Evaluation of Community Renewal’s Health Case Management Service in Craigmillar, Edinburgh

Report

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**Acknowledgements**

Thanks go to the clients and staff of Community Renewal and other third sector organisations who took part in questionnaires and interviews. This work was also supported by John Palmer (NHS Lothian, Edinburgh Community Health Partnership), and supervised by Dr Dermot Gorman (Consultant in Public Health Medicine, NHS Lothian).

The case report and “Client Hopes and Goals” was provided by Ursula Donnelly (Health Case Manager, Community Renewal) and the remaining text by Dr Janine Thoulass (Specialty Registrar Public Health, NHS) with contributions by Ursula Donnelly, Paul McColgan (Chief Executive, Community Renewal) and Nigel Green (Co-ordinator, Community Renewal).

# Executive Summary

Since 2011, Community Renewal, a not for profit organisation, has been providing Health Case Management Services to clients in Craigmillar, one of the most deprived communities in Scotland. This programme is funded by Edinburgh Community Health Partnership with the aim of addressing health inequalities.

This “Case Management” approach focuses on the 10% of the population regarded as being highly vulnerable with “multiple life-wrecking” issues. The Health Case Manager supports individuals or families with multiple and complex needs to co-ordinate input from multiple agencies.

This report provides a formative evaluation of the first year of this intervention. It aims to provide information for the future development of the intervention both within Community Renewal and other organisations which may wish to emulate this approach.

Methods used, included qualitative interviews with clients and key stakeholders, client satisfaction questionnaires and review of routinely collected information.

Several key themes emerged from the report. Awareness of the intervention in the community and other organisations was essential in getting traditionally hard to reach clients to engage. Development of the therapeutic relationship between the health case manager and the client was key to the success of the intervention. This required a lengthy engagement period and the first six months of the intervention was felt to be typical of the time required to do this, and eighteen months required for the intervention to have its full effect. The clients targeted by this intervention represented the hardest to reach clients that have failed to engage with other services. Despite the pro-active approach by the Health Case Manager a proportion still failed to engage. Further work is required to address this area. Building relationships and networks with other agencies was key to success of the intervention. Shared values and ways of working were integral to this collaboration. For those clients who did engage, the intervention was described as being life changing. Outcomes included addressing mental and physical health issues, drug and alcohol dependency, housing and financial problems and building social networks.

The future of the intervention has been financially secured over the next three years. Through collaboration with other organisations there has been a rising demand for the services of the Health Case Manager. This is being addressed through provision of support to other organisations to incorporate elements of the Health Case Manager approach to their own work. Whilst future summative evaluation will be needed to fully evaluate the impact of the intervention, this interim evaluation provides valuable information for the future development of this programme.

**Contents**

[Executive Summary 3](#_Toc379798628)

[1 Introduction 6](#_Toc379798629)

[1.1 Background 6](#_Toc379798630)

[1.2 Brief 6](#_Toc379798631)

[1.3 Research methods 7](#_Toc379798632)

[2 Setting 9](#_Toc379798633)

[3 Overview of the Health Case Management approach 10](#_Toc379798634)

[3.1 Description of case management approaches 10](#_Toc379798635)

[3.2 Health Case Management at Community Renewal 12](#_Toc379798636)

[4 Client satisfaction questionnaire 16](#_Toc379798637)

[5 Analysis of quantitative data 17](#_Toc379798638)

[5.1 Characteristics of Health Case Manager referrals and engagement 17](#_Toc379798639)

[5.2 How did people find out about the Health Case Manager service 19](#_Toc379798640)

[5.3 Socio-demographic information 20](#_Toc379798641)

[5.4 Issues identified by referrals for action 21](#_Toc379798642)

[5.5 Service activity 22](#_Toc379798643)

[5.6 Referrals from the Health Case Manager to other agencies 24](#_Toc379798644)

[5.7 Services provided directly by the Health Case Manager 26](#_Toc379798645)

[6 Analysis of client views 28](#_Toc379798646)

[6.1 Deciding to come and see the Health Case Manager 28](#_Toc379798647)

[6.2 Motivating factors for staying engaged 29](#_Toc379798648)

[6.3 How seeing the Health Case Manager supports engagement with services 30](#_Toc379798649)

[6.4 How provision of the service is perceived 32](#_Toc379798650)

[6.5 Clients perception of the impact on their life 33](#_Toc379798651)

[7 Analysis of stakeholder views 35](#_Toc379798652)

[7.1 Finding out about Health Case Manager 35](#_Toc379798653)

[7.2 Referring to Health Case Manager 35](#_Toc379798654)

[7.3 Health Case Manager role 36](#_Toc379798655)

[7.4 Working practices 39](#_Toc379798656)

[7.5 Liaising with other organisations 40](#_Toc379798657)

[7.6 Why clients fail to engage 42](#_Toc379798658)

[7.7 Health Case Manager attributes 43](#_Toc379798659)

[7.8 Health Case Manager resource requirements 44](#_Toc379798660)

[7.9 On-going support 44](#_Toc379798661)

[7.10 Difficulties for the Health Case Manager role 45](#_Toc379798662)

[7.11 Client drawbacks 46](#_Toc379798663)

[7.12 Disengaging from other agencies 47](#_Toc379798664)

[7.13 Discontinuing the Health Case Manager input 47](#_Toc379798665)

[7.14 Future for Health Case Manager service 48](#_Toc379798666)

[8 Additional evidence 50](#_Toc379798667)

[8.1 Cross sectional case studies 50](#_Toc379798668)

[8.2 Case study 51](#_Toc379798669)

[9 Discussion and Conclusions 52](#_Toc379798670)

[9.1 Difficulties with the evaluation 52](#_Toc379798671)

[9.2 Finding out about and first contact with the Health Case Manager Service 53](#_Toc379798672)

[9.3 Engaging with the Health Case Manager 54](#_Toc379798673)

[9.4 Impact of the Health Case Management service 58](#_Toc379798674)

[9.5 Service activity 59](#_Toc379798675)

[9.6 Working with other agencies 59](#_Toc379798676)

[9.7 Services provided directly by the Health Case Manager 61](#_Toc379798677)

[9.8 Health Case Manager resources and requirements 61](#_Toc379798678)

[9.9 Monitoring and evaluation 63](#_Toc379798679)

[9.10 Costs and benefits of the Health Case Manager intervention 63](#_Toc379798680)

[9.11 Future of the intervention 63](#_Toc379798681)

[10 Recommendations 64](#_Toc379798682)

[11 Conclusions 65](#_Toc379798683)

[12 Action Plan 65](#_Toc379798684)

# Introduction

Background

Edinburgh Community Health Partnership aimed to develop a programme to address health inequalities in Craigmillar with a focus on coordinating support to individuals receiving input from several agencies concurrently.

£50,000 was available to spend in 2011/12. The Health and Wellbeing sub-group of the Portobello and Craigmillar Neighbourhood Partnership determined that this should be used to allow Community Renewal to provide their case management services for 1 year. Community Renewal is a not for profit organisation with a focus on employability and more recently health in deprived communities.

This “Case Management” approach is to focus on the 10% of the population regarded as being highly vulnerable with “multiple life-wrecking” issues. This can either target an individual or family with needs that require input from multiple agencies. The aim is to support them with one worker – the Health Case Manager who can co-ordinate this input.

Community Renewal had been working in Craigmillar for two years (Muirhouse from April 2008 and Craigmillar from November 2008) prior to the commencement of the Health Case Manager post. Health Case Managers have been employed by Community Renewal in Edinburgh over the past 4 years though not continuously due to funding.

The most recent Health Case Manager has been in post since June 2011. The Health Case Managers employed by Community Renewal to date have come from either nursing or counselling backgrounds. Uniquely for the current Health Case Manager, there is not an explicit employability target attached to the role. The current post is full-time.

At present clients are drawn from the whole of Craigmillar which has approximately 8,750 residents. These clients are identified by several means including “Listening Surveys”. The aim is to see 40 clients over the course of a year with a caseload of 20 clients at any one time.

Evaluation of this project is being undertaken in response to a request for support with this from Edinburgh Community Health Partnership and Community Renewal. The scope of the evaluation was developed iteratively in discussion with stakeholders.

Brief

The objectives of the evaluation were identified as the following

* Process evaluation of Community Renewal’s “Health Case Management” intervention used in Craigmillar
* Evaluation of activities, outputs and outcomes
* An evaluation of the costs (if possible within constraints)
* To provide information for the project stakeholders, providers and funders for development and implementation of the “case management” approach

Research methods

The Health Case Management service is a complex intervention and the evaluation was intended to be formative. Therefore the most appropriate approach is to use both quantitative and qualitative methods. Given that the minimum time expected for engagement to see results is 18 months, the evaluation took a focus on process and early outcomes. Project scope and tools were submitted to the South East Scotland Research Ethics Service, which determined that it did not require ethical approval. This is a service evaluation and does not constitute research.

Setting

Community, Craigmillar, Edinburgh

Target population

Clients using the Health Case Management service established at the Craigmillar venue, stakeholders and service providers.

Time period

The evaluation covers the time period from inception of the post in June 2011 to end June 2012.

Methods

1. Review of project documentation and interviews with project service providers and stakeholders to describe the project

The Health Case Manager, Community Renewal Director and Community Health Partnership lead were asked for relevant background and project documentation. This was read and summarised as appropriate for the report.

1. Quantitative analysis
2. Collation and analysis of existing data, collected since project inception
3. Complementary data collection to inform on processes and outputs

A case report form was developed iteratively that collected information on client characteristics, referrals made and services provided directly by the Health Case Manager. This form was completed by the Health Case Manager and the researcher. It required collation of information from a range of sources including client files, letters, case notes (electronic and written), electronic databases and electronic records. It was complemented through discussion with the Health Case Manager of each client where needed. As the Health Case Manager extracted some of the information from individual electronic case files this information was validated by independently checking a 10% sample of the case notes. This information is presented in section 4.

1. Qualitative interviews

a. Clients

b. Project service providers and service providers who have received referrals from the case manager

A semi-structured interview guide was developed with input from key stakeholders. Using purposive sampling, 6 client, and 4 key informant interviews were conducted. Clients suitable for interview were identified in discussion with the Health Case Manager. Pre-requisites included that the engagement was of sufficient duration that the Health Case Manager was sufficiently familiar with the client to be satisfied that they would be able to take part in an interview and also that an interview would provide meaningful results. The interviews were conducted by the researcher in a private space (a soundproof room within the Community Renewal building for clients).

The purpose of the interview was explained and the content of the interview briefly described. Interviewees were informed that the interview could be stopped at any time. Written consent was obtained prior to the interview. The interviewee was offered the options of the interview being recorded via an electronic tape recorder and note taking or note taking alone. One client opted to have the interview recorded only by note taking. The interviews were transcribed and entered into NVivo. They were analysed using a thematic approach. Names of individuals used by the interviewees were anonymised in the transcripts. Where information was presented that might reveal the client’s identity this was either omitted from the results or edited to ensure anonymity was preserved. As there was only one Health Case Manager in post it was not possible to anonymise references made to or by this person. However all findings were discussed with the Health Case Manager at the draft stage of the report and agreement obtained that these could be used and were a fair reflection of their views.

1. Client satisfaction questionnaire

All clients were offered the opportunity to attend the Community Renewal office to complete a very brief satisfaction questionnaire.

1. Evaluation of costs

An evaluation of costs was not conducted as it was not felt to be appropriate at this stage in the intervention.

Dissemination

On completion of the project a meeting with the health care and other service providers in the area to feedback and discuss findings, identify where service improvements could be made and how to progress these.

# Setting

In 2006 Craigmillar contained the most deprived employment data zone and the second most deprived income data zone in Scotland with 74% of the population defined as income deprived. 1 It was also identified as the most health deprived data zone in Scotland.2

Overall the Portobello and Craigmillar ward, to which Craigmillar belongs, was significantly below average compared to the rest of Scotland for employment, health, crime, education skills and training. For housing this ward was below average with pockets of lower housing standards within Niddrie and Craigmillar.3

In 2011 the total population for Craigmillar was 8752 with 23% children, 62% working age and 15% pensionable age. Ethnic composition for the Portobello/Craigmillar ward is mainly white (97%) with Indian, Pakistani/ South Asian, Chinese and Other each accounting for 1% or less.3

# Overview of the Health Case Management approach

Description of case management approaches

There are a range of definitions used to describe case management. The Case Management Society UK (CMSUK) defines it as:

“Case Management is a collaborative process which: assesses, plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individual's health, social care, educational and employment needs, using communication and available resources to promote quality cost effective outcomes.”4

Case management approaches are used in a number of areas related to health and social care including elderly care, mental health and for patients with alcohol and drug use disorders. There are a number of different models used and their definition and content is not consistent. Examples of models that demonstrate the range of intervention include the brokerage model, the integrated case management model and the self-managed care model. The brokerage model has a central co-ordinator who co-ordinates the clients care. The integrated case management model provides co-ordination of care through the team that are providing that care. The self-managed care model has a case manager in an advisory capacity supporting the client to select and co-ordinate their own resources. 5 The core functions of case management are described as: assessment, planning, linking, monitoring and advocacy.6

A number of systematic reviews (including high quality Cochrane reviews) have been conducted looking at the evidence for case management interventions. These are relevant in terms of demonstrating the effectiveness of case management interventions, though it is important to consider the type of clients and settings that these interventions are being applied to. The evidence included here relates to clients groups with needs similar to those identified for the group using Health Case Manager services at Community Renewal namely mental health and substance use disorders.

A recent Cochrane review of intensive case management (defined by a caseload of less than 20 clients) for severe mental illness found some significant benefits compared to those receiving usual care. The benefits related to reduced loss to follow up, shorter hospital stays, accommodation status and user satisfaction. No significant improvement was demonstrated in mental health, mortality, contact with the legal system and employment (though the last 3 showed trends that favoured intensive case management). Where intensive case management was compared to non-intensive case management the only difference was that the intensive case management group was less likely to be lost to follow up.7

A further Cochrane review in 2011 examined the effectiveness of case management for substance use disorders. This concluded that it was effective in supporting linkage with other services but it did not provide conclusive evidence of reduced drug use.8

A review by the Kings Fund stated that some factors were more likely to be associated with successful case management models. These related to the role and skills of the case manager, programme design and factors within the wider system. It also outlined the core components of a case management programme (see Figure 1) (not applied in a linear fashion). 9

Figure 1: King’s Fund: Core Components of a Case Management Programme

* *case-finding*
* *assessment*
* *care planning*
* *care co-ordination (usually undertaken by a case manager in the context of a multidisciplinary team). This can include, but is not limited to:*
	+ *medication management*
	+ *self-care support*
	+ *advocacy and negotiation*
	+ *psychosocial support*
	+ *monitoring and review.*
* *case closure (in time-limited interventions)*

There are a number of national and international bodies promoting case management. The CMSUK has the express aim of becoming the professional body for case managers in the UK and has published Standards of Practice. It outlines the importance of the therapeutic relationship of the case manager and service user. It identifies the key elements of the therapeutic relationship as being appropriate use of power, trust, respect and empathy.

“The therapeutic relationship between the case manager and the service

user is established and maintained by the case manager through the use of professional knowledge, skills, competencies and an enduring empathetic attitude and behaviour. The therapeutic relationship is non-judgemental and based on unconditional positive regard, empathy, reliability, genuineness and warmth. It relies on the appropriate use of power or authority by the case manager.”10

The guidelines emphasise the importance of the case manager ensuring their own physical and psychological wellbeing whilst supporting the therapeutic relationship. The document outlines a number of auditable standards that can be applied to practice – these relate to the areas outlined in Figure 2.10

Figure 2: CMSUK Areas relating to auditable standards

* Professional development/ lifelong learning
* Safe working practice
* Research ethics
* People who provide support and assistance
* Service user protection
* The case manager as practitioner
* Business practice
* Referral
* Consent
* Assessment and goal setting
* Intervention and evaluation
* Discharge, closure or transfer of a case
* Record keeping
* Service quality and governance

Health Case Management at Community Renewal

Information in this section is derived from interviews recorded with the Health Case Manager, Paul McColgan (Chief Executive) and from relevant documentation.

The Health Case Manager was based in Craigmillar branch of Community Renewal’s offices. Up until June 2012 the offices were located at Niddrie House Park; they subsequently moved to a new location at Hay Avenue.

Clients were identified by other Community Renewal staff either through “Listening Surveys” or other clients, self-referral or referral by staff of another agency. “Listening Surveys” involved the staff pro-actively going out into the community and systematically knocking on doors and pro-actively engaging community members.11 Eligible clients for the Health Case Manager intervention were those with “multiple life-wrecking issues”. These clients were identified as being the 10% most vulnerable in the community. Referrals were seen based on position on the referral list with prioritisation of clients if required by individual need. Each client was assessed individually as to whether they needed the support of a Health Case Manager for the issues they were facing and there were no additional pre-determined criteria. There was also no maximum number of attempts to contact or engage. The Health Case Manager contacted new referrals via phone, text or letter proposing a date for a visit to the Community Renewal office. Alternatively if unable to reach the client on the phone a house visit could be made.

The anticipated caseload was 40 clients per year with a caseload of 20 at any one time. It was anticipated that the Health Case Manager would need to spend at least 18 months with each of the clients for the intervention to be fully effective. The intensity was dependent on client need and could range from an hour or more a week in the initial intensive period to an hour a month once that level of input is no longer needed.

At Community Renewal the role of the Health Case Manager was to identify what the client’s goals are through a holistic assessment which helps the individual identify their priorities. The Health Case Manager introduced clients to appropriate agencies co-ordinating their care and providing a continuous point of contact. An example of how this might work is given below using an anonymised composite example – this has been termed the Case-Management Wheel (see Figure 3). The service provided by the Case Manager was termed “Wrap-around services” with the Case Manager being identified as the “Wrap Co-ordinator”. Locally a working group including Community Renewal met and developed some guidance on Case Management (see Appendix 1) and there was draft guidance developed locally by a member of this working group on Case Management.12

Figure 3: Case Management Model used by Community Renewal



Source: Adapted from personal communication. Ursula Donnelly

At the first client visit to the service the Health Case Manager introduced the service and a registration form was completed. This included details of name, address, family, GP, medication and employment history. In some cases it took several visits before the client was ready to fill in the registration form with the Health Case Manager. They were asked to sign a consent form to agree with their information being shared with other agencies. At this point it was made clear that if information was to be shared then they would be alerted to this again and their agreement checked before it occurred.

The next step was completion of a holistic assessment using a form specifically developed for this purpose. This was often commenced at the second visit and may took a number of visits to complete. This form included 14 questions looking at family relationships, social networks, health, housing, finances and long term goals. A list of 4 or 5 client priorities was generated through a semi structured conversation that the client ranks in terms of importance to them 10 (very important) to 0 (not important). Client priorities were added or altered over time. These client priorities were also termed goals or hopes. Review periods were determined in partnership with the client at the beginning. At the time of the review the client was asked how much progress had been made. This progress was then measured by the Health Case Manager assigning a percentage value to it. Progress towards these goals was measured at regular intervals.

The holistic assessment form was an adaptation of the Canadian Occupational Performance measure. This was adapted for use in Community Renewal’s Health Case Manager service in collaboration with the College of Holistic Medicine in Glasgow. Additional information was collected in an additional sheet that mirrors the information collected by the Addictions Hub and ensures that the information required to refer the patient to additional services is available. The form as a whole aimed to be client centred and was completed using open ended questions.

The Health Case Manager made referrals for clients and accompanied them on visits to other agencies where required. Appointments usually lasted one hour, the Health Case Manager met the clients either in her office which is a private space, the clients own home or at other community venues. Travel to clients’ homes required up to 10 minutes, travel to other venues with clients took longer depending on location and was usually made using public transport. Resources were available to provide refreshments for clients.

Health Case Managers have an independent supervisor from their own profession with whom they meet at least monthly. There was line-management support from the project co-ordinator and a case manager mentor. The Health Case Manager received in-house training when commencing the post in using the registration and holistic assessment tools.

The standard Holistic Assessment Training takes 4-6 days and was usually done in groups of 6+ trainees. Training consists of:

* The purpose of the holistic assessment
* The role of the health case manager
* The structure and rationale of the holistic assessment
* Skills required
* Delivery style and personal presence
* Action planning and review
* Practice in triads with peer and trainer feedback forms about 70% of the training

Currently groups going through the standard training have 4 days before receiving 1-1 mentoring once they start delivering holistic assessments. This may be tailored depending upon previous experience, in some cases the training may be delivered in 1-1 in its entirety (and condensed if some aspects are not required). Additional training was provided for the Community Renewal Registration form.

The case manager worked in isolation so there was a lone worker policy. The Argyle System was used, a remote call centre based system which requires the Health Case Manager to carry a mobile telephone. The Health Case Manager provided an estimated time at which any visit would be completed and if she did not report back within that time then an alert call was automatically generated.

Community Renewal had a comprehensive staff handbook and folder of policies and procedures which are outlined to all staff as part of their induction. These included:

* Health and safety
* Lone worker policy
* Use of the Argyll system
* Data protection and confidentiality
* Equality and anti-discrimination policy

These have been recently updated and a new staff handbook published which includes some additional policies (May 2013).

Though Health Case Managers often had a professional background in nursing or counselling the aim of the Health Case Manager role is to support clients to access services rather than to provide them directly. Referrals could be made to a range of public or 3rd sector organisations; in some cases clients were supported to access services such as NHS clinical services that they would otherwise have failed to attend.

# Client satisfaction questionnaire

63.2% (n=12) of eligible currently engaged clients (n=19) agreed to complete the satisfaction questionnaire.

They were asked how they had found out about Community Renewal: 16.7% (n=2) had heard through the Listening Survey, 8.3% (n=1) through friends or family, 41.7% (n=5) had either heard from or been referred by another organisation, 25.0% (n=3) had seen the local office and come in.

Clients were asked if they were attending another service before they came to Community Renewal. The majority 66.7% (n=8) were attending another service though sometimes not immediately prior to coming to the Health Case Manager and 33.3% (n=4) had not been engaged with any other services. None had been engaged with a Health Case Manager type service.

Clients were asked how the Health Case Manager had helped them. All had received information about other services and referred to other services. 91.7% (n=11) had been accompanied to other services and 83.3% (n=10) had received services directly from the Health Case Manager. Another 16.7% (n=2) clients mentioned that it was helpful having someone who was there for you. All clients were very satisfied.

When asked whether they get to see the Health Case Manager when they want to 33.3% (n=4) said “Mostly” and 66.7% (n=8) Said “Yes always”. When asked whether they spend the right amount of time 8.3% (n=1) felt “Not enough”, 8.3% (n=1) felt “Too much” and the remainder said 83.3% (n=10) “About right”. The only desired changes were to the consultation room used in Community Renewal which was felt to be too small by one client.

# Analysis of quantitative data

The Health Case Manager came into post in June 2011. At this time there was a list of 35 referrals awaiting assessment. Additional referrals were made on a continuous basis as needed and joined this list. The following analysis describes the characteristics of those who were referred. It looks at the sub-groupings of those referred by whether they engaged and became clients (denoted as “continued engagement” if more than one meeting with the Health Case Manager); those who only had one face-to-face contact with the Health Case Manager but subsequently did not engage further (denoted within this analysis as “limited engagement”); and those with whom it was not possible to establish contact (denoted as “no engagement”).

## Characteristics of Health Case Manager referrals and engagement

Within the 12 months between 21/6/11 and 29/6/12 there were 62 referrals. Of these, 1 had occurred within 2 days of the end of the observation period and therefore could not contribute towards all areas of the analysis (it will clearly be stated in the remainder of the text where it contributes). Of the remaining 61 referrals 55.7% clients (n=34) engaged beyond the initial first contact visit, 18.0% clients (n=11) met with the Health Case Manager once and 26.2% clients (n=16) that the Health Case Manager attempted to contact never met with the Health Case Manager (see Figure 4).

**Figure 4**

Limited

 engagement

18%

No

engagement

26%

Continued

engagement

56%

**Engagement of referrals**

Interval between engaging with Community Renewal and attempted engagement by Health Case Manager

Clients of Community Renewal can be referred to the Health Case Manager at any time including before the Health Case Manager was in post. Here we consider only those clients who were referred once the Health Case Manager was in post. The following section is not waiting times but purely a reflection of the proportion of clients who are seen immediately by the Health Case Manager and the interval between engaging with Community Renewal and the Health Case Manager. It is important to note here that many of the clients will have been receiving support from existing Community Renewal services.

When only considering the clients referred to the Health Case Manager since the Health Case Manager has been in post (n=26) then the median time from engagement with Community Renewal to engagement with the Health Case Manager is 0 days (range 0 to 27) with attempted engagement of clients occurring on the same day as engaging with Community Renewal for 65.4% (n=17).

Date of engagement with Community Renewal

Engagement with Community Renewal either occurred prior to engagement with the Health Case Manager or if no previous engagement then it was taken to be at the same time as engagement with the Health Case Manager. The earliest date of engagement with Community Renewal was quarter 2, 2009 (approximately 2 years before the current Health Case Manager came into post) the most recent engagement was quarter 2, 2012 (immediately prior to completion of the observation period) (see Figure 5).

**Figure 5**

**Timing of referral engagement with Community Renewal**

0

2

4

6

8

10

2009

2Q

2009

3Q

2009

4Q

2010

1Q

2010

2Q

2010

3Q

2010

4Q

2011

1Q

2011

2Q

2011

3Q

2011

4Q

2012

1Q

2012

2Q

Timing of referral engagement with Community Renewal

Number of clients engaging in this quarter

Health Case Manager came into post

Date of first attempted contact by Health Case Manager

First contact with the Health Case Manager occurred from end June 2011 onwards (the low number of contacts in 2011 Q2 is a reflection of the small number of days since the Health Case Manager had become active). There is a clear pattern of high numbers of people being contacted following the inception of the post with falling numbers of new clients as increasing numbers of clients are engaged. By the end of the 3rd quarter of 2011 36 clients on the referral list had been contacted (note that though the original referral list had 35 clients on it further referrals would have been added over time) (see Figure 6).

**Figure 6**

**Timing of attempted referral engagement by Health Case Manager**

0

10

20

30

40

2011 2Q

2011 3Q

2011 4Q

2012 1Q

2012 2Q

Timing of attempted referral engagement by Health Case Manager

Number of clients

in this quarter

## How people found out about the Health Case Manager

The majority of clients 52.6% (n=32) had initially come into contact with Community Renewal through Community Renewal staff visiting their home (Listening Surveys) and subsequently been informed of the Health Case Manager. Smaller numbers of people had heard about it through friends or family 12.9% (n=8), other organisations 9% (n=4), had seen the local office and self-presented 14.5% (n=9) or been referred directly to the Health Case Manager by another organisation 14.5% (n=9) (see Figure 7). Referral sources included Cyrenians, CAN, Neighbourhood Alliance, Homeless Outreach Project and Health in Mind. From the available data it is not possible to make the distinction between finding out about Community Renewal and finding out about the Health Case Manager (i.e. some people will have come to Community Renewal specifically for Health Case Management where as others will have initially attended for Community Renewal’s employability services or money advice service).

**Figure 7**

When comparing between the different sources of referrals and who goes on to engage there was some variation. However it is important to note that this analysis is based on small numbers other than the “Listening Survey” category which means such findings could occur by chance (see Figure 8).

Figure

**Which referral sources go on to engage**

0%

20%

40%

60%

80%

100%

Listening Survey

Friend or family

Other organisation (heard)

Other organisation (referred)

Saw local office

Source of referral

Percentage engaging

Continued engagement

Limited engagement

(one appointment)

No engagement

## Socio-demographic information

All information in this section is based on the entire cohort of 62 referrals.

Age

Age was known for 88.7% of referrals (n=55). Information missing is primarily due to non-engagement. The youngest referral was 19 and the oldest was 59. The mean age of all referrals was 39.2 years (sd 9.9 years). Mean age for those who were referred but never had a meeting with the Health Case Manager was 40.5 years, for those who only had one meeting but subsequently failed to engage 33.4 years and those who had more than one meeting 40.6 years.

Ethnicity

The majority of referrals were White Scottish 77.4% (n=48), a further 8.1% (n=5) were White British or White Irish. For 11.3% (n=7) no ethnicity was recorded. In the majority of cases (71%) this was due to non-engagement. The remaining clients were of other origin and are not presented here due to small numbers. Those who then failed to engage or had limited engagement were White Scottish, White British or had no ethnicity recorded.

Gender

Gender was recorded for all referrals. The majority of referrals were male 62.9% (n=39) and the remaining 37.1% (n=23) were female. When only looking at those who subsequently engaged beyond one meeting 70.6% (n=24) were male and 29.4% (n=10) were female.

Of those referred 79.5% of male clients and 63.6% of women have one or more meetings with the Health Case Manager. If considering whether people who are referred subsequently engage then 61.5% of male referrals engage beyond one visit and 45.5% of women engage beyond one visit. This means that fewer women being referred and a smaller proportion of women then go on to engage.

The gender imbalance is present across almost all referral sources with the proportion of men from each group 59% of “Listening Survey”, 75% of “friends and family”, 75% “other organisations”, 78% of “self-presented” and 44% of “referred by other organisations”.

## Issues identified by referrals for action

Clients were requested to identify potential areas for action or problems at the time of referral and over the next few meetings with the Health Case Manager. For some, issues were identified in the referral itself. This is not necessarily a reflection of all underlying issues that the client had. They may have had additional issues they wished not to disclose e.g. due to stigma, legal implications; or they may subjectively have felt that some of these areas may not negatively impact on their life or be a priority they wished to address. The mean number of issues identified at the time of being referred to the Health Case Manager was 4.5. The minimum number was 2 and the maximum number was 9 (see Figure 9). For those that engaged the mean number of issues identified was 5.3, whereas for those that had limited engagement the mean number was 4.2 and those with no engagement the number was 3.6.

**Figure 9**



The most common issues identified overall were mental health (83.9%), social (this refers to lack of social networks) (54.8%) and housing (50.0%). A comparison was made between the frequency with which referrals who went on to engage and those with limited or no engagement identified particular health or social issues. The proportion identifying each issue within each group can be seen below in **Figure 10**. This shows that the issues identified for those with limited or non-engagement may be distributed differently.

**Figure 10**

**Health or social issues identified by referrals or clients**

0%

10%

20%

30%

40%

50%

60%

70%

80%

90%

100%

Mental Health

Social

Housing

Financial

Physical health

Drugs

Training/employment

Alcohol

Family/child

Smoking

Bereavement

Legal

Oral Health

Other

Continued engagement

Limited engagement

(one appointment)

No engagement

## Service activity

Meetings, cancellations and DNAs

Service activity included meetings between the Health Case Manager and the client that took place, those which were cancelled and those that were not cancelled but the client failed to attend (“Did not attend” or DNA). Meetings between the Health Case Manager and the client included three types. The client could visit the Health Case Manager at the Community Renewal building. The Health Case Manager could meet the client in the community, usually in their own home. The client could meet the Health Case Manager at an alternative venue, often for the purpose of accompanying to another service. Cancellations and “Did Not Attend” are recorded as these provide a reflection of the burden of work.

A total of 709 visits or meetings were arranged with clients over the 12 month period.

* 59.5% (n=422) took place
* 7.9% (56) were cancelled
* 32.6% (n=231) were DNA

Of the visits or meetings that took place

* 56.9% (n=240) occurred at the Community Renewal building
* 28.0% (n=118) took place in the community
* 15.2% (n=64) took place at alternative venues.

A detailed breakdown of the number of visits, DNAs and cancellation for those who went on to fully engage vs. those with limited or no engagement can be seen below (see Figure 11). By definition those with no engagement had no meetings and those with limited engagement had only one meeting. It is evident from this that DNA and cancellations contribute significantly to the Health Case Manager workload.

The Health Case Manager received 547 texts from clients and sent 559 over the 12 month period.

**Figure 11**



Duration of engagement and reasons for disengagement

Of the 34 clients who engaged beyond the initial first contact visit 44.1% (n=15) were no longer clients and there was an on-going case load of 55.9% clients (n=19) (one client with first contact at the end of the observation period is not included here). Of the current caseload the shortest time of engagement is 16 days and the longest is 374 days. The median duration of engagement is 331.0 days (IQR 164.0 to 352.0 days).

Of the 15 clients who had engaged but were now no longer accessing service, the shortest time of engagement was 7 days and the maximum was 313 days. The median duration of engagement was 147.0 days (IQR 65.0 to 282.0 days). Of these 15 clients, 20% (n=3) had been discharged from the service as they no longer required input after a mean duration of engagement of 176.7 days. A proportion of clients who were engaged 27% (n=4) ceased to access the service either due to the service not being suitable or reasons beyond the Health Case Managers or clients’ control “Threat to staff”, “Deceased”, “Client wanted services that were not part of Health Case Manager remit”, “Moved out of area”. The remaining 53% (n=8) of clients who had engaged beyond the first visit but were no longer accessing the service had disengaged from the service. For the majority of these clients the reason the client ceased to access the service was not known and they simply stopped answering calls or attending 46% (n=7) but in one case it was documented that the client was unable to engage.

For those with limited engagement with the service the median duration of time that the Health Case Manager spent trying to engage them was 72 days (IQR 1,110; range 0-164). For those who never engaged the median duration of time the Health Case Manager spent trying to engage them was 0 days (IQR 0,42; range 0-252).

## Referrals from the Health Case Manager to other agencies

Referrals made

The total number of referrals made was 109. Of these, 3 referrals were made for three clients from the group with limited engagement and 106 were made for 30 clients in the group with full engagement. The number of referrals made varied between 0 and 10 with the median number of referrals being made as 3 (IQR 0.0, 3.0). Referrals were made to a huge range of organisations both statutory and third sector. Even within different service providers there was a range of services that were used. The frequency of referral to various agencies is provided here for the top ten service providers most frequently referred to (see Table 1) and the top ten interventions that clients received from these services (see Table 2). (Note all figures below 5 have been suppressed.)

Table :Service providers Table : Interventions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Top ten service providers | Number of referrals |  | Top ten interventions | Number of referrals |
| Thistle Foundation | 18 |  | Neighbourhood Support Service | 14 |
| Edinburgh Council | 16 |  | Lifestyle management | 13 |
| Castle Project/Hub | 9 |  | Addiction services | 9 |
| Health in Mind | 9 |  | Volunteering opportunities | 8 |
| Edinburgh Volunteers Centre | 8 |  | Counselling | 6 |
| NHS services | 6 |  | Access to industry | <5 |
| Bethany Christian Charity | 5 |  | Befriender | <5 |
| Community Renewal | <5 |  | Mindfulness course | <5 |
| Transition | <5 |  | Outreach | <5 |
| Women's Aid | <5 |  | Gateway: Provision of household items | <5 |

Reasons for referrals to other organisations

The reasons for referral are identified below in Figure 12. Please note that each referral could have multiple contributory reasons for being made. Therefore a referral may have multiple “reasons for referral” and the total for the graph below exceeds 100% because of this. Mental health was most commonly identified as a contributory reason for referral, associated with 39.4% of referrals.

**Figure 12**



Previous links to other services

For 68.8% (n=75) referrals this was the first time the client had ever been linked to the service they were being referred to. In 21.1% (n=23) of referrals the client had been previously referred to the service but had never attended. For a small minority of referrals the client had either attended the service but attendance had discontinued 3.7% (n=4) or had been terminated by the provider 1.8% (n=2).

Support required from the Health Case Manager for the client to access other services

For the majority of cases 94.5% (n=103) a referral was made by the Health Case Manager to the service. In some case a referral was not needed e.g. if it was a NHS service that the client should attend but had previously not done so or if it was another Community Renewal service. Information was provided in 91.7% (n=100) of cases. In 41.3% (n=45) of referrals the Health Case Manager accompanied the client at the first visit, in 3.7% (n=4) of cases the client was accompanied on multiple visits. No clients required accompaniment on every visit. Reminders were provided for 4.6% (n=5) clients and other measures were needed for 3.7% (n=4) of clients. This demonstrates the input required from the Health Case Manager to support referrals.

Outcome of referral to other services

In 16.5% (n=18) of referrals the first visit was awaited at the end of the observation period. A successful outcome of the referral occurred in 30.3% (33) of referrals with either on-going engagement 22.0% (n=24) or discontinuation due to issue resolved 8.3% (n=9). An unsuccessful outcome of the referral occurred in 43.1% (n=47) cases, because either the client did not attend 20.2% (n=22) or the client attended but then discontinued 22.9% (n=25). In 6.4% (n=7) cases the referral was not accepted.

For those with a previous negative outcome from a referral (either a previous referral but not attended or attendance at a service which was discontinued for any reason) (n=29) then 24.1% (n=7) were waiting to be seen, 13.8% (n=4) had either completed or were under on-going care, 48.3% (n=14) either had discontinued attendance or didn’t ever attend and 13.8% (n=4) were not accepted by the agency.

Reasons for an unsuccessful outcome of a referral in general included a range of barriers (included here are only those identified from this specific section of the analysis e.g. from case notes, and does not include information from qualitative interviews). Examples included drinking excessively, feeling uncomfortable due to factors such as e.g., group setting, not feeling ready, personal dislike of worker or service, family problems, motivation, not finding the intervention useful.

## Services provided directly by the Health Case Manager

Services were provided directly to the clients by the Health Case Manager for 67.6% (n=23) clients. All these were clients who had engaged beyond one visit and the following percentages are based on the 34 clients who had engaged.

Up to three types of services were provided. 38.2% (n=13) clients had one service provided, 26.5% (9) had 2 services provided and 2.9% (n=1) had 3 services provided. Services were provided directly by the Health Case Manager in 34 instances. The majority of these services were Mental Health Support or Supportive Counselling for 64.7% (n=22) of clients, Assistance with benefits was provided to 29.4% (n=10). Further examples (all <5 and therefore supressed) included accompaniment to GP appointments and food hamper. Mental health support was provided for a range of issues including drugs education, anger management and work related stress. Some of these services were one-off events whereas others would take place over an extended period of time.

The reasons for providing assistance with benefits were solely financial. The need for mental health support was cited as being due to mental health in all cases, but in some, additional reasons such as bereavement, drugs or physical health were also identified. It was possible for the Health Case Manager to identify one or more reasons as to why she provided a service as opposed to referring to another provider. Reasons for the Health Case Manager providing the service (as opposed to referring on to another provider) included

* Health Case Manager was the most appropriate provider cited for 52.9% (n=18) of all services, in all cases this was for mental health support or supportive counselling.
* Delay in appropriate service provider becoming available 32.4% (n=11) in 9 cases this was for benefit assistance and in 2 cases this was for mental health services
* No appropriate service provider available 2.9% (n=1) for accompanying to GP appointments
* Client preference or does not want to attend appropriate service provider 35.3% (n=12), 8.8% (n=3) for benefits and 26.5% (n=9) for mental health
* Appropriate service provider declines referral 5.9% (n=2) in all cases this was for mental health support.

From the perspective of each service

* Reasons for the Health Case Manager providing mental health support was Health Case Manager most appropriate provider 81.2%, delay 9.1%, client preference 40.9%, declined by most appropriate provider 10.5%.
* Reasons for the Health Case Manager providing help with benefits; delay 90%, client preference 10%
* Reasons for accompanying to GP 100%

# Analysis of client views

Six interviews were conducted with clients who were currently receiving input from the Health Case Manager (just under a third of all current clients). No individual sociodemographic information is provided here to protect client identity. Clients being interviewed had been attending the Health Case Manager service between 6 months to a year. One of the clients reported being seen by a number of different Health Case Managers at Community Renewal over the past 3 to 4 years.

Not all clients that meet with the Health Case Manager were suitable for interview. Invitation was restricted to those for whom it was felt that an interview would be appropriate and who would be able to attend the Community Renewal building for it. Some clients invited were not able to attend.

## Deciding to come and see the Health Case Manager

Engaging with the Health Case Manager was described as occurring over several stages. The client not only had to find out about the Health Case Manager but had then to be willing to start seeing her and then be willing to stay engaged. Clients were asked how they first found out about the Health Case Manager service. There were a variety of responses. Some had initially heard about Community Renewal and then through attending this become aware of the Health Case Manager service, whereas others had heard about the Health Case Manager service specifically. Community Renewal has a proactive approach to going out into the community and conducting Listening Surveys and some of clients reported hearing of Community Renewal or the Health Case Manager through this. Other places that clients recollected hearing about the Health Case Manager included NHS and non-NHS services such as GPs, information desks at GPs, drug workers or mental health care providers.

There was also awareness of the service within the community described, with other active community members recommending the service. Some clients said they were aware of the service by virtue of it being sited physically within the community. Sometimes clients recalled hearing about or being recommended the service by several sources before deciding to attend.

“Well like I say its right opposite my house, so I went in to find out what is actually entailed within the building this is before I knew that they had the health case manager in there. I just went in looking for employment. Like I say when I went to my doctors, he recommended [the Health Case Manager]. So I went in and made an appointment.”

Client 1

Clients described a range of motivations to start attending the Health Case Manager. Both “push” and “pull” factors were identified. In some cases it was because of the recommendation by another health professional such as a GP. In other cases motivation came from the underlying issues the client was facing, often these were described as multiple, severe and heading towards a crisis point. Problems included mental and physical health, financial, housing, drug and alcohol. Some cases said they had been prompted to start seeing the Health Case Manager because another source of support with a finite duration had finished.

Some clients described an initial reluctance to start seeing the Health Case Manager because they didn’t understand what the service entailed. This was overcome by the perceived positive attributes of the centre and the Health Case Manager. Factors such as a relaxing, friendly atmosphere and just having a cup of tea were felt to be important. The co-location with other Community Renewal services was also identified as a positive factor.

## Motivating factors for staying engaged

Clients identified a range of factors that motivated them to keep attending once they had engaged with the Health Case Manager. Many of these were related to how the service was delivered rather than just the content of the intervention. The personality of the Health Case Manager was often mentioned and described as polite and caring. The relationship with the Health Case Manager was felt to be important, clients felt that she took their problems seriously and that they were able to build a trusting relationship with her. Others highlighted the flexible way in which the Health Case Manager worked, that she was always prepared to visit them in their own homes and always available and the confidence they had developed that she would always help. Services such as “chumming” to visits to other care providers and the positive impact that the Health Case Manager intervention was having on their life were also reported to be motivating factors. For some clients there was also a concept of mutual obligation that meant they felt a reciprocal commitment to attending visits and referrals. Encouragement and reassurance from the Health Case Manager was also felt to motivate attendance.

“… What were the things that kept you coming?”

Interviewer

“Honesty I suppose, do you know what I mean, she was always honest with me and I ehm…and her ways of trying to help and things like that. I dunno, it was just different, I think it was cause, because she chums me to the doctors or chums to like…..wherever I need to go, got a meeting or stuff like that. I think it just, it became more of a I dunno…. Again the trust thing I think, do you know what I mean, I think it’s more to do with that I trust her…..”

Client 4

Clients were asked whether they were engaged with other services at the time they started seeing the Health Case Manager. Some were, but had finished with a service which had previously been supporting them because it had come to a pre-set end. In some cases they had been told of the Health Case Manager by these services. Others reported using specific services for drugs or health but not accessing another service akin to a Health Case Manager. Some clients said they had been trying to access counselling or similar services but had found them unsuitable or difficult to access. In some cases clients had previously used the services of a Community Psychiatric Nurse, one client reported discontinuing this because of stigma.

“How does the health case management service that you are getting now compare to the CPN – is it the same type of services?”
Interviewer

It’s the same type of services. Relaxing environment don’t get me wrong [the CPN] was good at her job but it was pretty clinical and [the CPN] had a separate list at reception. Through no fault of [the CPN], it’s just the system they had working there and it stood out if someone was behind you they knew you weren’t there to see a doctor.”

Client 1

When asked about whether there was anything that put them off attending the Health Case Manager there were very few issues identified. Some recalled that they found it difficult before they got to know the Health Case Manager. Others felt there was a lack of privacy in the new premises. Some clients described personal issues that made it difficult e.g. on-going psychiatric condition.

“Is there anything that puts you off [attending the Health Case Manager], that makes it more difficult?”

Interviewer

“Eh… when it’s busy, crowded. She always made sure when I came round we went straight up to the room and talked. We never hung around in the place.”

Client 5

How seeing the Health Case Manager supports engagement with services

Two key areas of Health Case Manager input were explored with clients. One was the support to identify and access other services; the other was the services that the Health Case Manager provided directly.

Clients identified a wide range of services that they were accessing as a result of the Health Case Manager. This included not just for physical and mental health but services for other needs such as financial problems too. Clients described a pathway of accessing these services that extended beyond referral. In interviews clients described how having a Health Case Manager made it both easier to find the right services or combination thereof and then facilitated attendance.

“And are these things that you would have, what would have stopped you from being in touch with these things- did you not know about them?”

Interviewer

“I never knew nothing about them, and confidence as well, eh… and just I dunno. Confidence, she definitely built my confidence up a bit. I would never have been able to go to a gym before… do you know what I mean, ever. But I can do that now.”

Client 4

Some described initial anxiety around visits to other services or new places and how being accompanied by the Health Case Manager on the first visit helped. They also described feeling more motivated to continue attending or increase attendance for existing services (e.g. increased attendance at GP appointment). The Health Case Manager was described as being helpful in overcoming barriers to attendance.

“How has that impacted you being on you being able to use other services?”

Interviewer

I feel that it’s helped me a bit more; I’m getting out a bit more as well. With her help, I’ve been in touch with quite a few organisations that she sorted me benefits out, and me housing out, me debts out. Me health out. I’ve been to the doctors more than I usually go. My diabetes I’ve now got under control, so yeah. She put her foot down a few times, and I’ve listened,…”

Client 5

A range of services provided directly by the Health Case Manager were identified. Clients described filling in forms e.g. to get benefits, as being particularly challenging and that they really valued having the support of the Health Case Manager to do this. Other services included help arranging appointments. For some clients having the security that someone was available to help in an “emergency” was a very positive experience even if they had never needed her in this capacity. Other clients reported counselling sessions that they had with the Health Case Manager as being very beneficial. One attributed benefits being due to the way in which care was embedded within a wider programme of care with links to services addressing other issues.

“And you wouldn’t have had that with the other counsellor?”

Interviewer

“No, no well I never did have that wi the other counsellors that I’ve had, in the past eh… and well, it was just a matter of, they slotted you in, do you know what I mean type of thing. And you had that hour and that was it. And when that hour was over you walked away, but with [the Health Case Manager], it’s more than just your counselling that you’re getting, it’s all the other things that, that go wi’ it, know what I mean. Like starting the gym, and, or do you know what I mean. Just things that are making my life a hell of a lot easier.. and I would never have had all that if, if I hadney been going to the Community Renewal and meeting [the Health Case Manager].”

Client 4

## How provision of the service is perceived

Access to the service in terms of geographic location was felt to be reasonable as it was walking distance for the clients though there was some divergence of views on whether the old or the new centre had been easier to get to depending on distance to the clients house. One client highlighted that it was a big plus that Community Renewal and the Health Case Manager were in the same place.

All the clients described themselves as being satisfied with the service when asked directly – some using terms such as “100% satisfied” or “over satisfied”. Clients had a very positive view of the service with much of their focus being on the positive attributes of the Health Case Manager.

“So, [the Health Case Manager] has been a diamond- she needs to get a knighthood or something!”

Client 3

The Health Case Manager was felt to be easy to access and the client centred focus ensured that visits were arranged to suit client needs (both in terms of timing, time allowed and location), with longer visits when needed as weekly or even twice weekly frequency. This was said to be very positive by clients. Clients highlighted that they never felt they were rushed. In addition the option of texting or phoning, particularly because the Health Case Manager will phone back was felt to be beneficial.

“And, I think that’s, communication is… it’s not the easiest thing for me, but.. she was there, when I needed her. That I could phone her at any time, I could phone and leave a message and she’ll phone me back. So I could always contact her if I needed her. Which is superb.”

Client 5

Many of the clients reported the positive attributes of the Health Case Manager that they valued and how this has helped foster a trusting relationship. This encompassed characteristics such as the non-judgemental attitude, politeness and respect. When describing the environment and Health Case Manager interaction clients often used terms that indicated caring and relaxed.

“I think if you feel confident with somebody, it does make it a lot easier.”

Client 4

Clients were asked to identify if there were any areas of the service they would like to change. There were very few issues mentioned, most said there was nothing.

“And, are there any areas which you think could be improved?”

Interviewer

“The way she works, no,”

Client 5

A few clients identified some negative aspects of the new building. This included that it felt more clinical whereas the other had been located centrally in the community and had felt more relaxed. One client highlighted that they missed the gardens outside. In contrast one client preferred the new facilities describing them as “superb” because they were closer.

“Hmm…… No. I dinny think so. No, I think it’s really good, made easy. But I say, I’m not comfortable coming here…. as I was like over in the other house.”

Client 4

Comparison was sometimes made to other services – either spontaneously or at the interviewers questioning. This was uniformly positive. It was reported that the holistic nature of the service meant that a more personal and trusting relationship was developed with the Health Case Manager. Clients said that they felt more comfortable and liked that they didn’t have to start from the beginning with each new service. The counselling provided by the Health Case Manager was also compared favourably to other counselling services, in one case even the service that the Health Case Manager had referred the client to. Access to the Health Case Manager in the community was identified by one client as being important even through some of the services they are referred to may be elsewhere.

## Clients perception of the impact on their life

Both very specific and more generalised impacts were identified by clients as a result of the Health Case Manager intervention. As the more specific outcomes reflect the individual goals that the client went in with, they are intrinsically heterogeneous. Reported benefits included reducing or stopped alcohol and drug intake, improved diet and increased exercise. More general outcomes reported included significant improvements in mental health or wellbeing and physical health. Other issues that were potential areas for intervention were not perceived by clients as a problem e.g. smoking.

Examples of how these things had changed people’s lives included being able to undertake travel, volunteering and wanting to go back to work, better family life. Attitudes too were changed with people feeling empowered and thinking positively.

Often changes were described as being large but little changes were felt to be important too – such as keeping the flat clean. Clients were asked to comment on how quickly the process had changed. There was a range of responses which included very gradual to very rapid. Poignantly several of the clients contrasted what they felt would have been the likely outcome of their previous trajectory it hadn’t been for the intervention (see Figure 13).

Figure

“My mental, ma physical health, everything’s improved. My mental attitude, before I never used to make plans and now I look to the future.”

Client 1

“I get out more often I see things in different ways and actually it has given me some hope”

Client 2

“Aye, I swear if it wisney for [this Health Case Manager] I would still be, drinking these cans every day, and my life would still be zero.”

Client 3

“I dey ken where I’d be if I hadny have found our about all this, do you know what I mean, I dey ken what would have happened to me basically, If I’d even be here, do you know what I mean, type of thing.”

Client 4

“It was always black, and that was it. And she…well she gave me that light basically”

Client 4

“The biggest change. I’m here, I’m alive.”

Client 5

“… put it this way, if I didn’t have one I’d be depressed, I wouldn’t be going anywhere, I’d probably be stuck in the house, till I seen [my drug worker] and I’d be back home again. So basically she has made me feel better, within myself “

Client 6

# Analysis of stakeholder views

A further four interviews were conducted with stakeholders who were either staff at Community Renewal or referring organizations. In view of the small numbers of staff working directly on the project (i.e. one) the comments are simply attributed to “Key informant” and no further specification is made. Wherever possible an attempt has been made to anonymise comments however it is not possible in view of their only being one person delivering the service (see methods).

Finding out about Health Case Manager

Stakeholders described several different sources of new clients for the Health Case Manager service. When the new Health Case Manager came into post there was a list of clients who had been identified by Community Renewal as being potentially suitable for the service. Other reported sources of clients were self-referrals. This included clients who had heard positive reports of the Health Case Manager service from friends and family members or seen the benefits first-hand. In some cases stakeholders reported that clients had heard about the service by “word of mouth” from other community members or staff working for other organisations.

“And there’s been a few comments made to me, that have been said by other clients, you know to come and see me but only if they seriously want to make change do you know what I mean, or.. But then I think as well as people see the changes in somebody then they’re gonna want to know how that’s occurred and as a result then would be more likely…”

Key informant

One of the organisations had found out about the Health Case Manager through meeting her at Super Tuesday – a one stop advice shop that used to be run by the council.

Referring to Health Case Manager

Stakeholders described the referral processes. Internal referrals from Community Renewal were made on a referral form or referral database sheet. External referrals were usually phoned to the Health Case Manager, and no formal referral form used but an email was requested to ensure there was a record. Sometimes referrals were reported as being made through conversations and joint meetings. Stakeholders identified a range of organisations who refer to the Health Case Manager.

 “You know the fifty per cent of people who are fine and holding down a job and contributing to the community, and putting assets into the community. Then forty per cent of people who are a bit vulnerable and who could go either way; they could be supported to come into the fifty per cent or they could go down the way. And then there’s the ten per cent, and the ten per cent are people that they call are people who have ‘multiple life wrecking issues’ and so, multiple means at least three of these you know, kind of life wrecking issues, and so we would need to, when we receive a referral we would need to check out, well are we dealing with the right sort of person here, or is it someone who doesn’t need this intensity of support.”

Key informant

The identified criteria for referral were that the client has multiple and complex health issues; a chaotic lifestyle; and that they were in the most vulnerable group within the community – the “10%” with multiple life wrecking issues from very excluded groups. One stakeholder highlighted that in some cases clients were perhaps not from the most critical group at the time at the time of referral but were in a position where they would likely be in that group if there was no intervention.

Health Case Manager role

The Health Case Manager role was described by stakeholders as connecting organisations up around the care of complex clients. Aims of the service identified included improving client health and wellbeing, reducing poverty and addressing health inequalities through helping people to access services and benefits that they are entitled to.

When the current Health Case Manager first came into post her work was described as getting people to engage by being out in the community and knocking on doors. One respondent described the process of getting people to engage who don't usually and emphasised the importance of gaining the client’s trust and fostering a therapeutic relationship. This respondent highlighted some approaches that were conducive to building trust. These included helping with practical issues early in the engagement process (e.g. benefits), being flexible (e.g. no “3 strikes and you are out policy”) meeting with the client on their terms (e.g. not at the Community Renewal office), a non-threatening, non-official environment and reducing the perception of the traditional role (e.g. nursing). It was noted that clients were often not willing to attend Health Case Manager at the Community Renewal premises initially leading to the Health Case Manager meeting them in the community or alternative venues. This was however only possible if the client was not previously noted to be high risk (though this information was not always available).

The Health Case Manager role was described by stakeholders as finding out about a person’s priorities and life goals through a holistic assessment. These were reported by a stakeholder as being three to five issues both short and longer term. There may also be intermediate goals or barriers that need to be addressed. It was suggested that issues might be latent i.e. the client may initially not be aware of them and the Health Case Manager may need to help uncover them. It was felt that the Health Case Manager needed to spend a large amount of time with the person initially to build up trust, to help them identify their priorities and identify the barriers. Seeing clients in their own home was suggested to be beneficial in terms of giving greater insight. However, whether they were prepared to come to the Community Renewal building, was felt to be informative in terms of the client’s motivation levels.

“[The] holistic assessment form goes through fourteen questions which start off looking at their average week, looking at their family relationships, looking at their social network, social opportunities and relationships, moving on to look at any health concerns that they have, what their housing situation’s like, what their financial situation- are there any debt issues, and then finishing up with you know, where, where do you really want to go, is part of this intervention- what’s your long-term goal, what’s your long-term plan. If things were really good for you, a year or two down the line what changed. And that holistic assessment form usually creates a list of four or five priorities that the individual themselves scores into zero being not very high and ten being a really, really important priority. So at the end of that holistic assessment process, you get a good feel for, these are some of the things we want to work on together.”

Key informant

Stakeholders described the Health Case Manager role once the client was engaged as brokering relationships with other agencies in consultation with the client and coordinating input from different agencies. Throughout this process the Health Case Manager was seen to be a continuous point of contact over a longer period of time while the client received input from different agencies. The engagement of the client with other agencies was felt to be facilitated by accompanying them on their first visit as some clients had previously discharged due to non-attendance and faced barriers in attending. The benefits of continued Health Case Manager involvement were described as avoiding duplication in services, improving communication and increasing positive outcomes. Multiple respondents claimed that people who had previously been unable to sustain contact with other services were able to do this once they received support from the Health Case Manager. A further point was raised that clients were more likely to engage with other agencies even if they “didn’t see the point” initially, if there was a trusting relationship with the Health Case Manager. One stakeholder described another facet of the Health Case Managers role as being the client’s advocate.

“You know there, most of the people who would be you know have substance misuse, then [the Health Case Manager] really would be trying to get them involved in engage with the Castle Project and lot of people… maybe previously sort of haven’t been able to sort of sustain an engagement with the Castle Project, but with [the Health Case Manager]’s help you know, building up their confidence a wee bit first of all, then they’ve been able to, they’ve been able to take those services up and sustain them.”

Key informant

It was noted that though the Health Case Manager’s role was not to provide services directly, sometimes this was necessary. Some clients were felt initially not to be ready to be referred to other agencies so the Health Case Manager supported them, using motivational interviewing techniques. Other services the Health Case Manager was identified as providing included reports to evidence clients’ mental and physical health and current attempts to address these. The benefit of this was felt to be that it gave the Department of Work and Pensions some guide towards how long the client might not be suitable for work and increased the chances of a successful hearing.

“Ehm,.. yeah. It’s… anything and everything, Anything from practical advice, housing advice, benefit advice, mental health support, and obviously all contacts that I have with clients it’s in a, I’m not a counsellor but I utilise counselling skills by way of helping the client I suppose. So there would be a lot of emotional support would go on, accompanying clients to medical assessments by the DWP, or ESA tribunals and obviously completing reports for all of those.”

Key informant

Stakeholders described potential problems in developing the client / Health Case Manager relationship. One respondent voiced the concern that it was important to foster clients’ independence; however the counterpoint to this was that sometimes a small degree of dependence occurred initially when they first engaged which could then be overcome. A further stakeholder echoed this sentiment, stating that it was important to ensure that the client was being helped to take responsibility for their own health and wellbeing rather than to try and do this for them. It was also felt to be important that the client understood that the Health Case Manager’s role was not as a friend. An important factor in developing a successful relationship was proposed to be spending a lot of time developing the relationship early on.

Crossover with other roles was discussed by stakeholders. It was felt that is was important to ensure that the Health Case Manager role was distinct from that of a Community Psychiatric Nurse and clients may still have a Community Psychiatric Nurse. It was emphasised that clients requiring psychiatric services should be supported to access this. However there was also an acknowledgement that there was some inevitable overlap as the Health Case Manager provides “a listening service”. One stakeholder highlighted that the Health Case Manager would not get involved with clinical mental health unless it were to advocate for a change on the client’s behalf. The Health Case Manager role was contrasted as being more holistic compared to a Community Psychiatric Nurse.

“And have you worked with other Health Case Managers, or sort of similar groups at all, be that NHS or non-NHS?”

Interviewer

“No. No. I’m not really aware of... I’ve worked kind of with CPNs and stuff, but I wouldn’t have said they were as wide-ranging and as holistic as what [the Health Case Manager]’s role kind of really seemed to be”

Key informant

Changes in the Health Case Manager role at Community Renewal over time were described. Previously there had been an explicit employability target which was no longer the case. This meant that it had been possible for the Health Case Manager intervention to be more person centred and build the package around the person’s requirements

Working practices

The style in which the Health Case Manager worked was consistent with a strongly person centred approach. Adaptations in working practices to fit in with the needs of the client group were described by stakeholders. The process when receiving a referral was reported as checking if the person meets the criteria for the service, however it was emphasised that these were not exact. It also relied on the Health Case Manager meeting with the client and finding out if they were ready to engage. It was emphasised repeatedly that there was not a pre-set number of attempts to try and get clients to engage and that “a three strikes and you are out” approach would not be suitable for this group as many would fail to engage. Other respondents described the importance of finding a balance between being flexible with clients and putting in some limits. However one stakeholder countered this by highlighting the importance of being perceived as different from NHS organisations, easy and friendly and clients being able to drop in. Stakeholders believed that these characteristics were also valued as important by referring organisations.

Examples of modifications to working practices in response to client needs were given: issues such as literacy and people not opening their mail meant that “DNA letters” were not useful in this group. Instead texting to mobile phones was found to be effective.

“And also there’s no “three strikes and you’re out” there’s no.. you know. Which, within the NHS, obviously that needs to be the case, but within this project I wouldn’t have any clients on my caseload, if that was the case. And it’s about even whenever, last year whenever clients weren’t attending for initially, you know, the standard a kind of DNA that you would always have sent as a CPN, I then amended that. I have now actually stopped sending letters, because a lot of them can’t read or write, a lot of them don’t open mail, so I utilise text-messaging more, as massively now would be a main method of communication because people don’t have credit on their phone but they’ll have bolt-on text, so they can you know keep contact that way. So I think that that’s been something. I think as well, particularly where we were placed up the road in the previous building- was a very non-threatening, non-official.. you know it was a house and people felt more, and it had a drop-in facility- everybody knew that when they came in the door that they’d get a cup of tea and a biscuit, a friendly welcome. And I think that that helped with people recognising that it was something different from the NHS. “

Key informant

The first six months of working with the client were felt by stakeholders to be about getting them to engage with the Health Case Manager and the next six months about engagement with services. It was felt to be beneficial that the Health Case Manager was linked to an employability agency as this was felt to sometimes be the next logical step once the Health Case Manager input was no longer needed.

“… the first six months was getting them to get engage with me; and the latter six months has been about getting them to engage with other organisations and actually undertaking work to improve their lives.”

Key informant

Overall the expected duration of the Health Case Manager intervention was felt to be on average 18 months with intensity tailored to client requirements.

“I think you know, the nature of the people that we’re working with, you’re probably, we expect to spend at least eighteen months with them. So, you would hope within an eighteen month period, you’ve plugged them in to a set of services and, your input with them could be reduced down to a minimum, you know so if the input starts off at an hour a week maybe, by the end of the eighteen months they may be receiving services from two or three other agencies and they’ve made a bit of progress with their life goals, and you might be able to go down to like an hour a month. But, we’re, we’re only twelve month’s into [the Health Case Manager]’s project and we wrote in the, you know the kind of project proposal that we would on average expect to be working with people for about eighteen months, and really be able to see you know measurable change.”

Key informant

In terms of the relationship between the Health Case Manager and the wider Community Renewal organisation it was felt that it was a good fit and the rest of Community Renewal should be using a case management approach, though more informal than the Health Case Manager. There was also the perception that Community Renewal staff knowledge about local issues should complement the expertise of the Health Case Manager.

Liaising with other organisations

An important component of the Health Case Manager role was identified by stakeholders as helping people to access and sustain relationships with other organisations. One respondent felt that shared values and an asset based, person centred approach made it easier to work with voluntary compared to NHS organisations. Developing a good relationship and contacts within other agencies was highlighted by one respondent as being conducive to collaboration.

“So it’s much easier really working with other organisations, you know for example- Cyrenians very, very easy to work with. Similar ethos, similar values to ourselves, very person-centred. So it’s generally quite easy to make a referral and the referral will stick. Women’s Aid, again you know very easy for us to work with, good relationship, you know you can pick up the phone, you can talk to somebody. That type of thing makes it much easier. Where it’s a more formal you know, set up, it’s you know, you make a referral but you don’t have a sort of named person at the other side, you can’t really build up that relationship. You have to go through a process which is quite anonymous.”

Key informant

One stakeholder identified how the client’s engagement with the Health Case Manager service and trusting relationship the Health Case Manager could facilitate engagement with other organisations even in referrals where the client had a negative opinion of the other agency.

If they think that you’re, you know because there’s been families that I’ve been working with that have always had a really negative opinion of social services, have never engaged with social services, unless it’s been a legal requirement, ehm but as a result of their engagement with me I’ve now got them on voluntary basis engaged. And that was based around them trusting me, trusting me and believing you know if I said this was the best course of action, that even if they couldn’t recognise it initially that they were happy to trust my opinion I suppose.”

Key informant

For clients receiving care from NHS organisations stakeholders said that the Health Case Manager was being successful in getting people to engage with their care but that this required much time and effort. Attendance at NHS organisations was identified as requiring greater support compared to other, voluntary organisations. Usually for NHS the Health Case Manager didn’t refer but rather supported the client to attend.

“You know, I know she’s had some success in getting people to engage with their Hepatitis key workers, and people like that, but it’s taken her to actually make the contact, go with the person, introduce them. Which is fine, that’s what case management’s all about…”

Key informant

Referral processes to other agencies depend on the receiving agencies requirements and referral forms could be brief or very structured. One stakeholder described how after receiving the referral they had a meeting to explore the client history and expectations. On-going dialogue and joint visits were felt to be helpful and reduced barriers of referral processes. Joint working facilitated meetings with clients and tasks could be shared between the Health Case Manager and agency staff member according to strengths. Things that were felt by stakeholders to be conducive to a good working relationship were personality, communication and shared vision.

Stakeholders highlighted the beneficial impacts the Health Case Manager made on their ability to work with the client. The Health Case Manager was thought to have greater insight into the client’s circumstances and the knowledge and expertise to guide other professionals. One interviewee said they felt able to take more complex cases because of the client’s pre-existing relationship with the Health Case Manager. Because the Health Case Manager had built trust with the client engagement with the receiving agency was increased (both in likliehood and rapidity). Working with the Health Case Manager also meant that an intervention could be delivered and the benefits would be sustained when the agency withdrew. From this it appears that the Health Case Manager has an important role in clients being able to receive interventions and sustain impact of them.

“But also the good thing is when I think when you’re working with kind of chaotic, things can kind of fall apart a little bit again, and the great thing, I always thought with [the Health Case Manager] maybe working with families longer, is you, you kind of had that, I had that ability to go in and do the quick snappy thing that we do, You know, quick interventions and things that could be done and get kind of back on track. Where [the Health Case Manager]’s job was to kind of keep them on track a little bit more. You know where… and I suppose and that kind of… you know if you’re working with less chaotic people that are used to kind of support, then they can cope when you’re not there. But often there’s such a process of that, kind of… engagement not gonna be there, I would say”

Key informant

In contrast to this one stakeholder voiced a concern that there may still be residual barriers to clients taking up or sustaining referrals because of the different working practices.

And I know that [the Health Case Manager]’s, she’s referred a lot of people [to an agency that] have got quite a strict process you know, and some people haven’t been able to sustain, or they haven’t been able to really take up the [service] because, maybe they missed an appointment or they didn’t respond to a letter or whatever.

Key informant

Some stakeholders described barriers to working with other organisations due to difficulties in sharing information and inflexibility of roles. However these barriers were not perceived with the Health Case Manager even though the systems were very different. For all organisations one of the problems identified was that each organisation had their own assessment forms that required filling in for the client. From a Community Renewal perspective it was felt that collaboration would be facilitated if the Community Renewal assessment could be used by the receiving agency.

Why clients fail to engage

A range of reasons for non-engagement or disengagement with the Health Case Manager were described by stakeholders. One interviewee described how clients may be undertaking illegal activity and this will be a norm for them that brings benefits, other clients may not have the motivation or understanding to want to change. Some clients may disengage once they feel they have addressed their own immediate priorities and may not want to take it further but may do in the future when they feel ready. The importance of finding a balance between spending time trying to get a client to engage whilst others in the community may also be needing the intervention was also highlighted.

“I think that, well for ones that have engaged and then subsequently disengaged, I think that they maybe at this stage have reached as far as they can go...[discussion of this point further] Or if they don’t feel that you’re… passing judgement on them, they’ll be more likely to then come back.”

Key informant

Clients may also fail to engage with organisations they are referred to despite engaging with the Health Case Manager. One possible reason suspected for this by a stakeholder was that the client didn’t want to be referred but agreed but then failed to go. There was also a concern that the reasons stated by the client for not attending do not reflect underlying reasons. It was felt that this may be due to fear of changing behaviour such as drug taking – and that the client may not be ready. The most appropriate response to this situation was perceived by the stakeholder to be to find out more about what was motivating the desire to change and go at the client’s pace. Other reasons for disengagement with agencies were felt to be related to how the service is provided. In some cases services may not be suitable for Health Case Manager clients with shorter courses or stricter criteria in terms of attendance.

“A lot of people are being offered six session of CBT as a kind of starter for ten. And, the kind of people that we’re working with, it’s just not appropriate- they probably need much, much deeper kind of counselling.”

Key informant

Health Case Manager attributes

The attributes that were felt by stakeholders to be important for a Health Case Manager included well developed listening and counselling skills. Key desirable personal characteristics were described including being patient, caring, open, engaging well with people, non-judgemental and flexible. This was contrasted to the importance of maintaining professionalism and boundaries. A need was identified to be open and transparent and upfront with the client from the beginning about what the boundaries of the roles are. These characteristics were felt to be important in helping the Health Case Manager connect and communicate with clients.

“to be non-judgemental in your approach has to be number one, and clients will test that, and that is, that will make or break the relationship at the very beginning.”

Key informant

On a professional level other organisations felt that the current Health Case Manager’s openness and general approach made it easier to engage

“I think she does a really good kind of working and very kind of open and she engaged well with people, and yeah. I thought… it’s difficult to come across people that you can work so closely well.”

Key informant

Health Case Manager resource requirements

A background in health and social work or counselling, with an ability to work in the community were identified as key requirements for the Health Case Manager role by stakeholders. Additional post-specific training was reportedly provided by Community Renewal e.g. in paperwork for holistic assessment and registration forms with the complementary skills training to be provided as indicated by the person’s previous experience e.g. counselling.

“So if they come with a kind of nursing background, we usually you know try and give them a bit more training in counselling if they don’t have that and if they come with a counselling background, then we really train them in our own kind of, in-house tools that we use...”

Key informant

Stakeholders identified a good knowledge of available interventions and specialist knowledge of how to work with challenging clients as being important for the Health Case Manager. Though no formal risk assessment was conducted with the clients it was felt by one respondent that the Health Case Manager’s experience as a psychiatric nurse with training in management of violence and aggression and de-escalation was very relevant to the post. As the Health Case Manager was required to work by herself in the community it was reported that a lone worker policy had been provided at induction and a security system (Argyle system) was used when out in the community.

On-going support

One stakeholder reflected on the importance of being aware of boundaries and the need for professional support whilst working in isolation. Current measures in place including regular, independent supervision from the Health Case Manager’s profession from someone in a similar post were felt to be essential. Additional support identified as being in place were line management supervision and a case manager mentor. The difficulty of attending on-going professional training required to maintain CPD was highlighted by a stakeholder with the main barrier felt to be time constraints.

One stakeholder said that though no specific Health Case Manager guidelines or policies were in place at the moment they would be keen to develop them to protect clients and staff. Specific areas identified in interviews included risk assessment, sharing of information / confidentiality and how long to keep trying to engage someone

Administrative support for this type of role was felt to be important. Other needs identified by respondents that included factoring in time for writing up case notes, travel and research.

“And I think the kind of thing about being really realistic about time, in terms of really doing case notes and building in time to be able to have the time to research and look at what… I think that’s the only way you can provide a really good service for someone. And you’re not gonna know everything, you need... you know… I think in my role, you know I wasn’t full time but I worked [fewer] hours a week, so I had a slightly reduced kind of caseload, and then I had my travel time, and I had my case note time, and my face to face time. But I think I had about 8 hours a week that I was able to really research and look into what’s about. And I think that’s, that is vital.”

Key informant

One stakeholder identified the ideal caseload for clients requiring this intensity of input as being between 8-10.

“A full time person would have about a caseload of about ten people, eight to ten people per week, where I think on occasion I had spoken to [the Health Case Manager] and she’d maybe have 20 people, and they wouldn’t necessarily all have been engaging necessarily on that week, but she still had to kind of chase them up and keep her case notes up to date and… You know I always, vividly remember saying to her “that doesn’t seem sustainable, or manageable in my mind”, but that was just from a bit of an outsider... “

Key informant

Difficulties for the Health Case Manager role

One of the problems raised by a stakeholder was that the Health Case Manager was a new post which was often poorly understood meaning that the Health Case Manager needed to rely on professional credentials which in turn created confusion. It was felt that more professional recognition of the Health Case Manager post was needed as there was no automatic trust from other professionals.

“So having some sort of professional recognition that you know, that Health Case Manager is a valid post, is a post which is able to make referrals, it’s a post which is able to communicate with other health professionals on an equal footing. That would make it the biggest difference I think. Because at the moment you know, it’s bit of an unknown quantity and you know, within the NHS that’s never an easy thing to… there’s not this, you know, there’s not enough sort of… not an automatic trust there or there’s not an automatic sort of respect the way it would be, you know if it just another nurse or another GP or whatever.”

Key informant

One of the risks identified by stakeholders for the Health Case Manager was working alone in the community, going into homes at first contact with no risk assessment (the Health Case Manager is unable to speak to the psychiatrist or the GP initially). This was contrasted with other health professionals where the client’s background would be known. There was one report of a referral who may have posed a risk and the Health Case Manager was alerted to this through chance only. However alternative approaches discussed were not felt to be workable. One respondent said it would be difficult to have other Community Renewal staff accompany the Health Case Manager as not bound by the same professional codes of confidentiality and topics discussed such as sexual abuse may be distressing for someone from a different professional background. Joint visits with other organisations prioritise getting the client to engage with them and it was not clear whether this would be appropriate on a regular basis.

“So there was the potential for… a very risky situation- so in that respect communication with statutory organisations isn’t there and that is a concern in that respect.”

Key informant

“I suppose the only difficulty potential, and it hasn’t been an issue thank god, but the only difficulty is not, as a CPN, you had a medical referral, you had a risk assessment, you had you know you were able to get a collaborative history before you ever walked through somebody’s front door, whereas you’re walking through somebody’s front door with absolutely nothing”

Key informant

A further issue raised was that a Health Case Manager doesn't practice within a team undertaking similar work; the role was felt to be a bit detached from the rest of the office leading to a potential lack of professional support e.g. other team members to discuss management of difficult cases with. One of the stakeholders highlighted that this is something that is planned to be addressed.

“I think that the nature of the type of work that [a Health Case Manager is] doing, it’s important to have other people to be able to bounce ideas off, to just check different things cause it’s easy to lose objectivity”

Key informant

Client drawbacks

Stakeholders felt that the contrast between how the Health Case Manager and other agencies provide services may be difficult for clients. It was noted that there were barriers for other agencies to work holistically due to service or resource constraints. There was a concern that clients may not sustain their engagement with other agencies as a result and that the Health Case Manager may need to work longer with a client to overcome this. The importance of ensuring that the client doesn't become dependent on the Health Case Manager and replace the services was also highlighted.

It was felt that the move to new premises meant that the new environment is not as relaxed which was discouraging some clients from attending. The room which was purpose built to be sound proof was felt to be small and “prison like” and one client was reported to have had a panic attack. One respondent identified how the Health Case Manager had tried to use other premises (e.g. in the community or home visits) to address this.

“And what are the issues that clients are raising?”

Interviewer

“… one client had a panic attack in the room cause it was too dark and like there was no window, no outside light. It just feels like a very forced environment and people don’t generally be at their ease..”

Key informant

Disengaging from other agencies

One stakeholder described the process of disengaging at the client’s initiation. When the client starts to disengage they would have a dialogue with the client and the Health Case Manager to ascertain whether this is what they want and need. Sometimes the timing of the intervention might not be felt to be right for the client and the agency would allow them to re-engage in the future. The conversation with the Health Case Manager was described as being good to help identify other ways to engage the client or potential barriers. It was noted that sometimes clients’ needs can change as other agencies become more or less involved. Once a decision has been made the referring agency would then let the family and the Health Case Manager know.

“I suppose prior to us making the decision that actually now’s not the right time, we did have conversations with the worker who made the referral about what’s going on, do you know, ehm... What should we be doing, is there anything we should be doing differently here to try and engage this parent. Or is it clearly at this moment in time she’s overwhelmed and actually she’s reprioritising her focus…”
Key informant

One stakeholder described how they were very clear with the client from the outset that the input would be for a maximum of 6 months. That respondent felt that having the Health Case Manager support facilitated their provision of time-bound input for chaotic clients (i.e. the client receives support elsewhere when the intervention is complete).

Discontinuing the Health Case Manager input

The appropriate duration for the Health Case Manager intervention was felt by stakeholders to be approximately 18 months with cessation of the service being a very gradual process with a reduction in the intensity of input. It was noted however that some clients will disengage independently sooner. Potential reasons for this proposed included clients not being ready for change or not motivated. The view was expressed that even for those clients who disengage prematurely there may still be some benefits.

“But it would be, you know, this stage sort of twelve months in you would expect some clients to, the ones who I would think that [the Health Case Manager] would disengage, will be the ones that are not interested. You know the ones that are just not turning up or you know, they’re not ready to really move forward in their life. Otherwise I don’t think she would really be at the stage of disengaging with anyone yet you know, we’d really want to see people on their feet and you know have moved from the ten per cent to the forty per cent, which is kind of again, a very notional you know, you can’t measure somebody now in the forty per cent, but notionally you would want to, you would to be sure that they were kind of a bit steadier on their feet before you would completely disengage.”

Key informant

Clients who cease to access the Health Case Manager’s services because they no longer need them may still require other forms of input. This might be from other organisations or Community Renewal’s own employability service. Some clients were noted to be reluctant for the service to end, in some cases it was felt that this may be due to the help they receive with practical issues.

“I think that there’ll be some clients where they’re going to need on-going support, and that doesn’t necessarily mean to say that that’s needs to be me, you know it would be about identifying with that individual which organisation or which service or which person would be most appropriate in addressing those needs. And that may be me, but at the same time, you know there’s a lot of things that I do for clients that I know other organisations won’t do, and I do it because to get them to trust. I needed to be doing benefit stuff, and I needed to be doing that kind of thing so, they’re going to be more likely to come back to me, I think because they know that that’s what they’ll get instead of another organisation saying well- they don’t do that.”

Key informant

Future for Health Case Manager service

There were several areas of potential or planned growth and development identified by stakeholders. Some stakeholders mentioned practical issues such as the planned development of protocols for standardised working practices. Another area highlighted was the on-going development of a case management manual and shared processes for assessment and referral protocols between agencies within the Portobello & Craigmillar Health and Wellbeing subgroup. For the future it was also felt to be very important to look at how information about the Case Management approach could be disseminated and thus learning shared.

“what can we learn from what we’re doing that might be transferable in some way. Because what I don’t think is likely to happen in the future, you know in the short term or long term future, is that we’re gonna see lots and lots case managers. There’s no money in the NHS to develop lots and lots of new roles. But I think what would be interesting from my point of view is how can some of the principles be built into some of the roles that already exist. Because at the moment there are very few job roles within the NHS that I’m aware of where someone has the freedom to work with someone in such a holistic, do you know what I mean?”

Key informant

Some working practices were felt to need further development. This included approaches to information sharing and joint support plans to avoid duplication of work and repeated assessment for the client. Another area was processes around deciding which clients were appropriate for intervention and finding a balance between clients who can be supported to engage with other organisations and others who require very intensive input with motivational interviewing.

One stakeholder highlighted how the shift in focus of the organisation to more overt employability and a move in premises meant that the internal referrals were reducing, meaning that consideration of other sources of referrals such as GPs and social services was possible. In addition new approaches for engaging with clients were suggested such as group work or joint working e.g. a one stop shop at GP. A few changes that could be made to improve services were outlined: one was that a venue in the heart of the community was needed to deliver the Health Case Manager intervention.

“…having maybe like a drop-in at the GP surgery one afternoon and you know it can be a one-stop shop for people, and they can come along and talk about anything, we can identify what would be the best organisation to take that further for them you know so maybe, and I think that whenever the new council office opens it would be a facility to be able to do that kind of thing a bit more”

Key informant

# Additional evidence

Cross sectional case studies

The Health Case Manager prepared a document describing 19 of the cases currently on her client list. This following figure summarises the hopes and goals as identified by the client with the Health Case Manager. Where these goals are very specific some of the detail has been taken out to protect client confidentiality (see Figure 14).

Figure : Client Hopes and Goals

Hopes and goals identified by the client with the Health Case Manager

Financial

Sorting out benefits

Financial security

Deal with debts

Housing

Having a place of his/her own

Sort out flat (e.g. deep clean, organise repairs, move)

Social

Improve relationships within family

Improve social network

Address loneliness

Mental health

Improve self confidence

Improve mood

Address mental health symptoms

Dealing with bereavement

Physical health

Improve physical health (improve self-management of chronic disease)

Address chronic pain

Employment

Organise training/employment

Pursue volunteering opportunities

Drugs, alcohol and smoking

Stop or reduce methadone

Stop or reduce alcohol

Deal with drug addiction

Stop smoking

General

Sorting out daily structured activities

Able to fully care for him/herself

Case study

In order to preserve clients’ confidentiality we did not present a single case study but developed a composite case study which illustrates some of the typical problems, interventions and outcomes experienced by the clients.

Figure : Case study

**Background Information:**

* Man, mid 30s with history of poly-substance misuse, childhood trauma and significant family disharmony, spent a number of years in care.
* History of depression and previous suicide attempts
* No formal education or previous sustained employment
* In receipt of Employment and Support Allowance however regularly fails to submit medical certificates in time and payments tend to be stopped and this tends to lead to criminal activity.
* No day structure or support network.
* Rent and council tax arrears and at risk of losing his tenancy.
* Has a child but has limited contact due to previous substance misuse. Keen to re-establish contact and wants legal arrangement in place.

**Presenting issues client wanted to address:**

1. On prescription for methadone and keen to reduce and stop within a year
2. Improve mood and increase day structure
3. Attend dentist to address dental problems stemming from methadone use
4. Legal arrangements for regular access with child
5. Address debt issues and move to a different part of town to distance from local drug dealers

**Outcomes:**

* Following lengthy engagement period client decided to reduce methadone in consultation with GP and Health Case Manager.
* Mental state assessed and anti-depressant commenced by GP.
* Weekly sessions with Health Case Manager during the first year as engagement wavered with other organisations due to long standing entrenched mistrust in statutory and voluntary organisations
* Referral to following organisations:
	+ Neighbourhood support team to assist with financial arrears and assistance in obtaining a flat exchange
	+ 3 RT for information session, reduction to methadone in consultation with GP and longer term view to admit for inpatient rehab
	+ Accompanied to dentist drop in service for drug users
* Decision to postpone seeking legal advice regarding access to child
* Referral to EVC for day structure.

Client continues to make progress and the following issues have been resolved

* Financial arrears addressed and waiting to hear about new property
* Dental treatment ongoing and good engagement
* Methadone successfully reduced, awaiting inpatient rehab
* Antidepressant medication
* Ongoing psycho-social interventions by Health Case Manager

# Discussion and Conclusions

The overall aim of this evaluation was to be formative with a view to informing further development of the service. The objectives included:

* Process evaluation of the Community Renewal “Health Case Management” approach used in Craigmillar
* Evaluation of activities, outputs and outcomes
* An evaluation of the costs (if possible within constraints)
* To provide information for the project stakeholders, providers and funders for development and implementation of the “case management” approach

Difficulties with the evaluation

At the time of evaluation the Health Case Manager had only been in place for 12 months – the anticipated requirement for engagement is 18 months. Therefore it is not yet possible to establish what the full impact of the intervention is likely to be on clients’ health and wellbeing. As this is an intervention with only one Health Case Manager at present and it has only been in place for a limited time period there has only been a small number of clients to date. This means that it is important to be careful when drawing conclusions from their experiences. It was necessary to limit the amount of information provided within both quantitative and qualitative analysis where it might have breached confidentiality.

From the client group only those who had successfully engaged; were willing to be interviewed; and at a time in their engagement where it was appropriate to offer them the opportunity, were interviewed. Thus there is inherently some bias in the results. It is therefore important to consider that there will be additional barriers to starting or continuing to use the service that we have not captured here. In addition though it represents the views of a large proportion of the clients who have used the services, there are doubtless additional themes that would have arisen with a wider client group.

The client group was drawn from a very small geographic area and differences in implementation and results may be found if the client group changes or for those wishing to replicate the intervention in other settings. In addition those who engaged initially may differ from those in the future.

There is no comparison group available for this intervention. Therefore the best evidence available has been collected by focussing on short term objective outcomes such as engagement with the Health Case Manager and other agencies and client and stakeholder subjective assessment of the impact on the client’s life. However it was not always possible to triangulate information collected. In addition, evaluation of case management interventions is inherently complex and it can be difficult to attribute the benefits to any one element.9. The following sections will provide a synthesis and discussion of the quantitative and qualitative evidence collected in the different sections of the evaluation.

* Finding out about and first contact with the Health Case Manager service
* Engaging with the Health Case Manager service
* Impact of the Health Case Manager service
* Service activity
* Working with other agencies
* Services provided directly by the Health Case Manager
* Health Case Manager resource requirements
* Monitoring and evaluation
* Future of the intervention

## Finding out about and first contact with the Health Case Manager Service

Over half the clients had found out about Community Renewal or the Health Case Manager service through the Listening Surveys. This indicates that a proactive approach is conducive to identifying those in the community who need support. This may be particularly of benefit to those clients who are least likely to have presented to the service of their own accord. However future clients also heard about the service from friends, family and community and the previous central community location. Cumulatively over 1 in 4 had either heard about the intervention or been referred by another organisation. This is likely to be of growing importance as the Health Case Manager’s work with other organisations increases awareness. Some clients had heard directly of the Health Case Manager whereas others had first come to Community Renewal as an employability organisation. The previous Listening Survey process has now stopped, but more recently Community Renewal has started engaging younger people in the Craigmillar area through a range of methods including street work, referrals and linking in with a care provider for young people.

Clients heard about or were recommended the service by sometimes several different sources before making the decision to attend. Having awareness in all these places will increase the likelihood that someone will not only hear about but then go on to make contact. Seeing evidence of benefit in others, or hearing about it was a factor in motivating clients to seek out the service. The longer the service is present and is viewed positively, the more likely that people will present. However there is potential that the location change may impact on community awareness. Recommendations by others were important factors in deciding to come and see the Health Case Manager, as were the underlying problems which required help with a crisis potentially prompting attendance. This has implications in terms of the need for the Health Case Manager being able to respond to urgent referrals.

The client group was identified as having a history of failing to engage with services. It is clear from the evaluation that a considerable amount of work is required to engage this client group. Over the first 12 months of the evaluation the Health Case Manager attempted to engage 61 clients. Of these just under three quarters met with her once (74%) and over half (56%) went on to engage fully. There is no direct comparator group but they need to be viewed in the context of the client group.

Once the Health Case Manager was in post a very high proportion (almost two thirds) of clients engaged the same day, and for those that didn’t engage the same day a maximum interval of 27 days was found. Some early delays may be due to an initial period where the Health Case Manager came into post and referrals were already made.

By the end of the first 3 months in post the Health Case Manager had attempted to engage 36 clients meaning that all those on the referral list had had an attempted engagement. For other clients this interval may have been due to them either not needing intervention, or their need either not being felt or expressed for the service until their situation changed. Despite these factors attempted engagement with the Health Case Manager occurred on the same day for almost two thirds of clients once the Health Case Manager was in position. This may indicate that they were primarily attending for the Health Case Manager service or that it was immediately apparent that this is what was required.

## Engaging with the Health Case Manager

Characteristics of people engaging

The characteristics of clients engaging and not engaging were identified to evaluate whether particular groups faced additional barriers. There was a clear weighting towards men being referred and within this men were more likely to engage beyond one visit. There are a number of plausible reasons for this. It could be due to there being greater need amongst men for an intervention addressing multiple life wrecking issues or they may be more likely to express need or accept support. Alternatively it may be that women are facing additional barriers in asking for and accessing help. There were no gender specific reasons identified within the qualitative analysis that could account for this difference. The Health Case Manager is a female so this is unlikely to constitute a barrier. Review of the gender balance for different sources of referrals revealed a fairly uniform pattern (except for referrals from “other organisations”). Therefore it is important to be aware that there may be barriers for women and to pro-actively address them if they are found.

Referrals tended to be around middle age with the average age just under 40. There were no clients over the age of 59 – perhaps this is a reflection of the wider Community Renewal focus as an employability organisation. Likewise there were no clients under the age of 19. It is also possible that this reflects either different needs in these age groups or there are alternative service providers. It may be worth exploring whether there are people in the community out with this age range who could benefit if the service is felt to be appropriate for other age groups.

Ethnicity was mainly White (White Scottish, White British, White Irish) which reflects the local ethnic make-up (97% of residents are White) in the Portobello/Craigmillar Ward. There was therefore a proportional representation of the local population.

Key points

* Potential access barriers for some groups

Developing the therapeutic relationship

The qualitative information from both clients and stakeholders described the development of the therapeutic relationship with clients. Clients clearly related essential attributes of their relationship such as trust and confidence. They also identified the characteristics such as a non-judgemental attitude, respect and politeness which are key qualities that should be present in a Health Case Manager.10 This was echoed in the stakeholder interviews as being pivotal in the Health Case Manager role and particularly in this client group, where there will have been many additional barriers such as mistrust of all services, to developing a good relationship. In contrast to the clients, stakeholders also valued the importance of boundaries with the client and professionalism which are other key features of a successful relationship.

Evidence of the success of the therapeutic relationship is found in the clients’ description of feeling an obligation to attend services – it shows the value of the commitment that they feel they have developed with the Health Case Manager. Furthermore clients who felt reluctant or unsure about attending initially described as overcoming this due to the skills of the Health Case Manager and the right environment. The same factors which encouraged them to start coming such as a friendly relaxed environment were also conducive to continued attendance (though clients were more ambiguous about the new premises). Though the content of the service was important, the way in which it was delivered was also critical. None of the clients were using any other similar case management services when they came to the Health Case Manager though some were attending other services so no comparison can be made.

The first six months of the engagement with the Health Case Manager was described as establishing contact with a referral and developing the therapeutic relationship. Factors which were felt to be conducive towards this included a flexible approach, non-official relaxed environment, ease of accessing the Health Case Manager and her responsiveness (text, phone etc.).

This therapeutic relationship allowed clients to open up about goals and priorities. There was some divergence of views about dependence. Stakeholders perceived that the therapeutic relationship needed to be carefully negotiated with this client group, as evidenced by the concerns around avoiding dependence or conversely the perception of the Health Case Manager outside the professional role i.e. as a friend.

A final area that was identified as being important was the balance between adapting working practices to clients’ needs, and putting some limits into place. The Health Case Manager works in a very client centred manner but even within this there was felt to be a need for some boundaries.

Key points

* Developing the therapeutic relationship is central to the role
* Managing the therapeutic relationship may be complex
* Balance client centred care and limits

Identifying issues for action

Clients identified a mean number of five issues for action in keeping with the holistic assessment. The issues most frequently raised were mental health, social and housing. From the case studies it is possible to see that some of these issues are potentially very complex. For example, addressing low mood may require a number of referrals and could require long-term input. Some goals will take a long period of time to see improvements.

Key points

* Goals or hopes may require long-term and complex input

Duration of engagement, non-engagement and disengagement

As the expected minimum duration of engagement for clients to effect significant progress towards their goals was 18 months, the duration of engagement of clients to date must be interpreted with caution. This figure is skewed downwards as the intervention had only been in place for 12 months at the end of the observation period. This means that those that have disengaged to date are those with an early positive outcome or failed engagement. Following cessation of input from the Health Case Manager the client may still need input from other services. Guidance on how discontinuation of the Health Case Manager will be routinely managed is provided by the guidance from the working group (see Appendix 1) and draft Case Management Manual 12. These highlight the importance of discharge occurring by mutual agreement, the potential for maintaining contact if needed and re-engaging as a new client if further input is required following completed discharge. As the service had only been in place for 12 months at the end of the observation period it is not possible to comment further on this aspect.

For clients whose engagement discontinued due to circumstances beyond their or the Health Case Manager’s control there is little that can be done. However, almost a quarter of clients disengaged unilaterally without known reason. No figure is available for comparison for this client group and this type of intervention but for the population accessing mental health services a recent systematic review found rates of around 30% (O'Brien, Fahmy, and Singh 558-68). This may be an indication that the disengagement rates for the Health Case Manager are low given that client group served have both already failed to engage with traditional services and are all affected by multiple and severe health and social issues. A common concern however is that clients who disengage from services may be those with greatest need. For mental health services other authors have suggested that those clients who disengage from mental health services may be more likely to have a forensic history, substance misuse, personality disorders, a dual diagnosis of substance misuse and mental illness. (O'Brien, Fahmy, and Singh 558-68) Many of the Health Case Manager clients have identified with these issues and may therefore be at particularly high risk.

A large proportion of clients either never engaged or disengaged after one visit. A limited amount of information is available on this topic from the evaluation. Input is not available from those that fail to engage as the Health Case Manager is no longer able to contact them. Stakeholders identified some reasons such as “not being ready”, lack of motivation or understanding or drawbacks (e.g. financial). These mirrored the reasons identified for non-engagement with other agencies (though they may face additional barriers in view of their working practices). Though clients who engaged identified more goals, this is likely to be a reflection of the gradual disclosure to the Health Case Manager of other underlying issues rather than those who don’t engage having fewer issues. What is however striking is that despite the trend towards non-engagers disclosing fewer issues greater proportions disclosed drug use and an equal proportion identified mental health issues. Though this is only marginally greater than for those that go on to engage it is potentially larger as the clients disclose more underlying problems over time. This may mean that mental health and drug use constitute a barrier to engagement.

There is limited information on disengagement in this client group. This makes it a difficult issue to address. The current approach means that the Health Case Manager pro-actively seeks to continue to support engagement and only discharges a client from care after considerable input. Evidence from the evaluation would suggest that the measures in place are appropriate. However, even if a client disengages there may still have been some benefit and they may also go on to re-engage in the future.

Key points

* The expected period of engagement is 18 months
* Limited knowledge on why clients disengage
* There is a concern that those clients who had limited or no engagement may be those with greatest need
* Health Case Manager intervention may be of benefit in reducing disengagement in this client group with multiple and complex needs
* Processes are in place for appropriate discontinuation of service

## Impact of the Health Case Management service

The effect of the intervention was evidenced in the quantitative analysis by the success rates of clients attending referrals and receiving services directly from the Health Case Manager. This however only informs on the interventions received. The impact on clients’ lives was significant as evidenced by the statements outlined by each of them. Many of these indicate that the client’s perception of the intervention is life changing, touch on aspects of significant improvements in mental and physical health and changing attitudes with empowerment and positivity. It is important to view these results in the context that the majority of clients have not yet completed their engagement with the Health Case Manager.

Key point

* Impact of the Health Case Manager is perceived by clients to be life changing

Client satisfaction

Clients gave very positive feedback about the Health Case Manager and the service. Comparison to other services was uniformly positive though none had attended a Health Case Manager elsewhere which they could compare it too so this makes it difficult to interpret. However comparison to Community Psychiatric Nurse input was favourable. A recent review stated that though they were only able to find minimal evidence, high satisfaction with services is likely to be conducive to engagement.(O'Brien, Fahmy, and Singh 558-68)

There were previously very positive but mixed reviews of the current centre location and facilities since the move, mostly due to the small size of the office, and the location not being directly in the community. Ease of access was important and clients were more reliant on meeting the Health Case Manager elsewhere since the move. Access in the community to the Health Case Manager was felt to be important even though services that they are referred to are delivered elsewhere. The co-location with an employability agency was however a good fit for those ready to move on.

Key points

* Client satisfaction with Health Case Manager service is high and this may facilitate engagement

## Service activity

Caseload of the Health Case Manager

An average of 14 visits per week were arranged over the course of the 12 month period. That a large proportion of them were cancellations or DNA is consistent with the client group. Many of the DNAs were incurred in the process of trying to engage the client. The client group that engaged had a similar total average number of DNAs to those who only had limited engagement. For those with limited engagement the Health Case Manager would spend an average of 2 months trying to engage them. These meetings contributed significantly to the Health Case Manager workload as the Health Case Manager needed to set up the meeting, travel to and from it and follow up on the missed meeting potentially with the client and potentially a third party.

The Health Case Manager had a caseload of 20 fully engaged clients as at the end of June 2012. Only 3 clients had been discharged from the service because they no longer required input which is consistent with the expected intervention duration of 18 months.

Key points

* Clients who go on not to engage may contribute significantly to the Health Case Manager workload

## Working with other agencies

The referral process to the Health Case Manager was flexible and often over the phone facilitating referral by other organisations. The referral criteria were flexibly applied implying that the Health Case Manager’s judgement was important too.

Brokering relationships with other agencies was often not the focus of the Health Case Manager intervention until the second six months once the therapeutic relationship had developed. Clients were referred to an average (median) of three agencies. This encompassed a wide range of agencies providing a range of services which reflects the Health Case Manager’s intimate knowledge of the providers and services available. This is something essential to the post. In the qualitative analysis it is apparent that the Health Case Manager’s knowledge of which services to go to and the right combination thereof is essential along with the subsequent support to attend. The reasons for referral were consistent with those identified by the clients for action.

Though in almost two thirds of cases the clients hadn’t been previously associated with the service it is noteworthy that in almost a third they had. The barriers identified on the quantitative analysis were client factors (e.g. alcohol use) or intervention factors (e.g. group setting). The Health Case Manager helped overcome anxiety showing that being accompanied on the first visit can be critical. It was apparent that having a Health Case Manager also improved attendance at services with which the client was already linked. Mutual obligation is key, especially where the Health Case Manager is also going to the appointment.

Supporting clients to engage with other agencies rather than simply referring them was often a key part of the Health Case Manager approach. Additional information was provided to clients about the referral in almost all cases. In just under half the Health Case Manager also accompanied the client to the first meeting – this was termed “referral via introduction” and was felt on reflective discussion of the report to be a key element in the Health Case Manager activity. Only a small number required accompanying on multiple occasions. Reminders were also used very infrequently.

Almost a third of referrals led to a successful outcome. Only in a fifth did the client never attend, in another fifth the client attempted to go before disengaging.

In the qualitative analysis respondents reiterated that this group had previously been unable to sustain contact and were able to do this with the Health Case Manager support. This occurred even for interventions where otherwise the receiving agency might have thought engagement wouldn’t be possible. This was attributed to the Health Case Manager having developed a therapeutic relationship with the client.

Reasons for disengaging, from the stakeholder perspective, were felt to be the restrictions placed upon other agencies in how they could work compared to the holistic working practice of the Health Case Manager. Alternatively it was felt that sometimes it simply wasn’t what the client needed or wanted though it was important that a conversation between client, Health Case Manager and agency take place to establish this and if possible allow future engagement.

Shared values and approaches were felt to make it easier to work with the voluntary sector whereas there were greater barriers particularly with the NHS. Shared assessments were seen to be desirable so that different agencies could use each other’s. Some steps had already been taken towards this in the development of the holistic assessment form and set up of the Health & Wellbeing subgroup. From a professional standpoint it is clear that openness and collaborative approach are highly valued.

Key points

* Health Case Manager knowledge of local providers and expertise in recommending the right services is essential
* Flexibility in referral processes and criteria enhance collaboration
* Supporting clients, particularly by accompanying at the initial referral visit integral to referral success
* Therapeutic relationship with the Health Case Manager integral to referral success
* Shared values and approaches are conducive to successful collaboration

## Services provided directly by the Health Case Manager

A large proportion of the clients received a few specific services directly from the Health Case Manager and in the most part this related to mental health services or welfare benefits. Supportive counselling was found in the qualitative analysis to be needed to help people get to the point where they wanted to engage. This is consistent with the Health Case Manager being felt to be the most appropriate provider for this. Psychological support is thought to be key in developing the therapeutic relationship and in helping individuals in developing the motivation to change behaviour. 9 The Health Case Manager frequently helped clients with benefit applications. This is potentially an issue of urgency and priority to clients and the reason for the Health Case Manager providing this is the delay in the availability of the appropriate service. Another common reason for the Health Case Manager providing services was client preference either because the client preferred the Health Case Manager or an aversion to other service providers. Though the initial intention had been to provide Health Case Manager services using a brokerage approach, in practice this was supplemented by provision of discrete services.

For the clients having the security that someone was there should they be needed was an important positive aspect of having a Health Case Manager. This perception of the role is in keeping with the Kings’ Fund review 9 as was direct provision of counselling. Again this is a reflection of the value of the therapeutic relationship. At least in part, in this client group this is fostered through the counselling and the help with practical issues as this develops trust. Also by providing reports for DWP the Health Case Manager can act as clients’ advocate. There are several different models of Case Management which exist. These have varying degrees of direct service provision by the case manager. Here it would seem that provision of some services directly by the Case Manager has benefitted the client beyond the impact of the service itself as there is evidence to suggest it has fostered the development of the therapeutic relationship. However this needs to be balanced against the resource constraints of the Health Case Manager time available.

Key points

* Providing services directly may be necessary if they are not otherwise available
* Providing some services may be conducive towards development of the therapeutic relationship
* Providing services directly needs to be balanced against the limited resource of Health Case Manager availability.

## Health Case Manager resources and requirements

The qualitative results found that the training and ability to develop the therapeutic relationship, assess and manage risk, understanding of appropriate services were essential to the role. Case managers can come from a range of backgrounds and experience in health and social work or counselling was felt to be appropriate to this role.

However it was clear from the qualitative work and the background information from CMSUK and the Kings’ Fund review that it is essential that professional support from the Health Case Manager’s own profession, mentoring and on-going training and development is available.9, 10 The former was addressed by the supervision from a professional working in a similar role however additional opportunities for continuing professional development should be identified and pursued.

A need for some additional policies was identified and was already underway at the time of data collection. This has since taken place. Community Renewal has reviewed health and safety procedures for all NHS funded projects and made changes to practical elements of lone working, risk assessment and additional input has been provided to Health Case Manager from Community Renewal’s Keep Well Outreach Service Co-ordinator. The standards set out by the CMSUK provide some guidance on what would be appropriate though specific areas of risk assessment, sharing information/ confidentiality and processes for engagement/disengagement which were highlighted by respondents would be appropriate starting points. Additionally guidance from the Health and Wellbeing subgroup should be considered.

There was some concern raised about the workload and ensuring that adequate dedicated time was assigned for other activities such as case notes, report writing, travel and research. Administrative support was felt to be desirable. There may need to be some balance between where the clients are in terms of their engagement process, the clients’ required level of support and number of clients. Isolation of the Health Case Manager (as not working with other Health Case Managers) is likely to be a recurring issue and could be addressed through other forms of support.

Difficulties identified by stakeholders of recognition of the Health Case Manager post may need to be addressed and approaches to this should be considered. However this may improve over time as professionals working with the Health Case Manager will become familiar with the role. In addition, expansion and continuation of the working group with the inclusion of other agencies may also help address this barrier.

Key points

* Essential for a Health Case Manager to have skills and training appropriate to the role
* Essential that a Health Case Manager has professional supervision, on-going training and development
* Administrative support and allowing adequate time for all facets of the role may be conducive to its conduct
* Development of policies and procedures may strengthen the role
* Professional isolation may need pro-active approaches to address

## Monitoring and evaluation

Information was drawn from a wide range of sources. Future routine monitoring and evaluation would be facilitated by systems of routine data collection. This could be relatively simple but may require some additional administrative support.

As clients move toward the 18 month mark of engagement it will be possible to determine the full impact of the intervention. Consideration of outcomes and how success of the intervention can be measured will be important.

Key points

* Systematic collection of data can facilitate routine monitoring and evaluation

## Costs and benefits of the Health Case Manager intervention

The funding received for one year of the intervention was £50,000. It is difficult to estimate the benefits in financial terms in view of both the intervention still being within the first year at the time of data collection and the relatively small numbers of clients concerned. However some costs can be provided of NHS services of the type that clients with issues typical of those attending the Health Case Manager may come to require.13

Mental health services

* Intensive care (adult) £654/day
* Acute care £330/day
* Outpatient attendances (consultant services) drug and alcohol £94/episode
* Counselling services in primary medical care £65/hour of client contact

Debt advice interventions

* Face to face £255/intervention

Drug and alcohol

* Residential rehabilitation £661/week
* Inpatient detox £1,054/week

Children’s services

* Local authority care home £2,999 per week

## Future of the intervention

Much of the input from the qualitative data was outward looking, focussing on how learning can be shared with other agencies wishing to implement a case management approach. The working group identified (Health and Wellbeing subgroup) has the potential to take this area forward.

Potential areas of change were identified including the role and situation of Community Renewal and expansion to other client groups. These will provide new challenges and opportunities. For example, referrals from GPs might lead to a different client group with different needs; it may also facilitate issues such as risk assessment.

Key points

* Planning for shared learning
* Changes to client group will bring new challenges and opportunities

# Recommendations

Recommendations were developed by those involved in delivering and managing the service at Community Renewal and the author of the document who undertook the evaluation. These reflect both approaches to pursue for their own practice and for other organisations wishing to use a similar approach. They are based on learning from what has worked well, where they have had to adapt and changes that they hope to make in the future.

**Recommendations for Health Case Manager services**

* Develop links between Health Case Manager and key services such as counselling and benefits advice services with consideration to co-location of service where appropriate and feasible
* Encourage a more unified approach to assessment with sharing of forms across both NHS and 3rd sector
* Work with mainstream services such as the Primary Care Mental Health Team to identify potential future clients who may be suitable for the service
* Explore the potential for incorporating Health Case Manager principles and methods into other roles e.g. Community Psychiatric Nurse or Practice Nurse or Health Improvement Staff within other services such as the NHS
* Explore how clients who fail to engage or disengage from providers that the Health Case Manager refers them to can be supported to re-engage quickly
* Shared values and approaches between organisations is conducive to the Health Case Manager role and should be fostered
* Be proactive about identifying and addressing of potential access barriers for clients
* Ensure systematic collection of information to facilitate routine monitoring and evaluation is in place
* Ensure that the Health Case Manager has training and support appropriate to the role
* Input may need to be long and complex and the caseload should be selected with respect to both the client numbers and the intensity of input required

**Key learning around the Health Case Manager role**

* Developing a therapeutic relationship is key to the Health Case Manager role
* Provision of basic services early on in the client Health Case Manager relationship can foster trust
* Balancing client centred care and limits to achieve a successful relationship
* Health Case Manager knowledge of local services and capacity to develop good working relationships and networks is essential to the role
* Supporting clients to engage with referrals to other agencies in particular by accompanying at the first visit is key to referral uptake

# Conclusions

The intervention is viewed positively by both care providers and recipients. It addresses the needs of those in the community with multiple and complex health, social and financial problems who face numerous barriers accessing care and facilitates their engagement.

Whilst this evaluation is formative and early following implementation of the intervention, it is able to provide evidence on the success of the Health Case Manager approach to date. It highlights areas of on-going development which will support and inform future implementation of the intervention. As the intervention matures future evaluation will be able to assess the full impact on clients’ health and wellbeing.

# Action Plan

A meeting between Edinburgh CHP, Community Renewal and the author of the document took place on the 6/8/13. Action points were identified from the report

1. **Future evaluation**

A record of clients who don’t engage and the reasons for their non-engagement is to be kept to allow evaluation of reasons why people don’t engage and support development of approaches in the future for those who are hardest to reach (where appropriate and feasible).

Routine data collection has been strengthened so that the quantitative data collection conducted for this report will now be routinely available electronically. This will facilitate ongoing evaluation.

Future summative evaluation will be undertaken once information is available for clients who have successfully completed the intervention.

1. **Identification of clients who require services**

In order to identify those clients who are most in need of services the Health Case Manager will work with local health care providers (such as GPs). In the absence of the Listening Surveys alternative approaches need to be explored including collaborating with other agencies, engaging with community connectors and encouraging previous clients to use “word of mouth” approaches to raising awareness in the community. Referral criteria will be developed through the working group to help other bodies to identify suitable clients.

1. **Health Case Manager working practices**

A maximum caseload of 20 clients is realistic in view of the intensity of the intervention and is in keeping with identified caseloads in the literature for intensive case management.

Supervisory arrangements for the Health Case Manager will be formalised including professional supervision where appropriate (e.g. by a supervisor from the Health Case Managers professional group).

1. **Development of the intervention**

The existing Case Management Manual will be revised by the Health & Wellbeing subgroup in light of this report. This includes development of referral criteria. The working group will develop shared processes with other key agencies to which the Health Case Manager works, explore the opportunities for co-location of services (in particular financial services).

1. **Risk management**

Lone working was identified as a risk for the Health Case Manager with identification of a near miss. In response to this Community Renewal and the Edinburgh Community Health Partnership will develop new approaches to ensure an adequate risk assessment has been conducted. A recording system for near misses will be implemented to support this.

1. **Supporting other bodies in using Health Case Manager approaches**

A training session (including an instructional video of the holistic assessment) has been developed. Training sessions with other organisations have been planned. The working group will look at how this work can be supported to allow expansion.

1. **Dissemination of report findings**

Presentations will be made to NHS Lothian Public Health department and Edinburgh Community Health Partnership. The report will be shared with the Scottish Government Health Inequalities pilot with 17c Practices, the Portobello and Craigmillar Neighbourhood Partnership and agencies involved in its Health and Wellbeing subgroup and the DIG group of GP Practices in Edinburgh.

Appendix

CASE MANAGEMENT or WRAP-AROUND SERVICES

The following is a note of a meeting convened by Community Renewal to discuss with its partners its process of Health Case Management. Present were:

XXX

For some time service providers involved in this way of working have recognised that the term, Case Management is powerfully descriptive, but it is also cold and clinical and they have sought another phrase to describe what they do. The term Wrap-around Services is used here, with a Wrap Coordinator being the person who provides the health case management.

1. Assessment and Planning for the Future

1.1. Assessment is a continuous process which the Wrap Coordinator conducts with the client as they get to know more and more about them.

1.2. The assessment includes the personal hopes the Wrap Coordinator helps the client to develop. (The language is important; hopes are more understandable than goals and everyone has hopes, while not everyone has goals.)

1.3. A standard assessment form, which contains basic information, and can go with a client when being referred is useful.

1.3.1. The South East Access to Treatment pilot has developed a common Triage form, a copy of which is included as Appendix 1.

2. Confidentiality

Informed consent, ‘need to know’ and the statutory duty to report underpin all sharing of information about a client between participating agencies.

3. Referral

3.1. To go with the client’s personal hopes, the Wrap Coordinator helps them develop a personal statement to take to the receiving agency. This empowers the client to be, almost, self-referring.

3.2. A minimum amount of information should be passed between the agencies. Where the referral is to a partner agency that has worked with the Wrap Coordinator in this way before, information can be given verbally.

3.3. The client knows what information has been shared between the agencies.

3.4. The first meeting with a receiving agency can include some additional assessment

3.4.1. The main purpose is to look at the client’s hopes and build a common sense of where they want to get to.

4. Client Centred

The purpose of the wrap around service is to promote the emerging authority of the client.

5. Wrapping Around the Client

Community Renewal depict the case management process as a wheel wrapping around the client, with spokes off it leading to partner service providers supporting the client. Or it could be seen as a life-jacket, wrapped around the client, with floats (partner service providers) attached supporting them.

5.1. A wrap around service is circular, not linear; once a partner service provider has helped make the client more buoyant, they are referred back to the Wrap Coordinator.

5.1.1. Sometimes a service provider cannot make a client more buoyant; they might not be the right service, or the client may not be ready to receive the service. The client is then referred back to the Wrap Coordinator.

5.2. A client is not unwrapped, or left to float unaided until they are ready and have achieved all they hoped for.

6. Reporting

6.1. The partner service provider should provide verbal or written feedback to the Wrap Coordinator that they have met and supported the client.

6.1.1. In some funding regimes this reporting may need to be quite formal in order to claim outcome payments for the work done.

6.1.2. See 5.1.1 above, where a service may not be successful, a report is still required.

7. Recording

There was discussion of the benefits of paper case records and electronic case recording. It was agreed

7.1. A case record of the Wrap-around Service provided is required.

7.2. Verbal reports received by the Wrap Coordinator must be written down in the case record and written reports should be filed.

7.3. There is no requirement, at this stage of development of Wrap-around Services, to produce outcome reports, which electronic recording facilitates.

7.4. Minimum sharing of information and verbal reports are preferred in the current stage of Wrap-around Services.

Paper systems of case recording will therefore suffice.

8. Case Conferencing

8.1. Case conferences should not be seen as standard in Wrap-around Services; they should only be called if absolutely necessary.

8.2. The client should be at the centre of any case conference.

8.3. The Wrap Coordinator should ask partner agencies to provide their own reports for a case conference.

Case conferences may be a way of linking this emerging Wrap-around Service with GIRFEC, the Drugs & Alcohol Single Access to Treatment service, Tasking & Coordinating Group and Health & Social Care Resource and Referral groups.

9. Discharge

9.1. The Wrap-around Service should maintain contact with a client if they both agree a service may still be needed at some time in the future.

9.2. Success is when a client says they are buoyant enough to float on their own and will not need further contact or support.

9.2.1. The Wrap around service will need to agree with the client and record a formal statement from them saying this.

9.3. If a client has been recorded as not requiring further support, but comes back at a later stage looking for a service, they would need to be recorded as a new case.

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3/11/2011

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