Support Coordination Service
ALONE-HSE Pilot
Dublin North City & County

External Expert Review

WRC – October 5, 2018

Contents

Executive Summary

This report presents the results from a high-level review of the operation and outcomes from the ALONE-HSE Support Coordination pilot service for older persons in Dublin North City and County. The pilot project began in January 2017 and the review commenced in May 2018.

The ALONE service in the pilot project includes Befriending and Support Coordination. These are core elements of the supports that ALONE have been providing to clients in the Dublin region for quite some time, with funding derived from its own resources. HSE provided funding for ALONE to pilot a substantial expansion of the reach and volume of these services across the CHO9 area, and encouraged community and hospital services in the area to refer relevant clients to ALONE. During the period covered by the review some clients used only the befriending service, others availed of support coordination only, and some availed of both.

The befriending service arranges volunteers to make regular visits to older persons who are socially isolated; the support coordination service helps older persons to access the services and supports they need to remain living at home and maintain a good quality of life. It is a unique service that straddles a broad spectrum of key areas of support, including housing-related issues, health and social care, financial matters, and social participation. The service takes a holistic view of vulnerable older persons' needs and aims to facilitate and coordinate access to the various supports that can address these needs.

The review aimed to assess the pilot project process and outcomes, highlight key areas of value and contribution, and provide input to planning for the further development of the service. It included:

- review of project documentation and data
- analysis of the ALONE client database
- gathering feedback from service users and health & social care professionals making referrals
- review of the policy context and wider evidence on the value case for this type of service.

Main results of the review

The review's overall conclusion is that the pilot ALONE-HSE initiative has been broadly working very well and is providing a valuable contribution in addressing client needs and supporting HSE services. This supports the case for continuation and mainstreaming, with some existing aspects continued more-or-less 'as is' and a number of possible refinements that might improve quality and impact. Resourcing issues will also need attention to ensure that the appropriate capacity is in place for an agreed service scope and targeted client numbers.

Value of the service - client and HSE staff feedback

Feedback from clients and HSE health and social service staff consulted in this review gives a very positive indication of the value of the service offered through the ALONE-HSE pilot. There is also a growing body of evidence from larger scale evaluations and economic assessments showing the value and value-for money of support coordination and befriending services for older persons. A wider analysis suggests the service provides support for a number of key national policy objectives, links well with the HSE Integrated Care Framework, and can support enhanced care pathways for a range of important client groupings.

All clients reported the supports were useful and had made a difference in their lives. Most clients (84.6%) said the ALONE supports were 'very' useful and two-thirds (65.4%) said this had made a 'very big' difference in their lives.

Benefits and impacts reported by clients

• befriending made a big difference for very many clients
  ○ counters loneliness and social isolation
  ○ improves mental health
  ○ something to look forward to each week
  ○ help with minor tasks
• support coordination was very useful and made a big difference for many clients
  ○ knowing that they are there and will help if needed
  ○ help with sorting out problems and difficulties
  ○ making applications for entitlements/benefits, services, grants...
  ○ helping find reliable tradespersons
  ○ direct help with minor tasks

HSE staff referred clients to the service for social reasons and for practical difficulties, and reported substantial benefit and impact from this. This included the important improvements in clients' lives, the possibility for staff to refer to ALONE to address social and practical issues that they could not meet themselves (including IADLs), support for staff in their own work (e.g. earlier detection of needs and deterioration), helping avoid hospitalisation or entry to long-term care, and enabling (earlier) discharge from hospital.

Benefits and impacts reported by HSE staff

• social isolation and loneliness
  ○ befriending provides supports for needs that HSE staff cannot meet
  ○ someone coming to the house often suits people better than day centres
  ○ can help build confidence and get people going out again (e.g. after a stroke)
• practical needs
  ○ again, addresses needs that HSE staff cannot provide for, including:
  ○ housing issues
  ○ self-neglect - squalor, hoarding; cleaning and de-cluttering
  ○ navigate services (e.g. home adaptations), advocacy
  ○ sourcing reliable tradespersons
  ○ help with issues such as shopping
  ○ supporting carers who have difficulty coping
• important concrete benefits for health and social care system
  ○ enabling (earlier) hospital discharge
  ○ detecting needs at an earlier stage (risk of falls, health issues, etc.)
  ○ helping avoid un-necessary hospital attendance or admission
  ○ avoiding or delaying entry to long-term care.

Wider evidence base

The review of the wider research literature found good evidence for the value of befriending services for older persons as reported by older persons who use it, measurable impacts on loneliness, improved mental health, and an overall positive financial return on investment for the health and social care system. A growing body of evidence also indicates the practical value of information, signposting and service navigation supports. This includes addressing an important area of need identified by older persons themselves; providing a coordination and linkage function across the spectrum of formal health and social care services, and between the health and social care system and wider community supports; and indications of a good return on investment from funding provided for such services. Finally, good evidence exists for the value and value-for-money from direct practical supports with activities of daily living, housing and other areas of difficulty that older persons frequently experience. Such benefits are directly linkable to the ALONE service to the extent that it already provides hands-on help with practical matters as well as through its role in signposting to and facilitating access to such supports provided by other agencies.

Value for HSE

At the frontline level, the service clearly has a strong perceived value for HSE clients and also for HSE community- and hospital-based staff in their day-to-day work. Within the broader context of the HSE mission and operational challenges, it also contributes in a number of important ways.

Value for HSE

• Enhancement to social care for older persons
  ○ contributing to improved health and wellbeing
  ○ helping older persons to live at home with a good quality of life
• Important for the HSE Integrated Care Framework and enhanced care pathways
  ○ operates in an agile and responsive manner, much more so than HSE services can
  ○ holistic approach – addresses wide range of needs (social and practical)
  ○ straddles sectoral boundaries (health and social care, housing, social protection, community development)
• Reaches/addresses needs that HSE services cannot cater for (although are within scope)
  ○ support with IADLs
  ○ psychosocial supports (personalised)
  ○ practical trouble-shooting, intervention and sign-posting
  ○ continuity of engagement; detection of need, deterioration etc.
• Supports achievement of important HSE objectives
  ○ reduction of delayed hospital discharges
  ○ prevention of avoidable unplanned admissions and/or A&E attendances.

Value for money

A growing body of health economics and other evidence points to the value-for-money from public funding for befriending and support coordination services. It can be challenging to apply the standard health economics approaches to these forms of social care, and many studies apply a broader SROI (social return on investment) perspective to express the value of the contribution made in financial terms. Overall, the available evidence provides strong indications of a likely very positive value-for-money and return on investment for the HSE from funding the ALONE services. Large numbers of older people can be supported at a relatively low cost, and hospital bed-day or nursing home cost savings for even a small fraction of these would more than pay for the overall service.

Possible areas of improvement or expansion

In many respects the current service is operating very well, providing a useful contribution and good value-for-money. Nevertheless, the review found a number of aspects where there might be scope for sharpening the definition of the service, or particular elements of it, to maximise the value for HSE purposes, but keeping as much agility and flexibility as possible. For example, it might be useful to consider maintaining the current broad scope and wide-reach service whilst also establishing more focused and purposive models for supporting specified client groups, areas of need, and service settings (e.g. older persons attending A&E, preparation for discharge from hospital, older persons at high-risk of entry to nursing homes, falls management programmes, etc).

A more general co-production exercise involving HSE and ALONE frontline service managers and staff would be useful, to work on a more structured elaboration of the service model and its place in care pathways, and improve communications processes where indicated. An appropriate forum could also address refinement of the resource allocation and funding model for HSE commissioning of ALONE. At the back-office end, there would be value in sharpening aspects of ALONE's client record system and associated reporting possibilities.

One key area for attention might be the possibilities for sharpening and possibly expanding the specification and scope of some of the ALONE service and components. Suggested issues for attention here include befrienders providing more practical help alongside the social element, and support coordinators providing more active inputs alongside their sign-posting and service navigation supports.

Finally, to optimally address these various issues and work to maximise the effective operation and contribution of the ALONE service for HSE purposes, it may be useful to build-in a more structured formative evaluation dimension to the programme from now on. This would involve, each year of the programme, a preparatory (*ex ante)* exercise to identify required service changes/improvements and plan the evaluation approach for the year, and an end-of-year summative (*ex post*) evaluation to assess progress and measure outcomes in concrete terms.

1 Introduction

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2 Analysis of pilot service activity

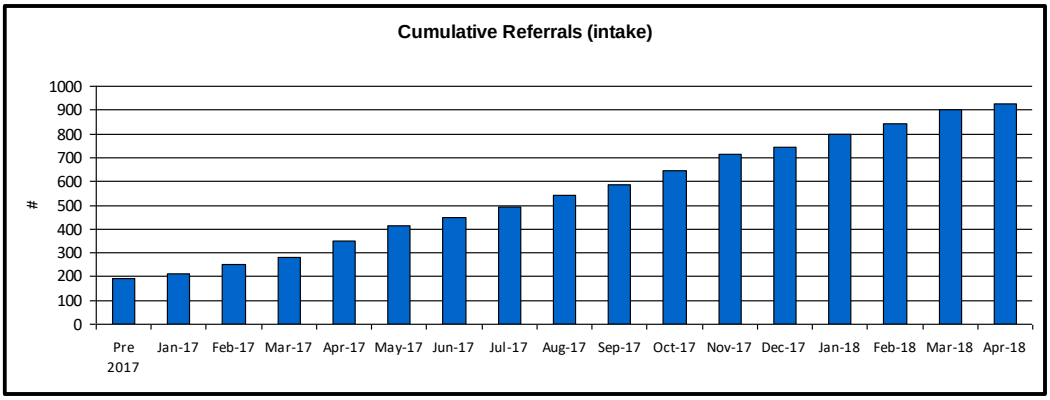
This Chapter presents data on pilot activity as of mid-April, 2018. It provides a profile of levels and growth of activity and the patterns of support provided.

2.1 Overall activity

At the time of the analysis there were 927 clients registered in the ALONE database for the CHO9 area. About two hundred of these were first registered before January 2017 (when the pilot formally commenced), and some of these have been registered with ALONE for a number of years.

Figure 2.1 shows the growth in client numbers over the 15-16 months period of the pilot covered by the data. This shows steady growth over time with some bursts of referrals a certain time periods, possibly coinciding with promotional activity around the pilot to encourage referrals.

Figure 2.1 Growth in clients over the course of the pilot



Almost two-thirds of clients (63%) were female and a little more than one-third (37%) were male. The vast majority were aged 65 or over, with a substantial proportion (43%) aged 80 years or over.

2.2 Types and combinations of support

Figure 2.2 presents a profile of clients according to types and combinations of support provided, based on the three main forms of input (roles) around which ALONE organises its support programme - befriending, brief intervention and comprehensive intervention. The analysis excludes 39 clients registered only as ALONE 'tenants', meaning they are residents in ALONE social housing but not receiving any other of the ALONE supports (at least as of yet), giving 888 clients who had received the types of supports covered under the pilot.

Figure 2.2a presents a profile of all of 888 clients. A number of these were initially considered for befriending but did not ultimately proceed to have a befriending arrangement put in place. This may be due to unsuitability, change of mind or circumstances, or other factors. Excluding clients who did not proceed to befriending, and for whom no other roles were opened, a total of 773 clients within the review period had actually received one or more support. Figure 2.2b presents the profile of supports for these clients. Amongst these clients, two-thirds (66.0%) received befriending, two-in-five (40.6%) received brief intervention, and just over one-quarter (26.3%) received a comprehensive intervention.

Almost one-half of those with a brief intervention also received befriending, as did about one-third of those with a comprehensive intervention. A small number of clients received all three types of support.

Figure 2.2 Types and combinations of supports

Figure 2.2a. At intake/assessment

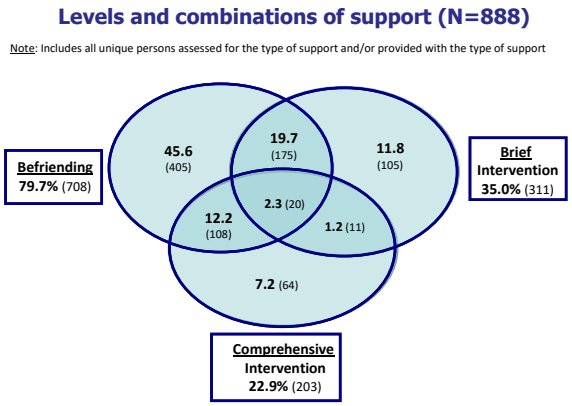
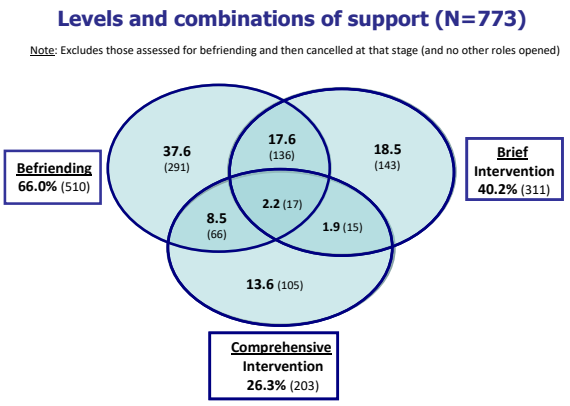


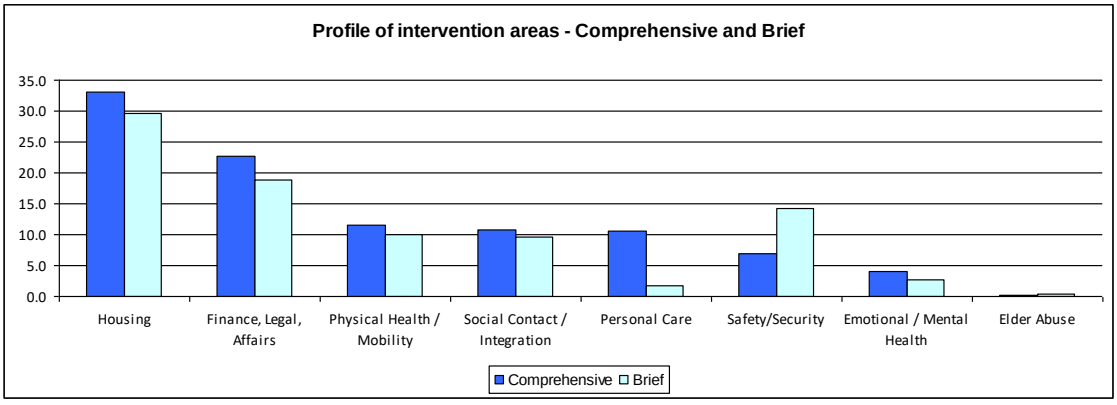
Figure 2.2b. After intake/assessment



2.3 Levels of support coordination provided

As indicated above, for the support coordination service ALONE distinguishes between *Brief* and *Comprehensive* interventions. Brief interventions involve very short duration interaction with clients, typically by telephone, and mainly concern information provision and sign-posting to other relevant services. Comprehensive interventions involve a more extensive engagement with the client, including a home-based assessment by a support coordinator and establishment of support plan objectives with the client, and implementation of the necessary actions by the support coordinator to address the objectives. Figure 2.3 shows the main areas of support provided through brief and comprehensive interventions. At this level of granularity the profiles are fairly similar, although those with comprehensive interventions were more likely to receive supports relating to personal bare and those with brief interventions were more likely to receive supports relating to safety/security.

Figure 2.3 Main areas of support provided - Brief and Comprehensive interventions



The following sections look more closely at the content of brief and comprehensive interventions, respectively. This more detailed profiling shows the more intensive/deeper engagement by ALONE with clients receiving comprehensive interventions.

2.3.1 Brief interventions

Overall 311 clients received one or more brief intervention. Most received only one such intervention but a minority received two or more, so the total number of interventions recorded was 380 and the overall average was 1.2 supports per client. Table 2.1 presents the profile of these interventions. Housing was the most common area of help (29.7%), followed by finance, legal affairs (18.9%), safety/security (14.2%), physical health / mobility (10.0%), and social contact/integration (9.7%). Table 2.2 presents a further differentiation of the specific types of support more commonly provided.

Table 2.1 Profile of areas addressed by Brief Interventions

	N	%
Housing	113	29.7
Finance, Legal, Affairs	72	18.9
Safety/Security	54	14.2
Physical Health / Mobility	38	10.0
Social Contact / Integration	37	9.7
Other	28	7.4
Emotional / Mental Health	10	2.6
Personal Care	7	1.8
Elder Abuse	1	0.3
Missing	20	5.3
Total	380	100.0

Table 2.2 Profile of Brief Interventions provided

Area	**Commonly provided supports**
Housing	Home repairs Access social housing Decluttering or cleaning Heating system Home Accessibility Homeless or Risk of Homelessness
Finance, Legal, Affairs	Benefits and Entitlements Financial Difficulties
Safety/Security	Pendant alarm
Physical Health / Mobility	Access Primary Care team Home help or Homecare Mobility Fixtures Transport
Social Contact / Integration	Local groups or clubs Social activities/groups Friendly call service Alternative befriending service
Emotional / Mental Health	Access counselling service
Personal Care	Meals on wheels

2.3.2 Comprehensive interventions

Overall 203 clients received comprehensive intervention and this often involved support in more than one area (or more than one support within a given area). The overall average was almost four supports per client. Table 2.3 presents the profile of these interventions. Housing was the most common area of help (33.1%), followed by finance/legal affairs (11.8%), physical health/mobility (11.6%), social contact/integration (10.7%), and personal care (10.6%). Table 2.4 shows a wider and deeper scope of comprehensive interventions compared with brief ones.

Table 2.3 Profile of areas addressed by Comprehensive Interventions

	N	%
Housing	266	33.1
Finance, Legal, Affairs	183	22.8
Physical Health / Mobility	93	11.6
Social Contact / Integration	86	10.7
Personal Care	85	10.6
Safety/Security	56	7.0
Emotional / Mental Health	33	4.1
Elder Abuse	2	0.2
Total	804	100.0

Table 2.4 Profile of Comprehensive Interventions provided

	Commonly provided supports
Housing	Housing adaptations Home repairs (internal and external) Appliances & furniture Decluttering & cleaning Access housing (homeless risk etc.)
Finance, Legal, Affairs	Benefits / entitlements Household utilities End of life matters
Physical Health / Mobility	Mobility aids & mobility furniture/fixtures Other aids Home help (access) Primary care / GP (access) Hospital (e.g. transport)
Social Contact / Integration	Other telephone befriending Community groups and events
Personal Care	Nutrition Carer support Hygiene Appliances Chiropody Clothing
Safety/Security	Pendant alarm Other
Emotional / Mental Health	Depression / anxiety / bereavement (support) Access to mental health services

2.4 Referral sources

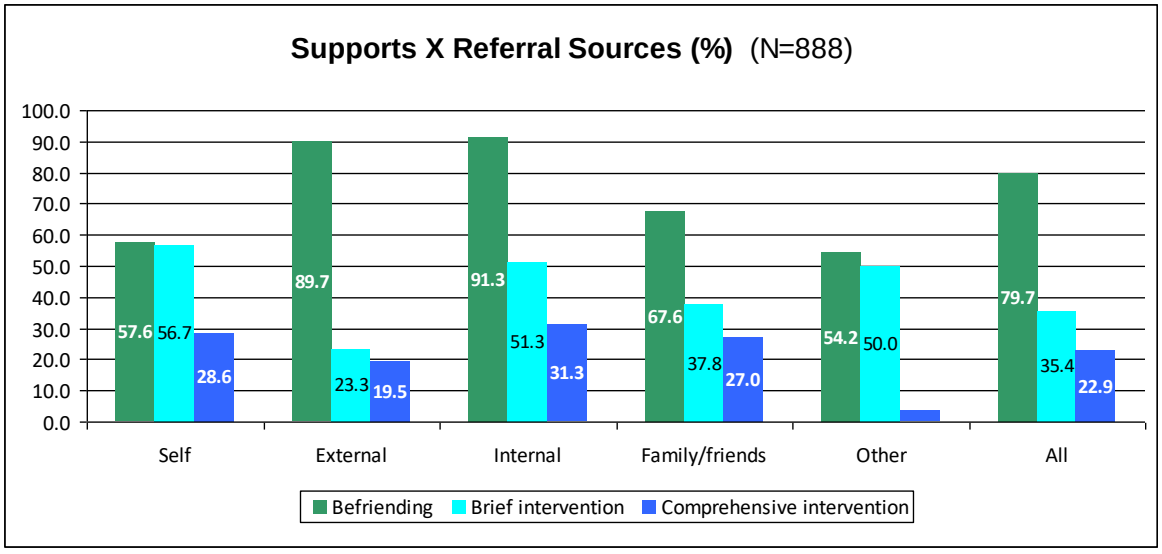
Table 2.5 shows the profile of referral sources for the ALONE clients covered in the review. More than one-half of clients (57.1%) were referred by external agencies, and a little under one-quarter (22.9%) were self-referrals.

Table 2.5 Referral sources

	N	%
Self	203	22.9
External	507	57.1
Internal	80	9.0
Family/friends	74	8.3
Other	24	2.7
All	888	100.0

Figure 2.4 presents a break-down of the types of supports provided to clients coming from the different referral sources. Self-referrals were especially likely to receive comprehensive interventions, possibly reflecting high levels of need but lack of contact with relevant support services.

Figure 2.4 Support profile of clients from each referral source

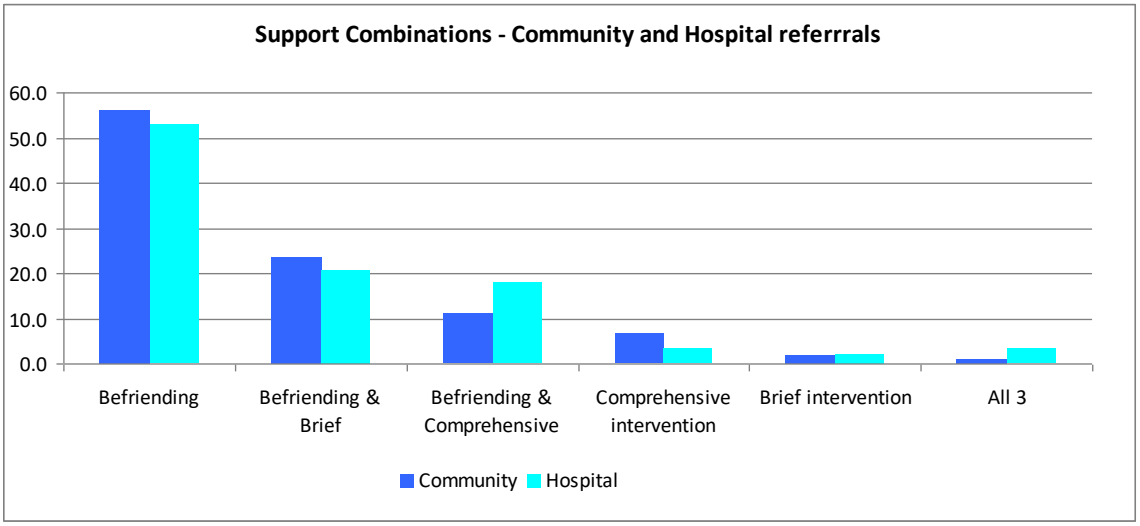


Note: as mentioned earlier, not all people assessed for befriending eventually proceeded to this support

Almost three-quarters (73.8%) of external referrals were from community or hospital-based health services, of which 61% were from community services and 39% from the hospital sector. The majority of

hospital referrals (92.5%) came from five hospitals - Beaumont (including St Joseph's), the Mater, Clontarf, Connolly, and Cappagh. Referrals were received from 28 different health centres, with one-third of referrals (33.3%) coming from 2 health centres (Roselawn, Malahide) and another one-third (33%) coming from 6 further health centres (Swords, Killester, Ballymun, Kilbarrack, Millmount, and Vernon Avenue).

Figure 2.5 Support profile of clients from each referral source



Note: as mentioned earlier, not all people assessed for befriending eventually proceeded to this support

Figure 2.5 compares community and hospital referrals in the types and levels of support provided or assessed for. In general, the profiles are quite similar at this level of granularity although, overall, a somewhat higher proportion (24.7%) of referrals from hospitals received comprehensive support in comparison to referrals from community services (18.4%).

3 Stakeholder feedback

This Chapter looks at feedback on the ALONE service from two key stakeholder groups: clients who used the service; and health service staff that made referrals to the service.

3.1 Client survey

3.1.1 Approach

WRC interviewers conducted telephone interviews to get feedback from clients. A total of 26 clients participated in the survey; these came from two random samples (40 in each sample) drawn from the overall pool of 773 clients who received supports during the period.

One sample of 40 was drawn from all clients, irrespective of the level of support provided; the other was drawn from those clients who received a comprehensive intervention. Participation rates were higher from the second sample, probably reflecting their stronger engagement with the support coordination element of the project.

The sampling approach ensured coverage of a broad range of clients, including those with befriending support, comprehensive intervention, or combinations of the two. Whilst it was not feasible to conduct a comprehensive survey for purposes of this review, the results provide a useful and broadly representative insight into client perspectives and experiences of the service.

3.1.2 Results

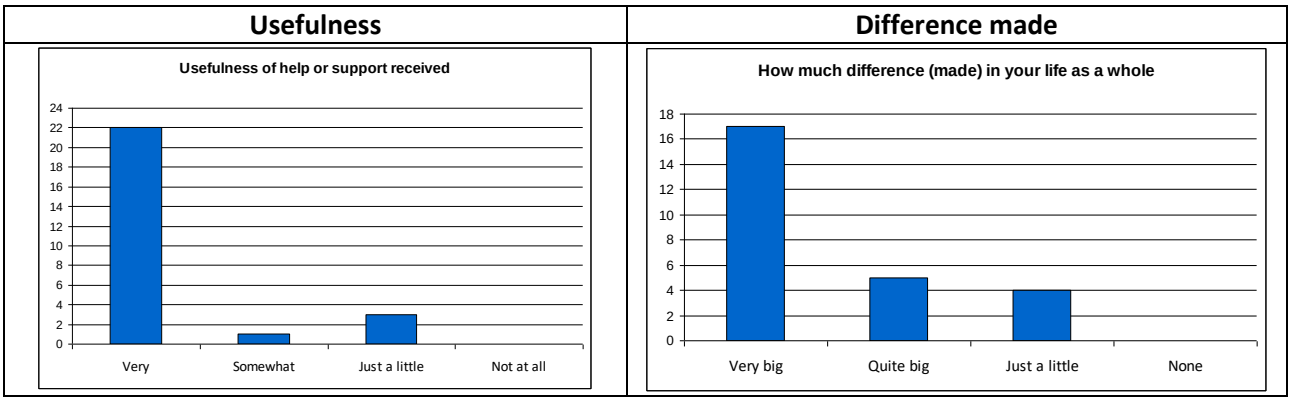
The interview schedule included some quantitative questions as well as a range of open-ended ones. The main topics covered were:

- how useful they found the help or support
- what aspects were most valuable for them
- any issues or problems they had with the service
- suggestions for improving the service
- help or support they might need in the future
- how much difference the support has made to their life as a whole.

Usefulness and Difference Made

Figure 3.1 presents the overall assessments by clients of the supports provided to them by ALONE. All clients reported the supports were useful and that they had made a difference in their lives. Most clients (84.6%) said the ALONE supports were ‘very’ useful, and two-thirds (65.4%) said this had made a ‘very big’ difference in their lives.

Figure 3.1 Overall assessments of ALONE supports received



The following sections present a flavour of client perspectives on befriending and on support coordination. Although clients were by and large very positive, a minority reported lack of successful achievement of what they were looking for. In some cases, this was due to unsupportive agencies and services (outside of ALONE's scope and/or capacity to influence); however, a few clients also felt, rightly or wrongly, that ALONE could have done more for them or suggested that ALONE could be better resourced to enable them provide a greater level of support.

<u>Befriending</u>

The majority of clients receiving befriending rated the service as very useful and that it had made a big difference in their life as whole. Below are some of the comments from clients that illustrate the value and impact of befriending for them.

> *...rings me and calls to me, more like friends; was very good to me when [family member] was in hospice (gave lifts...) ...Not to feel that I was all on my own...could ring [her] and go out...* ***She got me out of the house, I needed it badly, the depression lifted. I had become reclusive. I couldn't get on a bus...made me go back out again****. I had gotten into a rut, didn't want to mix with people...I know there is someone there for me, if I want to go out or have a chat ...I don't feel isolated.*
>
> ***I love the girl coming to me, like a daughter****...I miss her when she doesn't come... she doesn't come every week, but I understand her situation (busy, work...) ...*
>
> ***I look forward to it because I know he's coming****...[We have] chats about current affairs...I can ring him anytime if I need help...puts out bin, changes bulbs, batteries for alarms, reads ESB meter (up high), fix personal wrist alarm, advice on car tax, lift to doctors, daughters...*
>
> ***I can't wait for the day to come****...the hour goes very fast. Company for me, it helps with depression...Great to have a 1:1 conversation and not be laughed at...****I was getting that bad I was really thinking of committing suicide****...Friends told me to get over the depression, but arthritis is too sore...*

*'Absolutely wonderful...Companion, warm hearted person...When you live alone it's very hard... She'd get milk for me if I asked her to...She's a stranger to me, you can tell her stuff and she won't repeat it...Absolutely wonderful, even if you just want to cry [suffers from depression]...I'm on my own, no friends locally...**They're like a warm blanket, lovely. Someone cares**...*

A number of clients made suggestions for ways the service could be improved (in general) or could provide better or additional support for them. However, most of these clients emphasised that they were not in any way being critical, and were very happy with what they were getting from ALONE. Suggestions made included:

- visits more than once a week (e.g. 2 or 3 times per week, gap between visits is very long)
- to be brought out more
- more ALONE / befriender visits to people when they are in hospital
- more outings
- more volunteers for the befriending service
- more places on ALONE holidays [applied for but booked out].

Examples of client comments included:

***Befriender to call 2 or 3 times per week.** Gap between visits is very long, my voice is sort of gone from not talking enough...Something to look forward to. **If someone is calling, I'd make more of an effort to get out of the chair and tidy etc**. (arthritis, gets very sore, crippled with it, can't sleep). Fibromyalgia. Used to be very strong, fit and independent...'slipping away'.*

***Expand ALONE**...It's a pity more people don't sign up [don't know about ALONE] because **there are a lot of lonely people like myself**; if they [ALONE/befrienders] could call more than once a week.*

Some of those receiving befriending support also mentioned that they might need practical supports from ALONE in the future (e.g. help in getting a stair lift, help with painting, arranging a student staying, taking clothes for recycling, literacy classes, home help, social housing, help if was really sick, etc.). Again, clients emphasised the value they placed on what they were currently getting from ALONE and a recurring theme was that other people might need help more than them.

*I'm too embarrassed to ask for any more (like food vouchers), they're so good. **Other people might need help more than me and I don't want to take it from them.***

***If I was really sick...would like to know they would be able to come out** (if they had the staff.)*

Support coordination

The majority of clients receiving support coordination also rated the service as very useful and that it had made a big difference in their life as whole. Below are some of the comments from clients that illustrate the value and impact of support coordination for them.

> *10-out-of-10...they seem to know the inside track (re applications etc.), I'd be hopeless...It's just that after the stroke...a whole new world to me...need as much help as you can obtain...**ALONE don't make a big issue of anything**...*
>
> *Excellent, I can't do without ALONE, I would panic...I know I have backup...**It's great that** [support coordinator] **is there, he's my backup'.***
>
> *'Extremely useful... [SC] helped when partner died - sorted it out [accommodation issues] ...Got documents from [abroad] for Dublin county council...An enormous difference. I felt alone and destitute. To feel I was connected with [support coordinator] and the bigger ALONE group**, someone had my back...A sense of belonging...You feel there's someone there**...Any issues, you can contact [support coordinator] and he will help...*
>
> *I wouldn't have a roof over my head if it wasn't for [SC]...The 'chancers' that came here...Dealing with builders and paperwork for grants...**If** [SC] **hadn't come along and helped me I probably wouldn't be here. I was around the twist**...Peace of mind thanks to [SC].*
>
> *I wouldn't have been able to apply for pension. I used to get my sisters/brothers to help, they sent me to social worker but that didn't work out...**ring them** [ALONE] **and they'd come next day...It's private, I don't like letting people know my business...***
> *I have the number [ALONE's].*
>
> ***They care about you and that you're not alone...really terrific people...***
> *He [support coordinator] is very very good but he's getting nowhere with Dublin Corporation [re house transfer]...They're giving him an awful time, filling out forms, he did it 3 times...[Most useful help] toilet and shower and insulation...the house was freezing...They're very good to me, I think they're great. ALONE looks after people...rate them as number one.*

Again, a number of clients made suggestions for ways the service could be improved (in general) or could provide better or additional support for them. However, as for befriending, most of these clients emphasised that they were not in any way being critical, and were very happy with what they were getting from ALONE.

> *Anything that would present a problem...hospital, health board...**I'd feel confident with ALONE as my first port of call.***
>
> ***If anything comes up, I'll ring them, I have their number** and [SC's]...Have applied for the pension, due in about 2 weeks, can ring them if there are problems.*

I call [SC] when any documents come in and he calls out to help me go through them.

*Worried about dementia. Can see people in the day centre suffering from it. [SC] has offered the befriending service recently (is due to ring about it this week) but I don't want to be wasting people's time...**Looking for advice on 'power of attorney.***

Maybe befriending in the future...maybe help with getting repairs to apartment done. ***'I would love to live in social housing, feel more safe...ALONE gets places for people'****.*

[Would like more] ***socialisation of people, in small groups, more intimate****, so people can relate to each other, more frequent than dinner dances. Then when they go to the dinner dance, they will already know some people. Would need a pick up and drop off service for it...*

Suggestions made included:

- transport, especially when people have to go to hospital
- need more people working for ALONE; improve ALONE's finances to improve the service
- additional practical and other supports (e.g. a holiday; decorating; grab rail for back garden step; my teeth done; windows, plastering, shower).

3.2 Health service staff referring clients to ALONE

To get a health service staff perspective, the researchers interviewed eight fairly frequent referrers of clients to ALONE. These were from four service settings - two Health Centres (Roselawn and Malahide) and two hospitals (Beaumont's acute hospital and St Joseph's rehabilitation unit). Staff interviewed comprised a range of disciplines and settings - 5 medical social workers (including stroke, orthopaedic and vascular, and care of the elderly), 2 Community Registered General Nurses, and an Occupational Therapist.

An initial question asked staff how they first heard about and began to refer to ALONE and/or the HSE-ALONE pilot. In most cases they had already known about ALONE before the pilot (some for a long time), or ALONE was generally known about by colleagues, and some knew ALONE Support Coordinators through their work. Some, but not all, also said they got communications about the Pilot, for example through HSE broadcast email, ALONE (and HSE) coming in to their workplace and making a presentation, or HSE management introducing the pilot at meetings.

The main other questions addressed the following topics:

- general characteristics of their referrals so far - needs/circumstances and why referred
- views on the role and value of the ALONE service
- views on how (well) the service is defined and operates (currently / the pilot)
- suggestions on how the service could it be enhanced or improved.

3.2.1 Referrals so far - needs / why referred

Most staff reported making referrals both for social needs (befriending) and for practical difficulties.

Social needs

Social isolation and loneliness were common reasons for referral. Some staff mentioned the value of befriending services for clients who would not like to attend a day centre or other organised activities. For example, clients who were typically very independent prior to having a stroke may now experience mobility difficulties that limit their social possibilities. Going to a day centre often does not suit (they don't see themselves in that frame). In these cases, a volunteer coming to the house works better, and can also help to build confidence around leaving the house and meeting people (which people often find difficult after a stroke). This activating dimension of befriending was also mentioned by community nurses -'*a link for branching out (socially)'.*

Loneliness and low mood were also commonly mentioned, sometimes possibly associated with mental health issues. One interviewee felt that older persons in their area were quite well-off materially but didn't see their extended family very often and so were on their own a lot. Social isolation for people living in rural parts of the county was another issue. Bereavement was another factor that might prompt referral to ALONE for befriending.

Community nurses may detect social needs when visiting for physical health reasons, but don't have the time or scope to address this themselves. Sometimes befriending might be suggested for a client seeking a home care package but does not really have a physical need for it.

Practical needs

Staff commonly mentioned poor living conditions as a reason for referral, including housing issues and general self-neglect. Even where clients are keen to get these addressed, they often have difficulties to get help to fix things themselves or in finding reliable handypersons or trades persons for this. More generally, clients may have a need for advocacy and someone to help them navigate the complexities of getting help (e.g. home adaptations), something health service staff don't have the time or scope for.

A number of staff mentioned referring clients because of general squalor and hoarding, including cases where de-cluttering and/or extensive cleaning was necessary. Referrals were also for help with supports, such as shopping, that cannot be provided through homecare services. Support for carers was also mentioned in cases where they were not coping and needed social and practical support, for example carers of people with dementia or mental health issues.

3.2.2 Role and impact of the ALONE services

Community-based and hospital-based services/staff tended to assess the role and impact of the ALONE services from the perspective of their part of the overall care pathway(s), and their comments reflect this. Both groups of staff were very positive about the benefits of the service for clients and the important contribution made to supporting the health services in their work.

<u>Community-based staff</u>

> ***Huge impact****...Social isolation is a big thing (comes up a lot in the job) - ALONE can help through befriending...****ALONE fill a key 'niche' that HSE (and community nurses) cannot fill - social, practical everyday problems****...Excellent service; no other organisation offering a broad-spectrum quality service in this area.*

*Most impact probably in **helping people to remain living at home** for as long as possible; **someone coming in, being there, have a routine and form habits...two-way 'relationship'** is crucial service for this*

*Clients' relationships with volunteers - **they identify issues / early detection** (things that community nurse might not be told, or told only later) - e.g. report a sore leg so nurse can address early; falls (know they had one) ...*

Hospital-based staff

***Support Coordinator came in to the hospital to plan how to make the discharges safe** (bed downstairs, adaptations, pendant alarm, etc).*

*Complex cases / higher-risk discharges - ALONE provides broad range of supports... **flexible, preventive, 'give it a go' approach.***

*...had a client whose **discharge 'would have been months' without ALONE** …*

***Patients self-discharging when waiting for HCP** - ALONE can pop-in to check on them.*

***Housing needs / risk of homelessness (at discharge)** - doctors ask about this; home not suitable (wheelchair access, ground floor etc.) …availability of ALONE **can be the 'deal breaker' for discharge home**... an (essential) extra layer on discharge...*

3.2.3 How (well) the pilot service is defined/operates, possible areas for enhancement/improvement

Both hospital-based and community-based staff felt that the pilot service generally worked very well. Aspects highlighted included:

- generally good communications with ALONE staff (in both directions)
- responsiveness of ALONE to referrals made
- flexible and supportive approach by ALONE support coordinators when contacted
- support coordinators coming in to case planning meetings (e.g. complex cases with grey issues around capabilities; helpful for families also)
- ALONE identifying and communicating back needs of clients.

Staff also flagged some areas where improvements or enhancements might be useful:

- acknowledgement of referral/follow-up from ALONE to indicate whether client is accepted/supported (i.e. they have taken on the case)
- general tidying-up of the referral/feedback/communications between health system and ALONE
- more attendance by ALONE at case conferences; also, possibly in the A&E context?

- possibility that volunteers could help (more) with practical things - shopping, collecting medication, accompanying to events, mobilisation (walks etc), small jobs etc
- in-house (hospital) - maybe add an 'ALONE prompt' on relevant assessment/referral forms?
- look at the data protection issues that are relevant in the inter-agency communications
- tidy-up protocols about roles (and competencies) where multiple parties are involved in a case (e.g. HSE OT, support coordinator, etc), to ensure they are not at cross-purposes
- possible capacity issues for ALONE (e.g. volunteers in rural areas)?
- regular meetings (forum) of community services (coordination, reduce duplication, etc.)
- aggregate reporting of needs, patterns, trends etc. to support service planning.

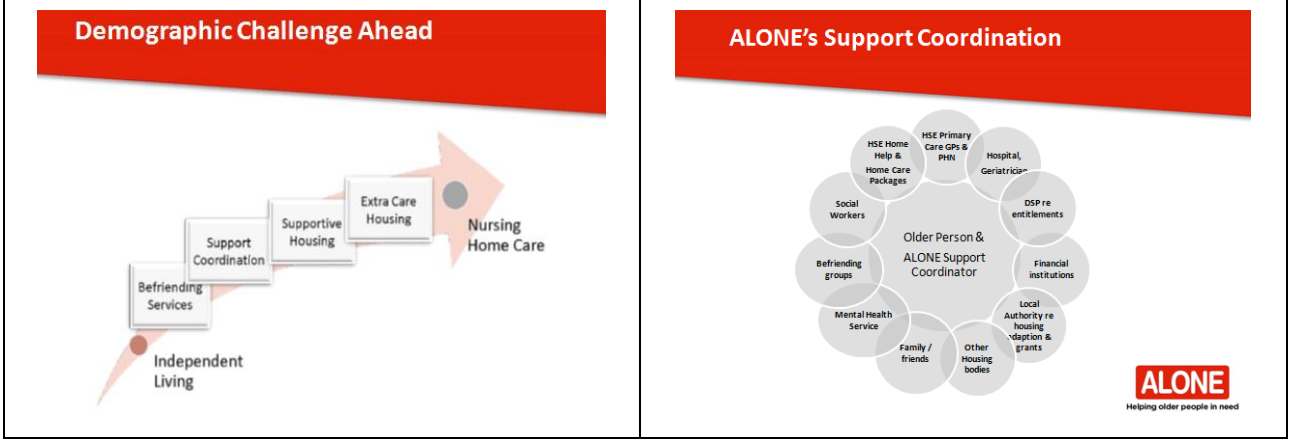
4 Position and value of ALONE in the wider care and support system

This Chapter looks at the position and value of ALONE services in the wider care and support system, drawing on the material presented in Chapters 2 and 3, and contextualising this within Irish health and social care policy and the research evidence-base.

4.1 Positioning ALONE services in the policy and service context

Exhibit 4.1 presents ALONE's perspective on the role their services play within the care and support system for older persons.

Exhibit 4.1. ALONE services



These services and supports align squarely with the repeatedly-stated Irish policy objective to help older people to remain living in their preferred home environment for as long as possible, with a good quality of life, and respond to demographic challenges in this context. Rather than reprise this general policy context, the following sections focus on a more operational and concrete positioning of the ALONE services within the spectrum of health and social care, housing, and other supports that together are needed to deliver on these policy objectives.

4.1.1 Integrated care and support

The HSE's Framework for Integrated Care and Support for Older Persons (Exhibit 4.2) provides an orienting frame that helps to locate the ALONE service from an operational perspective. Its vision for the care system from the user perspective is one where *'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'* (cited in HSE, 2017).

Integrated care pathways bring together all the services needed to deliver the right support, in the right place, at the right time. Through this they prevent or delay the need for more intensive community health and social care services, avoidable hospital admissions, and undesired nursing home admissions. Importantly, however, the framework recognises the substantive role and value of these types of supports in their own right. They should be part of the repertoire of services in comprehensive integrated care for their own inherent value, and not seen as something offered merely to avoid or reduce utilisation of more expensive services.

The supports provided by ALONE resonate especially with those listed under Step 8: Supports to Live Well (Enable older persons to live well in the community). The framework locates these supports at the core of an integrated care system.

Exhibit 4.2 HSE integrated care framework

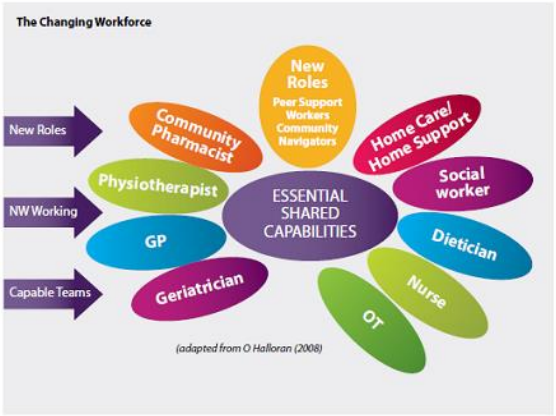
HSE (2017)

4.1.2 Coordination of access to community supports

As indicated in the Framework, a broad range of supports are required to enable older persons to live well in the community. These include supports from the formal health and social care system, the housing sector, and a variety of other forms of support often provided by third sector organisations. The importance of coordination of access to this range of community supports is well-recognised, and the Integrated Care and Support Framework suggests the value of new roles in an integrated system, such as 'community navigators' (Exhibit 4.3). This is a key feature of the ALONE Support Coordination approach.

The Framework also emphasises the importance of early detection of persons at risk in various ways, including frailty, falls, and cognitive deterioration, as well as those with high levels of acute hospital usage. Staff interviewed recognised the contribution of the current ALONE service in detection of un-flagged needs and in preventative intervention. Possibilities to further strengthen this aspect are discussed in Chapter 5.

Exhibit 4.3 New roles in integrated system



HSE (2017)

4.1.3 Practical and psychosocial supports in community care

From a resource allocation and practical perspective, the current levels of unmet demand for home help and home care packages has led to a restriction in the scope of HSE-funded social care services for older persons. A recent survey of social workers and analysis of social worker caseloads found *'a health and social care system focused on physical care needs'* (Donnelly et al., 2016).

The emphasis is very much on health-related and personal care, rather than more practical supports in daily life. In social care terminology, this means that needs for support with a range of Instrumental Activities of Daily Living (IADLs) are not addressed, such as help with shopping, cooking, transport to medical appointments, and so on. Not surprisingly, the current system has little or no scope for provision of psychosocial supports to address social and emotional needs. There is increasing recognition of the role and importance of psychosocial supports in health and social care, for older people in general and for specific groups such as people with dementia (Cullen and Keogh, 2018).

The ALONE service addresses gaps in both domains - IADLs and psychosocial. As shown in Chapter 3, the healthcare referrers interviewed for this study emphasised the importance of this form of service to support their work and reach needs that they are aware of but cannot address. The wider social worker survey (Donnelly et al, 2016) found this to be an issue across the system, both for hospital-based and community-based social care. Community-based social workers noted the lack of support for domestic tasks and for psycho-social needs, and the need for a more holistic approach. This results in a situation where in many cases the person's real needs are not met. Hospital-based social workers reported that waiting for Home Care Packages or Long-term Care placements were the main reasons for delayed discharges, but lack of access to community supports was a key factor in a number of cases.

4.1.4 Housing-related needs

Poor housing conditions and lack of age-friendly housing facilities are well-recognised factors affecting the ability of older persons to remain living in their own homes with a good quality of life. They also have direct impacts on utilisation of health and social care services, for example because of preventable falls or ill-health due to poor quality of the home environment. Under the formal support systems, some remedies fall within the scope of the health and social care system (e.g. assistive technologies, aids and appliances) and others within the scope of the local authority housing sector (e.g. home adaptations,

home repairs/improvements). The ALONE support coordination service includes these types of housing-related needs and supports within its holistic approach. There are also a growing number of third sector handy-person type services in this space, as well as many private providers of varying quality. The ALONE support coordination service provides 'navigator' support for older persons in this domain.

4.2 Deeper look at the nature and value of the ALONE services

The previous section shows the direct relevance and importance of the ALONE services within the health and social care system and the wider system of supports for independent living from the housing and other sectors. This section looks more closely at the ALONE services provided on-the-ground, the contribution that they make, and their value-for-money.

4.2.1 ALONE's characterisation of its services

ALONE currently characterises the supports it provides in a number of ways for internal recording of client-related activity and for reporting purposes. At the broadest level, the ALONE database classifies clients according to four 4 role types: Befriended; Support coordination - Brief Intervention or Comprehensive Intervention; and Tenant.

Clients may occupy more than one role type at the same time. The database includes a history of the client's engagement with ALONE, and some clients remain on the database for many years. A given role may be active for a period and then cease, and new roles may open as required over time.

Befriending roles are intended to be open-ended, and to last as long as the arrangement is working well for everyone. Support coordination episodes are intended to be time-limited, based on a short 'in and out' approach to address immediately presenting issues. Brief interventions are, by definition, short and generally simple supports often only involving telephone-based help with minor issues.

Comprehensive interventions involve more extensive engagement with clients. A Support Coordinator visits the client, makes an assessment, and establishes a Support Plan containing one or more specific objectives. The database records activities undertaken to address each objective, progress against the objective, and ultimate outcomes achieved.

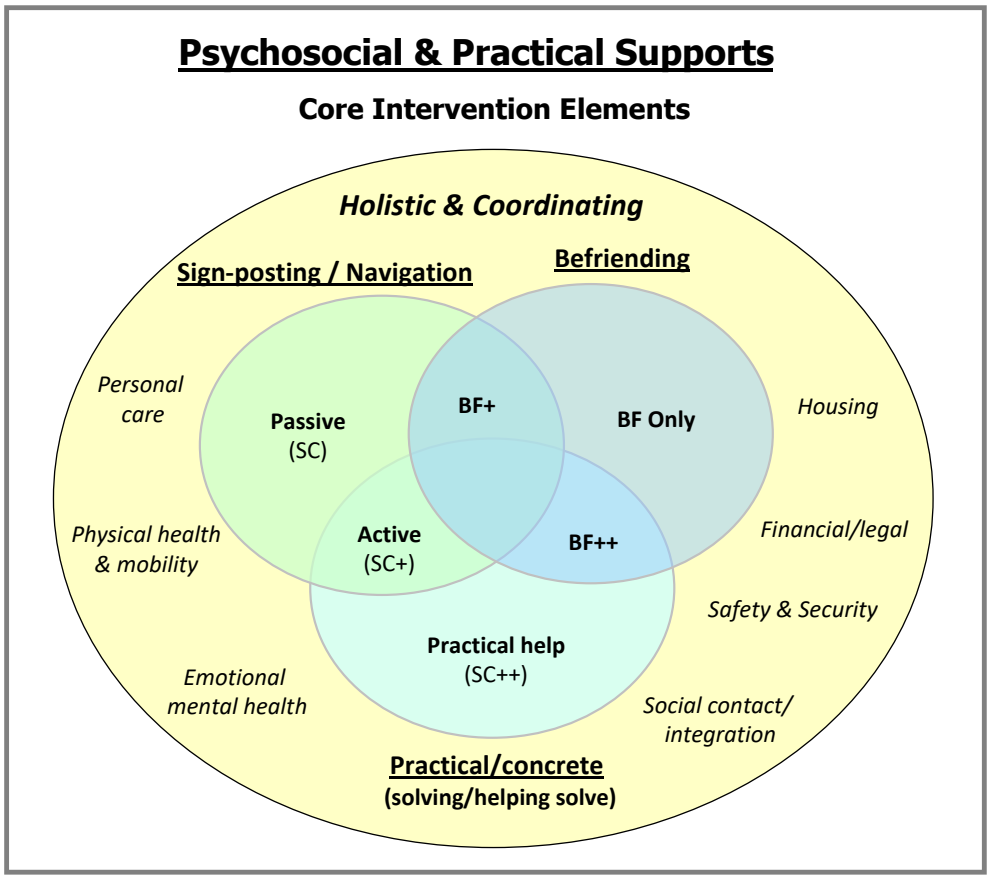
The ALONE database classifies support coordination interventions into 7 main domains: emotional/ mental health; financial/legal affairs; housing; personal care; physical health mobility; safety/ security; social contact/integration.

The database also records more specific details of the actual interventions involved, especially for clients receiving more comprehensive support coordination and for whom a support plan with specific objectives is established. This detail captures the characteristics of the actual supports provided by support coordinators to clients on the ground and helps to show the concrete contribution and impact that lies behind the broader 7 categories listed above.

4.2.2 The core ALONE service 'ingredients'

This section develops a higher-level conceptual framework to facilitate understanding of the core characteristics of the ALONE supports. Figure 4.1 presents a schematic view of the core 'ingredients' of the service. This perspective conceptualises the ALONE support service logic as comprising three core forms of intervention, offered and managed within an overall holistic and coordinating framework: befriending; sign-posting & navigation; and practical/concrete help.

Figure 4.1 Key ingredients of the ALONE service



Source: the authors

Note: The '+' and '++' notation indicates possible extension of the current scope of the service element

Each of these provides value for older persons, for the health and social care system, and from a broader societal and socio-economic perspective. The following sections provide an overview of some of the wider evidence on the value of these types of supports.

4.2.3 Holistic, Multi-component, Coordination

ALONE uses the term 'support coordination' to characterise its holistic and multi-component approach. Apart from the befriending service, the emphasis is primarily on coordination of access to services provided by others rather than direct tangible intervention, per se. In practice, the service does also provide a variety of practical/concrete supports for some clients, and these are discussed as they arise in the sections that follow.

Section 4.1 discussed the place and value of this type of service within the overall support ecosystem for older persons living in the community. The feedback from clients and from referrers presented in Chapter 3 shows the value of the overall ALONE model from both parties' perspectives. Below we highlight some of the wider evidence on the value of these types of service model.

Overall, no single study provides a complete picture in this field. This reflects the heterogeneity of the content and objectives of different programmes, and also the challenges to provide robust evidence of concrete impacts and benefits for clients and for the health and social care systems from these broad-based interventions.

The evaluation of the Partnership for Older People Projects (POPP), funded by the Department of Health in England, provides an extensive body of evidence in this field (Windle et al, 2009). This programme involved a large number of pilot initiatives across the country and more than a quarter-of-a-million older persons used the services provided. Projects varied widely in their organisational make-up and intervention components. Across the programme as a whole, the evaluation found positive impacts on health-related quality of life, as well as some evidence for reduced attendance at A&E and number of emergency hospital bed days.

Also, in the UK, economic modelling exercises have suggested a positive return on investment from community-based interventions such as those offered by ALONE (Knapp et al, 2013). One study looked at 'help-at-home' schemes operating at the interface between the community and the formal health and social care sectors (Bauer et al, 2016). These typically offer a mix of supports including emotional support (e.g. befriending), sign-posting, practical help (minor repairs etc), and financial advice. Economic modelling based on costs and outcomes from one such service (Shropshire Age UK) indicated a very positive return on investment, comprising costs savings for the formal care and support system and the monetised value of wellbeing gains for service users.

4.2.4 Befriending

Data from the TILDA survey shows that more than one-third of older people in Ireland report feeling lonely either often or some of the time, and similar percentages are relatively socially isolated (Timonen et al, 2011), and between one-quarter and one third report depression at clinical or sub-clinical levels (O'Regan et al, 2011). Befriending is "social support provided by an individual 'befriender' through an affirming, emotion focused relationship developed over time" (Knapp et al, 2013). As a psychosocial intervention in the social care context, it targets social isolation, loneliness and emotional distress. Evidence shows that befriending can help alleviate social isolation and prevent or reduce loneliness, particularly among older people (Windle et al., 2011; Charlesworth et al., 2008). In Ireland, a randomised controlled trial (RCT) found a reduction in loneliness for the befriended group (Lawlor et al, 2014).

Although it can be difficult to generate 'hard' evidence of the impacts of psychosocial interventions on health and social care outcomes, a systematic review of evidence on the impact of befriending on depressive symptoms and emotional distress found a modest effect in a range of service user groupings (Mead et al, 2010). Data from the English Longitudinal Study of Ageing found that both isolation and loneliness impair quality of life and well-being, and that social isolation was significantly associated with all-cause mortality higher (Steptoe et al, 2013).

Health economics studies have examined the value of befriending in monetary terms. UK research reports a potential 4-fold return on investment from spend on befriending services for older persons, deriving from quality of life improvements and reduced need for treatment and support for mental health needs (Knapp et al, 2010; 2013). The Association of Directors of Adult Social Care Services in England has published guidelines for commissioning of befriending services for social care providers (ADASS, 2011), indicating a formal recognition of its role and importance.

4.2.5 Sign-posting, service navigation and practical help

An Age UK evidence review focused on information and advice services (Age UK, 2013) and presents a summary of evidence showing the importance of these services for older persons (Raynes et al, 2006). Aspects emphasised include: its particular importance at times of personal, medical or financial crises (Age Concern, 2008); that timely advice can prevent further detriment down the line and that other problems are often uncovered when advice is sought (Citizens Advice Bureau, 2004); and its importance in helping older people navigate the social care system (Horton, 2009). Other reports have also highlighted the evidence supporting the contribution and value of such services (Bottery and Holloway, 2013).

The Age UK report provides a useful classification of the spectrum of services in this area, including:

- *information*: generic information materials not tailored to a specific client's needs
- *information services*: give clients information they need to take action themselves
- *signposting*: gives clients information about other providers of services appropriate to their needs; client has responsibility for taking further action and making contact
- *referral*: involves selection of an appropriate provider of services, making contact on behalf of the client, and securing an appointment with a specific person
- *advice services*: involve with the client's issue, giving information and explaining options, identifying further action client can take, and providing some assistance (e.g. contacting third parties, filling forms); usually completed in one session although may be some follow-up work)
- *advice with casework*: may involve all of the supports above and also taking action on behalf of the client to move the case on (e.g. negotiating with third parties by phone, email, letter, etc.)
- *advocacy*: distinct from information and advice, but all may overlap in practice.

The ALONE service primarily provides sign-posting and service navigation support, and also provides practical help with filling out forms, making applications, and connecting with services. Key areas of support include financial/benefits issues and housing issues (such as home repairs and housing adaptations).

Recent reviews and modelling exercises conducted in England indicate an important contribution to older persons' wellbeing and a positive return on investment for health and social care services from community services providing financial and welfare benefits advice and helping with access to housing supports (Knapp et al, 2013; Bauer et al, 2016).

Although the wider research literature indicates that it can be difficult to generate robust evidence on the health and social care impacts of such services or on their value-for-money, there is growing acceptance of their value and place within the overall care and support systems for older persons (Public Health England, 2015).

One evaluation focused on a Wayfinder Programme implemented in Dorset, where part-time (paid) personnel operated in GP practices, libraries and other locations to provide information and advice to older people (Harflett and Brown, 2014). This provides an illustrative analysis and costing showing how prevention for even very small percentages of clients would provide value for money.

Evaluations of large-scale national services in England also provide useful evidence. For example, the Support at Home service from British Red Cross has the overall aim to provide time-limited care and support for older people at times of crisis and operates in a variety of ways and settings across England. This includes supports provided at point of discharge from hospital and work with A&E services.

Evaluation research suggests positive impacts on wellbeing, ability to manage daily activities, increase in social participation and leisure activities, and improved coping skills (Joy et al, 2013).

Other evaluations also show promising results from these forms of targeted approach. For example, the Age UK 'Living Well' programme has been applied to provide health and social care navigation support for older people at high risk of unscheduled utilisation of hospital services. It includes proactive risk stratification to identify the core target group, direct liaison with GP practices, guided conversation with a voluntary sector support coordinator to initiate an anticipatory care plan, and ongoing supports after this. Preliminary studies have found evidence suggesting substantial savings in reduced non-elective hospital admissions and costs (Murray, 2016).

In Ireland, TILDA data shows the importance of help with housing issues for older people, and the self-reported need for assistance in this area. The data shows that 59% of adults aged 50 years and over experience some degree of housing problem, with 69% of these reporting the problems as 'minor' and 31% reporting them to be more substantial (Orr et al, 2016). The most commonly reported problems are damp/mould, structural problems and heating difficulties, and these are variously linked to physical and mental health issues. For example, older people with heating difficulties have poorer self-rated health and are more likely to report clinically relevant depressive symptoms.

The HaPAI survey of more than 10,000 older people across 21 local authority areas in Ireland found 25% had difficulty with housing maintenance, 10% had housing conditions problems, 20.7% had housing facility problems, and 10.4% were unable to keep their home adequately warm (Gibney et al, 2018). The survey also showed that more than one-half of older people with housing problems would like financial help for bills or upkeep, adaptation or physical improvements and/or nonfinancial help with housing maintenance.

In England, a major report identified a causal link between housing characteristics/defects and health, with a quantifiable increase in falls, cardiovascular and respiratory diseases, and poor mental health (DCLG, 2016). Also, the NHS Five Year Forward View emphasised the importance of radically upgrading prevention and expansion of evidence-based action in this area. Guidance documentation associated with the Care Act 2014 refers to the pivotal role of home repairs, adaptations and handyperson services (DH, 2014). Other research has estimated an annual cost to the NHS of £624 million in first year treatment costs resulting from the impact of poor housing amongst older households (Garrett and Burris, 2015).

5 Overall appraisal and some suggestions for consideration

The review's overall conclusion is that the pilot ALONE-HSE initiative has been broadly working very well and is providing a valuable contribution in addressing client needs and supporting HSE services. This supports the case for continuation and mainstreaming, with some existing aspects continued more-or-less 'as is' and a number of possible refinements that might improve quality and impact. Resourcing issues will also need attention to ensure that the appropriate capacity is in place for an agreed service scope and targeted client numbers.

5.1 Value of the service

Chapter 3 presented the feedback from clients and HSE health and social service staff consulted in this review, and this gives a very positive indication of the value of the service offered through the ALONE-HSE pilot. Chapter 4 presented some of the growing body of evidence from larger scale evaluations and economic assessments showing the value and value-for money of support coordination and befriending services for older persons. Also, in Chapter 4, a wider analysis suggests the service provides support for a number of key national policy objectives, links well with the HSE Integrated Care Framework, and can support enhanced care pathways for a range of important client groupings.

5.1.1 Feedback from clients and HSE staff

Table 5.1 presents an overview of some of the key areas of benefit and impact reported by clients. All clients reported the supports were useful and had made a difference in their lives. Most clients (84.6%) said the ALONE supports were 'very' useful and two-thirds (65.4%) said this had made a 'very big' difference in their lives.

Table 5.1 Benefits and impacts reported by clients

- befriending made a big difference for very many clients
  - counters loneliness and social isolation
  - improves mental health
  - something to look forward to each week
  - help with minor tasks
- support coordination was very useful and made a big difference for many clients
  - knowing that they are there and will help if needed
  - help with sorting out problems and difficulties
  - making applications for entitlements/benefits, services, grants...
  - helping find reliable tradespersons
  - direct help with minor tasks

Table 5.2 presents an overview of some of the key areas of benefit and impact that HSE staff identified from their referrals for social reasons and for practical difficulties. Benefits included the important improvements in clients' lives, the possibility for staff to refer to ALONE to address social and practical issues that they could not meet themselves (including IADLs), support for staff in their own work (e.g.

earlier detection of needs and deterioration), helping avoid hospitalisation or entry to long-term care, and enabling (earlier) discharge from hospital.

Table 5.2 Benefits and impacts reported by HSE staff

• social isolation and loneliness
  ○ befriending provides supports for needs that HSE staff cannot meet
  ○ someone coming to the house often suits people better than day centres
  ○ can help build confidence and get people going out again (e.g. after a stroke)
• practical needs
  ○ again, addresses needs that HSE staff cannot provide for, including:
  ○ housing issues
  ○ self-neglect - squalor, hoarding; cleaning and de-cluttering
  ○ navigate services (e.g. home adaptations), advocacy
  ○ sourcing reliable tradespersons
  ○ help with issues such as shopping
  ○ supporting carers who have difficulty coping
• important concrete benefits for health and social care system
  ○ enabling (earlier) hospital discharge
  ○ detecting needs at an earlier stage (risk of falls, health issues, etc.)
  ○ helping avoid un-necessary hospital attendance or admission
  ○ avoiding or delaying entry to long-term care.

5.1.2 Wider evidence base

Chapter 4 presents some key elements of the wider evidence base in this field and this provides further substantiation of the contribution and value of the types of service provided by ALONE. Good evidence exists for the value of befriending services for older persons as reported by older persons who use it, measurable impacts on loneliness, improved mental health, and an overall positive financial return on investment for the health and social care system. A growing body of evidence also indicates the practical value of information, signposting and service navigations supports. This includes addressing an important area of need identified by older persons themselves; providing a coordination and linkage function across the spectrum of formal health and social care services, and between the health and social care system and wider community supports; and indications of a good return on investment from funding provided for such services. Finally, good evidence exists for the value and value-for-money from direct practical supports with activities of daily living, housing and other areas of difficulty that older persons frequently experience. Such benefits are directly linkable to ALONE service to the extent that it already provides hands-on help with practical matters as well as through its role in signposting to and facilitating access to such supports provided by other agencies.

5.1.3 Value for the HSE

At the frontline level, the service clearly has a strong perceived value for HSE clients and also for HSE community- and hospital-based staff in their day-to-day work.

Table 5.3 Value for HSE

• Enhancement to social care for older persons
  o contributing to improved health and wellbeing
  o helping older persons to live at home with a good quality of life
• Important for the HSE Integrated Care Framework and enhanced care pathways
  o operates in an agile and responsive manner, much more so than HSE services can
  o holistic approach – addresses wide range of needs (social and practical)
  o straddles sectoral boundaries (health and social care, housing, social protection, community development)
• Reaches/addresses needs that HSE services cannot cater for (although are within scope)
  o support with IADLs
  o psychosocial supports (personalised)
  o practical trouble-shooting, intervention and sign-posting
  o continuity of engagement; detection of need, deterioration etc.
• Supports achievement of important HSE objectives
  o reduction of delayed hospital discharges
  o prevention of avoidable unplanned admissions and/or A&E attendances.

5.1.4 Value for money

A growing body of health economics and other evidence points to the value-for-money from public funding for befriending and support coordination services. It can be challenging to apply the standard health economics approaches to these forms of social care, and many studies apply a broader SROI (social return on investment) perspective to express the value of the contribution made in financial terms. Overall, the available evidence provides strong indications of a likely very positive value-for-money and return on investment for the HSE from funding the ALONE services. Large numbers of older people can be supported at a relatively low cost, and hospital bed-day or nursing home cost savings for even a small fraction of these would more than pay for the overall service.

5.2 Possible areas of improvement or expansion

In many respects the current service is operating very well, providing a useful contribution and good value-for-money. Nevertheless, the review found a number of aspects where there might be scope for sharpening the definition of the service, or particular elements of it, to maximise the value for HSE purposes, but keeping as much agility and flexibility as possible. For example, it might be useful to consider maintaining the current broad scope and wide-reach service whilst also establishing more focused and purposive models for supporting specified client groups, areas of need, and service settings (e.g. older persons attending A&E, preparation for discharge from hospital, older persons at high-risk of entry to nursing homes, falls management programmes, etc). A more general co-production exercise involving HSE and ALONE frontline service managers and staff would also be useful, to work on a more structured elaboration of the service model and its place in care pathways, and improve communications

processes where indicated. An appropriate forum could also address refinement of the resource allocation and funding model for HSE commissioning of ALONE. There would also be value in sharpening aspects of ALONE's client record system and associated reporting possibilities.

One key area for attention might be the possibilities for sharpening and possibly expanding the specification and scope of some of the ALONE service and components. Suggested issues for attention here include: befrienders providing more practical help alongside the social element; and support coordinators providing more active inputs alongside their sign-posting and service navigation supports.

5.3 Next steps?

To optimally address these various issues and work to maximise the effective operation and contribution of the ALONE service for HSE purposes, it may be useful to build-in a more structured formative evaluation dimension to the programme from now on. This would involve, each year of the programme, a preparatory (*ex ante)* exercise to identify required service changes/improvements and plan the evaluation approach for the year, and an end-of-year summative (*ex post*) evaluation to assess progress and measure outcomes in concrete terms.

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