Camden Resilience Network

Support and Connect service

Year 2 report

Contents

Anonymity

All names and identifying characteristics in this report have been changed to protect anonymity.

Links to resources

Links are ***highlighted like this*** and can be accessed by clicking on those links.

Executive summary

The Support and Connect Service (previously the Resilience Network Covid-19 Response) has continued its development over the last 6 months. It's success has been nationally recognised and it was shortlisted for the HSJ Partnership Awards. Building on this success, the reach of the project includes efforts to influence broader systemic change as per the Mental Health Community Framework. This evaluation looks at the impact of the service and the experience of those system change efforts. It uses a range of methodologies to highlight the challenges and potential improvements/solutions in creating a service and a network that delivers joined-up, community focussed and person-centred care to those living with mental ill health in Camden.

Process developments

- The service innovated a 'pause' feature, allowing for care intensity to move with the changing needs of people using it. This was appreciated across service stakeholders, but work may be needed to ensure the process is clear to people using the services, and to support key workers' decision-making around pausing.
- An edited version of Dialog has become the key tool used for understanding a person's needs and measuring impact. It is too early to draw data from Dialog, but feedback from people using the service and from key workers has been very positive in terms of its value and applicability.

> *"It feels so nice to be part of this service, my key worker is so kind! I find it really hard to get out the house but she is always encouraging me to go out with her or to meet her at the community hub... the support was there when I needed it, and that means a lot."* ***Jeremy***

Impact

Key Numbers

485	Total referrals
444	People worked with
+2.6	Average score increase in the Short Warwick-Edinburgh Mental Wellbeing Survey
77%	of people found their initial support offer either very or extremely useful
88%	of people felt either very or mostly heard and understood by the service
91%	Satisfaction with the service
93%	One hospital admission from a sample of 77 – a reduction of 93%
37%	Reduction in number of contacts with Secondary Care teams, including a 68% reduction with Mental Health A&E Liaison teams and a 45% reduction with the Crisis Team

- 80% of clients were recorded as either 'active' or 'on pause.' Alongside interviews, this points to the risk of capacity issues effecting the quality of the service – a concern articulated by key workers and clinical stakeholders as more people are introduced to the service. Key workers and clinical stakeholders pointed to the challenge of long-term needs in people using the service, and the challenges around using the 'pause' feature in these cases. The question of where and how long-term support sits alongside the service may be an important one to resolve.
- 60% of survey respondents wanted to be involved in future co-production, but predominantly through one-to-one means such as surveys and interviews.

- 8% of referred people declined the service. Of those we were able to reach, the predominant reason was that they were already well supported. Interviews pointed to the value of systematically checking-in on people who decline the service as needs had changed over time. They also point to the need to clearly articulate the service to make sure it is fully understood.

Qualitative feedback and impact data on service experience was very positive. However, several issues emerged that made it harder for people using the service and their key workers to make the most out of the service:

- Some people had been let down by the mental health system and no longer trusted clinical teams.
- Some people struggled to keep appointments and remember meetings, which made consistency difficult given high workloads.
- Some people had high anxiety or challenging behaviours that made it harder to engage with community spaces, meaning purpose became less clear and pausing/closing the service felt harder.

Connection with clinical teams

A key aim of the service is to improve work between the VCS and clinical teams. When both VCS and clinical stakeholders were active and responsive, collaboration was successful and highly valued, limiting duplication and ensuring full information and stronger care planning. However, responsiveness was dependent on the individuals involved: there were multiple examples of clinical staff not responding, as well as a need for some VCS workers to be more active in reaching out.

Systems change

The organisations who developed the Support and Connect service have been heavily involved in taking what was learnt in the process and attempting to share it with the wider local mental health network to build systemic change. Increased scale and bureaucratic limitations mean change has been slower and messier than initially hoped. However, optimism remains high and many possible solutions were offered to these challenges. An overview of the analysis is in the table below:

Systems change overview

Challenges	Suggested solutions
The pandemic created a tightly focussed purpose and traditional bureaucratic structures were cleared out of the way . As the pandemic has become normalised, more organisational divergence has emerged and more structural obstacles have presented themselves, such as the lag between desire to change and the slowness and rigidity of governance or funding structures.	Interviewees recognised the need to step back, clarify purpose together, and map out key issues to enhance understanding of the pressures and incentives of each organisation, and focus on what each actor can best bring to the table.
The increased number of individuals involved makes it harder to establish and share culture. VCS organisations have found it harder to bring their culture into pre-established spaces.	Processes, accountability, and governance need to be formalised together to create a real sense of mutuality. There is also a direct ask on the VCS to bring productive, solution-focussed leadership to these spaces.
Organisational divergence and the shift from singular project to big, complex system with multilayered teams and bureaucratic structures has created a sense of messiness.	Many interviewees referenced the value and desire for something like the Support and Connect Operations group – a concerted, consistent, mutually owned space to take shared desire for change from an enthusiastic principle into a reality. There was also a need to accept the inevitable increased complexity of the process.
The increased scale stretched capacity.	There is a difficult balance to be found between financial limitations and the need for resources to be invested in the aforementioned processes.

Introduction

This evaluation looks at the impact of and learning from the Resilience Network's Support and Connect service (previously known as the Resilience Network Covid Response project). The project emerged from the pandemic as a way of better joining up services to reach those with long-term mental health needs at a difficult time. The success of that service was demonstrated in the ***previous report***, with significant impact demonstrated alongside an analysis of the systemic changes that had enabled much better working across organisations. Since then, the project has been a key influence in attempts to transform the local mental health system based on the principles of the Community Mental Health Framework, and has been nationally recognised through shortlisting for the ***HSJ Partnership Awards.***

As such, this evaluation looks not only at the impact of the service, but also learns from the experience of service users, key workers, commissioners, directors, and other systemic stakeholders in order to inform thinking about how to proceed in scaling up more joined-up systemic working. It is far from definitive, but points to key experiences, structures, and changes that are influencing current systemic functioning, and makes suggestions based on stakeholder voice.

The first half of the report looks at impact and improvement at the practical level of service delivery, considering reach and engagement, outcomes and outputs, and connections between services. Case studies will be used to bring these to life. The second half examines the project's role in systems change, looking at scaling issues, relationships and governance. Challenges are identified and suggestions are made for moving forwards.

Before these, we will briefly introduce the service and the methodologies used to create this evaluation.

The Support and Connect service

Camden's Resilience Network consists of integrated commissioners from the Camden Directorate of North Central London CCG and Camden Council, Camden and Islington NHS Foundation Trust, and local VCS mental health organisations. At the outbreak of Covid-19 they came together to design and deliver a service that would:

A. Meet the needs of the most vulnerable people in the borough with Serious Mental Illness (SMI) during the pandemic.

B. Implement significant systems change to better respond to the social determinants of mental wellbeing, reduce the burden on an over-stretched NHS, and create a much more person-centred approach to mental health care across the borough.

The service has several key aims:

- Reaching and supporting the most vulnerable people living with mental ill health, including people who don't usually engage with services and those isolated or disconnected.
- Working to a 'whole person' approach, supporting people not only with mental health specific concerns but with the social determinants of wellbeing such as social contact, welfare, physical activity and beyond.
- Supporting smooth referrals between different partners.
- Utilising the skills and approach of the VCS organisations in Camden to enure everyone introduced to the service felt heard, understood, and treated as a full person.
- Using the above to support Camden residents struggling with their mental health and wellbeing to be as connected and as well as possible in their homes and in their communities.

The process

The service structure has been redeveloped over the last year. Its current iteration is as follows, but it is continually adapting based on input from people using the service, key workers, and community stakeholders.

- People are referred into the service predominantly through Secondary and Primary Care. If it is through Primary Care, they are then contacted by a Peer Coach, who explains the service, tries to understand needs, and confirms whether the service is wanted or not. A referred person will then be delegated to a key worker at either Mind in Camden or Likewise.
- The key worker will arrange to speak to or meet the person, whilst also contacting the referrer to understand the context of the referral and ensure the support fits with the rest of a persons care. The service is then split flexibly into three stages.
- The first is the "Getting to know you" stage, between 1 and 4 one-hour long sessions to build a relationship, understand needs, and make plans for how to best make use of the service. At the end of this, the key worker will inform the referrer what they have chosen to focus on together.

- The second phase is anything from 1-8 more sessions to work on those plans, whilst supporting people with what emerges – it is flexible to shifting and changing needs. People may be supported to engage with social groups, community spaces, legal advice, online support groups and more, or they may need to be up if the person, their key worker and the referrer agree they need more clinical support.
- After this, the person and their key worker will review how things are going. If there is still useful support needed, they can continue the service. If it feels the person is in a space where they are better connected and supported and able to make the most out of opportunities, they can either pause or close the service.
- Pause means their key worker will check on them after 2 months, then 3 months, then every 6 months – however, should they need support during that time, they can contact their key worker and quickly receive more intensive support.
- People may choose to close the service if they think the issues they were dealing with have been resolved, or if they are being supported adequately elsewhere.

The appendix has more detail about the underlying principles and approach of the service.

To evaluate impact on people using the service, staff, and the wider system, we have utilised a range of methods.

Methodology

- Service data (referrals, outputs, demographics) was continually recorded by key workers throughout the project and extracted from their dashboards.
- Hospitalisation and service contact was taken from a sample of 77 contacts who had been with the service for at least 6 months and had enough detail in their Care Notes to draw reasonable conclusions. Care Notes was used to track their contact with Secondary Care services 24 weeks prior to and 24 weeks following their initial contact with the service.
- Client surveys were completed on a voluntary basis by 35 people who used the service. This was from a random sample of 90 people contacted, with the only criteria being that they had engaged with the service in the last 6 months. Surveys were completed either over the phone with volunteers or over email, based on individual preference.
- Disengagement data was extracted from key worker notes and semi-structured interviews with an opportunity sample of 6 clients who had declined the service.
- Between May 2020-January 2021, Short Warwick-Edinburgh Mental Wellbeing Surveys were conducted with people using the service at the beginning and at the review stage of their time with the service. Refusals and incomplete data mean that the sample included 32 usable survey pairs.
- Qualitative staff feedback was collected from 2 semi-structured focus groups with 10 key workers from Mind and Likewise.
- Semi-structured interviews were also conducted with a GP and a Mental Health Social Worker referring into the service.
- Case Studies were built through interviews with key workers, key worker notes, dashboard data, and in one case review meetings with clinical teams.

Limitations of the data will be discussed where relevant in reference to each of the findings.

Impact measures

Reach and engagement

As of May 2021, the service has received:

Outcomes

Declined support	41	(8%)
Remain active	277	(57%)
On pause	113	(23%)
Closed	55	(11%)

Ethnicity

Asian	49	(10%)
Black	63	(13%)
Mixed	33	(6%)
Other	41	(8%)
White	225	(46%)
Unknown	74	(15%)

Age

18-28	26	(5%)
28-38	57	(12%)
38-48	100	(21%)
48-58	159	(33%)
58-68	106	(22%)
68-78	23	(4%)
78-88	3	(0%)
88-98	1	(0%)

Gender

Male	229
Female	228
Transgender	1

Inequalities

These figures are broadly in line with borough-wide demographics. The number of people from black and ethnic minority backgrounds worked with is slightly higher than Camden overall, but this is representative of the higher rate that this group receives mental health diagnoses.

Data has only recently started to be collected on sexual orientation, so it is not available at present. Given the disproportionate mental health impact of Covid-19 on ethnic minority communities, and of mental ill health on the LGBT+ community, continual efforts will need to go into ensuring accessibility and outreach.

Capacity

That 80% of clients are either on pause or active raises the prospect of capacity considerations. One of the key values of the service from key workers, clinical staff, and people using the service's perspective was the ability to provide flexible, humane and consistent support.

Simultaneously, it was noted that one of the reasons this was less likely in some clinical spaces was because of burnt-out or overstretched staff [1]. Whilst key-workers still felt they were able to provide this kind of service – a position supported by survey data – there was an acknowledgement that consistency and flexibility were harder to maintain as workloads continued to increase. Many stakeholders recognised the important relationship between capacity and quality.

Disengagement

We have tried to understand the reasons for people declining support through interviews and client notes. Of the 19 people we managed to either contact or get information about:

- 6 felt supported enough already.
- 3 actually engaged for a session or two, but then felt that they were doing well enough that they only needed check-in calls.
- 2 had too many other things going on (e.g. therapy, other team involvement).
- The rest were singular examples, including: finding contact too anxiety inducing; frustration at the lack of face-to-face contact during lockdown; not understanding the service initially and then later being re-referred; making clear that they didn't want the service to their GP, but being referred anyway.

This suggests that there is still work to do on making sure the service is articulated clearly to both people referred and those doing the referring, and on supporting those who are particularly anxious about contact.

2 people contacted for interviews had declined support but now required it, and so were referred to support services through the evaluation process. One person could not remember why they had not wanted it last year, whilst the other said that at the time they were turning away from all services as a result of their mental state. The service might continue to benefit from a process of systematic check-ins with those who disengage (unless they express a clear desire not to be contacted again).

Key workers also expressed the difficulty of working with people whose lives are particularly chaotic. Whilst such people can make use of the service, later disengagement was more likely due to not making planned meetings and key workers finding it hard to continually rearrange busy schedules or find different times to repeatedly call. As such, there is a risk they get forgotten, particularly as workloads continue to grow.

Co-production

60% of the survey sample felt they might want to take part in service improvement in the future. Of those, 60% would prefer to do this on a one-to-one basis, either through phone calls or surveys, whilst 19% would be happy to attend group discussions or meetings. That 19% amounts to 4 people, 11% of the sample of 35 people we were able to contact and who were willing to do the survey from an initial random selection of 90. This points to an issue of co-production, particularly through groups – it represents a tiny and possibly unrepresentative sample of the people using the service. The willingness to engage in one-to-one co-production is more promising and is an avenue for further development.

Outputs and outcomes

Support

Phone: befriending	114	(24%)	
Phone: practical support	104	(22%)	
In-person practical support	81	(17%)	
Phone: emotional support	41	(9%)	
Online group/service	38	(8%)	
Other	36	(8%)	
In-person emotional support	22	(5%)	
One-to-one therapy*	16	(3%)	
Home visits: practical support	16	(3%)	
Clinical MH service referral	5	(1%)	
Home visit: emotional support	4	(1%)	

*One-to-one therapy with Dr Hopkins

SWEMWBS data

Each client was asked to fill in a Short Warwick-Edinburgh Mental Wellbeing Survey during the assessment phase and before they either closed the service or were put on pause. The survey has been validated in many different settings – both clinical and community – to measure and track changes in wellbeing over time. Many clients struggled with filling it out, either as they did not like surveys, felt the questions were too imposing, or struggled to understand it. However, from a sample of 32 survey pairs, the headline numbers were:

Average Wellbeing Score change between measures	**+2.6**
Percentage of clients with positive changes	**60%**
Average change for those whose change was positive	**+5.6**

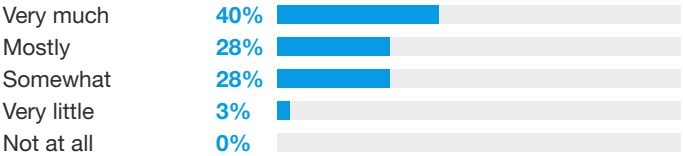
Most researchers agree that a score of +/-2 is a statistically significant change in wellbeing[2]. These changes have to be considered amongst national averages during the ups and downs of the pandemic – work by the ONS suggests that for people living with long-term mental illness, wellbeing has dropped and stayed low throughout[3]. Whilst using a different metric, it suggests that the majority of our clients are going against the national trend and improving their wellbeing after using the service.

Dialog

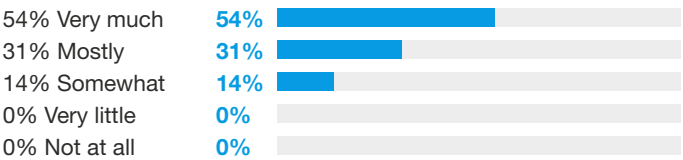
The lack of uptake in SWEMWBS and the desire for shared outcomes across the network has led to Support and Connect swapping the wellbeing survey for Dialog, which may shortly be rolled out across local mental health services. Dialog is a questionnaire that rates satisfaction with specific areas of a person's life across two categories – general (eg. physical health, mental health, employment) and clinical care (eg. medication, clinical relationships). Small edits have been made to the original questionnaire – a question about finance has been included (as this is a major area of concern for many people), as has a 'blank' question where people can choose their own life area, allowing for more control and a tailored approach (see appendix for detail). This may need to be addressed when Dialog is rolled out across the borough. Whilst it is too early to use this data for impact analysis, people using the service and their key workers have both stated that they prefer it.

Feedback surveys

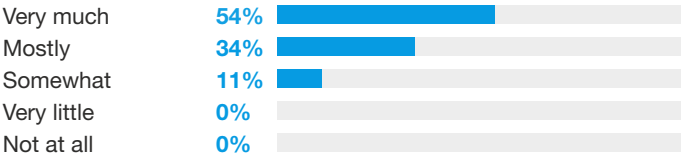
You were supported with what you needed



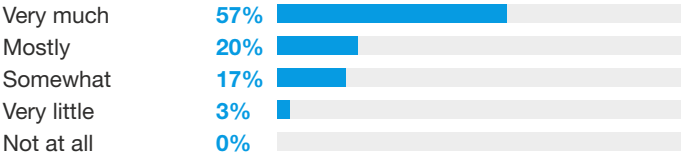
You were able to build a good relationship with your keyworker



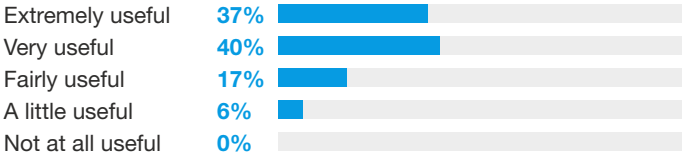
You felt the service heard and understood you



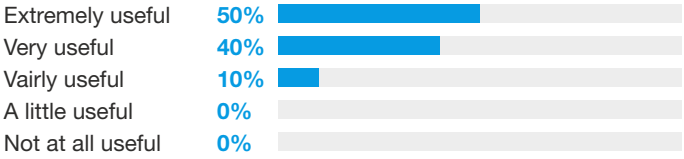
You feel you had control over the support you received



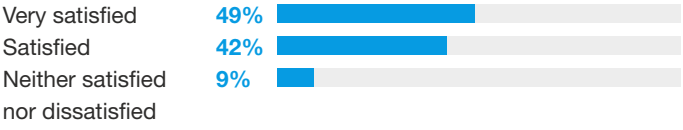
Of the initial support people received, respondents found it...



For those who received a second form of support...



91% of people were satisfied with the service



Much like last year, the primary support given was social, emotional, and practical. The most consistent feedback from people using the service related to these areas, with people experiencing the non-judgemental approach, the listening skills of key workers, and the consistency of the service as central to its value.

> *"The service gave me a lift and a guide rather than pushing me into things. The world would be a better place if all services were like that"* ***Terence***

Resolution of practical issues were the second most common explanations for satisfaction. Of particular note were resolving financial issues (getting grants, resolving benefits issues), but shopping, household issues (repairs, bills) and ensuring medication collection were also all commented on as particularly useful. Key workers struggled with housing issues again, particularly because they had very little success in getting any involvement from housing teams.

Both staff and people using the service raised an issue of not knowing what to do or how to make the most use of the service. Whilst key workers recognised the importance of 'small gains,' and of the value of 'walking alongside a person' regardless of the hard outcomes, the also felt that some needs were particularly challenging to cater for.

> *"I'd be more satisfied if my worker had more time to help me with everything. But she does her best, and she's very supportive."* ***Susan***

A few examples were given. One was long-term work in order to rebuild trust in the mental health system – several clients had felt traumatised or let down by their experiences under the care of clinical teams, and really struggled to engage with conversations or connections with them. One area where staff felt they could provide value here was in supporting people to understand exactly what support they are connected to and who to contact based on each issue – this seemed to alleviate some of the stress of confusing care pictures.

Another issue that emerged was that for some people referred to the service – particularly those with lifelong challenges with their mental health – community engagement was not what they wanted or could manage. Two sub-issues emerged here – firstly, the difficulty of working with people whose lives are chaotic. Whilst able to make some use of the service, some people struggled to settle on a particular area to work on, and later disengagement was more likely due to not making planned meetings and key workers finding it hard to continually rearrange busy schedules or find time to repeatedly call. This increased the likelihood of disengagement, and made it harder to build community connections.

> *"Some people can't get to that stage of interacting with community – it's really hard for them to just pick up and attend this or that centre, it takes time. This model and the way it's provided has helped – I've seen it first hand."* ***Mental Health Social Worker***

The second issue was for those who really struggled with social relationships. People using the service named issues around motivation (often linked to medication) and anxiety, whilst key workers also noticed that some of the people they supported sometimes displayed behaviours not often accepted in mainstream settings. In these cases, finding community connections where people felt safe and supported required real patience and flexibility from that community service. Whilst that could be and was provided by the Support and Connect service, it was a harder ask on other spaces such as community centres and arts projects.

> *"I wish I was more confident about the service, it would help me make the most out of it – I'm still quite nervous and anxious."* ***Nadim***

For clinical staff, these issues were not as central – they were fully aware of the challenges of working with people living with quite severe distress, and felt much value lay in the service's humane approach, it's responsiveness and flexibility to each individual, and its capacity to hold and support people consistently. They felt it helped address issues of isolation that existed prior to the pandemic. Indeed, the impression from all feedback was that it was this approach that was core to the identity and success of the Support and Connect service.

Pause Review

As the pause was a new feature, we set out to understand it explicitly. In qualitative feedback, people were generally positive about it – they felt it was far better than being left alone, and it was seen as very reassuring to know someone was there if they needed it. However, one person found it confusing, and one person suggested that they wanted to re-engage but had not done it yet. This points to the need for clarity of explanation and reassurance that re-connecting to the service is easy and accessible. Whilst key workers always tried to keep on top of check-in calls, capacity meant that if someone did not answer it was easy to forget until the next call was due.

> *"Pause is a good idea. It gives a window to see how someone manages, and that all helps with forward planning – by a certain stage we'll know whether they need longer term support or not. It allows everyone to work together early on to identify and prepare for that."* ***Mental Health Social Worker***

> *"I've felt supported by the knowledge that quick help or advice is an email away."* ***Izzy***

Key workers reported mixed responses to pausing. Whilst all agreed it was a good feature of the service, there was an awareness of the increased burden it put on them. Some found the decision very difficult to make when someone had lifelong needs that were still not being as supported as they would want, or when they remained particularly isolated but this did not look like being resolved any time soon. The lack of hard boundaries was also felt by some to make things more confusing for them and for people using the service.

Long-term needs

Both the pause review and the consideration of outcomes led to a question from people using, staffing, and designing the service around long-term needs. Whilst the value of simply being there for a person with long-term needs is important, the fact is that the service cannot work with them forever. Conversations have been started about how this might be managed by the network moving forwards – this evaluation finds that there could be real value to a longer-term service, particularly if it could integrate a pause feature in the same way.

Connecting the Network

Referral from

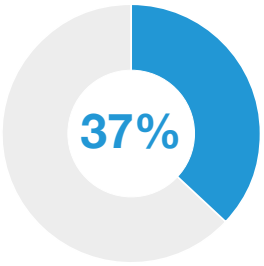
North Camden	164	(34%)
South Camden	117	(24%)
Primary care	133	(27%)
CDAT	20	(4%)
PD clinic*	8	(2%)
Other	43	(9%)

*Personality Disorder clinic

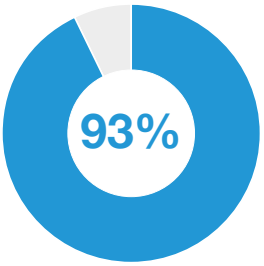
Running rates of clinical contact

One aim of the service is to prevent the kinds of crises and challenges that often lead to increased contact with clinical teams. Whilst reduced clinical contact is not the main goal of the service – much work might actually be about increasing contact with clinical staff, or ensuring it is better focussed on their specialisations – it nonetheless remains a useful metric to understand what impact Support and Connect is having on clinical care.

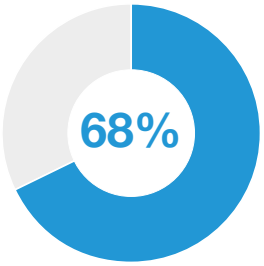
Headlines for our sample include:



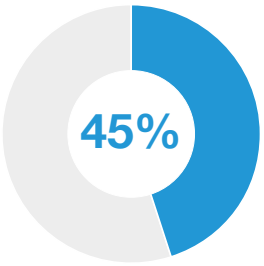
An overall 37% reduction in contact with Secondary Care teams, with 68% of people receiving the Resilience Network service reducing their contact.



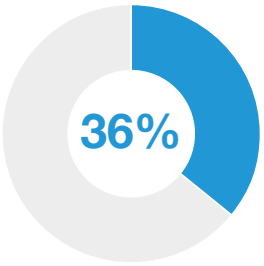
A 93% reduction in number of contacts with Acute Bed Management teams, with just one person hospitalised and another admitted to a Crisis House.



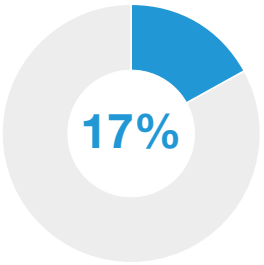
A 68% reduction in contacts with A&E Mental Health Liaison Teams.



A 45% reduction in contacts with the Crisis Team.



A 36% reduction in contacts with Care Co-ordinators.



A 17% reduction in contacts with Social Workers.

To contextualise this, we also tried to collect data for overall Secondary Care service contact and referrals as a comparison. Whilst detailed analysis has not yet been possible, the current limited indicators seem to suggest that across the clinical services included here, rates of contact/referrals have fluctuated but average out across the year – so far, we cannot see significant evidence of increases or declines in client contact across the reporting period. This makes it more likely that the above results are meaningful to the service intervention.

On a demographic level, there is no significant difference between results across different identity demographics including gender and ethnicity.

There are several limitations to these statistics. Firstly, they are correlational – causal inference is hard to prove without a control group and more evidence of direct impact. Secondly, data was collected and collated manually, leaving room for human error. Whilst the data set is a promising start, moving forwards we will be working with the informatics team to automatically generate results, and attempt to integrate a mechanism for demonstrating causality.

These numbers also need to be interpreted in relation to the community framework – we are looking to make better use of communication between the VCS sector and Secondary and Primary Care in order to make sure each person's whole support network is responsive to their needs. There were only 12 cases of this communication showing up in Care Notes. Whilst reduction in the contact with crisis and hospital services is reassuring and suggests success in preventing serious deterioration, we also interviewed clinical and VCS staff members to understand how lines of communication were and were not working.

Qualitative feedback

The biggest factor determining success of communication across teams was responsiveness. Confidence and collaboration was felt to be far easier and more productive when referrers replied relatively quickly. VCS key workers felt uneasy hassling clinical staff if they did not reply to their attempts at contact – they were unsure at what point they were becoming a nuisance.

Responsiveness was mixed across the network. Whilst GPs seem to be the hardest to contact, there were also several who were excellent. A question was raised as to whether there might be more direct ways of contacting GPs rather than through surgery reception. Secondary Care teams seemed to depend on the individual – again, some very strong relationships and collaborations were built between certain people, whereas others were unresponsive, making understanding the picture of care much more difficult for people using the service and their key workers.

> *"Responsiveness from mental health teams gives confidence that you can reach out – no response doesn't really feel like a resource that is helpful. We often stop reaching out to those people, and it can be really frustrating. I've had to ask for a manager in the past. I'd love to understand more about why some people don't respond – is it just that they are busy? Are we low on the priority list?"* ***VCS Key Worker***

This was also reflected by clinical stakeholders. When key workers were active in informing them of what was happening, they felt they could build a strong care plan, and appreciated the extra pair of eyes on the ground. They felt this kind of support – with its flexibility and co-operation – was a much needed and very useful service. However, some key workers were engaging with them less, meaning they could not build the same picture of what was going on for the person they referred.

It was also suggested that the VCS and clinical teams could do more to maintain engagement with each other. Group strategic and operational meetings had paused and the initial close contact between different service actors had drifted. There was a felt risk that this would create more distance and slow problem solving.

> *"It's really helpful cus I know form my perspective how the person is getting on, I get feedback from them too, but from yourselves I get this other perspective that is really useful."* ***Mental Health Social Worker***

Systems process issues were also named – a significant challenge for the network is in data sharing across different data systems, particularly between Primary and Secondary Care. Case studies revealed this to be particularly problematic.

An important take away from this data is that communication and relationships across the network have significantly improved in this service, every stakeholder values that improvement, and this has had real impact for people using the service. However, there remains lots of space for improvement.

Impact summary

Key impact

- High service satisfaction.
- Increase in wellbeing scores, decrease in contact with clinical teams (especially crisis-related teams).
- Positive feedback on 'pause' element.
- Representative service reach.
- Increased and valuable cross-team working.

Areas for development and enquiry

- Capacity issues risk becoming an issue.
- Housing remains a very difficult area for key workers.
- There is a significant number of people who have longer-term needs , raising aquestion as to whether this requires a long-term service or if key workers can be better equipped to flex to these needs.
- Space for significant improvement in communication between key workers and clinical teams – requires a dual response from both VCS and Secondary and Primary Care.

References

1 This is supported by wider research, see: ***https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3156844/***

2 Shar, Cader, Andrews et al (2018) 'Responsiveness of the Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS): evaluating a clinical sample'. Health and Quality of Life Outcomes 16:239

3 ***https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalwellbeingintheukquarterly/april2011toseptember2020***

Case studies

These have been selected not to 'sell' what we are doing, but to bring both strengths and weaknesses to life. They operate as reflective learning points about the nature of the service and how it might improve moving forwards. Names and identifying details have been changed to ensure anonymity.

Case study: Gary

Referral	From GP – however, main point of contact was named as psychiatrist. An attempt was made to contact the GP at the beginning of service, but no response came through.
Given reason for service need	To work on physical health, ensuring medication and food delivery during pandemic, and befriending.
Details	During the 'getting to know you' phase, Gary's key worker found that his food and medication issues were being well catered to by his cousin. His main issues were his finances – his PIP had not been coming through. This was already being managed by his R&R team. His lack of money meant he could not afford the furniture necessary to cater for his disability – as such, he was confined to his bedroom throughout lockdown. Gary's key worker – Tye – and a volunteer supported Gary in successfully applying for a grant for furniture. This allowed Gary to better make use of his home. The volunteer also did befriending calls with Gary throughout the lockdown. During these, it became clear that Gary was keen to start getting out of the house and doing more. The volunteer and Gary arranged regular walks. After a few weeks of building confidence with walking, Gary got used to going out and began meeting friends. He now meets friends regularly. He is still looking for an activity to do, and once he has found something he enjoys and has settled into, they will pause the support. Tye realised that there was a safeguarding issue relating to Gary and his cousin. Tye and Gary spoke about it, and Tye said he would contact the duty team as a result of the issue – Gary agreed, but asked to communicate that he wanted an additional week to sort things out himself. Tye and the duty team emailed back and forth, with the duty team agreeing that it made sense for Gary to try and resolve it himself first. This went well, and whilst it is something they remain aware of it is not an issue at present.
Key takeaways	• The nature of the referral process sometimes makes it harder to contact referrers. Sometimes key workers build contact with other members of the support team who are more involved or responsive. • It often emerges that the given reasons for accessing the service do not match up to the needs of the individual. • The relationship developed means safeguarding issues were seen early and managed without the need for intervention.
What could have been done differently?	• Could the key worker have better managed contact with referrer/ main point of contact? • Is their anything in the introduction and assessment process we can do to better engage those doing the referring?

Case study: Saeed

Referral

From R&R Psychiatrist – wanted a space for Saeed to relieve some of the anxiety around the pandemic and have someone to talk to. Saeed had worked with Likewise before, and found it useful.

Details

Initially, Saeed was confused due to the key worker who he previously worked with at Likewise contacting him again – he struggled to disentangle the two different support services Likewise run.

He used the space to talk and reflect on his anxieties and goals. They met outside to get Saeed out of the house. He found value in this and wanted to make use of it, but the conversations were fairly repetitive. He was keen to be involved in activities (eg. Digital Collective), but finds he has very high expectations and is often too anxious to engage. Where he did engage, it was only for one session.

The key worker was unsure of the value of the work, and where it was going. She had a sense that she wanted to do more, but was unsure what.

Contact with referrer had been very limited. Following the previous support from Likewise, the key worker had emailed to suggest long-term support would be more beneficial. There was no response to this. The key worker had not attempted more contact.

Support currently ongoing, but with conversation started about pausing.

Key takeaways

- Introduction into the service can be confusing for people, particularly if they have worked with the organisation before.
- Emotional support space can be very valuable, but can also leave key workers feeling like the support is not good enough.
- Getting involved in community activities can be highly anxiety inducing, resulting in lower take-up.
- Both key workers and referrers need to be pro-active in reaching out and being responsive.

What could have been done differently?

- Can better clarity distinguish the boundaries of different services?
- Does it make more sense to link people up with key workers they know, or to start afresh?
- How can we encourage more contact between referrer and key worker?
- Would a long-term support offer be more appropriate?
- Can we better support people into community spaces?
- Can we support community spaces to hold people living with mental distress?

Case study: Leslie

Referral

From GP. Leslie had been under a mental health team several years ago, but discharged. Since then, it had been a struggle to get her referred due to her not quite meeting criteria. Leslie found being denied support very difficult take, so this service made sense as the GP knew she would be accepted. The GP felt Leslie would benefit from some consistent emotional support, and knew therapeutic services were beyond her financial means.

Details

Leslie felt relieved to have the support, but was very anxious about being abandoned by it despite reassurances by Rachel, her key worker.

They set-up weekly visits to get to know each other, and also introduced a volunteer, Sazia, who could do more consistent visits. Leslie would use the time to talk through her week. She struggled with voices, and often had suicidal or destructive ideations – together, they would talk through these, establish if there was any risk, and enable Leslie to think them through. They went through therapeutic exercises that Leslie had done years ago, as Leslie found these helpful. Practical issues also came up during the meetings including hospital appointments and medication collection that Rachel and Sazia supported. Through these meetings, it became clear that Leslie was taking less of the medication she had been prescribed as they were making her so tired. However, this effected her mood. Leslie agreed that Rachel should share this information with the GP, and the Crisis Team got involved. During the Crisis Team discharge meeting, Leslie stated she was back to taking full medication – Rachel knew this was not the case, and brought it up, so the Crisis Team stayed with her for a few more weeks. Leslie reflected that she was pleased with Rachel's intervention. Following this crisis, they spoke about the warning signs and built a plan of what to look out for. This enabled for Rachel and Sazia to name when they thought things might be spiralling for Leslie, and helped Leslie reflect and respond to this.

Leslie cancelled a few appointments, and then stopped answering the phone to Rachel. Through a conversation with the GP, Lisa learnt that Leslie was doing well but felt that Rachel did not like her and no longer wanted to work with her. The GP said that pulling away from services was something of a pattern for Leslie. The service is now closed.

Key takeaways

- Introduced to service as a result of lack of access to long term mental health support.
- Timely and responsive contact between GP and key worker allowed for quick responses to crisis.
- Trust and knowledge built allowed key worker to ensure Crisis Team had the right information, even where it juxtaposed client's account – as a result of previous conversations, client did not feel undermined by this.
- Crisis prevention can take time for relationship building and learning warning behaviours.
- Very difficult to plan for some eventualities and circumstances.

What could have been done differently?

- Could pattern of retreating from services been addressed with Leslie early on?
- Rather than closing the service, could Leslie have been offered the opportunity to work with someone else?

Case study: Alice

Referral

Alice was referred by Camden R&R for support. Her Care co-ordinator had recently left, and she was being considered for discharge. She was also receiving support from a peer coach.

Details

Her Resilience Network key worker, Sean, noticed that she had no electricity for a considerable period of time, and was showing general signs of self-neglect. He flagged this with her team at Camden R&R. However, their attempts to visit her were unsuccessful. She did accept visits for food delivery from a volunteer with the Resilience Network service who continued to flag concerns about Alice's deteriorating mental health. However, further attempted visits to her by the R&R team were unsuccessful.

When the Camden Team contacted Alice's GP, it became clear that her medication had not been issued for several months due to lack of attendance at her annual physical health review. These concerns and the lack of contact meant she was referred to the Crisis Resolution Team, who were also unsuccessful in visiting her. As a result, she was eventually referred for a Mental Health Act Assessment and later went to hospital due to poor physical health.

As a result, safeguarding enquiries and a review have taken place to address these communication and connection issues, and to support learning and planning for better integration.

Key takeaways

- The lack of data sharing between GP's and Secondary Care teams meant a major issue (the ceasing of medication) was missed. This continues to be a tricky issue due to the differences in data systems the different teams use.
- The role of the volunteers/ peer coaches here was important in flagging problems – however, could this have been done earlier? Furthermore, without the relevant information sharing between clinical teams, action taken was ultimately too late.
- The care plan of the client after the previous Care-Coordinator had left was lacking – this is an issue RN key workers have identified for several of their clients, with their status in Secondary Care being in limbo or unclear.

Systems change

In this section, the evaluation looks at what has been learnt about influencing systemic change and shifting the relationship between Secondary Care, Primary Care, and VCS services through the Support and Connect project and its extensions over the last 6 months. Interviews were undertaken with 7 stakeholders, including commissioners, directors, social workers, VCS leaders, GPs and mental health nurses, alongside two focus groups with key workers. These have been used to draw out patterns and trends, and look at key opportunities and risks for the next 6 months.

The prior report pulled out several key facets of success in the initial Resilience Network project that offer a useful context. To recap, at the onset of the pandemic in a very short time the network significantly altered the way it interacted – shared purpose and language flourished alongside genuinely mutual relationships.

Three key structural factors contributed to this:

- The absence of competitive tender
- The create-as-we-go approach
- The capacity for people to flex in their roles

Four behavioural factors were also key:

- Common purpose
- Transparency and the ability for 'difficult conversations'
- Humility
- Reflective practice

In hindsight, interviewees reported that many of these structural factors were still considered integral. However, people recognised significant changes in the new context of broader working that brought more complexity and challenge.

The loudest element of this in the interviews was the value of the relationships and culture developed in the Support and Connect service and the challenge of maintaining and spreading those through the system with increased scale and bureaucratic obstacles.

Support and Connect had been developed somewhat organically, with trust, openness, and power-sharing developed on-the-go. This was made far easier in the context of the pandemic, during which bureaucratic structures were able to be leapfrogged and unity of purpose was tightly focussed – individual organisational interests were easier to bypass. It was also a relatively confined project, with the strategic group confined to 13 people and the operations group with 6-8. The desire for a genuinely person-centred, community and socially focussed network was universal, and the norms of working to achieve that were quickly shared between each member. A specific culture of values and belonging that excited and engaged people was developed.

As the pandemic became normalised and the ambitions to influence the wider system grew, there was a general sense that this culture became diluted. Whilst the service continued to function well and relationships remain strong between the original cohort – all interviewees spoke highly of each other – individual organisational pressures re-emerged and more and more actors were brought in who had not shared in that initial culture. As such, good will and personal energy no longer held the power that it had. Organisational divergences crept in, and cohesiveness loosened – almost all interviewees spoke about the lack of clarity or 'messiness' of the current system-change efforts. They acknowledged impatience, frustration, and disappointment at various elements of this.

Promisingly, though, optimism remains high, every interviewee remains committed to the community framework and a more person-centred systemic response to mental ill health and distress, and many potential solutions were offered. Together, the challenges and potential solutions point a way forwards through the current messiness of change.

Challenges	Suggested solutions
The pandemic cleared bureaucracy, allowing individuals to flex from previous roles and focus intently on building, providing, and maintaining the service. Many organisational pressures have now returned meaning individuals from each organisation are having to juggle more concerns and competing priorities. This makes progress slower and more complex than it used to be, and increases the divergence between organisations. One area in which this can be seen is in regulatory lag – whilst all partners are unified around the desire for change and the value of the community mental heath framework, legal and regulatory frameworks limit how much can change and how fast. From VCS governance to NHS financial regulations, individual organisational need and culture means that good will does not translate as easily into action as it did last year.	it was apparent that each actor could do more to better understand the pressures and incentives their partners are under. This requires transparency, open and challenging conversations, and patience. Supporting this, many interviewees articulated a need to step back and further clarify purpose together. Systems theory points to trust, mutuality, unification of purpose and shared understanding as central to productivity in complex systems changes [4]. As part of this, several suggestions for enquiry were made: • What it is each stakeholder does well, and how to utilise this. • How different sub-groups are running, and how to get the most out of them (including issues such as culture and decision-making). • What the organisational pressures and needs are for each actor; what each actor wants or needs from other organisations.
Whilst there is broad agreement and enthusiasm for the community mental health framework, as more actors emerge from the wider picture they inevitably have their own pre-established organisational norms and behaviours. Entering into such spaces has meant VCS organisations have found it harder to assert the values and approach that had mutual buy-in in the initial Resilience Network Support and Connect service. It also makes it more likely that people will misunderstand each others intention, language, and processes, and means collaboration has been more stunted. This is exacerbated by less regular contact between stakeholders, meaning more siloed working, slower response, and less rewarding relationships.	There is a need to formalise agreements and processes together. With increased scale and bureaucracy, reliance cannot be on the relationships built during the Support and Connect development. Clearer boundaries around how decisions should be made and how mutual accountability is held in different spaces is required to maintain cohesion and a sense of genuine mutuality across the different stakeholders. In particular, governance should be prioritised – external examples (eg. Somerset) have emphasised the importance of this in building alliances across systems. Commissioners and stakeholders have also asked for VCS to assert more leadership in the network. There is permission to bring the values and ways of working that enabled the Support and Connect service to thrive. It is important that such leadership is productive and solution-based – in maintaining the momentum of the changes and the mutual respect between actors, critique needs to sit alongside suggestion for improvement.

Challenges	Suggested solutions
Interviewees pointed to the increased messiness involved in making sense of the current picture. This was in reference to how things get done, when, and by who; in reference to each organisation and individual's position on various issues; and in reference to funding and bureaucratic structures. Where informal agreements sufficed to unify people in process and purpose last year, such agreements are more easily lost in the scale of change being attempted. Several interviewees spoke of time spent trying to build clarity and drive things forward being more complicated and time-consuming than they would like. A few individuals felt they had a clear picture of what was going on, but this did not apply to everyone.	In some spaces, clarity requires making the abstract more grounded – being explicit and practical about turning ideas and enthusiasm into reality. Several people referenced the value of the Operations Group in the Support and Connect service as it dealt with the nitty gritty of joined-up working, making the 'what' of systems change happen, bringing every partner round the table consistently to work on everything from sharing processes and outcome measures to maintaining shared culture and relationship building. It was a space well project managed by commissioners, but very much mutually owned. It was felt that a similar space might benefit broader changes. There is also a need to learn through the mess. Systems change is inherently messy, and something that needs to be adapted to. However, theory suggests one way to navigate this complexity is to ensure learning is continual[4]. Having structured learning/reflection points may support stakeholders to be reassured that mess is moving in the right direction, and support a course change if it is not.
The increased scale and ask creates capacity limitations. Whilst VCS, NHS and commissioning leaders are largely relishing the shift in their roles from inward focus to outward partnership working, they recognise they cannot be everywhere they want to be or build every relationship they want to – they have limited time and head space to consider the total complexity of the network. The funding for VCS systems work has been invaluable, but the demands of broader systems influence continue to stretch capacity.	The kinds of changes being attempted require significant time and resource – the whole system may be at a point where it needs to decide how to prioritise this. However, this sits uncomfortably alongside financial constraints and pressure to deliver as quickly as possible. A balance needs to be struck between cracking on and stepping back to make sure what moves forwards is in the shape imagined at the start of this process.

Conclusion

Systems interviews revealed many challenges typical of larger systems change at the levels of culture, structure and practice. Whilst there is a lot of work to do, the experience of the Support and Connect service and the appetite for solutions and progression bodes well for change.

Reference

4 See ***Lankelly Systems Behaviours*** and ***Human Learning Systems***

Appendix

Approach

The below is taken from a document used in a training workshop with Likewise and Mind key workers. It lays out the approach and underlying principles of the Support and Connect service.

Support and Connect: the 'Getting to Know You' phase

The first 4 sessions of the service we are calling the 'Getting to Know You' phase. This emphasises the relational nature of the service, and encourages both you and the client to relax into it and build mutual understanding. This is not to say you won't be active – people may want to get working on things straight away – but it takes the pressure off and allows time to really focus in on what matters to each person.

On this note, we would encourage you to experiment with avoiding all forms and tools in that first session. It might help set a tone of relationship first, and encourage you to use your creativity to build relationship.

Where are you and who are we?

A lot of people might come into the service with a very limited understanding of who we are and what we do, so it's important to set the scene and provide people with clarity.

People need to know:

- Relationship first – when we build better understanding of who a person is, what challenges they face, what strengths they can build from, what interests they have, and what they are like, and when they build trust in us, we're all more likely to make the most out of the support. Of course, if easy wins and actions are available, we can take them, but there is no rush – the first few sessions are designed to get to know each other.
- They are part of a network – whilst they are working with you, the advantage is that you can connect to their mental health team, their GP (if that's where the referral came from), other VCS services, social workers etc in order to support them in a way that makes sense to them.
- This network thinking also applies to understanding a person – we'll be able to support better decision making when both ourselves and the person we're working with have a full understanding of the networks they are connected to and the impact of these on their wellbeing.
- Whilst we are part of a network, the person is in control. Whilst professionals in their team might have suggestions worth listening to and encouraging, the support is about what matters to them and what they want to work on.
- Given this, confidentiality is important: we are part of a network and want to share information that can support a person's overall care – we hope this actually gives someone more control of their care and their wellbeing. However, if a person does not want to share info with any particular person or team, we will respect that. We might encourage conversations with that team to try and improve relationships, and if these don't work then we would inform that team or professional on what kind of information we would not pass on. The exceptions are if a person's health and safety is at risk: we have a Duty of Care and must follow Safeguarding processes, and this does require sharing information with the relevant people.
- We say that there are approximately 10 sessions of support. This is just a guide – the reality is that we recognise that some things take longer and some things take shorter – we'll work according to the realities of each person's situation and the capacity we have.
- It is important to be really open about these capacity realities. There is a waiting list, hundreds of other people across Camden who need support, and only so many staff hours. This means we will be there for people whenever we can, but if someone is doing better and has been connected to a network, we will talk to them about pausing the support. However, if things get difficult, being on pause means we can be right back with them if they need us.
- We will continually check-in on 'what's it for?' To make sure the support is working, both worker and client need to be aware of it's purpose.
- The service is meant to look different for each person – the worker and the person receiving support are allowed to be creative with what the support ends up being! Both should feel free to think dynamically about how to make it work together.

Dialog

The DIALOG Scale

What's it for?

A. It starts conversations and reflections about what we could work on together to support your wellbeing.

B. It helps us see what changes over time, noticing progress and whether we need to change our focus or our approach.

C. Your scores can help Camden understand what needs to be worked on as a whole to improve everyone's life.

Dialog is yours to keep an eye on – you can make changes whenever you want and based on what matters to you.

There's also a blank box at the bottom – if you think there is something missing, add it in!

What to do

For each of the questions below, rate your satsfaction level based on this scale:

1. Totally dissatisfied
2. Very dissatisfied
3. Fairly dissatisfied
4. In the middle
5. Fairly satisfied
6. Very satisfied
7. Totally satisfied

Name	Date

	Scores
Q1: How satisfied are you with your mental health? Notes	
Q2: How satisfied are you with your physical health? Notes	
Q3: How satisfied are you with your job situation? Notes	
Q3a: How satisfied are you with your financial situation? Notes	

	Scores
Q4: How satisfied are you with your accommodation? Notes	
Q5: How satisfied are you with your leisure activities? Notes	
Q6: How satisfied are you with your relationship with your partner/family? Notes	
Q7: How satisfied are you with your friendships? Notes	
Q8: How satisfied are you with your personal safety? Notes	
Q9: How satisfied are you with your medication? Notes	
Q10: How satisfied are you with the practical help you receive? Notes	
Q11: How satisfied are you with your meetings with mental health professionals? Notes	
Q12: Notes	

Ways we will work together

What works for you in support relationships? What doesn't work?
Is there anyone else we could usefully connect with? What are the boundaries?

Things we will focus on

Network map

Camden Resilience Network

A service provided by

Likewise

mind in Camden
for better mental health

C&I

Camden