**Community Links**

**Oakwood Hall**

**GUIDE FOR REFERRERS**

**Oakwood Hall was designed to provide a service to clients whose mental health difficulties and associated behaviours are beyond the scope of existing services. It only accepts referrals for clients who have been excluded from other services.**

Oakwood Hall is a 12 bedded residential home, which provides support for people aged over 18, who have serious and enduring mental health problems, which result in patterns of thinking and behaving which impact negatively on relationships, ability to cope with the demands of daily living and the person’s quality of life, and mean they are unable to access other services (mainstream).

The hostel is a dual registered Nursing and Residential care Home and provides both a residential service and a respite service. There are 3 staff on duty 24 hours a day, at least one of whom will be a Registered Mental Health Nurse (RMN).

The aim of Oakwood Hall is to provide a safe, stable, non-institutional and therapeutic residential environment in which service users are able to address those behaviours which have led to their placement, engage in the rehabilitative process and thereby develop to their full potential. Ultimately this should mean that clients are able to return to mainstream services or live independently.

The Hostel provides care for a broad range of client need and aims to offer an ‘inclusive’ service. Therefore the service is open to people whose mental health needs are enduring, have been defined as having a personality disorder, are challenging; involve drug and/or alcohol issues or those who self-injure. However, Oakwood Hall is not suitable for those who are in an acute phase of illness, those whose primary diagnosis is drug/alcohol use or whose severity of drug/alcohol use mitigates against communal living or those who require the security of a hospital environment.

The Hostel operates as a community with a strong emphasis on the rehabilitative function. As such staff and residents are expected to contribute to maintaining their own environment and participating in domestic activity within their ability. Assistance, support and guidance is provided by staff and the majority of meals are provided by the chef.

**Respite Service**

One of the twelve beds is used to provide a respite service for those living in the community or those requiring a short period of assessment. The service offers each resident a single bedroom for privacy and dignity, and use of the extensive communal areas. One room is converted for disabled access.

The respite service is offered to people who are currently living independently or in accommodation where staff support may be limited. Assessment for the respite service takes place exactly the same way as detailed below.

Our respite service offers 3 levels of support;

**Recovery skills –** Visits every six weeks (capacity of 9 clients)

This client group may feature on-going crises or recent discharge from hospital, they may also have chaotic behaviour, be at risk of relapse or feature high levels of risk. Support will be planned around 1:1 work, Psycho-social interventions, short-term risk management strategies, telephone support and day visits. These clients may move to Living skills group following period of stability.

**Living skills –** Visits every 8 weeks (capacity of 8 clients)

This group may have support needs featuring long-term coping skills, living skills, money management and self catering. They may benefit from Psycho-social interventions and use of the outcome star. In outcome star terms these clients may be in the 4-7 scoring areas, as opposed to perhaps 1-5 scoring areas in Recovery skills group. Following a period of support the clients may be suitable for discharge from this group, or may wish to continue to use respite in Social skills group.

**Social skills –** Visits every 12 weeks (capacity of 6 clients)

Long standing clients that may have predominantly social needs. Support plans may look at social engagement and inclusion in activities, trips and groups. Clients may use weekend activities, peer support models and telephone contact.

Admission for respite support is offered on a planned, rotational basis with the clients usually coming in for a period of two nights every 6, 8 or 12 weeks dependent on level of need.

**RESPITE IS NOT PROVIDED ON AN EMERGENCY OR CRISIS BASIS.**

**Admission Criteria**

**Individuals referred will:**

1. Be 18 or over and live in the Leeds area
2. Have mental health problems
3. Have complex needs not easily met by existing services, be reluctant to engage with services or experience frequent conflict with service providers, or be at risk through vulnerability and self neglect.
4. Having difficulties or a history of difficulties which exclude them from other services.

**Referrals considered unsuitable**

1. The need of the individual could be catered for by the other services.
2. There is evidence of dementia.
3. The client has learning difficulties.
4. The client is experiencing an acute phase of their illness.
5. The client requires a high level of physical care.
6. The client has behaviours that could endanger the local community.

There is an expectation that where an individual is not supported through the Care Programme Approach (CPA), that they will be registered on the CPA and allocated a Care Co-coordinator at the earliest opportunity. All individuals referred must have a Consultant Psychiatrist who accepts responsibility for their care.

All referrals must be accompanied by an up to date standardised risk assessment e.g. FACE, RAMAS,.

**Priority**

Priority of admission is determined by the date of referral and the readiness of an individual to move into a community setting.

The following factors will also be taken into consideration.

* **The client is a delayed discharge in Hospital**
* **The client is a Leeds resident in an out of area placement**
* **The client is at risk of tenancy breakdown/homelessness**

When a person is accepted onto the waiting list please keep us informed of any changes in their circumstances which may need to be taken into consideration.

**Assessment process**

On receipt of the completed referral form and other documents, the information is discussed at a referral meeting.

Additional information may be required to make a decision regarding acceptance on the waiting list and we will contact you to request this.

You will receive confirmation in relation to the client’s acceptance onto the waiting list.

Once we have all the **information** we require the next part of the process is **engagement**.

We aim to be **flexible** and **responsive** so can discuss the appropriate timeframe for commencing an assessment in relation to vacancies so the process is individual to each individuals needs.

Two workers will be assigned the responsibility of completing the assessment, and will contact the referrer and the prospective resident. The assessment will involve the person making a series of visits to the home, meeting staff and other residents and deciding if Oakwood Hall is right for them. The staff conducting the assessment will be talking to everyone involved in their care, to ensure that a holistic understanding of their needs is gained.

An important part of the initial assessment process is the completion of a risk assessment. This will involve the contact worker talking to the client, other professionals, carers and relatives about identified risk factors to the client’s health and well-being and the well-being of others. The client will be given every opportunity to give their views and perspective on problems, which affects them and what they hope to achieve whilst living at Oakwood Hall. The completion of the risk assessment will lead to the development of a risk management plan which will outline what should happen if there is any occurrence of identified risk factors. The assessment information will provide the basis for the development of a support plan and will also be important in the development of a multidisciplinary care plan (CPA).

Assessment occurs at the earliest opportunity following a referral and is made through a combination of some or all of the following, whichever are best suited to the needs of the client:

* assessment on the ward
* assessment at home
* meeting/s involving the carer/family
* visit to the Hostel
* meal at the Hostel with staff and other residents
* overnight stay in the Hostel
* trial period within the Hostel

Decisions as to the suitability of residents will include consideration of the following

* the ability of the resident to be supported within the current mix of residents
* an acceptable and manageable level of risk

When the assessment is completed, a decision will be made by the team about the appropriateness of the service for the person. A written response will be provided to both the perspective resident and the referrer.

**Funding**

Oakwood Hall is jointly funded by Leeds Adult Social Care and NHS Leeds. People moving into Oakwood Hall do not need to apply for funding before being offered a place. If the person moving into the home is entitled to ‘aftercare’ under the Mental Health Act (1983), they will not be expected to make any financial contribution to their place at the home.

**How to make a referral**

1. Make an initial enquiry via telephone, this will usually involve answering a few questions to check the client meets our referral criteria. Following this we will send you a referral form or signpost you to another service.

**If your service has an Accommodation Gateway worker attached all referrals should be made through that person.**

1. On receipt of the referral form we will respond within 7 days and either signpost you to another service or accept the client onto our waiting list **to be assessed for a placement**
2. If Oakwood Hall seems to be an appropriate service, a letter and welcome pack will be sent to the person being referred and/or we will invite them to look round the service and meet their contact worker where we will explain the referral and assessment process and answer any questions they may have.

**Contact details**

**team.oakwood@commlinks.co.uk**

**sarah.gilligan@commlinks.co.uk**

**matt.faragher@commlinks.co.uk**

**01132359079: Office**