Working with Adults with Complex Needs

– The Victoria Intensive Project (VIP)

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Summary
The Victoria Intensive Project (VIP) was launched in 2017 to work directly with individuals with complex drug and alcohol issues. Embedding a rapid, person focussed approach the team have sought to address the wider socio-economic causes of poor health, specifically around lifestyle choice and substance misuse. Investing time in building positive, trusting relationships – focussing on the needs that matter most to the individual the VIP has resulted in significantly improved outcomes for individuals, including: 82% reduction in alcohol dependency; 81% increase in levels of confidence and self-esteem; and, a 27% reduction in hospital attendances over the period of 12months.

Submission

Strategic Context
Improving health and wellbeing for Stockport residents and reducing health inequalities is a key priority for Stockport, our local community and Partners. Stockport Council has historically worked well across public services and the VCSE to support individuals within our local communities, but with a growing number of residents with complex alcohol/ drug issues and other needs we knew we needed to rethink our approach to better support some of our most vulnerable citizens.

The issue was initially raised by a local GP in the Victoria area of Stockport, who was seeing growing numbers of substance misusers who were neglecting their health and wellbeing and being crisis managed by emergency services rather than accessing other healthcare support. This was subsequently echoed by other local services and organisations and reflected in analysis. Whilst often in contact with a range of services (such as secondary care and the Police) these individuals were not engaging in community or primary care services. As such we knew we needed to work together differently and through this launched VIP which is a neighbourhood-focussed pilot programme targeted at complex drug and alcohol users.

Alcohol in general is a significant problem in Stockport, impacting on the health and wellbeing of residents and the safety of our communities. It places a significant burden on public services, causes health problems, affects the well-being of families, and is a major contributor to domestic abuse, violent crime and public disorder. Complex and dependent users, binge drinkers and those who regularly drink over lower risk limits, all create different demands and challenges on public services. In terms of the number of hospital admissions for alcohol-specific conditions per 100,000 population, Stockport's figure is 855 against an England benchmark of 563. Indeed, for all indicators around alcohol related admissions we are performing significantly worse than the England benchmark, as we are for alcohol specific mortality. We know that admissions related to alcohol are higher in areas of increasing deprivation despite consumption patterns being more equal. This means people in deprived areas are more likely to suffer health impacts as a result of alcohol.

By working across Partners and proactively with individuals VIP supports collective ambitions set out in Stockport's Health and Wellbeing Strategy, the needs identified in the local Joint Strategic Needs

Assessment (summarised above), and supports the local Community Safety Partnership Plan which seeks to address concerns around alcohol and drug misuse.

Funding
Working with a commissioned substance misuse provider, Stockport Council secured initial funding for the pilot from the then Department of Communities and Local Government (DCLG).

The funding allocation has enabled the recruitment of a Complex Needs Link Worker. The initial pilot phase started in June 2017 and ran until to February 2019. Since this point the work has been extended further with funding from the Stockport's local community safety partnership and Public Health. The breadth of funding streams is indicative of the recognised need for support for this group of individuals from across a number of organisations in the Borough.

Stakeholder involvement and project development
Given the complexity of the issues involved and the number of organisations that came into contact with these individuals, a multi-agency project team/steering group was established.

This comprised of representatives from a broad range of Stockport services/organisations and some service user representation. The agencies involved included: Stockport Council – Public Health team, GP and Primary Care, Clinical Commissioning Group, Stockport Foundation Trust, Drug and Alcohol services, GM Fire and Rescue, GM Police, North West Ambulance Service, Master-call, Stockport Homes, H3 Housing project, Adult Social Care, The Prevention Alliance (TPA) and a former local service user who became a volunteer.

Complex needs span many agencies, and each agency committed to being part of the steering group and ensuring their staff work together, are equipped with the skills to support people for whom engagement has in past proved difficult.

We researched other models e.g. Alcohol Concern Blue Light Project, and also used local intelligence to understand the issue overall and scope what could work for this complex population.

Scope of the Victoria Intensive Project
The project is targeted at dependent alcohol and/or substance misusers in a particular area in Stockport whose behaviour challenges services. Whilst the VIP cohort is relatively small (10-15 people on an individual caseload at any one time) they often have highly complex needs. In order to be eligible they must be referred from another agency (e.g. social care, housing provider, hospital) and be drug and/or alcohol misusers who:

- have identifiable barriers to accessing core drug and alcohol services
- are not engaging in treatment services
- have multiple and complex needs
- are not engaging with other organisations/services

The aim is to use a person centred approach to:

- Get the right outcome for the individual concerned
- Reduce demand at the hospital and blue light services
- Increase engagement with community and other appropriate services

The project is designed to:

- Identify the cohort using key data from local organisations
- Engage clients via a community based outreach worker
- Identify client needs and consider potential support options

- Make community / voluntary services more accessible
- Co-ordinate multi-agency operational meetings to review cases and pathways
- Maintain records of client engagement, interventions, and outcomes.

Aiming to deliver the following impacts for individuals and local services:

- Improvements in positive functioning
  (measured by questions derived from Chaos index headings – this includes engagement with frontline services; self-harm (intentional or unintentional); risk to others; risk from others; stress and anxiety; social effectiveness; substance use; impulse control; and housing.)
- Improvements in health and wellbeing (measured by Wemwbs - Warwick-Edinburgh Mental Well-being Scale)
- Increased planned engagement with primary care and community based services
- Positive case studies indicating improved understanding of how to support clients whose behaviour is challenging to local services
- Collateral benefits (including for those considered but not taken on the cohort)

The outcomes being measured for the system include:

- Reduction in hospital admissions per person
- Reduction in emergency department (ED) attendances per person
- Reduction in conveyances to hospital by ambulance
- Reduction in demand/ time on adult social care services
- Reduction in adult social care residential placements or support required.

How the VIP Team Work

The offer comprises of having a link worker in place who deals directly with the person, with the link worker being supported by a virtual team as part of a co-ordinated approach across all organisations involved. The workers in the virtual team are willing and empowered by their agencies to work in a collaborative and different way, and the risks associated with the care and support provided to the individual are shared across all workers / agencies. All people who are part of this virtual team understand and believe in the programme, and are ready to work creatively and in the best interest of the client, this includes stretching and enhancing their traditional roles.

VIP clients typically have highly complex lifestyles and are frequently socially marginalised or disenfranchised. For these people it can be overwhelming to keep appointments, maintain a diary and fulfil other requirements that are key to effective engagement with traditional provision. This has led to this cohort becoming alienated from agencies and, where support is sought, prone to seeking this from A&E, the hospital and primary care on an unscheduled basis, placing demand on resources.

VIP offers an approach that is rapid, targeted and able to respond to need across multiple domains in a flexible manner as it is not limited to any one field. Rather than immediately aiming interventions exclusively at one domain, VIP works by offering an opportunity for the client to simply become accustomed to engaging with support. This is before either involving agencies with a more specialised remit depending on where the greatest need lies, or to involve multiple relevant agencies whilst continuing to co-ordinate support and being a point of access for the service user.

VIP has become a useful resource that exists alongside mainstream agencies. It carries out the day-to-day engagement work for complex individuals who otherwise would be at great risk of dropping out of statutory provision, particularly in the early stages where engagement is fragile. It offers service users support and is flexible to the needs of the individual as they change and shape on a daily basis.

Building Positive and Trusting Relationships
The initial focus was ensuring all key stakeholders were engaged at the outset from local GPs, VCSE providers, community based health and care teams, housing and homelessness colleagues, Greater Manchester Police and Stepping Hill hospital. There were a series of initial meetings and workshops to draw out each agency's experiences, develop an understanding of the issues from each agency's perspective, and agree a shared understanding and vision. By having a shared vision and understanding we were able to secure buy in from key partners at a strategic and operational level, and use this to keep us on message / track as the project developed.

VIP seeks to get individuals, who had declined support on many occasions and mistrusted core services, to engage with this project. Invariably this can be challenging and as such the team spent time building relationships and motivation by adopting a person centred approach and spending time with individuals to understand and address what mattered to them (not necessarily their substance misuse or behaviour at the outset) such as reconnecting with friends or family. The intention was that by developing a relationship with them and helping to support them in other areas of their lives, they were more likely to be in a position to want to address their substance misuse and other health and wellbeing needs. This would subsequently benefit them, emergency services and the community. However, for some people this will be a long term plan as we focus on building trust as well as understanding when is the right time from their perspective to be involved.

Impact and Outcomes
Over the course of 12 months, there were 28 contacts, of which 22 fully engaged.

Data was requested for clients for the 12-month periods before and after starting on the VIP caseload. Where clients do not have a full 12-month period following their project start, data for the available months were extrapolated to provide an indication of the full year.

Headline impacts:
We have seen reductions across the majority of key outcomes including hospital attendance, ambulance conveyances, hospital admissions and social work placements / social worker involvement. In addition, there have been significant improvements in health and wellbeing outcomes.

	Unit	**Pre-cohort 12 months**	**Post-cohort 12 months (extrapolated)**	**Difference (- score is an improvement)**	**% difference**
Emergency Department attendances	*Incidents*	242	176	-66	-27%
Ambulance conveyance to ED	*Incidents*	212	162	-50	-24%
Hospital admissions	*Incidents*	109	88	-21	-19%
Police attending incident	*Incidents*	10	14	4	40%
Residential care	*Weeks*	14	0	-14	-100%
Social Care worker time	*Hours*	2,500	624	-1,876	-75%
Illicit drug dependency *	*Persons*	2	0	-2	-100%
Alcohol dependency **	*Persons*	22	4	-18	-82%

Increased confidence/self esteem	*Persons*	16	3	-13	-81%
Reduced isolation	*Persons*	16	5	-11	-69%
Positive functioning (autonomy, self-control, aspirations)	*Persons*	16	11	-5	-31%
Emotional wellbeing	*Persons*	16	8	-8	-50%

**Non-dependency includes client being stable on prescribed substitute medication*
***Non-dependency includes controlled drinking at non-dependent levels*

Cost Benefits Analysis

We have also looked at cost benefits analysis, using the New Economy tools that have been endorsed by the Cabinet Office and the Treasury. We have based the data on an extrapolated figure of 72 clients and used costs/benefits accrued over a 3-year period. The tools have calculated the following benefits:

Fiscal benefits: £364,238; (2.83 financial return on investment)
Economic benefits: £896,776 (5.50 economic return on investment)

Qualitative information was also considered to give an indication of the programme and the client group. This highlighted the benefits of the project's approach when meeting the varied needs of this complex cohort. For example, in one case, significant effort went into ensuring a safe discharge from hospital and subsequent re-engagement when he became street homeless and at risk of dropping off the radar altogether. In another, VIP was able to undertake intensive work to get him to the stage where he was motivated to access alcohol support this case study is expanded upon in appendix A.

Next steps and sustainability
Funding for this project is secured until September 2022, which ties in with the commissioning cycle for our local drug and alcohol provision. At this point, VIP will become part of the core provision and included in the new service specification.

In addition, we are currently exploring how VIP can develop to support the work of the Adult Social Care Front door. The aim is to enable early identification of those individuals who have been referred to Social Care, who could benefit from a VIP approach before being considered as Care Act eligible.

Appendix 1 - CASE STUDY

A middle aged male was referred to VIP in May 2018 by a local hostel. At the time he was drinking to dependent levels and although he had been known to substance misuse services for over a decade, had struggled to engage over the years and interventions offered had been unsuccessful.

He did not have a GP and felt that residing in the hostel was having tremendous negative impact on his mental and physical health. As a result, he was frequently attending at A&E. When xx met the VIP worker, initial engagement consisted of establishing a positive rapport and encouragement to register with a GP. Once this piece of work had been completed, xx was stabilised on appropriate prescribed medication for his mental health and his wellbeing improved exponentially; with xx gaining weight due to eating properly and appropriately, and establishing a daily routine. He was able to reduce his alcohol consumption as a result of this.

Work then focused on exploring his perceived barriers to accessing support for his alcohol use, and over the course of the next month he became contemplative about accessing Pathfinder (local substance misuse service). This was owing to in depth conversations about treatment that would be available to him, allaying fears about services which were rooted in past negative experiences, and an offer of support to attend a substance misuse service. The VIP worker accompanied xx to his first appointment with the substance misuse service and supported him to engage with the Pre Detox group. He has since been accepted for funding for inpatient detox, and has built up a positive relationship with his substance misuse service keyworker to the point where he now is able to attend sessions on his own.

Discussions with the service users highlight the benefits of the project's approach when meeting the needs of this cohort. In this case study, he noted that without the support of the VIP worker he would not have gone to a substance misuse service for support and got the help he needed. He expressed his gratitude to the VIP worker for being there for him, supporting him at the time when he really needed it and listening to what he wanted (rather than imposing their own views).