



Case Study 1

- GP Referral to Lightbulb for 89 year old lady, blind in one eye, has had falls previously and remains at risk of further falls
- Uses a stick and furniture to mobilise around her home
- Had been reluctant previously to have any involvement from services
- Housing Support Coordinator visited and the Housing MOT identified a range of support needs and solutions:
 - Community equipment including perching stool for kitchen to make it easier to prepare meals and wash up
 - minor adaptations to help her to get around her property more safely and minimise the risk of further falls
 - assistive technology (lifeline), giving her husband the peace of mind that he could go out in the knowledge that his wife could call for help if needed
 - sensor lights to help her get to the toilet safely during the night, minimising the risk of falling
 - Home Fire Safety Check which identified a faulty smoke alarm
 - CO2 alarm to improve home safety
 - garden clearance to reduce the chance of her becoming a victim of crime or anti social behaviour and enabled her to enjoy the garden again

From the referral date to the completion of the all work was four weeks, involved two visits in total by the Housing Support Coordinator who organised all of the work to be undertaken.

Case Study 2

- Patient admitted to hospital after being found by police wandering & confused
- Required a package of care before she could go home but carers would not go into property because it was very cluttered and unclean
- Referral to Hospital Housing Enabler Team from the social worker within the hospital
- Multi Disciplinary Team meeting arranged including Housing, Social worker and specialist discharge nurse
- Patient medically fit to be discharged and an interim residential care placement was being sought

- Hospital Housing Enabler team worked with the patient and arranged for the property to be deep cleaned and for main access areas to be cleared in order for the care package to be put in place
- The team have access to a small budget to fund this work; without this funding the only avenue would be to go down an enforcement route against the individual
- Due to intervention from the team, the patient only spent 5 days in the interim residential care placement before being able to return home with a care package in place
- Additional support at home was also provided by the team for the first few weeks following discharge
- Without the team's intervention the patient would have remained in residential care while enforcement action was taken against her regarding the condition of her property
- As well as avoiding the anxiety and upset this would cause for a confused individual, the team's intervention has saved an estimated £8,500 in avoided residential care costs by enabling her to return home at the earliest opportunity