PEOPLE WE HAVE HELPED

Case studies in Independent Living Co-ordination

About our work

Our Independent Living Co-ordination (ILC) service can be difficult to describe.

We believe it is the Gold Standard in supporting older people to live independent and fulfilling lives. We take a holistic, person-centred approach which supports the whole family environment, and is built on essential features of:

- Empowering the person we are supporting, using guided conversations to understand their needs and aspirations
- Co-ordinating services and resources around the needs of the individual, putting the person first
- Understanding that support for carers and family members may be integral to the independence of the individual
- Building independence, control and support networks so that when our service ends, the person is ready and empowered to continue living well
- Continuing to be available to provide support if the person's circumstances change after our service ends

Supporting people to live independently at home maximises the chance of the best outcomes for the individual, their family, and the community. It enables people to live safely in their home environment, surrounded by their own comforts and belongings. It gives relatives peace of mind that their loved ones can live independently with a support network. And it minimises costs to the health and social care system by avoiding unnecessary hospital admissions, enabling people to leave hospital when they are able to, with the right support, and reducing the need for residential care.

Case studies often illustrate our ILC service better than we can describe it. So we have compiled just a few examples of the thousands of people we have supported.

Case Study

Keywords
Poor housing and sanitation
Multiple long-term conditions
Maximising income

Housing Support – "David"

David's home was in a terrible state of disrepair and he was unable to use even basic sanitation facilities. He was also living in poor health. With our support, David's home is much more habitable and he is looking forward to a better life.

David was referred to us by a social worker following an alert raised by a district nurse. He is in his 70s and still lives in the house he used to live in with his parents. In recent years, his health has deteriorated, and he has developed conditions including diabetes and heart failure, COPD, and severe odema (fluid retention) on both his legs.

Referral to Age UK Sheffield

When he was referred to Age UK Sheffield, his house had got into an awful state of repair. Downstairs the house had severe condensation damp, especially in the kitchen where extensive black mould covered the entire back wall. The house had no central heating, no hot water as the immersion heater was broken, and David was using electric radiators.

Most of the windows in the house were completely rotten and leaking, and some had broken glass. In the kitchen the cold tap was working, but the sink drain was broken so waste water had to be emptied outside. Due to clutter, he was living in considerable dirt and dust.

Due to his health conditions, David was sitting and sleeping on a two-seater sofa in the living room. He was sleeping sat up and was only able to raise his legs due to a footstool, which was not helping his oedematous legs. He could not physically get upstairs where his only toilet was and this toilet had been broken for two years. He had been using bags which were thrown into the garden.

After discussing David's wishes with him, we supported him to have a new toilet installed in his porch outhouse, with a grab rail and raised toilet seat. We also did practical work decluttering the living room and later arranged for University volunteers to clear his garden.

We supported David to apply for Attendance Allowance, Pension Credit and Council Tax support - which increased his income by around £110 per week with an additional £1,000 backdated - and applied to the Central Heating Fund, who agreed to install a full central heating system for free.

We also supported David to obtain quotes for building work, replacing the windows, decorating and re-wiring, removing the mouldy plasterboard and re-plastering. We applied for grants for support with the cost of kitchen flooring and a new cooker. David's District Nurse obtained a reclining chair for David which he is now sitting and sleeping in instead of the sofa. This has already resulted in an improvement in the condition of his legs and reduced the swelling.

There is still a considerable amount of work to do and we are continuing to support David. He would like to rewire the house, decorate, fit carpets and flooring, buy a washing machine, and explore options for a stairlift and wet room. Due to the additional income he is receiving, he now has money available to make choices.

David says that our support "brought me back on my feet and brought me to my senses. All of a sudden I realised I wasn't on my own. You don't believe it and then you find that there are people out there willing to help".

Keywords
Hospital discharge
Domestic abuse
Housing needed

Case Study

Housing Support Pilot – "Mrs L"

Mrs L had been discharged from hospital to intermediate care, having suffered years of domestic abuse, and decided not to return home. Age UK Sheffield responded to the referral in one day and quickly enabled her to source her own home, in which she successfully lives independently.

Mrs L is 72 years old. She was in intermediate care at Newfield Intermediate Care Home following a spell in hospital, and the decision had been made that she would not returning to the home she shared with her husband, due to issues surrounding domestic abuse. Mrs L had slept on the living room floor for 20 years. She needed support to be rehoused.

Assessed needs

Mrs L was at the point of bed blocking her intermediate care bed. She was unable to return home due to domestic abuse, had a flat sourced by Housing Solutions, but needed support to actually set up the tenancy and settle at her new address. She needed support to view, sign for and furnish the property, as well as assistance to set up and manage bills. She needed help to rectify her pension and benefits to reflect her new status as a single woman, as well as support around housing benefits and council tax reductions. She had no proof of identification and was unaware of her income or what she should be entitled to receive, and needed help to understand this.

Actions

Age UK Sheffield supported Mrs L with viewing a property and signing for the tenancy. We then supported her to buy furniture and appliances, as she had no possessions to take.

We helped Mrs L to clarify her income and establish what money was in her bank. We supported her to apply for the correct pension rates as a single person. She now receives Pension Credit in addition to her State Retirement Pension. Mrs L had previously had little involvement with this, and therefore only knew (but was mistaken about) how much pension she was able to withdraw every week.

We helped Mrs L to get a birth certificate urgently in order to apply for Housing Benefit and Council Tax Support, and we helped her to set up bills and direct debit payments, including utilities, TV license, and get a new landline phone installed.

We worked closely with the intermediate care home to get Mrs L discharged and ensure that she had all the equipment she needed to maintain independence at her new address. For example, we organised the handyperson service to visit to do some required alterations such as fixing new curtain rails.

We provided assistance to register with the local GP, and one-off support to get medication urgently from the chemist. We encouraged Mrs L to get involved with activities in the sheltered accommodation she moved to. She now uses the shopping service on offer, as well as going to various lunches at the scheme.

We supported Mrs L to liaise with a solicitor over her legal rights now she is separated from her ex-husband. A lack of involvement from him over issues such as the property meant that she was unable to proceed further with this, but she has a solicitor to contact if and when necessary.

Outcomes

Age UK Sheffield was able to react quickly to the referral, and saw Mrs L within a day. We assisted her to view and sign for the property within 12 days, and move within a further four weeks. We worked with the intermediate care home to agree to timescales and facilitate a thorough yet speedy discharge for Mrs L.

Mrs L was supported to adapt to living alone at her new address. There were concerns that she was very comfortable at the intermediate care setting (as reflected in her original questionnaires) and that this would complicate independent living, but the prolonged involvement of Age UK Sheffield after discharge enabled Mrs L to settle and adapt accordingly.

Although Mrs L's health did initially slightly deteriorate following discharge, she did not return to hospital, and was able to manage this with the support of her new doctor. We worked to ensure that Mrs L understood her correspondence, pension and bill payments to ensure that she was able to continue to manage at home past our involvement, and to the point where she said she felt fully confident and safe in her new home environment.

Case Study

Keywords
Dementia
Hospital discharge
Preventing unnecessary readmission

Housing Support - "Kate"

Kate's memory issues meant she was highly likely to be readmitted to hospital unnecessarily in the future. Following our intervention, she now has a support network in place to minimise that risk.

Kate is in her mid-70s and was referred to us when in hospital. She needed a benefits check before she was able to return home as ward staff didn't know what income or access to money she had. Kate has no relatives in Sheffield and her only contact was an organiser and friend at the church she attended. Kate had not been in touch with any services at all.

Kate's referral

Kate had been admitted following a fall outside. She was found to be dehydrated and malnourished, weak and very confused. She had however, been very independent when at home and went out to the church group every day on the bus. She was able to look after her own personal care. When hospital staff went to her flat they found it to be very sparse but neat and tidy. However, Kate remained at times very confused and had difficulty in remembering things outside her day to day routine. This meant that she had not been dealing with correspondence and was largely unaware of her needs and problems.

What did Age UK Sheffield do?

- We visited Kate on the hospital ward and started to investigate her situation
- We obtained her keys and went to the flat to find paperwork and establish what repairs needed to be carried out
- We worked with Kate to establish that she did have money in her post office account and to locate her card
- We came back to the ward and opened letters and made phone calls with Kate
- We set up a payment plan for her water bill which was in arrears and applied for a refund of her rent and council tax which had been overpaid. We later took her to the bank to pay in her refunds
- We put stickers on all her payment cards with the correct amounts she needed to pay so she would be able to do this at the Post Office. We organised a key safe and spare key
- We contacted Kate's friend at the church who Kate was happy to be involved and updated her on the situation and our involvement. They agreed to liaise with me following Kate's discharge so we could alert any concerns to her whereabouts or health as she travelled between home and church
- We have regularly kept in touch with the friend so she is aware of what is happening and can remind Kate about appointments.

Home from hospital

We brought Kate home from hospital and supported her with the care assessment from the Short Term Intervention Team – Kate did not remember she had been in hospital at all a few hours after she had left. She needed support to explain her circumstances to the assessor and ensure that visits were organised around when she was going out to church. The carers' support stopped after a few weeks and we liaised with the social worker who assessed Kate for longer term support – social services decided that they would not continue care as Kate is independent with all her personal care. We did point out the risks around her not eating and taking medication; however the social worker didn't feel this met the criteria.

Home improvements

Since discharge we ensured that required repairs were carried out by her housing association. This included repairing the external door buzzer, installing a shower as there was no power supply to the shower that was there previously and repairing the heating as one radiator didn't work. Kate had hardly used her heating or hot water for years. We were present for most of these repair visits and liaised with the repair team when they had problems accessing the property.

Health improvements

Kate had not been registered with or attended a GP since she moved into her flat about 10 years ago. We supported her to register, attend assessment appointments, have vaccinations she had missed out on and also asked the GP to carry out a memory test which resulted in a referral to the Memory Service. Her friends from church have helped Kate get new glasses at the optician and have also agreed to support with her 3 monthly nurse visit for a B12 injection.

We have also set Kate up with a Pharmacy and arranged delivery and ordering of prescriptions for her Nutritional Supplement shakes. We have approached Kate's neighbour who has agreed to receive medication deliveries if Kate is out as she often is. There are still concerns that Kate is not eating enough – we were not successful in our attempts at supporting Kate with shopping as she would only buy minimal foods that she has always eaten. She does attend a lunch club once a week. We believe that she is taking her supplement shakes as they all seem to have been used and we continue to monitor this. We hope that once the mental health team becomes involved there may be some ongoing support with monitoring the situation.

Financial improvements

We supported Kate to apply for Attendance Allowance and the Severe Disability Premium to increase her income. We contact N Power customer complaints due to her electric and gas. We were able to get the gas meter removed which wasn't required as she has district heating and her £300 of arrears for her standing charge were cancelled. For the electric she had a pre-payment meter – we had seen bills in over a thousand pounds credit. The meter was found to have been faulty for over 10 years and we arranged replacement with a credit meter. Kate was credited with £200+ which she had already paid and we set up a payment card and plan which Kate now pays herself at the post office. Kate is also now on the Priority Register for gas and electric and has applied for a Warm Home Discount.

Summary

Kate is an extremely vulnerable lady who comes across as very capable and independent. However, she has severe memory and cognitive issues and was simply not aware of the many problems she had which could have caused her to be admitted to hospital again. Kate is now in touch with services and has a support network that will reduce the risk of this happening.

Case Study

Keywords
Dementia
Hospital discharge
Falls

Housing Support pilot - "Frank"

Frank's dementia had contributed to him missing health appointments and being behind on his bills. After being hospitalised by a fall, Age UK Sheffield helped to get him home from intermediate care, and living independently at home again.

Frank is 74 years old and was admitted to hospital after a fall. He had spent weeks in hospital and in an intermediate care bed. Following an Occupational Therapist's assessment that he could return home once his property had been cleaned, Age UK Sheffield supported the process – and found a number of other issues that needed to be addressed.

Frank lived in Council sheltered accommodation without any support from carers. His family all live in Canada, but he has several friends who he goes to the pub with and knows a number of people in his sheltered housing complex. Frank has a diagnosis of Dementia with Lewy Bodies, Parkinson's disease and Diabetes. Following a fall outside, Frank was admitted to hospital and had a stay of over 8 weeks.

What we did

- We visited Frank in the Intermediate Care home and he agreed to cleaning being arranged in his flat. We attended the flat with several cleaning companies. Only one company was able to quote, we discussed the price with Frank and he agreed to this, so the cleaning was carried out with our support worker letting the cleaners into the flat.
- We arranged for a few minor repairs we noticed to be carried out by the Council.
- Frank was discharged with a full care package. We helped to arrange the fitting of a new toilet frame.
- Once Frank was home again, we took him to his local bank to request a PIN number and ensure that Frank was independent in withdrawing his own money.
- We supported Frank to look through his correspondence and found a number of missed health appointments. We rearranged these appointments and wrote them on Frank's calendar. We supported Frank to plan his journey to these appointments and found him details of local taxi firms for locations that were more difficult to get to. We attended a Memory Service appointment with Frank so he could understand the information given.
- We supported Frank to check his finances and bill payments. We discovered the Council had previously taken Frank to court regarding Council Tax arrears. Frank was unaware of this. As Frank could afford to pay the arrears we supported him to do this, so the debt was cleared. We then supported Frank to set up Direct Debits for Council Tax and rent.
- Frank had Direct Debits going out of his account to a company he hasn't heard of. We investigated and found that he had previously taken out a loan for a Reclining Chair and was paying this off on a fixed term agreement. We are in the process of establishing whether it will be cheaper for him to pay the loan off in full.
- We applied for Attendance Allowance to increase Frank's income and he is now receiving this at higher rate. We are now supporting him to obtain a Premium on his Pension Credit.
- Frank did not have a washing machine and was using a hand wash tub. This was a problem due to his incontinence. We supported Frank to go out and choose a second-hand washing machine as he did not want to spend too much money and arranged for alterations by the council so this could be connected.

- Frank was already participating in social activities in his sheltered scheme and going to the pub with friends. We discussed with Frank concerns about risk of falls when drinking, though Frank had decided to limit his drinking.
- We have suggested to Frank that he might be interested in using Skype to contact his family in Canada.

Outcomes

Even though Frank could be discharged home, he was at a high risk of readmission because of his missed health appointments, lack of a care package, and low income.

Age UK Sheffield supported him to maximise his income and receive the health and social care support he needed, to enable him to live independently at home again.

Keywords
Dementia
Mental health
Hospital discharge
Use of Police resources

Case Study

Housing Support pilot - "Mr W"

Mr W was admitted to hospital after he had called the Police, believing he had been burgled. Following our intervention, he is now receiving services to enable him to continue living at home.

Mr W is a 90-year-old man living alone in a council property. He was admitted to hospital after he called the Police in a confused state, believing he was being burgled. During hospital admission he had a mental health assessment and mixed Dementia, Vascular Dementia and Alzheimer's were diagnosed.

Referral to Age UK Sheffield

We visited once Mr W had returned home and worked with the Older People's Psychiatric Liaison team who were involved for a short time. Mr W has no family locally who are willing to support him and no other contacts apart from a neighbour who keeps his front garden tidy.

Mr W's house had been somewhat neglected and he needed help with arranging cleaning. We helped him to get his kitchen sorted out so the care agency could continue keeping this clean and hygienic. Mr W's TV was not working, we assisted him to buy a new one, get this connected and wrote reminders on how to use the remote control.

Mr W had piles of letters around the house – we assisted him to open these and organise his correspondence in a folder. This brought to light a number of missed appointments. We were able to assist him to attend his Diabetic Eye check, a Podiatry appointment and to register with a Dentist and attend a series of appointments to obtain loose dentures and remove loose teeth. We also accompanied him to a Memory Service appointment regarding his Dementia diagnosis. We also assisted him to declutter some of his late wife's belongings.

Mr W has a car and believed that he was still able to drive this. We established that his licence had expired and arranged with his agreement for the car to be declared off road to avoid renewing tax, insurance and MOT. It was a risk that Mr W could forget and try to drive the car, we reported this to the care agency, GP and Mental Health Team and monitored the situation – it has become apparent that Mr W has not attempted to use his car, but we are still looking into working with him to sell the car and remove the risk.

We referred Mr W to the Alzheimer's Society and a worker will continue to visit Mr W once we have closed the case and also support him to attend social activities if he wishes. Mr W was also referred to the DWP who applied for Attendance Allowance on his behalf which was awarded. We have worked with Mr W to encourage him to accept some ongoing support with appointments and correspondence, but at this point he is reluctant to pay for this service himself.

Mr W no longer has the issues of confusion / delusions with which he was admitted to hospital and he is now established with the services he needs to enable him to cope with his short term memory loss.

Case Study

Keywords
Hospital discharge
Preventing residential care needs

Housing Support – "Fred"

When Fred was admitted to hospital, he didn't think he could manage to live at home any longer. But, with our support, he is now back in his old routine.

Fred was referred to the Housing Support service by an Occupational Therapist. He was fit for discharge but was waiting for a care package to be arranged. He needed his house cleaning and new kitchen appliances before he could safely return home. The referrer felt he would also benefit from some support managing his finances and moving to a one-level property.

Referral to Age UK Sheffield

Within two days of the referral we visited Fred in hospital and made contact with the Occupational Therapist. Fred had had a fall before being admitted to hospital and his mobility and independence had reduced. He was very concerned about how he would manage at home. We were able to reassure him at our visit on the ward about the support he could be given and he was happy for the things he needed to return home to be sorted out. Fred used to go out everyday to the market in town and have his dinner in a café and look at the shops. He wanted to get back to this routine. Fred had always lived alone and wanted to be very independent.

Fred said: "I am worried about my house and don't know how I am going to go on now when I go home. This fall has knocked me back a lot. My head has gone all mixed up."

We discussed and agreed with Fred and the Occupational Therapist that we would arrange for a quote from Environmental Health for cleaning and assist Fred to obtain the appliances and furniture he needed. Fred's brother George was looking after his post office card and had supported him to pay a bill he had been worried about.

Fred's house

We contacted George and his wife. George had little contact with Fred until recently and Fred had never let him enter his house. George was shocked by the condition Fred was living in, when they went into his home. His home was very sparse with very few belongings or furnishings and no kitchen appliances and few floor coverings except some worn out rugs. George and his wife were very concerned about how Fred would manage and thought he should be in residential care. We discussed the situation and gave information about the support that would be available to Fred and how he could manage independently.

What we did

George agreed to drop off Fred's keys and some money at the hospital so we could collect these from Fred to sort out the cleaning and furniture.

- We contacted Environmental Health and arranged to visit the house to get a cleaning quote and then we were present to let them in to carry out the clean
- While we were at the house we noted several repairs needed – lights not working and drainpipe leaking - which we reported to the housing association
- We referred Fred to St Vincent's furniture store and arranged delivery of a new bed and bedding, sofa, coffee table, curtains and kitchen utensils. We were at the house to receive these items – to make up the bed and set up the rooms

- We also went and purchased a microwave and fridge as agreed by Fred and put them in the house.
- We found all the keys, some of which had been missing, and got a spare set copied for Fred's brother.
- We went back to the hospital to update Fred on what had been sorted out and to collect payment from him and provide receipts. This was all completed within two weeks of the referral.

Discharge

Although the house was ready to return to, Fred's discharge was however, further delayed for another three weeks due to waiting for a care package to be in place and also that he was transferred to a different hospital to have a pacemaker fitted – his heart problems may have been the cause of unsteadiness and falls.

We kept in touch with the Occupational Therapist and when Fred was ready for discharge we collected him from the ward and took home. His brother and wife had done some shopping and also bought a few things for the house. We took Fred to the shop to buy milk and bread. Fred was very glad to be home and was pleased with what has been done with the house.

We checked up on his medication and health appointments and booked transport for him to attend the next outpatients appointment as he had been worried about how he would get there.

We followed up on the repair jobs to ensure they were carried out. We put a list on the kitchen wall of all his health and repairs appointments.

The old routine

Fred did have carers visiting for a few weeks, but it was clear that he was managing himself. George and his wife continued to visit him and do some larger shops, help clean up and keep an eye on how Fred is doing. Fred got back into his old routine of going into town on the bus and having dinner out.

Case Study

Keywords
Dementia
Carer support

Wellbeing Centre – William

William had been turned away by another day centre after just one visit. But our Wellbeing Centre found him to be the life and soul of the group. William's family's mind is more restful, and is able to care for him at home.

William is 85 years old and lives with his wife Janet who is 82. William has Alzheimer's, arthritis and is visually-impaired. He struggles with verbal communication and finds day-to-day tasks difficult. Janet is William's sole carer and provides comprehensive support on a daily basis. There are no formal care arrangements. William and Janet's daughter Bridie lives in Leeds but is in regular contact with her parents.

A bad turn

William's health deteriorated during the early part of 2016 causing Janet to feel overwhelmed and exhausted. The family decided to take steps in order to find somewhere for William to go one day a week. They felt that this would give Janet time to rest and give William the opportunity to socialise in a different environment. The family found a place for William at a local centre and were hopeful that it would meet his needs. However, after only one visit they were told by staff that they could not cope with William as he 'wanted to walk around' and they didn't have the resources to facilitate this.

Feeling disappointed and doubtful that anyone would accommodate William, Bridie contacted Age UK Sheffield. A visit was arranged for him at the Wellbeing Centre, where it quickly became apparent that William was still the life and soul of the party and a true showman! William began attending once a week in June 2016 where he rediscovered his magic tricks and entertained the other members with his singing and rhymes.

Staying safe at home

In August 2016 William left home alone for an afternoon walk in the local area. After failing to return home a police search was launched to locate him. The search intensified when William had still not been found by the following morning and there were grave concerns for his welfare. After almost 48 hours William was discovered alive and well a short distance from home. This incident highlighted a need for William to receive more support to keep him occupied, stimulated and to prevent a move into long term residential care.

Janet and Bridie requested an extra day for William at the Wellbeing Centre. This soon increased to three days per week. William and his family have benefited greatly from this additional support. William is able to remain in his own home and there is peace of mind for his family. William is full of enthusiasm and gets involved with a wide variety of activities at the Wellbeing Centre including writing poetry, which has always been William's passion. Bridie and Janet are relieved to have found a solution to the difficult situation they were facing and have noticed a change in William for the better.

Family feedback

"I'm so grateful for these images, they show Dad enjoying himself and doing what he always loved which is sport and music. The golf video is amazing; it shows that even with one eye he has still got the skills. That brought a tear to my eye. Thanks so much for everything you're doing for him."

"Mum and Dad have a case worker from the mental health team who is visiting on a reasonably regular basis and she seems to think that dad's dementia is so far advanced that it's unusual that my mum is looking after him on her own".

Case Study

Keywords
Scams
Income maximisation

Benefits at Home – "Fred" – 96 years old

Fred lost all his savings in a scam and was dependent on his 88-year-old brother for support. With our help, he is now £7,500 per year better off and able to afford a cleaner.

I live in sheltered accommodation in Sheffield and pride myself on my independence. I had a long career as an engineer, working into my 80s and still enjoy tinkering with computers and seeing how things work. I have become quite frail in the last couple of years, and am quite unsteady when I walk. I am also severely hearing-impaired which makes it hard for me to have a conversation with others, even though I am very sociable. My brother visits several times a week and helps me to keep my flat nice and do my laundry, but I worry about him working too hard as he is 88 and is a full time carer for my sister-in-law.

Age UK Sheffield support

My brother contacted social services to see what they could suggest to support me and they directed him to the Independent Living Co-ordination service at Age UK Sheffield. I had an assessment visit where an Independent Living Coordinator (ILC) came to see me for a chat about what support I wanted. I do not want carers as I manage to look after myself, but a cleaner who would check in on me regularly and help with the flat would take the pressure off my brother and be a big help to me. This was not the kind of service that I could afford though, as I had lost all my savings to a scam company earlier in the year. The ILC gave me lots of advice about keeping my money safe in future, and didn't make me feel stupid for giving my card details over in the first place. I wanted my brother to be able to help me keep a check on my financial situation so Age UK helped me by supporting with sourcing and filling in forms for my bank so my brother could have a third party mandate for my account.

Financial and housing issues

She then looked at my current financial situation (I am on a State Retirement Pension with a small amount of Pension Credit Guarantee), and suggested that a claim for Attendance Allowance could be something I am entitled to. She did the claim form during the visit so my brother could help me to communicate. The conversation also brought up the areas of my home where I struggle so I have had a referral to the Equipment and Adaptations Team at the council to check what can be done to make my home safer for me. While she was there she asked if there was anything else that was troubling me, and I mentioned my mattress was falling through my bed frame as it was in such bad repair. I couldn't afford to replace it even though it was very uncomfortable. I had told the ILC all about my service history as a Royal Engineer and radar specialist during D-Day and she used the contacts she had with SSAFA to request a new bed for me, which arrived shortly afterwards and is wonderful. The ILC also helped me find an NHS dentist and referred me for support with my hearing.

Benefits claim success

My Attendance Allowance letter came back as successful at the higher rate just before Christmas so I could buy presents for my family, and start looking for a cleaner. This made me feel so much better, as I could regain some independence and dignity. I am also entitled to some additional Pension Credit which will increase my income in total by £144.15 a week or £7,495.80 per year. I no longer worry about the future and how I will pay for the extra support I may need. I didn't know that Age UK Sheffield could provide support with all of these things, but would recommend them to my friends in my accommodation.

Case Study

Keywords
Income maximisation
Mental health
Carer support

Benefits At Home – "Pat" – 66 years

Pat's health conditions were severely affecting her life, and she had been refused an Attendance Allowance claim. Now she is financially better off and back to getting out and about.

In October 2016 I was feeling very depressed. I suffer from severe anxiety and have panic attacks. In the last year or two my mobility had significantly decreased, and my pain had become difficult to manage due to fibromyalgia and arthritis. I was stuck in my home, where I live with my husband and son. I was having difficulty standing or walking at all, was sleeping on a zedbed on the living room floor as I can't manage to get up and down the stairs, and was having to wash in a bowl, and use a commode at the bottom of the stairs as I can't get to the bathroom. My son was having to act as my carer around his work. I was embarrassed about the physical state I am in, and felt useless. I was isolated from my friends and hadn't been out of the house for some time.

I had decided a few weeks earlier to finally ask for some help and I applied for Attendance Allowance, but had received a letter saying that based on my form I wasn't entitled to any support. I spotted a mention of Age UK Sheffield's Benefits at Home service in a local newspaper and decided to get in touch.

Age UK Sheffield support

An Independent Living Coordinator (ILC) from the Benefits at Home service visited five days later and we had a long chat about what my difficulties were, but also what I would like from my life now to make me feel better. She made a lot of suggestions for me to think about and we made a plan together about how we could try and improve things for me. She wrote a letter back to the Department of Work and Pensions giving all the reasons they should reconsider my request for Attendance Allowance and that came back four weeks later advising me that I was entitled to the higher rate of the Allowance (I have £82.30 a week, £4,250 a year extra coming in).

She also provided advice about how my son could apply for Carers Allowance as he is on low earnings and would still qualify. That he is getting this financial support now makes me feel better about all the things he has to do for me. I much prefer having him provide care for me than a stranger coming in to my home.

The ILC assisted me to apply for a blue badge and to register for Sheffield Community Transport so that my mobility problems are now less of an obstacle to getting out of the house. I am now going out to my church three days a week for services and social groups and have re-connected with old friends that I hadn't seen for some time.

She referred me for an assessment from the Equipment and Adaptations Team at Sheffield Council and after chatting with them I am hopeful that they will be able to support with grab rails, alterations to my bathroom and a stairlift so that I can properly use my home again. She also referred me to the Community Continence Team, who I didn't know existed so now I receive my pads for free and they gave me lots of advice.

I know my health problems are never going away, but I feel so much better as I feel less of a burden on my family, I have a hope that my home will be improved for me, I have the money and the means to get out of my home independently and feel like I have friends and a purpose again at my church. When I rang Age UK Sheffield I didn't know that they could support me with all this (I was just happy that they said they could help me write a letter), but I have told my friends all about it now.

Case Study

Keywords
Mental health, agoraphobia and isolation
Multiple long-term conditions
Fire Service Home Safety Check
Domestic abuse

Integrated Care Pilot - "Angela"

Angela had not been out of her home for 12 years but is now looking forward to her daughter's graduation and doing voluntary work.

Angela is 55 and lives alone. She suffers from an extreme anxiety disorder, depression, and is agoraphobic, not having left her home for 12 years. She was recently diagnosed with a congenital heart defect and suffers from COPD. After 12 years in a physically and psychologically abusive relationship, Angela eventually told her partner to leave.

Her inability to leave the house, and on her worst days her inability to allow even family into her home meant that she became extremely socially isolated. She was struggling with basic needs like buying food and household items due to being unable to go shopping, and having a very limited income as a single person receiving Employment and Support Allowance.

Hospital discharge and referral

After a medical crisis related to her heart problems and COPD, she rang for an ambulance and left the house for hospital treatment. She spoke to the hospital team about the issues she was facing, her motivation to make changes to improve her life, and they suggested Age UK Sheffield could support her. On her discharge from hospital she referred herself to us.

The initial assessment was very difficult for her, as she had to let a stranger into her home, but after chatting about ways to make this easier for her on the phone she chose to invite family members along for support. Angela was very nervous and weepy but once she started chatting she started to relax and we were able to put together a support plan to work at her pace and which she was very happy with.

Over the next three months we applied for support towards health costs, and found a home-visiting optician and home-visiting dentist. Angela couldn't see clearly and was embarrassed by her teeth as she hadn't had any new glasses or dental treatment in over a decade. We provided support to complete Personal Independence Payment forms, organising a home visit for her PIP medical assessment, and attending the assessment which Angela considered would have been impossible on her own. The claim was successful and significantly improved Angela's income.

Angela was very proud of her home, but the garden had become overgrown. We provided support to find a gardener (which she could now afford) who would improve the fence and make the garden a place that Angela could enjoy and feel safe, which she said had significantly improved her quality of life. A referral for a Fire Service Home Safety Check and for a personal alarm allowed her to feel safer and more relaxed in the house.

Throughout this time we worked slowly on obtaining the support for Angela's mental health that she felt she needed at a pace that she felt able to cope with. Initially this was a referral for psychotherapy via Angela's GP, and then a referral to the team at MIND Sheffield who provided assessment, counselling and practical support with overcoming anxiety and leaving her home. This is ongoing and Angela is now able to walk to her local supermarket alone, something that she didn't really believe possible a few months ago.

She has a short term goal of attending her daughter's graduation, and a long term goal of volunteering to support other people dealing with problems like hers. In her words, the support she has received from Age UK Sheffield has allowed her to approach the rest of her life as 'a part of the world, not alone, and to have things to look forward to', whereas she had previously been feeling that with her isolation and health problems her life was effectively over.