The Winter Support Service 2022-23: a collaborative and preventative approach to promoting wellbeing and independence in Shropshire

Introduction

During Winter 2022/23, Shropshire Council commissioned a Winter Support Service (WSS) for a third consecutive year that aimed to work with vulnerable, and potentially vulnerable Shropshire residents. The service supported people to avoid a health and care crisis over the winter period and worked by connecting local residents to a range of support offered locally by the voluntary and community sector.

The service was delivered in partnership by Shropshire Council's Customer Services Team; British Red Cross; Shropshire Mental Health Support; Age UK; The Mayfair Centre; The QUBE; The Royal Voluntary Service and a variety of other VCS partners.

The service offered assessment and ongoing support for people identified as needing assistance, this provision included:

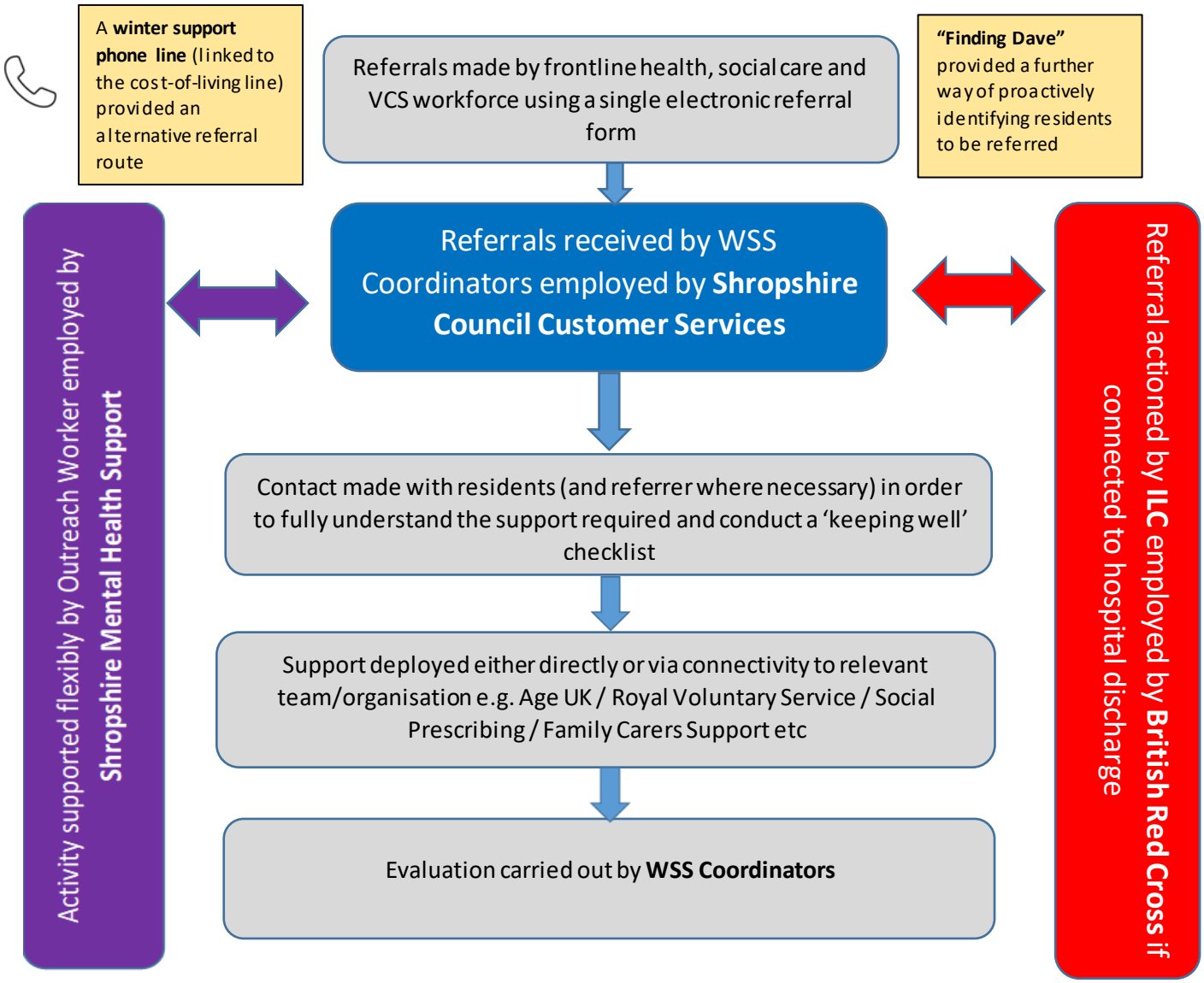
- Transport returning home from hospital
- Settling people in at home following discharge from hospital
- Simple aids and equipment following hospital discharge
- Collecting and delivering medications
- Shopping and delivery
- Transport to assist with attending appointments [subject to local availability]
- Wellbeing "check in and chat"
- Companionship for isolated or lonely people
- The expertise of a Mental Health Outreach Worker
- Signposting towards hot meal provision
- Cost of living advice and support
- Connectivity into the wider offer of support from across the voluntary and community sector

The service wasn't placed to provide a crisis response or personal care but functioned as a conduit into the health and social care system, ensuring that people were connected to the support that they need through appropriate referrals and signposting.

The service went live at the start of November 2022 and ran until the 31st March 2023. During this five-month period, the service accepted referrals from Practitioners working across the health and social care sector. The service was free for residents, but time-limited to the winter months. After this point, the offer reverted to the year-round services provided by our voluntary and community sector.

The pathway of support

A visual summary of the referral pathway can be seen below. The proceeding paragraphs provide more detail about the support on offer at the various stages



Winter Support Service (WSS Coordinators)

The service funded three FTE coordinators who actioned referrals upon them being made into the service. These staff members were employed by Shropshire Council on an agency basis and sat within the Customer Services Team. Their duties included:

- Making contact with referred individuals in order to clarify the support required and gain further insight into their specific needs and circumstances
- The facilitation of a 'keeping well' checklist with referred residents which covered themes such as: risk of slips, trips and falls; vaccine boosters (Covid/flu); hydration; nutrition; warm homes; medication; smoke detector installation; activity levels.

- Contact with the referrer, if necessary, in order to obtain further information. This may also have included further liaison with professionals involved in an individual's care and support.
- Contact with VCS providers in order to ascertain the suitability of a potential onward referral.
- The administering of new referrals into the VCS for the individual.
- Connectivity into other public sector teams such as housing, FPOC, welfare benefits, social prescribing, carers support team. Having a team sat under Customer Services really helped to facilitate these connections when the need arose.
- Accurate record keeping within a shared database held on SharePoint.

The WSS Coordinators received training in advance of the service going live in order to ensure that they were well versed in the process and were well informed of the local preventative offer. Furthermore, the Coordinators worked closely with Customer Services Manager and Seniors; The Resilient Communities Lead in ASC; and key partners within the VCS also.

Shropshire Mental Health Support

The service funded 1 FTE Outreach Worker who was employed by Shropshire Mental Health Support. We were really pleased to incorporate the post into this year's iteration of the service design as support for people experiencing poor mental health had presented a gap during previous years. This post was placed to provide:

- Outreach support in the community, within residents own home, support with housing (such as accompanying to appointments), DWP and other areas around supporting living arrangements.
- Planning and maintaining residents effectively within the community, making a WRAP (Wellness Recovery Action Plan).
- Telephone support as well as access into the other services provided by the charity.
- Advocacy and support with doctors' appointments.
- Understanding and dealing with stress and depression.
- Introduction to walking groups and general wellbeing programmes such as 'Reconnect'.

British Red Cross

As part of a year-round grant agreement with British Red Cross, three Independent Living Coordinators (ILC) were placed to support in the delivery by providing assistance for residents who were ready to be discharged from hospital or had recently returned home. The ILC's were placed to provide:

- transport home from hospital (ensuring that the resident could mobilise independently in and out of a standard vehicle)
- help with everyday tasks (for example, picking up prescriptions and shopping)
- weekly "check in and chat" calls
- support rebuilding confidence
- short-term use of a wheelchair and toilet aids
- door-to-door transport for essential health-care journeys
- fitting of a key safe to support a discharge
- free Installation of pendant alarm & 6-week trial
- onward referrals to other internal (i.e. Home from Hospital Team) or external teams or VCS partner organisations

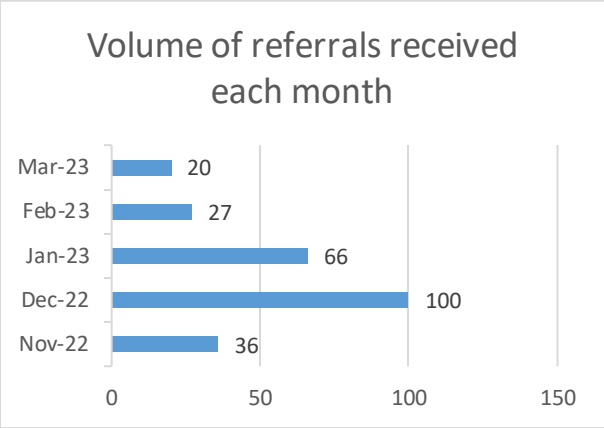
Wellbeing and Independence Partnership Service (WIPS)

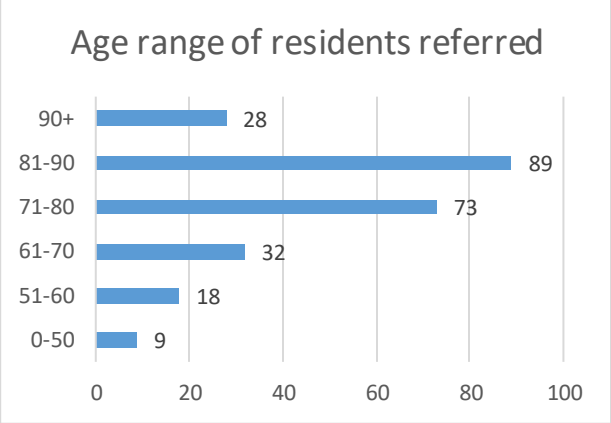
Various partners including Age UK Shropshire Telford and Wrekin; The QUBE; The Mayfair Centre and The Royal Voluntary Service were funded to ensure that they were placed to provide greater levels of capacity during this Winter period. This enabled the consortium of providers to assist with activity including:

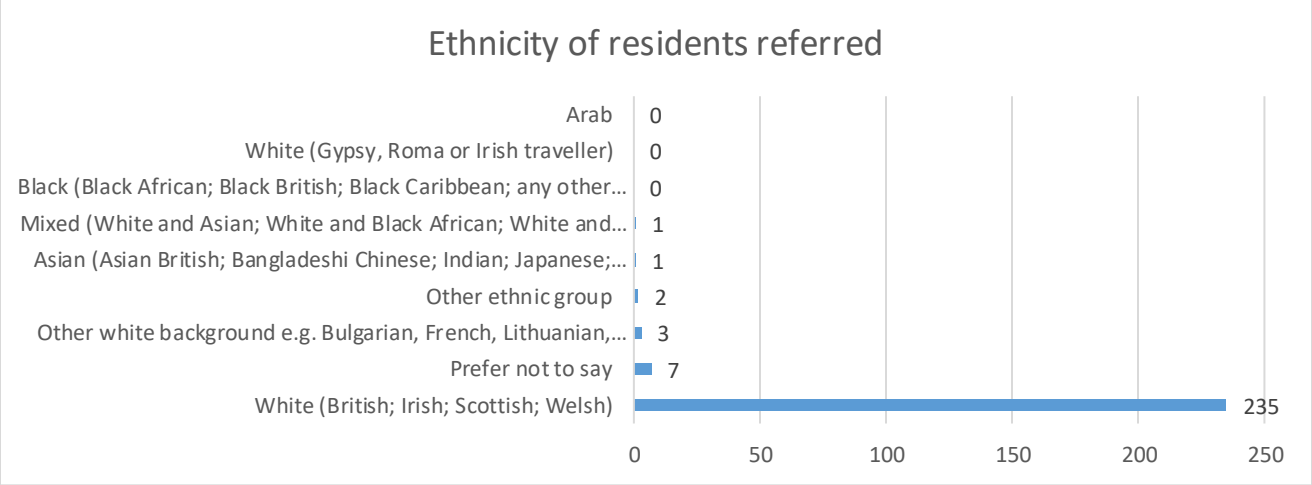
- Help at home (e.g. food shopping delivery / prescription collection)
- Befriending and engagement with community connections
- Community transport

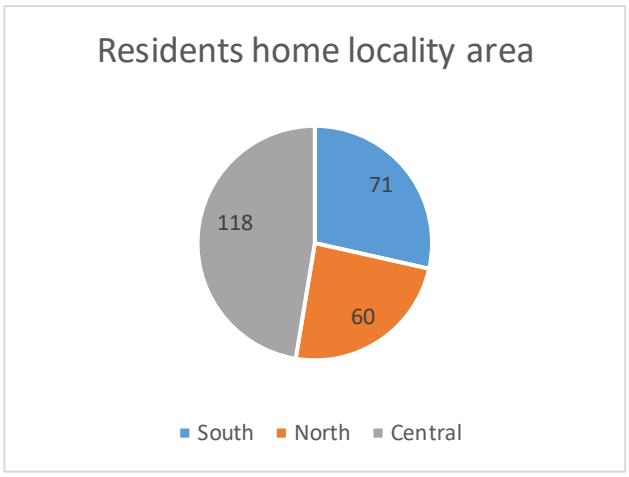
Referrals made into the service

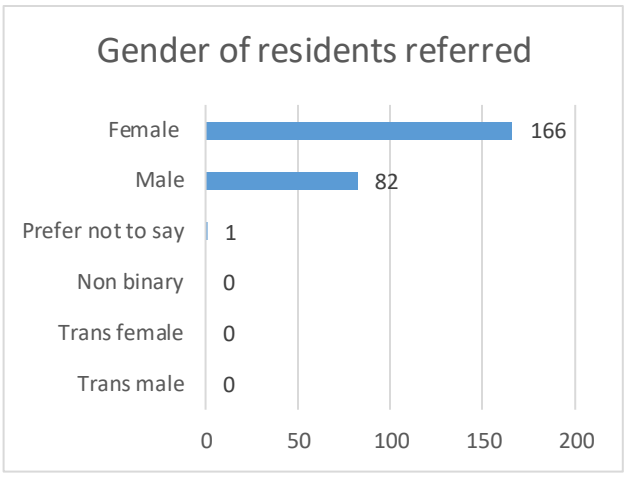
Between 07.11.22 – 31.03.23, **249** referrals were made into the service. The graphs below provides more detail in relation to the volume of referrals per month, and the demographics of the residents referred.

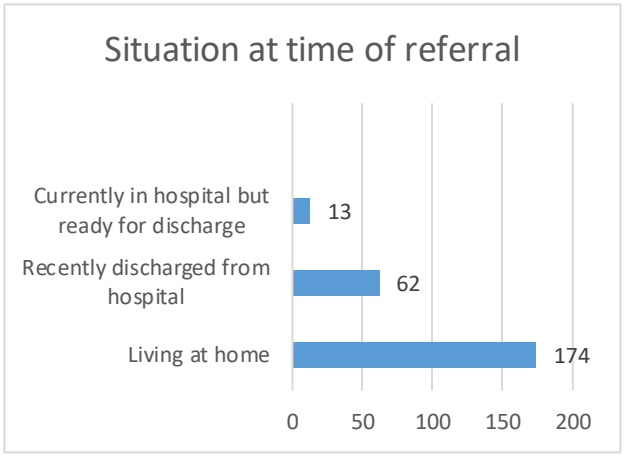


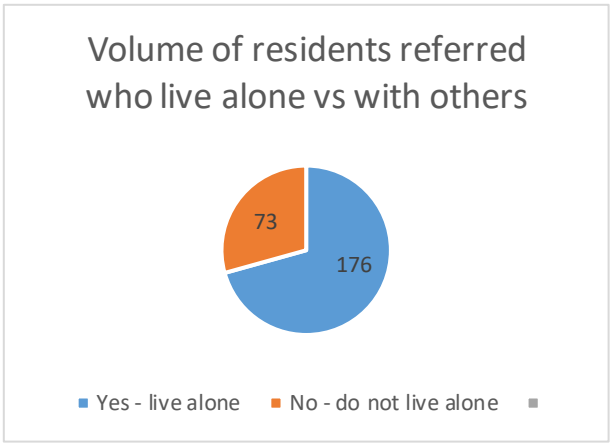




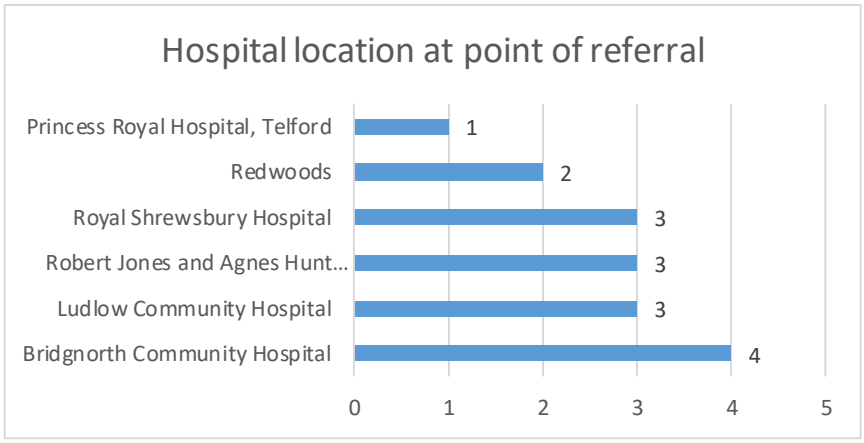








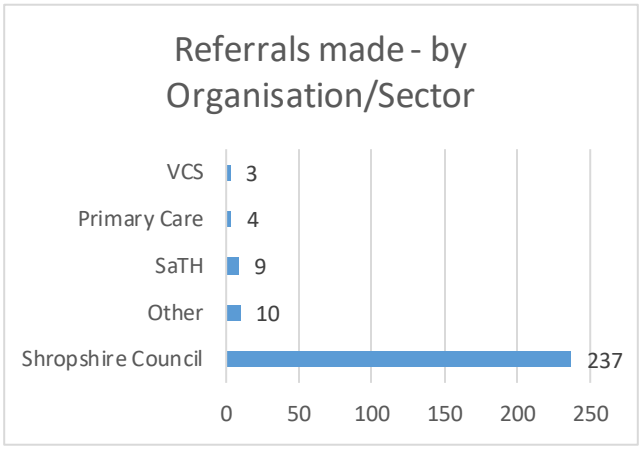
The graph below outlines a degree of insight into which hospital residents were located at in advance of a referral into the service:

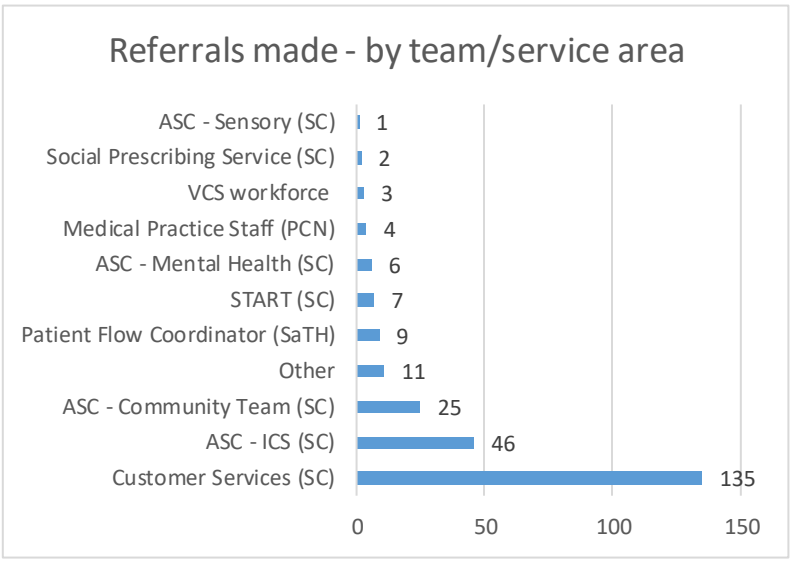


Our referrers

In advance of the service going live, there were a series of internal and external comms promoted in order to ensure a good understanding of the service and how to make referrals. Furthermore, the project lead attended various team meetings and briefings in order to share information and answer questions from our health and social care workforce.

The graphs below outline the organisations and teams that referrers were employed by.





Reason for Referral

The table below outlines the reasons why residents were referred into the service. Note that it was common for residents to be referred for multiple services.

Purpose	Volume
Wellbeing home visits	127
Shopping and delivery	118
Companionship for lonely or isolated people	102
Other - please specify within 'further information'	71
Collection and delivery of medications	55
Fitting of low-level equipment following hospital discharge e.g. key safes or pendant alarms	24
Transport returning home from hospital	12
Fitting low level equipment following hospital discharge e.g. key safes or pendant alarms	1

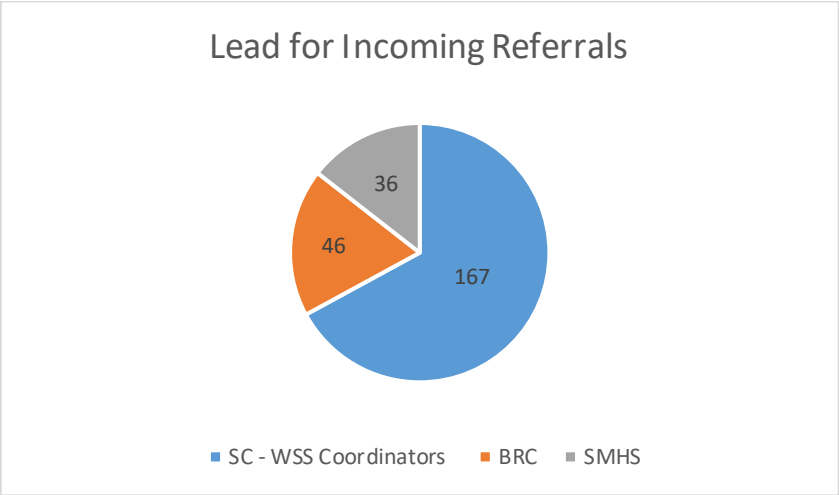
How the referrals progressed

When residents were referred into the service, the referrals were led by either:

- Winter Support Coordinators [Customer Services, Shropshire Council]
- Independent Living Coordinators [British Red Cross]
- Outreach Worker [Shropshire Mental Health Support]

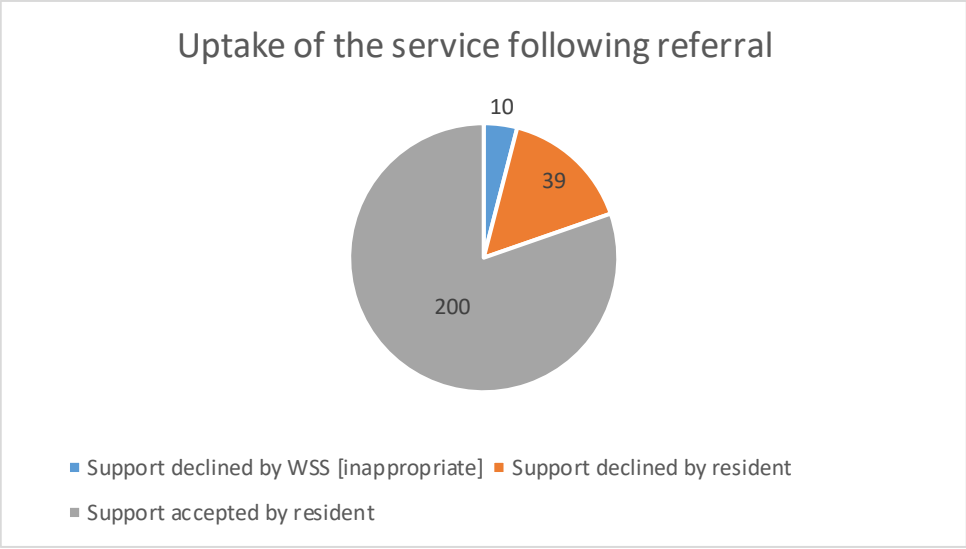
On occasion, some referrals were actioned jointly.

A breakdown concerning which provider led the referrals can be seen below:



Uptake of the service (following referral)

When observing the success rate of referrals, we were pleased to observe that 80% of referrals made into the service were progressed. This suggests that referrals made were typically appropriate; well managed; and that the breadth and quality of support on offer was well received and fit for purpose. A breakdown of this data can be seen below:



Activity surrounding progressed referrals

Of the 200 referrals that were progressed, the tables below outline the type of support that was provided, and the organisations/teams who provided the activity. As before, please note that some individuals will have gone onto be supported with more than one task.

Nature of Onward Support Provided	Volume
Shopping and delivery	58
Wellbeing home visit	39
Companionship	35
Other	32
Mental Health Support	28
Collection and delivery of medications	22
Community transport	18
Fitting of pendant alarm	16
Transport returning home from hospital	3
Fitting of key safe	2
Hot meal delivery	2

Support Provided by Team/Provider	Volume
Age UK	71
Shropshire Mental health Support	36
BRC – ILC	30
Royal Voluntary Service (RVS)	19
Other	15
BRC – Home from Hospital	14
Community Transport	10
FPOC	6
Mayfair Centre	6
Social Prescribing	5
QUBE/OsNosh	4
MHA Communities	3
North Shrewsbury Friendly Neighbours	3
Hands Together Ludlow	2
Marches Energy Service	2
Re-engage	2
Shropshire Carers	2
Welfare Support	1
Stroke Association Recovery Service	1
Crane	1
Fire Service	1
Silverline	1
Wiltshire Farm Foods	1
Oak House Foods	1

Signposting Activity

In some instances, residents were signposted towards teams, businesses, or organisations in addition or instead of a referral being made. This activity looked as follows:

Organisation	Volume
Morrisons	20
Age UK	13
Community Transport	11
British Red Cross – Home from Hospital	8
Silverline	8
Wiltshire Farm Foods	6
Mayfair Centre	4
QUBE	3
RVS	3
Feed the Birds	3

Smaller numbers of people were signposted towards the following: Barnabus / Highley Companions / Keep Shropshire Warm / Marches Energy / TV Licence info / Welfare Support / Home Plus / Christians Against Poverty / Sainsbury's / Jenny's Catering / The Barns Food / Hands Together Ludlow / Wem Meals on Wheels / North Shrewsbury Friendly Neighbours / Citizens Advice Shropshire / Good Neighbours Scheme / Medication delivery service / Chatterbox / Armed Forces Outreach / Social Prescribing

Reporting and Evaluation Methodology

Through the use of various Microsoft 365 applications, we were able to create a streamlined approach to the generation and communication of referrals. Furthermore, the IT systems deployed allowed our partners to seamlessly populate records with data connected with the referred residents and the support provided which the Local Authority could run live reports from.

Upon the conclusion of the service, an allocated WSS Coordinator conducted a series of telephone interviews with residents who had engaged with the service in order to seek their views and experiences. This was captured electronically by the Link Workers using an 'MS Form'. A further evaluation form was shared amongst referrers in order to gather their views.

Evaluation – findings

From a resident's perspective

In total, 73 residents provided feedback via a telephone-based interview. A summary of their feedback can be seen below.

Question	Average Response
Ease of using the service How easy did you find the service to use? 1 = not easy at all / 4 = very easy	3.6
How likely are you to recommend the service to others? 1 = unlikely, 4 = very likely	3.6
Would you know where to turn in the future for support if required? 1 = not at all / 4 = yes, feeling knowledgeable	3.5

Comments and feedback from residents were grouped into specific themes that the service has helped with. A snapshot of these comments can be seen below.

Support with Loneliness/Isolation:

- *"Mrs S was very isolated at home and she now comes into our social groups each week on our Dial A Ride transport."*
- *"It's been something to look forward to each week".*
- "It has been lovely having someone to talk to".

Practical Support:

- *"Just to let you know that Welfare Support have awarded payment for heating oil. Just got to arrange delivery, I feel so much better knowing it will be coming soon. I hate being so cold."*
- *It has offered peace of mind as the daughter was worried about her mum falling.*
- *A great help as Fiona from the Mayfair centre has helped with food bank and been to visit on a number of occasions.*

Support with fitting/providing low level equipment:

- *Was so glad to have the rails as it given more freedom to move around the house*
- *Was very grateful for the help from BRC and taking time to explain what was needed*
- *The pendent alarm has been a great help*
- *Resident prone to falling so provided peace of mind*

Help with Transport:

- *"Mrs H needed help to get to medical appointments. She joined Dial-a-Ride and we are now taking her for her physio appointments for the next six weeks".*
- *Has helped a lot as needed to get to appointments.*
- *Was very helpful and gave the information needed and Shrewsbury Dial a Ride was very friendly and helpful.*

Shopping and Prescription delivery support:

- *Helped a lot as residents PC was broken and needed help getting food.*
- *Was happy with the details as used them to order food shopping.*

Mental Health Support:

- *It was very helpful as the resident was feeling low after losing his wife of over 40yrs so he needed someone to talk to He now feels he is in a better place*
- *Resident reports that having support was helpful in keeping her motivated and reduced her feelings of loneliness.*

WSS needs to offer other types of support:

- *Service was ok - just could not offer what was needed.*
- *If there was any other company's/charity's that could help with housework (as a back log with getting Age UK support delivered).*
- *More support options.*

Lack of Face to Face/ 1:1 Support:

- *More one to one support*
- *More organisations offering face to face meetings and chats*
- *Was looking for someone to come sit with his mum while he was out (but this support was not available)*

All year-round support needed:

- *The funding stopped as would have been nice for all year around support*
- *Pity the service ran only for a short time*
- *Would have been nice for this service to have lasted longer*
- *That the service should run all year*

Wellbeing Score (adapted from MYCAW)

As part of the referral into the service, residents were asked to comment on their wellbeing via a tool that was adapted from MYCAW (Measure Yourself Concerns and Wellbeing). This included being asked to report on their most significant concern at the time of being referred and then allocating this concern a score from 0-6 (0 = "not bothering me at all" / 6 = "bothering me greatly"). This scaling question was then repeated at the end of the service in order to ascertain if there has been any change.

In total, 67 residents provided this data pre and post service delivery. The results were as follows:

What is your biggest concern?	Volume of response
Support remaining independent	24
Support getting out and about	19
Support feeling well	18
Support building connections	6

On a scale of 0-6, how much are these things bothering you?

0 = not bothering me at all 6 = bothering me greatly

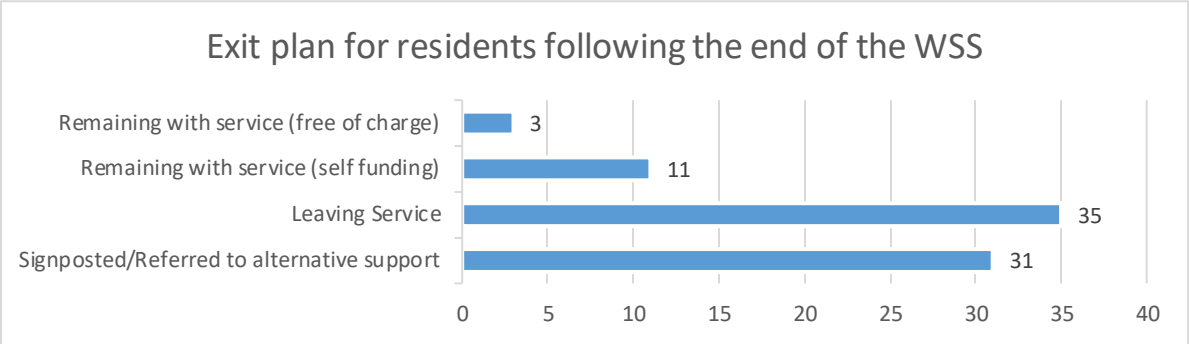
- Pre - average (mean) score at point of referral = 5
- Post – average (mean) score at follow-up = 2

Encouragingly this illustrated a significant improvement in residents reported levels of concern.

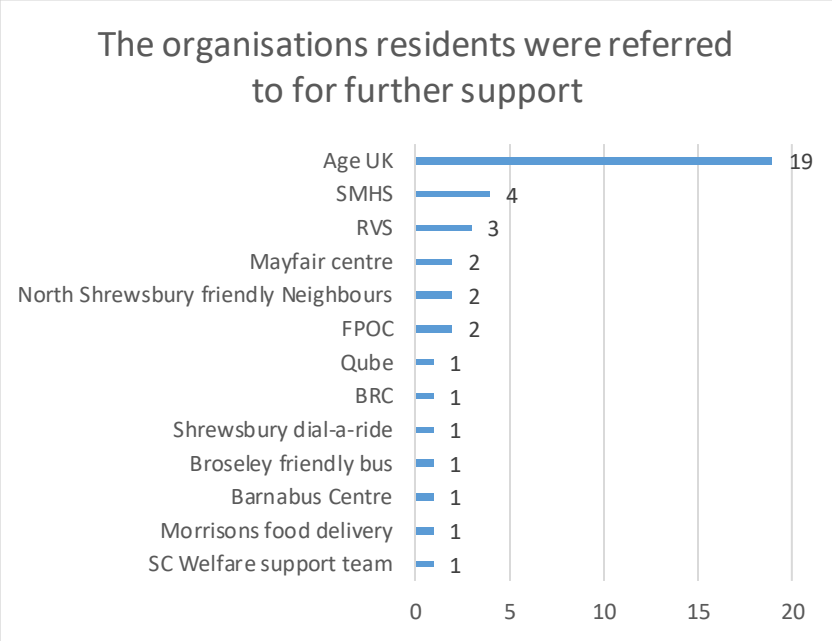
Exit planning

Residents who participated in the evaluation were asked to comment on what their intentions were once the service ended. A breakdown of this onward activity can be seen below:

Exit Planning following cessation of the service

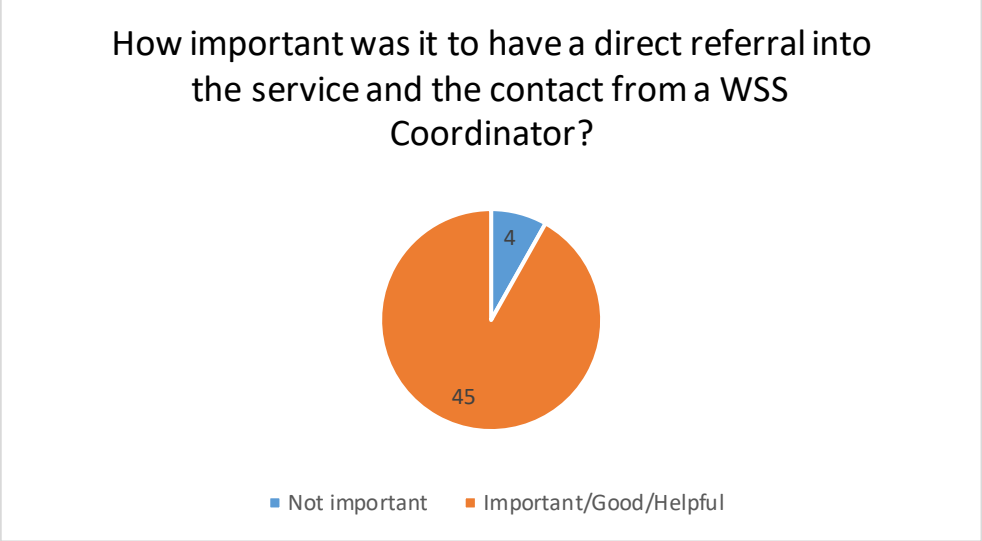


Of the residents who were 'signposted/referred to alternative support', this included:



The importance of a proactive referral

The WSS typically operated by receiving referrals via frontline practitioners, opposed to people being signposted to the service. By proactively referring residents (with consent), this worked as a helpful prompt for residents, who may have otherwise been hesitant to take action independently due to lack of motivation or confidence. As we can see from the chart on page 7, this approach helped to ensure that we had a good uptake of the service and very few "failed" referrals. Additionally, the chart below further outlines the impact and importance that residents found in this approach which ensured that referrals were coordinated in a consistent and comprehensive way, which extends to the way in which data was captured.



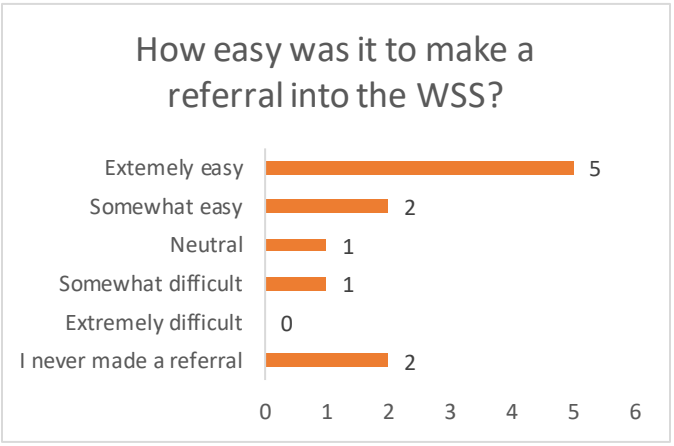
Further comments from residents relating to the question above:

- *"Was nice to have someone that could offer the support and was willing to help"*
- *"Was nice to see that there is help"*
- *"A great help as needed the support when left hospital"*
- *"Was nice to have a direct contact"*
- *"Was good but they could not give 121 visits"*
- *"Was nice to have someone who cared"*
- *"Was important to have a connection with someone"*
- *"Resident prone to falling so provided peace of mind"*
- *"Was good to have someone to talk to and was willing to help"*

Please see **appendix 1** for resident case studies.

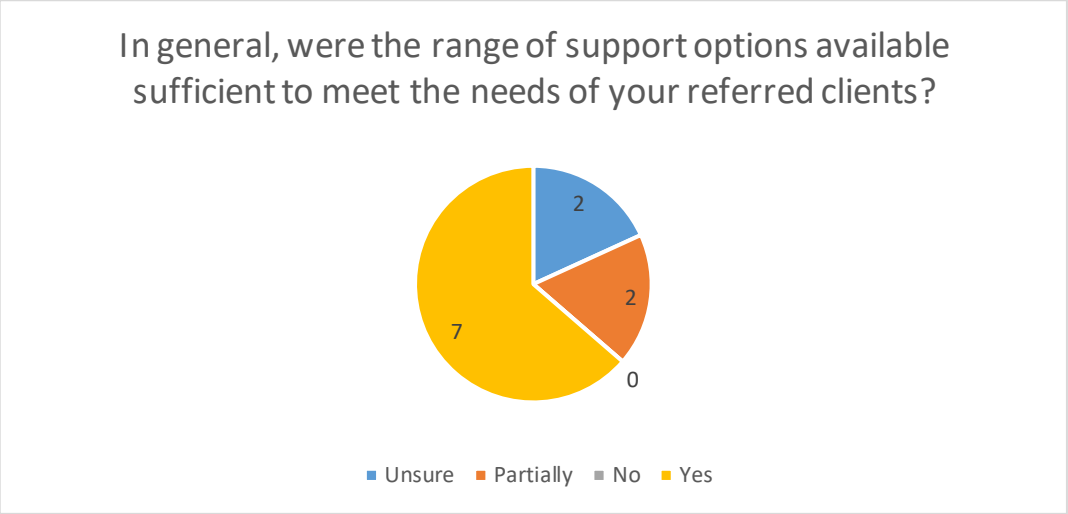
From a referrers perspective

In total, 11 employees from the health and social care workforce provided feedback via an MS Form. A summary of their feedback can be seen below:



Please see the points made below from referrers with respect to the support they'd like to see available in the future which wasn't available through the delivery of the WSS 22-23.

- *All year-round support*
- *We are having a lot of issues with people who only need medication support, we are struggling to meet this need as it i not a Social Care Need.*
- *Basic shopping*
- *Consider the WSS service being available all year round or during any heatwaves (if we have any this year) to help with ongoing pressures or increased pressure during hot weathers.*
- *I am FPOC advisor and found this service extremely useful and so did the customers that benefited from it.*



Concluding reflections

The Winter Support Service provided a coordinated and collaborative offer to residents which illustrated the ability to bolster the capacity of support on offer and deliver in a way that was both streamlined, efficient and holistic in nature. Further comments with respect to the future investment in this type of provision are as follows:

- Consideration to be given to whether this approach could be built into our operating model all year round. This approach to navigating the local offer has been taken by other rural local authorities which has helped to mobilise the VCS resources through the instigation of a community orientated front door.
- Further scope to improve our ability to measure impact and demand management through the mobilisation of preventative VCS activity.
- Improved coordination and engagement across the system to ensure that service delivery of this nature is invested in appropriately and proportionately.
- As resources become more pressured there will be greater need to ensure that provision is targeted amongst those most in need, considering both demand management and population health. Improved understanding and use of the JSNA data will provide a focal point moving forward.
- Continued commitment to ensuring that the system funds capacity and sustainability within the VCS.

Appendix 1 – Case Studies from VCS Partner Providers

1. Ms P

Ms P lives in a top storey privately rented apartment. She moved to Shropshire a few years ago to be near her sister and brother-in-law. Unfortunately, her sister became very ill and the brother-in-law now has to spend time looking after her sister.

Ms P found herself alone for days on end. We started Winter Support telephone friendship calls, which progressed to finding her a befriending visitor.

When we found that she was struggling to manage the stairs and drive her car, she was referred for Help@Home and now receives shopping support. She has told us how much she appreciates the fact that both her emotional and practical support needs are currently managed by Shropshire Age UKSTW.

2. Client 1

Client referred following telephone call came to Mayfair for face-to-face meeting. Had very complex home issues and safeguarding were involved. Mayfair role is to help build contacts outside home, discussed attending health walks as this was an interest and a way to meet others. She was interested but things stopped her attending including confidence. Agreed one-to one would be better but due to complex issues needed to find right befriender. Match made in February to an experienced befriender with support background.

3. Client 2

22nd December referral received person already known to us. Regular attender of Health Walks, a friend and volunteer walk leader expressed concerns in May. MAYSI been working to assist but client 2 since this time but she was very resistant, and family did not want community care assessment. Doctors were alerted and started processing a memory assessment, contact was made with relatives, a befriender was linked informally as she did not want support. Several incidents over the months where she came to Mayfair having lost keys/cards etc and support was given. Referred into the WSS via Social Worker for winter support, requesting daily welfare call. MAYSI made welfare call 23rd Dec and liaised with family. Mayfair Meal delivery set up so daily contact made when no relatives were around over Christmas. She paid for this herself. MAYSI gave assistance to fit a key safe, arranged a trial day service, completed Attendance Allowance form to help pay for care needed, provided practical assistance resolving key issues on number occasions.

MAYFAIR

4. Client 3

22nd Dec. Already known to Mayfair, MAYSI working with Adult Social Care. Client very confused and unable to get out. MAYSI did welfare call with GP on 23/12 and second visit 28/12. Mayfair meals set up for daily visit and check as well as a meal. He paid for this himself. Needs 4x day care but not getting it. GP happy not to admit to hospital as getting daily meal and contact. MAYSI liaison with Power of Attorney to set up care, MAYSI assisted them to find a care agency which he is tolerating - 4th Jan follow up. Set up tablets in blister packs to help with medication. Mayfair meals from 24th to 14th Jan - paid for himself. 2x Welfare visit

MAYFAIR

5. Client 4

Mayfair contacted 5th Jan - new to area stroke, disabled and recovering from fall, housing association tenant, MAYSI welfare visit, agreed deliver food bank weekly via ring and ride, housing referred to Connexus, registered with GP, awaiting social worker allocation, referred to CAB for help bills and they helping challenge PIP decision, requiring mental health support referred to Calmer Café in Mayfair. requested befriender, RA completed. 1 x Welfare visit, weekly delivery food

MAYFAIR

6. Client 5

Referred 1st Feb for social activities. Couple in Craven Arms he has dementia and cancer wife is carer with own health needs. Already known to Mayfair she has a befriender and receives support from a Social Prescriber. He was referred by Winter Support and also the Alzheimer's Society referred the wife. MAYSI referred to Beacon for day support and transport arranged by Ring and Ride, for him and to give his wife a break. They are now moving house to be near relative, Mayfair is providing volunteer support to help them with this.

MAYFAIR

7. Mrs E

Mrs E was referred to our service through the Winter Support Service. Mrs E is having treatment for cancer at the Lingden Davies Centre at the Royal Shrewsbury Hospital, where she has to go for chemotherapy every fortnight.

Mrs E was finding getting there and back very traumatic as the treatment times were all different and sometimes quite early. Also, it was a harrowing and frightening experience to face on her own.

Our volunteer Andrew was able to pick her up and get her to her appointments on time, and with the support and reassurance that he would be there to collect her after her treatment.

Mrs E said '' Andrew has saved me a lot of worrying as I would not have been able to get to my treatments as the times were all over the place, and some of them are very early ''.

Mrs E is happy to convert to our Support you at Home service once the Winter Support Service has ended.

8. Mrs L

Mrs L was also referred to us on the Winter Support Service. Mrs L has mobility problems and finds getting out and about extremely difficult on her own.

Our volunteer Colin was able to pick her up and escorted her around Sainsburys to do her shopping. Mrs L said '' Colin is wonderful, he is a great help, he lifts things down off the shelves for me and helps me to carry my shopping into the house ''.

Mrs L was concerned that the service would end as it is only Winter Support, she asked if we could help throughout the year, and if we would be able to take her to hospital appointments, which she has at both The Royal Shrewsbury Hospital and The Princess Royal in Telford. I worked out the cost of transport to both of these hospitals if she was to use our Support you at Home Service, although quite expensive for her, she valued the help that would be given by our volunteers and would be happy to be transferred over.

9. Mr H

We received a referral from Winter Support for a gentleman in Oswestry who needed to go to Leighton Hospital in Crewe for an operation.

The Service Manager contacted the gentleman – Mr H and discussed what support he needed. Mr H said he had to have an operation on his nose to enable him to breathe easier. He had tried to get transport with the Patient Transport Scheme, but he didn't qualify for their help.

He also contacted a taxi company, but the price quoted was much more than he could afford to pay. When the Service Manager said we would be able to help him through the Winter Support Scheme and it would be free of charge he was so grateful, he said '' he was at his wits end and didn't know which way to turn'', he was getting very anxious as his operation was in a few days time.

He had to be at the hospital for 7am so the service manager agreed to pick him up at 5.30am to get him to the hospital on time. He had to stay in overnight and our volunteer Rose offered to collect him from the hospital the following day.

Outcome

Mr H was very relieved to have the help needed to get to the hospital, he hoped that after his operation he would be able to breathe much better!

10. Mrs GH

BRC took the action for contacting the referral which initially came across for shopping support. When BRC receives any referral, our first action is to read all of the information on the referral, and ensure we know as much as possible about the person. We often find that a simple referral, can mask a myriad of other ongoing issues, and, maybe not always transpire to be as simple as one intervention being able to resolve a problem.

I spoke to GH, and we discussed her present situation. A family member had completed a large shop for her on discharge, and at point of referral, GH was fine. We discussed her health situation as it presents today, and agreed I would call back in one week on Wednesday, would block out half a day to visit, complete her shopping and assess how things were going. As GH likes to cook with fresh fruit and vegetables, something which she would not have in one week.I opened a record on BRC CRM system, with a note to call back in one week, and also diarised a visit.A week later, I made the call, agreed to visit GH at home that same day, on arrival, she was ready with cash, shopping list and bags. I checked if anything had changed, and if GH wanted me to accompany her shopping. This was declined. I drove to Sainsburys, purchased everything off a very precise shopping list, and drove back to her home. Carried in the shopping and helped put the heavy items away.

I then sat with GH and we had a long talk about her life now. Any concerns and if the Red Cross could support in any other way. As a result of this chat, it was apparent ongoing shopping would be needed. Also transport to a GP appointment, and a signpost on for a benefits review. We also discussed a pendant alarm, and how this may be a reassurance for her due to a recent spate of burglaries in the remote area where she lives. She was also concerned about falling and not being able to get up or reach a phone.

On leaving, I asked for consent to refer GH onto BRC Support at home team for an extra six weeks free support through a volunteer to continue with her Sainsbury shopping. I also requested BRC Support at home contact GH to take her to her GP appointment, wait with her and bring back home.

All the above is now in place. GH is looking like the extra six weeks will get her back independent again, and she is looking forward at being able to drive again and shop. The family do one online shop each month for frozen food, but due to previous bad experiences on the internet, this is not something GH would herself attempt.

11. Ms JBJ

J lives alone and has long-term depression (20 years on anti-depressants), in addition to multiple physical health concerns (poor mobility, incontinence, kidney cancer), and is a hoarder.
Initially, J was reluctant to engage in support and presented as very low and isolated. Her home was very cluttered, and we discussed risks around this. We explored the reasons behind her hoarding and why she refuses help from family and friends.
Once a relationship was established, she allowed me to help her organise her home. We worked at her own pace and although she was very reluctant to let go of items, together we were able to reduce some of the clutter.
J had weekly visits and overtime became more engaging and motivated. She reports that having support was helpful in keeping her motivated and reduced her feelings pf loneliness.

12. Ms JLD

J was referred in as a priority due to recent suicidal ideation and hospital admission. To begin with she was very anxious about engaging with our service, so we began with telephone support. Once her confidence had increased, we began weekly face to face visits.
J has a variety of complex concerns. She had come out of a long-term abusive relationship earlier that year and was frightened of him returning once he was released from prison.
J has an extensive list of physical health issues and struggled to leave her home and engage in the community due to anxiety and depression. She also has challenges with substance misuse which can cause a decline in her mental health.
During our visits, I was able to help J set up a security camera to help her feel safer in her home. Overtime, J became more motivated to change. She was binge drinking less frequently, resulting in less hospital admissions.
We went for 'walks and talks' in her local area and overtime she became more comfortable being outside. She reports that she now leaves the home independently on a regular basis.
J states she is now 6 weeks sober and is engaging with Telford Stars. She is planning on attending our support groups and continuing to engage with telephone support.

13. Mr RW

The eldest client in receipt of SMHS Winter Support was a gentleman in his mid-nineties, who lives in his own accommodation in a small rural town. 25 years widowed, living alone, and supported by a local care agency staff who visited three times a day to assist with routine daily living tasks, he is therefore largely alone.

Care staff quickly advised that he suffers from dementia, with a frequent tendency to confuse past stressful events from his time in military service with present day happenings, fuelled by snippets he hears on TV news bulletins. Often on arrival, I found this gentleman in a highly agitated and confused state, triggered by key words and place names he was hearing on the television and his loss of timeline.

On quickly discovering this gentleman's love of rural Shropshire and hills, local events, and military history we could both relate to, it was easy to engage him in conversation and diffuse his anxiety during visits. He took great pride in sharing stories behind his military photographs and those of his late wife. He generously commented that he looked forward to my visits as these were his only opportunity for "real conversation", as all other encounters with people focused solely on his care needs. On reflection, our conversations were very lucid and full of humour, providing him welcome relief from confusion, overthinking, and loneliness. It was an absolute pleasure and privilege to be able to support this gentleman.

14. Mr TJ

Homeowner- very independently minded gentleman with a small amount of savings, on pension credit and in receipt of basic state pension. TJ drives a car once a week to shop but admits he probably should relinquish his license. He is isolated, in that his only family is his sister and brother-in-law who live in the Oswestry area but do not own a car. There is no local transport connecting them. TJ is suffering from increasing ill health and fatigue and has been having some falls. I have helped him with the following:

Shopping
Answering letters from the council and DWP
Organising a hearing aid appointment and taking him to it
Getting a personal alarm set up
Visiting his sister with him

This has been very helpful. But TJ is getting older and frailer. He needs more help, to plan, to move house etc and now I am not available that's harder for him than ever.

15. Mrs V

V is an 85 years young Lady who I initially met in January 2023 when I visited her home. V lives alone and had recently been diagnosed with Dementia.Our initial encounter was not easy as V resisted anybody visiting her home where she considered herself to be "just fine" and certainly not in need of any form of support. V was suspicious of all visitors, myself included.
Over the weeks, with perseverance and regularity of visits, V became accepting of me and eventually welcomed me warmly with a beaming smile.
We developed a rapport that was based on trust; in her world where everything had become "cloudy" and uncertain, she came to recognise that my visits brought some clarity and familiarity, through continuity.

As a Support Worker for V emotional needs, when seeing someone in a holistic way, it was impossible to not recognise and act upon the many other areas of need that V had, which had undoubtedly impacted on her emotional well -being.
I visited weekly and during the time that I visited, I assisted to arrange daily meals as V was neglecting her nutritional needs. Through discussions with V family who lived at distance, a twice daily care package was commenced to ensure that V was supported to stay safe and well. Additionally, a visit by the Fire Safety Officer was arranged to ensure that V risk of fire was reduced.

Our time together became very special as I came to know the vibrant, sociable, lady whose character had been dampened by the effects of dementia and loneliness.
I discovered her love and talent for gardening, walking and her adoration for Freddie Mercury! My visits became very interesting, where we potted plants, looked at numerous photos of her gardens over the years and listened to Queen music, with singing and dancing!
It is often difficult to measure the benefits and success of such support, however, when I reflected upon the difference from my first visit to my final one, I saw that the many characteristics that had become lost through lack of stimulation, were unlocked for V and she blossomed and shone again!