



Supporting Wellbeing and Independence for Frailty (SWIFT)

Time to Shine report
June 2019



About Time to Shine

Run by Leeds Older People's Forum, Time to Shine aims to reduce social isolation and loneliness of the older population in Leeds.

Our vision is that older people need not experience loneliness and social isolation as an inevitable consequence of ageing but that our project will offer opportunities for fulfilment by breaking down barriers and building strong communities.

Time to Shine is one of fourteen areas which form Ageing Better; an ambitious large scale programme funded and developed by The National Lottery Community Fund. Ageing Better aims to improve the lives of people aged 50 and over by reducing social isolation and loneliness.

Introduction

The aim of this report is to provide a reflection on the Supporting Wellbeing and Independence for Frailty (SWIFt) service.

SWIFt was developed in 2016 with funding from the Leeds Clinical Commissioning Group(s) and Time to Shine. It brought together five third sector organisations to support socially isolated and lonely older people. By creating a referral pathway from health and social care the service has supported those often thought to be the most lonely.



The SWIFt model

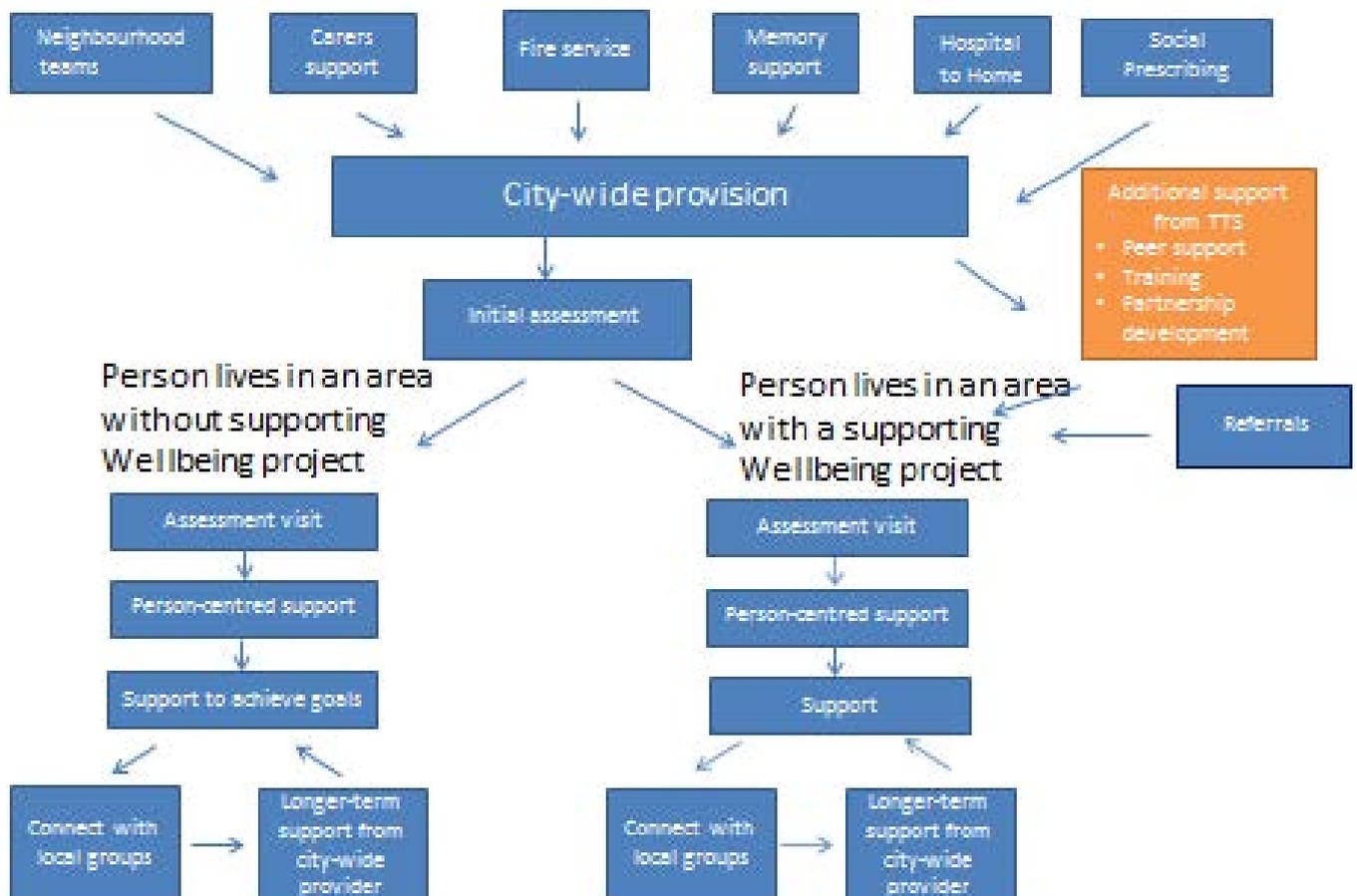
The SWIFt model was developed through consultation with voluntary sector organisations, health partners and older people. The important need to develop stronger working relationships with health and social care professionals was highlighted. In addition to this the need for flexible support for older people with increased frailty and those restricted to their own home was highlighted as a priority. It was felt that services are often time limited and staff resources restricted.

A model was developed to establish a referral pathway from health and social care providers. The referrals would be met by third sector providers who would have increased capacity to work on a one-to-one basis with the older person. Time would be taken to understand the older person's needs and aspirations. Support would then be provided to work alongside the individual to help them achieve their goals.

The model aimed to utilise the flexibility of a city-wide provider and the local knowledge and insight of four geographically focused projects.

After an open commissioning process in 2016 five organisations were awarded contracts to deliver this person-centred service:

- Age UK Leeds (city-wide provider)
- OPAL (in partnership with MAECare)
- Bramley Elderly Action
- Health for All
- Crossgates & District Good Neighbours



The difference SWIFt has made

Since the start of the service in 2016 the five SWIFt projects have worked hard to provide more person-centred support to older people experiencing frailty than is routinely available.

- The service worked with 983 clients
- 92 volunteers have given 2973 hours of their time to support the projects
- 3,332 home visits have been undertaken

The service has provided one-to-one support to an older person who has been identified as socially isolated, frail and in need of additional support. The worker visits the older person in their home and discusses their current circumstances. Together they discuss a plan of how to improve their quality of life. This could be through reconnecting with friends, joining a social group or giving someone the reassurance that support is there if needed.

The service has been heavily evaluated by self-reported tools such as questionnaires and an independent NHS evaluation using health and social care data.

The self-reported questionnaire was completed, where possible, before and after the intervention:

Loneliness

The De Jong scale measures loneliness. 162 older people fully completed this scale at entry and after the intervention. The average scores improved between entry and exit of the programme.

Results also indicate that the individual feels more lonely on entry to the service than for Time to Shine or wider Ageing Better projects.



The UCLA scales

The UCLA also measures loneliness. 163 people completed this scale at entry and exit, whereby more individuals improved. Results indicate that the individual feels more lonely on entry to SWIFt projects than other Time to Shine or Ageing Better projects.



Quality of life

169 people completed this scale at entry and exit from the service. For the majority of those average scores have improved.

The entry average for SWIFt indicates that the person has lower quality of life on entry to SWIFt than for wider Ageing Better projects.



Evaluation results

SWEMWEBS

The Warwick-Edinburgh Mental Wellbeing scale measures improvements to wellbeing. The entry average for SWIFt indicates that a person has a poorer wellbeing state on entry to the project. Again average scores have improved.

Matched cohort

A matched cohort technique was used to evaluate the impact of the SWIFt service on demand for health and social care resources such as Accident and Emergency admissions. Through collection of the individual's NHS number, the evaluation used the Leeds Data Model to access health and care resources that the cohort of people supported by SWIFt consume.

This evaluation compared a sample of the people who went through the service against a similar cohort selected by a matching programme. Overall this evaluation was limited by the small cohorts who have received support from the service for significant amounts of time, although emerging evidence suggests:

- The 'typical' person supported by SWIFt lives in an area with high deprivation, has more multiple long-term conditions and a greater level of frailty than average for the city.
- There is a lower mortality rate for people supported by the SWIFt service than the match cohort.
- Broadly stable A&E attendances for the intervention and matched cohort. However some evidence of a greater proportion of attendances resulting in a hospital admission for the SWIFt cohort in comparison with the control group, which could suggest more appropriate A&E attendances.
- Large proportions of the population supported by SWIFt neither attended A&E or admitted to hospital, with only a third admitted to hospital.
- Those who were admitted saw increased lengths of stay at hospital for older people supported by SWIFt service.
- Early signs of increases in some planned health care activity such as attendances from community health for the SWIFt group, but reductions in other types of planned activity such as outpatient and community based adult social care packages of care.
- Some early indications have shown a potential increase in health care costs to the commissioners for the intervention group in comparison to the match cohort.
- More evaluation is needed to examine the longer-term impact of the project. The evaluation relied on the collection of NHS number from the client. Many projects experienced difficulties in obtaining the number, so an easier method for collecting
- NHS numbers will increase the number of cases reported.

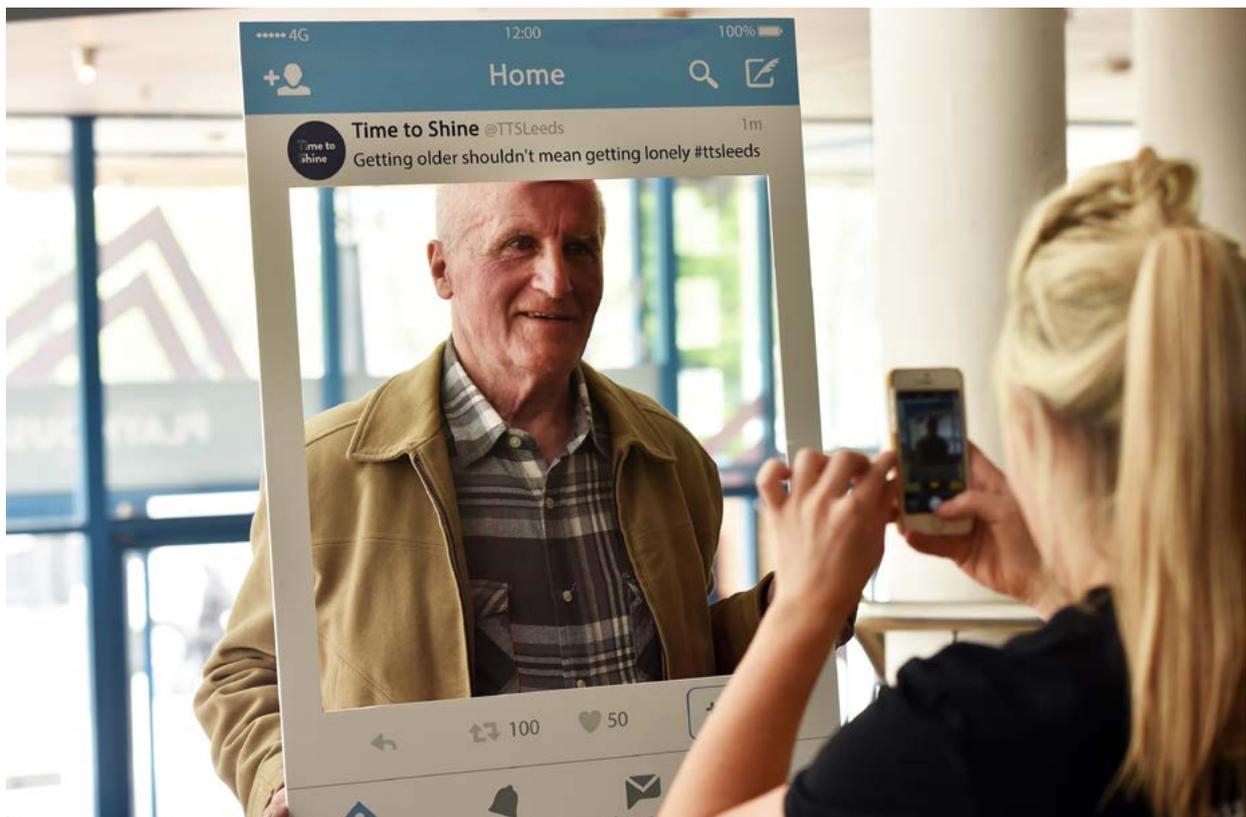
Case study

Mr and Mrs Moore have been able to reconnect to their social networks and build their confidence. Mr and Mrs Moore are in their 90's and were an active couple. However since Mr Moore's fall and Mrs Moore's recent dementia diagnosis they had become more isolated.

Following the fall, Mr Moore had a hip replacement. The lack of a grab rail outside their house also prevented them from leaving the house. They are a very close couple and rarely did things without each other. Before Mr Moore's fall they regularly attended the lunch clubs at OPAL together. When Mr Moore was unable to go Mrs Moore also stopped attending. Mrs Moore's recent dementia diagnosis has also affected her confidence to go out. Before the diagnosis Mrs Moore would meet up with friends for coffee and attend a poetry club. However, after getting lost on the bus a few times she decided not to go out again on her own.

When the SWIFt project worker visited the couple they were hesitant to engage. However, after a few visits, Mrs Moore agreed to go for walks with the project worker. The project worker succeeded in building a positive relationship with the couple and eventually Mrs Moore agreed to come to the lunch club without her husband; at first with the worker and then with the help of volunteers. Mrs Moore enjoyed this and has begun attending on a regular basis. Attending groups alone has been a big step in improving Mrs Moore's confidence and independence.

The worker was able to follow up the family's request for handrails to be installed and since then Mr Moore has been able to leave the house and also attend social activities again. The project has helped both Mr and Mrs Moore to reconnect with their social networks and attend regular social and physical activities. The project was able to offer timely and sensitive support which has led to much longer-term positive outcomes.



Key learning

The person-centred approach worked well, enabled project workers to go at the pace of the older person and allowed sensitivity to their needs. The positive attitude of project workers enabled older people to work through their own solutions.

Although projects worked hard to develop a clear referral pathway, at times referrals from health and social care professionals were slow and referrals were taken from a variety of sources including self referrals and family.

Projects worked well when a relationship of trust was built between the referral organisation and the project worker. Often the complexity of the situation was not clear on the referral. Referrals received stated a need for social support, although through assessment discovered a plethora of complex issues. Through time and the skill of the worker, staff unpicked the holistic needs of the individual. Issues such as mental health, housing and financial difficulties were extremely common. The additional capacity the funding was able to provide allowed these issues to be addressed before moving on to the purpose of the referral.

Projects worked well when a strong and open relationship was developed with Health and Social Care providers keeping the needs of the individual at the heart of the work. Staff worked alongside local health and social care professionals to compliment each other to reach the best outcome for the individual. Regularly attending local multi-disciplinary teams was seen as key to this.

All projects worked flexibly to achieve outcomes; many projects had planned to use a defined intervention model, for example 12 weeks in length. This was often used as a guide with many older people supported for longer periods of time.

The SWIFt service is heavily evaluated and the learning gathered as a result is invaluable. Often projects found the evaluation onerous. More often than not it was difficult to ascertain when to introduce the evaluation forms as it was vital to build up trust of the older person before introducing additional paperwork. Some older people refused to complete the monitoring or, due to the level of need the older person is experiencing, the forms were seen as inappropriate.



Photo credits for this report: Paula Solloway

Recommendations and references

The development of the service since 2016 has effectively supported older people experiencing frailty. Despite evidence of the positive individual outcomes the wider impact on health care resources is unclear. Further evaluation is needed to understand the costs/savings of this level of support.

One of the successes of the service has been the holistic and caring approach developed by the five projects, alongside the positive view that older people, despite many barriers, have a right and should have the opportunity for improved quality of life.

The service was developed alongside third sector providers with individuals and professionals experienced in working directly with older people. From the service's inception, trusted relationships between referrers, projects and commissioners have enabled wider learning and a deeper understanding of some of the difficulties of this work.

We are thrilled that Leeds City Council is now commissioning and expanding this service. In 2019 the Council through iBCF funding is committed to rolling this service out to a further six localities in the city, focusing specifically in areas with high numbers of older people experiencing frailty.

Further information about the SWIFt service, including the SWIFt interim evaluation conducted by the Health and Care Evaluation service can be found on the Time to Shine website: www.timetoshineleeds.org

