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SDM Pilot Project

Final Report

October 2023

NHS Ayrshire & Arran

south AYRSHIRE COUNCIL
Comhairle Siorrachd Àir a Deas
Making a Difference Every Day

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Section One. Introduction

The pilot began on 11th April 2023 and concentrated in working at Ayr hospital with additional support from the wider MHO team to explore early intervention in the community. The six-week and three-month report outlined some of the challenges in providing an SDM service in a hospital setting and to a greater extent these issues continue to present concerns in respect of ensuring that appropriate stage 1 or 2 referrals are made to allow the SDM process to have an impact for the person and professionals working with them.

This final report has given the service an overview of how effective SDM can be particularly around bed days saved where appropriate referrals are made the impact is significant. As this report will demonstrate more effective training and support is required for our colleagues in hospital settings to ensure that more referrals are made that can make an impact by using SDM with services users.

Below the executive summary gives a succinct view of the general findings of some of the benefits and challenges with SDM:

Section Two. Executive Summary

- SDM is most effective in working with older adults who are at stage 2 of the process. It works very well with people who are in a hospital setting with an early diagnosis of dementia. The body of the report will demonstrate that this is where the most significant amount of bed days are saved. It promotes people's ability to make good decisions about their lives without using legal measures or substitute guardians to help them move forward and plan their future effectively. The newly appointed SDM social worker will be based across the three hospital sites in the partnership where they can work most effectively with people at stage 2.

- The key to making SDM work is to ensure that stage 2 referrals are being made regularly to the service. In essence effective briefings need to be provided to all health staff that combine an understanding of S47 certificate's/POA/ Guardianship with an understanding of SDM. All staff in hospitals need better support to grasp the nature of these stage 2 referrals and have access to training that allows them to explore this option. This is a very significant task for our small team and for it to be effective we will explore a range of options from using training for trainers, to video presentation to assist people in being more effective in assessing when it is right for someone to use SDM to help.

- From the three-month stage of the pilot SDM broadened out and worked with service users in the community. Through the MDTs at the local CMHT for older adults 9 cases were screened and assessed for an SDM assessment in the community. The bulk of these were people effected by early onset dementia. SDM is very effective with this group of people in helping them make clear advanced choices for the future and in understanding their own abilities to continue to make positive life choices. SDM works again with people at the beginning of stage 2 in a community context.

- SDM does not work with people at stage 1 where they have full capacity. We explored the use of SDM with a number of younger adults who had full capacity to establish if it would support them in making advanced choices. It was not possible to make good, advanced choices plans with people in this area because the two biggest things that people wanted were not to accept treatment in particular drug treatment when they did not want to and secondly not to be admitted to hospital against their will which they often were.

Advanced choices where not viewed positively by people in this scenario because it would often be overridden by their RMO and MHO in much the same way advanced statements are currently.

- SDM does not work with people at stage 3 where they have lost capacity. Whilst a number of referrals were screened for people at stage 3 not one single person screened at this stage was found suitable for the use of SDM. Unfortunately given our current laws SDM cannot be effective with people at stage 3. The legal process and the need to seek a substitute guardian is required to support people in their onward journey. Significant changes in the law and resources are required to support people make advanced choices at stage 3.

- The pilot demonstrated that for SDM to work on a widespread basis cultural and resource shifts are required in society of a very dynamic nature. Culturally we are not ready to consider alternatives to drug therapy and hospital treatment on a widespread scale in supporting people with mental health issues. These are the prevailing methods for treating mental illness. It is one thing for Scott to say that he wants to rebalance the relationship between social and health care and put the persons decision making abilities at the centre of this and quite another to implement changes of this magnitude that would see a demise in spaces like hospitals being used to treat and support people. The pilot showed very little impact in shifting the dominant psychiatric culture of treating people with drugs and in hospital when they are in crisis.

- The resource issue is again of a magnitude that will not bring change in the use of SDM in stage 1 anytime soon. Changes to redress the ability of a person subject to detention to be offered an alternative to hospital for treatment are insurmountable in the short term. It is likely that we need to consider generational shifts that are of the same nature and size as the long stay closure of psychiatric hospitals in the 1980s and 90s.This issue will not be solved by a small pilot project in one health and social care partnership. It will require significant changes in law, health and social policy and additional resources to make it happen on a scale that truly allow people to make advanced choices that do not clash with current mental health systems.

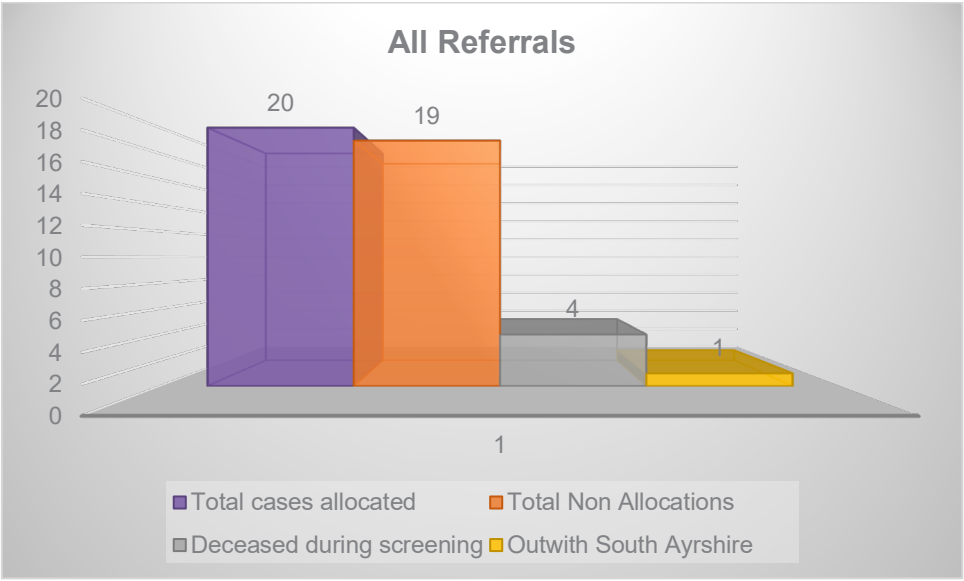
There are a further series of appendices which support the work of this final report and will give an overview of how the project developed and decisions about the assessment format were made:

- Appendix 1 - Supported Decision Making - Pilot Project
- Appendix 2 - Six-week report on the pilot
- Appendix 3 - Three-month report on the pilot
- Appendix 4 - Guidance for assessing Supported Decision Making June 2023
- Appendix 5 - SDM template July 2023

Section Three. Final Performance

Throughout the course of the pilot the most challenging issue has been to support staff in hospitals understand the referral criteria and refer appropriately to the pilot. This is reflected in the overall numbers being assessed using SDM as opposed to those who have been referred to the pilot project.

All referrals	44	%	H	%	C	%
Total cases allocated	20	46%	11	55%	9	45%
Total non-allocations	19	43%	15	79%	4	21%
Deceased during screening	4	9%				
Outwith South Ayrshire	1	2%				



We were asked to screen 44 people for SDM in the pilot and 20 people were assessed and used SDM effectively to the conclusion of an advanced choices framework. The total cases allocated were 46% of the total referred and it would be helpful if we could increase the number of people being directly referred and assessed for SDM rather than being screened.

Of the 24 screened, 19 went on to need further support in terms of intervention using AWI legislation. One very positive thing to emerge from these 19 was that 11 people already had an enacted POA and the worker was able to register this on the system, explain this to the care team and prevent a further assessment for intervention using guardianship.

A less positive note it is an indication of staff referring people who have already lost capacity and are unable to be supported by an SDM assessment. Several significant points are raised by these figures:

- We had considered the possibility that staff had referred people appropriately out of the 19 not allocated and that because capacity is ever changing by the time the worker got to assess the person, they had lost capacity, and it was not an appropriate referral. Unfortunately for us this turned out not to be the case in that it was evident in all 19 cases when screened that the person had already lost capacity in every instance.

This ensured that the evidence was weighted towards saying that staff needed further support to understand the referral criteria for an SDM assessment.

- The positive point to take from these figures, is that we managed in almost half the cases screened to complete an SDM assessment. That is 20 people who have not drifted towards requiring further intervention under AWI legislation. Overall, we made significant savings in bed days with these 20 people and when drilling down into individual stories it can be seen that many moved out of hospital on a voluntary basis with the right support package.

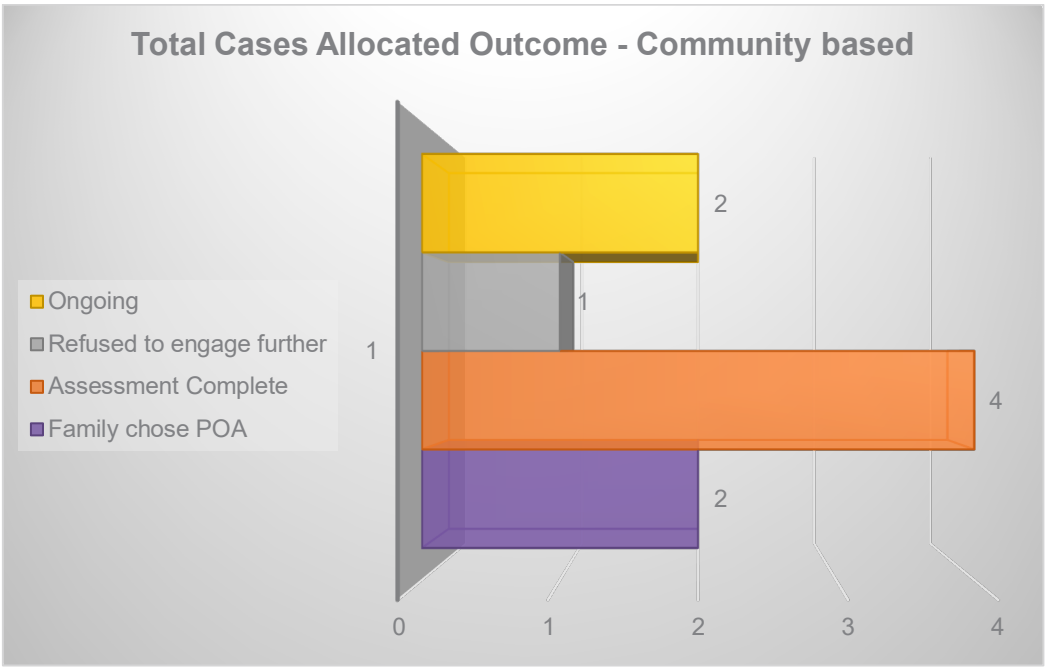
- The feedback from service users who were at stage 2, and were supported to make advanced choices, was that they liked the process of being involved in an SDM assessment and made them aware of their choices within the context of offering this in a voluntary basis. A continued positive experience for service users and carers. The most important feature to allowing the SDM assessment to work and make a difference with people.

Section Four. Referrals allocated

4.1. Community based referrals

This has been an area where SDM has worked very well for service users, carers and the MDT working with them. It is an area where development will continue with the support of the new SDM social worker. So far 9 people have been seen, 1 refused the service and 8 people have been assessed for SDM. All 8 benefited from the process and in one form or other where able to better make advanced choices because of the SDM assessment taking place. People also gave positive feedback stating in all 8 cases that the intervention was helpful but more importantly for service users helped them understand that the diagnosis of a cognitive impartment was not the end of their life but the beginning of something different in their lives where they would need support to continue to do the things they had always done.

Total Cases Allocated Outcome - Community	9	45%
Family chose POA	2	22%
Assessment Complete	4	45%
Refused to engage further	1	11%
Ongoing	2	22%



The background to developing SDM in the community came from the recognition of the importance of early intervention to support people with replacing substitute with supported decision making in the hospital. Links were made by the MHO and student social worker with the local community mental health team for the elderly. Regular attendance was established at twice weekly MDT meetings. It was evident from the outset that RMO and CPN colleagues in the CMHT had a greater understanding of the use and benefits of supported decisions making than colleagues in general hospitals. All 9 referrals were appropriate.

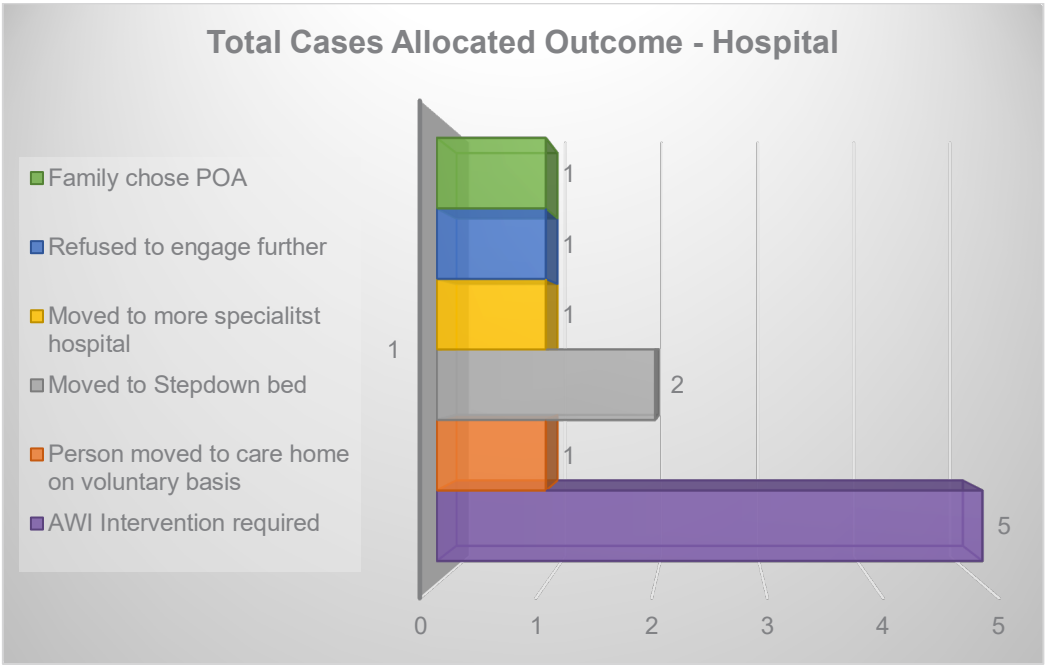
The essence of the success lay in setting the groundwork with people newly diagnosed with a cognitive impairment and being sensitive to their needs in terms of going at the persons pace in helping them understand how a cognitive impairment would impact their life and what they could do support the necessary changes to maintain a positive and active life. Clearly this was a small sample of people, but it is evident SDM works effectively with early intervention in this area. A much larger study would be required to assess the impact of SDM in saving time spent using AWI processes or in hospital for people because of having an early intervention of the kind outlined in this pilot.

From the perspective of the pilot this early intervention in the community is one of the two areas where SDM can work now without any of the legal or cultural changes suggested by Scott. The other of course is the much more targeted approach on stage 2 with people who are in their early presentation to hospital services. The resource issue is something different and needs to be explored in more depth. Most of the time with older adults in particular we are reactive and respond to a crisis. What if we moved the resources to the start of the persons journey, when newly diagnosed and assisted them in making advanced choices. In the 9 cases we explored in the pilot the impact was extensive and helped people prepare for what was coming and make plans for the types of support they would need.

It is of note to ensure that in the future we follow up these first 9 people seen in the pilot to explore how they are doing in a year from now and two years from now. This is something I will be asking the newly appointed SDM social worker to do. I am hopeful that the impact of making advanced choices now will mean that they avoid the complicated and lengthy process of an AWI intervention in the future. However, because of this positive relationship with older adults and professionals in the community the work in this area will continue and the new SDM worker will continue to attend MDT meetings at the CMHT to process SDM referrals

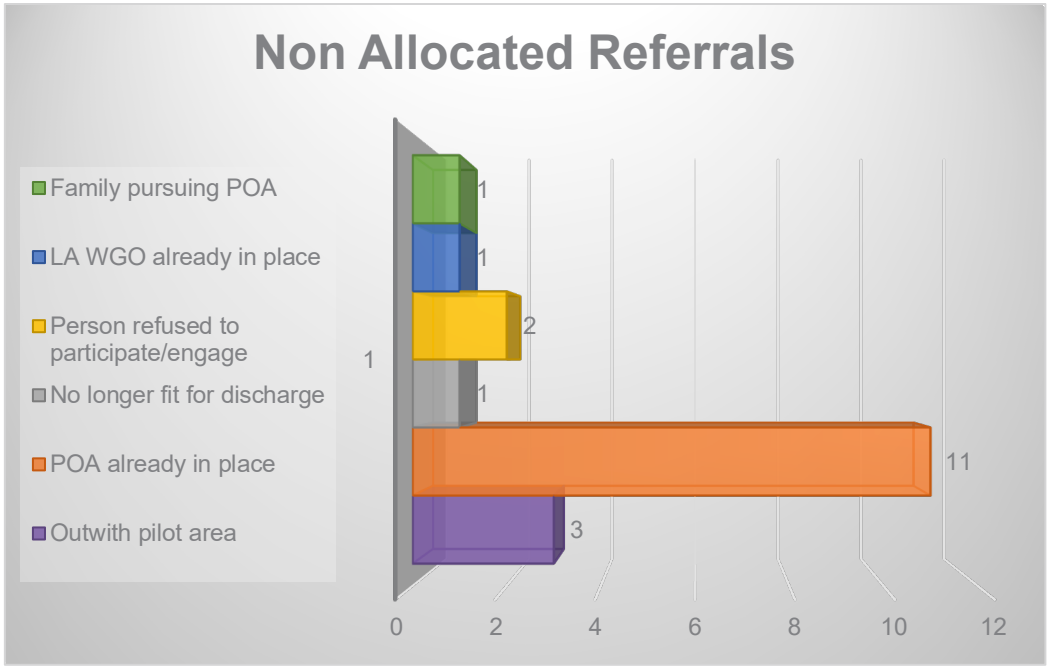
4.2. Hospital based referrals

Total Cases Allocated Outcome - Hospital	11	55%
AWI Intervention required	5	46%
Person moved to care home on voluntary basis	1	9%
Person moved to Stepdown bed	2	18%
Person moved to more specialist hospital	1	9%
Person refused to engage further	1	9%
Family chose POA	1	9%



Section Five. Non-Allocated/Inappropriate Referrals

Non-Allocated Referrals	**19**	**43%**	
Outwith pilot area	3*	16%	*All hospital based referrals
POA already in place	11*	58%	*All hospital based referrals
No longer fit for discharge	1	5%	
Person refused to participate/engage	2	11%	
LA WGO already in place	1*	5%	*Community based referral
Family pursuing POA	1	5%	



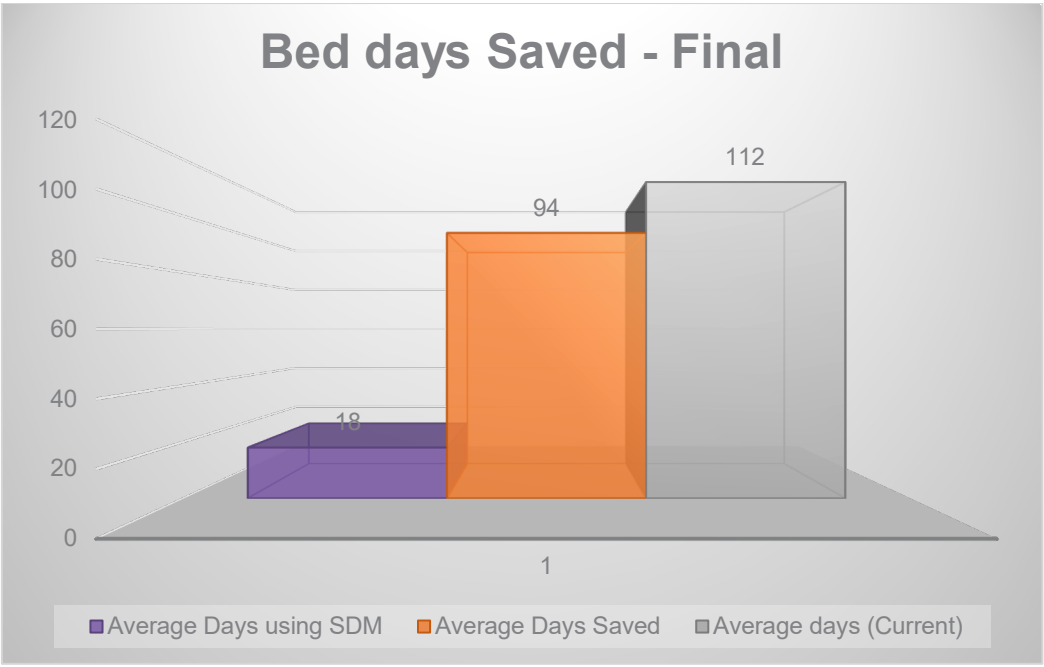
Of the 19 people not appropriate for an SDM assessment 11 already had full welfare and financial POA's in place that had been enacted. Despite having these in place colleagues in the hospital continued to refer people in this position for an SDM assessment throughout the pilot. It is evident that there is a significant lack of understanding about the use of S47 certificates and POA amongst hospital staff. There is a need for some direct training with all hospital staff particularly around POA and how it is used and enacted. One of the recommendations from this report will be the need to combine briefing's on S47, POA, Guardianship and the use of SDM for all staff within hospitals. My strong presence would be for this to be mandatory and be provided on a rolling basis within hospitals to support staff in understanding how this can support their work with someone who is struggling with a cognitive impairment.

The importance of this cannot be overstated. Half of the referrals to this pilot were inappropriate because staff did not have the time or did not understand what was required to make a referral. It will be important to assist staff in understanding that having a S47 certificate in place for treatment does not mean that a person has completely lost capacity and cannot continue to make decisions about their welfare. The practical support needed to ensure that questions have been asked if someone is subject to POA when admitted to hospital and to be clear if this is active or not is essential to the development of any SDM process.

A basic understanding of the process for applying for a welfare guardianship order and the importance of spotting when someone is reaching stage 2 and a referral can be made for SDM is crucial for all staff to know.

Section Six. Bed Days Saved

Average bed days using SDM	18
Average days (Current)	112
Average bed days saved	94



As can be seen from the graph above the average bed days saved using the SDM process were 94 per person. SDM was able to be successfully used with just under half the people referred to the pilot. It is evident that if we can get the training and support right to staff then it will have a significant impact on the hospital discharge process. The training for all hospital staff is key to promoting the use of this service. At present we have seen 20 people in a six-month period that were assessed using SDM which is not enough to say it is a resounding success but rather a positive start to understanding its use in this environment. More extensive work is needed to sustain its use in the hospital environment through developing a clear training and support plan.

This will be based on a plan that can implement a training for trainers scenario where the ideas about SDM can be cascaded across Hospital services. I have written a clear presentation with accompanying notes that gives an overview of the links between AWI legislation, incapacity and SDM. I want to use this across all Hospital services and settings in the partnership to promote the use of SDM with people at stage 2. The desired outcome would be for all health staff to be able to spot when SDM can be effective with people and be targeted and used specifically with people it will benefit.

Section Seven. Assessment Format

Throughout the pilot two different assessment formats were used to process the work done on SDM. An abbreviated version which looked the bare minimum someone would need to update broader community care assessment formats and include a view on the use of SDM for someone in their general record. Then a full specialist assessment to be completed by a social worker who was working in this area exclusively and regularly doing SDM work with service users and carers. I outline below some outcomes that will be recommended for including an abbreviated view in the partnership's community care assessment, My Life My Outcomes, and the guidance notes to accompany theses minor changes. Secondly the full SDM assessment which I will request becomes part of our information system and will be used by the newly appointed social worker for SDM.

The basis on which all SDM assessments will be referred and completed is in terms of stage 2 as outlined in the supported decision-making initial document attached as appendix 1 to this document. So, for a fuller picture of what is meant by all 3 stages please refer to appendix 1.

The importance of ensuring that everyone is aware of and can apply SDM where appropriate is important for the success of its use in the partnership and more widely. As part of the final recommendations, I will propose that our information systems are adapted to ensure that all social work staff have access to completing a case record and as part of their assessment provide views on the use of SDM for the person they are working with. In addition, a new formatted assessment as outlined in appendix 5 will form the paperwork to be completed by the newly appointed SDM social worker. Going forward then the organisation is consistently reporting on the use of SDM with service users and carers.

Section Eight. Training and Support for Staff

The training agenda for all staff within social work and the hospital is extensive. The following training needs to be designed:

- Briefing for all social work staff on the changes to the information systems, case work, and assessment format. Overview of the guidance for assessing supported decision making

- Targeted briefings for health staff across all three hospital sites in the partnership about the use of section 47, POA, guardianship and SDM. The links within and between these processes need to be made for health staff to assist them making the correct decision about who can be referred for an SDM assessment

- Briefings on the benefits and uses of SDM. An overview of the pilot and the value of applying SDM in your everyday work.

I have had some initial contact with senior nursing staff within the hospital about pursing training across the three sites in our partnership area. We are at the really stages of exploring a training for trainer's programme where I would develop materials with nursing staff who would then apply this with colleagues across all three sites .A training and support plan needs to be developed that delivers training on SDM on a rolling basis and can support the work the team is doing to promote SDM referrals and assessments. It is essential that the briefings for hospital staff are practical and assist staff in seeing the benefits of SDM and being able to refer people to us at stage 2.

The next phase post pilot if agreed by the senior management team is to develop training materials and a full plan that will support our work on an ongoing basis around SDM.

Section Nine. Service User Feedback

There was both positive and negative service user feedback about the use of SDM in the six months of the pilot project. Positive feedback in general came from older adults who found the opportunity to explore advanced choices useful. This ranged from solidifying the need to get a substitute guardian in place, to relief that a reasonable quality of life could continue, to more enlightened views about the impact of a diagnosis of cognitive impartment.

SDM failed in many cases to support the needs of younger adults particularly those who had been diagnosed with chronic mental health problems who were or had been subject to detention under mental health legislation. As stated earlier in this report very significant changes in policy and culture will need to take place before younger adults will be able to see the benefits of using SDM. Where it did help younger adults was in clarifying how they might respond to having the more major decisions in their lives removed from their control. Particularly when it comes to hospital admission and how they would react to that differently if their care team felt they needed admission.

The most positive results of using SDM came in a community context with the work done with colleagues from the CMHT for the elderly. The central reason for this was the combination of understanding between professionals, health, and social work, about the use of SDM and the ability for both groups of professionals to work together to support the person subject to the SDM assessment.

Section Ten. Recommendations

1. Accept the findings of this report and these recommendations and allow the statutory MHO team to continue its work on SDM. Allow this report to be shared with the wider staff group and external organisations out with the partnership.

2. A full time permanent social worker has been employed to continue the work of SDM. This worker should by employed across all three hospital sites and continue to support the work of SDM in them.

3. Specifically, the SDM social worker will work with elderly CMHT and continue supporting stage 1 and 2 referrals from the community and this team.

4. Mechanisms will be developed to further review and report on the benefits of SDM with services user at the early intervention stage. MHO coordinator to provide annual reports of developments in this area.

5. Regular reviews of the work of the SDM social worker will be provided to the SMT. Specifically the work on bed days saved because of this post will be reported on throughout the year.

6. Specific changes are required to the social work information system, care first, to support the work of the team. They are as follows:

- To ensure that all social work staff participate in SDM, one simple change to my life my outcomes for all workers to record. Halfway down page five Making decisions about your life, being listened to with regards to services you receive. Add an additional subcategory called My advanced choices-SDM assessment (please see detailed guidance on completing an SDM assessment)

- All social work staff involved in my life my outcomes assessments get a 45-briefing using the guidance/template to explain advanced choices and SDM

- A new SDM assessment format is added to care first as the attached template in appendix 5. This will allow the new SDM social worker to complete and record full SDM assessments on care first and use these as a means of obtaining care packages for individuals if required

- A new observation called advanced choices is added to care first and each time the advanced choices on my life's my outcomes is completed or new SDM social worker completes a full SDM assessment the advanced choices pull through to this observation so that workers in the future will automatically know that an advanced choices/SDM assessment has been completed for the person if they look at the observations.

- A new classification will pull through or be added in the front sheet of the persons records which states they have made an advanced choices statement. In this way anyone examining the record including inspection agencies and auditors can see that an advanced choices record is available to look at for the person

7. A full training and support plan is deployed to support the work of the new SDM social worker and secondly gives health staff a broader understand of the links between AWI legislation and the use of SDM. Essentially it assists in targeting referrals for stage 2 by:

    - Briefings for all social work staff on the changes to the information systems, case work and assessment format. Overview of the guidance for assessing supported decision making

    - Targeted briefings for health staff across all three hospital sites in the partnership about the use of section 47, POA, guardianship and SDM. The links within and between these processes need to be made for health staff to assist them making the correct decision about who can be referred for an SDM assessment

    - Briefings on the benefits and uses of SDM. An overview of the pilot and the value of applying SDM in your everyday work.

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APPENDICES

Appendix 1 –
Supported Decision Making - Pilot Project

Supported Decision Making - Pilot Project

Appendix 2 –
Six-week report on the pilot

SDM Pilot 6-week Review May 2023 (00:

Appendix 3 –
Three-month report on the pilot

SDM Pilot Project. 3 Month Review

Appendix 4 –
Guidance for assessing Supported Decision Making June 2023

Guidance for assessing SDM

Appendix 5 –
SDM template July 2023

SDM Template