



Ipsos MORI  
Social Research Institute

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# Liverpool Waves of Hope evaluation

## Year 3: Evaluation report

Ipsos MORI Social Research Institute



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# 1 Executive Summary

In January 2015 Ipsos MORI was commissioned, in partnership with the Institute for Psychology, Health and Society at the University of Liverpool, to conduct the local level evaluation of the Liverpool Waves of Hope (LWoH) project. This executive summary of the year 3 evaluation report considers the period January to December 2017 and follows the year 2 evaluation report (published April 2017). This third annual report presents findings from the LWoH project that focus on individual service user outcomes and the extent to which the project is influencing systems change.

## 1.1 Outcomes achieved by service users

Since last year, significantly more service users have engaged in training activities and in peer mentoring. Despite this, there have been fewer successful move-ons compared to last year, which was partly attributed to high levels of staff absence and turnover. There have also been fewer reductions in service users' use of A&E and in the number of service users being evicted from their accommodation.

However, delivery partners highlighted the importance of recording softer outcomes achieved by service users such as confidence, the ability to plan ahead, personal hygiene and attending appointments. It is also important to note the complexity of recovery journeys and the role that many outside factors play in influencing service users' outcomes, including their own willingness to change.

## 1.2 Effectiveness of project delivery

Safe and stable accommodation is key to recovery, yet both service users and case workers recognise the challenges of securing appropriate housing. Co-operation between different services is perceived to have improved since last year and service users explained how this had improved their experience of services. Activities such as walking and animal care are also perceived to help people avoid or cut down substance misuse, although the accessibility of these activities should be communicated better in order to ensure that they are inclusive.

Relationships between service users and support staff (e.g. case workers, peer mentors) are seen as another important factor in recovery. Case workers are perceived as persistent, dependable, easy to talk to and non-judgemental. Working with families is also considered an important element in supporting service users by addressing negative influences or distractions. However, the close relationships service users often develop with case workers and peer mentors may create setbacks when these individuals leave the project.

The evaluation has also identified some challenges to the effective delivery of support. Access to mental health support remains particularly problematic; individuals with a dual diagnosis of substance misuse are often excluded, and some service users are themselves reluctant to use mental health services, due to fears of discussing past traumas. Facilitating access to specialist mental health support, designed particularly for people

with a specific need (i.e. history of trauma) may enable individuals to receive more effective support. Lack of access to the right services may also be further hindered by inconsistent recording of service user information on Mainstay; the introduction of a dedicated data analyst as part of the service redesign may help to reduce some of these inefficiencies.

The service redesign has also been a cause for some apprehension and anxiety among service users. Discussing and planning a formal exit strategy for individuals at the start of the support will help to manage expectations and support move-on.

### **1.3 How LWOH is influencing the system**

LWOH has implemented a number of strategies to facilitate systems change and leave a legacy of better support services for people with multiple and complex needs (MCN).

While still in their early stages of influence, the Evaluation, Learning and Legacy Group (ELL) and Communities of Practice have created opportunities for multi-agency dialogue to identify priority issues. Previously, the project faced persistent challenges in shifting mind-sets away from meeting targets towards experimentation and learning. The service redesign has also required the CSG to focus on operational decisions in 2017 at the expense of more strategic level activity; however, the CSG is now well-placed to take the lead on systems change by making the required links at a strategic level.

Some external organisations have been less receptive to messages from LWOH and the disruption of the service redesign process may have harmed the project's credibility. Identifying clear messages to communicate, which are based on evidence from the project and which can be applied by other organisations may encourage greater reception.

Test and learn projects that have been implemented are perceived as an opportunity to try innovative approaches such as tackling domestic abuse affecting people with MCN or new routes to training or employment. Delivery partners and external stakeholders are also positive about the potential of new workforce development plan for the sector, including that they had been consulted so that it would meet their needs.

### **1.4 Steps LWOH has already made in influencing the system**

Overall, the project has had relatively little impact on delivery and commissioning to date. It is important to note that the project's potential to influence the system is limited by external factors such as commissioning cycles, as well as the consideration that some key issues (e.g. housing, dual diagnosis) are national in nature.

However, there is some initial evidence of systems change. The profile of MCN has been raised in Liverpool, including wider awareness of the benefits of psychologically informed approaches, and adoption of these approaches (for example in the specification of the LCC contract for support to homeless households). The domestic abuse test and learn pilot has led to a specialist service being created for abusive relationships

involving people with MCN and is one example of the success to date. The Lived Experience Hub is also perceived to be a positive environment and a good opportunity for service user engagement.

Service user involvement is another key element of the systems change work; however, service user involvement activities currently rely on a small number of people and should be developed to involve more and different people, particularly current and recent service users and those who are more isolated. Service users should not only be well-informed about the service redesign but at the centre of shaping it.

The service redesign process is using lessons learnt to inform a new approach to support which is linked in with the Homelessness Strategy to more effectively influence the system. Continuing to link in to the Housing First pilot and provide evidence to local decision-makers will demonstrate the importance of housing in supporting recovery. However, it will also be important to increase engagement with sectors other than housing, particularly the health sector, and work together at a strategic level.

## 2 Introduction

This year three evaluation report provides an assessment of the progress of the Liverpool Waves of Hope (LWoH) project. It focuses on service user experience and outcomes, and the wider influence the project has had in promoting improved ways of working with people with multiple and complex needs (MCN) in Liverpool.

LWoH is part of the Big Lottery Fund's Fulfilling Lives programme, which funds partnerships of local organisations to improve services for people with MCN, enabling them to live better lives. People with MCN are defined as those who experience problems in at least three of the following areas: homelessness, problematic substance misuse, reoffending and mental ill health. The Fulfilling Lives initiative is targeted at areas (including Liverpool) where there are high concentrations of people experiencing MCN. In September 2014, the Liverpool Waves of Hope project was selected by the Fund to receive £10m over a period of 5 years.

### 2.1 Policy context and background

In 2017 there were a number of policy developments both locally and nationally relating to MCN; more detail on these is given in section 2.4 of the annex. Government funding cuts in the region have continued, with a further estimated fall in funding of £15m by 2019/2020. Liverpool City Council (LCC) has experienced a reduction of 58% in central Government funding since 2010<sup>1</sup>, with more than 2,400 staff taking voluntary redundancy as a result<sup>2</sup>. In February 2017, the Council's director of adult social care resigned, warning that adult social care services in the city were under threat of disappearing altogether<sup>3</sup>. Liverpool Clinical Commissioning Group's reduced budget in 2017 resulted in cuts of over £1.5 million to 20 Liverpool charities, including those providing support for homeless people and people with mental health problems<sup>4</sup>.

### 2.2 Liverpool Waves of Hope project developments

The LWoH project is now in its fourth year. The Core Strategy Group (CSG) has outlined four key priorities: developing and communicating learning from the project; ensuring strategic buy-in across the city; continuing to refine and adapt the service delivery model; and embedding service user involvement throughout the project.

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<sup>1</sup> <https://www.theguardian.com/commentisfree/2017/mar/23/liverpool-tory-cuts-city-benefits-poorest>

<sup>2</sup> <https://www.liverpoolecho.co.uk/news/liverpool-news/council-budget-cuts-what-liverpool-12613097>

<sup>3</sup> <https://www.liverpoolecho.co.uk/news/liverpool-news/resigning-council-boss-warns-social-12563987>

<sup>4</sup> <https://www.liverpoolecho.co.uk/news/liverpool-news/health-boss-slams-tory-cuts-13206161>

### 2.2.1 Service redesign

The LWoH project is currently in a period of transition following the review and consequent proposed re-design of its delivery model, including a scale-back of the Intensive Support Service (ISS). This decision was taken following an audit of the ISS co-commissioned by LWoH programme management and Liverpool City Council on behalf of the Core Strategic Group (CSG), and conducted by MIAA<sup>5</sup> in early 2017. Public Services Lab<sup>6</sup> was appointed to create a proposal for a re-designed support service. Their proposed re-design was submitted in September 2017. In January 2018, project delivery partners produced a proposal for a new model of support using two approaches: intensive support for service users with higher-level needs, and support from a “community navigator” for service users who are more independent. The community navigator will keep in regular contact with service users and support them to access services through advocacy and accompanying them to appointments; but the level of support provided will not be as intensive overall. This plan has been approved by the CSG and it is intended that the new model will be in place by April 2018.

As a result of the service redesign process, the CSG made the decision to halt referrals into the project as of July 2017, and no new service users have been accepted since this time.

## 2.3 Evaluation scope and methods

### 2.3.1 Evaluation scope

The national Fulfilling Lives programme is subject to an evaluation by CfE Research<sup>7</sup>. The local evaluation is intended, as a complement to the national evaluation, to make recommendations for the development of LWoH through collecting and disseminating evidence about:

- **The outcomes (intended and unintended) which are experienced by service users** as a result of this model of support in the short, intermediate and longer term;
- **The process of delivering a model of intensive, coordinated, user-centred, and integrated support to people** with multiple and complex needs;
- **The cost-effectiveness of this model**, and its wider application beyond the lifetime of LWoH;
- **The changes which are adopted (intended and unintended) by the broader system for services in Liverpool** as a result of Waves of Hope.

This third annual report continues to focus on the effectiveness of the LWoH project and the outcomes it has achieved, with an increased focus on the influence LWoH has on improving support for people with MCN

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<sup>5</sup> <http://www.miaa.nhs.uk/>

<sup>6</sup> Public Services Lab (also known as Capacity) is a social business founded by Catch22, Interserve PLC, Big Society Capital and Clubfinance, and supported by public investment. It provides consulting and business modelling support to voluntary and community sector organisations’.

<sup>7</sup> <http://cfe.org.uk/index.php>: CfE Research, University of Sheffield (2014), ‘Evaluation Framework: Fulfilling Lives Supporting People with Multiple and Complex Needs’, Big Lottery Fund (<http://mcnevaluation.co.uk/evaluation/evaluation-reports>)



more widely in Liverpool. The evaluation's increased focus on systems change reflects the updated theory of change for the project, developed by the evaluation team following a workshop with stakeholders in July 2017. An updated theory of change diagram with increased focus on systems change is presented in Annex 4.

The evaluation is not intended to measure the impact of the project by estimating what would have taken place without it (a counterfactual). Other limitations to the evaluation's scope are identified in section 2.4.

### 2.3.2 Data collection methods

The evaluation of LWoH is based on the Theory of Change and a corresponding set of evaluation questions, which this report is intended to answer (presented in Annex 4 and 5). It is a mixed-methods evaluation, and draws on a range of data sources, as follows:

**Interviews with service users:** The evaluation team have interviewed 18 service users over the course of the evaluation to date, to form case studies for the project. These individuals are interviewed at six-month intervals to track their experiences over time. From an initial cohort of 12 service users first interviewed in October 2015, five are still involved with the evaluation; a further seven service users were added to these five to form 11 case studies for the year three evaluation. Interviews for the year three evaluation took place in August and December 2017 and January 2018. Data from interviews were triangulated with individual monitoring and outcome information, case worker notes and case worker interviews. A discussion guide was used to ensure consistency of coverage across the interviews. The guides are included in Annex 6.

**Analysis of monitoring information:** The local evaluation has made use of the monitoring information collected by the project for submission to Big Lottery Fund and the national evaluation. This includes information on the support received by service users, their needs, the time they have spent on the project and the outcomes they have achieved. This information has been used to inform the longitudinal case studies, the cost-effectiveness analysis, and an analysis of project outcomes.

**Stakeholder consultations (internal):** The evaluation team conducted semi-structured depth interviews with 15 individuals working on the LWoH project: members of the programme team and staff at delivery partners. These were conducted face-to-face wherever possible, and otherwise by telephone, between August 2017 and January 2018. The full discussion guide appears in Annex 6.

**Stakeholder consultations (external):** The evaluation team also interviewed 20 individuals who do not have day-to-day involvement with the LWoH project but who work in relevant sectors in Liverpool and have interacted with the project in a variety of different capacities. These interviews were carried out by telephone between October 2017 and January 2018. The full discussion guide appears in Annex 6.

**Document review:** The evaluation team has conducted an ongoing analysis of key project documentation to understand project developments, as well as a review of relevant local and national policy and strategy documentation to inform the systems change analysis.

## 2.4 Interpreting the findings and limitations

There are a number of points to bear in mind when reviewing and interpreting the findings from this evaluation report. Whilst it is important to detail the limitations of the evaluation here, these caveats are common when evaluating complex interventions; and are similar to the challenges faced by the local evaluations of other Fulfilling Lives projects.

**It has not been possible to evaluate all areas of the project:** Some areas of the LWoH project are not within the scope of this evaluation, such as the management, governance and finances of the project. The test-and-learn initiatives are subject to separate evaluations, and are therefore not considered in detail here. The effectiveness of the service redesign process to date has also not been considered in this year 3 report.

**There is a lack of information on service users who leave the project:** The monitoring information available to the local evaluation does not cover service users who have moved on from the project, and it is therefore not possible to systematically analyse what support these individuals receive nor the outcomes they have achieved since moving on. However, this is covered to some extent by ongoing longitudinal case studies of individuals who have moved on from the project, such as Laura.

**This evaluation is heavily reliant on the quality and availability of evidence captured by individual delivery partners:** The monitoring information collated for the national evaluation was not always complete and remained inconsistent across some quarters of data. Information about service use is based on reports from service users and their case workers, so issues with recall may have led to some inaccuracies.

**Qualitative research prevents generalisability:** Case study and stakeholder interviews are not intended to provide a representative sample of all service users or stakeholders; instead these are intended to elicit rich descriptions of a diverse range of experiences, attitudes and behaviours.

**Cost-effectiveness findings cannot be compared to a 'do nothing' case.** The evaluation has no evidence as to what would have happened if the individuals in question had not engaged with LWoH (given the unavailability of counterfactual data). It is therefore not possible to conclude that any changes in service use observed are as a result of LWoH. Moreover, the figures used to estimate costs are typically based on national averages, and therefore it is unlikely that they will correspond exactly to the actual cost incurred.

## 2.5 Structure of this report

The report is structured as follows:

3. **Service user outcomes:** an overview of participation, what outcomes have been achieved by service users, and why;
4. **Delivery of Waves of Hope support:** an assessment of the effectiveness of Waves of Hope support, and the factors which affect this;

5. **Case studies:** an in-depth presentation of individual journeys through the project;
6. **Cost-effectiveness:** illustrative examples of the costs and savings to the public sector associated with the project;
7. **Influencing the system:** a summary of the influence LWoH is having on the wider system of support for people with multiple and complex needs in Liverpool;
8. **Recommendations for delivery:** recommendations to improve the delivery of support to service users, based on the findings in chapters 3 to 5;
9. **Recommendations for systems change:** recommendations to further the project's systems change ambitions, based on the findings in chapter 7.

## 3 Service user outcomes

**This chapter presents information about the outcomes achieved by Liverpool Waves of Hope service users in 2017. The chapter draws on monitoring information and interviews with delivery staff, as well as service user case studies. A more detailed analysis of participation and outcomes is presented in chapter 9 of the annex.**

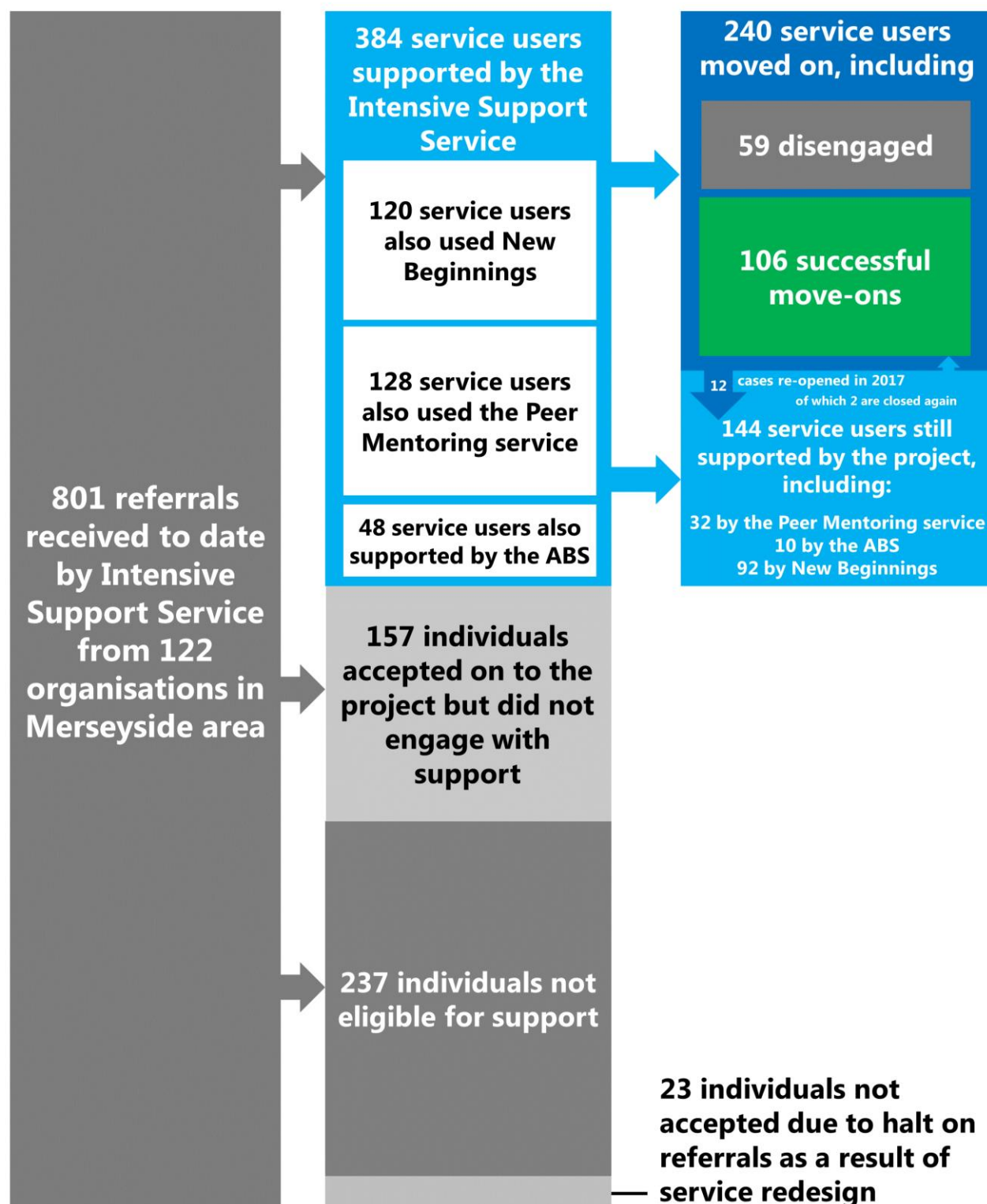
**In 2017, service users have demonstrated an increased level of engagement in training activities and in peer mentoring. However, there have been fewer reductions in service users' use of A&E and in the number of service users being evicted from their accommodation. High levels of staff sickness and turnover may have played a role in the lower number of successful move-ons compared to last year.**

**Delivery partners highlighted the importance of recording 'softer' outcomes achieved by service users such as confidence, the ability to plan ahead, and attending appointments. Related to this, it is important to note the complexity of recovery journeys and the role that many outside factors play in service users' achievement of outcomes, including their own willingness to change.**

### 3.1 Overview of participation

Between January and December 2017, a total of 209 service users received support from Liverpool Waves of Hope (LWoH). This included 133 existing service users, 64 service users who were accepted on to the project for the first time and 12 who had their cases re-opened. 65 service users moved on from LWoH support over the course of the year. There were 144 active service users in December 2017. The diagram overleaf presents an overview of participation in Liverpool Waves of Hope; figures relate to the project lifetime to 31<sup>st</sup> December 2017, unless otherwise stated.

Figure 3.1: Referrals, participation and move-on



Source: LWoH monitoring information Q4 2017

### 3.2 More service users have taken part in training and peer mentoring

The number of service users engaging in volunteering and other activities has increased over the past year, most noticeably those engaged in New Beginnings activities. 40% of service users in 2017 had taken part in training, including through New Beginnings, compared with 20% in 2016.

Efforts have been made to bring a wider range of service users into contact with peer mentors, through creating a less formal system. This has included group peer mentoring sessions and allowing peer mentors to provide ad-hoc support to service users through the ISS on-call process. These changes enabled service users for whom one-to-one peer mentoring would not be appropriate to benefit from the lived experience of peer mentors, as well as providing new pathways for service user involvement.

However, delivery partners commented that referrals from ISS staff into peer mentoring and New Beginnings were low, and this meant that involvement in volunteering and mentoring activities had mainly come from service users who were already engaged in activities (such as the Lived Experience Hub, Peer Mentoring, New Beginnings, or attending the Basement). The capacity of the New Beginnings service had also meant that it was not able to work with everyone referred to it straight away. Some service users were placed on a waiting list for support, which could result in those with higher support needs being more likely to disengage.

*“What it’s not doing is pulling the more isolated people in... We’re getting more access to the people who are doing relatively well but still not getting access to those who aren’t.”* Delivery partner

### 3.3 Service users have not reduced their use of A&E and evictions as much as last year

Service users who successfully moved on from LWoH support were more likely to have achieved outcomes relating to use of A&E, arrests and evictions, when compared to all service users. However, those moving on during 2017 were less likely to achieve these outcomes than in previous years, and overall fewer service users achieved these outcomes in 2017 compared with 2016. The largest difference in positive outcomes in 2017 was a decrease in the number of service users who had not been evicted within the last year<sup>8</sup>.

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<sup>8</sup>The evaluation undertook an analysis of the service users who had been evicted from their accommodation in 2017. The date of individual evictions is not recorded so it is not possible to pinpoint the type of accommodation an individual was living in when the eviction/s took place. However, looking at the group of service users who were evicted from their accommodation at least once in 2017, there was a decrease over the course of the year in the time service users spent living in temporary accommodation (e.g. hostels and night shelters) and in the time service users spent living in their own tenancies in the private sector, which may give an indication of the type of accommodation from which service users are typically evicted.

**Table 3.3: Outcomes for service users who have successfully moved on and across the project as a whole, relating to use of emergency services and evictions**

Outcome	% of all service users achieving this outcome (2016)	% of all service users achieving this outcome (2017)	% of all service users who successfully moved on achieving this outcome
No evictions in current year	79%	48%	73%
Reduction in use of A&E	92%	78%	83%
Reduction in number of arrests	91%	76%	82%

Source: LWOH Statistics Update, January 2018

Those involved in New Beginnings and Peer Mentoring were more likely to have seen a reduction in their use of A&E and arrests, although this is likely to be because these elements of the project tend to work with service users who are less chaotic (see section 3.1) and/or who have made more progress in their recovery.

### 3.4 Service users have also achieved “softer” outcomes which it is important to capture

Delivery partners emphasised the importance of recognising the progress made by service users in terms of softer outcomes, such as improvements in personal hygiene, confidence, and the ability to plan ahead. These softer outcomes are explored further through the case studies in chapter 5.

Wider stakeholders also considered it important to record these softer outcomes, recognising the role played by the project in enabling people to stay in accommodation for longer and providing stability in a way that other, more restricted services were not able to. Others commented that service users were better able to maintain and attend appointments with the support of their LWOH case worker.

*"It's got people to remain in accommodation longer. There's a little bit more stability for the service user ... We have certain rules, have to do things a certain way to maintain and manage risk. [LWOH] workers for the service user is like a different organisation that is not part of their problem, that can say "we can do this and do that for you". That's really useful."* Wider stakeholder

In contrast, stakeholders commented that hard outcomes were difficult to measure among this service group and in some cases were unlikely to be observable during the lifetime of the project.

### 3.5 Fewer service users successfully moved on in 2017 compared with previous years, and more service users disengaged

Nineteen service users successfully moved on from LWOH in 2017; this is a smaller number of successful move-ons than in 2016 (48) and 2015 (44). This is partly due to a higher proportion of service users being recorded as having “disengaged” from the project. The ISS had been experiencing a high level of staff turnover and sickness absence during this period. Although vacancies were filled by agency staff, this staff churn was

recognised by service users, staff and external stakeholders as leading to disruption and low morale. This may be one factor behind a decrease in successful move-ons.

Another major obstacle to successful move-on, highlighted by delivery partners, was a lack of appropriate services in Liverpool to support individuals with MCN once they were ready to move on from LWoH support. Particular issues that were identified by delivery partners included restrictive eligibility criteria preventing service users from accessing mental health support; a need for service users to prove their abstinence from drugs and alcohol before receiving support from external agencies such as social services; a shortage of appropriate sheltered accommodation; and less intensive staffing at other support services, reducing the service's ability to work with individuals who could sometimes exhibit challenging behaviour.

*"In terms of signposting them to the relevant services there's not much you can do. Social services won't support them until they're drug and alcohol free, but they'll never be drug and alcohol free."* Delivery Partner

*"There are other appropriate services out there, but more so for stable clients. Chaotic ones may be turned about by services saying they're not ready"* Delivery Partner

These issues impeded the ability of service users with MCN to move on with appropriate support in place. This is particularly pertinent given that the project will soon be moving towards an exit phase, during which support plans will need to be made for all service users still receiving support from the project. The project's exit strategy should therefore consider how these issues can be mitigated.

Delivery partners also acknowledged the need for improved communication when moving service users on from support; both delivery partners and wider stakeholders provided examples of cases where decision-making surrounding move-on had not been transparent to other delivery partners, other services working with service users, or to service users themselves.

*"There have been a couple who have just been told "oh look, we're not engaging with you, you don't meet the criteria, or you're not engaging with us" which does leave the resident asking why. That's been once or twice, not a regular occurrence."* Wider stakeholder

This meant that decisions to move service users on were not always based on accurate and up-to-date information. A process for move-on decisions to involve more internal consultation between delivery partners has been proposed as part of the service redesign.

The monitoring information available to the evaluation does not record what support services, if any, service users access once they have moved on from the project, so we are unable to analyse this, nor to assess whether this support is sustainable.

### **3.6 Recovery journeys are complex and outcomes are determined by many factors**

Service user case studies highlight the complex nature of progress towards recovery, and the role of outside factors, including the unpredictable nature of setbacks, and service users' own willingness to change and



accept help. Several service users commented that one of the biggest obstacles they faced was a lack of motivation to make changes; for example, Matthew (see chapter 5) reported that New Beginnings had shown great persistence in trying to contact him and encourage him to attend activities, but that his continued cannabis use prevented him from taking part. There was evidence that in some cases, case workers had been taking steps to encourage service users to take a more active role in the support relationship, such as moving from face-to-face daily visits to pre-arranged meetings at the ISS venue.

Other service users reported that a major event, such as being admitted to hospital, had acted as a “wake-up call” which prompted them to make changes in their lives. Therefore, while LWoH support has played a major role in service users’ lives, it is important to recognise that service users’ recovery may ultimately be determined by other factors which are outside of the project’s control.

## 4 Delivery of Waves of Hope support

This chapter assesses the effectiveness of the support provided to service users by LWoH. This is based on an analysis of the 11 service user case studies (see following chapter and annex), who are referred to by pseudonyms throughout this chapter. This chapter has also been informed by interviews with internal and external stakeholders.

Safe and stable accommodation is key to recovery and a priority for service users, but this is very challenging to secure. It has also been difficult to access appropriate mental health care for people with a dual diagnosis or a history of trauma. However, in other respects co-operation between services was perceived to have improved, resulting in a better experience for service users.

Service users typically praised their case workers as being persistent, dependable, easy to talk to and non-judgemental. However, the close relationships service users often develop with case workers and peer mentors may create setbacks when these individuals leave the project. The service redesign and resulting staff changes have consequently caused some apprehension among service users.

Service users reported that activities coordinated by New Beginnings had helped them avoid or cut down substance misuse and increased their motivation to engage with the programme, although some service users perceived these activities as less accessible to individuals with an injury or disability.

### 4.1 Safe and stable accommodation is key to recovery and a priority for service users

Nearly all the service users interviewed by the evaluation described both the importance of safe and stable accommodation in supporting their recovery, and the difficulties of securing this. Service users described how case workers had advocated on their behalf to ensure that their accommodation met their needs.

In particular, service users who were aiming to reduce their drug and/or alcohol use found it challenging to live in hostel accommodation that was described as chaotic and occupied by other drug and alcohol users (or, in Bill's case, with his brother who abused alcohol). Service users reported that moving away from these environments had been an important factor underpinning their recovery:

*"I feel a hell of a lot different. I was locking myself away, my room would just be a s\*\*\* tip, I wouldn't wash, I wouldn't shower. But now I'm here, I'm trying to look after myself. I feel a lot more at ease ... because I'm not getting harassed. [In previous accommodation] I've had people knocking on my door in the early hours*

*of the morning asking me to inject them. It's a lot better now than it was before. I'm being watched a lot more, and any messing, I only need to get on the phone and I phone downstairs."* Service user

In several cases it had also proved difficult to access appropriate accommodation for service users with mobility problems. For example, the layout of the accommodation where Tom (a wheelchair user) lived meant that he was largely confined to his room. Tom reported feeling bored and had relapsed into drug taking; however, this had set him back further in terms of being able to access alternative accommodation.

Several service users described ways in which their case worker had advocated on their behalf to ensure they received more suitable accommodation. For example, Tracey's case worker helped secure accommodation for her on being discharged from hospital, and Dave's case worker advocated on his behalf with social work teams to explain that Dave was unable to live alone due to the severity of his mental health problems. Dave explained that he had not been consulted about this directly by the social worker, and believed that without his case worker's intervention he would have been placed in accommodation where his mental health would have significantly deteriorated.

#### **4.2 Cooperation between services has improved and this improves service users' experience**

Service users were typically supported by several different individuals; for example, a support worker at their accommodation or a social worker, in addition to their ISS case worker. These service users reported that this support was well-coordinated and that professionals spoke to one another about their case, meaning that they did not have to repeat information. This is corroborated by evidence from delivery partners, who reported that coordination between services has improved, both within LWoH and with external agencies. In particular, Dave was very positive about the opportunity to attend multi-agency meetings to discuss his support plan and reported that this made it clear that support workers had his best interests in mind. Service users explained that support workers were able to cover for one another – for example, an accommodation support worker could accompany them to appointments when their LWoH case worker was not available.

Tracey's case worker from LYMCA reported that Tracey's two case workers (one from LYMCA and one from the ISS) could sometimes result in duplication, conflicting support plans or contradictory information being given to Tracey. However, Tracey herself did not identify this as a problem and was happy to have the additional support.

#### **4.3 Access to mental health support is still problematic for individuals with histories of trauma or dual diagnosis**

As in the first and second years of the project, case workers and other delivery partner staff consistently identified an unmet need for mental health support, in particular for service users with a dual diagnosis of mental health problems and substance misuse issues, who were often excluded from mental health services. This is an issue that has been identified at a national level (see section 7.9).

*"The main issues are around someone being deemed as not having mental health care needs – when they are in a lot of distress. That's come up again and again, a refusal to see what it is and say it's substance misuse, but it's just not."* Delivery partner

Several service users had been offered counselling but felt unable to begin or continue this due to a concern that this might provoke traumatic memories or raise issues that would be too distressing to cope with. This may point to the need for more specialist therapeutic support for service users, which takes into account the particularly traumatic nature of their past experiences.

#### **4.4 Activities such as walking and animal care help people avoid or cut down substance misuse – but there are some perceived accessibility issues**

Many service users had taken part in activities with New Beginnings at some point during their involvement with LWoH, and spoke positively about the contribution these activities made to their recovery, by providing a meaningful way to occupy their time which helped them to avoid or cut down substance misuse. In particular, several service users were especially motivated to take part in activities involving animals, such as dog-walking and horse-riding. One service user had identified this as the key factor which had influenced her to continue engaging with the project.

However, in several cases service users had stopped taking part in New Beginnings activities due to accessibility concerns, largely related to physical health problems. New Beginnings is able to arrange activities flexibly to meet the needs of service users; for instance, Julie looked after dogs from Merseyside Dogs Home in her own flat. Despite this, there appeared to be a widespread misperception among service users that, despite wanting to participate, they would not be able to take part in activities due to their disability or injury.

#### **4.5 Case workers are seen as persistent, dependable, easy to talk to and non-judgemental**

Service users generally reported a positive relationship with their case worker. The attributes most commonly cited as contributing to this good relationship included: informality and being easy to talk to; being accepting and not judgemental; persistence; and dependability – "being there when you need them". Some service users, particularly women, reported a close relationship with their case worker, akin to a friendship.

However, not all service users were interested in developing such a relationship. For example, Paul's hopes for LWoH support were primarily centred around receiving practical support to attend appointments and complete forms; Paul reported that the support he received was not aligned with what he needed and this had led to him disengaging from the project. Likewise, Jim did not identify a need for regular support from his case worker, disengaging from the project and only contacting his case-worker for help with a specific issue. This points to a need to adapt levels of support to meet the needs of service users who see themselves as more independent and may be alienated by the offer of intensive day-to-day support.

#### **4.6 The close relationships service users often develop with case workers and peer mentors can create setbacks when these individuals leave the project**

Some service users had experienced their case workers or peer mentors leaving the project. Although some service users coped well with a change in case worker, others had been disappointed by this and experienced setbacks in their recovery; this was particularly the case where close relationships had developed. For example, Julie felt anxious when a case worker, who she had become close to, suddenly left the project without informing her. Dave had built up a good relationship with his peer mentor, and this mentor's leaving the service in late 2016 was seen by his case worker as a factor that contributed to a deterioration in Dave's mental health and an increase in his drinking.

While it is not possible to directly link setbacks in recovery to case workers or peer mentors leaving, some service users described feeling low, unmotivated and more likely to disengage from the project following the loss of a caseworker they had built a relationship with. As described in previous evaluation reports, service users often attributed their motivation to make changes in their life to the trusted relationships they had built up with case workers; these contrasted with previous experiences of being let down, moved on or not listened to by support services. Therefore, the ending of these relationships may be experienced as a significant disappointment.

Several service users reported feeling apprehensive about the service redesign process, which they had heard about through word of mouth, believing that this would lead to further staff departures. The ISS formally informed service users about the forthcoming service redesign in September 2017 as part of a needs analysis. However, several service users remained uncertain about what the implications of this would be for their support.

#### **4.7 Work with family members or other people close to the service user can support their recovery by addressing negative influences or distractions**

Case studies highlight opportunities where case workers working with family members, or other individuals who are close to the service user, can support that service user's recovery. By working with Laura's son to address his challenging behaviour, and her daughter to help her access benefits, Laura's case workers had helped her focus on addressing her substance misuse and ultimately improve her relationships with her family. Paul's case worker acts as a responsible adult to supervise his visits to his son and ex-partner, helping Paul to work towards his goal of revoking the child protection order to which he is currently subject. Bill's brother is also supported by LWoH, which may present an opportunity to address the negative influence he has on Bill's recovery.

"Whole family" approaches are becoming increasingly common in social work, most prominently through the Troubled Families programme (known as the Liverpool Families Programme in Liverpool, where it has been operating since 2012). These approaches aim to understand the needs of the family as a whole, or, at minimum, to identify how the needs of other family members may affect the individual whom services are working with and how meeting those needs might benefit that individual. This may involve working with other

agencies. The CSG now includes representation from Families services at Liverpool City Council, in recognition of the need identified by the project to bring together children's and adults' services for a more preventative approach.

#### **4.8 Some delivery partners have limited access to information about service users on Mainstay, or reported that this was recorded inconsistently, leading to inefficiencies.**

Mainstay is a case management system owned by Liverpool City Council and used by a number of services in Liverpool that support individuals affected by homelessness and complex needs. The system allows providers to record events and outcomes of support. Delivery partners considered Mainstay to be very useful when one requires an overview of a service user's history or current service use. This can avoid duplication of support and ensure that service users are linked up to the correct services. However, a limitation highlighted by delivery partners and wider stakeholders is that data was sometimes recorded inconsistently, limiting the system's effectiveness. The evaluation was unable to access Mainstay case notes and data in order to independently assess this view; nor has it been possible to compare the quality of data completed by or available to LWoH staff with data completed by or available to other support services, to understand whether this is typical.

Due to access restrictions put in place by LCC, not all delivery partners are able to access the same information. The ISS has access to data on all service users supported by LWoH, but other delivery partners only have access to the service users that they support. The Lived Experience Hub coordinator also has access to enable risk management and safeguarding of those attending the Hub. Some delivery partners with more limited access to Mainstay considered this a barrier to supporting service users effectively. For example, case notes would act as a useful tool to identify people who might be suitable for referral into different parts of the project, or to understand why service users have had their support stepped down. However, some delivery partners also mentioned that even if they had access to this wider information on the Mainstay system, they would not necessarily have the time to review and make use of it.

## 5 Service user case studies

Four case studies of LWoH service users are presented in this section. These case studies are not a representative picture of all service users on the project, but are intended to illustrate the range and complexity of service users' experiences. However, from these stories it has been possible to identify some common factors which underpin recovery or present obstacles to it. Each of these stories also reflects the fact that recovery is a process which is unlikely to be straightforward or linear.

Dave's story demonstrates the way in which case workers have advocated to obtain appropriate accommodation for service users, as well as the value for service users of coordination between the different support services they receive.

Julie's story highlights the importance of the good relationships developed between service users, case workers and peer mentors. Although Julie experienced a number of setbacks in her recovery, LWoH were able to identify this and support her since she was still engaging with her peer mentor and the activities provided by New Beginnings.

Tracey's story shows the difficulties of accessing mental health support for people with substance misuse problems. Her story also provides a further example of case workers working to secure suitable accommodation, and the challenges this presents.

Matthew's story again highlights the importance of housing to service users' recovery, but also demonstrates the degree to which outcomes are affected by service users' own motivation and willingness to change.

### 5.1 Introduction

This section presents case studies of LWoH service users. The purpose of these case studies is to elicit a detailed and rich understanding of different individuals' experience of the project, how effectively they perceive this support to be working for them and how it relates to other aspects of their lives; and to examine the outcomes achieved by service users, and the facilitators and barriers to achieving positive outcomes.








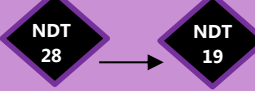


In order to fully understand the range of individual experiences on the project, the 11 service users were selected in order to represent as wide a variety as possible in terms of demographics and type and severity of needs. However, this means that these 11 individuals are not necessarily representative of the overall profile of LWoH service users, and therefore wider inferences about the overall impact of the project cannot be drawn from aggregating the evidence presented in this chapter.

The evaluation team conducted a series of in-depth face-to-face interviews with these service users at six-month interviews. Five of the service users have been interviewed up to five times over a two-year period, while the remaining seven joined the project more recently and have been interviewed at two points in August and December 2017 and January 2018.

To further support our understanding of these personal journeys, case workers provided additional detail on case study participants on an ongoing basis. Data generated from the qualitative interviews were triangulated with case worker notes and monitoring information, including detail of ongoing service use and New Directions Team (NDT) scores<sup>9</sup>. It was not possible to source full case notes and monitoring information for all case studies; appropriate references to these omissions are made in footnotes across the case studies.

In the case studies that follow, all service users have been given pseudonyms. Locations, organisations (beyond those delivering LWoH) and case worker names have also been changed, in order to protect individual anonymity. Above each case study is a graphic with basic information on demographics and level of need. A key for the graphic is included below. Four service user case studies are presented in this chapter, to demonstrate the range of different journeys through the project, with the remaining seven case studies appearing in an annex. All 11 case studies have informed the findings and conclusions presented elsewhere in this report.

**Figure 5.1: Key for case study graphics**

	Gender		Substance misuse
	Age		Learning disability
	Offending history		Physical disability
	Homelessness		New Directions Team Score (on referral-current)
	Mental health issue(s)		Length of time on project

<sup>9</sup> The New Directions Team assessment, previously known as the Chaos Index, is a measure of severity of need for an individual with multiple and complex needs. It is scored in ten areas relating to behaviour, risk and engagement with services. Eight of these areas are scored from 0-4 and two are scored from 0-8, giving a maximum possible score of 48, which represents the highest level of need



## 5.2 Dave



### Life before LWoH and support to 2017

Dave joined LWoH in September 2014, after being referred by Liverpool City Council's adult homelessness service. He was an alcoholic, which he felt was worsened by living in a hostel where others were also drinking. In the year before LWoH he had fortnightly contact with drug and alcohol services, and presented once at A&E. Dave had previously been a heroin user, resulting in liver problems, and had been using amphetamines for the past 20 years. He had mental health problems and suffered from a personality disorder, schizophrenia and suicidal thoughts.

Dave's poor numeracy skills meant he struggled with budgeting and was in debt. In the year before joining the programme, he spent one month in prison for non-payment of council tax. Dave is a father but had not had recent contact with his children. On joining the programme his NDT score was 34.

Dave started to see his ISS worker, Hannah, a few times a week and engaged well with a range of LWoH services. She gave him budgeting advice, and supported him to attend appointments. He saw an alcohol nurse fortnightly and attended drug and alcohol services. He also completed an equine therapy course and a money management course coordinated by New Beginnings. Dave joined the Peer Mentor service and built a positive relationship with his mentor who would attend

medical appointments with him. In June 2017 his NDT score was 20.

### Spring/Summer 2017

Dave remains in the same temporary accommodation. He is visited by his new caseworker Paul, every two weeks, alongside phone calls in between visits. He describes Paul and the LWoH staff as friendly, which he hugely appreciates as he feels most services in the past have just told him to "go away".

*"When I was on the street there was nothing like this...I've got all the people who are involved with me...it's the best system I've been involved with"*

Paul takes Dave to medical appointments and has arranged a 12-week place in an alcohol rehabilitation centre for the summer. Paul has organised a social worker for Dave who he will work with to support Dave to find permanent accommodation following his rehab. He has also arranged for a solicitor to pursue a claim for Dave after he was knocked off his bike and broke his wrist. Dave feels his confidence has improved because of Paul, which means he feels able to speak up in meetings and appointments. He also feels his self-care has improved and his overall wellbeing is in a more positive place. His outcome star self-care score was 6 in April 2017, as were his scores for motivation and taking responsibility.

Dave also has a support worker at his accommodation who helps with similar things to Paul, including looking online for housing. He is

aware that different services talk to each other about him and feels that this is the biggest difference from the support he's previously received. He is positive about different staff talking about him as it means his support is better co-ordinated.

*"They talk to each other, for me that's fantastic, it makes me feel fantastic."*

Before Christmas, Dave visited a counsellor. They talked about his relationship with his ex-partner; he found this very difficult and has not been back to see the counsellor since the first visit. Dave sees a psychiatrist who advises on his schizophrenia medication, and a doctor, who he has a good relationship with.

Dave also continues to be involved with New Beginnings where he volunteers at a stables and does dog-walking. He likes being able to do activities as they help him relax and distract him from drinking.

*"It's proper relaxing, I feel great for doing it."*

Whitechapel staff introduced Dave to the Basement, which he attends on Sundays. He aspires to do more DJing and was able to DJ at the Basement Christmas party. He would like to attend music lessons hosted by New Beginnings but finds the room they do the lessons in too small; this makes him feel anxious so he has avoided the class so far. Dave is focusing on becoming abstinent so he can play charity gigs as a way of giving something back to the community.

### Autumn/Winter 2017

Dave has attended detox for five weeks and as a result has reduced his alcohol intake. He now drinks four cans a day when he would previously drink a crate of stronger ale a day. He also feels that his reduction in drinking is because he feels more motivated to do so, and ready to change his life. His motivation and taking responsibility score is 8 in November 2017.

*"I want a better life"*

He has had no new A&E admittances in the third quarter of 2017. Dave has moved to a new hostel which he describes as less chaotic, as there are a smaller number of people there with alcohol and drug issues. He was supported to find this hostel by both his ISS case worker and his social worker.

*"I feel safe...I don't have drug addicts knocking on my door, on crack and smack."*

His reduction in drinking has meant he is able to manage his finances better and save the money he previously would have been spending on alcohol. He has saved up and spent his own money on new clothes and DJing equipment. He is looking forward to DJing at the next Basement Christmas party and still hopes to pursue his interest in music and use this to help the community.

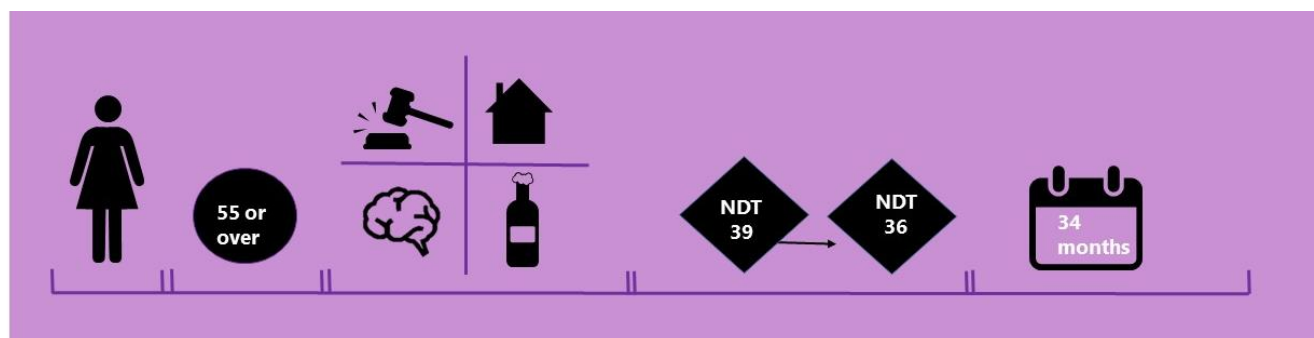
Dave spoke to Paul about his mental health needs and how he feels unable to live independently because of his schizophrenia, which can make him feel suicidal. Paul has spoken to Dave's social worker so this is taken into consideration when looking for accommodation.

*"I can't live on my own, I'll just talk to walls, and don't take this wrong, if it goes too far, I'll just set myself on fire."*

Dave decided not to pursue his claim against the person who knocked him off his bike and has experienced a lot of pain in his wrist since the accident. As a result, he has stopped attending dog-walking and volunteering at the stables with New Beginnings, but wants to restart this once his wrist is better.

As of September 2017 his NDT score was 14, owing to his strong engagement with services and strong impulse control, having experienced no incidents in the past three months. Dave's aims for the future include continuing to manage his drinking and pursue his interest in DJing.

### 5.3 Julie



#### Life before joining LWoH and support to 2017

Julie has a history of offending, alcohol abuse and homelessness. She also has a long history of mental ill-health, including severe anxiety and Borderline Personality Disorder. This means that her mood can change very quickly and she can feel suddenly aggressive and is at high risk of self-harming.

*"Things can change for me in minutes. I can feel aggressive, but I don't take it out on anybody."*

Before joining LWoH, Julie was convicted of criminal damage and spent 18 months in prison. When she was released, she moved into bail accommodation before spending time in a number of different hostels. The nature of Julie's conviction has made it difficult for her to find stable accommodation.

In the year before joining LWoH, Julie's lifestyle was chaotic and she struggled with her mental health. She had multiple A&E attendances due to repeat incidents of self-harm. She also received a police caution for public disorder while under the influence of alcohol, spending one night in police custody. Julie was engaging with the Community Mental Health team, with face-to-face contact with her Community Practice Nurse (CPN) every two weeks. She was also engaging with counselling and psychotherapy. Due to her high risk of self-harm and spiralling mental health problems, Julie was sectioned for 10 days during this period. She was engaging with drug and alcohol services and had

20 contacts over the course of the year, with five days spent in detox, although her alcohol dependence remained high.

Julie was referred into LWoH by her supported accommodation provider in February 2015. At her first assessment Julie's NDT score was high, at 39. This reflected her high risk of self-harm and high alcohol dependence, including daily drinking. Julie's drinking also meant that she was highly vulnerable to exploitation by others when under the influence of alcohol.

#### 2015: Julie's situation improves with support of her caseworker

Julie starts receiving intensive support from her caseworker, Roy. Roy visits Julie two to three times a week and takes her to her appointments, including with the community mental health team and to her counselling sessions. Julie also appreciates being able to call Roy when she feels anxious or needs someone to talk to. She finds that Roy and other LWoH staff are helpful, supportive and non-judgemental. In this way, LWoH is different to the support she has received in the past.

*"I've never been involved with an organisation like [LWoH] before. I really appreciate it... They accept you as they find you."*

Julie tells Roy about her love of animals and he refers her to New Beginnings, where she starts to

engage with dog walking through the animal shelter.

*"I love animals, they're better than people."*

Roy also refers Julie to the peer mentoring service and after an assessment and initial meeting, she is assigned a peer mentor, Mary. Mary helps Julie with her shopping and sometimes accompanies her to hospital appointments. They also go for coffee together and attend the Basement on Sundays. Julie feels that they "make a good pair" and that the peer mentoring service "made a good match".

*"I like her personality because she's crazy like me. We can practically talk about anything, know what I mean?"*

Because Mary has had similar experiences to her, Julie trusts her and feels she can speak openly and Mary won't tell anyone, unless she was going to hurt herself.

*"She doesn't give any confidentiality away, know what I mean? But I think if I said anything, like I was going to hurt myself, she'd do something."*

Julie lives in supported accommodation from Autumn 2015 until July 2016, with a short period in temporary accommodation at the end of 2015. In July 2016, Julie moves into her own social housing tenancy.

Julie continues to volunteer at the animal shelter and sometimes looks after the dogs in her apartment. At first, this is overseen by staff from the shelter. When this is seen to be working well, staff start to leave the dogs alone with her.

Julie's NDT score improves significantly during this period, falling to 17 in November 2015. Her score for engagement with services falls to the lowest level, as does her risk from others. However, her risk of unintentional self-harm remains high (3), and she has a high alcohol dependence and drinks daily.

## 2016: Julie moves into her own social housing tenancy

At the beginning of the year, Julie suffers a brief setback in her recovery. Her emotional and mental health decline and her drinking increases. She is feeling more stressed and anxious and exhibiting frequent impulsive behaviour. This is reflected in her increased NDT score in April, which rises to 24.

Julie receives a police caution and spends one night in custody. She presents at A&E six times and is admitted on three occasions. She also has contact with drug and alcohol services and undergoes four days of detox. Julie continues to be supported by the community mental health team, with eight meetings in the first half of 2016.

Julie continues to see Roy and her peer mentor. By the summer Julie's mental health stabilises and she is exhibiting less impulsive behaviour. Her risk of self-harm decreases and she is drinking less, although her alcohol consumption remains high (3). Julie's NDT score falls again to 17 in July.

Julie's mental health and engagement continue to improve over the second half of 2016. She considers herself to be taking more responsibility, including managing her money better and showing improvements in her relationships and social networks. Julie does not have any further contacts with the police during this period.

At the beginning of the summer, Julie moves into her own social housing tenancy, which she is managing well.

Julie continues to show improvements with her mental health, alcohol consumption and engagement with services. In October, Roy and Julie agree that she no longer requires intensive support and she moves onto tier 2 of LWoH support. This means that Roy no longer visits her or accompanies her to appointments, but she can call him when she needs additional support. Julie continues to see her peer mentor, Mary, and to

attend the Basement. Roy also refers her to the floating support service at the Whitechapel Centre. In December 2016, Julie's NDT score falls again, to 16.

She has the lowest score for engagement with services, indicating that she is actively engaging and rarely missing appointments, as well as managing her tenancy well. Julie's impulse control has improved since the beginning of the year (3 to 1), indicating that she is no longer exhibiting threatening or aggressive behaviour. However, Julie's alcohol use remains high (3), as does her stress and anxiety (3).

### Spring/ Summer 2017

Julie suffers another setback in her recovery. She has started to take drugs as well as drinking heavily. When she is under the influence of drugs and alcohol, Julie is very vulnerable as she is overly trusting; she invites strangers into her apartment and is at high risk of being exploited.

Julie's NDT score rises significantly, to 40 in July. This reflects her high risk of self-harming, inability to care for herself or manage her tenancy, and that she is putting herself at risk of harm. Julie's risk of harm from others increases to the highest level and there is evidence that she is being exploited. Julie's impulse control also worsens over this period, reflecting that she is frequently exhibiting aggressive behaviour. Her risk of harm towards others increases from 0 to 6. Julie's NDT score also indicates that she is drinking daily, with high alcohol dependence. She is also no longer managing her tenancy and is at risk of being evicted.

Due to the deterioration in her mental health, Julie has also stopped seeing her GP or engaging with other services, such as seeing her CPN. Because she is still attending the Basement and seeing her peer mentor, New Beginnings staff become aware of the deterioration in Julie's mental health and wellbeing. In May, staff refer Julie to the ISS for renewed intensive support.

Julie starts regularly seeing Roy again and accessing personalised support for housing, money & debt and addiction. Roy also helps her to apply for Personal Independence Payments and staff at LWoH put in an application for her to receive a blue badge, due to her poor eyesight.

### Autumn/Winter 2017

Since re-joining LWoH, Julie has not had any contact with the police. She also hasn't presented at A&E. However, she remains reluctant to engage with her GP again or take medication for her mental health, as she is worried about putting on weight. However, when she complains of chest problems, a LWoH caseworker persuades her to go to the doctor and accompanies her for a full health check.

Julie continues to suffer from periods of poor mental health. However, when she feels anxious and thinks that she might be at risk of self-harm she will call LWoH staff. On one occasion, when she calls a staff member from New Beginnings to say that she is frightened that she might hurt herself, two LWoH caseworkers visit her with the police. When the police leave, LWoH staff stay with Julie until she feels better.

On another occasion, LWoH staff respond to a call from Julie to say that she is feeling low and anxious. They visit her and take her to the park to walk a dog, which calms her down. In this way, Julie feels that staff have built up her confidence.

*"A year or so ago I promised no more self-harm. They've given me confidence."*

Julie continues to engage with New Beginnings activities, including attending the Basement and taking part in bingo with her peer mentor Mary. Staff at the animal shelter also continue to bring a dog to her apartment once a week for her to spend time with.

Julie is managing her tenancy better. However, LWoH staff feel that Julie requires a higher level of



support and would be more stable in sheltered accommodation. When Julie has been drinking heavily, she is at risk of falling and injuring herself. Julie agrees, although most of all she would like to move somewhere that she can keep a pet cat. LWoH staff take her to see a few different places and Julie hopes she will find a suitable place soon.

When Julie's caseworker Roy leaves LWoH, Julie finds this difficult to deal with, because they had built up a trusting relationship.

Julie is assigned a new caseworker, Bella. Julie has had contact with Bella previously through LWoH and Bella has taken her to appointments in the past when Roy wasn't available. This helps Julie to feel less anxious. Bella sees Julie on average twice a week and speaks to her almost every day.

However, Bella feels that Roy leaving has triggered Julie's anxiety and her mental health has deteriorated. In November, Julie calls LWoH twice because she feels that she is at risk of self-harming. LWoH staff visit Julie with the police and take it in turns to stay with her until she feels "ok".

Julie is also anxious about perceived changes to the LWoH project and is worried that her support might end.

*"It makes me feel unsettled because I don't like change; I get used to people."*

Bella secures Julie a place in supported accommodation and in December Julie moves in. Julie has her own flat and staff are available 24 hours a day. Julie is positive about the move and likes that there are group activities on offer, such as a supper club; as well as more support, including an alarm in her room to alert staff. Julie feels that staff at her new accommodation are available when she needs them.

LWoH staff help Julie to move into her new accommodation and arrange for a van to transport her belongings. Bella also helps Julie to get new

furniture for her room and arranges for appliances to be fixed when Julie tells her that they are broken. Bella encourages Julie to see her GP and is concerned about her health. However, Julie is reluctant to go due to her anxiety.

Julie is also not receiving medication for her mental health. In the past, Julie has been reluctant to take medication as she was worried it would result in her putting on weight. However, now she feels that her heavy drinking is a barrier. Julie is also reluctant to take up the offer from LWoH staff to refer her for counselling, as she is worried about how this might affect her mental health by bringing up things from her past.

*"I've been offered counselling... but I'm scared. I was offered it years and years ago, and it could be opening a whole can of worms in my head that I don't want."*

Julie continues to attend activities at New Beginnings, including art classes on a Monday, and attends the quiet hour at the Basement. Julie feels listened to when she attends the Basement and able to share her views and talk frankly to staff and mentors.

*"You can talk to [staff at the Basement], they give you every opportunity to talk, though sometimes I don't. But I've sat there and cried in front of [staff at the Basement]. I can't think of anyone that I don't [feel listened to by]."*

Julie feels that her self-confidence has improved since attending activities through New Beginnings, and this is a factor in her reduced self-harming.

*"A while ago, I used to self-harm quite a lot, and I stopped doing that... They [staff at New Beginnings] build your confidence up as well. I've not done it since. They build your confidence up to do certain things"*

Julie feels that her caseworker and other LWoH staff are there if she needs them. The knowledge that they are just a phone call away means that she

is more likely to get in touch when she is feeling anxious or at risk of self-harming, decreasing the chance that the situation will escalate and she will require police involvement or hospitalisation.

*"[Bella] is there, any of them [LWoH staff] are there. I don't like to bother them, but then I've got the chance to. I could leave things to get to a head and it'll go bang. At the minute it's usually [Bella] [who gets in touch with me] but I can phone up."*

Julie feels that she can text her peer mentor for support as well.

*"I text her, anytime, and she's there for me. I don't do it often, but I can."*

Since re-joining LWoH, Julie has not had any contact with the police and only one attendance at A&E for a stomach problem. This is a significant decrease from the year before she joined the project.

Bella continues to encourage Julie to see the doctor, and Julie starts attending the GP with Bella for weekly appointments to get her blood pressure checked.

Bella feels that Julie is "in a good place" currently. Julie has started to re-engage positively with health services and has also started dog sitting again now that she is more settled in her new accommodation.

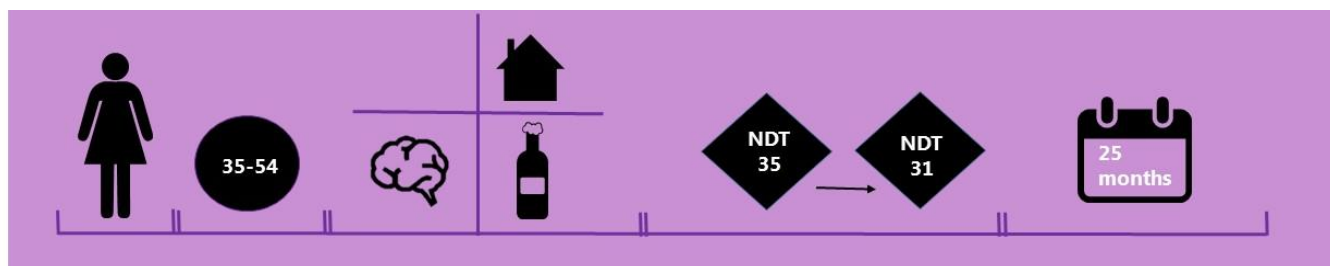
Julie is now more willing to address her alcoholism and Bella has referred her to community alcohol services. Bella feels that Julie's increased motivation to engage with services and New Beginnings activities reflects the confidence and stability she gets from knowing that staff are there for her and that she is receiving intensive support.

Despite a small reduction in her NDT score from 40 to 36, Julie continues to have a high level of need. Julie's risk of self-harm has decreased (4 to 2) and her risk to others has also come down (6 to 4). She

continues to have a high dependence on alcohol, which means that she remains highly vulnerable to exploitation from others.

Julie looks forward to settling into her accommodation. Together with Bella, Julie has set a goal of reducing her reliance on alcohol with the support of community alcohol services.

## 5.4 Tracey



### Life before joining LWOH

Tracey suffers from longstanding mental health problems and alcoholism, which manifests in binge drinking. She has a history of attending rehab for her alcoholism and having a period of abstinence and sobriety, sometimes lasting a few months, before suffering a relapse.

Tracey is also extremely vulnerable to abuse and exploitation from others. She lived in private tenancies until the breakdown of a relationship in 2012 due to domestic violence. Tracey suffered a deterioration in her mental health and was sectioned in a psychiatric unit for a year, before attending rehab. When she came out of rehab, Tracey moved into temporary supported hostel accommodation.

### 2015: Referral to LWOH: Tracey builds up a relationship with her caseworker

Tracey was referred to LWOH in November 2015 by staff at the hostel where she was living. Her NDT score on referral was high at 35. This reflected high levels of need across all indicators, most noticeably: risk of harm and exploitation from others (8), alcohol abuse (4), housing insecurity (3) and unintentional self-harm (5).

When Tracey is accepted onto LWOH, two intensive support workers go to visit her at her hostel. However, when they arrive, they discover that Tracey has been moved into a dispersed property. At her new accommodation, they find that Tracey has taken an overdose. She is taken to

hospital, where it becomes clear that she cannot cope in her new accommodation, as she cannot live alone and needs more intensive support.

When she is discharged from hospital, Tracey moves back into the hostel. Tracey's ISS caseworker, Jill, contacts social services and the mental health team for an assessment for sheltered accommodation. However, because of Tracey's alcohol problems they are unable to house her.

Tracey builds up a trusting relationship with Jill, who she sees two to three times a week. She appreciates that Jill is laid back and that they can laugh together, and describes her as a 'friend'.

*"We have to go girly shopping and stuff, when you live with men all the time. Just have a little giggle, like a little friend. We click. We pull men apart! [laughs]. She's pretty laid back, she's good with me, builds up that trust. If you build up the trust that's half the problem."*

Jill takes Tracey shopping and to her GP appointments.

### 2016: Tracey struggles to deal with a traumatic life event

In January, Tracey's ex-partner is convicted of domestic violence and is sentenced to 14 years in prison. Jill supports Tracey through this difficult period, visiting her regularly in her accommodation and keeping in touch over the phone.



Tracey struggles to cope with the effect of the trial and conviction. Her mental health deteriorates and her binge drinking increases. In February, Tracey suffers a serious fall while intoxicated and is hospitalised for three and a half months. During this period, Tracey goes through an unplanned detox as she does not have access to alcohol.

Jill visits Tracey in hospital. She coordinates with the nursing staff and social services to arrange longer-term supported accommodation for when Tracey is discharged, and challenges the decision to discharge without suitable accommodation in place. Jill is concerned that without suitable support and in an environment where other people are drinking, Tracey's mental health and alcohol misuse will both deteriorate.

Jill secures funding for Jill to attend Transforming Choices in-patient rehabilitation. In June, Tracey moves from hospital to Transforming Choices. Tracey credits her caseworker and other LWOH staff for ensuring that she did not become homeless at this point.

*"Waves was doing all the fighting... There was just all kinds of grief and battling, so they helped and intervened. They helped... I had nowhere to go."*

While in rehab, Tracey starts studying towards a college qualification. However, Tracey finds it difficult being in daily contact with other people who also recovering addicts. After 3 months, in September, Tracey suffers a relapse and is discharged from rehab for drinking. Following this, Tracey moves into several different supported temporary accommodation placements.

At the end of 2017, Tracey's NDT score remains high, at 33. Her risk of unintentional self-harm has reduced from 5 to 2, indicating that while risks to her physical safety remain, it no longer amounts to an immediate and present risk. Tracey's alcohol use has also reduced slightly but remains high, indicating that her drinking is still having a significant impact on her ability to function.

### **Spring 2017: Tracey struggles with her alcohol use and poor physical health**

Jill continues in her attempts to secure Tracey long-term supported accommodation, with support for both her physical and mental health needs. However, Tracey's alcohol use remains a barrier to this. Jill observes that when Tracey is drinking heavily, other services attribute Tracey's mental health needs to her drinking and will not offer her long-term support.

Tracey continues to see Jill and speak to her; Jill continues to take her shopping and to hospital and GP appointments. Tracey continues to drink heavily and starts to use class A drugs in her hostel, something she has not done before.

Tracey is robbed in her hostel and loses the victim compensation she received following her ex-partner's conviction. Jill feels that LWOH had been ignored when attempts were made to communicate Tracey's severe vulnerability and the risks of housing her in a hostel setting to the relevant statutory agencies.

Tracey is hospitalised again with pneumonia. Jill and another ISS caseworker, Jim, visit Tracey weekly in hospital and conduct an NDT assessment together with nurses and managers at the hospital. Tracey spends four weeks in hospital and undergoes an unplanned detox. The decision is taken by social workers to discharge Tracey to the LWOH landing at the YMCA.

### **Summer 2017: Tracey moves into the YMCA and starts engaging with New Beginnings activities**

Tracey moves into the YMCA in May. While her accommodation is now more secure, and her risk of harm posed to others has decreased to 0, Tracey's NDT score remains high at 31. Tracey feels safer and more supported at the YMCA. This is despite initial reservations due to her previous negative experiences in hostels.

*"When I thought I was coming here I was a bit scared because I've had bad experiences with hostels, they haven't been that nice to be honest. This is better. It's a bit more safe. Because you've got a key to get on this landing, so there's only so many people on this landing."*

Tracey appreciates that she can call staff 24 hours a day, either by phone or pulling the emergency chord in the bathroom.

Tracey is keen to stay sober. Tracey feels that being in hospital was the "wake-up call" that she needed to stop drinking, despite previous attempts resulting in relapse.

*"I've stayed off it for a while, I've done this before. But this time I thought no, I've been too ill, my body's been suffering too much."*

Now that Tracey has a LYMCA caseworker, Paula, she agrees to step down onto tier 2 of LWOH support. Paula takes her to her out-patient appointments and helps her with her shopping. Tracey feels that staff at the LYMCA understand her needs, are easy to talk to and are available for her when she needs them.

*"There's a lot of staff here. They're alright, you can talk to them. If you don't feel comfortable, you can go and talk to someone else. I find it very hard to talk to someone, but they know my needs."*

Although they have less contact, Jill still checks in and takes her shopping. Jill also accompanies Tracey to and from the post office to receive her benefits, as Tracey remains highly vulnerable to robbery and exploitation from other hostel residents.

Tracey's starts accessing outpatient mental health support, with four attendances. This is the first time she has engaged in a year.

Tracey also starts to engage with activities through New Beginnings, who organise activities twice a week on the LWOH landing. She also attends creative writing, history and sewing workshops at the Hub. Tracey enjoys the activities, as well as the chance it gives her to get her out of the hostel and feel more motivated.

*"It's just getting out, doing something with your day, by the time you've got ready to go. Better than sitting round all day, you've got to be active, not just sitting round thinking."*

Tracey's improved engagement with services (3 to 1), improved social skills and relationships (3 to 1) and abstinence from drinking (4 to 0) are reflected in significant improvements to her NDT score, which falls from 31 to 21. However, Tracey's risk of abuse or exploitation remains at the highest level, reflecting the difficulties she faces in the hostel environment.

## Winter 2017

Tracey suffers a setback in her recovery. She starts drinking again following a visit from her adult son. Jill views Tracey's son as a trigger for her alcohol abuse, as he can be financially exploitative and manipulative towards her. Tracey starts drinking again.

*"Alcoholic is alcoholic. I saw my son and I hadn't seen him for a year. It devastated me, and I started."*

Tracey is the victim of an attack from another resident in the hostel. She feels low and suicidal. She speaks to Jill and LWOH step up her support again. Jill helps Tracey with the process of reporting the crime to the police, which she finds very difficult.

Tracey's mental health deteriorates and she has suicidal feelings. Jill arranges a psychiatric assessment and takes her to the appointment. She also arranges for Tracey to be appointed a named Community Practice Nurse for mental health

support. Through her CPN, it is arranged for Tracey to move into temporary respite accommodation for three weeks to aid her recovery. Jill visits Tracey twice in her first week to check on her. Tracey starts to feel better and likes that her new accommodation is quiet.

*"I'm getting back on my feet a bit better... I've gone really into myself, terribly into myself, but I'm feeling a lot better. It's very quiet there."*

Tracey also finds it helpful that staff can help her to remember to take her medication, which they couldn't do at the YMCA.

Tracey stops drinking again and intends to stay sober. Although she feels stronger, Tracey is worried about returning to the "chaos" at the hostel. She feels that she will struggle to maintain her sobriety when other residents are drinking and using drugs and "there's always bottles of alcohol outside". Jill also worries that Tracey's mental health will deteriorate if she moves back to the YMCA. In January, Jill organises a place for Jill at a hostel with fewer residents and 24-hour support.

Tracey is seeing her CPN every week. She has started re-engaging with New Beginnings and starts taking part in sewing, cookery and creative writing activities.

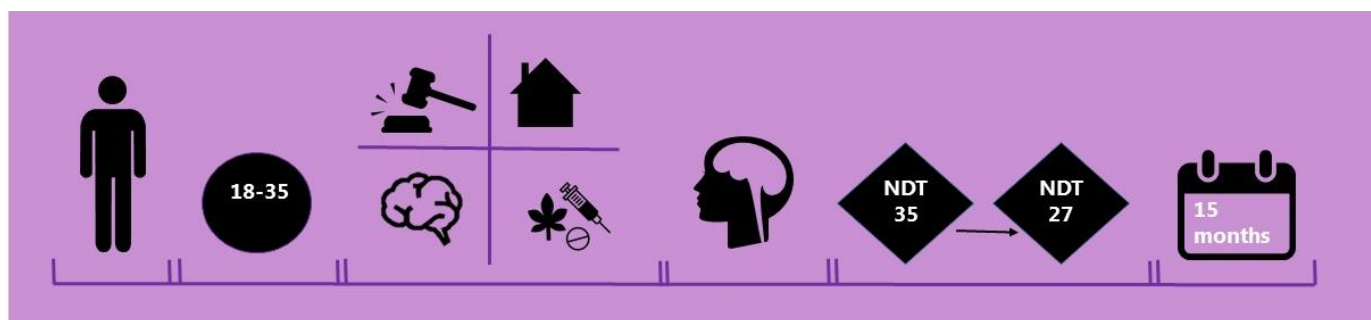
Jill helps Tracey to maximise her benefits and transfer from Disability Living Allowance to Personal Independence Payments. Tracey is assessed as having high needs and accepted for enhanced housing benefit and PIP.

Together, Jill and Tracey put together a new support plan. They agree a budgeting plan with staff at Tracey's hostel, to reduce the risk that Tracey is financially exploited by others. Tracey's benefits are kept in a safe and she receives small amounts each day.

Tracey's NDT score has increased to 31, reflecting the deterioration in her mental health. However, Jill feels that Tracey is in a better place and hopes that

once long-term housing is secured, this will aid Tracey's recovery longer-term. Jill feels that the different services and agencies that Tracey is in contact with are finally "on the same page" regarding the long-term mental health and housing support that she requires. Tracey wants to maintain her sobriety and feels her needs are being recognised.

## 5.5 Matthew



### Life before LWoH and referral to project

Matthew has Asperger's syndrome, which affects his social interactions and makes him vulnerable to exploitation from others. In the past, he has been taken advantage of by people he had considered friends, and this has contributed to his offending. Matthew also has learning disabilities, including Attention Deficit Hyperactive Disorder (ADHD), and suffers from severe anxiety and depression.

Matthew was expelled from school aged 15. From the age of 17, he had repeated contacts with the police for drug offences and spent two periods in prison for supplying drugs. When he was released from prison for the second time Matthew lived with his grandmother. Matthew's offending continued and in the year before he was referred to LWoH he received two police cautions for supplying drugs and spent a night in police custody.

Matthew was referred to LWoH by family members in August 2016. His grandmother had recently moved into a nursing home and Matthew was sofa surfing with friends and family.

On referral Matthew's NDT score was high, at 35. This included severe stress and anxiety and a high risk of self-harm. Matthew smokes cannabis most days and has low engagement with services, only seeing an ADHD specialist once every three months. He does not take medication for his ADHD or anxiety, as he believes non-natural medicines to be harmful. However, he also recognises that his recurrent cannabis use contributes to his depression, affects his mood and sleep patterns,

and means that he finds it difficult to feel motivated or engage with services.

### 2016: Matthew moves into supported accommodation and starts engaging in New Beginnings activities

Upon joining LWoH, Matthew is assigned an intensive support worker, Kelly. Having his own space is important to Matthew and he wants Kelly to help him to find a flat. He also wants help to challenge a recent assessment for Asperger's syndrome, which was negative. With the support of the doctor, Kelly arranges for Matthew to be reassessed; Matthew is diagnosed and Kelly links Matthew to the community nursing Asperger's team.

Kelly finds Matthew a room at a hostel for single people with 24-hour support. She also helps Matthew to successfully apply for Personal Independence Payments (PIP).

Matthew and Kelly discuss his goals for the future. Matthew wants to go to college to study to be a personal trainer, but knows that he will need to improve his maths and English skills to be accepted onto a course. Matthew also mentions that he is interested in cooking. Kelly refers him to New Beginnings and a cookery course is arranged for him to go on.

### Winter 2017: Matthew takes part in activities and his life improves

Matthew is engaging in and enjoying the cookery course. Despite being anxious about the group

activities, he also participates in group walks and plays football.

Matthew speaks to Kelly once or twice a week. He continues to find it difficult to engage with activities consistently, due to his continued heavy cannabis use and insomnia. Kelly helps Matthew by reminding him about his appointments and motivating him to attend.

Kelly refers Matthew to an ADHD and Asperger's support group and he attends a couple of sessions. However, Matthew finds the group format difficult due to his anxiety, and also finds it hard to sit still and listen to others in the group, due to his ADHD. He stops attending after a couple of sessions.

### Spring 2017: Matthew continues to find it difficult to engage

Matthew continues to play football through New Beginnings, when he has the energy. Kelly notices that Matthew's confidence has improved from taking part. Matthew's NDT score improves slightly, reflecting his improved engagement with services, however it remains high at 33.

To improve his maths and English and prepare him to apply for university, Kelly arranges for a tutor to come and see him once a week, through Crisis.<sup>10</sup> However, Matthew's insomnia and cannabis use remains a barrier to engagement and he stops attending the sessions.

At Matthew's supported accommodation, other residents ask him for money and cigarettes. There is evidence that Matthew is being exploited as he finds it difficult to say no. Matthew's family arrange a private tenancy for him and he moves in April. However, the property is in a poor condition and the landlord refuses to conduct repairs. Matthew moves into another private tenancy, but there are similar problems with the landlord and his living situation remains insecure.

### Summer 2017: Matthew gets into a routine

Following the cookery course that he completed through New Beginnings, Matthew is offered a job as a kitchen porter.

*"I was prepping with the veg and that, after I did the cooking course. I was loving it there; they did vegetarian meals as well."*

Matthew enjoys the job and having something to do every day. Kelly notices that the routine of getting up for work every day has been positive for Matthew. His drug use decreases and he often goes to the gym or the sauna before going to work.

Matthew's NDT score drops to 23 over the summer. There are improvements in most areas, including decreased risk of self-harm (3 to 1), decreased stress and anxiety (4 to 2) and improvements to his impulse control (3 to 1). His drug use also reduces to 3, from the highest level, but remains high.

Kelly also notices an improvement in Matthew's physical health and his relationships. When Matthew joined LWoH he was spending most of his time alone or with people who were not a constructive influence, whereas now he feels that he is building a positive social network. Matthew speaks to Kelly on the phone every week.

*"She's a lovely person. She's always there if I need her"*

Kelly also helps Matthew to get his deposit back from his previous private landlord and he receives advice about his housing rights through New Beginnings. Towards the end of the summer, Matthew's cousin arranges for him to move into a privately rented bungalow and Matthew hopes that this will be a stable place for him to live.

<sup>10</sup> Crisis is a national homelessness charity

Matthew continues to engage with New Beginnings, however his involvement is patchy due to his insomnia and continued cannabis use. Matthew is still smoking cannabis most days. He wants to stop and sometimes does for a couple of weeks, before starting again.

Due to changes in management at the restaurant, Matthew loses his job. Matthew wants to continue using and improving the skills he has learnt, either through a course or paid employment.

### **Autumn/Winter 2017: Matthew is evicted and stops engaging with services**

In October, Matthew has to move out of his cousin's bungalow due to issues with rental payments. He moves in with his mother, where he shares a bedroom with his younger brother. Matthew says he needs his own space and feels that his mental health has deteriorated. He is finding it very difficult to sleep due to insomnia and anxiety, which is exacerbated by going out late with friends and smoking cannabis.

Matthew's insecure living situation, anxiety and sleep deprivation has meant that he has stopped doing activities that he was enjoying previously, such as playing football through New Beginnings and going to the gym. His NDT score remains the same across most indicators, although his stress and anxiety worsens. As a result, his NDT score rises to 27 at the end of 2017. Kelly encourages Matthew to take medication for his anxiety and ADHD, which could also help with his insomnia, and he agrees to consider this.

*"I've spent my whole life being anxious and didn't realise the things anxiety stops you from doing, it takes up so much of your thoughts."*

Kelly continues to call Matthew once or twice a week and encourage him to take part in activities, such as New Beginnings and attending the ADHD and Asperger's support group. As Matthew is not seeing Kelly as much as he used to, he is unsure whether his support is continuing.

*"I think I've been dropped out of it now because... something to do with, they've done all they can for me now, or something. But [caseworker] said if you need any help then just phone us. I haven't seen her since she said that. I'd like to carry on."*

Kelly believes that Matthew's living situation is strongly linked to the deterioration in his mental health and drug use, which in turn makes him less motivated. She sets Matthew up on the housing property pool to bid for his own social housing tenancy and arranges for Matthew to come to the ISS office once a week to look at and bid for properties with her. Eventually, after discussing Matthew's needs with him and his mother, Kelly arranges for Matthew to move into high needs supported accommodation. With Kelly's support, Matthew is still bidding on properties and hopes to move into his own social tenancy soon, achieving a long-term goal.

Kelly also sets up a meeting between Matthew and the educational support worker at LWOH to discuss maths and English classes. She continues to hope that Matthew will engage with this, to work towards his long-term goal of attending university. Matthew is also interested in attending the Hub to do creative writing and listen to music. He would like to focus on improving his physical health and stop smoking cannabis, so that he is more motivated to take part in these activities. He doesn't feel that Kelly can help him with this and plans to do this on his own.

Kelly thinks that once Matthew's housing situation is secure and he is in a constructive routine again, he will no longer need intensive support as this will provide him with the stability he needs to move forward. However, he will need some form of support, due to his developmental and learning disabilities. Kelly continues to encourage Matthew to attend group support sessions and to engage with the Asperger's team.



## 6 Cost-effectiveness

The local evaluation analysed the costs incurred to public services by the individuals taking part in longitudinal case studies. This analysis is intended to understand the reasons for increases or decreases in cost across a range of different journeys through the project. The service users included in the analysis are not a representative sample, and the figures presented cannot be multiplied up to draw conclusions about the overall costs or savings made by the Liverpool Waves of Hope (LWoH) project.

In the majority of cases, overall costs to public services have increased in the short-term for individuals supported by LWoH. This is due to the project's role in improving access to the services individuals need and are entitled to, such as health care and welfare benefits. Costs typically increase in an individual's first year on the project, with no overall trends thereafter. These findings suggest that the support provided by LWoH does not create savings for public services during the time that an individual is supported by the project, unless the individual had already been engaging with very high cost services (e.g. residential rehabilitation or prison).

It is possible that the project results in savings over a longer time period by supporting service users to move towards stability and independence, and thereby reduce their use of services in the longer-term. However, given the timeframes involved and the information available it is not possible for the local evaluation to assess whether or not this is the case.

Given the nature of the project, the CSG may wish to consider whether creating savings for public services is an appropriate measure of effectiveness. An alternative approach could be to consider efficiencies created by the project, such as service users being able to access more appropriate support for their needs rather than making repeated use of crisis services.

### 6.1 Introduction

Public services in Liverpool have experienced a significant reduction in budgets in recent years, and consequently organisations such as Liverpool City Council and Liverpool CCG are under pressure to create savings. At the outset of the LWoH project, stakeholders anticipated that the project's model of support could generate savings by reducing service users' interaction with expensive, unplanned crisis services such as A&E and the police; and that this would be an important factor in demonstrating to commissioners and others the value of the LWoH model.

The local evaluation has undertaken a cost-effectiveness analysis in each year of the evaluation, to explore the extent to which such savings have been realised. The year two analysis<sup>11</sup> indicated that, although service users' interaction with emergency services had decreased, overall costs to public services had increased, since their participation enabled them to access services such as health care and welfare benefits from which they were previously excluded. This chapter provides an update of this cost-effectiveness analysis, using data from the third year of the LWoH project.

## 6.2 Overall approach

The cost-effectiveness analysis is based on a small sample of individuals supported by LWoH who have taken part in longitudinal case studies for the local evaluation. For each individual, the local evaluation has estimated the costs of that individual's use of services during the year prior to their referral to LWoH; and the costs of their use of services, including LWoH, while they have been receiving support from the project. The year three cost-effectiveness analysis therefore considers the ten individuals for whom there was sufficient data to make a reliable year-on-year comparison<sup>12</sup>. Service use is only observed while individuals are participating in LWoH, and therefore the analysis does not consider costs to services incurred by those who have moved on from the project.

The individuals concerned have spent different lengths of time on the project and started at different points, so to enable a comparison, each person's time on the project has been split into years starting with the date they joined. Therefore, we can compare the costs incurred during the first, second and third 12 months of participation across all service users in the analysis.

The results from these ten individuals cannot be aggregated in any way to estimate the overall costs or savings of LWoH. The individuals interviewed by the evaluation team were selected in order to provide a broad range of different experiences, and as such do not comprise a representative sample of individuals supported by LWoH. It is not within the remit of the local evaluation to provide a cost-effectiveness analysis of the project overall; this task was assigned to the national evaluation.

A detailed description of the methodology for this analysis is included in section 3.3.8 of the annex accompanying this report, and more detailed tables are presented in chapter 10 of the annex.

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<sup>11</sup> *Liverpool Waves of Hope Evaluation* Ipsos MORI Social Research Institute, 2017: <https://liverpoolwavesofhope.org.uk/wp-content/uploads/2017/03/LWoH-Year-2-Local-Evaluation-Report-May-2017.pdf>

<sup>12</sup> Specifically, the individuals referred to as Paul, Craig, Amy and Laura in the chapter 4 case studies do not appear in the cost-effectiveness analysis. However, we have included the individuals Gemma, Brian and Hannah, who took part in longitudinal case study interviews in years 1 and 2 of the evaluation. See *Liverpool Waves of Hope Evaluation*, Ipsos MORI Social Research Institute, 2017: <https://liverpoolwavesofhope.org.uk/wp-content/uploads/2017/03/LWoH-Year-2-Local-Evaluation-Report-May-2017.pdf>



### 6.3 Results of cost-effectiveness analysis

The findings of the cost-effectiveness analysis in year three are similar to the findings from year two of the project. Three service users have demonstrated cost reductions during their time on the project, whereas seven service users have incurred cost increases.

Cost reductions are partly due to individuals' having been admitted to inpatient mental health facilities, prison, or residential detox and rehabilitation facilities during the 12 months prior to joining LWoH. The high costs of these services mean that a reduction in costs is apparent when individuals return to living in the community. Reductions in costs are also seen when individuals reduce their offending behaviour or reduce engagement with mental health and substance misuse services. Interviews with these individuals and their case workers suggest that this reduction in engagement does not necessarily reflect reduced need, and therefore may not represent a positive development.

**Table 6.3A: Service user case studies demonstrating a cost saving<sup>13</sup>**

Service user	Average NDT score <sup>14</sup>	Costs in the 12 months prior to LWoH participation	Average annual cost while participating in LWoH	Average annual saving (negative numbers represent decreased cost)
Tom	25	£61,100	£31,700	-£29,400
Julie	25	£46,900	£21,600	-£25,300
Gemma <sup>15</sup>	23	£51,700	£32,100	-£19,600

Increased costs are typically due to individuals accessing support services which they had previously been excluded from or otherwise unable to access. Most of the service users in this analysis experienced an increase in their income from welfare benefits. Some service users have also received a significant amount of care for physical health needs since taking part in LWoH. As described in previous evaluation reports, many LWoH service users have disabilities and other physical health needs, which in some cases have been exacerbated by long periods of substance misuse and a street lifestyle. This analysis also takes into account the costs of LWoH support; for service users supported by the ABS, this typically represents a significant increase in costs compared with their previous living situation.

<sup>13</sup> In this table and those that follow, costs have been rounded to the nearest £100.

<sup>14</sup> Average of all NDT scores recorded during their time on the project.

<sup>15</sup> Gemma, Brian and Hannah refer to individuals who took part in longitudinal case study interviews in years 1 and 2 of the evaluation. See *'Liverpool Waves of Hope Evaluation'*, Ipsos MORI Social Research Institute, 2017: <https://liverpoolwavesofhope.org.uk/wp-content/uploads/2017/03/LWoH-Year-2-Local-Evaluation-Report-May-2017.pdf>

**Table 6.3B: Service user case studies demonstrating a cost increase**

Service user	Average NDT score	Costs in the 12 months prior to LWoH participation	Average annual cost while participating in LWoH	Average annual saving (positive numbers represent increased cost)
<b>Hannah<sup>16</sup></b>	19	£21,800	£24,100	£2,300
<b>Matthew</b>	30	£9,800	£14,000	£4,200
<b>Dave</b>	17	£16,200	£23,300	£7,100
<b>Jim</b>	28	£12,800	£24,900	£12,100
<b>Bill</b>	26	£12,000	£26,400	£14,400
<b>Tracey</b>	30	£10,900	£74,200	£63,300
<b>Brian<sup>17</sup></b>	16	£12,200	£77,100	£64,900

The costs or savings attributable to different service users do not appear to correlate with the severity of their needs as assessed by an NDT score. This may suggest that supporting an individual to stabilise their lifestyle may not necessarily lead to a reduction in their use of services. For example, the service users supported by the ABS reported in case study interviews that their lives are less chaotic; however, the cost of providing this supported accommodation is significant.

## 6.4 Year-on-year cost comparison

The year two cost-effectiveness analysis found that costs were highest during individuals' first year on the project and decreased in their second year. Year three shows that this is still the case. However, of the six service users for whom there are three years' worth of data, only one showed a year-on-year reduction in costs.

## 6.5 Discussion of findings

This analysis has a number of limitations. The small and potentially unrepresentative sample means it cannot be used to draw wider conclusions about the project as a whole. It has also been hindered by a lack of data on some individuals.

The analysis in year three suggests that costs may fluctuate over the time an individual spends on the project, rather than tending to decrease, as hypothesised in year two. This may partly be due to individuals whose recovery fluctuates more being more likely to have spent longer on the project, whilst others no longer appear

<sup>16</sup> Gemma, Brian and Hannah refer to individuals who took part in longitudinal case study interviews in years 1 and 2 of the evaluation. See *'Liverpool Waves of Hope Evaluation'*, Ipsos MORI Social Research Institute, 2017: <https://liverpoolwavesofhope.org.uk/wp-content/uploads/2017/03/LWoH-Year-2-Local-Evaluation-Report-May-2017.pdf>

<sup>17</sup> Gemma, Brian and Hannah refer to individuals who took part in longitudinal case study interviews in years 1 and 2 of the evaluation. See *'Liverpool Waves of Hope Evaluation'*, Ipsos MORI Social Research Institute, 2017: <https://liverpoolwavesofhope.org.uk/wp-content/uploads/2017/03/LWoH-Year-2-Local-Evaluation-Report-May-2017.pdf>

in the data. The evaluation does not have access to information about service use for individuals who have left the project and therefore it is not possible to say whether there is a longer-term reduction in costs for these individuals.

As discussed in the year two evaluation report, and the project's subsequent paper on cost-savings, although the cost of support individuals receive increases whilst they are on the project, it may be that participating in LWoH leads to changes in an individual's life which will result in greater independence and less demand for public services over that individual's lifetime<sup>18</sup>. This will not be apparent from a shorter-term comparison. A longitudinal analysis taking place over a longer period would be able to provide more evidence on whether LWoH represents an "invest-to-save" approach which leads to reduced spending in the long-term. However, it is also important to acknowledge that many individuals supported by LWoH, are likely to need long-term - potentially lifelong - support and care, even if they are able to achieve increased stability in their lives<sup>19</sup>. This may limit the extent to which LWoH, and similar projects to support people with MCN, can be anticipated to save money for public services.

Along with other Fulfilling Lives projects, LWoH is intended to ensure that people who were previously excluded from, or not reached by services can receive the support they need and deserve. This means that overall, current LWoH service users are likely to be accessing more services than they did before joining the project. As demonstrated by the case studies, this is likely to result in significant improvements to service users' quality of life. However, it is also likely to result in a corresponding increase in costs to public services whilst individuals receive this support.

Given the nature of a project such as LWoH, the question as to whether cost savings for public services are an appropriate measure of effectiveness warrants further consideration. An alternative method may be to consider the project's potential to lead to more efficient use of public services. For example, through the project, an individual may access more appropriate services for their needs and receive support in a more timely manner than if they were not involved in the project (e.g. registering with a GP and receiving planned treatment rather than presenting at A&E), thus reducing unnecessary burden on unsuitable services. However, the creation and use of such a measure of efficiency would require creating estimates of what would have happened in the absence of the project; and this would also present challenges for evaluation.

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<sup>18</sup> See e.g. LankellyChase Foundation, *Hard Edges: Mapping severe and multiple disadvantage*, 2015

<sup>19</sup> See e.g. Bretherton, J, and Pleace, N, *Housing First in England: An Evaluation of Nine Services*, University of York, 2015

## 7 Influencing the system

This chapter examines the LWoH project's work to create a legacy of better support services for people with MCN, by influencing the system from policy through to delivery of services. The chapter presents evidence gathered by interviews with both internal and external stakeholders of the project, and through a documentation review. It first considers the activities undertaken by the project in 2017 to further its systems change objectives, and the effectiveness of these (7.1 to 7.6) and then assesses the impact these activities have had to date (7.7 to 7.10).

In 2017, LWoH created several initiatives to encourage discussion of MCN issues at different levels, including the ELL at a strategic level, Communities of Practice at an operational level and the Lived Experience Hub for individuals with experience of MCN. These were identified by stakeholders as having significant potential to identify learning from the project, which had previously been limited by risk aversion and a focus on day-to-day delivery.

Test and learn projects were also viewed as an opportunity to explore innovative approaches, and have already been having an impact on the support available for people with MCN.

Stakeholders from across the board identified a need to improve the project's service user involvement work, which has been reliant on a small number of people. This is now a priority for the project.

The profile of MCN has been raised in Liverpool, and LWoH is credited with creating wider awareness of the benefits of psychologically informed approaches, and adoption of these approaches. However, the impact of the project on delivery and commissioning has been relatively limited; to some extent this may be because of external constraints such as commissioning cycles and national policies.

### 7.1 The ELL and communities of practice have created opportunities for multi-agency dialogue to identify relevant issues – though there are concerns over whether there is a clear plan to translate into impact

#### 7.1.1 Evaluation, Learning and Legacy Group

The Evaluation, Learning and Legacy Group (ELL) is a key element of the project's systems change strategy, and was set up in April 2017.<sup>20</sup> The role of the group is to develop and implement LWoH's strategy around

systems change by identifying the learning gained from LWoH and disseminating this widely to relevant sectors in Liverpool, as well as providing direction to the CSG about priorities for systems change.

ELL meetings have largely focused on discussion to identify priorities for systems change, and the creation of a Systems Change Framework, which sets out these priority areas and identifies how progress made against them can be measured. The group has also reviewed case studies of LWoH service users to identify common issues in supporting people with MCN. As a next step, the group has plans to create a short paper about these issues for dissemination to different forums in the city; this will be the first of a series of dissemination outputs tailored to a range of different audiences.

The ELL chair, through connections with other forums such as the Health and Wellbeing Board, engages with senior stakeholders in relevant sectors such as elected members and the CCG in order to share learning from the project and make the case for systems change. The January 2018 meeting of the ELL was attended by senior commissioners from Liverpool City Council, which led to a request from the adult social commissioning team for input and scrutiny from individuals with lived experience, and an invitation for the ELL chair to attend the next senior management meeting.

### 7.1.2 Communities of Practice

Following the disbanding of the Collaborative Case Management Forum (CCMF) in 2017, some stakeholders expressed concern that there would be fewer opportunities for practitioners to discuss particular cases and identify consistent themes across them, and for learning to be shared with frontline workers. These stakeholders identified a need to improve communications on the ground between frontline workers.

In order to further this aim, LWoH set up a series of meetings for frontline workers and people with lived experience using the Communities of Practice model<sup>21</sup>. This model involves the development of a shared, collective approach to problem solving and innovation that draws from group experience, expertise and knowledge and the ability of group members to challenge each other. The first Communities of Practice meetings took place in three locations across the city in October 2017, with a follow-on set of meetings in January 2018. The October events were intended to focus on discussion of problems and barriers within the system, in order to identify opportunities for change; while the January events were intended to focus on identifying solutions and best practice. These events were well-attended by delivery partners, and programme

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<sup>20</sup> This is a bi-monthly meeting attended by delivery partner managers and programme management; senior managers with expertise in MCN from Liverpool City Council; Liverpool Clinical Commissioning Group; and the voluntary sector. Currently, the voluntary sector is represented by attendees from Liverpool Charity and Voluntary Services (LCVS), Addaction, and Making Every Adult Matter (MEAM). However, the majority of attendees at ELL meetings are representatives of LWoH delivery partners and it was noted that some sectors, such as mental health, were under-represented. The group was set up in recognition of the need for multi-agency discussion of MCN issues, and is chaired by the Chief Executive of LCVS in order to achieve a level of independence from LWoH programme management.

<sup>21</sup> Communities of Practice can be defined as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly." (Wenger, E (2009) *Communities of Practice: a brief introduction*) For more information: <http://wenger-trayner.com/introduction-to-communities-of-practice/>

management reported that the broader discussion of cases and themes appeared to be more successful than an approach focusing on individual case studies. It is anticipated that in future these events will become an important source of learning about MCN which can inform the work of the ELL and others.

### 7.1.3 Stakeholder views of the Evaluation, Learning and Legacy group

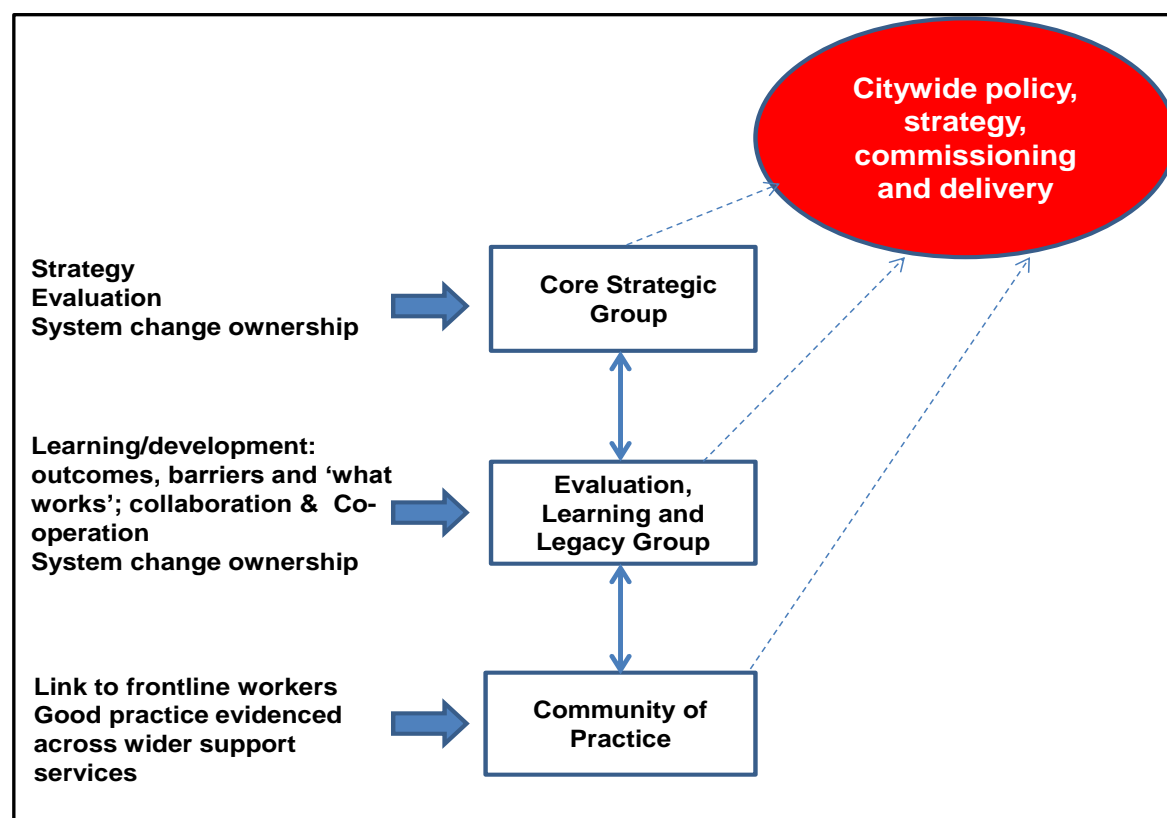
ELL members were enthusiastic about the potential for the group to identify opportunities for systems change and influence relevant decision-makers.

*"I think it is really important the ELL Group and the community practice and front-line worker events are in place. What that enables us to do is engage with elected members, leader officers in the local authority, the clinical commissioning group ... we have opportunity over the next 8 to 10 months to do something with that... Things that aren't working for people, I think we can change them for the better."* External stakeholder

However, other stakeholders expressed concern that there was not yet a clear plan for how discussions at meetings would translate into actions and influence, and that therefore the impact of the ELL would be limited.

*"We take our case studies to the legacy group, which is intended to create systemic change within Liverpool, picking up the learning from the case studies. But, where does this information go? How is it going to influence strategy and lead to changes? We're all around the table, all enthusiastic, all managers, some higher up than others. But then the meeting's ended and six weeks later we go to another meeting and nothing's happened."* Delivery partner

A related concern was a lack of clarity about the relationship between the ELL and other meetings (such as the CSG), and a resulting risk that discussions would be duplicated or that actions would not be taken forward. The CSG is responsible for acting on the next steps suggested by learning from the ELL; a diagram has been produced to demonstrate the relationship between these groups (Figure 7.1), and this has been set out in meetings of both groups. However, some stakeholders expressed uncertainty about how this would work in practice, particularly as CSG discussions were dominated throughout 2017 by urgent operational issues relating to the service redesign. It is hoped that, once these issues are resolved, the CSG will be able to focus on taking forward learning from the project.

**Figure 7.1: Liverpool Waves of Hope structure**

Source: *Liverpool Waves of Hope Policy and Strategy Update, January 2018*

## 7.2 Previously learning from the project was not always generated or captured due to persistent target-driven mind-sets, risk aversion and distraction of the service redesign

As described above, the LWoH project was intended to generate learning about “what works” to support people with multiple needs, and identify opportunities for services and the system as a whole to work better. However, stakeholders commented that some LWoH delivery partners did not appear to have fully recognised their strategic role as part of a test and learn programme and their responsibility to generate and promote learning. This issue was attributed to an initial focus on getting the service up and running, at the expense of more strategic thinking, which continued for the first two years of the project; and a perceived need to achieve targets for service delivery. This target-driven mind-set appears to have persisted well into the delivery of the project, despite efforts to communicate the “test and learn” ethos within the project; this was seen as leading to risk aversion and an unwillingness to experiment.

*“I think what we never fully appreciated is how flexible the Lottery was willing to be and how we could ask for things to be different, and I think we failed to do that as people were chasing targets.”* Delivery partner

The service redesign process is likely to have been a further impediment to strategic thinking in the short-term, due to the resulting disruption and uncertainty at delivery level, and the resource needed to manage this process at a strategic level. As well as this, one delivery partner commented that they did not feel the programme management had held them to account to a sufficient degree, which may have reduced



opportunities to identify what was not working well. However, delivery partners received updated service specifications at the end of the project's second year which included a stronger and more explicit requirement to engage with the systems change objectives of the project.

### **7.3 Test and learn projects are seen as an opportunity to try innovative approaches and generate learning about new ways of working**

As identified in the project theory of change, LWoH is intended to provide an opportunity to generate learning about what support is effective with this client group. One of the ways in which this has been intended to happen is through "test and learn" pilots, in which innovative approaches to supporting people with MCN were suggested by delivery partners or other service providers and, if approved by the programme management, piloted on a small scale and evaluated.

There have been no new test and learn pilots approved in 2017, and there will be no further pilots during the project's lifetime. However, the pilots which have become operational in 2017 are innovative and diverse in terms of the target groups and the treatment/intervention offered; and there are good plans in place to evaluate their effectiveness. An overview of each of these pilots is provided in section 2.4.3 and chapter 8 of the annex.

There was an improved level of awareness of test and learn initiatives amongst both internal and wider stakeholders, some of whom considered that this had been a genuine opportunity to test innovative approaches without pressure to meet specific targets or outcomes. This provided a *"refreshing viewpoint"* compared to how services were used to working. In particular, the Acquired Brain Injury test and learn pilot was viewed as forward-thinking and as a real opportunity to test a different way of working with MCN. Evidence generated from the pilot has the potential to directly inform best practice ways of working.

### **7.4 Some external organisations are not receptive to messages from LWoH**

Both internal and external stakeholders identified several factors that prevented learning from the project being taken up by other services. With many services facing cuts, particularly in adult social care and the voluntary sector, staff can feel under pressure to focus on day-to-day support rather than strategic development. At the same time, the existence of LWoH as a specialist MCN support service in the city may have demotivated some other organisations from learning more about how to support people with MCN.

Different services and sectors will also have different cultures and delivery models, and may therefore believe that learning from another service is not applicable to them. This applies between the LWoH delivery partner organisations as well as to those outside of it. For example, one organisation was sceptical that the CAT approach used by the ABS could be implemented effectively in a more open environment. Likewise, adult learning providers commented that the extensive support provided to service users by New Beginnings, whilst effective in supporting potential learners with MCN to engage in activities, could not be replicated by them given their lower levels of resource; and that they did not feel comfortable working with learners who exhibited

challenging behaviour. However, this does not appear to be the case across all sectors, with the CCG in particular committing to researching and investing in support for people with complex needs.

*"I think a lot of the learning providers will come back and say it's not rocket science. If you have the money and the time to spend on an individual to build that relationship, then obviously that will make a difference."* Delivery partner

As well as differences in organisational culture, both delivery partners and wider stakeholders observed that some organisations were not receptive to messages from LWoH due to a competitive environment in relevant sectors in the city and resulting negative attitudes towards LWoH. The challenges leading to the service redesign, and the resulting disruption and staff attrition, were perceived to have harmed the project's credibility (as well as affecting the project's ability to disseminate learning). As a result, other providers in the city may not be receptive to messages about best practice coming from LWoH delivery partners.

## **7.5 Delivery partners and external stakeholders were positive about the potential of the new workforce development plan for the sector**

The new iteration of the workforce development plan was received positively by delivery partners, who described how they had been consulted in its development (although delivery partners also have their own training budgets) and given genuine opportunity to highlight the aspects that they considered important. For example, the need for case workers to have knowledge about the Mental Health Act and housing legislation, and to work in a psychologically informed way.

However, there was also some scepticism, as some delivery partners commented that previous workforce development plans had not been communicated properly or given enough time to be fully implemented; this led to concerns that their input would not be actioned. Communications around investment in the plan and resourcing to deliver it has been passed on to delivery partners to emphasise the strategic, joined up nature of the plan and that it is intended to go beyond the lifetime of the project. Wider stakeholders were more positive, acknowledging that while the plan was in its early stages there was potential for impact.

## **7.6 Service user involvement work currently relies on a small number of people, and needs to be developed further**

Service user involvement activity is intended to be at the core of the LWoH project, but there is concern across both delivery and external stakeholders that this had not been incorporated into the project as much as it should be.

### **7.6.1 Service user involvement developments in 2017**

In May 2017, the Service User Policy Statement was co-produced with service users. It provides a framework for service user involvement across LWoH and values and principles to be incorporated by all current and future delivery partners. As part of the continued focus on service user involvement, and as a response to

ongoing concerns about the level of meaningful involvement by service users, a Service User Involvement Manager was appointed in August 2017 by the programme team.

In January 2018, the CSG approved a report produced by the Involvement Manager, which set out key priorities for developing LWoH's service user involvement offer. These included extending the Hub opening hours and improving the venue for the Hub (see section 7.7.2); recruiting a lived experience team to support partners in developing involvement and co-production activities; and creating a more structured approach to involving people with lived experience in scrutiny and governance, in particular to support delivery partners in developing the Community Navigator proposal.

### 7.6.2 Reliance on small number of individuals

Individuals with lived experience of MCN are members of the CSG and have contributed to the new workforce development strategy.

*"At the strategic level, the service user involvement and voice is being much more heard and I can safely say that the two service user representatives absolutely share their opinions around the group and really inform and influence decision making"* Wider stakeholder

However, while these individuals act as valuable representatives of current service users, by means of the Service User Forum and other channels, it is important to acknowledge that they are not current LWoH service users themselves. Moreover, this reliance on a small number of people does not represent best practice in service user involvement and was believed to have put pressure on the individuals concerned.

## 7.7 The profile of complex needs issues has been raised in Liverpool

Delivery partners reported that the LWoH project was now better known across the city, especially in the homelessness sector. However, it was recommended that more work could be done to extend awareness of the project to other services in Liverpool, for example probation, health and adult social care services. Whilst these sectors were represented on the CSG, this had not always progressed to widespread awareness at an operational level. This was corroborated by some external organisations working with LWoH service users.

Stakeholders identified some specific examples of systems changes which they attributed to LWoH. Some of these had already been apparent at the end of the project's second year; for example, the work done by LYMCA and the project more widely was believed to have raised awareness of psychologically informed approaches among services in Liverpool and led to their adoption (for example in the specification of the LCC contract for support to homeless households). Moreover, LWoH was reported to have highlighted gaps in commissioned services such as the lack of hostel accommodation for people with physical health problems. This had resulted in Liverpool City Council commissioning more beds for people with complex needs. These changes are covered in more detail in the year two local evaluation report. Other specific examples of changes are listed below.

### 7.7.1 The domestic abuse test-and-learn pilot has led to a specialist service being created for abusive relationships involving people with MCN

In year three, the domestic abuse test and learn pilot was seen as a potential success story around impact. Stakeholders commented that LWoH had provided an opportunity to improve understanding of the dynamics of abusive relationships involving people with MCN, and led to a specialist service being created accordingly. Moreover, by training staff at agencies working with those individuals, the pilot was intended to influence mainstream service delivery and leave a legacy in the city beyond its lifetime.

*"The idea is that it's sustainable that way, there are a whole load of people in their own agencies who have a much better understanding of domestic abuse, and a therapeutic approach, psychologically informed processes for changing how people behave and supporting them to reduce violence."* External stakeholder

### 7.7.2 The Lived Experience Hub is a positive environment and good opportunity for service user engagement

The Lived Experience Hub is a venue where people with lived experiences can socialise, engage in activities and share experiences. It was funded as a test-and-learn pilot in order to facilitate service user involvement within the programme, and is part of a wider strategic vision around service user involvement (see section 7.6). The hub opened in March 2017 and as of January 2018 is open three days a week.

Activities at the hub have been developed by a combination of delivery partners and service users; they focus on building the confidence of service users and their capacity to speak up and take effective action. So far, activities have included painting and drama courses, capacity-building training<sup>22</sup>, and creative writing courses, which give service users an alternative opportunity to speak about their experiences by means of fictional characters. Plus Dane also ran a housing course at the Hub to inform service users how to raise issues about their housing, as housing was identified as one of the areas where service users often struggle to communicate their needs and preferences.

*"The vision is to build the capacity of services users to speak out for themselves. A legacy of users who can articulate what they want."* Delivery Partner

The Hub provides an opportunity for service users to take steps towards involvement in the programme's governance and scrutiny, if they do not feel ready to participate more actively. For example, service users are able to informally meet and get to know peer mentors, rather than officially enrolling on the Peer Mentoring scheme, and the informal setting and opportunity to meet people has encouraged other service users to consider taking part in the service.

The pilot was evaluated by Big Life, who found that the Hub was successfully acting as a friendly, positive environment where members felt valued. This had been achieved through creating an informal environment by

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<sup>22</sup> This training is intended to develop skills such as communication and team-work and build personal confidence.

having rules such as not being able to wear lanyards or ask personal questions relating to service users' histories, for example asking about previous offending.

The evaluation reported that the Hub was attended by 14 members (service users, peer mentors and staff) each week, on average. These were typically service users who have less severe needs, who are therefore able to attend the Hub independently. However, the Hub is considering ways in which to engage with service users with more severe needs.

### **7.8 The project has had relatively little impact to date on delivery and commissioning; however, the extent of LWoH's ability to influence others may be limited since some key issues are national in nature**

In spite of evidence of increased awareness of complex needs issues, some stakeholders expressed disappointment that, to date, the LWoH project has had relatively little impact on decision-making about service delivery and commissioning in the city; and could not identify any major changes that had taken place to the way that services are designed or delivered as a result of LWoH.

In particular, stakeholders identified missed opportunities to influence the housing sector (via Plus Dane and Riverside), and to influence other services via a workforce development strategy implemented at an earlier stage.

*"It actually comes down to the number of different multi-agency workstreams that are happening, that are all asking for workforce development. And some of the core characteristics and core competencies are consistent across the board, and... [LWoH] has not necessarily been influencing those other agendas as much as it could have. I think it is getting better at doing that and I think there's a real opportunity for the remainder of the programme."* External stakeholder

To some extent, the limited influence described above reflects constraints such as nationally determined eligibility criteria and centralised decision-making, which limit the extent to which services are able to respond to locally generated learning. Moreover, some of the major issues identified are those affecting people with MCN at a national level. For example, while new NHS guidance was published in late 2016 stressing that individuals with severe mental illness should not be excluded from mental health services because of substance misuse, Fulfilling Lives projects across the country continue to report exclusion on the grounds of dual diagnosis as an issue faced by their service users.

Likewise, securing appropriate accommodation for service users is made more challenging by local and national housing shortages. The July 2017 Housing First feasibility study<sup>23</sup> described high levels of unmet need for hostel services in Liverpool, as well as significant "churn" within the system. The Mainstay<sup>24</sup> database

<sup>23</sup> Blood et al., Housing First Feasibility Study for the Liverpool City Region. Crisis, 2017.

<sup>24</sup> Mainstay is a database that stores service user data (e.g. assessment and referral data) for users of commissioned homelessness accommodation and other homelessness support services (including LWoH) in Liverpool.

recorded that 379 people had experienced four or more hostel placements in the last four years, with some having as many as ten different placements in this time period. This may be a reflection of the appropriateness of accommodation available; Liverpool City Council's October 2017 Routes out of Rough Sleeping paper<sup>25</sup> reported service users' concerns about the quality and safety of hostel services in the city. At a national level, in December 2017 the cross-party Homeless Households Enquiry was published, which highlighted the rise in homeless households and the cost of this to the taxpayer; and called for a renewed focus on the increasingly prevalent issue of homelessness.

## 7.9 The CSG is key to developing the project's systems change work, but may have some structural issues

Given the structure of Waves of Hope described in figure 7.1, the CSG will be key to driving forward the project's systems change objectives by making the required links at a strategic level. The restructure of the Core Strategic Group to include higher-level stakeholders was therefore recognised as a useful step forward.

However, stakeholders also identified potential negative consequences of this restructure; some commented that having senior commissioners so closely involved with the programme may have inhibited more experimental ideas; due to commissioners' concerns about sustainability or the potential for defensiveness about prevailing service delivery.

*"I guess maybe the unintended consequence is you limit how radical you are during the five years to keep it safe enough that it's within the remit of the what commissioners may feel comfortable with later on... I think commissioners are very defensive about the policy of existing services – nobody wants to feel that they've been backing the wrong cause or they're not delivering things of a high standard."* External stakeholder

From January 2017, delivery partner managers were also encouraged to attend the CSG. This was intended to increase transparency, but some attendees noted that the increased size of the group could be unwieldy. It was also suggested that dynamics within the CSG may inhibit effective communications, particularly since delivery partner organisations also provide other commissioned services and may therefore be mindful of the need to maintain good relationships with commissioners.

## 7.10 The service redesign process is using lessons learnt to inform a new approach and making links with other local developments

Finally, the service redesign process was seen as an example of effective systems change work, using lessons learned from the first years of project delivery to inform the development of an alternative model of support. The redesigned service is intended to strengthen links with other agencies in the city, and its implementation will involve working closely with LCC's strategy to tackle rough sleeping and street homelessness, which is a

<sup>25</sup> <http://liverpool.gov.uk/media/1356431/routes-out-of-rough-sleeping-report.pdf>

priority for Liverpool mayor Joe Anderson<sup>26</sup>. This is intended to create a model of delivery that is sustainable following the end of the funding for the LWoH project.

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<sup>26</sup> <http://www.independent.co.uk/news/uk/home-news/liverpool-council-rough-sleeping-centre-all-homeless-people-invitation-government-policy-ignored-a8110351.html>



## 8 Recommendations: project delivery

This chapter presents recommendations relating to the delivery of support to LWOH service users, with a view to increasing the effectiveness of this support and facilitating service users' recovery and progress. These recommendations have been developed based on the findings presented in chapters 3, 4 and 5 of this report.

### 8.1 Facilitate access, on a systematic basis, to specialist MH support for people with substance misuse or history of trauma

Consider how the project can facilitate access to specialist mental health support that is able to meet the needs of people with substance misuse issues and/or particularly challenging backgrounds. Provision of appropriate mental health support and improving access to this support should take place on a systematic rather than a case-by-case basis, which will require dialogue with the relevant sectors at a strategic level.

### 8.2 Discuss and plan ending of support from the start to manage expectations and support move-on

Manage service users' expectations about the support they will receive from their case worker by agreeing at the outset the steps needed to move towards their goals, the nature of the support the case worker will (and will not) provide with this, and the ways in which service users are expected to engage with support. This is already taking place at the ABS and should be implemented across the project as a whole. The service user forum has suggested creating an "endings document" for each service user, which would set out such an agreement and explain the length of time over which service users can expect to be supported. The ISS or its successor should continue working to develop such a document.

### 8.3 Ensure activities are as accessible as possible and that service users are aware of this

Ensure that New Beginnings activities are as accessible as possible to service users with a disability or illness; that as far as possible illness or injury does not prevent service users from continuing with New Beginnings activities they had previously engaged with; and that service users are fully informed of accessible options to take part in activities and encouraged to take these up.

### 8.4 Dedicate additional resources to recording and quality-assuring monitoring information

Project data is vital in determining pathways for service users, but outcomes data is often missing for service users and the quality of case notes produced from across the partnership is sporadic. This was acknowledged to result in part from high staff turnover at the ISS. The new Data Analyst should work with delivery partners to develop written and verbal guidance, and delivery partners should ensure this guidance is passed on to staff and that staff understand the importance of good quality data to the aims of the project. Random 'spot checks' should be undertaken across the partnership in order to identify issues with service user data recording early on, and before issues arise at key data delivery times.

## 9 Recommendations: influencing the system

This chapter presents recommendations for how the project can further its ambitions to create a legacy of a more effective system of support for people in Liverpool with multiple and complex needs. These recommendations have been developed based on the findings presented in chapter 7 of this report.

### 9.1 Based on identified priorities, facilitate more widespread service user involvement and ensure that this is flexible and collaborative

Delivery partners should consider how to involve service users who may not wish to, or be unable to, take part in group activities or travel to a central location, and the programme team should ensure that, at a strategic and governance level, service users are represented by current or recent service users of the LWoH project. The newly appointed Involvement Manager should hold relevant delivery partners accountable for implementing the agreed involvement activity schedule. The Lived Experience Hub should capitalise on a good launch and engage with a wider range of service users.

### 9.2 Ensure that service users are not only well-informed about the service redesign but at the centre of shaping it

The service redesign process presents a major opportunity to work with statutory services to create a sustainable and effective support service for people with MCN. However, service users reported being poorly informed about the service redesign and viewed what they knew of the plans with some apprehension. It is of paramount importance to ensure that the service redesign process is not only communicated effectively to service users, but informed by service users' views and expertise throughout. The new Lived Experience Team should ensure that LWoH service users (not just individuals with lived experience) contribute to the redesign at all levels of decision making.

### 9.3 Identify clear messages to communicate, which are based on evidence from the project and which can be applied by other organisations

The systems change work that has taken place in 2017 has created several new opportunities for multi-agency discussion of MCN issues, including the ELL group, Communities of Practice and planned workforce development activities. In order for these opportunities to lead to systems change, it is vital that emerging learning about "what works" is captured by these groups, complementing the work of the local evaluation; discussions should focus on solutions rather than problems wherever possible, and aim to identify examples of best practice which can be adopted by other services.

The ELL group should build on the work they have done so far to establish the priorities for systems change, by continuing their work to determine what the key messages emerging from LWoH are, identify the audiences to whom these should be conveyed, and implement a strategy for doing so, with clear assignment of responsibilities to members of the group.

The learning generated from the project (and the messages related to 'what works') needs to be communicated in an accessible way to a range of audiences. In 2017 the project has increased and developed its range of communication channels, including a website, stakeholder bulletins, events and policy briefings. Building on this progress, and led by service users and key decision makers, the project should develop a communications plan for the final months of funding. These messages should be delivered by credible voices from the project, including CSG members and people with lived experience, in order to maximise opportunities to influence future service design and policies related to MCN. The communications plan needs to consider innovative ways to engage with a range of stakeholders both at the local and national level. In particular, the project should continue to link in to the Housing First pilot and provide evidence to local decision-makers about the importance of housing in supporting recovery.

#### **9.4 Implement workforce development plan at pace**

The latest iteration of the project's workforce development strategy has been positively received, and should be implemented at pace in order to achieve the greatest possible impact within the lifetime of the project. With LCC now appointed to lead the implementation of this plan, there is a strong steer from both internal and external stakeholders for implementation to get underway as soon as possible, in order to meet the immediate needs of frontline staff, challenge negative perceptions of LWOH, and begin to create a tangible impact for other services in the city.

The workforce development plan should link clearly to the Systems Change Framework by providing training to staff on how to share learning and best practice with other practitioners, alongside basic resilience skills training and developing effective ways of working with multiple and complex needs service users.

#### **9.5 Do more to engage with other sectors (not just homelessness) and work together at a strategic level – particularly the health sector**

To date the project has been heavily identified with the homelessness and housing sectors; stakeholders identified a need to strengthen the project's strategic links with other sectors, particularly health, to increase its influence. The CSG is well-placed to take the lead on implementing this recommendation.

#### **9.6 Work collaboratively with city commissioners and service users on redesigning the core support service in order to support a lasting legacy**

The service redesign is an opportunity for the project to influence the way in which MCN support is delivered in Liverpool beyond the lifetime of the project, by developing an approach that provides effective support for MCN and has the potential to be sustainable beyond the Fulfilling Lives funding period. Recent opportunities to collaborate with the city council on developing a service to support the street homeless in the city should be capitalised upon. The service redesign should also be aligned with the project's exit strategy to ensure that LWOH service users have appropriate move-on support in place.