Old Windsor Outreach coordinator project

Advice & support for the elderly and their carers

Update for RBWM Health and Wellbeing Board
8 August 2017

Context

- The population of the parish is circa 5000 with generations of residents staying in Old Windsor all of their lives. This has resulted in Old Windsor having the largest percentage of elderly residents in the borough compared to other RBWM .
- The village is quite geographically contained with the Parish Council Hub, the Day Centre, shops, cafes and medical centre all being within walking distance of one another.
- Old Windsor has a very strong sense of community with many local organisations and opportunities for residents to interact with one another – supported by an active social media presence which can be used to share important information and to reach out to residents when seeking support for an event or initiative. Many older villagers particularly self-funders have informal arrangements with others for support which is often inadequate.
- BCF Funding for a part time post – 16 hours per week over 12 month programme Jan – Jan 2018 to offer targeted support, advice and signposting for older residents in Old Windsor– linked to the GP practice at Newton Court.
- Demanding specification for the post – undertaken by a local resident with local knowledge and extensive social care experience.

- Open referral approach through residents themselves (self referral) GP, family/neighbour, community wardens, local community services.
- Engagement built up around the 3 conversation “Each Step together” model

1 Conversation 1 : Listen & Connect

Listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

2 Conversation 2 : Work intensively with people in crisis

What needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, stick like glue to help make the most important things happen.

3 Conversation 3 : Build a good life

For some people, support in building a good life will be required.

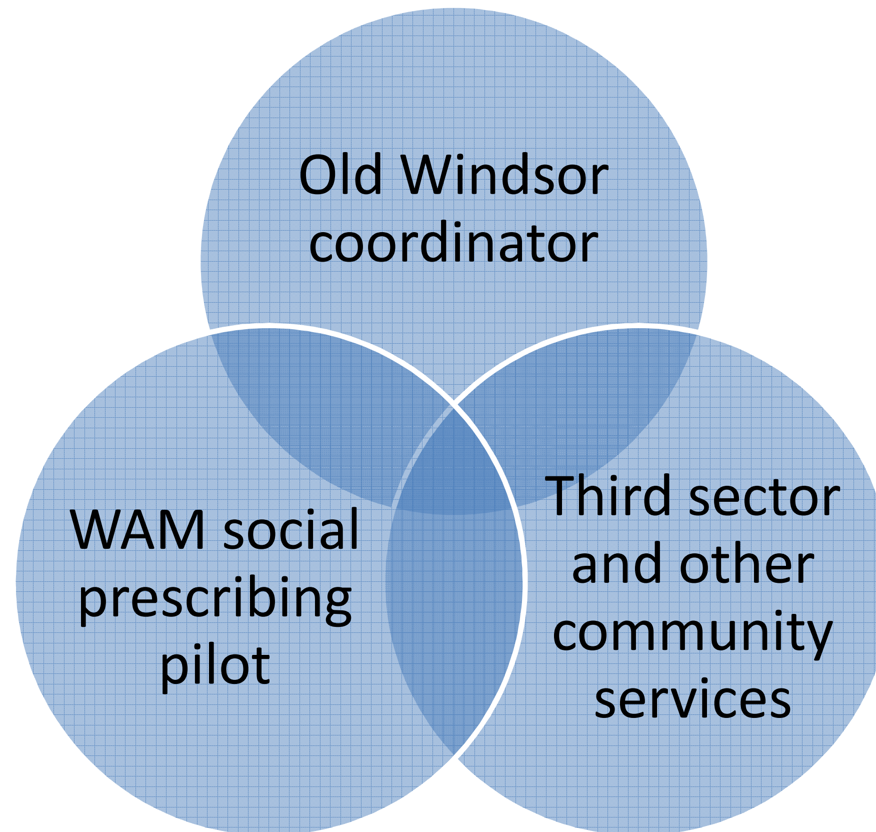
What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organized?

Activity January – July 2017

- **87 referrals to 26/7/17**
- Varied levels of simple to complex challenges, building individual and whole family solutions
  - Listen and connect - (example)
  - Work intensively with people in crisis – (example)
  - Build a good life – (example)

- **Ingredients for Success and positive feedback**
  - Accessibility of Hub/coordinator service
  - Speed of response to individual referral/need
  - Credibility and breadth of expertise of coordinator
  - Ability to build local solutions
  - Trust in service provider/openness to personal discussion/option development
  - Relevance of service to self funders
  - Avoiding long term dependency – promote self confidence and self determination

Od Windsor – part of a network of support – adding value to the wider community



Continuously sharing information, expanding networks, identification of gaps/delays in services follow up, promotion of good added value support and positive outcomes across the RBWM footprint

What next?

- Seek continued funding from all sources – promote our model of local support
- Contribute to wider evaluation of RBWM/STP social prescribing models
- Continued focus on reducing avoidable Non elective admissions
- Reduce Delayed transfers of care – particularly for self funders
- Opportunity to provide targeted support for neurology patients with MS/Parkinson's (and feed into STP Accountable Care project via BCF)

Impact – resident stories

- More joined up information sharing
- More timely and creative interventions to promote independence and reduce risk of crisis/contingency
- Focus on preparation for later life/end of life – what happens next
- Tailored support for different needs and combinations of circumstances -
- Fast tracking access to relevant services
- Whole person – extended family – not just at initial diagnosis and snapshot response – gateway to ongoing advice and support throughout patient journey
- Patient and Carer/family – supported individually and together –
- Better/ increased use of other community services – cross referrals and reduction in dependency on unnecessary services or inappropriate support

Mr S

Mr S is an 81 year old with Alzheimer's Disease.
He was diagnosed in 2015 but he has difficulty accepting it and his family have decided not to speak about it with him as it upsets him so much. They describe him as having a Peter Pan personality.
Unable to discuss as he refuses to have a conversation about being "old person".
Dgter lives nearby and is concerned as he is not eating and has been losing weight.
Developed leg pain and can not access his local coffee shop.
Now taken to his bed
Dirty crockery now building up, so Dgter called DCA for advise.

<u>EST actions</u>
DCA visited, needs discussed;
Refused POC in the past, did not want to attend any groups
DCA discussed using a personal assistant with Mr S and his Dgter.
Same person coming in he would be more relaxed and accepting.
Work on personal care, go in late and encourage him to get up.
Encourage meals- Breakfast, coffee, etc.
Encourage outdoor mobility
Accompany him out- re-establish routine
Support plan completed.

<u>Outcome;</u>
PA- via CareBank, number of C.V's able to choose. Developing rapport and daily routine due to review in 2 mth's. Mr S Dgter- thanked DCA for giving them this option and Mr S is delighted with his new P.A.

Questions.