An Evaluation of the impact of Elmore's Waiting List Engagement Role

Evaluation commissioned by

Elmore Community Services

Service commissioned through and in partnership with

WE ARE BETTER TOGETHER
The Oxfordshire Mental Health Partnership

An Evaluation of the impact of Elmore's Waiting List Engagement Role

by **Dr Claire Timlin**

February 2022

Contents

1 Introduction

1.1 Elmore Community Services

Elmore Community Services was founded in 1989 to support citizens deemed "difficult to place", living on the margins of society, and in need of support. The founding principle of the Charity is to provide support to clients with a wide range of complex needs, many of whom are falling between the gaps of existing services and innovate creative solutions.

Elmore's motivated team, with wide ranging expertise, provides individual support to each client. Clients may have very chaotic lives and be distrustful of statutory agencies. Elmore is essential in building the trust required to engage, and maintain engagement, with agencies that can provide clients with much needed support.

1.2 Floating support client needs

Clients will usually have multiple and separate support needs such as mental ill health, homelessness and rough sleeping, substance misuse, offending, physical disability, self-harm, learning difficulties, domestic abuse, sex working, or experience of abuse and neglect. Elmore deals with some of the most complex clients in Oxfordshire, and complexity and quantity of issues being faced by clients classified as complex needs are on the increase.

Clients supported by Elmore's complex needs and mental health floating support services come to the Charity with a wide range of mental health diagnoses and difficulties and physical health issues. A 2022 evaluation of these services has demonstrated that the most common mental health diagnoses are depression, personality disorder, and anxiety disorder, and the most common mental health difficulties include feeling depressed, feeling anxious, and having suicidal thoughts.

The lives of Elmore clients are typically punctuated by various traumatic events which have led to an inability to process emotions in a conventional fashion. Crises and escalating difficult behaviours can punctuate people's lives. Escalating behaviours can result in a range of adverse consequences for the person, including loss of housing and livelihoods, financial difficulties, and interactions with the criminal justice system. Self-harm, alcohol, or other drugs may be used by complex clients to reduce their emotional dysfunction and manage periods of emotional distress and crisis.

In times of crises, multiple agencies may be contacted by or involved in the life of an Elmore client, often at the same time. These agencies can include General Practice, Police, Social Care, Acute Medical Services, Mental Health Services, Third-Sector Providers, and A&E. These contacts can be multiple as well as simultaneous, and without clearer communication and join-up, they can risk overwhelming agencies and, indeed, an overall system that is not designed for such behaviour.

The majority of clients live in Oxford, but support is provided across Oxfordshire, and in particular in Banbury, Abingdon, Witney. The age range of adult clients is large, with the oldest clients in their seventies. During the period covered by this analysis of the impact of a waiting list engagement role innovated by Elmore, 61% of complex needs and mental

health floating support clients identify as female and 36% as male, with a small percentage not recorded.

1.3 Elmore's mental health and complex needs floating support services

Elmore's services include complex needs and mental health floating support services delivered as part of the Oxfordshire Mental Health Partnership (OMHP) since October 2015. The complex needs floating support service is an evolution of the Elmore team set up in 1989 and the mental health floating support service is an evolution of a county-wide service set up in 2010 to offer support to people whose needs were less complex and who otherwise might not be supported through Elmore's complex needs service.

The complex needs service works with people who struggle to access existing service provision, with the aims of enabling them to stabilise their lives and facilitating access to services. The mental health service provides practical and emotional support to help clients to manage their mental health and, like the complex needs floating support service, is closely linked with local mental health teams (including NHS teams) to help people work towards recovery.

Over the period covered by this analysis—29/05/19 to 17/03/22 inclusive—41% of Elmore's clients were supported by the complex needs floating support service and 23% by the mental health floating support service. However, cases assigned to floating support services tend to last longer than those allocated to brief intervention services, so a more accurate metric for Elmore resource allocation is represented by mean clients. On average 46% of Elmore's clients were supported by the complex needs floating support service and 32% by the mental health floating support service over the period covered by this analysis.

Both services offer tailored support to clients over a timescale that is client-led. The duration of cases for both services vary significantly due to the client-led nature of care provided, as opposed to a "one style fits all" programme. Many well-developed services for mental health issues in Oxfordshire have been developed around a model that relies on briefer interventions, but it was the brevity of interventions which partly explains why Oxfordshire developed an outcomes-based contract and created the OMHP. Most clients work with Elmore for 1.5 years or less, but a small proportion were open for as long as 5 years.

1.4 Sources of referral to Elmore's floating support services

Referrals to Elmore's complex needs and mental health floating support services come from a range of sources. Since October 2015, Elmore has been providing a Mental Health (MH) Floating Support Service and a Complex Needs (CN) Floating Support Service, as part of the Oxfordshire Mental Health Partnership. Elmore receives referrals from within the OMHP and people with complex needs and mental health issues can self-refer or access Elmore through the non-OMHP services they deliver or with which they partner.

At the start of the period covered by this analysis (June 2019) about 60% of referrals to Elmore's complex needs and mental health floating support services were accepted. Of the referrals that were rejected, 40% were because the potential client either did not wish to proceed or did not engage with Elmore. 32% were because the service was considered inappropriate.

In 2019 Elmore changed its process for entering someone into the service as a client, so that assessment takes place when there is capacity to allocate. This did not change the overall wait from referral to allocation as this now happens in a single episode, rather than as a wait for assessment followed by a wait for allocation. The driver for change was a desire to improve the client's experience, in particular to address a client's difficulty in having to repeat their story to a new caseworker on being allocated, and potentially retraumatise themselves, and to minimise inefficiency which could arise from a change in circumstances between assessment and allocation.

1.5 The impact of the pandemic on waiting times and waiting list length

1.5.1 Waiting list length and waiting times

Elmore operates in a more flexible and effective way with some of the most disenfranchised people, but as a medium-sized charity, it can get over-subscribed. Elmore is aware that more people could, and would be, referred if the charity had additional capacity—this is feedback received frequently and from multiple sources, not least from OMHP partners.

The pandemic and resulting lockdowns produced a clear impact on waiting times. At the time of the first Government lockdown in response to COVID-19 in March 2020, 111 people (Figure 1) were waiting to be assessed for complex needs or mental health services, and the mean waiting time was on average 5.0 months, 5.1 for the complex needs floating support service (Figure 3) and 5.0 for the mental health floating support service (Figure 3). By November 2020, the number of people waiting to be assessed had increased by more than 50% to 167, and the waiting time had increased to 9.3 months. The mean waiting list time rose to 10.3 months in January 2021 but has been falling since as a result of Elmore interventions. As the definition of the waiting time is the duration from referral to allocation, the waiting list time figures do not include those referrals rejected pre-allocation.

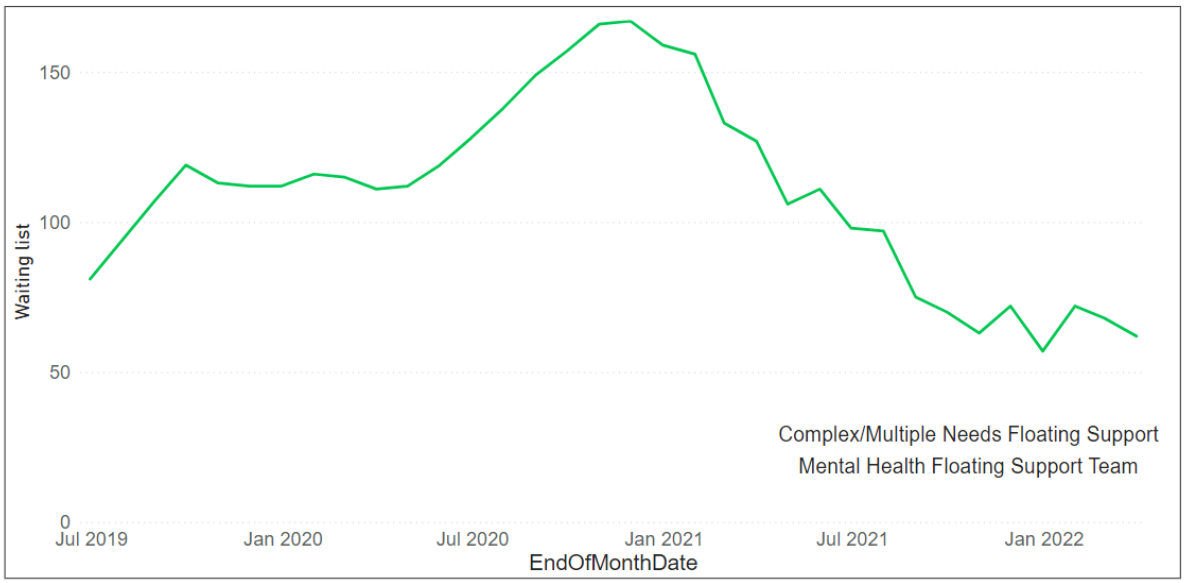

Figure 1: Number of referrals to Elmore's complex needs and mental health floating support services on waiting list vs time.

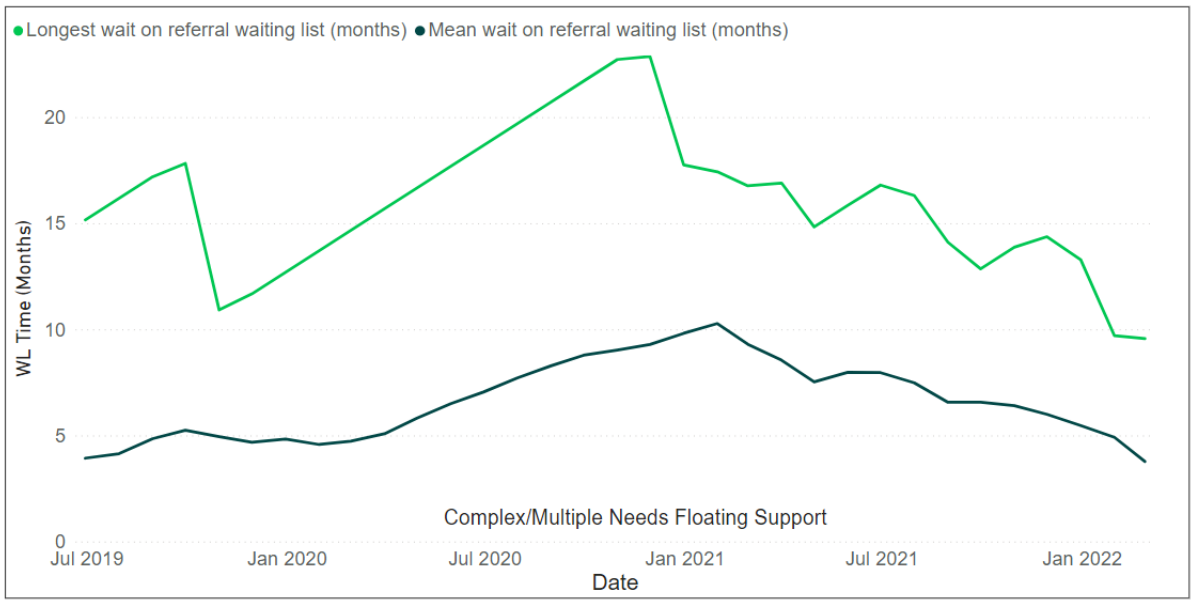

Figure 2: Mean time from referral to allocation vs time for Elmore's complex needs floating support service. Referrals rejected pre allocation are excluded.

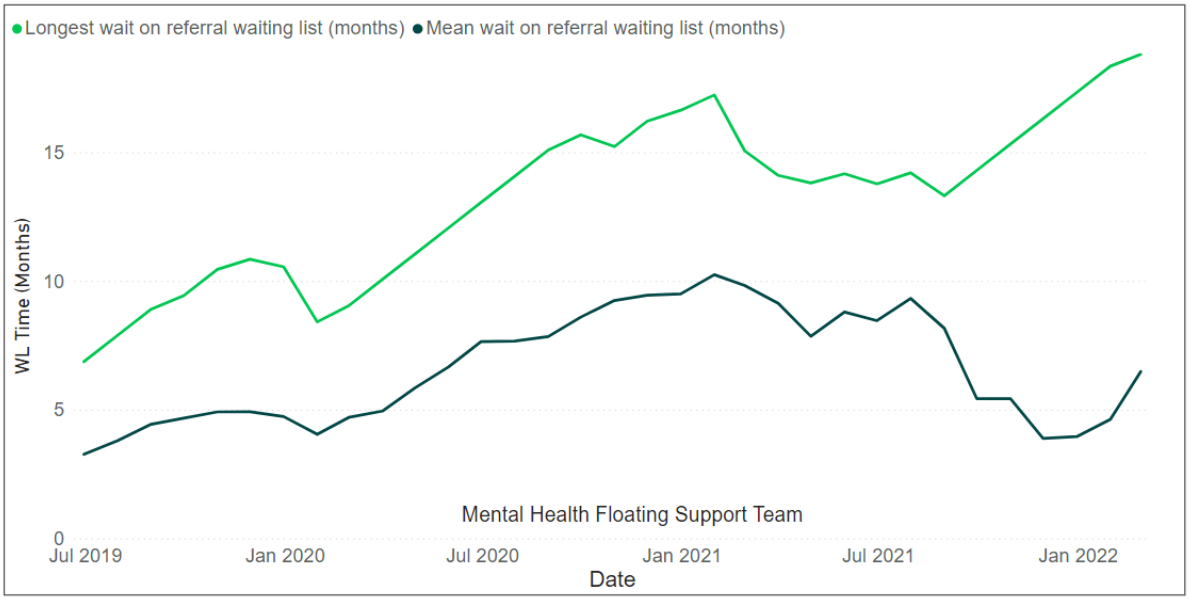

Figure 3: Mean time from referral to allocation vs time for Elmore's mental health floating support service. Referrals rejected pre allocation are excluded.

1.5.2 Allocation and closure rates

During COVID-19 and the first lockdowns, the assessment rate dropped significantly. There were some cases where caseworkers were concerned about closing cases for safety reasons. As Elmore only allocated referrals for assessment when a caseworker had closed a case and created capacity to support new clients, the closure (and assessment) rate dropped as caseworkers felt unable to safely close cases. When a caseworker had been unable to safely close a client, they had been carrying out a care coordinator role, organising other services and advocating for the client.

This point emerged in a case review consultancy project commissioned by Elmore in 2020-21:

- Caseworkers often felt unable to safely close clients because they could not access support from statutory and other services and had Elmore closed their case, clients would have been left extremely vulnerable. (While this was a theme during the pandemic, it is a longer-term theme: part of Elmore's role has been to encourage services to carry out their statutory duties).
- It was noted in cases that where work had to be carried out in-person, such as graded exposure, they would be kept open unusually longer in order to carry out this work.[1]

[1] As part of work to bring Elmore's waiting list down, Gillian Attwood was commissioned to review cases which had been open to Elmore for the longest periods of time. This case review consultancy began by simply moving backwards through the list of cases open for longest. Caseworkers participated in reviews of relevant cases where clients did not have a closure plan in place. These sessions were set up to be two-way conversations, with Gill Attwood facilitating a reflective space to the caseworker and their manager to examine the

Figure 4 shows that during the initial lockdown, which started just before the first quarter of financial year 2020/21, Elmore's closure rates of complex needs and mental health floating support clients were below normal rates. Referrals also dipped during this time. This is possibly due to decreased capacity of referring agencies such as community mental health services.

Figure 4: Referral and case closure rates for Elmore's complex needs and mental health floating support services vs time.

Figure 5 shows that this decrease in closure rates during the first lockdown occurred in both complex needs and mental health floating support services.

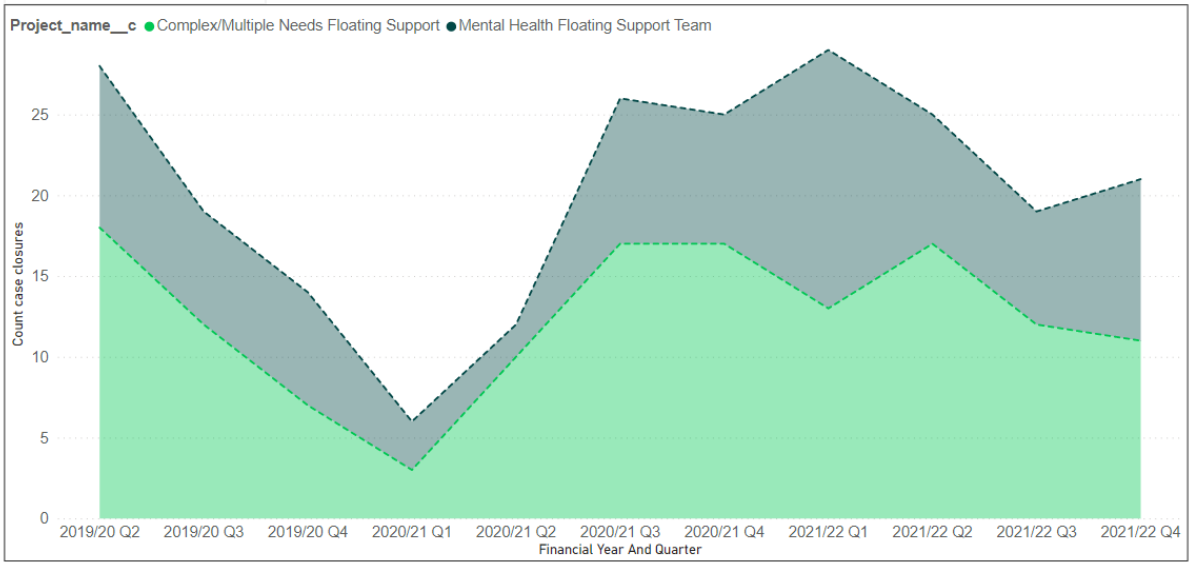

Figure 5: Case closures for complex needs and mental health services separately vs date.

---

case, and providing advice and suggestions, rather than being directive, with the aim to develop a collaboratively agreed plan.

During the first lockdown the way Elmore coped with the higher demands of clients, and working from home staff, was by not allocating or opening many clients during this time. This is evidenced in Figure 5 where the numbers of allocation and cases opened in March to August 2020 were considerably less than pre-pandemic levels. This led to a decrease in the number of floating support clients both open and allocated. Due to the inabilty to close many cases during this time, the first half of financial year 2020/21 saw the lowest total number of allocated complex needs and mental health floating support clients (Figure 7).

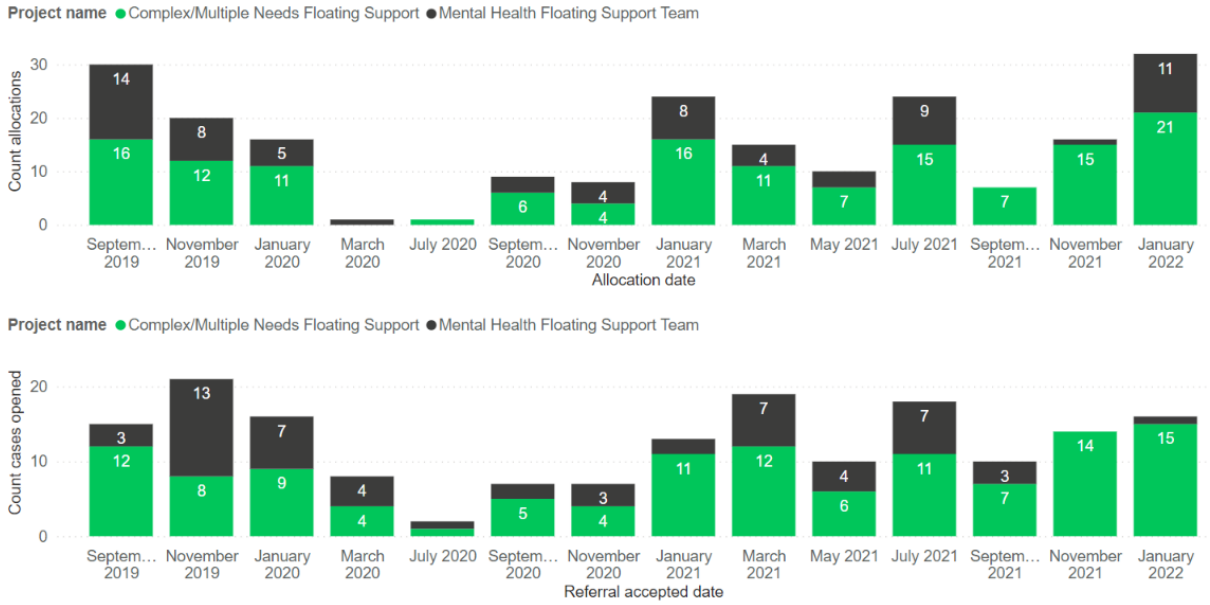

Figure 6: Number of referrals allocations and case opens by 2-month time period for complex needs and mental health floating support services.

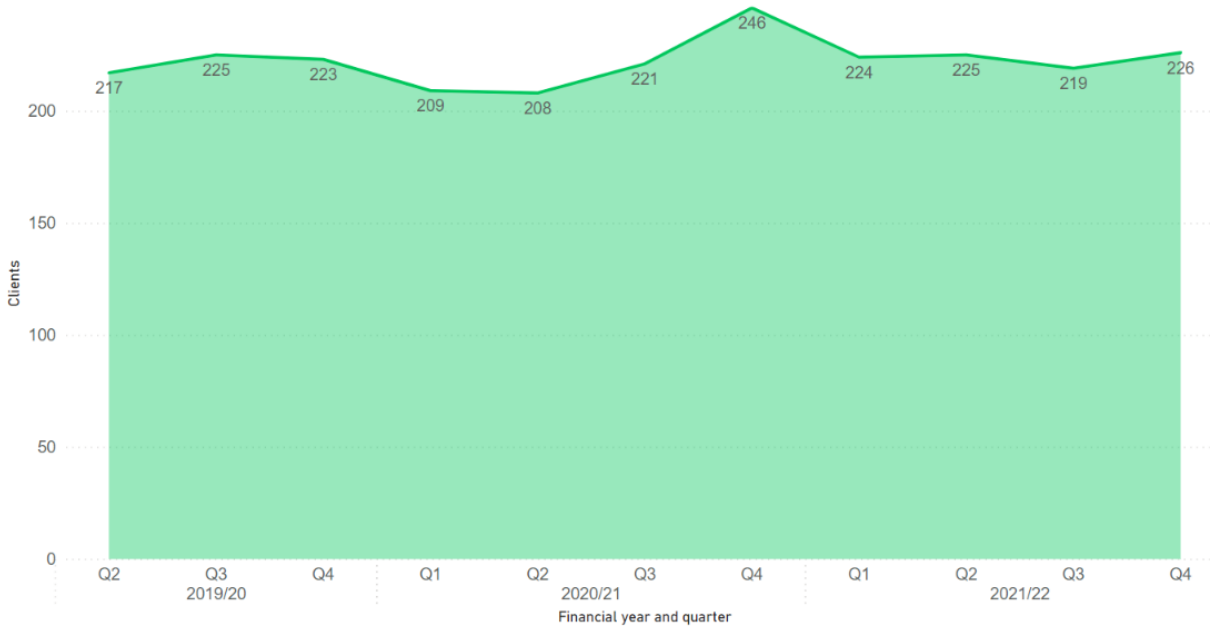

Figure 7: Total allocated cases for both complex needs and mental health floating support services vs time.

Closure and allocation rates dropped because of a reduction in capacity with some caseworkers forced to reduce or change working hours to support their own wellbeing in the sudden move to lockdown and/or to perform caring responsibilities for family members as services they would rely upon closed.

At the most challenging staffing point in the pandemic (using data recorded on 07/05/2020), working hours fell to 82% of contracted working hours. This equates to capacity that would have been provided by 3.75FTE caseworkers, resulting in a redistribution of responsibilities across a reduced team.

1.5.3 Changing needs of floating support clients

Figure 8 shows the number of actions per client in the second quarter of 2019/20 to the final quarter of 2021/22. Actions per client rise during the first half of financial year 2020/2021, showing that clients being supported by Elmore required more support than usual at this time. This is because a large number of clients were destabilising, needing extra support from their caseworkers, due to the adverse effects of the pandemic. Figure 9 shows that the number of phone calls with clients (a substitute means of contact for in-person contacts once the latter became impossible in lockdowns) increased significantly from the start of the first lockdown, in March 2020, to the end of the most recent lockdown, in March 2021.

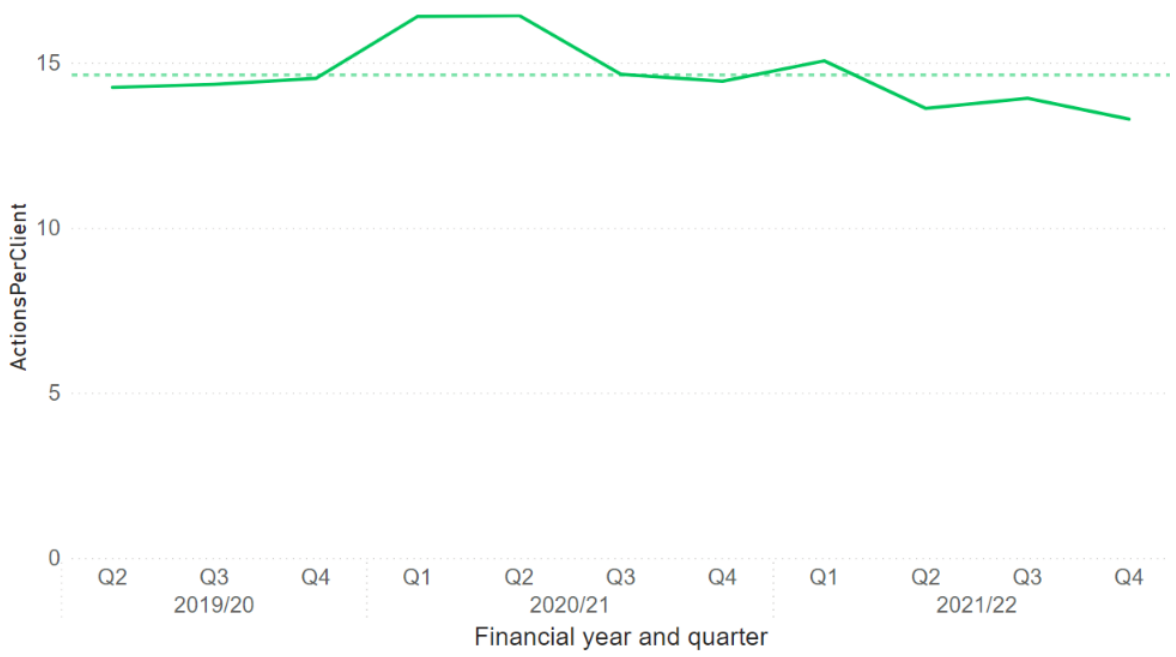

Figure 8: All Actions per client post allocation.

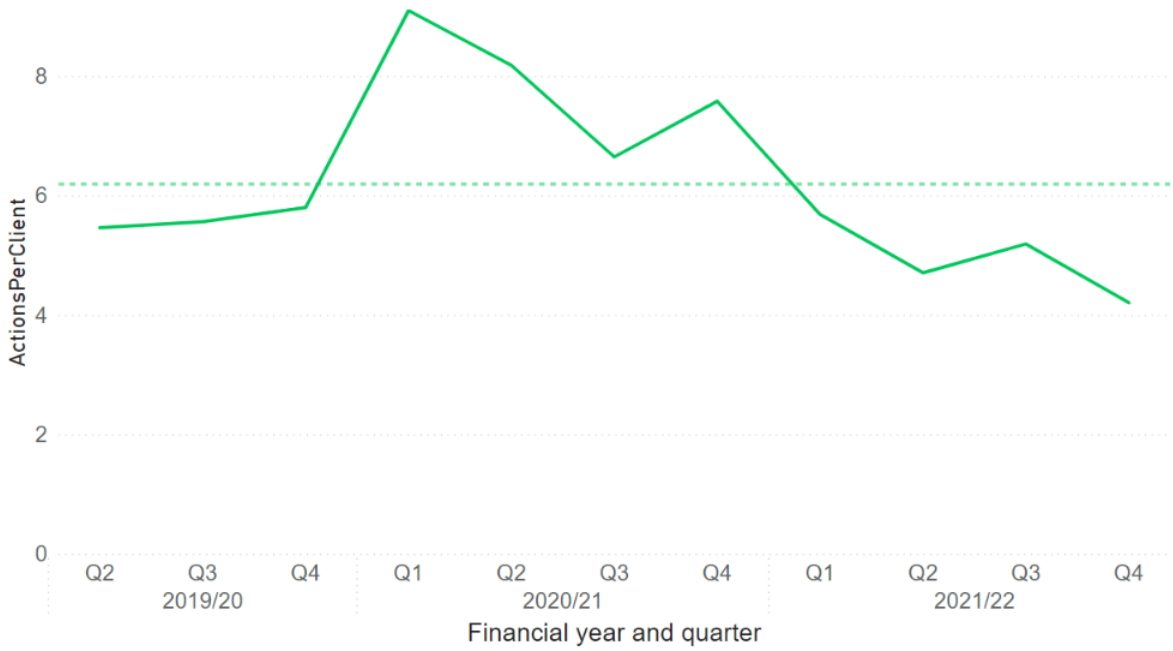

Figure 9: All Actions per client post allocation - Phone only.

In addition, Elmore caseworkers moved into new areas of activity to meet client need and compensate for the absence of provision, for example securing food parcels from SOFEA to deliver to Oxford-based clients (in the period before Oxford City Council establishing food delivery networks to which clients could be referred) and across Oxfordshire (until a version of Oxford's food delivery network emerged from within communities at a later point). Between March and May 2020 Elmore supported 30% of Elmore's floating support clients by delivering food to their doorsteps in COVID-safe ways. Caseworkers also arranged the delivery of puzzles, jigsaws, and other entertainment to ensure clients and younger dependents were better placed to manage the pandemic without going outdoors in ways that contravened lockdown rules.

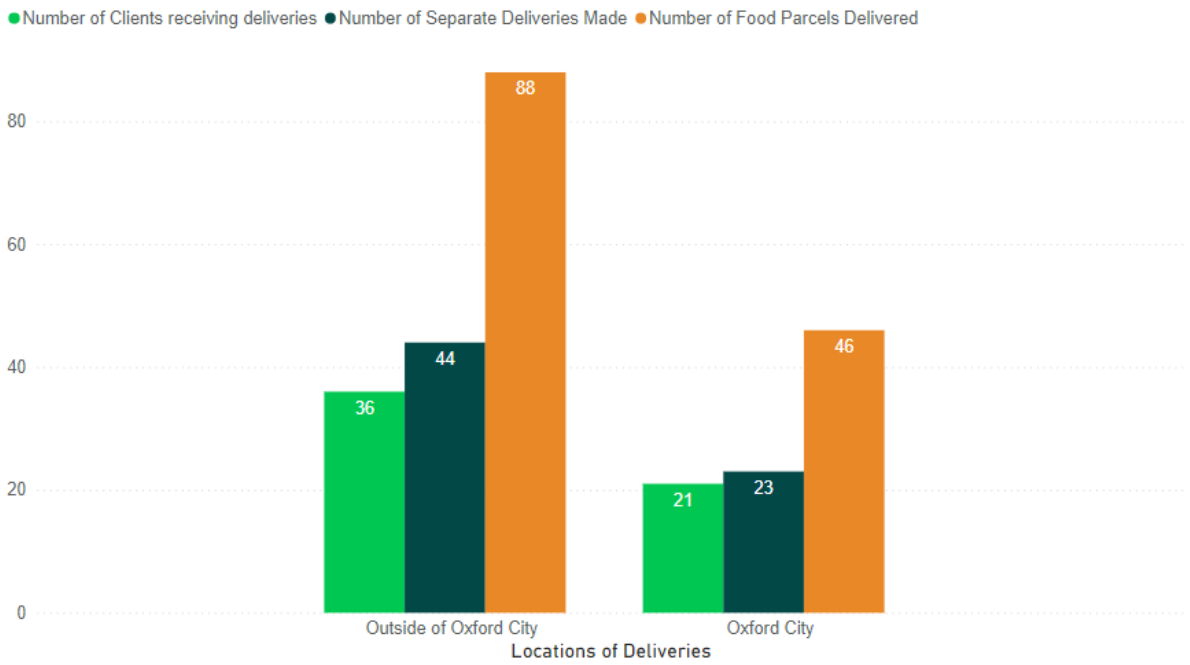

Figure 10: Deliveries of Food Parcels to Elmore clients (March-May 2020)

1.6 The creation of a waiting list engagement role

Prior to the creation of the role, not only were referrals waiting a long time to be allocated to a keyworker, but also, the longer the wait the greater the number of mental health diagnoses and difficulties recorded during assessment. This was especially true for complex needs clients (Figure 11). This shows that a long wait, without support, was leading to an increase in mental health needs of clients, evidencing the need to reduce waiting times and to provide support during the wait.

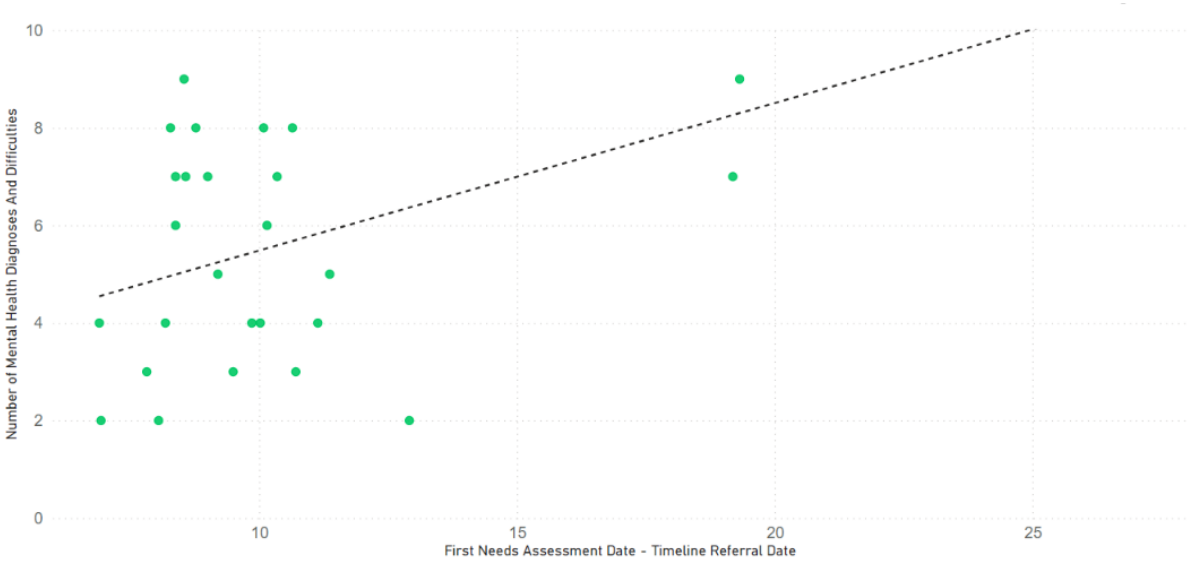

Figure 11 Correlation between time from referral to first needs assessment and the number of mental health difficulties and diagnoses for complex needs referrals.

Alongside other measures to bring down current waits, Elmore created a waiting list engagement role. The waiting list engagement role started contacting potential clients on Elmore's floating support waiting list on 9/11/2020, at which point the mean waiting time was 9.3 months, with a possible wait of up to 22 months. The earliest referral supported by the role was referred on 03/05/2018.

As people tend to be in crisis when they are referred, the period between referral and assessment can involves little or no interaction, and the pandemic raised concerns about the wellbeing of those who were waiting to access Elmore's services. Therefore, it was deemed necessary to develop this role to offer support during the wait and better understand the needs of potential clients.

The role provided a new form of pre-assessment, so that referrals could be diverted elsewhere if Elmore was assessed to be unsuitable to meet a person's need at the time of their referral. Referrals requiring short-term support and assessed as suitable for a brief intervention received support while remaining on the waiting list. As Elmore's brief intervention might have changed a person's support needs, referrals could be redirected somewhere more suitable at the end of the brief intervention.

This report follows the conclusion of the role which ran for 17 months and provides an initial view of its impact. The report focuses on how the role has affected a person's journey from referral to being declined or accepted by Elmore and analyses the level and type of resource involved in supporting the referrals during their wait.

It is currently too early in clients' timelines to provide any firm conclusions about whether the role has helped to minimise, if not reduce, the length of a client's time with Elmore. However, it is the intent of this report to review clients' timelines at an appropriate point to perform this analysis.

1.7 Referrals to the floating support services

On average, referral rates for Elmore's mental health floating support service have stayed constant over the time period covered by this analysis. Referrals to Elmore's complex needs floating support service have fallen by about 25% over this same time period (see Figure 12). There has been a recent increase in referrals to both services which appears to be driven by an increase in self-referrals (see Figure 13), most probably due to the increased simplicity of doing so via Elmore's new website which includes a Quick Self-Refer button at the recommendation of clients, caseworkers, and partners. Since the introduction of this functionality there has been a high, 26%, conversion rate from unique visit to referral form submission.

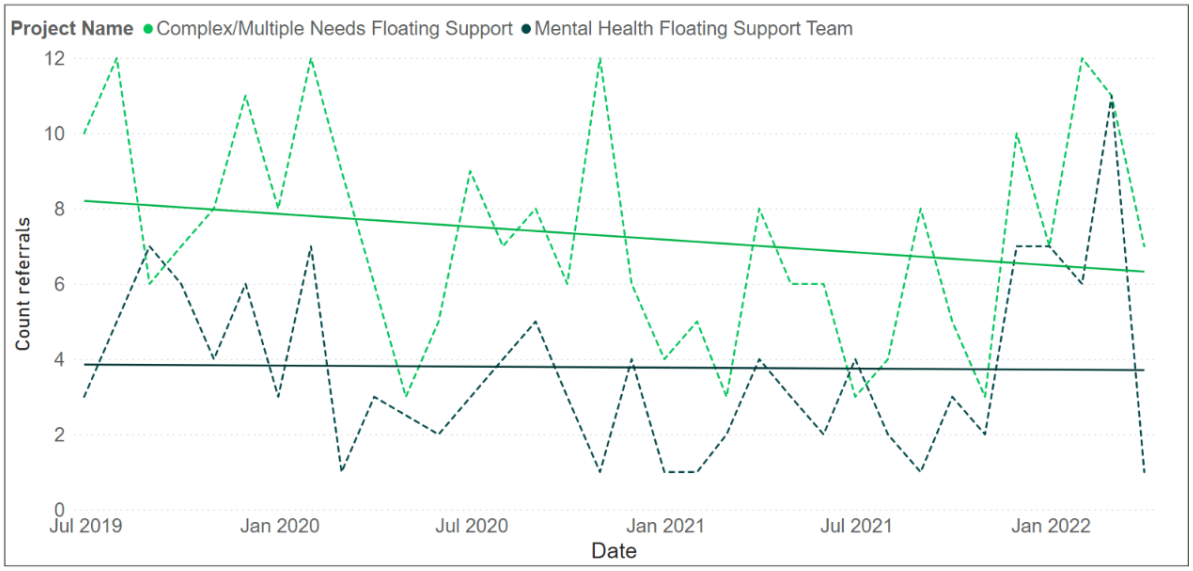

Figure 12: Referral rates to Elmore's complex needs and mental health floating support services vs time.

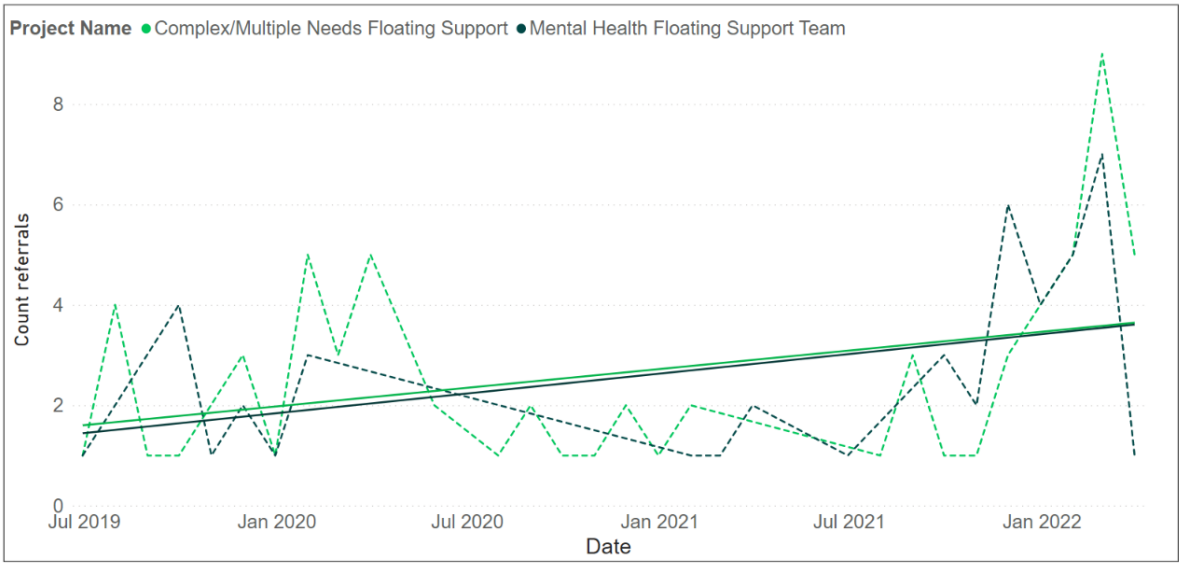

Figure 13: Self-referral rates to Elmore's complex needs and mental health floating support services vs time.

2 Results of the analysis

2.1 Analysis methods

The analysis methods are fully explained in Section 5 “Appendix 1: Impact analysis method”.

2.2 Summary of the results

Since the role was operationalised, 136 people referred to Elmore have been contacted and supported to various extents. The average amount of time committed to each client by the role is 2.5 hours, with a maximum of 19 hours for a client. 341 hours (approximately 45.5 working days) have been committed by the role (the figures include referrals to the 17/03/2022).

As Figure 5 shows, the hours have been broken down by type of support and outcome. The outcomes are as follows:

- Outcome 1: Brief intervention, stays on waiting list
- Outcome 2: Brief intervention, diverted elsewhere and leaves waiting list
- Outcome 4: Client no longer wants/needs support
- Outcome 5: Impossible to engage or contact

In total, the largest amount of time was committed to referrals that required a brief intervention but remained on the waiting list.

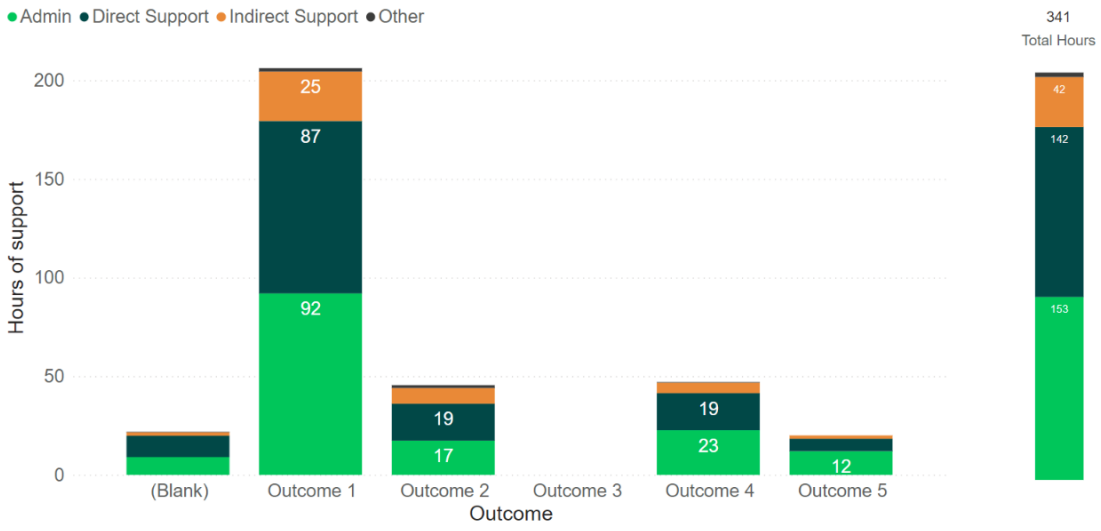

Figure 14: Hours of support from waiting list role by type of support and outcome.

Figure 15 shows the mean hours of waiting list role support per referral. The greatest amount of time committed per client (3.8 hours) was for Outcome 2 (people requiring brief intervention who were then redirected and/or suitable to leave the waiting list).

Figure 15: Mean hours of support per client from waiting list role by type of support and outcome.

2.3 Communication methods used by the role

To understand the role's interaction with potential clients in the pre-allocation phase, this report assesses the communication methods for each action (Figure 16). Actions performed by the role are far more likely to consist of an in-person meeting and less likely to consist of electronic communication. Potential clients supported by the role received the highest form of personalised interaction to a greater extent than before the waiting list role started.

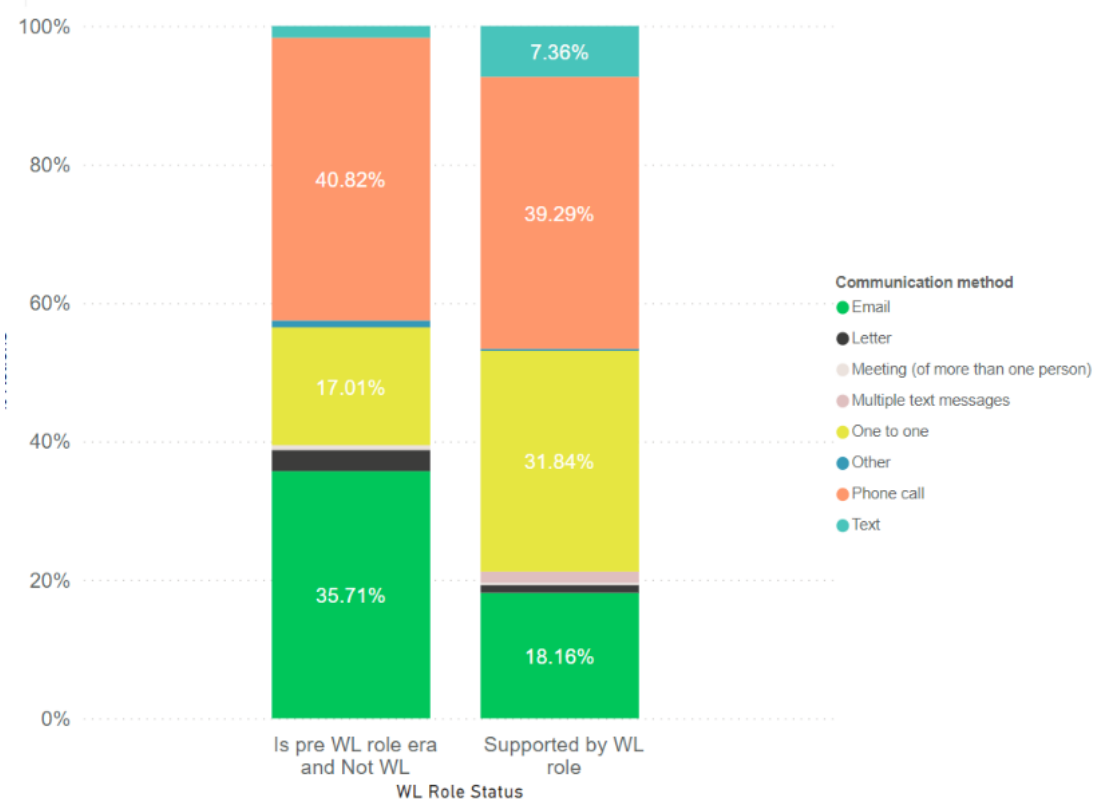

Figure 16: Post-referral and pre-allocation actions by communication method. Pre waiting list role (left column) and waiting list role (right column).

2.4 Sentiment of Initial interactions with the role

The sentiment of the first phone calls made to clients by the waiting list role were analysed. There was a moderate negative correlation between the time that people had been left waiting, with no support, and the sentiment of those initial interactions (Figure 17). Hence, the longer people had been on the waiting list, the more negative, in general, their initial interactions with the role were.

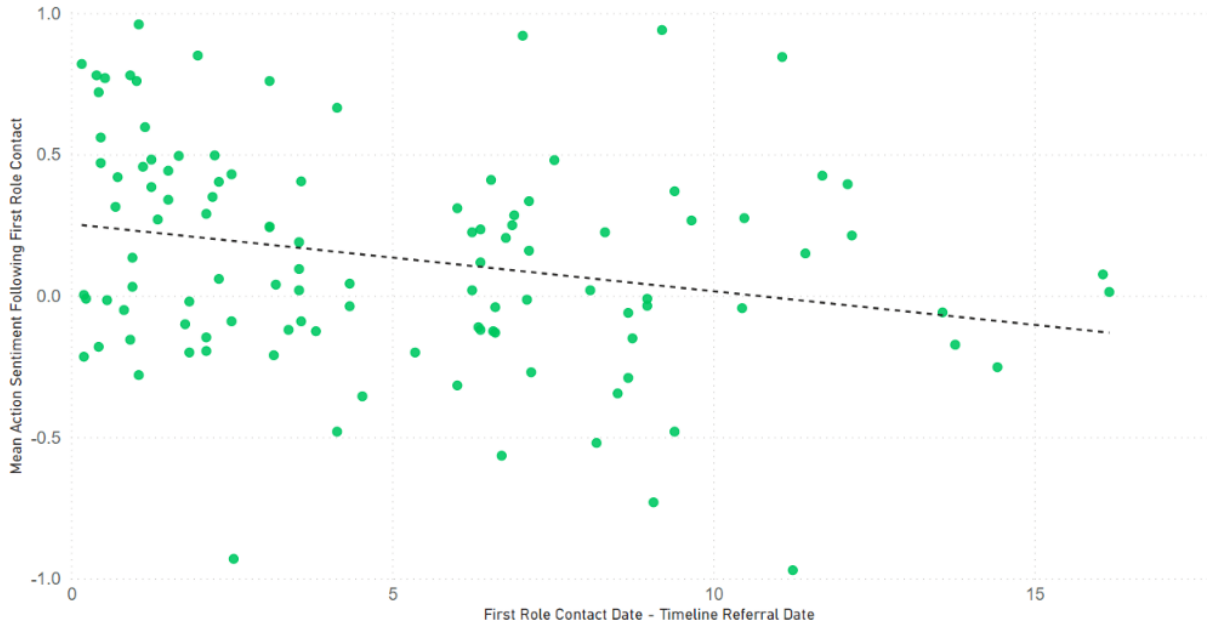

Figure 17 Correlation between the time from referral to first contact by the role and the sentiment of these initial phone calls.

2.5 Declined referral comparison

Figure 18 shows the time between a referral being received and a referral being declined vs days post referral[2]. In the pre-role era, some referrals were rejected at an early stage if they were unsuitable in terms of age/ catchment area or if they no longer wished/were unable to proceed with receiving support. All other referrals had to wait until they could be allocated to a caseworker for assessment. This is evidenced by the plateau in the light green curve in Figure 18. In contrast, due to ongoing interaction with the role, pre-assessment could be done prior to the allocation of an Elmore caseworker, meaning that referrals could be declined as soon as they were deemed inappropriate, rather than requiring a wait to be allocated to a caseworker for assessment.

Whilst other factors have contributed to a reduction in the length of the waiting list (for instance, the creation of caseworker capacity and recruitment to these roles), this approach has benefited clients because they could be redirected to a more suitable service

[2] The decision date is not currently recorded in the database, but it will be in the future. The referral declined date has been taken from the timeline history table or, if not present, from the date of last action associated with that timeline.

more speedily or provided the support they need in the form of brief intervention whilst on the waiting list.

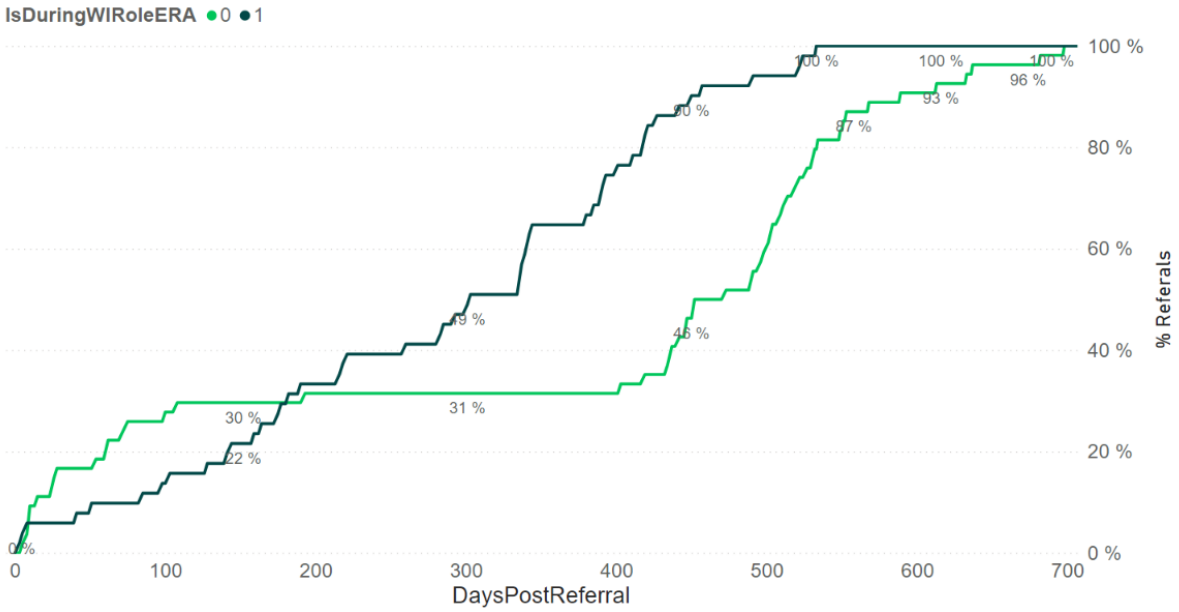

Figure 18: Percentage referrals declined on or after days post referral with regard to total referrals declined. Light green is pre waiting list era and dark green is referral date >= 01/03/2020 and <01/03/2021.

Figure 19 shows that referals in the era of the role are far less likely to be allocated to a caseworker for assessment because some of the necessary assessment was being done by the role itself instead of by a caseworker. Before the creation of the role, about 80% of all referrals were allocated to a caseworker for assessment; following creation of the role this decreased to 63%. During the role era, for referrals which were declined, only 29% were allocated to a caseworker to be discovered as unsuitable and ultimately rejected; hence 71% of all rejected referrals in this period were assessed by the role. Pre-waiting list era, 58% of people referred to Elmore had to wait until they could be allocated a caseworker to be assessed, only to go on to being declined, expending time that could be spent identifying appropriate support

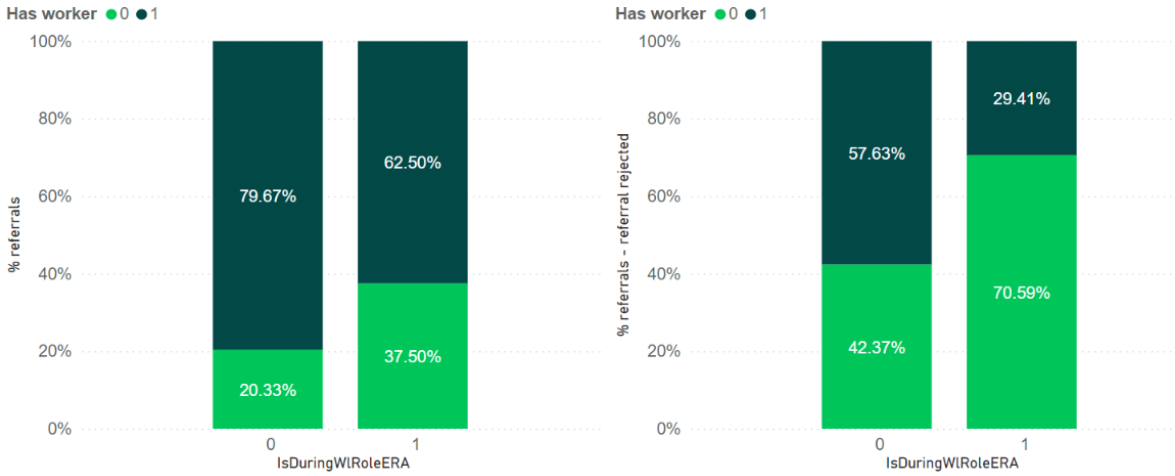

Figure 19: Percentage referrals that were allocated a caseworker for both pre- and post-waiting list role era. Light green means no caseworker was allocated; dark green means referral was allocated a caseworker for assessment. Left is all referrals; right is referral declined.

Figure 20 shows the number of actions between allocation and referral rejection. They have been steadily decreasing since the summer of 2019. As the waiting list role rejects a larger proportion of referrals, the sum of actions (correlated to time spent) on declined referrals is less during the era of the role. The number of referrals rejected post-caseworker allocation has been decreasing since the role was operationalised; hence the role is doing an efficient job of rejecting referrals prior to allocation to an Elmore caseworker.

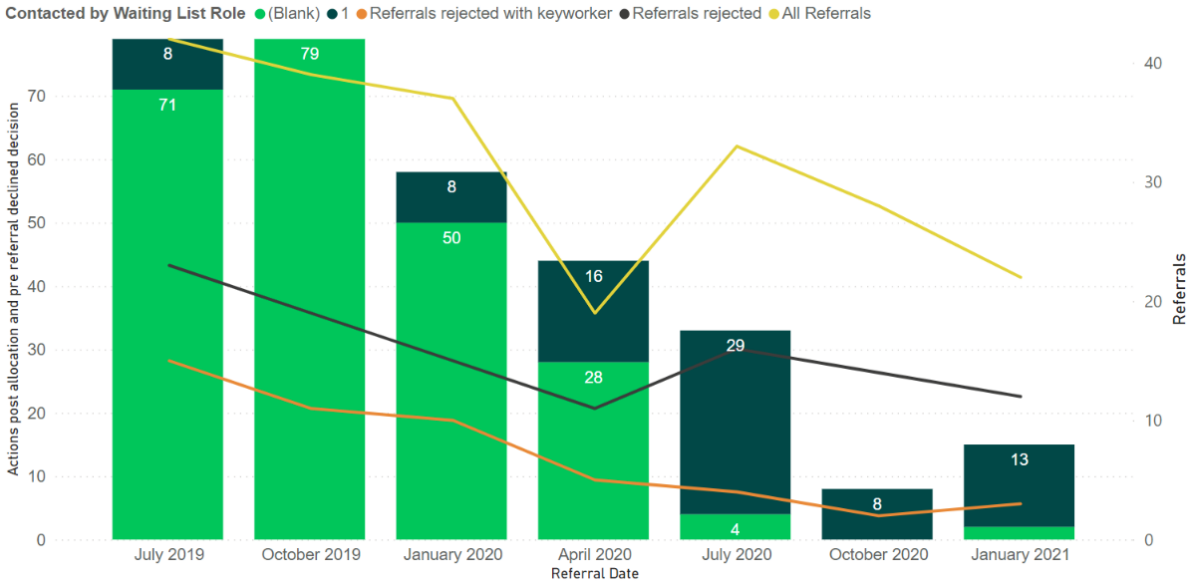

Figure 20 Left axis (columns): Sum of actions between allocation and referral decision vs referral date, for referrals that were declined. Right axis (lines) shows all referrals, rejected referrals, and rejected referrals that were allocated a caseworker.

Figure 21 evidences the mean number of actions per referral, for declined referrals only, vs referral date and waiting list role vs non-waiting list role. The total number of actions, occurring between the referral and referral rejection date is larger for those on the waiting list role (11 vs 6). This is unsurprising as the role provides brief intervention to people who need it, some of whom no longer continue to require longer-term Elmore support or go onto be referred to suitable support elsewhere.

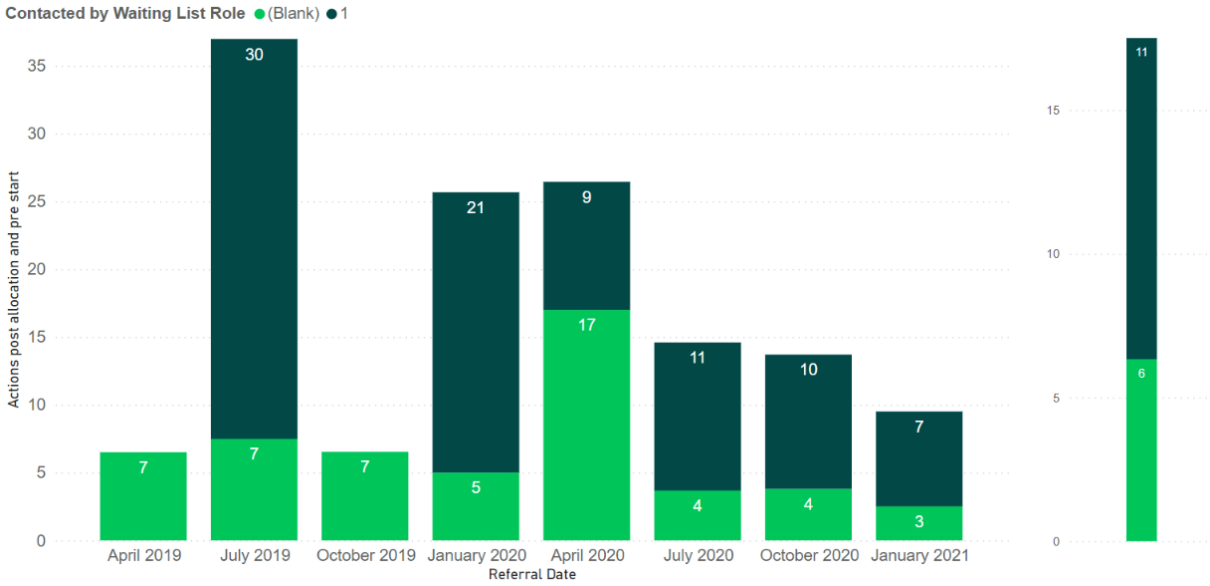

Figure 21: Mean actions per referral between referral and referral declined decision.

2.6 Referrals that become clients

Figure 22 shows the mean actions, per referral, between allocation and start date, as a function of referral date for those that become clients. This has been decreasing with time throughout the era of the role. This is partly due to pre-assessment by the role, which has the effect of reducing the post-allocation assessment caseload. The average number of actions, between caseworker allocation and case start, pre-waiting list role era is 10.6, compared with 7.6 during the role era.

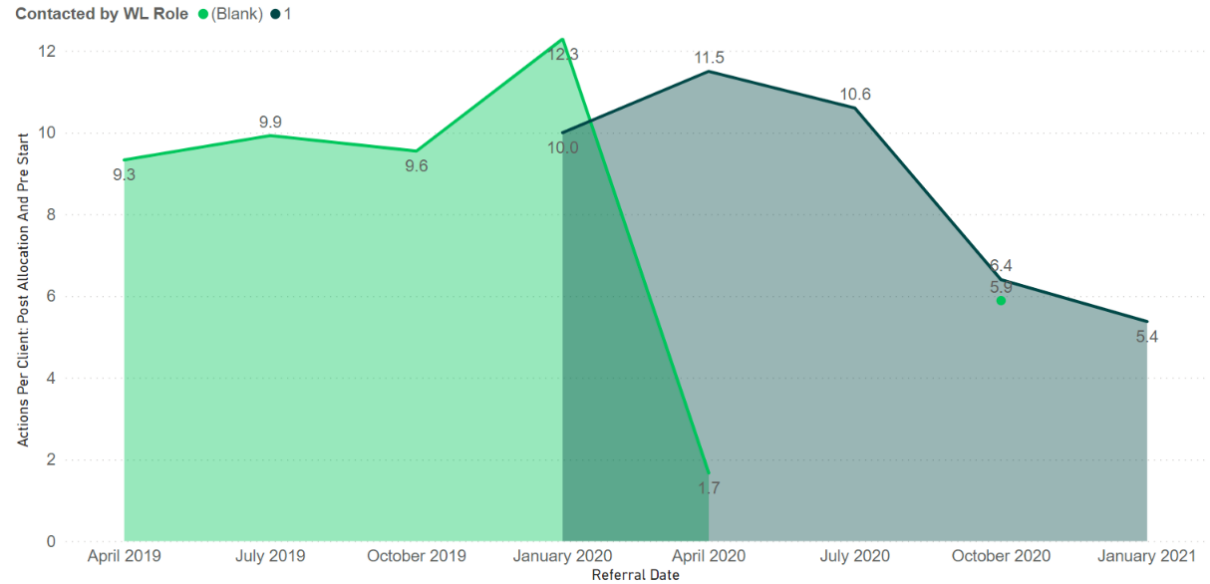

Figure 22: Mean post-allocation and pre-start actions for referrals that became clients.

2.7 Percentage of referrals accepted

Figure 23 and Figure 24 show the percentage of referrals accepted for all referrals for which a decision has been made (hence those rejected or accepted). Figure 23 includes referrals both allocated and not allocated to a caseworker; Figure 24 only includes referrals that were

allocated. A lower percentage of referrals supported by the role were accepted (44% vs 52%). This could be partly attributed to the role negating the need for some referrals to become clients because it has provided a brief intervention when the person needed support most.

Once they have been allocated a caseworker, a referral supported by the role has a higher chance of being accepted into Elmore's complex needs and mental health floating support services (74% vs 65%). This is because the pre-assessment conducted by the role has declined clients who no longer need/want help, who are unsuitable, or are more suitable for redirection to other services.

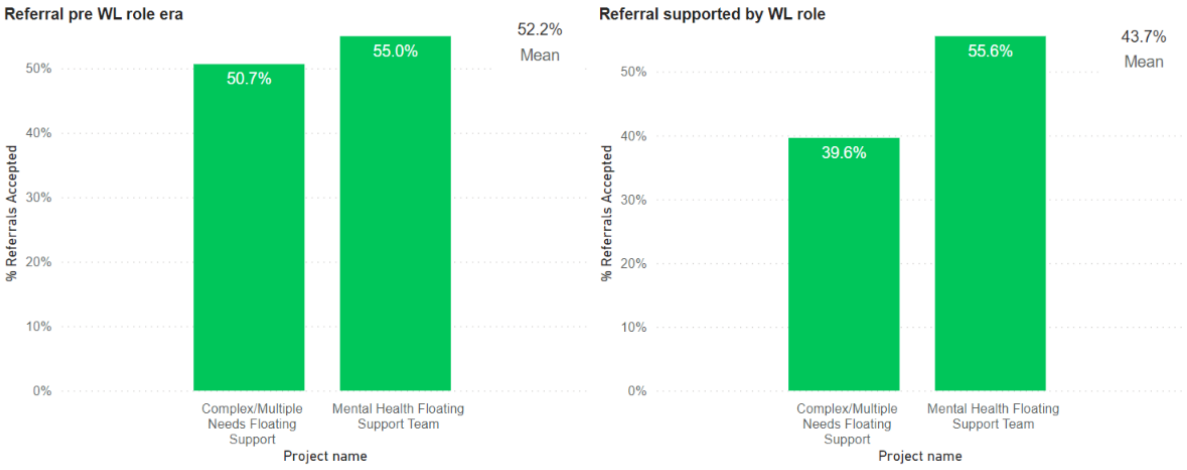

Figure 23: % referrals accepted with regard to all referrals for which a decision has been made.

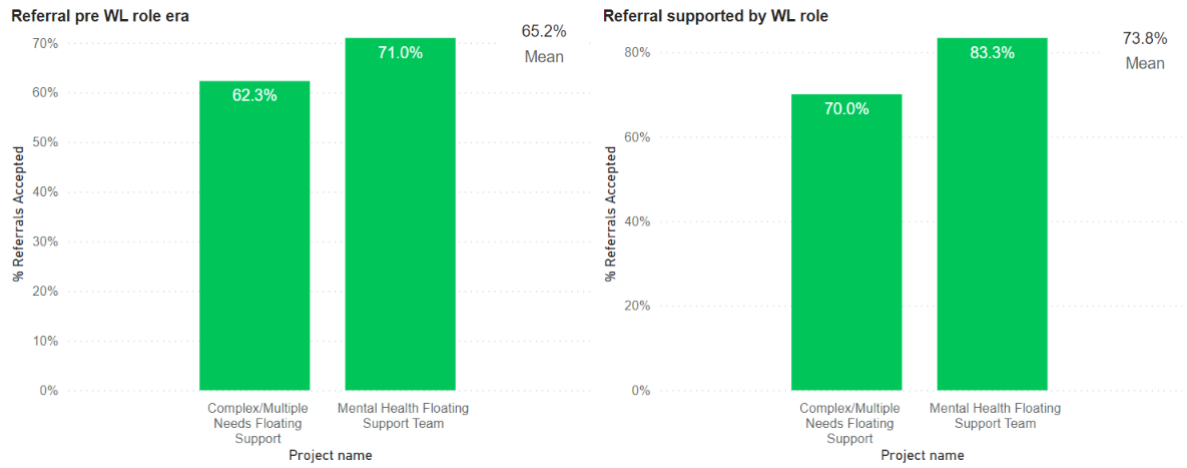

Figure 24: % referrals accepted with regard to all referrals for which a decision has been made - Allocated only

For a greater understanding of referrals, Figure 25 shows % accepted as a function of referral source. For referrals not supported by the role, the most common referral source was self and the second most common came from community mental health services. For referrals supported by the role, the most common referral source was community mental health services. A proportion of self -referrals will be evidently unsuitable for Elmore and therefore can be declined quickly, without need to be passed to the role.

Whilst the acceptance rate is lower for referrals supported on the role (40% vs 49%), the acceptance rate of self-referrals shows most variation. For referrals not supported by the role the acceptance rate of a self-referral is 56%, compared to 25% for those referrals supported by the role. This is partly attributable to an increase in unsuitable self-referrals being entered via the website. However, the presence of the role allowed these to be declined as soon as possible and directed elsewhere where appropriate.

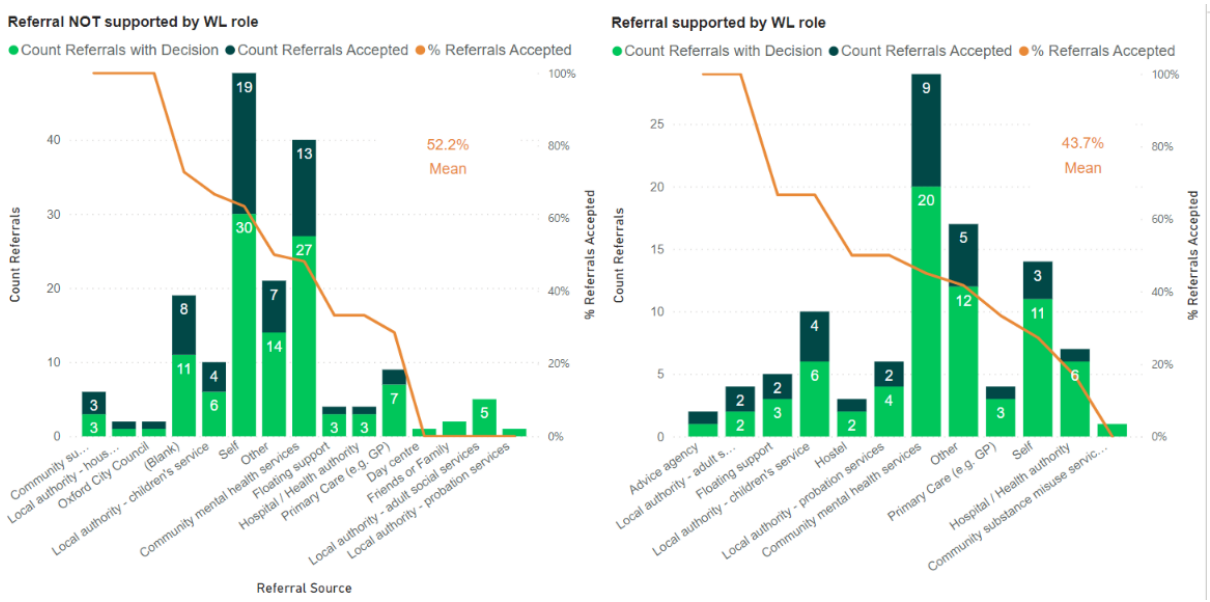

Figure 25: % referral accepted with regard to referrals for which a decision has been made, by referral source.

2.8 Signposting and onwards referrals

The waiting list role was responsible for 56 signposting actions and 29 onward referrals of people engaged. The maximum number of organisations that someone was signposted to was four. The maximum number of organisations which somebody was referred on to was five. 34 individuals engaged by the role benefited from signposting actions and 19 were referred onwards.

The most common services that the waiting list engagement role signposted individuals to is Oxford Safe Haven, a non-clinical space offering crisis support, signposting, safety planning and listening support (8 individuals in total); Cruse Bereavement Care, which provides free care and bereavement counselling to people suffering from grief (4); Benefits for Better Mental Health (BBMH), which provides advice on benefit entitlement and help to gain and maintain support (3), Calmzone, which helps people to feel calmer (3); Turning Point, which supports wellbeing and recovery from addiction (3); and Step Change, which provides debt support (3) (Figure 26).

The most common organisations that the waiting list engagement role referred individuals onto is Oxfordshire Mind (8) and Connection Support (6) (Figure 26).

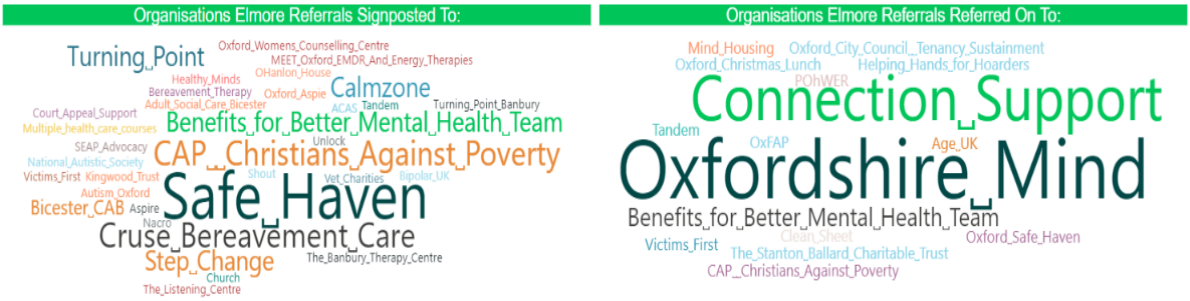

Figure 26 Word clouds showing the agency names of organisations to which Elmore referrals were signposted to (left) and referred on to (right).

2.9 Future analyses

Analyses have been set up to assess the impact of the role on clients' cases. However, insufficient time has elapsed to draw any conclusions from these at present. Details are provided in Section 6 in the appendix.

3 Reflections on the role

3.1 Elmore's worker performing the role

The individual performing the waiting list role explained that people had diverse reactions to the intervention, some were open and upfront with their stories straight away and others took time to build trust, over repeated interactions. A lot of crisis management was required, as people had been on the waiting list for a long time and this intervention was at a time of global pandemic. The main form of communication with clients was via phone and this mainly worked very well and people felt able to open up and trust the worker.

The role set out to provide brief intervention, where appropriate, for referrals for six weeks. However, some individuals were in mental health crisis, and in some cases suicidal, so the length of time often exceeded this six-week limit. This made the role difficult to predict, in terms of resource allocation, as once Elmore had made contact, it was not always possible to simply curtail this without support in place. It was noted that advocating for people with housing issues, by liaising with the council, was time consuming and often exceeded the criteria for brief intervention.

Whilst some people's needs were complex, requiring them to remain on the waiting list for longer term support, it was clear that some referrals needed help with a specific problem, for example finding a job despite having a criminal record. Such referrals could be signposted or referred on to the relevant organisations, in a timely fashion, and swiftly removed from Elmore's waiting list.

In summary, the presence of the role enabled those on the waiting list to build trust in Elmore and received the necessary support whilst waiting. The formation of this role sets Elmore apart in acknowledging its responsibility to all those referred, not only their clients.

3.2 Reactions of those being supported

The large majority of people being supported by the role really appreciated the interactions with Elmore. They didn't feel so forgotten about and the worker was able to provide them with information about the length of the waiting time and give reassurance that they were coming closer to being allocated a worker. The ability to provide some support in the meantime was especially important in times of COVID lockdowns, where mentally unwell people were often spending long periods of time on their own. When first contacted, some referrals who had been on the waiting list for a long time, did complain about the time they had been waiting but were then mostly grateful to receive the support.

3.3 Main challenges

A notable challenge of providing the role was that many people on the waiting list were in mental health crisis, especially as they were spending so much time at home alone. Part of the job was to schedule calls at a time when the worker felt most able to provide support for each person. If the role needed to continue, because referrals exceed the ability to close cases, then it is recommended that it is handled possibly by two people, and most definitely that the role receives regular supervision.

3.4 Recommendations

- Analysis and discussions regarding this role have highlighted the need for a dedicated role to triage referrals. It was clear from contacting referrals as part of the waiting list role that some of those on the waiting list already had support in place with other organisations e.g., Connection support. Liaising with them to facilitate this existing link was all that was required to remove these referrals from Elmore's waiting list.
- The role has also stressed the importance of adding the question "What other support do you have in place?" to the referral forms, including on the website.
- It is also suggested that drop-in service to provide face to face reassurance and signposting to relevant organisations should be reinstated.
- Reinstating of "red referrals" is recommended because, whilst most people could wait their turn on the waiting list, a small minority needed urgent longer-term support. Making this an official protocol is proposed.

4 Discussion

4.1 Impact of waiting list role to date

The role has been important, especially at times when Elmore's waiting lists for complex needs and mental health floating support services have been longer (Figure 27). The role, along with the creation of capacity and recruitment to it, has contributed to the reduction of Elmore's waiting list and times.

The role has reduced the number of actions per referrals between the allocation and support starting dates for those referrals that become clients. This is possibly because some assessment has already been completed per allocation.

The role has enabled a diversion of clients to appropriate services more swiftly after their referral, without requiring them to wait to be allocated a specific caseworker to identify inappropriateness for Elmore's support. This is possibly because a brief intervention is sufficient to stabilise a referred person and/or establish a better understanding of them sooner in their time since referral.

To highlight the contributions of the role, it is important to think about what the situation might have been had the role not existed. Suitable referrals that were accepted as clients would have been waiting for up to 22 months, 9 on average, to receive the support they needed. One would expect that this would lead to clients being in greater need by the time their case could be opened by an Elmore caseworker and support could begin to be provided. In addition, clients would have waited up to 9 months, on average, to be allocated a caseworker to discover that their referral needed to be declined for reasons that could have been established much sooner.

In both circumstances, the role has facilitated referrals to access Elmore's support or more appropriate support sooner. The role has, therefore, potentially helped to prevent an escalation of mental ill health and complex needs which would have required Elmore or another service provider to provide support on a more intensive and protracted basis. Indeed, the services which Elmore has been able to refer or signpost individuals onto at an earlier point in their pre-allocation period will typically be services that do not specialise in the provision of complex needs or personality disorder support. This ensures that such services are rationalised and concentrated on those who need them to the greatest extent. Further information is given in Section 6, Appendix 2: , concerning organisations to which individuals were signposted and referred to by the role.

4.2 The future of the waiting list engagement role

When the role began, it was supporting clients that had been on Elmore's waiting list for about 9.3 months, on average (Figure 27) with the earliest client referral having been 30 months earlier (this waiting time does not appear on the graphs because it was pre the date of the start to the salesforce system). The current duration from referral to Elmore to allocation to a caseworker is approximately 5 months (5.1 for the complex needs floating support service and 5.0 for the mental health floating support service), with a subsequent allocation-to support starting time of under a month.

With waiting times and the waiting list length significantly reduced, the role is no longer as essential. However, in a post-waiting list era, it nonetheless seems efficient for Elmore to

provide some level of pre-assessment if this can produce a positive effect by a) enabling Elmore to reject or redirect an unsuitable referral as soon as possible after their referral and b) decreasing the number of required actions per referral, post-allocation, and pre-start date, for referrals that go onto become clients of Elmore's complex needs and mental health floating support services. It is not yet clear if the continued deployment of the role could lead to a decrease in resource between referral and support starting date in total.

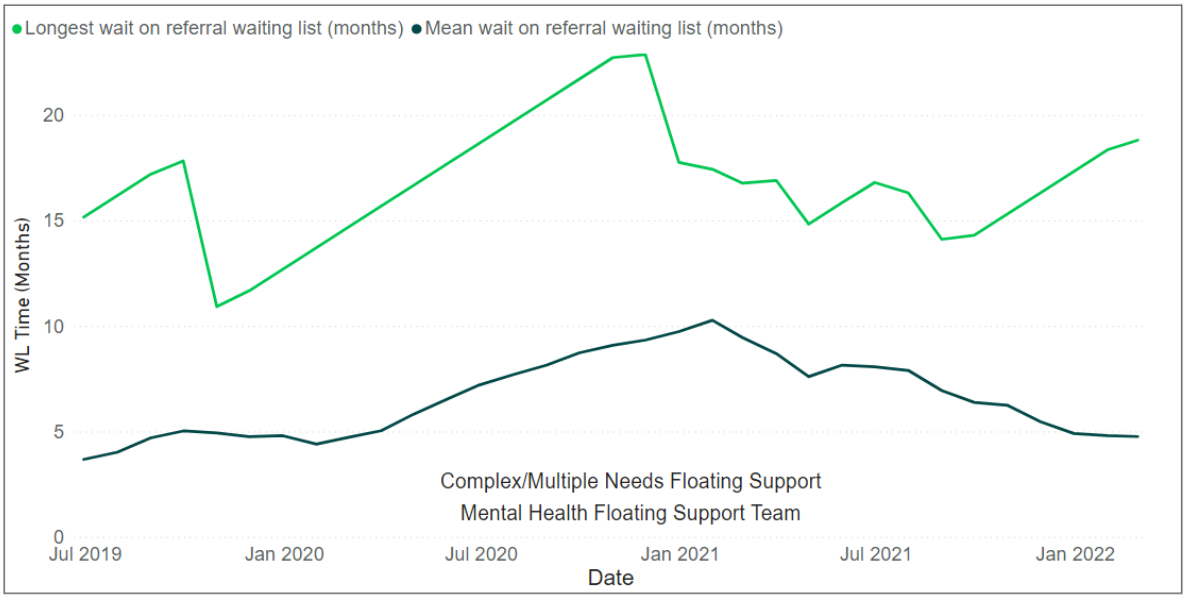

Figure 27: Min, mean and max of referral to allocation time (in months) vs referral date.

5 Appendix 1: Impact analysis method

5.1 Obtaining relevant records from the database

Referrals to Elmore get entered onto a Salesforce database by a designated manager. When a waiting list is not in operation or operating modestly, referrals are promptly passed to a suitable caseworker. The optimal client-caseworker match is decided by a committee of Elmore's managers, based on client needs and caseworker expertise, experience, and availability. When waiting times were longer, referrals would have to wait months to be allocated to a caseworker. Once the role became operational, most floating support referrals were passed to the Elmore staff member committed to the role. All interactions with referrals on the waiting list were entered into Elmore's Salesforce database by this individual.

5.1.1 Waiting list engagement role records criteria

To identify interactions by the waiting list engagement role with potential Elmore clients, the report uses records which met the following criteria:

- the action was created by an employee who performed the role
- the client's name associated to that action matches a name in the waiting list role spreadsheet
- the date of the action is on or after the referral and on or before the date the client gets allocated to a caseworker

5.1.2 Services supported by the waiting list engagement role

Figure 28 shows the number of referrals from 28/05/2019 to 17/03/2022 to each Elmore service and whether referrals were supported by the role. The report focuses on the role's support provided to referrals to the complex needs and mental health floating support services. (The role also supported two Rise & Shine referrals and one Tenancy Sustainment referral.)

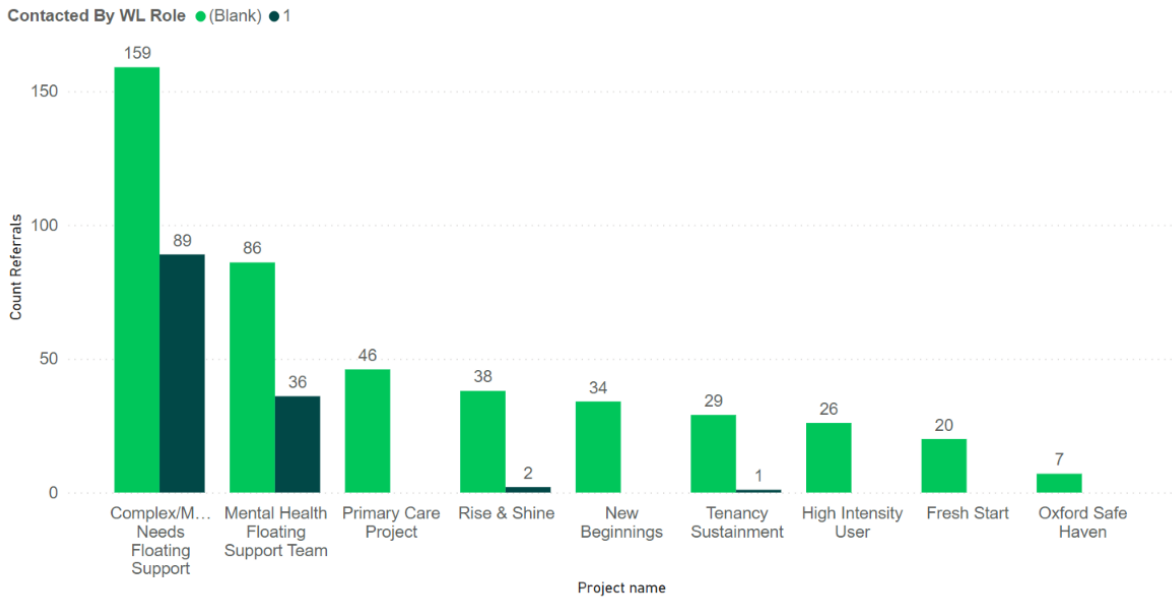

Figure 28: Referrals from 28/05/2019 (transfer to salesforce database) to 17/03/2022 by service and waiting list role status (light green/ dark green are referrals supported/ not supported by the WL role).

5.1.3 Date criteria

Only referrals post-28/05/2019 (the transfer date of Elmore client records to the Salesforce system) were included to have a recent comparable sample in terms of waiting list times and ensure all data collection is consistent. Referrals were filtered out if they were transferred from a service to another without returning to the waiting list.

Figure 29 shows whether referrals were supported at any point in their time with Elmore by the waiting list engagement role. To assess the impact of the role, referrals pre- and post-role creation must be compared. The date chosen was 01/03/2020 because this is the date in Figure 29 on which referrals were mainly passed to the role. When the report quotes pre-role creation, this equates to a referral date which is less than 01/03/2020. Anything following this date is regarded as post-role creation as most referrals post-01/03/2020 were passed to the role. Those referrals not passed to the role were declined shortly after the time of referral as they were deemed unsuitable (e.g., not meeting the age-criteria or residence in eligible geographies) or the referrals did not wish to proceed.

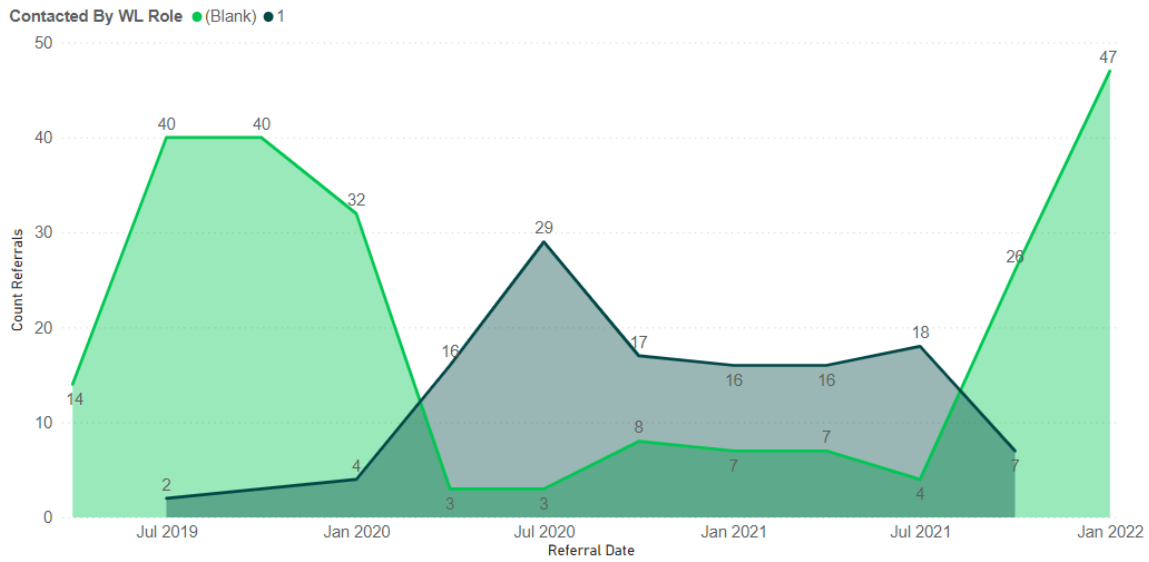

Figure 29: Referrals from 28/05/2019 to 17/03/2022 by binned referral date and waiting list role status (light green/ dark green are referrals supported/ not supported by the WL role).

It is not valid to compare waiting list-era referrals up to the present day because insufficient time has passed to create a comparable sample to pre-role data. Pre-role referrals have mostly been declined, allocated to an Elmore caseworker, led to the start of support, or once support has started, have closed. The role started 16 months ago, when the mean waiting times for mental health and complex needs services were around 9-months long, to a maximum of 22 months, so many waiting list role era referrals have not yet been fully assessed. It is clear from Figure 30 that if we consider all referrals up to the present date, a sizeable proportion (40%) will have status referral, meaning a decision on whether to accept or decline the referral is pending.

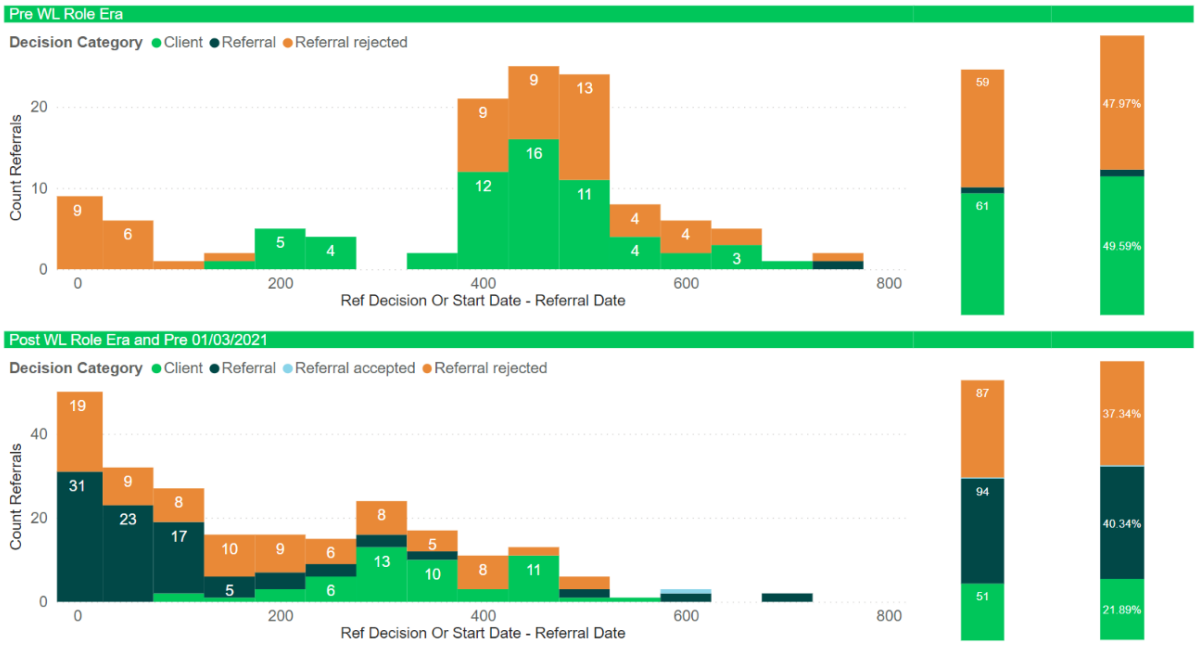

Figure 30: Count referrals by outcome vs referral decision date or today minus referral date. The top chart is pre 01/03/2020 and bottom is on or after 01/03/2020 to 17/03/2022.

Figure 31 shows the time from referral to referral decision for these date criteria:

- Pre waiting list role era (top chart): 28/05/2019 <= referral date <01/03/2020
- Waiting list role era (bottom chart): 01/03/2020 <= referral date <= 01/03/2021

These date filters provide comparable samples for pre and post-role data. Most results presented from this point on in this report have these date filters applied unless otherwise stated.

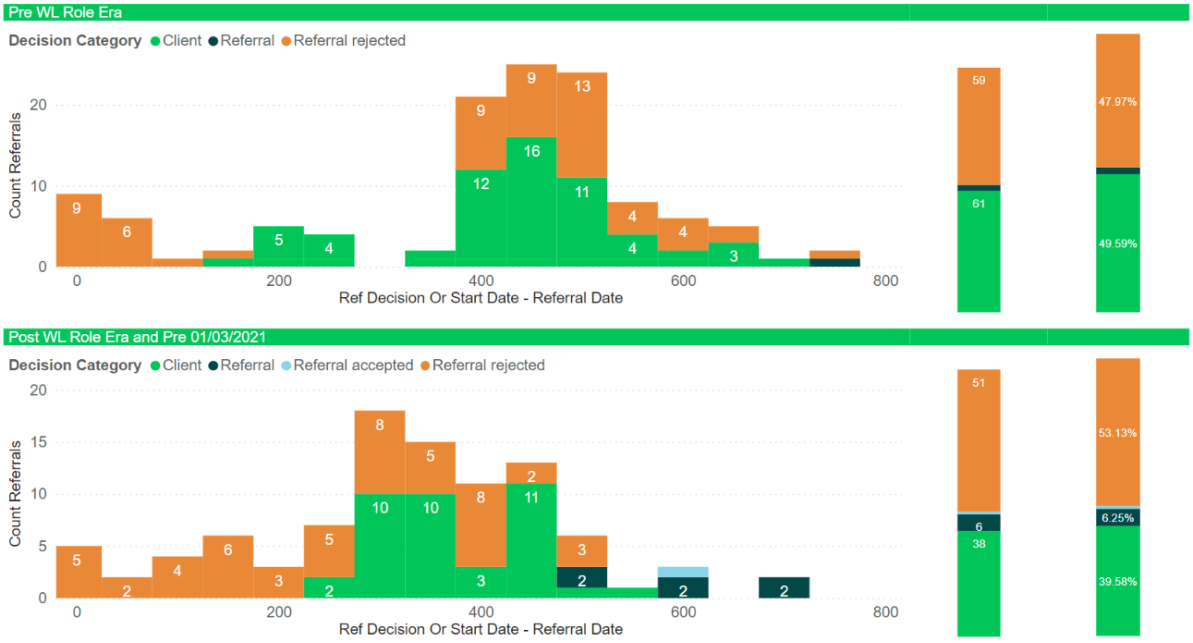

Figure 31: Count referrals by outcome vs either start date, referral rejected decision date or today minus referral date. The top chart is pre 01/03/2020 and bottom is on or after 01/03/2020 and before 01/03/2021

6 Appendix 2: Intended investigations once more data becomes available

6.1 Case duration

Only three cases supported by the role have been closed and, in all cases, this is because the clients disengaged. As the role started 17-months ago, insufficient time has elapsed to fully understand its impact on the duration of a client's time with Elmore. This analysis has been set up to track results around case duration as data becomes available.

6.2 Time to support plan

The time between a client's start date to first receiving support has been investigated. However, a considerable number of cases don't have all the support plans recorded in the database, so this analysis has been problematic. For a sample filtered for high quality, the results shown in Figure 32 show a very weak negative correlation hence –the more support given by the role, the shorter the time from case start to the completion of the first support plan. Hence, the more information that was gathered about the individual whilst being supported by the role, the quicker the first support plan could be put in place once the referral became a client. This analysis will be extended as more data become available.

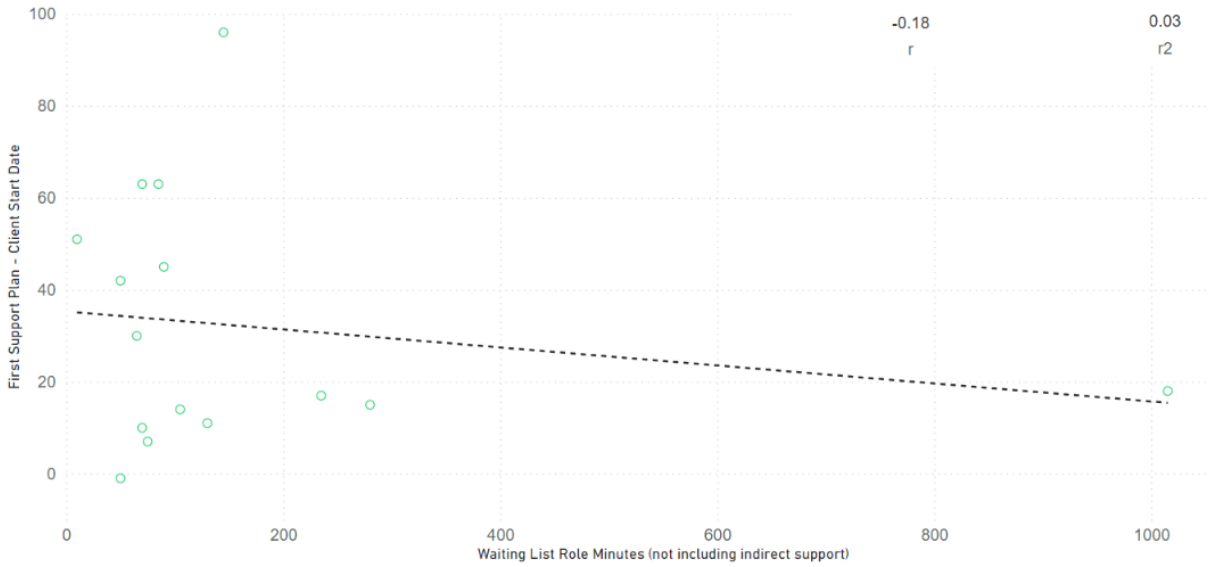

Figure 32: Correlation between time to first support plan vs minutes of support on waiting list role.

6.3 Time to disclosure of Domestic Abuse and/or Sexual Violence

Currently, not enough time has elapsed to have a strong statistical evidence base on this, but an analysis has been set up to track the latest data. The intent of performing an analysis is to understand the ways in which Elmore can speed up the creation of trusting relationships between caseworkers and clients which can lead to a speedier disclosure of domestic abuse and/or sexual violence.

Elmore
Community Services

elmorecommunityservices.org.uk

Elmore Community Services are a registered Charity (1090616)