Age UK Wiltshire Living Well Service - Bradford on Avon

The Age UK Wiltshire Living Well service was introduced to Bradford on Avon in June 2017. Since that date, over 100 local older residents have been referred to the Age UK Wiltshire senior Living Well project worker who is based at St Margaret's surgery whilst also attending the weekly Leg Club and the HUB each Wednesday.

Age UK Wiltshire truly believes that the Living Well Service at Bradford on Avon has made significant improvements to the patients who have been referred to it since 2017 and would like the opportunity to continue with this work.

What makes the Living Well Service different from many other services is the Guided Conversation that takes place in the client's home once a client has been referred. The referrals are primarily made by one of the Health Professionals at St Margaret's (a GP or someone from the Older People's Team) when non-medical support is thought to be of benefit to the patient but residents of Bradford on Avon can also access the Living Well Service through the Leg Club and the HUB.

The Guided Conversation includes 6 categories which are explored in detail:
social engagement – what relationships does the patient have with other people
physical activity – how much physical activity does the patient engage in
healthy living – how does the patient manage nutrition and hydration
finances – is there an entitlement to additional financial benefits
housing – is the patient managing in their home
health & care support – what are the current arrangements, is a review necessary

The senior project worker has now completed nearly 80 Guided Conversations, helping patients to identify which of the 6 categories they require support in:

- Over 75 patients were identified as being socially isolated or lonely and information pertinent to each individual was produced and discussed with each of them to help them address those feelings. The majority of patients were, with gentle encouragement, able to access a wide range of suggestions themselves and 12 patients were referred to the Age UK Wellbeing to access volunteer support and engage in a programme, specific to them, to help make significant improvements to those feelings of loneliness and isolation.
- Over 50 patients were identified as being at risk of falls and were given a range of information and often support to arrange: personal alarms; exercise classes; podiatry appointments, aids and adaptions. 5 patients were referred to the Age UK Wiltshire Fitness & Friendship club at Winsley and receive volunteer support to attend.
- Over 20 patients were given information about additional benefits that they may be entitled to and when appropriate referred to the Age UK Information & Advice service for additional volunteer support to apply for those benefits.
- Over 30 patients were helped to access transport, additional domestic and/or domiciliary care, gardening and handyperson services – to maximise the patient's independence and potentially enable them to continue living in their home.

As well as the advantage of being able to access further resources and expertise from within Age UK Wiltshire, the project worker has access to other partner organisations who work closely with Age UK Wiltshire and when appropriate and to the benefit of the patient, referrals can and have been made to: Wiltshire CIL (Make Someone Welcome); Alzheimer's Support; Carers Support Wiltshire; Dorset & Wiltshire Fire and Rescue SAIL; IAPT; Wiltshire Council Health Trainers.

Statistics themselves however do not fully capture the lengths that the project worker goes to, to improve the wellbeing of the individual but the following summaries of just a few examples of help and support given give a better idea of how the project worker has helped, sometimes over many weeks.

Case Studies

A patient was referred by a community nurse who was worried about the mental wellbeing of the patient having repeatedly heard them saying 'I wish I wasn't here'. Following the Guided Conversation to explore why the patient was feeling that way, a link was made with a volunteer, they soon discovered a shared interest, the patient was introduced to a local group which they attended together and the patient was able to form other friendships within the group.

A patient was referred to the service by his GP because of the patient's anxiety about developing dementia – tests had revealed no abnormal changes in his cognitive behaviour. The Guided Conversation revealed that the patient was experiencing significant stresses relating to his wife's recent cancer diagnosis, a house move, financial worries, bringing up a teenage daughter and working. The patient was given the opportunity to talk about his anxieties in detail and the project worker was able to offer practical assistance to help overcome some of the anxieties he was feeling. The patient was encouraged and supported to: contact Carers Support Wiltshire; access benefit advice to ensure he and his family were in receipt of all benefits they were entitled to; manage basic, everyday memory problems as well as health advice on how to support healthy cognitive function; follow up on an interest group that the patient had said he would like to join. The patient said he felt 'resurrected' by the opportunity to discuss his concerns and by the information provided through the Living Well project. He now has information on relevant services and how to access them, and has made contact with and started attending the local interest group.

A patient was referred by the care co-ordinator due to concerns that she was becoming socially isolated following a recent fall. At the Guided Conversation the patient was tearful and identified that she felt lonely and bored at home, she struggled to accept that she deserved any support to overcome this, feeling that she was 'past her use by date'. The patient was a very independent and capable person and part of her frustration was that her carers were doing tasks that she herself could do slowly throughout the day. The project worker was able to discuss at length ways that the patient could regain some control over her life again: a referral to an occupational therapist to provide appropriate aids and equipment to enable the patient to maintain her independence; a review of her medication so that the patient had pain relief patches as opposed to oral medication; a referral to AUKW Wellbeing for a volunteer link to help re-build confidence so that the patient could once again attend the social groups.

A patient was referred by a member of the Older People's Team due to frequent non-clinical attendances at the surgery. The Guided Conversation revealed that the patient was still grieving for her husband and was feeling lonely despite having a supportive family and neighbours. The patient was referred to the AUKW telephone befriending service and given volunteer support so that she could attend one of the AUKW Fitness & Friendship clubs. The patient quickly became good friends with another older person that the same volunteer also supported to attend the F&F club.

A patient was referred following the sudden bereavement of her husband because it was thought that support to increase social connections would benefit her especially

as her husband had always managed all their affairs and had been the patients only social contact. The Guided Conversation revealed that the patient was not ready to engage in social activities and initially declined support, preferring to put her time and energy into sorting practical matters around the home and relating to her husband's financial and legal affairs. Information and contact details of the project worker were left with the patient should she change her mind. A few weeks later during a welfare and follow up call, the patient explained that over the intervening period she had come to realise how lonely life was without her husband, and how she would benefit from some support to adjust to living life on her own and in particular help to manage practical problems such as attending appointments, finding a plumber, using a mobile phone. Over a number of weeks the project worker helped to resolve a fault with her phone line, adjust and manage her medication prescription, hire a wheelchair, access the optician and the bank, and set up plans for how to overcome and manage similar issues into the future. With the right information and some reassurance the patient was able to resolve the issues herself and having gained the confidence to address practical problems the patient then acknowledged that it would be prudent to increase her social connections and is now actively engaged in making that happen.

Bradford on Avon Living Well – Budget 2019/20

Living Well – 2019/20 Budget (based on 48 weeks to allow for annual leave)		
Direct Service Costs		£
Staff	0.6FTE Senior Project Worker (including on cost @ 20%)	£16,200
Expenses	Travel & parking expenses @ 45p per mile	£240
IT & Telephony	Monthly mobile phone tariff £15pcm and IT £25pcm licences (office, Timetastic etc.)	£480
Supervision	2 hours per week – Area Manager South	£2,057
Sub-total		**£18,977**
Direct Support Costs		
I&A Services	Providing Information and Advice Services and resources (printed materials) (10% of direct service costs)	£,1882
Sub-total		**£1,882**
Indirect Costs		
Central Support	Charity Log entries, HR management system, Insurance (5% of direct service costs)	£941
Senior Management Oversight	Oversight Director of Services (1 hour per week)	£1,371
Training & CPD	Safeguarding, Guided conversations, community development, risk assessing, IT systems	£200
Sub-total		**£2,512**
Total		**£23,223**