THE DEVELOPMENT OF LEARNING DISABILITY SERVICES.

Appendix One

Case Study One

A is a young man with severe learning disability, epilepsy and autism. He is without speech and is known to present with significant behavioural challenge.

A resided in an out of county specialist residential placement from the ages of x yrs to the age of almost xyrs due to difficulties managing his behaviour.

His placement was located in a rural area with acres of wooded grounds, requiring transport to access community resources.

Family contact, although regular every fortnight , was restricted by the 2 hour journey.

In April 201x , he moved back to locality and now resides in a smaller, supported living setting which is centrally located and only a 5-10 mins drive away from the family home.

This has enabled daily access to a much wider range of local community resources and activities.

A is also able to visit the family home very regularly and more frequently, often staying overnight.

Mum is also able to just drop by or call in on her way home from work, which she often does. Mum has also been more able to participate in A's daily care and support in practical terms since his move closer to home

Additionally, A is able to have more frequent contact with extended family members like his aunt, uncle and cousins as this no longer involves extensive travelling time. This has enabled A to participate in ordinary family events and celebrations like birthdays , Christmas etc. or simply just to go out with them for his evening meal.

Case Study Two

B was living at home with his family; he has ASD and a learning disability. B's family were finding it increasingly difficult to care for B who has very ritualised and routine behaviour. B had a direct payment to enable him to access the community and give his family respite. B also has a friend, C with a direct payment and they would engage in community activities together.

The care manager coordinated discussions between a local landlord who had a house for rent close to B's home and it was agreed that B and C would have a shared tenancy in the house. It was also agreed that support would be provided to B and C by the existing P.A's by combining and increasing the two direct payments.

A support plan was agreed and B and C have been living independently in the community close to their families for 5 years. They both access a range of community groups and activities and have their own home. They are also able to maintain close contact with their families who are very happy with the arrangements.

Case Study 3

Who was the beneficiary in this particular example?	K
What was the specific issue/problem you were trying to solve in this case?	K is a former LAC to H Social Services and has resided in the Bridgend area for approximately 7 years. It was identified that K had eligible care and support needs throughout adulthood and therefore, H claimed that K was OR in BCBC which our legal team accepted. K had no transitional planning whatsoever whilst open to H social services, K was 19 years old and due to leave school in two months at the time of the referral. Further, K wanted to remain in the care of her former Foster Carers who were due to be de-registered following a child being removed from their care as a result of safeguarding concerns. K does not have capacity to decide where she lives or to consent to her Care and Support Plan, K is a vulnerable adult and therefore, placing her with carers who were likely going to be de-registered was not deemed appropriate. My role in this case was to: -Carry out a care and support/ transition assessment -Determine K's capacity to make decisions in respect of her care and accommodation -Familiarise myself with those who know K best and hold a best interests meeting in terms of her care and accommodation -Put a transition plan in place to consider accommodation, day time activities and finances.
How did they become part of this project/service?	K was referred to BCBC at the age of 19 by H Social Services. It was identified that K has eligible care and support needs and a transition plan required.
How did the project/service make a difference? What were the steps/activities that were undertaken?	Throughout the assessment I met with K several times in different settings. I met with her at school and in the care of her Carers at placement. K is able to voice some of her views and wishes and these were considered as part of the assessment. K was adamant that she wanted to remain in the care of her former Foster Carers, this remained consistent throughout the assessment process. I carried out a Capacity Assessment and determined that K lacked capacity to make this decision. Dr has carried out his

	own assessment and has concluded the same. Therefore, I held a Best Interests Meeting which included all those involved in K's care, the meeting determined that it would be in K's best interests to remain in the care of former Foster Carers despite their possible de-registration and them not being registered with a scheme to care for vulnerable adults. As a result, a plan was devised to ensure K's safety and wellbeing whilst remaining in her placement and a referral made to the Adult Placement Service requesting that these carers be assessed as hosts. The safety plan included regular visits from social worker, being seen every day by Day Centre staff and K accessing a DP Package on the weekend. The APS assessment is underway and appears at present to be very positive. I have provided references for both carers based on my knowledge and experience of working with them over the past few months to support them to continue caring for K under the APS. K was unsure about what she wanted to do after school, she was not consistent in her responses. The Bridgend College ILS Department stated that they were unable to meet her behavioural needs, therefore, in order to make sure K was seen every day to support her placement with carers, K was enrolled in Day Service.
What outcomes/changes were achieved? What was the outcome for the service user? What difference did the interventions make?	K was able to remain in the care of her former Foster Carers despite their de-registration and not being registered with a scheme to care for vulnerable adults. K has accessed Day Services. K has been assessed by the health service in terms of her physiotherapy and nursing needs.
Quotes/Feedback Please provide a direct quote from the service user. What did they say about the service received and the difference this has made to them?	When I informed K at M House that she was able to remain with her carers with a safety plan in place she stated: 'I am so happy and excited. They are my Mum and Dad.'
Next steps – how do you intend to develop this further?	K wants to explore College options therefore, I have had a behavioural assessment completed and am now awaiting a meeting with the ILS Department manager to discuss a plan moving forward. Carers are due to be presented at APS Panel and will hopefully be registered as hosts to continue caring for K.

	DOLS will be applied for, capacity and best interests documentation already completed. COP3 received from Dr also.

Case Study Four

P is a twenty-two-year-old male with a diagnosis of a Learning Disability, Epilepsy, Cerebral Palsy and Attention Deficit Hyperactivity Disorder (ADHD). Previously, P was prone to displaying physically and sexually challenging behaviours, using inappropriate and sexualised language and regularly presenting with unexplained bruising. P's Mother is physically disabled, has learning difficulties and is vulnerable to all forms of exploitation. P and his Mother were provided with a significant care and support package since P was of a young age, to stabilise P's placement at home and to manage the risks around his behaviours. However, P's challenging behaviours escalated in terms of severity, frequency and intensity resulting in him posing a risk to himself and others. This led to a Strategy Meeting with Safeguarding where the decision was made to accommodate P in his best interests.

P lacks capacity to make decisions regarding his care and accommodation provision and therefore, the decision to accommodate P was the result of a best interests discussion at a Strategy Meeting.

P moved in to emergency accommodation provision in BCBC for individuals with Learning Disabilities who find themselves in crisis.

P was supported by specially trained staff to settle into the emergency accommodation, he thrived on the routine, structure and consistency provided and his behaviours settled significantly. Staff got to know P very well and had an excellent understanding of his care and support needs. P was supported at staff throughout the Pandemic, staff were able to manage his behaviours in the most challenging of times such as lockdowns etc. P remained in emergency accommodation for quite some time, owing to the Pandemic and the MDT needing to identify the most appropriate long-term accommodation provision.

Accommodation was identified for P and he now resides in a specialist provision in Bridgend where highly trained staff are always available to meet his needs and manage his unpredictable behaviours that are associated with a change in his living arrangements. Staff at both services worked hard to co-ordinate a transition plan, share information and to settle P into his new placement successfully.

P has now settled into his long-term placement, is not displaying any challenging behaviour and has regular contact with his Mother. P and his Mother's relationship is now far more positive and P is thriving in his new provision.