Case Studies – Examples of joint working across health and social care – and some areas for improvement.

Case Study	Example of
Adults System (pgs 2-10)	
1. Older People's Mental Health Team and Stockport CCG	Co-ordinated support across health and care teams Need for improved co-ordination to prepare for discharge
2. Mental Health discharge (u-65s)	Delayed discharge processes
3. Active Recovery Service	Holistic, multi-disciplinary team approach Opportunities to improve flow of information to avoid delayed discharge
4. Joint working with CCG – Quality Improvement Team	Working with CQC and CCG to improve quality standards in care homes
5. Community Hospital Social Work Team	Referral and discharge process with Foundation Trust for service user with complex needs.
6. Discharge to Assess (D2A)/ Routes	Timely and responsive multi agency intervention working together to ensure the health and wellbeing of a family guaranteeing that they remained together in their own home, preventing a further admission to hospital and preventing further intervention by Children and Family Services.
Integrated Neighbourhood Teams (see separate slide deck)	Health and social care teams working together in the community to proactively support people to remain healthy and independent and prevent hospital admissions - with an overview of the model for context.
Reflections: *In terms of negatives, the main issue has been managing the mis-match between the 8 x SMBC/SFT Neighbourhoods and the 7 x Primary Care Networks. During COVID the multidisciplinary teams (MDTs) moved to virtual meetings which helped to overcome the issue – agendas can be agreed in advance and attendees come along to the section that relates only to their patients / service users. Because the meetings are virtual, there is no need to travel across different neighbourhoods and you can attend multiple MDT meetings easily. It doesn't resolve the issue of feeling part of a team (e.g. #teamheatons) but does make things easier*	
Children's System (pgs 11-15)	
7. Stockport Family – Team Around Early Years	Early Help Assessment providing co-ordinated support to refugee family
8. Stockport Family – Team Around Early Years	Co-ordinated support on child development and parental mental health
9. Comma Project - Team Around the Family Adult	Strength-based approach to supporting vulnerable adults

Case Study 1	Older People's Mental Health Team

Below are two examples from officers within the Older People's Mental Health Team (OPMHT) which reflect both proactive, positive case working with health colleagues and an example of an area for joint development with Stockport CCG.

P - Joint working

P said at her most recent review;
"I have my team around me now. My GP, my Community Psychiatric Nurse (CPN), my Social Worker, my Support Worker and my Independent Mental Health Advocate (IMHA)."

P knows that the team communicate with each other and are transparent about this.

P has aftercare under s117[1] and is on a Community Treatment Order (CTO) and is difficult to engage with and needs a respectful yet assertive approach. Her baseline is that she experiences a high degree of ongoing symptoms, many strengths in relation to some aspects of her social functioning but significant difficulty meeting outcomes. She needs continued support so we can understand when risks are increasing.

The OPMHT have developed shared values in relation to work with P and this has been arrived at by clear person-centred practice and acceptance that there will be a degree of risk to P in living her life in the way that she wants to, but there are things that the team can to do mitigate these which form the basis of her care plan.

There have been some fairly robust discussions within the team on occasion relating to P, but due to the longstanding relationships with health partners, expertise and professional integrity are valued, and these enhance the care and support provided for P.

Since her discharge in June 2020, the OPMHT and health partners have worked together to ensure that she is seen twice a week by staff from the 'Meadows' team in relation to her CTO conditions. She is prone to misunderstanding and impulsively 'sacking' different staff but because there is such tight communication, cooperation and support between ASC and health staff there is always at least one worker who she has an open channel of communication with.

Whilst the team members act within their professional competence, the fact that they work so closely means that each can discuss different aspects of Ps needs. The OPMHT can assess and feedback her alcohol use for example and the Community Psychiatric Nurse is able to provide reassurance to her about the Court of Protection (COP) Deputyship proceedings that ASC have commenced. The OPMHT are less likely to work within their own "bubble" and see progress with supporting her as multi-faceted.

[1] **Section 117 funding** is provided when an individual has been detained under certain section of the Mental Health Act (1983).

S - Older People's Mental Health Hospital Discharge.

S is a 65-year-old gentleman who has been on Rosewood ward for a 10 months Section 3 order with advanced Alzheimer's disease.

A placement was required, with 50/50 funding between the Council and CCG under s117 of the Mental Health Act.

The CCG required evidence of the placement that had been identified. At the point of the home accepting, they then requested a large amount of health information. The social worker had completed a Care Act assessment and identified the placement, but the information required by the CCG was largely health-related, including; whether a nurse was required for feeding; amount of 1-1 hours required; why local care homes refused placement; cost breakdown for nursing care; input required for qualified nursing care; core costs including speech therapy involvement; diet and timing of feeding and requirements for administering medication.

The social worker had already completed a Care Act Risk Assessment and identified the placement, met the patient, attended all ward rounds throughout the month etc so felt frustrated that all this was being asked at the point of discharge, thereby delaying the transfer of care (DTOC).

The information request held up the placement process and ultimately the offer of a place for S was withdrawn. Whilst understanding that this is important information, the team felt that this could have been avoided if the CCG had been involved sooner not just at discharge, when all this information could have been gathered by a named nurse from the CCG.

This has been raised with the CCG and a Complex Case Worker is due to start work in the near future. The intention is that they will be available to make an assessment before discharge and avoid the breakdown of placements in future.

Another issue arises when the CCG request the patient is moved and funding negotiated later. This is not usually possible as care homes request funding to be confirmed from all parties prior to the admission date.

Case Study 2	Mental Health Discharge (u-65s)

G (age 62) was detained under Section 3 of the Mental Health Act. When Medically Optimised Awaiting Transfer (MOAT), a Best Interests Assessment (BIA) was carried out under the Mental Capacity Act and a discharge planning meeting was held which included a capacity assessment.

This identified the need for a placement which was referred to Stockport CCG regarding the necessity for Section 117 funding[2] and also Funded Nursing Care (FNC)[3] due to the degree of challenging behaviours.

The service manager worked with the family and between us, selected Eden Mansions to ask to assess a possible placement. The CCG were notified of the impending assessment.

Eden Mansions assessed and accepted G. Adult social care agreed to cover 50% of the Section 117 funding but when CCG responded, another funding application form had to be completed, in addition to the existing CCG applications already completed (eg consent).

The form is totally anonymised so cannot be copied and pasted from other forms, creating additional administrative work. The form then goes to a monthly panel, causing further delay, especially when discharge from an acute bed is required and the person is at their optimum for discharge.

This process is different for the over 65s. When ASC requests CCG Section 117 funding for these individuals, they can usually get a response and agreement quickly and promptly, with no additional funding panel forms required.

In G's case, there was a lengthy email exchange that culminated in ASC funding as CCG couldn't commit, pending the monthly panel. When the panel eventually considered the application, funding was authorised.

This is a protracted, slow process where additional work is required that is not required of service users over 65, and which delays discharge.

[2] **Section 117 funding** is provided when an individual has been detained under certain section of the Mental Health Act (1983). In this case Section 3 of the Act – which is applied to someone to allow them to be detained involuntarily in hospital for the purpose of assessment and treatment.

Section 117 funding is a joint responsibility of both the local authority and/or the CCG – split or fully funded by either agency dependent on local policies and the circumstances of the individual concerned.

People who are deemed eligible for S117 funding are not financially assessed or charged for aftercare relating to their mental health needs under this section of the Mental Health Act.

[3] **Funded Nursing Care** is funding paid by the NHS to supplement social care funding where an individual has additional health needs over and above their social care needs. Usually these would be applied to support provided in nursing, rather than residential care homes.

Case Study 3	Active Recovery Service

Active Recovery Service is a partnership between health and social care professionals. This multi-disciplinary team (MDT) approach works well because it allows a wrap-around approach to an individual's care and support needs usually comprising input from social workers, therapists and nurses ensuring a holistic approach. When all areas work well, and the information is available, this holistic approach serves to ensure a person-centred planning approach and ultimately the best outcome for the individual/patient/service user/client.

With that said, individuals who enter the Active Recovery Service can struggle with the amount of involvement at the start of the care package, as all professionals are trying to complete their own assessments – usually the result of individual service governance and obligations. Once this settles down individuals are usually very happy with the level of support they receive and the input from professionals.

Operational managers have identified some areas for improvement, including the allocation of a named therapist/nurse to the individual, which is not the case currently. Not having an allocated therapist can potentially delay discharge from the service and therefore impact on the customer journey.

A good example of this is the case of an individual coming from Bramhall Manor – the referral did not contain all the relevant information from the care home around behaviours and triggers. As the social worker was not made aware, this only became known once staff started to visit the individual and the service was unable to meet their demands, resulting in a complaint being raised.

Case Study 4	Joint working with CCG – Quality Improvement Team

The Quality Improvement Team, part of the wider Quality and Commissioning Team is joint funded by health, with quality improvement officers, a social worker and 2 nurses.

Recently JB has been appointed to the role of Community Matron at CCG and this has enabled a more cohesive approach to quality assurance and improvement across the care home sector, not just nursing homes but residential homes who are supported by District Nurses and need access to support with medication management, escalation of deteriorating residents and prevention of hospital admission.

A series of joint visits is planned with JB and JM (Quality Team Manager) to Care Homes, in anticipation of the return of visiting by families and friends, to ensure that that each provider is prepared and able to meet this need and to gain assurance regarding the quality of care.

All monthly provider forums are attended by CCG colleagues to ensure that the information shared is consistent and relevant – this has been crucial during the COVID 19 pandemic. Additional sessions regarding PPE, vaccinations, mental capacity and vaccinations and testing have been held jointly with the Health Protection Team and CCG colleagues.

Concerns are discussed fortnightly at Quality Issues and Concerns, attended by CCG, Safeguarding, ASC, CQC and Health Protection Team. This ensures co-production of action plans and that all aspects of care delivery can be scrutinised.

Example

Cale Green Nursing Home was a 50 bedded dual registered home. The Quality Improvement Team (Equip) has provided a significant level of support to the new owner and new manager, since August 2018. This included support from the Quality Improvement Nurse, who provided access to training for pressure care and continence care; and the Safeguarding Lead for the Clinical Commissioning Group (CCG) who provided awareness sessions on clinical supervision.

There was also support from the Quality Improvement Social Worker and Quality Improvement Officers regarding staff files and auditing. The home had a history of periods of poor care, during which time a suspension would be put on further placements. By the end of 2019, we were confident that the home was in a good position regarding the standards of care and concluded the intensive support being provided.

However, in February 2020 it became clear that the previous standards were not being achieved. Significant joint work with CQC and the CCG was undertaken, culminating in the decision to remove all residents from the nursing home by the end of May 2020. This process was undertaken during the pandemic, but despite the challenges, all 33 residents were successfully and safely moved to alternative placements.

Case Study 5	Community Hospital Social Work Team

This case came into the Community Hospital Social Work Team (CHSWT) as a Safeguarding Cause for Concern raised by NW Ambulance Service (NWAS) re: patient not coping with his personal care at home and 'skin was a mess' as described by nursing staff on the Acute Medical Unit (AMU). It was also stated he was not taking his medication. The patient is cared for in bed 24/7 with 3 carers visiting daily provided by on site carers (extra care housing scheme). NWAS requested a re-assessment of need and safeguarding concern follow up.

Prior to his hospital admission, the service user was living in an Extra Care housing scheme with carers visits for 15 minutes three times daily. He has a history of refusing support from carers around his personal care. He is cared for in bed at home (his choice previously) and is known to the District Nurses who also monitor his skin and overall health. He is supported by his sister with practical domestic activities (such as putting shopping away/laundry/paying bills) who was becoming increasingly stressed in her role and felt her brother needed 24-hour care. He is unable to communicate over the phone due to previous throat cancer.

Timeline of events:
13/12/20 – Admitted to Stepping Hill Hospital

14/12/20 – Safeguarding alert received. AMU and the Integrated Transfer Team (ITT) advised NOT to be discharged without full social work review due to safeguarding concerns raised.

15/12/20 Service user transferred to ward A3 from AMU. Patient Covid positive.

17/12/20 – Contact made with care provider who confirmed the service user constantly refused offers of help around his personal care and with cleaning his flat. Care providers are unable to re-start the package of care (POC) due to low staff numbers. Also, District Nurses contacted who confirmed they were monitoring skin (monthly) and had done this shortly before admission. Both District Nurses and care staff confirmed that the service user had capacity – a view also supported by his sister.

18/12/20 – Service user very poorly on nasogastric tube not able to discuss safeguarding concern raised with him directly.

22/12/20 – Service user doing better from a medical point of view. Unable to speak to him as no mobile on ward and nurse still feels he will struggle with the phone. Need to explain to him need for social care involvement and gather his views on the safeguarding concerns raised by NWAS in terms of Keeping Safeguarding Personal.

24/12/20 – Service user now declared MOAT (medically optimised awaiting transfer). Allocated worker on leave. Attempt made by duty worker to try and speak with patient (unsuccessfully) via a team member from ITT.

29/12/29 – Attempted to arrange speaking to the service user via staff nurse and ITT. He had now tested Covid negative so advised he cannot go to Bluebell where advocating he needs to go for further assessment/discharge planning. Service user confirmed to have capacity in medics view however his needs were complex. Emailed

the ITT to request information which was also discussed with the nurse in charge on the ward.

The service user's sister and main carer was also expressing concerns about him going home, however after discussion accepted it was his decision and he has capacity and the right to take risks or live how he wishes to.

DCO (discharge coordinator) had a lengthy conversation with next of kin regarding carer breakdown and spoke with the service user about discharge plans, initially refused suggestion of a short-term placement but did agree to transfer to Bluebell ward for further assessment following discussion with DCO who was aware of the concerns raised and the importance of engaging the service user in discharge planning for home. She agreed to refer to Bluebell ward and arrange a subsequent transfer to Bluebell for further assessment/ discharge planning.

30/12/2021 – Duty informed service user now listed to Bluebell ward. He agreed to flat tidy up with the Ward Tracker. Agreed with the Assistant Team Manager to progress the safeguarding concern once at Bluebell ward.

05/01/21 – Advised by Occupational Therapist at Bluebell that the service user was ready for discharge, has capacity and will accept increase in POC. Wishes strongly to return home asap. His sister has cleaned up the flat but is continuing to state she wishes to withdraw some of her support due to her own health concerns. Also awaiting a new mattress. Emailed copy of safeguarding alert (password protected) to nurse looking after him who agreed to print it and ask him for his views. Updated TAHCT (trusted care home assessment team) received with different information re: dietary needs/thickened fluids – requested Speech and Language Therapy review which they did and changed recommendations. Night assessments requested to confirm he can meet his continence needs during the night. Advised by staff nurse that they would arrange a time to speak with the service user on loudspeaker with a staff member present re: safeguarding concerns.

07/02/21 – Updated with all the information requested and arranged to ring physio on the ward so they can take the phone to the service user who has now read safeguarding concerns. Spoke with him over the phone with a physio present. He did not agree carers had been neglectful nor that he was not taking his medication correctly. He did not want the safeguarding alert progressing, he was happy to accept an increased care package that would support him around personal care. Aware we are awaiting a new mattress.

14/07/21 – As Extra Care provider unable to support increase in care package this had to be re-commissioned. POC found with local care provider with suitable times which the service user was consulted with and agreeable to.

15/1/21 – a mattress and bed rail were delivered.

16/01/21 – Service user discharged home with carers x 4 daily under Covid funding (for 3 weeks post discharge as some of this used up by stay in Bluebell ward). Welfare check made by out of hours service confirmed he was home safely.

22/01/21 – POC reviewed. No concerns although he was again declining support around personal care but has capacity. District nurses made aware. Request for early area team allocation and review to ensure services are not cancelled without a review and that patient is not put at risk again.

OUTCOME: Feedback taken from the area team is that POC is working well to date.

What went well:

- Good joint multi-disciplinary team (including nursing staff/OT/Physio/ITT staff) working/discharge planning both while on ward and while on Bluebell ward.
- Further assessment time at Bluebell ward allowed for a thorough and comprehensive assessment of service user's complex needs to be undertaken so the right level of care and equipment was provided for a safe and successful home discharge. Early social work involvement may have contributed to him being transferred out of hospital earlier due to complexities being highlighted and a quick decision from Trust to allow transfer to Bluebell.
- Highlighted Trust's ability to take an individualised approach to applying the criteria for Bluebell.
- Despite communication difficulties, service user kept central to the process and consulted when needed through collaborative working. Upholding Social Work Values of person-centred planning and 'Keeping Safeguarding Personal' principles.
- Service user was discharged home in line with his wishes where POC is working well.
- Main carer was supported by additional help being made part of the support plan (laundry and shopping). Time spent with the main carer explaining and reinforcing the Mental Capacity Act (MCA) principles.
- Ensured prompt post CHSWT input to hopefully prevent further safeguarding / self- neglect issues.

Obstacles/difficulties:

- Initially told could not go to Bluebell due to no longer being Covid positive however when the list of assessments required to support safe discharge (highlighting the complexities of the service uses needs) sent to ITT decision reversed and discharged to Bluebell.
- Communication was very difficult due to not being able to visit the patient and complete a face-to-face assessment however this kept social work staff safe from Covid infection risk and communication was possible eventually however this is not the ideal way of dealing with safeguarding concerns.
- Stress/tension between professionals when asking staff (at SHH and Bluebell) to support by taking a phone to a patient due to the impact on their time and them not seeing this as part of their role.

Case Study 6 | Discharge to Assess (D2A)/ Routes

Overview

This case was a multi-agency response which included the services of:

- Routes
- Adult Social Care
- Stockport Family
- Community Health Services (D2A Hub and Crisis Response)
- Age UK
- System partners Senior Management Teams

Hospital discharge

- The patient was discharged via the D2A hub, assessed by a therapist within two hours of discharge. It was deemed that a package of care of 4 calls a day with 2 carers was required
- At this point the patients pain management was under control.
- The patient lives alone with two young children.

Routes

- Routes are a domiciliary provider commissioned to support Pathway1 hospital discharges.
- They attended multi agency project board.
- A service user with spinal injuries required support after her husband left her alone with their children, who she was not able to care properly for and there was no food in the house.
- A safeguarding alert was raised via Routes.
- Her controlled medication had not been changed, which meant that it was an unmanageable pain, Routes were unable to dispense the change.
- Routes extended their initial visit to cook food for the children and raised the alarm to Adult Services.

Case Description

1. A safeguarding alert was raised via Routes with Senior Management who organised an immediate protection plan
2. Informed Stockport Family who visited that day.
3. Use Routes to support the whole family with 4 daily visits consisting of 2 carers.
4. Social Worker provided an initial welfare visit with a food package.
5. Social Worker liaised with pharmacist to ensure appropriate pain medication in place.
6. Age UK provided an immediate response and visited twice, which was at first refused, then accepted.
7. There was a further discussion with system partners Senior Management Teams.

Learning from Senior Management Teams discussion

- Lack of community pain management service – to discuss with commissioners.
- The Crisis Response pathway led to meeting with Routes to discuss offers of available support if required in the future. i.e., clinical staff to support pain management and arranging correct medication.
- Communication to be sent to all domiciliary providers to inform of Crisis Response Team support available.

Case Study 7	Stockport Family Team Around Early Years

This referral came through a Start Well team discussion involving a refugee family with four children who are now applying for leave to remain in the UK.

They had been housed in Stockport only receiving the bare minimum, both in furniture and possessions along with financial support. The new-born child was healthy and well and the two other children had started at a local preschool setting and primary school. The eldest child has a range of challenging additional needs and had never received any diagnosis or investigation prior to coming to the UK.

Mum did not speak any English and was suffering from a bad back following giving birth but had an appointment at Stepping Hill Hospital for this. Other than this she was healthy and well following birth.

Dad spoke good English and had been involved with a peaceful group who wished to protest for true democracy, a fair voting system and social justice in his country of origin. Some opposing groups took offence at this and hence he and the family had to flee the country. They had received threats. His own father had been kidnapped and held illegally before being returned with the threat that his sons would be next.

The family has had to leave everything behind to start a new life in Stockport along with all their family and friends. They were isolated, not knowing anyone in the community or Greater Manchester.

The professionals involved with the family included a Start Well Coordinator (SWC), Preschool setting lead, Start Well Health Visitor (HV), Start Well Early Years Worker (EYW), Empowering Parents Empowering Communities (EPEC) Hub Coordinator and local school.

The main methods of assessment used were initial discussions with HV and subsequent completion of an Early Help Assessment (EHA).

Evidence based interventions were an initial assessment by the SWC, leading to completion of the EHA. Observations by the HV and SWC, along with 1:1 Incredible Years support via an interpreter over the phone or with dad translating.

As a result, practical support was provided, including –

- Start Well team obtaining a Moses basket, steriliser, bottles, and milk powder for new-born, along with clothes and toys.
- School/Preschool uniforms/coats and shoes for two older children
- Foodbank with culturally appropriate foodstuffs
- Christmas presents/tree and decorations
- Engaging the EYW for support with playing with baby and Book Start with middle child, and potty training
- Advice on applying for High School for eldest child
- Signposting to ESOL classes – currently held virtually
- Signposting to volunteering opportunities for Dad
- Signposting to refugee support groups – currently on hold due to COVID
- Liaised with GMP and local PCSOs about the distressing anti-social behaviour

the family were exposed to from the next-door neighbours.

- Exploring the possibility of a house move due to antisocial behaviour.
- Liaison with another HV who also had a very isolated young mum from the same country of origin who also spoke very little English – gave both families the option to make con-tact with each other – swapped numbers.
- Involving family in local community by supporting attendance at local groups to support children's learning and development.
- Referring dad to the Empowering Parents' Empowering Communities (EPEC) groups as he would make a good volunteer in time – he attended the Being a Parent (BAP) group to support pathway into the Parent Group Leader training course.

Completion of the EHA enabled a holistic assessment to be made of the family and a robust package of support put in place. They are now feeling less isolated in the community and have benefitted from the children attending education. They are now accessing support through peer groups which has supported confidence building and enabled a sense of community belonging. Mum is also attending ESOL classes. The police have supported addressing the anti-social behaviour and they now feel safe in their surroundings. The family are now on track for better outcomes as all support is in place.

Therapeutic support included allowing mum to speak (with telephone interpreter) to speak independently of dad translating her words – she confirmed that they were in a happy and good relationship and dad does his utmost to support her with the children. Parenting support was also given, including advice on 'tummy time,' overheating baby, allowing him to have time out of his bouncy chair to wriggle and allow his hands to go into his mouth as this is the very early beginnings of language acquisition.

On reflection, the family engaged very well with the SWC and wanted to make a difference. They were open about their needs and the support required which enabled a robust plan. There was a good professional relationship between the SWC, HV, pre-school setting, and GMP via the Team Around the Place and EPEC.

Improvements identified were that some of the support they needed had to be virtual or had been postponed totally due to COVID. The ASB could have been resolved sooner. This caused the family considerable distress due to past incidents in their country of origin.

Case Study 8	Stockport Family Team Around Early Years

The family was identified for support from the Start Well Coordinator by Health Visitor. There were concerns around mum's mental health, family finances and aspects of child's development e.g. potty training and speech & language.

The family (mum, dad and 4-year-old child) had moved from Scotland and did not have support from family or friends.

A number of professionals were involved with the family, including Health Visitor, Speech and Language Therapy (SALT), Paediatrician, SENCO at local primary school and Start Well Coordinator.

An Early Help Assessment (EHA) was carried out. A coordinated approach was needed to support school readiness and to address mum's mental health issues.

A range of evidence-based interventions were carried out to support the family, including SALT, paediatrician, toileting support, motivational interviewing techniques, restorative approach and Solihull parenting techniques.

Child is now attending nursery whereas before her parents were reluctant to send her. This provided opportunities for observation. With support and explanation, parents were on board with referrals into other services. This resulted in the child receiving the support she required to meet her individual needs and allowed professionals to identify areas of needs and provide 1-1 support which has been vital in promoting school readiness.

Reflections from Start Well Coordinator

"I have been able to build a positive relationship with Mum who has felt confident to divulge personal information which then enabled me to offer support to the whole family. This relationship proved vital in some referrals as Mum would often talk to me separately from any Team Around the Family reviews of professionals.

Through observation I realised that Mum was unable to read and write, therefore I ensured that I read any referrals, documents, and letters to Mum to make sure that she understood what they were. With permission I informed the school so that they could adapt any correspondence going home to the family to make certain that it was accessible."

Mum is happy that we were able to coordinate support as child is now attending nursery and has support in place which will continue into Reception and throughout her education. Mum is relieved to have support in place as she has often worried about her child's future. Mum is also happy that with support her child has begun to show signs of communicating when she needs the toilet.

Case Study 9	Comma Project - Team Around the Family Adult

Comma: a service co-designed with mothers who have had their children removed through care proceedings, with the long-term aim of reducing recurrent care proceedings. It is intended to support families in their choice to place longer intervals between pregnancies and access a package of support individualised to their unique needs.

Lead practitioner KD Specialist Health Visitor Stockport Foundation Trust / Stockport Family

Mother and partner were keen to engage with the Comma project to prepare for future parenthood. When mother felt ready to consider becoming a parent again, she expressed understandable anxieties about the process of assessment and the real possibility of it resulting in the removal of another child.

We explored how Mother and Partner might be supported in preparing for the process that would inevitably be put into action if Mother became pregnant. We identified the key people in Mother and Partner's life and their function in supporting them both. This included personal and professional relationships.

Mother identified that she would feel more confident if she could be more explicit about her anxieties and expectations and in return, if others were explicit about the support they could commit to. Mother told me that she had felt 'let down' by services in the past when she had made assumptions about what they could provide.

This culminated in the couple asking for and, with support, arranging and leading what we called a 'Team around the Adult' meeting.

The invitation list included a Children's Social Worker (CSW), Probation Service, Drug and Alcohol Services, the local church leader, the family GP, MIND, and 2 close friends. I had concerns about the size of the meeting, but Mother was clear about the membership.

To begin the meeting Mother was able to communicate her anxieties and asked the CSW to describe the process and scope of a Social Work Assessment (SWA). This led to the group identifying the couple's strengths and the changes they had made, as well as areas of continued need. Each member is able to offer a different perspective. A plan was created with each identifying where they could provide support, resources, information, or guidance.

The result was that the CSW met with Mother and Partner to describe the SWA and identify Mother and Partner's main concerns. Their previous experience was 'unpicked,' assumptions explored, and some fears allayed. The social worker was, however, realistic and transparent about how the experience might feel.

The GP was able to gain a richer understanding of Mother's support network and vulnerabilities and could liaise with Comma and the MIND worker to ensure Mother was offered the most appropriate management of her mental health.

Probation were able to support Partner to share his previous traumatic experience with appropriate professionals, which Partner told us 'felt like a weight had been lifted' as

people understood his anxieties better and, ‘he didn’t feel he had to hide anything.’

A course of joint therapeutic sessions between Mosaic and Comma was provided to help the couple look at the impact of parental drug use on children and develop safety plans. This resulted in the couple being able to be very honest with each other about what they needed from each other to avoid relapse.

The church leader and friends committed, when possible, to providing the couple with out of hours support if either needed someone to talk to or short notice childcare if the couple went on to have a child.

Drawing up the plan resulted in Mother and Partner saying that they feel more confident and comfortable in asking for help and accessing support. It enabled professionals to see the couple as central to a whole system, each of its parts influencing the couple and itself. Mother told me afterwards, that she felt ‘more optimistic about the future and not so scared of being judged by people when I’m struggling.’

Consent, trust, a willingness to work in new and different ways, and transparency between all members of the group were essential for the success of the plan.