Complex needs care and support at Active Prospects

2024-2025 Review

Community Benefit Society Registration 26618R.

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About Active Prospects

Active Prospects is a charitable organisation providing high quality supported living, residential and community services, activities and employment for people with learning disabilities, autistic people, and people with physical and mental health needs across South East England.

We have received national awards for Social Enterprise, Workforce Development, Employee Wellbeing and Positive Behaviour Support, reflecting sector leading innovation and creativity.

In 2024–2025, we achieved **Great Place to Work – Large Employer** status and were the **top placed care organisation nationally**, recognising exceptional employee engagement. We also received national recognition for our wellbeing approaches, learning culture and **women's engagement.**

We are ambitious for the people we support, our staff and our organisation. We are proud of the energy, commitment and achievements that deliver our purpose: enabling people to live aspiring lives.

This review focuses on our work with people who have complex needs, highlighting outcomes achieved over the past year, summarising effective support approaches, outlining future priorities, and reflecting on current system challenges.

Intensive support enabling people with Complex Needs to live aspiring lives in their communities.

The Wellbeing Annual Report 2024-2025 by Active Prospects provides a comprehensive review of the Organisation's work supporting people with complex needs, detailing outcomes, support approaches, innovations, challenges, and future priorities.

What are Complex Needs?

Active Prospects currently supports **42 people** whose needs we define as complex, requiring an **intensive support approach.** Typically, this includes:

- Multiple diagnoses (e.g., autism, learning disabilities, serious mental illness); and
- A history of behaviour that puts the person or others at risk of harm, or significantly impacts quality of life; and
- Frequent previous placement breakdowns and/or frequent or long term hospital admissions.

17 of the people we support have experienced **more than five years** in hospital settings. Many have experienced traumatic life events, disrupted relationships and education, and may have become institutionalised.

Homes not Hospitals

Active Prospects fully supports the **Homes not Hospitals** ambition to end prolonged, inappropriate hospital stays for people with complex needs by creating high quality community alternatives.

Since 2015, we have created **48 homes** in Surrey and West Sussex specifically for this cohort. We have successfully delivered **£12m** of NHS capital grants, alongside **£4m** in social investment from Social and Sustainable Capital, mainstream mortgages via Barclays, our own investment, and partnerships with other landlords.

Our homes are **capable environments** – robust, sensory informed, and homely – using assistive technology to promote privacy and independence. We believe a home is a sanctuary: a safe place to rest, rejuvenate and be inspired to go out into the world.

Impact 2024–2025

99% placement success rate within the complex needs cohort.

11 people have now lived well for **over three years** in community placements following hospital admissions of 3–26 years.

8 new homes created for people with complex needs.

Spotlight Valley Drive, Brighton

Opened in December 2024, Valley Drive is our first complex care service in Brighton. The service has a warm, "family" feel, known as the house of fun! People support one another through difficult days and celebrate achievements as they settle into the neighbourhood.

In a short time, the team has supported people to build friendships, find voluntary roles and social opportunities, and improve health and life skills – with families integral to the team.

Support Approaches

At Active Prospects we do not believe that one size can fit all, so we have developed a Complex Needs Framework that draws on different approaches to create the right support for the person.

The framework is led by our Clinical Director, who assesses each person's needs, preferences and skills, considers compatibility with other tenants and staff preferences, and designs the support approach individually in conjunction with the person, their family and other professionals involved in the person's life.

The key approaches we use include:

Capable Environments

We plan and design our services around the needs of the individuals, creating robust homes that meet the sensory needs of individuals and are still cosy and homely.

Wellbeing Outcomes

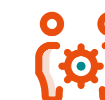
We utilise a highly developed wellbeing approach measured across eight domains on the basis that if you feel content, you are more able to cope and better equipped to manage life's ups and downs.

Positive Behaviour Support

We provide functional assessments, Positive Behaviour Support plans and behavioural strategies where needed and appropriate.

Aspiring Lives

All our support aims to achieve the same vision, people living their best life. This includes celebrating the everyday things as well as the exceptional in line with Gloriously Ordinary Lives movement. Our support plans, training and quality assurance all measure this aim.



Wellbeing Coaching

We have continued developing a social prescription approach identifying activities, experiences, and opportunities to give wellbeing a bump start or new direction. Thanks to the Mental Health Investment Fund, Suicide Prevention Grant and Nationwide, we have now supported 100 people to find their pathway to better wellbeing.

Outcomes 2024-2025

Throughout the year we track the progress and support of every person we support with Complex Needs. The following outcomes are reported monthly to the Executive Leadership Team, quarterly to the Board of Trustees, and shared more widely annually through this report.

Behaviour of Concern:

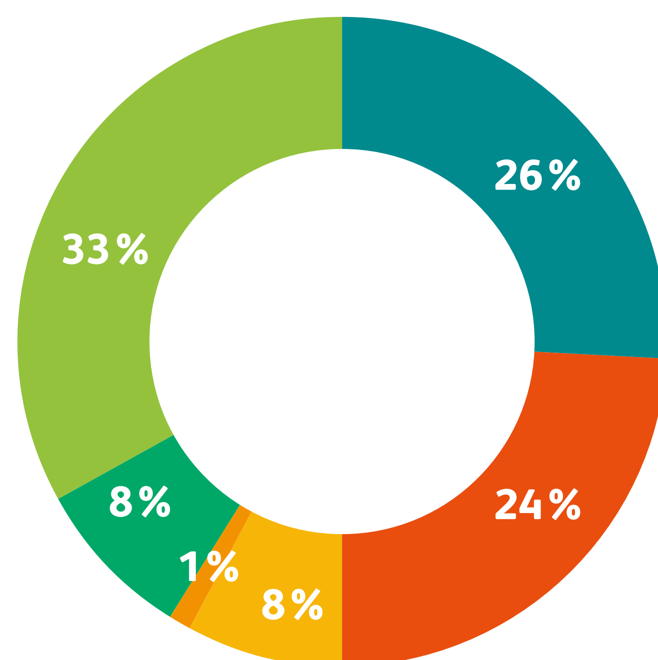
There were 1062 occurrences of behaviour of concern recorded across the Complex Needs cohort in 2024-2025.

88% of these occurrences were resolved without the use of restrictions (physical intervention, as required medication, withdrawal or increase of support).

The most common type of behaviour was Deliberate Self Harm and suicidal ideation consitituting 33% of all reporting. It should be noted that 39% of the complex care cohort have suicidal ideation and self harm risks in 2024-2025. This was discussed in last years report as there were 4 individuals who had recently been discharged with high self harm risks. However, this need has continued to be a priority for health and social care, resulting in more individuals moving into the services who have this need.

In addition, 2 individuals have experienced significant mental health decline this year, following changes in medications, which have resulted in high frequency of distress and self-harm. 32 individuals have been receiving our support for over 1 year and therefore we are able to look at change in behaviour over time.

Type of behaviour recorded 2024-25



Key data for 2024-2025

49% of people had a decrease or no behaviour of concern over the year.

51% had an increase in behaviour of concern during 2024-2025 – albeit still an overall significant reduction measured against their previous placement.

This shows that progress alongside many people is often not linear and often reflects deep complex issues.

Key reasons for increases in behaviour

25% of the complex care cohort experienced physical or mental health crisis in the last year, sometimes impacting others that they live with.

3 people (9%) had NHS-Led medication changes because they were settled and having great outcomes, it was felt they could start to reduce and cease antipsychotic medications. Unfortunately, the experience of rapid withdrawal was exceptionally difficult for these individuals, leading to 2 people requiring hospital admission whilst their medication was stabilised. This took several months to organise however, and in the meantime the impact on the placements was significant. One individual is now much better and will be returning to Active Prospects thankfully. The third person managed to remain at home with their dedicated and determined staff team, though was at risk of losing employment and a criminal record. The learning from this for both us as a provider and local services is that planned and joined up medication changes must be considered for this vulnerable group of individuals and signed off by our Clinical Leadership.

We have since reviewed our procedures to flag medication changes as high risk, allowing us to instigate planning if it is not led by health professionals. 2 people (6%) who both developed friendships and social networks, began drinking alcohol, problematically. Unfortunately, whilst staff advised and attempted to redirect this, it quickly became an addiction leading to mental health decline and increase of behaviours of distress. 1 person has made a full recovery; the other is still on their recovery journey.

2 people (6%) had physical health difficulties in 2024-2025. Both these individuals have a severe learning disability, are non-verbal and find it difficult to express pain or other symptoms. Their behaviour change indicated that something was wrong. Thankfully, staff teams, families and health professionals were able to work together to support one of these individuals through the tests required, their health issues were identified and treated, resolving their distress. The other person is still waiting for a multi-disciplinary approach to be coordinated but is currently stable.

Aside from these very specific setting events to an increase in behaviours of distress, we are able to identify the following that have impacted people in 2024-2025:

- 43% of the complex care cohort had key changes in staffing over 2024-2025. This included management changes or preferred long-term staff being promoted or leaving. These services had been settled for some time, so the changes were particularly notable. Our goal is to support as stable staff teams as possible, but some change is also unavoidable. We are always looking at ways to minimise the impact of this.
- 37% of the complex care cohort had significant life events involving family or friends. This including critical ill health, bereavement, family moving away or being unable to visit for long periods, or changes in key professionals who had been involved in their care for a long time.
- 6% of the complex care cohort were living with others experiencing mental or physical health crisis, which could be disruptive and difficult for all concerned.
- 6% of the complex care cohort had other significant life changes e.g. debts, housing, loss of employment.

Steps to Recovery

Many of the Complex Care Cohort have had difficult and challenging experiences at young ages including:

- Frequent long term hospital admissions
- Trauma and abuse histories
- Disrupted educational and life experiences

Adverse life experiences such as bereavement, long term illness of a friend or family member, debts or money worries, loss of employment have an impact on everyone's stress levels and wellbeing, but for the Complex Care Cohort this is amplified by their past experiences, or lack of experience and skills to manage change. Following discharge from hospitals there is often an extended period of anxiety about the possibility of readmission. Steps to recovery are often delayed as new routines, experiences and adjustment to every day life embeds.

Action for 2026

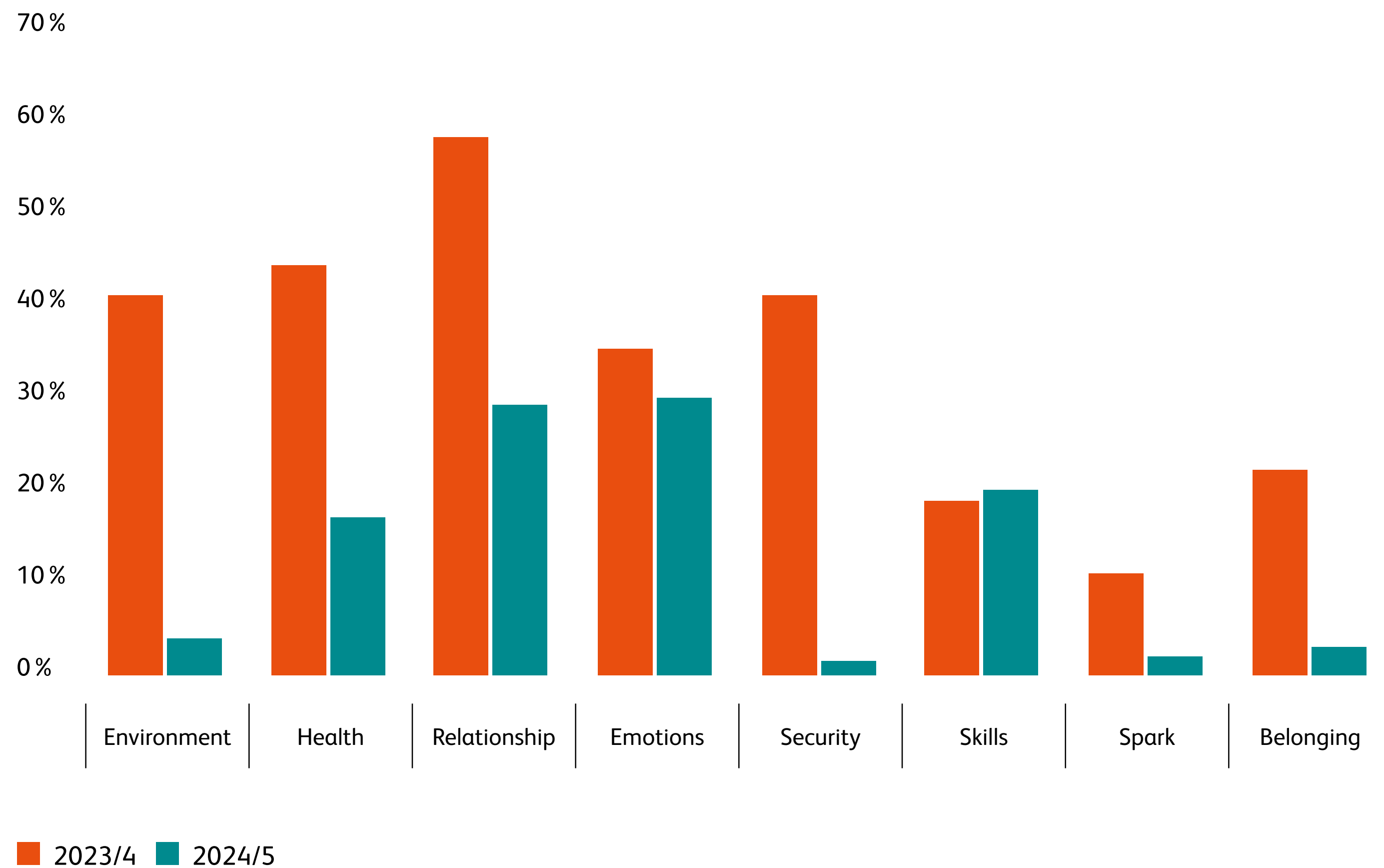
Developing a skills based programme to support people to take the next steps and manage the ups and downs of ordinary life.

Wellbeing Outcomes in Complex Care:

Active Prospects have developed a wellbeing model that we are now able to use to understand what areas of wellbeing are influencing behaviour of concern. By analysing every recorded occurrence, talking to the people we support and people who know them well, we are able to identify key areas and themes across the Complex Care Cohort over the last two years.

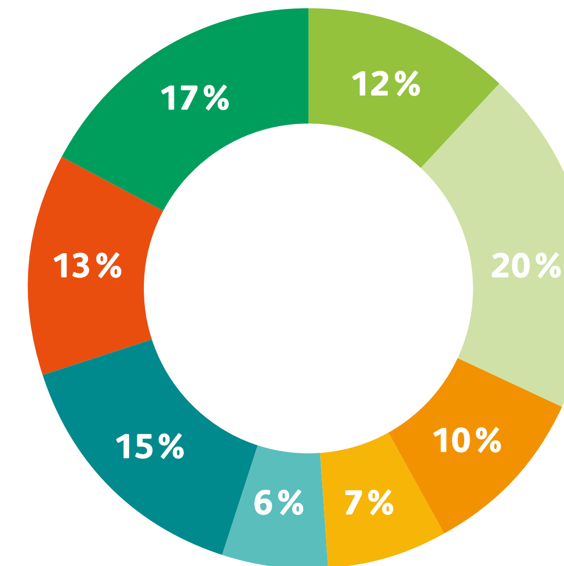
We can see from this graph the impact of gathering this kind of data and using it to target initiatives, training for staff and designing support plans with people. In 2024/5 there were specific projects, use of assistive technology, and funded social prescription with the complex care cohort on the domains of environment, health, relationships and belonging. Work began and continues on emotional regulation.

Wellbeing domains impacting behaviour



Outcomes set and achieved across Wellbeing Domains

This graph shows that goals set and achieved occurred in every domain. Examples of the outcomes are listed adjacent.



Environment

Improved sensory equipment, access to subscription tv and music, getting outdoors into nature, joining gardening groups or allotment use.

Health

Using assistive technology to monitor exercise and sleep goals, improving diet with use of Hello Fresh or Gusto, cooking classes, losing weight, accessing health care including blood tests, specialist consultant appointments and having surgery that was previously felt not possible.

Relationships

Joining new groups, making new friends, having parties or celebrations, sharing meals with others, helping other people

Emotions

Accessing trauma therapy, feelings groups, psychoeducation on emotional coping strategies and understanding emotions

Security

Use of crisis response planning and assistive technology to promote independence with support safety net, positive risk taking

Skills

Vocational qualifications, independence skills, communication skills and social skills. Improved routines, travel training.

Spark

New experiences like walking with alpacas or going to concerts, and growing experiences by joining groups with a shared spark, leading others in their interests.

Belonging

Signposting and supporting people to link in with local community groups such as Brick Stop in Caterham, Autism Friendly Community groups, Steel Band in Brighton and Include Choir. 30% of the Complex Care Cohort give their time to volunteer for causes that were important to them.

We also launched a Wellbeing Programme across East Surrey which 6 of the complex care cohort have been able to engage with. This programme also gave us very detailed data and allows us to consider the kinds of resources and social prescriptions that have impacted their lives most. A higher wellbeing score represents an improvement in wellbeing for that individual. We are most interested in people's progression and building on what is important to them.

Person	Wellbeing score before coaching	Wellbeing score after coaching	Goals set	Resources and social prescription provided
1	28	52	Moving to flat Part time employment Increased exercise Gaining qualifications	Membership of gym Vocational courses Trial of Hello Fresh Sensory resources
2	36	45	Gaining qualifications Voluntary work Social groups	Music lessons Gardening equipment Trial of Gusto Emotional Assistance animal training
3	49	61	Social groups Decluttering Vocational course Exercise increase	Sensory items Emotional regulation cards Travel training Structure and planning resources Text reader
4	45	48	Sensory and emotional regulation strategies	Sensory items Games and puzzles Emotional regulation cards Art activities
5	32	49	Sensory and emotional regulation strategies Exercise Sleep Gardening	Sensory items Tv subscriptions Gaming Emotional Assistance animal training
6	38	48	Social groups Voluntary work Nature Exercise	Social groups subscriptions Social events

The learning we have taken from use of the wellbeing outcomes tool and funded social prescription projects for the complex care cohort is:

Co-designing sensory spaces had significant benefit for autistic people. By creating more sensory elements into their homes people reported improvements in:

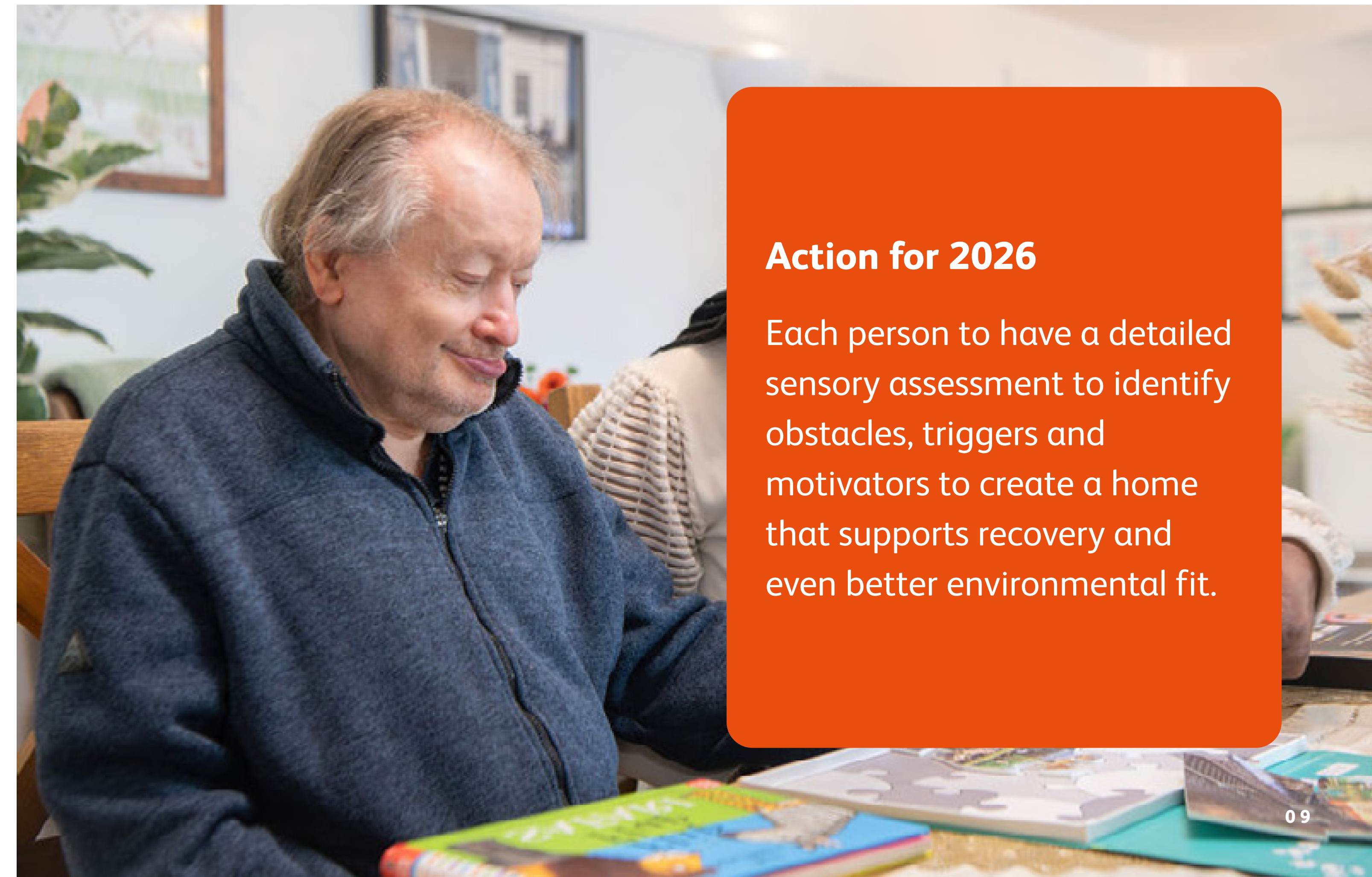
- Sleep quality
- Emotional regulation
- Feelings of safety and recovery

The type of resources that were commonly requested were weighted blankets, sensory lights, good quality sensory fidgets and storage solutions. Less common requests but with huge benefits were rocking chairs, decluttering support, different textured bowls and plates (eg wooden, metal, bamboo) and washer driers.

Getting into Nature had big benefits for this group. Incentives such as either a group activity, a separate goal that just happens to include nature, or a structured add on such as a steps counter, or a treasure hunt were much more motivating. The learning taken from this is investment in projects that prioritise nature has multiple impacts on wellbeing.

Social isolation and loneliness are alleviated with a supported and planned approach to linking people with local groups with a shared interest. People need lots of support to build confidence and be able to attend independently or even with support staff. That support can be more around transport, finances and planning for the week and day, than around finding the groups or coping with the activity.

Supported living is not funded for transport or for activities, so these things can often be obstacles that are to big to overcome independently. Temporarily funding these can provide enough motivation and opportunity to find ways to get there and continue going without funding.



Action for 2026

Each person to have a detailed sensory assessment to identify obstacles, triggers and motivators to create a home that supports recovery and even better environmental fit.

Restrictive Practise:

At Active Prospects we are committed to providing the least possible restrictions to maintain safety and take pride in being creative and having a positive approach to risk taking to achieve this goal. In 2024-2025 45 % of the people, we support with complex needs had a Court of Protection approved Deprivation of Liberty Safeguard, Community Treatment Order, or Ministry of Justice restrictions. This is a decrease of 11 % compared to 2023-2024. This decrease is due to the recent tenants being deemed to have capacity or fluctuating capacity and any restrictions being consented to. These include the following restrictions:

40% of people use assistive technology to reduce the time spent in continuous person to person supervision.

23% of Complex Care Cohort have had a reduction in hours of support required since 2020

7% of people use assistive technology to enable them to leave independently for short periods without direct supervision.

64% of people did not require any use of physical intervention

85% of behavioural occurrences were resolved without physical intervention. This included 132 recorded uses of deflection and redirection and 9 recorded uses of seated holds or walking escorts.

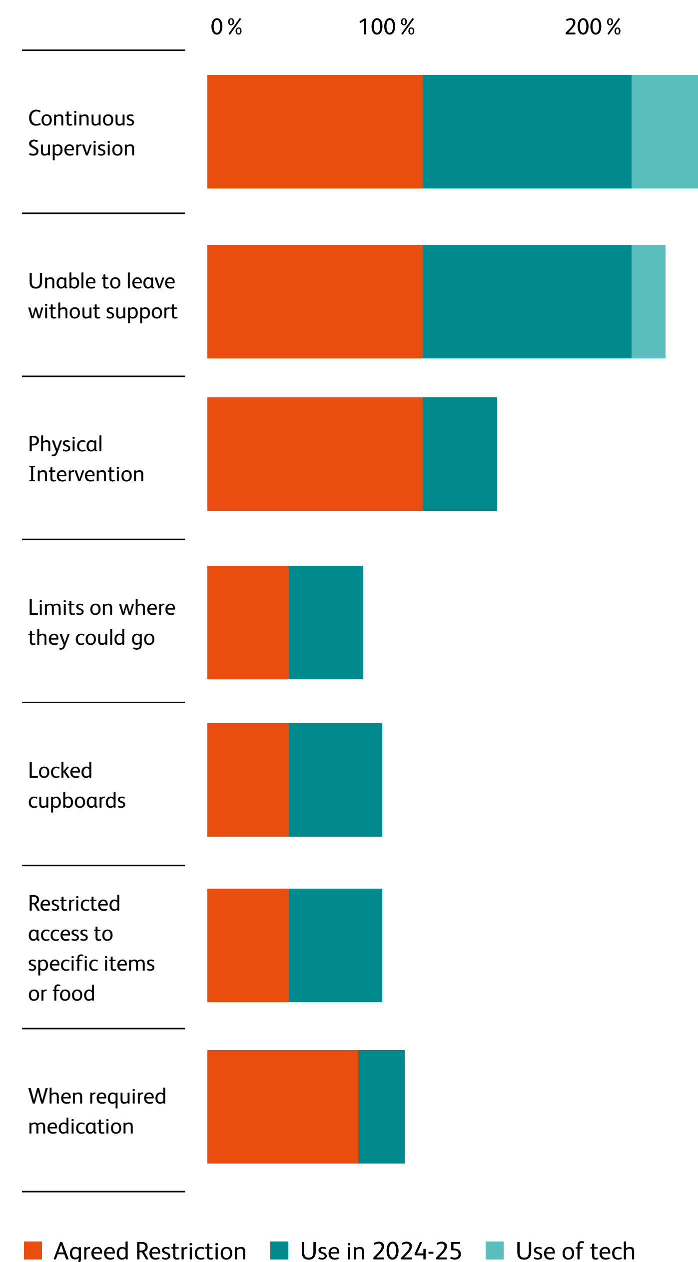
99.9% of behavioural occurrences were resolved without the use of restraint

74% of administrations of when required medications were requested by people before behaviour occurred. All of the people who requested when required medication have had long term hospital admissions.

Restricted access to specific items related exclusively to items that could be used for severe self harm including cooking knives, razors and medications.

Restricted access to food is exclusively for individuals with a diagnosis of PICA or type 1 diabetes who lack mental capacity in this area.

Restrictions agreed vs use in 2024-25



Training and Supporting Staff

All Staff employed by Active Prospects complete a comprehensive induction which is delivered by our in-house training team, this includes:

+ Medication
+ Safeguarding
+ Manual Handling
+ Emergency first aid at work
+ Professional standards in care
+ Person centred planning
+ Oliver McGowan Training Tier1 and Tier 2
+ Positive approach to behaviour
+ Wellbeing outcomes

We have a robust training schedule that has been designed to ensure that staff working in the complex care services are equipped to provide safe and effective support. All staff undertake mandatory training as stated above as well as the following additional training.

+ Self-harm and suicide prevention
+ Positive approach to behaviour*
+ Safer Deescalation*
+ Personal safety and disengagement*
+ Safer holding*
+ Autism
+ Positive behaviour support
+ Mental Health conditions
+ Trauma informed care
+ Supporting people experiencing a mental health crisis
+ Wellbeing Outcomes
+ Emotional Regulation

All new staff employed to work within the complex care homes receive all their **mandatory training within 4 weeks** of starting their employment to ensure compliance and then ongoing professional development.

Working in Partnership

Our track record is resonating regionally, and we continue to develop new services for people with complex needs.

We are working with **Surrey and Borders Partnership NHS Foundation Trust** and system partners to develop a bespoke home for two people and to reconfigure a site for a service for young autistic people in mental health crisis.

We are working with **Brighton and Hove City Council and Sussex Partnership Trust** to provide support for an individual with very complex needs.

What we bring

+ Proactive, creative collaboration with commissioners and funders to meet priority system needs.
+ Ability to attract resources to co design solutions around identified people.
+ Expertise in developing capable environments tailored to each person's needs.
+ Skilled teams delivering high quality, impactful outcomes.

*BILD certified and RRN approved.

Future Priorities and Call to Arms

We know what works to help people with complex needs live successfully in their communities: great partnerships, trusting and transparent system behaviours, and sufficient, sustainable resources.

Current challenges:

Funding pressures

Health and social care funding has not kept pace with inflation, and true joint commissioning remains rare. As a charity paid largely by the hour for direct support, options to reduce costs are very limited.

System change

Health and local government reorganisation has fragmented strategic commissioning and shortened planning horizons.

Life course investment

We need system wide recognition that investing at the right time in the right home, approach and support saves money over a person's life—and, more importantly, enables people to thrive.

Capital investment

With changing national structures, there is uncertainty about where/how central investment will be prioritised for this cohort.

Workforce parity

Although our model offers strong public value compared to NHS cost profiles, it remains challenging to secure rates that sustain skilled, stable and fairly rewarded teams. Parity is essential; charitable providers should not be viewed simply as "cheaper", especially when outcomes are better.

Capable homes

Public capital subsidy is essential, but current funding streams are small, limiting the ability to scale to demand.

Housing benefit constraints

Growing scrutiny on costs (specialist equipment, larger flats, adaptations, tenant damage) creates funding gaps that must be met somehow.

Transitions in/out of secure provision

Cross sector planning for step down and move on remains piecemeal.

Reviewing Our Goals

In the 2023-2024 Annual Report we said we would:

Publish and share the results of the Wellbeing Project for learning in the sector about support for neurodivergent people with mental health needs

This project is ongoing until April 2026, however early results have been presented at local events in Surrey, and the wellbeing outcomes tool has been shared at two co-produced events. A monthly and quarterly feedback is shared with the funding body and internally. A final report is due in June 2026.

To further develop a suicide prevention approach for people with complex care needs in the organisation

We have completed additional external training with Positive Support Group on an alternative framework for suicide prevention for autistic people. We have utilised this in organisational policy and procedure and have trained 22 people to be able to use motivational interviewing, de-escalation and co-produced crisis plans. We have strengthened our risk management approach and communication regarding people at risk of acting on suicidal ideation and continue to inform MDT of concerns.

To develop a needs based Sensory Assessment for core daily living tasks

The aims of this action is to further understand the obstacles to success, independence and empowerment for autistic people in supported living.

To develop a loneliness project specifically designed to meet the needs of people with complex care needs

We were unable to fund a specific project in this area; however we have utilised the Wellbeing Team and developed a number of small projects, information and events to promote connection for the complex care group. This is part of our wellbeing outcomes approach. Through a project entitled Moments of Joy, in which small groups of people came together to share an interest or experience something new or that they would not normally have access to, we were delighted that several people found friendship and remain in contact and doing social activities together.

Actions for 2026

To understand and evidence factors that lead to obesity in people with complex care needs and approaches that support lifestyle change.

To launch Emojo – a web-based app that tracks wellbeing outcomes, gives suggestions and encourages people to engage with wellbeing. The app will also have additional resources and videos on the home website. This gives us an opportunity to house all the tools and strategies we have to share on the 8 domains and to highlight where further resources are available.

To plan a focused project on Next Steps: For many in the complex care cohort they were discharged from hospital settings and have had disrupted attachments to others throughout their lives. Relief at having their own home and staff to guide and support them has enabled many people to achieve their immediate goals and stabilise.

Longer term planning is now needed for some individuals to really focus on next steps and learning to live adult lives with all the ups and downs that brings.

Just Roaming – how assistive technology enhances Complex Care

In 2023, Active Prospects was invited to take part in a pilot study to trial **Just Roaming**, an innovative assistive technology designed to **promote independence and safety.** The system uses discreet movement, activity, sound and heat sensors placed on doors, cupboards, drawers, beds, taps and household items such as kettles. When activated, sensors send an alert to a handheld device monitored by staff in another building. Alerts are reviewed in real time and also analysed over time to identify patterns that may indicate changes in wellbeing.

The aim of Just Roaming is clear: to provide privacy and independence, while ensuring timely support when it is most needed. Initially, we expected the technology to be particularly useful for people with epilepsy or a high falls risk – individuals who require increased monitoring to manage health risks, but not constant face to face support. However, as our understanding deepened, it became clear that Just Roaming had the potential to deliver life changing benefits for people with complex needs.

Why this matters for people with complex needs

Across social care, the profile of people requiring complex care has been evolving. Increasingly, individuals have mild or no learning disability alongside multiple neurodivergent and mental health needs. This shift is positive evidence that community providers are helping prevent hospital admissions for people with complex care needs, but it poses new challenges for the sector.

For many people we support:

- complexity lies in emotional regulation
- social isolation
- navigating a world that can be inconsistent and overwhelming

Triggers may arise without warning – from social media, unexpected phone calls, letters arriving, or difficult interactions. Responses can be intense, and the level of support required is often high.

However, many in this cohort have full or fluctuating mental capacity. They may decline support, insist staff leave, or make decisions that place them at risk. Unlike those under a Deprivation of Liberty Safeguards (DoLS), restrictions cannot be imposed without consent. This creates a dilemma: the safest option may be continuous staff presence, yet the person may not want, or legally need, someone with them at all times.

Just Roaming offers a solution, enabling:

- privacy and autonomy
- reduced feelings of being "watched"
- rapid response when support is needed
- a respectful balance between safety and independence

Benefits seen in 2024–2025

The technology has delivered significant improvements for people with complex needs. These include:

- preventing serious self harm and suicide attempts
- detecting and responding to epileptic seizures
- providing space for emotional regulation without staff physically present
- identifying patterns in behaviour, eating and sleep to inform support planning
- improving acceptance of support, as staff involvement is less intrusive
- building confidence, with clear evidence of safe periods spent independently.

Outcomes for individuals

Living independently for the first time: J has been able to move into her own flat without 24 hour on site staffing for the first time. Just Roaming allows her to:

- request support when she needs it
- live privately and independently
- feel confident that staff will be alerted to any signs of distress

Previously, J required staff availability 24 hours a day but often found this overwhelming; she would leave the service to avoid support and struggled living with others. After 10 years in hospital and 3 years in 24 hour supported living, J now has the space and stability to reflect on what she needs to live well. J experienced no incidents of self harm in 2024–2025.

Stability after a decade of hospital admissions: A had spent over 10 years in hospital settings and had multiple placement breakdowns, the longest lasting nine months. With Just Roaming, A can spend short periods alone with staff immediately available when alerted. This has helped him:

- build core life skills
- better tolerate staff time and independent time
- manage emotional dysregulation more effectively

The technology ensures staff can be in the right place at the right time, supporting early intervention rather than crisis responses. A has now lived successfully in the same home for two years, the longest stable period he has had in the community.

Jay’s journey – building stability through consistent support

Jay (name has been changed to protect identity)

Jay is a young autistic man with a diagnosis of schizoaffective disorder, a condition that can lead to periods of high energy, motivation and productivity, followed by episodes of low mood and reduced capacity to manage daily tasks. Jay also has a significant trauma history and had been in long term hospital and secure settings since the age of 10.

In early 2024, Jay moved to an Active Prospects complex care service. Initially, he was on Section 17 extended leave while a Community Treatment Order (CTO) was being agreed. Jay thrives on structure, predictability and clear boundaries, which help him to feel safe. With this in place, he quickly built a meaningful weekly routine including volunteering, exercise and social groups—activities he enjoyed and sustained.

The first challenge: inconsistent responses across services

The first major test came when Jay transitioned to his community mental health team, whose CTO arrangements were less robust than he needed. Jay began requesting frequent medication changes through both the community team and his GP. Although he had the mental capacity to understand each change he requested, he struggled to weigh up the consequences of multiple adjustments. When changes did not lead to an immediate improvement in how he felt, his anxiety increased.

Historically, when Jay feels unsafe or uncertain, he seeks out hospital environments. At this point, he began to self harm through inserting objects, requiring attendance at A&E. Without a unified plan across services, Jay received inconsistent advice depending on where he presented, which increased his sense of unpredictability and caused further escalation.

Creating consistency: a system wide agreement

To restore stability, Active Prospects worked with the local hospital, his community team, Jay’s GP and social services to establish a single, consistent approach:

- any physical health concerns would be treated in A&E.
- any mental health assessment would be undertaken only by the community mental health team.

This gave Jay clear and predictable outcomes, helping him understand what would happen when he sought help. With this in place, he stabilised and made several months of strong progress.

During this time, Jay celebrated his birthday and Christmas in his community for the first time since childhood. He began attending college and actively explored opportunities for paid employment – important steps toward living the adult life he wants.

A second setback: withdrawal of Clozapine

In early 2025, Jay asked to come off Clozapine, believing his significant progress meant he no longer needed it. The medication was withdrawn gradually, but Jay became very unwell both physically and mentally. He experienced hallucinations, had a seizure, and his sleep and appetite deteriorated. His incidents increased, and he was admitted to an acute hospital.

In hospital, the consistent boundaries and crisis plan that supported him in his community were no longer in place. Jay requested further medication changes and struggled without the predictability he relied on. After several changes in setting and medication, he was transferred to a private hospital further away, making it harder for Active Prospects staff who knew him well to share insight and maintain continuity.

Fortunately, Jay’s social worker continued to work closely with us, supporting capacity reviews and ensuring we were involved in decision making.

Next steps: Returning with stronger safeguards

Jay has now been in three hospital settings and is preparing to return to an Active Prospects complex care service—this time in a different setting, offering a fresh start while drawing on everything we have learned together.

He will return with a Deprivation of Liberty Safeguards (DoLS) authorisation in place, enabling us to prevent some of the high risk situations that led to his hospital admission, and to provide the consistent, structured support he needs to flourish.

Drew's journey – how the right environment and approach enable Drew's progress at Brighton House

A home that finally fits Drew's needs

Drew's self contained flat at Brighton House has been key to his progress. It removes the anxiety he previously felt about others entering his space and allows staff to be consistently present, helping him feel safe and settled. He now explores his home confidently, spends more time alongside staff, and chooses to join activities in the annexe – knowing he can return to his flat whenever he needs to.

What Drew has achieved in just one year

Since moving to Brighton House, Drew has made transformational progress:

- Better health and routines – significant weight loss, improved diet, and no longer relying on food incentives.
- Increased physical activity – he now requests walks, visits places like Wakehurst Place and Falmer Pond, and even completed Day 1 of the Surrey Three Peaks.
- Achieving personal goals – fulfilled his ambition to visit the Vue cinema in Eastleigh twice.
- Greater participation – attends monthly house meetings, chooses dates, prepares with social stories, and shares meals with neighbours.
- Accepting a wider staff team – a major change from previously only trusting a few individuals.
- Re established family relationships – has resumed weekly dinners with his grandma for the first time since before COVID.

What made this possible?

The team took a thoughtful, confidence based approach that has created a stable, trusting relationship between Drew and the team, this has been built on:

- Learning from his previous placement's challenges
- Providing calm, nurturing responses to early anxiety
- Introducing new staff gradually using a visual "staff you may see" guide
- Regular communication with his parents to maintain consistency and address concerns early

Feedback from family and professionals

Drew's parents describe the change as "so positive I have to pinch myself" and say he is thriving because of the caring, consistent team around him. His case manager reports he now rarely hears from the family or the service – an indicator of confidence, stability and significantly reduced incidents.

Summary

Drew is now healthier, more active, more engaged and more confident than he has been in years.

With the right environment, thoughtful support and a committed team, he has been able to rebuild routines, relationships and aspirations—showing what truly personalised complex care can achieve.

Reg's story – 2025 marked a turning point

Our Brighton House service is our first in Brighton & Hove. It contains four purpose-built flats for people with complex needs, and has quickly been nicknamed the House of Fun by Reg, one of its new tenants. After spending much of his life in care or hospital, Reg celebrated his 40th birthday this year by visiting his new flat in Brighton, the city he has always called home.

Reg's journey has not been easy. Past decisions left him vulnerable, and he spent several years in hospital, most recently returning there in 2022. **But Reg was determined to change his story.** Early in 2025, he began visiting Brighton House, getting to know his new support workers and neighbours.

With patience and planning, Reg made the move on extended leave from hospital. By August, he received the news he had been waiting for: full discharge, and the chance to begin building a new life back in his home town, as he calls it.

Now Reg has his **own bespoke flat - his home - with everything he could have ever dreamed of**. Spacious and welcoming, it gives him the freedom to enjoy his films and music, while also offering the quiet space he needs to feel settled. Working closely with the team, Reg has also developed simple ways to communicate how he is feeling day to day, helping him feel understood and supported.

When asked about his new home, Reg said, "The team are good company and supportive - and this is the best home I have ever lived in."

Adam's story – finding the right home, and the right people

Adam needs specialist support every day, and finding the right home was critical to his wellbeing and future. Like many families, his mum Annette worried about whether he would find a home where he would feel safe, understood, and able to be himself.

Before moving to Active Prospects, this uncertainty weighed heavily. Annette wanted more than care for her son – she wanted him to feel settled, comfortable, and surrounded by people who truly knew him.

Today, Adam lives in his own home with a consistent support team who understand his needs, routines, and communication. This personalised support has helped him feel secure and at ease in his daily life. Annette describes the difference this has made:

"The care that Adam receives here is about Adam... It's about having the right people around him."

Knowing Adam is supported by people who understand him has brought deep reassurance. Adam now lives in a place where he feels safe, valued, and truly at home.

You can watch Adam and Annette share their story in their own words in our short film.

Beth’s path to independence

Beth spent much of her early adulthood in hospital, and often far from home. She felt misunderstood, restricted, and without a place she could truly call her own. “It felt like being trapped,” she recalls.

Her move to **Great Meadows** marked a turning point. From the moment she arrived, she felt listened to, cared for and genuinely supported. “No one’s given up on me,” Beth says. “I’ve been given endless chances.”

Today, Beth lives in her own flat with her much-loved dog, Lenny, who gives her motivation and joy each day. She’s developed routines that support her wellbeing and volunteers with Include, helping create Easy Read materials and supporting others to get involved. “If I’m having a bad day, making someone else’s day better makes me feel better too.”

Beth is working towards even greater independence, including going to the gym on her own. Her journey shows what’s possible when people have the right support, the right environment and the chance to belong.

At Active Prospects, we’re proud to support Beth to lead a life filled with **purpose, confidence and choice** - in a home she can truly call her own.

Watch Beth share her story in her own words in our short film.

Active Prospects enables people with learning disabilities and autism, physical and mental health needs to live full and aspiring lives.

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We are a Community Benefit Society (26618R) with charitable status.