ADULTS AND HEALTH SELECT COMMITTEE

15 OCTOBER 2020

ADULT SOCIAL CARE MENTAL HEALTH UPDATE

Purpose of report: To provide the Committee with an update on the progress made since the termination of the Section 75 agreement.

Introduction

1. Following a review of the arrangements for the commissioning and delivery of Adult Social Care (ASC) Mental Health services, Surrey County Council (SCC) terminated the Section 75 (S75) arrangements with Surrey & Borders Partnership Trust (SABP) in February 2019. SABP have been responsible for the delivery of Mental Health Social Care Services through direct management of council staff.

2. The transfer of staff and cases from SABP to SCC was completed during the period 11 November to 2 December 2019.

3. Following the transfer of staff and services to ASC, phase 2 of the Mental Health Programme Review began with a view to bring about the strategic and operational changes needed to deliver services that are consistent with our obligations under the Care Act, and achieve our ambition to be at the forefront of best practice and to establish a clear Mental Health professional identity.

4. The transformation work was paused during the response to the Covid-19 pandemic although restarted during the summer.

Workforce and structure

5. During November to December 2019, 180 social care staff moved into the locality offices from SABP offices. The decision was made not to implement a new structure immediately but to move the staff to their new office locations. The moves went well with staff being welcomed into SCC by ASC colleagues.

6. **Training –** All Mental Health staff have completed mandatory training covering the following:
    - Care Act
    - Safeguarding
    - Mental Capacity Act
    - LAS training
    - Information Governance
    - “Supporting You” sessions focussing on cultural change
    - Management training
    - Continuing Health Care

7. **Strengths-based practice training** is being rolled out in the Mental Health service in September-November 2020. The approach has been co-designed with the mental health staff and people who use services.

    It will be rolled out virtually as follows:
    - All mental health staff will watch two narrated slideshows on ‘new ways of working’ and ‘strengths-based practice’ – late September
    - Local managers will convene small group meetings/reflective sessions to discuss slideshow content, what it means for their practice and answer questions – early October
    - Virtual strengths-based practice workshops for all mental health staff, will be held via Zoom in mid/late October
    - Reflections on key messages from narrated slideshows
    - Videos of people with lived experience and a carer
    - Redacted assessments and support plans
    - Breakout sessions to reflect on the videos/assessments and support plans/case studies
    - Regular reflective practice sessions run by local managers within teams – November onwards
    - Audit of cases to assess and reinforce strengths-based practice – November onwards
    - Two case studies are included in appendix A of this report.
    - Identify next steps

8. **Motivational Interviewing** has been applied to a social work context and is highly compatible with strengths-based practice, promoting autonomy, empowerment and self-efficacy.

    The training is designed to help staff:
    - Understand the person (a formulation of the person rather than just their needs) and within that what would support behaviour change.

- Provide options in a way that will maximise the chances they will engage in a new healthy lifestyle (for example)
- Increase awareness in staff to understand how their behaviour and relationships with customers can support behaviour change or undermine it – e.g. not finding the right balance between doing for, doing to and reinforcing/encouraging self-directed behaviour and self-management.

The trainer will use:

- Motivational interviewing
- Solution focused brief therapy principles
- Reflective practice – so staff understand how their own emotional reactions drive their behaviours
- Transactional analysis (or reciprocal roles)
- Learning theory.

9. **Current structure –** at present the teams are divided up into East, West and specialist services. There are 11 locality teams and an East and West Approved Mental Health Professional (AMHP) service all line managed by two senior managers. Currently the specialist services are the Forensic Team, Substance Misuse team, Prison team, Older Adults and the new Hospital discharge team described in section 12. The Enabling Independence service also sits within specialist services – the plans for this provision are outlined in section 14.

10. **The AMHP service** is split across East and West Surrey and remans co-located with SABP. AMHPs are mental health professionals who have been approved by the local authority to carry out duties under the Mental Health Act. They are responsible for co-ordinating Mental Health Act assessments. One of their functions is to make decisions to apply for compulsory admission to hospital for people with mental disorders.

    The training to become an AMHP lasts for six months and is University based. There is a national shortage of AMHPs and Surrey is committed to developing our existing staff in order to enable them to train as AMHPs, this is often a stressful and demanding role for staff. Staff need to maintain their warrants and the expectations of legal literacy are high. A further pressure on the service is the available bed capacity within the mental health trust.

    The table below shows the number of Mental Health Act assessments completed by the AMHP service this year.

2020	Section 2	Section 3	Section 4	Section 5	Section 135 (warrants)	S136	Total for month
Jan	47	28	0	4	3	31	113
Feb	39	16	0	7	3	25	90
Mar	40	35	0	6	11	24	116
Apr	35	29	0	5	11	25	105
May	39	24	0	5	6	21	95
June	57	40	0	11	11	37	156
Jul	45	48	0	5	15	40	153
Aug	40	35	0	0	9	35	119
Total for Outcome	342	255	0	43	69	238	**1106**

The table below contains the data for the Emergency Duty Team.

2020	Section 2	Section 3	Section 4	Section 5	S136	Total for month
Jan	6	2	0	0	19	27
Feb	17	1	0	0	28	46
Mar	18	1	1	0	21	41
Apr	17	1	0	0	21	39
May	20	2	0	0	31	53
June	18	4	0	0	36	58
Jul	15	2	0	0	39	56
Aug	12	5	0	0	26	43
Total for Outcome	123	18	1	0	221	**363**

New Services

11. **Mental Health Duty Team** – In November 2019 an interim ASC Mental Health Central Duty Team (MHCDT) was established. The intention was to provide a single gateway for both professional referrers and people with mental health needs and/or carers to access Surrey ASC Mental Health services and to ensure effective management of new referrals into the service. The operational model has been reviewed and the team will now be made permanent as the

data shows an increasing demand for the service. The MHCDT operates Monday to Friday, 9am to 5pm, outside of these hours the Emergency Duty Team (EDT) is available for any urgent referrals and mental health act assessments. The EDT is primarily staffed by AMHPs.

12. **Hospital Discharge Team** – The ASC Mental Health Hospital Discharge Team (MH HDT) was established on 1 April 2020. The role of the team is to facilitate safe, timely, person centred, Care Act (2014) compliant discharges for Surrey mental health inpatients who have care and support needs.

    This dedicated team is working closely with SABP to ensure that there are coordinated, robust processes across the mental health system to enable residents to have enhanced health and social care outcomes in a flexible way and which aims to minimise delays in the system. There is a great pressure on the need for hospital beds within mental health services, the team is integral to alleviating the system pressure.

13. **Staffing Structure –** we are currently looking at models for a new ASC Mental Health structure. A commitment has been made to maintain the service separately with an Assistant Director in post to manage the mental health teams. The issues we need to address in the new structure include the introduction of Team Managers and Occupational Therapists as we currently do not have these roles within our staffing establishment. We are also working with the Assistant Director for Learning Disabilities and the Transitions Team to explore the development of a service that meets the needs of people with a diagnosis of Autistic Spectrum Disorders with complex mental health needs, this is particularly relevant in the Forensic Team.

    A further consideration is the Wellbeing and Prevention agenda and so the future structure needs to align the teams to the Primary Care Networks (PCNs) to enhance our prevention offer.

    The transformation work is being overseen by the Mental Health Programme Board. The intention is to reinstate the Reference Group (made up of members from the Independent Mental Health Network) to help us codesign and shape services. The Reference Group were integral to informing the transfer of social care staff to the County Council as part of the dissolution of the Section 75 agreement.

14. **Mental Health Reablement Model:** Following the work with the Social Care Institute of Excellence (SCIE) as our Improvement Partners it was identified that we currently have gaps in service provision relating to those residents who have Mental Health needs in terms of short-term support to maximise their independence.

    Through both the Mental Health and the Reablement Transformation Programmes we are exploring opportunities to re-design the existing service to meet the needs of this group. Using the Mental Health Recovery Model and the Occupational Therapy Skills Gain process we are designing short term services that will enable people to remain living independently in their own communities and prevent the need for ongoing long-term statutory services.

    Proposals include two new models of delivery:

    - **Woking GPIMHS (GP Integrated Mental Health Service) linked Mental Health Reablement Pilot** £100k investment from the Community Services Transformation Budget secured to pilot a Mental Health Reablement service in the Woking Area. This money will fund 1FTE Mental Health Reablement Occupational Therapist and 1.4FTE Enabling Independence workers.

      The pilot also involves the Occupational Therapist working with both the current Enabling Independence workers and in-house reablement staff to ensure a skills gain and mental health focus is all service delivery.

    - **Co-Locating Enabling Independence Service with In-House Reablement under a Therapy Led approach.** Through co-locating both services we will be able to ensure a therapy led approach, which will enable residents to receive a clear and joined up short term intervention that will be aimed at promoting their levels of independence from both a physical and mental health perspective.

    Physical and mental health needs are not mutually exclusive and combining the support and leadership across these two services will enable ASC to offer a single clear vision promoting and maintaining independence through short term, area based local services.

    This model is still in the scoping phase, the aspiration is that both teams will come together and be based across area hubs for service delivery that have strong link with local social care teams.

15. **Future developments for people with Autism and Mental Health needs.** We are currently working with the Assistant Director for Learning Disabilities and Autism and the Transitions Teams to improve the pathways for young people with Autism, Disabilities and Mental Health needs, who are care act eligible. For many young people with mental health needs, the transitions pathway into adulthood is unclear or at times non-existent.

    The intention is to:

    - Establish a Transitions Steering Group across the SEND (Special Educational Needs and Disability) Social Care, and Health System in Surrey – to improve the levels of partnership working across the stakeholders in the system
    - Expand the role of the Transitions Service to provide Transitions Assessment & Support planning into adulthood for young people with mental health needs.

Mental Health Commissioning

16. The supported living dynamic purchasing system (DPS) for people with mental health and/or substance misuse needs went live in April and is now an established way for practitioners to source supported living. All the providers on the DPS framework have been evaluated for quality and cost, making sure that care is both affordable and of good quality. Commissioners and assistant team managers in the mental health locality teams are working together with the providers to develop robust working relationships, helping to troubleshoot any issues as they arise and supporting people to move onwards in their recovery journey in a timely way.

17. Whilst supported living would be the accommodation with care and support of choice as a short-term option to help people recover, some people with complex mental health needs may require residential or nursing care. The Adult Social Care Joint Central Placement team is increasing its scope, and mental health staff and commissioners are part of this work to make sure the team is appropriately skilled and able to source residential and nursing care for this group of people.

18. Mental health teams can sometimes struggle to find appropriate care at home packages for people, so commissioners are working with the teams, providers,

service users and carers to develop appropriate home care services that meet the needs of people with mental health needs as part of the upcoming home-based care tender. The tender will aim to ensure that home-based care providers who work with SCC do have the right skills and staff to meet the needs of people with mental health problems. Cabinet will receive a paper on the upcoming home-based care re-commissioning on 27th October.

Finance and Performance

19. **Finance –** The table below summarises the different aspects of Mental Health care services and staffing in terms of 2020/21 budget, forecast outturn as at the end of July and forecast variance.

    The forecast overspend on care packages was £0.5m but this was offset by a £1.8m underspend forecast for the staffing budget, leading to a combined forecast underspend across all Mental Health budgets of £1.4m (when rounded).

    Further work is ongoing regarding budget efficiencies as the spend on care packages remains high. This includes ensuring income is received, work with commissioners on market development, review of the section 117 policy (see section 16.3 below) and work with SABP to implement a discharge to assess model.

Budget area	Expenditure / income	2020/21 Budget £m	M4 Forecast Outturn £m	Outturn variance £m
Care packages	Gross expenditure	12.1	13.7	1.7
	Income	-3.7	-4.9	-1.2
	Net expenditure	8.4	8.9	0.5
Community Connections service	Gross expenditure	1.8	1.8	-0.0
	Income	-1.8	-1.8	0.0
	Net expenditure	0.0	-0.0	-0.0
Housing related support	Gross expenditure	2.3	2.3	-0.0
	Income	-0.1	-0.1	-0.0
	Net expenditure	2.3	2.3	-0.0
Staffing	Gross expenditure	9.6	7.7	-1.9
	Income	-0.3	-0.3	0.1

	Net expenditure	9.2	7.4	-1.8
Total	**Gross expenditure**	**25.8**	**25.6**	**-0.2**
	Income	**-5.8**	**-7.0**	**-1.2**
	Net expenditure	**19.9**	**18.6**	**-1.4**

20. **Performance**

- Mental Health caseloads have increased across all teams to 1,680. At the time of the transfer in November 2019 the case load was 1,324. We have seen a steady increase in the number of new cases. This is likely to be because we are seeing more people from primary care than we would have done as part of the S75. There has also been a significant increase due to Covid 19 in terms of urgent work over this period. It is also widely acknowledged that there is likely to be a longer-term impact on mental health needs and resultant increased pressure on MH service provision beyond the peak of the pandemic. There has also been an increase in the complexity and acuity of presenting individuals.
- The percentage of new contacts that progress to social care assessment is 12% (Target 30%)
- The percentage of people reviewed or reassessed in the last 12 months has risen to 89.5% (Target: 80%), in October 2019 this figure was 34%
- The percentage of contacts diverted to community resources via information, advice, signposting and guidance has risen to 26.6%. The target for this is 25% so it is good to be high. This reflects on the conversations held at the front door.
- The percentage of people in the community who purchase their service with a Direct Payment has decreased to 13.9% (Target: 30%). This is an area of concern and is being addressed with the teams through training and at consistent practice meetings.

Further details are attached in Appendix B

Work with partners

21. **NHS** – Adult Social Care is a key partner in the mental health integrated care system. The Surrey Heartlands Mental Health at Scale Board provides system-wide leadership and sets the strategic direction, agrees priorities and operational planning for the mental health, care and well-being of the population of Surrey Heartlands. The current focus is on the system Covid recovery plan and planning the third phase of the Covid response. We are leading one of the recovery objectives in the mental health system recovery plan and

engaged on the other workstreams to ensure that the increased demands on adult social care mental health teams and resources are reflected in this work.

22. **Community and Mental Health Transformation**
Money was awarded to Surrey Heartlands and Frimley Health to improve the health and wellbeing of people with significant mental health conditions by developing new services that provide support to people closer to their communities. Staff from NHS, social care and the voluntary sector will be working closely with GPs in Primary Care Networks (PCNs) to improve local services.

Each PCN will develop a core team that includes a mental health practitioner, community connector and admin. Each PCN can also access further support such as a clinical lead or psychiatrist.

Surrey Heartlands ICS has branded the teams as General Practice Integrated Mental Health Service (GPIMHS)

Frimley Health ICS has branded the teams as Mental Health Integrated Community Services (MHICS). Frimley Health PCN sites are split into two key areas Frimley Blackwater and East Berkshire. The Frimley (Blackwater) PCN are closer aligned with Surrey Heartlands.

As the schemes develop ASC mental health teams will align more closely with the PCNs. ASC were awarded £100k to pilot a mental health reablement model linked to the Woking GPIMHS service (detailed above in section 10.1). The money will fund a full time Occupational Therapist who will work with the multidisciplinary team to identify individuals who will benefit from a short-term skill gain programme. The money will also fund some Enabling Independence workers to work with those individuals in their own homes.

ASC representatives attend the Transformation Boards and have an active role in the recovery work.

23. **Surrey and Borders Partnership NHS Foundation Trust** is a provider of health services for people of all ages with mental ill health and learning disabilities in Surrey, they also provide drug and alcohol services. They provide a range of services to residents including in patient care, crisis support and therapies. The trust is CQC registered. ASC continues to work closely with SABP to ensure that good relations are maintained and that the needs of our residents are met. Workshops have been held with the SABP leadership team to look at hospital discharge processes and rehabilitation in order to alleviate the pressure on the whole system. We

continue to attend the Length of Stay meetings and other relevant meeting/Boards as it is important that we continue to maintain good relationships with SABP.

24. **Surrey Heartlands CCG –** We are working with the CCG to ensure we are meeting our legal obligations under Section 117 of the Mental Health Act and we will jointly review the policy in the near future. Section 117 aftercare services apply to individuals who have been detained under section 3 of the Mental Health Act and they are intended to:
    - Meet the need that arises from or relates to mental health problems
    - Reduce the risk of a mental condition deteriorating and a readmission to hospital

    Section 117 aftercare services are not chargeable under the Charging Policy. The financial agreement in Surrey is a 50:50 split with the CCG as it is a joint responsibility.

25. **Voluntary Sector** – We continue to work closely with our voluntary sector colleagues, supporting and developing their capabilities to deliver services across the mental health pathway. We continue to work closely with the independent mental health network who help guide and influence commissioning and operational plans by offering insight and challenge.

26. **Independent Mental Health Network** (IMHN) – ASC Mental Health staff attend the IMHN meeting on a bi-monthly basis to update on phase 2 of the mental health programme. The IMHN also work in co-production with social care to improve and challenge our ways of working and help guide and influence commissioning and operational plans by offering insight and challenge.

27. **Surrey Care Record and the sharing of patient data** – the shared care record launched in June this year and is rapidly expanding to create a rich data set combining GP records, Adult Social Care data, SABP records and acute hospital data across Surrey Heartlands. Clinicians and health and social care professionals can access information via the Surrey Care Record for the purpose of providing joined up direct care. There are no plans to extend access to the third sector at the present time. The data in the Surrey Care Record is confidential, personal data covered by both common law duties of confidentiality and by the General Data Protection Regulations. Wider sharing is prohibited under the existing Information Sharing Agreements. However, in the longer term, with the development of patient

portals, it is likely that the patient will be able to share their own data with others on an individual basis.

Carers

28. Since the transfer of SCC staff from SABP, our Carers Practice Advisors are now embedded in the Mental Health Locality Teams. This is promoting a 'think family' approach within the teams and enabling our staff to work more closely with carers.

29. The weekly team meetings provide opportunities to discuss the families they are working with and any issues facing carers. The whole family approach fits with the strengths-based practice being developed in the teams.

30. The teams offer carer conversations, assessments, and reviews, alongside emotional support to prevent carer breakdown.

31. During the Covid pandemic, the support offered to carers has been crucial due to the isolation people have faced and the risks a deterioration in their mental health. We have been involved in carrying out welfare checks to carers and providing support when necessary.

32. A new area of work that we have been able to progress is with families who do not meet the criteria for secondary mental health support. Families are now being supported and no longer 'falling through the net'. The embedding of family work, identifying carers as supporters within the teams is the way forward.

33. We work closely with partner agencies to support carers, including Action for Carers, the CCG and the Helios Project. We attend the weekly Community Mental Health team's multidisciplinary meetings, to raise awareness of carers and encourage referrals to our service when appropriate.

34. We are now beginning to link in with the GPIMHS projects across Surrey and will be working with colleagues in primary care to support them with training, advice and guidance for carers.

35. We attend the SABP Carers Action Group, the Carers Commissioning Group and link closely with the GP lead for carers in the CCG. This ensures that mental health is on the agenda and our staff can contribute and support new pathways and strategies.

36. The Young Carer and Young Adult Carer Strategy Plan from 2021 to 2024 is in draft and this promotes young carers rights, action plans to endure a voice for young carers. We have been fully involved in developing this with young carers.

Covid-19 Pandemic

37. There was excellent collaboration between all agencies including community organisations and staff to support people with mental health needs during the Covid-19 pandemic.

38. The Mental Health teams have continued to operate throughout the pandemic visiting residents and carrying out Mental Health Act assessments (using appropriate PPE). ASC teams supported high numbers of shielded residents during the pandemic including people known to the Mental Health teams.

39. Guidance was issued by the Department of Health and Social Care on the use of remote/virtual assessments during Mental Health Act assessments, this was successfully implemented by the teams. The number of assessments carried out in this way have been very low in keeping with the guidance.

40. Mental Health services across the system have seen an increase in the need for mental health support, activity continues to increase, and levels have passed pre-Covid demand. The acuity and complexity of presentations are higher and there has also been an increase in the use of Mental Health Act detentions over this period.

41. The Emotional Wellbeing and Mental Health Reference Group was set up at the start of the Covid-19 pandemic with the remit of ensuring the development of a coordinated approach to supporting the emotional wellbeing, resilience and mental health of the Surrey workforce and volunteers. The reference group continues to meet, and ASC has an active role within this.

42. From May to August 2020 Public Health commissioned Mental Health First Aid (MHFA) lite course. To date 326 delegates have attended this training from:
    - Surrey County Council – call centres
    - Adult Social Care
    - Borough and District – housing, community services

- Care homes
- Family services
- Voluntary sector
- BAME networks

43. Seven further MHFA lite courses have been commissioned by the Public Health Team for September-December 2020. Overall, this will enable 140 number of people to become trained in MHFA lite. The target for this training is people working with high risk groups.

Conclusions

44. The report sets out the progress and development of the ASC Mental Health Service over the last 10 months.

45. The report also highlights the collaborative work with partners that has been done but clearly there is further work needed to embed the prevention and wellbeing agenda.

Recommendations

46. Adults and Health Select Committee members are recommended to note the contents of this report and any further issues arising from the report that may require further investigation.

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Appendix A Case studies

Tackling issues of anxiety in a motivational strengths-based way – case study

What was the issue?

What did we learn about the person?

Ann is a 46-year-old lady. She has a diagnosis of Somatoform disorder and Autistic Spectrum Disorder. In the past, due to illness and associated poor mobility, Ann previously lived in a nursing care home.

It was then identified that living in a nursing home was not appropriate for Ann.

Ann was supported by the Community Psychiatric Nurse to move into an independent flat and provided weekly visits supporting Ann psychologically and emotionally. Ann had carers who provided support with Ann's personal care and daily living skills.

Ann had direct payments for many years which she managed independently however concern had been raised that she was not using them correctly.

Ann had built up good relationships with her Community Psychiatric Nurse but had become overly dependent on her over the years and now the Community Psychiatric Nurse had left.

Ann said she finds forming social relationships and accessing her local community difficult due to her anxiety and Autism but had a volunteer from Welcome Buddies who would accompany Ann when out in the community. This was working well, and Ann felt the support given by the volunteer was invaluable.

Ann had been receiving the same support services for some time and this hadn't been reviewed. Her Community Psychiatric Nurse left her role and the Mental Health Social Worker became Ann's allocated Social Worker and carried out a review with Ann.

What happened as a result of the assessment?

In order to carry out a review of Ann's services, The Community Mental Health Social Worker spent many months getting to know Ann. They gradually built up a relationship in which Ann felt comfortable to share what mattered to her the most, and what she wanted to do in the future.

Ann advised the Social Worker that she found it difficult to access the community alone, so she had support from Welcome Buddies. Ann felt it was important for this support to continue as

she did enjoy spending time outside of her flat and found her buddy invaluable. Her buddy also supports her with paperwork.

Ann said she sometimes felt isolated and lonely. She enjoyed the time spent in the local community with the support of her buddy and found it easier to interact with others at these times, so this was continued.

The Mental Health Social Worker soon learned about Ann's love of cats and her aspiration to work with them. The Social Worker arranged some volunteering sessions for Ann at the local Cats Protection League.

Ann agreed that the Social Worker should share that she can sometimes get anxious with the other people at the Cats Protection League and they are very supportive. She now spends two days a week volunteering and looking after the cats and making new friends.

Ann raised that she needs support to complete forms and make future decisions around how her care needs are met. Ann's Community Mental Health Team would be able to assist Ann should a difficult decision arise, and they would consider linking her with an advocate if required. Ann's buddy is happy to continue to help her with filling in forms.

As a result of the review and reassessment of Ann's needs, she no longer requires the support of paid carer workers.

Why is this a good example of strengths-based practice?

Ann has been put at the centre of the review of her care and has been treated with respect and listened to.

The Practitioner has taken the time for them to get to know each other and build a trusting relationship. Ann has therefore felt in a safe place to be able to tell the practitioner what her interests, passions and aspirations are, and they have jointly identified how she can make her life more meaningful and enjoyable, a truly person-centred approach.

The Practitioner and Ann have identified that Ann has built on her strengths and is able to carry out her personal care independently. Her services were therefore right sized to allow her continued independence.

The Practitioner and Ann have moved away from traditional services which would have supported her to survive, and instead identified voluntary services that have allowed her to thrive and

reach her aspirational outcomes, which have had a transformational effect on her wellbeing.

Ann has been able to contribute to the local charity and society in general giving her a rewarding job leading to a sense of empowerment and achievement.

Ann has been equipped with support from her network of supportive carers and her newfound friends at the Cats Protection League to be able to overcome difficulties in forming new relationships and they have agreed how they support Ann in moments of anxiety.

Ann continues to be supported by a volunteer from Welcome Buddies to learn coping strategies and feel less anxious when accessing the local community and is widening her friendship circle making her feel less lonely and isolated. She has made new friends at the cat's protection league and meets up with one, a fellow volunteer every fortnight at a local gardening centre.

The Community mental health team have been on hand as a listening ear for when Ann gets a bit overwhelmed and anxious but respond with a reassuring ,coaching approach that gives Ann the opportunity to explore her own solutions to her difficulties with social situations , giving Ann the skills and confidence to come up with tactics to manage her own anxieties.

The services they have identified are non-costed but have led to better outcomes.

Through listening to what matters to Ann, identifying her interests and aspirations and putting her at the centre of planning her support Ann's life has been transformed. She has gone from a lady in her forties in a nursing home, to a lady who lives independently in her own flat and now has a job working with cats, her passion. She has made new friends and lives a fulfilling life.

Tackling issues of anxiety, depression, motivation and substance misuse in a strengths-based way – case study

What was the issue?

Amy referred herself for assessment using the online self-referral. She is 40 years old and told us that she suffers from anxiety and depression and low motivation, and that these issues are exacerbated by her cannabis addiction from which she is having trouble recovering. She told us that she felt overwhelmed and unsupported and that whilst trying to get her life back on track she constantly feels overwhelmed and gives up, and that she has little by way of a support network.

Amy told us she lacks motivation to make food and eat, to get washed and dressed, to form and maintain positive relationships, and find suitable employment that is of more value than simply for the pay cheque.

What did we learn about Amy?

The assessor Hannah visited Amy at home, and as well as talking about the needs that Amy had identified in her referral, took time to explore which of these were most important and what motivated and interested her. We learnt that Amy wanted to feel more content with her life overall and also to put behind her a past incident that had caused significant distress.

Amy had started a university degree and as a result was worried about student debts as well as the ability to pay other household bills and that this was feeling overwhelming, significantly impacting her wellbeing. Amy was in a job that did not suit her and negatively impacted upon a back condition and she wanted to find a job that she felt committed to. We found out that her interests were more about artistic creativity rather than the cleaning job she had.

Amy was frank about her increased uptake of cannabis when she had money, and she had insight into the detrimental impact this was having on her motivation. We also learnt that Amy was subject to unwelcome cuckooing behaviours from some local young men coming to her house to smoke, and that this was not helped by her high hedge and poor fencing, meaning it could go unnoticed by others.

What happened as a result of the assessment?

In discussion with Hannah, Amy identified that she needed support to manage in the community, to develop new skills, find ways to prompt herself to eat regularly, dress appropriately and create a day to day routine for independence and recovery. She recognised that she felt overwhelmed by trying to work and in consultation with her GP it was agreed that she was so tired emotionally and physically that she needed to be signed off work to give her time to overcome some of the issues that were impacting upon her. A goal was identified around changing career to one with a more creative focus, and to tackle this by first keeping herself busy with hobbies, before then volunteering, and eventually finding a new career.

Hannah referred Amy to the Enabling Independence service and Kim has been working with Amy for some months.

Counselling has been recommended by Amy's GP, and an iterative support plan aimed at independence was co-developed

– prior to the current public health pandemic, significant progress was occurring supported by Hannah and Kim.

Kim also supported Amy to attend Citizens Advice appointments where debt management has been started and Amy's entitlement to benefits explored to compensate for lack of income.
Amy articulated a wish to abstain from cannabis and wanted to re-engage with I-Access – she has been re referred and is also exploring attending Narcotics Anonymous.

As a result of a safeguarding enquiry, local community police offered support in relation to the cuckooing. In addition, support from the probation service via Amy's housing officer has been sought to cut the high hedge, giving greater visibility, and funding for a high gate is being investigated to reduce access for unwelcome visitors.

Amy identified that she would like some help with CV writing to learn how to make herself more appealing to potential employers. She also identified that she would like to look at other educational classes through Richmond fellowship.

Amy's support plan incorporates her love of art and the use of a wipe board at home, where she set targets for herself in relation to eating and personal care and can track her own successes.

Kim's plan to escort Amy to an initial meet with Oakleaf charity are on hold due to Covid but will be followed up in due course. They have upholstery courses which Amy is interested in to develop work related skills, reduce her isolation and increase her interactions and confidence. Amy has also attended local knit and natter groups.

Charitable funding has been sought for a new washing machine and freezer by Karen a support worker from Catalyst. Karen also provided Amy with some gardening tools, books, food parcels and phone top ups (using Covid funding) and has been an enormous support during lockdown.

Why is this a good example of strengths-based practice?

Staff established a relationship with Amy by listening carefully and found out what was most important to her. Hannah and Kim explored Amy's whole life including her interests rather than just her needs.

It took time and responsibility was shared, with greater input when Amy needed it and less input as progress was made. Kim and Hannah 'walked alongside' Amy in iterative steps to support her rather than 'doing for' Amy and tapped into her own motivation to change.

Amy's strengths and capacity for independence were explored, and choice and control were promoted by Hannah and Kim who encouraged Amy to take more care of herself and practice a little more of what they called 'self-love'.

Amy's support plan was co-produced with her and the focus was on the self-determined outcomes she wanted to achieve, rather than services that would 'fill a gap'.

Hannah and Kim built a relationship with Amy and supported improvement through stepped successes.

Community resources and other organisations who had a positive role to play were accessed. The role of Karen from Catalyst was integral to supporting Amy and keeping her motivated during the Covid lockdown.

Amy was provided with initial support to try out new experiences and build confidence and independence so that she might subsequently undertake them on her own.

Appendix B – Performance

Caseload

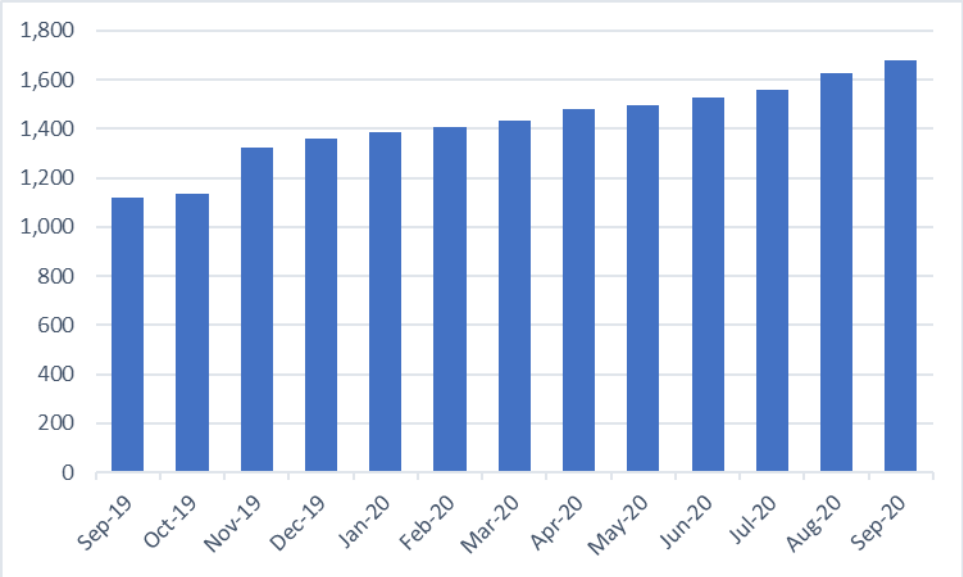

Figure 1: The number of open care cases as at the 1st of the month for the MH Service

Since the split with SABP in November 2019, caseload numbers for the MH Service showed a jump from 1,137 to 1,324 and since then has shown a steady increase to 1,680 in September 2020.

Number of New Contacts

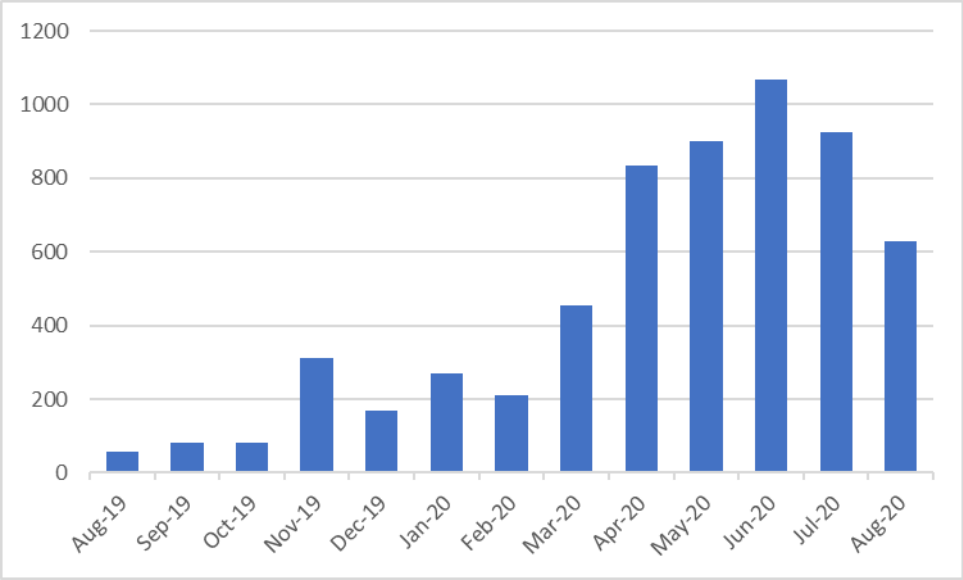

Figure 2: The number of new contacts from the community on clients not open to ASC for the MH Service – based on ASC01

Since the split with SABP in November 2019, the number of new contacts for the MH Service showed a jump from 81 to 310 and

since then has shown an upward trend to 1,068 in June 2020 before falling to 627 in August.

ASC02: Reviewed or Assessed in the Last 12 Months

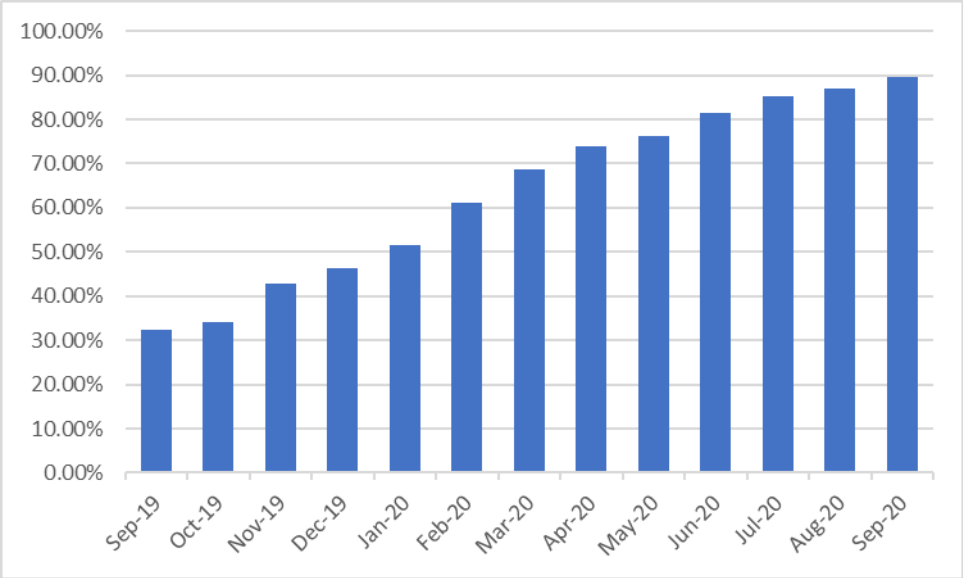

Figure 3: Percentage of people reviewed or assessed in the last 12 months for the MH Service

Since the split with SABP in November 2019, the percentage of reviewed or assessed by the MH Service has shown a jump from 34% to 42.9% and since then has shown an upward trend to 89.5% in August. Target 80%

ASC03: Community DPs

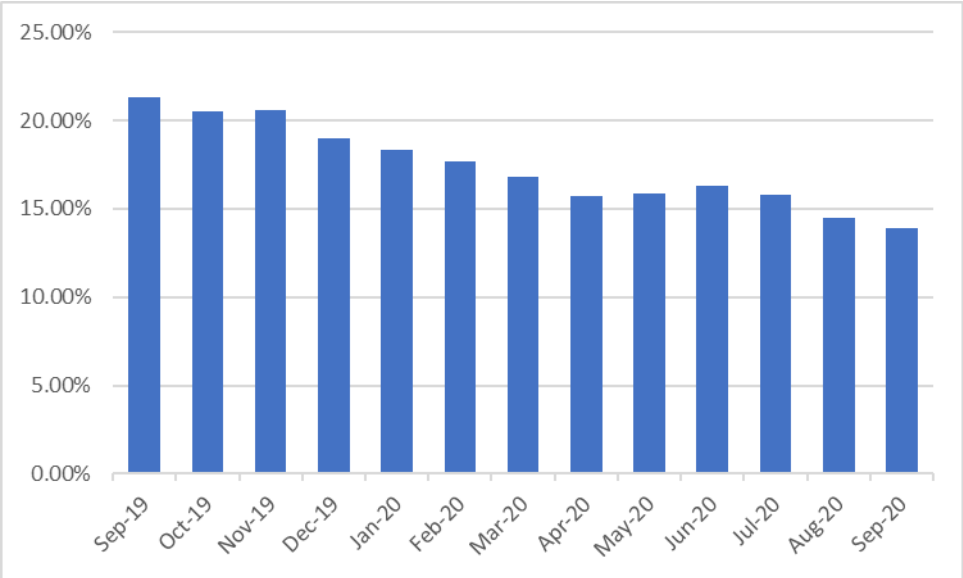

Figure 4: Percentage of people in the community purchase their service with a DP for the MH Service

Since the split with SABP in November 2019, the percentage of Community DPs for the MH Service has shown a downward trend from 20.6% to 13.9% in September. Target 30%

ASC17: Safeguarding Over 52 Weeks

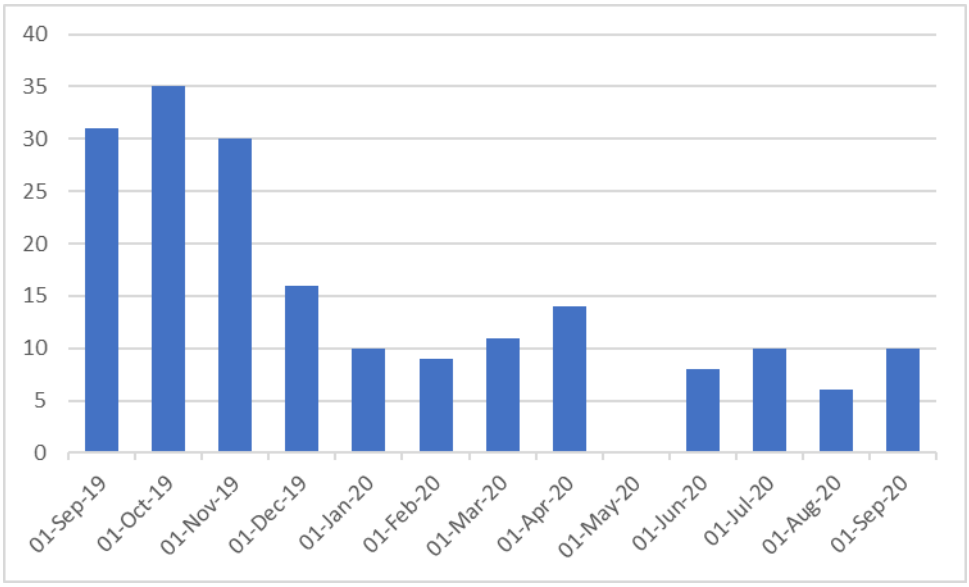

Figure 5: Safeguarding referrals open over 52 weeks for the MH Service (Note: no data for May)

Since the split with SABP in November 2019, the number of Safeguarding referrals open for over 52 weeks with the MH Service has shown a downward trend from 30 in November 2019 to 10 in September 2020.

ASC20: Services No ASCA

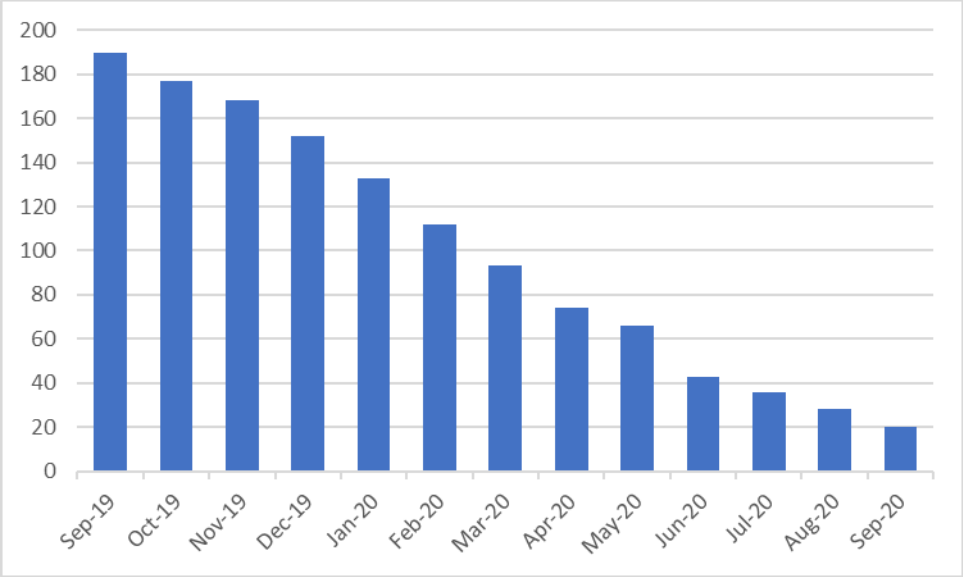

Figure 6: Number of open cases with costed services and no Care Act Assessment for the MH Service

Since the split with SABP in November 2019, the number of non-compliant Care Act Assessments for the MH Service has gone down from 168 in November 2019 to 20 in September 2020. The target is zero.

ASC21: Safeguarding No Process Type

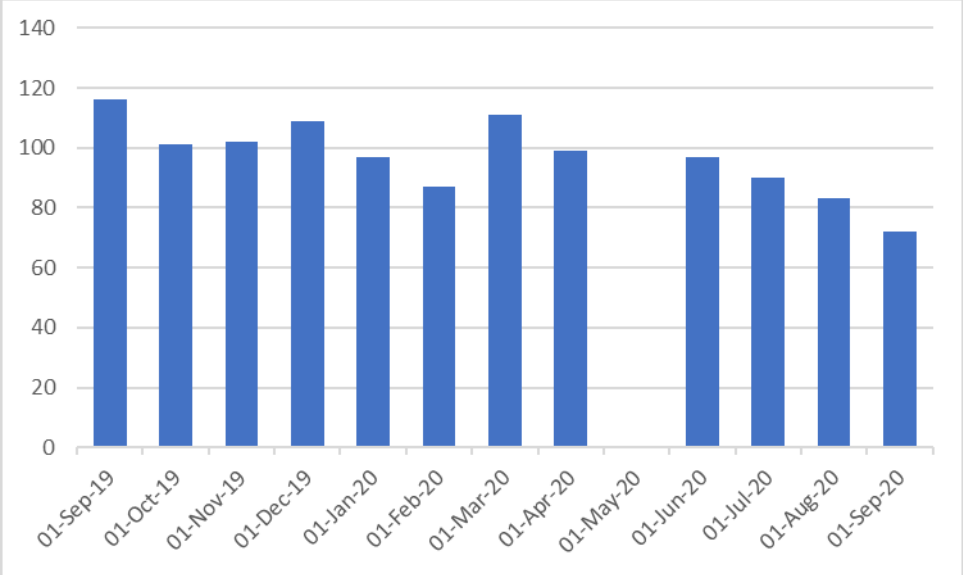

Figure 7: Safeguarding referrals with no process type recorded for the MH Service (Note: no data for May)

Since the split with SABP in November 2019, the number of safeguarding referrals with no process type with the MH Service has shown a downward trend from 102 in November 2019 to 72 in September 2020. There is no target but it is good to be low.

ASC22: Safeguarding No Coordinator

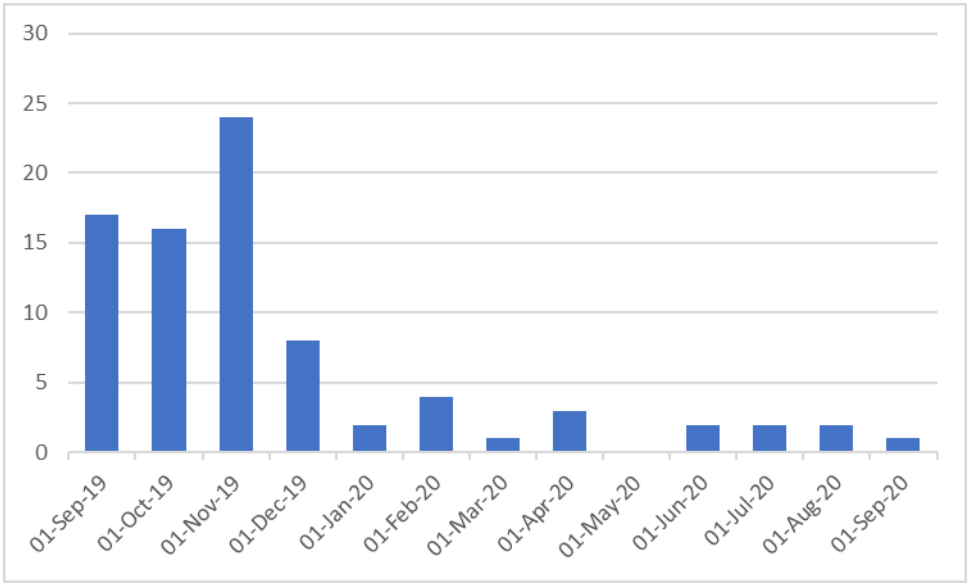

Figure 8: Safeguarding referrals with no co-ordinator for the MH Service (Note: no data for May)

Since the split with SABP in November 2019, the number of safeguarding referrals with no co-ordinator for the MH Service has shown a downward trend from 24 in November 2019 to 1 in September 2020. There is no target but it is good to be low.

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