

# MANAGING MENTAL HEALTH THROUGH COVID-19: TIPS FOR GOOD PRACTICE

The Association of Directors of Adult Social Services

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## 1. INTRODUCTION

Throughout the different stages of the pandemic – national lockdown or local restrictions – a considerable degree of fear, worry and concern has developed, both for the population at large and for professionals who work to support individuals in need of care and support. In recognition of this the Government has published the [Wellbeing and Mental Health Support Plan for COVID-19](#) with some important messages for VCSE, Local Authorities and social care services. It should be considered alongside the Social Care Covid-19 Task mental health advisory group [Social Care Covid-19 Task mental health advisory group report published earlier this year](#).

The COVID-19 pandemic presents various mental health challenges for a wide range of communities across the UK. Evidence has emerged of a specific and serious impact for those with underlying health conditions and for Black, Asian and Minority Ethnic (BAME) communities. This includes impact on individuals who require care and support services, their families and their carers, and colleagues who work within the sector. Data suggests that disproportionately high numbers death rates from COVID-19 amongst older people, those living in care homes, people from Black, Asian and minority ethnic (BAME) groups, people with underlying health conditions, people with learning disabilities. This document takes into consideration all these factors.

Particular challenges have been experienced in statutory Approved Mental Health Professional (AMHP) services, where requests for [Mental Health Act 1983](#) (MHA) assessments on people not previously known to services (or not known for many years) have occurred at an increased rate (source, BASW/CSWO report on COVID-19 impact on AMHP Services). Concerns were also expressed in this report, that during the period from March to July 2020 many other mainstream mental health services stopped doing face to face visits, either leaving people to become more unwell or to be referred very quickly to AMHP services for an assessment, which (even where the person may not need that level of intervention) would mean they were seen by experienced mental health professionals. Rethink has developed guidance because of the coronavirus crisis, meaning professionals might have to change the way they use the MHA. The guidance can be accessed [here](#).

In public mental health terms, the main psychological impact to date is elevated rates of stress or anxiety. Within social care we are certain that there is likely to be considerable trauma, especially for those who have been significantly impacted by COVID-19, and not least those who have been bereaved.

As new measures are introduced, their effects on many people's usual activities, routines or livelihoods multiply, resulting in increased levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behaviour.

This publication highlights some overarching principles and local innovative practices that are being adopted by different local authorities to meet these increasing needs and prevent people entering secondary mental health services unnecessarily, and we hope that by sharing them they can be adopted more widely. Whilst highlighting local practice we recommend practitioners read [To the top of the cliff - How social work changed with COVID-19](#), written by The International Federation of Social Workers. It looks at the effort by social workers to re-orientate services to meet the needs of those who have accessed care and support services and the many people whose lives have suddenly been thrown into turmoil by the virus across the globe.

## **2. PARTNERSHIP WORKING AND COLLABORATION**

There is now more than ever, a recognition of the importance of strategic communications, as Local Authorities and the wider health and social care sector adjust to the 'new normal', while continuing to support people who need care and support services. Beyond local authorities, staff are adapting across the system – from intensive care units (ICUs), GP practices, ambulance services, mental health support services and care services, to wider stakeholders including the police, fire service, housing and voluntary sector not forgetting informal and community networks – to meet the needs of the people in an increasingly challenging and stressful environment. Partnership working and collaboration are no longer aspirational goals, they are necessary for rising to the challenge of providing socially ordained mental health care and support people at this time.

[Case study: Nottinghamshire County Council](#)

## **3. SHARED DUTY ROTAS**

Rota planning has become an essential skill. The saying 'failing to plan is planning to fail' applies even more in these unprecedented circumstances. Sharpening rota planning skills is getting more important as the demand for flexible and collaborative working grows. Sharing duty rota systems supports joint visits and aids good communication, further strengthening relationships. This can include regular online 'catch-ups' during especially challenging times to ensure people supported by professionals in different systems receive the joined-up care they need.

[Case study: London Boroughs of Camden & Islington](#)

## **4. CASE MANAGEMENT & SUPPORTING 'SHIELDED' PEOPLE**

Effective case management is an important tool for helping to manage flow. It is even more critical as organisations face not only the typical challenges of managing demand, volume and capacity, but also the added stressors of the short- and long-term effects of the pandemic. Local Authorities have responded to COVID-19 to:

- Develop care and support plan for transitions and follow up through well-coordinated assessments, partnerships, and patient engagement
- Identify and connect people with services that are paid, unpaid, formal or informal that will provide for psychosocial needs and address social determinants of health through community advocacy
- Collaborate with post-acute care facilities for timely transfers, including by using discharge to assess funds to create socially focused support for those clinically ready to leave hospital, but in need of additional support in order to cope in the community
- Engage people, families and community networks in recovery regarding next steps, through communication and education.

[Case study: Mersey Care NHS Foundation Trust](#)

## **5. INCREASED COMMUNICATION AND CONTACT WITH INDIVIDUALS WHO NEED CARE AND SUPPORT SERVICES**

It should go without saying that clear, transparent communications should be of paramount importance to you, as both your employees and people who use services will expect it at this time. During this period of massive upheaval, effective communication within teams and with people who use care and support services, their families and their carers, goes a long way to providing reassurance in tough situations - even if just to provide a semblance of life as they knew it or to confirm potential changes. Practitioners are modifying the way they approach business as usual whilst ensuring safety and reduced transmission risk remain top priorities. Across services they are faced with explaining unprecedented situations to people who need care and support services, to their families and to their carers, and with no road map.

Make sure any communications with staff and people who use services are authentic and sensitive to the situation we all find ourselves in right now. Communication during COVID-19 is all about empathy, whether that is communicating internally or externally in these ever-changing times.

[Case study: Nottinghamshire County Council](#)

## **6. SUPPORTING PERSON-CENTRED CARE IN COVID-19 SITUATIONS**

Staff are demonstrating new ways of communicating compassionately in COVID-19 situations where the usual ways of interacting are not possible, either due to restricted visiting or to wearing personal protective equipment (PPE). Small acts of compassionate care make big differences to the people being cared for and their families and, in turn, to health and care staff. The use of technology has been adopted widely to engage with people who need services and maintain safety wherever possible. Where virtual contact is not appropriate, face-to-face meetings are taking place in a variety of open-space settings, such as gardens and parks, while maintaining social distancing. Services are being offered outside of usual operating times (e.g. weekend services) to ensure that service demand can be met. Some individuals are having their needs met with just telephone support, which are sometimes more frequent or intensive, therefore reducing the amount of face to face contact needed and also having a positive impact on the length of time and individual may have on the support needed.

In the Summer of 2020, it was recognised that although some people had found phone and video calls less intrusive and more suited to their situations, a number were struggling and becoming unwell without the face-to-face visits they were used to. Services therefore needed to adapt to ensure support was offered in the most appropriate way for the individual, including face to face contacts where necessary.

[Case study: Essex Partnership University Foundation NHS Trust](#)

## **7. CO-PRODUCTION**

It has never been more important for people to come together and do what they can to respond to the challenges presented by a worldwide catastrophe, which can appear insurmountable. When responding to the global pandemic, professionals are often seen as the ultimate resource and we forget that people with lived experience are often well-placed to create

solutions in partnership with others. Co-production in such challenging circumstances will often bring about creative solutions that may not have been considered in isolation.

Skills for Care commissioned NDTi to produce [Co-production in mental health: Not just another guide](#), working with a range of individuals who need care and support, alongside practitioners, employers and commissioners. Although this guide was produced pre COVID-19, it remains relevant in the current climate as it explores what stops people from attempting co-production and what can help, using the experience of people trying to do it in different settings across England.

## **8. INVESTMENT IN LEARNING AND DEVELOPMENT**

Professional development remains important – even more so when no one knows what shape our ‘new normal’ may take. Formal learning in the shape of webinars or other virtual workshops is being delivered to members of staff, a comprehensive programme which includes the coronavirus pandemic, racism in the workplace, and employment law and ethics, to name but a few. Informal learning is being encouraged, for example ‘learning from others’ and taking part in discussions with colleagues or a wider network such as the CIPD community or LinkedIn members group. Early in the pandemic, networks of professionals formed based on locality or specialism to provide mutual support and advice. In addition, employers are investing in online development and opportunities for managers to network, learn from one another and find mutual support.

[Case study: Ashfield and Mansfield Community Mental Health Team](#)

## **9. LEGAL LITERACY FROM A HUMAN RIGHTS PERSPECTIVE**

Legislation on its own is not the solution. However, an understanding of broad legal concepts (such as fundamental Human Rights) helps to provide a framework for thinking about ethical dilemmas and ensures that any approaches adopted are consistent, proportionate and strengths-based, and that they will enable people to take risks and experience opportunities on a personal level.

For example, understanding the balance between the right to life (Article 1) and to a private and family life (Article 8) is fundamental to finding a way through challenges such as care homes preventing visits to limit infections, and the people they support maintaining meaningful contact with their loved ones. Health and social care are at their best when used to enable people to access their own networks, families and supporters, rather than simply providing them.

Where the individual lacks capacity, wishes and preferences must remain paramount in decision making with a requirement to consult with the person’s LPA’s, advocates, persons of importance to the individual, and any other professionals where necessary. Mental capacity assessments must be completed with best interest decisions clearly documented in these situations. The government has published advice on [MCA and DoLS during the COVID-19 pandemic](#) and Essex Chambers has hosted useful webinar that specifically looks at the [legal issues surrounding the provision of care and support during the second national lockdown](#).

The Government has made some temporary changes to the MHA due to the coronavirus crisis, these changes were not used and subsequently the easements were removed from the [Coronavirus Act](#) practitioners will be using the MHA in the normal way. Following extensive

feedback from AMHPs, NHSE and DHSC jointly developed [guidance on how to use the MHA during COVID-19](#).

## **10. REGULAR TEAM MEETINGS AND CONTACT WITHIN TEAMS**

Many teams are waking up to a new reality of working remotely. This change has created a new set of challenges which are amplified by the stress of school closures and other anxieties caused by the pandemic. A crisis like this can either widen the cracks in a team's foundations or make a team even stronger.

Regular team meetings and virtual catchups are being used to establish a sense of community. Feelings of solidarity and mutual support can be brought about by encouraging staff teams to discuss the varied challenges they face when working from home, ideas for dealing with them, and by sharing personal strategies for coping. These meetings can also help to clarify expectations, for example, around performance, workflow and performance management. Above all else it makes team members feel able to access support directly related to their work tasks or to any challenges they might be personally facing in the new situation.

[Case study: Nottinghamshire County Council](#)

[Case study: Nottingham\(shire\) COVID-19 Mental Health & Well-being Group – Facebook](#)

## **11. STAFF WELLBEING**

In these challenging times, being able to support your team is crucial. North West ADASS took what is effectively a triaging approach to helping people navigate their way through a plethora of mental health and wellbeing support offers, advice and information based on three levels of need:

- Level one: Self-help resources that people can access themselves whenever convenient
- Level two: 'Someone to talk to', offering direct access to volunteers or professionals who can talk to people as and when needed
- Level three: 'Someone there for you', meaning support over a longer period and best accessed via the person's GP or other health professional, or referral to a specialist service.

North West ADASS: workforce wellbeing and mental health toolkit and directories can be found [here](#).

The BASW, Bath Spa University and Social Worker Union launched the [Social Worker Working Conditions and Wellbeing Toolkit](#) in June 2020. While a long-term resource, it includes sections throughout that relate its evidence-based and practical guidance to the pandemic situation, drawing on national Health and Safety Executive Standards, organisational psychology research and literature, social work wellbeing literature and the lived experience of practitioners. It is aimed at empowering and motivating social workers in practice, but its contents encouraging self-care, healthy teams and organisational development, are of benefit to supervisors, managers and leaders too. Its messages are relevant across professions and disciplines, with its numerous practical exercises now used in organisations as a supportive and organisational development tool. It was taken into

consideration when the LGA Social Worker Health Check Questionnaire for Adults' Services was designed and can support employers to address issues that arise in the health check.

The World Health Organization has also published [mental health and psychosocial considerations during the COVID-19 outbreak](#). This provides advice to a range of audiences, including team leaders and managers, to protect staff from chronic stress and poor mental health during this response. Tips include:

- Ensure that good quality communication and accurate information updates are provided to all staff
- Rotate staff from higher-stress to lower-stress areas and functions
- Partner inexperienced workers with their more experienced colleagues – the buddy system helps to provide support, monitor stress and reinforce safety procedures
- Initiate, encourage and monitor work breaks
- Implement flexible schedules for workers who are directly impacted or have a family member affected by a stressful event
- Ensure that you build in time for colleagues to provide social support to each other
- Ensure that staff are aware of where and how they can access mental health and psychological support services and facilitate access to such services
- Be a good role model for self-care strategies.

Recognition of hard work in such challenging circumstances and adversity goes a long way!

Further consideration should be given to the needs of BAME staff given the inequality issues exposed by COVID-19:

- Carrying out comprehensive and continuous equality analysis including impact assessments on staffing issues relating to COVID-19, including reviewing the allocation of shifts, and access to PPE and to fit testing for BAME workers
- Updating their risk assessment processes to include ethnicity in their vulnerable and at-risk groups. Managers should be encouraged to have supportive and confidential conversations with BAME staff about any underlying health conditions
- Ensuring that all staff are aware of the support and counselling services that available to them to maintain and promote wellbeing
- Ensuring that, where available, staff are able to self-refer to occupational health service for advice and support
- Ensuring that staff know how to raise concerns about their safety including completion of incident forms, are not subject to detriment for raising concerns and that concerns are acted on.

While work is being done nationally to understand why people from BAME communities are disproportionately affected by COVID-19, many local authorities have been carrying out supplementary risk assessments and conversations with their BAME employees to find out what additional support can be put in place to manage the safety of these staff at work. Some examples of risk assessments and additional support are shared below:

- [Bristol City Council – BAME staff counselling offer: Letter 1](#)
- [Bristol City Council – BAME staff counselling offer: Letter 2](#)
- [Camden Council – individual risk assessment for those at increased risk from COVID-19](#)
- [Bishop Wilkinson Catholic Education Trust - BAME safety assessment for schools staff](#)
- [All Wales NHS and social care – COVID-19 workforce risk assessment for vulnerable groups](#)
- [London Councils – Model risk assessment for at risk staff](#)

The [Workplace Race Equality Standards](#) has established a shared framework and principles for progress in workforce race equality. This involves submitting data reports on an annual basis around a set of metrics (there are nine in the NHS version) which highlight disparities in

experiences between white and non-white staff. The current initiative in social care builds on this and also our own prior work and thinking over the last three years.

[Case study: Birmingham City Council](#)

## **12. CONCLUSIONS**

While mental health is determined by much broader factors than access to mental health services, these are critical for people experiencing mental illness. Services were already stretched, with many providers reporting an inability to meet the rising demand prior to the pandemic, and lockdown is adding pressure that is likely to increase in future. These good practice examples show what can be achieved with good partnership working, excellent communication channels and a genuine desire to improve the lives of those who experience mental health issues.

## **APPENDIX Examples of good practice and innovations**

Individual names have been changed for the purpose of this document to preserve anonymity

### **PARTNERSHIP WORKING AND COLLABORATION**

#### **Nottinghamshire County Council**

Dennis lived alone and had not been coping for some time. His family had struggled to persuade him to let them help and he was pushing them away. His house was deteriorating in condition. His ability to manage daily tasks had reduced significantly and he was eating very little and losing weight rapidly. The deterioration was reflected in his behaviour. He had refused any support from his GP or the MH team. While the team were acutely aware that to assess him under the MHA would cause further distress, leaving him unsupported was not an option.

The AMHP arranged for approved doctors to be part of the assessment, people who would be understanding of Dennis' situation and would consider alternatives to admission to hospital if possible. Dennis was very distressed during the visit and the concerns about his living situation and mental health were substantiated. All present felt that some sort of intervention was needed. The AMHP discussed options with the local team and alternatives to a hospital admission. The alternative option was to consider a placement in a residential setting to offer some respite and support for Dennis to engage with the community support plan, allowing him to build good working relationships with his support system. The plan was not without its challenges, however with appropriate support from the psychiatrists during the assessment process, the ambulance paramedics including a driver from the fire brigade to whom Dennis responded best of all), and the local mental health social care team and residential home, we were able to bring Dennis to a safe community space using the supportive powers of Guardianship (MHA, s7) held by the local authority to enable him to get the support he required. Dennis began engaging with his support plan and it reflected in his presentation.

### **SHARED DUTY ROTAS**

#### **London Boroughs of Camden & Islington**

For the duration of the pandemic, AMHPs in both boroughs are dual approved so that they can confidently assess people under the MHA in either borough and address shortages caused by sickness if necessary. In addition, the EDT teams in both boroughs agreed to collaborate around the provision of sessional AMHP staff to undertake MHA assessments.

For example, if a sessional AMHP from one borough was already on site at the Health Based Place of Safety (HBPoS) and a second assessment was requested, that

second assessment would be taken on by the available AMHP, regardless of their home borough, rather than waiting for the additional AMHP to attend.

This happened on a number of occasions, as both the HBPOs and Assessment Unit set up to divert people away from EDT were in one borough, but assessments still came in via police stations and one A&E in another borough. One AMHP who worked full-time in the personality disorder service worked flexibly to assess people with a personality disorder presenting out of hours. This resulted in better support to these individuals and fewer admissions, as the AMHP was more familiar with them and their crisis plans and was able to make better informed judgements about risk.

## **CASE MANAGEMENT & SUPPORTING 'SHIELDED' PEOPLE**

### **Mersey Care NHS Foundation Trust**

The national Shielding List was introduced in March 2020 during the COVID-19 pandemic to identify those deemed to be clinically 'extremely vulnerable' and thus more likely to experience severe illness should they contract COVID-19. Experts, including medical professionals, agreed the criteria for the shielding list based on what was known about the virus at the time. Identifying this group of people enabled services to keep 'extremely vulnerable' people safe during the pandemic. Although guidance has changed regarding who should shield and to what extent, this group continues to need extra focus to ensure that they remain well and receive appropriate practical support.

Mersey Care NHS Foundation Trust believes we have a duty of care to ensure that a) we are aware of all those under our care who are on the Shielding List, and b) we ensure that their care needs are being safely met. The MCNHSFT Local Division 'Shield Project' commenced in March, with the goal of ensuring that every shielded patient under our care was safely shielding themselves and that their care needs were fully met. The project consisted of approximately 25 staff, including nurses, social workers, psychologists, physios, occupational therapists and support workers, most of whom were also shielding and therefore working from home. Patients on the list received a phone call from a professional and contact was maintained with carers/family members. In addition, an integrated approach was taken to ensure that conversations took place between all services involved. This included discussions between community mental health teams, social services, community health providers, housing providers and care agencies, ensuring that a joined-up approach took place to provide holistic care to each patient.

Behind the scenes, collaboration took place between Mersey Care, Liverpool, Sefton and Knowsley social services to ensure that patient data was safely but rapidly shared, meaning health and social care could support one another to carry out this essential work without duplication and bureaucracy.

All issues were escalated and resolved at the point of being identified, ensuring that every case was safely resolved. All escalated cases were tracked by the project team and any unresolved escalations were raised in the Local Division Safety Huddle. As a result, all escalated cases were resolved. The project completed at the

end of June 2020 with a safe outcome of “no further action” marked for all 8,000 patients.

## **INCREASED COMMUNICATION AND CONTACT WITH INDIVIDUALS WHO NEED CARE AND SUPPORT SERVICES**

### **Nottinghamshire County Council**

Elsie had been placed at a care home for two weeks whilst on medication for an infection and had developed the first signs of dementia. There were concerns on behalf of social care staff, her GP and her family that she would not comply with her medication without the support of the care home placement, which could lead to her becoming very unwell.

Elsie struggled living in the care home, as people with dementia often do, due to the loss of familiar surroundings and routines that made her feel safe, and this led to her getting uncharacteristically angry at people. Once home, Elsie was more settled and could go back to her comfortable routine. However, on this day she made her way to the local hospital to find her purse – people became very worried that she was confused and may need to go back to the care home or into hospital for an assessment of her needs – but we already knew that this could make things much worse for Elsie so needed to try and avoid changing her safe space living at home. Usually it would have been possible to put in some assistive technology at Elsie’s home that could monitor her safety at the home or if she was gone for a long period (which would trigger support), but with COVID it appeared very difficult to get the ‘usual’ services and the AMHP team were asked to assess Elsie.

Once the team were able to identify the issues, they worked together with the local mental health team to find a way to enable the ‘Just Checking’ technology to be released for collection. The local team then allocated workers to arrange for its installation at Elsie’s home. This prevented distress to Elsie and her family and enabled Elsie to continue living at home. Bringing Elsie into hospital would have increased her risks of coming into contact with COVID as well as distressing her greatly and causing her mental health to become more challenging unnecessarily. Working in partnership we are able to ensure that we uphold Elsie’s human rights and offer her the least restriction option in line with the Mental Capacity Act 2005.

## **SUPPORTING PERSON-CENTRED CARE IN COVID-19 SITUATIONS**

### **Essex Partnership University Foundation NHS Trust** Adult Mental Health Family Group Conference (FGC)

This case relates to a 35-year-old woman Saima who lived alone under mental health services for severe depression/suicidal intent due severe back pain. S had become increasingly isolated and her mental and physical health deteriorated at the beginning of the pandemic; this was as a result of the closure of the groups she attended in support of her mental health and the support she received in managing her back pain. Saima had no social contacts, depending on her mother, who was

isolating, and her father, who lived 90 miles away. Her sister was local but struggling to manage her family and work due to home schooling. The family were overwhelmed and unable to support or communicate without frustration. Saima's care coordinator left at the beginning of the pandemic and a new one was due to be allocated. She was being managed by duty but found it hard to ask for help. The dynamic with her mother was difficult pre-pandemic. She was perceived to be too forceful in her opinions with medical professionals, was critical of S, was frustrated that she needed help in the home/accessing appointments, and was reluctant when she did help her.

The team held twice weekly video calls to prepare for the FGC and to help Saima feel more connected and less isolated. Conversations were centred around supporting her with planning for the FGC and voicing her thoughts and feelings in a helpful way. We did the same with family members to get them to think about how they could individually improve the situation, rather than looking to one another to change.

The first FGC was held virtually to explore mental health support and support between family members. The family made a good plan and were satisfied with the process, feeling heard and supported in their lives and also in their relationships during the pandemic. The family became less stressed and less isolated. Tensions around receiving and giving support were addressed and ways to manage these were considered. Fun interactions and virtual contact with the grandchildren and nieces helped to support the sister. Discussions allowed Mum to go about her day and give responsibility to Saima to ask for help rather than say she did not want it, which was creating negative interactions between them.

The second FGC focused on carer support and management of medical appointments and ongoing help. Mum agreed to step back and allow the sister or a friend of Saima to accompany her when possible, and to be less outspoken about how she wanted Saima to respond to professionals, allowing S to develop her own voice and learn to advocate for herself. Saima agreed to accept help and pursue adaptations offered by social care and re referral for a self-directed support package, acknowledging that this did not indicate a lifelong need. The relationship could then move away from a carer/patient arrangement to one between mother and daughter.

Mum agreed for ongoing support as a carer, which previously she had not felt the need for, and Dad agreed to continue with weekly calls.

Saima felt empowered that she had a voice and that her requests and feelings were acknowledged. While her physical health was not resolved yet, she was comfortable to proceed with a further meeting with medical and mental health professionals to address her care, as this was an ongoing frustration due to there being no clear treatment plan or explanation for the psychological/physical pain.

This is now in progress and the reports remain positive.

## **INVESTMENT IN LEARNING AND DEVELOPMENT**

## **Ashfield and Mansfield Community Mental Health Team**

Prior to lockdown, Simon spent several months in hospital after experiencing a bipolar episode. As he was socially isolated, he was discharged home with reablement to connect with social groups. However, soon after he was discharged, the lockdown began and services were paused. Simon's brother died at the beginning of the lockdown, triggering a depressive episode and leading Simon to become withdrawn, paranoid about his property being broken into, and actively suicidal. As a result, he stopped leaving the house. Simon was offered a visit (with social distancing measures, wearing a mask etc) and a referral was made to the Crisis Team. He accepted the referral and daily visits commenced to avoid hospital admission.

Simon did not have access to a phone, making contact with him limited. Agreement was given to provide Simon with a basic phone so that he could maintain contact with Social Care and the Crisis Team and so that he could phone for emergency support in a mental health crisis, should he need it.

Reablement was reinstated following social distancing measures. As a result, Simon began to engage with services, his mood lifted and he began to leave his property. Simon was known to be dog lover and had also recently lost his dog. Simon's support worker agreed to bring his dog so they could go on walks together, which had a positive impact on his mental health. Once lockdown eases, the plan is to involve Simon in more community group activities, including access to a local musicians' group as Simon has a love for playing guitars.

The coordinated approach between different agencies and adoption of a strengths-based approach really demonstrates how a hospital admission can be avoided during this pandemic.

## **REGULAR TEAM MEETINGS AND CONTACT WITHIN TEAMS**

### **Nottinghamshire County Council**

When COVID-19 hit, the Nottinghamshire County AMHP Team offices closed and adjusting to new ways of working took priority for practitioners and practice educators with students on AMHP placements. Although Skype and systems for home working were in place, further consideration was necessary to ensure that placements could continue during the pandemic. Lines of communication using existing systems were kept open, with additional virtual team meetings and teaching sessions.

Staff were all on board with supporting students and knew who to contact each day. The main challenges were supporting students to make calls to doctors and close relatives, and how to meet their observational requirements. Creative suggestions were banded around the team, while there were occasional (risk-assessed) returns to the offices. We discovered Skype conference calls, which enabled the student or practice educator to listen in where permission was granted. Debriefs became a challenge with no office base, and for students at home with children, not all the discussions were appropriate. To solve this the team used offices on the ward

alongside health colleagues, allowing limited period for debriefs and discussions in keeping with occupancy limitations.

The University played their part in moving lectures to online classes and all meetings with students and placement became virtual meetings. Supervision was conducted virtually (via video link) to alleviate any anxieties and support as robustly as possible, which maintained the human element between supervisors and students and allowed for that non-verbal communication we rely on as practitioners to “check in”. On reflection, and as we enter varying levels of restriction, we have done and continue to provide the AMHP training course with creative changes and adjustments, and students have continued to learn.

### **Nottingham(shire) COVID-19 Mental Health & Well-being Group – Facebook**

The Facebook group acts as a “therapeutic, peaceful space for people, away from all the panic [and] without them having to disconnect”. It allows people to make individual connections and reach out for or offer support, and provides advice and information. Examples of support include:

- podcasts from Empower Nottingham
- information on NHS helplines
- advice around those with autism, learning disabilities, breathing conditions and permission to not wear a mask
- links to the COVID survivors’ group
- information from the NHS on mindfulness etc that we have been able to share with people assessed under the MHA.

## **STAFF WELLBEING**

### **Birmingham City Council**

Birmingham City Council is leading work locally to review the disproportionate impact of COVID-19 on people of Black, Asian and Minority Ethnic (BAME) backgrounds and working with partners on what needs to change in the response. The council convened an urgent meeting of the city's Health and Wellbeing Board with a call out to the public through social media for questions and concerns, leading to more than 600 questions being received and highlighting the scale of local concern. The Board invited several additional observers from BAME community organisations and senior equalities leads from NHS partners. This important meeting represented the start of a conversation and also fed into the national review where the questions raised were collated and sent to the Secretary of State for Health and Social Care along with a link to the audio recording.

The special Health and Wellbeing Board was broadcast live through audio link, at one point being streamed live by 400 people, and the recording has subsequently been downloaded by many others. The Board openly and honestly worked through a synthesis of the questions submitted and following the meeting, the Chair of the Board has written to everyone who submitted a question with a personalised response to their specific questions.

Key themes included:

- discrimination in service provision and clinical decisions in NHS settings
- reasons behind the differences in death rates in different ethnic groups
- perceived delays in identifying differences and concerns about BAME staff and patients
- the engagement and commitment of the Board in tackling health inequalities.

Feedback from communities following the special meeting has been incredibly positive and although in many cases there was no definitive answer, citizens appreciated the open and authentic responses from the members of the Board. Since the meeting there have been further small engagement sessions with different ethnic communities to provide follow up Q&A sessions alongside the existing weekly engagement sessions with faith and community leaders.

The NHS has also since reviewed its approach to communication and engagement and looked at what more can be done to support BAME patients who have other risk factors for increased mortality, such as poorly controlled diabetes. Across the board, partners have reviewed the visibility of BAME individuals in media and engagement materials, particularly in NHS trusts via survivor and patient stories.

The Special Health and Wellbeing Board exploration of the current understanding of ethnicity and COVID-19 has provided a unique opportunity for citizens to voice concerns to senior officers and partners and hear an open and honest discussion in the response. Prior to this meeting the Health and Wellbeing Board routinely invited questions from citizens but had relatively poor uptake. It is hoped that following this meeting the level of citizen engagement will be maintained and grow.