for the successful implementation of the BCF plans. Alongside this they also had oversight of alignment of the various strategies, including the intermediate care joint commissioning strategy and the joint commissioning strategy The Great North Care Record (API).

- The North Tees Partnership Board acted as the unit of planning to provide strategic leadership and oversight to the development and delivery of the Hartlepool BCF. This was aligned with wider strategic plans across health and social care to improve health and social care outcomes for people.

- Four local authorities, including Hartlepool Borough Council, plus Hartlepool and Stockton-on-Tees CCG and Cleveland Police formed the wide range of statutory partners who had committed to work together through a single Teeswide Safeguarding Adults Board. Frontline staff in primary and secondary care stated that safeguarding was taken seriously and raising any issues of concern resulted in action.

- The LADB aligned partners across health and social care and provided an effective forum for system leaders to monitor key strategic aims and objectives. The LADB had oversight of and responsibility for improving A&E performance, and for monitoring performance and progress of discharge to assess and delayed transfers of care. Our analysis suggested NTHFT's A&E was performing well, with better than average performance against A&E waiting times targets and the trust nearly meeting the 95% target in 2016/17.

Risk sharing across partners

- There were established risk sharing arrangements between the CCG and the local authority and well-developed scrutiny processes in place with quality assurance at a local and regional level. System leaders across the system were working collaboratively and were actively involved in the HWB which addressed areas of risk and issues relating to health and social care in Hartlepool.

- The BCF plan was facilitating elements of risk sharing between partner organisations. For example, the CCG and the local authority had agreed plans set out in the BCF that needed full investment to a pooled budget. Both agreed to manage the risk of increased emergency admissions to hospital and increased admissions into residential services.

- As part of the BCF a risk register was maintained and monitored with mitigating actions identified. One of the risks specified was insufficient data at the correct level and quality to effectively monitor outcomes and ensure overall delivery of the BCF plan.

- The North Tees Partnership Board addressed areas of risk, agreed contingency and risk management plans and arrangements; and oversaw the Care Quality Improvement Programme which brought together all the initiatives that were underway to support care homes.

Information governance arrangements across the system

- Hartlepool and Stockton-on-Tees Local Digital Roadmap Narrative 2016/17 outlined the vison to empower the public, patients, care providers and commissioners to improve health and care through digital transformation.

- There was no current unified care record, however, systems leaders informed us that the development of a fully integrated digital care record remained a priority to inform the best decisions at the point of care and for the person to only have to tell their story once.

- GP practices, hospitals, community and mental health trusts were leading a project called The Great North Care Record to develop a specification for a system to provide integrated digital care records across the North East. All partners had been involved as part of the BCF and system leaders were very positive about its potential impact and had worked hard to overcome the technical and governance challenges.

- In the 2016/17 BCF return the HWB confirmed it was working towards better data sharing between health and social care. All GP practices in Hartlepool were signed up to data sharing through the Medical Interoperability Gateway (MIG). This enabled clinicians in 15 providers (within acute and mental health trusts and out-of-hours services) across the North East to access relevant records at the point of care. This had been initially rolled out in A&E and the UCC, with plans to implement this throughout NTHFT.

- There were also plans to make health records available to social care providers; it was evident that processes towards this had already been started, and people in the local area had been invited to meetings to discuss the implications of the proposals.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Developing the capacity and capability of the health and care workforce was recognised as a key challenge for Hartlepool. There was a system-wide strategy in place as part of the BCF and STP to ensure the system had sufficient numbers of suitably skilled staff. However social care providers felt there was no system-level support for, or oversight of, long term requirements of the workforce; and ambulance staff were concerned about staff shortages.

- From the STP and CCG operational plans we reviewed it was clear that the development of a sustainable workforce that was suitably skilled and experienced to support the needs of local people was a priority for system partners. The BCF and the STP plan outlined a comprehensive strategy to address workforce issues. There was a focus on recruitment and retention, training and development and supporting new ways of working.

- One example of a new way of working was the McKenzie House community integrated service pilot. The primary purpose of this pilot was to provide more timely access to assessment, treatment and support for the frail elderly by facilitating closer communication and collaboration between health and social care practitioners working in the community.

By sharing relevant information, improving coordination and more proactively engaging with identified people, the aim was to maximise community based health and social care resources so that people would receive a more targeted and responsive service.

- The local authority and the CCG had actively engaged with social care providers and had developed a bespoke North Tees Education and Training Alliance programme led by NTHFT, which was available to all care homes in Hartlepool and Stockton-on-Tees. The programme started in February 2017 and by mid-August 2017, 780 members of staff had attended training, and at the time of our review, 64% of care homes in Hartlepool and Stockton-on-Tees had confirmed or booked training.

- System leaders were committed to continuing to work with Health Education England (North East) and the BCF plan acknowledged that future challenges could not be met by any single organisation and reflected the importance of working with all stakeholders and providers. Consideration had also been given in the BCF plan to succession planning through supporting new employees and working with local colleges to develop the future workforce.

- System leaders confirmed that partners were working collaboratively across health and social care to better understand the implications of proposed STP workforce plans with a particular focus on primary and community care.

- However, social care providers reported that recruitment of nursing staff was a significant issue, with providers competing with each other for staff. They felt there was no system level support or oversight of the workforce requirements in long term care.

- To tackle the difficulties of retaining staff in the single point of access team, the service had developed progression opportunities by introducing band three and four supervisory roles. The innovative work at the McKenzie Practice (a GP Practice) was having a positive impact and attracting new GPs to the practice. Health Education England and system leaders told us there was investment in the primary care workforce with an increased number of staff being attracted to Hartlepool through a range of recruitment, retention and education initiatives. Partners were also introducing some new roles, working to change the skill mix of staff, and expanding roles such as the advanced practitioner role.

- The reablement and rehabilitation services were well staffed and there were good opportunities for career progression within the team. Community Matrons identified that more training was needed for care home staff, but they felt they didn’t have the necessary resources to be able to facilitate this at the time of our review. They also reported having to provide staffing cover at the Holdforth Unit when it was short of staff, and described that this impacted upon the availability of skilled staff to undertake work in the community.

- Ambulance staff were concerned about staff shortages and even though there were plans to recruit additional staff there was a consensus that these plans were not sufficient. They reported that a number of measures had been put into place to recruit staff and they were also working with Health Education England, the CCG and GPs in Hartlepool via the A&E delivery board to help categorise calls better and make more efficient use of resources.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Commissioning frameworks enabled a coordinated and strategic approach to commissioning across the health and social interface, which was informed by the identified needs of local people though the Hartlepool Matters report. System leaders were working jointly towards developing a diverse and sustainable market and the Care Quality Improvement Programme would enable resources to be effectively targeted where there was likely to be the greatest impact. Although capacity in the adult social care market had increased, so was the complexity of people's needs increasing, which would impact on bed availability and resources in the community.

Strategic approach to commissioning

- Work had been ongoing to establish a strategic commissioning approach across the local authority and with partners. These joint approaches led to the Hartlepool Matters report and implementation plan which was the agreed strategy between system leaders and was driving local authority and CCG commissioning. Partners acknowledged that the BCF process had been a challenge but it was evident that this was now working well through pooled budgets between the CCG and the local authority.

- A detailed and comprehensive report which looked into current commissioning frameworks was presented to the Adults Services Committee on 5 October 2017. The committee noted the complexity of the commissioning framework for adult services and the requirement for flexibility to ensure there was a vibrant and sustainable care market in accordance with the statutory duties set out in the Care Act 2014.

- The CCG’s annual report 2016/17 demonstrated a commitment to ensure a coordinated approach to the delivery of the STPs locally, plus their two year operational plan, efficiency programmes, BCF plans; as well as a number of service improvement and related activities and initiatives developed by member organisations.

- Winter plans covering resilience arrangements across the system had been approved by NHS England. We found that all system partners were aware of the plans and had contributed to their development and they were committed to implementing these. While frontline staff across primary and secondary care stated they hadn’t contributed to the planning they were always informed about the plans and were aware of the key themes and wider system preparation.

- The local authority had good working relationships with social care providers and worked with them closely in relation to the support provided to their employees. This included paying the national living wage, which was a stipulation of all Council contracts, and requirements regarding continuity of carers. Social care providers indicated that they had an effective relationship with local commissioners.

Market shaping

- The local authority undertook a feasibility study for Alternative Service Delivery Models in March 2017, which identified three key options for change as the current model of adult social care was not seen as financially sustainable. These were evaluated against the objectives the local authority and partners had highlighted as important and fed into the BCF plan and Hartlepool Matters implementation plan. The BCF plan clearly articulated these challenges and set out funding arrangements to enable the local authority (and CCG) to support the local care market and invest in initiatives that supported the integration agenda and promoted new ways of working.

  Our analysis showed that the provision of adult social care beds was lower per population in Hartlepool compared to comparator local authority areas and the England average. While the number of residential beds had increased by 1% between April 2015 and April 2017, there was a 20% reduction in the number of nursing home beds in the same period. There were more domiciliary care agency locations per population in Hartlepool than in comparator areas.

The provision of adult social care beds was a concern as the key issue over the last two years had been a shortage in nursing home capacity, following the closure of a number of care homes. The local authority had worked with potential providers of social care to encourage them to develop services in Hartlepool and to support new providers to develop sustainable services. System leaders anticipated this would further reduce the numbers of DTOCs.

- Our data demonstrated a continuing rise in CHC funding agreements, evidence of the increasing complexity of people's needs. This will impact on demand for beds and resources in the community. It had been acknowledged by system leaders and frontline staff that there was a deficit in the number of specialist beds for mental healthcare of older people and for end of life care beds for people requiring palliative care. There had been an increase in the number of long term end of life care beds at the hospice, and a new nursing/residential home had been opened, with another planned, which would increase capacity and help reduce the system's deficit, but further measures would be needed to resolve the overall deficit and to meet growing demand.

- The local authority had invested in housing related support, extra care housing and assistive technology that supported people to maintain their independence. The local authority was building positive relationships with social care and housing providers in order to reshape the market to suit the needs of older people in Hartlepool.

Commissioning support services to improve the interface between health and social care

- System leaders and frontline staff were working closely with the voluntary and community sector for example with The Community Hubs, The Bridge, and Home from Hospital services. Healthwatch Hartlepool told us that they felt the voluntary sector were underutilised within commissioning arrangements. However, system leaders informed us that links with VCS services would be further developed with the Community Engagement and Cohesion Strategy 2018-2021 to support the admission avoidance agenda and recognising the role of all local providers in delivering a more holistic approach to person centred care planning.

- To increase funds to meet social care demand, the local authority raised council tax by 1.9% for 2017/18, plus 3% to cover the Government's Adult Social Care precept. The additional 2017/18 funding for adult social care, (as announced in the Spring Budget 2017), would be spent on adult social care services which include supporting older people (aged 65 and over), adults with learning and physical disabilities, adults with mental health issues, helping people to access residential care and supporting people to live in their own homes.

Contract oversight

- Our analysis showed that the majority of GP services in Hartlepool were rated by CQC as good and NTHFT was rated as requires improvement following its last inspection. Hartlepool also had a high percentage of adult social care services rated by CQC as requires improvement. System leaders had worked with social care providers to make improvements by utilising the Responding to and Addressing Serious Concerns Policy &

Procedure. The local authority also proactively monitored the quality of care provision in care homes through the Quality Standards Framework (QSF) and fed back concerns to providers following monitoring visits.

- The iBCF was being used to address key local priorities around the sustainability of the local care market. As part of this, the Care Quality Improvement Programme would enable resources to be effectively targeted where there was likely to be the greatest impact,
- We received positive feedback from a newly opened care home about the support that commissioners had given them during the process of opening, and on an ongoing basis.
- Both of the main domiciliary care agencies felt that they had an open and transparent relationship with their commissioners and felt supported through their contract. However some social care providers said that although they had good working relationships with individual officers, they did not feel engaged in commissioning developments.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence?

We looked at resource governance and how system partners assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

We found a shared understanding and whole system view of the challenges and priorities for using resources to achieve high quality care and promote people's independence. There was some joint working between system partners to manage demand and govern resources; evident in Hartlepool's Health and Wellbeing Strategy 2013-18 and the BCF plans.

- System leaders told us that the delivery of a sustainable financial position across the health and social care economy, while managing the needs of an ageing and growing population within available resources, was proving a significant challenge. As a response, savings proposals had recently been approved by the local authority, with further savings to be identified over the next three years. Considerable work had taken place to continue to protect frontline services in the context of budget cuts over the last five years.
- New models of care had been explored and system leaders were encouraged to think differently about using resources to best meet the needs of the local population. The BCF pooled budget had supported this, and had played a key role in protecting frontline services and in providing additional investment in services focused on promoting independence and wellbeing including information and advice, low level services, enhancements to the early

intervention model and further growth of assistive technology.

- A pilot programme, the McKenzie House community integrated service, was using a multidisciplinary approach to provide timely access to assessment, treatment and support for the frail elderly by facilitating closer communication and collaboration between health and social care practitioners working in the community. This was identifying ways that services could make efficiencies and this learning could be implemented at other practices. However there were concerns expressed from the LMC and GP federation about the challenges of having short term pilots and the importance of collecting quantitative data to evidence impact to ensure continuation of the projects.

- Our data analysis showed the number of people eligible for standard NHS CHC per 50,000 adults in Hartlepool on the last day in Q1 was slightly below the level across the Cumbria and the North East region (63.73 compared to 65.20); however it was higher than the England level (43.04). The rate eligible for Fast Track CHC (usually used for end of life care) was significantly lower in Hartlepool than across the region (16.68 compared to 26.75 across the Cumbria and the North East region). It was also lower than the England level of 18.45. System leaders acknowledged that the uptake of continuing healthcare funding would continue to present a risk and identified there had been a 16% increase in spending on CHC between 2013/14 and 2015/16.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence

Are services in Hartlepool safe?

There was a system-wide commitment to maintaining people in their usual place of residence with joint working arrangements for assessing, mitigating, monitoring and managing risks to prevent avoidable harm. Systems were in place to identify people who were frail, with complex needs or who were at a high risk of deterioration in their health or social situation and there was support for them to stay well and avoid hospital admission. Although there had been initiatives put in place, some concerns remained in respect of access to primary medical services.

- Statutory partners had committed to working together through a single Tees Safeguarding Adults Board formed across four local authority areas. The board had developed a Serious Concerns Protocol to enable a multi-agency response to serious safeguarding concerns.

The board had engaged with the public and provided information through informal opportunities, for example awareness campaigns in local libraries. This helped to increase the number of people accessing the board website and information. The number of reports about concerns arising in people's own homes increased last year. Cleveland fire brigade also worked with health partners across Tees to help keep people safe and well in their own homes.

- Frontline staff, across health, social care and voluntary services demonstrated effective partnership working to safeguard people from avoidable harm. Staff told us there was a responsive approach to safeguarding referrals and these were always investigated. However, the outcome of safeguarding referrals was not always fed back to the referrer, particularly when referrals crossed organisational and local authority boundaries. There was also scope to further involve social care providers in strategy meetings to share system learning.

- There were systems in place within primary care to identify and support people who were frail, with complex needs or at high risk of deterioration. The McKenzie House community integrated service pilot used a multidisciplinary approach to provide timely access to assessment, treatment and support for the frail elderly, identified through the 2% Direct Enhanced Service and fragility registers. The formal evaluation of the pilot is pending and will inform decisions about future developments and potential roll out of the model across all GP practices.

- A care coordinator pilot programme was also in place, funded through the LADB. All GP practices had a linked care coordinator who worked proactively with the practice's most frail and complex patients to coordinate a social response to their needs to prevent deterioration. We received extremely positive feedback about this service from frontline staff and care providers.

- Hartlepool residents told us that they did not always have access to primary care services and support in a timely way, which meant they would rely on emergency and urgent care services. Concerns were also expressed by GPs, social care providers and people using services that the lack of capacity within primary care for GPs to conduct home visits to people who were housebound, was a risk to monitoring and maintaining people within their own home. The GP federation and LMC were aware of the capacity issues within primary care.

- Analysis of survey data from March 2017 indicated that a comparatively low percentage of GP practices in Hartlepool offered full provision of extended access to pre-bookable appointments outside core contractual hours (15.4% of the 13 practices surveyed, compared to 22.5% across England and 19.6% across comparator areas). However, access to primary care had been extended through joint local strategies and LADB funding, and the Improved Access Scheme had been commissioned to deliver seven day access, provided at hub level, for all registered patients. This to enable greater resilience and flexibility within service delivery, included extending GP access at evenings and weekends. A 24/7 GP facility was also provided at the UCC.

- There were initiatives to provide rapid support to people at risk of deterioration in their own homes to prevent avoidable admission to hospital. People with chronic obstructive pulmonary disease had access to a Hospital at Home service. People who accessed this service reported that it had prevented them having to go into hospital.

- The total rate of A&E attendance in 2015/16 for people aged over 65 in Hartlepool was lower than the national average (351 per 1000 people, compared to 414 per 1000). However, analysis undertaken by Department of Health showed that the rate of emergency admissions per 100,000 populations (65+) between March 2016 and February 2017 was also higher than the national average at 29,006 compared to 24,092.

- Our analysis of rates of avoidable admissions from care homes from October 2015 to September 2016 showed that the rates of avoidable admissions for pneumonia, decubitus ulcer and urinary tract infections (UTIs) in Hartlepool were higher than both the England and comparator averages. More recent data provided in the response to the System Overview Information Request indicated that recent initiatives such as the Hospital at Home service had impacted on these avoidable admissions; the overall non-elective admissions report for Q1 2017/18 (all over 65 admissions from Hartlepool and Stockton) showed a 41% decrease in UTI activity and a 38% decrease in cost. Although the admission rate for diseases of the respiratory system had not reduced, the average length of stay decreased from 16.4 days in 2015/16 to 14.7 days in 2016/17.

- Care home and nursing home providers were supported to maintain people safely in their place of residence in a number of ways. The BCF had been used to launch a training and education programme to support providers in maintaining and improving quality. The ambulance service also told us that they had offered training to care homes with regard to falls and manual handling manoeuvres. A medicine optimisation initiative was in place and each adult social care home had a link pharmacist who undertook reviews. A care home confirmed this service took place and that it was helpful in streamlining use of medicine and preventing admissions to hospital due to medicine errors.

- Care homes and nursing homes felt well supported by community services. A community rapid response team was available to people and professionals via a single point of access. The single point of access contact centre could provide advice and rapid referrals as an alternative to admitting people to hospital. A community matron service linked community matrons (who were also prescribers) directly to residential and nursing homes. This aimed to mitigate against health risks, reduce the occurrence and severity of crises and prevent avoidable harm and admissions to hospital. However, although community matrons told us although their role was working well, they didn't have the necessary resources to spend as much time as they would like on education in care homes as they were very busy and they also had to provide cover at the Holdforth Unit when it was short of staff.

Are services in Hartlepool effective?

Hartlepool had embedded systems alongside new projects and initiatives aimed at improving population health and integration of care delivery. The reconfiguring of hospital based services and technology was being used to strengthen care delivered outside of hospital with a focus on early intervention and prevention.

- Delaying dependency was a key priority for the area and there was a local commitment to investing in improving population health, early intervention and prevention. Over many years, the local authority had invested in housing related support, extra care housing and assistive technology that supported people to maintain their independence in their local community for as long as they were able and wished to do so. Hartlepool Borough Council Housing Strategy 2015 - 2020 outlined the housing options and priorities for the future and BCF investment has enabled these approaches to be maintained and further developed.

- The local authority had successfully opened three community hubs in the areas of greatest need. These provided access to information, health education and advice and services to promote wellbeing. Furthermore, the Enhanced Early Intervention Model had increased focus on prevention of hospital and care home admission through proactive partnership working between health and social care services.

- Our analysis showed that average GP funding per patient had increased from being below England and comparator averages in 2013/14 to being above England and comparator averages in 2015/16 (£145.94 compared with the England average of £142.63 and comparator average of £132.37). There was an improving picture regarding access to seven day primary care services.

- In addition, there was an agreement for the delivery of a seven day service in the BCF submission, and this was currently being provided through the community hub approach and the UCC 24 hour, seven days a week provision.

- The McKenzie House community integrated service pilot was leading the way in embedding a multidisciplinary coordinated approach to maintain people's health and wellbeing in their usual place of residence. The pilot was seen to be effective because of the high level of buy in across agencies to attend multidisciplinary meetings. The Care Coordinator also attended the meetings, to support a holistic approach to planning care and support to frail people. All 20 people who received the service in the previous six weeks had provided very positive feedback, including describing the service as making a "vast difference" and "life-changing."

- The UCC had been highly successful in recruiting GPs to the service to assure continuous cover 24 hours a day seven days a week. Triaging by the North East Ambulance Service (NEAS) out of hours visiting service was effective in ensuring people received services in a more timely way as staff reported that they were managing to see the vast majority of people in their own home without GP input and rarely needed to call out a GP for issues they couldn't address.

- A seven-day single point of access for NHS community services (provided by NTHFT) was facilitating a coordinated rapid response between agencies. The service had been enhanced through BCF investment to add a clinical triage nurse. This ensured that a holistic assessment and timely response was provided across community services, linking in to other key services like the out of hours provider, the rapid response team and physiotherapy in order to keep people at home. This system was working well and received positive feedback from frontline staff.

- Our analysis showed that in 2014/15 the rate of admissions to residential and nursing care homes in Hartlepool was significantly higher than the national average (1056 per 100,000 people aged 65+ compared to 669 per 100,000 people aged 65+). In 2015/16 the rate of admissions dropped considerably to 688 per 100,000 aged 65+, and although the rate then increased again in 2016/17 (to 922 per 100,000 aged 65+) it remained below its previous peak in 2014/15.

- As outlined in the North Tees Education and Training Alliance Q1 report February - April 2017, residential and care homes received a range of support to develop the skills and knowledge of staff to maintain people in their place of residence. Ambulance staff provided training in respect of falls and manual handling. Tees, Esk & Wear Valley NHS Trust promoted an ongoing training campaign to spot delirium. Through the BCF, enhanced pharmacy support was provided, along with a training and education programme that incorporated piloting National Early Warning Scores (NEWS) to support early identification of deterioration or changing needs. Care homes had signed up to a forthcoming programme of free training offered by the CCG.

- Systems leaders had worked to reduce social isolation and loneliness based upon research by Age UK and the Social Care Institute for Excellence (Adults Services Committee report, 23 November 2017). Hartlepool’s BCF plan included a commitment to “help identify and combat social isolation, as a major influence on overall health and wellbeing”.

- There were initiatives in place to reduce social isolation and loneliness, supported by Hartlepool’s vibrant voluntary and community sector, such as ‘Hartlepool Getting Out and About’. A befriending service (funded by the local authority until March 2019) was commissioned in 2016 from Age UK. Outcomes for individuals using the service had been very positive with a high level of satisfaction. However, the Age UK befriending service felt they were not linked into wider systems as they didn’t get any referrals from hospital discharge teams or GPs, despite having promoted the service.

- The local authority and the CCG had undertaken work with Cleveland Fire Brigade to make the most of contact with isolated older people through their rolling programme of Fire Safety Checks. Data collected indicated that the Fire Brigade had completed approximately 470 screening tools for Hartlepool residents since November, 330 of whom had been identified as the most vulnerable using GP data.

Are services in Hartlepool caring?

People living in Hartlepool were empowered to manage their health and wellbeing so that they were able to stay at home for as long as possible. The right people were given opportunities to be involved in discussions about people’s care and treatment; however people sometimes had to tell their stories more than once and carers wanted more information and support in respect of direct payments.

- BCF plans supported personalisation and choice through development of coordinated alternatives to hospital and residential care, including investment in personal health budgets, which allow a more person-centred approach to meeting people’s health needs. NHS England’s NHS continuing healthcare data shows that in quarter one of 2017/18 the rate of people (all adults) receiving personal health budgets in Hartlepool and Stockton-on-Tees CCG area was above the England average (9.62 per 50,000 compared to 5.82) and also above the rate across Cumbria & the North East (8.16). The rate of care direct payments per 50,000 was 8.12 – above the regional average (4.73) and the England average (3.63). People and their carers who were using direct payments told us this enabled them to have a say and to be more involved in their care plans and reviews.

- Hartlepool Matters set out a clear implementation plan to maintain people in their usual place of residence by empowering them to play a lead role in managing their own health and wellbeing. Hartlepool's integrated care and support strategy supported this as well as ensuring people worked with staff who understood their needs and desired outcomes.

- Our analysis of data measuring how successfully the NHS supported people with long term conditions to live as normal life as possible demonstrated that people's health related quality of life in Hartlepool had been below the national average for the six year period from 2011/12 to 2016/17 and was often below its comparator group average as well.

- In 2016/17 the quality of life score for people with long-term conditions in Hartlepool was 0.70, just above the comparator average of 0.69 but below the national average of 0.74. Initiatives had been implemented to ensure people's needs were promptly identified and actions put in place to meet these across the health and care system. Integrated community care teams and the Hospital at Home service provided timely support to people with a long-term condition and frail elderly people to effectively manage their condition(s) and improve their outcomes and experience.

- Despite the comparatively low quality of life score data from the GP patient survey 2016/17 showed that 70.5% of people with long-term conditions in Hartlepool felt supported compared to the England average of 64% and the comparator average of 64%. Furthermore, our analysis of ASCOF data showed that reported levels of overall satisfaction with ASC care and support were also above national and comparator averages in 2015/16 and in our more recent analysis of 2016/17 data (64% in 2016/17 compared to comparator average of 63% and England average of 62%) this demonstrated services were achieving the outcomes that mattered most to people.

- A CCG funded project with GPs had increased the number of people identified as carers. The Carers Forum was regarded as a strong community asset, providing a support network to carers and an information point for access to services and support. For example, every carer registered with the service was referred for a carers' emergency respite care card and would be given advice about direct payments. The Carers Forum would also contact the person's GP to inform them that they were a carer.

- Although some carers told us they had been offered direct payments, there was a view that these needed to be requested, and were not automatically offered; they felt that if people were not members of the Carers Forum they may not have access to information about direct payments. The Local Account of Adult Social Care Services in Hartlepool showed that in 2016/2017, 78% of carers (all, not just older people) were satisfied with the support or services they and the person they cared for had received from Social Services in the last 12 months and the proportion of people who used services and carers who found it easy to find information about services (carer-element only),' performance for Hartlepool for 2016/17 was 80.6%.

- While CHC data for Q1 17/18 showed that the number of standard CHC referrals exceeding 28 days was 0.64 per 50,000 in Hartlepool and Stockton-on-Tees CCG (far below the England average of 10.27), we did speak to some people who reported long waiting times for direct payments. Data from Q1 2017/18 data showed that 39% of Decision Support Tools for CHC were completed in an acute setting, above the England average of 27% and far above the target of 15%.

- The Bridge centre was providing invaluable advice, support and social interaction for people living with dementia and their carers. Since The Bridge opened in 2015, its Dementia Advisors had supported more than 500 carers and people living with dementia to ensure they lived life to the full. Positive feedback was received about this service stating that the friendly approach of the team had enabled people to be involved in decisions about care, that their wishes were listened to and that they were able to discuss their diagnosis and find out what support was available in a relaxed and welcoming atmosphere.

- Frontline workers we spoke with demonstrated a strong commitment to supporting people to reach their maximum level of independence. They took a person-centred approach and told us they would flex their services to ensure people's individual needs were met in a timely way. However, there was scope to better coordinate the use of resources as there was duplication in some assessments which resulted in people having to tell their story more than once.

Are services in Hartlepool responsive?

People's individual needs were assessed and risks were identified and proactively responded to in order to help maintain them in their usual place of residence. Signposting systems for people played a key part in enabling timely access to the right support in the right place. Access to primary medical services remained a concern, although it was anticipated that the reconfigured services and hub models would address this.

- There were processes to ensure people's needs were promptly identified and actions put in place to meet these across the health and care system. Work had been done to reduce the number of points of entry into the system and signpost people to the right services and support. The single point of access was streamlining the referral process by replacing multiple referral routes and points of entry. Positive feedback was received about the single point of access, stating that it worked well and was a responsive service which had prevented admissions to hospital. Although community based staff told us that referral records could sometimes lack detail and cause some inappropriate visits there was evidence within the Pooled Budget Partnership Performance report Q4 - Single Point of Access Clinical Triage Nurse evaluation report – January-March 2017 that these had been acknowledged and analysed.

- There was a system-wide awareness of capacity challenges in primary care and how this impacted on access to GP services. The GP hub approach, the out-of-hours service and the UCC had been initiated to reduce the burden on primary and secondary care services and to cope with increasing demand. This was part of the CCG's vision for an integrated seven day service to prevent patients attending A&E because they hadn't been able to access a GP appointment. Further pressures had been taken away from GPs through the community matron and care coordinator roles. However, community matrons had reported they were extremely busy and were called to provide cover at the Holdforth Unit when it was short of staff.

- The focus on prevention was embedded in the provision of community services to enable people to maintain their health and wellbeing and independence. A Community Integrated Assessment Team (CIAT) included therapy and rapid response nursing to provide responsive care, supporting admission avoidance and hospital discharge. Care Coordinators along with other community based staff provided timely support to people with a long-term condition and/or the frail elderly to effectively manage their condition(s) and improve their outcomes and experience. People who were having difficulty in managing their conditions were referred to the team for a short period of time to stabilise their health.

- People using services and carers had mixed experiences of accessing GP appointments and reported that challenges accessing a GP created additional pressures on carers supporting people living with dementia. The BCF return for Q4 2016/17 stated the system's performance was 1% below the target for dementia diagnosis at the year end, which represented 12 fewer people being diagnosed with dementia than was aimed for. Primary care stakeholders said that they were conducting more mental state checks, and felt there was a good dementia service they could refer into at The Bridge. Overall people who used services told us that strides had been made in recent years to increase awareness of dementia and make Hartlepool a dementia friendly place to live.

- Additionally, some providers indicated that some GPs were reluctant or unable to attend people in their usual place of residence if it was a care home, but they would refer them to the older person's team who had nurse prescribers or offer telephone appointments instead.

- Our analysis of A&E attendance rates between April 2015 and March 2016 for people 65 and over showed that attendance levels for Hartlepool residents were lower than the national average, and the average of their comparator areas throughout the year. More recent updates to our analysis showed that A&E attendance rates remained consistently below national and comparator averages throughout 2016/17 as well. During 2015/16 the rate of A&E attendances of people aged 65 and over from care homes in Hartlepool increased, and although they were below the comparator averages, by the last quarter of the year they had increased to being above the England average (11 per 1000 compared to 9 per 1000). Updated analysis for 2016/17 shows that A&E attendances from care homes for older people decreased again below both comparator and national levels.

- The GP federation and the LMC were aware of people's concerns and it was expected that the new seven day service and the UCC access would help alleviate some of these challenges. Frontline staff in health and social care reported that GPs were responsive and understanding of preventive services and were effective in contacting the single point of access, Care Coordinators and other community based teams.

- There were initiatives in place to promote older people's independence and access to information. In response to feedback from people living in Hartlepool, three community hubs were opened in July 2017 to provide information, advice and services that supported and promoted wellbeing. There had also been investment in the 'Hartlepool Now' website, a project to support older people to access the internet (Project 65) and the home library service for people who were housebound. People using services welcomed these initiatives and the impact these services were having. Our analysis of ASCOF data showed that Hartlepool performed significantly better than comparators and the England average in 2015/16 in respect of the proportion of people aged 65 and over using ASC services, who said they found it easy to access information and advice about social care (87% compared to 76% and 75% respectively), which is a key factor in early intervention and reducing dependency.

- The local authority invested in extra care schemes and sheltered housing, which provided community villages for older people. When we visited one scheme, people told us how this enabled them to remain independent and safe and well in their own home.

- People were given support to make adaptations to their homes to enable them to remain in their usual place of residence. The Disabled Facilities Grants figures in year 2016/17 showed that 65% of total grants were given to people aged 65+ (stair lift and level access shower were the most common adaptations) and waiting times had reduced. Improved performance in waiting times for adaptations had been achieved through BCF pooled budget investment. The disabled facilities grants waiting list and budget position 2016/17 Q3 evidenced that the waiting times had decreased from 202 days in the previous quarter and at the time of our review, the average time from first contact to certified date was 127 working days.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Hartlepool safe?

Risks were managed operationally to prevent people at time of crisis being admitted to hospital. There was effective multiagency communication during a health or social care crisis enabling people to be kept safe as they moved across the health and social care system. However the falls management process was impacting upon workloads for the emergency response services and the wellbeing of people using services.

- There were formal methods to share information around risks to people's care and treatment across the system through the Quality Surveillance Groups. It was confirmed that when concerns or a crisis occurred, the CCG worked closely with the local authority to resolve them.

- NTHFT had undertaken a lot of work to ensure systems, processes and practices were in place across the trust to reduce avoidable harm. Emergency frontline staff could feed into and obtain advice from safeguarding panels attended by trust staff and the community safeguarding team. A triaging system ensured urgent matters were addressed within the hour and emergency frontline staff told us this was effective and they received the necessary advice and feedback. Case records we reviewed confirmed safeguarding referrals were made and investigated in a timely way, and a multidisciplinary approach had been taken.

- The single point of access was available to people, their carers and professionals in times of crisis. For example, health and social care professionals could call the single point of access and ask for an urgent occupational therapy assessment and any necessary equipment to keep people who were at risk of deterioration safe in their home. The single point of access and the CIAT team could mobilise staff quickly and make referrals in a timely way and respond when people were at risk by following crisis escalation plans. The single point of access's key performance indicators demonstrated a consistently high performance had been achieved over the last year in responding to both urgent and non-urgent calls.

- There was a system within A&E to identify frail older people. A&E staff were completing frailty assessments for all people over 65 which the therapy teams followed up so people did not go home without the support they needed. Furthermore, A&E staff were completing falls risk assessments for anyone over the age of 65 so that appropriate referrals could be made to other services.

- Concerns were raised in respect of falls prevention following changes in service provision, providers felt this was less effective and that the falls service for people living with dementia was difficult to obtain. Community rehabilitation staff told us there was a clear criterion of 'one fall and then refer in' but the bulk of their referrals came in from ambulance or emergency care service.

- The telecare system made people feel safe and confident about being able to access appropriate support at a time of crisis. Support was also in place for carers as a red card scheme gave them information about who to contact in a time of a crisis.

- Once people were admitted to hospital the percentage of older people who stayed longer than seven days in 2015/16 was higher in Hartlepool than similar areas. Our analysis showed that the percentage of older people whose admission lasted longer than seven days in 2015/16 was higher in Hartlepool than across similar areas and England (34.4% in Q1 2015/16 compared to 32.7% across comparator areas and 32.3% across England). However our updated analysis for 2016/17 showed that the percentage of older people staying longer than seven days reduced to be more in line with similar areas and the national average, as a result of recent initiatives to improve patient flow. Despite this, analysis undertaken by the Department of Health covering the period March 2016 to February 2017 showed that in Hartlepool, 10% of older people admitted as emergencies stayed in hospital for more than 24 days.) This was longer than most of Hartlepool's comparator areas, so while more older people may have been discharged within seven days of their admission in 2016/17, a small percentage of people were still staying longer than in comparator areas.

Are services in Hartlepool effective?

During a health or social care crisis people's needs were effectively assessed by a skilled workforce. Information was shared across the system to enable people to make choices and maintain their independence. However vital information could be missed as transfer *documentation didn't always follow people though their journey and people also had to tell their story more than once to a range of professionals. Ambulance performance data was consistently below the England average for Red 2 and Red 19 responses.*

- Effective systems were in place to support people at a time of crisis. The single point of access offered a centralised MDT approach and specific pathways for people's needs. Furthermore, the CIAT could be mobilised quickly to attend at times of crisis and offer an MDT approach to assessment, treatment and support. If people did get 'stuck' in the system or there were transferal issues, the principal social worker said they would be informed so that pathways could be clarified and appropriate professionals involved.

- Urgent care services and the emergency department had effective triaging systems in place so people were seen at the right time, by the right person in the right place to avoid hospital admissions whenever possible. Although there was limited joint information sharing systems, the single point of access team had access to many different systems and the UCC had access to 'System1'. This supported effective multiagency communication during a crisis, enabling people to be kept safe as they moved across the system. We saw that the 'front door' system engaged effectively with voluntary sector providers to enable people to return home from A&E rather than be admitted.

- Our analysis shows that the percentage of A&E attendances of older people that were referred there by a GP was significantly lower in Hartlepool throughout 2015/16 and 2016/17 at around 2% in each quarter, compared to an England average of 7%-8%.

- A rapid assessment unit has been established to ensure effective flow through A&E, which would enable NTHFT to flex capacity during winter.

- Multidisciplinary working prevented avoidable admissions and improved patient flow. Patent flow facilitators worked closely with doctors in A&E and the Emergency Assessment Unit (EAU) and with the emergency care therapy team to ensure flow was maintained and people were discharged in a timely and appropriate way. MDT meetings with the A&E and patient flow facilitators, including social workers and the Integrated Discharge Team took place. There were also good links with the mental health liaison team and there were clear pathways for supporting people who had moderate to severe dementia when they presented at the department. Frontline A&E staff told us that as a consequence the flow of people through the system had improved and it was very rare to get people arriving at the department who only had social care needs.

- Staff in the EAU had been trained to conduct mental health capacity assessments and the majority had been on dementia training which led to the creation of the area designated for people with dementia. They had also had interaction with the delirium team who offered specific advice about the best medicines to prescribe when someone was in crisis. Staff on the EAU could complete the first few pages of the CHC and mental health referrals and assessments were being completed in a timely way.

- A workforce review had taken place in A&E to ensure that staffing levels were fit for the winter period by changing some shift patterns so more staff were available at the time of highest need.

- Ambulance staff expressed concerns in respect of staffing levels, especially at the weekend and frontline ambulance staff felt that more paramedics were needed as people were waiting on the floor too long following a fall. Impacting on this was the number of 111 referrals which were not appropriate, and which they had fed back to the department.

- Ambulance response time data for North East Ambulance Service NHS Foundation Trust between December 2016 and May 2017 showed that response times for Red 2 (types of potentially life-threatening incidents) and Red 19 (how quickly ambulance services get a vehicle to the scene able to transport a patient) were consistently below the England average but Red 1 (assigned to patients in cardiac arrest) response times were in line with or better than the English average. Our analysis also showed that the proportion of 999 calls resolved by telephone advice was consistently lower than England average as was the proportion of 999 patients who were seen by an ambulance crew and the incident was managed without need for transport to A&E (The NHS England Ambulance System Indicators, June 2016-May 2017).

Are services in Hartlepool caring?

Frontline staff understood the importance of people, their family and carers being at the centre of decision making during the time of crisis. People that we spoke with, their family and carers confirmed this was the case. Although streamlining of systems had taken place in Hartlepool and is continuing, some people using services and some carers felt there were multiple confusing points of access and issues with access to GP services.

- Although systems had been streamlined to avoid multiple confusing entry points into the system, some people using services and carers still reported issues accessing services. GPs and care coordinators had been working with older people to identify those most frail and vulnerable so they knew who to access in the time of a crisis.

- Carer’s Emergency Respite Cards were given out by social services which gave details of services to contact in a time of crisis. However there was a sense from carers that the support they received was sometimes insufficient and carers' assessments were not widely offered unless asked for. In addition, carers felt the threshold for support was too high; for example, one carer said that the person they care for had caused a fire in the house and it had not been deemed necessary to provide support.

- To encourage patients, family and their carers to play an active role in making decisions about their care the EAU had an open visiting policy and the Integrated Discharge Team and MDT held drop in sessions three times a week. While there were a number of assessments resulting in people having to tell their story to different professionals, the integrated discharge team had worked to try and reduce this by completing one overarching assessment as part of the CHC assessment. It was evident that this system had worked well in the case files we viewed and that people and their family had been involved in this process and were listened to when deciding upon outcome.

- Frontline staff acknowledged the importance of involving families in decisions about their care and understood the importance of informed decision making based on people's wishes at a time of crisis. Staff held review meetings and reassessed care needs to ensure that appropriate decisions could be made in future. We saw an example of where this had resulted in a positive outcome for a person when following a review of their needs they were able to secure a placement at a nursing home of their choice.

- The North of Tees Dementia Collaborative strategy promoted person-centred care and people told us that voluntary groups, such as the Dementia Action Alliance, were extremely helpful in offering a single point of access for support, signposting and advice. Carers spoke positively of the support they had received at hospital and in the community when the person they care for experienced a mental health crisis.

- Some providers expressed concern at the support and availability of skilled staff for people living with dementia when they attended the A&E at a time of crisis. However, from reviewing care records of people living with dementia who had attended A&E, we found that people were cared for and supported well. Staff across the A&E department had received training and there was also an adapted space in the EAU for people living with dementia. Furthermore, mental health assessments took place in a timely manner and once on the hospital wards there were care coordinators to support people and prevent distress. Volunteers were also available in the discharge lounge to ensure people had someone to talk to or ask questions if they had concerns.

Are services in Hartlepool responsive?

There were systems in place to ensure that people received care in the right place; however, the *ambulance response times impacted upon people's experiences. Triaging systems were effective in ensuring people were seen in a timely manner and there were also systems such as the emergency care therapy team to improve patient flow.*

- There were systems in place to prevent people being admitted to hospital at a time of crisis. The Hospital at Home service provided responsive care for people with chronic obstructive pulmonary disease, usually within two hours of referral. People using this service told us it was excellent and it had been successful in avoiding hospital admissions.

- Responsive services, such as the single point of access, CIAT, care coordinators and community matrons also all helped avoid admissions to hospital. There was evidence that the single point of access team were dealing with calls in a timely way and making the necessary referrals to other services. The CIAT team received a high number of referrals to enable people to be supported at home in the community. The total number of internal referrals in 2016/17 was 405 people and the number of community referrals during this same period was 1471 people.

- The use of enhanced care paramedics also prevented avoidable admissions. Ambulance staff told us that they were having a significant impact and if they were not part of every crew there was a higher chance that a person would be admitted to A&E. The ambulance staff told us more people would like to undertake the advanced paramedic training; however there was a two year waiting list.

- Care home staff reported that delays occurred in transferring people to hospital due to a lack of trust in their assessments when they called the emergency services. The care home staff didn't feel there was a formal route through which they could feedback their concerns. Ambulance staff told us that as trust in their assessments of people's needs was developing, ambulance staff were able to take people straight to hospital wards rather than going through A&E.

- Ambulance staff told us there were staffing issues which impacted upon response times, they were aware there was funding for seven more crews but they felt this would have little impact on staffing numbers.

- Although there was ongoing work to improve the triage of emergency calls, workforce issues continued to impact on ambulance response times, resulting in social care providers reporting widespread issues of waiting for non-emergency cases which had led to distress when people had experienced a fall.

- In each of the last three years, NTHFT had performed at or slightly below the 95% target in terms of percentage of people being seen, treated and either admitted or discharged within four hours in A&E with scores of 95.2, 94.6 and 94.2%. This was better than the England average in each year. Since the establishment of the new UCC in April 2017 there had been a review of the flow for people attending A&E. The department took an admission avoidance approach and used a triaging system to ensure people were seen in the right place, by the right person at the right time. This meant that people with primary care needs and minor injuries were seen by the GP led units, supporting a better flow of people through the system.

- Positive feedback was shared with us about the support people received from the mental health care team; their timeliness and commitment to providing a service and educating staff, people using services, their families and carers. There was a crisis team who were able to respond to concerns in the community or at the UCC or A&E. A&E staff told us they had access twenty-four hours a day to a mental health and frailty team who were very active in preventing admissions if there were signs of dementia.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Hartlepool safe?
When people returned to their usual place of residence or an alternative setting, systems and processes were not always in place to enable them to be supported to do so safely. Further work was needed to ensure the relevant people had timely access to sufficient discharge information and ensure people's experiences were monitored and any lessons learned undertaken.

- We received mixed views from people using services, carers, social care providers and the VCS about the safety of discharge processes from hospital and heard that they did not always protect people from harm. Social care providers told us they did not always receive feedback after they raised safeguarding referrals about delayed and inappropriate discharges, which was a missed opportunity to learn when things went wrong. System leaders acknowledged this and said that the integrated discharge team would be exploring further ways to improve systems, reduce duplication and intervene more proactively at the earliest possible stage to facilitate safe and timely discharge.

- Social care providers reported good relationships with the integrated discharge team and stated that this process worked really well, but there were instances when the discharge team had been bypassed by the wards and out-of-hours services and that this had resulted in poor discharge planning. They cited issues with trust regarding the quality and validity of discharge assessments and that some people were not as well as reported on discharge.

- People using services and carers reported issues about medicine information not being passed to GPs, leading to inconsistent advice. Some GPs confirmed discharge information could be improved and although they received information in a timely way there was often confusion about medicine information. The chief pharmacist at NTHFT told us collaboration and communication with the medicines optimisation team in the community could be improved.

- Further concerns were expressed about the timeliness of discharge, especially for those people requiring an end of life care pathway. The impact of these discharges had been a lack of clarity in medicine administration times resulting in numerous calls being made and safety concerns as staff would not be able to contact the pharmacy team until the next day. These findings were supported by the responses to our online feedback tool about the discharge information flow. This had a risk of impacting on readmission and poor experiences for people returning home.

- The BCF performance report Q4 2016/17 showed that the system was not achieving against the BCF plans for DTOC, and our trend analysis showed an increase in delays above national and comparator levels from April 2016 onwards, resulting in a significantly high spike in October 2016. The HWB reported that the main reason for delays in Q4 2016/17 was ‘awaiting nursing home placement’ (accounting for 345 delayed days or 30% of delays). To address this, a new nursing home was opened in May 2017. We found that this had reduced the pressures and it was anticipated that the imminent opening of a further nursing home would reduce pressures further, especially for specialist beds for mental healthcare of older people. Analysis of DTOC for July 2017 showed that daily delayed days in Hartlepool had reduced to 12.3, below the England average of 13.6.

- The bed manager in the discharge lounge told us that waiting for prescriptions for medications in the discharge lounge could cause delays. However to prevent long waits for medicines, we were told that, a “man in a van” initiative was used to deliver patients’ medicines to them after they had been discharged, if this was required.

- Although the timeliness and availability of medicines had been reported as a barrier against people returning home safely, we found that processes at NTHFT were in place to support timely medicines management on discharge. Data showed that medicines dispensed from the remote dispensary location were processed in a timely manner with 25% of discharges in under 30 mins, 50% in under 60mins and 75% within 90mins; all were processed on the day requested.

- Our analysis of the percentage of older people readmitted to hospital within 30 days on discharge showed that Hartlepool's performance was in line with the England average in 2015/16 (18.3% compared to the English average of 18.4%) and was lower than comparator areas. The percentage of emergency readmissions of older people in care homes within was also similar to the national average (19.4% compared to 19.8%). This indicates that more than 80% of people aged over 65 had been discharged at an appropriate time with support as needed in the community.

- However, our updated analysis suggests that emergency readmissions increased in the last two quarters of 2016/17, and by the last quarter of the year were above national and comparator averages (22% compared with comparator average of 20% and England average of 19%). There was an even sharper increase in emergency readmissions of people from care homes in the last quarter of 2016/17, increasing to 27% which was significantly higher than the England and comparator averages of 20%. It is possible that this could relate to the reductions in length of stay during 2016/17 having a perverse outcome in increasing emergency readmissions, as some people may be being discharged too early. This is an area of provision that requires prompt analysis and appropriate action.

Are services in Hartlepool effective?

There were some effective systems and processes in place to enable people to return to their usual place of residence. However the Holdforth Unit's admission criteria and expected length of stay was not clear, which resulted in inappropriate placements and extended lengths of stay.

- Local arrangements such as Daily Discharge Planning Meetings and the Integrated Discharge Team were very effective in ensuring that older people received an integrated response, concentrating on the longest DTOC and "stranded patients". We saw daily huddle meetings taking place during our visit to NTHFT and evidence within patient records showed that the Integrated Discharge Team held meetings with a range of professionals and that discharge planning started as soon as possible so there were fewer delays. Any delays in discharges were monitored through a board report and analysis of performance took place to drive system improvement. The length of stay had reduced in 2016/17 demonstrating the impact of these initiatives. While this is to be commended, the system should note the increasing emergency readmissions and take action to ensure that patient flow and discharge is both efficient and safe.

- The Emergency Care Therapy Team (ECTT) facilitated rapid discharge of returning care home patients if their needs hadn't changed and they had been in hospital for less than 72hrs and had no need for an acute medical bed.

- Trusted assessors had been piloted for elective orthopaedic surgery and the results from this had shown that the pilot had reduced length of stay by 61% with the average length of stay at 3.06 days at the time of our review. We received positive feedback about this service from people using services. There were plans to roll this programme out at West View Lodge.

- Since May 2017 a bed manager had worked in the discharge lounge to improve patient flow and reduce lengths of stay. They told us the flow had also improved since the opening of a new care home. Data demonstrated that there had been improvement in patient flow since this role had been initiated. For example; the percentage of patients through the lounge in under 90 minutes in 2016/17 was 37.21% and during 2017/18 to date was 53.45%; the number of patients discharged before 15:00 hours in 2016/17 was 35.76% and in 2017/18 this had increased to 43.88%. During our visit it was acknowledged that more work needed to be done to ensure the discharge lounge was effective and there was a need to identify if the lounge was an area/unit to wait for transport or if it should be a more integrated unit which had links to the community.

- From reviewing care records it was evident that continuing healthcare assessments were taking place as a matter of routine, however some community based staff felt that CHC assessments were being used a tick list rather than enabling a holistic approach. They cited incidents where assessment had begun before the person was medically fit for discharge which had a significant impact for the CIAT.

- The Home from Hospital service was a new service which had been in place for less than six months. It was used to enable people to be discharged in a timely way. The organisation supporting the delivery of this service expressed that there was a need for greater recognition of the service and they had looked again at the criteria for eligibility in a bid to increase referrals. We received positive feedback about this service and the impact this was having on people when discharged from hospital.

- Frontline staff took collective responsibility for identifying people in need of reablement and rehabilitation services and systems were in place to support people on discharge from these facilities. A multidisciplinary approach was taken and a specialist practitioner for reablement for people living with dementia supported the reablement team.

- The percentage of people in Hartlepool who required readmission to hospital after discharge from reablement services was lower than the England average. The Department of Health's analysis of Hartlepool's reablement figures for 2015/16 showed that Hartlepool had a marginally higher percentage of people aged 65 and over still at home 91 days after discharge from hospital into reablement services (82.9%), compared to the England average (82.7%) and comparator group average (82.5%). System leaders reported that 78.4% of people had no ongoing social care needs after a reablement intervention, and 94.1% of reablement goals had been achieved at the end of the period of reablement. If there were any residual needs, telecare or telehealth could be arranged as could a personal budget or a longer term package.

- Our updated analysis of ASCOF returns for 2016/17 showed the percentage of people offered reablement who were still at home 91 days after discharge had continued to decline in Hartlepool to 76.2%, below the England (82.5%) and comparator averages (83.6%). This was below their target of 89.2%, as reported in the BCF performance report for Q4 2016/17. System leaders explained this was because the target set had been too challenging and was unrealistic given the complexities of people's needs. Therefore an audit was undertaken to understand the reasons for this and actions would be agreed following a findings paper.

- We raised concerns about the range and nature of services provided on the Holdforth Unit as the admission criteria and expected length of stay was not always clear. This had resulted in people being admitted to the Holdforth Unit when an alternative and more suitable environment was required; for example people at the end of their life. There was also an issue with the flow in the step down on this unit which had resulted in extended length of stay for some people. The Holdford Unit was unable to cite length of stay data or bed occupancy rates and appeared disconnected from the main hospital campus at NTHFT. It was acknowledged that there was a need for greater clarity as to the purpose of the unit. We were given assurances that work would begin urgently to address the matters raised.

Are services in Hartlepool caring?
We saw a strong commitment among operational staff to delivering a person-centred approach when managing how people returned to their usual place of residence or to step down care. Despite this we found that some discharge processes from hospital meant that not all people were being treated with dignity, respect and compassion.

- There was a lack of multidisciplinary assessments meaning that people would need to tell their story more than once. The rapid response team told us if the person was discharged home without their paperwork, they would have to repeat the assessment again. Significant work had already been undertaken to make the assessment more personal so as to better understand the underlying reasons for an admission, through using a ‘my voice my choice’ care and support plan.

- The CIAT worked closely with other multidisciplinary professionals to support discharge and therapy staff were very passionate and focused on helping people reach their full potential. There was evidence of a person centred approach to reablement and involvement of people, families and carers.

- Staff across agencies displayed a willingness to discharge people home with a package of care when this was their wish, even if they were likely to require residential or nursing care in the longer term. Drop in sessions were held three times a week for people, carers and their family to spend time discussing discharge options and needs. We saw this had a positive impact on ensuring people were involved in the plans for their ongoing care and that they were listened to in terms of their wishes and aspirations.

- Our analysis of reasons for delayed transfers of care between February and April 2017 showed that ‘patient choice’ was reported as a one of the main reasons for delay in Hartlepool, accounting for an average daily rate of 3.5 delayed days per 100,000 population for aged 18+. In contrast, over the same period this reason was only reported as contributing to an average of 2.1 delayed days per day across similar areas and 1.5 delayed days per day across England. The CIAT team told us they had introduced a robust patient choice policy. Prior to this they had been dependent upon people telling social workers where they wanted to go and there had been difficulties due to reduced services in Hartlepool. This policy was now managed by the CIAT team and they held MDT meetings with people and their relatives to explore options. We saw within care records that these meetings were taking place.

- We found that some discharge processes from hospital meant that not all people were being treated with dignity, respect and compassion. We received reports of discharges that had caused people distress through a lack of communication and planning to check if anyone was at home to support them. We were also informed of examples of people sometimes returning from hospital with missing aids and equipment which impacted on their health and wellbeing.

- Social care providers and VCS organisations reported concerns with transport and timing of discharges. Providers also reported that they were not invited to discharge planning meetings and they felt that there was limited family involvement at discharge resulting in a lack of choice and families finding out about decisions after they had been made. It was felt that communication could be improved, as the staff who provided the day to day care could be the only point of contact for some people.

Are services in Hartlepool responsive?

System leaders were working collaboratively to improve systems and processes to enable people to return to their usual place of residence or an alternative setting in a more timely way. Although these had been effective, some people still experienced delays or poor experiences on discharge.

Although CHC assessments were taking place, the process was not working as well as it should be, resulting in a higher proportion of people entering into the CHC process to subsequently be denied funding.

- The primary reason cited in our data for delayed transfers of care was ‘waiting for packages of care’. System leaders acknowledged that one of the capacity challenges they faced had been a lack of access to nursing home beds, particularly specialist beds for mental healthcare of older people to facilitate timely discharge. Our analysis of data from September 2017 showed that provision of nursing care home beds was lower per population in Hartlepool compared to comparator areas and the England average (300 per population in Hartlepool, compared with 409 across comparator areas and 391 across England). The number of beds appeared to have decreased between April 2015 and April 2017, particularly in nursing care which saw a 20% reduction in beds. However a new residential/nursing home had opened in April 2017 and another service was expected to be registered with CQC in the very near future which would give the system more capacity. This would also enable people using services to have more choice when looking for a suitable placement.

- People using services, their carers and family and social care providers raised further concerns about timeliness of assessments, involvement in discharge arrangements and transport home following discharge, and particularly regarding the time of day people were arriving home.

- System leaders had been working collaboratively to drive improvement and this had resulted in a number of initiatives such as The Perfect Week’ As a result, changes in the system took place and initiatives such as the daily huddles had begun in an attempt to resolve system issues. Also on a day-to-day basis local arrangements such as daily discharge planning meetings with representatives from health and social care took place to focus on people’s journeys and facilitate a timely discharge and effective follow on care. We saw evidence of these planning meetings taking place and the positive impact they had on people using services.

- According to the HWB’s BCF submission for Q4 2016/17, 20% of delayed transfers were due to 'awaiting completion of assessment'. The CCG CHC team were responsible for eligibility assessments (including fast track process), decision making process, case management and reviews (including out of area placements), appeals, and restitution.

- NHS CHC quarterly figures for all adults (NHS England) for Q1 2017 showed that the CCG had a standard NHS CHC assessment conversion rate for all adults (% of newly eligible cases of total assessments) of 21%.This was low compared to the England average (31%) and the Cumbria & the North East region average (26%). The referral conversion rate for all adults (percentage of newly eligible cases of total referrals completed) was also lower (21% compared with 25% for the region and England respectively). This suggested that the processes for accurately identifying people for standard CHC were not working as well as they should be and a higher proportion of people were entering into the CHC process to subsequently be denied funding.

- Frontline staff told us that they understood the CHC process and CHC assessments were undertaken as part of the integrated discharge team assessments. They didn't indicate any delays or issues with applications being denied. In the applicable case notes we viewed whilst at NTHFT we saw that CHC assessments were taking place and there was no indication that applications were being refused. Therefore it was not clear why the process was not working as well as it could be.

- A pilot for trusted assessors had been taking place and this had supported discharge to assess for those patients undergoing elective orthopaedic surgery. This encouraged timely discharge and received positive feedback from people using services.

- It was evident that people received seven-day care while in hospital. Analysis undertaken by the Department of Health showed the percentage of discharges of Hartlepool residents that took place at the weekend was 18% between October 2015 and September 2016. This was similar to other comparator areas, but lower than a few who were achieving 20% or above. The availability of the rapid response team, single point of access and the GP hub approach was evidence that seven day working was being supported and developed.

- Social care providers, the reablement and rehabilitation services team manager and the Head of Patient Flow confirmed the main reasons for delays were a lack of nursing home beds and a lack of rehabilitation beds. However, transitional/rehabilitation beds to enable people to receive care and treatment in the community rather than in hospital were available. Local measures indicated that 583 reablement packages commenced in 2015/16 with 78.4% of people having no ongoing social care needs after a reablement intervention, and in 2016/17, 94.1% of reablement goals had been achieved at the end of the period of reablement.

- Assistive technology services such as telecare Lifeline pendants (sensors/detectors that automatically send a signal to either a carer, community alarm or monitoring service) and GPS trackers were highly valued by the people who used them for supporting them or a person they care for, to feel safe.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Hartlepool?

- Hartlepool Matters and the Health and Wellbeing Strategy presented a clear and consistently articulated vision locally which all system partners had signed up to. Overall there were positive cross agency relationships in Hartlepool. There was an acceptance among system leaders that a wider shared vision was required with leaders working collaboratively to improve and develop sustainable services across the Sustainability and Transformation Plan footprint.

- System leaders were working collaboratively to agree and shape a structure of services that were sustainable and responsive to the needs of the local population and in particular to manage the needs of an ageing population and the associated risks, although some adult social care providers would welcome more involvement in this process. There were effective escalation processes to work proactively with service providers in maintaining and developing performance and delivery.

- The governance arrangements, as set out in the BCF plan, included recognition by system leaders that more collaboration and a system-wide approach was required to provide solutions for local issues. Although frontline staff were aware of the local vision, not all were aware of the BCF and STP and how the system aligned to this. System leaders and frontline staff were focussed on the needs and welfare of people who lived in Hartlepool and expressed a desire to improve outcomes for people through collaborative working.

- System leaders were working collaboratively in stabilising and shaping the adult social care market through the Feasibility Study for Alternative Service Delivery Models and integrated working initiatives. The local authority has supported new care home providers by offering to block book a proportion of nursing beds on a fixed term basis, which has been welcomed by providers. Resilience planning had been taking place with all system partners involved.

- There were clear processes in place for how system leaders were using the BCF funds. There was a good approach to using the money to address priority needs and pooled budgets supported this, protecting frontline services. New models of care had been explored and system leaders were looking at the resources available and how best to use them to meet local needs.

- The BCF, STP and CCG plans outlined a comprehensive plan and priorities regarding the development of a sustainable workforce that was suitably skilled and experienced to support the needs of local people. There was a focus on recruitment and retention, training and development and supporting new ways of working. Various fora took place to share best practice at an organisational level; how these were shared across the system was unclear.

- A fully integrated digital care record remained a priority and the Great North Care Record project was at the time of the review developing a specification for a system to provide integrated digital care records across the North East. There was data sharing by way of the MIG and System1 records within primary medical care and urgent care services.

- There was evidence that integrated working was developing and where this was in place it was effective in supporting pathways and integrated systems across health and social care. System leaders recognised the benefits of this approach and secondary care that supports the wider objectives of health maintenance.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- System leaders including those representing the STP in Hartlepool must continue to improve their working relationships and engagement to enhance a system wide focus and commitment.

- Develop the partnership framework to support the governance of partnership working.

- Continue to embed the Hartlepool Matters implementation plan.

- Ensure that there is effective use of the patient choice policy across the system.

- Review the purpose and function of the Holdforth Unit. Include in the review the criteria for admission and plans for patient flow, and also the use of community matrons on this unit and the impact this has on the skills and workforce available in the community

- System leaders should ensure there are robust and regularly evaluated plans to manage the complexity of commissioning to ensure a flexible and sustainable care market to address the current shortfall of care home provision for specialist beds for mental healthcare and end of life care beds.

- Evaluate CHC funding to aid better understanding of why a higher proportion of people who were entering into the CHC process were subsequently being denied funding.

- Promote the use of pilots and initiatives system-wide to ensure these resources are used to their full potential. Continue to evaluate the effectiveness of these on completion to ensure best practice is promoted and shared.

- Explore people's experiences of discharge through follow up by the integrated discharge team, so any changes in methodology or services can be considered. During this review evaluate the effectiveness of the discharge lounge and quality of discharge information particularly in respect of medicine administration.

- Undertake an assessment of people's experiences in respect of access to primary medical services to evaluate the effectiveness of hub working in resolving issued identified by people.

- Continue to develop integrated working to support effective use of resources and people only having to tell their story once.

- Continue to develop relationships with social care providers so they play an active part in service provision and strategy, maintenance of people's health and wellbeing, managing crisis and the return from hospital.

- Continue to develop and embed the trusted assessor scheme.

- Work with Health Education England and Skills for Care in respect of challenges with the recruitment of nurses and ambulance staff and further develop a contingency plan while this work is underway.

- Evaluate the increasing emergency readmissions and timeliness of discharge to establish if there is any correlation between the two and take action as required to ensure that patient flow and discharge is both efficient and safe.

ADULT SERVICES COMMITTEE

11 January 2018

Report of: Director of Adult and Community Based Services

Subject: CARE AND SUPPORT FOR DEAFBLIND ADULTS

---

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide members of the Adult Services Committee with information regarding the Council’s duties under the Care Act 2014 to support adults who are Deafblind.

3. BACKGROUND

3.1 Local authorities are required to identify, make contact with and keep a record of all Deafblind people in their local area (including those people who have multiple disabilities which include dual sensory impairment)

3.2 Local authorities must ensure that when an assessment of need for care and support is carried out, this is done by a person or team with specific training and expertise relating to Deafblindness - in particular to assess the need for communication, one-to-one human contact, social interaction and emotional wellbeing, support with mobility assistive technology and rehabilitation.

3.3 Services provided to Deafblind people should be appropriate, recognising that they may not be able to benefit from mainstream services or those services aimed primarily at blind or deaf people who are able to rely on their other sense. This may involve access to specifically trained one-to-one workers.

3.4 Information and advice needs to be presented in ways which are accessible to Deafblind people.

3.5 Local authorities must also assign a Director level member of the local authority senior team with overall responsibility for Deafblind services.

4. DEFINITIONS

4.1 The generally accepted definition of Deafblindness is that persons are regarded as Deafblind ‘if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss’ (Think Dual Sensory, Department of Health, 1995). Deafblindness can be found in all age groups, including children and young people, but the incidence is greatest in older adults.

4.2 The term ‘dual sensory loss’ can be used interchangeably with Deafblindness denoting the fact that combined losses of sight and hearing are significant for the individual even where they are not profoundly deaf and totally blind. It is the way in which one sensory impairment impacts upon, or compounds the second impairment, which causes the difficulties, even if, taken separately, each single sensory impairment appears relatively mild. Similarly the term ‘multi-sensory impairment’ can be used interchangeably with Deafblindness but is usually used in relation to children.

4.3 Many people do not define themselves either as Deafblind or having dual sensory loss. They may use such phrases as “I don’t see too well or hear too well”. However, they do describe their vision and hearing loss in terms which indicate that they have significant difficulties in their day-to-day functioning and may need support to live independently.

5. IDENTIFICATION

5.1 There are issues surrounding locating and contacting Deafblind people not known to local authorities. In addition people with dual sensory impairment who receive social services may not be recognised as being Deafblind. This can be because an initial assessment was carried out when only one sense was impaired or because both senses have deteriorated since the care package has started. Other impairments (such as a learning disability) may 'mask' the Deafblindness.

5.2 A particular approach for helping non-specialists recognise and understand the impact of Deafblindness is to provide a set of descriptors based on a supported self assessment. This can be an important aid to identifying the appropriate type of interventions needed.

6. ASSESSMENT AND ELIGIBILITY

6.1 Local authorities must undertake an assessment for any adult who appears to have needs for care and support, regardless of whether or not the local authority thinks the adult has eligible needs and regardless of their financial situation.

6.2 When carrying out the assessment, local authorities must identify the adult's needs, the impact these have on the adult's wellbeing and the outcomes the adult wishes to achieve in their day-to-day life. The assessment must be appropriate and proportionate to the needs and circumstances of the adult.

6.3 Local authorities must also consider whether and, if so, to what extent, matters besides care and support can contribute to the adult's desired outcomes (for example support from the adult's wider support network or within the community), and whether any preventative services, information and advice or other services available locally could help meet their needs

7. LOCAL PROGRESS

7.1 In Good Hands (IGH) is a Deafblind Support Project based in the new Centre for Independent Living which continues to work in partnership with the Council to develop and improve services to people with age related dual sensory loss.

7.2 IGH has the support of the Social Care Institute for Excellence (SCIE) as their national training partner. IGH also receives support from the Big Lottery which funds the training delivered in Hartlepool free of charge.

7.3 To date IGH has delivered the following training.

- Level 3 OCN accredited training to 32 HBC staff, two day Deafblind Specialist Assessor Course (equivalent cost of £300 per head)
- Level 2 OCN accredited training to 66 HBC staff, one day awareness course (equivalent cost of £150 per head)
- Level 2 OCN accredited training to 54 staff from community providers (equivalent cost of £150 per head)

7.4 Local providers receiving this free support and training from IGH include:

- Hartlepool Healthwatch
- Hartlepool Community Pharmacies
- Hartlepool Carers
- Hartlepool Deaf Centre
- Cleveland Fire and Rescue (Hartlepool)
- Hospital of God

7.5 Free training provided by IGH to date would otherwise have cost in the region of £27,600.

7.6 A key aim of the IGH project is to raise awareness amongst professionals and front line workers in relation to identifying people with Dual Sensory loss.

7.7 As a result of the work to date the number of people known to the department as having dual sensory loss has increased to 50 (a 51% increase). Whilst this is a significant increase it only accounts for 10% of the estimated number of people living Hartlepool with dual sensory loss, which is 500 based on national prevalence information.

7.8 The work and investment over the past 12 months included working with key contact points within both the Council (contact centre staff) and with primary care providers (Pharmacies) across the Borough.

7.9 Training was delivered to frontline staff with the aim of identifying people who may present with a sight or hearing loss and offering the option of completing a self assessment to identify if further support was required.

7.10 Presentation by Bernard Quinn (IGH)

8. FUTURE ASPIRATIONS

8.1 The Council is working with IGH to develop an E-learning platform and course. This is currently being tested by Council staff and if supported will complement the existing training offer for staff.

8.2 The IGH project has recently published the outcomes of its work across the North East following an evaluation by the University of Teesside looking at the impact of the project and its social return on investment (appendix 1)

8.3 Incontrol-able (a Community Interest Company and User Led Organisation) has received further funding from the Northgate Community Fund to continue the Project 65 tablet loan service. IGH has been working with Incontrol-able offering advice to people with sensory loss and enabling people to explore a variety of accessibility features that allow those with vision and hearing impairments to use the devices with greater ease.

9. RISK IMPLICATIONS

9.1 There are no risk implications associated with this report

10. FINANCIAL CONSIDERATIONS

10.1 There are no financial considerations associated with this report

11. LEGAL CONSIDERATIONS

11.1 Local authorities have a legal duty to complete an assessment for any adult who appears to have needs for care and support, regardless of whether or not the local authority thinks the adult has eligible needs or of their financial situation.

12. CONSULTATION

12.1 There are no consultation requirements associated with this report

13. CHILD AND FAMILY POVERTY

13.1 There are no child and family poverty considerations associated with this report.

14. EQUALITY AND DIVERSITY CONSIDERATIONS

14.1 There are no equality and diversity considerations that require an impact assessment. The DeafBlind guidance has been developed nationally to support improved access to services for people who are DeafBlind.

15. STAFF CONSIDERATIONS

15.1 There are no staff considerations associated with this report

16. ASSET MANAGEMENT CONSIDERATIONS

16.1 There are no asset management considerations associated with this report

17. RECOMMENDATIONS

17.1 It is recommended that members note the information provided.

18. REASONS FOR RECOMMENDATIONS

18.1 This report provides the additional information that Members requested in relation to support for people who are Deafblind.

19. CONTACT OFFICER

Neil Harrison
Head of Service - Adult Services
neil.harrison_1@hartlepool.gov.uk
Tel: 01429 284371

7.2 Appendix 1

fuse The Centre for Translational Research in Public Health

IN GOOD HANDS
DEAFBLIND SUPPORT PROJECT

Final Report

FUSE

Fuse, the Centre for Translational Research in Public Health, brings together the five North East Universities of Durham, Newcastle, Northumbria, Sunderland and Teesside in a unique collaboration to deliver robust research to improve health and wellbeing and tackle inequalities. Fuse is one of the five UK Public Health Research Centres of Excellence, it works hand-in-hand with the NHS, local and national government, voluntary and community sectors to help transform public health. Fuse is a founding member of the NIHR School for Public Health Research (SPHR).

Centre for Health and Social Evaluation (CHASE)

CHASE is a high quality research facility at Teesside University, which was established in 2006 to provide evaluation and research expertise for agencies in health and social care fields. It comprises a team of researchers from a variety of professional backgrounds with extensive experience of working with health authorities, local authorities, community groups and others involved in evaluation of health interventions. Experience includes evaluation of:

- health promotion programmes and campaigns
- community health initiatives
- service delivery in health and social care
- behaviour change
- professional and workforce development
- role change programmes
- organisational change impacts
- cost-effectiveness and social return on investment
- impact of new technologies

The centre is based within the School of Health and Social Care. As well as undertaking research contracts, the centre provides consultancy and advice, training in evaluation expertise, and a range of networking activities to promote good practice in evaluation.

For further information contact:

Pat Watson, Research Fellow for CHASE

Address: Teesside University, Health and Social Care Institute, Constantine Building,
Middlesbrough, UK, TS1 3BA.

Tel: +44 (0) 1642 384167
Email: pat.watson@tees.ac.uk
Website: www.tees.ac.uk/chase

IMPORTANT – PLEASE NOTE

The content and format of this report must not be changed without the permission of CHASE, and CHASE cannot be held responsible for any changes made without their prior consent.

Social Return on Investment Evaluation

In Good Hands Deafblind Support Project

SUMMARY REPORT

Project Overview

The In Good Hands Deafblind Support Project is funded by the BIG Lottery and managed by SCENE Enterprises CIC to build the capacity of organisations and services and to increase the number of older people identified with age acquired deafblindness. This project included awareness raising, training, qualifications and opportunities to volunteer to support older people with age acquired deafblindness. It also included the provision of advice and training around age acquired communication disorders. The project covered the whole of the North East region and included work with older people, carers, public, independent and voluntary sectors, deafblind people and their families.

Aims

- To raise awareness of older people with age-acquired deafblindness
- To improve the skills of people providing care to deafblind people
- To provide training and qualifications to volunteers, caregivers, health and social care staff
- To provide opportunities for older people to become volunteers and support older deafblind people.

The key objectives of the IGH Deafblind Support Project are to:

- To raise awareness of deafblind issues
- To increase the personal resilience of older deafblind people
- To increase the numbers of early assessments
- To train health and social care staff to ensure they are better equipped to identify, assess and support older deafblind people
- To improve communication skills
- To provide specialist bespoke training for social workers and health professionals to enable them to carry out statutory deafblind assessments in compliance with the Care Act 2014
- To provide training for volunteers and caregivers to enable them to provide better support to deafblind people
- To ensure that community organisations with volunteers are better placed to reduce the social isolation often faced by deafblind people

In accordance with The Care Act 2014 all local authorities have a statutory duty to assess any adult who appears to have a need for social care or support. If deafblindness is present (regardless of level of sight and hearing impairment) the local authority must offer a specialist deafblind assessment. According to the Care Act, all assessments should be undertaken by individuals with appropriate training in the identification of deafblindness

and experience working with people with the condition. This training must be at OCN/QCF Level 3, or higher for individuals who have more complex needs.
The In Good Hands Deafblind Support Project has successfully engaged with all 12 local authorities across the North East primarily providing accredited specialist assessment training for adult social care team.   All local authorities in the North East now have social work staff trained to provide deafblind assessments, better able to identify deafblindness in older people; and now have a clear understanding of the impacts on mobility, access to information and communication. They are also now better placed to understand the gaps in skills amongst local providers supporting older people with deafblindness – all Care Act duties.   A total of 206 social work staff have gained a Level 3 qualification in Specialist Deafblind Assessment. This means that all local authorities in the North East can be deemed as Care Act Compliant with regard to having qualified staff to provide specialist deafblind assessments.

In addition to the specialist deafblind assessment training for local authorities, IGH have also engaged with the voluntary and independent sectors in each of the 12 local authorities and provided a range of training to staff, carers, volunteers and family carers.

Training

In total 98 training courses were provided and 1052 people attended. A further 240 people from outside of the North East region also completed training. The voluntary and independent sectors engaged particularly well with the foundation training creating a much wider awareness of age-acquired deafblindness and the issues faced by their clients. The majority of the public sector involvement has focused on the Specialist Deafblind Assessment training.

A breakdown by course was:

- Foundation Training – 556 people
- Communicator Guide – 123 people
- Acquired Communication Disorder – 151 people
- Specialist Deafblind Assessor – 206 people
- Rehabilitation & Assessment – 16 people

Respondents were positive about the courses they attended with the majority of respondents on each of the courses saying the course was either very good or good. Almost 96% of respondents reported that the training met their expectations. Respondents also reported that while the training offered key learning which supplemented their existing knowledge of deafblindness, that it also provided new knowledge and understanding of deafblindness. Course participants clearly appreciated the practical elements within each of the courses.

Impacts of training

Within the training a number of techniques were explored to better support people who are deafblind. Respondents reported that many of these techniques are now being used in their everyday practice. These included:

- Using a separate room or quiet area to talk
- Positioning themselves to maximise communication
- Producing large print documents
- Using Deafblind Manual/Block to communicate
- Adjusting lighting
- Talking books
- Regularly checking hearing aids
- Promoting amplified telephones so they can keep in touch with family
- Touch techniques

While these are primarily simple, practical skills they have resulted in a substantial improvement in how a deafblind person is supported and on how they benefit from such support. Almost 67% of respondents reported having put some of the learning from the training they completed into practice either in their work or with family.

Questionnaire respondents reported that:

- Almost 89% either strongly agreed or agreed that the training had been important in enabling them to support their clients:
- 93% either strongly agreed or agreed that the training was beneficial in improving support they gave to their clients
- Almost 89% either strongly agreed or agreed that they had increased confidence when dealing with deafblind clients as a result of the training
- 70% either strongly agreed or agreed that the training had resulted in changes to their usual practice when supporting with deafblind people
- Over 95% of respondents felt they were better able to support deafblind people as a result of the training.

As well as initiating changes in individual practice for supporting deafblind people, the training has also made some headway to changing working practices at an organisational level. While policy level changes take time, there is evidence to support attitudinal changes in how organisations provide services or support deafblind people.

Project Developments

While primarily a training project, the In Good Hands Deafblind Support Project evolved over time to ensure it continued to work towards meeting its aims and objectives. A flexible approach allowed them to continue to meet the needs of stakeholders, build on the knowledge and understanding gained throughout the project, improve the training and access larger numbers of deafblind people directly.

National Profile

As a result of the IGH Deafblind Support Project it became clear that the need for this training was wider than the North East and SCENE were approached to provide the same training outside of the region and internationally.

SCENE have also provided training for Social Care Institute for Excellence (SCIE), Deafblind UK (DBUK) and all Big Lottery offices across the country. In 2016 a Partnership Agreement was drawn up between SCIE and SCENE, again raising the profile of the organisation but also giving them a key role in raising awareness and as training providers at a national level. The development with SCIE is a significant step meaning local authorities and care providers across the UK will be able to access the SCENE accredited training and support. The collaboration agreement with DBUK has seen a joint project using the identification Tools created through IGH being tested nationally and it is now making a significant boost to DBUK's ability to identify and support hundreds more deafblind people throughout the UK.

Talk and Try events

Talk and Try events were established as a way of engaging directly with groups of deafblind people and offering advice, support and signposting to relevant services/agencies. Talk and Try events were provided in a wide range of venues across the region. IGH staff attended existing group sessions, coffee mornings etc using the Identification Tool to identify people with dual sensory loss and to provide information, advice, referrals and specialist support where necessary.

The Talk and Try events have proved very successful in identifying people with dual sensory loss who had not been diagnosed. Over 200 people attended the Talk & Try events and 50 people have been identified as being deafblind.

Deafblind people reported receiving a more individualised support package, family carers were made more aware of what was available and care staff had a raised awareness of the impacts of any sensory impairment. Having IGH as a first point of contact to raise any concerns further improved support and services to deafblind people. Some sessions were run in care provider settings and these helped raise awareness among staff as well as directly helping residents with their deafblindness.

One lady attending a Talk and Try event stated:

> *I wasn't going to come but am so pleased that I did. The new phone has made all the difference to me. I can keep in touch with my family now so I don't feel so lonely.*

Networking events were also arranged for deafblind people and their carers. Almost 120 deafblind people and their carers attended these events. Many of the attendees were identified through the Talk and Try events. These events were also an opportunity to get feedback on the project work and help older deafblind people make new friends.

Equipment Loan Service

The Equipment Loan Service was established by IGH to raise awareness of sensory aids available to support and improve the daily living for deafblind people. The Loan Equipment Service was set up by IGH to provide an opportunity for a deafblind person to test out whether a particular piece of equipment was suitable to meet their needs prior to purchase. Deafblind people informed IGH that quite often they had bought a piece of equipment only to find it was not what was needed. Given the cost of some specialist equipment, the loan service proved very popular with deafblind people and their families. The evidence from the interviews with deafblind people clearly shows that after testing out equipment, many had gone on to purchase it with confidence that it was suitable.

Further support was also provided to familiarise deafblind clients with new equipment. Participants and carers reported this to be particularly valuable. One participant commented:

> *It's really good that they show you how to use it and not just leave you to it. She even came back to make sure everything was working properly and that I wasn't having any problems.* (Participant 47)

Hi-Vis

A new charity; Hearing Impairment + Visual Impairment Support UK , Registered Charity Number: 1166368 (Hi-Vis UK) has now been established to build on and develop the work of the IGH Deafblind Support Project. Using many of the methods developed as part of the IGH project – and with early identification and early support, they intend to reduce support costs and help people remain independent. Their objective is that by working with professionals, families and carers and providing improved support to them they will be better able to provide support reducing and/or delaying the need for the more expensive option of residential care.

While subsuming IGH staff into Hi-Vis and incorporating the learning, experience and methods of the IGH Deafblind Awareness Support Project, Hi-Vis will open up new opportunities for future funding and further training but more importantly to continue to build on what has already been achieved and develop new strands of work.

Case study models

As the project developed, two models of working emerged in two areas – Hartlepool and Sunderland. These models were very different and provided an opportunity to explore the potential for replicating these models across a wider area. The two models involved:

- Seeking to embed deafblindness within local authority policy and also working with other sectors operating in the area to raise awareness and improve support for deafblind people
- Supporting a voluntary sector organisation to make a change to becoming a dual sensory loss organisation.

The time available for these case study pieces of work did not allow either model to reach completion but the evidence is strong that good progress has been made in both areas and indications are that both models will continue on (through Hi-Vis).

Hartlepool

Hartlepool Borough Council were keen to become Care Act compliant but more importantly wanted to embed deafblind awareness within their services and provision. As a local authority they wanted to raise awareness of deafblindness across all sectors, increase the number of deafblind people on the register and have staff trained to support and assess deafblind people within the area.

As a result, 33 social worker/social work practitioners/assistants in Hartlepool have completed the level 3 Specialist Deafblind Assessor training. In addition to this another 33 local authority staff have completed foundation/communication/ACD training. These included staff involved in service provision, those with face to face contact with people e.g. contact centre staff, blue badge unit (disabled parking). The aim of involving people in these roles was to raise awareness of deafblindness, improve the ability to identify those who were showing signs of having some level of deafblindness and provide knowledge to be able to offer referral for early intervention and/or assessment and to improve information and guidance.

Working closely with senior management within the local authority changes have been made to working practices. There are now clear pathways from identification to assessment to services to registration. Recent reports on access to healthcare included people with dual sensory loss.

Resources continue to be a key issue as any increase in identification, assessment and service provision are likely to be resource intensive at a time when resources were already stretched to a critical level within all local authorities. However, Hartlepool Borough Council were clear that while this could create many challenges financially, any assessments and service provision would be explored. In order to do this more effectively, voluntary sector services needed to be more fully utilised.

IGH now have a physical presence in the Hartlepool area and has allocated Hi-Vis staff time in the area for the foreseeable future to continue the work. They will continue to offer training and will help local organisations in continuing to identify and support deafblind people. The profile of IGH appears to be rising in Hartlepool and is better recognised as part of the Hartlepool Borough Council Framework with elected members, directors and key teams now all actively engaged with the project.

A pilot project with Hartlepool community pharmacies ran between June – September 2017 as part of the Hartlepool model. The project trained pharmacy champions and managers to use the deafblind identification tool with customers. A poster campaign ran in each pharmacy with the Tees Local Pharmacies Committee (TLPC) monitoring progress. This will be developed further in 2018 to cover all pharmacies in the Tees Valley combined authority, another indication of the impact of the IGH Deafblind Support Project.

Sunderland

Sunderland & Durham Royal Society for the Blind (SDRSB) believed that by changing to a dual sensory loss organisation they would be able to provide an improved service to their clients and also be in a better position to attract future funding. Working with IGH they are now making some headway in achieving this changeover. Such a change is a major organisational move including the philosophy, the Constitution and the name all of which provide a history and a profile and change must be handled in a way to ensure its history, ethic and experience goes along with it.

While still in its early stages IGH have worked with the organisation in a number of ways to support them, not only in the decision making but in providing a number of activities which would provide the foundation for such a change.

A Memorandum of Agreement was agreed whereby IGH provided training to SDRSB staff and volunteers, tested out the identification tool to identify clients with a dual sensory loss. The proposed timescales proved to be optimistic and while inroads have been made it was not possible to complete this work. Although progress has been slow, both staff teams and the SDRSB Board remain committed to bringing about this change and the foundations are in place to move this forward.

Staff and volunteers have received training. Volunteers are also taking an active role in contacting people on the existing database and working through the Identification Tool with them as a way of identifying if they are deafblind and for those who are, asking permission to refer them for a specialist assessment.

To date, approximately 200 people currently involved with SDRSB have been identified as having both sight and hearing loss to differing degrees. Already SDRSB are developing and expanding networks in terms of deafblindness. RNIB are using them as an example of demonstrating good practice and they are being approached by other organisations across the region to discuss future collaborations in terms of deafblindness.

SDRSB continue to embed deafblindness into their work, particularly when looking at future funding and contracts.

SROI Evaluation

Working within the action research framework, the evaluation team from Teesside and Sunderland Universities and SCENE worked together to identify and agree outcomes in line with key performance indicators (KPI) for the In Good Hands Deafblind Support Project. Every attempt has been made to ensure that information and evidence used in this report is both significant and relevant and will provide an accurate assessment of the service.

Stakeholders

This SROI evaluation includes a range of stakeholders deemed as relevant. These include:

- Local authorities
- Independent care providers
- Voluntary Sector organisations
- Deafblind people
- In Good Hands

Outcomes

Within the SROI framework each of the stakeholder groups have achieved a range of outcomes as a result of the IGH Deafblind Support Project.

Stakeholder	**Outcomes**
Local Authorities	• Local Authorities and staff can identify the named lead person at director level and better understand their role • Increased awareness of deafblindness • An increase in number of deafblind assessments • More staff qualified to Level 3 • Increased confidence in communicating with deafblind people • More relevant/improved services to deafblind people • Now all Care Act compliant in terms of deafblind assessment requirements
Independent Care Sector	• Staff more aware of deafblindness • Increased confidence and skills in caring for deafblind people • Providing more appropriate care • Improved care and support • Staff gaining an accredited qualification • Better able to communicate with deafblind people
Voluntary Sector	• Staff and volunteers more aware of deafblindness • An increase in volunteers supporting deafblind people • An increase in the number of deafblind people accessing voluntary sector services • Increase in number of people identified as deafblind • Improved services to deafblind people
Deafblind people	• People report being more socially active • Reports of improved/more effective support • Increased number receiving full deafblind assessments • Improved quality of life • Improved perception of own health and wellbeing • People remaining independent in their own homes for longer
IGH	• A range of training opportunities provided • Improved organisational profile • Direct support to deafblind people

Local Authorities

In terms of supporting local authorities to become Care Act compliant in terms of their deafblind responsibilities, IGH has identified that some local authorities now have a designated lead (director level) for deafblindness and staff awareness of the role and responsibilities of this person is increasing. This is an area of work for further consideration.

IGH have provided specialist assessment training to 206 local authority staff which ensures they are able to offer specialist deafblind assessments to clients. However, to date there is little evidence to support an increase in the number of specialist assessments carried out.

Two reasons for this emerged: a) that local authorities remain reticent about providing assessments and b) deafblind people are also reluctant to consent to such an assessment.

Deafblind awareness within local authorities has also increased substantially and foundation, communicator guide and acquired communication disorder training has also been provided to social work assistants, call centre staff and first point of contact staff in some areas. The numbers of people identified as being deafblind is increasing in some areas

Local authority staff also reported increased confidence in communicating with deafblind people which has resulted in improved support, more relevant and appropriate services being put into place.

Independent Care Sector

The level of awareness of deafblind issues in the independent care sector was deemed generally low prior to the IGH Deafblind Support Project. In total 336 staff from the independent sector completed deafblind accredited training. Of these, 200 completed the foundation training, 70 the ACD and a further 63 completing the Communication Guide training. Staff from this sector reported increased awareness, skills and understanding, all of which are now being implemented in their practice.

> *I didn't know anything about what was available or even what it meant if the TV was really loud or they just wanted to sit on the chair all day. I now know he is lonely and needs someone to talk to so I don't rush out any more.*

Improved knowledge and understanding has resulted in providing more appropriate care as they are now addressing individual needs of clients. Increased confidence and awareness has also resulted in improved working practices. There is also some evidence to support that additional services have been identified and provided within some settings.

Staff reported more confidence in caring for deafblind people and being better able to communicate with them using the skills and techniques tested within the training.

Voluntary Sector

Almost 300 staff from the voluntary sector completed accredited deafblind training. Of these 220 completed the foundation training focusing on raising awareness of deafblindness across the sector. Participants included both staff and volunteers, both of who reported changes in working practices as a result of the training. The evidence clearly supports that the support to deafblind people had improved significantly.

> *The training really made me think more about things. I listened more, made sure they heard me, instead of just assuming they had, had ideas of things that could help so could talk to them about them. Nothing mind boggling but I felt that the clients really appreciated the extra effort and responded really well.*

Volunteers have also played an active role in identifying people who are deafblind in some areas and to date have identified almost 150 people who had previously been designated as being blind. This work is continuing and there is a likelihood that these numbers will increase further in the near future.

As a result of improved identification, there have been some increased pressures on the voluntary sector to provide additional services and support to deafblind people. Given the economic climate and cuts to funding and local authority grants, this is proving difficult. While there is no doubt regarding the need for such services and support, resources are limited.

Raised awareness, knowledge and understanding have also meant some changes in organisational policy including a change to a “no touching” policy within one organisation to allow touching when working with/supporting a deafblind person. Another voluntary sector organisation is currently working towards a major shift in organisational status requiring major structural changes operationally and strategically. While there is still much to do to achieve this, good foundations have been laid on which to build and move this forward in the future.

Deafblind people

Deafblind people reported a range of changes/improvements in terms of the support they received, the services they attended, how staff/carers communicated with them, feeling less isolated and aided to remain independent in their own homes for longer. Many deafblind people reported becoming more socially active and developing new networks consequently reducing social isolation and feelings of loneliness.

> *Attending groups has made a big difference. I mix with people who understand what it’s like [to be deaf and blind] and I like talking to them. I went to a summer fayre in Ashington and many people said hello . . . it makes me happy.*

Deafblind people were clear that they received improvements to services and supports. Some of these were minor changes but had significant impacts on a deafblind person. Advice and information made available has made accessing equipment much easier and this has also resulted in positive changes in their daily living.

As a result, many deafblind people reported improvements to their quality of life and having an improved perception of their own health. This included a positive outlook, feeling less frustrated, meeting more people and the ability to achieve some general everyday tasks were very important to them.

Living in familiar surroundings helps provide deafblind people with some control. Very few would opt for residential care. The improved support services and equipment made available has helped some to maintain that independence and goes some way to keeping deafblind people in their own home for longer. Some deafblind respondents reported having doubts as to whether they could remain in their own homes. Some of these doubts have been allayed with the introduction of some simple measures to reduce falls, reduce accidents and help with everyday tasks.

> *I want to stay at home. I don’t want to move at all. I’d be happy if they carried me out in a box but I know I need help and I am getting it. I feel I could last out for a good while yet.*

In Good Hands

IGH have designed and delivered 98 training courses across the lifetime of the project offering participants a range of experience and qualifications. They have developed strong networks across all sectors in the North East region and nationally as a result. Reviews of the training have been very positive, particularly the practical aspect of the training.

As a result, the profile of IGH as a training provider has also increased. Links with national organisations such as SCIE and Skills for Care and embedding deafblind training within these organisations further raises that profile.

As the IGH Deafblind Support Project has developed and evolved, the IGH team have gone on to provide more direct services to organisations and deafblind people. They became a first point of contact for organisations seeking advice, information and support and also worked directly with deafblind people to help them build up their confidence, work on coping strategies and test out potential equipment with them to help retain their independence. Deafblind people reported huge benefits from face-to-face contact with an expert and that even the small changes made a massive difference to them.

> *Being able to make a cup of tea for myself and any visitors was really important to me but I kept burning myself. Now with my little gadget I can do it and it means the world to me.*

SROI

Working through the SROI process, the total impact values of the IGH Deafblind Support Project is £6,266,186.38. The net present value (NPV) is £5,271,186.38 which is the total extra value created by the IGH Project.

This means that for every £1 of investment in the IGH Deafblind Awareness Support Project, it achieved **£5.30** in social value across the stakeholder groups. This shows a significant social return on investment and confirms that the project has had a very positive effect on stakeholders.

Conclusions

The IGH Deafblind Awareness Support Project was designed to bridge a gap in awareness, knowledge and serve to improve services for deafblind people by building the capacity in terms of knowledge and skills of stakeholders. The project was well designed and the training provided was of good quality. While primarily developed as a training programme, the over-arching aims and objectives included providing focused training ensuring local authorities were able to meet their legal requirements under the new legislation. Also to upskill social workers, care staff, voluntary sector staff and volunteers and family carers as a way of improving support and knowledge for deafblind people.

There is clear evidence to show that they have achieved success across all the local authority areas increasing/improving social capacity. IGH has effectively engaged with all sectors across the North East region and social work teams, generic staff teams, care staff, volunteers and family carers have completed training and gained a qualification. We understand that a large percentage of these stakeholders have gone on to put their learning into practice.

The format and content of the training was well received and beneficial to trainees, the majority of whom, rated it very highly. The provision of different levels of training opened it up to a wider array of people and helped IGH to engage well with their target groups. The fact that all the training was accredited, while not a key factor, was also well received.

Over 1,000 people completed the training. Alongside these an additional 240 people from outside of the North East completed training. This is testament to the fact that there is a clear need for such training and that demand is high. The North East region benefitted from free training as part of this project which proved to be an important factor in terms of take-up. However, it also shows that there is a demand outside of the region and given the fact availability of such training is low, organisations and local authorities are willing to pay.

The Specialist Deafblind Assessor training has been identified as a vital element in the success of this programme. Social work teams from across the region engaged to ensure that they were qualified to provide specialist deafblind assessments as required under the Care Act. A total of 206 staff are now qualified to provide these assessments. Given that IGH are the sole provider of this accredited Care Act compliant training (both in the North East and nationally), the potential for local authorities failing to meet compliance in terms of specialist deafblind assessments would have been much higher without IGH input.

While delivering training was the primary output for IGH, they have provided ongoing support to local authorities and voluntary sector organisations on how to improve services for deafblind people. This has resulted in two separate models of working in the two case study areas. The models were very different, using different approaches and the anticipated outcomes quite different from the main project. The local authority model case study allowed us to see how deafblindness could be embedded within a local authority. While not totally unproblematic, this model has identified some key methods that can be adopted in order to do this. This model continues to develop and the evidence does suggest that in terms of developing and testing processes and protocols, bringing grassroots, face to face staff into the mix, including deafblindness in publicity materials and rolling out the use of the ID Tool do offer insight to ways of achieving success. There is clear potential for this model to be replicated nationally.

Very few organisations nationally are involved with dual sensory loss. The fact that one voluntary sector organisation is taking steps to do that is a major accomplishment for this project. Working with the Board to review and update their Constitution was a major achievement and again while there remains some way to go until full changeover, there is little doubt that IGH has played a major role in this proposed transformation.

While additional work is required to complete both of these, without IGH input and support any headway made to date would have been substantially reduced or possibly never started. The importance of IGH in these areas cannot be downplayed. While commitment to succeed is present and there is a belief that this is the correct route to take, without direction and guidance this is likely to have been a much slower process. Even with IGH input, things moved slowly and this in itself created some frustrations. However, working together to continue this work has carried on and there are no indications that it is likely to stop as the IGH project comes to a close and Hi-Vis takes the helm.

The IGH work continued to evolve throughout its lifetime and while training provision remained at the heart of it, improving engagement with deafblind people through the Talk and Try and networking events also proved to be very successful. Deafblind people readily reported on the benefits they have had experienced as a result. Direct contact with IGH staff able to provide advice and ideas had very positive effects for many. In addition, the development of the equipment loan service further supplemented the support provided. The opportunity to test out equipment, ensure they could use it, that it did what it was meant to do and most importantly it met the needs of that person was hailed by many as one of the highpoints of the project.

Alongside meeting individual needs the IGH project also opened up good opportunities to bring people together thus improving engagement with the project but also building up self-confidence to explore more social activities. Social isolation is a real issue for many: deafblind people involved with the project reported it affected their mood, confidence, general health and wellbeing. While it is noted that the majority of these activities are provided through voluntary sector organisations and that resource issues are currently problematic, focus was given to informing improvements to existing services through raising staff awareness and offering new techniques particularly around communication. The evidence gathered also shows that IGH has achieved real success in this area.

There is little doubt that involvement with the IGH project has resulted in increased numbers of people being identified/recognised as being deafblind. While originally it had been anticipated that these people would be included in the register and/or be referred for a specialist deafblind assessment, this has not always proven to be the case. In reality, many of those people identified as being deafblind are refusing consent to be registered or be assessed. While the project team can do little to change this, they have continued to provide direct support and also provide advice, information and support to any staff requesting it which has provided some continuity and the opportunity to refer people directly back into IGH as opposed to adult social care.

The evidence clearly supports success in achieving many of the expected outcomes. Given extra time and resources, these could easily have expanded. Future demand for specialist assessor training has the potential to increase significantly given the high staff turnover of social workers so Hi-Vis could continue to have an active role in this outside of this project.

This SROI evaluation shows that each of the stakeholder groups have benefitted from the changes brought about by the IGH Deafblind Support Project. While for some it is about training and skills, for others it is more personal. For example, self- confidence, impacts on health and wellbeing, changes perceptions of self, improves communication and also access to services.

Findings show that the IGH Deafblind Support Project has created a significant social value of £5.30 for every point invested in the project. This is based on a robust evaluation process using qualitative and quantitative techniques to ensure that any assumptions and estimates used are realistic and based on information provided by the key stakeholders.

Overall the evidence from this SROI evaluation supports the view that the IGH Deafblind Support Project has been successful in meeting its aims and objectives. Awareness of deafblindness is much higher than before, staff are better informed, qualified to support deafblind people and more confident when providing care. Some deafblind people were sure that without the support they received as a result of the training and direct support that it was highly likely that they would have needed residential care. As independence is very important to them, they were very thankful that this has been averted so far.

In conclusion, the evidence clearly shows that the IGH Deafblind Support Project has been effective in bringing about change for stakeholders and deafblind people. IGH has continued to provide training and support taking a longer term view and is already identifying ways of escalating the current project to provide more focus on family carers and family members. A new national charity, Hi-Vis UK has been established to take the project's work forward and is working with SCIE, DBUK and others to take the work of the IGH Deafblind Support Project to the whole of the UK.

The accredited training is still unique and as yet, no other training provider is offering this training.

7.2 Appendix 1

fuse The Centre for Translational Research in Public Health

IN GOOD HANDS
DEAFBLIND SUPPORT PROJECT

Final Report

Social Return on Investment Evaluation

In Good Hands Deafblind Support Project

FINAL REPORT

SCENE ENTERPRISES CiC

Pat Watson

Professor Jonathan Ling

Professor Sharon Hamilton

September 2017

FUSE

Fuse, the Centre for Translational Research in Public Health, brings together the five North East Universities of Durham, Newcastle, Northumbria, Sunderland and Teesside in a unique collaboration to deliver robust research to improve health and wellbeing and tackle inequalities. Fuse is one of the five UK Public Health Research Centres of Excellence, it works hand-in-hand with the NHS, local and national government, voluntary and community sectors to help transform public health. Fuse is a founding member of the NIHR School for Public Health Research (SPHR).

Centre for Health and Social Evaluation (CHASE)

CHASE is a high quality research facility at Teesside University, which was established in 2006 to provide evaluation and research expertise for agencies in health and social care fields. It comprises a team of researchers from a variety of professional backgrounds with extensive experience of working with health authorities, local authorities, community groups and others involved in evaluation of health interventions. Experience includes evaluation of:

- health promotion programmes and campaigns
- community health initiatives
- service delivery in health and social care
- behaviour change
- professional and workforce development
- role change programmes
- organisational change impacts
- cost-effectiveness and social return on investment
- impact of new technologies

The centre is based within the School of Health and Social Care. As well as undertaking research contracts, the centre provides consultancy and advice, training in evaluation expertise, and a range of networking activities to promote good practice in evaluation.

For further information contact:

Pat Watson, Research Fellow for CHASE

Address: Teesside University, Health and Social Care Institute, Constantine Building,
Middlesbrough, UK, TS1 3BA.

Tel: +44 (0) 1642 384167
Email: pat.watson@tees.ac.uk
Website: www.tees.ac.uk/chase

IMPORTANT – PLEASE NOTE

The content and format of this report must not be changed without the permission of CHASE, and CHASE cannot be held responsible for any changes made without their prior consent.

Contents

List of Tables

List of Figures

Glossary

ACD	Acquired Communication Disorder
DB	Deafblind
DBUK	Deafblind UK
DH	Department of Health
DSI	Dual Sensory Impairment
HBC	Hartlepool Borough Council
ID	Identification
IGH	In Good Hands
KPI	Key Performance Indicators
LA	Local Authority
NE	North East
SCIE	Social Care Institute for Excellence
SDRSB	Sunderland & Durham Royal Society for the Blind
SROI	Social Return on Investment

7.2 Appendix 1

fuse
The Centre for Translational
Research in Public Health

Social Return on Investment Evaluation

In Good Hands Deafblind Support Project

Executive Summary

Project Overview

The In Good Hands (IGH) Deafblind Support Project was funded by the Big Lottery Fund and managed by Scene Enterprises CIC to build the capacity of organisations and services in identifying individuals with age acquired deafblindness and to increase the number of older people identified with age acquired deafblindness. This project included awareness raising, training, qualifications and opportunities to volunteer to support older people with age acquired deafblindness. The project also included the provision of advice and training around acquired communication disorders. The project covered the whole of the North East region and included work with older people, carers, public, independent and voluntary sectors, deafblind people and their families.

In accordance with The Care Act 2014, all local authorities have a statutory duty to assess any adult who appears to have a need for social care or support. If deafblindness is present (regardless of level of sight and hearing impairment) the local authority must offer a specialist deafblind assessment. According to The Care Act, all assessments should be undertaken by individuals with appropriate training in the identification of deafblindness and experience working with people with the condition. This training must be at OCN/QCF Level 3, or higher for individuals who have more complex needs.

Training

The In Good Hands Deafblind Support Project successfully engaged with all 12 local authorities across the North East primarily providing accredited specialist assessment training for adult social care team. All local authorities in the North East now have social work staff trained to provide deafblind assessments. A total of 206 social work staff have gained OCN Level 3 qualification in Specialist Deafblind Assessment. This means that all local authorities in the North East can be deemed as Care Act Compliant with regard to having qualified staff to provide specialist deafblind assessments.

In total, 98 training courses were provided which were attended by 1052 participants. A further 240 people from outside of the North East region also completed training. The voluntary and independent sectors engaged particularly well with the foundation training creating a much wider awareness of age-acquired deafblindness and the issues faced by their clients. The majority of the public sector involvement was for the Specialist Deafblind Assessment training.

A breakdown by course was:

- Foundation Training – 556 people
- Communicator Guide – 123 people
- Acquired Communication Disorder – 151 people
- Specialist Deafblind Assessor – 206 people
- Rehabilitation & Assessment – 16 people

Respondents were positive about the courses they attended with the majority of respondents on each of the courses saying the course was either very good or good. Almost 96% of respondents reported that the training met their expectations. Respondents also reported that while the training offered key learning which supplemented their existing knowledge of deafblindness, that it also provided new knowledge and understanding of deafblindness.

> *I didn't know anything about what was available or even what it meant if the TV was really loud or they just wanted to sit on the chair all day. I now know he is lonely and needs someone to talk to so I don't rush out any more.*

Course participants reported appreciating the practical elements within each of the courses. Over 95% of respondents felt they were better able to support deafblind people as a result of the training.

Impacts of training

Within the training a number of techniques were explored to better support people who are deafblind. Respondents reported that many of these techniques are now being used in their everyday practice. These included positioning themselves to maximise communication, using Deafblind Manual/Block to communicate and adjusting lighting.

> *The training really made me think more about things. I listened more, made sure they heard me, instead of just assuming they had, had ideas of things that could help so could talk to them about them. Nothing mind boggling but I felt that the clients really appreciated the extra effort and responded really well.*

While these are primarily simple, practical skills they have resulted in a substantial improvement in how a deafblind person is supported and on how they benefit from such support. Almost 67% of respondents reported having put some of the learning from the training they completed into practice either in their work or with family.

Project Developments

While primarily a training project, the In Good Hands Deafblind Support Project evolved over time to ensure it continued to work towards meeting its aims and objectives. A flexible approach allowed them to continue to meet the needs of stakeholders, build on the knowledge and understanding gained throughout the project, improve the training and access larger numbers of deafblind people directly.

National Profile

As a result of the IGH Deafblind Support Project it became clear that the need for this training was wider than the North East and Scene were approached to provide the same training outside of the region and internationally.

Scene have also provided training for SCIE, DBUK and all Big Lottery Fund offices across the country. In 2016 a Partnership Agreement was drawn up between SCIE and Scene, again raising the profile of the organisation but also giving them a key role in raising awareness and as training providers at a national level.

Talk and Try events

Talk and Try events were established as a way of engaging directly with deafblind people and offering advice, support and signposting to relevant services/agencies. IGH staff attended used the Identification Tool to identify people with dual sensory loss and to provide information, advice, referrals and specialist support where necessary. Over 200 people attended the Talk & Try events and 50 people have been identified as being deafblind.

Deafblind people reported receiving a more individualised support package, family carers were made more aware of what was available and care staff had a raised awareness of the impacts of any sensory impairment. Also having IGH as a first point of contact to raise any concerns further improved support and services to deafblind people.

One person attending a Talk and Try event stated:

> *I wasn't going to come but am so pleased that I did. The new phone has made all the difference to me. I can keep in touch with my family now so I don't feel so lonely.*

Networking events were also arranged for deafblind people and their carers. Almost 120 deafblind people and their carers attended these events. Many of the attendees were identified through the Talk and Try events.

Equipment Loan Service

The Equipment Loan Service was established by IGH to raise awareness of and training with sensory aids available to support and improve the daily living for deafblind people. The Loan Equipment Service was set up by IGH to provide an opportunity for a deafblind person to test out whether a particular piece of equipment was suitable to meet their needs prior to purchase. The evidence from the interviews with deafblind people clearly shows that after testing out equipment, many had gone on to purchase it with confidence that it was suitable.

> *Being able to make a cup of tea for myself and any visitors was really important to me but I kept burning myself. Now with my little gadget I can do it and it means the world to me.*

Case study models

As the project developed, two models of working emerged in two areas – Hartlepool and Sunderland. These models were very different and provided an opportunity to explore the potential for replicating these models across a wider area. The two models involved:

- Seeking to embed deafblindness within local authority policy and also working with other sectors operating in the area to raise awareness and improve support for deafblind people
- Supporting a voluntary sector organisation to make a change to becoming a dual sensory loss organisation.

The time available for these case study pieces of work did not allow either model to reach completion but the evidence is strong that good progress has been made in both areas and indications are that both models will continue on (through Hi-Vis).

SROI Evaluation

Working within the action research framework (Fujiwara 2014), the evaluation team and Scene worked together to identify and agree outcomes in line with key performance indicators for the In Good Hands Deafblind Support Project. Every attempt has been made to ensure that information and evidence used in this report is relevant and will provide an accurate assessment of the service.

Stakeholders

This SROI evaluation included a range of stakeholders deemed as relevant. These include:

- Local authorities
- Independent care providers

- Voluntary Sector organisations
- Deafblind people
- In Good Hands

Outcomes

Within the SROI framework each of the stakeholder groups have achieved a range of outcomes as a result of the IGH Deafblind Support Project.

Stakeholder	**Outcomes**
Local Authorities	• Local Authorities have a named lead person at director level and staff now know who they are • Increased awareness of deafblindness • An increase in number of deafblind assessments • More staff qualified to Level 3 • Increased confidence in communicating with deafblind people • More relevant/improved services to deafblind people • Now all Care Act compliant in terms of deafblind assessment requirements
Independent Care Sector	• Staff more aware of deafblindness • Increased confidence and skills in caring for deafblind people • Providing more appropriate care • Improved care and support • Staff gaining an accredited qualification • Better able to communicate with deafblind people
Voluntary Sector	• Staff and volunteers more aware of deafblindness • An increase in volunteers supporting deafblind people • An increase in the number of deafblind people accessing voluntary sector services • Increase in number of people identified as deafblind • Improved services to deafblind people
Deafblind people	• People report being more socially active • Reports of improved/more effective support • Increased number receiving full deafblind assessments • Improved quality of life • Improved perception of own health and wellbeing • People remaining independent in their own homes for longer
IGH	• A range of training opportunities provided • Improved organisational profile • Direct support to deafblind people

Hi-Vis

In order to build on the success of the IGH Deafblind Support Project, a new charity; Hearing Impairment + Visual Impairment Support UK , Registered Charity Number: 1166368 (Hi-Vis UK) has now been established to build on and develop the work of IGH. Using many of the methods developed as part of the IGH project – and with early identification and early support, they intend to reduce support costs and help people remain independent. Their objective is that by working with families and carers and families and providing improved support to them they will be better able to provide support reducing and/or delaying the need for the more expensive option of residential care.

SROI

Working through the SROI process, the total impact values of the IGH Deafblind Support Project is £6,457,818.38. The net present value (NPV) is £5,462,818.38 which is the total extra value created by the IGH Project.

This means that for every £1 of investment in the IGH Deafblind Support Project, it achieved **£5.49** in social value across the stakeholder groups. This shows a significant social return on investment and confirms that the project has had a very positive effect on stakeholders.

Conclusions

The IGH Deafblind Support Project was designed to bridge a gap in awareness, knowledge and serve to improve services for deafblind people by building the capacity in terms of knowledge and skills of stakeholders. The project was well-designed and the training provided was of good quality. While primarily developed as a training programme, the over-arching aims and objectives included providing focused training ensuring local authorities were able to meet their legal requirements under the new legislation. Also to upskill social workers, care staff, voluntary sector staff and volunteers and family carers as a way of improving support and knowledge for deafblind people.

> *Attending groups has made a big difference. I mix with people who understand what it's like [to be deaf and blind] and I like talking to them. I went to a summer fayre in Ashington and many people said hello…. It makes me happy.*

IGH engaged with all sectors across the North East region and social work teams, generic staff teams, care staff, volunteers and family carers have completed training and many have gained a qualification. Numerous examples were given by stakeholders of how they had to put this learning into practice.

The Specialist Deafblind Assessor training has been identified as a vital element in the success of this programme. Social work teams from across the region engaged to ensure that they were qualified to provide specialist deafblind assessments as required under the Care Act.

While delivering training was the primary output for IGH, they provided ongoing support to local authorities and voluntary sector organisations on how to improve services for deafblind people. This resulted in two separate models of working in the two case study areas. The models took different approaches and the anticipated outcomes quite different from the main project. The local authority model case study allowed us to see how deafblindness could be embedded within a local authority. This model identified some key methods that can be adopted to do this. This model continues to develop and the evidence does suggest that in terms of developing and testing processes and protocols, bringing all staff into the delivery, including deafblindness in publicity materials and rolling out the use of the Deafblindness Identification Tool do offer insight to ways of achieving success. There is clear potential for this model to be replicated nationally.

Talk and Try and networking events were very successful. Deafblind people readily reported on the benefits they have had experienced as a result. Direct contact with IGH staff able to provide advice and ideas had very positive effects for many. In addition, the development of the equipment loan service further supplemented the support provided.

IGH has resulted in more people being identified/recognised as being deafblind. Future demand for specialist assessor training has the potential to increase significantly given the high staff turnover of social workers so Hi-Vis could continue to have an active role in this outside of this project.

This SROI evaluation shows that each of the stakeholder groups have benefitted from the changes brought about by the IGH Deafblind Support Project. While for some it is about training and skills, for others it is more personal. For example, self- confidence, impacts on health and wellbeing, changes perceptions of self, improves communication and also access to services.

Findings show that the IGH Deafblind Support Project has created a significant social value of **£5.49** for every pound invested in the project.

Overall, the evidence from this SROI evaluation supports the view that the IGH Deafblind Support Project has been successful in meeting its aims and objectives. Awareness of deafblindness is much higher than before, staff are better informed, qualified to support deafblind people and more confident when providing care. Some deafblind people stated that without the support they received as a result of the training and direct support they felt that they would have needed residential care. In conclusion, the IGH project has been effective in bringing about change for stakeholders and deafblind people, but more work is needed to address deafblindness as part of a focus on the increasing needs of an ageing population.

1. Introduction

FUSE was commissioned by SCENE Enterprises CIC to provide a Social Return on Investment (SROI) evaluation of their In Good Hands (IGH) Deafblind Support Project. This evaluation was carried out as a collaborative between Teesside University and Sunderland University and forms part of the FUSE portfolio of work.

Aims and objectives of the IGH Deafblind Support Project

The In Good Hands Deafblind Support Project is funded by the BIG Lottery and managed by SCENE Enterprises CIC to build the capacity of organisations and services and to increase the number of older people identified with age acquired deafblindness. This project includes awareness raising, training, qualifications and opportunities to volunteer in support of older people with age acquired deafblindess. It also includes the provision of advice and training around age acquired communication disorders. The project covers the whole of the North East region and includes work with older people, carers, public, independent and voluntary sectors, deafblind people and their families.

Aims

- To raise awareness of older people with age-acquired deafblindness
- To improve the skills of people providing care to deafblind people
- To provide training and qualifications to volunteers, caregivers, health and social care staff
- To provide opportunities for older people to become volunteers and support older deafblind people.

The key objectives of the IGH Deafblind Support Project are to:

- To raise awareness of deafblind issues
- To increase the personal resilience of older deafblind people
- To increase the numbers of early assessments
- To train health and social care staff to ensure they are better equipped to identify, assess and support older deafblind people
- To improve communication skills
- To provide specialist bespoke training for social workers and health professionals to enable them to carry out statutory deafblind assessments in compliance with the Care Act 2014
- To provide training for volunteers and caregivers to enable them to provide better support to deafblind people

- To ensure that community organisations with volunteers are better placed to reduce the social isolation often faced by deafblind people

The projected outcomes of the In Good Hands Deafblind Support Project were:

- That older volunteers and care givers can communicate effectively with elderly deafblind people, who are enabled to feel less socially isolated, have the confidence to participate in community activities and know how to find support from neighbours
- That elderly deafblind people experience improved mental health and physical wellbeing and feel able to access public services and re-engage in social activities
- That elderly deafblind people maintain their independence and understand and access the range of services and specialist equipment available to support them living in their own homes or care settings.
- To ensure that local authorities are Care Act compliant

The IGH Deafblind Awareness Project worked towards achieving these outcomes by:

- Raising awareness of deafblind issues
- Raising awareness of older people with age-acquired deafblindness
- Raising awareness of acquired communication disorders
- Training health and social care staff, volunteers and families to ensure they are better equipped to identify, assess and support older deafblind people
- Providing specialist bespoke training for social workers and health professionals to enable them to carry out statutory deafblind assessments in compliance with the Care Act 2014
- Providing training and qualifications for volunteers, caregivers and health and social care staff to enable them to provide better support to deafblind people
- Improving the skills of people providing care to deafblind people
- Providing opportunities for older people to become volunteers and support older deafblind people.
- Capacity building of organisation and communities
- Increasing the personal resilience of older deafblind people
- Increasing the numbers of early identification
- Improving communication skills
- Improving positive mental health & wellbeing
- Ensuring that community organisations with volunteers are better placed to reduce the social isolation often faced by deafblind people.

The Deafblind Support Project has been operational from June 2014 – October 2017. This report will provide an overview of the process, evidence of how the project has developed and evolved over time, success against its aims and objectives (as stated above) and impacts achieved. In the latter stages of the project it was decided to focus on two particular areas within the North East – Hartlepool and Sunderland. Work in these areas tested two different models for raising awareness of deafblindness and findings for these two areas will be presented in the report as mini case study sites and will include models, inputs, outcomes and impacts specific to the work carried out in those areas.

Design of the SROI evaluation

The aim of the evaluation was to provide a Social Return on Investment (SROI) evaluation of the In Good Hands (IGH) Deafblind Support Project. IGH has provided training from September 2014 to the July 2017. Additional training was scheduled for September 2017 but this does not form part of this evaluation.

Using SROI guidance from the Social Value Network[1], the evaluation design comprises 3 phases and includes:

- **Phase 1**
  - Sensitising interviews with key stakeholders
  - Baseline interviews with key stakeholders
  - Sensitising interviews with deafblind people
  - Training and support for volunteers recruited to assist with the evaluation
- **Phase 2**
  - Online questionnaires for training beneficiaries – Cohort 1 (September 2014-March 2015
  - Progress Report
- **Phase 3**
  - Evaluation of Model 1 (Sunderland/Durham) and Model 2 (Hartlepool) developments
  - Endline interviews with key stakeholders
  - Interviews with deafblind people
  - Analysis of monitoring data (September 2014 - September 2017)
  - Online questionnaire for training beneficiaries – Cohort 2 (April 2015-April 2016), Cohort 3 (May – December 2016) and Cohort 4 (January-July 2017).
- **Phase 4**
  - Analysis of online questionnaire data
  - Qualitative data analysis of Models 1 & 2
  - Analysis of monitoring data
  - Final SROI Evaluation Report

---

[1] Social Value UK - http://www.socialvalueuk.org

This report will pull together findings from both the quantitative and qualitative data collected throughout the lifetime of the project[2]. It will include results of the online questionnaires, baseline and final stakeholder interviews, case study sites and views and perceptions of deafblind people.

This report includes a review of the literature (Section 2) and details of the methods used (Section 3). Section 4 will provide an analysis of the Monitoring data provided by In Good Hands (IGH) including demographics and uptake. Section 5 will include an analysis of the online questionnaire responses including perceptions of training, issues, key learning, examples of putting learning into practice and impacts of the training on practice.

Section 6 will provide insight to how the project has developed over time and Section 7 will follow the SROI Framework illustrating the transparency required for an SROI evaluation and incorporating all the evidence collected throughout the evaluation. Conclusions will be provided in Section 8.

---

[2] In Good Hands Deafblind Awareness Support Project

2. Context

This section draws together existing literature with regards to deafblindness, its effect on the ageing population, assessments and care provision.

Deafblindness is a dual sensory impairment[3] involving the loss of some degree of both sight and hearing. According to the most recent guidance on deafblindness, people should be regarded as deafblind if their combined visual and auditory impairments lead to difficulties with communication, access to information and mobility (Mental Health – Divisional Intelligence Unit, 2014). Dual sensory impairment has also been found to cause psychological distress when support needs are not met (Bodsworth et al., 2011). Statistics on the prevalence of deafblindness are sparse and somewhat conflicting. For example, the Department of Health (2001) estimated a prevalence of 40 per 100,000 (approximately 20,000 people); however, this is now generally considered to be a substantial underestimate. According to work based on a range of national data sources, Robertson and Emerson (2010) estimated a prevalence of 212 per 100,000 (equating to 132,000 people) for people with more severe impairments, and 572 per 100,000 (356,000 people) for those with some impairment to hearing and vision.

The Care Act 2014 clearly indicates that the above figures are not a true reflection of the numbers of deafblind people and a pilot study carried out by SCENE in Northumberland also found evidence that the figures are much higher.

Deafblindness in later life

Deafblindness is most prevalent in later life, with an estimated 87% of people with more severe dual sensory impairment being aged 60 or over (Robertson & Emerson, 2010). Rising life expectancy and increasing numbers of older people in the population (Flatters et al., 2007) means a growing number of individuals are affected by dual sensory impairment (Roberts, et al., 2007). Given the difficulties with communication and mobility caused by deafblindness, the impact of the impairment is particularly profound for those in later life, where acquired communication disorders also often coexist with other issues including difficulties with performing everyday activities and mobility being particularly apparent (Tiwana et al., 2016). Being able to live independently, access to support and social isolation are significant issues to people who are deafblind (Pavey, et al., 2009). Social isolation is a negative outcome in its own right; however, it also means that people with dual sensory impairment may also not be known to local authorities. Even if they are, they may not be recorded as being deafblind, but rather as individuals with a single sensory impairment and so may be provided with information that is not straightforward for them to use. Given that

---

[3] In keeping with other work, we use the terms ‘deafblindness’ and ‘dual sensory impairment’ interchangeably.

deafblindness is likely to be under-recorded, there is likely to be under-provision of appropriate services for people who are deafblind within local authorities and other service providers, as well as care homes and hospitals.

Recent changes to the way in which social care is funded are likely to affect the ability of local authorities to provide services for older people, with one estimate based on national data estimating that closing the gap would need to increase the funding available for adult social care by two-thirds (Iparraraguire, 2015). People who are deafblind (including those older people with some residual sight and hearing) are highly likely to meet the National Eligibility Minimum Thresholds for support and are entitled to request a specialist deafblind assessment for eligibility of care under The Care Act 2014 (Department of Health, 2014a) – including being unable, without support, to achieve two or more of the nine wellbeing areas specified in the Act, such as having a sense of personal control, developing and maintaining relationships, being able to make use of their home safely - which would qualify them for social care. Therefore, any tightening of funding for social care is likely to impact on a significant proportion of those who are assessed as being deafblind.

Recognising and Assessing Deafblindness

Recognising

Recognising deafblindness for service providers can be difficult, and will require training in order for frontline staff to be aware of the dual sensory impairment and the impact of this in terms of the provision of advice and appropriate signposting to services. In addition to the problems experienced by local authorities in locating and identifying individuals with deafblindness mentioned above, the progressive nature of sensory impairment means that individuals initially assessed and determined to have only a single sensory impairment, may at a later stage develop another. These individuals are most likely to be older, and these are a group that already tend to be more socially isolated than other groups and as such are less likely to come into contact with individuals who would be able to offer them appropriate signposting to services. Furthermore, some people who could be classified as having dual sensory loss may not define themselves as such, for example, they might consider themselves to have minor and relatively inconsequential problems with both hearing and seeing. Other physical or mental impairments, as a consequence for example of a stroke, dementias, Parkinsons, learning difficulties, can mask other coexisting conditions and so may also reduce the likelihood of a diagnosis of deafblindness being made. While local authorities should be aware of their duty to identify, contact and keep a record of individuals with deafblindness, it may be that there is less awareness of the impact of other disabilities in masking dual sensory impairment.

Assessing

Local authorities have a statutory duty (see Care Act 2014) to assess any adult who appears to have a need for social care or support. If deafblindness is present (regardless of level of sight and hearing impairment) the local authority must offer a specialist deafblind assessment. However, before this requirement can be met, people with deafblindness need to be identified, preferably as early as possible in their contact with service providers. This issue has important implications for training – not only of those staff involved in the assessment of individuals believed to have dual sensory impairment, but also training for all staff who have a client-facing role who would be able to make an initial basic assessment of deafblindness and then refer for an appropriate specialist assessment. Specialist knowledge of deafblindness is needed to correctly assess individuals, and social care professionals with such specialist knowledge are more likely to identify the impacts of dual sensory loss (Sense, 2013). According to the Care Act, all assessment should be undertaken by individuals with appropriate training in the identification of deafblindness and experience working with people with the condition. This training should be at OCN/QCF Level 3, or higher for individuals who have more complex needs, such as people who are born deafblind or have other coexisting conditions. This assessment must take place against national eligibility criteria in order to determine whether an individual has needs for care and support. The Care Act 2014 also requires that appropriately trained and registered interpreters and advocates are made available when necessary to support assessment and subsequent care planning. Most people who have been diagnosed as having deafblindness will have yearly appointments to assess their vision, and in some cases also their hearing. Assessments have to be repeated because support needs change over time, regardless of whether vision deteriorates (Thetford et al., 2009), and particularly because service users may be unable to correctly identify their own support needs (Sense, 2014).

Caring for people who have deafblindness

Care Act, 2014

The Care Act 2014 changed the way in which social care and support were delivered. A key element of the Act is that local authorities must follow the guidance enshrined within it, unless able to demonstrate legally sound reasons for not doing so. Local authorities were specifically alerted to the needs of people with complex conditions, including deafblindness, and guidance was provided in relation to the assessment of people who are deafblind (Department of Health, 2014, pp. 94-95). From April 2015 specific guidance relating to care and support for deafblind children and adults policy came into force (Mental Health – Divisional Intelligence Unit, 2014) which helped clarify how the Care Act 2014 should be applied to the people with deafblindness.

In relation to deafblindness, the Care Act 2014 states that local authorities must do the following:

- Identify, contact and record all people with deafblindness
- Ensure that any needs assessment is conducted by someone with appropriate training and expertise in relation to deafblindness
- Provide appropriate services for people who are deafblind, and recognise that there may be a need to develop additional services specifically for people who are deafblind. This includes a market-shaping duty where services may need developing or connected with other services to improve support
- Give access to appropriately trained support workers for individual assistance if required based on assessment
- Ensure that information is provided that is accessible for people who are deafblind
- Ensure overall responsibility for deafblind services is at director level within local authorities.

At the core of the Care Act 2014 is therefore a requirement that there are staff working within local authorities and other agencies engaged with the providing or signposting towards services who are trained to identify and assess those who are or may be deafblind. Prior work conducted by the deafblind charity Sense (Sense, 2010) found that deafblind guidance was implemented inconsistently within local authorities, and that the number of deafblind individuals identified was much lower than expected. There is also a need for staff to have an understanding of the support that people who are deafblind are likely to require, including an understanding that support requirements will not be the same for everyone, as well being able to offer services or signposting to services to provide appropriate support and information for people who are deafblind. Appropriate support could be specific equipment (such as a liquid level indicator, bump-ons, coloured buttons, a vibrating alarm clock), interpreters/communicators, communicator guides, advocates or other services, such as deafblind groups. Support would almost certainly include rehabilitation assessment and training e.g. to improve lighting in the home or for a task, in this example maximising any residual sight.

Reductions in resourcing to social care may undermine the operation of the NHS (Mortimer & Green, 2015) and people who do not receive appropriate support for their health needs are more likely to require more intensive support, and sooner than those who do. Earlier work has called for ongoing contact and relationship-building between service users and providers and greater inter-agency communication (Thetford, et al., 2009); however, it is so far unclear as to whether the Care Act has been able to achieve these aims. The Care Act requires that progress in identifying and contacting people who are deafblind is monitored by clinical commissioning groups (CCGs) and local authorities (Department of Health, 2014b). Measures of success include deafblind people being able to live independently, stay physically and mentally healthy, participate as active and healthy citizens and have the best possible quality of life.

What is clear is that currently the support provided to individuals who are deafblind does not meet their needs. For example, 57% of people who are deafblind reported receiving information from the NHS in a format that they could read themselves and 59% of respondents felt that healthcare staff were not aware of their needs as a deafblind person (Deafblind UK, 2006). Based on these findings, Deafblind UK called for action on increasing awareness, making information more accessible, improving communication and the physical environment. Such recommendations were echoed in a later report by Sense (2014), calling on training for staff in health and social care to identify and understand the needs of people who are deafblind, the provision of equipment to maximise independence and to make changes to the physical environment to accommodate the needs of those who are deafblind.

In Good Hands

Preventative services delivering social care to support people to live independently can help reduce the burden on the existing health and social care system (Goodwin et al., 2012). In Good Hands (Scene, 2013) is a project run by Scene Enterprises and funded by the Big Lottery to build capacity of organisations and services, and through them increase the number of older people identified with age acquired deafblindness. It involves a programme of awareness raising, training, qualifications and opportunities to volunteer in support of older people with this dual sensory condition. In Good Hands also delivers support and training around age-acquired communication disorders to local authorities, care homes and other stakeholders.

3. Methods

Evaluation aims and approach

The evaluation team adopted an action research approach to this work. This involved working alongside IGH staff, accessing existing information and using regular feedback sessions to inform the development of the evaluation and SROI as it progressed.

IGH identified the key research questions to be answered as:

1. Who are the most important stakeholders for *In Good Hands*?
2. What outcomes do they value from *In Good Hands* and how are these outcomes related to the inputs and outputs of the project
3. How can the outcomes be measured and evidenced?
4. What is the social impact of *In Good Hands* on different stakeholder groups?
5. What outcomes can be expressed as a monetary value?

Objectives of Evaluation

The key objectives for the evaluation were to:

- Identify stakeholder groups
- Map the projected outcomes of the project
- Evaluate the social value of *In Good Hands* Project for the different stakeholder groups
- Identify and understand what change has been effected by *In Good Hands* and the benefits gained for each stakeholder group through identifying and measuring outcomes
- Calculate the social impact of the *In Good Hands* Project.

The project being evaluated is developmental in nature and whilst there are core outcomes, how these were achieved was dependent on how the project developed both strategically and operationally. Therefore, the evaluation needed to capture the changing landscape of the project so it could accurately reflect its dynamic and context driven nature. An action research approach was chosen as it offered an evaluation framework which emphasised the need to work closely with those who are developing and delivering an innovation and also service users who are likely to benefit from the project. As a result, a range of data was collected, from multiple sources.

These have included:

- Developing a logic model to highlight complexities of this project
- Ongoing dialogue with the project team in order to understand and identify new developments as they arise taking an action research approach
- A rapid review of existing literature
- Training for volunteers to take an active research role
- Sensitising Interviews with people who have completed one or more of the training packages provided to inform content of questionnaire
- Online questionnaire for people who have completed training
- Semi structured baseline and endline interviews with key stakeholders
- Semi structured interviews with deafblind people.

The evaluation team has worked closely with IGH in ensuring the evaluation meets the needs of SCENE Enterprises CIC. This has included input to the review of literature, interview guides for both training beneficiaries and deafblind people and the online questionnaire. However, this remains an independent evaluation and SCENE Enterprises CIC has not influenced the findings or the final outcome of the report.

Sensitising interviews were used to provide an oversight of the training and inform the development of the online questionnaire for wider distribution. Baseline and endline interviews were also carried out with key stakeholders, volunteers and deafblind people.

Table 1: Fieldwork

Method	**Number of participants**
Sensitising/baseline interviews with people who had completed the training	16
Endline Interviews with key stakeholders	10
Interviews with deafblind people	32

A cross section of interview participants was recruited to provide a broader perspective to include representatives from all stakeholder groups.

The online questionnaire was developed and distributed using the Bristol Online Survey Tool and included input from IGH. Invitations to complete the questionnaire were sent by IGH staff via email to a total of 1,084 people who had completed some training. This figure included questionnaires sent to people who had completed the training outside of the North East region. In total 70 were returned as undeliverable leaving a total of 1,014 questionnaires distributed. In total 199 completed questionnaires were received giving a 20% response rate.

Ethical considerations

Ethical approval for this evaluation was granted by the Teesside University School of Health & Social Care Research Ethics and Governance Committee prior to the start of this evaluation.

Data Analysis

A thematic analysis model (Charmaz 2006) has been adopted for data analysis and using NVivo10 a qualitative data analysis programme to manage the qualitative data and aid analysis. The online questionnaire data was analysed using the Bristol Online Survey Tool.

Limitations

While this evaluation was designed to involve representation from all key stakeholders and also for the online questionnaire to reach a wider range of participants, the number of interviews within each stakeholder group was limited due to available resources. However, and although every effort was made to include representatives from within each of the stakeholder groups, full representativeness cannot be guaranteed. Priority was given to including deafblind people as this is an under represented group in research and evaluation. Given the scope of the project and the resources available, it was not possible to increase the number of interviews carried out. However, care was taken to ensure a mix of gender, age, other existing co-morbidities were achieved and all deafblind people interviewed had age-acquired deafblindness although at differing levels.

4. Analysis of Monitoring Data

This project has continued to develop over time and, while maintaining a local context, has also begun to establish a national profile.

The mainstay of the project and the key focus of the evaluation is the provision of training to raise awareness of deafblindness and its impacts on people. The training also provides practical support and advice to professionals supporting deafblind and also individuals who have a dual sensory impairment.

Uptake of training courses

Between September 2014 and July 2017, SCENE delivered 98 training courses.

Table 2- Number of courses delivered

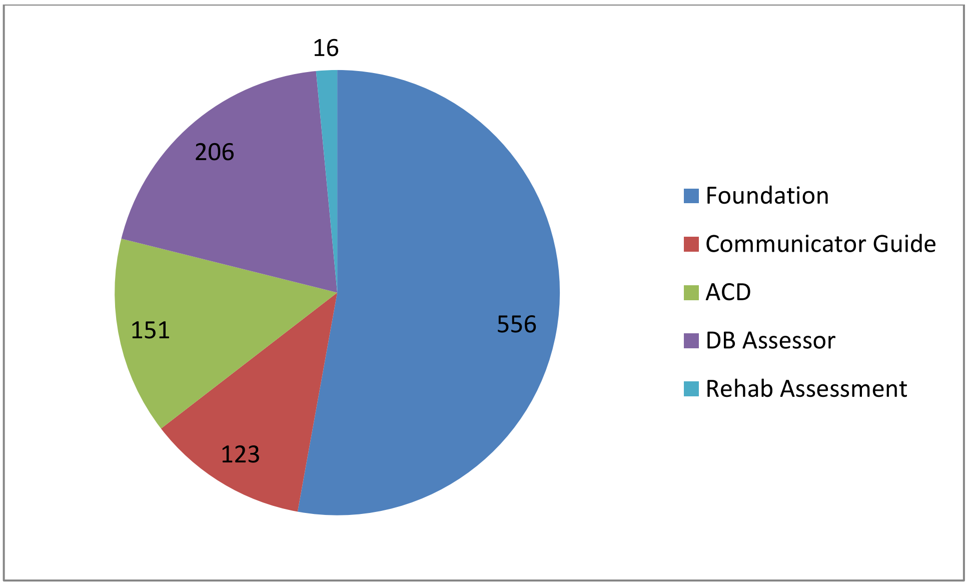
Course	Number of Courses
Foundation	47
Communicator Guide	12
Acquired Communication Disorder	15
Specialist Deafblind Assessment	23
Rehabilitation and Assessment	1

These courses offered four levels of accredited training across the North East region and were validated by the Open College Network (OCN). These include:

- Foundation Certificate in Deafblindness – 2 credits at Level 2
- Deafblind Communicator Guide – 3 credits at Level 2
- ACD (Acquired Communication Disorders) Communication Facilitator – 3 credits at Level 2
- Specialist Deafblind Assessor – 5 credits at Level 3
- Deafblind Rehab and Care Assessment – 4 Credits at Level 3

Monitoring data collected by IGH across the lifetime of the project shows that 1,052 participants in the North East had successfully gained accreditation for completing courses to the required standards. A further 240 people successfully gained accreditation from outside of the North East region.

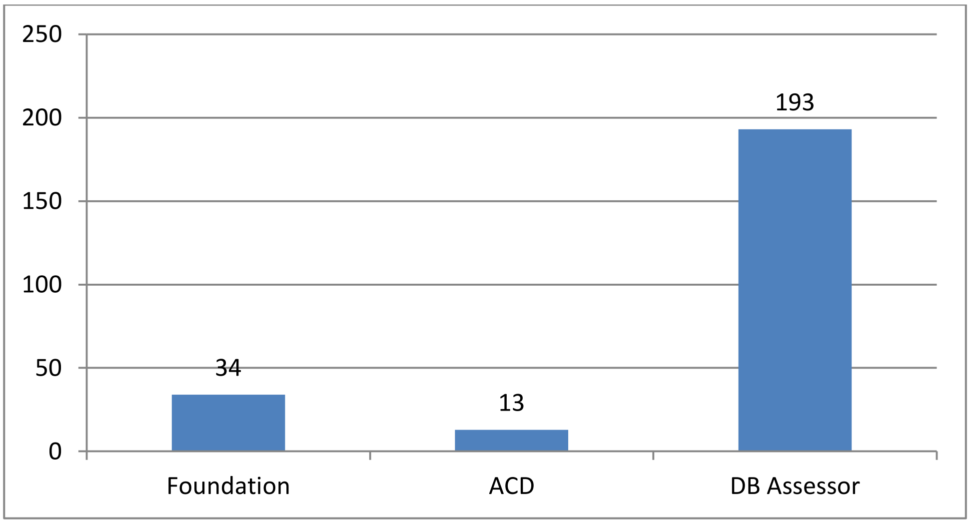
Figure 1: Uptake of Courses



Some people have completed more than one course. Just over half (53%) of completions were for the foundation course (see Figure 1). This was to be expected given the aim of raising awareness and it would appear to provide a good baseline with some people moving on to higher level courses.

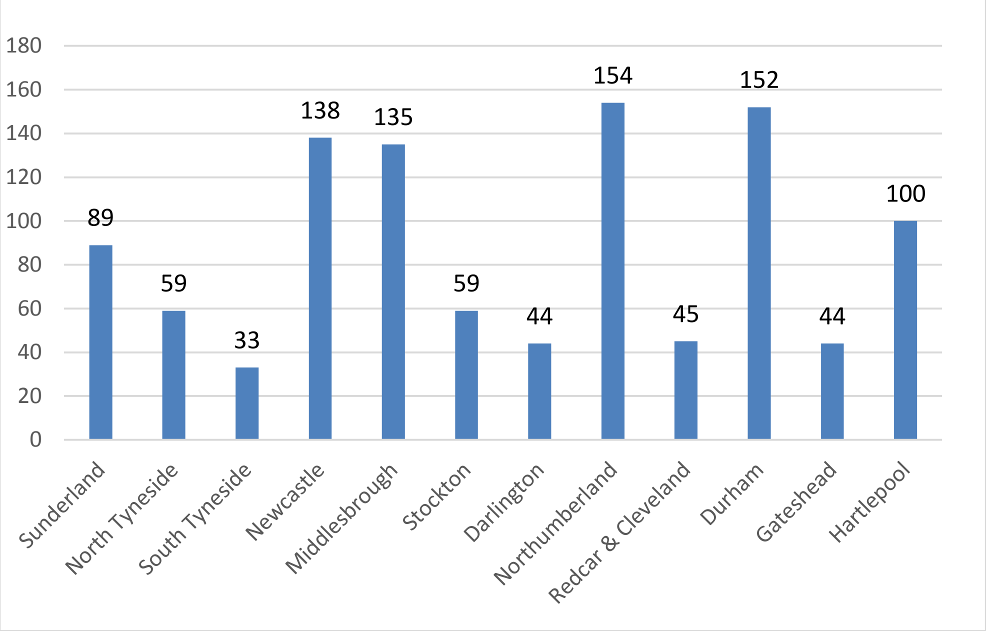
The provision of the IGH courses outside the North East was not within the remit of the project. However, it is worthy of note that much of this training came about as a direct result of the work and delivery within the North East. The project team were also asked to deliver training to Big Lottery staff which provided funding for this IGH initiative. These numbers were not included in the analysis.

Figure 2: Out of Area completions



The remit for this project was to engage with all local authority areas in the North East to raise awareness of deafblindness and increase knowledge, understanding and skills to increase the identification of deafblind people and to improve the care and support they receive.

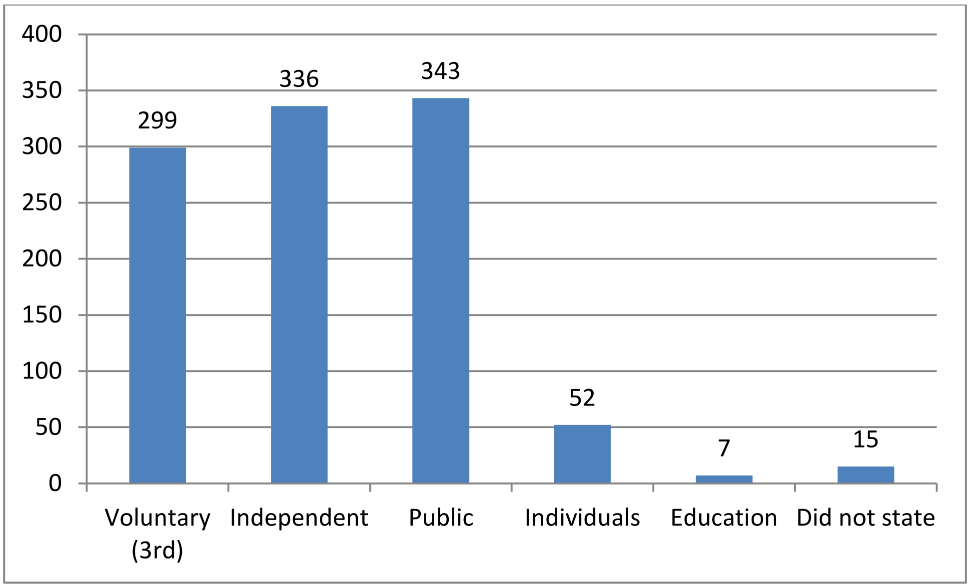
Figure 3: Engagement by Local Authority area



All local authorities in the North East engaged with the IGH Deafblind Support Project. In particular Durham, Newcastle, Middlesbrough, Northumberland, Hartlepool and Sunderland areas engaged well throughout the lifetime of the project.

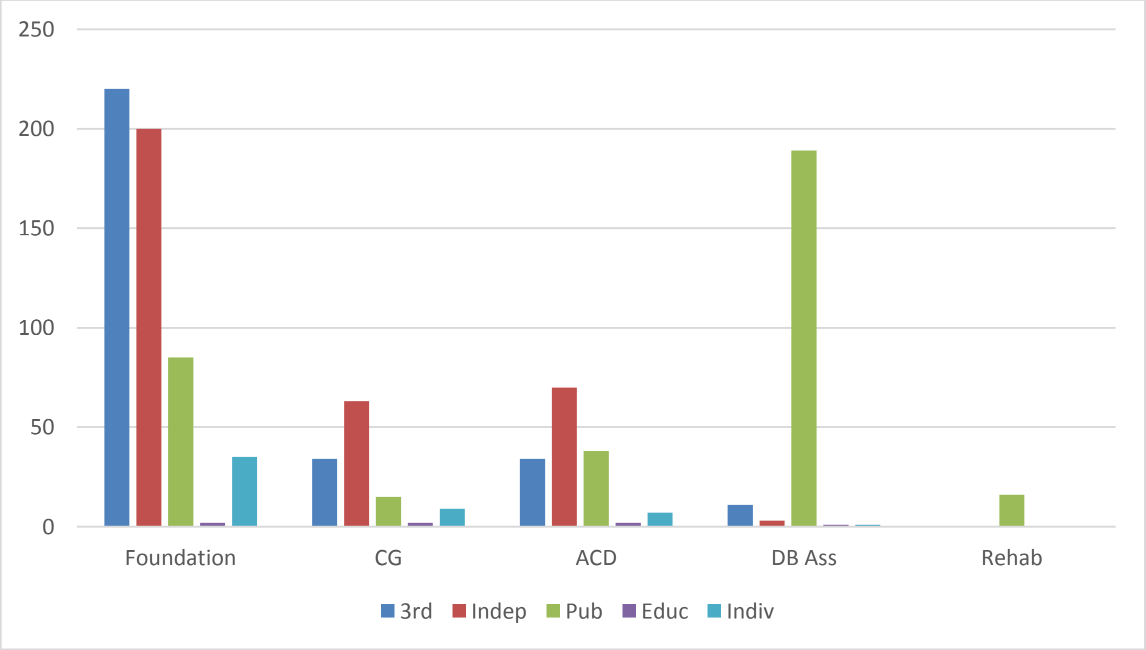
All levels of training were provided free of charge and were open to all sectors that have some form of contact with deafblind people. This included the voluntary, independent (care and support), public sectors, and individuals e.g. families and voluntary carers.

Figure 4: Uptake by sector



A further breakdown of course by sector (Figure 5) shows that the voluntary and independent sectors have engaged particularly well with the foundation training creating a much wider awareness of age-acquired deafblindness and the issues faced by their clients. The majority of the public sector involvement has focused on the Specialist Deafblind Assessment training.

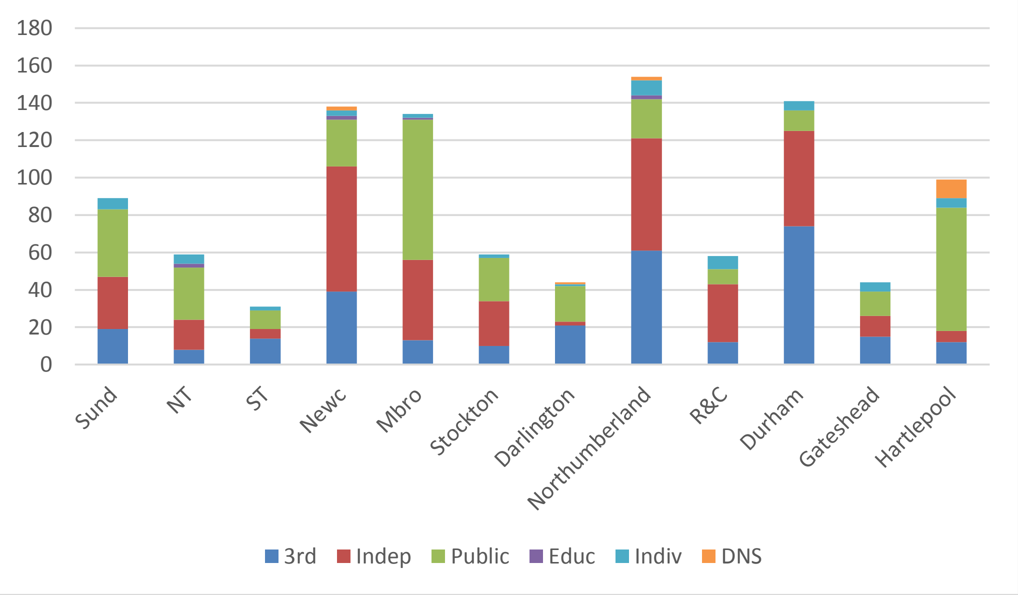
Figure 5: Course by Sector



The specialist assessor course is aimed at social work staff teams who have a responsibility to assess the needs of deafblind people. The Care Act 2014 stipulates that deafblind people are entitled to a specialist assessment, and this training aims to provide the necessary knowledge and skills to properly assess the needs of this group.

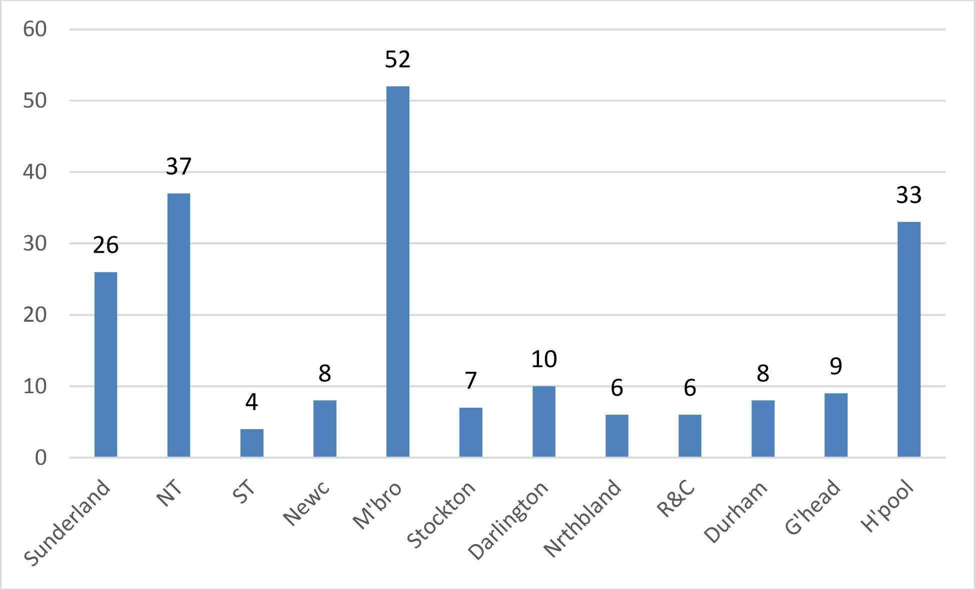
Figure 6 indicates the levels of involvement in each of the areas by sector. All sectors engaged with training in each of the local authority areas.

Figure 6: Engagement by Local Authority area and Sector



All twelve local authority areas in the North East now have social work staff trained to provide deafblind assessments (See Figure 5). A total of 206 social work staff have gained a Level 3 qualification in Specialist Deafblind Assessment. This means that all local authorities in the North East can be deemed as Care Act Compliant with regard to having qualified staff to provide the assessments.

Figure 7: Specialist Assessor Training



5. Analysis of Questionnaires

Online questionnaires were distributed to all participants who had completed any of the IGH training programmes. The questionnaire was distributed in 4 cohorts. These were:

1. Cohort 1 – completed training Sept 14- June 2015
2. Cohort 2 – completed training July 2015-June 2016
3. Cohort 3 – completed training July 2016-December 2016
4. Cohort 4 – completed training between January-August 2017.

It was agreed with the commissioners that questionnaires would be sent out a minimum of 3 months after participants had completed the training in order to provide time to put the training into practice and identify any impacts gained as a result of the training.

A total of 1084 were sent out using the Bristol Online Survey Tool. This included some out of area participants. Of these 70 were returned as undeliverable. Overall 199 questionnaires were completed and returned. Three questionnaires were returned to the research team as a hard copy. These were then inputted onto the Bristol Online system and included in the overall total.

The questionnaire (Appendix 1) aimed to gain a wider response of demographic information, views and perceptions of the training, key learning, outcomes and impacts on both participant and their clients.

Demographics

Age and Gender

A gender breakdown of respondents shows that 85% of respondents were female and 15% male. This reflects the adult social care workforce generally.

Figure 8: Gender breakdown

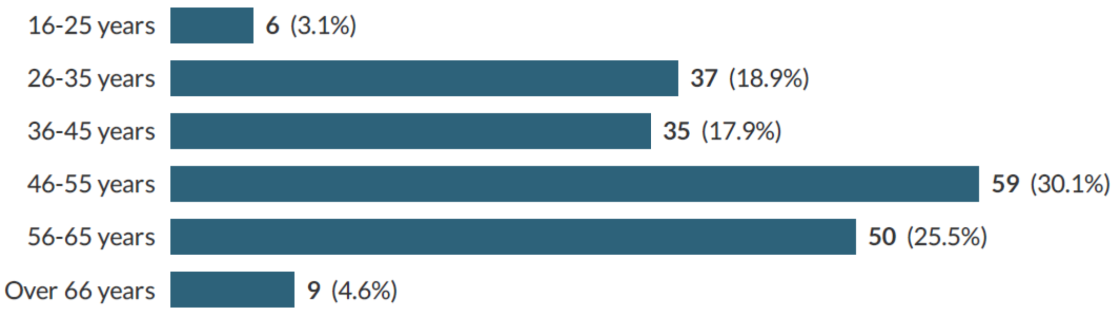
The Kings Fund study found that 80% of all jobs in adult social care are done by women and that this increases 85-95% when looking at the proportion in direct care and support providing jobs.[4]

---

[4] Accessed at: https://www.kingsfund.org.uk/projects/time-think-differently/trends-workforce-overview 5th Sept 2017

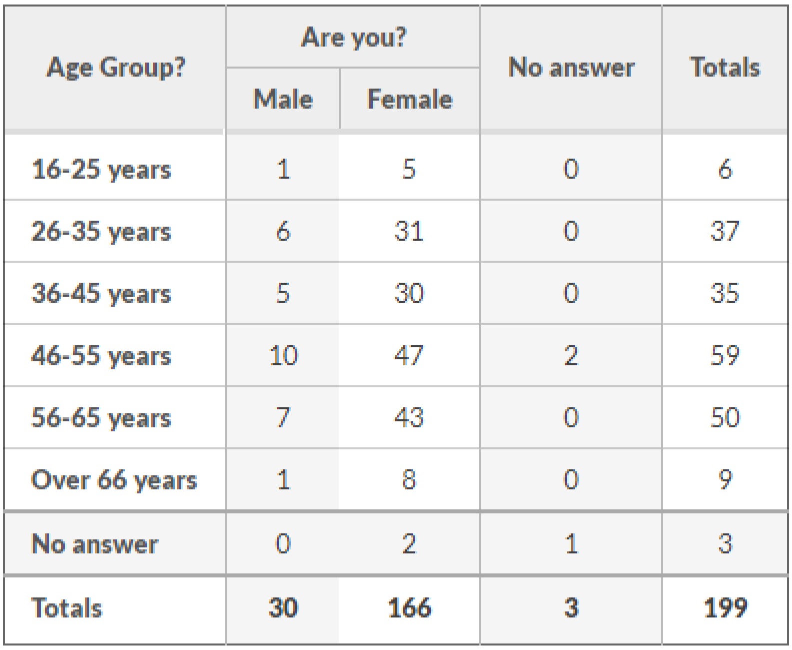
Training was aimed at those people involved in providing care/support to people who had a dual sensory loss.

Figure 9: Age breakdown



Over 65% of participants were aged over 45 years. Table 3 shows a breakdown by age and gender. Again these figures are reflected in the Kings Fund Study.

Table 3 - Breakdown of respondents by age and gender



Age Group?	Are you?		No answer	Totals
	Male	Female		
16-25 years	1	5	0	6
26-35 years	6	31	0	37
36-45 years	5	30	0	35
46-55 years	10	47	2	59
56-65 years	7	43	0	50
Over 66 years	1	8	0	9
No answer	0	2	1	3
Totals	**30**	**166**	**3**	**199**

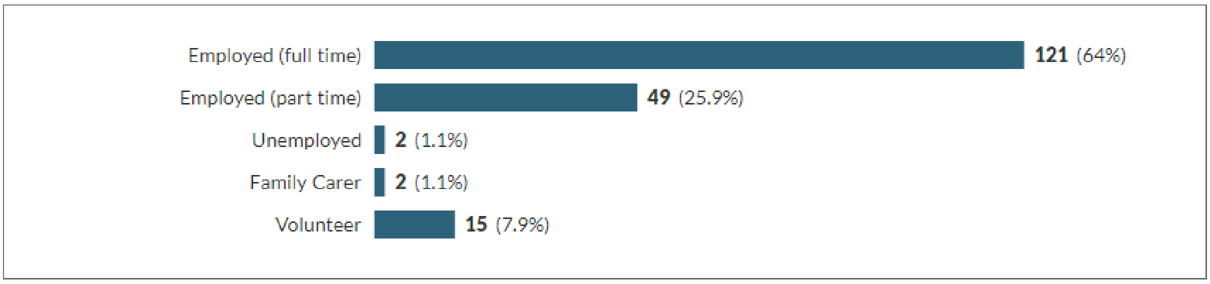
Location

When asked for the first four digits of their postcode, it is clear that respondents from each of the local authority areas within the North East and out of area respondents were represented within the analysis. However, it is noted that respondents included the postcode of their home as opposed to where they worked so it is not possible to provide a specific breakdown by local authority area.

Employment

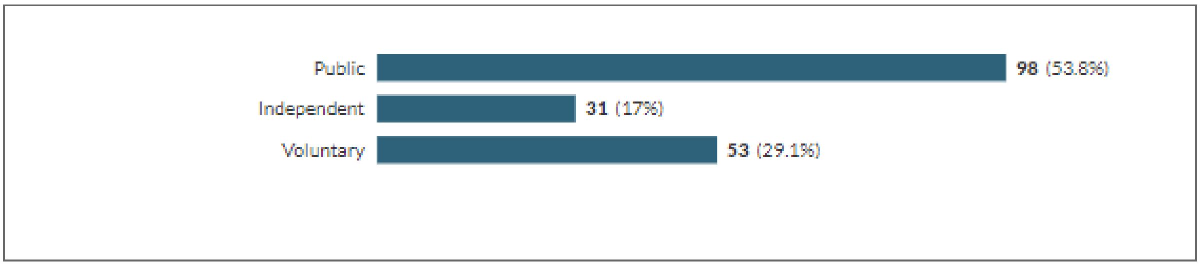
Almost 85% of respondents were employed – 64% full time and 25.9% part time. A further 9% of respondents were volunteers or family carers.

Figure 10: Employment



Respondents held a wide range of job roles. These can be seen in Appendix 2.

Figure 11: Employment by sector



Further breakdown by employment and sector shows that the majority of respondents (over 53%) were employed in the public sector.

Table 4 - Breakdown by employment and sector

If employed, which sector are you employed by?	Are you? Employed (full time)	Employed (part time)	Unemployed	Family Carer	Volunteer	No answer	Totals
Public	68	21	1	2	2	4	98
Private	24	7	0	0	0	0	31
Voluntary	26	20	0	0	6	1	53
No answer	3	1	1	0	7	5	17
Totals	**121**	**49**	**2**	**2**	**15**	**10**	**199**

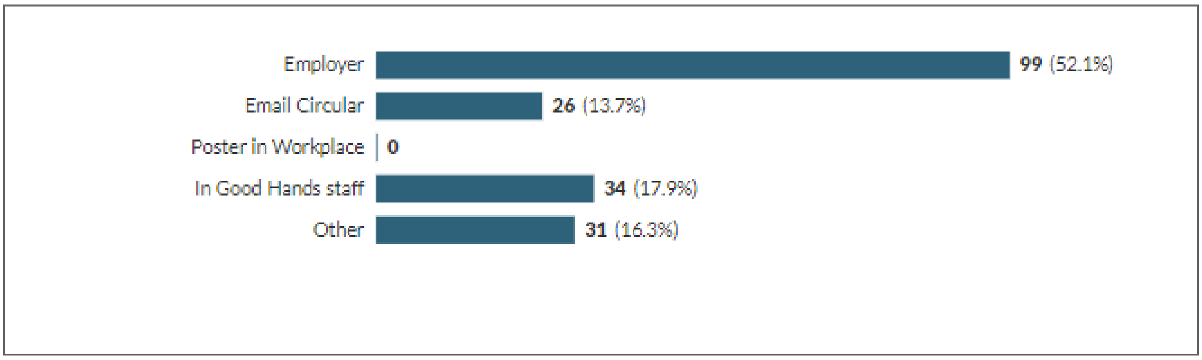
Perceptions of Training

In Good Hands advertised and promoted the training using a range of methods. These included:

- Using existing networks across all sectors
- Direct contact with local authorities
- Direct contact with care providers
- Direct contact with Care Alliances
- Website
- Presentations, posters, leaflets

Respondents were asked how they became aware of the training. Most were informed by their employers. Information on the training was often included in staff briefings, internal email circulars within the organisations.

Figure 12: How respondents became aware of IGH training



IGH used a range of methods for promoting the training. These focused primarily on email contact but also included networking with key organisations to raise awareness of the training and presentations at meetings and events. Internet searches and social media were also identified as a source of information for the training by respondents.

Reasons for participating in training

Enhancing knowledge of deafblindness and increasing skills to improve support were the key reasons for people participating in the training. The most popular reasons being:

- Wanted a better understanding and knowledge
- Personal/family experience of deafblindness
- Wanting to improve the service and support to their service users
- The qualification
- To become care act compliant
- Pertinent to job role
- Employer request/demand
- Personal development

Views of Training

Respondents were positive about the courses they attended with the majority of respondents on each of the courses saying the course was either very good or good.

Figure 13: Foundation Course

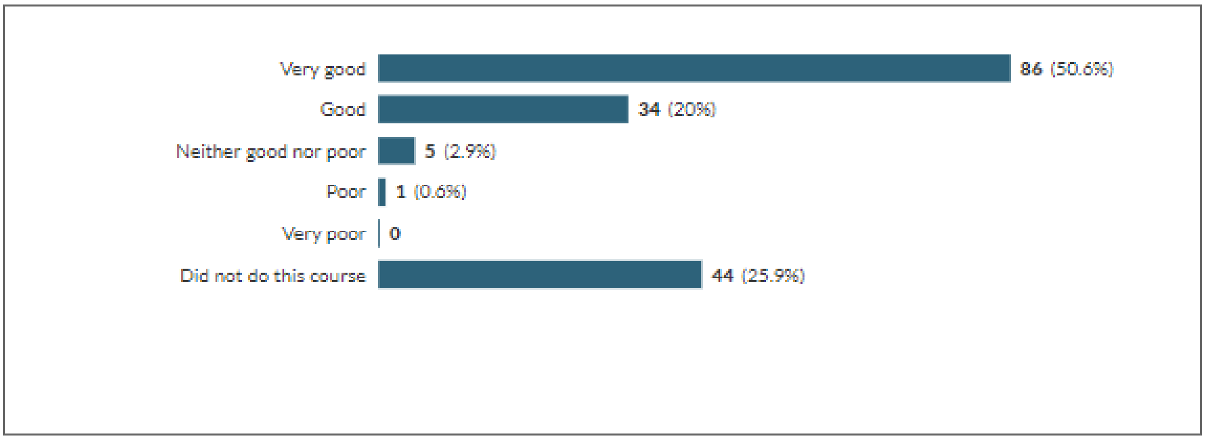


Figure 14: Communicator Guide

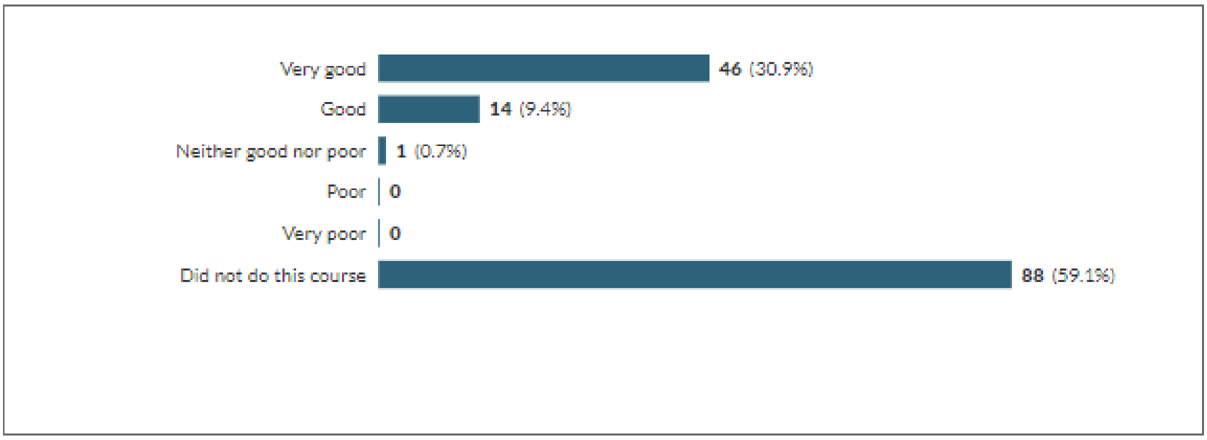


Figure 15: Acquired Communication Disorder Facilitator

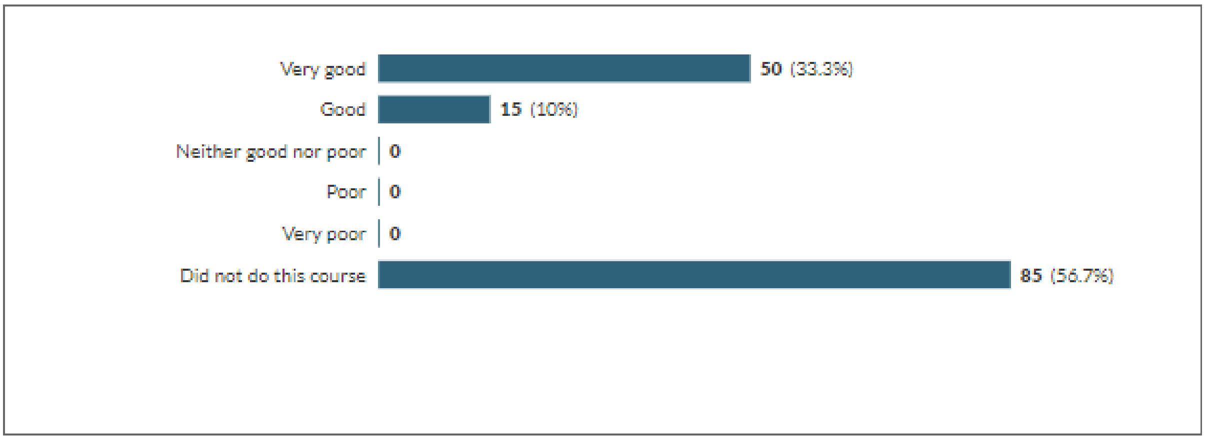
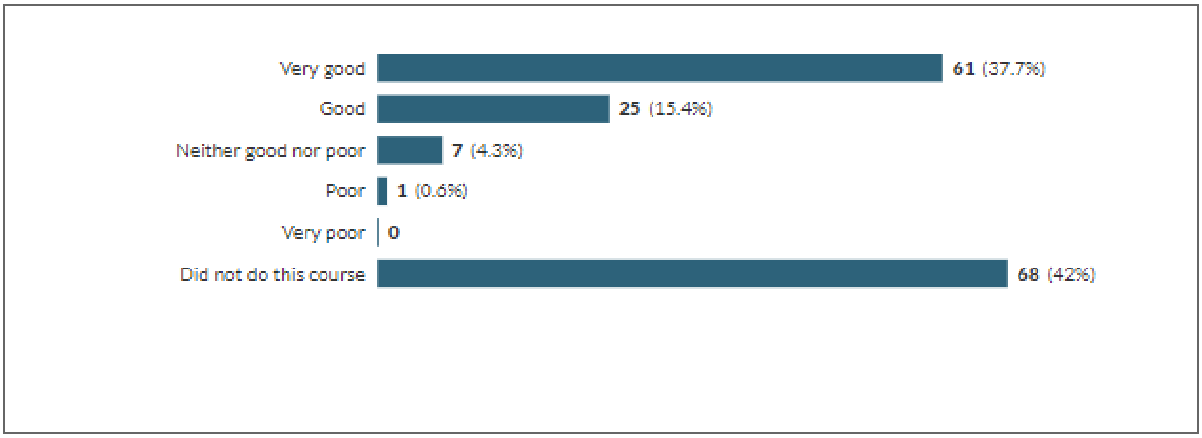


Figure 16: Specialist Deafblind Assessor



When asked whether the training met their expectations, the majority of respondents (almost 96%) reported that the training had met their expectations.

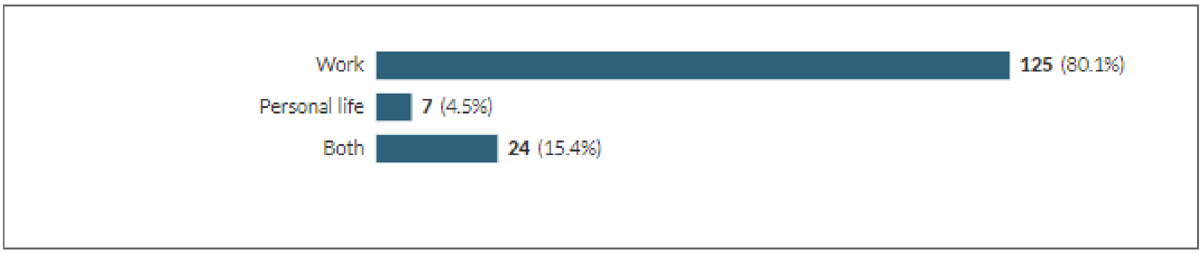
Figure 17: Expectations Met

Respondents were clear that the training offered key learning which supplemented their existing knowledge of deafblindness and in many cases provided a new knowledge and understanding of deafblindness. The most common key learning points included:

- Recognising deafblindness
- The importance of listening, understanding, compassion and patience
- Changes to Care Act and impacts on practice
- Equipment – availability and how to use
- Supporting independence
- Communication skills
- Issues experienced by deafblind people
- Impacts on quality of life
- Practical skills in assisting deafblind people
- Mobility Issues
- Social isolation
- Outside resources
- The impact of deafblindness on family/carers
- Deafblind Assessment techniques

Over 66% of respondents undertaking the training reported having had some experience of supporting people who are deafblind. Over 46% of respondents were currently supporting people who are deafblind. For most people, their experience of supporting a deafblind person/people was primarily through work.

Figure 18: Experience of supporting a deafblind person



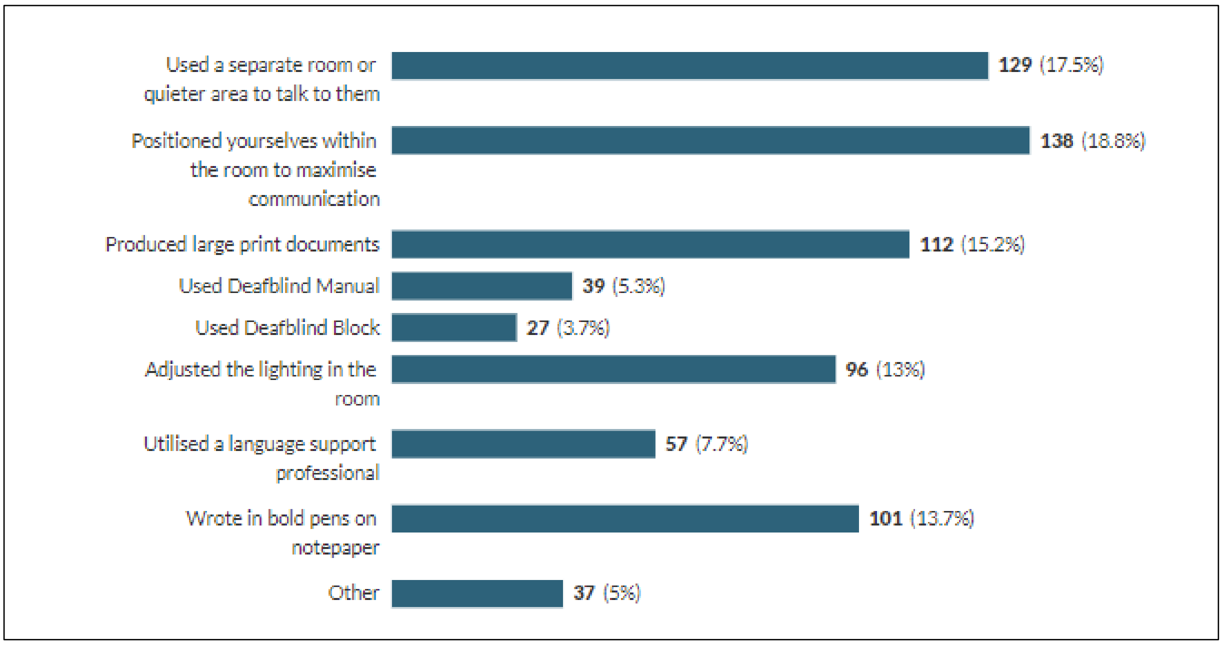
Impacts of Training

Respondents clarified the types of support they were currently providing to deafblind people. The most common included:

- General support – shopping, reading mail, preparing food, escorting to medical appointments, help in home
- More person-centred support
- Emotional support
- Practical support – sourcing equipment
- Providing initial assessments identifying people who are deafblind
- Facilitating leisure activities
- Transport to leisure activities
- Referrals for social work and rehabilitation assessments
- Buddy visits
- Advice and signposting
- Housing related support
- Independent living advice
- IT teaching and support
- More informed Care Planning
- Adaptations – lighting, grab rails, key safes, pendant alarms, magnifiers etc

Within the training a number of techniques were explored to better support people who are deafblind. Respondents reported that many of these techniques are now being used in their everyday practice.

Figure 19: Techniques now used in practice as a result of the training



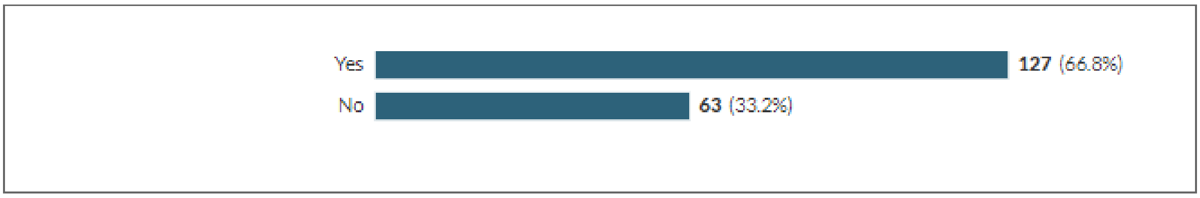
These are primarily simple, practical skills yet have resulted in a substantial improvement in how a deafblind person is supported and on how they benefit from such support.

Other techniques also used include:

- Providing large print books, leaflets, letters etc
- Use of talking books
- Moving closer and directly facing client when talking to them
- Regularly checking hearing aids
- Changing telephone so they can keep in touch with family
- Devised prompt cards
- More involvement with family member/carers
- Using touch techniques to let them know you are there
- Turning TV off when communicating with a deafblind person
- Describing things in more detail

Almost 67% of respondents reported having put some of the learning from the training they completed into practice either in their work or with family.

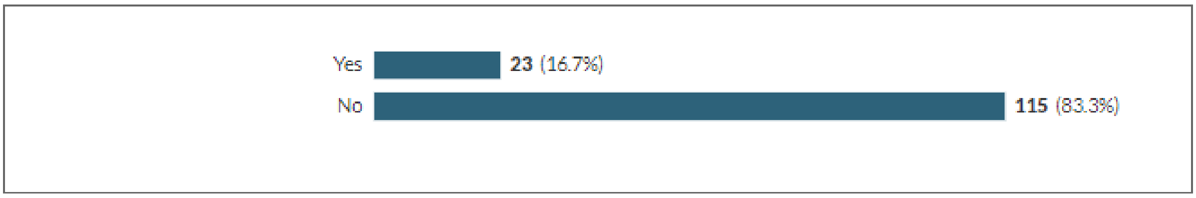
Figure 20: Learning into practice



The main reasons given for not putting the learning into practice related to limited opportunities to work directly with deafblind people.

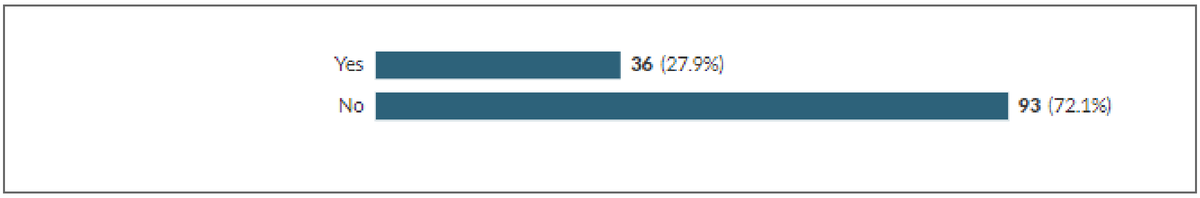
It had been anticipated that an increase in awareness and a better understanding of the issues faced by deafblind people would result in more referrals being made for a specialist assessment by people who completed the training. However, respondents reported that referrals for a Specialist Deafblind Assessment have remained low (16.7%). This figure is based on number of referrals and does not include social workers carrying out deafblind assessments as part of their general practice so is unlikely to be an accurate reflection of the number of deafblind assessments carried being out. There are indications that while referrals for deafblind assessments were offered to a much higher number of clients (a key aim of IGH), some of these were refused so no referrals could be made.

Figure 21: Referrals for Deafblind Assessment



Referrals to other agencies/organisations were slightly higher (almost 28%). It is recognised that not everyone will necessarily require a referral for a full specialist assessment.

Figure 22: Referrals to other agencies/organisations



Respondents referred clients on to a range of organisations as part of the assessment process. These included:

- Telecare
- RNIB

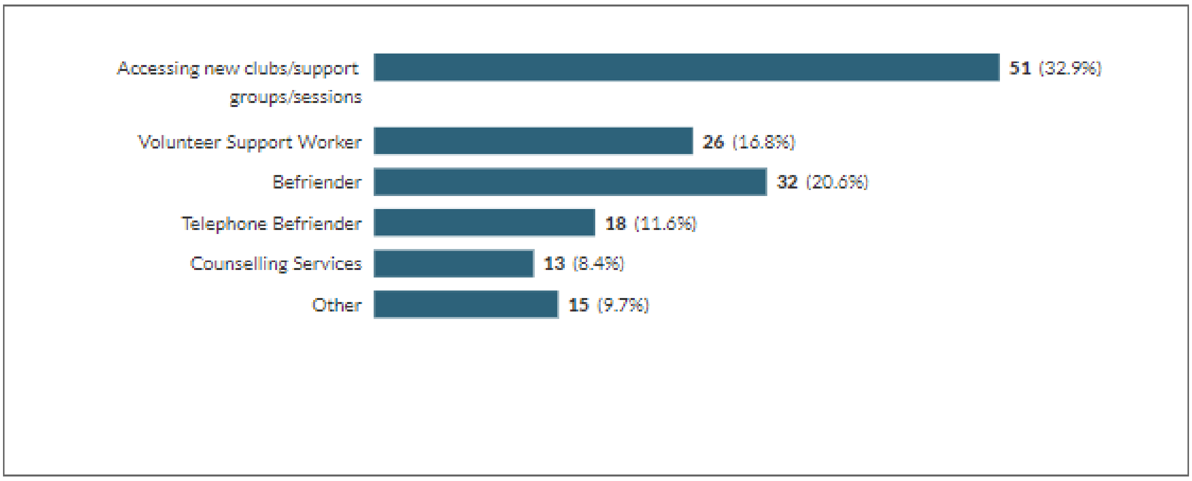
- DWP
- Occupational Therapist
- Speech and Language Team
- GP
- Adult Social Care
- Action on Heating
- Local Housing Support
- Hartlepool Carers
- SENSE
- Community Connect
- IGH

Another outcome for the project was to reduce social isolation. When respondents were asked if they had developed/applied any strategies for reducing social isolation for the deafblind people they have been involved with, almost 59% reported this to be the case.

Figure 23: Tackling social isolation

Respondents reported tackling social isolation in a number of ways – accessing new clubs/support and befrienders being the most frequently used.

Figure 24: Methods used to tackle social isolation



Other strategies for tackling social isolation included:

- Befriender with a dog
- Day Centres
- Advocacy Services
- Supporting Direct Payment process for Personal Assistant support
- Age UK setting up a specific sensory loss group

Respondents were asked to specify the importance of the training in:

- Supporting their clients
- Improving the support they gave to clients
- Increasing their confidence when dealing with deafblind clients
- Whether they have changed their usual practices as a result of the training.

Figures 25-28 below illustrate those responses.

Figure 25: The training was important to enable them to support their clients

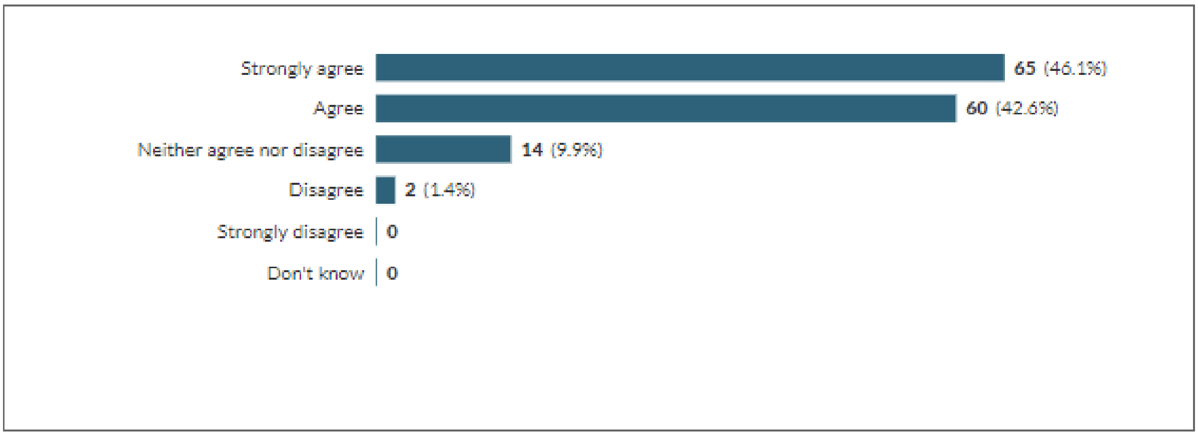


Figure 26: The training was beneficial in improving the support they gave to clients

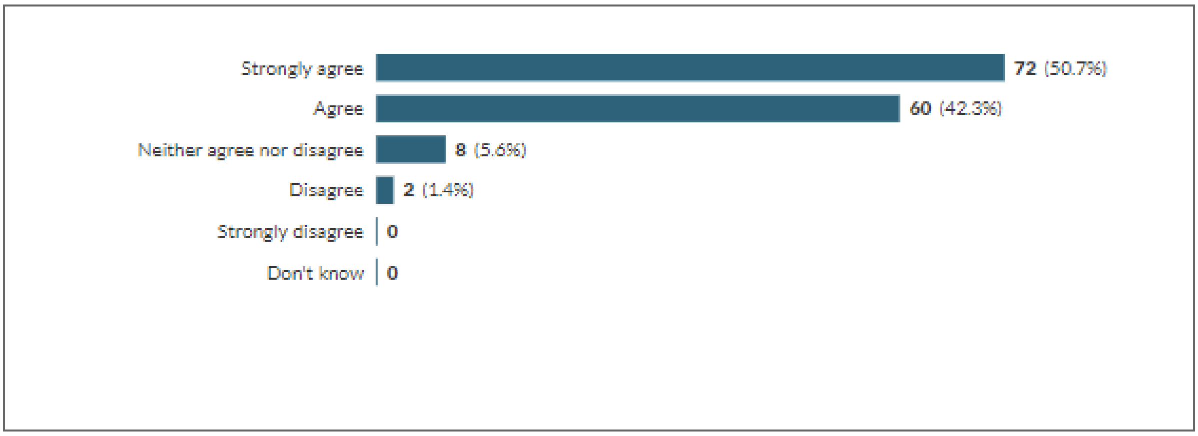


Figure 27: The training increased their confidence when dealing with clients

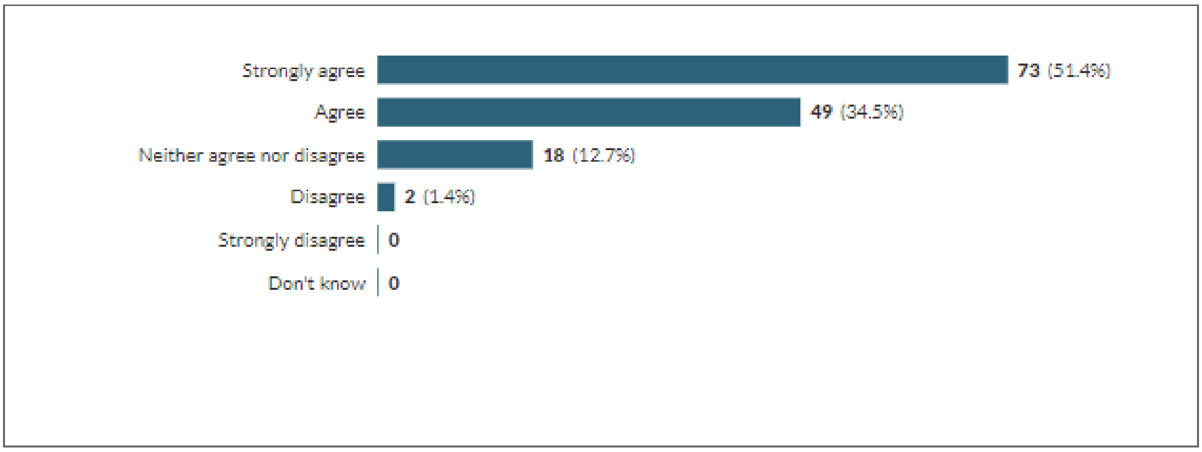
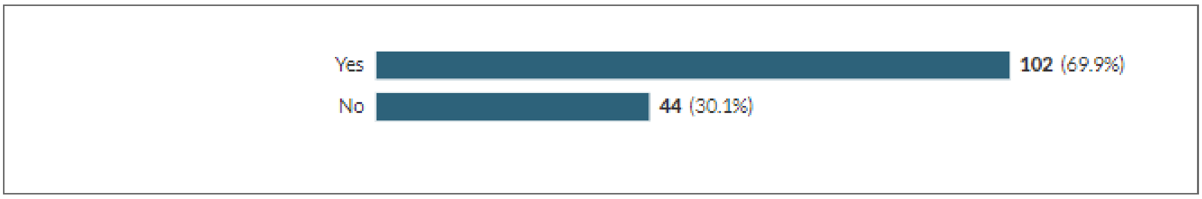


Figure 28: The training has resulted in changes to their usual practices

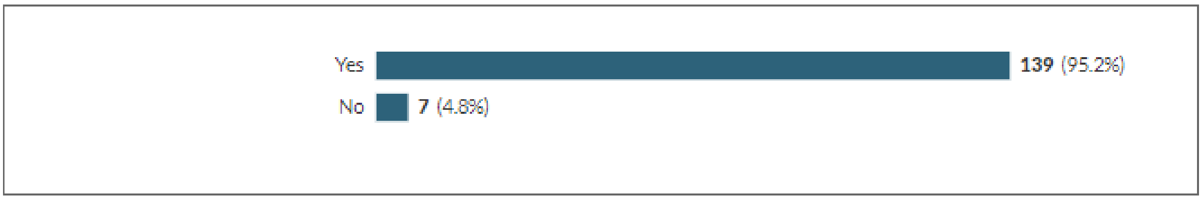


Changes to normal practice included:

- Being more conscious of light levels with people who have mild sight impairments
- Taking into account the environment they live in
- Looking harder at unmet needs when doing initial assessments
- Using different methods to improve communication
- More readily signposting to other organisations
- Focusing on strengths to maximise independence
- Talking more slowly in a quiet environment
- Being more conscious of and making more effort to find out their wishes
- Adding extra questions to their assessment process – considering things not previously considered

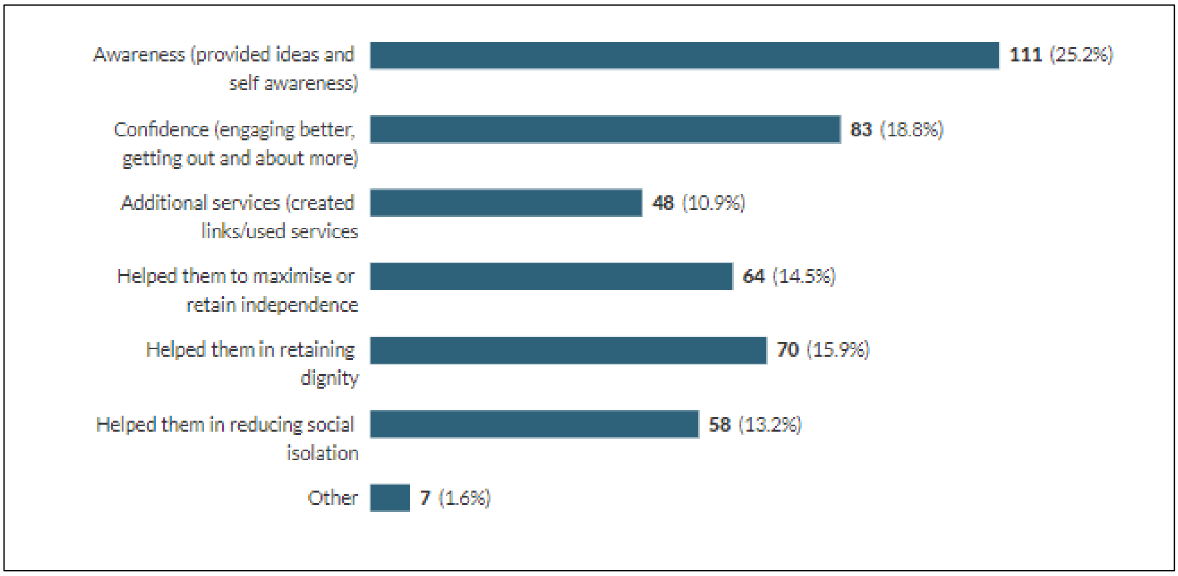
When asked if respondents felt they were better able to support deafblind people as a result of the training, over 95% reported that this was the case.

Figure 29: Do you feel better able to support deafblind people as a result of the training



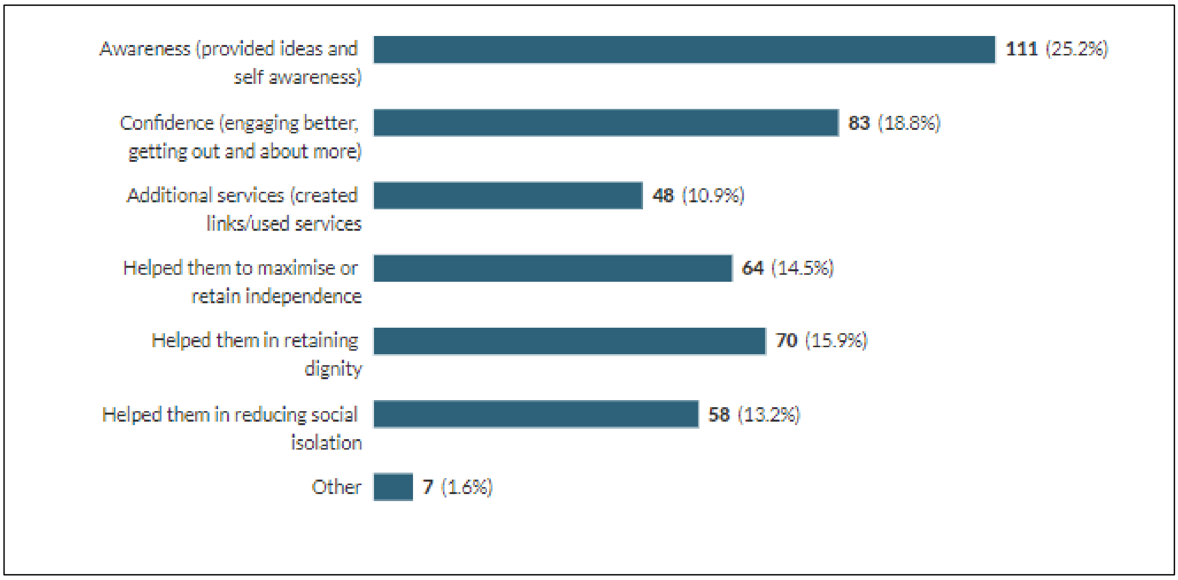
The majority of respondents also reported that they felt that the training meant they were better able to support deafblind people.

Figure 30: Ability to better support deafblind people



Over half (57.5%) of respondents reported having identified areas for improvement in terms of practice, knowledge, equipment and service provision for supporting a deafblind person rebuild their confidence and retain independence. Again these changes were practical changes that were highlighted within the training – most of which, many respondents were unaware of prior to the training.

Figure 31: Improvements made for supporting deafblind



Cascading training within organisations was anticipated and 54% of respondents had played a role in sharing their leaning with other colleagues. Also, over 20% of respondents also reported teaching deafblind people new skills. These include:

- Deafblind Block
- Deafblind Manual
- How to use specific pieces of equipment – magnifiers, liquid level indicators, bump-ons, telephones
- Mobility techniques
- How to be guided

While the majority of people completing the training did so because of their work, they were also asked if they had found the training useful in their personal lives with family, friends or neighbours who are deafblind. Over 39% of respondents reported that they had used some of the knowledge and/or techniques from the training in their personal lives. Many respondents reported having parents, family members or neighbours who are deafblind and that their increased understanding enabled them to:

- Provide advice and information
- Improve communication
- Identify someone who has a sensory impairment
- Signpost people to access equipment
- Be more patient

As well as initiating changes in individual practice for supporting deafblind people, the training has also made some headway to changing working practices at an organisational level. While policy level changes take time, there is evidence to support attitudinal changes in how organisations provide services or support deafblind people. These include:

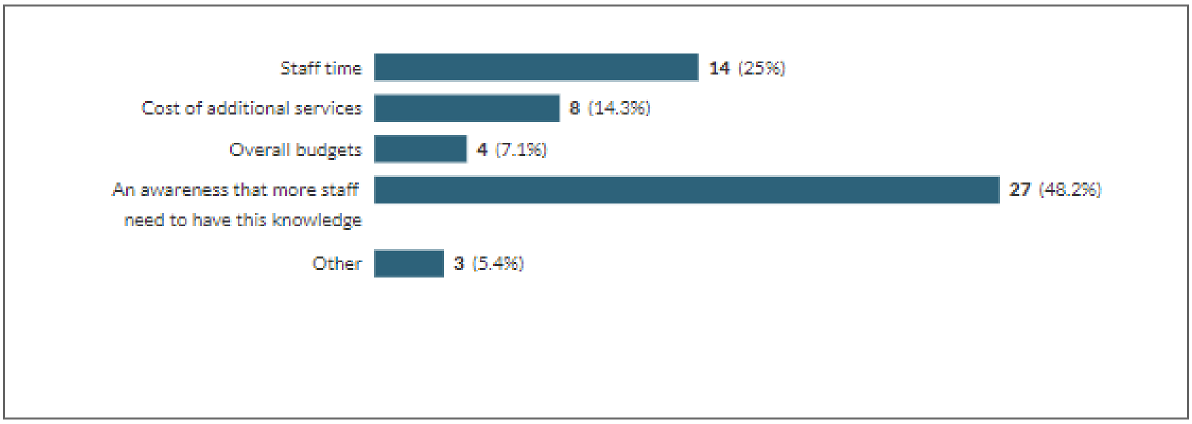
- Prioritising sensory loss within organisations
- Improving frameworks for specialist assessments
- Referring to specialist workers for assessment and rehabilitation support
- Introducing a new Deafblind Assessment form
- Staff more actively asking service users if they have sensory impairment
- Changing attitudes
- Utilising a Deafblind Register
- Offering counselling to deafblind people
- Making every contact count – identifying hidden needs now part of the visit
- Improving recording systems
- Securing funding to train 64 staff using an e-learning package developed by IGH to provide basic awareness across the local authority
- Changing practice and protocols

At this point, such attitudinal changes are not common across the whole of the North East region but many organisations have made a good start in embedding deafblindness within the work of local organisations and local authorities.

At a policy level, one organisation recognised the importance of touch in order to communicate effectively with a deafblind person. A "No Touching" policy was rescinded for deafblind people. Another organisation is currently working through the process of changing to becoming a dual sensory loss organisation.

Respondents from some organisations (19%) reported that there were resource implications as a result of the changes in practice such as a need for wider training and more staff time.

Figure 32: Resource implications



Staff time includes time out to attend training, backfill for staff attending training and also more time allocated for home visits.

Almost 12% of respondents reported that their organisation had been able to save money/costs/staff time as a result of the knowledge gained in the training. Examples of such savings included:

- Ability to offer a specialist deafblind assessment as opposed to two separate deaf and blind assessments
- Reduction of reliance on one very specialist worker
- Prevention of waiting lists due to silo/specialist working on one sensory discipline
- Use of equipment aids rather than home care services – retaining independence in own home
- Improved compliance with the Care Act

6. Project Developments

This programme of work has continued to develop from the outset. The programme design allowed for flexibility and adaptation to ensure that it would continue to meet the needs of its target groups and also increase its impact for both stakeholders and deafblind people.

Throughout the project, the team have explored and implemented changes. As the project has evolved these have included:

- Raising awareness on a national level
- Talk and Try Events
- Equipment Loan Service
- Case study areas – developing models of engagement

The IGH team has continued to seek out opportunities to further develop their work. This has been achieved through existing networks and the development of new networks – both local and national, linking with both policy and practice organisations. In order to illustrate some of the key developments Appendix 3 provides a timeline of key activities that shaped the direction of travel taken by this project.

We will now explore these developments further.

National level

Raising awareness of deafblind issues and the need for specialist services and assessments was a key target of the programme. This had primarily been focused on the North East region. However, it became apparent that the need for such training was widespread and SCENE (IGH) were approached to provide the training outside the region.

SCENE (IGH) have provided both foundation and specialist assessor training across the country and internationally in Poland. In addition to the delivery of training across the North East region, SCENE (IGH) continued to offer the training more widely as a result of networking and requests from particular areas which had identified a real need, often in order to ensure they were Care Act compliant. Areas included:

- Bradford – Specialist Assessment
- Preston - Foundation and ACD training
- Belfast - Foundation
- East Sussex – Specialist Assessment
- Manchester - Foundation
- Portsmouth – Specialist Assessment
- Sheffield – Specialist Assessment

- Peterborough DBUK – Specialist Assessment
- North Yorkshire – Specialist Assessment

In addition to these, SCENE have also provided training for SCIE, DBUK and all Big Lottery offices across the country. In January 2016 a Partnership Agreement was drawn up between SCIE and SCENE, again raising the profile of the organisation but also giving them a key role in raising awareness and as training providers at a national level.

While training provided outside of the region is not included in this evaluation, it is note-worthy as it illustrates a wider need for the training and served to increase the profile of IGH as a project and SCENE as a training provider nationally and also add further credibility at a local level.

In addition to providing deafblind training SCENE have also offered Care Act compliance training, upskilled Big Lottery staff across the country and worked closely with SCIE to raise awareness of deafblindness, influence policies and train staff.

Talk and Try Events

Talk and Try events were established as a way of engaging directly with deafblind people and offering advice, support and signposting to relevant services/agencies.   These events were provided in a wide range of venues across the region (Appendix 4). Originally, it had been anticipated that IGH would gain access to deafblind people as a result of referrals for more specialist support from people completing the training. While this did happen to some extent, the numbers were lower than expected so a new approach was required.

Through new and existing links, IGH contacted voluntary sector organisations and care homes to offer Talk and Try sessions to clients and/or residents. IGH staff attended existing group sessions, coffee mornings etc using the Identification Tool to identify people with dual sensory loss and to provide information, advice, referrals and specialist support where necessary. Sessions were advertised and were generally well attended.

The Talk and Try events have proved very successful in identifying people with dual sensory loss who had not been diagnosed. Over 200 people attended the Talk & Try events and 50 people have been identified as being deafblind. Deafblindness is often something that people do not recognise as an issue as the decline is often steady. In many cases refuse to acknowledge. Holding the events at pre-existing meetings/coffee mornings encouraged people to attend as they see them as an informal group.

One participant commented:

> *Because it was advertised as a Talk and Try coffee morning, it's more informal and a lot of people and their relatives pop in to see what it's about. More people have attended and are more receptive. . . It can take a long time for people to accept help but they are more likely to come to a coffee morning than a formal appointment.* Participant 17)

The Talk and Try events also provided the opportunity to use Deafblindness Identification Tool devised by IGH and as a result 50 people were newly identified as having some dual sensory loss at these events. In addition to these, others were directly referred to the local authority or other special sensory loss organisation. As the sessions continued, word of mouth played a key role in encouraging others to attend.

Face to face contact with large numbers of deafblind people has also meant an increase in the direct support provided by the IGH team. The events helped people recognise symptoms of dual sensory loss, discuss the impact on their daily lives, guide them to relevant support in terms of services and equipment, as well as provide ongoing direct support in a small number of cases. These events also provided IGH with the opportunity to make care staff more aware of other issues for example, that dementia can be incorrectly diagnosed rather than deafblindness.

An example identified by IGH staff was:

A carer mentioned to a member of the IGH team that one of the residents was having some problems. Although he did not attend a Talk and Try event, as it was in his building he did agree to speak to one of the IGH team. The carer informed IGH that his dementia had worsened and as a result he often just sat in the chair but also had started wandering during the night. During the visit the man was sat facing the window with the sun in his face. The IGH staff explained to the carers that this was not satisfactory given his eye condition and that the position of the chair should be moved. After discussions about his wandering during the night it was realised that the reason for the wandering was due to the fact that he could not easily differentiate between night and day, nor could he see a clock so when he was waking up he was disorientated and had started to get up. He was provided with a talking clock which helped greatly. He is now using the clock to ensure he stays in bed during the night. Being able to spot the signs meant that his quality of life was greatly improved.

Generally, awareness of the equipment available to help deafblind people to manage independently was low. Raising awareness of this with deafblind people, family carers and care staff has been a major outcome for the Talk and Try events as more information has often resulted in people purchasing or accessing equipment and subsequently making their lives easier.

Evidence of the value of Talk and Try events is clear. Deafblind people received a more individualised support package, family carers were more aware of what was available and care staff had a raised awareness of the impacts of any sensory impairment. Also having IGH as a first point of contact to raise any concerns further improved support and services to deafblind people.

One participant attending a Talk and Try event stated:

> *I wasn't going to come but am so pleased that I did. The new phone has made all the difference to me. I can keep in touch with my family now so I don't feel so lonely.*

Alongside the Talk and Try events, networking events were also arranged for deafblind people and their carers. Many of the attendees were identified through the Talk and Try events. These events included presentations from sensory loss organisations, displays of potential equipment etc but more importantly provided an opportunity for deafblind people to come together, share experiences, provide peer support and develop and expand social networks. These events were well attended. In total 144 people attending.
IGH staff also attended events organised by other agencies to further promote IGH, raise awareness of deafblindness and also to identify people with dual sensory impairments. These included:

- Stepping into Spring Event for Older People
- Golden Age Forum – Wansbeck
- Northumberland County Blind Information Day
- Blyth Blind Club
- Older Peoples Event – Walker
- Blind Club – Houghton
- NCBA Activities Club
- Alnwick Blind Club
- NCBA Women's Group
- Older Peoples Lunch Group – Walker
- Volunteer Recruitment and Networking Event – Blyth
- Older Persons' Day – Hartlepool
- Disability Event – Stockton
- Health & Wellbeing Review Day – Hartlepool
- National Carers Week
- National Deafblind Awareness Week – NE/Teesside

In total, approximately 875 people attended these events and the issue of dual sensory loss was incorporated within each of the events to raise awareness and introduce In Good Hands.

Equipment Loan Service

Another development that tied in with the Talk and Try events was the Equipment Loan Service which was established by IGH to raise awareness of sensory aids available amongst provider organisations, families and carers to support and improve the daily living for deafblind people.

Previous experience of dual sensory loss meant that the IGH team already had a good awareness of available equipment, which organisations were likely to provide it free of charge, companies it could be purchased from, the costs for people paying for it themselves and which has worked best in different situations.

The Loan Equipment Service was also set up by IGH to provide an opportunity for a deafblind person to test out whether a particular piece of equipment was suitable to meet their needs prior to purchase. Deafblind people informed IGH that quite often they had bought a piece of equipment only to find it was not what was needed. Given the cost of some specialist equipment, the loan service proved very popular with deafblind people and their families. The evidence from the interviews with deafblind people clearly suggests that after testing out equipment, many had gone on to purchase it with confidence that it was suitable.

Equipment loaned and tested included:

- TV amplifiers
- Large button and amplified telephones
- Talking clocks and watches
- Special bulbs to improve lighting
- Doorbell amplifiers
- Reading and writing aids
- Large print newspapers
- Mobility aids

Alongside the loan equipment, IGH continued to provide support, recommending suitable equipment, sourcing and supporting people to make a purchase. Further support was also provided to familiarise deafblind clients with new equipment. Participants and carers reported this to be particularly valuable. One participant commented:

> *It's really good that they show you how to use it and not just leave you to it. She even came back to make sure everything was working properly and that I wasn't having any problems.* (Participant 47)

Hi-Vis

In order to build on the success of the IGH Deafblind Support Project, a new charity; Hearing Impairment + Visual Impairment Support UK , Registered Charity Number: 1166368 (Hi-Vis UK) has now been established to build on and develop the work of IGH.   The vision of Hi-Vis is to achieve:

> *A deafblind friendly country where early identification and early support make a real difference to the mental health and wellbeing of older people in our ever increasing longer living society.*[5]

Through the use of many of the methods developed as part of the IGH project – and with early identification and early support, they hope to reduce support costs and help people remain independent. Their hope is that by working with families and carers and providing improved support to them they will be better able to provide support reducing and/or delaying the need for the more expensive option of residential care. The longer term aim is to ensure that future generations are both self-aware and better able to support older family members by encouraging them to continue with their activities even as their sight and hearing deteriorates with age.

Throughout this project the challenge has been the lack of awareness of deafblindness generally in our society, the issues and impacts experienced by those with such an impairment. The IGH Deafblind Support Project has gone a long way in improving this. Through the project IGH has identified that more work is needed to raise awareness of deafblindness with carers and family members and although some have been involved with this project, the numbers were low.

While subsuming IGH staff into Hi-Vis and incorporating the learning, experience and methods of the IGH Deafblind Support Project, Hi-Vis opens up new opportunities for future funding and further training but more importantly to continue to build on what has already been achieved and develop new strands of work.

Case Study Sites

As the project developed, the original priority of providing training to raise awareness expanded and relationships and networks in two particular areas emerged. Raising awareness and ensuring improved support and services for deafblind people remained the mainstay but two new opportunities to explore this is more depth as “models” emerged. These models were therefore tested to explore whether they could be replicated across a wider area.

---

[5] http://hi-vis.org

IGH staff had begun to work closely with staff within Hartlepool Borough Council who were keen to engage all sectors in raising awareness and supporting deafblind people. As this work developed, IGH went on to develop links with the independent and voluntary sector organisations operating within the Hartlepool area. While in some ways this model partly mirrored what was happening across the region, the key difference was the intensive support provided to ensure not only that people were better aware and trained in deafblindness but also that supporting deafblind people became embedded in local authority policy and practice. Becoming Care Act compliant was also a key factor but the local authority wanted to go beyond that and possibly become a Beacon area in identifying and supporting deafblind people.

The model adopted in Sunderland was based on a voluntary sector model. IGH worked closely with the Sunderland & Durham Royal Society for the Blind who were exploring the feasibility of changing their Constitution to change to a dual sensory impairment organisation. This was a major change in philosophy and way of working and IGH staff worked with them to move this forward.

The time available for these case study pieces of work has not allowed either model to reach completion but the evidence is strong that good progress has been made in both areas already and the indications are that both models will continue on (through Hi-Vis) despite the current IGH project coming to an end. Any outcomes and impacts achieved to date in each of the case study areas have been included in the overall SROI evaluation.

The next section looks at the case study models in more detail.

Hartlepool

Hartlepool Borough Council had not engaged well with IGH in the initial roll out of training. As a result, both local authority representatives and IGH began to explore ways of taking this work forward in the Hartlepool area. Given the changes required by The Care Act 2014, Hartlepool Borough Council were keen to become Care Act compliant but also make some headway in embedding deafblindness awareness within their services and provision. As a local authority they wanted to raise awareness of deafblindness across all sectors, increase the number of deafblind people on the register, have staff trained to support and assess deafblind people within the area.

As a result, 33 social worker/social work practitioners/assistants in Hartlepool have completed the level 3 Specialist Deafblind Assessor training. In addition to this another 33 local authority staff have completed foundation/communication/ACD training. Some of these were contracted by the local authority to provide services while others were in roles with face to face contact with people e.g. contact centre staff, blue badge unit (disabled parking). The primary aim of having those who are first point of contact involved was to raise awareness of deafblindness, improve the ability to identify those who are showing signs of having some Level of deafblindness and ensure they had the knowledge to be able to offer referral for early intervention and/or assessment and to improve information and guidance.

Early work included:

- Understanding processes
- The Care Act 2014
- Developing a Draft Pathway
- E-Learning platform (rolled out to all local authority staff)
- Hartlepool Now – HBC Online Newsletter
- Training
- Use of IGH Identification Tool
- IGH provided with office space in the new Independent Living Centre to facilitate closer links

IGH has worked very closely with senior management within the local authority to plan, design and implement some major changes to working practices. At times this has proven to be challenging, resulted in some delays and intensive reviewing but the partnership has remained strong and the commitment for Hartlepool to become an example of good practice to others continues.

There are now clear pathways from identification to assessment to services to registration. Recent reports on access to healthcare include people with dual sensory loss. Other things include:

- Information has been passed to audiology and ophthalmology services offered in Hartlepool
- Events at the local college
- Awareness sessions including guest speakers and public speakers
- Information and available training included on the Hartlepool Now website

One manager commented:

> *We have done a lot in a short time. . . Lots of awareness raising, had lots of support from the other sectors which has been really nice, council members have come on board. . . Already we have managed to integrate deafblindness into other organisations as well as our departments.* (Participant 18)

Resources continue to be a key issue. If more people are registered, the local authority then has an obligation to provide assessment and services. Both can be resource intensive at a time when resources are already stretched to a critical level within all local authorities. However, Hartlepool Borough Council was clear that while this could create many challenges financially, any assessments and service provision would be explored. For them this included wider support outside of statutory provision. In order to do this more effectively, voluntary sector services would need to be more fully utilised.

IGH now have a physical presence in the Hartlepool area and has allocated Hi-Vis staff time in the area for the foreseeable future to continue the work. They will continue to offer training and will help local organisations in continuing to identify and support deafblind people. The profile of IGH appears to be rising in Hartlepool and is better recognised as part of the HBC Framework.

While no formal Service Level Agreement between IGH and Hartlepool Borough Council is in place, they have continued to work in a close partnership to develop the programme of work specifically to meet needs in Hartlepool. Hartlepool already had an active voluntary sector with close links with the local authority. IGH developed links with a range of voluntary/ independent sector organisations across Hartlepool. These included Hartlepool Carers, Hartlepool Deaf and Blind Societies, Healthwatch, Healthy Living Pharmacies, Fire Brigade, The Joseph Rowntree Care Village amongst others. The aim of this was to provide a single approach to identifying, supporting and providing services for people who are deafblind across all the sectors. As a result, the partnership between the sectors opened up opportunities for access to more people who are deafblind providing a “Hartlepool Model”.

IGH have redesigned some of the existing training to meet the needs of specific groups of people – shorter workshop style sessions, tailored to specific groupings – e.g. fire brigade and Healthwatch. IGH staff have continued to further develop links and ways of working with the voluntary sector in the area. Although primarily, this involved raising awareness, protocols and referral processes are emerging to aid future development and sustainability. One participant commented:

> *‘Health watchers’ have the power to visit organisations who provide health and social care services for patients and residents. One of the things we were interested in was ensuring that the enter and view visitors who are all volunteers had an understanding of dual sensory loss and could identify what that would look like for a resident or a patient and they would be able to identify whether or not the particular service involved was actually working to meet the needs of that patient or resident.* (Participant 20)

The link with Healthwatch has been particularly beneficial. They report their role as ”being a voice” for patient groups, particularly those that are seldom heard. Not only have volunteers been trained but they are also implementing the learning in their face to face contact with people in hospital, residential and nursing care settings. This highlights additional needs but also improves communication with those residents or patients. One participant stated:

> *We have the powers to go into hospital wards, GP surgeries, pharmacies, dentists, opticians, residential homes and we aim to include deafblindness into everything we do.* (Participant 20)

Training has been provided to both staff and volunteers within a wide range of organisations. Carers have also accessed training to increase their understanding and also provide much needed information about services and equipment.

IGH has provided information to Equipment Finder (an online information service) on useful equipment that can play a vital role in increasing a deafblind person’s perceptions of self-worth, improve self-confidence and help to keep people independent in their own homes for longer. It had been identified that knowledge of the existence of a lot of available equipment was very low and including much of it on Equipment Finder raised awareness of what was available.

Alongside all of the work carried out within the local authority and the voluntary sectors, IGH staff have also provided Talk and Try events within the independent care sector. As mentioned earlier, the primary purpose of these events was to raise awareness and identify deafblind people. However, the direct contact of people has also resulted in direct support. Some of this support has focused on referrals to key services while other has consisted of direct support in dealing with issues caused by deafblindness, suggesting, testing and review of specific information, mobility aids and general support. These have proved very effective. One participant attending one such event stated:

> *I was feeling lonely, had lost contact with family because I couldn’t see the numbers on the phone and could not hear them talking on the phone, she (IGH) let me try a phone, showed me how to use it, set it all up so I could hear it. It’s fantastic I can speak to my family whenever I want to and it makes all the difference.*

IGH and the Tees Local Pharmacies Committee (TLPC) devised a 3 month pilot programme involving community pharmacies in Hartlepool. The learning from this is forming the basis for a larger project in 2018. Pharmacies are now part of the local authority referral pathway mentioned earlier. This has resulted in pharmacy staff receiving training on how to use the ID tool. As they are often the first point of contact for people and they have often developed a relationship with their customers, it was felt that they were in a unique position to notice any changes or deteriorations in terms of sight and hearing when customers visited for prescriptions and other services. Steps were taken to pilot the ID tool and it was felt that it was time consuming which was difficult for staff, therefore the tool was shortened. While time was of key concern, pharmacy staff have continued to identify people showing signs of deterioration and to date 11 people have been referred for further assessment. It is noted that a higher number have been identified but some refused consent for referral. Those people will continue to be monitored by pharmacy staff.

IGH and Hi-Vis will have an ongoing presence in Hartlepool. They now have accommodation and while this work is far from completed, IGH will continue to support the local authority and other sectors within Hartlepool in successfully embedding deafblindness not only in practice but also in policy.

Sunderland

The closure of the Sensory Support Team at Sunderland City Council has raised concerns as to ensuring that deaf, blind and/or deafblind people are able to access the support they need and the services they receive. Sunderland City Council has contracted out some of the work to the Sunderland & Durham Royal Society for the Blind (SDRSB) who have vast experience in sight loss and who have employed a rehabilitation worker part time.

However, the local authority has a duty of care to provide these services, the former team has been disbanded leaving only one part time team member and there is also a freeze on all recruitment. While discussions are in place to contract out some of the work, these have been delayed and SDRSB are providing a holding role while waiting for tender documents to be agreed and procurement to begin (expected 2018).

In the meantime, SDRSB are also in a position whereby they cover not only Sunderland but also Durham who have sustained an effective sensory loss team so the inequity in services across the two areas is more profound (Participant 21)

SDRSB had already begun to be more aware that there were a lot of people who they were supporting that had started to suffer from hearing loss alongside their vision problems. One team member stated:

> *I guess we are in a very good position in that we run all sorts of support groups for people with sight loss and therefore we are in an ideal situation to identify those that either have hearing loss, or they are starting with hearing loss* .(Participant 21)

> *I have noticed it most in our monthly macular support group. It tends to be older people who are losing their central vision and we try to get a speaker for each of the monthly meetings and what became apparent was members asking 'could you ask them to speak up a bit I can't hear'. To my ears they were talking quite adequately, quite loud enough so it became evidence that there was a problem with hearing loss.* (Participant 22)

The timing of this and the IGH project was critical in including Sunderland as a potential case study site.

> *To get an opportunity with IGH just couldn't have come at a better time. This and the fact that there isn't that support now available through the Council.* (Participant 50)

A Memorandum of Agreement was agreed whereby IGH and SDRSB would collaborate on the design and delivery of a project which aimed to:

- Build the capacity of SDRSB around dual sensory loss via IGH training
- Test an identification tool and referrals process and resource
- Identify older people with dual sensory impairment (DSI)
- Build capacity of those supporting the older person with DSI

This project would build on existing skills and expertise within both of the organisations and would be developed in two phases. These were:

- Sunderland – September 2016 to end of February 2017
- County Durham – March 2017- August 2017

It had been hoped that this project would help SDRSB help and support them in moving from a single sensory loss organisation to dual sensory loss. Such a change is a major organisational move including the philosophy, the Constitution and the name all of which provide a history and a profile and change must be handled in a way to ensure its history, ethic and experience goes along with it.

As a result, developing links with the Board of Trustees has taken a lot of time although they have now agreed that the organisation become a dual sensory loss organisation. IGH have worked with the organisation in a number of ways to support them not only in the decision making but in providing a number of activities which would provide the foundation for such a change. Tasks were agreed and the IGH contribution included:

- Planned roll out – training, identification, referral processes, reviews
- Supporting groups of volunteers in identification and training

- Training significant others – carers, family, members, friends to increase their capacity to understand and support older people with DSI
- Provide training to staff and volunteers

SDRSB contribution included:

- Targeting existing members who are not yet identified/self-identified as DSI
- Sharing information on progress
- Application of Identification Tool and collation of data across the SDRSB area of benefit
- Sharing of data from Phase 1
- Collecting and including data on to the SDRSB database and sharing data with IGH whilst adhering to the Data Protection Act
- A joint evaluation of Phase 1

The proposed timescales proved to be optimistic and while inroads have been made and some of the actions above achieved for Phase 1, it was not possible to conclude Phase 1 so Phase 2 has not yet begun. However, while progress has been slow, both staff teams and the SDRSB Board remain committed to bringing about this change and the foundations have been put into place to move this forward.

Staff and volunteers have received training. Volunteers are more aware of the issues around deafblindness and in identifying it. They are also taking an active role in contacting people on the existing database and working through the Identification Tool with them as a way of identifying if they are deafblind and for those who are, asking permission to refer them for a specialist assessment.

To date, approximately 250 people currently involved with SDRSB have been identified as having both sight and hearing loss to differing degrees. The key problem in moving this work forward has been that while IGH are able to support, direct discussions and inform decision making at a strategic level, the fact that austerity measures have decimated practical support on the ground has meant that there are very few services available in the Sunderland area that people could be referred to. In addition to this, a lot of people contacted and identified as deafblind go on to refuse consent for referral for a specialist assessment which also means they are not registered on the Local Authority register.

Already SDRSB are developing and expanding networks in terms of deafblindness. The Royal National Institute of Blind People (RNIB) are using them as an example of demonstrating good practice and they are being approached by other organisations across the region to discuss future collaborations in terms of deafblindness.

SDRSB are continuing to embed deafblindness into their work, particularly when looking at future funding and contracts. It is too early to say at this point if this will improve the success rate of securing funding but at this point it is viewed as a positive element as current support and services are particularly low and demand appears to be high.

7. Social Return on Investment Framework

This section examines scope and boundaries for the SROI study and the Theory of Change for the In Good Hands Project and also identifies the key stakeholders involved in the project.

Scope of Analysis

This SROI evaluation was developed in a way to utilise the SROI framework (Fujiwara 2014) testing its applicability in measuring the impact of the SCENE IGH Deafblind Support Project. While building on a pilot study carried out in 2011 in one area, this project has continued to develop and evolve so it is essential that this evaluation includes the impact. The SROI model was chosen as it enables us to understand the social impacts of the project across the stakeholder groups and that this would support future funding applications to take this work forward.

SCENE CiC intend to use this report to:

- Highlight any success in ensuring local authorities have become Care Act compliant. This is a legal requirement and could have repercussions for any local authorities not achieving this.
- Be able to show the impacts of the project to project partners, potential funding bodies and other stakeholders involved
- Understand the difference the project has had on the lives of deafblind people
- Be able to show potential funding bodies the benefits of the project and the social return on investment

Materiality

The SROI framework is clear that only outcomes that are "material" (relevant to the stakeholders and the project itself) should be included when calculating the SROI. It is also clear that any outcomes have to be both relevant and significant to stakeholders to be included. Working within the action research framework, the evaluation team and SCENE have worked together to identify and agree outcomes in line with key performance indicators (KPI) for the In Good Hands Deafblind Support Project. Every attempt has been made to ensure that information and evidence used in this report is both significant and relevant and will provide an accurate assessment of the service.

Stakeholder Groups

This SROI evaluation includes a range of stakeholders deemed as relevant so need to be included in the SROI analysis. Table 5 shows the stakeholders identified as involved in the In Good Hands Deafblind Support Project and show the reasons for inclusion or exclusion.

Table 5 - Inclusion and Exclusion of Stakeholders

Stakeholder	Included	Reason
Local Authorities	Yes	Care Act compliance, upskilling workforce
Independent Care Providers	Yes	Upskilling workforce, raising awareness
Voluntary sector	Yes	Increase in numbers of volunteers. Increased caseload for service provision, different ways of working
Deafblind People	Yes	Direct benefits and beneficiaries of project
Carers	No	Difficulty accessing due to available resources
IGH	Yes	Are the project managers and service providers for this programme of work

The key stakeholder groups included in the analysis are:

- Local Authorities
- Independent Care Providers
- Voluntary Sector service providers
- Deafblind People
- IGH

The key reasons for excluding potential stakeholder groups include:

- Given the geographical spread, it was not possible to include sufficient carers given available resources

Theory of Change

A social return on investment evaluation focuses on changes and outcomes achieved as a result of the investment made. Therefore, a theory of change model was developed following discussions with the IGH team. (See Figure 1 below). This model illustrates the context to which this project relates and the benefits and changes alongside the moderate term outcomes and potential longer term impacts.

Stakeholder engagement

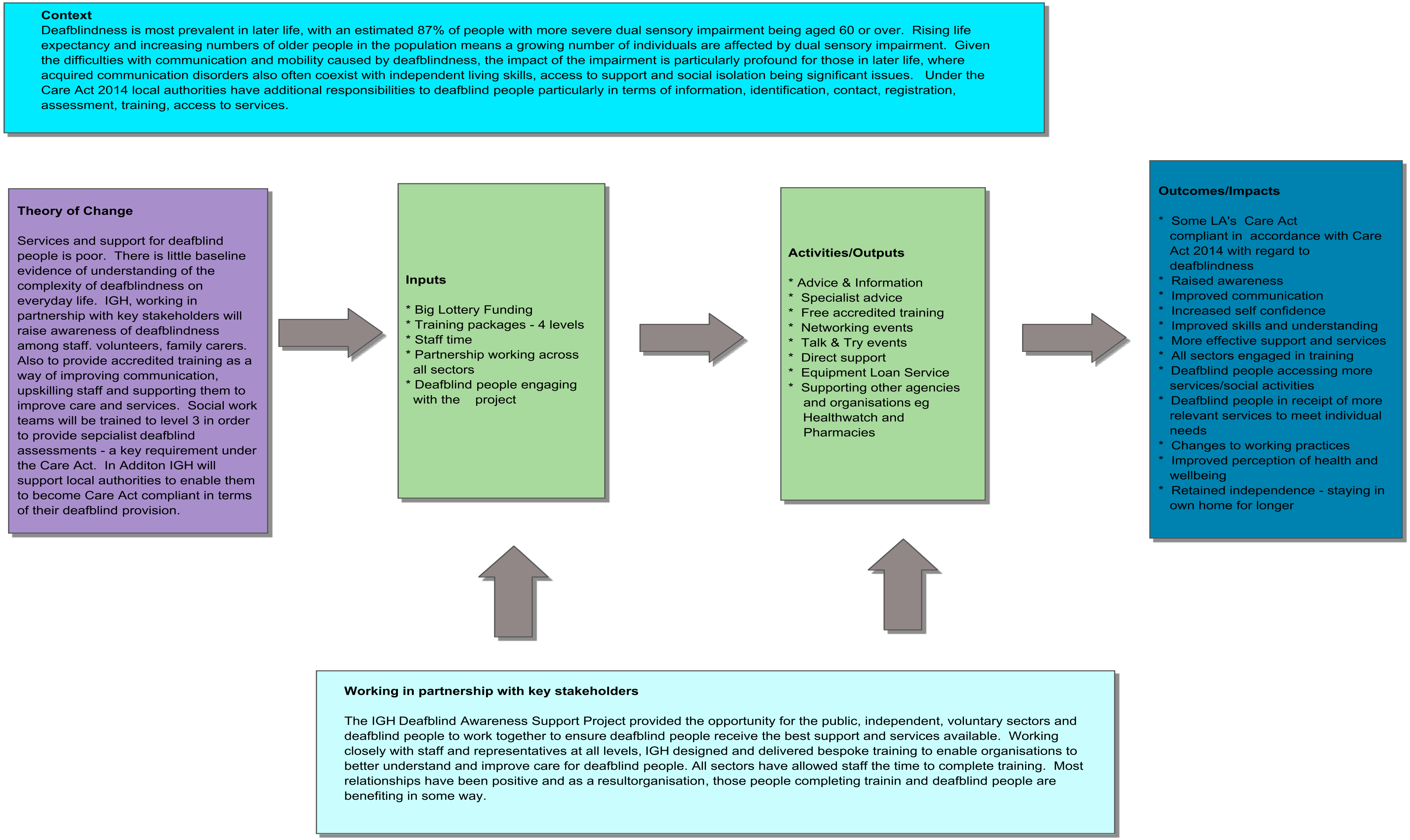
The theory of change model was based on a logic model approach and was developed based on early interviews with key stakeholders and the IGH team. Using the logic model approach, it was possible to clarify aims and objectives, agree activities and outcomes and longer term expectations and also highlight the complexities of the project and at the same time illustrate indicators for change and impacts.

Early progress meetings with the commissioners were used for clarification purposes and interviews with key stakeholders informed this process.

The Theory of Change illustrated in Figure 1 has been continuously tested throughout the interview process and the information and evidence collated from each of the stakeholder groups on an ongoing basis. In addition to this, the evaluation team have maintained regular contact with the IGH team and other stakeholders as a way of testing out findings verifying the evidence gathered.

Findings have regularly been fed back to the commissioners as a way of informing future developments.

Figure 33: Theory of Change



Context

Deafblindness is most prevalent in later life, with an estimated 87% of people with more severe dual sensory impairment being aged 60 or over. Rising life expectancy and increasing numbers of older people in the population means a growing number of individuals are affected by dual sensory impairment. Given the difficulties with communication and mobility caused by deafblindness, the impact of the impairment is particularly profound for those in later life, where acquired communication disorders also often coexist with independent living skills, access to support and social isolation being significant issues. Under the Care Act 2014 local authorities have additional responsibilities to deafblind people particularly in terms of information, identification, contact, registration, assessment, training, access to services.

Theory of Change

Services and support for deafblind people is poor. There is little baseline evidence of understanding of the complexity of deafblindness on everyday life. IGH, working in partnership with key stakeholders will raise awareness of deafblindness among staff. volunteers, family carers. Also to provide accredited training as a way of improving communication, upskilling staff and supporting them to improve care and services. Social work teams will be trained to level 3 in order to provide sepcialist deafblind assessments - a key requirement under the Care Act. In Additon IGH will support local authorities to enable them to become Care Act compliant in terms of their deafblind provision.

Inputs

* Big Lottery Funding
* Training packages - 4 levels
* Staff time
* Partnership working across all sectors
* Deafblind people engaging with the project

Activities/Outputs

* Advice & Information
* Specialist advice
* Free accredited training
* Networking events
* Talk & Try events
* Direct support
* Equipment Loan Service
* Supporting other agencies and organisations eg Healthwatch and Pharmacies

Outcomes/Impacts

* Some LA's Care Act compliant in accordance with Care Act 2014 with regard to deafblindness
* Raised awareness
* Improved communication
* Increased self confidence
* Improved skills and understanding
* More effective support and services
* All sectors engaged in training
* Deafblind people accessing more services/social activities
* Deafblind people in receipt of more relevant services to meet individual needs
* Changes to working practices
* Improved perception of health and wellbeing
* Retained independence - staying in own home for longer

Working in partnership with key stakeholders

The IGH Deafblind Awareness Support Project provided the opportunity for the public, independent, voluntary sectors and deafblind people to work together to ensure deafblind people receive the best support and services available. Working closely with staff and representatives at all levels, IGH designed and delivered bespoke training to enable organisations to better understand and improve care for deafblind people. All sectors have allowed staff the time to complete training. Most relationships have been positive and as a resultorganisation, those people completing trainin and deafblind people are benefiting in some way.

Project Inputs

This section describes the inputs of all the stakeholders to the In Good Hand Project.

The inputs for each of the main stakeholder groups will now be examined.

Overall Input

For SROI purposes the total input to this service has been valued at **£995,000** (Table 6 below). While the training was provided free to all key stakeholders, this does include any in-kind contributions identified.

Table 6 - Breakdown of Inputs

Stakeholder	Financial Contribution	In-kind contributions	Total
IGH	£993,000 (Big Lottery funded project)		£993,000
Local Authorities	£2,000 – accommodation costs per year	(staff time for training)	£2,000 Staff time off-set by free training
Independent Sector	NIL	(staff time for training)	0 - offset by free training
Voluntary sector	NIL	(staff time for training)	0 – offset by free training
Deafblind people (key beneficiaries)	NIL	NIL	0
		GRAND TOTAL	**£995,000**

Outcomes and Evidence

This section will describe the projected outcomes of the In Good Hands Project, the indicators agreed for measuring that those outcomes have been achieved, the numbers attached to each outcome, the period of time attached to the outcomes and the financial proxies used to measure them.

Outcomes

The model adopted for the IGH Deafblind Support Project has continued to develop and evolve. The project team have continued to work closely with a wide range of stakeholders across the North East region and also at a national level alongside this project.

The project has continued to work toward meeting the aims and objectives as shown on page 2.

Table 7 - Stakeholder Reflections on Outputs and Outcomes

Stakeholder	**Outputs/Activities**	**Outcomes**
Local Authorities	• Care Act Training • Deafblind Awareness Training • Deafblind Specialist Assessment Training • Communication Training • Supporting LAs to meet Care Act requirements	• LAs have a named lead person at director level who are now known to staff • Increased awareness of deafblindness • Increase in number of deafblind assessments • Number of Staff qualified to Level 3 • Increased confidence in communicating with deafblind people • More relevant/improved services to deafblind people • Local Authorities Care Act compliant
Independent Care Sector	• Deafblind Awareness Training • Communication Training • ACD Training	• Staff more aware of deafblindness • Increased confidence and skills in caring for deafblind people • Providing more appropriate care • Improved care and support • Staff gaining an accredited qualification • Better able to communicate with deafblind people

Voluntary Sector	• Deafblind Awareness Training • Communication Training • ACD Training • Accessing specialist support to facilitate future policy changes • Changes in organisational policy	• Staff and volunteers more aware of deafblindness • An increase in volunteers supporting deafblind people • An increase in the number of deafblind people accessing voluntary sector services • Increase in numbers of people identified as deafblind • Improved services to deafblind people
Deafblind people	• Accessing specialist support • Attending information sessions • Attending networking events • Requesting and accessing relevant services	• People reporting being more socially active • People reporting improved/more effective support • Numbers receiving full deafblind assessments • People reporting improved quality of life • Improved perception of own health and wellbeing • People remaining independent in their own homes for longer
IGH	• Deliver training	• Training provided • Improved organisational profile • Direct support

Many of the outcomes identified and reported throughout the interview process link with the key aims and objectives of the service, indicating that the project is clearly working towards meeting its aims and the needs of the clients.

Outcomes for each stakeholder group

Local Authorities

LAs have a named lead person for deafblind issues who are now known to staff

As part of the Care Act 2014 legislation, all local authorities must have a named person at director level responsible for ensuring deafblind people in the area are identified and registered (if they consent) and be a point of contact for deafblind issues. This is now a legal requirement but no financial inputs were made available to provide a more focused deafblind service which has made it difficult for local authorities to take on such a role effectively. In some local authorities the Head of Service has been nominated as the lead person but there is some evidence to suggest that even this fact is not well known within

> As far as I know we don't have a named person, I just try to do the best I can and anything I can't deal with take to my line manager. (Participant 5)

the authority and that grassroots workers are not aware of either the legal responsibility to have a named lead person or the role of that person in terms of their practice.

IGH has identified that some local authorities now have a designated lead (director level) for deafblindness and staff awareness of the role and responsibilities of this person is increasing. This is an area of work for further consideration.

Increased awareness of deafblindness

Most local authorities recognised that awareness of deafblindness was low among staff. Part of this was due to the recent demise of many of the sensory loss teams within the adult social care framework. While some local authorities may have someone with sensory loss expertise on the team, the way in which referrals are distributed does not mean that sensory loss referrals go directly to that person. This is because most social work teams are generic teams. One way of combatting this has been that more social work staff have received deafblind training and are better informed and better able to understand some of the issues.

> We are doing our best but resources are tight, there are staff shortages but ideally we would like all the key people to have at least some understanding to make sure people don't fall through the cracks. (Participant 23)

This increased awareness goes beyond the social work teams and includes social work assistants, call centre staff, first point of contact staff in some of the local authorities giving a broader awareness within some local authorities. However, this does not appear to be the case in all local authorities and further work is needed to continue to ensure deafblindness is embedded within its services and that staff are able to identify and provide relevant support as well as make appropriate referrals for services and assessments.

> We can't raise expectations or promise the earth when we know that in most cases we are really dependent on other sectors to provide any services. (Participant 21)

However, in some areas, some real headway has been made with local authorities engaging well with IGH, are beginning to take on board their legal requirements and are more actively seeking to ensure compliance.

Increase in number of deafblind assessments

> I asked for a deafblind assessment but didn't get one. (Participant 26)

While it had been anticipated that as the provision of deafblind assessments was a requirement of the Care Act, the numbers of deafblind assessments would increase significantly, this has not proven to be the case. Baseline figures from local authorities prior to the Care Act showed little to no such assessments being offered or carried out in the past. Deaf and blind assessments were carried out but not as one entity. Reducing the number of separate deaf and blind assessments for people with dual sensory loss was one benefit as well has the ability to provide better insight to the difficulties encountered for those people.

> I was asked if I would like a deafblind assessment but I said no. It seems a bit like labelling to me and I didn't want that. (Participant 48)

While the number of staff qualified to provide such an assessment have increased, it appears that there continues to be some reticence about providing such assessments. It would appear that available resources in order to meet such needs remain limited so local authorities are aware that assessments could result in additional costs. In addition, deafblind people themselves have also shown a reluctance to have such an assessment.

Number of Staff qualified to Level 3

> Most of our team has either completed the training or planning to in the near future. We are a small team but by the end of the year the majority of us will be accredited. (Participant 8)

Across the North East, all 12 local authorities engaged with IGH Specialist Assessor Training. In line with the Care Act requirements, in order to provide a specialist deafblind assessment, the assessor must be qualified to Level 3. IGH designed and developed a bespoke training course to provide knowledge, understanding and upskill social work teams in supporting deafblind clients. Alongside this, the training was accredited by the OCN at level 3. As a result, 206 people have gained a level 3 qualification and are now able to provide deafblind specialist assessments. The range of uptake across each local authority differ between 4 and 52 staff. Some local authorities have also trained additional staff involved in assessments which accounts for much of this difference. As a result of IGH, each local authority now has some staff trained to level 3 and can, under the Care Act requirements, provide deafblind assessments. More work is needed in supporting social work teams to further roll out the assessments in order to increase the numbers provided. In recognition of this, the Deafblind Rehab and Care Assessment training was written and piloted to 16 participants. However, it is also clear that while the number of assessments has not increased as anticipated, social work teams are putting learning into practice in terms of information, knowledge, understanding which is frequently passed on to other staff and deafblind people.

Increased confidence in communicating with deafblind people

Communicating with deafblind people can be difficult and there is little doubt that the training has provided skills and techniques to improve communication. This serves two purposes. Not only does it reduce frustrations but it also provides the opportunity for deafblind people to be heard and receive appropriate and relevant support to meet individual needs.

> Actually knowing what to do and trying it out made it easier to use it back at work. I started making little changes almost immediately and because I had done it I was more confident that it would work. (Questionnaire open responses)

The majority of people completing training (varying levels) are very clear that they feel more confident in supporting and caring for deafblind people as a result of the training. Actually being able to test out some practical techniques within the training was deemed vitally important as it increased the likelihood of putting that learning into practice.

More relevant/improved services to deafblind people

> We are not in a position to provide additional services but we can make sure that we improve what we have and because we know more about what is needed ensure that contracted out services are also able to meet the demands. (Participant 18)

The increased awareness of not only deafblindness but also the types of support and services that are available, meant that staff and carers are better informed, have improved skills and networks and as a result are providing/referring to more informed/ individual services.

The aim of this project was not to increase the number of services but to ensure that people were aware of existing support and services, were in a better position to refer to the most appropriate services and also, as training expanded across all sectors, that existing services would be improved and better meet the needs of deafblind people.

The evidence clearly supports that increased awareness, knowledge and understanding has meant that people are providing better levels of support and that when referrals are made, services are better able to meet an individual’s needs.

> The fact that I have a better idea what’s out there and more importantly I now have a point of contact if I need any information makes a huge difference. (Participant 12)

Local Authorities Care Act compliance

As mentioned earlier, all local authorities must become Care Act compliant. This means they are meeting all the requirements stipulated within the Care Act 2014. This is a massive task for local authorities as it covers all elements of care of which deafblindness is only one factor. As a result, full compliance within this timeframe is very unlikely. The fact that no additional resources were provided by the Department of Health (DH) or the Government has also served to slow the process substantially. In England, the Care and Support of

Deafblind Children and Adults Guidance (Section 6 Deafblind Guidance) issued in 2014 by the Department of Health (DH) reflects on the new Care Act. All local authorities must follow this guidance unless there is a legally sound justification for not doing so. These guidelines include:

- Identify, make contact with and keep a record of deafblind people in their catchment area (including those who have multiple disabilities that include dual-sensory impairment);
- Ensure that when an assessment of needs for care and support is carried out, this is done by a person or team that has specific training and expertise relating to Deafblind persons – in particular to assess the need for communication, one-to-one human contact, social interaction and emotional wellbeing, support with mobility assistive technology and habilitation/rehabilitation;
- Ensure services provided to Deafblind people are appropriate, recognising that they may not necessarily be able to benefit from mainstream services or those services aimed primarily at blind people or deaf people who are able to rely on their other senses;
- Ensure that Deafblind people are able to access specifically trained one-to-one support workers if they are assessed as requiring one;
- Provide information and advice in ways which are accessible to Deafblind people;
- Ensure that a Director-level member of the local authority has overall responsibility for deafblind services. (DH 2014)

This evaluation has explored Care Act compliance purely in relation to the requirements and amendments stipulated with regard to deafblindness. The IGH Deafblind Support Project was designed to support local authorities in meeting these requirements. Examination of outcomes clearly support that IGH has been successful in achieving this. However, it is worthy of note that while IGH have made good headway, further work is needed to ensure full compliance which is outside the scope and timescale of this IGH project.

Independent Care Sector

Staff more aware of deafblindness

IGH has continued to work closely with staff working in the independent care sector. This has been achieved through publicity, direct contact and direct work in some settings.

> I went in knowing just about nothing and came out thinking about which of my residents were showing some of the signs that I had been missing. Some of the things that had been happening began to make sense to me. That training was the best I'd ever done. It fitted in so neatly with what I was doing. (Questionnaire open responses)

In total 336 independent care staff have completed IGH training. Monitoring data shows that the majority of these staff focused on the foundation level training although some went on to also complete the communicator guide and ACD training. All three courses focus on raising awareness, increasing knowledge, skills and understanding and the training included many practical elements. Questionnaire respondents and interview participants were very clear that the training had been very successful in raising their awareness.

A lack of awareness prior to the training appears very pertinent within this sector. Identifying people showing signs of dual sensory loss appeared problematic. Many respondents highlighted that this changed as a result of the training and that they were much more likely to pick up on the signs and act accordingly.

Increased confidence and skills in caring for deafblind people

People completing the training were very clear that the improved knowledge and understanding had resulted in them being more confident when caring for and supporting deafblind people. There was a view that knowing some of the issues that a deafblind person has to face helped them spot difficulties that they would not have identified as a problem. Also as a result of the training they were more confident in speaking to other professionals about some of the problems and in some cases even recommending a referral.

When you don't know what it is you are actually seeing you can't really do much about it. I am spotting things now that are obviously causing some problems so I can look at ways of making things easier. I even told my boss about getting one of the residents a hearing test. (Questionnaire open responses)

Providing more appropriate care

I didn't know anything really about what was available or even what it meant if the TV was really loud or they just wanted to sit on the chair all day. I now know he is lonely and needs someone to talk to so I don't rush out anymore. (Questionnaire open responses)

Those completing the training were also very clear that improved awareness and understanding meant they could provide more appropriate care. Knowing the issues, understanding the effects and also having information on equipment and other services has resulted in them being able to look at the individual needs of their clients and make decisions accordingly. In the past there had been a tendency to offer what they knew was available regardless of whether it was the most appropriate option.

I am much more alert and picking up on things that are needed. Quite often I waited to be asked but now I ask questions. (Questionnaire open responses)

Improved care and support

The improved awareness and increased confidence has resulted in reports that staff have improved their working practices and as a result have improved the care and support they are providing. This is reiterated by some of the deafblind people who are reporting the benefits of those improvements.

The independent and care sector have engaged well with IGH across all the local authority areas. Generally management was keen to raise awareness among staff and we have some reports from managers regarding the benefits of upskilling their staff and how implementing learning into practice has been valuable for residents.

> After discussions with IGH, we now have someone who comes in bi-monthly. Residents register with the staff that they need to see her. She can only support people who have NHS hearing aids but provides any maintenance, cleans them, replaces tubes etc. The residents love it. It's just a pity that those with private hearing aids still have to go direct to the supplier. (Participant 15)

In some care homes, residents often face difficulties attending hospital appointment including audiology appointments. As a consequence of IGH input, external services have been sought out to offer maintenance and servicing of hearing aids. This reduces the transport issues for hospital visits and also ensures that hearing aids are well maintained and functional on a regular basis.

The fact that the training was free and that larger staff teams could be accommodated with delivering training on site made engagement easier. There were some challenges identified in terms of staff having to do the training off-shift so staff cover was maintained.

Staff gaining an accredited qualification

While gaining accreditation for the training was not identified as a key factor in completing, many respondents reported that such a qualification could be useful if looking to move on or for career progression. Within the independent sector all 336 completions received an accredited award. As mentioned earlier this has not only increased their confidence and skills but many felt the certificate was a reward and were very proud for achieving this.

> I didn't even know it was a qualification when I went but now it's on the CV. It's something not everyone will have so could give me an edge. (Questionnaire open responses)

Managers also reported benefits of accredited training as apart from NVQs, generally there is little accredited training available to staff. It was also noted that while some staff were paid to attend the training off-shift, others were not paid and gave their own time to take part.

Better able to communicate with deafblind people

Communication was identified as a key issue and prior to the training even general communication was difficult for some. Quite often staff reported that they shouted to be heard. The training showed them that this is not the best option and what would be better so other models and techniques were used and both staff and clients were feeling the benefits from this. The ability to communicate is critical in order to provide effective care and support. It also enables the staff to engage more positively with the client, improving relationships, building rapport and reducing frustration.

> I used to stand in front of her or at the side and shout into her ear but I realised shouting doesn't help. I now take in other factors like background noise, checking hearing aid batteries and it's so much easier. (Participant 9)

A small number of respondents also reported using the deafblind block alphabet with some clients which they had learned in the training. In those cases they showed the client how to use it so passed on their learning. While generally it was felt that it was a painstakingly slow process it did further help engage and develop new communication strategies for individual clients.

Voluntary Sector

Staff and volunteers more aware of deafblindness

Almost 300 staff from the voluntary sector completed deafblind training throughout the lifetime of the project. The voluntary sector engaged well with IGH across all 12 local authority areas. The majority of voluntary sector staff (n=220) completed the foundation training. The main goal for the training was to raise awareness of deafblindness within this sector. In addition to the staff completing the training a further 52 individuals also completed the training. These individuals were primarily made of volunteers and family carers.

> This training formed part of our training package for our volunteers so that they had an understanding of what it was like to be deafblind and also able to identify it when working with clients. (Participant 20)

> It was really good to have the opportunity to do this training. I found it really useful and relevant. (Participant 8)

Much of the support and service provision appears to lie within the voluntary sector. Given austerity measures and the impacts of major reductions to local authority funding and the resultant cuts to voluntary grants and services, this is proving to be a difficult time. However, engagement with the IGH project has been good. Again, the fact that the training was provided free of charge did play a role in the numbers attending training as voluntary sector participants all reported severe cuts to training budgets. The impact of this is that it is unlikely that the training can be provided free on a rolling programme basis to account for staff changes and turnover.

An increase in volunteers supporting deafblind people

There is evidence to suggest that more volunteers are now supporting deafblind people. However, interviews and questionnaire respondents indicate that while more deafblind people are being supported, this is not necessarily due to an increase in volunteers. The evidence suggests that the volunteers providing the support were largely part of the existing volunteers' pool. The benefit of the training appears to be that existing volunteers are now more knowledgeable and are identifying deafblind issues from within their client base resulting in more deafblind people receiving support.

An increase in the number of deafblind people accessing voluntary sector services

> I have started going to a craft group at the community centre. I can't really see to do the crafts but the company is good. (Participant 31)

There is some evidence to suggest an increase in referrals to the voluntary sector for services for deafblind people. It appears that these are primarily around social activities and events as a way of reducing social isolation. These include lunch clubs, activity groups etc and deafblind people interviewed reported an increase in attending such activities. However, there is little evidence to support additional services to meet increased demand which is in line with the reductions in local authority funding to voluntary sector organisations. What is clear is that awareness of increasing services is much improved. As a result people are being referred to voluntary sector services and they are doing their best to meet demand within resource constraints.

Increase in numbers of people identified as deafblind

A wide range of voluntary sector organisations have registered staff for deafblind training. This has opened up opportunities for deafblindness to be on the radar of each of these organisations. The training includes identification and some organisations have also been trained in using the ID Tool as a way of establishing if a person is in fact deafblind, more people have the ability to make such identification. While knowledge of new people being identified as deafblind is reported widely, there is little evidence to suggest that these newly identified people have gone on to register as deafblind at this point in time.

> Working through the lists has served two purposes. One in identifying people no longer with us and two identifying those who have both sight and hearing difficulties. It's been a long job but rewarding. (Participant 19)

A number of volunteers within SDRSB and a member of the IGH team have begun to update their database and in doing so are contacting all people on the list and working through the ID tool with those who consent. To date, over 150 people on the existing database registered with some measure of sight loss have been identified as being deafblind. The database is currently being updated and once complete further contact will be made to examine what the additional needs of these people are and whether a deafblind assessment is required. A difficulty with this process is that the SDRSB are currently not in a position to provide any additional services around hearing loss. The lack of available services within Sunderland generally also mean there is nowhere to refer them on to immediately following identification. In addition, volunteers found that some of those identified as being deafblind did not actually class themselves as such. They often put poorer sight or poorer hearing down to age and therefore did not feel the need for additional support or did not know it existed.

Improved services to deafblind people

Improved awareness and knowledge has been as a factor in improving the services provided by those people completing the training. As within the independent and public sectors, there is much evidence to support changes in working practice as a result of the training which goes some way to improve services.

> It [the training] really made me think more about things. I listened more, made sure they heard me, instead of just assuming they had, had ideas of things that could help so could talk to them about them. Nothing mind boggling but I felt that the clients really appreciated the extra effort and responded really well. (Participant 22)

Both questionnaire and interview participants report providing a better service for their clients supporting the view that generally the services deafblind people are currently receiving are improved.

A number of examples of improved practice were also highlighted in terms of ensuring people who were deafblind were positioned in a certain way in group settings to ensure they could hear what was going on or sat close to the front so they could see what was happening. This makes it easier for deafblind people to engage with activities or services.

Policy change

A small number of examples where the IGH involvement is bringing about policy change already exist. While this is still early days, the fact that these examples are being put forward at this point is an indication that more changes can continue to happen. So far an internal policy and a potential organisational change have been identified.

It was recognised that the existing “no touching policy was detrimental when working with deafblind people as touch is often a vital method of communication. This has now been changed. (Participant 11)

An organisational change moving from being a visual impairment organisation to a dual sensory loss organisation. This requires a full constitutional change and backing from trustees. In its early stages but making headway. (Participant 24)

Any policy change could be regarded as an unintended outcome considering the timeframe would normally preclude such developments.

Deafblind People

People reporting being more socially active

Social isolation is a key problem for people who are deafblind. This view is clearly supported within existing literature. Any sensory loss can reduce confidence, communication and mobility, all of which reduces engagement in activities.

Attending groups has made a big difference. I mix with people who understand what it’s like and I like talking to them. I went to the summer fair in Ashington and many people said hello. . . . it makes me happy (Participant 27)

Deafblind people interviewed as part of this evaluation discussed how as a consequence of IGH input, they have gone on to develop new social networks either through referrals for volunteer befrienders or through attending social groups. While not all were willing to engage in such activities, those that did reported a range of benefits in terms of improving their general health and wellbeing.

I was really pleased I attended the event at Bowburn and was really grateful that they sorted a taxi otherwise I may not have gone. It put me in touch with friends old and new and lifted my spirits. (Participant 41)

The opportunity to meet with others experiencing similar issues and share stories was also seen as a good way of developing and re-establishing social networks. The Networking events facilitated by IGH were often regarded as a social event. They were really well attended and deafblind people attending, some along with their carers, provided very positive feedback about the presentations, information, venues and food. Most importantly they were very clear that such events were ideal for learning from others.

Loneliness has a major impact on perception of health and quality of life and therefore social interactions/activities are important to elderly people generally, but a necessity for deafblind people. Many have outlived or lost contact with friends, are housebound and have family living at a distance. Being deafblind, options for keeping contact with long distance relatives is much more difficult. Training in the use of technologies to improve contact was available in some areas.

> I got some advice about a new phone that was much louder than the usual phone. I could hear it ring and could also hear when people were talking to me. It has made all the difference. I can talk to my family any time I want to – nearly every day now. It's great. I hadn't realised how much I had missed that. (Participant 50)

People reporting improved/more effective support

Deafblind people have reported improvements to the service and support they have been receiving. Often, these are small improvements such as taking the time to listen, touching, communication skills. It is noted that quite often they do not know the reason for any improvement or even that those providing the improved services have completed IGH training informing these improvements. The deafblind people participating in this evaluation all have a connection with either people completing the training or with the IGH team. To this end, we can assume that the project is the common denominator.

> I actually find it much easier to talk to the carers now. They understand me better and have offered some really good advice and helped me follow up on it. (Participant 45)

> I had always said no to group stuff but they talked me into it and now I love it. (Participant 34)

Numbers receiving full deafblind assessments

Very few of the deafblind people involved in the evaluation had received a specialist deafblind assessment. A small number had been referred for assessment but no date had been set. Some reported being asked but having refused.

People reporting improved quality of life

Quality of life is a difficult thing to measure. In this instance the main indicator was perceptions of general improvements to health and how they feel. Not all deafblind respondents reported on this outcome but those that did were very clear that the help and support they had been receiving had made a big difference to them. Some reported feeling less frustrated, that things were beginning to happen, that they were getting out more, meeting more people but they were also able to achieve some general everyday tasks as a result of accessing/purchasing equipment that they had tried at an IGH Talk and Try event or IGH staff had shown them.

Bump-ons on tins was a biggie for me. I could tell it was beans and not soup. (Participant 38)

Just feeling better in myself. Having someone to talk to means I don't get so stressed about things. (Participant 51)

Elastic bands on shampoo or conditioner. Simple but so effective. (Participant 34)

Improved perception of own health and wellbeing

I have a volunteer who comes in every week. We sit and chat, have a cup of tea and cake, talk about family. It just makes my week. I can't even explain how much better I feel. (Participant 33)

Being deaf and blind creates many obstacles. The fact that this is age acquired also raises the likelihood that they suffer from other long term conditions e.g. COPD, stroke, brain injuries, physical disability. The receipt of improved services and support for deafblindness is unlikely to result in huge improvements to existing long term health conditions although improved services and perceptions of own health has made conditions more manageable and tolerable for many. Many of the deafblind people reported "feeling better in themselves, "more positive" and "more confident". Increasing social activity and interaction is known to help reduce stress and anxiety in some cases and some respondents reported "just feeling better". This appeared to be in terms of their own wellbeing.

Getting out and about a bit more is great. I've even started going to the club to play bingo and dominoes. I got some new gadgets and now it's like being one of the lads again. (Participant 32)

People remaining independent in their own homes for longer

I wouldn't have been able to stay here [home] for so long without my volunteer. He has been invaluable to me, (Participant 37)

Given the age of many deafblind people, it is likely they will require residential care and support at some point. Remaining independent in their own home is very important to elderly people generally but even more so to deafblind people. Living in familiar surroundings, alongside their memories often helps to provide some control. Moving into a residential setting is often the last thing they want to do. Support services and equipment that help to maintain that independence goes some way to keeping deafblind people at home for longer. Remaining independent is known to impact positively on general health and wellbeing. Some deafblind people involved in this study reported having doubts as to whether they could stay in their home and that they have been able to do that because of some simple changes/ interventions such as measures to reduce falls, lighting, liquid level indicators preventing burns, support in developing coping strategies and encouragement to meet new people.

> I want to say at home. I don't want to move at all. I'd be happy if they carried me out in a box but I know I need help and I am getting it. I feel I could last out for a good while yet. (Participant35)

In Good Hands

Training provided

IGH provided a total of 98 training courses across the lifetime of the project. Half of these were foundation training. They successfully designed, developed, reviewed and delivered training across the lifetime of the project. Alongside this, they successfully provided training on a national and international level. Reviews of the training were very good.

> Brilliant training, learned a lot and even remembered most of it. It was a great learning experience. (Participant 4)

People completing the training reported improved awareness, knowledge and understanding, implementing training into practice thus improving care and support to deafblind people.

Many of those completing the training reported that the content and delivery method were good and that the practical aspect of the training improved engagement and aided them to turn it into practice.

Improved organisational profile

SCENE had a reputation for delivering training and providing support to organisations prior to the Deafblind Support Project. However this project allowed them to further develop their wider networks. Utilising existing links with SCIE and Skills for Care helped to integrate deafblindness on to wider agendas. This resulted in a closer working relationship with SCIE and as a result a number of SCIE staff completed the training as well as publicising the training on SCIE publicity materials and regular newsletters.

Deafblindness training was also provided to Big Lottery staff across England, Scotland, Wales and Northern Ireland.

Direct Services

> People were coming in from all over the place to talk to [IGH team]. They were so helpful and came up with things I would never have thought of because I didn't have that level of knowledge. Being in the know about visual and hearing loss is a skill that not many have and being able to cover it all in one session makes a real difference. (Participant 10)

Providing direct services was not part of the original brief for the project. This was an area of work that developed over time. The skills within the team made it easy to take this step and while care was taken not to become too overloaded by demand for direct support, this was provided on an ad-hoc basis as the need arose. The Talk and Try events meant that IGH staff regularly gave advice and support including rehabilitation advice, referrals to other agencies, providing equipment through the loan service and sourcing relevant equipment. Much of this has been covered in the Talk and Try section so it will not be repeated here but suffice is to say that deafblind people reported huge benefits from having face-to-face contact with an expert and as a result of what often were small changes, had made a massive difference to them.

> Being able to make a cup of tea for myself and any visitors was really important to me but I kept burning myself. Now with my little gadget I can do it and it means the world to me. (Participant 31)

Outcome Indicators

In order to ensure this SROI evaluation is as accurate as possible we have identified indicators for each of the outcomes with the stakeholder groups as a way of measuring the quality and depth to which these outcomes have been achieved. (See Table 8 below)

Table 8 - Outcome Indicators

Stakeholder	Outcomes	Indicators	Source
Local Authorities	• LAs have a named lead person at director level who are now known to staff • Increased awareness of deafblindness • Increase in number of deafblind assessments • Number of Staff qualified to level 3 • Increased confidence in communicating with deafblind people • More relevant/ improved services to deafblind people • Local Authorities Care Act compliant	• LAs have a named lead person for deafblind issues • Increased awareness of deafblindness • Number of deafblind assessments • Number of staff qualified to Level 3 • Staff reporting increased confidence • Staff reporting putting learning into practice • Numbers of local authorities who are Care Act compliant with regard to deafblindness	• Monitoring data • Freedom of Information data • Interviews • Questionnaire
Independent Care Sector	• Staff more aware of deafblindness • Increased confidence and skills in caring for deafblind people • Providing more appropriate care • Improved care and support • Staff gaining an accredited qualification • Better able to communicate with deafblind people	• Staff more aware of deafblindness • Increased confidence and skills in caring for deafblind people • Providing more appropriate care • Improved care and support • Numbers of staff gaining accreditation • Staff reporting they are better able to communicate with deafblind people	• Monitoring data • Interviews • Questionnaire
Voluntary Sector	• Staff and volunteers more aware of deafblindness • Numbers of volunteers supporting deafblind people • An increase in the number of deafblind people accessing voluntary sector services • Number of organisations changing policy	• Staff more aware of deafblindness • Increased confidence and skills in caring for deafblind people • Providing more appropriate care • Improved care and support • Numbers of staff gaining accreditation • Staff reporting being better able to communicate with deafblind people	• Monitoring data • VCS data • Interviews • Questionnaire

Deafblind people	• People reporting being more socially active • People reporting improved/more effective support • Numbers receiving full deafblind assessments • People reporting improved quality of life • Improved perception of own health and wellbeing • People remaining independent in own homes for longer	• Numbers reporting being more socially active • People reporting improved/more effective support • Numbers receiving full deafblind assessments • People reporting improved quality of life People reporting a reduction in depression/anxiety • Numbers reporting staying independent for longer	• Interviews
IGH	• Training provided • Improved organisational profile • Direct support	• Numbers of people trained • Publicity materials • Services provided	• Interviews • Monitoring data

Every effort has been made to avoid double counting. The next section will focus on the numbers of people who have achieved these outcomes and for how long they are likely to continue to feel these benefits.

Quality of Outcomes

Using the responses provided in the stakeholder interviews and the monitoring data collected by IGH, we have examined the reach of the outcomes in detail and attached the numbers of those people likely to have achieved the benefits from those outcomes (see Table 9 below). In some cases these are the actual numbers; however, in other cases these are a conservative average based on the data and interview responses. An explanation of where these figures are derived from is included in the table below for clarification purposes.

Table 9 - Quantity of Outcomes

Stakeholder	Outcomes	Quantity	Justifications
Local Authorities	LAs have a named lead person at director level who are now known to staff	12	Social work staff completing training were tasked with identifying who this is in their local authority
	Increased awareness of deafblindness	343	Numbers completing courses
	Increase in number of deafblind assessments	23	Based on numbers referred for DB assessment and interview/questionnaire data
	Number of Staff qualified to level 3	206	Numbers successfully completing Specialist Assessor training
	Increased confidence in communicating with deafblind people	275	Based on 80% reporting ability to communicate more effectively
	More relevant/improved services to deafblind people	172	Based on 50% reporting putting learning into practice
	Local Authorities Care Act compliant	12	All LAs now have Level 3 trained staff to provide assessments but less than 40% have taken further actions under Care Act[6]
Independent Care Sector	Staff more aware of deafblindness	336	Based on numbers completing the courses
	Increased confidence and skills in caring for deafblind people	269	Based on 80% reporting increased confidence – questionnaires, interviews
	Providing more appropriate care	168	Based on over 50% reporting putting learning into practice with DB clients
	Improved care and support	168	Based on 50% reporting using techniques and information to direct the way they care and support DB people
	Staff gaining an accredited qualification	336	Based on numbers completing accredited courses
	Better able to communicate with deafblind people	269	Based on 80% reporting improved communication skills

---

[6] It would appear that some local authorities have achieved some level of compliance but evidence of full compliance is not available. Based on interviews, questionnaire data we advocate 3 as being compliant. This is a conservative estimate.

Voluntary Sector	Staff and volunteers more aware of deafblindness	299	Numbers completing training courses
	An increase in volunteers supporting deafblind people	50	Volunteers regularly supporting deafblind people based on questionnaires and interviews
	An increase in the number of deafblind people accessing voluntary sector services	90	Numbers of people referred to voluntary sector services
	Increase in numbers of people identified as deafblind	300	Numbers identified as deafblind using ID Tool
	Improved services to deafblind people	120	40% of deafblind people involved in project reporting improved services
	Changes in organisational policy	2	Changes to internal policies due to learning and a constitutional change from single to dual sensory organisation
Deafblind People	People reporting being more socially active	175	Based on approximately 65% of referrals being for social activities
	People reporting improved/more effective support	270	Based on 1 in 5 people training plus those receiving direct support from IGH accessing improved support
	Numbers receiving full deafblind assessments	25	Based on number of referrals for deafblind assessments reported
	People reporting improved quality of life	108	40% of those receiving support reported improved quality of life
	Improved perception of own health and wellbeing	189	70% of deafblind people involved with project reporting feeling better due to improved support – less stressed, more confident and relaxed
	People remaining independent in their own homes for longer	27	10% of those reporting improved support reported ability to stay independent in own home for longer
IGH	Training provided	1052	Based on numbers attending training
	Improved organisational profile	22	12 local authorities and a minimum of 10 organisations who have accessed training from outside the area
	Direct support provided	250	People receiving direct support from IGH

Duration of Outcomes

Assessing duration of outcomes for a project of this nature is difficult. This is exacerbated by the fact that while the number of people completing the training increases with time, some go on to change roles resulting in them no longer working with/supporting deafblind people. This is likely to impact on outcomes achieved.

In order to assess the duration of outcomes more accurately, information from the stakeholder interviews and discussions with the IGH have been used to corroborate these findings.

For the purposes of this evaluation we have assessed the duration for the majority of outcomes as being 4 years -3 years actual duration of the project and 1 year after IGH where the project can be linked to outcomes (see Table 10 below). Linking outcomes to project actions is much more difficult after that time period. This is a conservative estimate to avoid over-claiming. The exception to this is any outcomes related to training or qualifications which will be 3 years as funding will cease and no further free training will be provided in year 4.

Table 10 - Length of time outcomes are likely to last

Stakeholder	Outcomes	Duration (years)	Assumptions
Local Authorities	LAs have a named lead person at director level who are now known to staff	3	Having a named lead is a legal requirement under the Care Act and will continue regardless of IGH input
	Increased awareness of deafblindness	4	As people continue to work with/ support deafblind people awareness will continue to increase
	Increase in number of deafblind assessments	4	Part of Care Act legislation
	Number of Staff qualified to Level 3	3	The numbers qualified through this programme will not increase into year 4 as training is completed
	Increased confidence in communicating with deafblind people	4	The more they use the skills the more competent they become so likely to use those skills after the lifetime of the project
	More relevant/improved services to deafblind people	4	Awareness and information will continue to inform referrals to relevant services
	Local Authorities Care Act compliant	3	Compliance is a legal requirement so LAs involved will have to become compliant or face sanctions

Independent Care Sector	Staff more aware of deafblindness	4	As people continue to work with/ support deafblind people awareness will continue to increase
	Increased confidence and skills in caring for deafblind people	4	The more they use the skills the more competent they become so likely to use those skills after the lifetime of the project
	Providing more appropriate care	4	Increased awareness likely to improve referrals to relevant agencies
	Improved care and support	4	Upskilling staff likely to improve care provided after the lifetime of the project
	Staff gaining an accredited qualification	3	The numbers staff completing accredited training will not increase into year 4 as training is completed
	Better able to communicate with deafblind people	4	The more they use the skills the more competent they become so likely to use those skills after the lifetime of the project
Voluntary Sector	An increase in volunteers supporting deafblind people	4	Existing volunteers more likely to take on this role after receiving the training and this will continue after the lifetime of the project
	An increase in the number of deafblind people accessing voluntary sector services	4	Awareness and information will continue to inform referrals to relevant services within this sector after the lifetime of the project
	Increase in numbers of people identified as deafblind	4	People more likely to recognise deafblindness and also key people will continue to use the ID Tool after the lifetime of the project
	Improved services to deafblind people	4	Trained staff and volunteers will continue to use their newly acquired knowledge and skills to improve their services
	Changes in organisational policy	2	Foundations for this have been laid and likely to happen after the end of the project

Deafblind people	People reporting being more socially active – reduced social isolation	4	Building social networks are likely to extend beyond the lifetime of the project as relationships continue to develop over time this reducing feelings of isolation and loneliness
	People reporting improved/more effective support	4	Those providing services will continue to use their new skills and deafblind people will continue to reap the benefits
	Numbers receiving full deafblind assessments	4	This has to be offered under the Care Act although it is dependent on consent but numbers receiving one can only increase after the lifetime of the project
	People reporting improved quality of life	4	Based on an average length of time for age and health to deteriorate further
	Improved perception of own health and wellbeing	4	Based on an average length of time for age and health to deteriorate further
	People remaining independent in their own homes for longer	4	Likely to retain independence for longer with specialist support but ultimately will possibly require residential/nursing care regardless of IGH inputs
IGH	Training provided	3	Free training will cease at the end of the project
	Improved organisational profile	4	The work of the project has already begun to embed in more national organisations and is likely to continue past the life of the project
	Direct support provided	4	IGH will continue to provide some support to clients after the lifetime of project

Financial Proxies

Financial proxies have been used to determine the value to be attached to each of the outcomes. Where possible the actual financial costs have been included e.g. training costs. For those outcomes without a clear market value, a range of sources have been used. Service beneficiaries and carers found it difficult to place actual values on some of the outcomes. For many “increased independence”, “self-confidence” was “priceless”. For outcomes of this nature we have used a number of sources which offer accepted values. Table 11 below shows the financial proxies and the values given. The sources can be found in Appendix 5: Impact Map.

Table 11 - Financial Proxies

Stakeholder	Outcomes	Financial Proxy	Value
Local Authorities	LAs have a named lead person at director level who are now known to staff	Care Act non-compliance – penalties – average value of potential costs and loss of reputation	£10,000[7]
	Increased awareness of deafblindness	Estimated value of increased awareness	£215
	Increase in number of deafblind assessments	SW hourly rates for assessment – 5 hours per assessment (Appendix 6)	£200
	Number of Staff qualified to Level 3	Value of training for individuals	£1,798
	Increased confidence in communicating with deafblind people	Social confidence values	£995
	More relevant/improved services to deafblind people	Average cost of accessing services per year	£826
	Local Authorities Care Act compliant	Care Act non-compliance - penalties	£10,000
Independent Care Sector	Staff more aware of deafblindness	Estimated value of increased awareness	£215
	Increased confidence and skills in caring for deafblind people	Social confidence values	£995
	Providing more appropriate care	Average cost of accessing services per year	£826
	Improved care and support	Average cost of accessing services per year	£826
	Staff gaining an accredited qualification	Value of training for individuals	£1,798
	Better able to communicate with deafblind people	Social Confidence Values	£995
Voluntary Sector	Staff and volunteers more aware of deafblindness	Estimated value of increased awareness	£215
	An increase in volunteers supporting deafblind people	Average value of volunteering	£7,490
	An increase in the number of deafblind people accessing voluntary sector services	Average cost of accessing services per year	£826
	Increase in numbers of people identified as deafblind	Estimated value of increased awareness	£215
	Improved services to deafblind people	Average cost of services	£826
	Staff and volunteers gaining an accredited qualification	Value of training for individuals	£1,798

---

[7] Estimated minimum costs for legal challenge

Deafblind people	People reporting being more socially active	Average value of regular social activities/interactions	£1,850
	People reporting improved/more effective support	Average cost of services	£826
	Numbers receiving full deafblind assessments	SW hourly rates for assessment – 2 hours per assessment	£80
	People reporting improved quality of life	Wellbeing measures on value of health	£500
	Improved perception of own health and wellbeing	Functional independence	£1,400
	People remaining independent in their own homes for longer	Those reporting likelihood of residential care without additional support	£28,756
IGH	Training provided	Average cost for training in specialist areas per person - GVE	-£399
	Improved organisational profile	Greater involvement with out of area and national organisations	£1,772
	Provision of direct services	Average hourly rates	£20 per hour

Programme Impact

This section examines the overall impact of the project and acknowledges other elements that may also have influenced the outcomes.

The key objective of this SROI evaluation is to show the full impact of the service in question. Using the SROI framework, we have identified the key stakeholders, gathered evidence of impact and verified findings. However, the key questions are whether these impacts would have been achieved without IGH involvement, whether IGH just replaced existing services, whether any other organisation/department could also claim responsibility for some of the impacts and whether these impacts are likely to reduce over time.

In some ways IGH is a unique entity as there is very little deafblind training available so they are the primary provider. Also, it appears that they are alone in working within the independent sector to not only raise awareness for staff and volunteers but also offer individual support to residents/clients. However, even taking that into consideration they could not operate effectively as a standalone project as they do not have the resources to provide all care and services. IGH are constantly referring clients to both public and voluntary sector organisations for equipment, support and services. There is also some likelihood that the deafblind people involved with IGH are also likely to be receiving additional support from other agencies and services albeit not necessarily specialist deafblind support.

To this end, in order to ensure that the SROI evaluation is accurate (avoiding any over-claiming), it is essential that we look at the effects of deadweight, displacement, attribution and drop-off and include these into the final calculation. These terms are defined below.

IMPACT

Deadweight: How much of the outcome would have happened anyway

Displacement: What similar existing activities/service were replaced by the IGH training and services

Attribution: Acknowledging the effect of others in achieving the outcomes

Drop-off: To what extent the benefits of the outcomes will reduce over time.

The figures included for each of these will be subtracted from the final values to provide a more accurate assessment of the social value.

Deadweight

Examining the deadweight is generally acknowledging the amount of each of the outcomes that would have happened anyway without IGH input. The issue of deadweight was examined with each stakeholder group. Table 12 below shows the deadweight attached to each of the outcomes for each stakeholder group and also the rationale for those percentages.

Table 12 - Deadweight

Stakeholder	Outcomes	Deadweight	Rationale
Local Authorities	LAs have a named lead person at director level who are now known to staff	20%	Legal requirement but unlikely without IGH input
	Increased awareness of deafblindness	20%	IGH primary training provider
	Increase in number of deafblind assessments	20%	Legal requirement but unlikely without IGH input
	Number of Staff qualified to Level 3	0%	Specialist training developed and provided by IGH and accredited through OCN
	Increased confidence in communicating with deafblind people	20%	IGH primary training provider
	Knowledge of more relevant/improved services to deafblind people	20%	IGH primary training provider
	Local Authorities Care Act compliant	20%	Legal requirement but unlikely without IGH input
Independent Care Sector	Staff more aware of deafblindness	20%	IGH primary training provider
	Increased confidence and skills in caring for deafblind people	20%	IGH primary training provider
	Providing more appropriate care	20%	Unlikely to be able to identify without IGH training and input
	Improved care and support	20%	Unlikely to be able to identify without IGH training and input
	Staff gaining an accredited qualification	0%	Training developed and provided by IGH and accredited through OCN
	Better able to communicate with deafblind people	20%	IGH primary training provider
Voluntary Sector	Staff and volunteers more aware of deafblindness	20%	IGH primary training provider
	An increase in volunteers supporting deafblind people	25%	Given national shortage of volunteers – IGH has trained and supported volunteers in supporting deafblind people
	An increase in the number of deafblind people accessing voluntary sector services	20%	Unlikely to be able to identify without IGH training and input
	Increase in numbers of people identified as deafblind	20%	Unlikely to be able to identify without IGH training and input
	Improved services to deafblind people	20%	Unlikely to be able to identify without IGH training and input
	Changes in organisational policy	40%	As a result of funding and tender requirements

Deafblind people	People reporting being more socially active	20%	Potentially those being supported for other long term conditions
	People reporting improved/more effective support	20%	Unlikely to be able to identify without IGH training and input
	Numbers receiving full deafblind assessments	10%	Lack of suitably qualified staff without IGH
	People reporting improved quality of life	10%	Minor and major changes have occurred as a result of IGH upskilling and direct input
	Improved perception of own health and wellbeing	10%	Minor and major changes have occurred as a result of IGH upskilling and direct input
	People remaining independent in their own homes for longer	50%	Given age, health conditions some will still require residential care regardless of IGH input
IGH	Training provided	10%	IGH primary training provider
	Improved organisational profile	20%	Project widened opportunities for links with wider/national organisations
	Provision of direct services	0%	Direct services provided by IGH

Displacement

Displacement refers to what activities, services were displaced by IGH training and inputs.

IGH provided this programme of work following a successful application to the Big Lottery. IGH is one of the only training organisations providing deafblind training and over time has expanded its provision in order to meet demands. As a result of this we would concur that IGH training and input did not replace any already existing services. As a result the Impact Map will show a zero percentage in relation to displacement across all outcomes.

Attribution

Attribution is a key factor for achieving an accurate measure of impact of all IGH inputs. In terms of the training this is solely provided by IGH so no other organisation can co-claim on outcomes achieved as a result of the training.

In terms of deafblind people, it is acknowledged that they will be receiving support from other organisations and some will be in receipt of care packages all of which can have some impact on the outcomes achieved. In order to more accurately assess social value we have estimated the percentage of the outcome than can be attributed to others and provide the rationale for these estimates in Table 13 below.

Table 13 - Attribution

Stakeholder	Outcomes	Attribution	Rationale
Local Authorities	LAs have a named lead person at director level who are now known to staff	20%	Although a legal requirement most LAs lacked awareness and skills to achieve this requirement
	Increased awareness of deafblindness	10%	Deafblindness on radar due to Care Act but IGH sole provider of training in the NE area
	Increase in number of deafblind assessments	0%	IGH sole provider of accredited training in area
	Number of Staff qualified to Level 3	0%	IGH sole provider of accredited training in area
	Increased confidence in communicating with deafblind people	0%	No LAs reported using any other training or input
Local Authorities (cont.)	More relevant/improved services to deafblind people	20%	Although a legal requirement most LAs lacked awareness and skills to achieve this requirement
	Local Authorities Care Act compliant	20%	Although a legal requirement most LAs lacked awareness and skills to achieve this requirement
Independent Care Sector	Staff more aware of deafblindness	10%	IGH sole provider of accredited training in area
	Increased confidence and skills in caring for deafblind people	10%	IGH sole provider of accredited training in area
	Providing more appropriate care	10%	IGH sole provider of awareness training in area
	Improved care and support	10%	IGH sole provider of awareness training in area
	Staff gaining an accredited qualification	0%	IGH sole provider of accredited training in area
	Better able to communicate with deafblind people	10%	IGH sole provider of training in area

Voluntary Sector	Staff and volunteers more aware of deafblindness	20%	IGH sole provider of awareness training in area
	An increase in volunteers supporting deafblind people	20%	Deafblind awareness is necessary for volunteers to support deafblind people effectively. IGH is currently the primary provider of training.
	An increase in the number of deafblind people accessing voluntary sector services	20%	Without IGH input the awareness and knowledge limits effect on impact
	Increase in numbers of people identified as deafblind	10%	Without IGH input the awareness and knowledge limits effect on impact
	Improved services to deafblind people	20%	Without IGH input the awareness and knowledge limits effect on impact
	Changes in organisational policy	20%	Without IGH input the awareness and knowledge limits effect on impact
Deafblind people	People reporting being more socially active	40%	Other care and support services encouraging social activity
	People reporting improved/more effective support	20%	Without IGH input the awareness and knowledge limits effect on impact
	Numbers receiving full deafblind assessments	20%	IGH primary provider of accredited training in area to meet Care Act requirements
	People reporting improved quality of life	40%	Other care and support services impacting on quality of life
	Improved perception of own health and wellbeing	30%	Other care and support services available outwith deafblindness
	People remaining independent in their own homes for longer	50%	Given age, health conditions some will still require residential care regardless of IGH input
IGH	Training provided	0%	IGH primary provider of training in region
	Improved organisational profile	30%	Based on existing reputation having some impact on this outcome
	Provision of direct services	0%	IGH providing direct support

Drop-off

Drop-off explores how the benefits derived from each outcome are likely to reduce over time. It is important to include any reductions when calculating the values to ensure a better degree of accuracy.

Calculating drop-off for IGH services is difficult, given the constant turnover and increasing numbers of trainees and deafblind people involved. Therefore, we have estimated the percentage of the drop-off and provide the rationale for these estimates in Table 14 below.

Table 14 - Drop-off

Stakeholder	Outcomes	Drop-off	Rationale
Local Authorities	LAs have a named lead person at director level	0%	This is a legal requirement under Care Act and all LAs will have to comply at some point
	Increased awareness of deafblindness	50%	Reduction in training provision from IGH
	Increase in number of deafblind assessments	20%	This is a legal requirement under Care Act and all LAs will have to comply at some point
	Number of Staff qualified to Level 3	20%	This is a legal requirement under Care Act and all LAs will have to comply at some point
	Increased confidence in communicating with deafblind people	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
)	More relevant/improved services to deafblind people	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Local Authorities Care Act compliant	0%	This is a legal requirement under Care Act and all LAs will have to comply at some point
Independent Care Sector	Staff more aware of deafblindness	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Increased confidence and skills in caring for deafblind people	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Providing more appropriate care	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Improved care and support	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Staff gaining an accredited qualification	50%	Reduction in training provision from
	Better able to communicate with deafblind people	30%	Reduction in training provision from IGH but implementing current learning into practice will continue

Voluntary Sector	Staff and volunteers more aware of deafblindness	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	An increase in volunteers supporting deafblind people	50%	Access to deafblind training will reduce although existing trained volunteers are likely to continue as organisations move forward with their deafblind agenda
	An increase in the number of deafblind people accessing voluntary sector services	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Increase in numbers of people identified as deafblind	20%	Continued use of ID tool in a range of settings
	Improved services to deafblind people	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Changes in organisational policy	50%	Ongoing support from IGH may not be available
Deafblind people	People reporting being more socially active	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	People reporting improved/more effective support	30%	Reduction in training provision from IGH but implementing current learning into practice will continue
	Numbers receiving full deafblind assessments	0%	This is a legal requirement under Care Act and all LAs will have to comply at some point
	People reporting improved quality of life	40%	Other care and support services will continue to impact on quality of life overall
	Improved perception of own health and wellbeing	30%	Other care and support services available outwith deafblindness
	People remaining independent in their own homes for longer	50%	Given age, health conditions some will need residential care but some existing support will continue
IGH	Training provided	70%	Free training scale will decrease
	Improved organisational profile	20%	Profile likely to further improve due to this programme of work into the future
	Provision of direct services	70%	Current direct work will become more focused in line with future funding

All percentages provided for deadweight, attribution, displacement and drop-off are conservative estimates to avoid over-claiming.

8. Social Return on Investment

In this section we will show how the SROI value for the In Good Hands Deafblind Support Project is generated.

This SROI evaluation has closely followed the SROI Framework developed by the SROI Network (SROI Network 2012). Working through this process, the final calculation must also include an adjustment to the values that indicates the present day value of the benefits (PV) that are expected into the future. In line with SROI requirements, a 3.5% discount is applied to values projected for more than a one-year period. This 3.5% discount is recommended in the Government Green Book (HM Treasury 2011) as an acceptable discount.

Working through the process we can see that the total impact values of the IGH Deafblind Support Project is £6,457,818.38. The net present value (NPV) is £5,462,818.38 which is the total extra value created by the IGH Project.

The equation used to calculate the SROI is:

$$\text{SROI} = \frac{\text{Net Present Value}}{\text{Total Inputs}}$$

These figures give us an SROI ratio of the net present value divided by the total investments giving us a value of £5.49 for every £1 invested. This means that for every £1 of investment in the IGH Deafblind Support Project, **£5.49** social value has been created across the stakeholder groups. This shows a significant social return on investment and confirms that the project has had a very positive effect on stakeholders.

9. Conclusions

The IGH Deafblind Support Project was designed to bridge a gap in awareness, knowledge and serve to improve services for deafblind people by building the capacity in terms of knowledge and skills of stakeholders. The project was well designed and the training provided was of good quality. While primarily developed as a training programme, the over-arching aims and objectives included providing focused training ensuring local authorities were able to meet their legal requirements under the new legislation. Also to upskill social workers, care staff, voluntary sector staff and volunteers and family carers as a way of improving support and knowledge for deafblind people.

There is clear evidence to show that they have achieved success across all the local authority areas increasing/improving social capacity. IGH has effectively engaged with all sectors across the North East region and social work teams, generic staff teams, care staff, volunteers and family carers have completed training and gained a qualification. We understand that a large percentage of these stakeholders have gone on to put their learning into practice. The fact that much of the training focused on practice as opposed to theory only made this possible.

The format and content of the training was well received and beneficial to trainees, the majority of whom, rated it very highly. The provision of different levels of training opened it up to a wider array of people and helped IGH to engage well with their target groups. The fact that all the training was accredited, while not a key factor, was also well received.

Over 1,000 people completed the training. Alongside these an additional 240 people from outside of the North East completed training. This is testament to the fact that there is a clear need for such training and that demand is high. The North East region benefitted from free training as part of this project which proved to be an important factor in terms of take-up. However, it also shows that there is a demand outside of the region and given the fact availability of such training is low, organisations and local authorities are willing to pay.

The Specialist Assessor training has been identified as a vital element in the success of this programme. Social work teams from across the region engaged to ensure that they were qualified to provide specialist deafblind assessments as required under the Care Act. A total of 206 staff are now qualified to provide these assessments. Again the fact that availability of such training from alternative sources is very low in the North East, the potential for local authorities failing to meet compliance in terms of specialist deafblind assessments would have been much higher without IGH input.

Almost 85% of those trained were in employment – 64% full time and 26% part time. It is difficult to accurately assess numbers of deafblind people supported by these staff as we cannot assume that all have had direct contact with deafblind people following the training. However, indications are that this is the case for many and that not only deafblind people but organisations from each of the sectors have reaped benefits as a result of this training.

While delivering training was the primary output for IGH, they have provided ongoing support to local authorities and voluntary sector organisations on how to improve services for deafblind people. This has resulted in two separate models of working in the two case study areas. The models were very different, using different approaches and the anticipated outcomes quite different from the main project. The local authority model case study allowed us to see how deafblindness could be embedded within a local authority. While not totally unproblematic, this model has identified some key methods that can be adopted in order to do this. This model continues to develop and the evidence does suggest that in terms of developing and testing processes and protocols, bringing grassroots, face to face staff into the mix, including deafblindness in publicity materials and rolling out the use of the ID Tool do offer insight to ways of achieving success. There is clear potential for this model to be replicated nationally.

Very few organisations nationally are involved with dual sensory loss. The fact that one voluntary sector organisation is taking steps to do that is a major accomplishment for this project. Working with the Board to review and update their Constitution was a major achievement and again while there remains some way to go until full changeover, there is little doubt that IGH has played a major role in this proposed transformation.

While additional work is required to complete both of these, without IGH input and support any headway made to date would have been substantially reduced or possibly never started. The importance of IGH in these areas cannot be downplayed. While commitment to succeed is present and there is a belief that this is the correct route to take, without direction and guidance this is likely to have been a much slower process. Even with IGH input, things moved slowly and this in itself created some frustrations. However, working together to continue this work has carried on and there are no indications that it is likely to stop as the IGH project comes to a close and Hi-Vis takes the helm.

The IGH work continued to evolve throughout its lifetime and while training provision remained at the heart of it, improving engagement with deafblind people through the Talk and Try and networking events also proved to be very successful. Deafblind people readily reported on the benefits they have had experienced as a result. Direct contact with IGH staff able to provide advice and ideas had very positive effects for many. In addition the development of the equipment loan service further supplemented the support provided.

The opportunity to test out equipment, ensure they could use it, that it did what it was meant to do and most importantly it met the needs of that person was hailed by many as one of the highpoints of the project.

Alongside meeting individual needs the IGH project also opened up good opportunities to bring people together thus improving engagement with the project but also building up self-confidence to explore more social activities. Social isolation is a real issue for many: deafblind people involved with the project reported it affected their mood, confidence, general health and wellbeing. While it is noted that the majority of these activities are provided through voluntary sector organisations and that resource issues are currently problematic, focus was given to informing improvements to existing services through raising staff awareness and offering new techniques particularly around communication. The evidence gathered also shows that IGH has achieved real success in this area.

There is little doubt that involvement with the IGH project has resulted in increased numbers of people being identified/recognised as being deafblind. While originally it had been anticipated that these people would be included in the register and/or be referred for a specialist deafblind assessment, this has not proven to be the case. In reality, many of those people identified as being deafblind are refusing consent to be registered or be assessed. While the project team can do little to change this, they have continued to provide direct support and also provide advice, information and support to any staff requesting it which has provided some continuity and the opportunity to refer people directly back into IGH as opposed to adult social care.

The evidence clearly supports success in achieving many of the expected outcomes. Given extra time and resources, these could easily have expanded. Future demand for specialist assessor training has the potential to increase significantly given the high staff turnover of social workers so Hi-Vis will continue to have an active role in this outside of this project.

This SROI evaluation shows that each of the stakeholder groups have benefitted from the changes brought about by the IGH Deafblindness Awareness Support Project. While for some it is about training and skills, for others it is more personal. For example, self-confidence, impacts on health and wellbeing, changes perceptions of self, improves communication and also access to services.

Findings show that the IGH Deafblindness Awareness Support Project has created a significant social value of £5.49 for every point invested in the project. This is based on a robust evaluation process using qualitative and quantitative techniques to ensure that any assumptions and estimates used are realistic and based on information provided by the key stakeholders.

Overall the evidence from this SROI evaluation supports the view that the IGH Deafblind Support Project has been successful in meeting its aims and objectives. Awareness of deafblindness is much higher than before, staff are better informed, qualified to support deafblind people and more confident when providing care. Some deafblind people were sure that without the support they received as a result of the training and direct support that it was highly likely that they would have needed residential care. As independence is very important to them, they were very thankful that this has been averted so far.

In conclusion, the evidence clearly shows that the IGH Deafblindness Awareness Support Project has been effective in bringing about change for stakeholders and deafblind people. IGH has continued to provide training and support taking a longer term view and is already identifying ways of escalating the current project to provide more focus on family carers and family members. A new national charity, Hi-Vis UK has been established to take the project’s work forward.

10. References

Age UK (2016). *Later Life in the United Kingdom Factsheet*. Age UK

Age UK (2015). *The health and care of older people in England 2015*. Age UK: London.

Age UK (2014) Improving later life: Services for older people – what works. Age UK: London

Alzheimer's Society (2014). Dementia UK Update. Alzheimer's Society: London

Barlow JG, Singh D, Bayer S, Curry R (2007). A systematic review of the benefits of home Telecare for frail elderly people and those with long-term conditions. *Journal of Telemedicine and Telecare*, vol 13, no 4, pp 172–79. Available at: www.ncbi.nlm.nih.gov/ pubmed/17565772 (accessed on 27 October 2010).

Bayer, S., & Barlow, J. (2010). Analysis of data on the impact of Telecare provided under Telecare capital grant. *: Imperial College Business School: London*.

Bonner, S., & Idris, T. (2012). Assistive technology as a means of supporting people with dementia: a review. *Housing, Learning & Improvement Network (HLIN)*. Available from https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Reports/HLIN_AT_Report.pdf (Accessed 8 November 2017).

Cartwright, M., Hirani, S., Rixon, L., Beynon, M., Doll, H., et al. (2013). Effect of telehealth on quality of life and psychological outcomes over 12 months (Whole Systems Demonstrator telehealth questionnaire study): nested study of patient reported outcomes in a pragmatic, cluster randomised controlled trial. *British Medical Journal*, 346, f653.

Davies, A., & Newman, S. (2011). *Evaluating Telecare and telehealth interventions.* The King's Fund: London.

Deafblind UK (2006) *Cause and cure: Deafblind people's experience of the NHS*. Deafblind UK: London.

Department of Health (2009). Whole System Demonstrators: An overview of Telecare and telehealth. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/ documents/digitalasset/dh_100947.pdf (Accessed on 21 October 2010).

Department of Health (2001) *National framework for older people*. DoH

Forder, J., & Fernandez, J. L. (2011). *Length of stay in care homes. PSSRU Discussion Paper 2769*. Personal Social Services Research Unit: Canterbury.

Fugiwara, D (2013) *Guide to Social Return on Investment.* HACT

Henderson, C., Beecham, J., & Knapp, M. (2013). The costs of Telecare and telehealth. *Unit Costs of Health & Social Care 2013*, 26-32.

HM Government (2007). Putting people first: A shared vision and commitment to the transformation of adult social care.Department of Health: London

HM Treasury (2011) Government Green Book. London TS. Accessed online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf. September 2017)

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS Med*, *7*(7), e1000316.

Mirando-Costillo et al (2010) People with dementia living alone: what are their needs and what kind of support are they receiving. International *Psychogeriatics, 22*(4) 607-617

National Housing Federation. (2012). On the pulse: housing routes to better health outcomes for older people. *London: National Housing Federation.*

Oliver, D., Foot, C., & Humphries, R. (2014). Making our health and care systems fit for an ageing population. *The King's Fund: London*.

Personal Social Services Research Unit (2010). The national evaluation of partnerships for older people projects.*Personal Social Services Research Unit: Canterbury.*

Scottish Collaboration for Public Health Research and Policy (2010). Promoting health and wellbeing in later life: interventions in primary care and community settings.Scottish Collaboration for Public Health Research and Policy: Edinburgh. Available at: www.scphrp.ac.uk/ node/198 (accessed on 21 November 2013).

Sense (2014). What does good care look like for a deafblind person? A report written for the Care Quality Commission (CQC). Sense: London.

SROI Network (2012) Guide to Social Return on Investment. SROI Network. Available from https://www.bond.org.uk/data/files/Cabinet_office_A_guide_to_Social_Return_on_Investment.pdf (Accessed 8 November 2017)

Steventon, A. & Bardsley, M. (2011). Partnership for older people: evaluation of impact on emergency hospital use. Available at: www.nuffieldtrust.org.uk/our-work/projects/partnershipolder-people-evaluation-impact-emergency-hospital-use (Accessed 17/05/2016).

Steventon, A., Bardsley, M., Billings, J., Dixon, J., Doll, H., et al. (2012). Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial. *BMJ*, *344*, p.e3874. 346, f653.

Tiwana, R, Benbow, SM, Kingston, P (2016). Late life acquired dual-sensory impairment: A systematic review of its impact on everyday competence. *British Journal of Visual Impairment, 34*, 203-213.

Wessels, R. Dijcks, B. Soede, M. Gelderblom, G.J. De Witte, L. (2003). Non-use of provided assistive technology devices, a literature overview. *Institute of Rehabilitation Research*.

Wilson, R.S., Krueger, K.R., Arnold, S.E., Schneider, J.A., Kelly, et al. (2007). Loneliness and risk of Alzheimer’s disease. *Archives of General Psychiatry*, *64*(2), pp.234-240.

Whittenberg, R, Sharpin, L, McCormick, B & Hurst, J. (2014) Understanding emergency hospital admissions of older people. Centre for Health Service Economics & Organisation (CHSEO): Oxford. Available from https://www.chseo.org.uk/downloads/report6-emergencyadmissions.pdf (Accessed 8 November 2017)

World Health Organisation (2015). World Report on Ageing and Health. WHO: Geneva.

11. Appendices

1. Questionnaire
2. Job roles of participants
3. Timeline
4. Talk & Try Events
5. SROI Impact Map
6. Deafblind Assessment Guidance

Appendix 1 – Questionnaire

Dual Sensory Loss Training Survey

Page 1: INTRODUCTION

Welcome to the Dual Sensory Loss Training Questionnaire

At Teesside University we are carrying out an evaluation of the Dual Sensory Loss Training provided by the "In Good Hands Project" which aims to provide a range of training for people working in the care sector, volunteers and family carers of people who have age related hearing and sight loss.

Why is this project being carried out?

- This project is funded by The Big Lottery and we would like to know what people think of the training they received, how they have used the training and what difference it has made.

Who can take part?

- We would like to hear from anyone who has participated in any of the training events.

How can I share my views?

- You can complete the online questionnaire to tell us what you thought about the training and any impact it has had on how you do your job or how you provide care and support to a person with dual sensory loss.
- Please be honest when filling in the questionnaire. All questionnaires will be anonymous and accurate information will help us to improve the training.
- If you feel that there are some questions you would rather not answer, leave them blank and move on.
- Questionnaires are submitted online and are anonymous so it is not possible to decide to withdraw your questionnaire once it has been submitted.

Thank you for taking the time to read this information.

If you have any further questions or would like to take part in a discussion group please fuse The Centre for Translational Research in Public Health

contact: Pat Watson, Health & Social Care Institute, Teesside University, Middlesbrough TS1 3BA, Tel: 01642 384167, Email: pat.watson@tees.ac.uk.

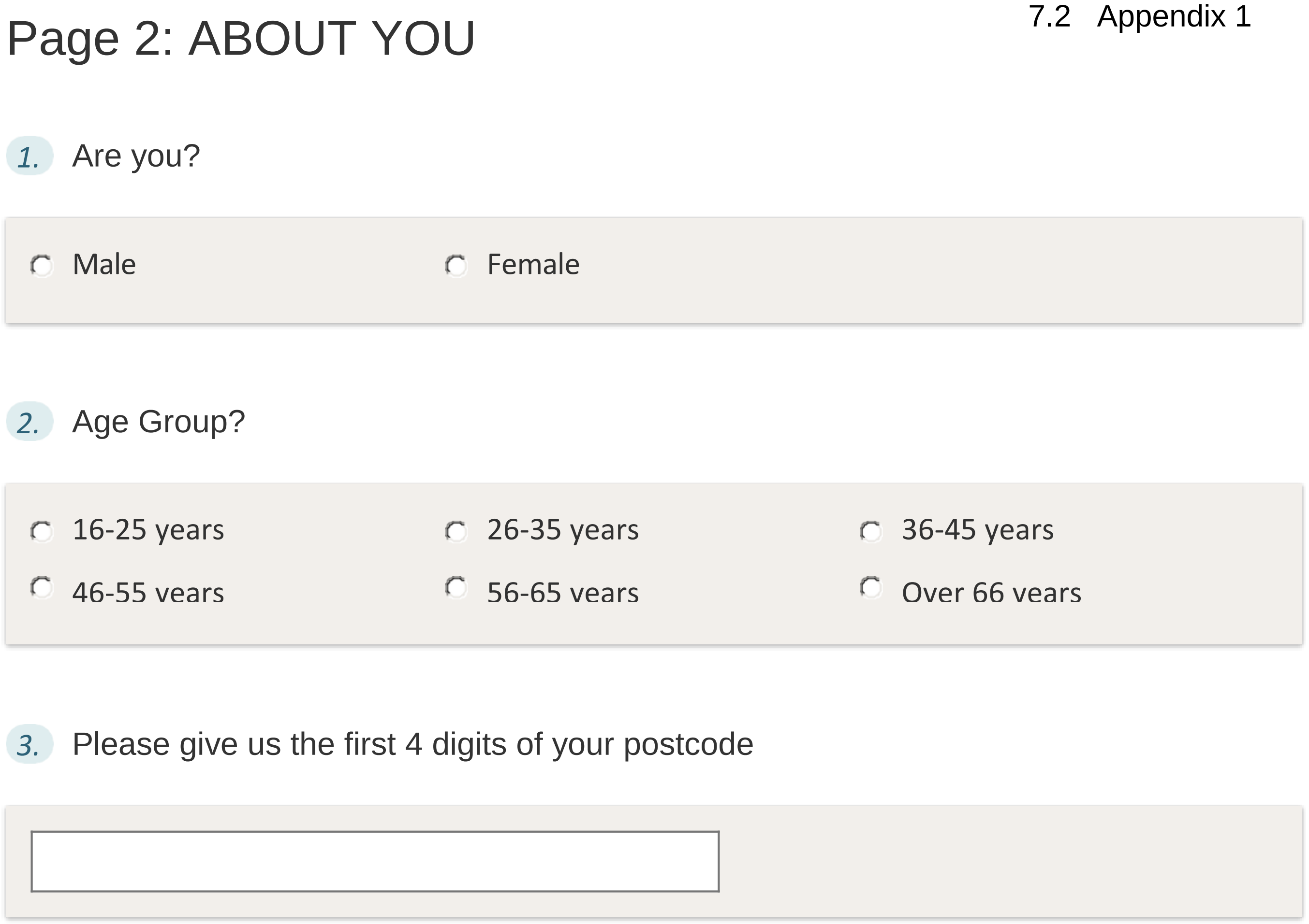
Additional instructions for the questionnaire:

As you will see, there are no 'submit' buttons in this questionnaire. Just click 'Next' at the end of each section. You cannot return to a page once you have clicked the 'Next' button.

You don't need to send your completed questionnaire to anyone. Your answers will be automatically submitted when you click “Finish” on the final page.

If there are any questions you would rather not answer, leave them blank and move on. Fully completed questionnaires would be of most value to us, but if you don't want to answer certain questions you do not have to.

7.2 Appendix 1



Page 2: ABOUT YOU

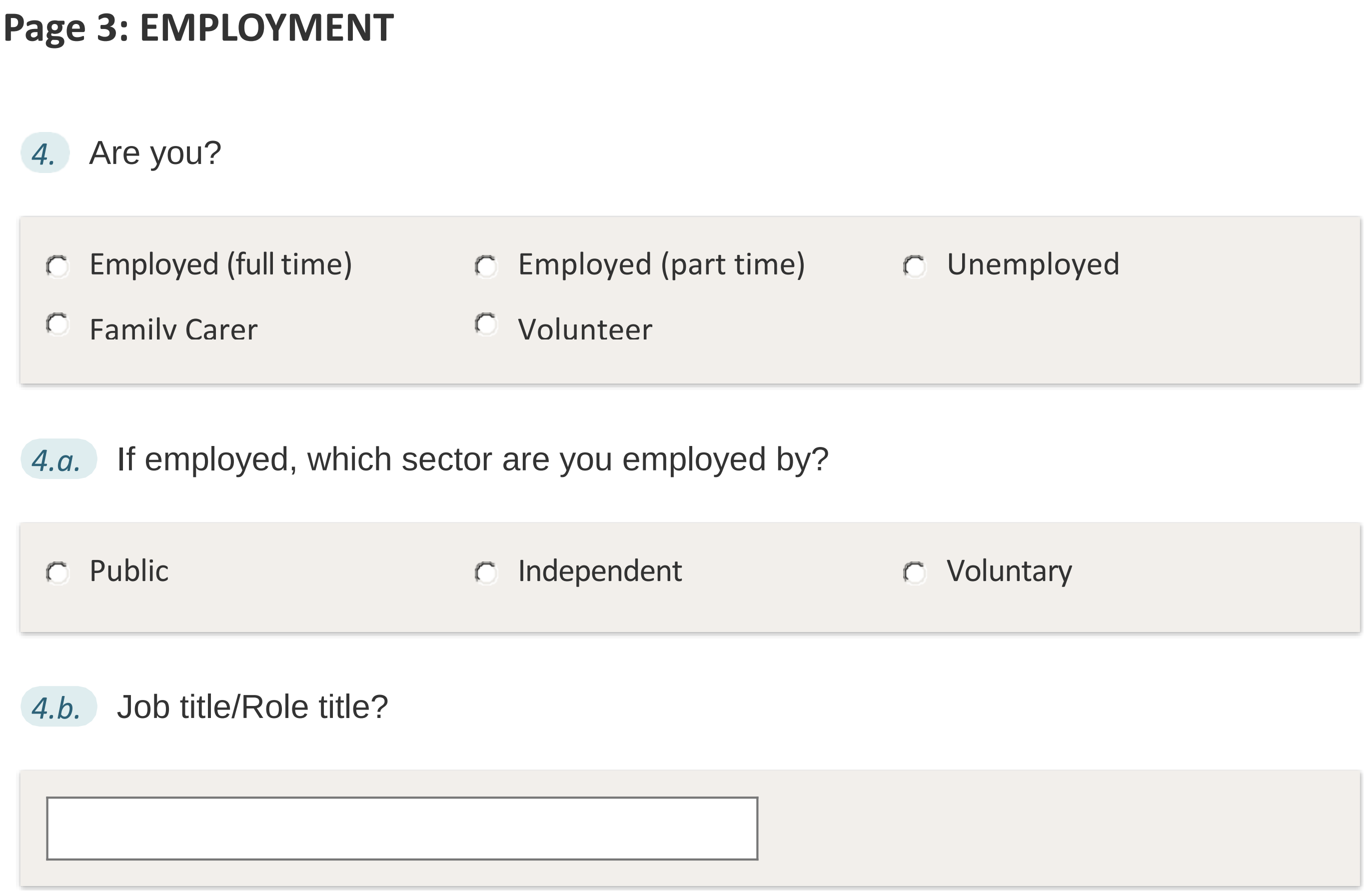
1. Are you?

○ Male ○ Female

2. Age Group?

○ 16-25 years ○ 26-35 years ○ 36-45 years
○ 46-55 years ○ 56-65 years ○ Over 66 years

3. Please give us the first 4 digits of your postcode



Page 3: EMPLOYMENT

4. Are you?

○ Employed (full time)	○ Employed (part time)	○ Unemployed
○ Family Carer	○ Volunteer	

4.a. If employed, which sector are you employed by?

○ Public ○ Independent ○ Voluntary

4.b. Job title/Role title?

Page 4: IN GOOD HANDS TRAINING - DEAFBLIND/SENSORY LOSS

5. Where did you hear about the Deafblind/Dual Sensory Loss Training?

5.a. If this was through 'In Good Hands' was this by:

○ Telephone
○ Email
○ Visit to website
○ Other

5.a.i. If you selected Other, please specify:

Page 5: IN GOOD HANDS TRAINING

6. Looking at the courses listed below, please could you tell us what you thought of them. IF YOU DID NOT TAKE PART IN THE COURSE, PLEASE TICK 'DID NOT DO THIS COURSE'

Please don't select more than 1 answer(s) per row.

	Very good	Good	Neither good nor poor	Poor	Very poor	Did not do this course
Foundation	☐	☐	☐	☐	☐	☐
Communicator Guide	☐	☐	☐	☐	☐	☐
Acquired Communication Disorder Facilitator	☐	☐	☐	☐	☐	☐
Specialist Assessor training	☐	☐	☐	☐	☐	☐

7. Why did you decide to participate in the training?

8. What did you expect to gain from the training?

9. Were your expectations met?

○ Yes ○ No

10. What were the 3 main learning points you took away from the training?

10.a. 1.

10.b. 2.

10.c. 3.

Page 6: EXPERIENCE OF SUPPORTING PEOPLE WHO HAVE DUAL SENSORY IMPAIRMENT

11. Have you experience of supporting people who are deafblind/dual sensory loss impaired in the past?

○ Yes ○ No

12. Are you currently supporting a person/people who are deafblind/dual sensory loss impaired?

○ Yes ○ No

13. Is this experience through your . . .

○ Work ○ Personal life ○ Both

14. Please explain what type of support/activities you have provided/do provide?

☐

15. What types of communication tecniques have you used to communicate with people who are deafblind/dual sensory loss impaired?

☐ Used a separate room or quieter area to talk to them

☐ Positioned yourselves within the room to maximise communication Produced
☐ large print documents
☐
Used Deafblind Manual
☐
Used Deafblind Block
☐
☐ Adjusted the lighting in the room
☐ Utilised a language support professional
☐ Wrote in bold pens on notepaper

15.a. If you selected Other, please specify:

Page 7: IMPLEMENTING TRAINING INTO PRACTICE

16. Have you put some of your learning into practice since the training?

○ Yes

○ No

16.a. If NO, can you tell us why . . .THEN GO TO QUESTION 32

16.b. If YES,please tell us what this was . . . THEN GO TO QUESTION 17

17. Did this include a referral for a specialist Deafblind Assessment to the social work team?

○ Yes

○ No

18. Did this involve a referral to another agency or organisation for additional help and support for your client?

○ Yes

○ No

18.a. If YES, can you please tell us which agencies or organisations?

19. As a result of the training have you developed and/or applied any strategies for reducing social isolation for people with dual sensory impairment you are working with/supporting?

○ Yes

○ No

19.a. If YES please tick all that apply

☐ Accessing new clubs/support groups/sessions	☐ Volunteer Support Worker	☐ Befriender
☐ Telephone Befriender	☐ Counselling Services	☐ Other

19.a.i. If you selected Other, please specify:

20. Please tell us how much you agree or disagree with the statements below:

Please don't select more than 1 answer(s) per row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The training was important to enable me to support my clients.	☐	☐	☐	☐	☐	☐
The training was beneficial to improving the support I give to my clients.	☐	☐	☐	☐	☐	☐
The training has helped me to be more confident when dealing with my clients.	☐	☐	☐	☐	☐	☐

Page 8: OUTCOMES

21. Do you feel you have changed some of your usual practices as a result of the training?

○ Yes ○ No

21.a. If YES can you please tell us how?

22. Do you feel you are able to support dual sensory loss impaired people better/differently as a result of the training?

○ Yes ○ No

23. In what way do you feel that your input has benefitted the client? (Tick all that apply)

☐ Awareness (provided ideas and self awareness)

☐ Confidence (engaging better, getting out and about more)

☐ Additional services (created links/used services

☐ Helped them to maximise or retain independence

☐ Helped them in

☐ Helped them in reducing social

☐

23.a. If you selected Other, please specify:

24. Have you identified any areas for improvement needed to support a person who is deafblind/dual sensory loss impaired to help rebuild confidence and/or retain independence?

○ Yes ○ No

24.a. If YES please state in what way

☐ Colour contrast

☐ Use of equipment (such as tactile markers, bold marker pens, signature guides, lighting eg task lamp, additional lighting on stairs

☐ Additional services

☐ Marked cane with tape

☐ Liquid level indicator

☐ Lighting Assessment

☐ Other

24.a.i. If you selected Other, please specify:

25. Have you taught any person with dual sensory loss any new skills as a result of your training?

○ Yes ○ No

25.a. If YES please tick all that apply

☐ Deafblind Block ☐ Deafblind Manual ☐ How to use a specific piece of equipment

☐ Other

25.a.i. If you selected Other, please specify:

26. Have you played a role in cascading your learning from the training to other colleagues?

○ Yes ○ No

27. Have you found the training useful in your personal life with family, friends or neighbours who are dual sensory impaired?

○ Yes ○ No

27.a. If YES, please give examples

28. Has your learning from the training resulted in changes to working practices across your organisation?

○ Yes ○ No

28.a. If YES please give examples

☐

29. Has your learning from the training resulted in any policy changes within your organisation?

○ Yes ○ No

29.a. If YES please give examples

☐

30. Have any changes in practice or policy resulted in resource implications for you or your organisation?

○ Yes ○ No

30.a. If YES was this due to . . . (tick all that apply)

☐ Staff time
☐ Cost of additional services
☐ Overall budgets
☐ An awareness that more staff need to have this knowledge
☐ Other

30.a.i. If you selected Other, please specify:

31. Have you or your organisation been able to save money/costs/staff time as a result of knowledge gained in the training?

○ Yes ○ No

31.a. If YES please give examples

32. Has your organisation participated in a "Talk and Try" Event?

○ Yes ○ No ○ Not applicable

33. Is there is anything you would like to add about the training, how you or your organisation have benefitted, how those people you support have benefitted please use the space below.

Page 9: THANK YOU

Thank you for taking the time to complete this questionnaire, it is much appreciated. Findings will be included in the final report to the Big Lottery in 2017. If you have any questions please do not hesitate to contact me. My contact details are:

Pat Watson

Research Fellow, Teesside
University Phone: 01642 384167
Email: pat.watson@tees.ac.uk

Appendix 2 – Job roles

Community support officer

Activities Co-ordinator

Activities leader

Admin Assistant

Administrative Officer

Adult Social Care Team Manager

Advocacy, Rights and Awareness Manager

Advocate

Area manager

Assessing Officer within Adult Physical and Mental Health team

Assessment & Review Officer

Assessor

Assessor for the Visually Impaired

Business Admin Apprentice

Business Support Analyst

Care assistant

Care Manager

Care Navigator

Care Navigator

Care Worker

Carer

Carers Lead Officer

Caseworker

Communication and events coordinator

Community Development Worker

Community Engagement Officer

Community Evaluator

Community Service Manager

Community Support Officer

Contact Officer

Counsellor/People with sight loss

Customer & Business Assistant

Customer & Business Officer

Customer and Business Assistant

Customer and Business support officer

Deaf Services Officer

Dementia Adviser

Deputy manager

Development Worker

Director

Disability Forum co-ordinator

Dual sensory specialist

Employment Advisor

Employment Team Leader

Equality officer

Equipment/Rehab Officer Deaf Services Team

Freelance Consultant

Funding Manager

GC Service Manager

Hard of Hearing worker

Head of Services

Retired Nurse

Hearing Impairment Officer

Housing Officer

Independent living coordinator

Independent Living Coordinator

Lead on Learning Disabilities Executive Committee

Line manager /coordinator

Local Taxation and Housing Benefit Officer

Logistics Manager

Manager

MSI Teacher

MSI Teacher (in Training)

Occupational Therapy Assistant

Occupational Therapist

Office manager

Operations Manager

Outdoor Instructor

Paediatric Hospital Social Worker

Parent carer assessment worker

Peer Support Manager

Pharmacy Assistant

Pharmacy Technician

Project Officer

Project Support Worker

Psychotherapist

Reablement Assessor

Registered Manager

Rehabilitation Officer Visual Impairment

Resource Officer

Scheme Officer

Self-employed qualified Lip speaker

Senior Care Officer

Senior Community Engagement Officer

Senior Customer and Business Officer

Sensory Impairment rehab officer

Sensory Needs Officer

Sensory Service Team Manager

Service Manager

Sheltered Housing Scheme Officer

Social Care Assessor

Social Care Officer

Social Services Officer

Social Worker

Specialist Hearing Assessor

Staff Nurse

Student

Support Worker

Team Leader

Team Manager

Technical Officer

Training Co-ordinator

Training Manager

Troubled Families Work Coach

Unpaid Social Worker Returnee

Voluntary Services Manager

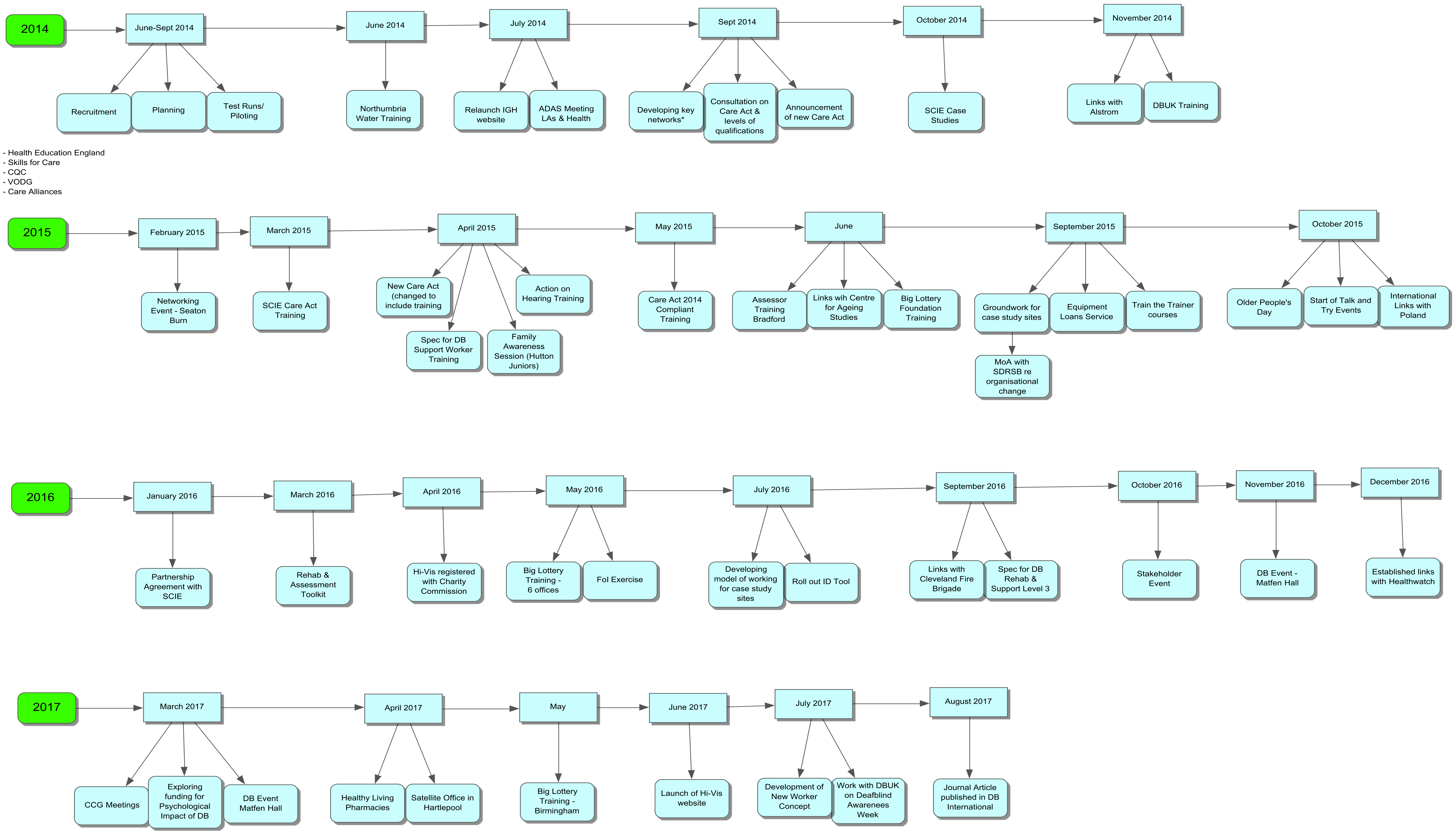
Volunteer

Volunteer Co-ordinator

Volunteer Manager

Workforce Development Manager

Appendix 3 – Timeline



Appendix 4 – Talk and Try Events

Location	Total attendees	Amount of people identified as Having dual sensory loss/DB
Eastbourne House	16	3
One Stop Shop	13	1
St Martins Community Centre	22	2
Bensham Grove	1	1
Age UK, Durham	15	3
Ferndale Court, Consett	19	2
St Pauls Court (Anchor) Alnwick	10	3
Blind Life, Simpasture Crt, Newton Aycliffe	17	6
Resource Centre, Middlesbrough	10	1
Hollis Court, Middlesbrough	5	5
Redesdale Court, North Shields	11	2
Durham Catherdral	23	2
Age UK, North Road	3	2
Search	3	1
Hartfields 1	12	4
Sunderland RP Group	3	2
Bullion Hall	9	3
Hartfields 2	4	3
Hartfields 3	4	2
Carers Hartlepool	2	1
Total of attendees	**202**	49

Referrals made from Talk and Try Events

- AOHL Hear to Help Service (hearing aid maintenance)
- Sight Tests, Hearing Tests, Sensory Assessments (Sight and Hearing)
- RNIB Equipment and other services including talking books, Large Print TV Guide and Newspapers.
- Freeman Hospital - due to difficulties with hearing aids
- Rehabilitation
- Action on Hearing Loss Equipment Brochures/Advice Leaflets
- Mobility,
- Durham Deafened Support
- Age Concern
- Durham Deafened Support, Equipment Demo, information and advice
- Local blind societies/associations for services including volunteer visiting service, telephone befriending equipment demo, newsletters, information days, clubs and support groups
- Local Deaf Centres
- Local Authority Sensory Support Teams, Blind Registration Card, free equipment/services including Specialist Deafblind Assessment
- Low Vision Services for Low Vison Assessments/Magnifiers
- IGH Equipment Demo, Loan Service advice and information including info on training for anyone support an older person.
- British Wireless for the Blind Service (Accessible Radios/CD Players/USB)
- BT Free Directory Service for the blind
- Info about red and white cane, white walking sticks, rehabilitation, IGH Computer support, advice and information, eccentric viewing techniques, mobility and lighting assessment. Preparation Rehab Assessment IGH, lighting advice, RNIB Equipment
- Hobbies
- Discussed counselling services
- Explaining how to use magnifier correctly (correct distance from page, expectations etc)
- Information on Tinnitus masking devices
- TV Licence (free for Blind)
- OT Assessment
- GP for referral to other services including Low Vision and audiologist referrals
- Eye Condition Information/Leaflets

Stage 1		Stage 2				Stage 3								Stage 4											
Stakeholders	**Intended/unintended changes**	**Inputs**		**Outputs**	**The Outcomes (what changes)**									**Deadweight %**	**Displacement %**	**Attribution %**	**Drop off %**	**Impact**		**Calculating Social Return**					
Who do we have an affect on? Who has an effect on us?	What do you think will change for them?	What do they invest?	What is the value of the inputs in currency *(only enter numbers)*	Summary of activity in numbers	Description	Indicator	Source	Quantity	Duration	Outcomes start	Financial Proxy	Value in currency	Source	What would have happened without the activity?	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Quantity times financial proxy, less deadweight, displacement and attribution		Discount rate		3.5%			
					How will the stakeholder describe the changes?	How would you measure it?	Where will you get the information from?	How much change was there?	How long does it last after end of activity? *(Only enter numbers)*	Does it start in period of activity (1) or in period after (2)	What proxy would you use to value the change?	What is the value of the change? *(Only enter numbers)*	Where did you get the information from?							**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Local Authorities - adult social care managers, social workers, social care officers	Compliance with Care Act requirements	Accommodatoin Costs	£2,000	Care Act Training Deafblind Awareness Training Deafblind Spcialist Assessment Training Communication Training Steps towards Care Act compliance	LAs have a named lead person for deafblind issues who is now known to staff	Number of LAs with named lead person	*Monitoring data *Freedom of Information materials *Interviews *Questionnaires	12	3	2	Average cost penalties for non compliance	£10,000	Care Act	30%	0%	20%	0%	67,200.00		67,200.00		67,200.00	67,200.00	0.00	0.00
	More staff qualified in deafblind assessments				Increased awareness of deafblindness	Numbers reporting increased awareness	*Monitoring data *Interviews *Questionnaires	343	4	2	Average estimated value for increased awareness	£215	GVE	20%	0%	10%	50%	53,096.40		53,096.40		26,548.20	13,274.10	6,637.05	0.00
	Raised awareness and understanding of deafblind issues				Number of deafblind assessments	Number of assessments completed	*Monitoring data *Interviews *Questionnaires	23	4	2	SW hourly rates for assessment - 2 hours per assessment	£200	PSSRU	20%	0%	0%	20%	3,680.00		3,680.00		2,944.00	2,355.20	1,884.16	0.00
	Staff trained in identification of deafblind people				Staff qualified to level 3 in compliance with Care Act requirements	Number of staff qualified to level 3	*Monitoring data *Interviews *Questionnaires	206	3	2	Value of training for individuals	£1,798	GVE	0%	0%	0%	20%	370,388.00		370,388.00		296,310.40	237,048.32	0.00	0.00
					Staff reporting increased confidence	Feedback from people completing the training	* Interviews * Questionnaires	275	4	2	Social confidence values	£995	GVE	20%	0%	0%	30%	218,900.00		218,900.00		153,230.00	107,261.00	75,082.70	0.00
					Staff reporting putting learning into practice	Feedback from people completing the training	* Interviews * Questionnaires	172	4	2	Average cost of services accessed per year	£826	GVE	20%	0%	20%	30%	90,926.08		90,926.08		63,648.26	44,553.78	31,187.65	0.00
					Local authorities in region who are Care Act compliant	Numbers of local authorities in region who are Care Act compliant	* Interviews *Freedom of Information data	3	3	2	Penalties for non-compliance	£10,000	Care Act	20%	0%	20%	0%	19,200.00		19,200.00		19,200.00	19,200.00	0.00	0.00
Independent Care Sector	Care staff trained in deafblind awareness	Staff time (offset by training costs	£0	Deafblind Assessment Training Communication Training ACD Training	Staff more aware of deafblindness	Feedback from people completing the training	* Interviews * Monitoring data	336	4	2	Estimated value of increased awareness	£215	GVE	20%	0%	10%	30%	52,012.80		52,012.80		36,408.96	25,486.27	17,840.39	0.00
	Improved communication with deafblind people				Increased confidence and skills in caring for deafblind people	Feedback from people completing the training	* Interviews * Monitoring data * Questionnaires	269	4	2	Social confidence values	£995	GVE	20%	0%	10%	30%	192,711.60		192,711.60		134,898.12	94,428.68	66,100.08	0.00
	Increase in number of clients identified as deafblind				Providing more appropriate care	Numbers reporting providing care to meet individual needs care	* Interviews * Monitoring data * Questionnaires	168	4	2	Average cost of accessing services per year	£826	GVE	20%	0%	10%	30%	99,912.96		99,912.96		69,939.07	48,957.35	34,270.15	0.00
					Improved care and support	Numbers reporting improved care	* Interviews * Monitoring data * Questionnaires	168	4	2	Average cost of accessing services per year	£826	GVE	20%	0%	10%	30%	99,912.96		99,912.96		69,939.07	48,957.35	34,270.15	0.00
					Staff gaining accredited training	Numbers of staff gaining accredited training	* Monitoring data * Questionnaires	336	3	2	Value of training for individuals	£1,798	GVE	0%	0%	0%	50%	604,128.00		604,128.00		302,064.00	151,032.00	0.00	0.00
	Clear pathways to LA for recording and assessment of clients as deafblind				Staff reporting they are better able to communicate with deafblind people	Numbers of staff reporting improved skills in communicating with deafblind people	* Interviews * Monitoring data * Questionnaires	269	4	2	Social confidence values - putting learning into practice	£995	GVE	20%	0%	10%	30%	192,711.60		192,711.60		134,898.12	94,428.68	66,100.08	0.00
Voluntary sector organisations	Increase in numbers of VCS organisations/staff/volunteers supporting deafblind people	Staff time (offset by training costs		Deafblind Assessment Training Communication Training ACD Training Accessing specialist support to facilitate future policy changes Changes in organisational policy	Staff and volunteers more aware of deafblindness	Feedback from people completing the training	* Interviews * Questionnaires	299	4	2	Estimated value of increased awareness	£215	GVE	20%	0%	20%	30%	41,142.40		41,142.40		28,799.68	20,159.78	14,111.84	0.00
	Staff trained in deafblind awareness				An increase in volunteers supporting deafblind people	Numbers of volunteers reported as supporting deafblind people	* Interviews * Questionnaires	50	4	2	Average cost of volunteering	£7,490	GVE	25%	0%	20%	50%	224,700.00		224,700.00		112,350.00	56,175.00	28,087.50	0.00
	Volunteers trained in deafblind awareness				An increase in number of deafblind people accessing voluntary sector services	More people reported as accessing voluntary sector services	* Interviews * Monitoring data * Questionnaires	90	4	2	Average cost of accessing services per year	£826	GVE	20%	0%	20%	30%	47,577.60		47,577.60		33,304.32	23,313.02	16,319.12	0.00
					Increase in number of people identified as deafblind	Number of people recorded/registered as deafblind	* Interviews * Monitoring data * Questionnaires	300	4	2	Estimated value of increased awareness	£215	GVE	20%	0%	10%	20%	46,440.00		46,440.00		37,152.00	29,721.60	23,777.28	0.00
					Improved services to deafblind people	More people reported as receiving better services and support	* Interviews * Monitoring data * Questionnaires	120	4	2	Average cost of services accessed per year	£826	GVE	20%	0%	20%	30%	63,436.80		63,436.80		44,405.76	31,084.03	21,758.82	0.00
					Changes in organisational policy	Numbers of policy changes reported	* Interviews	2	3	2	Value of training for individuals	£1,798	GVE	40%	0%	20%	50%	1,726.08		1,726.08		863.04	431.52	0.00	0.00

7.2 Appendix 1

Stage 1		Stage 2				Stage 3								Stage 4											
Stakeholders	**Intended/unintended changes**	**Inputs**		**Outputs**	**The Outcomes (what changes)**									**Deadweight %**	**Displacement %**	**Attribution %**	**Drop off %**	**Impact**		**Calculating Social Return**					
Who do we have an affect on? Who has an effect on us?	What do you think will change for them?	What do they invest?	What is the value of the inputs in currency	Summary of activity in numbers	Description	Indicator	Source	Quantity	Duration	Outcomes start	Financial Proxy	Value in currency	Source	What would have happened without the	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future	Quantity times financial proxy, less deadweight		Discount rate		3.5%			
					How will the stakeholder describe	How would you measure it?	Where will you get the	How much	How long does it	Does it start in period of	What proxy would you use	What is the value of the	Where did you get the							**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Deafblind people	Receiving more appropriate support	Service beneficiaries	£0	Accessing specialist support Attending information sessions Attending network events Requesting and accessing relevant services	Deafblind people more socially active	Numbers of people reporting being more socially active	* Interviews * Monitoring data * Questionnaires	175	4	2	Average value of regular soial activities/interactions	£1,850	Health & Wellbeing measures	20%	0%	40%	30%	155,400.00		155,400.00		108,780.00	76,146.00	53,302.20	0.00
	In receipt of deafblind assessments				People reporting improved/more effective support	People reporting improved/more effective support	* Interviews * Monitoring data * Questionnaires	270	4	2	Average cost of services accessed per year	£826	GVE	20%	0%	20%	30%	142,732.80		142,732.80		99,912.96	69,939.07	48,957.35	0.00
	Improved services				People receiving full deafblind assessments	Numbers of specialist assessments	* Interviews * Questionnaires	25	4	2	Average cost of services accessed per year	£826	GVE	10%	0%	20%	0%	14,868.00		14,868.00		14,868.00	14,868.00	14,868.00	0.00
	Reduced social isolation/engaged or re-engaged in activities				People reporting improved quality of life	Numbers reporting reduction in stress/anxiety	* Interviews * Monitoring data * Questionnaires	108	4	2	WTP for stress reduction therapies	£210	GVE	10%	0%	40%	40%	12,247.20		12,247.20					
	Re[prting improved sense of wellbeing				Improved perception of own health and wellbeing	Numbers reporting improved perceptions of own health and abilities	* Interviews	189	4	2	Functional independence	£1,400		10%	0%	30%	30%	166,698.00		166,698.00		116,688.60	81,682.02	57,177.41	0.00
					People remaining independent in own home for longer	Those reporting likelihood of residental care without additional support	* Interviews	27	4	2	Average residential care costs	£28,756	PSSRU	50%	0%	50%	50%	194,103.00		194,103.00		97,051.50	48,525.75	24,262.88	0.00
IGH	Bespoke training packages designed and delivered across sectors and at different levels	Project funding (Big Lottery)	£993,000.00	Deliver training	Training Provided	Numbers of people trained	* Monitoring data	1052	4	2	Average costs of training per person	-£399	GVE	20%	0%	0%	70%	-335,798.40		-335,798.40		-100,739.52	-30,221.86	-9,066.56	0.00
					Improved organisational profile	Greater involvement with out of area and	* Project documentation	22	4	2	Greater unvolvement	£1,772	GVE	20%	0%	30%	20%	21,831.04		21,831.04		17,464.83	13,971.87	11,177.49	0.00
					Provision of direct services	Time spent providing direct support	* Interviews * Project documentation	1000	4	2	Average hourly rates	£20	PSSRU	0%	0%	0%	70%	20,000.00		20,000.00		6,000.00	1,800.00	540.00	0.00
		Total	£995,000.00														**Total**	2,881,884.92		2,881,884.92		1,994,129.41	1,391,778.54	638,645.73	0.00
																	Present value of each year			2,784,429.87		1,861,541.14	1,255,304.51	556,542.86	0.00
																	Total Present Value (PV)								6,457,818.38
																	Net Present Value								5,462,818.38
																	(PV minus the investment)								
																	Social Return								**£5.49**
																	Value per amount invested								

Appendix 6 – Deafblind Specialist Assessment

At the beginning the Local Authority must find out what the person requires in terms of accessible information and communications. This involves ensuring their communications/ forms are all in accessible format/communication is in a suitable form for that older person. This required under Disability Discrimination (1995) (within Equalities Act 2010) and the NHS Accessible Information Standard 2015.

An assessment to help determine eligibility under the Care Act for social care for someone with acquired dual sensory loss involves at least two face to face conversations. This means making visits so travel time and making necessary plans for each visit need to be added to the time / cost of assessment. They will require being conducted in different locations to understand the full impact of the sight and hearing loss when in the various environments that are central to the person's lifestyle, wishes and needs. The conversations will involve not only questioning and listening but also watching the person demonstrate how their dual sensory loss affects every day tasks. This will almost certainly require an assessment of lighting and mobility around the home/outside. Communication may take longer with or without professional communication support. Understanding and completing forms will either be impossible / inappropriate or need to be taken at a pace that ensures the person is always at the centre of the process. If early intervention teams wish to try out some interventions before completing the assessment, allowed under the Care Act, then this will require more visits to demonstrate the effectiveness and impact on the need. If more than one professional is needed to look at the need then of course the cost / time is per person involved.

Look at this linear pathway to see how many people could be involved in current LA social care assessment practice (simple example):

- Adult visits/contacts LA for help
- Contact centre deals with their queries initially –
- Referred to early intervention team for initial visit –
- More complex than thought as dual sensory identified –
- Triaged up to more experienced or sensory trained social; care staff or social worker
- Follow up visit by more experienced social care staff
- Range of assessments (could be included one or two visits) covering practical issues and solutions
- Assessment findings fed into determination statement for decision by LA and/or some interventions tried so determination paused to see if these have any effect
- Determine eligibility under the Care Act
- Share draft findings with dual sensory person
- Once agreed assessment concluded (for now).

Back cover