Halton Borough Council: Mental Health Outreach 1

Out-of-hours support

The Mental Health Outreach Team (MHOT) is an in-house provider service that is part of the Adults and Community Directorate at Halton Borough Council. It provides support to adults with severe and enduring mental health problems to live independently and inclusively within the local community.

As part of the Working together for change initiative, staff and people supported identified that people didn't always get the right kind of support at the times that made sense for them. They decided to work together to see how services could be made more outcomes focused and more tailored to each individual. The team particularly focused on **when** support was offered, in particular on out-of-hours and weekend support and how this could be delivered in more personalised ways by accessing community based resources.

The team decided to:

- gather people's views about the service.
- conduct person-centred reviews for everyone supported.
- review the current service in light of people's priorities.
- introduce weekend visits for certain individuals and a more enabling, community based approach for all.

As a result of this work and through delivering a more personalised brand of support in a more flexible way the MHOT has seen reductions in formal support for some people and has noted a
similar, sometimes significant impact, on people's reliance on other statutory services. This has improved the cost effectiveness of the service and has led to more independence and choice for people supported who are generally more settled in their behaviour and report feeling in greater control of their support and their lives.

Feedback from people we support:

"Life's good now. I feel really positive about the changes in my life." John

"I feel a bit more motivated recently and more confident in general. I would still like to have more friends of my own age and to feel more confident to speak to other people." Sam

"I feel more focused on my goals since having my review and more able to achieve them." Joan

"I feel less dread about weekends now I have the support and am beginning to feel 'normal' again." Sarah

"Words cannot describe the major impact that you have had on my journey to becoming well again. You have listened to what I want from my life and supported me in achieving that. Hopefully I will now remain well, thankyou!" - received by a member of staff in a card on closure of a case.

As a team we have found the whole experience very useful in many ways. We always thought we were delivering a high quality all-inclusive service, which to some extent we were, but by undertaking the processes used in this project it made us more aware of current service deficits, what people actually want, and what wasn't working for them. It has made us all become more outcomes focused both at a service and individual level, and aware of individual's preferences and alternative ways of providing quality effective support.
About us

The Mental Health Outreach Team is a provider service within Halton Borough Council and is part of the Adults and Community Directorate. It has been in operation for 16 years. The Outreach Team is based in Widnes but provides services for the whole of Halton. The service operates flexibly between the hours of 8am to 9pm Monday-Friday, with planned weekend activities between the hours of 9am-5pm. The team consists of 4 full-time and 1 part-time Support, Time and Recovery Workers (StaR workers), 1 full-time Support Worker, 2 part-time Day Service Officers, 1 part-time admin worker, and 1 Team Manager. Also located within the team, with a service level agreement, is a full time Carers Family Support Worker from another agency.

The Outreach service offers structured support to adults with severe and enduring mental health problems to live as independently as possible in their local communities and fully promotes social inclusion. The Outreach team role particularly focuses on enablement and recovery, working across boundaries of care, organisations, and roles, focusing on the direct needs of people. Outreach provides clients with many different types of one-to-one support and a variety of activities all in accordance with their individual care plans. Group work is also available for social inclusion, sports and education. Outreach support is very flexible in its approach and tailors the service to people's individual needs.

The service also provides "in-reach" support to individuals in hospital to prepare them for returning home, increasing levels of social inclusion, and reducing the length of time spent in hospital. Recently support has increased across the team by the addition of 2 specialised workers, to provide outreach support for people with Physical and Sensory disabilities.

Referrals are made to the team following an
assessment of need from the Community Mental Health teams, Early Intervention teams, Brooker Centre (Mental Health) Wards, Single Point of Access (assessment team) and the Physical and Sensory Disability (PSD) social work team. Outreach has established good working links with the Community Bridge Building team and refers people to the service for employment and lower level social inclusion support. The team also have good working relationships with various physical health teams, G.P.'s, Community nurses, Welfare Rights, and the Citizen's Advice Bureau.

Website: [http://www.halton.gov.uk/](http://www.halton.gov.uk/)

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What people told us

We used the *Working together for change* process in March and April 2011 to work in partnership with commissioners, other providers and some of the people we support to look at information from people's reviews to see what it told us about our service and what people say is important to them. This information included the things people said were working well in their lives, things that were not working and the things that were identified as most important for the future. Some of the things people said were not working were:

"I am unable to do things in the community without support."

"I am not able to get out and about as much as I would like."

"I have difficulty making decisions for myself."

"I don't meet new people - I see the same people every week."

The group worked together to identify themes in the information. The two themes that were most important for us were:

"I don't get enough of the right kind of support for me."

"I don't get out and about."

We then thought together about what some of the root causes of this were for people we supported, which included services being built around people's needs rather than the whole person, a lack of responsiveness at the time's people need support and the availability of support outside of regular hours. Having identified some of the root causes we then thought about what success would look like from different perspectives if this were no longer an issue for people, and decided
that the people we support might be saying things like:

"Services are flexible and responsive so I can go out when I want."

"I can choose my own activities to be supported with."

"I can access my community."

"I can access services when I need them."

In the second *Working together for change* workshop we developed an action plan for what we would do to try and put this right for people. From a range of ideas, we used the *Working together for change* process to agree on a project. We decided to look at how we could increase out-of-hours support, particularly evenings and weekends, and make greater use of community groups/events, educational resources and social activities. We wanted to do this in an enabling way so that people's support could gradually be decreased over a period of time in order that they could participate in activities away from traditional services and more restrictive times.
What we did

The project was led by Vicky Lockwood, manager of the Mental Health Outreach Team (MHOT) with input from other staff members, support from commissioners and the continued engagement of people supported. They decided that the first task was to gather a more detailed understanding of people’s views of the strengths and weaknesses of the existing service and how well the service was meeting people's needs and aspirations.

They took a three-pronged approach to this.

- Firstly, by designing two questionnaires - one for people supported and the other for commissioners - to gather specific feedback on the service, what was working well and what could be improved.
- Secondly, following the very useful sample of person-centred reviews that had been conducted for the Working together for change events, they decided to complete reviews for the rest of the people they supported to develop a more thorough understanding of what was important to people.
- Finally, the MHOT with support from commissioners also held several workshops with a wide range of people, including other providers, people supported and family members to develop a list of the sorts of activities people would be interested in being supported with.

The next stage was to conduct a mapping exercise to match what people had said was important to them and the kinds of activities they would be interested in with social and other activities going on in the local community. As a result of the feedback from Working together for change there was a particular focus here on out of hours support and weekends in particular for both one-to-one and small group activities. This was when people had said they would most value
support but was also when the service was least well staffed and therefore least flexible.

Given that there were no additional funds available to address this, the team worked together to find practical and pragmatic solutions that would improve things for people within the same resource. This involved discussions with the staff team about how this might work and has led to a change in the policy and process concerning lone working. Where in the past people working on weekends had worked in pairs for safety reasons, the team have now joined the council's lone working system, which has meant that weekends are treated like any other day, with people working individually and thereby covering more people or groups. Staff rotas for weekends have also been reviewed so that people work a two-day weekend one in every six instead of one day in every three, which has also served to increase weekend capacity.

The next step was to raise awareness of this increased capacity with social work teams and other referrers and to explain the new availability and opportunities this represented for people. A change to the referral form to make this more apparent was helpful but this has also required time with teams in their meetings and discussions with team managers to ensure that this has begun to translate into changed practice and ultimately more weekend referrals.

Weekend and other support has been focused around community based activities and supporting self-sustaining groups as part of the team's enabling approach and to make best use of the available resource.

One notable success has been supporting three women who did not previously know one another to come together to support each other by doing the things they are all interested in. This has included going to the cinema, having lunch, shopping and joining a gym together and two of the three are now firm friends and planning a holiday together for the summer. All three are now
reporting feeling far more confident and are keeping appointments which previously they had often missed.

The impact on the service has been equally significant as the MHOT has been able to entirely withdraw formal support from two of the three women who are now relying on their own networks and community provision rather than specialist support of any kind.

The MHOT have agreed that the next steps for this work are:

- To ensure that everyone supported by MHOT open has a person-centred review and personalised support plan.
- To increase the numbers of people with personal budgets for their support.
- To further increase the uptake of weekend support by working to raise awareness and change social work practice, particularly around referrals.
- To look at introducing evening calls if there is demand.
- To start another small befriending/social group.
- To introduce annual consultations with relevant parties regarding service provision, perhaps using the Working together for change approach.
- To create a database to match up skills and interests of people supported with staff and to look at the times people require support to see if they can also be matched on this basis to create a natural befriending scheme.

To continue to review progress and collate information on customer satisfaction; effectiveness of service; changes in service; and move on statistics and outcomes data (such as length in service, reduction of hours compared to amounts prior to refocusing the service, closures and the reasons why).
Outcomes
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<td>Scheduled weekend visits. To one particular service user instead of a visit during the week. This was a time that they felt particularly vulnerable, lonely and anxious and would end up phoning the crisis team several times over the weekend and also would contact emergency services when feeling particularly anxious. Family relations were also strained, as they would also be contacted regularly with quite difficult and emotional conversations.</td>
<td>Following the introduction of the weekend visit, which was for 1½ hours on a Saturday mid morning, the individual stopped contacting emergency services altogether. Phone calls to the crisis team also greatly reduced and some weekends they received no calls. Family relationships have improved resulting in her daughter now staying over and them doing family activities on a Sunday. The service user has also reported that she feels more confident and in control and willing to participate in more activities. Statistically: • No phone calls to emergency services. • Crisis team used to receive 8 - 10 phone calls over the weekend averaging ½ hour each call. Now they receive two to three calls at most over the weekend. Saving approximately 4 hours of manpower per week. • This equates to approximately £35 - £40 per week. • Family members now visit at least twice a week whereas they avoided physical contact previously. • Outreach support reduced during the week by 1 hour therefore freeing up this time for another service user. Strong friendships formed</td>
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Social befriending scheme. We introduced 3 people to each other, who were already open to the outreach service, which had similar interests and needs. We facilitated the visits / activities in addition to their usual individual support sessions for 3 occasions and then reduced our input over the next 2 visits to allow for a more natural progression of friendship to form. Activities included shopping, lunches out, trip to the local gym and garden centres.

- Between 2 people quite quickly and they continue to see each other at least twice a week and regularly phone each other. This occurs both during the week and weekends. They really enjoy each others company and feel quite supportive of each other and have even supported each other to attend medical appointments. They both report an increase in confidence and have subscribed to a 12-month gym membership where they will attend together.

Statistically:
- Outreach has now closed with both these people. This amounts to 5 hours per week, 20 hours per month of support time.
- This equates to approximately £65 per week, £270 per month.
- One person has now been closed to mental health services and her care has been placed back with her GP. Saving on consultant and care co-ordinator time.
- Both have lost weight, a total between them of 1-½ stones, resulting in better physical health too.

Update: We have run another befriending scheme introducing another three people to each other. Another two have become good friends and are also very supportive of each other. They regularly socialise with each other and are travelling further a field.
with support from each other therefore expanding their social arenas. (e.g. Liverpool, Chester, using public transport) This has also helped one of them to become more confident in travelling on the bus to Liverpool resulting in them visiting their family members, who reside there, more often. We have also closed with one of the person who had been receiving approx 2 hours per week support from our service. A saving to the service of approx £27 per week, £108 per month and a faster move on for this person.
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<td>Individual support improved. We looked at the type of support we were offering one individual around his finances. This gentleman is currently under appointee with Halton Borough Council and receives a weekly allowance from this. He is a gambler and not very financially aware. Previously we had worked with him around budgeting but to little effect. He continuously wanted more money and would ring the outreach team, the care co-ordinator, community mental health teams, and also the appointee team incessantly becoming more verbally aggressive, upset and symptomatic with each call. It would be very difficult to reason and discuss matters once this behaviour started. We started having weekly business meetings where only finances were to be discussed. This gave the gentleman the opportunity to plan and request extra monies in advance and become more aware of his future financial commitments.</td>
<td>The gentleman reports he feels more in control of his money and feels he can now have a say in planning how and when he is going to spend it whilst still having some security measures in place. He feels less paranoid about services and more willing to engage appropriately. Statistically • This gentleman now usually just contacts the outreach team around financial issues. Saving approximately up to 4 hours per day of contact time from other teams. • Abusive phone calls are now very rare and he feels more relaxed when dealing with his finances.</td>
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<td>More focussed service. As a service we became more focused on what we wanted to offer and what would best benefit each person. We became more purposeful around moving people on from specific, specialised mental health services onto more generalised, low level services and where possible out of provider services. This required the team to develop a different approach to risk.</td>
<td>Since the start of this pilot we have closed with 7 people all recorded on closure sheets. The reason stated for all 7 closures were &quot;involvement completed&quot;, &quot;mental health stable at present&quot;. Four closure sheets also stated that personal goals had been achieved and any ongoing or developing issues can now be supported by other means already in place. Two sheets recorded that people had moved onto other services that were more low level.</td>
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<td>Previously a lot of cases remained open in order that we could monitor individual's mental health or just keep some contact. Whilst this may be important to some people it does not necessarily need a specialised more intense service to provide this support and more natural systems may be better suited. This enforced us as a team to become more proactive in positive risk taking.</td>
<td>Update: We have since closed with a further 4 people whose needs had changed and now only require low level, non-specialised support. This has allowed space in the team caseload to take on a total of 8 people with high level needs who need specialised or more intense support at this time.</td>
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<td>Awareness and consultation with other teams with the people we support about the option for out-of-hours working and what can be offered.</td>
<td>There have been 2 new referrals requesting weekend visits but unfortunately when offered to the individuals they were declined, as it wouldn’t necessarily be the same member of staff for each visit due to the rota system. We have now included a tick box option on our referral forms for weekend / weekday support and will look at adding out-of-hours box if a need is identified. Update: We have 3 regular weekend visits directly resulting from referrals. 2 visits focus around medication, the third around daily living skills. We also have the staffing capacity to offer additional weekend visits to those individuals who are becoming unwell and / or need extra support when other services are not open.</td>
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| 7 | Implications on staffing hours, rota, working practices. A new weekend working rota has been implemented and therefore an alternative procedure for lone working during out-of-hours had to be implemented. We had to also ensure that when time was taken back for weekend visits usual weekly support was not affected. | Usual visits completed. Staff only working contractual hours. New rota in place. Feedback from staff and monitoring. |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------|
| 8 | Outreach team more flexible. From an organisational aspect the outreach team is becoming more flexible in its entire approach to support. In the long term this may result in reducing individual levels of support thus allowing for more people to be supported at any one time. This process has also increased links with other providers, agencies, and community groups resulting in a more integrated approach and ways of thinking. It has also resulted in the team becoming more outcomes focused not only within the team but also holistically for the individual. | The team now use newly developed outcome sheets with all the people we support. These sheets are broken down into sections such as economic wellbeing, social and emotional, social inclusion, health and safety. This aids both staff and the people we support to be better focused and are able to acknowledge personal goals and achievements. This also helps the team members to recognise when 'move on's' are appropriate or needed. |
| | Sharing our experiences and achievements with other providers. I have attended and made a short presentation on a personalisation awareness / progress day for Halton Borough Council. There were other council teams, carers, the people we support, and representatives from other | |

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agencies present. One person supported by our team also talked about her journey at this event. This lady struggled to make conversation and look after herself 12 months ago. At this presentation she talked to a fairly large crowd about her journey so far and how this project and consequent support has helped her develop personally, feel more in control and has increased her confidence and motivation levels.
Since this presentation this lady alongside myself has appeared in a video for Halton, which describes the various steps to personalisation and support planning. She talked about the review process we used within the project and how she has spent her individual budget on the support she required. This video will now be used across the borough to help explain the process to all its residents and relevant people.
I have also given a short presentation about the project, our findings and the possible implications for other services, at the Halton Voluntary Sector Forum. This appeared to be greatly accepted and created lots of discussion around personalisation, support planning and individual budgets.
Outcomes summary

As a team we have found the whole experience very useful in many ways. We always thought we were delivering a high quality all-inclusive service, which to some extent we were, but by undertaking the processes used in this project it made us more aware of current service deficits, what people actually want, and what wasn't working for them. It has made us all become more outcomes focused both at a service and individual level, and aware of individual's preferences and alternative ways of providing quality effective support.

The project has also helped with the change process as a whole, as staff and the people we support are more willing to change when they understand the reason behind it and the possible benefits change can create. As a consequence the staff have shown energy and commitment to look at new ways of working, finding solutions to barriers or problems, and moving the service and individuals forward.

All those involved in this project feel that change has occurred in a fully collaborative manner and that as a provider service we have learnt the importance of the full engagement of individuals using services, recognising that they are in the best position to shape services for the future. The project has also helped us to identify a clear process for planning change based on actual people's needs rather than assumptions.

We all feel confident that further changes to the service could be made, if identified, with minimum disruption and improved effectiveness. We will keep reviewing and evaluating our service to ensure that any changes or needs are quickly identified, which will hopefully result in resolving any issues or providing a better service to individuals.