Think Local Act Personal (TLAP) is a national strategic partnership of more than 50 organisations committed to supporting the continued implementation of personalisation and community based health, care and support.

The Partnership spans central and local government, the NHS, the voluntary, community and independent provider sectors and people with care and support needs, carers and family members, through the National Co-production Advisory Group.

TLAP is:

- A catalyst for change
- An enabling framework
- A knowledge exchange
- A model of co-production in practice.

Sitra is part of Homeless Link, a national membership organisation that provides training and consultancy services alongside advice, policy and representative roles.

Sitra's unique selling point is our unparalleled expertise in the housing, support and health & social care sectors. Homeless Link is the national membership charity for organisations working directly with people who are homeless in England.

Together we represent over 850 members from local authorities, Registered Providers and voluntary organisations.

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Introduction

Making it Real for Housing Case Studies

This document is a compendium to Making it Real for Housing, produced by Think Local Act Personal and Sitra. It has a set of case studies which describe how housing organisations can embed personalisation following the Making it Real ‘I’ statements. The statements were initially produced by people who use services and carers and describe what personalisation can achieve when it is working well.

The case studies were submitted by supported housing organisations in response to a request for examples. Shorter summaries can be read within the body of the report - Making it Real for Housing.
**Title:** Abstinence based model of support delivery

**Name of the organisation and brief description of nature of its business:**

Adullam Homes Housing Association.

Adullam Homes is a specialist provider of quality housing and support services and was founded in July 1972 by Walter Moore MBE. The housing association houses and supports 1,200 people at any one time throughout England.

Adullam Homes provides high quality accommodation ranging from hostels, self-contained flats, bedsits through to houses. In addition we also work with private rental agencies, local authorities and other registered providers to further enhance the accommodation available to meet the ever changing needs of the people we support.

A range of support services are provided in Cheshire and Staffordshire including; floating support and accommodation for young mothers, their children, vulnerable women and those fleeing domestic abuse and those women aged 16 and over who are either pregnant or have a child, single homeless people, young people aged between 16-25, vulnerable women and those fleeing domestic abuse as well as those excluded from local authorities housing register.

We provide support accommodation to people who have completed a detoxification from drugs and alcohol and want support to complete their return to independent living.

**Contact person:** Jenny Morgan

**Email:** JMorgan@adullam.org.uk

**Phone:** 01260294412

**Personalisation activity:**

Development of an abstinence house that leads to a peer led recovering community
Who was involved?

Adullam’s clients and support teams main partners in this service development were:

- Cheshire East Council – Supporting People, Strategic Commissioner
- Cheshire DAT
- Acorn Rehabilitation centre
- Addaction
- ECAS
- Trust the Process
- Intuitive recovery
- Cheshire service user frame work
- Housing Providers / departments
- And Mutual support groups such as AA, NA, Changing lanes, recovery coaching, and butterflies.
- Faith centres – Elim church

Description:

Service has been a substance recovery since its implementation in 2003 where it was commissioned for supporting those with a drug and alcohol need in the various stages of recovery. Although the outcomes were relatively good in terms of positive move on it was identified by residents that these could be improved (as many were revolving door cases) and it was felt the longevity of the work completed could be increased post move on via community links and the development of a recovering community where the project was central to services.

The project used the Home Office Drug Strategy “Reducing demand, restricting supply, building recovery: supporting people to live a drug free lifestyle” 2010 and the white paper “putting full recovery first” as a springboard to motivate clients towards this fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence. In line with the commissioner and the 12 clients supported the projects mission, aims, objectives and policy / structures were changed.

The service would aim to focus on the following to compliment the aims of the drug strategy –
• Putting more responsibility on individuals to seek help and overcome dependency
• Place emphasis on providing a holistic approach to address substance misuse in addition to treatment by focusing on areas such as employment, offending, housing and wider health needs
• Educate and empower individuals in tackling substance misuse highlighting the impact on relatives and communities
• Challenge and reduce persistent barriers encountered by individuals who have experienced addiction by providing training & employment (Adullams Matt 25 initiative or peer mentor programmes)

“Putting full recovery first” is a further document outlining the government’s roadmap for building a new treatment system. This includes payment by results for drug treatment services, which focuses on being drug free rather than payment for those being maintained on drug substitutes programmes. Tackling the New Psychoactive Substances (NPS) and unclassified substances such as gasses and glue are also a focus which means that increasingly new clients will be encompassed within drug treatment rather than entrenched class A drug users.

The project morphed into a Peer-led recovery community (with a co-ordinating staff member), through which recovery is supported and maintained solely by individuals who are in recovery themselves. Adullam recognise and accept this as one of the most effective ways to maintain lifelong abstinence from drugs and alcohol.

The clients were involved in reviewing the policies, procedures and licence agreement used within the accommodation to ensure it met the needs of those we were aiming to support and to ensure the boundaries were in place for the accommodation to remain a safe environment. The service users advocated new substance screening policy and regimes and visitors polices, in addition to engagement and house agreements tenants also sign up as part of their support plans.

Although the large part of this work was done the tenants have taken for their accommodation by continuing to use the structure and the regular house meetings lead by the peers which staff are invited to for specific agenda points (where needed) to evolve the project to include visitors amendments, pet therapy days and the
development of groups and recovery pathways outside of the house and for the wider community.

The service users progress into peer mentor roles as their sobriety time increases and they complete their support plan. This is usually 6 months plus. And they have the opportunity to become senior peers and coaches and group facilitators to other residents and people in the wider community.

However the service provides much more than just a support housing setting for its residents. It is a hub or “corner stone” of a solid foundation around which recovery for the town and surrounding area has been built. The service links into the community groups and schemes and provided mutual aid groups which are facilitated by the peers. Our peer mentors and volunteers provide groups and services (changing lanes recovery group, AA, NA, GA, Abstainers group, job clubs, learning centre and disabilities support centres, foodbanks, furniture distribution to needy families) within the county and are placed in good areas to see the people who they can support to refer. Current services complete drop-ins at local places of interest (children’s centres, churches, night shelters) to support entrenched clients into services.

We have links to listening services and counselling services that may also be utilised to support clients in identifying issues over coming barriers and contemplating change.

Links to health /wellbeing workshops and expert patients’ programmes / life links also facilitate change highlighting health conditions and possible treatment or lifestyle changes which are often a motivating factor for people to change their substance use level /habits

We have expert citizens within the Cheshire East services working for Adullam who are a resource and a motivator for change as these 3 former clients (now employees) had over 70 years of addiction between them and have remained clean since being in service, progressed through to becoming peers and successfully applied for full time employment.

As part of our offer Adullam supported the development of a recovery community around the localities in which the accommodation is based. The support team and peers have attended Asset based community development days / projects to ensure there is a co-ordinated approach to recovery to aid:
• People seeking recovery are best supported by people in recovery.
• Abstinence is an achievable goal for everyone.
• Recovery in the community is best for the community.

Referrals are received through the council single point of access and through direct referrals by rehabilitation and detox centres. Each referral is assessed in terms of support needs and risk by both the staff co-ordinator and nominated peers for their suitability for being accommodated within the project. The service provides accommodation based support to 8 individuals and 4 floating support spaces which provide a seamless service when clients move on into the community.

**Time frame:**

October 2010 - Present

**What evidence have you had that this has improved outcomes for individuals using services?**

* I have statistics going back to the restructure if required

Between April 2014- April 15 the projects outcomes included:

The service being utilised 99.7% of the time, a throughput of 118.8%. There were 11 departures 87.5% of these were planned with an average length of stay being one year 2 months.

The project uses a distance travelled method to measure how able and confident residents feel in the 5 areas of being economically well, enjoying and achieving in life, managing their health, and having life skills. Residents cored themselves 50% more able and confident in these abilities upon leaving service than when they arrived.

They also reported feeling more able to keep themselves safe from risks, relapse and that their accommodation was safe /secure at a score of 85% more positive than when they entered service.

**How this resulted in improved outcomes for the service itself?**

Yes see above
What challenges did the organisation face? How were these resolved?

Throughput – ensuring the service maintained a 2 year timeframe to work with those in addiction and see their recovery through.

Establishing the change in service use and the promotion of abstinence with partner agencies.

Lack of knowledge and testing regimes in prisons and social services. Can test negative in institutions but our tests screen for more substances so referrals are not always appropriate from other agencies.

Are there any resources or top tips to share?

We have an NVQ accredited peer mentoring package and training system through our social enterprise team that supports the work done within project.

DOMINICS STORY

I was a season ticket holder with Manchester United and I travelled the world watching them play. I had a good job, a nice home, a wide circle of friends, and played a lot of sport. I was drinking, but I thought I was in control.

I lost both my parents. This hit me hard and the way I coped was to do everything to the extreme. This was socialising, work, traveling, and drinking.

Looking back it is hard for me to pinpoint when the social drinking became problematic. I went from drinking with friends at evenings and weekends to drinking every day, and at every opportunity.

Over a period of time alcohol took over my life and this caused me to lose jobs, homes, relationships, independence and my health. Within 12 months I was homeless.

I spent a lot of time blaming everyone but myself and became angry and resentful.

It was my family who eventually saved me. I don’t know why they continued to stay supportive but they did.
I was taken to the GP where I was diagnosed with chronic alcoholism and referred to the priory unit. I went into detox and following my discharge I was referred to Adullam Housing. This was my first experience of supported housing.

The support staff there arranged regular health appointments. I had support with my benefits and encouraged me to attend support groups with other recovering addicts. I was supported in managing my money, eating healthily and given general emotional support.

I progressed well, and I reached 2 years sobriety and was at peace with myself having found serenity. Serenity, however, wasn’t quelling all my urges so I started a relationship with a girl who I met at one of my recovery groups. She was everything I was looking for. She was on my wave length, she was very attractive and educated.

She was also in recovery but struggling to maintain her sobriety. I spend some of my time saving her, some of my time loving her, some of my time hating her, and some of my time at peace with her. The relationship became so strong I left Adullam and moved in with her. Looking back I think I still had some reservations but I loved her and wanted her to find serenity like I had.

We lived together for 3 years.

One day I arrived home from work. I had been feeling the strain of the relationship for quite some time. This night was different. I never knew what to expect a lot of the time but it was clear she wanted to say something and I did also. It was at this moment we both decided the relationship was going nowhere and we agreed to split. I needed to find accommodation and move on.

Almost like a full circle I knew I was still in recovery and needed the support of Adullam and other people in recovery to get me through this difficult and emotional period.

I moved back into the Mill lane project in June 2012.

This time was different. I was more focused on my goals. I was determined to sort my own life and prioritise me.

I am now 10 years sober and have moved on from Mill lane. I have my own house in Macclesfield
I’ve changed, so much over the years. I am more confident, I am working part time and run the in house support group. My experience of living is different. My core values remain the same but I am taking even more opportunities and creating a balance in my life

So what do I want from my future…..

I want Adullam to succeed and continue to identify the funding for the supportive environments which have helped me so much. I want to give back, I want to support others as I have been supported myself.

But most of all I want Man Utd to win the Champions League

Dream on!

Martins Story

I, m 63 and have just celebrated 12 months sober. This is the only time I’ve been sober and living without drink since I was first taken into a pub when I was about 11 years old. This was with my dad, and it was the ‘norm’ to go into the pub after dad finished work more or less every night.

I started working for a butcher when I was 15 with Dad. The drinking continued every night after work, but I didn’t think it was ever problematic, I was just been sociable!

I left the butchers for a better paid job and working as a steel erector/roofer. The drinking increased with more income but again I thought I am in control.

I went into the army in 1969 and I was stationed in Londonderry. This is when the drinking became out of control. I saw things in Ireland that will haunt me for the rest of my life, and I probably was suffering post traumatic shock when I returned Macclesfield although this was never recognised then.

The drinking became worse. I was married and that failed. I went back as a roofer/steel erector and it is only by the grace of god that I managed to stay alive as I was so drunk when I went to work it’s a wonder I didn’t injure myself let alone others.
In the end I was told not to come to work. I was considered too risky, and this is when my life took a spiral downwards. With no income I became homeless and ended up sleeping under bridges or anywhere who would have me for a few nights.

I recognise I needed help and did attend AA but I was an angry drunk. I would swear and shout and shake my fist, and generally disrupt the meetings. I became the man no one wanted to know.

I did find a flat but I used to lock myself away, drinking all day, and generally shunning the world. I used to line my bottles up fall asleep and then drink from the moment I woke up.

One day I woke up and as usual I had wet myself. I was shaking so much, I could hardly reach my bottle. I tried to make a cup of tea but I couldn’t hold the cup. I needed help.

It was then I contacted the alcohol tem and my worker came out and after checking this time I really wanted it I began a home detox. This was followed by a short spell in a rehab unit before finally moving to mill lane.

I’ve always lived in Macclesfield, in fact I was born, grew up, became an alcoholic and am now in recovery all within a mile radius.

My life is completely different. I am content. I have a circle of friends who I have known all my life, back in my life.

I volunteer at the local church and recently cleaned the windows which haven’t been cleaned for 20 years. The sunbeams shine through them and this makes me feel good.

I have a partner Sarah, and we enjoy shopping and getting together with our friends. I enjoy life without alcohol and I enjoy the simple things in life.

I am soon to become a senior peer at the project and I am looking forward to helping people on their recovery journey and hope I can show them that even with a lifetime of addiction it is never too late to start living again.
Title: Join Us

Name of the organisation and brief description of nature of its business:

AmicusHorizon provide homes and services to communities across London and the South East of England. They own or manage just under 28,000 homes, around 1,300 in sheltered or extra care retirement schemes.

Contact person:

Robin Deane - Head of older people’s services

Email:
Robin.deane@amicushorizon.org.uk

Phone:
Tel: 01424 728200

Personalisation activity:

With the help of a bursary from East Sussex County Council, AmicusHorizon working with Lewes District Council established the Join Us network of older people living in and beyond retirement schemes. The project is now continuing with its own resources with support from participating landlords.

Who was involved?

The Join Us resident steering group made up of residents of sheltered housing in the Rother area of East Sussex, with support from Lewes District Council and Residents of All Rother (ROAR) - a group led by older AmicusHorizon residents. Eastbourne Homes have helped by providing space for meetings. The steering group is formally constituted which allows them to apply for independent funding for activities.

Description:

The project aimed to expand the programme of activities in and around sheltered housing schemes in order to reduce isolation and improve health. A project coordinator was appointed to support residents and scheme managers to help make things happen.

Achievements include:

- Digital champions have been recruited and as a result digital inclusion has reduced
- AmicusHorizon now has public wifi in all its sheltered schemes
- Join Us has a Facebook page which schemes are using to communicate with each other
- Training has been organised in online security and safety which toured schemes
- A number of events have been held for resident activists (the ‘doers’ in each scheme) to get together, network and find out about resources
• The reach of the project has been extended with non-sheltered residents represented on the steering group
• The Join Us ‘brand’ has become a banner for a range of events and activities – such as an amazing talent show to celebrate International Older People’s Day 2015 at the White Rock Theatre in Hastings.

In 2016/17 the focus is on key strands:
• Supporting the ‘doers’ or activists in each scheme through networking events – aim is to get them sharing information and supporting each other
• Events designed to entice the hard-to-reach residents ‘who sit in their flats’
• We’ve given scheme managers performance objectives of organising at least one digital inclusion and one wellbeing event in each scheme – this is a minimum and we expect most to do much more
• AmicusHorizon’s community development team is leading projects to tackle social isolation and promote creativity – e.g. creating mosaics
• Supporting the Join us residents steering group – you can find their community page on Facebook (search for ‘JoinUsToo’)

Time frame:

So far the project has been focused in East Sussex. In 2016/17 the aim is to extend the project to residents of other social landlords and to all of AmicusHorizon’s retirement housing including schemes in Kent and London.

What evidence have you had that this has improved outcomes for individuals using services?

The Join Us Facebook page is putting people in touch and promoting digital inclusion. New friendships and networks are growing. A baseline survey was undertaken at the start of the project which will be repeated.

Residents co-design and co-produce an expanded programme of activities which have included a garden and photography competitions; arts open events, sport, armchair exercise, and health promotion events, intergenerational activities e.g. with local schools.
Title: Building dignity into design

Name of the organisation and brief description of nature of its business:

TP Properties design, develop and manage specialist supported housing projects for people with a range of needs including: learning disabilities; physical disabilities; autism, brain injuries; mental health needs and other associated complex physical and health needs.

Being uniquely funded, with a long history in properties and care, the team provide swift and comprehensive supported accommodation assignments including apartment projects and flat schemes, houses and bungalows. These can include full builds, conversions or minor refurbishments of new and existing properties. The team base each project on the individual needs and requirements of the individual – taking a person centred and bespoke approach.

Contact person: Barbara Graham (Managing Director)

Email: Barbara.graham@tpproperties.co.uk

Phone: 07879 773384

Personalisation activity:

Over the past 18 months assistive technology has been a key feature within all building and renovation work – demonstrating that design and technology can truly make supported housing more personalised. Taking a person centred approach to each development, the team have worked with individuals directly to tailor make and build or renovate properties in line with their specific support needs.

Adopting creative and person-centred design ideas and looking at different ways assistive technology can be integrated into the design stages means the team are not only creating homes for life, but also working to improve health and wellbeing, as well as enhancing dignity, empowerment and independence within a safe environment.

Who was involved?

The whole TP team. They are uniquely skilled: all with long backgrounds within the care industry; hands on experience of delivering support; and an understanding of the barriers and issues that can be linked to providing good quality housing to people with disabilities.

Description:

TP properties worked with an individual and a PCT to design and develop a supported housing project for an individual who had been in hospital for five years due to her profound medical needs.
The team ensure the design was ‘tenant’ led – with the team organising weekly meetings to support the future tenant to contribute towards the design, build and furnishing of her home from her hospital bed.

This consultation and involvement helped to ensure that the intention and delivery of the dwelling met not only the current needs but was sustainable for the future.

The outcome was the development of an open plan supported living bungalow, on a site that the tenant identified.

This property was flexible enough to accommodate very distinct health needs including being fully wheelchair accessible, with an adapted kitchen and bathing area.

The team also worked creatively to design and integrate ports in each room of the house to allow for medical oxygen supply.

To compliment the interior the garden areas were planned to avoid certain potentially harmful plants due to strong tenant allergic reactions.

**Time frame:**

12 months from planning to move in

**What evidence have you had that this has improved outcomes for individuals using services?**

After 5 years in hospital the individual was able to live in her own home, in her chosen community. The design of the property, with discreet oxygen ports in each room, has given her dignity: allowing her to receive the medical intervention she needs without her environment looking clinical.

**How this resulted in improved outcomes for the service itself?**

Her new home has allowed a sense of normality and moved the individual away from a ‘clinical setting’ without the risk. She is integrated back in her community, living in her own home with the design built around her specific health needs.

**What challenges did the organisation face? How were these resolved?**

Funding in the austere times for people supported is limited. In response we have repositioned ourselves as local facilitators and leaders, helping our partners use housing as a way to work together to design better services that deliver shared priorities and better health outcomes. Together we help to propagate cost neutral or low cost opportunities that improve health and wellbeing.

Providing our customers with homes, not houses, is what makes the difference. Our commitment to the citizenship rights of tenants has resulted in an organically grown enterprise that is proud to rest on its previous successes.

**Are there any resources or top tips to share?**

Lots on our website with information for people supported and their families:
All believed that this was housing with support at its very best, but this belief was best phrased by the tenant who said:

‘This is honestly one of the highlights of my life. The Development Team were patient and fantastic. After five years of feeling like services had let me down I now feel that I can get on with my life. It was so emotional on the first day I kept pinching myself as I couldn’t believe it was real. I will miss the team enormously – so please stay in touch!’
Title: Conversion of large block contract of 83 people with learning disabilities into Individual Services Funds (ISFs)

Choice Support.

Charity and company limited by guarantee, established in 1984

Work with people with learning disabilities, mental health problems, physical disability, Autism, Asperger's syndrome,

Turnover approaching £36 million

Employs 1600 staff (approx.)

Support 1400 people

Services provided are Supported living, residential care, outreach, employment, experts by experience

Operate in Wakefield, Stockport, Cheshire Nottinghamshire, Mansfield, Bedfordshire, Milton Keynes, Buckinghamshire, Hampshire, Portsmouth, 9 London boroughs

Contact person: Juli Carson

Email: juli.carson@choicesupport.org.uk

Phone: 07810 378 372

Personalisation activity:

The Southwark block contract was converted to 83 ISFs with 83 personalised support plans created.

‘Waking-nights’ were removed from 11 services (29 people) making Southwark ‘waking-night’ free. These were replaced with Sleep-ins

There was an increased use of Assistive Technology.

21 care homes were de-registered.

Phased closure of a former PCT campus-like site began.

A Shared Lives service was established.

Local authority was offered a £1,795,073 reduction in price on a £6.5 million contract (29.75%)

Independent research identified improvements in quality of life for the individuals involved around the night wakes and ISF implementation
**Who was involved?**

A director oversaw the process, four area managers worked with services managers and social services. The individuals were at the centre of everything. Their circles of support were involved and consulted as well as access to independent advocacy.

**Description:**

Person Centred Plans were developed for each individual

Each individual plan went to Panel and was signed off by Care Management and Commissioning

Individual Service Funds (ISFs) were devised from this

Changes in support- We got creative!

Personal Assistants were introduced

Better Nights including AT was implemented, Sleep-ins for all

21 Services were de-registered. Individuals now had right of tenure and access to benefits. They more had disposable income now.

Robust risk management of changes

Culture Change- training for all

Creative Response- everyone got creative as more flexibility was an outcome

Managed: Strategically and Operationally

Externally audited outcomes

Continuous review followed

**Time frame:**

There was a six month time frame for creation of the support plans and their implementation. After that the ISFs were implemented into services with the plans outlining what each individual needed. Savings were made year on year over a period of 5 years in order for implementation to be done effectively.
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What evidence have you had that this has improved outcomes for individuals using services?

We had the work evaluated and reviewed by the University of Buckinghamshire. The outcomes they found were:

‘Very positive outcomes of work, consistently across different groups with only small differences in perspective’

There was good evidence that quality of life has improved for individuals. We found that people had more opportunities, more control and control of money, greater happiness, more privacy, fulfilment and life direction, greater independence and increased living skills. For example people learnt how to prepare meals and make drinks without needing staff support, People accessed vehicles so they could go out more, people chose not to attend day centres but instead do alternate preferred activities like pottery classes. People had more disposable income so could have holidays and improvements to their home environment

How this resulted in improved outcomes for the service itself?

Individualised funding. This was a provider-led process.

Social workers and commissioners allowed more flexibility of support

There were opportunities for staff and managers to think differently about how to provide support, this had an empowering effect.

There was a chance for family and friends to get more involved in things

Chance for people to change things they’d previously been stuck with.

We came to believe that anything is possible (as long as it’s legal)
The organisation now no longer needed to tender for these services as ISF’s take individuals out of the tendering arena. There was flexibility to achieve desired outcomes and protected Budgets which were now portable.

We were making good on our promise to put the individual at the heart of everything and provide good personalised services that meet people’s needs.

**What challenges did the organisation face? How were these resolved?**

The challenges we faced were staff redundancies due to the termination of Waking nights, the need to make savings: this was achieved by reducing the cost of each support hour i.e. changes in existing staff terms & conditions and a management restructure.

Reducing direct support hours, including waking nights and increased use of Assistive Technology (AT), reducing overheads and closure of the local office.

There were some staff conflicts due to introducing the new way of working in a more personalised way. This was tackled with training and consultation. We needed to change our financial systems to accommodate the new ISF’s.

**Are there any resources or top tips to share?**

The best tip is to embrace change and motivate the workforce to follow. Work together in partnership with all stakeholders. Create a trusting relationship with Commissioning and care management.

Feeling Settled, NDTi (2011)

Feeling Settled Toolkit (2013)

ISFs in Action: Personalising Block Contracts, CfWR (2012)

Social & Health Evaluation Unit Bucks New University, CfWR (2012)

Social & Health Evaluation Unit Bucks New University, CfWR (2014)
Title: Health service for homeless people

Name of the organisation and brief description of nature of its business:

Derventio Housing Trust tackles homelessness head-on, providing accommodation, support and opportunities to help people who have lost their way to get back on their feet, from our twelve years' experience responding to what homeless people want and need. We support over 1,000 people each year. Most of our services are based in Derby and Derbyshire. We also deliver housing and support in Staffordshire, Shropshire, Nottinghamshire and Wiltshire.

Contact person: Jackie Carpenter

Email: jackie.carpenter@derventiohousing.com

Phone: 01332 292776

Personalisation activity:

Healthy Futures

Who was involved?

Healthy Futures operates in partnership with

- Clinical Commissioning Groups: Southern Derbyshire, Erewash, Hardwick, North Derbyshire
- Derby Hospitals Foundation Trust
- Derbyshire Healthcare Foundation Trust
- Local Authorities: Derby City, Derbyshire Dales, Amber Valley, Erewash, Chesterfield, North East Derbyshire, Derbyshire County Council.

Description:

Healthy Futures acts as a bridge between hospital and home, assisting homeless patients in hospital to find suitable, safe housing, preventing discharge from hospital onto the street and enabling people to start on the path to a healthier future.

It provides crisis intervention to individuals who are homeless in hospital, using a “Housing First” model to address their immediate housing crisis plus 12 weeks of holistic support to resettle them into the community.

It also supports high impact users to reduce their use of urgent care services (999 ambulance, accident and emergency departments).

Time frame:

Healthy Futures has been operating since October 2013.
What evidence have you had that this has improved outcomes for individuals using services?

All the outcomes that we have achieved have only been possible because of our clear focus on a genuinely person-centred approach. Our two-year evaluation of Healthy Futures, *Beyond the Ward*, shows:

- 66% improvement in mental and emotional wellbeing
- 94 people housed
- 66% improvement in mental and emotional wellbeing for older people who were socially isolated.


How this resulted in improved outcomes for the service itself?

Personalisation enabled the service to achieve impressive outcomes. *Beyond the Ward* shows:

- 88% reduction in non-planned admissions
- 88% reduction in A&E presentations
- Average 16 days shorter stay in hospital
- 90% engagement with community health and treatment services
- 66% improvement in mental and emotional wellbeing
- £11.85 return on investment for every £1 invested

These outcomes were only achieved by starting with the individual, and using principles such as non-judgemental and holistic approach, and behaviour change through encouragement and appropriate challenge.

What challenges did the organisation face? How were these resolved?

One of the main challenges we knew we might face in the early days was information governance. Our previous experience of running a Making Every Adult Matter (MEAM) service was invaluable. Starting from scratch, we’d found that sorting out information sharing with a wide range of public sector agencies took longer than the 12 months we had for the pilot.

This was largely because we were VCSE sector, so didn’t fit any of the existing information sharing agreements, which relied on shared public sector and statutory services structures and processes. In the end, we asked each beneficiary to sign an explicit consent form, and that with an information sharing agreement, did the trick. So for Healthy Futures, we did the same and were ready to start the project from day one.
**Are there any resources or top tips to share?**

Focus right from the start on evidencing outcomes, particularly the ones that mattered to the Clinical Commissioning Groups. Part of our discussions with commissioners, which shaped the bid, were to identify the crucial outcomes. Throughout, we have had an extremely business-like focus on outcomes and evidence, creating our own spreadsheets to record all that the project achieved. This meant that we were well-placed to show commissioners that investment to cover project costs would be worth it to them. We’ve also been in dialogue with them when renewing funding to add in extra outcomes, and we use the tools they select to record beneficiaries’ self-determined physical and mental health. We also ask, and listen, to see, if there are additional things that the CCG would like, that we can help them achieve through Healthy Futures.

Our other main innovation is that we are continuously willing to tweak the project to improve it, and actively look for ways round barriers. I gather that this is now, as the current buzzword has it, called prototyping. But it’s what DHT has always done, just get on and do it and learn as you go.

**Quote from a person who uses services**

“I was in a bad place when I first met my support worker, I don’t know what I would have done without her – probably would have given up. I can now look forward to a fresh start in my own home where I can better manager my health – she is my angel!”

“Thank you so much for helping us, we didn’t really understand what the doctors were saying so thank you for talking to the nurse and getting her to explain things”

“It was the light at the end of the tunnel. It was so uplifting when Healthy Futures staff came to visit me in hospital. I am better, fitter and healthier now. I just wouldn’t be here now if it wasn’t for the help I have received”.
Title: Craft sessions

Name of the organisation and brief description of nature of its business:

Enable is part of the EMH Group and have care and support services throughout the East Midlands region. Services range from Registered and Domiciliary care, Day services, Extra Care, hostel accommodation, self-contained and floating support. We provide care and support as required in a person centred way to clients with varying needs for example learning disabilities, mental health issues, physical disabilities, homeless, and teenage parents.

MYST Lodge and Westbourne House, Melton Mowbray are supported housing services where enable staff are on site to work with residents and their families.

MYST Lodge is a 10 bed space hostel for vulnerable, young homeless people aged between 16 and 25 years. Westbourne House has 15 self-contained flats for homeless families. They are both on the same site and one staffing team supports all 25 residents.

Contact person: Baska Read who completed this activity with residents or Tracy Quigley who compiled the details for this document

Email:  
  baska.read@emhenable.org.uk
  tracy.quigley@emhenable.org.uk

Phone: MYST Lodge/Westbourne House – 01530 278195  
  Tracy Quigley direct – 01530 278746

Personalisation activity:

38 craft sessions, weekly on a Wednesday.

Westbourne House session 16:00 to 17:00.

MYST Lodge session 20:00 to 21:00.

Who was involved?

Residents, their children, their families and visitors were also welcomed to join this activity.

We had help from one of our ex residents who is a talented local artist. He regularly volunteered and helped with the preparation for the craft sessions and helped run and organise the activities, especially for the residents of Westbourne House who brought their children in to participate.
He is extremely passionate about our Craft Sessions and as an artist gives a lot of inspiration to our residents to express themselves and to be more creative.

**Description:**

During the activity staff talked to all participating residents about general health and safety.

All of the residents participated in craft activities, learning and exploring new ideas, they enjoyed socialising with other residents over refreshments.

The sessions also taught residents how to relax and have fun as well as being creative.

The sessions also gave residents a platform to talk to staff about what matters to them in relaxed and friendly atmosphere.

**Time frame:**

The sessions were an hour long and ran throughout the period of 2/06/2015 till 24/02/2016

**What evidence have you had that this has improved outcomes for individuals using services?**

Residents worked together in order to make crafts, they relaxed and interacted with each other. They confirmed that they were able to express their point of view.

All of the residents enjoyed getting together and having fun, they agreed that the benefits of the Craft Sessions were:

- Getting tenants together and working on satisfying projects.
- Encouraging individuals to develop new social skills and making a positive change.
- Encouraging working as a team.
- Helping individuals to gain confidence, learn new skills, socialise with others, share experiences and relax after a difficult week of struggles.
- Being creative promoted a healthy way of expressing bad emotions and frustrations.

**How this resulted in improved outcomes for the service itself?**

Because the residents are more familiar with each other they interact more in communal areas

**What challenges did the organisation face? How were these resolved?**

Getting the residents interested and involved and encouraging them to participate was the main challenge.
• We used posters and leaflets and staff talked to residents about the craft sessions to update them on times they were being held, encouraged them to join in when they were in their one to one review meetings or having an informal chat over coffee.
**Title:** The Gatesbield experience

**Name of the organisation and brief description of nature of its business:**

Gatesbield Quaker Housing Association Limited.

Gatesbield is a Sheltered Housing Scheme in the centre of Windermere providing one-bedroomed flats for persons over 60 years, although most tenants are over 80 years on application. Our current age range is 70 years – 96 years.

Gatesbield staff (Warden) are on duty from 09.00 – 17.00hrs. every day of the year.

Out of hours alarm monitoring is provided by a Community Alarm Service.

Out of hours emergency response is provided by St Gregory’s Homecare.

Gatesbield tenants have a morning every morning between 09.00 and 09.30, unless they choose either to opt out of this service or request a morning visit instead.

Gatesbield provides a fresh cooked two course meal five days per week, tenants are asked to order lunches 24hrs in advance, and are invoiced monthly for the meals they have had. Friends and family are always welcome and encouraged.

Our lunch service is also open to residents of our neighbouring Sheltered Housing Scheme and clients of Gatesbield at Home, which is our Community Warden / Alarm response service for older people living in the Windermere and Bowness area.

Gatesbield offers a taxi service to the local supermarket each week for those tenants who wish to do their own shopping.

This service enables people to do their heavy shopping using the taxi, and to still be able to walk to the village to shop for bits and pieces.

Gatesbield has both regular and occasional social events, these can either be initiated/led by staff, tenants or volunteers. All tenants are encouraged to join any activity which may be of interest to them, but never made to feel obligated to attend.

Tenants are encouraged to continue where and for as long as possible with their interests outside of Gatesbield.

A Quaker Meeting for Worship is held at Gatesbield each week, all tenants as well as members of the public are welcome to attend. Quaker tenants are also where possible engaged in the wider Quaker community.

Contact person: Andree Cook

Email: andree.cook@gatesbield.org.uk

Phone: 015394 45578
Personalisation activity: End of life care

Who was involved? Gatesbield Staff; St Gregory’s Homecare; Cumbria Care and the District Nursing Service.

Description: Gatesbield staff, in partnership with statutory agencies have recently enabled a 102 year old resident of Gatesbield to die at home by providing end of life care. The lady had lived at Gatesbield for eighteen years, and in recent years had sought reassurance that if at all possible she could remain in her home and not have to move to 24 hour care. Gatesbield staff were able to provide support to both the lady and her family with frequent visits to give fluids and small amounts of food in between visits from statutory agencies. We were also able to make sure she was comfortable and were also available to allow her to talk through her thoughts and feelings following a terminal diagnosis.

This is not the first occasion Gatesbield has enabled someone to have their wish to die at home, one former tenant came home from hospital to have her final days at home.

Time frame: Three weeks (on this occasion).

What evidence have you had that this has improved outcomes for individuals using services?

On a previous occasion when we were able to provide end of life care, several tenants expressed how reassured they felt that Gatesbield would provide this level of support, and would do everything possible, in partnership with other agencies and family, to enable someone to remain in their own home. This more recent case has further reassured our tenants and their families.

How this resulted in improved outcomes for the service itself?

Applicants to Gatesbield are attracted by its ethos which is well known among local people, and the wider Quaker community.

This has resulted in Gatesbield holding a healthy waiting list of over 40 persons.

What challenges did the organisation face? How were these resolved?

Gatesbield has a small staff team who are committed to providing a high level of service, however, this did result in additional pressure being placed upon the team who were also managing the day to day life of the scheme.

Challenges were resolved by support from other tenants; volunteers (Friends of Gatesbield) and Board members.

Are there any resources or top tips to share?

Resource: Gatesbield staff are experienced in End of Life Care.
Top Tips:

It is Gatesbield’s philosophy to provide a personalised service where possible for our tenants, enabling them to maintain their independence for as long as they are able.

Gatesbield has a good working relationship with other agencies, both voluntary and statutory, which we consider vital to the success of our scheme.

**Quote from a person who uses services**

Part of email received from a Friend of Gatesbield....

“... How lucky she was to have Gatebield staff to support her to the end. How many people are fortunate enough to be surrounded by so much care.

“I don't imagine there are many supported housing schemes with the ethos you have brought to Gatesbield, how incredibly lucky the tenants are.”
Title: Tenant's book

Name of the organisation and brief description of nature of its business:
Leading Lives, provides a wide range of high quality social care support for people with learning disabilities, physical, multiple complex needs and autism, older people, young people in transition and family carers across Suffolk

Contact person: Rebecca Steer

Email: Rebecca.Steer@leadinglives.org.uk

Personalisation activity: Promoting rights & Responsibilities of tenants living in our Supported Living Services

Who was involved? Inneka Winser & Jenny Mills, team leaders

Description: A visual guide, encompassing all responsibilities of living in your own home, demonstrating inclusion & progression

Time frame: 1-2 months

What evidence have you had that this has improved outcomes for individuals using services?
All tenants have actively participated, enjoy signing when tasks completed, good feedback during house meetings, increased understanding that the home belongs to tenants & staff are there to support. People making choices

How this resulted in improved outcomes for the service itself?
Meeting all safety regulations, e.g. fire, infection control, food safety. Staff are now ‘doing with’ rather than ‘doing for’. Tenants have greater control, making decisions & choice in their home. Good evidence for CQC and REACH stands

What challenges did the organisation face? How were these resolved?
Changing the mind set of staff. By using the book it highlighted how important it was that the tenant had control

Are there any resources or top tips to share?
Tenant’s Book

Person who uses services quote

I like signing in the book AB

This helps me remember when jobs need doing & makes things safe LA
Title: Making it Real for the people we work for

Name of the organisation and brief description of nature of its business:
Loretto Care, part of the Wheatley Group

At Loretto Care we provide a range of personalised services to deliver positive outcomes. We work with over 2000 people every month over 10 local authority areas. We specialise in providing personalised support to those experiencing homelessness, mental health issues, individuals with learning disabilities, older people, young people and individuals with Alcohol Related Brain Damage. We support people to be leaders in designing their support to live a fulfilled life.

Loretto Care is part of Wheatley Group, Scotland’s leading housing care and property-management organisation.

Contact person: Michael Timmons

Email: michaellt1@lorettoha.co.uk

Phone: 0141 274 7622

Personalisation activity:

Loretto Care provides a personalised service across all of our services regardless of how the support is funded. We have created several initiatives to support this. One such initiative is the Community Engagement and Activities Team.

In consultation with the people we work for, we recently developed the Community Engagement and Activities (CEA) Team as a dedicated resource which:

- improves community engagement
- increases opportunities for meaningful activities
- encourages increased participation.

The CEA Team complement the work of the service staff and strive to support and enhance the health and wellbeing of the people we work for. They work to ensure people are equal partners in the design, shaping and review of their support, service and the organisation.

Who was involved?

The team was developed in consultation with the people we work for, Scottish Government and staff as well as using feedback from external agencies such as the Care Inspectorate. There are currently seven Community Engagement and Activities Coordinators across various services and locations across the organisation. There is also a CEA Lead who oversees and coordinates the work plan for the team.
Description:

The CEA Team creates and facilitates a number of meaningful activities to tackle social isolation, promote a healthy lifestyle, and build the skills of the people we work for. The work the CEA Team plans, promotes and facilitates is dictated by what the people we work for want. The team facilitate opportunities to engage in:

- exercise through walking, gardening, physical activity groups and other projects
- creative art, music and photography
- accessing employment, volunteering, further education and training
- new technology
- taking lead roles in their service, support and activities
- having a say in national campaigns, consultations and events
- information sessions about key topics such as Self-Directed Support and personalisation
- recruiting, inducting and training staff.

The CEA Team also works to ensure people can have their say at every level of Loretto Care. One way of ensuring this is through the creation of Advisory Groups. This is an opportunity where the people we work for meet with staff in strategic roles such as the Head of Care and Service Development Leads. The Advisory Group actively seeks to share ideas and encourage the co-designing of policy, procedures and the plans to improve the services provided. One person we work for involved in the Advisory Group said: “It makes me feel very proud of myself, putting myself forward for it, because at the end of the day it was a chance for getting back into it, and putting my experience back. They pick up and take on what I’ve been saying and that makes me very happy.”

Time frame:

This is a new initiative developed in June 2015 from a previous post. Loretto Care is committed to developing this team further.

What evidence have you had that this has improved outcomes for individuals using services?

There has been a significant increase in the number of people involved in meaningful activities and this has had a positive impact on their outcomes. Those who have engaged in the various activities and participation have reported an increase in their confidence, self-esteem as well as supporting some people in their recovery from addictions or mental health issues.

A person we work for involved in a creative art group which progressed to a community art exhibition said: “I’m very lucky to have access to the opportunities I have access to. My passions for music, art and keeping my fitness up will keep me on the straight and narrow and give me a more exciting and healthy way of life”. Another person said: “Art exhibitions and the wide range of services offered help change lives for the better,
including my own.”

Another person commented on their involvement in a photo project for people who have experienced homelessness. “I liked getting involved; I like to go out as it helps with my anxiety and depression. I have taken part in 5k fun runs along the Clydeside and Queens Park. I took photographs for the exhibition while doing these.” Another person said: “I thought I’d give it a shot, get out the flat and do something different. My pictures tell the story of my recovery from addictions…Life can be an uphill battle and I was trying to make it uphill alone, using drink and drugs…now I see things in a different light, now I’m seeing reality, and this place is good for me…”

In addition to positive feedback from the people we work for, Care Inspectors have seen the value in creating a dedicated team. They said:

“The organisation were exemplary for the work undertaken to promote participation and involvement. For example; there was a dedicated team that focussed on participation and engagement and visited all services…”

“The action plan for the community engagement and activity team that we saw was very comprehensive and identified various areas where the service will continue to review and develop the ways that it can support individuals to get involved in the service, organisation and their individual care and support. We look forward to seeing how this service continues and develops the excellent work that it has been doing.”

How this resulted in improved outcomes for the service itself?

The people we work for have a real say in how their support, their services and the organisation improves. The creation of the CEA Team has enhanced the capture of their feedback, expertise and input. This in turn improves the services Loretto Care provides.

What challenges did the organisation face? How were these resolved?

One challenge is ensuring people have the skills and confidence to have their say, be heard and speak up for themselves and others. To resolve this, personalising the way each person we work for engages in participation, is essential. The CEA Team works with people one to one and in groups to identify the support people need to engage in the opportunities and to build their skills and confidence.

Are there any resources or top tips to share?

Every person will want to engage in different ways. Traditional methods of participation and engagement such as meetings may work for some people but not for others. Personalising the way each person engages in meaningful activity or participation is essential. Meaningful activity is an opportunity to engage with individuals, which can lead to wider involvement. We have also piloted the use of technology to reflect changing demands of how and when people will want to engage in support provision.
Having the time to spend on improving participation and engagement is crucial for success. Having a dedicated team is making a difference within Loretto Care. The CEA coordinators have a different relationship with the people we work for. They have time to spend with people, gradually identifying how individuals want to engage and what support they need.
Title: Genuinely involving the community

Name of the organisation and brief description of nature of its business:

Ormerod Trust is a charity that provides care and support to adults and children with a learning disability across the Fylde, Blackpool, and Wyre areas of Lancashire. Every person we support has a personalised service designed around them – this makes sure the service fits around the person, and never the other way around.

Our services include supported living, domiciliary, specialist support and a large choice of different community groups to choose from. We are focussed on supporting people to achieve wellbeing, maximise independence, uphold their rights, achieve their personal goals, and take control of their own lives as active and valued members of their local community.

Our commitment is to provide a service that is based on individuality, innovation, and independence – all in the heart of the community.

Contact person: Kyla Hunter / Daniel Jones

Email: info@ormerodtrust.org.uk

Phone: 01253 723513

Personalisation activity: Flexible and integrated support

Who was involved?

The person we support (JR), her friends, community, support staff, commissioners.

Description:

JR is a lady who previously lived in what could be described as a ‘conventional supported living setting’ where there was support during the day at all times on either a shared basis / 1:1 and a sleep-in member of staff at night. Whilst JR likes where she lives and the people with whom she lives it was clear from her person centred plan that she wanted time without support. This raised the challenge that is often encountered around needing to balance risk, safety and independence.

JR is well known in her local community where she has friends and associates examples include her local church, cafes, and a local friendship group (none of these are for people with a learning disability specifically). She also likes to attend a local dancing group, visit our office which is located in her community, and go on holidays. JR also likes to attend evening events such as drama and musicals which often go beyond the start of conventional ‘sleep in’ shift times and she needs her support to be flexible to accommodate this.
We worked with JR to design a service that utilises her community. She attends her church and accesses her local groups without support and has an emergency pendant if she were to have an issue and somebody was not there to help.

**Time frame:**

The outcomes in this example were achieved over a 12 month period but it is important to realise that community inclusion and genuine involvement is an ongoing process, not one that can be ‘ticked off’ as complete as things in the community change, choices and preferences change. A culture of continually trying to improve things and challenging barriers in the community is critical for ongoing success of the people we support.

**What evidence have you had that this has improved outcomes for individuals using services?**

JR is actively involved in her community without paid support, she is not just present but she actively participates and contributes to her community. For example she took a lead role with the placement of Baby Jesus in the crib at Christmas time as part of the church Christmas service.

JR is known and welcomed in her community but where she has faced prejudice we have robustly challenged this and educated people to ensure she could access her activity without feeling isolated.

JR tells us what she wants every day and she also attends the service user forum in which she takes an active part.

JR chooses the staff she wants the have the right culture and values to deliver services the right way.

**How this resulted in improved outcomes for the service itself?**

Our staff are hugely motivated by JR being as independent as possible, as a result this creates improved job satisfaction.

By sharing the community contacts and lessons learnt in the service we have been able to share this with other people who have similar interests and goals so they have also been able to benefit.

Staff see that this approach is fully supported and backed by management and trustees and this helps build confidence and trust.

**What challenges did the organisation face? How were these resolved?**

Creating a balance between opportunities for independence and maintaining safety in the 'worst case scenario'.

Ensuring the community was supportive.
Ensuring creative and flexible rotas were in place.

**Are there any resources or top tips to share?**

The right organisational culture is key, these approaches need to be publically endorsed and have the support from all grades of the organisation from Support Worker to CEO. Organisations must be willing to maximise unpaid support and community inclusion and be more outcomes focussed – this includes being honest that reduced financial revenue as a result is actually a good thing as it shows that the support is working.

Work to establish **genuine contacts and real opportunities** with your local community, there is too much tokenism in support providers saying these links exist when they do not. This takes time, effort, and cost but any provider that truly values community inclusion and independence of the people it supports will see this as an essential part of the service not an ‘optional extra’.

Things rarely happen by chance so use **community inclusion tools** to move people from simply being present to actively participate. By using these we can be honest with how involved somebody genuinely is e.g.

![Presence to contribution diagram](image)

To deliver truly person centred services we must unlock the capital of the communities that people live in. Use **social inclusion webs** to map out the places and people involved in a person’s life, be proactive in working with the person to move from paid support to community inclusion e.g.
Without dedicated and good staff who have the support of their manager it will not work. Consider supporting the person to create a staff profile to match staff to the person and include them in interviewing e.g.

A supportive commissioner with a shared approach to risk is important. Risk can often be balanced by using an important to / important for approach to look at what the person wants and what might need to be put in place so they do what they want in as safe a way as possible.
Title: Back of the Net/Studio Radio.

Name of the organisation and brief description of nature of its business:
SAHA (Newhaven Foyer) is a Registered Provider delivering varied housing services across the UK. Newhaven Foyer delivers a housing support service to 37 16-25yr olds experiencing homelessness.

Contact person: Anna Cooley-Greene

Email: anna.cooley-greene@saha.org.uk

Phone: 01273615301

Personalisation activity: Back of the Net/Studio radio

Who was involved? Numerous residents in the two years we have been delivering the programme.

Description: Back of the net is a programme run in partnership with Brighton and Hove Albion’s Albion in the Community. The programme has football as its focus however it offers support in relation to employability skills, confidence and self-esteem. The programme offers young people the opportunity to gain qualifications which can support their journey to education and employment.

Studio Radio is delivered in partnership with Rhythmix. Newhaven Foyer has a recording studio and the weekly sessions offer young people the opportunity to use creativity to make music and write lyrics. The programme has set up its own website to sell music which they have made. Any profits will be channelled back into the programme to support its development.

Time frame: The programmes are on-going as we have accessed funding from differing streams to support this. Studio Radio additional funding was from the Amy Winehouse foundation and Back of the Net year two has been funded by the Sussex Police and Crime Commissioner.

What evidence have you had that this has improved outcomes for individuals using services?
I have attached a case study for a young person who was involved in both programmes with amazing outcomes. Young people who have entered the service in chaos and been challenging to engage have commenced their trust within the service via these programmes.
How this resulted in improved outcomes for the service itself?

The outcomes for young people who have engaged are reflected when they leave the service. The programmes are part of our wider foyer offer which provide young people with opportunities to develop talents and skills alongside the ability to be able to sustain a tenancy. Our programmes over the past two years have seen a significant lessening of ASB within the services.

What challenges did the organisation face? How were these resolved?

Staff time required to deliver the programmes. We factored this into the programme costs to ensure that staff involved are not those responsible for the delivery of our service specification. We also work with partner agencies who deliver the programme in conjunction with us.

Are there any resources or top tips to share?

Ensure that the programme is one clients wish to engage in.
Write the programme outlines and specification with clients.
Make sure you factor all costs into the funding applications and programmes.
Name of the organisation and brief description of nature of its business:

Shared Lives Plus

Contact person:

Tim Moore

Email: tim@sharedlivesplus.org.uk

Phone: 07881 521269

Personalisation activity:

In Shared Lives a Shared Lives carer shares their home and family life with an adult who needs care and support to help them live well.

Who was involved?

There are around 13,000 people across the UK supported in Shared Lives arrangements and over 150 Shared Lives schemes.

Shared Lives arrangements are an option for people with Learning Disabilities, and increasingly for people with support needs related to mental health, dementia, older people and physical disabilities.

Description:

- A Shared Lives carer shares their home and family life with an adult who needs care or support to help them live well.
- Shared Lives Plus’ UK wide network of local, regulated schemes individually match trained and approved Shared Lives carers with people who need their support.
- People are increasingly choosing Shared Lives over other forms of care because it’s a unique way to live well and feel independent but not alone.
- The Care Quality Commission consistently rates Shared Lives as an exceptionally safe and effective form of care, and in addition Shared Lives delivers major savings for local councils and the NHS compared to traditional forms of care.

Time frame:

Around half of people in Shared Lives arrangement use Shared Lives for long term support, whilst others access Shared Lives as a short breaks option for a number of days a week.
The length of Shared Lives arrangements vary depending on circumstances and the wishes of those involved – but some Shared Lives arrangements can continue for 30 years or more.

**What evidence have you had that this has improved outcomes for individuals using services?**

87% of people working in Shared Lives have seen their support had improved the mental health of participants, and three quarters have received positive feedback from an NHS professional about the effect of their support on the health of people in Shared Lives. Half of Shared Lives carers have supported someone they care for to directly access the NHS in a way that they may not have been able to via other forms of care or support.

People who use Shared Lives services tell us they feel less isolated, make new friends and are better supported as a result.

90% made new friends via Shared Lives, half went on holiday for the first time and a quarter joined a club that was not exclusively for disabled people for the first time.

**How this resulted in improved outcomes for the service itself?**

Out of the 20 Shared Lives schemes inspected by the CQC, 2 have been rated outstanding and the rest good. This compares very favourably with other forms of care/support. Shared Lives also saves authorities on average £26,000 per person, per year for people with Learning Disabilities, and £8,000 per person per year for people with support needs related to mental health.

**What challenges did the organisation face? How were these resolved?**

**Are there any resources or top tips to share?**

Please see [www.sharedlivesplus.org.uk](http://www.sharedlivesplus.org.uk) for more information

**Claire, a Shared Lives Ambassador says**

It’s hard to know what good is when you have not had it. More people need to know about Shared Lives. They need to know it is not about being stuck in a flat on your own. It is not about being lonely. It is about family. It is about having choices. It is just lovely. It is a good life. My message to you is that everyone should be able to have a good life. Everyone should have the choice.
Title: Supporting people on their journey towards independent living

Name of the organisation and brief description of nature of its business:

Together for Mental Wellbeing is a national charity that supports people with mental health issues to lead fulfilling and independent lives. We value people as experts in what works best for them, and each individual we work with influences and shapes the support they and others receive from us.

We work with approximately 4,000 adults every month in around 70 locations and our services include support in the community, accommodation-based support, advocacy and criminal justice services. For more information, visit www.together-uk.org

Contact person: Sarah Thompson-Turvey

Email: contact-us@together-uk.org

Phone: 020 7780 7300

Personalisation activity: “Flexible integrated care and support: my support, my own way”

Who was involved?

Quality team, central management team, service users and project staff

Description:

Together for Mental Wellbeing provides around 10 supported accommodation services across England. These services support people with mental health issues who are preparing to move on to independent living.

They offer a personalised approach, tailoring support to meet the needs of each individual, and therefore offering people greater choice and control over the support they receive.

The support each individual receives includes working with people to build on their strengths, skills and resilience, helping them to develop their own set of resources to self-manage and stay well.

Together also supports people to manage general housing issues, benefits and finances and supporting them to identify and engage with training, volunteering and employment opportunities in line with their personal recovery goals. Together also helps them to develop hobbies and engage in social activities, building informal and personal support networks to protect against relapse.
The aim is for each person to become equipped to live an independent, fulfilling life in their community. When people are ready to move out, the staff offer a transitional service, including help with funding arrangements.

To ensure that all of Together’s services offer the same approach, in its supported accommodation services and beyond, it has developed a Model of Support. This is based on four principles which underpin how staff work with every individual, no matter which service they use.

Alongside this, it has developed a range of tools and processes that correspond to each step on the customer journey to ensure it consistently applies its approach to support planning, feedback and risk management. In doing so, it ensures all of its services adhere to the same principles and that people using its services always receive high quality, personalised support. When redesigning the paperwork it uses throughout the support planning process, Together consulted with people that use its services. By doing this, Together was able to ensure that the language used is as accessible and relevant as possible, and that the process enables people to be at the centre of their support.

Together’s model of support:

- **Seeing the whole individual**
  - We focus first on the individual as a whole person with a range of circumstances and needs.

- **Compassionate enquiry**
  - Trauma and distress impact people differently and our capacity to bounce back varies from person to person. Understanding where people see themselves helps us to tailor support to their specific needs.
  - To put this into practice, we ask people in their first meeting to tell us on a scale of 1-5 where they feel they are at now in terms of mental and physical health and social skills, where they were before and where they would like to get to.
  - We also carry out a needs assessment covering how we can support the person, what has helped in the past and where they would like to be in five years time.

- **Doing it together**
  - We work alongside each individual as they progress towards recovery on their own terms, our ultimate aim being that they will eventually be independent enough to manage without us.
  - To do this we have created a 'staying well plan' which asks people what recovery means to them and what they will do to achieve it. This includes a daily maintenance plan, what they would like to achieve, how they can develop coping strategies and monitor triggers. They don’t have to share the plan with us but they can if they want to and we can offer support at any stage.
  - At this stage we also work with each individual to set goals, decide when they want to be achieved and how we can support them to do so.
**Planning for the future**

- We start by finding out what outcomes people want to work towards and support them to develop their own tools, approaches and support networks to achieve these.
- We ask people ‘how’s it going’ covering where are they now, what steps they are taking to get to where they want to be and what is and isn’t helping. We also ask if they are happy with our support.

The paperwork also enables people to provide honest, confidential feedback about their support, so that we can continually improve what we offer. We want to know how people are doing once you have stopped receiving our support. What helped, what didn’t, where people want to go in the future, what they have achieved, what we could have done better, and we use this to continually improve our services.

**Time frame:** 3 years

**What evidence have you had that this has improved outcomes for individuals using services?**

We recently carried out a survey across 21 of our accommodation services, including a number of supported accommodation sites. We found that:

- 87% of people have a support plan in place that outlines the support that they want
- 81% of participants either strongly agreed or agreed that they could take a lead in planning their support plan
- 67% of people had plans for the future

These findings indicate that people within our accommodation services are taking responsibility and ownership over how they are supported and this has led to a positive impact on their plans for the future.

**How this resulted in improved outcomes for the service itself?**

Our satisfaction surveys show that people are pleased with the support they receive from our services. For example:

- 93% of people said that our Support Workers were good at their jobs
- 83% of people said the support they get is very good

By making our support planning as straightforward as possible, people can set meaningful recovery goals, and we can work with them towards the outcomes they want to achieve the most. This has been shown to have a real impact on what people are able to achieve.

**What challenges did the organisation face? How were these resolved?**

Creating a model of support, agreed by all, was not an easy task. The process included obtaining feedback from our National Steering Group. From this we learnt
that it was important to stress that the answers people gave on the form would be kept private and confidential, so we put this in a more prominent place on the form. We also changed a few things so that the form didn’t just ask general questions like ‘were you satisfied with the support’, but instead asked for specifics, such as, ‘was your support worker always on time’. This gave us tangible feedback and things to act upon if necessary.

**Are there any resources or top tips to share?**


“I feel at the epicentre of my recovery. It is my choice what decisions are made and this alone has had a very positive impact.”

“The support from Together has been of the highest level, I regularly feel lucky to have the support that I’m receiving.”

“I can't sing Together’s praises enough. No matter what else is going on in my life, they make me feel safe, secure, uplifted and equal.”
Title: Summer Fit Club

Name of the organisation and brief description of nature of its business:

Chapter 1 – Turner House

Supported housing for 11 young mums aged 16-25

http://www.chapter1.org.uk/turner-house--st-leonard-s

Contact person: Jean-Paul Dunin (Service Manager)

Email: jeand@chapter1.org.uk

Phone: 01424 427613

Personalisation activity: Summer Fit Club

Who was involved?

7 clients (age range 17-24). Five had babies or young children and two were expectant mothers.

All participants were white UK and none had a recorded disability; however six (86%) had reported experiencing mental health issues ranging from anxiety to bipolar disorder.

Description:

Turner House received a bursary from East Sussex Supporting People Team for the development of a project for the personalisation of services. A number of strands were developed including Individual Client Budgets; and clients were (and have been since) actively involved in service development. The development and successful implementation of the project; and activities such as Summer Fit Club would not have been possible without the support of the SP team.

This was an 8 week programme co-produced with the clients at Turner House. The idea came from discussion at a house meeting where the group considered health issues and agreed to design a programme that would:

- Be accessible to all clients at Turner House (and young people who had previously used the service)
- Be free to participants or have a minimal charge
- Would include activities that all would enjoy, or be able to pick and choose
- An opportunity to signpost to other healthy living activities such as smoking cessation
Time frame:

Planning/co-design/co-production: 4 weeks – May 2015
Delivery: 8 weeks – June/July 2015

What evidence have you had that this has improved outcomes for individuals using services?

Participants were asked to complete feedback following the sessions and all reported the following:

- An increase in feeling healthy
- More energy
- Increased motivation to exercise
- Greater confidence to continue exercise

Three participants were signposted to smoking cessation (Quit 51).
Two participants accessed weight management resources.
Turner House procured more resources for clients (information and signposting)

How this resulted in improved outcomes for the service itself?

Health and wellbeing is an increasingly important factor when developing service outcomes. Information and data provided from the programme supported a bid for CCG reducing health inequalities funding.

It is important for Turner House to be able to evidence health improvement within our contracted outcomes and our personalisation approach supports this.

For future planning and development, we are able to use our outcomes and learning to support our alignment with Adult Social Care and CCG priorities including East Sussex Better Together.

What challenges did the organisation face? How were these resolved?

The main challenge for innovation at Turner House is childcare. As all clients have, or are expecting, young children; access is almost universally restricted if childcare is not available. We address this as much as possible by providing in-house activities however there remains the risk of disruption. We are sometimes able to facilitate a level of supervision within the staffing structure and we encourage clients to mutually support each other. This approach is not however ideal as it prevents community engagement/involvement and severely restricts a truly personalised approach as choice is limited. We continue to seek innovative and cost neutral solutions to this most enduring barrier.
Are there any resources or top tips to share?

Co-production works! Have clients involved at the onset – even before any service planning takes place. By doing so and identifying at least one champion you are setting out from a person centred base.

As a result of the project, we have skills and experience here at Turner House – this is a

“It’s great to be active in the garden and I could do the exercise without being laughed at in a gym” – Katie (not her real name).