APPENDIX F – PERSONAS TO ILLUSTRATE IMPACT OF BUSINESS PLANNING PROPOSALS

Persona for Learning Disability

A lady who has a mild Learning Disability and in many respects could live independently but has complex and unstable epilepsy. She will avoid situations where she feels challenged or she finds stressful by having “fits”. Close observation is needed by people who are familiar with her condition to understand if these are instances of epileptic activity or behaviour.

Our approach will be to provide a minimal package of support, because she has clear understanding of how to manage her condition.We would try to avoid a long-term care package for this person, and support her to live independently.

The initial involvement and planning with this person would focus on short-term interventions with clear goals. Firstly, we would link her with voluntary and community organisations that support people with epilepsy, so she gets to know people with a similar condition to her and can build a friendly and empathetic social support network. Secondly, we would work with her to develop her resilience, by understanding her stressors at the moment and helping her to deal with them successfully. These might include supporting her to improve her housing situation, or to deal with anti-social behaviour in her neighbourhood for example, and could involve commissioning working with a voluntary sector organisation or an independent sector provider to achieve specific goals and working with her friends and family. Thirdly, we would explore with her ways that she could secure employment, and help her to access support into employment via adult learning, JobCentre Plus or voluntary and community organisations.

This work would lay the groundwork for her to manage future stresses independently; we would withdraw this support when there was improvement. We would not seek to provide pro-active support from that point onwards – but temporary support would be available if a situation escalated and she was about to experience crisis. That support would follow a similar pattern –provide immediate support, recover her resilience, and rely on networks of understanding friends and family to help her manage her own vulnerabilities.

Persona for Learning and Physical Disability

Young man with both learning and physical disability who also has a deteriorating life limiting heart condition. He is due to finish formal education at the end of the summer term and wants to live in a flat on his own within the same area as his mum – but to have 24 hour support including a waking night.

This young man has high needs and is likely to die when he is young because of his heart condition. Our approach to this would be to have a full and early conversation and not raise expectations. This would include understanding what mum wants, and whether the young man needs to live alone. If he does not have a need to live on his own then we would not support this preference we would instead support the family to access Disabled Facilities Grant, and explore whether any care budget could be used to adapt the family home as necessary if it reduced the need for long-term support and meant that the young man could remain in the family home. If this was not possible we would look for alternative shared living accommodation within the county. Furthermore, we would ask whether he really needs 24 hour care, including supervision from a support worker whilst asleep, to keep safe. We would explore whether assistive technology could meet any night time needs as well as any daytime support needs, particularly where this supported family in their caring role or reduced the need for paid support staff to be present.

Given this young man's needs, we would liaise with health care services to secure appropriate health care input; for example, 'Hospital at Home' services could help him to remain in his own home rather than visit hospital frequently if he needs to.

Persona for Older Person

A woman who is 83 and has had several hospital admissions due to falls and other complex health needs and suffers from recurring urinary tract infections. She is now not confident that she will be able to manage on her own, and is unstable on her feet. She is about to be discharged from hospital following a stay of a few weeks.

Our approach to supporting this person will be to provide immediate support to help her to manage independently given her reduced abilities to get around. Upon discharge from hospital we will provide reablement and occupational therapy (as we do currently), which will help her to adapt her home and do basic tasks using the adaptations like preparing food, getting to the toilet, and doing shopping. We will also work with her to see if there are technological solutions to problemsgetting help quickly if she falls over or has a crisis, or staying in touch with her family and friends. This is intended to reduce or eliminate the need for long-term formal home care.

She is likely to need significant medical help too. Her GP will have access to a multi-disciplinary team of community healthcare and social care workers with a variety of specialisms, so she can be supported quickly if her health deteriorates. Especially important for this lady will be access to a new preventative / early intervention continence service, to help her remain continent. We will also arrange an introduction to the local Community Navigator service. This will help her to join in with any local groups or social events that she would like to, in order to keep her mobile, enjoying life, and physically active. If she has any friends or family who care

for her, we will work with them to ensure that their input is co-ordinated with health services' input and that they know how to access short-term support if they need it.

Persona for Adult Mental Health

A man of 49 who has a diagnosed mental health need which is contributing to him behaving anti-socially. His housing provider is saying they can no longer cope.

Our approach to supporting this man would be to work with the housing provider to create a more supportive and tolerant environment that would enable him to remain in stable housing, thus avoiding the need for him to move into supported accommodation. Provided that his housing situation is maintained, he would be able to live independently without social care support.

Firstly, we would work with him to understand what he wants in the situation he is in. That would provide the starting point for establishing the motivation for him to change his behaviour and highlight actions the housing provider could take to support him to maintain his tenancy. We would make sure that the social care thresholds were clearly understood, and that the aim is to try to stop the situation escalating to the point where his needs were substantial or critical, because that implies an immediate and severe risk to his health and wellbeing.

A variety of options, based around ensuring that he is connected to his local community and feels well-supported by his family and friends, would be explored in working with him. We would try to ensure that he was able to share social interaction with other people who were understanding, patient and friendly, to try to reduce his need to behave anti-socially. In order to do this, we might call upon a housing-related support contract to provide some short-term support.