HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

17 OCTOBER 2017

OVERVIEW OF MEDWAY COMMUNITY SUPPORT OUTREACH TEAM

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Summary

This report provides an overview of the work of the Medway Community Support Outreach team.

1. Budget and Policy Framework

1.1 Consideration of this report is within the Council's policy and budget framework.

1.2 The information in this report is brought together to provide the context requested as a result of a request made by the Chairman, which was agreed at the pre-agenda meeting on 28 September, for the Committee to be provided with an overview of the work of the Community Support Outreach Team.

2. Background

2.1 Due to the closure of many Mental Health institutions in Kent, like St Augustine's Hospital and Oakwood Hospital, the Community Care Service (named originally) was initially started as a pilot service in the Canterbury area. It proved to be so successful that it was used as a model across the whole of Kent. In Medway and Swale the service was started in Gillingham in August 1989, adapting and changing the Canterbury model to suit the areas specific needs.

2.2 Throughout the Community Support Outreach Team's life there have been a number of changes since the start of the service in 1989, including the name of the service which was chosen by our service users. The team has been innovative, creative and has remained customer focused adapting and being responsive to the changing needs of both the service and the needs of our service users. Although there have been many changes to the service, we have never lost this ethos and the values and principles that underpin our day

to day work. The best outcomes for the service user are always best met working with the service users strengths and them being at the fore and centre of everything we do, working holistically with the individual the family and carers.

3. Service Overview

3.1 The Community Support Outreach Team (**CSOT**) offers needs led, flexible and responsive provision to service users who reside in all of the Medway areas. The CSOT operates 7 days a week, 365 days of the year including evening, weekends and bank holidays at times and days best suited to the individual. The support that is delivered is tailored to individual needs. Accessing the CSOT is via a referral pathway and is delivered to adults who are aged 18 years and above.

4. Current Staffing Establishment

4.1 Current Staffing Establishment for Community Support Outreach Team consists of:

- Manager 1.0 FTE
- 3 Community Support Outreach workers Supervisor 2.8 FTE
- 9 Community Support Outreach Workers 7.57 FTE
- Support Service Assistant 1.0 FTE

4.2. We support individuals who have been assessed to have social care needs with severe and enduring complex needs to first time mental health presentation whose mental health impacts on how they live. The symptoms that an individual may experience may have behaviours that challenge including self harm and self neglect and some individual service users may be subject to a Community Treatment Order (CTO) or have a social supervision order due to forensic history.

5. Clients known to the CSOT have a diverse array of mental health conditions including:

- Personality disorder
- Bipolar affective disorder
- Obsessive compulsive disorder
- Paranoid Schizophrenia
- Panic Disorder
- Drug-induced psychosis
- Mixed anxiety- depression
- Severe anxiety
- Self harm
- Mild to Severe depression
- Post Partum Psychosis
- Post Traumatic syndrome (PTSD)
- Agoraphobia
- Eating disorders
- Dual Diagnosis

6. Examples of intervention

6.1 Intensive Support Preventative Crisis: This is for service users who need a higher level of support than they would normally need with the aim to prevent further relapse and maintain them in their home rather than hospital admission. This is for a limited time to support the person initially through their crisis.

6.2 Link Workers Pre- and Post discharge from Acute Mental Health Units: Reablement intervention - The link workers will provide the support by giving time to inpatients/service users, thus promoting and assisting in their recovery in order to facilitate the patient's discharge back into the community and their home as smoothly as possible. This support can be up to 6 weeks from commencement of support.

6.3 Short term – Longer term: The support is to provide outcome focused support as identified in the individuals support/care plan. This enables the service user to maintain/develop their independence.

7. Service Aims

7.1 The aims of the service are:

- Working alongside and supporting the service user in a community setting; home environment; on acute hospital ward: supporting them to build confidence and self esteem. Enabling, empowering and promoting independent living through reinforcing and maintaining existing skills, as a specified part of the support/care plan, with the aim to focus and support the service user with the recovery approach.

- Access to local community: re-building confidence in using public transport to allow the service user to travel freely and independently within the community.

- Social skills: interacting with other people in the community, re-building confidence, self-esteem and friendships as well as family networks.

- Domestic skills: Independent activities of daily living such as: shopping, cooking, budgeting/debt management and support to maintain their home environment and tenancy. All of which requires an awareness of the service user's component skills such as; ability to plan, sequence and organise, adequate social skills, motivation, adequate knowledge of each step or process of the above activities (Shopping = meal planning, being able to access local shops, being able to locate and choose items and being able to budget and communicate with others). These activities are at a level and pace in keeping with the service user's strengths and limitations.

- Advocacy: support when engaging in independent advocacy – e.g. claiming benefits, attending a meeting.

- Supporting: facilitating, enabling and motivating service users to live in the community.

- Bridging Care: i.e. supporting people in finding and taking part in occupational and leisure activities including paid or unpaid work, encouraging them to build on their social networks.

- Securing a communication channel: between the service user and the multi-disciplinary teams they gather valuable information on service user's progress and feeding it back to other agencies responsible for assessment.

- Empowering and choice: showing the service user that there are other alternatives and they do have a choice on how to live.

- Health Issues: Encourage and prompt compliance regime with medication and treatment plans prescribed by a qualified medical practitioner. This may necessitate feeding back any concerns or issues identified; Support the service user during visits to the GP, hospital appointments or depot clinics; Supporting healthy life styles and encouraging service user in taking responsibility to have an active role in their treatment plan and overall wellbeing.

- Partnership working with service users is centre to the ethos of CSOT.

- Support via the telephone: Warm Line offers a listening and friendly ear at Gun Wharf, Chatham. This service of extended office hours Monday – Friday 8:00 till 20:00 hours. Saturday and Sunday the phone is diverted; this has been well received by our service users and staff. If there are any urgent issues arising from a service user phone call, then staff will contact the CSOT on-call Manager of our service or the Out-of-Hours and the relevant agency will be advised.

8. Service Performance

8.1

- As of April 2016 - March 2017 we delivered 21,000 direct support hours.

- As of 30th September 2017 CSOT supports a case load of 104 individual clients.

- Our current weekly direct contracted hours as a team add up to 302 hours.

- Out of the 104 service users, 65 are subject to Section 117 aftercare, while 41 require short term support and 63 require longer term support. We currently are supporting 61 men and 43 women.

- The duration of support varies according to each individual need and type of intervention, but the range of involvement is between a week and several years.

9. Service Outcome

9.1 Our CSOT Team has successfully:

- Created opportunities to allow people to reach and maintain their full potential to go on and live productive lives.
- Ensured that the rights of individuals are Safeguarded and that independent advocacy services support this process.
- Provided support to individuals on social prescribing, to access learning and development, build confidence, motivate and rebuild self esteem whilst connecting individuals back into their local community.
- Helped service users to regain control of their lives so they can make real choices in relation to their lives and live within their own homes for as long as it is possible and safe to do so.
- Prevented service users from declining in their social care needs and/or ill health and have helped reduce this. For example maximising the potential for them to live at home rather than 24 hour residential accommodation (including step down from residential to independent living).
- Diverted prevalence of vulnerable people moving on to and up the care escalator.
- Supported service users to engage in community life in a way that helps breakdown stigma and discrimination.
- Supported service users who are on acute ward back to their own home resulting in reducing delayed transfer of care (DTOC).
- Continued the use of a strength based approach to support service users to achieve their desired outcomes.

10. Risk management

10.1 The purpose of this report is to provide an overview of the service provided by the Council's Community Support outreach team. There are no risks arising directly from this report.

11. Financial and Legal implications

11.1 There are no specific financial or legal implications for Medway Council arising directly from the report.

12. Recommendations

12.1 It is recommended that the Committee notes the report and comments on the update provided.

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Appendices

None.

Background papers

None.