To: Leadership Board

On: 04 December 2019

Report by: Chief Officer, Renfrewshire Health and Social Care Partnership

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Heading: Adult Social Work Services – 6 Monthly Update Report 2019/20

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1. Summary

1.1 Adult Social Work Services were delegated to Renfrewshire Integration Joint Board (IJB) on 1 April 2016. These services are managed through the Health and Social Care Partnership (HSCP). Six monthly reports are provided to the Leadership Board outlining key activities and providing a summary of current performance.

1.2 This report provides an up to date summary from June – December 2019.

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2. Recommendations

2.1 It is recommended that members note:

- the contents of this report updating activity and performance of adult social work services delegated to the IJB; and
- that the 2019/20 annual performance report will be presented to the Board on 17 June 2020.

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3. Background

3.1 The list of functions that must be delegated by the Local Authority to the IJB is set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions, etc) (Scotland) Regulations 2014, and is noted in Annex 2, part 1 of Renfrewshire's Integration Scheme. These include:

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers' support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Respite provision
- Occupational therapy services
- Reablement services, equipment and telecare

3.2 Whilst regular reporting in relation to these services is reported in detail to the Integration Joint Board (IJB), it was previously agreed that regular updates would be provided to the Leadership Board in relation to the delegated services. This ensures oversight of the key achievements, challenges and wider context relating to the delivery of these services.

4. National Direction

4.1 Public Health Reform

4.1.1 Despite improvement over time, average life expectancy in Scotland remains significantly lower than in other countries of the UK and the rest of Western Europe. There are also marked differences between the most and least deprived areas of Scotland.

4.1.2 The Public Health Review published in February 2016 described how public health can work more effectively to increase healthy life expectancy and reduce inequalities. In responding to this review, the public health reform programme was established and is a partnership between the Scottish Government and the Convention of Scottish Local Authorities (COSLA) and has three key components:

1. the development of Public Health Priorities
2. establishing Public Health Scotland
3. the development of a whole system approach to public health.

Public Health Priorities

4.1.3 The Scottish Government and COSLA agreed six Public Health Priorities in June 2018. These are intended to support national and local partners across Scotland to work together to improve healthy life expectancy and reduce health inequalities in our communities. The priorities are:

1. A Scotland where we live in vibrant, healthy and safe places and communities.
2. A Scotland where we flourish in our early years.
3. A Scotland where we have good mental wellbeing.
4. A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
5. A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
6. A Scotland where we eat well, have a healthy weight and are physically active.

4.1.4 The Scottish Government and COSLA are currently building on the approaches and engagement that have helped develop the priorities, in order to drive a strong focus on effective partnerships of national and local government, the NHS and wider public services, the third and private sectors and communities themselves.

Public Health Scotland

4.1.5 A new national public health agency is being established, which brings together three domains of public health into one organisation. Public Health Scotland will come into being on 1 April 2020 and will be comprised of: NHS Health Scotland; Health Protection Scotland and Information Services Division.

4.1.6 In July 2019, Professor Jim McGoldrick was appointed the Shadow Chair of Public Health Scotland. This was followed by the appointment of the first chief executive Angela Leitch in September 2019. Public Health Scotland will have a key contribution to make in supporting the delivery of these priorities, with a focus on supporting the delivery of change at a local level, and providing data, intelligence and leadership in digital innovation.

4.2 The Public Bodies (Joint Working) (Scotland) Act 2014

4.2.1 Integration Schemes offer a blueprint for the delivery of integrated services, setting out how the partner organisations, the Health Board and Local Authority, will locally work jointly to integrate and plan for services in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014. The partner organisations, Renfrewshire Council and NHS Greater Glasgow and Clyde must carry out a review of their Integration Scheme every 5 year for the purpose of identifying whether any changes to the Scheme are necessary or desirable.

4.2.2 In line with the Act, the Renfrewshire Integration Scheme must be reviewed by June 2020. The Schemes will be updated to reflect progress made with integration, the proposals / recommendations made in the Audit Scotland and Ministerial Strategic Group Review of Integration. This approach will allow greater consistency in approach and will also enable any amendments to all the existing stated hosted arrangements to be jointly agreed. Prior to being submitted to the Scottish Government for approval, the revised Integration Scheme will require to be agreed by both Renfrewshire Council and NHS Greater Glasgow and Clyde Health Board.

5. Partnership Activities relating to the delegated functions

5.1 Modernising our services

5.1.1 Renfrewshire HSCP has a Change and Improvement Programme which is focused on proactively developing health and social care services in line with national direction and statutory requirements. The programme is delivered by the following four workstreams:

1. Optimising joint and integrated working and shifting the balance of care.
2. Statutory Requirements, National Policy and Compliance.
3. Service Reviews.
4. Delivering Safe and Sustainable Services.

Workstream 1: Optimising joint and integrated working and shifting the balance of care

5.1.2 This workstream seeks to establish a health and social care service managed and delivered through a single organisational model, unlocking the benefits which can be derived from streamlined, joined up and wherever possible, integrated working.

5.1.3 A number of service improvements/developments are ongoing:

- Work to build an effective and dynamic approach to ‘locality’ and ‘cluster’ based working, and to build collaboration and joint working between services to better support the needs of local patients and service users.
- Implementation of a Joint Unscheduled Care action plan with colleagues in the RAH, which aims to demonstrate how the HSCP can reduce demand on Acute Services and create a compelling case for resource transfer.
- The Care at Home Services Transformation Programme has been continuing to work with staff, service users, trade unions and partners to develop services which will enable us to better manage the ongoing demand for our services, within current budgets, whilst supporting people to remain as independent as possible with their own home.

- The HSCP has formally agreed a contract with Totalmobile Ltd to provide the Care at Home Scheduling and Monitoring System which officially commenced from 29 April 2019. Initial testing and setup up of the new system is underway with Care at Home staff, which will inform the full implementation approach. Full implementation is scheduled for the end of 2020.

Workstream 2: Statutory Requirements, National Policy and Compliance

5.1.4 The current work programme for this workstream includes: the GP Contract; the requirement to upgrade telecare equipment from analogue to digital; embedding Self-Directed Support (SDS); delivery of the new Dementia Strategy; the introduction of Free Personal Care for Under 65s; the replacement of the Social Care Case Management system and the Supported Living Framework.

More recently, the HSCP together with its partners has undertaken Scottish Government self-assessments in relation to health and social care digital maturity and the Ministerial Steering Group's review of health and social care integration.

- Digital is central to addressing the challenges and realising the opportunities we face in health and social care, and it has a key role in developing the ways that we improve health and wellbeing outcomes through tailored, person-centred care. The digital maturity assessment aims to baseline, measure and enable ongoing monitoring of the readiness of all NHS Scotland, Local Authorities and Integration Authorities. The overall outputs will be used to review, shape and re-design services using the correct resources in the right place and at the right time as part of the Scottish Government's Digital Health and Care Strategy. It is intended that the self-assessment will be completed every 18-24 months as progress is made towards delivery the ambitions of the strategy.

- As detailed in the 2018/19 Annual Adult Social Work Services report to the Leadership Board on 19 June 2019**,** a Ministerial Strategic Group for Health and Social Care undertook a 'Review of Progress Under Integration Authorities' and produced a set of 26 proposals.

  The Ministerial Strategic Group required every Health Board, Local Authority and IJB to evaluate their current position in relation to this report and the Audit Scotland report, and take action to make progress using the support on offer. Renfrewshire's evaluation has been submitted to the Scottish Government and an action plan approved by the Integration Joint board is currently being implemented.

Workstream 3: Service Reviews

5.1.5 In June the Integration Joint Board approved several service reviews, an update on each of these reviews is as follows:

1. Learning Disabilities Services – Over the last six months the HSCP has led a significant programme of consultation and engagement with carers, families, staff, providers and in particular with the people who use the service. This has informed the development of an action plan which will become the work plan for the Learning Disability Planning Group. The HSCP will continue to work closely with families, carers and staff to ensure that people with a learning disability can live their best life in Renfrewshire
2. Older People Services –.Phase 1 of the review has concluded and the intention of Phase 2 of the review is to build upon the momentum already established, ensuring that the focus is on delivering the best possible outcomes and quality of life to all older people in Renfrewshire, with a clear emphasis on supporting greater numbers of older people to remain living in the community for as long as possible. Actions already progressed include:
    - Reinvigoration of the Older People's Steering Group
    - Formation of an Older People's Reference Group
    - Review of best practice
    - Workforce Capability – structured and comprehensive communication with staff to enable them to effectively embrace new ways of working
    - Reframing of the eight themes from Phase 1 – a review of the Phase 1 themes has resulted in two broad categories:
        - Service Themes (Health & Wellbeing / Early Intervention & Prevention / Services & Supports / People & Community).
        - Cross-Cutting Themes (Place / Partnership Working / Information and Communication / Enablers).

    These will be tested with the project Steering Group and Reference Group before being explored in detail during the co-design workshops
3. Addictions Services - The Whole Systems Review of Addiction Services has been completed and has now reached its implementation phase. To take forward the recommendations from the Review, an Implementation Steering Group has been established, supported by Renfrewshire Alcohol and Drug Partnership. Key areas of progress include:
    - Funding has been secure from the Alcohol and Drugs Partnership to refurbish the Whitehaugh Centre, Glasgow Road, Paisley to develop a recovery hub. The is anticipated that this work will be completed early 2020. In the interim, a Recovery Forum has also been established with key stakeholders who will lead the development of a programme of activities which will be provided as part of the recovery orientated system of care.

- It has been agreed that Renfrewshire will adopt NHS Greater Glasgow & Clyde Share Care Model to enhance current provision in Renfrewshire. The new model will also incorporate a training and development element and will be implemented early 2020.
- Communication and engagement with staff regarding the review is ongoing, however a series of events and briefings have already taken place.
- The post of Service Manager for Addictions has been recruited and will be instrumental in providing strong leadership in further developing a recovery and outcome focused service to meet the needs of service users supported by a highly developed workforce.

Workstream 4: Delivering Safe and Sustainable Services

5.1.6 As outlined in the Chief Finance Officer's 'Financial Report 1 April 2019 to 31 July 2019', the HSCP Senior Management Team, led by the Chief Finance Officer, has developed a two-tiered financial planning model. This will enable Renfrewshire to address our 2019/20 financial pressures, whilst in parallel introducing a more strategic approach to ensure the financial sustainability of the organisation in the medium term.

5.1.7 The short-term financial planning work for 2019/20, Tier 1, is being supported by experienced external support to provide independent challenge to SMT thinking. This work is focused on where we can derive benefits from a more integrated organisational structure. Proposals will be presented to the IJB for approval in late 2019 / early 2020.

5.1.8 The HSCP's medium term approach, Tier 2, to develop a 2022/23 Delivery Plan recognises the need for a radical programme of financial and service re-modelling which focuses on the way we work and engage with each other, our communities and our partners, all of which will take time.

5.2 Key Partnership Activities

5.2.1 The HSCP has been working closely with Healthcare Improvement Scotland on the living and dying well with frailty collaborative. This is an opportunity for the HSCP and one of our GP Clusters to work together to improve earlier identification, anticipatory care planning and shared decision-making, to ensure that people aged 65 and over living with frailty get the support they need, at the right time, at the right place. By November 2020 the collaborative will aim to:

- Reduce the rate of hospital bed days per 1,000 population for people aged 65 and over by 10%.
- Reduce the rate of unscheduled GP home visits per 1,000 population for people aged 65 and over by 10%.
- Increase the percentage baseline of Key Information Summaries (KIS) for people living with frailty by 20%.

5.2.2 Over the past 12 months, Renfrewshire HSCP and Renfrewshire Council have been working closely with Macmillan Cancer Support to develop the Macmillan Renfrewshire Improving the Cancer Journey (ICJ) project. Since the last update to the Leadership Board on 19 June 2019, significant progress has been made to further develop the project including:

- Recruitment of two Renfrewshire ICJ Co-ordinators.
- Induction and training plan for staff has been agreed by the ICJ Board and will be delivered over a four-week period commencing 2 December 2019.
- ICT, HR and managerial arrangements are in place.
- Accommodation for staff has been identified within Johnstone Town Hall.
- A service user group has been established and representatives from the group are now members of the ICJ Board.
- Engagement with existing organisations, services and groups has been undertaken and will be ongoing.
- Performance monitoring and indicators have been drafted and discussed by the ICJ Board.

5.2.3 It is anticipated that the project will receive its first referrals in January 2020, as planned. The HSCP will continue to support the development and delivery of the ICJ project in Renfrewshire.

5.2.4 The HSCP Chief Officer and members of the senior management team continue to support Renfrewshire Community Planning Partnership's Alcohol and Drugs Commission – one of the first of its kind in Scotland. The commission is working to build a true picture of alcohol and drug use across Renfrewshire to help improve life outcomes for people in our communities.

5.2.5 Since its inception in April this year, the Commission has discussed the impact that alcohol and drug use has on individuals and families, and members will make recommendations about how partners can work together to take a fresh approach to tackling alcohol and drug use.

5.2.6 One of the most important parts of the work of the Commission continues to be listening to the voices of those with lived experience: talking to service users and people in recovery. To hear these voices, Commission members have visited Renfrewshire services including the Sunshine Recovery Café, the Renfrewshire Men's and Women's Groups, Renfrewshire Family Support Group, and Renfrewshire Adolescent Drug and Alcohol Resource (RADAR).

5.2.7 The Commission will continue to review how services are operating across Renfrewshire and consider how best to reach people most in need of support, before reporting on its findings in early 2020 to Renfrewshire Community Planning Partnership.

5.2.8 A multi-agency response is typically warranted for assessment and subsequent intervention to address issues arising from hoarding that impacts on individuals, communities and partnership services. Within Renfrewshire several examples of hoarding behaviours have emerged and has led to significant resource implications, including demands on staff time and financial resource implications.

5.2.9 In recognition of the impact of hoarding behaviours, a multi-agency short life working group has been established to develop a cross-partnership approach to identifying and managing such cases. The intent is to develop interagency strategies and training as well as being a direct resource for individual practitioners.

6. Adult Social Work Performance Overview

6.1 Adult Social Work services are managed and monitored via regular internal HSCP professional governance and operational management arrangements, including meetings, case management, and regular service and case reviews. These meetings involving Heads of Service and Service Managers take place on a four to six-weekly basis, covering a variety of local and national strategic and operational indicators. They allow Managers to scrutinise and discuss performance data, agree remedial action, timescales for improvement, and consider future challenges which may affect services to allow planned actions and mitigation where appropriate.

6.2 In addition to internal scrutiny, performance is reported at every Integration Joint Board meeting, with the Scorecard presented twice yearly. The report charts data for the last three years, and where possible, associated targets, the 'performance direction of travel' and whether the indicator is currently on track to meet target. The reports provide a detailed picture of what is working well, current challenges and intended remedial action where necessary.

6.3 The Renfrewshire IJB Scorecard reports on Adult Social Work indicators alongside a variety of both local and national health service indicators. All indicators are reported under the nine national health and wellbeing outcomes. The most recently reported performance data recorded for Adult Social Work Services is detailed in Appendix 1 of this report.

6.4 To better understand the impact that our adult social work services are having on individuals and communities, a series of case studies are included within Appendix 2 of this report.

7. Current Adult Social Work Services Performance

7.1 Current performance for the 19 Adult Social Work Services' indicators is as follows:

Performance Indicator Status		No.
	Target achieved	1
	Warning	1
	Alert	2
	Data only	15

7.2 Areas of Strength – Green Indicators

The following indicator is rated green and is consistently exceeding the target of 55%.

Status	Performance Indicator	16/17 Value	17/18 Value	18/19 Value	19/20 Value	Target	Direction of Travel
	Percentage of clients accessing out of hours home care services (65+)	89%	89%	89%	Q2 – 89%	55%	

7.3 Warning – Amber Indicator

The following indicator is an amber warning given that it is 2% below target.

Status	Performance Indicator	16/17 Value	17/18 Value	18/19 Value	19/20 Value	Target	Direction of Travel
	Average number of clients on the Occupational Therapy waiting list	340	302	349	Q2-365	350	

7.3.1 It is well documented that the demand for Adult Services is increasing, over the past 3 years contacts received by the service has risen by 5% from 28,757 in 2016/17 to 30,314 in 2018/19. Given that occupational therapy (OT) assessments constitute a substantial element of these contacts, the number of assessments carried out in the last 3 years (2016/17-2018/19) is in excess of 3,400, in addition the number of reviews completed increase by 36% in the same time period from 3,777 in 2016/17 to 5,132 in 2018/19.

7.3.2 Over this period the OT service has been reorganised, resulting in improved working practice. However, the upwards trend in contact rates has continued and demands to complete assessments and reviews has impacted the services capacity, while the resource to respond has remained static. This has resulted in the upwards pressure on the OT services

7.3.3 Actions to address performance

- To address high levels of demand in particular geographic areas, managers are now allocating OT work across the whole Renfrewshire area to ensure a more even distribution.
- OT duty systems are ensuring non-complex cases are dealt with quickly and not added to the waiting list.
- Urgent cases will be seen more quickly, and lower priority may wait longer.

7.4 Areas for Improvement

The performance indicators included within the table below are rated as red and behind target.

Status	Performance Indicator	16/17 Value	17/18 Value	18/19 Value	19/20 Value	Target	Direction of Travel
	Percentage of long term care clients receiving intensive home care (national target: 30%)	27%	28%	28%	Q2 – 25%	30%	
	Sickness absence rate for HSCP Adult Social Work staff (work days lost per FTE)	3.65	4.34	4.13	Q1 – 4.64	2.40	

7.4.1 Factors that require to be considered in relation to the percentage of long term care clients receiving intensive home care including:

- The service continues to routinely review individuals home care needs and requirements which may result in amending the level and/or provision of services.

- The percentage is calculated using national criteria and excludes the support provided by our community meals service. However, where food preparation support is provided by frontline care at home staff this can be included, this therefore results in higher percentages of service users meeting the criteria of "intensive home care". The figures should therefore not be considered in isolation from our approach.

7.4.2 The HSCP senior managers are working with Renfrewshire Council services to support staff and improve attendance. Recent and planned actions to improve absence performance includes:

- HR operational teams continue to work closely with service's management teams to identify areas that require greater support. This will result in strategies to support the employees in those areas to return to work.
- A review of the current supporting attendance policies covering all staff continues. Meetings have taken place with the respective trades unions to ensure this is a fully collaborative process;
- Continued delivery of supporting attendance training at a corporate level for managers, with the provision of tailored training for managers and employees at a service level on request;
- Ongoing work to improve the absence information available to managers and to streamline supporting attendance related processes to facilitate prompt absence reporting, recording and updating of relevant systems.

8. Next Steps

8.1 The annual performance report on delegated Adult Social Work functions will be reported to the Leadership Board on 17 June 2020.

Implications of the Report

1. **Financial - none.**

2. **HR & Organisational Development - none**

3. **Community/Council Planning – none**

4. **Legal – none**.

5. **Property/Assets – none**

6. **Information Technology – none**

7. **Equality & Human Rights**

   The Recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement of individuals' human rights have been identified arising from the recommendations contained in the report because it is for noting only. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.

8. **Health & Safety – none**

9. **Procurement – none**

10. **Risk – none**

11. **Privacy Impact – none**

12. **Cosla Policy Position – none**.

13. **Climate Risk –** no risk, however a cross party working group has been established to tackle the climate emergency declaration

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List of Background Papers

None

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Appendix 1

Adult Social Work Services Scorecard as at the end of Quarter 2 2019/20

Performance Indicator Status		Direction of Travel	
	Target achieved		Improvement
	Warning		Deterioration
	Alert		Same as previous reporting period
	Data only		

National Outcome 2: People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community							
Performance Indicator	**16/17 Value**	**17/18 Value**	**18/19 Value**	**19/20 Value**	**Target**	**Direction of Travel**	**Status**
Percentage of clients accessing out of hours home care services (65+)	89%	89%	89%	Q2 – 89%	55%		
Average number of clients on the Occupational Therapy waiting list	340	302	349	Q2-365	350		
Percentage of long term care clients receiving intensive home care (national target: 30%)	27%	28%	28%	Q2 – 25%	30%		
Homecare hours provided - rate per 1,000 population aged 65+	460	459	444	Annual Indicator due end November 2019	-	-	
Percentage of homecare clients aged 65+ receiving personal care	99%	99%	99%	Q2 – 99%	-	-	
Population of clients receiving telecare (75+) - Rate per 1,000	29.13	39.47	40.17	Annual Indicator due end November 2019	-	-	
Percentage of routine OT referrals allocated within 9 weeks	-	-	52%	Q2 – 46%	-	-	

National Outcome 6: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing							
Performance Indicator	**16/17 Value**	**17/18 Value**	**18/19 Value**	**19/20 Value**	**Target**	**Direction of Travel**	**Status**
Number of adult carer support plans completed for carers (age 18+)	-	-	93	Q1 – 25 Q2 data due end November 2019	-	-	
Number of adult carer support plans refused by carers (age 18+)	-	-	78	Q1 – 5 Q2 data due end November 2019	-	-	
Number of young carers' statements completed	-	-	78	Q1 – 19 Q2 data due end November 2019	-	-	

The performance indicators identified in the table above are designed to support carers' health and wellbeing and help make caring more sustainable. These measures were introduced on 1 April 2018, as a result of the implementation of the Carers (Scotland) Act 2016.

National Outcome 7: Health and social care services contribute to reducing health inequalities							
Performance Indicator	**16/17 Value**	**17/18 Value**	**18/19 Value**	**19/20 Value**	**Target**	**Direction of Travel**	**Status**
Number of Adult Protection contacts received	2,578	2,830	2,723	Q2 – 1,542	-	-	
Total Mental Health Officer service activity	200	200	723	Q2 - 319	-	-	
Number of Chief Social Worker Guardianships (as at position)	107	117	113	Q2 - 118	-	-	
Percentage of children registered in this period who have previously been on the Child Protection Register	12%	23%	24%	Q2 – 28%	-	-	

National Outcome 8: People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged in the work they do							
Performance Indicator	**16/17 Value**	**17/18 Value**	**18/19 Value**	**19/20 Value**	**Target**	**Direction of Travel**	**Status**
Sickness absence rate for HSCP Adult Social Work staff (work days lost per FTE)	3.65	4.34	4.13	Q1 – 4.64	2.40		
No. of SW employees, in the MTIPD process, with a completed IDP	543	909	1,000	Annual Indicator Available June 2020	-	-	

National Outcome 9: Resources are used effectively in the provision of health and social care services, without waste							
Performance Indicator	**16/17 Value**	**17/18 Value**	**18/19 Value**	**19/20 Value**	**Target**	**Direction of Travel**	**Status**
Care at Home costs per hour (65 and over)	£23.56	£22.40	Due early 2020	Due early 2021	-	-	
Direct Payment spend on adults 18+ as a % of total social work spend on adults 18+	3.7%	4.25%	Due early 2020	Due early 2021	-	-	
Net residential costs per week for older persons (over 65)	£360	£414	Due early 2020	Due early 2021	-	-	

Appendix 2

Case Studies

Case Study 1: Adult Support and Protection (ASP)

Mrs Q is a 56 year old woman who lived alone. In early 2017 she became involved with alcohol services due to concerns about increasing alcohol use and potential dependency. Her first adult at risk referral was compiled in January 2018 by a staff nurse at the alcohol clinic. She was concerned about Mrs Q after she had reported a fall (to which she bruised her face) and alleged an assault had also taken place in the community. Further information was gathered from her sister that highlighted concerns that people were waiting at the local ATM for Mrs Q and they were asking her for money. Mrs Q had an established diagnosis of Alcohol Related Brain Damage (ARBD).

Under the Adult Support and Protection (Scotland) Act 2007, Section 4 inquiries took place which highlighted several vulnerabilities including excessive alcohol use, access to money, inability to maintain appointments and concerns about being exploited by others. Increasing welfare concerns were received through-out early 2018 and a risk assessment was completed recommending further ASP intervention. An AP Case Conference was held in July 2018 and Mrs Q was placed on a detailed Adult Support and Protection plan. Her Social Worker was able to build rapport through the weekly visits that the plan enforced and under the legislation shared concerns with housing, police and health services. It became increasingly clear that Mrs Q was at ongoing risk of significant harm and in addition her physical and mental health was worsening (she had a historical brain injury from childhood, was developing epilepsy and her ARBD was worsening). Hospital admission was sought and Mrs Q's status as an adult at risk of harm provided priority for available ward space.

Mrs Q was detained and hospitalised in August 2018. She was admitted into psychiatric care to assist her with an alcohol detoxification and to provide an opportunity to undertake an assessment of her mental state. Her admission also allowed Social Work to complete an assessment of needs in a less chaotic environment with input from nursing and OT. The assessment of need concluded that Mrs Q had a high level of care needs and would benefit from supported accommodation. Again, being subject to an ASP plan allowed for Mrs Q to have an increased priority for support (both in relation to a placement and budgeted support) and she was able to move relatively quickly into her new home. Mrs Q was not liable for charges for her support either whilst she remained on an ASP plan which allowed her time to settle into the routine and for a review to take place to ensure she was happy, and her needs were being met.

Mrs Q has excelled since she moved to the supported accommodation. The ASP plan ensured that Mrs Q had intensive support during her last few months in hospital and first few in the community from her care team. Regular core groups ensured that the central professionals were all aware of important information and plans of contact could be made. Mrs Q benefited from a weekly visit from at least one professional which meant any issues could be quickly highlighted and addressed and managers requested more detailed oversight which added a further layer of protection. Most importantly Mrs Q felt safe and supported. She understood people were concerned about her and that she was at risk in the past. She demonstrated insight into not wishing to return to her previous lifestyle, and has not returned to drinking alcohol. She admits she used this to cope with loneliness in the past. Now in her supported accommodation as she has access to support staff, and she advises she no longer feels lonely and therefore has no need to become intoxicated. She is now highly motivated to stay away from the individuals that took advantage of her. ASP intervention ended at a review meeting in July 2019.

Case Study 2: Renfrewshire's Learning Disabilities' Gateway Service

Ryan's Story

Over a period of many years I gradually lost most of the skills I needed to live on a day to day basis. My mobility deteriorated, and I withdrew from the activities I used to love. My hearty, baritone laugh became a barely-audible whisper. I was the drummer in a rock band at my day service. We used to raise money at our charity gig! But eventually I just sat at the drums staring in front of me. Even when prompted I didn't respond. I didn't appear interested in any of the things going on around me.

The same happened on the hill walking group. I physically slowed down, taking ages to walk a short distance. I'd often stop mid-stride, or on stairs with one foot on one step and one on another. Sometimes I'd walk sideways, slowly, stopping a lot.

At lunch I lost the ability to pick up a spoon, put it into my soup, move it to my mouth and eat it. I simply got stuck at one point in the process and had to be prompted and physically shown how to do it. Even that stopped working.

I'd still be sitting at lunch an hour after all my friends had already finished. Sometimes staff had to actually feed me. I stopped cooking and doing jigsaws. I wouldn't pay attention to the iPad or my DVD player. I lost interest in social group activities. Physical tics appeared, and I would Grimacee and seem to pull faces. I often became anxious and scared. Sometimes I would have loud outbursts: shouting, waving my hands and sweating profusely. I would often go to a quiet room to calm down.

At home my family found it extremely difficult to cope with these changes in my behaviour, especially in the social settings I used to enjoy. My sleep became disturbed and I was often tired on arrival at Gateway. My communication skills faded away – once I could use a complex picture symbols system to communicate my needs, eventually I found it difficult to recognise a single picture.

The deterioration was relentless, and nobody knew where it would end. Well, that was up until a few months ago. Something remarkable happened and I can now do most of the things I used to. My family have noticed a marked improvement in my life skills and are continuing to offer me all the love and support I need on this journey.

If you want to know what changed for me please read Gateway's Story!

Gateway's Story

Ryan's developing symptoms were closely observed and recorded by concerned Gateway staff. Gateway is a specialist autism-specific day service. Our experienced team are highly trained in strategies and interventions that support the profile of autism. These include SPELL, sensory integration, Picture Ex-change Communication System (PECS), Touch Trust, DIR Floortime, Intensive Interaction, Promoting Positive Behaviour, massage and music therapy. There are many more.

We employed the full range of our interventions to support Ryan, but nothing seemed to be working. Then there was a Eureka moment. At a conference on Autism and Movement, Gateway's team leader heard a delegate speak of Autism and Catatonia. She was struck by how similar the symptoms matched the behavioural evidence the team had been gathering.

She shared her understanding with a psychologist within the Renfrewshire Learning Disabilities Service (RLDS) team who at the time was mentoring a trainee clinical psychologist, who had neurology experience. She then compiled a report discussing Ryan, his autism, epilepsy and catatonia.

Her findings were then presented to the psychology team and a psychiatrist. This led to Ryan being given a formal diagnosis of Autism and Catatonia. The team prescribed medication for Ryan. Unfortunately, the medication could not be given to Ryan in a hospital setting, so a RLDS practice nurse became involved to monitor any potential adverse side effects. Thankfully, however, the medication had a positive impact. Ryan began to become more aware and alert.

A physiotherapist then became involved to encourage physical movement and advised Gateway staff on an exercise regime for Ryan. Gateway decided to assign a single worker to Ryan to ensure consistency in his care. He was partnered with a staff member from the Autism Connections' team who then began the process of reintroducing the PECS system. A speech and language therapist was also on hand to offer valuable advice. Ryan is now beginning to use his communication aid in various settings; at the centre, in restaurants and supermarkets etc.

He has once again taken his rightful place behind the drums in the 'Gateway Clash' rock band. His mobility has improved. His life skills and independence have increased and he is more aware of the people and activities around him.

Case Study 3: GP referrals to Integrated Alcohol Team and reducing the number of inappropriate attendances at the Emergency Department and emergency admissions

Tony, 56 years old – Alcohol Use, Gastritis (stomach complaint), Angina (heart condition), Claudication (leg complaint affecting mobility)

The GP contacted Tony, who has a long history of alcohol use but was keen to get better. The GP referred Tony to the local Integrated Alcohol Team and the Link Worker based within the surgery. He also referred Tony to Gastroenterology at the local hospital for treatment for his stomach complaint. Tony has now attended hospital and has been through alcohol detoxification. This has led to reduced symptoms and Tony's life is getting back on track.

Brian, 38 years old – Diabetes, Mental Health Issues, Alcohol Abuse

The GP contacted Brian who has multiple issues, mainly around alcohol use leading to poor control of his diabetes. The GP referred Brian to the Integrated Alcohol Team and encouraged him to keep his diabetes appointments. As a result, Brian is now drinking less and his diabetes is much better controlled.