Local Government Association

Blackburn with Darwen Borough Council

LGDC
local government delivery council

Improvement

Customer led transformation programme

Case study – Blackburn with Darwen

Care Trust Plus

47/58

Contents

The Customer Led Transformation Programme

Blackburn with Darwen Borough Council's work has been funded under the Customer Led Transformation programme. The fund aims to embed the use of Customer Insight and Social Media tools and techniques as strategic management capabilities across the public sector family in order to support Place-Based working.

The Customer Led Transformation programme is overseen by the Local Government Delivery Council (supported by the Local Government Association).

The fund was established specifically to support collaborative working between local authorities and their partners focused on using customer insight and social media tools and techniques to improve service outcomes. These approaches offer public services bodies the opportunity to engage customers and gather insight into their preferences and needs, and thereby provide the evidence and intelligence needed to redesign services to be more targeted, effective and efficient.

About Blackburn with Darwen

Blackburn with Darwen is a unitary authority in Lancashire, North West England. It consists of Blackburn, the small town of Darwen to the south of it, and the surrounding countryside.

The estimated population of Blackburn with Darwen borough in 2010 was 140,000. It has one of the highest proportions of young people aged 0-19 years compared to England and Wales's local authorities. 42,500 residents fall into this age group which represents thirty percent of all residents (compared to 24 per cent nationally).

The majority of the population (77 per cent) is from a White ethnic group but around a fifth of the borough's residents are from an Asian heritage background. Both birth and death rates for the borough are above the national average.

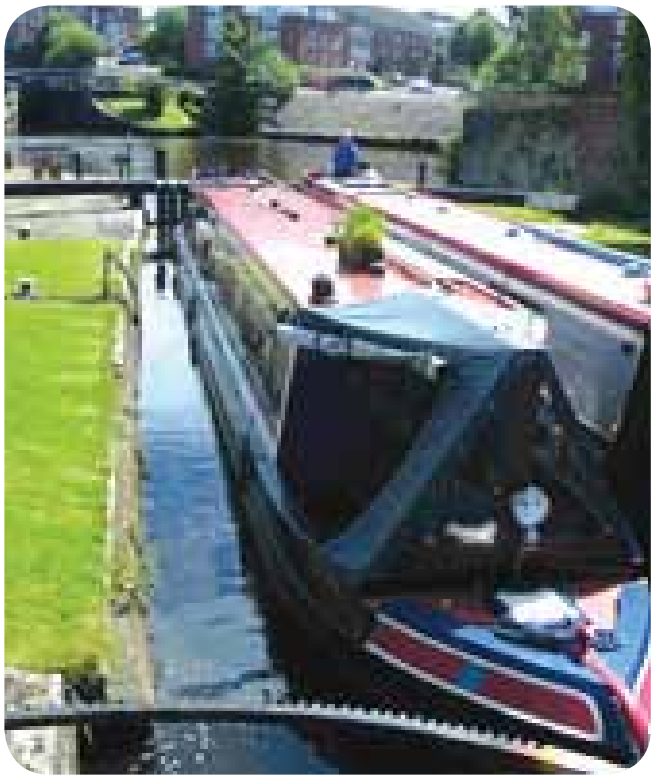
Between 2009 and 2033 the population of the borough is projected to grow by 7,100 (4.7 per cent) to 146,500. This growth will be driven by an ageing population. In 2009 the proportion of people of pensionable age was 21.6 per cent and this is projected to increase by 9.2 per cent points to 30.8 per cent.

A greater proportion of jobs in the borough (23 per cent) are in the manufacturing sector compared to regional (11.6 per cent) and national figures. However, this is declining whilst the service sector has been experiencing a growth and now provides 76 per cent of jobs.

The Borough's gross weekly earnings for full time employees are just below the regional and national averages. 2010 figures put average borough earnings at £439.90, compared to £471.30 regionally and £501.80 nationally.

For the April 2010 to March 2011 period, unemployment within Blackburn with Darwen was at 8.9 per cent of the economically active population, compared to 7.8 per cent regionally and 7.6 per cent nationally. Almost a fifth (18.1 per cent) of residents aged 16 to 64 are claiming out of work benefits and it is estimated that 29.5 per cent of children in the borough are living in poverty.

Using the 'rank of average score' summary, Blackburn with Darwen Borough Council is the 17th most deprived out of the 354 local authorities in England. Around 34% of residents lived in areas that were considered to be within the 10 per cent most deprived in England in 2010.



Leeds and Liverpool canal

Background

Blackburn with Darwen Borough Council (BwD) and Blackburn Primary Care Trust (PCT) established a Care Trust Plus (CTP) organisation in April 2010. The CTP is responsible for providing primary and community health and adult social care services and commissioning a full range of hospital services for the borough.

This body faces numerous challenges but one that was signalled early on concerned the health implications resulting from the misuse of alcohol. There were numerous statistics identifying the extent of the problem – for example:

- men in BwD have an alcohol attributable mortality rate of 48.83 per 100,000 (compared to 35.86 for England as a whole)
- hospital admission for alcohol related harm rose from 940 in 2002/03 to 2014 in 2007/08.

However, the impact of alcohol misuse goes beyond the health of the individual concerned and can have a major effect on the whole family:

- nationally 2.6m children live with parents who drink seriously and of these 750,000 live with 'dependent' drinkers
- parental alcohol misuse is a factor in over 50 per cent of child protection cases.

An Alcohol Harm Reduction Strategy was developed in 2008 which sought to identify local priorities and develop practical approaches to reducing alcohol misuse across the borough. Although this has enabled the CTP to improve services that support people with alcohol related problems it is uncertain how successful the strategy has been in helping individuals and their families to change their behaviour **before** serious issues arise.

Against this backdrop the CTP set out to run a customer insight project to improve their understanding of the problems faced by families.

As a separate initiative, Blackburn with Darwen Council was delivering a Think Family pilot that has used findings and early success criteria evidenced through the pathfinders initiated by the Department for Education – a government programme that aims to secure better outcomes for children, young people and families with additional and complex needs.

The local pilot had demonstrated the need to coordinate the support families receive from across the range of public sector providers and their partners.

In the latter stages of this CTP project, on alcohol related issues in families, the two projects worked together to benefit from the customer insight and shared learning and to improve the service offer available locally.

Blackburn cathedral

Objective

The original aims of the customer insight project were:

- to understand the needs and aspirations of families effected by alcohol misuse
- to understand and challenge how current service delivery arrangements support these families
- to identify improvements to the way in which these families are supported.

However, as the project progressed the aims evolved and broader view of alcohol harm was applied – ie alcohol 'misuse' includes hazardous as well as dependent drinking and therefore although 'clients' would not yet be official 'service' users they would still potentially require early intervention or a different kind of 'service'.

Approach

The project was split into several phases. The project team from the CTP commissioned Aperia Government Services to help them with this project. Aperia utilised their Circles of Need approach to understand the needs of the customers and to challenge the current service provision.

This methodology is composed of four main stages:

- **Understand** – Know who your customers are, what their needs are, what services contribute to fulfilling those needs, what activity you carry out to deliver the services.
- **Challenge** – Are we meeting the need sufficiently? Are we prioritising our resources in the right areas? Can we be more proactive in delivering services? Is there any duplication of activity? Can we make better use of professional

disciplines? Can the service providers work more seamlessly?

- **Design** – Consider the results of the Challenge stage, focus the service on meeting a need and determine which organisation is best placed to deliver a service, consider the best way for the customer to access the service, line up the flow of work to avoid failure demand, remove non-value adding activity.
- **Change** – Articulate the reason for change, identify champions of the change, generate urgency in communicating the need to change, empower people to carry out the change themselves, ensure the benefits are realised and embed the change in business as usual.

The work undertaken in BwD was as follows:

Customer research
To understand the needs and aspirations of customers the following activities were undertaken:

- **Customer definition workshops**
  The project team sought to define the customer segment that would be researched by running two events for stakeholders. These involved about 25 stakeholders from council, health, police and housing. The events started with a presentation of the project and research to date.

  This was followed by a discussion of the customer segments that could be included in the alcohol project – identifying aspirations, risks/issues and unmet needs of the segments. The discussion culminated in the selection of suitable segments for the alcohol project to focus upon.

- Because of the scale of the problem the Customer Definition Workshop initially selected two customer segments to focus upon:
  - an adult 'harmful' drinker who is a parent and where the child spends some of their time in their home
  - a child who has some residence in the home of a parent who is drinking at harmful levels.

  For clarity, 'harmful drinking' is defined as follows:

> "Harmful drinking is drinking at levels that lead to significant harm to physical and mental health and at levels that may be causing substantial harm to others."

  However, as the alcohol project progressed the scope was widened to recognise that hazardous drinking is a pre-emptor of harmful drinking and it is important to have an insight into the families which are not yet hitting the radar of specialist services. So the project began to focus more on early intervention.

- **Data analysis**
  Service take-up data was taken from a range of service databases (eg from the NW Public Health Observatory). This was analysed together with various other demographic data and the addresses of individuals used to identify key geographic hotspots with regards to alcohol related incidents and services. The hotspots were found to be in areas of deprivation.

- **Customer engagement workshops**
  Having selected the target groups, three workshops were run with parents who have a significant relationship with alcohol to improve the understanding of their aspirations, concerns and perspectives. Individuals that were in specialist alcohol treatment programmes, commissioned by CTP, were invited, by their service providers, to attend these workshops.

  In an attempt to make the sessions as open as possible and to solicit the honest views of the participants, it was agreed that no service providers would be present at the sessions and they would be held at a neutral venue.

  About 30 individuals attended and they represented a range of backgrounds. Naturally, some were quite outgoing whereas others were more reticent to discuss certain issues in particular their relationships with and the impact upon, their children.
- **Service research**
  In order to build up a picture of the current and possible future models of service provision the following activities were undertaken:
- **Service provider interviews**
  These were conducted with key service providers to understand the support that was provided to families with a significant relationship with alcohol and to identify potential opportunities to improve that support.

  A number of interviews were undertaken with providers of specialist alcohol services commissioned by the Care Trust Plus and with providers of other public sector services that frequently interact with parents who were likely to be misusing alcohol.
- **Interviews were held with the following agencies/services**
  - Evolve – Inward House (a specialist alcohol service provider commissioned by the Care Trust Plus)
  - Greater Manchester West (a specialist alcohol service provider commissioned by the Care Trust Plus)
  - Lifeline (a specialist alcohol service provider commissioned by the Care Trust Plus)
  - VOICE (a specialist alcohol service provider commissioned by the Care Trust Plus)
  - Family Intervention Programme – Action for Children
  - Community Safety Team – Blackburn with Darwen BC
  - Police
  - A&E – Royal Blackburn Hospital
  - Drug and Alcohol Team – Care Trust Plus
  - Children and Young People Services, Commissioning – Care Trust Plus
  - Adult Services, Commissioning – Care Trust Plus
  - GP – Witton Medical Centre
  - GP – Ewood Surgery
  - Housing – Blackburn with Darwen BC
  - Health Outreach Team – NHS BwD
  - Shadsworth Community Centre

- These interviews were undertaken in order to gain a better understanding of the following:
  - The services delivered and the support that these services provide to parents
  - Service accessibility
  - Number of service users
  - Service capacity
  - Information capture
  - Performance monitoring
  - Potential improvement opportunities
  - Service provider perspectives on the key issues that contribute to Blackburn with Darwen's large alcohol-misusing population.
- **Challenge workshops**
  Two workshops were undertaken to challenge the project findings and identify potential improvement opportunities. The first workshop was with a group of practitioners. The findings from the project were reported to the group. The group discussed these and considered the implications for service delivery. (For details, see Working Practices, below). At the end of the session the group produced a list of possible recommendations or options.The second workshop had a managerial focus. This group considered the outputs from the first workshop and decided on a way forward (see Outcomes).
- **Costing research**
  An analysis of existing research was undertaken, utilising sources such as the NW Public Health Observatory, to identify the impact cost of alcohol misuse for the public sector across the borough. The work defined costs borne by the NHS, the Police and Criminal Justice System and BwD as a result of providing health services, responding to crime and delivering welfare benefits as a result of alcohol misuse.

This research identified an overall expenditure of £33.5m per annum. The details of this spend are covered in the Findings section.

Findings

The scale of the problem

The analysis of existing research highlighted some important statistics that helped to convey the scale of the problem Blackburn with Darwen faces with regards to alcohol misuse and families and has subsequently been used to strengthen the overarching approach when working holistically with families.

- Total population of Blackburn with Darwen = 137,470[1]
- Adult population (16 years and above) = 102,787[2]
- Child population (under 16 years) = 34,683[3]
- 17.6 per cent of adult population drink at 'hazardous' levels = 18,091[4]
- 5.5 per cent of adult population drink at 'harmful' levels = 5,653[5]
- Adult population misusing alcohol = 23,744
- Alcohol Concern agency has estimated between 24,000 – 25,000 'hazardous' and 'harmful' drinkers in Blackburn with Darwen[6]
- An estimated 8,000 children live with a parent/s who drinks at hazardous or harmful levels[7]
- Annual number of alcohol-related hospital admissions = 2,939[8]
- Annual number of customers receiving partial/full programme support from specialist alcohol services commissioned by Care Trust Plus = 628
- Annual number of children engaged in specialist alcohol services commissioned by Care Trust Plus = 103

1 Census 2001 Data - http://www.statistics.gov.uk/census2001/profiles/00ex.asp
2 Census 2001 Data - http://www.statistics.gov.uk/census2001/profiles/00ex.asp
3 Census 2001 Data - http://www.statistics.gov.uk/census2001/profiles/00ex.asp
4 2009 Local Alcohol Profile for Blackburn with Darwen, NW Public Health Observatory – www.nwph.net/alcohol/lape
5 2009 Local Alcohol Profile for Blackburn with Darwen, NW Public Health Observatory – www.nwph.net/alcohol/lape
6 www.alcoholconcern.org.uk
7 Estimation made using Census 2001 data on the number of children per adult within Blackburn with Darwen alongside the 2009 Local Alcohol Profile for Blackburn with Darwen
8 Royal Blackburn Hospital data – 2009/10

Customer research

The initial research found that the over-riding aspiration from the 'harmful' drinkers taking part in the customer workshops was: "I want to stop drinking"

However, the workshops also identified a number of other aspirations:

- ensuring that their children could look forward to a good future
- forming strong, supportive relationships with their family
- understanding what support was available and how to access it
- feeling that they were of value.

Two primary fears were also identified:

- fear of relapse: eg once specialist treatment had finished
- fear of not being able to keep occupied: a fear that not having constructive activity might lead to relapse.

This diagram shows the barriers associated with 'Harmful' Drinking Parents

BwD undertook a full Circles of Need analysis – see Appendix 1 for a diagram of the findings. This is complex and detailed, but the customers also gave a high level insight into the support provided by the public sector and offered the following comments:

- the trigger to seeking help is always when issues have spiralled out of control
- the public sector is unable to identify those people who need help before it is too late
- in all cases parents are completely unaware of the totality of support that was available to them
- support is required across a number of needs – not simply help with alcoholism, but employment, training, welfare, housing etc – this support is not very well 'joined up'
- support is available from 9am to 5pm – ie not when it is most urgently needed.

Service provider research

The insight arising from the service provider interviews shows a degree of overlap with the issues highlighted by customers but with a different perspective.

Many points were made, key amongst them were:

- limited resources contribute to the perception that inadequate support is available to people who are misusing alcohol before they come to a crisis point
- there is a complex web of support and referral agencies and systems which even the professionals do not always fully understand or utilise
- some areas of the public sector do not make clear links between dealing with alcohol misuse and their own strategic objectives and staff from some agencies do not consider that it forms part of their remit.

Costing research

As part of this project research was undertaken to identify the costs associated with dealing with and reacting to the consequences of alcohol misuse to the public sector across BwD.

The work defined costs borne by the NHS, the Police and Criminal Justice System and BwD as a result of providing health services, responding to crime and delivering welfare benefits as a result of alcohol misuse.

A total expenditure of over £33.5 million per annum was identified.

Although the detail of this calculation will always be open to debate, it is clear that the opportunity cost available, if alcohol misuse could be reduced, is significant.

aperia Government Services

Impact Area / Service	Total Cost Alcohol Related per Year (BwD)
Health / NHS	
Hospital Inpatient and Day Visits	
- Directly attributable to alcohol misuse	£444,701
- Partly attributable to alcohol misuse	£2,713,580
Hospital Outpatient Visits	£1,001,058
Accident and Emergency Visits	£286,563
Ambulance Services	£1,919,279
NHS GP Consultations	£4,596,279
Practice Nurse Consultations	£889,960
Total - Health / NHS	**£11,631,409**
Criminal Justice	
Violence Against Person	
- Homicide	£415,408
- Common Assault	£89,972
- Wounding	£8,029,901
Sexual Offences	£167,700
Burglary – Business	£147,810
Criminal Damage	£172,686
Robbery	£230,969
Drink Driving	
- Drink driving arrests	£35,476
- Magistrates courts	£107,800
Drunk and Disorderly	£631,400
Total - Criminal Justice System	**£10,029,121**
Benefits	
Incapacity Benefit	£633,095
Disability Living Allowance	£173,550
Job Seekers Allowance	£2,783,981
Housing Benefit	£8,299,616
Total - Benefits	**£11,890,233**
Total	£33,550,763

Early findings from the research element of the emerging Think Family approach, which included feedback from the families, defined obstacles which were documented as a catalogue of things that didn't work for families and which presented as barriers to effective practice for staff.

These were subsequently fed in to the discussions with substance misuse service providers who adopted them as obstacles with the current system which would require solutions.

The findings included:

- interventions carried out at a time when the family may be least likely to embrace change
- investing in intervention at a time when families don't want it
- repeated interventions
- large numbers of organisations involved without knowing about each other
- professional led interventions which are not sustainable in the longer term
- long periods of assessment driven by professionals schedule and not the needs of the family
- families become attached to the professional and are then left without them
- families not being supported to sustain change
- contracts and sanctions which are not enforceable or psychologically motivating – service providers acting as parents and the family being the child told off for naughty behaviour
- being 'referred' for support implies they 'are not good enough'
- professional led action plans reinforce the feeling of failure for the family
- families may play the system for what they want (secondary gains, such as a house move or additional benefits)
- financial expenditure with no evidence of success
- individual ring fenced budgets with no flexibility.

Described by Dr Deborah Thompson as:

"Sticking a plaster on the problem without addressing the underlying problems."

Outcomes

Methodology
In an attempt to address the identified shortcomings of the current system, described above, partners (with the CTP as a key player) utilised Think Family as the conduit to trial alternative methods of service delivery.

Lesley Wilson, Children's Services said:

"It was really a simple decision to stop doing what didn't work and do more of the things that were working."

Model pathways to deliver services differently and which saw the families themselves take more control over the types of interventions were being tested by Think Family. Although many of the early success stories were anecdotal at this time these early findings seemed to address many of the shortcomings identified in the customer insight research. Following the Challenge Workshops, CTP decided to utilise a similar approach to service provision for families with alcohol related problems.

The defining features of the Think Family model are:

- A family-led approach. The Think Family model sees families enter through a new nominations pathway. They are guided and facilitated in developing their own family plans with the holistic support and commitment from all relevant agencies as they seek to implement those plans.
- Considerable support came from all agencies and partners, including a signed and adopted information-sharing protocol, stakeholder agreement to support families in implementing their plans (removing the sometimes complex existing pathways), therapeutic sessions which were offered through a charitable organisation and a multi-agency provision of 'advocates'.
- The work is underpinned by relevant work streams to ensure any system and process changes required are tackled. These include ICT and Communication, Human Resources and Workforce Development, Neighbourhood delivery, Research and Evaluation.
- Advocates are integral to the model. They provide a single point of contact for the family and hence move away from a professionally led dependency model towards a family focussed one. Cases are not closed and the advocate stays in contact for as long as is needed and utilises sustainable community and social networks as a route for referral and longer term support.
- There is an initial six week therapeutic programme which, to date, has been offered through a partner charitable organisation, during which families confront their own issues. This includes the use of an emotional health and wellbeing tool which enables a family to measure their own progress. The two key concepts in this part of the pathway are emotional capacity and willingness to make changes.
- The ethos of the model is early help which is underpinned by social capital has been achieved by relying on the nomination of families by the people who know them (eg the bobby on the beat) rather than waiting for a crisis to occur.

This approach was described by Deborah Gornik, Head of Service Children's Services as

"A new ethos, whereby we invest in our families, for as long as it takes rather than doing things to them."

Pilots
To date Think Family has applied this thinking in 3 pilot areas (Shadsworth, Batswell and Sudell wards) and has utilised data made available from the families and alcohol project to strengthen the scope of the change.

The work in each pilot area has involved up to 10 families, alcohol as an issue for many families is further substantiated through case studies detailed as an outcome of research and evaluation.

Families
From the 30 families that participated in these pilots, a number of positive outcomes for families have been achieved. These are best described by the following selection of case studies.

Susan

A mother and grandmother with 3 older children and a younger son aged 8. Susan has experienced a huge amount of loss in her life which she has never come to terms with. She has also experienced very serious domestic abuse relationships which have impacted on her long term emotional wellbeing and thus her ability to parent her children effectively.

Susan has been somewhat dependant on alcohol for a number of years although she has chosen not to address this issue previously. There is no doubt that Susan's life experiences have negatively impacted on her ability to cope with daily life and her relationships with her children.

Susan initially engaged with professionals to improve very poor home conditions and address behaviour and school attendance issues re her youngest child. Once these issues were mainly addressed Susan completed the six week therapeutic programme. She later went on to complete a course of 1:1 counselling to address bereavement issues.

Susan has continued to make improvement to her home of her own volition and the family are now very proud of the home that they live in. Relationships with her family, especially her teenage daughter and granddaughter are much improved. Susan has also reduced her drinking significantly to the point where she does not seem to be alcohol dependant; she has achieved this herself without support from any alcohol misuse service.

Susan has an excellent relationship with her advocate and sees her on a regular basis. Susan now seems to be taking control of things in her life and presents as being proactive and assertive rather than aggressive.

Steve

A father with one young daughter. Steve and mother of child are no longer together. This was and still is a very problematic relationship. There is a history of alcohol misuse leading to domestic abuse perpetrated by Steve during and after the relationship. Steve is in full time employment.

Over the past few months contact between Steve and his daughter has increased and been overseen by paternal grandma. The relationship between Steve and his daughter has flourished.

Steve has completed the six week therapeutic programme and completed his family plan which identified that he wanted to be a better parent and provide a better home for his young daughter.

Steve has reduced his drinking significantly, and now feels able to do undertake this now and again on a normal social level rather than frequently binging. Steve has tried to improve relationships with his ex partner, obtained his own rented property and is in the process of furnishing this in order to be able to have his daughter to stay on a regular basis.

Steve and his advocate have a good relationship and regular contact and support is provided.

Carl and Sarah

A couple who live with their 12 year old daughter and Sarah's 15 year old son from a previous relationship. Carl also has three other younger children from a previous relationship whom he has no contact with at the present time due to ongoing problems with his ex partner. Carl and Sarah were married several years ago and had their 12 year old daughter. They split up, entered into relationships with other partners and then resumed their relationship approx two years ago and left their respective partners.

Both parents have had mental health issues, Sarah suffers from depression and anxiety and Carl has been diagnosed with schizophrenia. Carl's mismanagement of this condition has had an effect on his long term emotional health and wellbeing and for many years he used alcohol as a coping mechanism which impacted negatively on his behaviour. All of these factors obviously impacted on the couple's relationship and their relationships with their children.

Both parents attended the Think Family Therapeutic group together in August 2011. Following the group a Family plan was identified by the parents and the advocate. Sarah highlighted that she needed to take her medication regularly in order to stabilise her anxiety and depression and enable her to cope with everyday issues in the family. She also highlighted that she needed to stop taking on the problems of her extended family and neighbours and deal with her own immediate family relationships as a priority. Sarah has achieved and maintained both of these goals which has had a huge positive impact on her and every family member within the household.

Since attending the group Carl has also achieved and sustained huge positive changes. Carl no longer uses alcohol at all and has not done so for a considerable period of time. Encouragement and advice from his advocate and mental health worker has supported Carl with this process. Carl is now able to manage his mental health effectively and is totally compliant with medication and after years of involvement, the mental health service has now discharged Carl.

These changes have affected Carl's relationship with Sarah and the children very positively. Carl is now able to communicate appropriately with Sarah, and they are able to make decisions as a family unit. This was one of the changes Carl wanted to make as both he and his partner did not feel secure in their relationship.

The children in the family were subject to the CAF process and through support by the advocate the parents are able to meet and manage the children's needs and behaviour and now have stable routines within the home. As a result of this all professionals in the TAC meetings were happy for the CAF to close as the children were achieving well at school with the support of both parents.

Carl is able to sit and join in family meals or watch films with the children which he was unable to do previously due to his alcohol use and erratic mental health state.

Sarah also feels her relationship is a lot better with the children as she now has more family time at home. Sarah also feels confident to address sexual health issues with the children which she was unable to do prior to attending a sexual health course (provided through the Think Family Pilot - via Brook) and feeling low in confidence to do this.

Carl and Sarah have concentrated on making their family home comfortable which they have achieved as the family have redecorated the living room and carpeted the hallway. Again, this was another goal the family identified on their Family plan. The family also have a debt relief order in place which they have worked towards resolving as they were in debt. The family are now able to budget due to support provided to them from Mainstay Floating Support. Due to Carl not drinking, the family are better off financially. Therefore, Carl is now in the process of opening an account with Credit Union and is saving money towards a car.

It is fair to say that the positive impact on the improved quality of relationships and life in this family has been dramatic for all family members, since the parents commenced on the Think Family programme. The Family Plan has been totally led by the family and they have made each of the changes when the time has been right for them.

Parents refer to their advocate as their 'safety net'. Explaining that they feel they are doing really well now but they know that if they are ever struggling, their advocate is always there in the background to offer support and help them get back on track.

There are a wider range of cases that could be considered, for example:

- One mother has taken up a place in college as a result of this intervention
- One family suffering from the effects of domestic violence were rehoused. The relocation was facilitated by the advocate who even managed to work with the mother to navigate a school appeal panel and achieve a successful outcome for the family ensuring the admission of all the children in to one school.
- Another family, through choice, relocated to live outside the BwD boundary, the long term commitment made to the family ensures that the advocate still supports them.

In addition, the advocates themselves have a number of positive stories to tell:

"The role as an advocate has differed, we would have usually gone in straight away and completed an assessment with the family and identified what support is required. However this method of working is family led and they are given time through the therapeutic group to recognise things in their life they want to change and how this would impact on their family life."

"Working with the traditional model of intervention Linda (mother) would have had a lot of barriers to overcome before she could have made any positive changes, Linda (mother) would have had to wait a considerable length of time before she could access counselling which in turn has given Linda (mother) the confidence to push herself that little bit further to achieve goals set on her plan. I feel that under the Think Family way of working and supporting families in an advocate role, we are empowering families to take the lead with regards to change. We now work at the families pace, allowing them to develop their own family plan with realistic, achievable targets."

"Due to the think family approach, I worked in a solution focused way and Lyndsey (mum) has been able to answer her own questions and has discovered her own solutions."

Benefits

Customer insight research
The 'Circle of need' project delivered through Aperia Ltd. provided insight into both customer and provider views of substance misuse services. It also identified the associated financial costs.

The research demonstrated evidence of the complex relationship between a number of issues, including housing, family tensions debt and unemployment that are linked to and perhaps trigger alcohol misuse – leading to the belief that dealing with alcohol in isolation is insufficient.

Combining this with the existing intelligence from the Think Family pilot enabled the refinement of the model to incorporate the research. This made a significant difference to the outcomes for those customers participating in this pilot – as indicated by the individual stories above.

The research provided a deeper understanding of the needs and aspirations of families affected by substance misuse.

The work also provided clear insight into how partners and stakeholders viewed their services. Very often agencies working on the 'substance misuse' element with a family member did not take into consideration the impact on the whole family.

Partnerships
BwD has a good track record of partnership working and seeking more effective ways to do business. However adopting new ways of working using a customer focussed approach has tested and continues to challenge corporate priorities, strategic approach and operational delivery.

Originally the work focussed on strategic and corporate sign up across all public sector organisations and key partners. A pledge to work differently and make things happen was a significant undertaking. The initial insight research enabled partners to have a shared understanding of the barriers existing in the current systems of delivery and a focus on changes that they could make collectively and as individual services or organisations. It has established an approach that has been co-created with its service users and who are in turn telling us that it is effective and is making a real difference to the lives of these individuals and families.

Developing an infrastructure which incorporated an information sharing protocol and strong links to work being explored nationally around community budgets and total place played a pivotal role. This means that everyone is clear who is leading, and how to share information across different services so that they can respond more quickly and effectively to support their customers thus improving the outcomes.

Running parallel to these developments, a group of middle managers developed and sustained (during this set up period) an action learning set to make sense of what ideas where emerging and demonstrate if and how they could be incorporated into delivery models to benefit more families.

The practical delivery of customer focussed methodology was not a quick fix and it has taken an extended period of time to both set up and start to deliver effective practice. It has disrupted traditional modes of delivery, pushed the boundaries of comfort zones and silo working for many, made difficult decisions and returned to the drawing board on countless occasions, to rethink its approach.

Whilst leaders and backers were keen to see results and at times became frustrated in their ambition for the work to demonstrate a difference – all involved would state that there was little room to question the ambition of the programme and even less to argue with the discernible benefits and difference it is starting to make.

Gladys Rhodes-White, Director of Children's Services and Education:

"This project is shaping and influencing changes that are happening, for families, services and organisations."

Reduction on financial investment

Research and evaluation of the model remains central to the 30 families or control group. At this stage there is limited evidence of hard financial savings., however, there have been improved outcomes for these families and as a result savings will have be made which will continue over their lifetimes where they sustain these changes.

For example, whilst recognising that the impact of alcohol misuse is difficult to estimate because of the complex nature of the issues faced by these families, the cost alone to the public purse of an 'average' case of harmful alcohol abuse in BwD can be estimated at approximately £6,000 per annum - £33.5m per annum (see table on page 14) divided by 5,600 (harmful drinkers – page 11).

Using this to model the three cases outlined above, if Susan, Steve and Carl maintain their reduced dependency on alcohol then a saving of £18,000 per annum could result. If this was extended over the 30 families, all of whom have alcohol misuse issues, then this will save £180,000.

Clearly from this evidence alone, and if improvements continue as a theme, then significant financial savings will be realised in the longer term

Stakeholders

Research throughout the project informs us of the value of stakeholder involvement – stakeholders as users and providers of services. This central premise has seen practical involvement at every level.

As a direct result of his involvement in this project, Anil Mehta, of Twin Valley Homes, is investigating how to utilise customer insight and engagement as a basis for a co-regulatory approach to social housing.

Anil Mehta, Customer Services Development Manager, Twin Valley Homes:

"This project and the social marketing training have acted as a catalyst to enhance the organisations customer focus and initiate a cultural shift for the organisation."

Governance

The families and alcohol project reported into the Health and Wellbeing Partnership, a subgroup of the LSP Executive and LSP Board.

The Health and Wellbeing Board includes officers and councilors from Blackburn with Darwen Council, Care trust Plus, Twin Valley Homes and a range of other community and third sector bodies. It has five key functions:

- to provide a governance structure for local planning and accountability of health and wellbeing related services
- to assess the needs of the local population and lead the statutory integrated strategic needs assessment (JSNA)
- to promote integration and partnership across areas through promoting joined–up commissioning plans across the NHS, social care and public health
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense
- to review major service redesigns of health and wellbeing related services provided by the NHS and local government.

Care Trust Plus has been governed through a Board arrangement which has elected member representation, that includes:

- the leader of the council
- portfolio holder for adult social care
- deputy leader of shadow opposition party.

Think Family reports through a strategy reference group to the LSPB.

Resourcing families and alcohol

£52,725	'Circle of Need' project delivered through Aperia Ltd. The insight work focused on families with alcohol problems and their service needs. In early 2010 the project was then linked with a wider 'Think Family' programme looking at the holistic needs of target families through partnership working.
£6,051	Change Management Seminar. The seminar was for the Borough Council and CTP Executives to review the results of the Implementation History Assessment and introduce the concepts of AIM. The focus of the session was the role of the leaders as sponsors of the changes taking place within the organisation.
£30,648	It is proposed that the remaining funding, £30,648, will be used to fund a skills exchange programme. We will make a bid for external organisations to support the CTP, council and partners to create a targeted social marketing programme on alcohol. The process of developing the programme will be used to develop skills across the organisation.
£21,575	UCLAN secondment. A senior research fellow was seconded to the CTP from March 2010 to February 2011 to assist in the production of the original bid to IDeA, to examine and support the implementation of AIM and the Customer Insight Project. The fellow gave advice on stakeholder mapping and data collection for the customer insights project and was a member of the steering group and I agreed to help with the final report.
£18,000	Web 2 Accelerator project. The project is part of a match funded North West NHS development which includes access to over £400,000 worth of NHS focused websites/tools designed to enhance engagement, improve productivity, promote wellness and /or strengthen community and free access to all future products.
£15,000	ICE Creates – social marketing programme in Think Family neighbourhoods.
£15,000	Unique – social marketing training for LSP members.
£158,999	**Total**

Challenges and lessons learnt

Information sharing
All the stakeholders recognised the benefit to be gained from sharing information about families. The customer insight research demonstrated the cross-over of service involvement which many service users complained about. This included them having to 'tell their story repeatedly every time a new service was accessed'. However practically for some stakeholders their own organisational governance prevented this.

This presented a significant challenge and required commitment and tenacity to agree an information sharing protocol. Whilst achieving the protocol was seen as the end result, the learning from this work has informed the team that 'information governance' and the practical sharing of the data presents challenges.

Organisations should consider their information management systems in line with any agreement on protocol, for example the use of secure email technology. Stakeholders confirm that the agreement has enabled significant benefit to families but ongoing oversight of this is required.

Stakeholders
Families clearly identified the difficulty in finding out about services and navigating the complex pathways presented to them. Developing links and partnerships with the stakeholders reduced this confusion and through working together in neighbourhood groups overlap of services could be identified. Asset mapping carried out by neighbourhood teams also provided useful information for practitioners in relation to what was available in their area – many of whom were not aware of some services or were new to the area.

Adopting a whole family approach whilst supporting individual needs
Learning from the initial research clearly outlined the need for both individuals and families together to access support. When adopting a whole family approach, service providers needs to ensure that any system and process does not lead to a loss of focus on an individual.

The definition of 'a family' was left intentionally vague so that it can be used to fit individual needs and personal circumstances.

Flexibility in pathways is required to deliver services in a family and individual manner. In circumstances where a couple have wanted to go along one of the pathways together this was facilitated by them attending group sessions at different times to ensure they had space for self. It has also been the case that some couples have had a separate advocate to ensure that they address not only family but personal development needs.

A further note is that young people and older children may require access to an advocate/ mentor to ensure their needs outside of those of their parents are addressed through a skilled specialist.

Continuity
A key element of this approach is that the advocate stays with the family for as long as they are needed and early evidence is starting to see families move away from their advocate when they feel strong enough to go it alone.

A point for further research would be to look at how long it is taking for families to become 'independent' – early indications are that whilst families are achieving and sustaining outcomes and making their own plans for changes they are still finding the involvement of an advocate beneficial 12 – 18 month after entering a pathway. Careful consideration needs to be given to advocate training in order not to create a dependency.

Although this hasn't occurred so far, it is recognised that transitions will need to be carefully planned and orchestrated when individual advocates move on to other positions. A volunteer strategy is being developed which incorporates specific substance misuse advocates.

Community engagement
Each of the Ward areas in the 3 think family pilot areas have developed a dedicated neighbourhood group of staff and community representatives who know the patch, the presenting issues and the families themselves.

Each has been led by a different sector - including a health/neighbourhood lead, a social housing lead and an adult social care lead. This variety has contributed to situation where local issues are dealt with in a way which respects the local people and culture. Families have largely been nominated through this group and see being invited to attend Think Family as a privilege rather that a punishment reinforcing failure and poor parenting.

Families and Alcohol – project management
The Families and Alcohol project was undertaken at a time of considerable organisational change and was influenced by a number of other initiatives that were under way (particularly Think Family). As a consequence the focus of the project had to change to remain viable. Although the project has been a success, it is accepted by those involved in BwD that stronger project management would have enabled them to keep tighter control and to monitor outcomes against initial targets more closely.

Next steps

Scaling up and mainstreaming the benefits
The current position for this work will see a case for change detailed which will highlight a number of options. Scalability and mainstreaming are key to these options. Families tell us that they have developed their own social networks as support groups for each other. The belief that building social capital is the underpinning philosophy combined with the long term ambition that there is a potential to use individuals from (or indeed whole) families that have been through this process as advocates for others will drive the next steps.

Risk Taking Behaviour project
As a natural extension of this project, CTP has launched another project to tackle risk taking behaviour amongst 16 – 19 year olds. The project is examining the extent of and attitudes towards risky behaviours involving the use of alcohol (eg binge drinking), illegal drugs and unsafe sex.

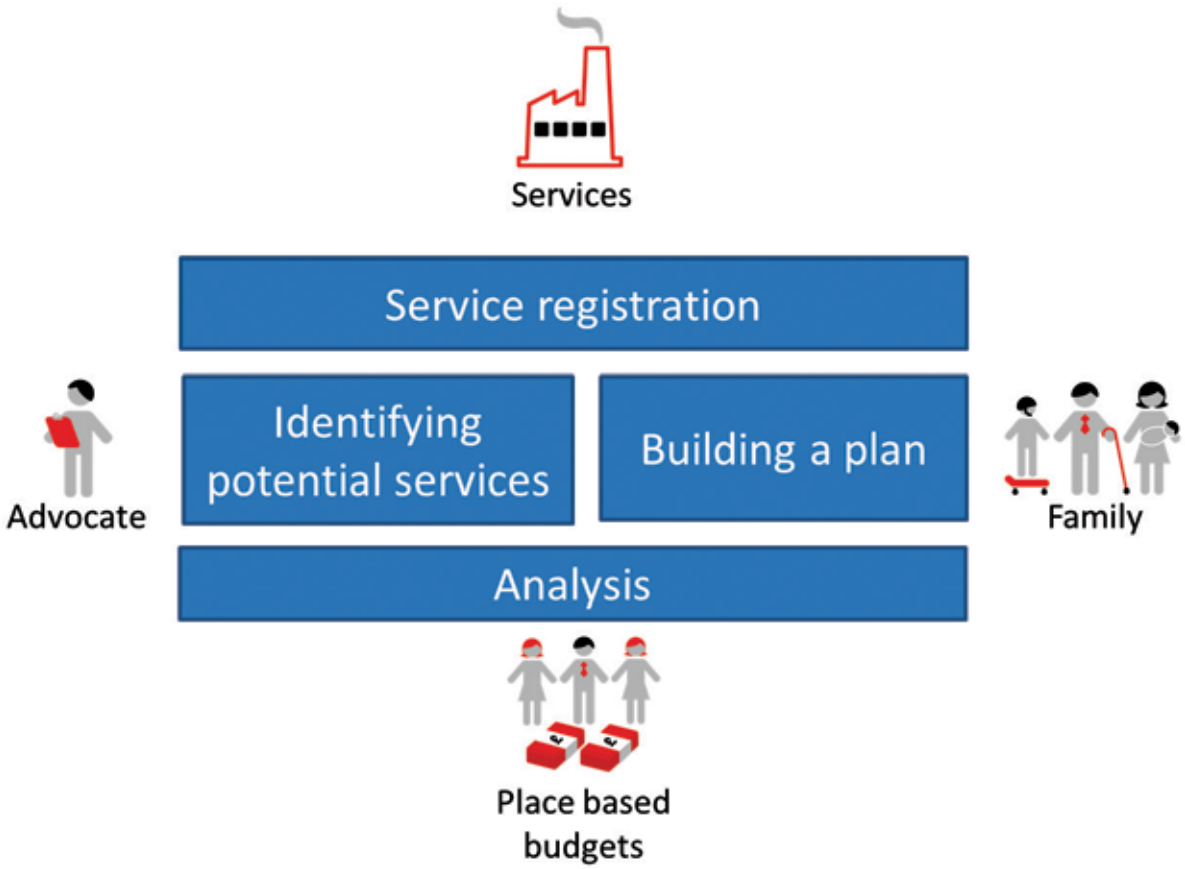
The project is focused in the Think Family neighbourhoods. However, this project includes all families in these neighbourhoods, and takes an early intervention/prevention approach. The aim of the project is to introduce preventative measures (eg using social media) in an attempt to redress this behaviour before they need a full Think Family approach.

The project also included social marketing training. All partners from the LSP were invited to learn about the value of understanding customers and how social marketing tools can be used to target programmes more effectively.

Family service planner

Following this project a proposal has been made to consider the implementation of a family service planner. Essentially, this is a structured service directory that could be used by advisors to help to build a family plan.

The following diagram shows the different elements and stakeholders involved in the model.



There are four processes and these are described in more detail below.

1. Service registration
Service registration is about building a directory that contains summary information about an available service.

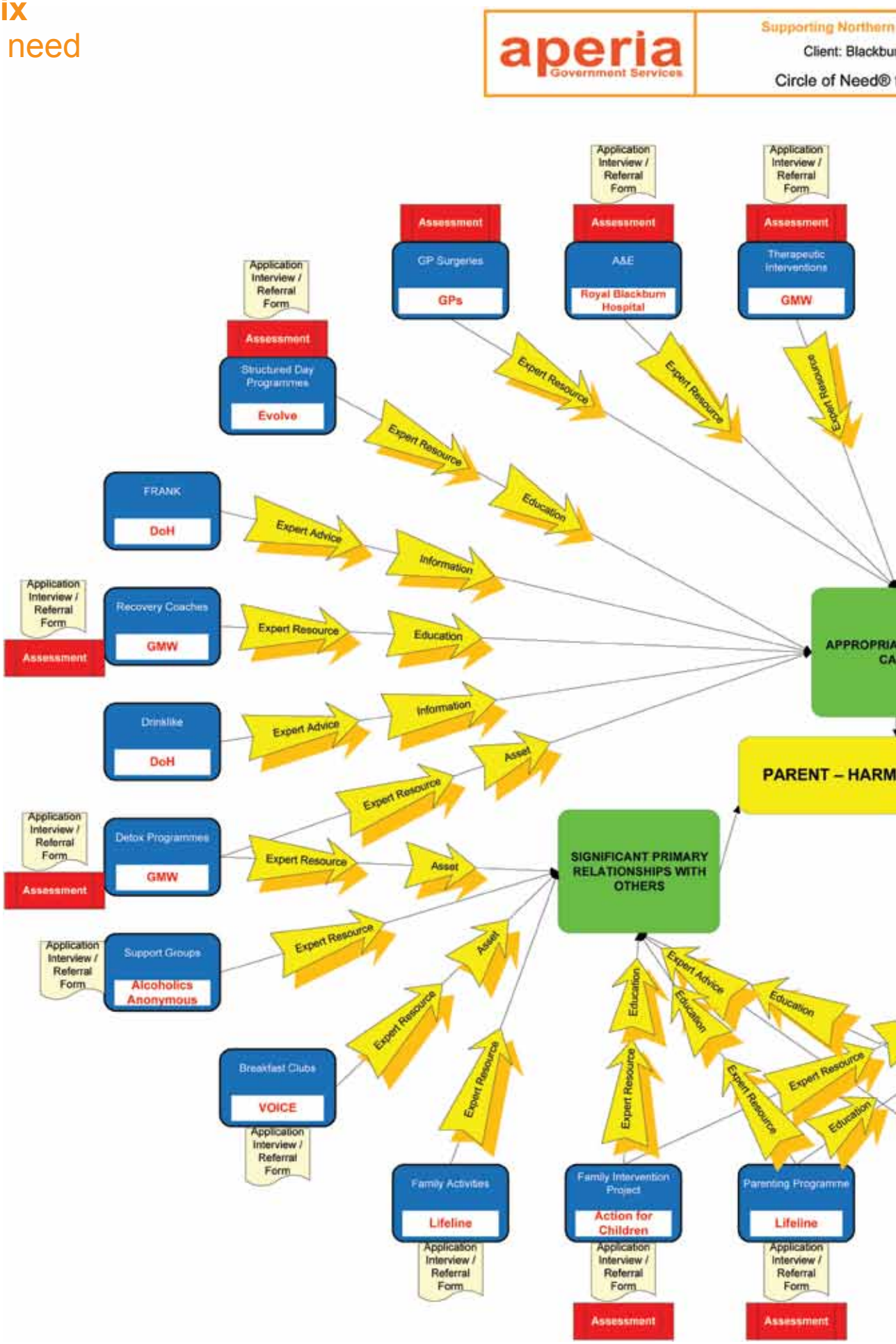
2. Identifying potential services
In order to match a family's needs with services available, a system needs to be devised that will be easy to use and in a language that was understood by advocates and front line staff who may not be aware of technical terms in various professional disciplines.

It was observed that people generally talk about family issues and it is proposed that a list of family issues is created. This list might include topics such as: homelessness, worklessness, low income, poor health etc.

3. Building a plan
The planner should include a tool to assist front line staff by capturing issues as they come to light. For example, if a front line member of staff in the one stop shop was asked about benefits (low income), and in the discussions it came to light that the citizen has been workless for a while and may need some support, then the services identified to help low income can be added to the family member service plan.

4. Analysis
The model should allow analysis of the information collected.

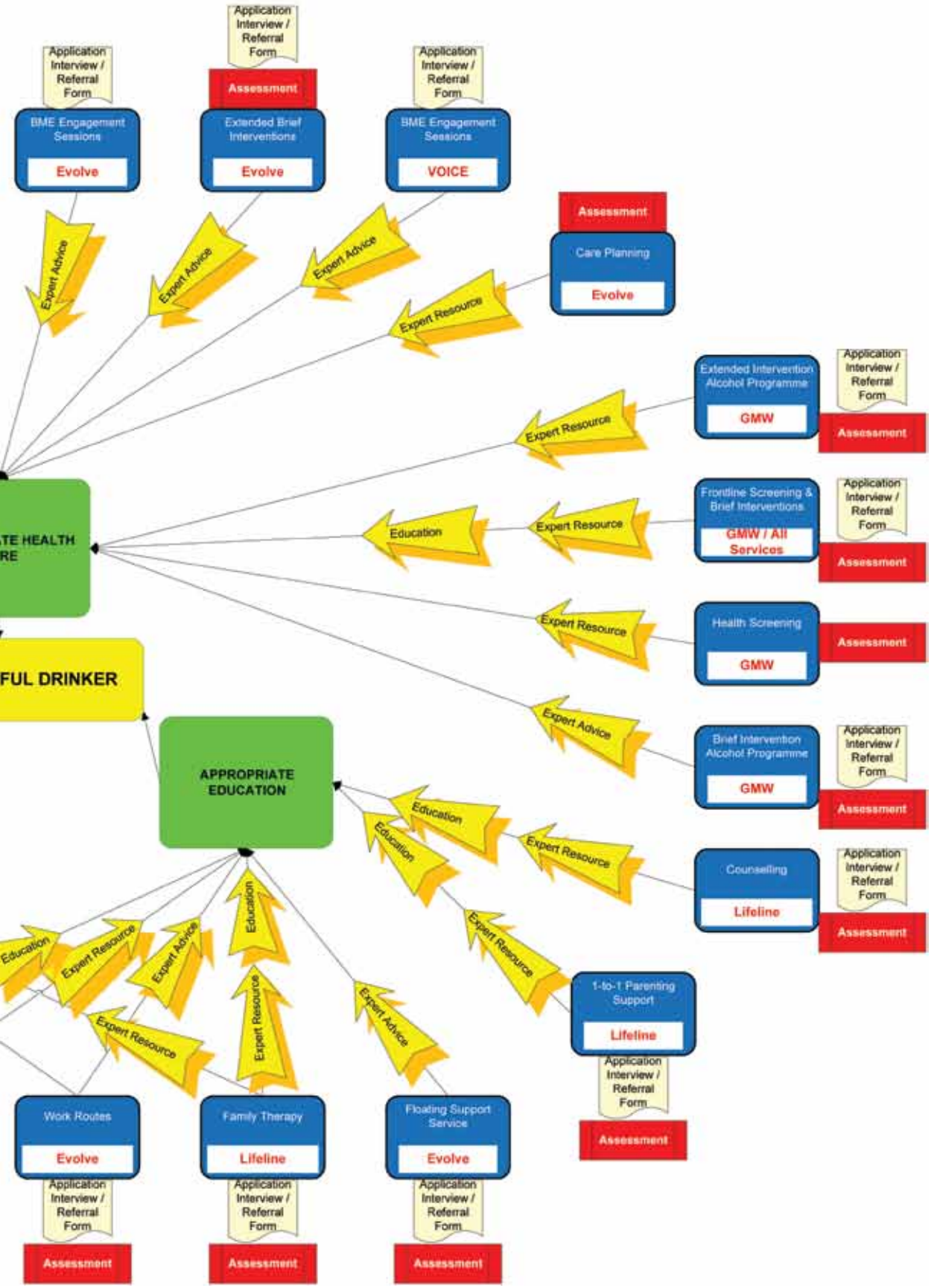
Appendix
Circle of need



Local Government Transformations

rn with Darwen Care Trust Plus

for Parents – Harmful Drinkers



Local Government Association
Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

For a copy in Braille, larger print or audio, please contact us on 020 7664 3000. We consider requests on an individual basis.

L12-976