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Promoting Independence: Interim Evaluation Report

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Executive Summary

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This report presents the interim findings of an independent evaluation of the Promoting Independence programme. The University of Sheffield has prepared it, under contract to Sheffield City Council (SCC). The findings and interpretations in this report are those of the authors and do not necessarily represent the views of the services or organisations involved in the delivery of the programme.

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Background

The aim of the 'Promoting Independence' intervention is to support approximately 113 service users with severe mental illness (SMI) to move from 24-hour staffed accommodation to more independent tenancies, over a 5-year period. This project, which is being undertaken in partnership with South Yorkshire Housing Association (SYHA), is a key element of Sheffield City Council's (SSC) strategy to commission social care in ways that support personal recovery.

The evaluation brief is extremely challenging in duration, scope and budget and consequently there are limitations for the questions that can be answered. We understand that the need to report on outcomes over the full 5-year lifespan of the project is sacrosanct. We have therefore prioritised this at the expense of other potential aims, including an in-depth examination of cultural changes among providers of residential care for people with SMI in Sheffield.

Following the initial set-up period, the evaluation will be primarily quantitative and focused on tracking outcomes for the cohort of service users identified as potentially eligible for the new service. We propose to achieve significant efficiencies by using routine clinical and service-use data collected and held by Sheffield Health and Social Care Foundation Trust (SHSC), which provides mental health treatment and care for all of the service users in question. This is a cohort with complex mental health and social care needs. As such, they have frequent service contacts, which are all recorded on Insight; the Trust's electronic patient record.

In an update to the original proposal, and based on findings from the initial stage of the evaluation, we are endeavouring to include linked data from the SYHA in the ongoing monitoring plan. We consider this to be important, in order to associate use of mental health services with the customer journey within the promoting independence programme. This will hopefully make the monitoring process more sensitive to nuances such as preventative work and the identification of unmet needs.

An initial, set up phase (Work-stream 1) will be used to design the evaluation framework, define data requirements, secure data access, describe the setting and anticipated benefits (in the form of a logic model), and secure all necessary permissions and governance arrangements. This will be followed-up with two rounds of monitoring of routinely collected data, held in the SHSC electronic patient record; to track service outcomes and the progress towards key goals.

This monitoring work-stream was originally intended to be complete after 4-months. However, it has taken the programme some time to settle into a steady delivery state, and there are still difficulties being experienced regarding Covid-19 precautions. For this reason, the evaluation has concentrated on establishing the programme theory through qualitative exploration. The evaluation activities will now focus on developing the monitoring framework and establishing the necessary permissions and approvals.

Workstream 1: Project set up

The problem: A detailed evaluation and monitoring plan and evaluation framework for the new service is required.

Our solution: In order to achieve this, we will begin by carrying out qualitative evaluation work to understand the programme theory and processes. A process-logic model describing the rationale, linking activities with specific anticipated outcomes, will be developed and refined.

As part of Workstream 1, we will collaborate with the service innovators to begin to identify existing key performance indicators for evaluation and ongoing monitoring. We will recommend and advise on the ongoing collection and management of indicators where there are gaps in data collection.

Workstream 2: Routine data monitoring

The problem: The starting point for any service monitoring or evaluation is good quality service-level outcome measurement, preferably which can be benchmarked against other services. There is also an imperative to adopt the most efficient evaluation design possible, given budget constraints.

Tools have not been identified or developed for ongoing monitoring, and routinely collected data have not been assessed for their evaluability potential. Evaluation activities also require formal ethical and governance oversight.

Our solution: Using data that are routinely collected and sharing evaluation responsibilities with service providers creates significant efficiencies, although this requires careful planning in terms of specifying the data to be analysed and close working with Trust IT colleagues. The further advantage of using routine data is that we will be able to describe (and adjust our analyses for) prior service use among the cohort of service users who are deemed eligible for the new service. We will therefore be able to compare outcomes such as time in hospital or open to mental health crisis service and engagement with care (e.g. numbers of contacts and missed appointments) before, during and after transition from being intensively supported to more independent living arrangements.

By doing so, we will be able to take account of the fact that most individuals in this group will have long experience of using mental health services, including hospital stays and compulsory treatment under the Mental Health Act. For instance, some will have histories of drug and alcohol misuse and/or episodes of serious self-harm. The use of routine data will also enable detailed characterisation of each person's clinical history, diagnosis and treatment. Given the highly sensitive nature of these data, access might depend on obtaining informed consent from each person in the cohort, depending upon whether data are able to be rendered suitably non-identifiable.

We will design and implement data processing protocols for analysis and monitoring purposes. Providing we are supplied with appropriate, good quality data, we will analyse and provide an interim report for these routine data in year-two and a final report covering five years.

Evaluation Objectives:

The following are the main objectives of the evaluation:

1. Work-stream one:
    a. Development of a detailed proposal and project documentation

b. Securing necessary permissions and ethics approvals, including development of a data management plan for qualitative work
c. Description of the intervention and specification of a logic model. This will be done through documentary analysis and by means of interviews with key stakeholders, including the commissioner and project partners (SYHA and accommodation providers)

2. Work-stream two:
    a. Specification of the service provision and clinical dataset (SHSC) in collaboration with the Trust's information department and a programme dataset in collaboration with SYHA
    b. Development of evaluation, monitoring and reporting frameworks
    c. Securing necessary permissions and ethics approvals, including development of a data management plan, for informed consent of customers and access to and linkage of SYHA and SHSC routine data

Methods

The project is mixed-methods and applies Realist Evaluation methodology, with prioritisation given to developing theory that will inform a useful ongoing monitoring system for the development and assessment of the project.

Documentary analysis

Key documents were obtained to inform the initial programme theory development. Documents were subject to descriptive content analysis and Realist synthesis to describe the intended and reported status of the programme and to inform the development of initial programme theory. The analysis was conducted to provide a description of the programme processes and to begin to understand how the programme is intended to achieve the intended outcomes. This also resulted in an evaluation framework, based on key processes and decision-points, which incorporates evaluation questions.

Documents included:

- Annual review
- Live Tracker, Monitoring framework
- Customer Journey
- Meeting minutes
- Quarterly reports
- Programme summaries
- Expression of interest/consent form
- Allocation and key milestones process document
- Modelling and budget spreadsheet

Interviews

10 staff interviews were carried out during February and March 2021. Interview schedules were based on an initial programme theory, which was developed through informal discussions with the project management and documentary analysis.

Interview schedules were designed for specific groups of respondents:
1) Health and Wellbeing Coaches
2) Housing Workers
3) Representatives from SYHA
4) Representatives from SCC
5) Funders and service commissioners

These were designed to test the assumptions from the documentary analysis, elicit new areas of theory or hypotheses, and to test and refine existing hypotheses. Potential participants were identified through discussions with the project management. Selection was be based on their knowledge and understanding of the project and gaining an overall and balanced view of the programme.

Participants were informed of the study, provided with an information sheet and asked to contact the evaluation team if they wished to take part. The evaluation team then re-sent a participant information sheet and consent form, by email and arrange a time and date for the interview.

Due to Covid-19 restrictions, interviews were conducted by video link. Prior to each interview a completed consent form was returned by email to the evaluation team. The interviews were focused on understanding hypotheses about how the project is intended to work in specific contexts to create desired outcomes, or the types of unintended consequences that might come about. 8 interviews were transcribed verbatim and 2 were analysed using comprehensive notes. Analysis focused on intra-case and cross-case thematic analysis. In addition, elements of programme theory were identified and synthesised.

Findings

Documentary analysis

Programme aims

The programme aims to move people from residential or nursing care into their own tenancy. The intended outcomes are to:

- Create financial efficiencies
- Refocus the residential market on recovery and rehabilitation
- Improve the lives of people who use residential and nursing care, now and in the future

Funding and remuneration

The project has £3 million of funding, which will only be repaid if the set outcomes are achieved. These are:

- Move from CQC registered residential or Nursing Care into own tenancy
- Sustain tenancy 6 months
- Sustain tenancy 12 months
- Sustain tenancy 24 months

Each outcome has a fixed outcome payment, confirmed by a panel upon evidence of tenancy. The project has also secured £750,000 life chances fund from the national lottery.

This 5-year project will be funded over the next 7 years. The repayment schedule will over-run the activity by 2 years, due to timing of the outcome measures.

Start date

Contract start April 2019, started to deliver in October 2019.

Eligibility/cohort

People in registered 24-hour homes, which are funded by adult mental health care purchasing are eligible for this service. However, it is recognised that a cohort of people will not be able to make the move out of residential care for clinical or social care purposes. Work was planned with the statutory providers to understand who these people are and to establish an indicative length of stay to assist future allocation panels and help with future profiling.

Key Roles and Mechanisms

Direct mechanisms

The customer Journey (SIB) document states that independent clinical representation will “challenge barriers perceived to be preventing a customer from moving out of residential care”. Which indicates that many barriers, that are assumed to prevent ‘moving on’ from residential care, can be overcome by thinking differently and advocating for alternative approaches.

The mechanisms to achieve this are associated with three roles within the project:

1. **Health & Wellbeing coaches**: building customers' strengths regarding capabilities and confidence. Health & Wellbeing coaches take responsibility for building customers' strengths. These allied health professionals ensure a multi-agency, coordinated approach to health and wellbeing.
2. **Housing Workers**: ensure that the practical elements of 'moving on' are managed, as well as ensuring that the practical skills of customers to manage their own housing are developed (such as financial inclusion).
3. **Peer Mentors**: share their experiences of living out of residential care with teams and existing customers.

Indirect Mechanisms

Capacity-building in existing services will potentially benefit customers who are unable to move on.

- **Training** will be provided for teams responsible for planning and delivering support in strengths based/motivational interviewing approaches.
- **Co-location of Health & Wellbeing coaches** will offer the opportunity for potential customers to discuss moving on.
- **Group sessions** led by Health & Wellbeing Coaches will be available to customers within services

Planned Activity and Economic Model

The plan is for the project to move out 113 people in next 5yrs with an expectation at least 75 people thrive in their own tenancy (approximately 66%).

Modelling expected 2 (base case) people to make the first outcome in year one

Year 1 April 2019 – March 2020 = 3 people made the 1st outcome.

Efficiency savings for 3 people over 2-years: 3 x £41,600 (average cost of a residential placement) = £124,800 pa. £124,800 x 2yrs out of residential =£249,600

Financial benefits for 3 people over 2-years: 3 x £36,200 = £108,600 outcome payments over 2 yrs
36% of 108,600 = £39,096 income from LCF

Costs of direct contact with project workers: 30hrs 1:1 per week x £17.95 x 52 =28,002
Total saving = 249,600 + 39,096 – 108,600 – 28,002= £152,094

The following performance figures reflect the initial programme activity up to Q5 and demonstrate the building of outcomes for the early cohort. Up to date figures will be used to contextualise the monitoring outputs.

The following table describes outcomes up to the end of Q5 of the program (July 2020).

new to cohort contracted 24 pa over 5yrs	outcome 1	Outcome2	Outcome 3	Outcome 4

Qrt 1	4	0	NA	NA	NA
Qrt 2	4	0	NA	NA	NA
Qrt 3	5	1	0	NA	NA
Qrt 4	8	2	0	0	NA
Qrt 5	7	8	2	0	NA

Up to July 2020, 11 people were supported to move from their residential home to their own tenancy. To meet targets the project needed to successfully move another 5 people between July 2020 and April 2021. Failure rates were higher than expected at this point in the model due to 1 death and 1 mental health relapse.

Observed Impacts of the Program

The following have been reported as changes directly related to the activities of the project.

Work with the SCC quality team is exploring opportunities for rehabilitation as they visit housing provision in the city, such as questioning if people can have budgets to buy their own food with the help to cook themselves and safe access to internet via Wi-Fi.

One home has closed nine beds. This is reported to be as a direct result of the project influencing changes in the market.

Five homes (80+ beds) now identify as residential rehabilitation units (not care homes).

One home has deregistered seven beds.

Developments

SYHA are linking with recovery teams and rehab homes to stimulate people joining the project.

Recruiting customers as they move in an emergency (either party terminating) increases the risk of failure. The model is to work with people for up to 9-months prior to their move.

On the other hand, there were some early cases where the project has recruited residents that have terminated their placement and it has been a success. This could be due to the customer having a strong desire to move to their own tenancy and having previous skills to manage the tenancy.

These contrasting experiences have reinforced the process of assessing each case on its own merits, although the preference is still to have a lead in of 3-9 months.

It is not clear whether a formal theory of change model is being used for this assessment. However, the COM-B model seems a possible good fit: including capability, opportunity and motivation to change behaviour.

The impact of Covid has potentially had a negative effect on rehabilitation efforts in residential homes. As of October 2021, this continues to be a problem as many homes have restricted access policies that are still in place.

Evaluation Framework and Programme Model

The following table has been adapted from the program descriptions in the analysed documents. It is separated into the three customer engagement phases (Preparation, Resettlement & Transition) and by the two main program roles (Health and Wellbeing Coach (HW Coach) and Housing worker). In addition to the information extracted from the documentation, we have added columns for Theory/Questions, Contextual Variables and Indicators/Outcomes.

- The 'Theory/Questions' column includes elements of program theories and evaluation questions. These contributed to the development of interview schedules.
- The 'Contextual Variables' column includes factors that might influence outcomes for individual customers.
- The 'Indicators/Outcomes' column describes what data might be useful for ongoing evaluation and monitoring of the key program activities. Some of these are expressed as questions to be explored.

Phase & responsible person	Activities	Theory/ Questions	Contextual Variables	Indicators/ Outcomes
Preparation: HW Coach	Assess ADLs (How? Barthel?)	-Thresholds for inclusion -How are ADL deficits addressed	-Types of ADLs that might be more of a barrier than others	Raising competence/ ability for ADLs or providing appropriate support
Preparation: HW Coach	Co-design action plan: customer, provider, S117 co-ordinator	-Co-design method -Any conflict of interests & how resolved	-How do customers' individual contexts define/ influence the plan	Having an action plan that is successful: requires minimal adjustment
Preparation: HW Coach	Baseline recovery star	-How is the star assessment used	-Are there specific domains that are easier or more difficult to improve on -Are there some domains that have a greater or lesser effect on successful outcomes	Improvements in star domains
Preparation: HW Coach	3-monthly review	-The reviews should pick up on progress and identify any changes to the plan	-Are there patterns in any issues recognised	How the 3-month review effects the success of interventions
Preparation: HW Coach	Assess and arrange for ongoing social care/SDS	-Ongoing social care could be critical for independent living -How is this assessed	-Any barriers in addressing specific care needs for certain customers	Putting appropriate social care SDS packages in place
Preparation: HW Coach	Engage in education/training	-How are education/training needs assessed -What resources are available	-Any barriers in addressing specific needs -Are there patterns of needs recognised	Successful engagement and completion of appropriate education or training
Preparation: Housing Worker	Establish housing preferences and options	-There will be an improved potential for successful resettlement if preferences are met and appropriate options are chosen -Possibly customers' preferences might not align with professional opinion	-Individual preferences -Local availability -Professional opinions	Variety of preferences and options taken into account and acted upon

Preparation: Housing Worker	Identify and address barriers to access	-How are barriers identified and addressed -Assumption that addressing barriers to access will improve success of resettlement	-Types of barriers identified -Ease of identifying specific barriers -Ease of addressing barriers	Record of identified barriers and actions taken
Preparation: Housing Worker	Begin housing registration process/arrange log on process for bidding	-Are there any elements of this process that might determine success		
Preparation: Housing Worker	Apply for any grants/ furnishing arrangements	-Financial input will assist in making housing fit for purpose	-Eligibility for grants -Furnishing needs/ preferences	Grant success Record of furnishing
Preparation: Housing Worker	Financial inclusion work	-Independence depends on being able to independently manage finances	-Extent and type of work required for financial inclusion	Possible checklist of financial inclusion topics
Preparation: Housing Worker	Familiarisation with the area /assets	-Independence depends on feeling comfortable in the area and understanding what it has to offer	-Previous associations with the area/ social environment -Personal preferences and requirements for the area	Are any changes or recommendations regarding suitability of the area made at this stage
Preparation: Housing Worker	Viewing properties & support with tenancy agreements	-Customers might be lacking in competence/ confidence -Mediation with housing providers might help to improve outcomes from these interactions	-Do customers have specific problems with these interactions -Are there specific aspects of agreements that are problematic for specific customers	Recorded difficulty of property viewing or managing tenancy agreements at this stage
Preparation: Housing Worker	Set-up utilities	-Customers might be lacking in competence/ confidence to manage this independently	Is this a notable difficulty for any individuals	Success in setting up utilities as anticipated
Phase & responsible person	**Activities**	**Theory/ Questions**	**Variables**	**Indicators/ Outcomes**
Resettlement: HW Coach	Agree phasing of move with	-To ensure that the pace of change is appropriate	-The priorities and processes of commissioners	Are there indicators of alignment

	commissioners and current provider		and current providers might not coincide with customers' needs	between stakeholders Are delays or accelerated progress of customers recorded
Resettlement: HW Coach	Review plan	-To ensure learning and customer development or changing status are acted upon	-Customers might experience setbacks or negative reactions to the project as well as improvements	Is this a point where any negative impacts or difficulties in transitioning can be recognised
Resettlement: HW Coach	Register with primary health care (PHC)	-To provide independent access to health services and reduce reliance on intermediaries	-Customers will have variable PHC needs and styles of engagement	Registration and use of PHC services Independent access (referral through GP or self-referral) to other health services
Resettlement: HW Coach	Agree ongoing HW coach support	-This longer-term use of resources will impact on throughput but also could be protective against failure of the placement or deterioration of health and wellbeing - Could any ongoing needs be addressed earlier	-To what extent is ongoing support expected - What types of ongoing support are required/able to be provided - Availability will reduce towards the end of the project	- Hours of ongoing support planned and provided - Distribution of support amongst customers
Resettlement: HW Coach	Confirm social care/SDS support	- How well does ongoing statutory support meet customers' needs	- Ability to meet longer-term requirements for care might determine success	- Failures due to lack of adequate ongoing care/ support
Resettlement: HW Coach	Develop Wellbeing Recovery Action Plan	-To manage any exacerbation in condition	- Concordance with action plan in case of exacerbation	- Service-use post resettlement
Resettlement: HW Coach	Continued engagement in education/ training	- What suitable education and training is available		- Training or education undertaken
Resettlement: HW Coach	5 ways to wellbeing assessment	- How is this assessment used to create transition plans		- Inclusion of assessment in Transition plans
Resettlement: HW Coach	Signpost Individual Placement Support	- What placement support is available	- Possibly variable uptake of signposting	

		- How are customers signposted		
Resettlement: HW Coach	Recovery Star	- How is this assessment used		
Resettlement: Housing Worker	Set up rent account & landlord transactions	- Supporting relationships and interactions can help to prevent difficulties		
Resettlement: Housing Worker	Tenancy-ready training	- Addressing final competencies to support independent living	- Variety of different training required	
Resettlement: Housing Worker	Respond to any housing management needs that arise	- Contingency for arising issues		
Phase & responsible person	**Activities**	**Theory/ Questions**	**Variables**	**Indicators/ Outcomes**
Transition: HW Coach	Agree further support outside the project	- How well does ongoing statutory support meet customers' needs	- Ability to meet longer-term requirements for care might determine success	- Engagement with further support - Failures due to lack of adequate ongoing care/ support
Transition: HW Coach	Referral for future support	- How well does ongoing statutory support meet customers' needs	- Ability to meet longer-term requirements for care might determine success	- Engagement with further support - Failures due to lack of adequate ongoing care/ support
Transition: HW Coach	Customer designed transition plan built on 5 ways to wellbeing	- How well suited is the 5 ways to wellbeing assessment for designing transition plans		
Transition: HW Coach	IPS employment support (through other provider)	- Integration/ collaboration with other provider		
Transition: HW Coach	Final recover star	- How is this assessment used		
Transition: Housing Worker	Customer understands how to access future support for any tenancy related matters	- How is future support accessed - What support is available	- How is access and understanding facilitated	- Records of access to future support for tenancy related matters

Qualitative stakeholder experiences

Aims and scope of the evaluation to date

Initially, we conducted a documentary analysis to provide an evaluation framework, develop the underlying theory of the program and understand the proposed theories of change. We then conducted stakeholder interviews, as part of a theory-based evaluation to examine the implementation of the Promoting independence Program. There are a number of topics below that are related to this programme logic, which were tested and refined through the interviews with key stakeholders.

The interview data were coded into seven high-level themes, which each contained sub-themes. These high-level themes are summarised in the table below:

High-Level Theme
Access and appropriate customer identification
Individual customers
Principles, values and design of program
Program structure and processes
Challenges
Whole system
Evaluation information

Theme 1: Access and appropriate customer identification

Eligibility: now or potential for the future

It was stated that most people that express an interest are eligible for assessment. This relies on receiving appropriate expressions of interest (referrals). Eligibility is also linked to support available in the programme. For instance psychological support is reported to have had limited use in the program, but could be useful to take on customers with greater psychological needs.

The difficulty in identifying sufficient numbers of customers raised the **possibility of expanding the cohort**. The following are some areas discussed:

- People who will probably **take longer before they are able to live independently**. There are some incidents of this already, with staged approaches; moving to supported living to further develop independence skills.
- People **receiving drug and/or alcohol services**. However, drug and alcohol services are geographically distant, so there are practical issues in working with these people.
- Possibly start to look at **people in supported housing** to become increasingly independent.
- Revisit the original plan to identify 20 customers through **adult social care**.
- **Elderly people** are considered to be largely inappropriate for the programme, owing to potentially declining ability to live independently and reliance on social support.

- **People that independently move out of residential care**. Possibly work with people that have moved out of residential care without adequate support.

Safety and risk

This theme is divided into two main sub-themes:

1. Actual or evidence-based risks, which need understanding and managing carefully.
2. Perceived risks associated with 'risk-aversion' and maintaining the status quo. This can be on the part of mental health professionals, care home staff and customer's family members and are considered detrimental to appropriate engagement with customers.

This issue is clearly contentious, as whether a risk is considered 'real' or 'perceived' is influenced by an individual's perspective, experience, knowledge of the customer, ability to accurately assess and mitigate risk etc. This view assumes that attitudes towards risk are only associated with the assessment of risk. However, the use of the term 'risk aversion' implies that there are other factors leading to a resistance to change, which are not directly associated with the assessment of risk. These can be such factors as organisational resources, shifting of responsibilities or involvement in previous decisions that are contrary to the ethos of promoting independence.

Actual or evidence-based risks

Examples of evidence-based risks include history of significant deterioration in mental health, specifically associated with not receiving residential care. Additionally, somebody just discharged from hospital might need a period of observation and adjustment, hence the initiation of a 12-month wait. This 12-month wait is being reconsidered, potentially to allow earlier intervention in appropriate cases. Included in this change to process is addressing the question: when is the optimum time and manner to open up conversations about independent living? This is likely to be different for each customer.

Perceived risks associated with 'risk-aversion'

Perceived risks on the part of influential stakeholders, which are, however, considered within the realms of the programme to adequately manage need to be overcome. These can present barriers to initiating work with the customer, or might emerge during engagement with the programme, thereby presenting unexpected challenges.

Family members: One identified barrier is that potential customer's families might be risk averse and present barriers to independent living, prior to or during engagement on the programme. Especially if the customer has been in residential care for several years. Family members can be very reluctant to 'get on board' with the idea that they are not going to be looked after. The difference between being 'looked after' and being 'supported' can be a difficult adjustment for family members.

Care homes: The traditional culture of some care homes is that they are viewed as a home for life, rather than being recovery-focused and potentially temporary, which might cause conflict with positive risk-taking approaches.

CMHTs: Possible 'risk-aversion' could also be a factor in optimum working with mental health services. Questions were asked, for instance, about how much people in the CMHTs know about the project and what it is that Promoting Independence does. Additional workload associated with mitigating risk could be a contributing factor to 'risk avoidance'.

Understanding the program: Indeed, concerns were raised that there could be some misconceptions held by all of these stakeholders about the program that contribute to a more 'protective' attitude. The ethos of the programme was perceived as being substantially misunderstood. This situation was summed up by one of the interview respondents in the following quotations.

> *"we would never kind of put somebody in a situation where…they wouldn't have the care or safe environment… it's about exploring what their strengths are, how we can help to build on them, how we can move forward and looking at different options"*

> *"…automatically assume we're gonna come in and somebody's not… ready for independence and were gonna pluck 'em out and we're gonna put them in their own flat, it totally isn't that"*

Joint working: It was suggested that joint working partnerships should involve decision makers, social workers and people in the field who have been working in a way for many years. This could be achieved by helping partners feel they are part of the programme, and by promoting the understanding that this may not be for everyone in the cohort they work with, but may work for some.

Referral route and initial assessment of suitability

Expression of interest: The expression of interest form is perceived as suitable for someone that has been identified as eligible, right now. This might potentially conflict with programme ambitions for identifying people that might benefit from early engagement and a more gradual process. The referral form is considered relatively quick and easy to complete, which removes referral barriers.

Admission route: Currently there is one standard admission route; people who are placed into residential care, largely from medium or low secure hospitals or wards or a step down from nursing care.

Initial assessment: The initial assessment of suitability for expression of interest includes basic assessment of motivation to want to live independently, identifying the customers' perceptions of their challenges, whether they have considered it before, and their skills and the determination. Then the expression of interest is considered by the decision panel. It was not clear from the interviews how potential customers that are not appropriate right now, but might be in the future, are managed regarding potential future engagement?

Extended pathway: Suggestions were made of the possibility of developing a pathway starting from hospital where there is an expectation of involvement with independent living.

Ways to address the current challenges in the identification of sufficient customers were suggested:

- **Relationships with referral organisations**: Maintaining the profile of the program with potential referrers will be a process requiring ongoing effort. Despite a lot of marketing in the Care Trust, there was a sense that referrals are not becoming routine practice.

- **Client reviews**: It was suggested to have a timeframe for care coordinators to review clients in residential care. The possibility of in-reach to care homes to review people without care coordinators (on the tier system) was also suggested.

- **Pro-active identification approaches**: More pro-active approaches to customer identification were considered to be necessary. Just raising the profile of the project will probably not be enough. It was suggested that perhaps providing the program with lists of people in care homes with names of care coordinators, so that people from the program can initiate conversations. This might also help to raise the profile of the program.

- **Discovering covertly motivated customers**: It was recognised that the customer's attitude to raising the issue of independent living could be an important factor, and different approaches were required for different characteristics. Some potential customers will discuss living independently and be overtly motivated. However, others will not talk about this without prompting, possibly due to being told that they cannot live independently (which might be associated with culture of the residential home or prior communication with health professionals). Discussions might need to be on an ongoing basis, to build confidence etc. This seems to be a difficult judgement regarding how much persuasion should be used?

Linking referrals to capacity

Concerns were expressed about the ability for the program to achieve the expected numbers of customers.

Original cohort estimates: Respondents expressed doubts about the accuracy of original estimates of eligible customers. However, it was accepted that this was difficult to estimate without experience, due to the unique nature of the program. Possible tensions around the timing and preparation were suggested. Before appropriate customers are actively searched for, it is difficult to estimate numbers that are suitably recovery-focused. Care homes could possibly have reviewed their cohorts more extensively, prior to the program start. However, this would have been difficult to achieve, whilst the program was being developed.

Refreshing the cohort: Potentially, moving people from residential care into the program could open up new residential spaces, which could provide additional potential customers. However, not all of these potential customers will be 'recovery focused'. Therefore, there is a possibility of diminishing returns and exhausting the eligible cohort. One respondent stated that the potential cohort might start to run out after 2-3 years, and asked the question; if the cohort is not there, whom should the program work with?

Care home engagement: An additional current limitation on the identification of appropriate customers is the observation that not all residential homes are equally engaged with the program, so most referrals seem to be coming from the same four homes. This problem is currently amplified by Covid-19 precautions, which are restricting access to care homes.

'Failure' and ongoing engagement

Later interviews explored definitions of 'failure'. It seems a little unclear regarding when the program should abandon working with certain customers as opposed to viewing difficulties as temporary set-backs and how these processes might work. It is possible that this is difficult to formalise, as ongoing engagement depends on complex individual and external circumstances, which require delicate inter-professional judgement. It is possible that this issue relates to program capacity and customer numbers and characteristics and is therefore possibly worthy of ongoing attention.

The following quotes illustrate the difficulty of decision-making when extreme difficulties are experienced.

> "…we have to make a decision to pull out, erm, and you know, we leave the offer of if, if things change for you that, … you can contact us at any time. I doubt very much that that'll happen if we reach that point."

> "… he needs to put a little bit of effort in …but this client wasn't ready…to do anything of that sort … I don't think they've discharged him, I think they've left him to think, and then they might, they will visit again, cos they're quite pushy and wanting to come back…And, so, they've just left it be for some time because (mm hm) he said he doesn't want to see them"

Theme 2: Individual customers

Individual barriers

Possibly, the two most commonly considered individual customer situations that might result in difficulties progressing with the program are **relapsing mental health problems and refusal to participate**, which might be due to a number of factors. Exploring individual customers' circumstances and characteristics allowed us to develop details regarding a number of other common themes.

Possibility of history repeating

There were several elements related to the possibility of history repeating, from various perspectives. One respondent suggested that individual history should not be a barrier.

> "nothing should stop someone from moving from a care home if they want to move from that care… whatever their history is, whatever they've done and …if they've got capacity … and the MOJ (Ministry of Justice) say that they can move"

This view closely relates to the ethos and values of the program. However, there were several nuances that should be considered.

Regarding what was known about the customer's history; some respondents had concerns about the extent to which mental health relapses/crises or continued problematic behaviours could be managed and the impact this might have on timescales.

> "in a matter of months, if you think about history, it's going to repeat itself. So working with the CMHT, with the psychologist…, it will, you know, take some time"

> "If self-sabotage is in someone's history, that might be worth considering – this is likely to be a point of panic and anxiety so needs to be considered as likely to repeat"

Where the customer's history might have an impact on their ability to maintain a property (e.g. a history of arson or hygiene problems), or only reside in a certain area (for instance due to legal restrictions) this resulted in additional complexity.

> "there's been incidents of arson… I rang the council up and they was 'oh on our system it says erm indefinite', … he used a word that this person couldn't never be rehoused with the council"

> "where there's a danger of neglect to the property… from hoarding to more kind of significant hygiene issues… we couldn't advocate that without the intervention… not only would it not be ethical it wouldn't be right for the person, to be, you know, forced into that.

> "some individuals may have…ministry of justice restrictions which means they're only allowed to move to certain areas, they can't be in certain areas, so it depends on when we can find accommodation suitable to fit those needs, which you know, generally we can"

An additional way in which history was described as having an impact on the success of the program was the customer's experiences of services. If a customer has been let down by services in the past, there might be a lack of trust and it might take a bit longer to build rapport.

Program processes

Despite the flexibility of the program, it involves the customer engaging in various processes and systems, which might be unsuitable for some people. For instance, engaging with paperwork or following staged processes.

Customer understanding of 'relationships'-based recovery goals

One of the elements of the recovery star described as being potentially problematic with some customers was 'relationships'. One respondent stated that it was sometimes difficult to create goals around this element, as customers sometimes did not have any social contact beyond members of their family.

Differences of opinion between the program and the customer

Despite the customer centred ethos of the program, there were some examples of how this might result in tension. Particularly when the customer had strong ideas of what they wanted. A number of areas were described where differences of opinion between the program and the customer emerged. These included the pace of change, whether goals were considered realistic, the level of support needed and the level of input required from the customer.

Pace of change (too slow for some customers)

For some people wanting change to happen very quickly, a professional stance might need to be taken that they are moving at too fast a pace.

> “she hates living where she’s, where she’s living …we’ve come up to conflict because … she wants to move yesterday and we’re talking with her and trying to…find a way through it where she addresses certain things before she moves”

> “we try and make the actions plans as centred to that person as possible… they’re setting the actions, they’re setting the goals with a bit of guidance from us, it depends on the customer, some will tell you exactly what they want, how they’re gonna do it, when they’re gonna do it”

Perception of customer’s support needs

Other barriers occur when a customer feels they do not need as much support as the program staff or related professionals actually feel they do. Possibly this could be related to the customer presenting themselves as more able than they are for the benefit of program staff (i.e. recipient design).

> “so it’s about trying to strike that balance of making them feel like they are still gaining some independence but making sure we’re not setting them up to fail as well”

Input from customer

Another area of potential conflict is regarding the extent of input expected from the customer. The strength-based approach of the program relies on customers doing daily activities for themselves, which (based on a history of care) they might not be used to.

Resolving these issues was described as relying on advanced negotiating skills. The details about the customer’s wishes, that were recorded in the program documentation, seem to be critical to this process of reaching agreement.

> “there is a way that you can be person-centred and go with that, whatever that person wants, without kind of causing a conflict or like a rupture in your relationship… I think through general conversation you can kind of get to a point where you’re both in agreement about what goes on those sheets”

Ability to cope with changes

Whilst there might be many aspects of a customer’s life that would benefit from change, the ability to work on these could be limited by the individual’s capacity to manage a number of changes at once. One such situation that was discussed is gaining employment. This could result in further areas of tension, when the primary focus is on moving to accommodation where further changes to more independent living might then be possible. It should be noted that the cohort are potentially vulnerable to the destabilising effects of change.

Another situation was described in which a significant personal difficulty in the customer’s life (immigration status) meant that they were unable to manage the additional stresses of engagement with the promoting independence program.

Establishing customer's income and funding support

Securing universal credit for customers was described as causing problems. The housing element was considered very complicated. The move to independent living could result in changes to benefit status, for instance moving from employment support allowance (ESA) to universal credit, and possibly having to apply for severe disablement payment on top of ESA so that customers are not moved onto universal credit. Financial assessments could also impact on the customer's income.

Another potential barrier to independence was described as the cost of providing support. It was not clear to what extent additional service costs, such as mental health support might be a barrier to independent living.

Significant mental health conditions

Related to the previous theme, due to certain behaviours and mental health conditions such as OCD or agoraphobia, some customers were described as potentially requiring 'quite advanced clinical input'. Particularly when they move from the 'comfort and safety of, of a familiar place to be'. Symptoms of mental ill health could mean that the program has to defer to mental health services.

> "if that person wasn't ready, as in they were mentally unwell … there were signs of aggression and violence, that there … were constant relapse signs…but they still wanted to move. … we get guidance from psychiatrists and from the care coordinator. We have to follow their, we have to follow what they…"

Extent and type of family involvement

It was considered to be appropriate to involve supportive family-members. However, this introduced an element of unpredictability, as sometimes family-members (informed by knowledge of what it is like for that person to have some responsibility) might seem 'risk-averse'. This could potentially result in, for instance, all possible accommodation being deemed unsuitable by the family member.

Phased approach

Some customers might not currently be considered appropriate for independent living. However, by taking a phased approach by moving to accommodation where they can practice and develop independent living skills could provide a way forward.

Theme 3: Principles, values and design of the programme

Group work

Although Covid restrictions have put a stop to group work, it is considered an effective part of the programme. It allowed more one-to-one time with customers, had social elements (for instance to help build confidence) and physical exercise elements.

Potential benefits from group work could be to build networks, friendships and confidence. This could also motivate customers by experiencing social interaction outside of the residential care environment. Particularly by bringing people together from different care homes.

Importance of care coordinator

Care coordinators are critical for the operation of the program. One respondent stated that referrals can only be done by a care coordinator. It was also recognised that the contractual arrangement of the program is that people referred into the promoting independence team should have a named Care Co-ordinator. However, capacity issues regarding the availability of care coordinators to engage with the program were recognised.

> "CMHTs are under that much duress that allocating a Care Co-ordinator to this project… is contesting against you know, say possibly a client who maybe sort of, who is at far greater risk"

Important aspects of recovery star

Whilst all aspects of the recovery star were considered important, the managing mental health aspect was considered particularly useful, because it encourages people to consider and reflect on their own mental health. The living skills aspect of the Star was considered key in someone moving forward to then living independently, to help build on those living skills.

Personalised approach

Many of the same topics in this sub-theme coincide with those discussed in the section about individual customers. However, there is also value in considering how the program responds to individual needs and circumstances. For instance using flexible approaches to overcome some customer's aversions to paperwork and engagement with formal process. Sometimes there are clearly tensions between focusing on the customer's wishes and what the program team think will realistically work, and these need to be managed sensitively to achieve consensus.

Programme roles working together

Whilst this sub-theme is mostly focused on **how the Housing Workers and Wellbeing Coaches work together**, there are some interesting findings regarding the ways that these roles interact with the wider system.

Despite having separate housing plans and wellbeing plans, close and effective team-working between the Wellbeing coaches and Housing Workers and customers was reported; "we always make a point of kind of highlighting … that the three of us are a team". This rapport was reported to be developed during the initial 6-weeks as 'necessary paperwork' was completed together.

Even though Housing Workers take on more of the work with the customer at certain times, continuing wellbeing work and close communication can quickly help to address emerging issues, especially when customers have negative responses to change.

One respondent considered that the balance between Wellbeing coaches and housing Workers could be refined towards a stronger concentration on wellbeing and this could increase the number of clients per housing worker.

The skill and experience of the Housing Workers was praised as an essential driver to keep momentum towards achieving customers' goals.

Working with care homes: A contrast was described between the care providers in the 'consortium' that were recovery-focused and strengths based in their approach and ones that did not align with the ethos of the program.

Relationship with the Care Trust: A disconnect was reported between the promoting independence team and the CMHTs. Co-location was suggested as a possible way to address some of these issues. Co-location could help to raise the profile of the program. A danger was reported that the lack of consistent presence amongst mental health teams could lead to potential problems with misunderstanding the relationship between the program and Care Trust.

An incident was described, which highlighted a misunderstanding between the mental health services and expectations of the expertise within the Promoting Independence team, specifically the housing workers involvement in mental health assessment.

The intervention depends on effective communication between the program and care coordinators, and open lines of communication were reported. The programme has since taken moves towards introducing co-location.

Motivational Interviewing and strengths-based working

Strengths-based approaches seemed to be firmly embedded into the project and were referred to throughout the interviews with programme staff. The following quotation is representative of the ways that strength-based approaches within the program was described.

> "we would never kind of put somebody in a situation where you know they wouldn't have the care… or safe environment you know, it's about exploring what their strengths are, how we can help to build on them, how we can move forward and looking at different options"

Unique aspects of program

Whilst some similar types of projects were described. There were substantial differences described with previous or existing services, which highlighted the unique aspects of the program. Key differences were the focus/aims, the cohort, staff skill-mix and support provided.

- The provision of the service through the housing association was considered one of the elements that contributed to being able to deliver a unique service, specifically having a good organisational history in terms of peer mentoring and volunteer opportunities.
- The enthusiasm and motivation of the team to promote independence was recognised as a unique focus. The long-term involvement was also seen as an unusual, yet essential part of the program.
- Importantly, the program fills a gap in services for people that do not want to continue living in residential care and might take action to move out without support, which could pose significant risk for that person.
- The rehabilitation focus of the program for this cohort was also seen as unique, and was discussed as an attitude that would benefit the system if it were spread to other organisations and services.

Organisational & program goals

The goals for the program were reported to differ from one organisation to another. However, it was not entirely clear what might constitute success or failure from all perspectives. Questions were raised regarding the ability of the program to save costs. This aspect is particularly complicated as the program is a system-wide intervention, which transcends many organisations and services. Therefore, additional costs in one service might result in savings in another.

Questions currently are being asked about whether the initial cohort will need to be redefined, which could influence the goals of the program.

The funders seem keen primarily to learn from the experience. Another potential ambition is to better align the priorities and processes of commissioners and providers with customer's needs.

Interestingly, one respondent noted that an alignment of four key goals might indicate that the program has been an unquestionable success:

- High success rates
- Positive client feedback
- Commissioners happy with value for money
- Shift the way we think about residential care (from the last step to the start of something else)

Theme 4: Program structure and processes

Assessment and preparation

Whilst respondents seemed to clearly understand the aspects of the assessment and preparation that they were involved in, there were other aspects that they did not have first-hand experience of and were more mysterious. For instance initial eligibility criteria, and the acceptance requirements if the case is assessed by the panel.

Initial 6 week stage

The initial six-weeks are considered an important time to work through the recovery star, set goals, decide what sort of accommodation might be suitable and create rapport with the customer and between other team members. This is a time when the Housing Workers and Wellbeing Coaches work closely together. From this point, the Housing Workers tend to have less of a role, until engagement with the practicalities of moving.

Review stages

Opinions of respondents differed regarding the formality of the review that occurs at three months. However, the recovery star is usually not reviewed at three-months. Then a more extensive review happens again at around six or seven months, or before the transition phase.

Timing of stages

The documentary analysis defined three stages of the program, from Preparation to resettlement and transition. Some program staff members seemed to have a different view of the order of the program

stages than is described in the program literature. This is probably due to difference of opinion regarding the definitions of the stages rather than what these comprised.

> "I wonder if transition in my mind is transition is residential to the independent living or whether transition in your case is out of PI (Promoting Independence)"

The formalising of the timing of stages in terms of nine months preparation and two-years of ongoing support had tensions with the personal focus of the program and the individual needs and circumstances of each customer. This meant that the timing of stages could actually be flexible. There were reports of customers moving sooner than nine-months or taking longer.

> "even though it's nine month preparation and move, and two years continued support it doesn't kind of follow like that, not … one size fits all"

> "when somebody's moved whether its nine months or ten months, eleven months… we continue to work with them for two years alongside the care package"

In terms of delays to resettlement, customers requiring additional support was recognised as a possible reason.

> "if the individuals got something like … learning disability alongside mental health that can sometimes take the individual a little bit longer to get their head around processes with us and we just have to adjust to that which is fine, so that can sometimes mean they need a bit more in terms of support"

System-based issues were identified regarding the lack of control that the program can experience regarding the timing of resettlement.

> "I think the things that normally, for people who are quicker that can be that it's out of our control sometimes. So because we don't oversee or take the lead on that person's care that decision may be taken outside of our decision making. So, like I said earlier the Trust really hold the line with. There's a care coordinator come in and said …'I think we should look at a two month transition plan for you to move out'. We can try and navigate that sort of issue but equally we don't have a real standing to say 'well actually we think they need this long'"

Theme 5: Challenges

- **Covid restrictions:** the availability of staff and ability to go out to provide support was identified as a challenge; working online was not felt to be as effective. Staff were not able to work physically in the same space as much as anticipated and group activities could not take place, which reduced efficiency. The whole system was affected with examples of vacancy changes not happening as much as possible, limited access to residential settings and increased demand and reduced staffing capacity. It was reported that customers sometimes felt safe in their existing home and were reluctant to move.
- **A lack of other staff and capacity in other parts of the system was highlighted as a barrier.** For example, lack of CPN, lack of interpreter, lack of financial support (nationally and locally administered) and the lack of suitable housing.

- **Significant barriers that were repeatedly mentioned included lack of care co-ordinators and mental health service capacity.** The lack of care coordinators in the system was identified and this resulted in delays for people going through the transition process. Lack of capacity in mental health services was felt to affect the PIP through staff not having time to engage with the project or provide sufficient input to customers. As well as a lack of sufficient specialist capacity for some customers, it was felt that these customers were perhaps less risky for mental health service staff and as a result did not get the input they needed. As previously mentioned, there were also reports linking to risk tolerance; it was felt that lack of staff capacity might be contributing to a reluctance for moving customers out of 'safe' settings because of the additional work it might create.
- **Lack of additional mental health support.** Although the programme was supposed to have a method for purchasing additional specialist input, this had not yet been utilised and it was reported that it wasn't possible to try some additional support even if that might be the difference that meant someone could remain independent.
- **Individual customer challenges.** As previously described in the section on individual customers, such circumstances as specific past offences were a barrier to some types of housing and support and move-on. The potential for 'self-sabotage' was also identified and the additional challenges and skills customers required to manage budgets and themselves and their lives.

Theme 6: Whole system

- **Personalisation or payment driving process & practice?** There was a perceived tension between a personalised approach and a payment schedule linked to time-lines. Concerns were expressed about whether the payments might drive process rather than practice and needs driving process.
- **Flexible partnership:** The partners have been flexible enough to consider changes to the payment schedule (Covid was expressed as the reason for the change being needed – so an external reason)
- **Risk-share between partners:** Some respondents expressed a feeling that perhaps there was too much risk put onto the provider with the previous rate card not having an 'engagement fee'. There was a tension between this and a desire to spend public money only on 'success'.
- **Flow and planning of the capacity across the whole system needs to be managed as a system.** At present, respondents described a system that seemed disjointed. A shared understanding of what capacity is available would be helpful to integrate elements of the system. There was also a suggestion of jointly and proactively reviewing the full list of people who might benefit through a panel to see whether potential customers should be referred, rather than leaving up to individuals to make a referral.
- **The programme needs to be jointly owned with shared processes that are assimilated and embedded in all organisations.** Respondents described the preference for a shared process rather than separate but joined-up processes. The programme was described as feeling like a 'bolt-on' to current services, rather than feeling integrated into pathways and processes.
- **The range of support needed and available is a potentially limiting factor in success.** There are a wide range of customers' needs and some variability of available housing. However, it is not clear whether these match. Limited capacity in different parts of the system (e.g. care co-ordinators) and other gaps identified in the Challenges theme have potential to limit the success of the programme.
- **A recovery mind-set and philosophy across the system is an aim.** Whilst the strength-based ethos of the programme seemed uniformly understood and practiced. Some details around what a recovery mind-set means are still being articulated, some ideas explored were about a spectrum

of what recovery means, a personalised approach to it, and not a straight-line journey. Communicating this idea can be challenging. Difficulties were expressed in the programme falsely being seen as a 'move-on' service and being able to get staff across the system to spend the time to understand the goals and ethos of the programme.

- **A potential limitation to shifting to a recovery mind-set is national policy & governance practices.** An example of the CQC inspections was given. The CQC was seen as only being interested in safety, rather than promoting independence or other more holistic areas of wellbeing.
- **Funding and risk tolerance were also identified as potential barriers.** Risk tolerance is covered elsewhere and funding is connected to the flow and planning of capacity being managed at a system level rather than individual organisational budgets driving or influencing decision-making.
- **A potential enabler is where individuals are committed to the same agenda.** An example was given of commissioners bringing different budgets together to support the same agenda.
- **Different perspectives from different partners.** There is a question about where different perspectives make the programme better or worse that it would be interesting to continue to explore. Additionally it would be useful to explore where specific partners contribute to the customer journey.
- **Can this programme catalyse broader system change beyond the specifics of the programme?** For example shifts to more investment and capacity in prevention, or better use of public funds, better contracting/commissioning. What this looks like in practice could be explored further. It would be useful to monitor whether people have started to think differently and whether there is a strong group of partners for future collaboration.

Theme 7: Evaluation information

During the interview process, we were keen to explore areas that might help to inform the evaluation or ongoing monitoring of the program.

As part of the ongoing program evolution, a recording process has recently been put in place to record reasons for delayed resettlement, which goes beyond 9-months.

As discussed earlier, definitions of success and failure for each of the main stakeholders could be quite different. This should be taken into consideration in terms of the relative priority of outcomes.

One of the respondents mentioned that it would be useful to have a process map of how different organisations, departments and services worked with the cohort. Another respondent said that it would be useful to have some information about the longer-term quality of life of customers.

Involvement of mental health services might not necessarily indicate problems encountered, alternatively, appropriate mental health interventions could indicate improved working relationships between organisations. Therefore, the details of involvement of mental health services is important, particularly if this is preventative, by helping a customer to become engaged with the program, overcome specific times of stress related to resettlement or assist with setting up ongoing monitoring and support.

> "I think having a clinician…to come out… and have a chat with them and say 'actually I think you can live independently in the next nine to twelve months' you know 'and this is kind of my rationale around it and I think working with Promoting Independence would be a really good

> stepping stone for you'. That type of language would just give us a massive boost to start working with people. Because some barriers we have at the minute are that people who have come from a forensic background don't think it's supported by the clinician"

> "when they move out it depends where they move to and it's about us and the care coordinator or named worker establishing those new partnerships with the provider, to say well this is what their mental health looks like, these are some concerns we have, you know, around, this is what a decline looks like"

Additional services might also be required, owing to issues recognised by the program but not as a direct result of a customer's response to becoming more independent. Therefore, in the case of additional service use, the issue of attribution is highly important, but also highly complex to unravel.

> " if somebody's mental health does decline to a stage or they're not having the right support, or they're not receiving the right support, we need to act on that because, you know, that's why we're here. … But it doesn't come without its own significant challenges… because…, we're not the lead in any of this. We're kind of the bolt on for existing services of each one. Some of those existing services don't want us"

From the point of view of evaluation and ongoing monitoring, any changes in the cohort, such as increased incidents of drug or alcohol use will need to be taken into account. In particular, additional agencies or services could become more centralised as key stakeholders. The relative responsibility of different services could also become an important issue.

> "we haven't seen a lot of issues around drugs and alcohol substance misuse from people who've moved out, that hasn't yet been an issue. But as we start working with new people or people, that might be a presenting thing that we need to look at in terms of support"

> "substance misuse in that regard… we would make those referrals to those sort of agencies … to get them the support, but again its finding where our balance, is that a care coordinator role, is that a Promoting Independence role? Is that a provider role? You know we're trying to find the subtlety of who leads on that. Because it could be all three of us… None of it's done in silo"

Process Diagrams

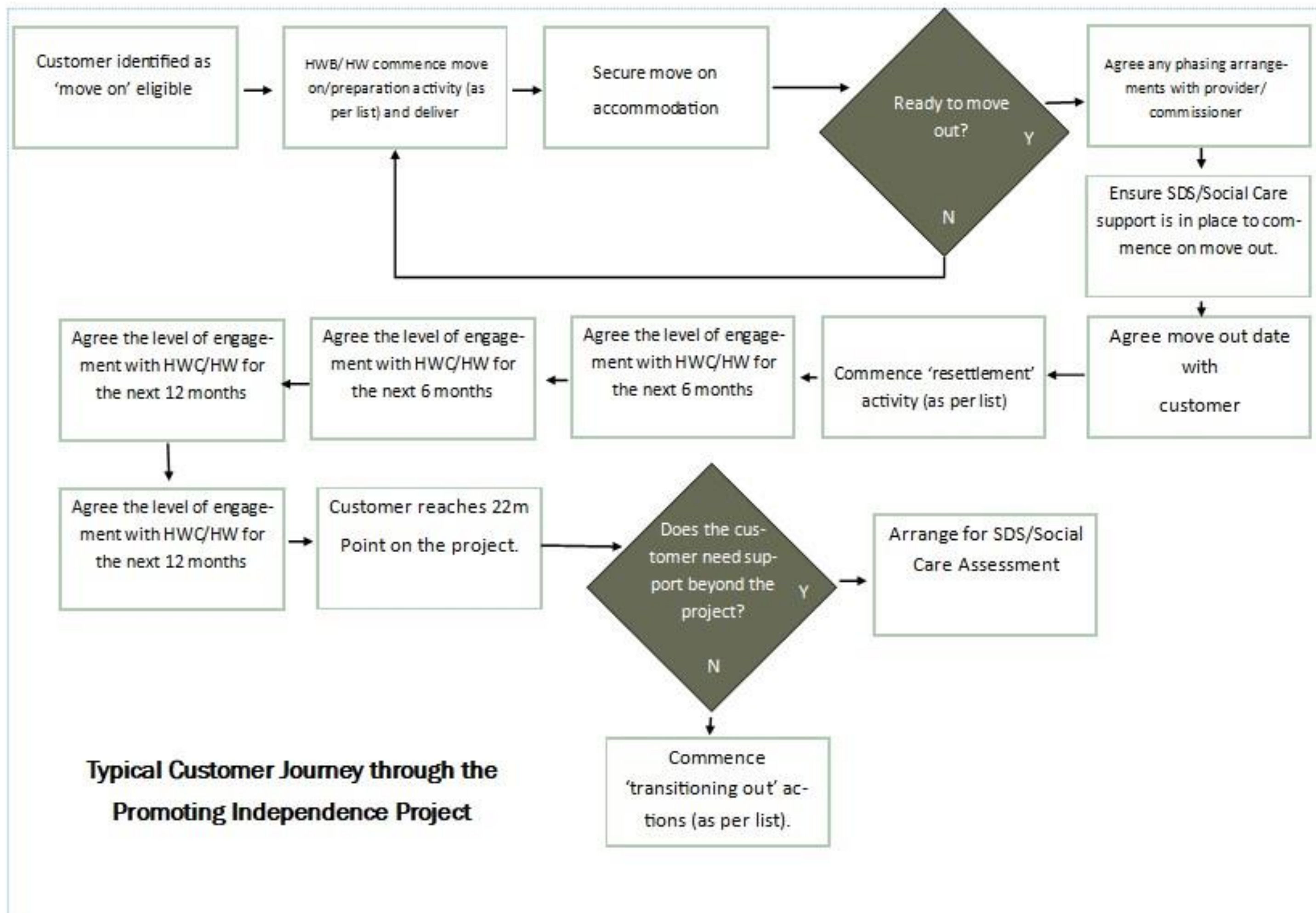
Process diagrams have been developed for discussion and refinement. It is intended that these will be useful tools to understand the programme framework from the following three perspectives:

- From the perspective of **the service**
- From the perspective of **the customer** using the service/s (NOTE: this will need to be developed based on information from customers, which have not yet been consulted)
- From the perspective of **the system**

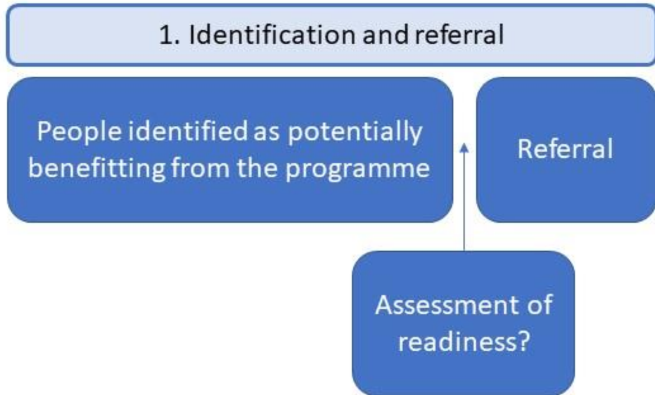
We will be refining these models initially by asking the following questions:

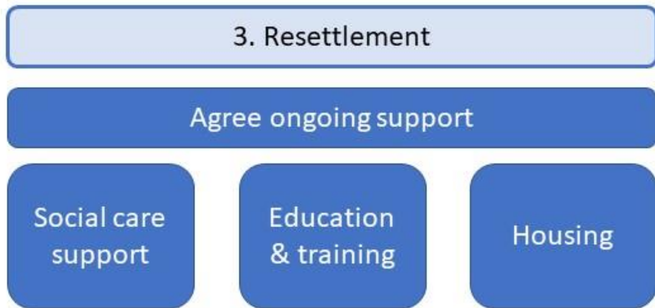
1. What is missing / wrong / needs changing about these diagrams?
2. Could we add on to the map all the departments that 'touch' the path / journey? so we can see who is involved where?
3. Can we use the maps to identify the data that we would want to collect for each of these aspects of the programme?

Customer **Perspective**


Customer identified as 'move on' eligible
HWB/ HW commence move on/preparation activity (as per list) and deliver
Secure move on accommodation
Ready to move out?
Y
N
Agree any phasing arrangements with provider/ commissioner
Ensure SDS/Social Care support is in place to commence on move out.
Agree move out date with customer
Commence 'resettlement' activity (as per list)
Agree the level of engagement with HWC/HW for the next 6 months
Agree the level of engagement with HWC/HW for the next 6 months
Agree the level of engagement with HWC/HW for the next 12 months
Agree the level of engagement with HWC/HW for the next 12 months
Customer reaches 22m Point on the project.
Does the customer need support beyond the project?
Y
N
Arrange for SDS/Social Care Assessment
Commence 'transitioning out' actions (as per list).
Typical Customer Journey through the Promoting Independence Project

Service **Perspective**





System **Perspective**

People who have used or would have used nursing / residential care are living independently and meeting their own goals for health & education

MDT

Strengths-based approach

Enough time and support

Active role in own support

Peer support

Organisations in the system take appropriate risks

Residential market focused on prevention, recovery and rehabilitation

Strengths based training

Peer supervision in strengths based working

What else?

Financial efficiencies and learning about effect of social investment and public service reform

Partnership working for the benefit of the system

Enough appropriate referrals

Roles of each partner in the programme and system

Organisations in the system take appropriate risks

Monitoring and metrics

We had originally intended to only use SHSC Trust data to monitor the service-use of customers. However, as a result of the initial findings from the qualitative interviews, it has become apparent that the rate of progression through the program and points at which customers can get stuck or progress rapidly are very individual. Consequently, interventions are not following the ideal timeframe of nine months, with reports of customers moving before the nine month milestone or taking longer. Relying solely on the Trust data is therefore insufficient, as not enough context is available to understand how each customer's data maps onto their intervention (e.g. start and end dates, failure points, delays, recognition of issues etc.). Accessing service-use data directly from SYHA will provide this context and allow for a mapping exercise between a customer's programme timeline and their routine clinical data. This could indicate if there were any trigger points or reductions in service use associated with the programme.

Arriving at this decision following the analysis of interview data has delayed the commencement of the monitoring phase. However, this is not anticipated to have any longer-term negative effects on the outcomes of the evaluation, as once the necessary data sharing agreements are in place and customer consent has been obtained, we intend to collect all the required information back-dated from the point each recruited customer started on the programme.