APPENDIX 2

Case studies from Scottish Borders Local Area Co-ordination (LAC) Team – Older Adults & Adults with a physical disability

Case study 1

Lady in her 80's. Referred by Mental Health Older Adults Team (MHOAT), diagnosis of dementia. Husband was also main carer.

Referral to increase social connections & remain independent, and to offer some opportunity for break from caring for her husband. Potential for some risks around transport, awareness of risk around road-crossing/traffic that required to be considered.

Local walk-it group identified as something potentially of interest, however times for walk-it group clashed with Carer coming into apply medication (pain patch). Care had been arranged as view of social work was that due to levels of carers stress this was required.

Husband/main carer frustrated as walk-it walk been so positive and offering him some time too, and he didn't understand why he couldn't apply the patch. LAC contacted social work to discuss whether he could apply patch. It had been arranged as feeling was the gentleman was under such carers stress that care was needed.

Husband felt it was really important to his wife and to him for his wife to be able to access the walk-it group to see if would be an activity she would enjoy.

Input from the LAC Team with the walk-it had resulted in such an improvement that gentleman is now able to apply patch himself, so individual still able to attend walk-it and gentleman gets some time to himself. Also reducing the need for care service.

The individual is continuing to attend Walk It with support of the LAC Team whilst work is ongoing as per the LAC approach for a gradual withdrawal of direct LAC team support and identifying alternative options including a buddy arrangement or that the individuals husband may in fact join the walkers at the coffee part and this still allows him some respite whilst the walk is taking place.

LAC team are also looking to make a referral for the RVS Social Centre, to enable the individual further opportunity for social contact and her husband some further respite.

Case study 2

Gentleman, aged 89. Referred by Community Care Reviewing Team who advised the individual had an active life prior to a hospital admission earlier in the year and was social isolated and currently he was unable to leave his home.

On first visit LAC established that due to stairs at the front of his house, the gentleman was unable to physically get out with his walker as unable to get walker himself and walker down the stairs and as a result completely housebound as per referral. Following further conversations and exploring options with the individual during the home visit the LAC identified during there was another entrance & exit to the house that was all on one level

which would enable the individual to get out of the house, with the provision of a second walker that could get be kept in that part of the house.

LAC sought second walker but was advised a letter would need to be written to request this and considered it likely to take at least 2 – 3 weeks for this to be progressed during which time the gentleman would continue to be confined to his home.

LAC then took matter to one of the daily huddle locality working meetings. Whilst on the call, Red Cross co-ordinator said they do have walkers that have been donated to them and was welcome to come along to see if any would be suitable on the individuals behalf. LAC followed up swiftly and the delivery of a second walker was arranged for the Monday of the following week.

The gentleman is absolutely delighted and this will now allow the LAC team to support the individual to get out and about and make social connections.

Evidence of the LAC approach in actively exploring all options and proactively working with partners to seek solutions that enable people to continue to live active and less socially isolated lives.

Case study 3

Referred to the LAC service in February 2020. Client was ninety-year-old woman wishing to increase her strength / fitness whilst making social connections. The Link Worker and LAC had an initial meeting with Client at her home, but a few days later the country went into Lockdown.

Just as Client was hoping to get 'out and about' and improve her fitness, the Pandemic halted all plans. Clinically vulnerable, it would transpire that Client would spend the next year confined to her flat.

Indeed Lockdown greatly affected Client's physical and sometimes mental capacity. A bright and 'young at heart' individual, she found that her strength was diminishing. This lead to falls and a couple of hospital admissions during 2020. Living alone with only brief visits from homecare, confusion and memory loss became apparent during phone conversations with the Link Worker.

The Link Worker had regular contact with Client's daughter and they discussed the impact of Lockdown on her mother. At one point, the daughter became so concerned that she believed her mum was 'maybe ready for residential care'. To which she was signposted to discuss with social work.

Whilst home visits were not possible, the Link Worker continued with regular phone contact. This often involved giving emotional support as well as tips and advice about staying mentally and physically fit. Client often spoke about her mobility concerns and that when Lockdown was over she 'would no longer be able to walk'.

In response, the Link Worker referred Client to physio and OT for equipment, sourced an Age Scotland gentle exercise pamphlet and posted it through her door. Client received an Ipad and internet connection after a referral to the Connecting Scotland initiative.

Once visits resumed, the Link Worker acted as Client's 'digital champion', setting up the Ipad and giving one to one IT support.

The home visits proved beneficial to Client, boosting her mood and providing much needed company, especially as Client's daughter was self-isolating and unable to visit. The Link Worker accessed Youtube Exercise videos and together with Client helped perform the routines. Client was then encouraged to access the videos between visits.

Once Client had received both COVID vaccinations, the Link Worker was able to accompany her on short walks outdoors. This then gradually increased to walks down the high street to a café and back. With each trip, Client's mood and physical ability increased and so did the distance.

A sociable and well-known lady, Client often bumped into familiar faces up the street and stopped for a chat. Client had incredible motivation, determination, and she 'really looked forward to these trips out' according to her daughter and Client.

By the end of summer, Client had started visiting the local park, which she had not been to for years. Then joined a weekly lunch club connecting her with old friendships.

Client's daughter, kept informed of all developments and new activities; she commented to the Link Worker that she was doing 'a great job'.

Proof that even in her nineties both Client's physical and cognitive ability significantly improved, given time, support, and her own personal determination.

Case Study 4

Mrs & Mr Packard (name changed) are in their 80s and live in their own home in the Tweeddale area. Although initially it was only Mr Packard, who has been referred to the LAC service, it has become obvious that both he and his wife would benefit from LAC support. Mr Packard, a retired umpire, has been diagnosed with Parkinson's disease, which has affected his mobility and speech. Mrs Packard is his main carer. At the beginning of their contact with LAC Mrs & Mr Packard identified the following issues, which LAC supported them to address:

1. Replacement care for Mrs Packard, as she is the main carer and needs short periods of respite

2. Occupational therapy assessment for Mr Packard environment and walking aids

3. Gentle exercises opportunity for Mr Packard

4. Activity opportunities for Mrs Packard, who is keen on arts & crafts/art therapy

5. Social interactions for Mr Packard, who finds talking about music and sport important

Following actions were undertaken by LAC in partnership with the local Social Work department:

1. Mrs Packard has been referred to the Borders Carers Centre for a replacement care project. She has been allocated 4 hours of replacement care per week. This gives her time to rest and take part in her own activities and engagements.

2. Mr Packard has been visited by LAC and by Social Worker/Occupational Therapist and went through a complete OT assessment.

3. LAC completed the research related to the gentle exercises which can be done at home. The link to the exercises website ('In 80 days around the house') has been sent to Mr Packard's e-mail. Mr Packard continues with exercises. He also wrote an e-mail back to the LAC.

4. Mrs Packard has been referred to the Craft Box project and enjoys workshops organised by them.

5. Mr Packard has been contacted with Outside the Box project, who connected him with a local 'buddie', with whom Mr Packard can meet on regular basis and talk about jazz music and sport. Mr Packard has also been referred to the local social group run by the Royal Voluntary Service. He is due to join the Wednesday group when it starts in October 2021. (Initially the Monday group was considered, but it clashed time-wise with his 'buddie' meetings. Hence the delay.)

Clients own account of being supported by the Local Area Co-ordination Team

A PENSIONER - AND FINISHED?

I started work at 17 and retired nearly 50 years later without a day's unemployment. For much of that time I was also active, healthy and effectively illness-free – there's was one period of 27 years without a single day's absence. Unfortunately I then fell into an extended period of clinical depression where I had a breakdown and was diagnosed by my psychiatrist as "*passively suicidal*". The recommended treatment was cognitive therapy rather than medication – essentially being active mentally and physically. With support, this worked very well for a long period – I had a challenging job and I played football in some form until nearly 60.

This support programme disappeared almost overnight on retirement – opportunities for mental and physical agility disappeared simultaneously and I felt myself slip into dark moods, bad ways and poor health. Depression, although a mental illness, brings with it a host of physical problems as the ability – even the interest - to fight **any** illness disappears as well. It's a downwards spiral.

Walking football pulled me out of that spiral.

I spotted the opportunity advertised in local publications and shops. Checking Walking Football generally on-line was not encouraging – it has an air of "care in the community for old folk". However when I spoke to the local contact, Amanda Renwick, she was very positive, emphasising the fun side - with the benefits flowing as natural outcome. I was persuaded. When I first attended I found her enthusiasm and commitment infectious, something that has been constant ever since. I may not match her for effort and energy but she sets a standard to aim for.

Since I began attending I have missed only one night – due to the snow. I have also identified additional outlets in Gala. Much of my week is now taken up with football. Foremost fun – with benefits to follow as promised. My social skills are coming back and extending beyond football: my self esteem has been restored. I'm using my brain again. My health is better than can be expected for someone approaching 70, my fitness compares with many 50+. I have regular bruises and strains from playing but these are badges of honour, carried with pride!

Depression never goes away but I am once again handling it as an irritation in the background and not as a life-threatening issue. Who would have thought all this from walking football - and Amanda?

I am grateful to them both.