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SOUTHWARK MENTAL HEALTH SOCIAL CARE SERVICE REVIEW

Internal Review (3 month)
30th March 2017

1 Background

1.1 On 28th November 2016 the London Borough of Southwark's (LBS) Mental Health Social Care service began new working arrangements following the implementation of the Mental Health Social Care Review report (Dick Frak, August 2015). The implementation plan was presented to the Healthy Communities Scrutiny Committee on 22nd November 2016 for approval, with David Quirke-Thornton (Strategic Director of Children's and Adults Services), Richard Adkin (Project Implementation Lead, Adult Social Care), Simon Rayner (Assistant Director, Adult Social Care) and Andrew Farquhar (Operations & Development Manager, Southwark Wellbeing Hub, Together UK) in attendance.

1.2 The Review (Dick Frak August 2015) reinforced the need for strengthening the social care offer in accordance with the Care Act 2014. The aim was to enable people with mental health needs to access assessment and social care support in the community. It embodied a commitment to achieving healthier, safer and fairer communities within the Borough.

1.3 Consequently, LBS Mental Health Social Care Teams were remodelled to reflect the findings of the Review. This included the return of social care funded posts previously seconded to the Mental Health provider trust (SLaM) to the direct management of LBS.

1.4 The 'first phase' of implementation, in transforming the Social Care offer, commenced on the 28th November. The following Social Care teams have now been established:

The Mental Health Adult Care and Social Support Team, supports people with complex and long- term mental heath issues in meeting their Social Care needs under the Care Act 2014. This Team works closely with SLaM teams, as well as other council and external teams, in carrying out joint assessment, taking part in Multi Disciplinary Team discussions etc.

The Substance Misuse Team has joined the AMHP Service and Assessment and Reablement Service at Camberwell Road and provides a stronger focus on dual diagnosis.

The Reablement Team has been enhanced to become the Assessment and Reablement Team and is working closely with the Wellbeing Hub, which provides an essential broader more inclusive point of entry to Services. The Assessment and Reablement Team is collocated and working in partnership with SLaM.
The AMHP Service has been strengthened with an experienced AMHP/BIA to help manage the scale of AMHP referrals, in addition to other service pressures including the location of a centralised Place of Safety within the Maudsley Hospital site.

The Move On Support Team (MOST) is working with people with complex mental health needs who have required residential care or supported living. A 'reablement focused approach' and peer support are enabling more people to live independently, and reducing reliance on residential and nursing care. This Team moved to the base at Camberwell Road in January 2017.

1.5 3 and 6 month reviews were included in the review implementation plan to ensure that the service scrutinises progress made and identifies any key learning from the project.

2 Achievements to date (Dec to March)

TEAM & SERVICE UPDATE

2.1 The establishment of a new **Mental Health Longer Care Team (MHLCT)** to support people with complex and long-term mental health issues enabling them to live independently through creative care and support planning:. The team is comprised of Social Work and Occupational Therapy staff and has a current caseload of 285 people who have an assessed Social Care need. The team is working closely with SLaM and is developing relationships with a number of other organisations and teams in the borough.

ES (MHLCT client) is a 51yr old single man with a brain injury and diagnosis of schizophrenia who had been arrested for assaulting his neighbour when mentally unwell, leading to a lengthy admission to hospital under a section of the Mental Health Act. Social isolation and poor daily living skills made ES vulnerable to exploitation and exacerbated his mental health in the community. ES was placed in supported housing to help with safeguarding concerns and provided with a personal budget which pays for a Peer Supporter to help ES socialise for 3hrs a week and for a personal carer to visit ES three times a week to take him shopping and to help him cook and prepare meals. This support package has been successful in preventing ES from returning to hospital and he continues to make improvements in his rehabilitation.

2.2 The **Assessment & Reablement (ART)** team has been enhanced by additional Social Care staff with personalisation remaining a key element in supporting individuals and families, advocating the national and local agenda in providing choice and control over the support that individuals receive. The Team has established successful joint-working protocols with a number of teams and organisations and has participated in a significant number of joint-assessments in order to reach a more holistic conclusion regarding the service user's care and support needs, and subsequent care plan.

2.3 The ART team continues to work closely with acute psychiatric wards within the Borough to facilitate discharge and prevent readmission and the team and service manager regularly attend weekly bed management meetings with SLaM colleagues to offer professional expertise to individual cases as well as active involvement with certain service users. Moreover, the team has continued to have a positive impact in reducing the various needs of service users, with 77% of service users having their presenting needs reduced following the team's intervention.

2.4 The Service has also successfully established a **Single Point of Access** for professional referrals, with the vast majority of these coming from SLaM teams. Since the service's opening a total of 586 referrals have been received. 238 of these have resulted in an assessment of need, completed by the Assessment & Reablement Team. They have also received 47 referrals relating to safeguarding.

*"Generally my experience of the new adult social services mental health team since the changes has been good if not better than before. Assessments have been timely and full and led to allocation of workers who have been present at meetings (*Consultant Psychiatrist, South London & Maudsley NHS Trust).*"*

"It is very good that we get an instant response from the referrals [to mental health Social Care], and allocation of assessor and an appointment offered (Care Coordinator, Psychosis Promoting Recovery Community Team, South London & Maudsley NHS Trust)."

"I had a very positive experience of referring a client for blitz clean recently with a rapid turnaround when pointed out the state of urgency – I had been told to cancel but went ahead and pursued Adult

Social Care and they came good! (Manager Promoting Recovery, South London & Maudsley NHS Trust)."

2.5 The **Move-on Support Team** (MOST) continues to work with people with mental health needs who live in residential and nursing care homes and various rehabilitation settings. The Team supports this cohort to improve their wellbeing and to make meaningful choices about their lives by engaging with them in a person-centred and holistic way. They are also increasingly providing more specialised and skilled occupational therapy interventions, often working with people who are reluctant and unmotivated to change. The Team has also begun to work with a number of service users who have recently moved to mental health accommodation, to ensure that there is a firm focus on recovery, developing independence and that 'move-on' is kept on the agenda.

In recent months, MOST has supported a service user to move from a 24 hour supported living project to the newly opened extra care housing scheme. The service user had been keen to move into his own flat for many years, to have space/light to work on his paintings and somewhere he would be proud for his family to visit. He is delighted that this has now happened for him. Although he continues to experience symptoms of his mental disorder, he is now in an environment in which he feels a sense of home and has furnished and decorated his new flat to his own taste and preferences. He continues to be co-worked by SLaM and MOST, he is receiving the right level of support to meet both his health and social care needs

2.6 The Southwark **AMHP Service**, strengthened by an additional social work advanced practitioner post following the implementation of the Review, has benefitted from colocation with the Council's mental health service and the core AMHP staffing team. The AMHP provision is now more clearly underpinned by broader social care values and aims. The focus is enabling people to remain living at home and/or reducing the duration of their inpatient admission via more consistent approach to referrals/assessments. Since the Review Implementation, the Team has received a total of 220 referrals, as of the time of the review, including 128 from hospital sources (SLaM community and inpatient teams, A&E, general admission wards etc.).

2.7 The Council's **Substance Misuse Team** has been co-located with the Adult Mental Health Social Work Service since 28/11/2016 at 27 Camberwell Road, reinforcing the Service's commitment to dual diagnosis whilst also enrichening the professional staffing body and affording related opportunities for a more compressive approach to Social Work. This move has resulted in better communication across the service for those service users known to multiple teams. At the time of this internal Review the team had received 46 new referrals since December 2016.

3 What Needs To Be Achieved

3.1 Improved use of case management systems - Mosaic. (New Local Authority IT system). To enhance individual and team performance analysis by utilising reporting and other tools available to the Service through Mosaic. Continue the modernisation of the Service through information and other time/performance management systems.

3.2 More work is required to ensure the integration of social care values within the mental health crisis care pathway in the borough – Home Treatment Team and Psychiatric Liaison at King's College Hospital and Guy's & St. Thomas' Hospital – to reduce unplanned admissions, provide earlier assessment and intervention and facilitate earlier discharge, reducing reliance on hospital based services and secondary care health services.

3.3 Continue to strengthen links with LBS Housing department in order to enhance the Local Authority offer, with a particular focus on supporting people with hoarding issues or anti social behaviour.

3.4 Further develop working links with GPs and supporting Local Care Networks by offering strong social care input within a primary care setting and the Wellbeing Hub.

3.5 To extend and further strengthen working relationships with the Voluntary Sector.

3.6 Co-production of services with users and carers, especially in relation to Peer Support – fostering a more inclusive relationship in relation to commissioning/designing services.

3.7 Stronger role with supporting the Transition of young people with Mental Health problems.

3.8 The Implementation Plan recommended further phases of service development but this needs to be tied in to the Joint Mental Health and Wellbeing Strategy.

4 Partnership & Integration

SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST

4.1 The Service has continued to maintain a strong working relationship with colleagues at **SLaM**, with senior managers from both organisations meeting on a fortnightly basis as part of a '**Partnership & Integration**'' working group, whilst team managers meet on a monthly basis to discuss any case specific or general issues. In addition, LBS Social Work managers are in regular attendance at weekly Trust '**Bed Management'** meetings and '**DTOC' (Delayed Transfer of Care)** calls, whilst an LBS service manager jointly chairs the fortnightly Southwark **personalisation and placement panel** and monthly **forensic placement panel**.

4.2 Whilst LBS teams continue to work with SLaM colleagues on a daily basis, including through the joint assessment of service users, the list below underlines a few key areas in which the mental health division has promoted partnership and ensured a strong Social Care focus at multi-agency discussions:

Attendance at

- Monthly '**Complex Needs Advisory Panel'**
- Monthly '**High Support Team/Supported Living Team interface mtg**.'
- Monthly '**SLaM/CCG Task & Finish placement monitoring mtg**.'
- Attendance at some **SLaM clinical mtgs**.
- Involvement in **SLaM/CCG interview panels**

OTHER ORGANISATIONS & PROFESSIONALS

4.3 Since implementation, the Service has also sought to engage a number of other stakeholders in Southwark with the Assistant Director and Project Implementation Lead attending **GP Locality meetings** in the north and south of the borough on 23/02/2017 to present and explain the changes to Mental Health Social Care and how to access the Service. The Service is also represented at the following meetings:

- **Community MARAC**
- Regular meetings with **Look Ahead Housing, SLaM** and other **Housing providers**
- **Hoarding Panels**
- **Cator Street Extra Care Housing Steering Group**
- **MOST** participate in regular meetings with **nursing and residential care providers**
- Regular contact with **home care providers**

- **Substance Misuse Team Panels**
- **NRPF Operations Board**
- **Temporary Accommodation Working Group**
- Close working with **Experts by Experience**
- **Senior Management Team Meeting** (Mental Health, Learning Disabilities, Transitions)

4.4 The Service continues to enjoy a strong relationship with Third Sector providers. The **Wellbeing Hub** remains closely associated with the Service and has a direct line to the Single Point of Access for referrals and general Social Care queries. The Assessment & Reablement team meet with hub managers on a monthly basis. The Assistant Director for Mental Health is to provide an update on the progress and implementation of the review at the **Provider Led Group Forum** hosted by Community Southwark.

5 Key Issues

5.1 As outlined in this document, the Single Point of Access (SPoA) has received a significant number of referrals since implementation and is looking at ways to manage the volume of referrals.

5.2 Following the establishment of a Single Place of Safety (S136 Suite) at the Maudsley, the out of hours AMHP service has had increased referrals. However, with the recently agreed Memorandum of understanding, with the other 3 boroughs, the referrals and workload have been shared between the 4 boroughs and has mitigated most of this extra work for Southwark. This area will require ongoing monitoring and liaison with SLaM.

5.3 Following the implementation of the Review, the Council needs to work further with SLaM to ensure both organisations are clear about the adherence to statutory responsibilities with regards to safeguarding.

5.4 The newly developed service needs to consolidate the teams further, by improving internal working relationships and support networks, to offer good development and training opportunities, so as to enhance good social work practice.

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London Borough of Southwark

March 2017