Personalisation
Individuals' Stories

Bracknell Forest Council

Mr W

This gentleman has advanced Alzheimer's and is also a stroke survivor. He is 90 years old and widowed. He lives with his daughter and her husband.

His daughter has supported him continually since March 2009, only getting a break when other family members could support her father. Mr W and his family did not want him to be supported by someone he doesn't know as this is very distressing for him.

After a couple of meetings of working together and finding out their needs, a plan was devised to help support the individual and his daughter.

Mr W's support plan included employing his granddaughter as his PA to support him for 29 hours per week. For Mr W, this meant that he is supported for by somebody he knows and gets on well with. This arrangement has had a positive impact on Mr W and his family. His daughter has spoken to everyone she knows through the Alzheimer's Café.

Mrs G

This lady is 43 years old, and lives with her husband and two teenage children. She was diagnosed with fibromyalgia 16 years ago, and apart from a small remission a few years ago, her condition has been getting progressively worse. Her condition means that she suffers from chronic pain in her shoulders, back and legs, her mobility is reduced and she requires support from crutches for short distances and a wheelchair for longer ones. She also suffers from sporadic movements in her extremities, exhaustion and constant fatigue, and eye sensitivity to light and skin sensitivity to touch. In addition to the physical symptoms, the condition manifests itself cognitively as she struggles to retain new information and finds it difficult to concentrate for long periods of time. She also suffers from depression and has on occasion demonstrated aggressive behaviour (born out of her depression and frustration of her current set-up).

The level of support provided prior to the personalisation team's involvement was a one hour call at lunch time during the weekdays to support with housework and meal preparation. Mrs G struggled with the many different carers who provided support for this call, and a suspected theft took place which left the family distrustful of the care agency.

The level of support was not assisting her with any other aspects of her life and this was leaving her husband with a large caring role and left her feeling isolated and housebound. Her husband's health was also deteriorating and the stress of his caring role was affecting both his memory and the quality and balance in their relationship.

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As part of the support planning process the outcomes for all the family were considered. Long term goals were considered (such as learning British Sign Language) as well as simpler wishes such as support to cook the evening meal for her family (rather than having her husband or a carer doing this task for her).

The personal budget was used for items such as heat pads (to ease the pain, boost mobility and mood), a mobility scooter (to allow her independence during the day), support from a personal assistant to not only help with the housework, but to take her shopping and do the laundry. The flexibility of the budget allowed the hours of support to be tailored to her needs, for example in winter her condition is worse and more support is required. Building on the support she received from her friends already was a priority and support to make the time with them more regularly and sustainable was included in the support plan to assist both the individual and her husband in his caring role.

The outcomes of the support planning process were based around supporting the individual to complete the tasks herself as much as possible, whilst still supporting her with the tasks she is unable to do independently. The support plan also was focussed on supporting the carer and trying to prevent any further deterioration of his own health and reduce the risk of a relationship breakdown caused by his caring role.

Mrs S

This individual was diagnosed with symphysis pubis dysfunction during her second pregnancy and this did not subside and she now has chronic pain in her lower back and struggles to stand for prolonged periods.

One of the biggest things the individual wanted from the support plan was to be more independent in her home in terms of bathing and housework. She also wanted to take the pressure off her family and she wanted to have a contingency in place when things got bad.

The individual had already had a care plan written from the traditional model which wouldn't have worked for her as it was based on having someone coming into her home to carry out task based duties. Neither she nor her husband wanted a stranger coming into the home and the individual has a really good support network she can utilise.

As part of the support planning process the main thing has been to get a new bathroom fitted to enable her to be independent in the bath so she can physically get in and out of a lower level bath without her husband having to help her do this everyday.

The individual uses a friend to get her ironing done and pays for this by paying for her friend and her to go out for a meal together. The individual has support from her friends to get the kids to school and so on.

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Personalisation has helped make it possible to get things like a lightweight vacuum cleaner so on the days when she is able she can do some housework. She has had help from an Occupational Therapist to get the right equipment into the kitchen that will make it easier for her to use.

Another strand was support from other people in similar situation to her and we identified a hydrotherapy session locally, online forums and the expert patient programme.

For the carer's the support plan should take some of the strain off the family and help the individual make a contribution. We identified a young carer's youth group to provide support for her eldest daughter and applied for a carer's grant so the family could have support for a break.

Mrs B

This lady lives in Bracknell with her husband and four of her seven children. She has had multiple sclerosis for 7 years. The main effect this has on her life is lack of energy and issues with mobility.

Before deciding to be part of the personalisation pilot Mrs B was not having any support. In the past she had had a direct payment to employ domestic support from BFVA and support from the in house home care service to take her children to school. This ceased when the home care service stopped and her direct payment stopped due to financial assessment.

Mrs B became eligible for support again due to changes in financial circumstances in May 2009. Mrs B joined the personalisation pilot in September 2009.

The strain on the whole family was apparent as Mr B had to reduce his hours at work to do more at home. Mrs B's support plan focussed on trying to give her energy back so she can have a better quality of life with her family.

In order to do this we spent time discussing the times that support could help and the types of support options.

Mrs B felt that having support in the morning to help get her three younger children ready for school and get to school would save her a large amount of energy. Support with daily domestic chores was also important to her. Mrs B is currently recruiting a personal assistant to provide this support.

Mrs B finds the support and therapy provided by the MS centre in Reading very valuable. She is using some of her budget to help with travel costs as it is too far for her to drive.

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As Mrs B will also be using her personal assistant for a couple of hours of support to look after her children once a month so that she and her husband can spend some time together to go to the cinema or out to lunch.

Mr O

This gentleman has progressive multiple sclerosis, he was diagnosed with MS fourteen years ago, he is now 33 years of age. He only has partial use of his right hand and that is deteriorating. He can speak, but his voice is weak and he talks very slowly.

After a couple of meetings with Mr O it was clear that he was very isolated and he wanted the opportunity to learn again.

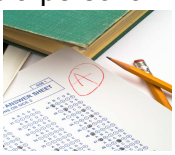
Mr O's care needs are very complex. He lives with a live in carer in a bungalow which has been adapted for his needs. The self assessed questionnaire met his care needs with a small amount of money remaining.

Mr O's main stimulation is via his television we managed to get him sky television which meant he had many more channels to select from.

Mr O needed social stimulation, he wanted to learn, he wanted to be able to speak and see his brothers who live abroad by using skype. To help him achieve this he needed his computer adapted for his use. He needed a home tutor, support from a local school or college and a befriender to give him some social stimulation. To fulfil his aspirations there was not enough money remaining after his care plan was paid for, so funding letters were written and sent out to appropriate charities and organisations.

In return Mr O received three donations, totalling to £740 combined with the remaining money from the self assessed questionnaire.

This means he can afford to have computer adaptations. He can hire a personal home tutor to help him with his Chemistry GCSE & Biology A Level.



Mr O is also having two visits per week from a volunteer befriender agency. He is in contact with his brothers and he is preparing to start studying for his exams in the New Year. With the adaptations and donations it has made a big difference to his life.

Mr E

This gentleman is a stroke survivor, he has arthritis and he has just been diagnosed with vascular dementia. His wife currently looks after him 24/7 with a little bit of help from their daughters.

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His wife is exhausted from looking after her husband and has no time to herself and because of her exhaustive state she is unable to give her husband any quality time.

After completing a self assessed questionnaire there are funds available to help Mr E and his wife to make a big difference to their lives.

They both wanted to employ someone to help with looking after Mr E and help his wife with her house work. Mr E and his wife decided to employ a friend who they had known for many years she was employed for 15 hours a week and is now looking after Mr E and doing some domestic work for his wife.

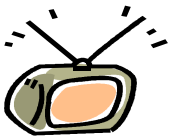
This has meant that Mr E is cared for and taken out to places. The friend is going to take him fishing which he used to love and make models with him which he also liked, but generally just take him out to places and support groups for advice and social contact.

This means that his wife can do as she pleases during these times and in particular continue with her gardening or have some rest.

In addition a raised flower bed is being looked into for Mr E to enable to him join his wife in the garden. Also his wife is looking to join the BFVA for support and advice.

Mr N

This gentleman suffers with Aspergillosis and is 90 years of age and is quite frail. His wife looks after him all of the time with little help from family or friends. He feels very guilty about his wife looking after him and worries a lot about her health probably more than his own.



He would like some visitors, he feels quire isolated and he would like more channel options on his TV, he is quite happy sitting at home everyday, but wants his wife looked after.

They have both agreed that they could do with some domestic support and a sit in carer twice a week. The domestic support will take care of the laundry, hoovering, ironing and making the beds.

A sit in carer will allow his wife to go out at least twice a week to do some shopping and to see family and friends in return this will make Mr N feel happier. Mr N will have a befriender to visit him once a week and the sit in carer will keep him company during the sit in occasions.

This is a big decision for this couple they are a proud couple and don't want to bother anyone but they have accepted they need some support to improve and maintain their health. They are happy to have support that is flexible, that means they are in charge.

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Mrs R

This lady has Progressive Supranuclear Palsy, she was in a care home and desperately wanted to go home. In order for her to return home she needed to have a live in carer.

Working with her and her daughter & son the personalisation team looked into care agencies to ensure the right one was hired.

During the support planning process Mrs R's support became 100% funded by the PCT through continuing healthcare.

Bracknell Forest Council and Berkshire East PCT have an agreement in place to allow the individual to continue receiving personalised support even though they are health funded. In this instance Mrs R and her family were happy about keeping them in control, informed and maintaining a familiar contact and PCT continue paying for the care.

Mrs R returned home two days before Christmas. She is quite content and is steadily building a good relationship with her live in carer. Mrs R's children are happy and reassured that their mum is happy and being cared for whilst at home.

Miss J

This lady already had an individual budget. She moved into shared accommodation in July. This was the first time she had lived away from family.

Miss J has a learning disability and needs emotional support and support to live independently.

The personalisation team started working together with Miss J in September 2009. We reviewed her current support plan and Miss J was able to identify areas where she felt she needed support and we worked together to update her support plan.

Miss J wanted to get a job and find other things to do during the week.

Miss J is now about to start a voluntary job once a week. She is supported through Breakthrough Employment service.

Miss J has found the move from her family home into independent living difficult emotionally. This led to her having a short stay at the Little House.

Since returning home we have reviewed the level of support she needed and wanted and she has decided to change her support provider.

Miss J is now working with staff from a new support provider to find things to do during the week.

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Mr D

This gentleman has a learning disability and lives with his Mum and family in Bracknell.

He would like one day to have his own place and live away from his family. He identified that he needed to learn many skills before he could have his own place.

We worked together to identify areas that he needed support with. Mr D decided he wanted a support worker from a provider agency as he did not want to be an employer. We put together an advert which we sent to local agencies. Mr D interviewed and chose someone he wanted to support him.

As well as learning skills for independent living Mr D will spend some time with his support worker to look at leisure activities and to increase his social network.

Mr D uses some of his budget to purchase support from Breakthrough Employment service to help him look for employment opportunities. Mr D did have a part time job for many years which he has recently left and is now looking for future employment.

Miss W

This lady has a learning disability, she also suffers with anxiety around changes in routine and with accessing new activities, and if she is not supported appropriately it can result as it has in the past, with complete withdrawal from anything outside of the home.

She lived with her family and attended day services prior to the personalisation team's involvement.

Miss W was supported to identify activities through the planning process she would like to try in the community and slowly began to attend these with support whist continuing to access day services.

The parents of Miss W looked into housing options for their daughter and were provided with support to identify the options available.

They decided that they would purchase a property for their daughter that she could live in for however long she wanted to, the parents were also of the opinion that they were not getting any younger and wanted to see their daughter settled. They were to act as the landlords for the property.

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During this time Miss W was supported by her parents to choose a property that would meet her needs and supported to understand the different types of property available and finally the house that she was going to live in.

Miss W and the family were presented with options for how Miss W could be supported once she lived independently and chose an agency to provide the support. The support staff were gradually introduced to Miss W supporting her to access community activities whilst gradually reducing her time spent at day services, this was facilitated via the personalisation team.

Miss W decided that she would like to share the house with someone to provide company and share the associated living costs. Miss W was supported to identify this person.

The personalisation team provided support to the family to complete all the necessary housing applications, either sign posting the family to appropriate services or direct support to complete.

Through planning with Miss W outcomes were set that would continue to promote her independent skills and a programme was introduced to support this.

The planning also identified how the support was to be managed and measure's to ensure that Miss W continued to be happy with the arrangements in place.

Miss W moved into her new home with her housemate, supported by people who understand her needs and promote her independence.

The family are pleased to see their daughter settled and accessing new activities that previously she had refused to try.

Mrs W

This lady is 75 years old and suffers from spinal decompression. She had just had her second operation to try and relieve the pain when she was referred to the personalisation pilot. She is fiercely independent and wanted to remain so, but she was keen to go out more. She lives in quite an isolated location and relied on family coming to her, rather than her going out. The year prior to our involvement, she had also lost both her husband and her dog, which left her low in mood and added to her feelings of isolation and loneliness. This lady is self-funding, as she declined a financial assessment as she felt her savings would result in her contributing fully. Due to this lady's savings she is self-funding her support but felt that she would benefit from having a support plan to enable her to assess her options.

She is well supported by her family, and due to her wanting to maintain her independence she mainly wanted contingency plans in place and contact details should more support be required. A major hurdle for this lady was transport, so the involvement of Dial-a-ride meant that she could do more meaningful activities with her sister who lives locally, and meant that they can visit garden centres, visit the day centre where her neighbours, and get to Bracknell town centre.

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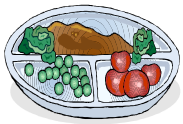
A lot of contingency and preventative measures were put into place to ensure that the caring role fulfilled by her daughter remained sustainable, such as the Carers Emergency respite scheme, information on age concern handyman scheme, frozen food providers with delivery, domestic support agencies as well as social services details should she decide that additional support is needed in the future.



Other ideas such as hydrotherapy to aid her pain, a trip to see Holiday on Ice, attending a gardening club and bereavement counselling were also discussed for possible future take-up.