THE TAYLOR FAMILY

Mutual caring and support

This tells the story of Jeannie and Peter and how personalised care using a whole family approach can help; maintaining strong family relationships and promoting wellbeing for them both.

Personalised care is based on 'what matters' to people and builds on individual strengths, needs and preferences. This means understanding the context in which each person lives, their important relationships as family and carers.

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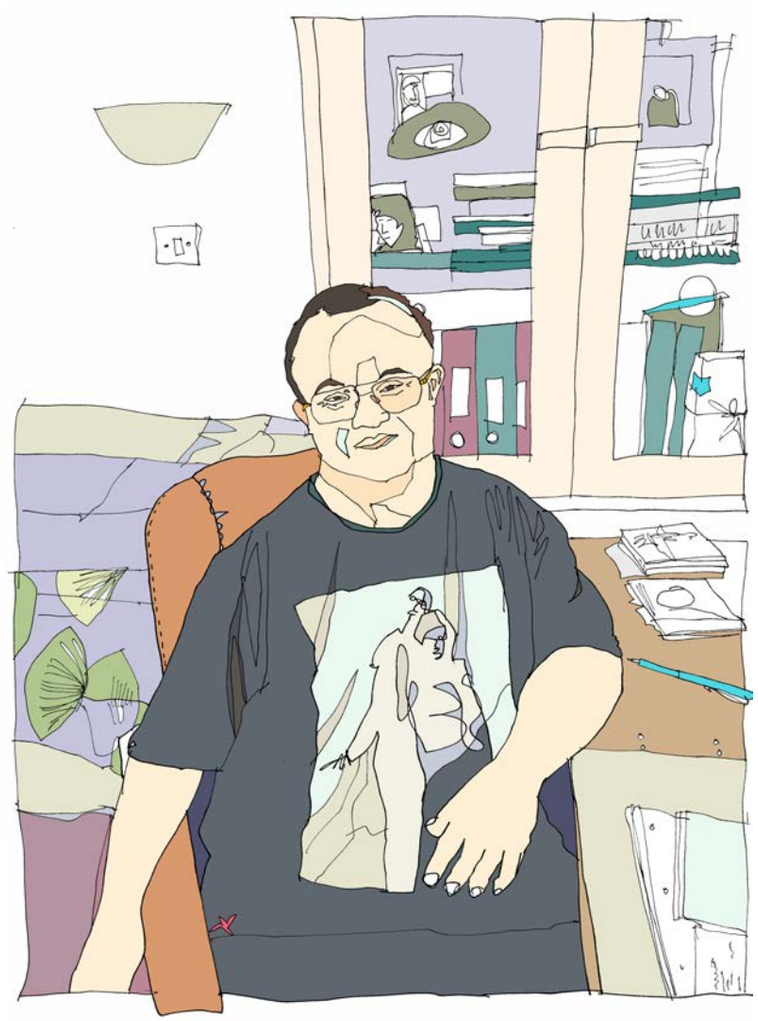
Meet the family Jeannie and Peter

Jeannie and Peter live together and mutually support and care for each other since Jeannie's husband (Peter's dad) died 10 years ago. They see themselves as a great team.

Meet **Jeannie** aged 84. She spent her whole working life as a baker and balancing this with being a mum to her only child Peter who has learning disabilities. She still loves to bake and tries new recipes on her friends. She is now having some health issues and struggles to get about.



Meet **Peter** aged 52, he has Down's Syndrome. He loves helping his mum round the house and doing the shopping but also works three days a week at a local charity shop. A job he loves. He also enjoys taking his dog Bertie out for long walks and going to watch his local football team.

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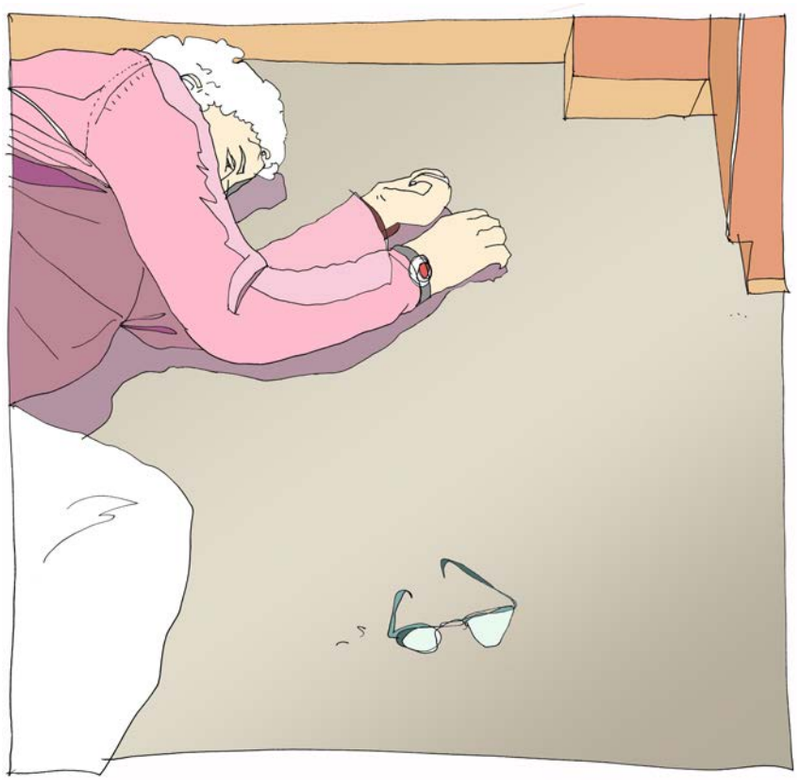
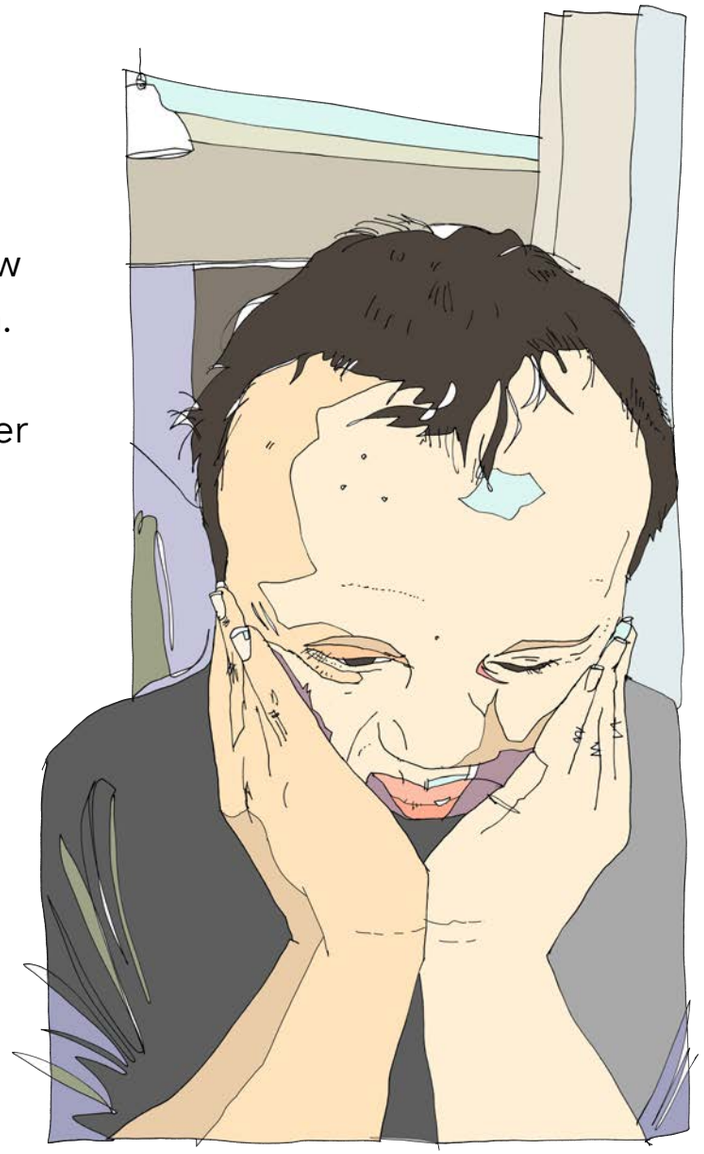
They see themselves as a great team and support one another without paid support services, until Jeannie has to be admitted to hospital after a fall.



Jeannie falls and is taken to hospital with a fractured hip and has to have an emergency operation. The multi-disciplinary team say that she may remain in hospital for up to two weeks.

Peter is very worried because his mum is in hospital. He doesn't know when his mum will return. He's distressed, not sleeping, not looking after himself and has stopped going to work.



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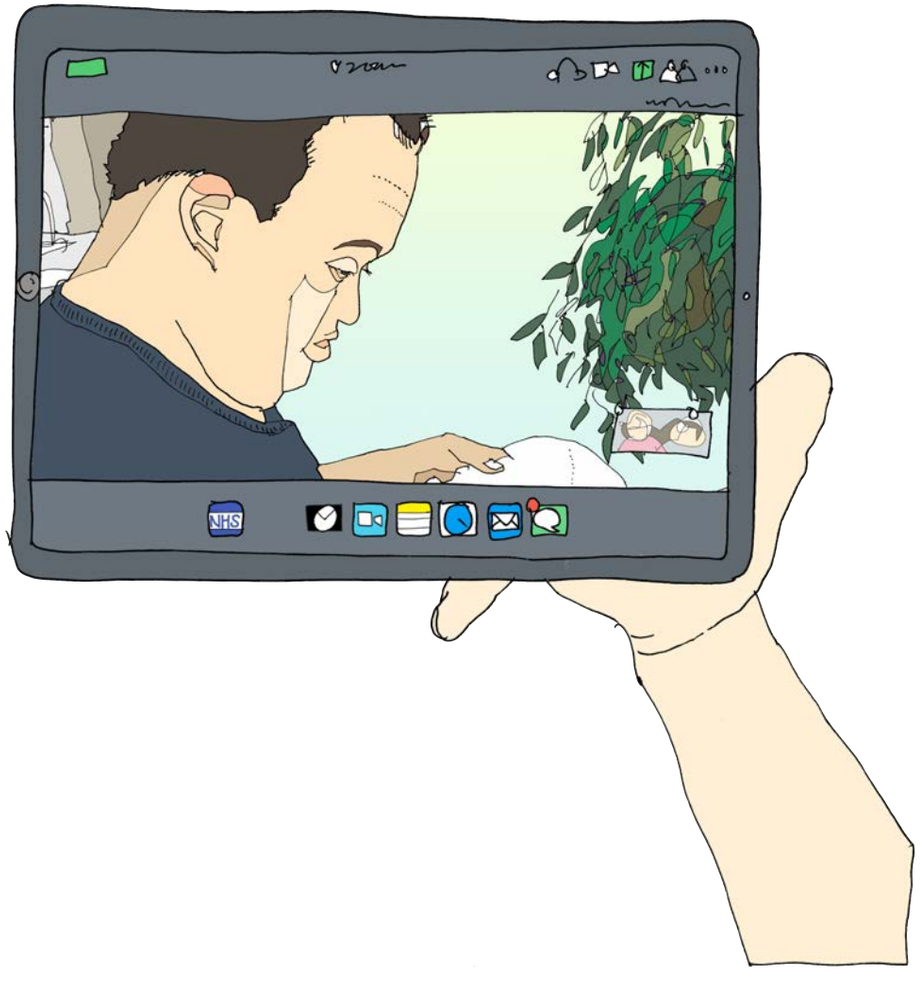
Jeannie is fretting about Peter

Jeannie worries about Peter being at home by himself but feels awkward about asking anyone for help. Vicky, the staff nurse, sees Jeannie is worried and makes time to sit down with her and have a chat. Jeannie is able to tell her that she is worried about Peter at home by himself.

Vicky encourages Jeannie to call her neighbour Rose on the telephone. Rose says that she is keeping an eye out for Peter. Jeannie uses the wards tablet to video call Rose and Peter. She realises that Peter is struggling and that she must get home as soon as possible.



THE TAYLOR FAMILY

Good discharge planning: getting ready for a safe discharge

Vicky talks with the hospital team and they realise that they need to work with Jeannie to get her home as safely and quickly as possible. She calls the reablement team to explain Jeannie and Peter's situation.

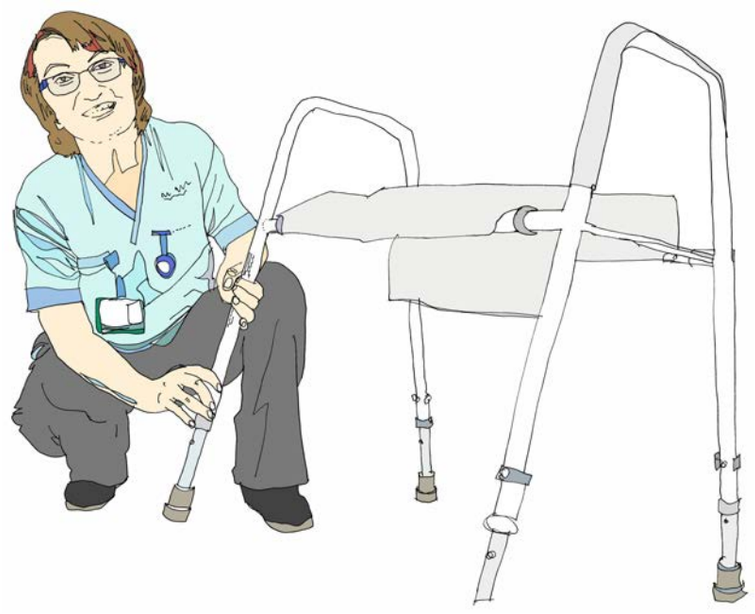
They will also meet the short term goal of keeping Jeannie safe and helping her get her independence back whilst at the same time providing some time to do some personalised care and support planning with Jeannie and Peter.

THE TAYLOR FAMILY

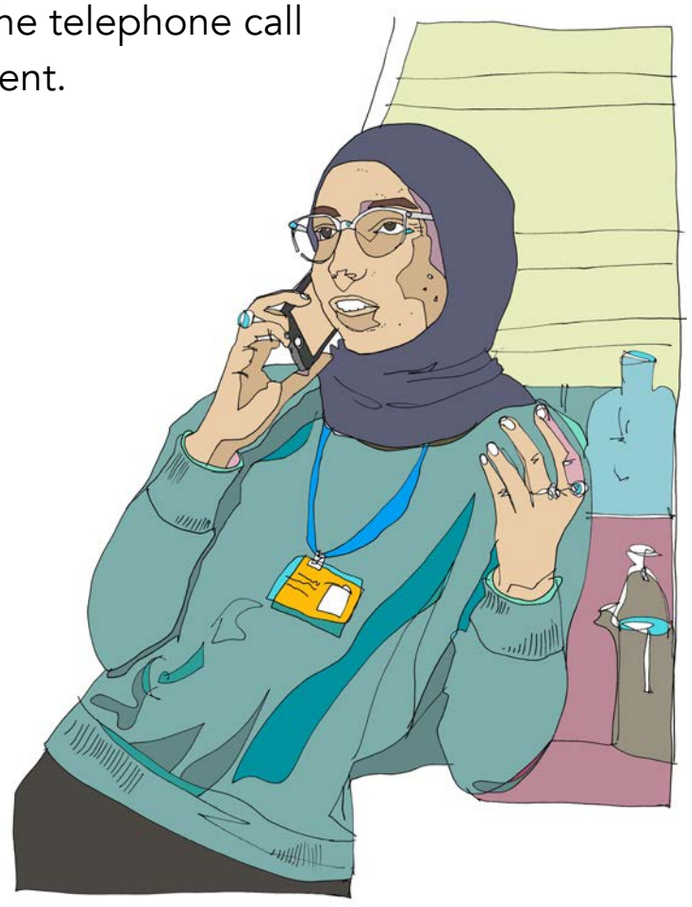
Supporting Jeannie and Peter to get their lives back on track.

Anna, from the reablement team is supporting Jeannie with her personal care and helping her feel more confident.

Peter is less anxious because his mum is home and getting support. He still feels worried about leaving her to go back to work.



Anna contacts **Meena**, a social prescribing link worker, who gets in touch. She arranges to come out and have a 'what matters to you' conversation with Jeannie and Peter. She talks to them about what the Carers Centre might have to offer them both. She supports them to make the telephone call and get a carers assessment.



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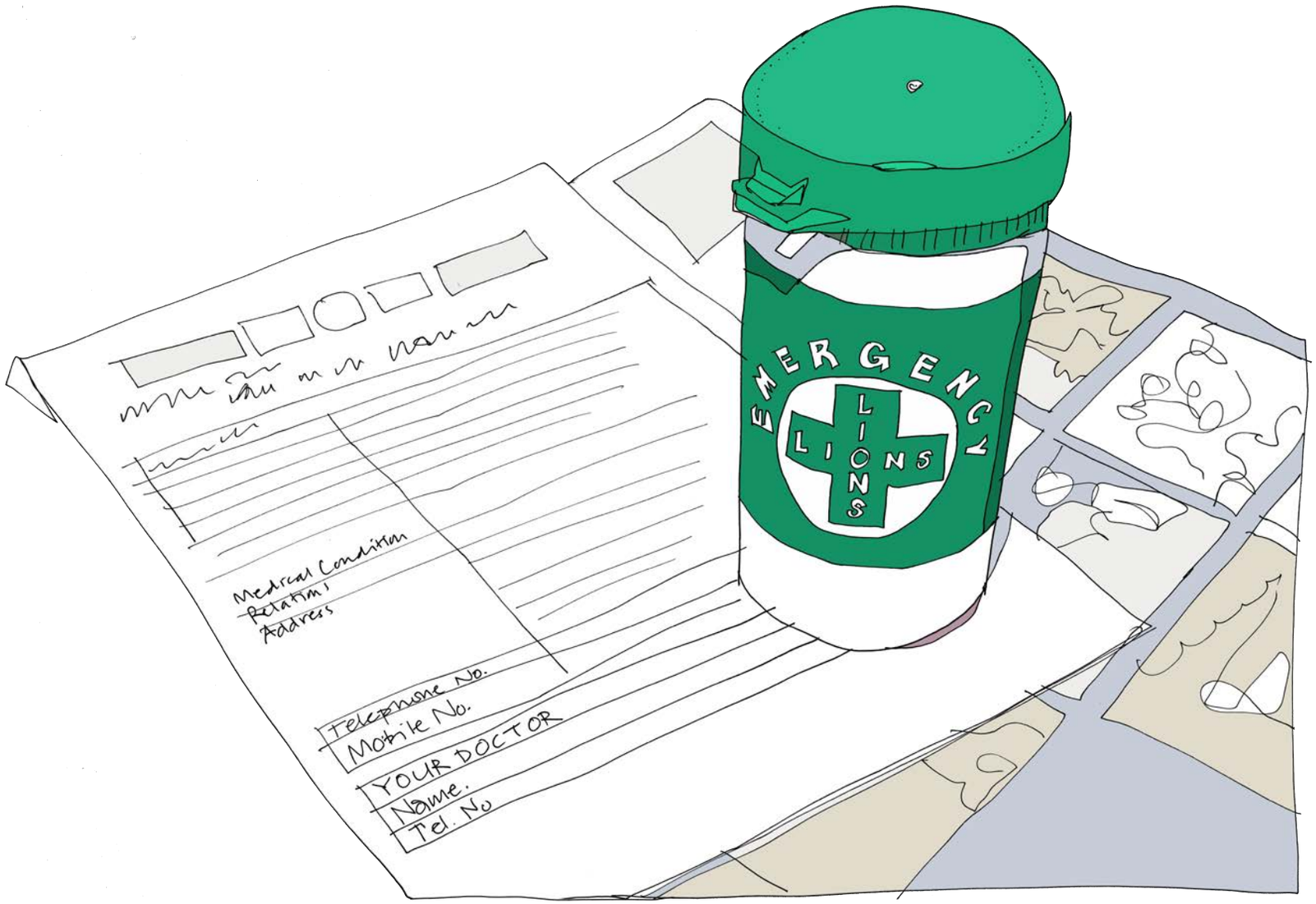
Planning for the future
(Contingency planning)

Tracey at the Carers Centre tells Jeannie & Peter about the Lions Message in a Bottle scheme – where emergency contact numbers are stored in case anything happens to them in the future.

A more detailed conversation with Jeannie and Peter takes place. They agree how they would like to be supported in the case of an emergency.

This information is kept in their summary care records and a full plan is held at the carers centre.

Meena, the social prescribing link worker talks with them both about their long term plans.



THE TAYLOR FAMILY

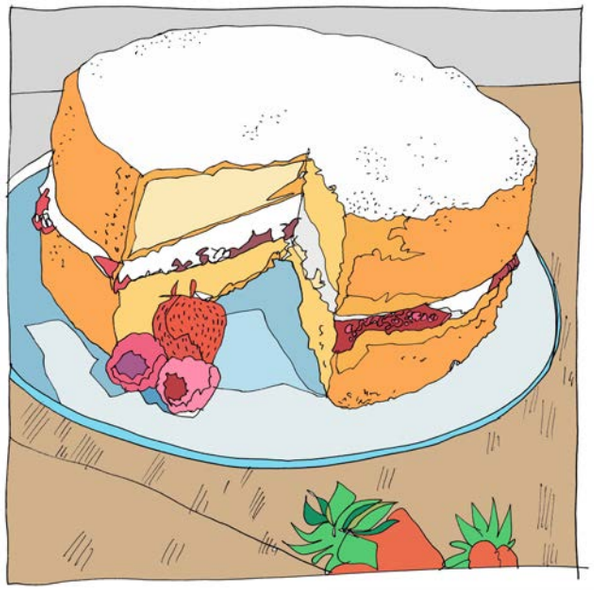
Getting on track reconnecting to their community

During the carers assessment Jeannie identifies that it is important to both her and Peter to be part of their community and make new friends.

Through the Carers Centre they are both introduced to Time Banking.

Jeannie contributes her cake baking and exchanges the time for someone to keep her garden tidy.

Peter banks his time by walking other peoples' dogs and using his hours to get support to go out to the disco.



Jeannie makes new friends at an older family carers peer support group

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Getting on track reconnecting to their community

Peter tells Meena what matters to him is finding a friend to go and watch football.

Peter mentions Stan who he has known for many years and they share a passion for football.

Stan agrees to take Peter to the local football matches on a regular basis.

Peter now feels confident to go back to work at the charity shop.

Meet **Stan**, he used to work at Peters old school.

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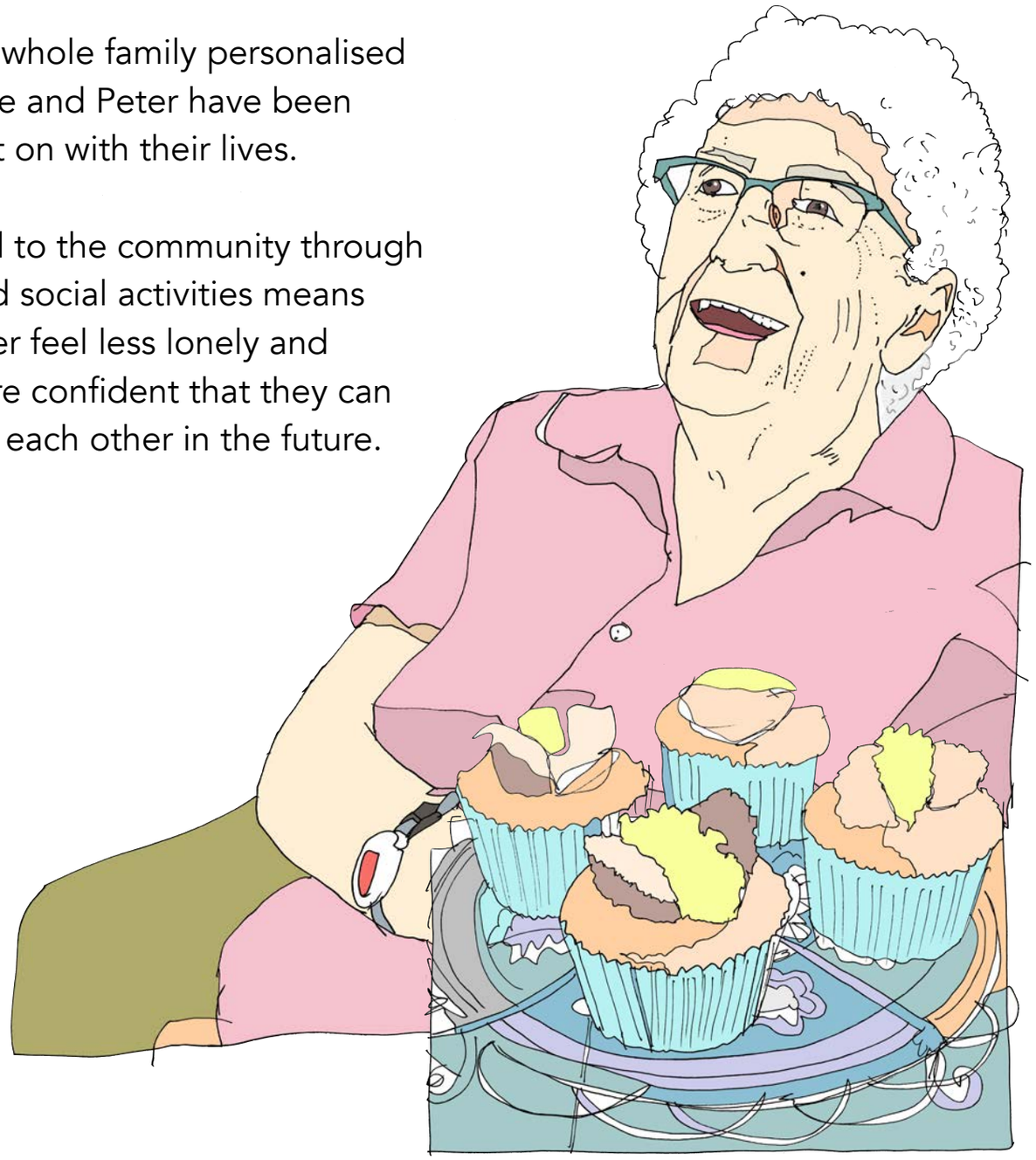
Team Jeannie and Peter are back on track.

Through using a whole family personalised approach Jeannie and Peter have been supported to get on with their lives.

Being connected to the community through peer support and social activities means Jeannie and Peter feel less lonely and isolated and more confident that they can keep supporting each other in the future.



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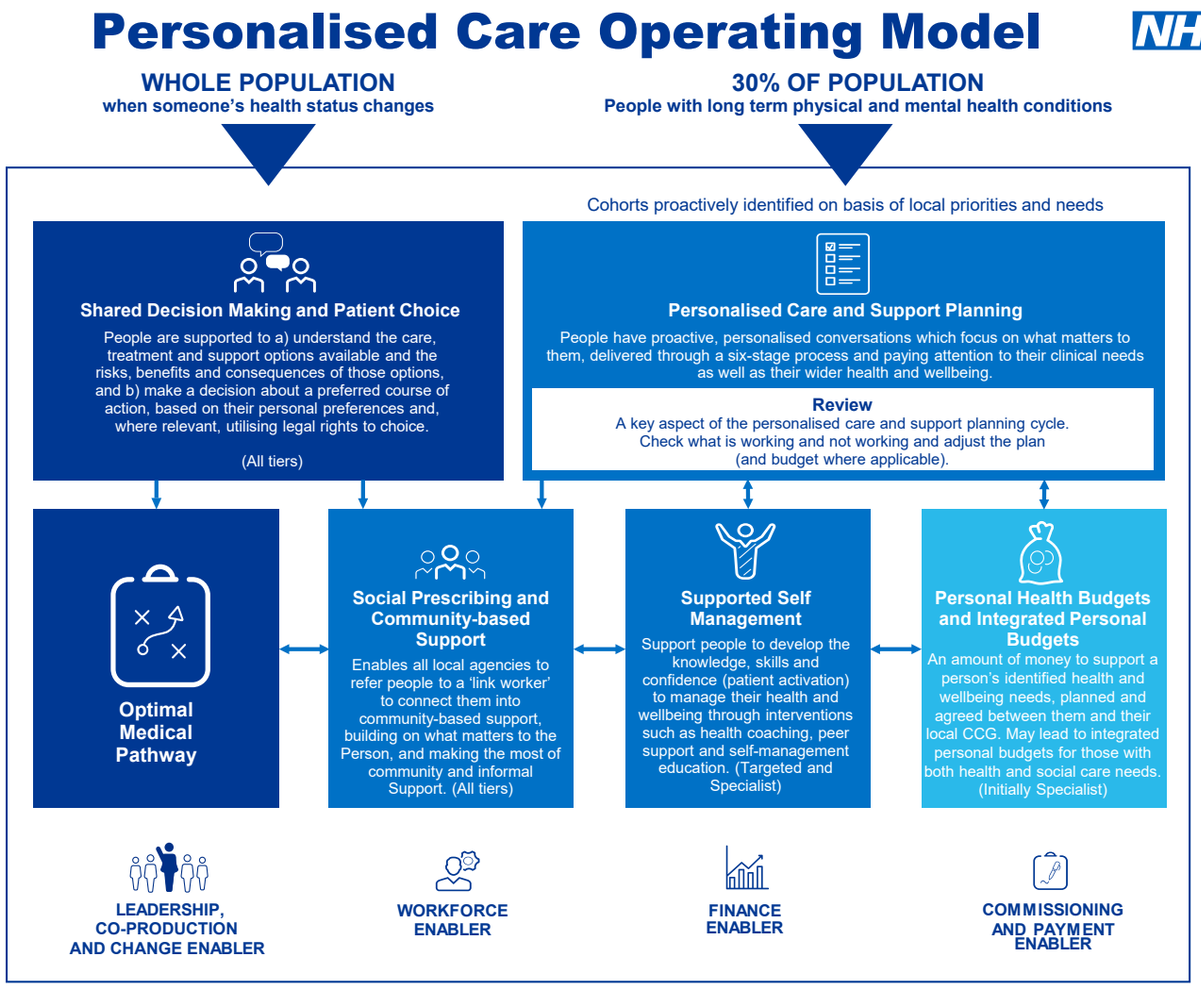
This story demonstrates how a whole family approach incorporates components of personalised care and joined up working.



Click the image to find out more about personalised Care Operating model.
Click on the link below to find out more.

https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/

This story shows how personalised care works best when it recognises the needs of each significant family member including considering their caring roles.

It demonstrates how social prescribing connects people to practical and emotional community support, through social prescribing link workers, based in GP practices. Link workers have time to build trusting relationships, start with what matters to the person, create a shared plan and introduce people to community support.

It helps people get more control over their lives, to manage their needs and in a way that suits them.

Planning for future emergencies through carers contingency planning and embedding these in summary care records, enables practitioners to know when and how to call these personalised plans into action when they are needed.

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