Journey back to Sheffield

Forest Close

3 years in

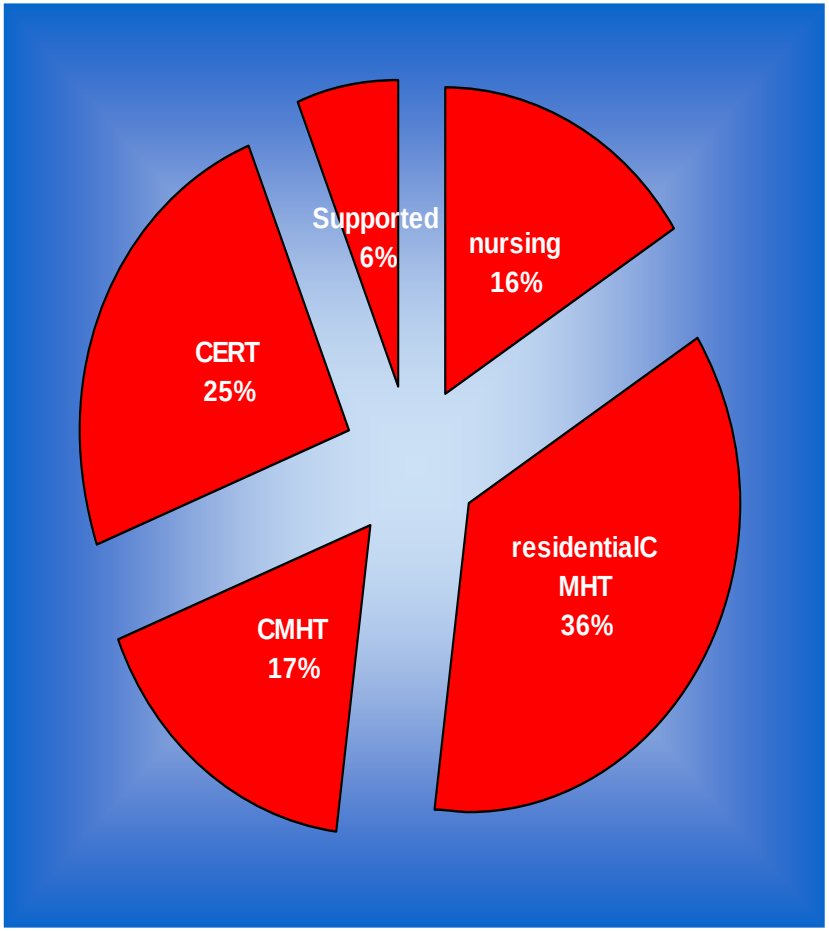
Journey begins January 2015

Old world: two wards (Forest Close + Pinecroft)

- Forest Close – 4 bungalows, 45 beds between them. All beds filled with service users that had been in hospital for over 5 years. All deemed requiring long stay/slow stream rehabilitation
- Pinecroft – 17 beds; faster paced

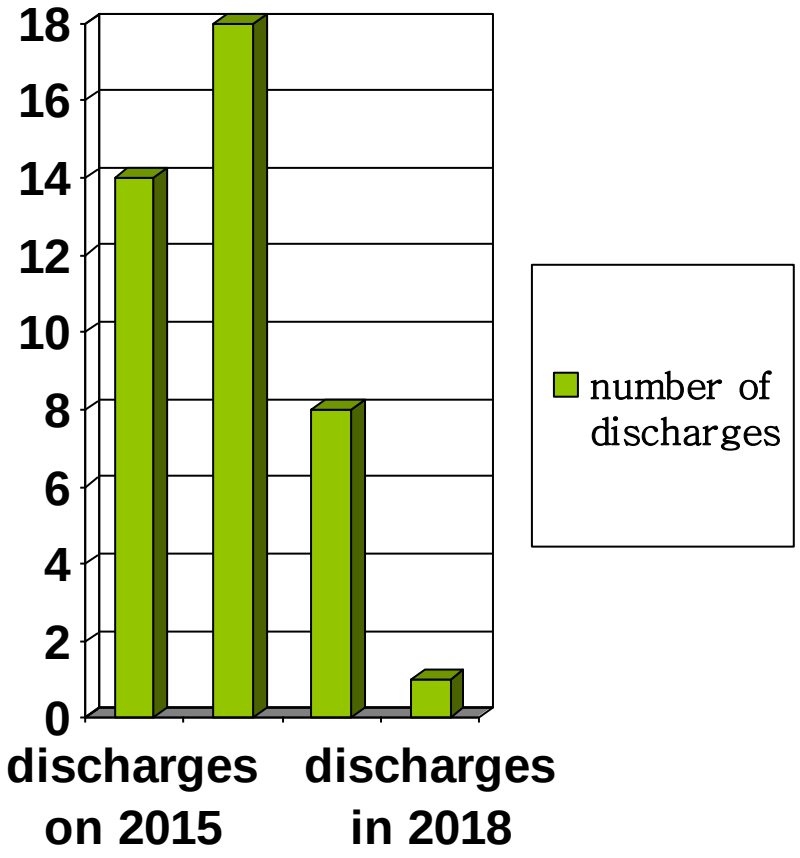
Forest Close/Pinecroft discharges

- In last three years we have had 100 discharges
- Of the original 65 clients from January 2015 only 2 remain within the service
- Both of these are working towards discharge



Out of city Work

- Out of city list had 37 clients at January 2015
- Issues -
- Outcomes – In three years have agreed to 7 going out of city. 5 of those have already been discharged
- Currently 10 out of city with 8 having clear plans to be discharged in next 6-8 weeks



Old World

- SU GT in hospital for 20 plus years institutionalised required a lot of input re discharge lot of resistance from family
- Nursing staff highly skilled empathic used to working with Psychosis and long term needs reluctance to change
- Stable workforce

New World

- SU LH Schizophrenia/EUPD out of city approx 8 years, lost hope
- Staff uncertainty about future role/provision
- Staff training, support supervision, reflective practice leadership and debriefs

Task :

- To discharge all long stay SUs at Forest Close to less restrictive environments.
- To work with the out of city SU to ensure clear pathways out of their current placements and back to Sheffield
- Don't send anyone out of city!!

Starting point

- Focus on the Forest Close SU
- Assess current needs, Liaise with the wider team/family carers and external providers
- Develop a discharge pathway, linked to ACP standards
- MDT to focus on goal setting for SU, recording discussions/challenges to ensure clear pathways out of service

Out of City Work

- Attend CPAs/discharge meetings/ organise telephone conferences and ensure discharge planning is discussed as part of this process
- Working with the care coordinators to identify appropriate move on placements
- Develop working relationships with the out of city providers

Out of City Issues

- Risk averse (Forensic teams)
- Reluctance to engage with new ways of working (resistance to change)
- Number of Learning disabilities out of city and transforming care agenda
- Distance
- Processes! Working with external teams

One Site, One Service

- Refurbishment
- In mid June 2016 moved from 65 beds to 30 beds and became one service
- Issues
- What worked well

What we learnt!!

- Holding our nerve (don't evolve into a forensic service). Positive risk taking, using least restrictive practice.
- Logistics (don't admit too many SU at once).
- Staff training - different approaches EUPD, PBS.
- Ways to minimise compassion fatigue (e.g. using reflective practice, team formulation, supervision, away days, mixing staff teams).
- Meetings with service users/relatives old SU were told "home for life".
- Working collaboratively with new service users, relatives and future care providers

Our next project!

- Preparing for accreditation of the RCPsych!