Health and Wellbeing Board
Hertfordshire

Agenda Item No.
4

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
THURSDAY, 2 MARCH 2017 AT 10.00AM

HERTFORDSHIRE YOU CAN PILOT PROJECT (ADULTS WITH COMPLEX NEEDS)

Report of:

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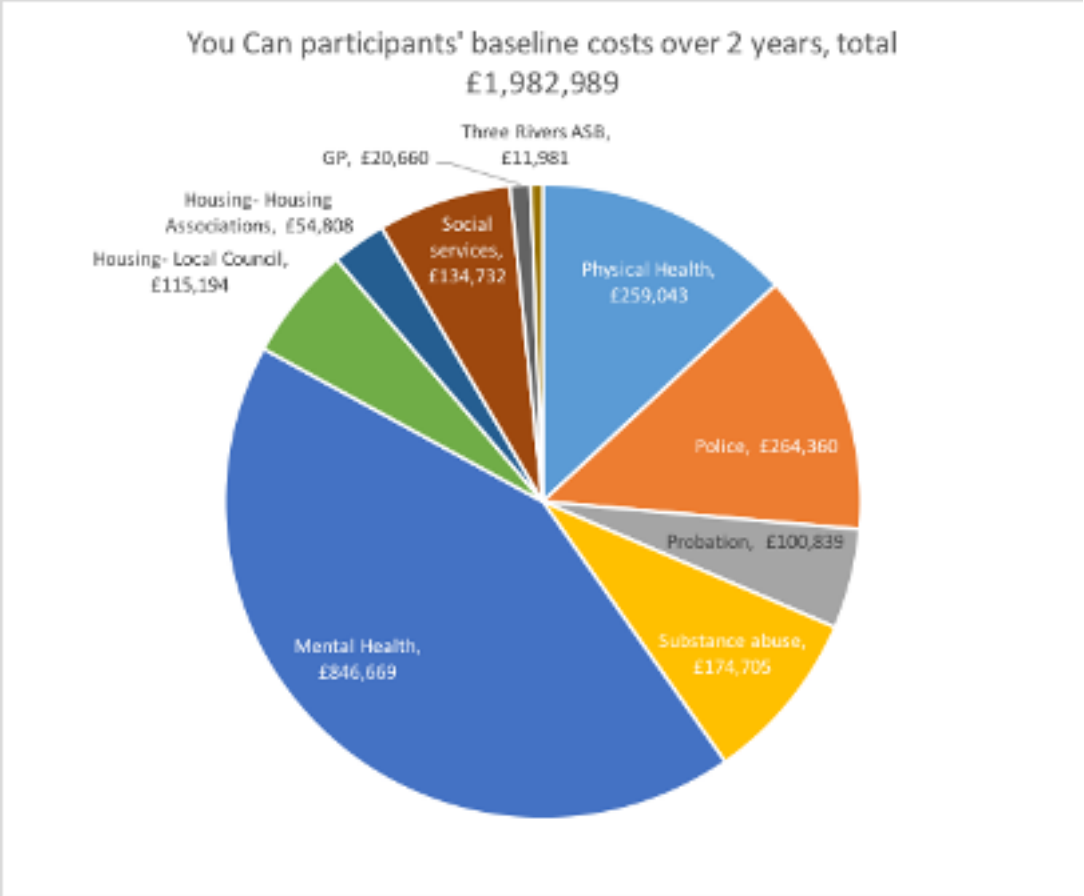
1.0 Purpose of report

1.1 The purpose of this report is to update the board on progress and outcomes to date of the You Can (Adults with Complex Needs) pilot project, and outline next steps

2.0 Summary

2.1 The Adults with Complex Needs project is a two-year, local public sector-wide pilot based in Hertsmere and Three Rivers, seeking to prove a way of working that is more preventative, intensive and better supports adults with complex needs. Crucially, it seeks to generate data which proves that this way of working represents a better way of spending across the public sector, saves money, and leads to sustainable improved outcomes. Adults with complex needs are defined as individuals who are known to and have multiple and ineffective contract with multiple agencies. They have multiple issues in their lives contributing to their chaos.

2.2 The ongoing service use data for 55 adults who have so far engaged with the service has been collected to investigate any changes in service use before, during and after the You Can Team support. This data has been used to explore the changes in costs across various areas of need. The 2-year baseline costs of all participants across the two localities was £2,788,760. Of this, costs for services which could be categorised as reactive and avoidable is £1,982,989. The following graph shows the breakdown of baseline costs by main service area using the limited data set of reactive costs:



2.3 The service provides a keyworker for each participant following acceptance through the referral process. In the early stage of engagement, time is taken to build a working relationship with the participant. The support offered is personalised, putting the participant at the centre of the contact and focuses on the assets that they have within them and around them with the aim of supporting them to take greater responsibility and control of their lives so that they can self-direct their care and support. Most participants have 'opted out' of traditional services resulting in their reactive use times of crisis. The project therefore does not seek to get the participants to fit the service, but focus on what will make a difference to the participants. The service does not replace more formal interventions by social workers, health professional, probation officers or housing staff, but helps the participants to engage with these services positively in a planned way as part of a programme of support that they have helped to shape and agree.

2.4 The keyworkers of the project have a range of skills, experience and backgrounds to support the needs of participants. The skills used by the workers include:

- Care co-ordination
- Multi-agency working
- Sign posting
- Person centred planning

- Mindfulness and meditation skills
- CBT skills
- Problem solving skills
- Assistance with task of daily living
- Goal setting
- Monitoring
- Modelling positive relationships
- Behavioural interventions
- Motivational interviewing
- Budgeting
- System navigation
- Advocacy

2.5 This provides a wide range of tools and interventions that can be deployed, depending on the outcomes agreed with the participants and the resources available within the team and the wider community. Further details of the service delivery model are attached at Appendix 2.

2.6 The project has received national attention for its innovative approach to funding, and its user-led approach to service design. In particular, the DCLG Troubled Families team are interested in our model in light of potential future policy development. The team are also in contact with other local agencies who wish to share best practice and our learning to date to inform their own work, including across the Herts and West Essex STP footprint. The project has also been shortlisted for an LGC Award for Health and Social Care.

2.7 In addition to the potential for financial savings that the project offers, the service has the potential to make a significant difference to the lives of individuals with multiple and complex needs. We have started seeing some early indicators of success for individuals who have engaged with the service. See attached Appendix 1 for more detailed case studies.

2.8 Encouraging stories are emerging from the project, where the flexible and responsive nature of the service is having a positive impact on the lives of people with multiple and complex needs. Each participant is at a different stage of engagement with their allocated project worker. The project worker engages with the individual to identify and work towards the participant's own goals, in line with a client centred approach to care planning. The project team is tracking progress for each individual using the Outcomes Star.

2.9 The early qualitative report from Interface Enterprises (external evaluator) also reported on outcomes that had been achieved at that early stage of engagement. This included:

- Reduced calls to the police

- Fewer cancellation of appointments
- Reduced attendance at A&E
- Abstinence from substances
- Occasional, case specific cost driven interventions.

2.10 The data from Resolving Chaos, shows average costs savings of £199.53 per person per month, or £9976.72 for the whole group. However, this does not take into account the cost of delivering the 'You Can Service'. Nonetheless at this stage, we would not expect to see a saving achieved whilst the average length of engagement is 5.15 months. However, this early data does show some interesting indicators of a decrease in use of mental health services.

3. Recommendation

3.1 The partnership would like the Health and Wellbeing Board to note the project update and next steps, outlined below, being taken by the sponsor group to extend the pilot.

3.2 The 'You Can Team' has been in operation for over 12 months. In this short time, the model is starting to demonstrate that there are positive outcomes for a very vulnerable, challenging and complex cohort of participants. To assist at this project milestone, we have analysed and shared some of our initial learning, with a view to support the future evolution of the pilot service.

3.3 The partnership is keen to extend the project to the end of the 2017/18 financial year to ensure that the full results of the qualitative and quantitative analysis are given time to emerge so that the most robust case to extend the project across the county can be made.

3.4 We are seeking funding to extend the multiple and complex needs pilot in order to enable a robust evaluation and extrapolation of data for a cost analysis of the project to prove the case for a multiple needs service across Hertfordshire which reduces demand and cost to public services and improves outcomes.

3.5 External options for funding are also being sought. A funding bid has been submitted to the Department of Communities and Local Government to support the pilot extension to the value of £70,000.

3.6 All partners will be considering the next steps, outcomes so far and funding for the extension of the pilot.

4.0 Background

4.1 In looking at the potential cost to extend the project to the end of March 2018, it is recognised that monthly costs will be less than those initially incurred due to the service now working with 40 clients and therefore not needing as many key workers. The total anticipated cost of

extension is £150,000. This does not include the accommodation costs for the project currently being met by Three Rivers District Council and Hertfordshire County Council.

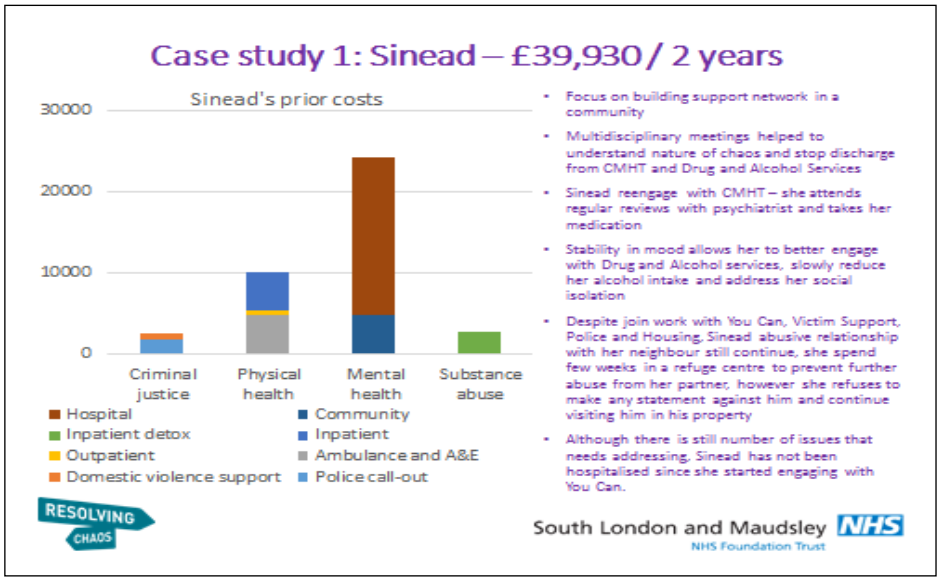
4.2 Depending on the total funding that can be secured across the partner agencies and from external sources the project could be extended proportionately. Given the level of investment in the pilot to date, the Sponsor Group strongly felt there is a need to complete the pilot with sufficient evidence being gathered to reach an informed decision as to whether the model works.

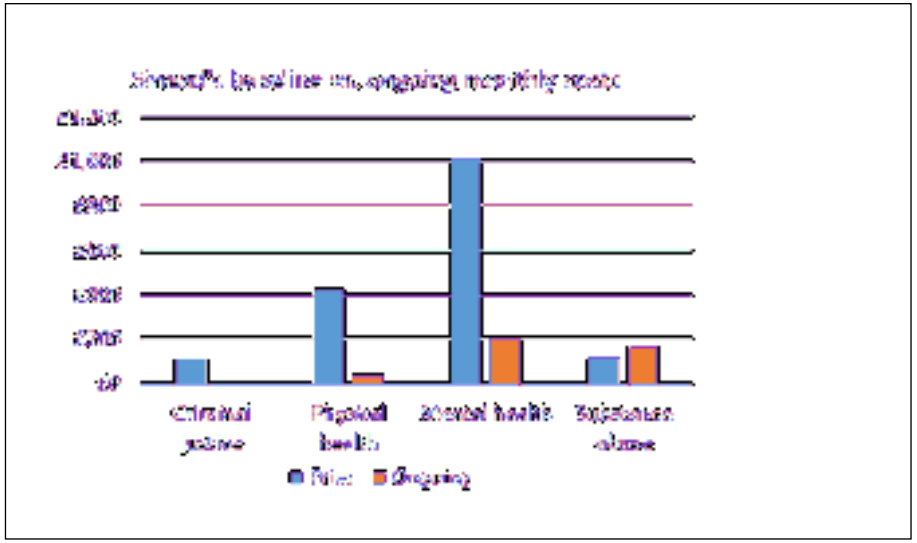
4.3 Once clear evaluation data can be captured on the long term impact of this model of working it is not anticipated that a standalone service will be commissioned. Rather, that existing services and service specifications can be reviewed to commission the model of working as an integrated part of how agencies work across Hertfordshire. The request to identify funds to support the pilot extension is not a recurring request but a one-off request that could provide data with which to make better informed commissioning decisions and specifications in the future.

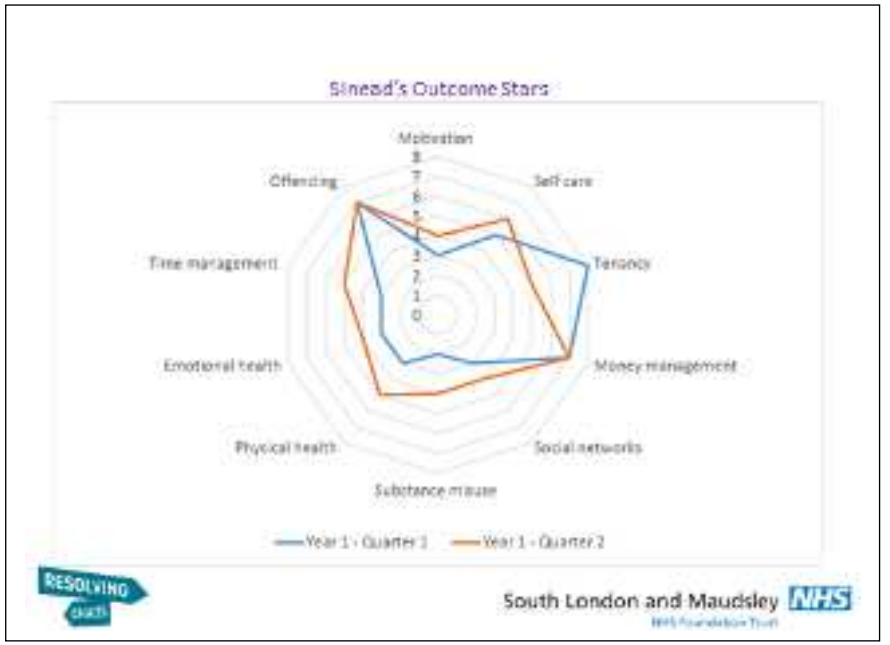
Report signed off by	Sponsor Group Chair
Sponsoring HWB Member/s	The Chair
Hertfordshire HWB Strategy priorities supported by this report	Living and Working Well
Needs assessment (activity taken)	
Consultation/public involvement (activity taken or planned)	
Equality and diversity implications	
Acronyms or terms used. eg:	
Initials	In full
DCLG	Department of Communities and Local Government
LGC	Local Government Chronicle
STP	Sustainable Transformation Plan

Appendix 1 – Case Studies

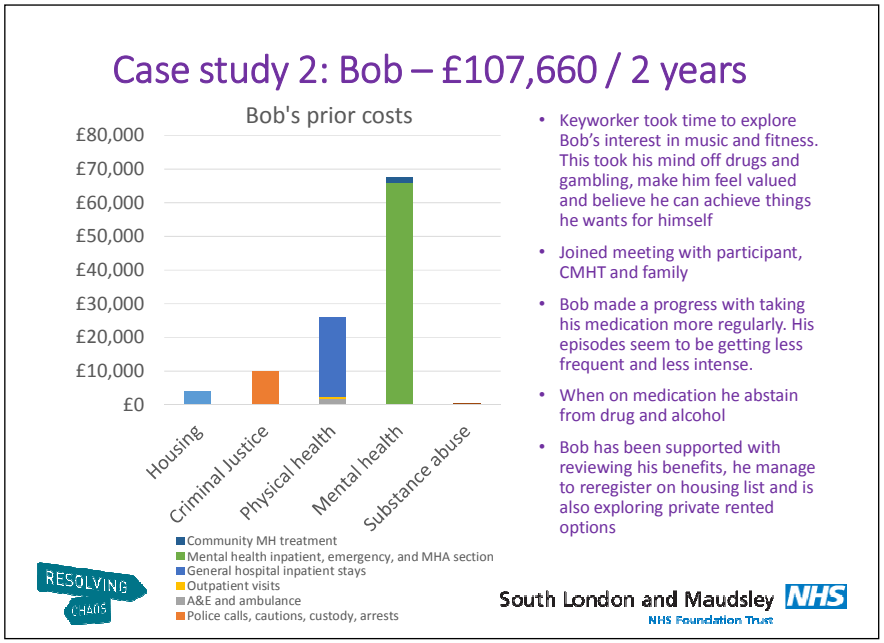
Case study 1:

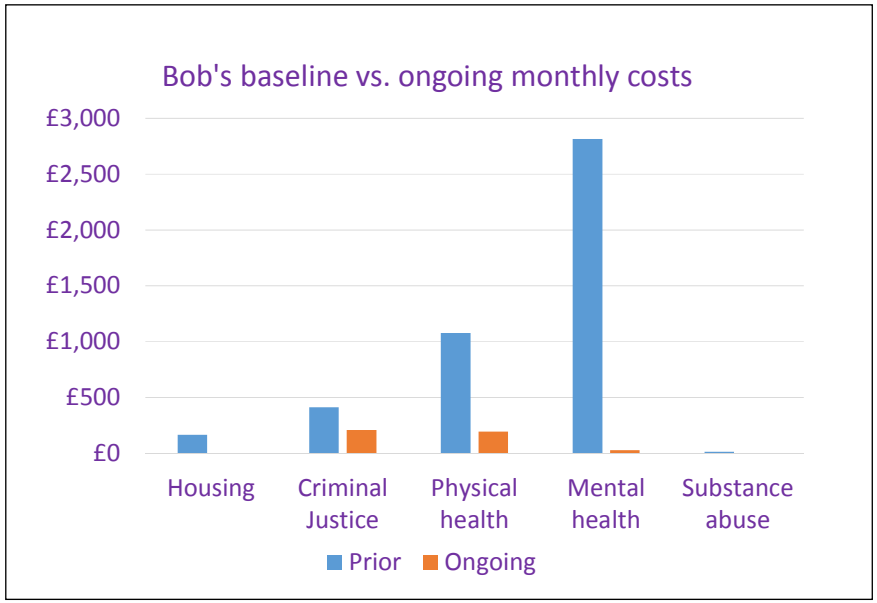


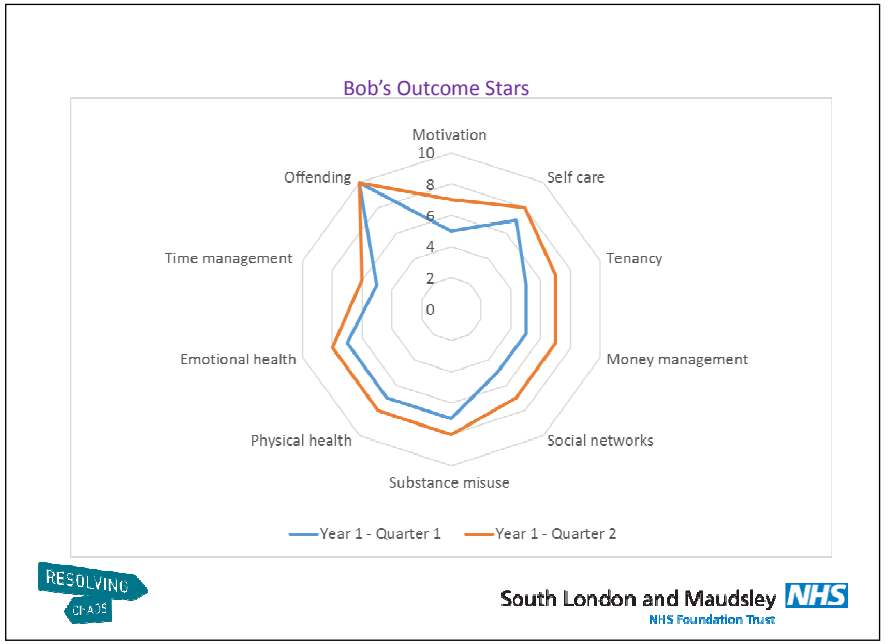




Case study 2


Case study 2: Bob – £107,660 / 2 years
Bob's prior costs
£80,000
£70,000
£60,000
£50,000
£40,000
£30,000
£20,000
£10,000
£0
Housing
Criminal Justice
Physical health
Mental health
Substance abuse
Community MH treatment
Mental health inpatient, emergency, and MHA section
General hospital inpatient stays
Outpatient visits
A&E and ambulance
Police calls, cautions, custody, arrests
• Keyworker took time to explore Bob's interest in music and fitness. This took his mind off drugs and gambling, make him feel valued and believe he can achieve things he wants for himself
• Joined meeting with participant, CMHT and family
• Bob made a progress with taking his medication more regularly. His episodes seem to be getting less frequent and less intense.
• When on medication he abstain from drug and alcohol
• Bob has been supported with reviewing his benefits, he manage to reregister on housing list and is also exploring private rented options
RESOLVING CHAOS
South London and Maudsley NHS
NHS Foundation Trust


Bob's baseline vs. ongoing monthly costs
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
Housing
Criminal Justice
Physical health
Mental health
Substance abuse
Prior
Ongoing


Bob's Outcome Stars
Motivation
10
8
6
4
2
0
Self care
Tenancy
Money management
Social networks
Substance misuse
Physical health
Emotional health
Time management
Offending
Year 1 - Quarter 1
Year 1 - Quarter 2
RESOLVING CHAOS
South London and Maudsley NHS
NHS Foundation Trust

Appendix 2 - Delivery Model

The model, originally based on the model employed by the You First Team in South London employs a long term personalised and person centered approach. The model moves away from traditional approaches to support where services define how, where and what services are provided to an individual. The team works with participants to identify their own goals for the work they do with the You Can team.

It is currently made up of 3 major parts including:

- Participant Pathway
- Evaluation
- Data Analysis

Participant Pathway

1. Referral/Nomination and Data Collection
2. Assessment (Pre-engagement)
3. Acceptance or Signpost elsewhere
4. Engagement (Very High, High and Medium Intensity Work – Traffic Light System)
5. Discharge (Planned and Unplanned)

Participant Pathway

1. Referral/Nomination

Originally, high cost individuals (those costing more than £500 per week) were identified through a Multi- Agency Panel at 'Superday' events. This was found to be a successful way of identifying a group of potential participants for the project.

Following on from this, service use data was collected across agencies. This data, in addition to meeting the criteria of having needs in three of the 4 identified areas was used to indicate acceptance into the project.

Delays between nomination and obtaining the service use data proved to be a significant barrier to access the service at critical times. Whilst the project was not set up to be a direct entry service, being responsive and flexible can mean capturing a person at this critical time. To address this issue, as guided by the sponsor group, moved away from using service use data as the criteria for acceptance to the pilot, the most recently used criteria for acceptance onto the project is as follows:

There are now two pathways for being referred to the service:

- Nomination through the multi-agency Superdays (original route)
    - With consent to be obtained after service use data collected (most used pathway)
    - With consent already obtained
- Direct referral to the You Can Team (later developed in response to need).

Nomination Criteria

- *Evidence that the individual is complex and chaotic (from data and/or general professional knowledge)*
- *Has three of the four areas of need (housing issues, offending behavior, mental health issues and drug and alcohol issues)*
- *Engagement with services is chaotic, costly and unhelpful (both for the individual and for the service)*
- *Evidence that the individual would benefit from the You Can service offer over and above what is already in place and this could contribute to improve out comes (economic and/or otherwise)*
- *Evidence that the individual is motivated to change (despite potentially being reluctant to engage with services)*

2. Assessment

Following a direct referral or nomination the You Can team explore the case with relevant partner organisations and organise initial meetings with nominees. It is important at this stage that the referral agency is still engaged and/or an appropriate partner who can make the initial introduction or link to the You Can team. At this point a decision is made about whether this is the best service for the nominee depending on their engagement to sign up to the project and support offered as well as if they prove to be costly to public services when data is available.

3. Acceptance or Signpost

At this point if consent has not already been achieved at referral stage consent to receive support and be part of the service is signed and engagement can begin. However, if the nominee is not accepted onto the project they are signposted by the referrer on to a more appropriate service.

In both cases the referrer receives feedback as to the decision. More general feedback is also provided at the quarterly collaboration forums. Currently, the purpose of these forums are to:

- Receive an update about the You Can Pilot Project.
- Collaborative discussion about specific participants we are working with.
- Share and receive information about services working with people with complex needs.
- Discuss opportunities for partnership to help meet the needs of individuals.

4. Engagement

In the early stages of engagement, the team works with the participant to identify who is already a part of the support network and ensure they are in communication with these stakeholders, including calling multi- disciplinary meetings to discuss seamless support of individual across agencies.

Where there is no support network around a participant the Project Worker works toward building a team around them. The team identifies areas of need that are not being met, explores possible barriers (internal and external) to accessing these services and supports the participant towards engagement.

The project worker spends time engaging with the individual to identify and work towards the participants own goals, in line with a client centred approach to care planning. This takes place in participants own environment empowering them to make positive changes to their lives.

The key workers and participants work towards changing pattern of behaviour away from using costly emergency/crisis service.

The skills keyworkers employ include:
Care co-ordination, Multi-agency working, Sign posting, person centred planning, mindfulness & meditation skills, CBT skills, problem solving skills, assistance with tasks of daily living, goal setting and monitoring, modelling positive relationships, behavioural interventions, motivational interviewing, budgeting and system navigation, advocacy as well as befriending.

Some the most important elements of the You Can service that make the difference to our participants are:

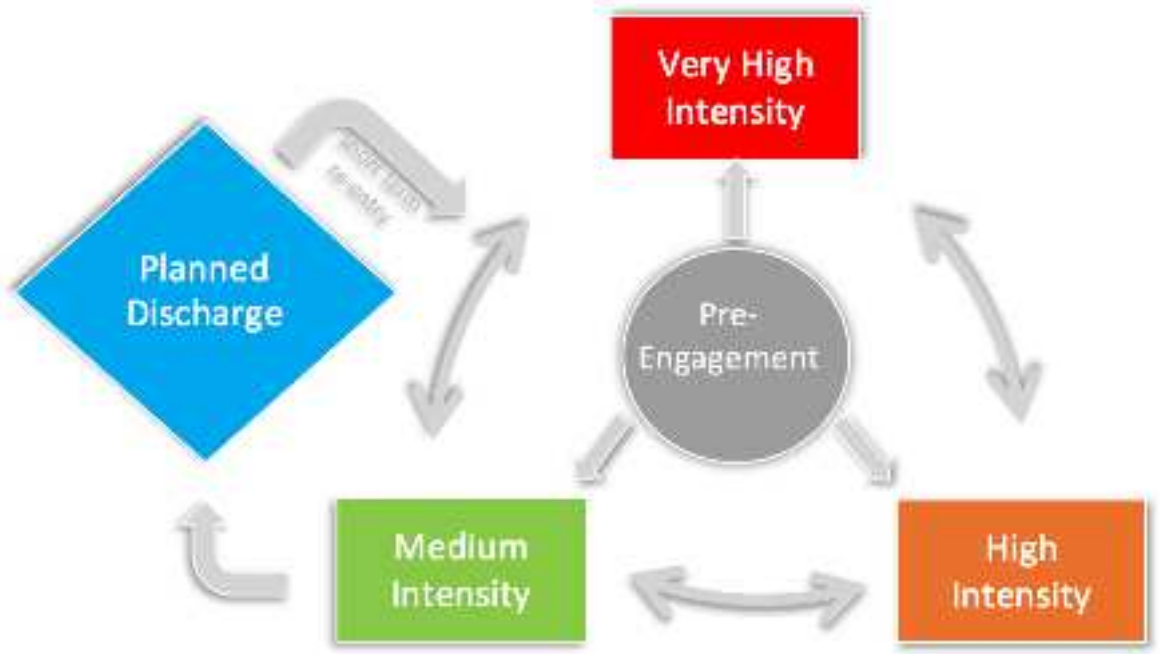
- *Small caseloads and quality time with participants.*
- *Personalised and person-centred approach.*
- *Working across and with other services to ensure support integration*
- *Working from the participants' environment and observe their strengths and harness their assets.*
- *Provide a non-judgmental, person focused service.*
- *Working with people who otherwise would not have the chance to receive the support they need to change.*

Recent upgrades to Inform (You Can Case Management System) mean that goals relating to the Outcome Star – self-rating measure, that helps participants to explore 10 areas of wellbeing and develop related goals, are now being captured by the team.

In addition to this, the team uses a Traffic Light system which helps them to monitor progress towards goals and where necessary a planned discharge, as indicated by the level of support that they require from the team.

The Traffic Light System

Red: Individuals requiring a very high level of support, contact with participant twice per week or more and frequent contact with related agencies.
Orange: Individuals require a high level of support, once – twice weekly and weekly contact with other agencies.
Green: Individuals have reached a level of stability, requiring infrequent contact, sometimes less than weekly, participant has reached a level of stability.
Grey: Pre-engagement, the team is working with agencies and the participant toward engagement. In some of these cases, the participants are not currently motivated to change.



5. Discharge (Planned and Unplanned)

Planned discharge

- The aim of a planned discharge is to ensure the participant can independently access services in the community in an appropriate way to meet their needs and avoid chaos.
- As such, project workers will work with participants to identify their needs, introduce (or in many cases reintroduce) them to appropriate services, assist in appropriate engagement or services in the early stages and support them to access services independently in the later stages.
- The more independent a participant is at accessing services to meet their need, the closer to discharge they are.
- Discharge would be planned and discussed with the participants and other supporting agencies.

Unplanned discharge

- An unplanned discharge refers to where a participant is discharged from the service before a planned discharge is achieved, usually due to difficulty with engagement.
- Other reasons for unplanned discharge may be due to death, movement

outside of area with no planned return (keeping in mind chaotic nature of participants) and other reasons as assessed on a case by case basis.

- For an unplanned discharge to occur, where engagement is the barrier, there needs to be a documented period of 3 months with no contact (face to face or otherwise) between the participant and the project worker
- The You Can Team will continue to attempt to engage with a participant during this 3 months, methods of engagement may include but are not limited to:
  - Direct visits to them at home
  - Liaising with other agencies
  - Sending emails and letter
  - Phone calls
- Discharge from the service would be communicated to other agencies know to be involved with the support of the participant
- Re-opening participants who have been discharged will be assessed on a case by case basis in-line with the eligibility and capacity for the project.