Report to:	**RESILIENT COMMUNITIES SCRUTINY COMMITTEE**
Relevant Officer:	Karen Smith, Director of Adult Services
Date of Meeting	8 December 2016

ADULT SERVICES REPORT

1.0 Purpose of the report:

1.1 To inform the Committee of the work undertaken by Adult Services on a day to day basis in order to allow effective scrutiny of services.

2.0 Recommendation(s):

2.1 To consider the contents of the report and identify any further information/action required.

3.0 Reasons for recommendation(s):

3.1 To ensure services are effectively scrutinised.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1
- The relevant Council Priority is 'Communities: Creating stronger communities and increasing resilience.'

5.0 Background Information

5.1 Care and Support – Adult Services

5.1.1 Blackpool Council operates a five-bed residential respite service for adults with learning disabilities; meeting a range of needs.

5.1.2 The service currently supports 50 carer families and during Quarter 2 2016/2017 (July-September) delivered 425 nights of respite (92.4% occupancy) to service users, enabling their carers to have a break from their caring responsibilities.

5.1.3 The Coopers Way Respite Service is purpose built to meet the needs of disabled adults with modern equipment and adaptations including ceiling track hoists, 'H' frame and specialist bathing equipment.

5.1.4 The service is registered with the Care Quality Commission (CQC) and was inspected in 2016 and achieved a ***GOOD*** in all five domains:

5.1.5 **C**aring - GOOD
Safe – GOOD
Effective – GOOD
Responsive – GOOD
Well Led – GOOD

5.1.6 The case study below clearly illustrates how the care and support is delivered through outcome focused approaches ensuring that the 'person' is at the centre of all decisions made with, for and on behalf of the person:

5.2 Case Study – Background

5.2.1 X is a 31 year old woman who lives at home with her parents. She accesses day care services Monday to Friday. Up until 2015, X had never accessed any form of Residential Respite Service, although she had been accessing Brian House for day care, but did not have confidence in the service to have overnight Respite care.

5.2.2 X has Rets disorder, Valsalva breathing , is fitted with a PEG for all medication and fluids to be administered through, has Epilepsy and requires Oxygen , and has profound physical disabilities and associated needs.

5.2.3 X underwent transition to Coopers Way Respite Service during 2015/2016, and following this lengthy transition and 'getting to know you' period; the team has built up a trusting relationship with her parents and X and she is now an active User at Coopers Way.

5.3 **Service Provided**

5.3.1 X accesses Coopers Way two days a month, typically on a Friday and Saturday, her parents will drop her off on Friday evening and will pick her back up on a Sunday afternoon. Whilst X is accessing Coopers Way, all her personal care needs are tended to by the staffing team and due to X's physical disability, she requires 2:1 staffing to meet these particular needs.

5.3.2 X needs full support to bathe, dress, feed and to take her medication. All X's medication is administered through her PEG, and should X not be drinking very well, fluids will also be administered through the PEG. All meal choices are made with X and her body language, eye contact and knowledge of her likes and dislikes assist staff in understanding her choices.

5.3.3 X accesses the community in her wheel chair with a 1:1 support. X is a very sociable young woman and likes to be in the 'hub' of activity, she likes to be stimulated and entertained by all the up to date music and television programmes either in her personal bedroom or in the communal lounge at Coopers Way.

5.4 **Outcomes**

5.4.1 X's parents receive a needed break from their caring role, enabling them to maintain this caring role.

5.4.2 X undertakes activities that are valued and stimulate her, and are empowering her to make choices where possible for herself.

5.4.3 X health and well- being is monitored, maintained and all personal care and support is provided with dignity and respect, following her person centred care plan. Ensuring her needs and preferences are met.

5.5 **Assessment and Rehabilitation Centre (ARC) Service Update**

5.5.1 The ARC Service changed significantly in April 2016 to become a truly integrated Health and Social Care delivery service. In the first six months of operation the **123** people have been admitted to the ARC following a stay in Hospital, with a total of 168 admissions. The aim of the ARC service is to support people who have had a significant change in their health and wellbeing which has impacted on their level of independence. It is a therapy led service, with the focus on assessing and supporting people to regain as much independence as possible and, wherever possible, to help them return to live in their own home.

5.5.2 A new registered manager is in place and registered with the Care Quality Commission, who is a qualified registered nurse.

5.5.3 Taking the same period last year, the overall number of admissions to ARC have increased by 26%, with 101% increase on the number directly from hospital. A new referral pathway has been put in to support referrals from community health services, these are row routed through the Rapid Response team who will, on receipt of the referral, explore all options to support the person to stay in their own home. This has had a positive impact on the number of people requiring admission from their own home.

5.5.4 There are consistently two to three vacancies in residential rehabilitation at any one time, so we can be confident that there are not referrals routinely being declined due to service availability. There has for short periods been a higher demand for clinical beds than can always been met. On one occasion to date there was a delay in admission of intensive stroke patients due to therapy availability, though admissions were arranged for these patients as soon as possible and alternative care was not required.

5.5.5 Last year, the 74% of people discharged in the first two quarters were able to return home. Despite a significant increase in both volume and acuity with the introduction of clinically enhanced beds, 70% of the people discharged in the first six months of the service have been able to return home.

5.5.6 The service continues to evolve as new ways of working bed in, and we expect to see more positive outcomes achieved for individuals through the year.

5.6 **Case Study**

5.6.1 Mrs H was referred to the ARC by the hospital discharge team. She had been in hospital for four months after a fall at home where she had sustained serious injuries. The ARC was discussed with Mrs H to extend her rehabilitation and regain her baseline of mobilising independently before she returned home.

5.6.2 On admission Mrs H was assessed by Occupational Therapist and Physiotherapist as needing to use a stand hoist with assistance of two members of staff for all transfers and a wheel chair to mobilise. Mrs H needed full assistance with personal care, could not dress independently, became tired after only slight exertion and her medication was managed by the team.

5.6.3 Mrs H worked with the therapy staff and Rehabilitation Support Workers to gain her strength, confidence and stamina to progress from using the stand hoist and wheelchair. Over a period of days and weeks, she progressed to walking a short distance with two members of staff and Zimmer frame, then one member of staff with Zimmer frame, to being able to mobilising with Zimmer frame independently.

5.6.4 As her rehabilitation progressed, Mrs H participated in the self-medication assessment process and Mrs H was able to manage her medication without any problems.

5.6.5 Within a month of her admission Mrs H was taken home for a home visit with her therapy team. Mrs H had a full assessment at home and it was identified that she would benefit from some small items of equipment to help maintain her independence.

5.6.6 Mrs H was discharged home just over a month after she left hospital. The therapy team followed her home with the equipment and ensured it was all set up correctly and Mrs H was settled and confident.

5.7 **Fire Safety – Working with Partners**

5.7.1 Adult Services have received a letter of thanks from the Assistant Chief Fire Officer for Lancashire Fire and Rescue. The thanks reflects the excellent joint working which has been undertaken by key officers leading to new Information Sharing Agreements (ISAs) being set up to enable relevant Adult Social Care data to be shared with Lancashire Fire and Rescue Service (LFRS).

5.7.2 This joint work is crucial as it enables the Service to better target its prevention resources towards those who are most vulnerable and at risk from suffering a fire in the home linked to poor outcomes.

5.7.3 Lancashire Fire and Rescue are working with us to develop their new "safe and well" visits to ensure they are as effective as possible. We were pleased to be able to progress this piece of work at some pace and to be part of something intended to promote increased resilience in our communities.

5.7.4 The letter refers to the agreement as "a significant milestone for the Service in that it's the most significant ISA we have been able to secure to date in terms of scale and scope".

5.8 **Deprivation of Liberties Safeguards**

5.8.1 High numbers of applications for authorisations for Deprivations of Liberty (DoLS) continue to be received by the Council and each authorisation for a Deprivation will require at least one full reassessment in any 12-month period.

5.8.2 At the current rate the Council's Deprivations of Liberty team expects to receive in the region of 1100 applications in 2016/2017; some of those will be for reassessment, some will be new applications and some are referred on to the appropriate supervisory body (other Councils) where they are the funding body for that person's placement.

5.8.3 The purpose of an authorisation is to ensure that those who lack capacity to agree to their care and treatment and are not free to leave the placement (in that they would be brought back in their best interests should they leave) receive the care that is

proportionate to their needs. The benefits of such a specific focus on the needs of such individuals are that they can be provided with care that is dignified and respectful and delivered in the least restrictive way according to each circumstance.

5.9 **Safeguarding Adults**

5.9.1 During the period 1 April 2016 to 30 September 2016, 424 concerns were referred to Adult Social Care for safeguarding consideration; 182 were referred into the formal enquiry process after further consideration and preliminary enquiries. Concerns that do not warrant a formal safeguarding enquiry process are dealt with in a number of other ways by (for example) Social Work intervention with the individual or their family or carer, by Social Workers and health colleagues working alongside the individual and the provider services to improve the quality of care required to an individual, or through contract monitoring processes.

5.9.2 In some cases, the numbers or level of concern regarding a particular care provider who appears not to be able to meet resident needs will generate a complex multi-agency approach.

5.9.3 To achieve this, Adult Social Care staff teams work in partnership with a number of other agencies with individuals - as far as practicable- families, advocates the provider and others. The composite case study below provides an insight into the types of approach that may be taken where a particular provider may require intensive support.

5.10 **Onset of issues**

5.10.1 A staff member at a residential care home raised concerns anonymously with the Contracts Team about staffing levels in the home. The staff member said that the staffing levels were having an impact on the cleanliness of the home. Shortly after this report was received, the Contracts Team was notified by Public Health that there had been an outbreak of diarrhoea and vomiting at the home. The outbreak was confirmed as the same strain of C Difficile that had flared up at the home a year previously. The home had not reported the outbreak to the Care Quality Commission (CQC).

5.10.2 Within the same week anonymous reports were also being made to the Care Quality Commission and a number of professionals raised additional concerns, for example:

- Food Standards inspection resulted in a rating of 1.
- Resident on resident assault.
- Environmental issues including heating not working.
- Insufficient staff to meet needs of residents.
- Increased admissions to emergency healthcare.

5.10.3 A joint visit was undertaken by a Quality Monitoring Officer from the Contracts Team and a Social Worker. The visit revealed that:

- Staff did not consistently provide safe and appropriate care to people.
- Procedures in place to protect people from the risk of abuse had not been followed.
- Staffing levels were not sufficient to provide safe care.
- People who had high care needs, were left with little stimulation or attention for long periods of time.
- Infection control practices did not ensure cleanliness or reduce the risk of cross contamination.
- Staff did not have a working knowledge of the Mental Capacity Act.
- Some people were not provided with appropriate level of care and attention.
- Poor care practices were observed from some staff when they supported people.
- Information within care plans was not always in place or did not adequately guide staff to assist them to respond to people's needs.
- Staff provided care in a task centred way rather than in response to people's individual needs and preferences.
- A number of systems to keep people safe had failed.
- A number of systems to monitor the quality of the service and keep people safe had failed.

5.11 **Taking Action**

5.11.1 The Contracts Team advised the Care Quality Commission of its own concerns received about the home, and informed the Fire Service of potential issues with fire risk assessment and evacuation processes. Social Workers began enquiries into safeguarding cases arising from the concerns and the Contracts Team began to address quality issues with the provider.

5.11.2 The Care Quality Commission carried out a full inspection during which a number of concerns were noted and shared with the Contracts Team including breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was deemed to be inadequate or require improvement in all areas of the Care Quality Commission standards: safe, effective, caring, responsive and well-led.

5.11.3 A multi-agency 'risk summit' was convened and a joint risk assessment was conducted by the Council and Blackpool Clinical Commissioning Group as the bodies responsible for the care and funding of individuals within the home. Professionals who attended the Risk Summit included the Head of Commissioning and representatives across all agencies with an interest in the issues raised.

5.11.4 Information considered and discussed at the meeting included:

- Analysis of the risks to residents resulting from the joint risk assessment.
- Review and update of Care Quality Commission activity.
- Review and update of safeguarding activity.
- Review and update of Contracts Team activity.
- Feedback from professionals.
- Impact of quality issues on individual residents.
- Impact of quality issues on all residents.

5.11.5 A decision was taken that the Council would suspend making new placements to the home and review the needs of existing residents against the home's ability to meet those needs. The Fire Service agreed to undertake a compliance visit and served an enforcement notice on the home.

5.11.6 The provider was invited to a meeting with the Director of Adult Social Services (DASS) and the Head Of Commissioning and informed of the suspension, the reasons for it, and how the situation was to be managed. Reviews of each individual resident's care needs were undertaken promptly with family and/or advocates and a small number of residents were moved because the issues that the home had meant that the home was not in a position to provide appropriate levels of care.

5.12 **The Action Plan**

5.12.1 A programme of weekly progress review visits to the home was put in place and all stakeholders were updated on progress regularly.

5.12.2 Resources and support were provided to the home including:

- Audit and advice from Medicines Management Pharmacist.
- Environmental advice from Dementia Care Homes Officer.
- Access to free staff training around the use of the Mental Capacity Act
- Advice and information from the Fire Service.
- Close support from dedicated Quality Monitoring Officer.

5.12.3 Where further issues were uncovered by people supporting the service further remedial action was added to the action plan and the provider's progress was tracked at the weekly performance management meeting held between Adults Social Care and Contracts Team.

5.13 **The Current Picture**

5.13.1 The Care Quality Commission has now deemed the service to have improved and it is likely that the home will be judged Good overall.

5.13.2 The owner has made significant investment in the management, staffing, and fabric of the home, a new manager and deputy are in place, staffing levels and all staff are appropriately recruited and trained.

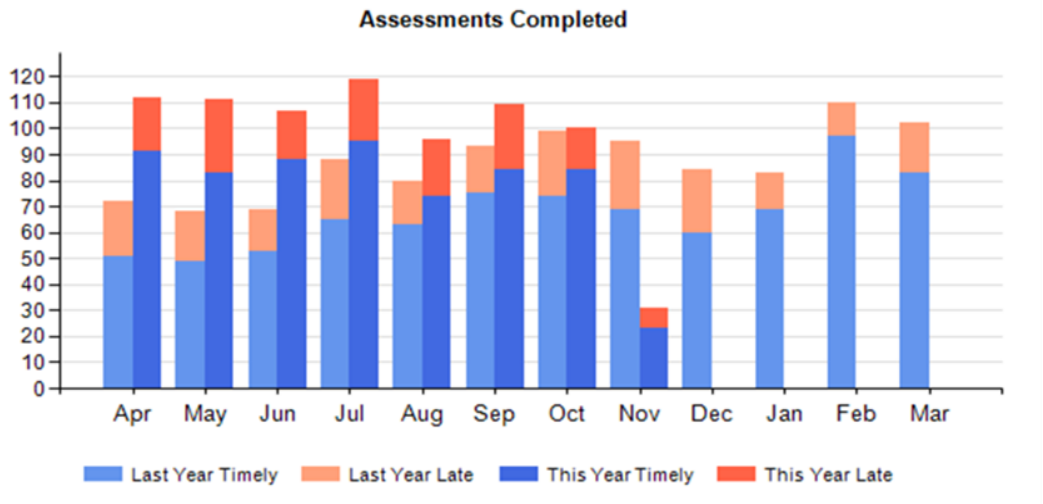
5.13.3 Systems to ensure that residents are safe have been overhauled and care practice has improved significantly and staffing levels are such that safe care can be provided.

5.13.4 Safeguarding activity has fallen to almost zero and residents report that they feel safe and are well cared for and that they are happy at the home.

5.13.5 The suspension to new placements has been lifted with a programme of further support through an enhanced monitoring regime to ensure that improvements are sustainable.

5.14 Adult Social Care (ASC)

5.14.1 Adult social care continues to register a rise in the number of requests for assessments, as detailed in the chart below. We are continuing to manage these through the system with no waiting list. Although there are no statutory time limits to complete an assessment, we measure our performance against an internal target of 28 days. Where the assessment goes beyond this it is usually due to either a particularly complex set of circumstances, or a change in circumstances, for example an admission to hospital. Quality assurance in this area is undertaken via the regular supervision that staff have with their line manager.



5.14.2 Work with our NHS partners in respect of the new models of care continues. The third year of the New Models of Care/Vanguard developments is approaching and we are working with the Clinical Commissioning Group and local NHS Trust in considering what can be developed over the coming year to support people to remain in the community. The aim is to avert hospital admission wherever this is indicated and possible, and where people have been in hospital provide the necessary support and rehabilitation to for them to return home as soon as they are able. Not only is this the preferred option for most people, it will help with the Accident and Emergency, Primary Care and in-patient bed pressures which are local and national issues.

5.14.3 A particular focus of our work at this time of the year is working with relevant partners, primarily the NHS, in what is referred to as the "winter pressures period". Seasonal factors tend to impact on people's health and well-being and the effects of this are felt throughout the care and health system. One of our key services in trying to ensure the smooth running and throughput in system terms is the Hospital Discharge Team (HDT).

5.14.4 The Hospital Discharge Team in its widest sense consist of a multi-disciplinary team of social workers, nurses, support workers, working across Blackpool Victoria Hospital (BVH), Clifton Hospital, The ARC and the Hospice. Sub-teams cover all these areas, apart from a lone worker at the latter. A brief description of how the service works at the main hospital is as follows.

5.14.5 The Blackpool Victoria Hospital team consists of a team manager, deputy manager, five social workers and seven nurse discharge coordinators. Between them they are allocated to all wards to ensure that every ward has cover from both health and social care when planning peoples' moves from an in-patient setting. Although the majority of patients go home to their own support networks, some may need extra work to maximise their independence before they can get home, and some simply do not have any support but will need this either at home in a cared for setting.

5.14.6 Ideally all discharge planning starts from admission. The work of the team is usually generated from a daily white board round on each ward, a multi-disciplinary meeting on the ward looking at all patients and thinking about their move on needs. There are a number of routes available, but the preferred option is re-ablement. This is a service which allows people the opportunity to regain those skills and abilities which they may have lost through either illness, or the debilitating effects of their illness. For example, muscle wastage for older people spending time in bed can occur rapidly and takes time to recover. Clearly the aim is to help people to recover their independence, or regain as much independence as possible.

5.14.7 When looking at discharge, the needs of the person are paramount and they are central to the process. Where there are family members or carers they too will be involved. Decision making when you are unwell is not easy, can take more time than usual, and can be very significant in terms or your future living arrangements and quality of life.

5.14.8 Re-ablement options available to people can be either in their own home, or in the integrated residential setting of the Assessment and Rehabilitation Centre (ARC). The service is available free of charge, usually up to a maximum of 6 weeks, although many people meet their aims before this period. The outcomes could range from a return home, a return home with a package of domiciliary care to help you remain at home, or in a fewer number of cases into either residential or nursing care. People with particularly complex rehabilitation needs will often go to Clifton Hospital, where the process tends to be longer due to the complexity. They will then be dealt with by the Clifton sub-team.

5.14.9 Those people who do not go down the re-ablement route but who require on-going services in the community have a range of other options which the Hospital Discharge Team will work with them to meet their needs. This could include either a new or re-started domiciliary care package, a move into residential or nursing care, or indeed end of life services. These packages will be reviewed by the hospital team within the first six weeks as obviously people's needs can change quickly once at home, and any appropriate changes made. On-going work then passes over to the community teams, as the Hospital Discharge Team have high turnover levels to manage.

5.15 **REGULATED SERVICES**

5.15.1 Care Quality Commission Residential Care Inspection Outcomes Update.

5.15.2 Sixty seven Residential and Nursing Providers have been inspected under the Care Quality Commission's new methodology. There are four Providers who have yet to be inspected or who have been inspected and we are awaiting the Care Quality Commission's report.

	Blackpool	Blackpool	National Total	National Total
	Number	%	Number	%
Outstanding	3	4.48%	122	0.88%
Good	54	80.60%	9926	71.65%
Requires Improvement	9	13.43%	3490	25.19%
Inadequate	1	1.49%	316	2.28%
	67	100.00%	13854	100.00%

National figures correct as at 1 November 2016
Blackpool figures correct as at 1 November 2016.

5.16 **Case Study - Residential and Nursing Provider A**

5.16.1 Early in 2014 thirty eight issues were raised in relation to the quality of the service. There had been issues with quality of service in 2010/2011 and the home had been put on an enhanced monitoring regime.

5.16.2 Recurrent themes included:

- Poor care standards.
- Poor recording practice.
- Poor staffing levels.
- Significant training issues.
- Reliance on agency staff for nursing.
- Inconsistent management arrangements.

5.16.3 As a result of continuing concerns about the quality of care the home was suspended in November 2015.

5.16.4 Joint working between Blackpool Council and Blackpool Clinical Commissioning Group to support the provider has resulted in the provider making significant improvements:

- Management was stabilised.
- Appropriate staffing levels were achieved.
- Training issues were addressed.
- There was a reduction of safeguarding activity.

5.16.5 The suspension to new placements was lifted in January 2016 and a regime of enhanced was put in place during which the provider has been supported to ensure that improvements are sustainable.

5.16.6 The home is currently performing well and safeguarding activity has fallen below average for the size of the home and the type of residents it cares for.

5.16.7 The home beginning to regain its reputation and the enhanced monitoring regime will shortly be ended.

5.17 **Care Quality Commission Care at Home Inspection Outcomes Update.**

5.17.1 Seventeen contracted Care at Home agencies have been inspected under the new methodology. There are no Providers who have yet to be inspected or who have been inspected and we are awaiting the Care Quality Commission's report.

	Blackpool	Blackpool	National Total	National Total
	Number	%	Number	%
Outstanding	0	0.00%	63	1.32%
Good	14	82.35%	3728	78.39%
Requires Improvement	3	17.65%	894	18.80%
Inadequate	0	0.00%	71	1.49%
	17	100.00%	4756	100.00%

National figures correct as at 1 November 2016
Blackpool figures correct as at 1 November 2016.

5.18 **Case Study - Provider B**

5.18.1 Provider B is spot contracted to provide care for four Service Users with a Learning Disability in two locations.

5.18.2 A number of quality concerns with the service in December 2015 prompted a Risk Summit to be held, the outcome of which was a decision to undertake a contract review of the service.

5.18.3 The contract review process identified a number of additional issues with the service. Key concerns included:

- Staffing levels due to difficulty recruiting and retaining staff.
- Management support to operational staff. Two service managers were relatively new to post and did not appear to have extensive knowledge or experience to manage teams of staff. Their manager was based out of area.
- Staff did not appear to have access to robust risk assessments and guidelines.
- Issues of consistency around Deprivation of Liberty Safeguarding.
- Staff were missing some skills to support people with a Learning Disability.

5.18.4 These issues were deemed by Social Workers to be having a detrimental impact on the people using the service. The Care Quality Commission was informed and an action plan was developed and agreed with the provider. Weekly contact was then maintained with the provider.

5.18.5 The CQC published an inspection report in January 2016 which deemed the service to be Requires Improvement. The Council then suspended the provider to new packages of care and refreshed the provider's action plan. The Contracts Team then supported the provider to make the improvements necessary to address the concerns.

5.18.6 The Care Quality Commission re-inspected the service in July 2016 and found the service to be Good in all areas.

5.18.7 The service is still being monitored from a staffing perspective as it is vulnerable to local labour market pressures.

5.19 **Case Study – Richmond Fellowship mental health housing**

Background

5.19.1 AM is a 36 year old male diagnosed as having Paranoid Schizophrenia and had been an inpatient several times due to his mental health. He began hearing voices in 2013 but has had a history of paranoia and depression attributed to excessive cannabis use as a teen.

5.19.2 While in his own flat in 2013, AM was concerned that people were driving past his residence revving their engines and that they posed a threat to him. He later added that at this time he believed that he was subject to an experiment and believed that this was why he was sensing things that others could not. AM has often claimed that many of his persecuting voices threaten him to keep quiet about these experiments and he has believed that this is why 'they' want to find him. AM had also confronted a group of young men he believed were talking about him and he was assaulted as a result.

5.19.3 Just before his last hospitalisation in 2014, it was noted that AM had become suspicious of his medication and claimed the tablets were the wrong colour. At this point AM was finding difficulty in maintaining a rational conversation. He would burst into fits of laughter, but also bouts of tears. It is important to note that at this point AM showed no insight into mental illness but did agree to voluntary admission to a psychiatric unit.

5.19.4 While in hospital, AM became distrustful of his fellow patients and demanded that he be transferred to another ward or he would kill himself. AM claimed that he had tried to hang himself and that no one cared. There were no witnesses to the attempted suicide; however, red marks were clearly visible around his neck. He had 'evil' voices that were threatening towards him and was experiencing hallucinations both visual and olfactory, reporting that he had seen other patients moving objects with their minds and claimed to have perceived strange smells that were not detectable by others.

5.19.5 He was placed on Bowland Unit, a quieter ward with only six patients, where he was treated with the anti-psychotic Clozaril and was eventually discharged to the Blackpool supported living scheme in 2014.

Details of support

5.20 Staff at Richmond Fellowship worked from the notes provided by his care coordinator to provide basic support needs for AM. As time passed a more person centred support plan was created and tailored to AM's needs. His cooking and dietary choices were monitored and advice was offered for healthier choices when he was supported to shop.

5.20.1 Initially AM was unable to access the community due to sustained paranoia and his delusional convictions. This agoraphobia extends back to his late teens. He believed that people were either talking about him or intended him harm. Staff would support him to attend his GP appointments, Blood Tests, Chemist, Shops (local and Supermarket) and AM would use a Taxi for all of these outside activities rather than public transport.

5.20.2 AM has been supported to manage his finances and is open and honest about how things can get out of shape. AM is supported to make phone calls and deal with his mail. Over the months various measures have been put in place to make budgeting easier, these include:

- Paying his electric via a meter.
- Setting up a standing order to pay off his credit card bill weekly.
- Full budget plan discussions and suggested allowance for eBay purchasing.
- Assisted grocery shopping with planned budget.
- Weekly checks on mail correspondence and open discussion.

5.20.3 AM also has difficulty in controlling his alcohol consumption as he attempts to self medicate. Staff have maintained giving advice of safe drinking levels. It has been continually explained how the short term relief from his persecuting voices may result in him having a worse night next time as the alcohol can counter his prescribed medication as well as having health and financial detriments.

5.20.4 Big changes began in 2015 with a combination of increased trust and his willingness to engage in confidence building methods. This has mainly been through carefully executed verbal support and well managed monthly reviews and revised support plan goals.

5.20.5 AM has been provided with many examples of how to live with Schizophrenia and how others cope. Many months of conversations have been had discussing ways to deal with voices, getting to know his main five voices and understanding how they seem to know everything about him. AM has worked hard with staff to rationalise his mind and accept his illness.

5.20.6 Coping methods have been identified to re-enforce the notion that his voices are internally generated. One method was as simple as placing his fingers in his ears to see if the voices he believed were emanating from outside would continue or not.

5.20.7 Another idea was used, which involved making an audio recording when his voices are at their most insistent. The device was played back to staff the following day and only his breathing was detectable. This has been repeated several times and usually has been confirmation enough that the characters he hears are neither in the room nor just outside his window.

5.20.8 AM seems to respond well to logic and this has been used while discussing his delusions. Staff have complimented AM for his readiness to engage so openly. Often repeating his delusional thoughts back to him, as if he were the one listening to another person's difficulties, has him doubt their reality.

5.21 **Community integration:**

5.21.1 To build confidence it has been beneficial to encourage AM to push himself out of his comfort and expand his social world. This has needed challenging discussions with a good mix of humour and goal setting. In the last twelve months AM has been supported on many occasions to go cycling. This has been done as a stand-alone activity and also by way of saving money on to attend his blood tests.

5.21.2 Other social support has occurred by going to a local golf driving range (AM's suggestion) and a supported walks to the local shop or simply around the block to get him out of his flat. These walks have increased in length but his preference is to go cycling.

5.21.3 By closely monitoring AM's mood, reasons for drinking and intensities of persecuting voices, he has been guided to identify additional triggers for relapse. One major trigger has been the thought of moving out from the support and safety of supported living with Richmond Fellowship. This became a source of heightened anxiety a good nine months before his two year placement would have been up for review. Staff worked hard to reassure AM that he was under no pressure and his concerns were overly premature.

5.21.4 A change of tack was decided three months into this cycle to actively support his move on and refocus his perceptions more positively. Staff supported him to register with two housing associations and to plan as to what areas may be suitable for his individual needs so as to set him up with the best chance for more independent living.

5.22 **Results of intervention:**

5.22.1 The primary benefit AM has had by working with Richmond Fellowship staff is his increased independence. AM is now at the stage where he can:

- Perform a full unsupported bimonthly supermarket shop.
- Attend GP appointments without support.

- Walk to the local Shop independently.
- Mostly attend his own blood tests (occasionally wanting support)
- Cycle to his various appointments or to his Dad's house unaccompanied.
- Identify financial difficulties and seek help earlier.

5.22.2 AM continues a good relationship with his family. He visits his Dad usually on a weekly basis now and last summer he managed a day in The Lake District, which although not perfect, was a big step . AM was well enough to enjoy Christmas with his family this year. AM also has maintained a relationship with his girlfriend who also has mental health difficulties. Despite a break from each other towards the end of 2015, this relationship seems to be stable and provide positive mutual support.

5.22.3 AM has a far better understanding of Schizophrenia and how it affects him. More importantly he has reached a stage where the voices are more of an irritation that annoys him rather than a perceived reality that frightens him. This has been through a concerted effort of one to one support, listening, understanding and considered method and approach.

5.22.3 In September of 2015 AM began to show signs of anxiety at the thought of potentially moving on from Richmond Fellowship in May 2016. Initial support was based around taking the urgency and pressure away from this but by December 2015 a change was decided upon to make looking for a new flat a positive exercise.

5.22.4 AM bid on a several properties, was accepted on one and has now successfully moved into his own tenancy.

Outcomes/Values Achieved for Service User	
Coping with voices: AM has learned to identify voices as being internal and not outside threats. This has resulted in turning them from a source of fear to an annoyance. The next step is to ignore them and AM is now empowered to fight towards this goal.	Stay Safe: Support given to help understand written communication and maintaining contact with external agencies and companies has improved living skills. AM keeps on top of all his bills and other payments and abides by the rules of his tenancy. He is able to maintain his tenancy with no problems.
Enjoy and Achieve:	Mood and outlook:

AM has developed a closer relationship with his father. Although his Dad does not full understand what AM has to go through, their relationship has been strengthened as AM has learned to express himself.	AM has new found pride in his achievements. He is more confident and has a better sense of life direction. Leisure activities such as Golf, Cycling, Eating out and one day Go Karting are now achievable.
Be Healthy: His increase in independence is at the best level he has achieved since his late teens. This has been aided by confidence in cycling and walking which increases his general physical health. Access to supermarkets has also had a dramatic effect on his dietary choices and cooking options.	Understanding his Mental Health: AM now has a good grasp of what Schizophrenia is. This has empowered him to regain control and accept his situation. To understand his mental health has released him from living in fear so he can focus on getting enjoyment from life.

5.23 **Respite**

5.23.1 Following the closure of Hoyle at Mansfield respite service on 31 January 2016, a respite pilot has now commenced in partnership with two private residential care homes. The pilot will run from February 2016 to February 2017. An interim evaluation on progress will be presented to Adult Executive on 18 November 2016. The homes are monitored on a monthly basis by the contracts and commissioning team.

5.24 **Case Study**

5.24.1 Provider A

5.24.2 Has received a total of 20 referrals for overnight respite care since the start of the pilot, 50% are carers who had previously accessed respite at Hoyle at Mansfield.

5.24.3 Of those referrals:

- Due to a change in need three service users are now permanent residents in the home.
- Due to personal reasons two service users are no longer accessing the home for respite and are being supported to identify alternative provision.
- One person has recently passed away.

5.24.4 An interim survey has been undertaken to better understand carers views of the respite provided by the home for the person they care for, overall carers were satisfied with the level and quality of the service however where issues have been raised appropriate steps have been put in place to resolve them. These are verified at monthly monitoring meetings

5.25 **Transforming Care**

5.25.1 Blackpool continues to work collaboratively with Lancashire Transforming Care Partnership to ensure successful delivery of the Pan-Lancashire Learning Disability Transformational Plan. A localised version of the plan has been developed to account for the difference in the composition of community learning disability teams, maturity of local Learning Disability services and our relative size.

5.26 **Case Study**

5.26.1 Transition is a key area for Transforming Care. Evidence has shown that transitions between child and adult services can be problematic for young people and families as there is a lack of innovation and collaboration to 'wrap services' around people who are complex. The Lancashire plan makes clear that young people with behaviour that is complex and challenges should be the subject of focused attention and support. Therefore commissioners must work to ensure that local capacity and confidence is built to improve support and increase resilience in the system.

5.26.2 As a local response, the community Learning Disability team in collaboration with Commissioning and a specialist provider has recently tested out a new approach which introduces behaviour focused assessments at an earlier stage in the transition process, in order to develop more effective and proactive plans to minimise placement breakdown. Evaluation has been undertaken to measure the effectiveness and intended benefits using the views and experiences of practitioners, provider, service users, families and carers involved in the pilot. It is intended that the framework will be used in future transitions as best practice.

5.26.3 Key outcomes:

- Individual Behaviour plans have been developed collaboratively and in consultation with young people and their families.
- Increased collaborative working between adults, children's and third sector colleagues to develop services which are Person Centred, outcomes focused and proportionate to presenting risks increase resilience in the system and agree future good practice.
- Plans belong to the young person rather than the 'provider'.
- Promoted co-production based on choice and control.
- Shared approach encouraged positive risk taking and open mindedness.
- Pro-active provider has made this a truly shared project.

- Use of flexible and intelligent commissioning arrangements has resulted in the right service being commissioned in the right way at the right time in order to meet needs.

5.27 Does the information submitted include any exempt information? Yes/No

5.28 **List of Appendices:**
None

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None