Appendix One

Transforming Lives Case Studies

Case Study One

Betty is 78 years old and has a diagnosis of multiple Sclerosis (MS). She lives in her own home and has adaptations which include a ceiling track hoist, hospital bed, pressure mattress and cushion. Betty had received funding for a 24 hour live- in carer for the past 15 years, she had originally received support from the Physical Disability service and transferred to Older People's services when she became 65 years old. Betty had a 24 hour live-in carer and a second carer in the morning to assist with personal care.

When the social worker visited Betty she informed them that she felt uncomfortable having someone in her home for 24 hours a day. Betty said that they would often spend time in other rooms of the house and this made her feel uneasy even though this was her home. Betty was confined to her living room which also acted as her bathroom and living room due to her decreased mobility.

The social worker asked Betty if she slept through the night to which she confirmed that she did. The social worker then made a referral to assistive technology to provide some technology for Betty to communicate to someone in an emergency at night time, if this was needed. Betty was supplied with a lifeline which she could press or nudge and this would go through her lifeline to alert them and then her sons. The social worker also requested that her smoke detector and carbon monoxide sensor were to be linked to her Lifeline which was completed.

Betty's 24 hour live in carer was decommissioned and replaced by a package consisting of five calls a day. Betty wore incontinence pads but still wanted to use the toilet throughout the day, which involved hoisting her onto the commode. This information was all recorded into Betty's support plan with the outcome of maintaining her personal dignity and wellbeing.

The social worker then made a referral to the double-up team to assess if two carers were required or if there were other techniques or equipment that could support Betty with the use of one carer. The double up occupational therapist visited Betty and assessed that she only needed the support of one carer if they used a wedge and replaced her old hospital bed with a new one. The equipment was delivered and used immediately.

Betty now has five calls a day with one carer. The social worker spoke to Betty and reviewed the package and she seems so much happier and feels less of a stranger in her own home. Both of Betty's sons are in full time work but have now started to visit more at the weekend and have stayed over which was not an option before, when there was a live-in

carer. Betty is now seeing more of her family which is a great outcome for her and her family, and Betty enjoys the time in-between her calls.

Not only does this meet Betty's needs and achieve outcomes, it is also a cheaper option for the Council. This is a saving of £7,278.60 from her package being reduced from a live- in carer to five calls a day. In addition, the live-in carer required a two hour break each day, so another support worker was being employed for these two hours. Removing the need for this cover has contributed an additional saving of £16,560.44 per annum. Total savings £23,839.04 per annum.

Case Study Two

Miss S has a physical disability and had previously attended a specialist support organisation for two days per week and had transport provided to the service. Miss S had a personal budget of £8,300 per annum. When the social care professional visited Miss S for a review, Miss S shared that although she enjoyed the craft sessions she did not feel that the service was able to support her in developing relationships with people who lived local to her because of the distance that she travelled to the service.Miss S also explained that she found the days she attended the support organisation to be extremely tiring due to the distance she had to travel from her home to the organisation's base.

Following this review Miss S was quite clear that she really didn't enjoy attending the support organisation, apart from the craft opportunities. Miss S's mother was concerned about her not attending the service because it provided herwith respite.

Since the review Miss S now receives a direct payment which she uses to attend local craft classes four times per week. As these are local to where she lives,Miss S's mother is able to drop her off and collect her or another family member will provide transport. Recently, Miss S has begun to socialise outside of the sessions with other attendees; sometimes they go for a coffee after the session. Miss S's mother is therefore still able to have some respite andhas time to run errands. Miss S is able to pursue herinterest in crafts and this has also provided her with an opportunity to meet new people who live locally. Miss S has informed the social care professional that being able to go to these local sessions is really enjoyable and she feels that she is gaining a lot from them.

As well as providing a better experience for Miss S which has helped her to achieve her outcomes, and make friends locally, the change has made a saving for the Council as her personal budget has now been reduced to£3,000 per annum – a saving of £5,300 per annum.

Case Study Three

Miss D has a Learning Disability and lives at home with her elderly parents for whom English is not their first language. Miss D can speak limited English, and a limited amount of the language her parents speak. Miss D has a brother who lives nearby and is very involved in supporting Miss D and their parents, and also acts as a translator for them.

Miss D had attended the local day services for a number of years. Miss D enjoyed attending the day services and had a good network of friends who attended who were also from the local area. Sadly, Miss D suffered a severe accident and her injury meant that her care was split between two hospitals. Miss D was very unwell for a year, and then had major surgery. Miss D's recovery was limited and this meant that she had to stay at home and was unable to attend the day service as she was too unwell. Miss D became increasingly unwell and had to have more surgery. Following her discharge from hospital her health deteriorated further and she required further extensive surgery.

Following this surgery, the hospital advised that Miss D would require 24 hour care, and suggested that the family would be unable to support her at home. This was very upsetting for the family, who had strongly expressed their wishes for Miss D to come home and for the family to provide support to Miss D themselves. Miss D was also very keen to go home and work towards regaining her previous level of independence.

As part of the Transforming Lives approach, the social care professional explored with the family how they could be supported to make this possible. The social care professional had some difficult conversations with the family. The family were very keen that they help with all elements of the care for their daughter, and culturally they saw this as their responsibility. However, in reality Miss D's parents were frail and for example, were unable to support Miss D to take her for a walk. The family wanted to support Miss D with her personal care, and an occupational therapist and physiotherapist were involved to ensure that they could support her safely and minimise risk.

The social care professional recognised that there was some risk, including all three members of the family being at risk of having a fall. The risks were discussed, and the family felt that from a wellbeing point of view, Miss D living at home was the best outcome for her and them.

The social care professional developed a short term plan for the family to enable Miss D to be discharged from hospital. The plan identified the need for rehabilitation for Miss D, mobilising her and building up her stamina. The support which was discussed with the family, involved support from a local provider for six hours per week, in three two-hour blocks on alternate week days. The provider went in for two hours a day to support Miss D to take a short walk, building up her strength. After a month, the provider supported Miss D to begin to return to the day service, by taking Miss D to the centre for short periods of time. This enabled Miss D to regain her confidence and stamina and she was able to see her friends and day service staff again.

The family were closely supported and the situation monitored by the social care professional and health professionals through this transition period. Regular discussions with the day service and the provider contributed to the ongoing review of the plan.

After two months the transition was complete and Miss D was able to attend day services without the support of the provider, which was the outcome that she and her family had wished for.

The social care provider had adopted a tier two approach (of the Transforming Lives model) and this had enabled them to provide quick, short term, outcome focused support to Miss D and her family. The cost of the 6 hours of provider support for the two month period was a total of £678.

The hospital staff had anticipated that Miss D would need more support, possibly 24 hour care, as they were concerned that the family would be unable to cope at home without this level of support. Had this level of support been put in place, whilst Miss D recuperated it would have been likely that Miss D would have had to move into a respite service, and as these services were not nearby, this would have meant that her parents would have had to travel to visit her, and caused additional stress on the family who wanted her at home. Miss D would not have been able to access her local day services, and so would not be able to see people within her networks. The cost of respite would have been approximately £11,400 for the two months. A saving of almost £10,000 over the two month period.

There could have been a risk to her mental health and further anxiety for her parents with detrimental impact on the health and wellbeing of Miss D and her family. Miss D and her family were listened to, and their choices were supported by the team to enable Miss D to safely return home and regain her previous levels of independence.