Fulfilling Lives

Supporting people with multiple needs

# Fulfilling Lives: Supporting people with multiple needs

*Annual report of the national evaluation 2016*

BIG LOTTERY FUND

The University Of Sheffield.

CFE research

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# Acknowledgements

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We would also like to thank the partnerships, service users and peer researchers who have actively supported the design of evaluation tools, collected data and participated in interviews and discussions. Particular thanks to those projects that kindly submitted case studies for the report – unfortunately we could not include them all.

# Contents

# Glossary

**Beneficiaries:** For the purposes of the national evaluation a beneficiary is someone who receives intensive support from one of the 12 funded projects. A beneficiary is someone who has been accepted as a suitable referral, contact has been made and they are actively receiving support, for example, from a key worker, service navigator or similar.

**Dual diagnosis:** Co-existing mental health problems and substance misuse.

**Homelessness:** This includes those who are statutorily homeless, sleeping rough, single homeless people living in hostels, shelters or temporary supported accommodation, and hidden homeless households including those living in overcrowded conditions or temporarily sharing with family and friends.

**Homelessness Outcome Star™:** This is a tool for supporting and measuring change when working with people who are homeless. It consists of self-assessment on a scale of one to ten for ten different issues including offending, managing money and physical health. An increase in the score indicates progress towards self-reliance (so high scores are good). An interpretation of star scores can be found in Appendix 1. The Star is completed by beneficiaries with support from key workers within two months of them engaging with projects, and then at six monthly intervals thereafter. For more information see www.outcomesstar.org.uk/homelessness/

**Multiple needs:** Two or more of homelessness, reoffending, substance misuse and mental ill-health.

**National Expert Citizens' Group (NECG):** Scrutineers that use 'Lived Experience' to help shape better services for complex needs. The NECG is made up of representatives from the 12 projects funded by the Big Lottery Fund as part of Fulfilling Lives (Multiple Needs). The group meets quarterly and has sub-groups focussing on communications and marketing and peer research.

**The New Directions Team assessment (NDT - formerly the Chaos Index):** A tool for assessing beneficiary need. It focuses on behaviour across a range of areas to build up a holistic picture of need rather than the traditional demonstration of serious need in a specific area only (for example, mental health). It also explicitly measures involvement with other services, which is not routinely used as a measure of service eligibility otherwise. The result is an index which identifies chaotic people with multiple needs who, despite being ineligible for a range of services, require targeted support.

The NDT assessment covers ten areas including engagement with services, self-harm and risk to self and others. Each item in the assessment is rated on a 5-point scale with 0 being a low score and 4 being the highest score; there are two areas where the score counts double (0 is the lowest score and 8 is the highest). Low scores denote lower needs (so low NDT assessment scores are good). The NDT assessment is completed by key workers as soon as possible after the service user engages with projects and then at six monthly intervals. For more information see: http://www.meam.org.uk/wp-content/uploads/2010/05/NDT-Assessment-process-summary-April-2008.pdf

# 01. Introduction

*This chapter introduces the Fulfilling Lives: Supporting people with multiple needs initiative and the national evaluation.*

CFE Research and the University of Sheffield have been commissioned by the Big Lottery Fund to carry out an evaluation of the Fulfilling Lives: Supporting people with multiple needs initiative. This is the second annual report from the evaluation.

## Project background

### About the initiative

Big Lottery Fund (the Fund) have made an eight-year investment of up to £112 million aimed at better supporting people with multiple needs. These are defined as people who are experiencing at least two of homelessness, reoffending, substance misuse and mental ill health. Voluntary sector-led partnerships in 12 areas of England are working to provide more person-centred and co-ordinated services. The initiative aims to achieve the following outcomes:

- People with multiple needs are able to manage their lives better through access to more person centred and co-ordinated services.
- Services are more tailored and better connected and will empower users to fully take part in effective service design and delivery.
- Shared learning and the improved measurement of outcomes for people with multiple needs will demonstrate the impact of service models to key stakeholders.

The partnerships were awarded funding in February 2014 and began working with beneficiaries between May and December 2014.

**The 12 partnerships**

Birmingham Changing Futures Together

Fulfilling Lives Blackpool

Fulfilling Lives South East Partnership (Brighton and Hove, Eastbourne and Hastings)

Golden Key (Bristol)

FLIC (Fulfilling Lives Islington and Camden)

Lambeth, Southwark and Lewisham (LSL)

Liverpool Waves of Hope

Inspiring Change Manchester

Fulfilling lives Newcastle Gateshead

Opportunity Nottingham

Voices (Stoke on Trent)

West Yorkshire – Finding Independence (WY-FI)

### About the national evaluation

The national evaluation has the following aims:

- To track and assess the achievements of the programme and to estimate the extent to which these are attributable to the projects and interventions delivered.
- To calculate the costs of the projects and the value of benefits to the exchequer and wider society.
- To identify what interventions and approaches work well, for which people and in what circumstances.
- To assess the extent to which the Big Lottery Fund's principles are incorporated into project design and delivery and to work out the degree to which these principles influence success.
- To explore how projects are delivered, understand problems faced and to help identify solutions and lessons learned.

The evaluation comprises a number of activities.

- **A common data framework** to ensure beneficiary data is consistently collected across all 12 funded projects. This comprises demographic information, support received, the Homelessness Outcome Star™ and New Directions Team assessment (see Glossary on pages 1 and 2 for further information).
- **Administrative data on public service use** is sought to assess the public cost of people with multiple needs and to track how this changes over time.
- **Longitudinal surveys of beneficiaries** collect information on their perceptions of the support received from funded projects and wellbeing.
- **Six comparison areas** that have not received Big Lottery funding are collecting comparable data on people with multiple needs. We will use this to determine what might have happened without the Fund's investment (the counterfactual) and better attribute any change to the funding.
- **Qualitative research** with partnership staff, beneficiaries and stakeholders
- **A comprehensive learning programme** for partnerships, including a virtual learning environment, seminars, webinars, action learning sets and practice guides.

In addition, each partnership is carrying out their own local evaluation and reporting this separately. CFE Research has worked closely with partnerships and their commissioned researchers to ensure that, as far as possible, local evaluation work aligns with and complements that undertaken for the national evaluation.

## This report

This report draws on all the data collected to date. This includes:

- beneficiary data collected by partnerships,

- interviews with project managers from all partnerships,
- interviews with eight frontline staff from a sample of three partnerships, and
- monitoring reports submitted by partnerships to the Big Lottery Fund.

We begin, in Chapter 2, by exploring the extent to which the partnerships have been successful in reaching and engaging people with multiple needs, the profile of beneficiaries and which strategies appear to be effective. Chapter 3 then looks at early indicators of individual change for beneficiaries and positive outcomes achieved to date. We summarise some of the key features of the 12 partnerships' projects in Chapter 4 with a view to using this as a basis for analysis in future years. In Chapter 5 we explore one aspect of partnerships' work – the role of key workers – in more detail. This includes the perspectives of frontline staff on how best to support beneficiaries to navigate the system.

Throughout the report we have included additional information about the initiative in blue boxes. For those unfamiliar with the initiative this will be essential reading, but those who know it well may already be aware of this descriptive or contextual information and wish to concentrate on the main body of the report.

### A note on the data

Unless otherwise stated, the quantitative data about beneficiaries included in this report is collected by partnerships. The data is updated and sent to the national evaluation team every quarter. The data is shared with the national evaluation team on the basis of the informed consent of the beneficiary. To date 1,304 beneficiaries have agreed to share their data with us. Where beneficiaries do not agree to share any data we only know their start and end dates (so that we can count them as beneficiaries at a particular project). Most statistics in this report therefore exclude those who have not provided consent to share their data.

Collecting information from people with multiple needs can be challenging – especially at the early stages of engagement before trusting relationships with project staff have been built. Data sets are not always complete and, again, where data is missing we have excluded this from our analysis. As a result, base numbers may vary depending on the variable.

Our analysis of change over time (chapter 3) considers only those beneficiaries who have been involved over a 12 month period and for whom complete data is available for the variable in question. As a result, the figures reported in chapter 3 may not correspond to the total population figures reported in chapter 2.

# 02. Reaching people with multiple needs

*Who are projects working with and how are they engaging them?*

## Key points for this chapter

- A total of 1,604 beneficiaries have been engaged on the programme to date.
- Most beneficiaries (94 per cent) have at least three of the four needs, and over half have all four needs.
- Of the four needs presented on engagement with the programme, homelessness is the least prevalent.
- The profile of beneficiaries is similar to what we know about people with multiple needs – with most being aged between 25 and 44, male and White British.
- The initiative appears to be successfully reaching out to women with multiple needs.
- The proportion of beneficiaries with a disability is almost twice that of the general population.
- Just under a third of beneficiaries receive income from unsafe or insecure sources.
- 395 (25 per cent) of the beneficiaries have already left the programme. The most common reason for this is that the beneficiary disengaged from the project.
- Some projects have needed to amend their referral and acceptance criteria due to high levels of demand.
- Generating sufficient good quality referrals does not appear to be a major issue for projects.

Identifying people with multiple needs and engaging them on projects is clearly a key element in the success of the programme. Projects are targeting those with the greatest needs and who have the most chaotic lifestyles; finding them is not necessarily straightforward. In this chapter we look at the number and profile of beneficiaries who have been involved in the programme to date across each of the participating projects and how projects have gone about engaging them.

## Who has benefited?

**Up to the end of December 2015 a total of 1,604 beneficiaries had been engaged on the programme.** 395 of these have since left for a variety of reasons, including because they no longer need support but also because they have disengaged (we explore this further later in the chapter).

### What do we mean by 'beneficiary'?

A beneficiary is someone who receives intensive support provided by the 12 projects funded by Big Lottery Fund. A beneficiary is someone who has been accepted as a suitable referral, contacted, and is actively receiving support, for example, from a key worker, service navigator or similar.

A lot of time and effort goes into considering referrals and reaching out to potential beneficiaries. While some will not make it onto the project caseload, they may benefit from being supported to access other, more appropriate help (funded from other sources). A key aim of the Fulfilling Lives (Multiple Needs) initiative is to improve the way the wider system of support works; if successful, this will undoubtedly benefit a wider range of people than the direct beneficiaries covered here. Projects are also providing support and opportunities for people with lived experience of multiple needs to contribute to project design, delivery and evaluation and to gain the skills, confidence and experience to take on new opportunities, including paid work. **While acknowledging these wider beneficiaries, the statistics reported here relate only to those receiving intensive support from projects.**

**The engagement of beneficiaries peaked in quarter 4 of 2014** (Oct-Dec 2014), and has tailed off in each quarter since then. Figure 1 below shows the trend for the number of beneficiaries accepted onto the programme over time. The trend reflects the fact that projects started at different times, with all actively engaging beneficiaries by the end of 2014. This follows an expected pattern whereby there is a sharp increase in beneficiaries when projects start, followed by a gradual, sustained reduction in new beneficiaries once the projects are up to capacity.

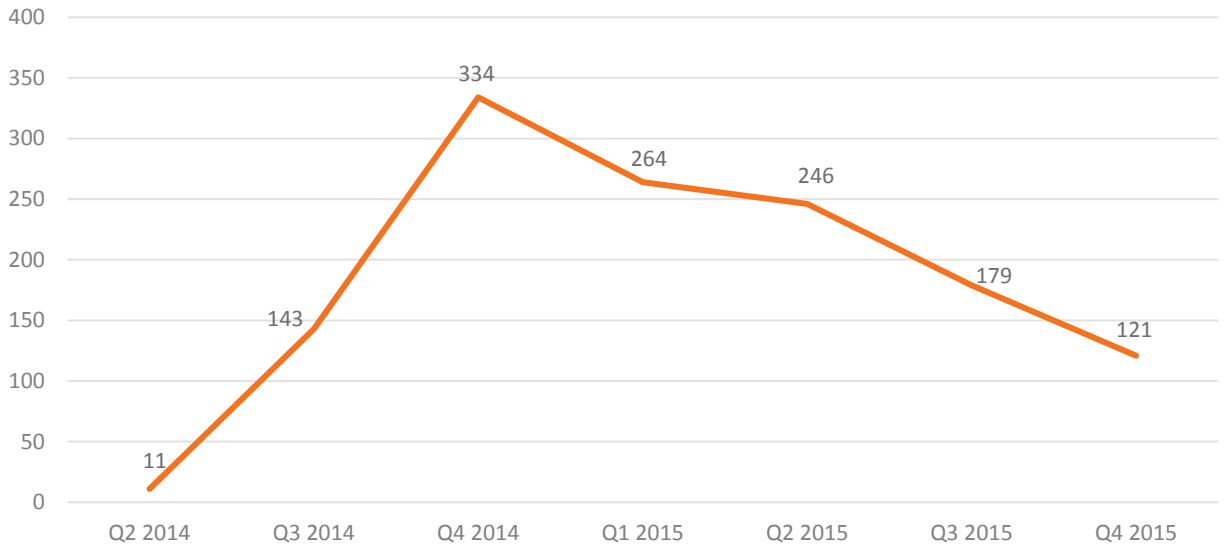



**Figure 1: Beneficiaries engaged on the programme each quarter. Quarters are calendar quarters (Q1=Jan-Mar, Q2=Apr-Jun, Q3=Jul-Sep, Q4=Oct-Dec)**

**There is large variation in beneficiary numbers across projects**, ranging from 307 to 35. This is reflective not only of varying start times but also different models of delivery, budgets, project areas and overall targets. Partnerships receive between £5.5 and £10 million in Lottery funding for between 5 and 8 years. They have configured their projects with different levels of staffing and caseloads. The Fund were keen that projects should be different as this provides an opportunity to explore how different approaches may impact on outcomes for different beneficiaries.

All projects have set targets for beneficiary numbers and these are shown for 2016 in Figure 2 overleaf, along with actual beneficiary numbers per quarter for 2015. Many projects are roughly in line with targets (see Stoke, Lambeth Lewisham and Southwark and Nottingham), and some (West Yorkshire in particular) are ahead of target. Others such as Brighton and Blackpool, will need to increase beneficiary recruitment to meet targets. There are reasons why projects may not be where they planned to be by this stage (such as later than planned start dates and challenges recruiting staff – see chapter 5). It is important that a focus on target numbers alone does not predominate as the target-driven culture of the current system is one of the features that has been identified as presenting a barrier to a person-centred approach and good outcomes.


**Figure 2: Actual beneficiary recruitment for 2015 compared to target beneficiary numbers up to the end of 2016 by project**

Analysis of beneficiary recruitment by partnership (see Figure 18 in Appendix 3 for detail) highlights a variety of trends and approaches, including an initial 'big bang' to engage lots of beneficiaries, more gradual starts and several periods of more intensive recruitment. This reflects varying approaches to generating referrals to the projects.

Projects are generally heavily reliant on other organisations referring people to them. Various approaches are used in combination by projects to generate referrals. Open and continuous referrals allow any organisation to refer potential beneficiaries to the projects at any time. To help control the flow of beneficiaries, some projects have set time periods or referral windows during which referrals can be made, and at least one project initially restricted the organisations that were invited to make referrals.

Several projects carried out initial publicity campaigns (networking, attending meetings, giving presentations) to raise awareness of the projects amongst a wide range of organisations including hospitals, mental health services, hostels, drug services, service user groups and other community groups. These appear to have been successful in generating good initial interest and a flow of referrals. Partnerships continue to monitor the levels and type of referrals received, with some carrying out additional, more targeted campaigns to generate referrals from groups and sectors that are felt to be under-represented.

One project convened a meeting of local stakeholders who have contact with people with multiple needs and invited them to identify people who fit the criteria. This generated an initial caseload and will be repeated at intervals as necessary, augmented by an additional open referral process.

While in theory self-referral is possible for most projects, in practice very few referrals come via this route. As projects seek to work with the most excluded and complex cases, those who are able to self-refer are unlikely to fit this description. Two projects reported receiving referrals from family members. Another said they occasionally bring people onto the project as a result of working with a partner or peer rather than through a direct referral.

Some projects were initially inundated with referrals but found that many of them were not appropriate. Feedback from projects suggests that this has improved as the focus of projects and criteria become better known and projects develop and hone their communication strategies. Generating sufficient good quality referrals does not appear to be a major issue. It remains to be seen whether the initial levels of referrals are an indicator of pent-up demand in the system and to what extent initial levels of demand are maintained throughout the lifetime of the initiative.

Placing boundaries on the referrals process is necessary, particularly in the early stages of projects, to ensure projects can manage beneficiary numbers within the target caseload levels for workers. Several projects explicitly stated that they are keen to avoid having waiting lists.

## Levels of need

Once a referral is received, projects gather information and make an assessment of whether it is appropriate to accept someone onto the project. Referral forms are generally kept simple to ensure the process is quick and easy. These may be supplemented by interviews with referring agencies and / or proactive research undertaken by the project teams to gather additional information.

Some projects have set up panels of stakeholders to contribute to the decision-making process but these are used differently. Where meetings are convened to identify potential beneficiaries, an assessment and the decision whether to accept an individual is taken at the same time. Panels may be used to review and make a decision on borderline cases, or to review referrals simply to provide accountability to stakeholders and offer challenge. In other projects, staff meet on a regular basis to review referrals.

Criteria for acceptance onto the programme are also kept relatively simple and projects avoid excluding people for reasons that may prevent them from accessing other services (such as a past history of violence or other perceived high risk factors). Indeed, **the programme is largely aimed at providing access to services for those individuals who are routinely excluded from services.**

At the most basic level beneficiaries must meet the Fund's definition of having multiple needs (see Glossary on page 1). To date, **the initiative is successfully engaging those with the most complex needs**. Almost all of the funded projects are targeting those with three or four of the identified needs. Most beneficiaries (94 per cent) have at least three of the four needs, as shown in Figure 3 below.


**Figure 3: Number of needs per beneficiary (n=1269)**

Other than adopting a broad definition of homelessness (to include not just rough sleeping, but living in hostels, temporary accommodation and 'sofa surfing') the Fund have not defined the other areas of need in any more detail. Projects are taking a similarly broad view to ensure that the programme is as inclusive as possible and barriers that can prevent access to other support services, such as a diagnosis as evidence of mental ill health, are overcome.

> We've not [got] that firm criteria, because we were worried about weeding people out, people not coming into the programme. [...] I think there's way too much of that already. People are not hitting thresholds around need and we're trying to get away from all that.
> **Project lead**

Figure 4 below shows that while nearly 70 per cent of beneficiaries are homeless at the time of being engaged on the project, this is a less prevalent issue than offending, mental ill health and substance misuse.


**Figure 4: Breakdown of presenting needs (n varies: 1302-1329)**

Exploring the data further, we see that **just over a fifth of beneficiaries are mainly living in their own tenancy at the start of their engagement with projects** (22 per cent, with slightly more living in social housing than in the private sector). A similar proportion are in supported accommodation (20 per cent). This is followed by temporary accommodation (18 per cent), rough sleeping (14 per cent) and staying with family and friends (14 per cent).

**There is some evidence that the profile of needs may potentially be changing over the course of the programme to date.** Figure 5 shows that the gap between the number of beneficiaries with three and four presenting needs has narrowed over the last three quarters. In the last quarter of 2015, more beneficiaries joined the programme with three presenting needs (the purple line) than with four presenting needs (the green line) for the first time. The number presenting with just two needs has remained consistently low throughout. It may be too early to deduce from this that acceptance criteria have relaxed over time – an alternative explanation is that projects have targeted those most in need first. It will be worth monitoring this over future quarters in order to see if this trend continues.

The data shows the needs that are identified when a beneficiary is accepted by a project – some needs will not become obvious until later on, as the relationship with the project develops. In addition, projects highlight a range of other needs that beneficiaries present with that are not captured in the data, such as domestic violence and learning difficulties.

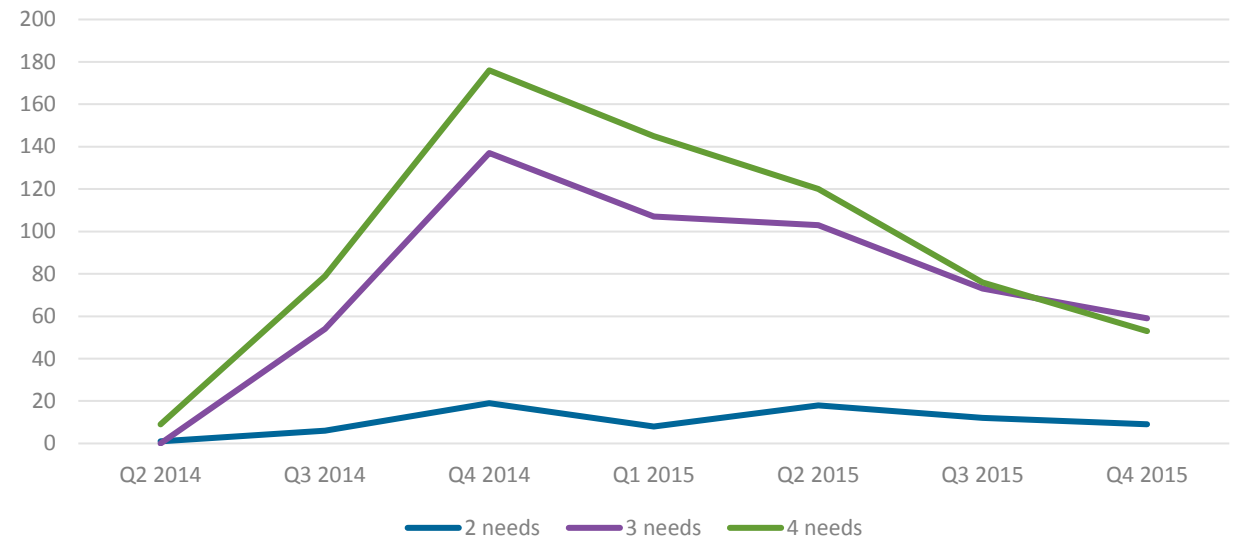



**Figure 5: Number of presenting needs of beneficiaries engaged each quarter (all beneficiaries)**

When we look at the profile of needs in each project we can see different patterns. Figure 6 shows the proportion of beneficiaries recruited for each project with two, three and four needs. We can see from this that the two London projects of Camden and Islington and Lambeth, Lewisham and Southwark are most likely to have participants with all four complex needs. Blackpool has generally higher levels of people with two and three needs and fewer than average with all four needs. Liverpool only accepts beneficiaries with three or more needs and therefore have none with just two. Appendix 3 provides further time-series data on presenting beneficiary needs by project.

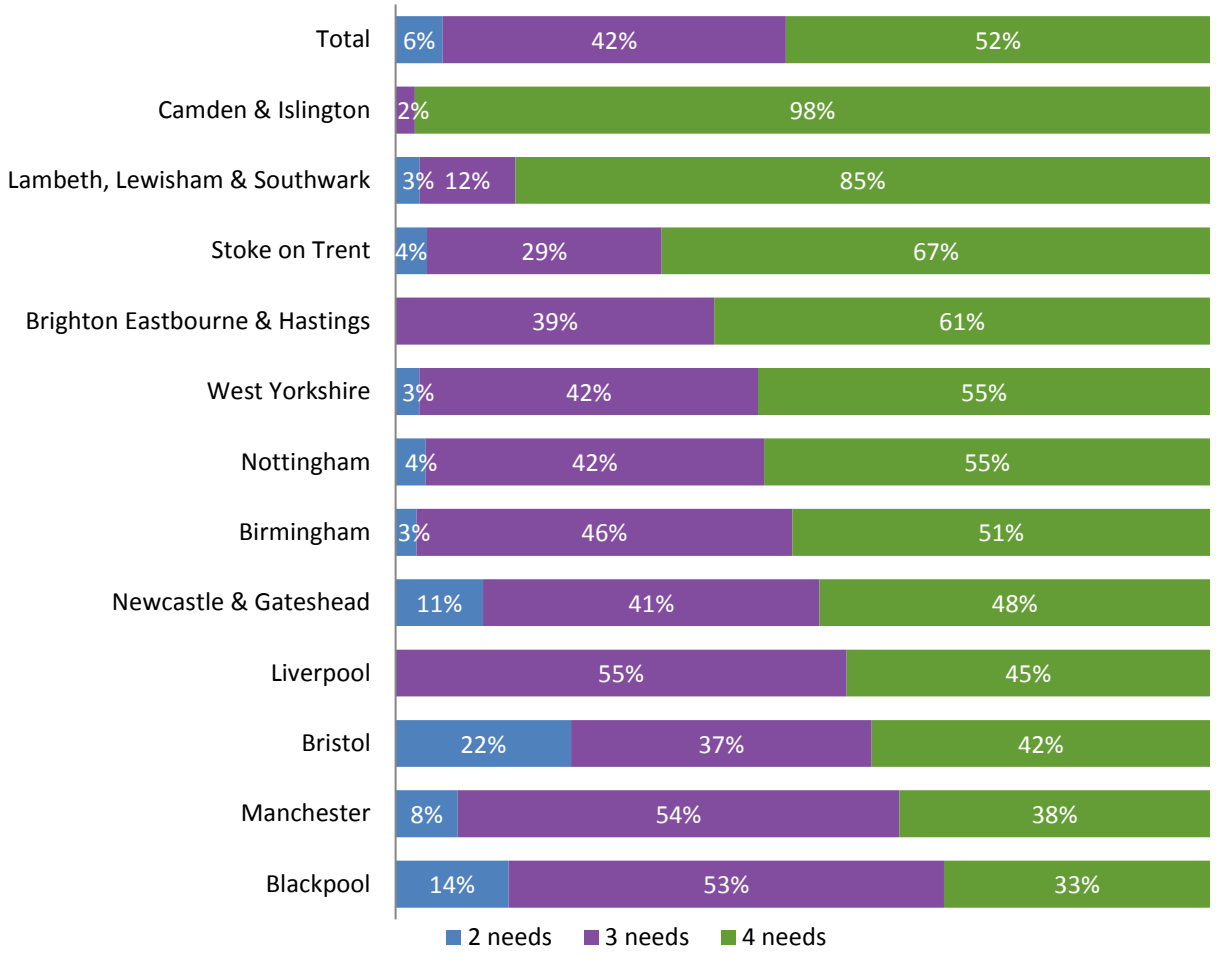



**Figure 6: Presenting needs by project (percentages)**

The four presenting needs (which define multiple needs for this programme) are relatively rudimentary indicators and projects are generally supplementing this with other measures and criteria for assessing need and managing referrals. As well as being used by all projects as part of the evaluation, **the NDT assessment (see Glossary) is widely used by projects to help prioritise those who are most chaotic**. Some set a minimum score on the NDT assessment in order to be accepted onto the project, while others use the score as a prioritisation tool when considering long lists of referrals. A particular issue highlighted by one project that could arise as a result of setting a minimum score as a threshold is that it could lead to referral agencies artificially inflating scores in order to ensure their referrals are accepted, even if they are not the most chaotic cases.

At the start of engagement, average NDT assessment scores range from 25 in Birmingham, Manchester and Newcastle and Gateshead to 37 in West Yorkshire (see Figure 7). A higher score represents a greater degree of chaos, with a maximum score of 48, so the West Yorkshire project has taken on participants with the highest degree of chaos to date.

| | |
|---|---|
| **Maximum possible score** | **48** |
| West Yorkshire | 37 |
| Blackpool | 36 |
| Stoke-on-Trent | 32 |
| Lambeth, Lewisham & Southwark | 30 |
| Brighton & Hove, Eastbourne and Hastings | 28 |
| Bristol | 28 |
| Liverpool | 28 |
| Nottingham | 28 |
| Camden and Islington | 27 |
| Birmingham | 25 |
| Manchester | 25 |
| Newcastle and Gateshead | 25 |

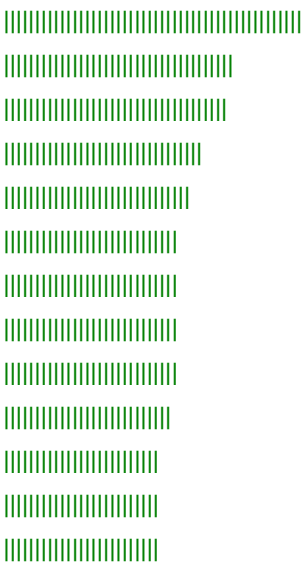


**Figure 7: NDT assessment scores at start of engagement by project area**

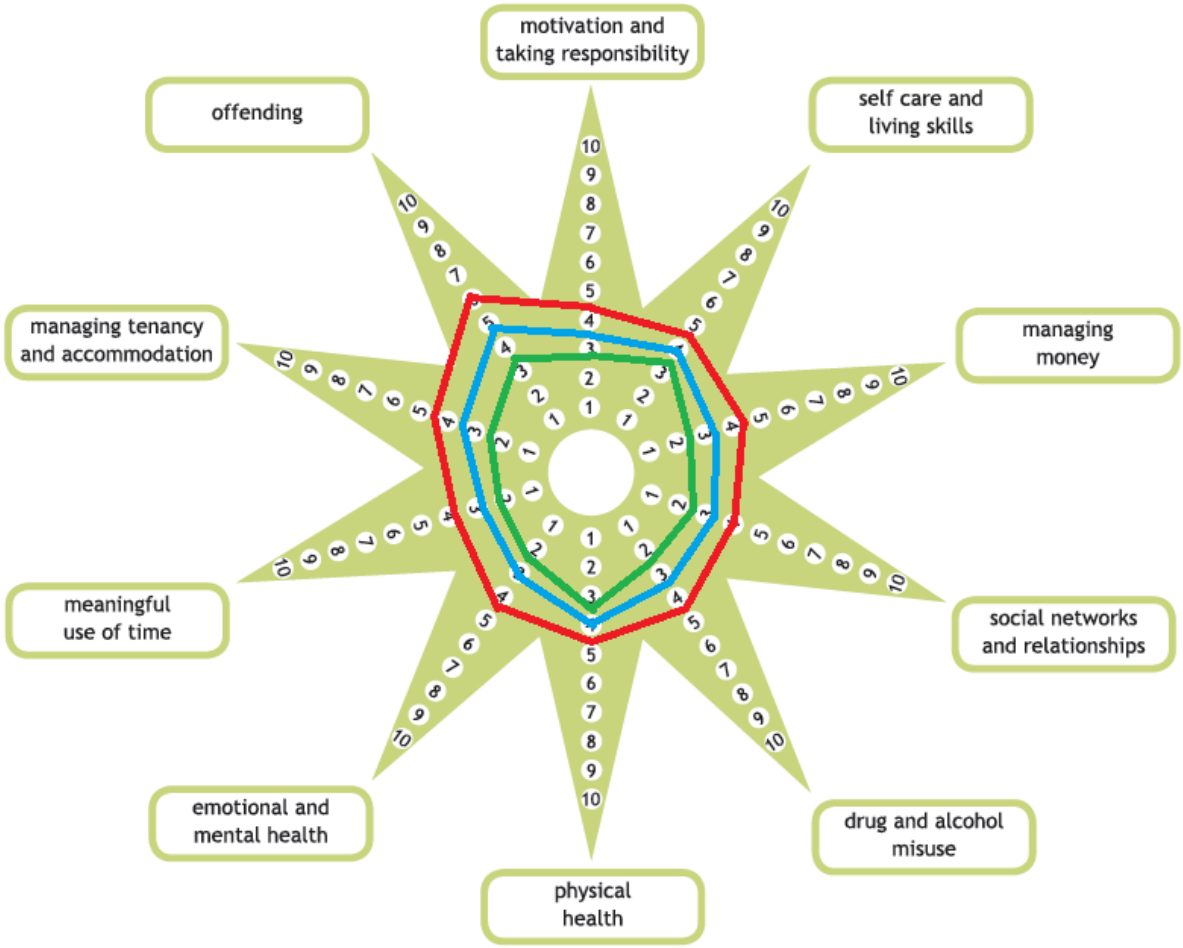
At least two projects (Nottingham and Liverpool) have, or are planning to raise the NDT assessment score required for acceptance onto the project in order to maintain manageable levels of referrals with the resources available and to ensure that those most in need are supported.

In addition to using the NDT assessment and the areas of multiple need as criteria for accepting people onto projects, many are also seeking to work with the most disengaged people or those who are not receiving (adequate) support. One of the few reasons why someone may not be accepted onto a project is if they are already engaging well with support services.

One project is specifically targeting two types of people: women and people with dual diagnosis (coexisting substance misuse and mental ill-health). This provides an additional criteria for accepting beneficiaries. One of the projects accepts people onto the project based on their public service costs.

Another metric we are using to measure the wellbeing and personal development of project beneficiaries is the Homelessness Outcome Star™ (see Glossary). At the start of engagement, average scores range from 2.9 to 4.8 on the ten criteria (see Figure 8), placing beneficiaries generally in the 'Accepting help' stage (see appendix 1 for more information). Higher scores - progression towards the point of the star for each criteria – represents improvement. Again, we see that each project has a slightly different profile of beneficiaries, with those from West Yorkshire having the lowest initial scores overall (that is, the highest needs). This result is to be expected given West Yorkshire's beneficiaries also have the higher NDT assessment scores at engagement and demonstrates consistency between the two measures (see appendix 2 for more information). Bristol in contrast has the highest average Outcome Star™ scores at the start of engagement.

To a certain extent, both the NDT assessment and the Outcome Star are subjective measures and liable to vary with the staff member undertaking the assessment. All projects were provided with training on using the NDT assessment and Outcome Star at the start of the evaluation. Additional training to ensure consistency of assessment is planned for 2016.




Blue line = average across all projects;

Red line = highest baseline scores (Bristol)

Green line = lowest baseline scores (West Yorkshire)



**Figure 8: Average Homelessness Outcome Star at the start of engagement.**

## Profile of beneficiaries

**Overall the initiative is successfully reaching out to women with multiple needs.** A third of all beneficiaries where sex is recorded are female (33 per cent). While most projects support more men than women, this varies across projects. Brighton & Hove, Eastbourne and Hastings are specifically targeting women and as a result have the highest proportion of female beneficiaries (58 per cent). In Manchester 20 per cent of beneficiaries are female.

Some of the best available data on the population with multiple needs comes from the recent Hard Edges report commissioned by Lankelly Chase[1]. This finds that those facing severe and multiple disadvantage are 'predominantly white men aged 25-44'. The Hard Edges research developed the profile based on data from three key administrative datasets – offender services, substance misuse services and homelessness services. However, women with multiple needs are often less visible to services[2] and may be under-represented in such statistics.

Projects experience this on the ground too, reporting that **it can be harder to get referrals for and to reach women who are eligible to access this support**. Several projects have tackled this proactively, through targeted engagement of specialist women's services and outreach to those services where women with multiple needs are likely to appear – in particular, GP surgeries, Accident and Emergency Departments and social services. It is encouraging that overall the projects are working with a substantial number of women. Those projects with lower levels of female beneficiaries are planning ways to address this.

Flexibility in the acceptance criteria is also regarded as important when seeking to engage women. The four core areas of need do not include domestic violence and yet there is a high degree of overlap for women with regards to substance misuse, mental ill-health and domestic violence.[3] This is also reported qualitatively by projects:

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[1] Bramley, G. and Fitzpatrick, S. (2015) *Hard Edges: Mapping severe and multiple disadvantage* Lankelly Chase Foundation Available online at: http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/ Last accessed 31 March 2016

[2] Homeless Link (2015) *Women and homelessness* Research briefing September 2015 Available online at: http://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20women%20and%20homelessness%20briefing.pdf Last accessed 30 March 2016

[3] Rosengard, A. Laing, I. Ridley, J. Hunter, S. (2007) *A literature review on multiple and complex needs* Scottish Executive Social Research Available online at: http://www.gov.scot/resource/doc/163153/0044343.pdf Last accessed 10th May 2016

> All but two [of the women we are working with] are currently in very violent, abusive relationships or have just come out of them in the last year.
> **Project lead**

A couple of the projects stated that women will generally score lower on the NDT assessment than men as they pose less risk to others (one of the assessment points) and yet our data shows that on average female beneficiaries have a higher score (Table 1). One explanation for this could be that women with multiple needs are often less visible and therefore need to reach a higher level of chaos before being referred to projects. Table 1 also shows that those who are older (age 50 plus) score slightly lower on the NDT assessment than younger age groups.

| Male (140) | Female (64) | Age 17-29 (21) | Age 30-49 (115) | Age 50+ (41) |
|---|---|---|---|---|
| 31.4 | 33.8 | 31.9 | 32.2 | 30.7 |

**Table 1: Average NDT assessment scores by gender and age group (n values in brackets)**

**The programme beneficiaries have a similar age and ethnic profile to the wider known population of people with multiple needs.** The majority of beneficiaries (62 per cent) are aged between 25 and 44 (as highlighted in Figure 9 below), which is in line with the Hard Edges report findings. Similarly, 79 per cent of beneficiaries describe themselves as White British and 17 per cent as other ethnic backgrounds (the rest do not provide this information).


**Figure 9: Age ranges of beneficiaries (n=1238)**

**The proportion of beneficiaries with a disability (self-assessed) is almost twice that of the general population**. In the 2011 UK Census, 18 per cent of adults declared a health problem or disability[4]; the figure for project beneficiaries is 39 per cent.

[4] Office for National Statistics (2013) *Disability in England and Wales : 2011 and comparison with 2001* ONS Available online at http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/disabilityinenglandandwales/2013-01-30 Last accessed 7th June 2016

**Just under a third of beneficiaries (29 per cent) receive income from unsafe or insecure sources** (such as begging, family and friends, sex work and illegal activities) during the early stages of their involvement in the programme. The most commonly reported sources of unsafe or insecure income are illegal activity and begging (both 14 per cent of all beneficiaries). Women were more likely to have three or four different sources of unsafe income and were far more likely to admit to gaining income from sex work. 8 per cent borrow from family and friends. In contrast, most beneficiaries (82 per cent) were in receipt of at least one state benefit. Of these, the majority (92 per cent) were receiving Employment and Support Allowance[5].

## Disengagement from projects

**395 of the beneficiaries have already left the programme**, equating to around a quarter of all beneficiaries to date (25 per cent). The most common reason for this is that the beneficiary disengaged from the project (as highlighted in Figure 10). Considering the number of beneficiaries on the programme as a whole, **the disengagement rate is 7.5 per cent.** This feels low given the programme is targeting those with the greatest needs; it will be interesting to look at the rate of disengagement from comparison projects in future too. Even more positively, 82 people have left because they no longer require support. We explore this in more detail in the next chapter. Sadly, 32 people have died, which only serves to emphasise the importance of working to better support this cohort of people with multiple needs and often very chaotic lifestyles.

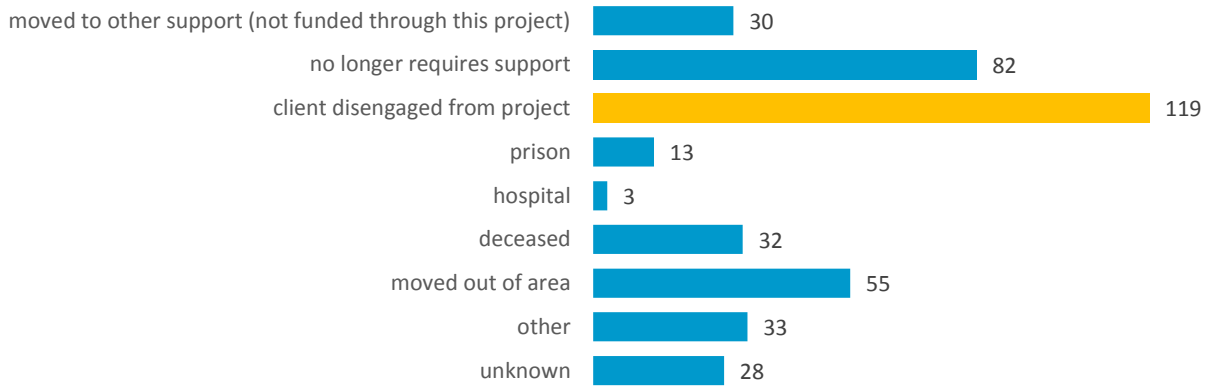


**Figure 10: Destinations of people who have left the programme**

Of those who disengage (119 beneficiaries) the average length of time on the project is about six months (183 days). Figure 11 below shows the distribution of time on the

[5] Employment and Support Allowance (ESA) is a benefit for people who are unable to work due to illness or disability.

programme for those clients who have disengaged. We can see that time on the programme ranges from less than a month to over a year.

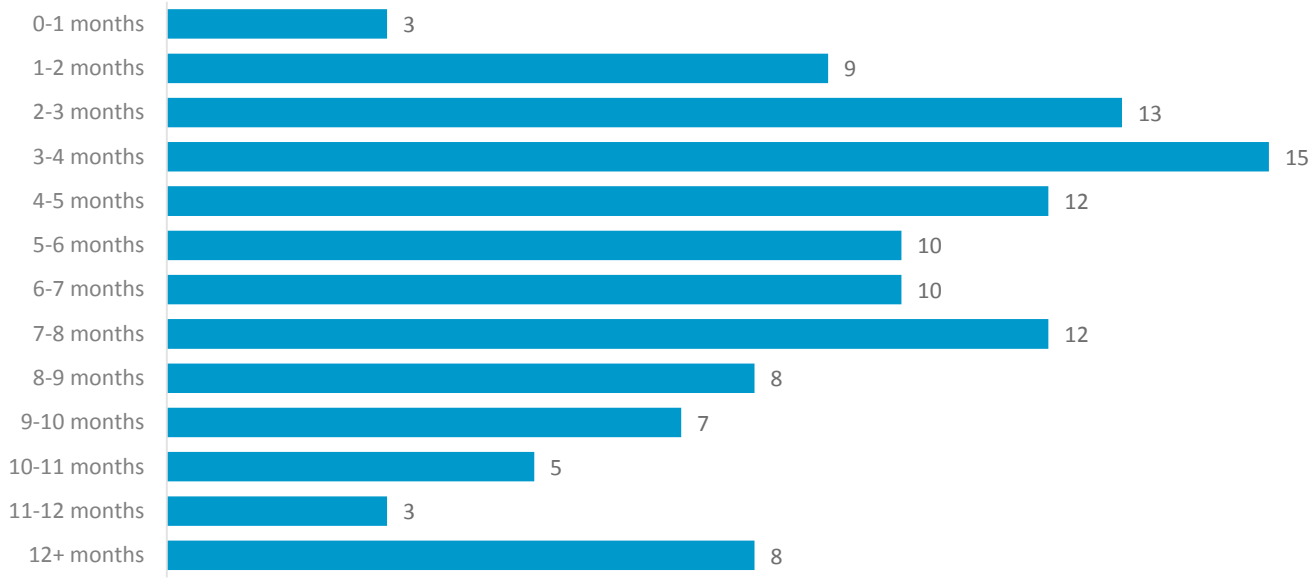


**Figure 11: Length of time (where known) on programme for beneficiaries who have disengaged (n=119)**

# 03. Supporting individual change

*Outcomes and progress achieved so far by people with multiple needs*

## Key points for this chapter

- In total 82 people have left the programme because they no longer require support.
- Beneficiaries who successfully move on spend an average of six and half months on the programme, although length of time on programme varies from less than a month to over a year.
- Homelessness Outcome Star™ and NDT assessment scores show that beneficiaries are making progress, beginning to accept help and engaging better with services.
- Addressing alcohol and drugs misuse appears to be harder than some other issues and may occur later in beneficiaries' journeys.
- By the time beneficiaries have been engaged for a year on projects, a larger proportion are spending most of their time in supported accommodation.
- Moving people from rough sleeping to more secure forms of accommodation remains a challenge.
- Of those who have remained engaged on programmes for at least 12 months, the proportion of beneficiaries who report incomes from unsafe or insecure sources (begging, borrowing, illegal activity) actually increases slightly.

In this section we examine the progress of beneficiaries as they participate in the Fulfilling Lives (Multiple Needs) programme. We look at those who have successfully moved on – those that left the programme having been assessed as no longer requiring support. We also consider other indicators to demonstrate the progress of individuals who remain on the programme, such as changing Homelessness Outcome Star™ scores, stability of accommodation and reliance on unsafe sources of income.

## Moving on

As shown in Figure 10 in the previous chapter, **82 people have left because they no longer require support from the programme**.

As we would expect, this is not spread evenly across the 12 projects and around half of those who have successfully moved on come from just one project - Liverpool. Even when we take into account that Liverpool has a larger number of beneficiaries overall, the stark difference remains. 21 per cent of Liverpool beneficiaries have moved on because they no longer require support. The proportion for other projects ranges from 1 to 6 per cent.

We looked specifically at the Liverpool beneficiaries who have successfully left the programme to see if there was a pattern emerging. The beneficiaries tended to be engaged at the start of the project, with all bar one of them joining within six months of Liverpool starting to work with beneficiaries. While the average Outcome Star™ score upon exit of the programme was similar to other areas, the average Outcome Star™ score at the beginning of engagement was higher at 42.8 in Liverpool compared with 36 on the programme overall. One explanation for the high number of successful exits from Liverpool is that in the initial stages of their project a number of inappropriate referrals were made resulting in individuals with less extreme needs being accepted onto the initiative. The project has since adjusted its referral process.

**Beneficiaries who successfully move on spend an average of six and a half months (195 days) on the programme**.[6] The sample size is relatively low and there are no significant differences between different demographic groups or indeed differences between Liverpool (with its high proportion of people moving on) and other projects, but we will continue to monitor this. The range of time periods spent on the project is shown in the figure below, where we again see that there is a generally even spread between beneficiaries on the programme for a short amount of time and those who are on the programme for longer.

[6] Mean figure based on 77 individuals where date information is available.

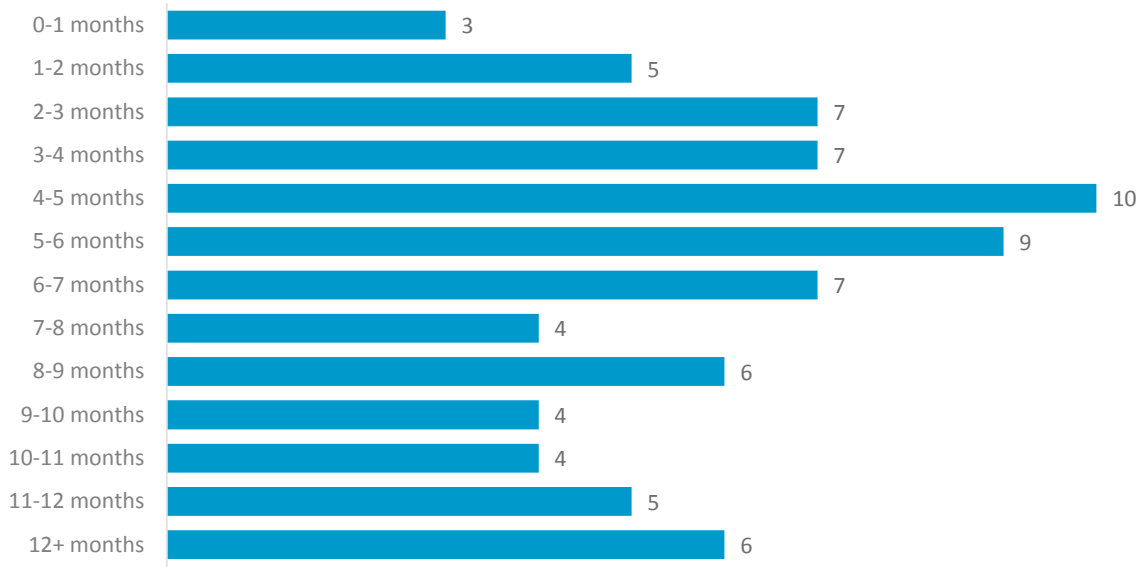


**Figure 12: Breakdown of time on programme for participants no longer requiring support (n=82)**

**The average Outcome Star™ score of all beneficiaries who moved on because they no longer required support was 50.7** (or 5.07 per individual measure). This places beneficiaries in the 'Believing' stage of the journey of change (see appendix one). We might have expected a higher total score but the sample is small (only 57 people had completed at least one Outcome Star™ before leaving the programme) and for many with only one star reading this may not reflect their final score before moving on. Of those who had more than one Outcome Star™ reading (n=19) most increased their score by an average of nearly 3 points; just one beneficiary showed no change.

**The NDT assessment scores show a decrease in chaos for those successfully moving on.** The final overall NDT assessment score for those successfully moving on is 24 (among 65 beneficiaries with at least one NDT assessment score). 22 people had more than one NDT assessment score before leaving the programme, with an average decrease in score of 9.2 over the ten attributes.

## Making progress

Supporting people with multiple needs to become self-reliant is likely to take time and involve set-backs and relapses along the way.[7] Some may always require additional support. It is perhaps unsurprising that so few people have successfully moved on at this

[7] Terry, L. and Cardwell. V. (2015) *Understanding the whole person: Part one of a series of literature reviews on severe and multiple disadvantage* Lankelly Chase Available online at: http://www.revolving-doors.org.uk/partnerships--development/research-network/literature-review-series/common-concepts-for-recovery-and-desistance/ Last accessed 10th May 2016

relatively early stage. However, we can explore various measures to assess the extent to which beneficiaries on the programme are making progress.

For beneficiaries that have remained on the programme long enough to complete three Homelessness Outcome Stars™ (215 beneficiaries) overall scores increase though only by a small amount. This is the case for all ten of the individual measures as well as for the total (see Figure 13– a full breakdown of average scores can be found in Table 3 in Appendix 3).

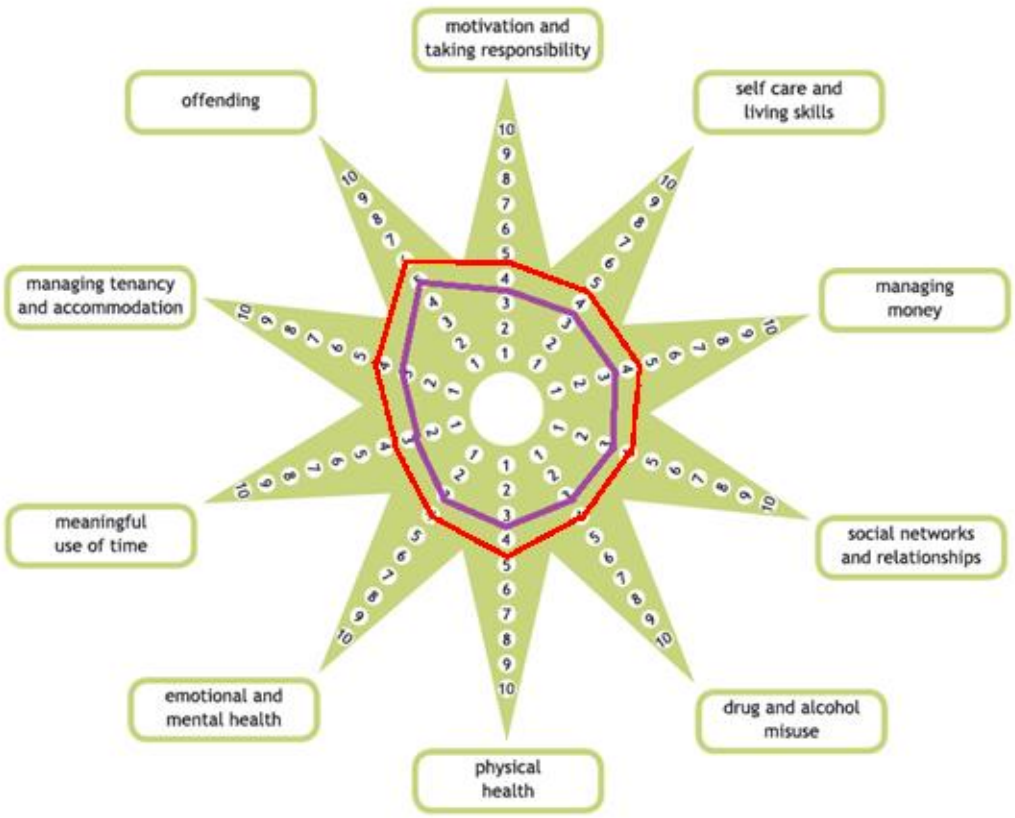


**Figure 13: Average Outcome Star™ scores at start of engagement and 12 months on. Purple: first reading Red: third reading**



**While overall progress has been made, some beneficiaries undergo setbacks in their journeys of change.** We can visualise this using a Sankey Diagram (see Figure 14).

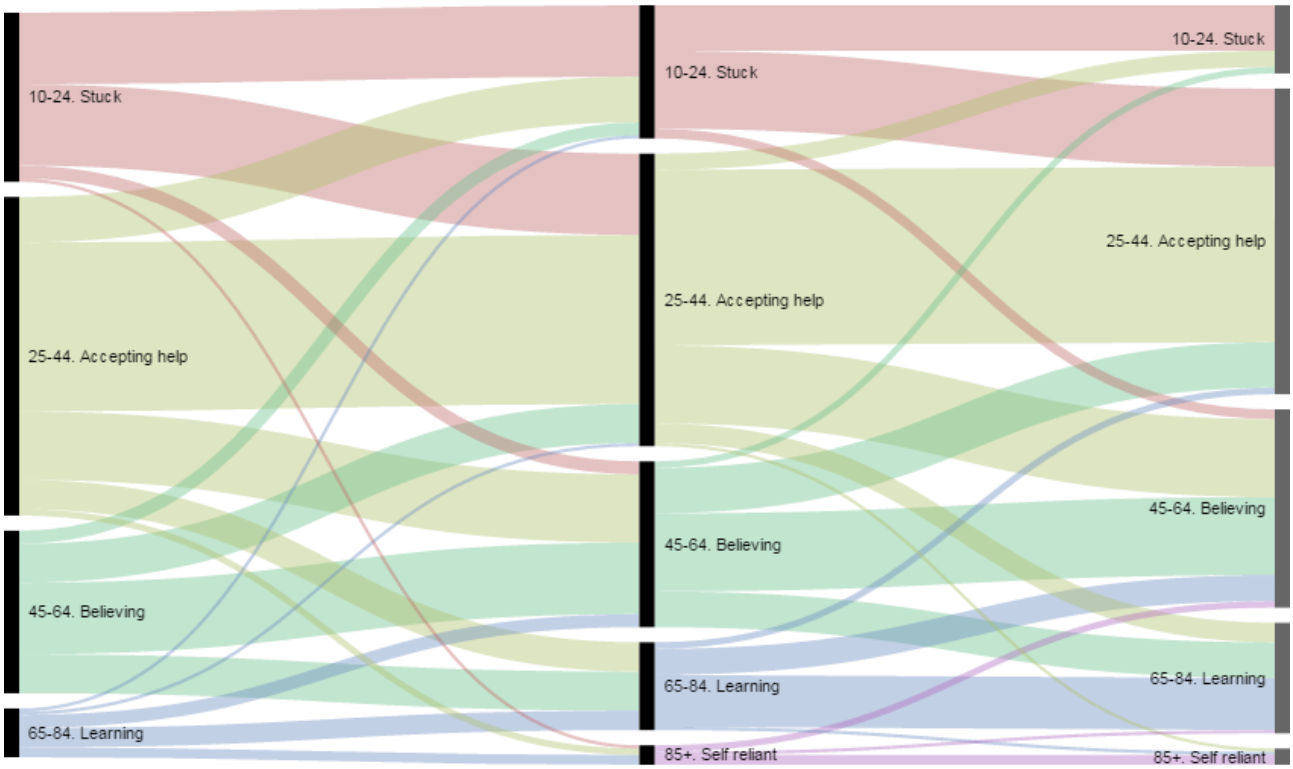


**Figure 14: Sankey Diagram: Outcome Star™ total scores - journey of change (Base: all beneficiaries with at least 3 complete readings n=215)**

In this and each of the Sankey Diagrams which follow, the leftmost set of black bars represent the overall scores on the first reading at the start of engagement (first reading). The middle bars represent the overall scores at the second reading (six months on), and the bars on the right represent the overall scores at the third reading (another six months on).

The size/height of each black bar represents the number of beneficiaries in each score band, so we can clearly see for example that the number in the "Stuck" category decreases between first and second readings, and again between second and third readings. The "Accepting help" band is the biggest at all three sample points, and remains pretty constant in size. There is a small increase in the remaining categories over time (from left to right): "Believing", "Learning" and "Self-reliant".

We can get additional information from the coloured bands. Here the red bands show movement from the "Stuck" category, the yellow bands show movement from the "Accessing help" category, the green bands show movement from the "Believing" category, blue from "Learning" and purple from "Self-reliant". In particular, looking at those who are stuck at the first reading, we can see that a red band representing about half of the beneficiaries has moved on to the "Accepting help" category, with smaller slivers making even further progress down the chart towards higher scores. This is counterbalanced somewhat by a section of the yellow "Accepting help" beneficiaries at the first reading

moving back to the "Stuck" category at the second reading. Again, between the second and third readings, over half of the "Stuck" respondents make progress to "Accepting help" and sometimes beyond, but this is offset, to a smaller extent this time, by beneficiaries previously in "Accepting help" and other categories.

We can see that overall progress has been made – the size of the black bars demonstrating that on average, progress has been made away from "Stuck" to "Accepting help" and beyond, with the overall proportion who are still "Stuck" at the third reading approximately half of what it was to start with. However, the movement of coloured bands within the chart that shows that there are small numbers of beneficiaries undergoing setbacks in their journeys of change. It is also possible that people over-estimate at the first reading where they are, with a more realistic assessment at subsequent readings.

The first three sets of NDT assessment scores also show steady beneficiary progress. This is shown in Table 2 below.

| Assessments | Average NDT assessment total score |
|---|---|
| First | 32.2 |
| Second | 25.9 |
| Third | 23.8 |

**Table 2: Comparison of NDT assessment scores across first to third assessments: n=205**

Looking just at the NDT assessment scores for engagement with frontline services the results show a noticeable improvement between the first and second readings. An important objective for projects is to improve the level of engagement of beneficiaries with services and this forms a key part of the NDT assessment. The Sankey diagram (Figure 15) indicates that the large majority of those scoring 4 at the first assessment ("Does not engage at all or keep appointments") improve to a score of 3 or 2, with very little movement back to a score of 4 by other beneficiaries. This indicates that overall the majority of beneficiaries start engaging with services in a positive way once they are reached by projects. By the second assessment, we can see that improvement has continued so that there is a much larger group with a score of 2 ("Follows through some of the time in daily routines or other activities"; "Usually complies with reasonable requests") or better.

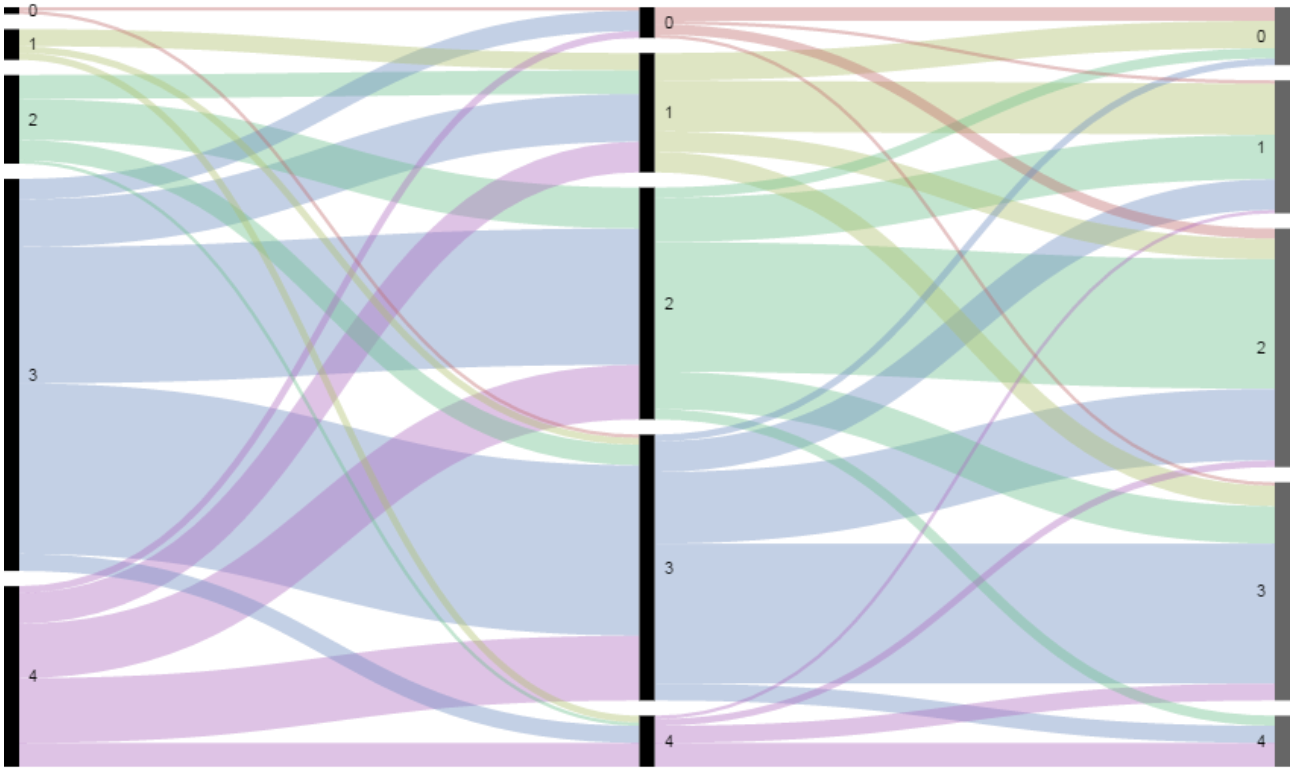


**Figure 15: Sankey Diagram: NDT assessment score for engagement with frontline services (n=205)**

We now go on to look at two other early indicators of progress – the extent to which beneficiaries are moving into stable accommodation, and the extent to which they are reducing use of unsafe and insecure forms of income.

Encouragingly, **by the time beneficiaries have been engaged for a year on projects, a larger proportion are mainly living in supported accommodation** (an increase from 24 to 28.5 per cent); many of these have moved away from temporary accommodation, such as hostels, night-shelters or B&Bs. People mainly living in temporary accommodation, supported accommodation and rough sleeping have also moved into their own tenancies, with 26 per cent mostly living here, up from 19 at the start of engagement.

Yet the data also indicates that **moving people from rough sleeping to more secure forms of accommodation remains a challenge.** Of those who were mainly rough sleeping during their first three months of engaging with projects (55 people), just under half (21) were still spending most of their time rough sleeping six to nine months later.

Challenges include a lack of suitable local temporary or supported accommodation, requirements for a 'local connection'[8] in order to access social housing and people being classed as intentionally homeless.[9] There can also be safety issues, particularly for women. Projects tell us that women often do not feel safe accessing temporary accommodation.

> If women are saying 'I feel safer sleeping under the arches than I do in a hostel' then it's pretty clear that they're not going to use that accommodation.
> **Project partner**

21 per cent of beneficiaries (88 people) who reported staying in multiple types of accommodation at the start of engagement are staying in a single type of accommodation six to nine months later. Spending time in multiple types of accommodation can be an indicator of unstable housing, in which case this change could be an indicator of progress. However, that single type of accommodation may still be insecure; 7 of the 88 people were just rough sleeping. Furthermore, we cannot see whether beneficiaries are moving between locations within the same type of accommodation, for example, different hostels.

Homelessness Outcome Star™ scores for 'Managing accommodation and tenancy' also indicate progress for many – the average score on this issue increases from 3.27 on the first reading to 4.38 on the third reading. Over half of those who felt they were 'stuck' at the first and second reading have made progress to 'accepting help' and beyond. Although this is counterbalanced in part each time by others slipping back.

While Homelessness Outcome Star™ and NDT assessment scores show that there is progress for beneficiaries, **it appears to be harder to address misuse of alcohol and drugs than some other issues.** The Homelessness Outcome Star™ results show that more participants considered themselves "Stuck" than for other measures, and that there was a little less movement out of the stage than for other measures. On the NDT assessment we also found more beneficiaries in the highest level of chaos at each assessment than for other measures. There is a high degree of overlap between mental ill health and substance misuse (dual diagnosis).[10] Projects tell us that people with multiple

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[8] For example, living in an area for six months out of 12 or three years out of five, having close family in the area or working in the area.

[9] Being intentionally homeless means that you are homeless because you left accommodation that you could have stayed in. Common reasons for becoming intentionally homeless include: not paying rent when you could have, personal finances were neglected or professional advice was ignored and eviction due to anti-social behaviour. Going to prison is also classed as becoming intentionally homeless.

[10] Department of Health (England) and the devolved administrations (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly and Northern Ireland Executive Available from: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

needs often misuse substances due to their need to supress trauma. Without alternative tools to cope with their past experiences it is difficult to relinquish a substance which is used to self-medicate. However, there are acknowledged barriers in accessing mental health support for people who also are also misusing substances. We explore these in one of our themed briefings.[11] Professionals working with this client group find that addressing substance misuse often occurs at the later stages of someone's recovery journey and is therefore an end result rather than an initial indicator of progress.

Of those who have remained engaged on programmes for at least 12 months, the proportion of beneficiaries who report income from unsafe or insecure sources (begging, borrowing, illegal activity) actually increases slightly from 23 per cent to 28 per cent. Interestingly, some 12 per cent of those who did not report income from unsafe sources at the start, do so by the fourth quarter. While this may simply be some people starting to use unsafe income sources, it could also be indicative of more trusting relationships between beneficiaries and the partnerships and, as a result, greater openness and honesty about income. Developing personal relationships with key workers based on trust is seen by projects as crucial to providing effective support. We explore this further in chapter 5.

[11] Go to www.mcnevaluation.org.uk to access other reports from the national evaluation.

# 04. Interventions and approaches

*Understanding the emerging models of delivery*

## Key points for this chapter

A number of approaches are beginning to emerge that are common to and shared by many of the projects. These are:

- comprehensive and meaningful service user involvement
- innovation in referral and access to services
- a key worker to support and navigate the system
- peer support
- open-ended and persistent support
- personal budgets
- psychologically informed environments
- Housing First
- progression pathways, and
- systems change strategies.

In some cases these approaches are still in the planning stage or are in development; others are currently being piloted. We will continue to explore the use and effectiveness of these approaches in greater depth in future reports, briefings and case studies.

In this chapter we map the key features of Fulfilling Lives (Multiple Needs) projects. The way each project supports people and creates change is unique, shaped by the specific needs and contexts of the local area and the organisations involved. The work is constantly evolving, through testing, learning and refinement. However, there are clear, common approaches that are shared by many of the projects. In order to begin to assess 'what works' it is important to first identify and understand what projects are delivering and, importantly, how it differs from activity to support people taking place outside of the funded areas.

## Key features of interventions and approaches

We have identified ten broad features of funded projects that characterise the Fulfilling Lives (Multiple Needs) programme. Based on project plans, monitoring reports and interviews with project leads we have distilled the following descriptions. While these approaches may also be adopted by projects and organisations outside the funded areas, it is the combination of these that makes the funded projects distinct. The chart at the end of this chapter shows how the approaches are being used by funded projects. In some cases the approaches are still in development, are planned for future implementation or will initially be pilots.

Our list of key features will form an important basis for future analysis and evaluation. We will continue to review and add to the list to ensure it encompasses important elements of the funded projects' approach, reflecting the holistic and joined-up principles of delivery set by the Fund. We will explore the different dimensions, interpretations and implementation of these features in future reports and case studies.

## Comprehensive and meaningful service user involvement

One of the core principles of the Fulfilling Lives (Multiple Needs) programme is that partnerships engage service users in every aspect of the design and delivery of services. People with lived experience of multiple needs are provided with the necessary training, support and opportunities to enable them to take an active part in developing the programme and influencing wider systems change. All projects have a group of people with lived experience of multiple needs who provide advice, expertise, challenge and recommendations. People with lived experience contribute to all aspects of the partnerships, including:

- participating in staff recruitment (this was the subject of the first national peer-led research project, which resulted in a research findings report and good practice guide. Both can be downloaded from the evaluation website: www.mcnevaluation.co.uk)
- conducting research
- reviewing plans and decisions

- mystery shopping services
- sitting on commissioning panels, and
- contributing to policy consultations.

## Innovation in referral and access to services

Simply gaining access to services can be a barrier for people with multiple needs. Funded projects are developing innovative approaches to the referral and assessment of clients to make accessing services easier. Innovation in referral and access to services generally incorporates some, or all, of the following elements:

**No Wrong Door:** A network of service providers who together provide access to a comprehensive range of services. If someone has needs other than those an organisation can support, they are connected to another member of the network. Wherever someone enters the system, they can get the help they need – there is no 'wrong door'. Members of the network may be quality assured or all work in an agreed way. Information shared across the network is vital.

**Common, single assessment:** An agreed common assessment of need. Data is collected from the beneficiary once and shared with other service providers removing the need for multiple assessments and ensuring that service users do not have to tell their story to different agencies numerous times (the principle of COUNT: collect once, use numerous times). Once the assessment is completed, it provides a 'passport' to a range of services without further assessments.

**'Anonymous' referrals:** Referrals that do not come with past histories. Service users are freed from historical issues following them and are not excluded from services based on past behaviours.

## A key worker to support and navigate the system

Although frontline staff assigned to work with beneficiaries come with a variety of job titles, such as lead worker, specialist worker, service co-ordinator and navigator, they play two important roles:

- to provide intensive support for beneficiaries, and
- to guide them through the system, securing and co-ordinating the package of services beneficiaries need.

In some projects the role is very clearly demarcated as the latter with other organisations providing the support. In other projects the role is much more focused on traditional support work. In practice, we see that there is often some degree of overlap between the two, as service co-ordinators still need to work closely with beneficiaries to build trust,

identify appropriate services and support beneficiaries to access them. We explore the role of key workers in more detail in the following chapter.

### Caseloads

A particular feature of many funded projects' key worker model is a relatively low caseload, enabling staff to provide the intensive support required. The average caseload of workers on funded projects ranges from 4 to 12. Workers on comparison projects have caseloads of between 9 and 25.

Reports from projects have revealed that some initial assumptions about caseloads have been revised. For example, in one project a planned caseload of 15 was unrealistic due to the intense nature of the work. Consequently the project has reduced their caseload to ten.

## Peer support

Support from peers (people who have lived experience of multiple needs, sometimes referred to as expert citizens or experts by experience) features in all of the funded projects and demonstrates the practical implementation of the Fund's key principle of involving service users in all aspects of the programme. Peer roles include peer mentors, peer support or peer advisers. Peers work alongside key workers and carry out activities such as accompanying beneficiaries to appointments, providing emotional support, motivation and encouragement, and helping carry out tasks as part of support plans.

Their shared experience may mean beneficiaries find peers easier to relate to and some messages may be better received through this route. Peers can also act as positive role models and a symbol of hope. The peer can also benefit through training and experience, building confidence and self-esteem, and a possible pathway to employment.

Peer supporters are generally voluntary roles but at least one project has paid peer mentors.

## Open-ended and persistent support

A particular characteristic of funded projects is their ambition to do everything in their power to continue working with people, being persistent and not placing limits or other barriers to engagement. This approach manifests itself in a number of ways:

- **Assertive outreach** – going to the places where people with multiple needs are and returning again and again to build trust and encourage engagement with services. Staff do not give up or close cases if they cannot immediately engage people.
- **No time limits on support** – help is available for as long as beneficiaries feel they need it.

- **No closed cases** – if someone disengages from support their case is put 'on hold' rather than closed.
- **No exclusions policy** – making every effort to continue to provide support, even if someone lapses or behaves inappropriately.

## Personal budgets

Personal budgets are being introduced across health and social care as part of enabling greater personalisation and control over support and care. While some projects have emergency or hardship funds that beneficiaries can draw on, others go further and allocate all beneficiaries an individual set budget. Budgets are used for a wide variety of purposes, including:

- practical items, such as clothing or furniture.
- sports and fitness, such as gym membership, swimming, yoga classes. Physical activity not only helps improve overall health and fitness but can also mitigate symptoms of health conditions.
- entertainment, such as TV, radio, adult colouring books. These activities can help to stave off boredom and drug cravings.
- education, such as courses in IT and cookery.
- employment, such as clothes and travel to interviews.

Fulfilling Lives Newcastle Gateshead have asked MEAM[12] to produce a report on personal budgets using case studies from the Fulfilling Lives (Multiple Needs) initiative, which will provide further information on this topic.

## Psychologically Informed Environments (PIE)

A Psychologically Informed Environment (PIE) is one that is consciously designed to address the emotional and psychological needs of people with multiple needs. PIEs mean understanding the underlying reasons for a person's behaviour (in the case of multiple needs, this may often be linked to past experiences and trauma) and responding accordingly. PIEs seek to understand and address problematic behaviours in a therapeutic way, rather than simply excluding people as a result. This may require services to be more flexible and tolerant. Key elements of PIEs include developing and working within a psychological model, comprehensive staff training and reflective practice.

Some partnerships are also exploring how they can create a PIE that extends beyond their project by offering training and guidance to a wider range of people who may come into

[12] Making Every Adult Matter (MEAM) is a coalition of Clinks, Homeless Link and Mind, formed to improve policy and services for people facing multiple needs. http://meam.org.uk/

contact with people with multiple needs such as police officers, prison staff, housing officers and GP receptionists. Fulfilling Lives Newcastle Gateshead is undertaking local evaluation around the impact of developing PIEs within their project and will share this once completed.

For more on the concept of PIEs see: http://www.rjaconsultancy.org.uk/PIEconcept.html

## Housing First

The Housing First approach places people in permanent and independent tenancies with open-ended, flexible support without first requiring them to undergo treatment or otherwise demonstrate that they are 'housing ready'. The approach originated in the United States, where it has been shown to be effective in supporting those who were chronically homeless.

For more information on the model, see Shelter's good practice guide: http://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/policy_library_folder/housing_first_-_a_good_practice_briefing

Homeless Link have also produced a review of Housing First in England: http://www.homeless.org.uk/sites/default/files/site-attachments/Housing%20First%20or%20Housing%20Led.pdf

We will be publishing a case study on the Housing First approach in action in Camden and Islington shortly.[13]

## Progression pathways

As part of service user involvement programmes, projects offer opportunities to volunteer, gain work experience and ultimately take up paid posts as part of the recovery journey. Some projects have taken this further and provide a comprehensive programme of activities and support for people who no longer require intensive one-to-one support to help them move on and into education, training and/or employment. In addition to opportunities to contribute to the design and delivery of projects and services, progression pathways can include:

- work placements and trials
- access to further and higher education, and
- enterprise opportunities such as micro social enterprises.

[13] This will be available from www.mcnevaluation.co.uk

## Systems change strategies

An important ambition of the Fulfilling Lives (Multiple Needs) programme is that it leads to sustainable changes to the wider systems of services used by people with multiple needs. All partnerships therefore have a strategy to achieve the desired system change. Approaches to date include:

- mapping the current system
- recording examples of barriers or other instances where the system is failing people
- systems change brokers who work to facilitate change
- innovation funds
- pilots and demonstration projects
- high profile leadership, for example, Ambassadors for Change and Change Champions, and
- evidencing impact and cost savings to influence change.

Figure 16 overleaf shows which projects are using or planning to use the different approaches. As can be seen, some are used by all (service user involvement, peer support, and system change strategy) and form the core of the Fulfilling Lives (Multiple Needs) approach. We will develop a similar table in future showing the use of the approaches by comparison projects.

| | Comprehensive service user involvement | Innovation in referral and access to services | Support workers | Service coordinators | Peer support | Open-ended and persistent support | Personal budgets | Psychologically informed environments (PIE) | Housing First | Progression pathways | System change strategy |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Birmingham | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| Blackpool | ✓ | | | ✓ | ✓ | ✓ | | | | ✓ | ✓ |
| Brighton & Hove, Eastbourne and Hastings | ✓ | | ✓ | | ✓ | ✓ | | | | ✓ | ✓ |
| Bristol | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | | ✓ |
| Camden and Islington | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | Pilot | ✓ | | ✓ |
| Lambeth Lewisham and Southwark | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | | ✓ |
| Liverpool | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Manchester | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | Pilot | ✓ | ✓ |
| Newcastle and Gateshead | ✓ | | | ✓ | ✓ | | ✓ | Pilot | ✓ | ✓ | ✓ |
| Nottingham | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Stoke on Trent | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| West Yorkshire | ✓ | ✓ | | ✓ | ✓ | | ✓ | | | | ✓ |

**Figure 16: Interventions and approaches used by projects**

# 05. Working the frontline

*The role and perspectives of frontline staff on engaging, supporting and navigating*

## Key points for this chapter

- Seconding frontline staff from other organisations can offer benefits such as developing cross-specialism knowledge. However, in practice projects have struggled to second staff.
- Potential seconding organisations need to fully buy into the idea and be able to envisage the benefits. This has been difficult to achieve in a context of scarce resources, service re-commissioning and shortages of skilled staff.
- Projects using individuals with lived experience on the frontline has resulted in quicker relationships forming with beneficiaries due to their shared experiences and understanding.
- The flexible, holistic and well-resourced approach of Fulfilling Lives (Multiple Needs) appears to be helping key workers to engage and support beneficiaries better.
- In particular, frontline staff highlight the following as key to successfully engaging and supporting beneficiaries:
    - being persistent and not having a restricted timeframe
    - making the most of windows of opportunity
    - taking a flexible and spontaneous approach
    - focusing outreach at transition points
    - building a personal relationship based on trust
    - learning the beneficiary's routine
    - understanding, not lecturing
    - finding ways to leave beneficiary's past history behind
    - focusing on the beneficiary's own priorities, and
    - providing purpose.
- Frontline staff play a key role not only in navigating the system with beneficiaries, but in opening up access to new services and facilitating improvements in how beneficiaries are treated.

This chapter focuses on the frontline workers. We begin by examining the different types of key worker roles and what they look like on a day-to-day basis. We explore the different recruitment approaches used by projects and the learning which we can draw from this. We then summarise key workers' perspectives on effective ways to engage and support people with multiple needs. The chapter concludes by providing some examples of how the key workers have helped beneficiaries to navigate the system but also, crucially, about how they have brought about changes to the system.

## The role of the key worker

All projects have a team of staff that work closely with beneficiaries. This role has many names - navigator, key worker, practitioner and lead worker – but in effect they all have the same role: to engage chronically-excluded individuals with multiple needs and work with them to access services. As set out in the previous chapter (see page 32), some projects clearly differentiate between staff *providing* intensive support and those who act as service *co-ordinators;* for others the two aspects are combined. Frontline workers, whatever their precise job title or role, see first-hand many of the dead ends and obstacles in the current system of support for people with multiple needs. They therefore have a vital role to play in highlighting and tackling system failures.

Key workers locate and reach out to potential beneficiaries, encouraging them to engage with the project. This process may take many weeks as staff gradually build confidence and trust with the person. Early priorities for frontline staff when working with engaged beneficiaries will often be on meeting immediate basic needs relating to accommodation, health and finance. This could involve obtaining benefits, opening bank accounts, sourcing and maintaining accommodation (and avoiding evictions) and arranging GP appointments or access to rehabilitation or detox programmes. Once their basic needs are being addressed, staff support beneficiaries through their recovery journey, in particular by helping them to identify and pursue a purpose, whether that be volunteering, training, taking up a hobby or establishing a social network.

No two days are the same when working on the frontline and projects have different models of staffing and approach. However, the example below gives a flavour for the key worker role.

**A day in the life of a Blackpool Fulfilling Lives navigator**

The day starts with a 'flash meeting'. At this meeting navigators, assistant navigators and volunteers meet to talk through their plans for the day, who they will be working with and identifying any potential risks. Staff must work in pairs and it is during the flash meeting that volunteers are paired with navigators. Staff review beneficiary case notes and volunteers can decide if they feel it is appropriate for them to get involved. For example, a volunteer may feel that a beneficiary's history is too similar to their own and they may feel uncomfortable attending particular appointments.

Frontline staff will spend the rest of their day visiting or phoning beneficiaries. Navigators will often accompany beneficiaries to appointments and advocate on their behalf. Appointments might be with the beneficiary's GP, drugs services, outpatient mental health clinics, housing services and so on. However, the reality can be that many clients will frequently miss their appointments.

Staff may spend time supporting beneficiaries with independent living, such as taking a client food shopping before they spend their benefits on substances, helping them access social and leisure activities or just providing support over the phone. Time is also spent negotiating access to services with other organisations.

Keeping records up to date also forms part of the day. This consists of recording case notes, writing risk assessments, creating action plans and recording outcomes (including for the national evaluation). Navigators also attend training on an ongoing basis. For example, navigators recently attended a course on CPR (cardiopulmonary resuscitation).

The planned day's activities are often quickly changed when the service receives a call that a beneficiary is in crisis – this could be being evicted, arrested or taken to hospital, for example. This beneficiary is prioritised and the day may be cleared to address the issue.

## Recruiting key workers

Most projects have simply advertised openly for key workers, seeking out individuals with appropriate qualifications and/or experience in at least one of the four areas of multiple needs: mental health, housing, offending or substance misuse.

**A secondment model can offer benefits to a programme such as this, but projects who selected this approach have struggled in practice to implement it.** This is one of the key learning points from the early phase of the process evaluation of the programme.

A secondment is the temporary movement or 'loan' of an employee from one organisation to another (or another part of the organisation in the case of internal secondments).[14] The Fund had expressed an interest in projects adopting a secondment model. It was felt that this would not only provide the opportunity to establish a multi-disciplinary team with the relevant skills and experience but also any programme learning would be more sustainable beyond the initiative.

The South East Partnership (Brighton and Hove, Eastbourne and Hastings) successfully seconded nurses to work in the Brighton and Hove area and have seen benefits as a result. Sharing knowledge between services helps improve awareness and understanding of some of the key barriers experienced by beneficiaries. This has enabled staff seconded to the project to highlight areas for development or improvement within the seconding organisation. Access to professional networks and resources within services is more readily available when seconded staff are used. The South East Partnership also found that employees of the local NHS have greater 'clout' in getting resources and services for beneficiaries. More information about the South East Partnership approach is provided in a separate case study.[15]

However, many projects that pursued the secondment model initially were unable to get it to work for them. **The seconding organisation needs to be fully bought into the idea of the secondment and able to envisage real benefits for them** (such as enhanced employee skills and motivation) and for the secondee (such as opportunities for personal and career development) and not just see the secondment as benefitting the host. Projects struggled to convince seconding organisations that the benefits outweighed the potential risks. For example, one project only managed to second in two staff members despite meetings and presentations to sell the idea and providing an attractive financial package including covering the secondee's salary, an out-of-hours working bonus and

[14] CIPD (2015) Secondment factsheet Available online at: http://www.cipd.co.uk/hr-resources/factsheets/secondment.aspx Last accessed 5 April 2015

[15] This is available from www.mcnevaluation.co.uk

additional payments to cover the administrative fees of the seconding organisation. The perception is that the wider context of scarce resources, budget cuts, service re-commissioning and a shortage of skilled staff has made potential seconding organisations particularly risk averse and reluctant to 'lose' skilled staff.

> There was stuff going on in the background. There were tender processes in development around homelessness, around housing, around substance misuse. People generally lock down in those times, don't they, and grip on, when there's uncertainty … Because of the uncertainty around what the project was about back then, people didn't quite understand it, did they? … They felt threatened by us, [concerned about us] stealing workers … at one point in the homeless forum, one manager said to me, 'Well, why am I going to give you my best workers?'
> **Project lead**

Projects were also seeking secondments from multiple organisations; this caused additional complications when agreeing standard contracts across all parties. Contract negotiations could include which costs the host and seconding organisation should pay, employment location, insurance, training and working guidance. Project managers were unable to find any best practice guidance on this recruitment model within a multiple needs context. Those who successfully used the model used formal agreements to mitigate risks for all involved.

Creating opportunities for people with lived experience of multiple needs to become trained frontline workers as part of a progression pathway also has benefits. One of the key aims of the Fulfilling Lives (Multiple Needs) programme is to put people with lived experience at the heart of the design and delivery of services; employing them as frontline staff is clearly a way to meet this aim.

There is a difference in the roles that might be played by those with very recent and historical lived experience of multiple needs. However, a typical progression pathway of this kind might begin with someone volunteering as a peer mentor or similar. In this position individuals can accompany key workers on outreach and beneficiary visits where they learn about engaging and supporting people with multiple needs. Volunteers receive training and support and can also develop a sense of purpose through volunteering (see the Supporting beneficiaries section below for more on this). Following on from volunteering an individual might be employed as an assistant navigator or similar where such a role exists. Here they have their own caseload of clients but will be heavily supported by a more experienced key worker. The next obvious step is becoming a key worker. The programme has not been running long enough for beneficiaries to have reached this stage. At the National Expert Citizen Group (NECG – see the Glossary) meetings some concerns have been raised about the extent to which people with lived experience of multiple needs can make that crucial step from voluntary work on the project to paid employment. This could potentially be the topic of a future peer research project by the group.

**Projects using people with lived experience as frontline staff have found that they can often form relationships with beneficiaries more quickly due to their shared experiences and understanding.** While this is positive, in some cases this has led to staff taking on larger caseloads of beneficiaries than they may be ready to cope with. There are concerns that some could relapse on their own journeys if placed under too much stress and pressure in the role. Monitoring of caseloads is important as is providing timely support.

## Engaging and supporting beneficiaries

The flexible, holistic and well-resourced approach of Fulfilling Lives (Multiple Needs) appears to be helping key workers to engage and support beneficiaries better. Key workers have a wealth of experience and insight into engaging and supporting beneficiaries effectively. In this section we set out the key messages from frontline and other project staff about what they think works.

### Be persistent

The frontline staff we spoke to agree that persistence is the key to engaging chronically-excluded individuals with multiple needs. **Not having a restricted timeframe** in which to engage and work with beneficiaries provides staff with the opportunity to develop relationships, learn behaviour patterns, and provide personalised, intensive, solution focused support.

> I know in a lot of services that there's, kind of, a rule that if someone doesn't meet you for three times, that's it, you sign them off, but with us, we can keep on approaching people and trying for as long as it's needed, so it's pure perseverance, I think. They realise you're going to be there for them, that you're committed to supporting them and they might let you in a little bit at a time. They might be willing to speak to you just a little bit more each time.
> **Frontline staff member**

### Make the most of windows of opportunity

There are likely to be moments in people's lives when they are willing to make a change and to engage in services. A persistent approach from project staff can mean potential beneficiaries are more likely to turn to them at these times.

> That's the day when they've had enough, it's raining, they've earned no money and, 'Do you know what, I can't keep living like this,' ... by being persistent you're planting the seed, each time you go and speak to someone, even if their mind is closed to it, somewhere it has been planted, and on the day that they want the help they'll remember.
> **Frontline staff member**

Crucially, workers need the flexibility to be able to take advantage of these windows of opportunity – especially as they may be short lived. This is something that the Fulfilling Lives (Multiple Needs) way of working offers.

> For the individual clients who want treatment and support on that day you need to strike while the iron is hot, don't you? Or else there's another payday and the dealer comes along and things quite quickly change.
> **Frontline staff member**

### A flexible and spontaneous approach is key

Project staff highlighted how the resources (personal budgets in particular) and additional freedoms of the Fulfilling Lives (Multiple Needs) initiative are important in enabling them to address beneficiary needs quickly and effectively.

> So if you go to see someone and they're really, really poorly and you know they desperately need to go and see a doctor as soon as possible but they're refusing to go. They don't want to go on the bus. They don't want to walk. You can say, 'Okay, let's get a taxi, let's go, I'm going to call it now and let's go do that,' and again, financially, in other services, they probably wouldn't allow you to do that, or there would be a lot of paperwork involved in getting it authorised.
> **Frontline staff member**

### Focus outreach at transition points

The current system relies on individuals taking responsibility for their own care pathways between services. People with multiple needs are often unable to do this and therefore 'fall through the gaps' at service transition points – such as when leaving prison or being discharged from hospital. Frontline staff focus on these points in order to engage individuals. For example, staff focus on obtaining rent bonds for people in prison so they are set up to enter private housing upon their release:

> If they get that rent bond in place that gives the worker a chance to get properties lined up for the person to come out and have a look at. Instead of starting the application when they are coming out, being homeless in between.
> **Project lead**

### Build a personal relationship based on trust

Getting to know a beneficiary personally helps build trust and is more likely to encourage someone to engage. Initial approaches should be informal and friendly; approaching with assessment forms and paperwork leads to beneficiaries feeling that there is an agenda involved that they may not be willing to engage with. Staff suggest varying the location for conversations - a walk in the park, going for a coffee - in order to develop the relationship as you would with a friend and confidante. Frontline staff also talk about remembering key pieces of information about people to help develop relationships

> You know, that recognition…their aunt's dog is not well or something…remember that and next time say 'Oh, how's your aunt?'…little personal details, making it more person-centred.'
> **Frontline staff member**

However, there is a balance to be struck here. Frontline staff caution that they need to remain 'a professional friend' so that beneficiaries do not become wholly dependent on them. For example, helping a beneficiary access services by taking them to appointments in the worker's car may be necessary and appropriate in some instances but beneficiaries need to eventually take responsibility and not rely on the worker to provide support that they can access themselves:

> He'd want me to pick him up, take him to the appointment, come into the appointment, come back, take him home and it was getting where it was like a three-hour round trip, kind of thing. I said, 'Listen, I can't do this today but what I can offer you is, here's a bus pass.
> **Frontline staff member**

### Learn the beneficiary's routine

Knowing a person's routine, where they bed down or spend their time during a day helps staff find potential beneficiaries and encourages engagement. Knowledge of someone's routine has meant that frontline staff have been able to find beneficiaries who may disengage part way:

> [The beneficiary] left the hostel one day, but because [the key workers] knew him so well, they went straight back to his old rough sleeping spot and he was there very, very unwell and ended up getting sectioned into a mental health hospital.
> **Frontline staff member**

### Understand, don't lecture

Focusing on solutions and positive outcomes is felt to achieve a greater level of engagement with beneficiaries than focusing on their personal accountability, which can often lead to disengagement.

> One of the things I find is you go into an appointment and the person [the beneficiary has] come to see spends the first ten minutes telling them how bad it was that they didn't come to the last appointment, or they left in a strop or they didn't behave as they should have done and we need to change this and consequences and accountability. … It's so negative that [the beneficiaries] just get up and walk out the door again … There's no understanding.
> **Frontline staff member**

### Find ways to leave beneficiaries' past history behind

Service users who have previously declined help or missed appointments can believe they have missed their chance at receiving help. Key workers on the Fulfilling Lives (Multiple Needs) programme seek to dispel that belief and encourage engagement by advocating on a beneficiary's behalf. People with multiple needs often feel judged, so approaching them with an open mind and being non-judgemental is most likely to enable engagement. Staff we spoke to gave examples of previously disengaged individuals who, when placed in new environments without their past history being known, have been enabled to pursue their recovery journey.

> They're obviously also not coming to him and saying, 'I know you from before and this was the issue before.' There's none of that. So he's not kind of being reminded constantly of mistakes he's made in the past.
> **Frontline staff member**

### Focus on beneficiaries own priorities

By focusing on an individual's personal priorities and interests, rather than service defined targets, frontline staff have found that individuals will more readily engage and good results are more likely. Again, the flexibility of the programme makes this easier to achieve.

> They may want to cut down as opposed to stop....maybe stop begging or stop offending. So whatever that they identify - some of them just want to reconnect with family. Whatever it is they want to do as their initial steps, we've got that flexibility to support them to do that, rather than being hit over the head with, 'This is the target, we've got to have so many people drug free by the end of this month'.
> **Frontline staff member**

### Provide purpose

Frontline staff agree that providing a sense of purpose and positive activities is important in supporting the recovery journey. This can help lessen the isolation that is often caused by multiple needs, and in particular addiction. Understanding an individual's aspirations and motivations helps staff to encourage an individual when they are having bad days. Personal budgets can be helpful in enabling beneficiaries to pursue interests.

> It's one of the things that I know from experience, and I think we pretty much agree on, is that if you are stopping addiction, you have to replace what you were addicted to. ...Like, if you spend all your time drinking, and you suddenly stop drinking, you've got all this time, so you need to be doing something else. I mean, whether it's going to mutual aid meetings, or going out to the library, or going to do a class at night school, or going to a gym, you need to do something.
> **Frontline staff member**

The case study below (provided by Fulfilling Lives Newcastle Gateshead) illustrates the role of Service Navigators in enabling someone to get the support they need and make progress through persistent, flexible and tailored support.

**Case study: Dean**

Dean is 37 with a long history of substance misuse starting at the age of 19. Dean has a diagnosis of schizophrenia and is difficult to engage yet is known to multiple services. At the time of referral to Fulfilling Lives Newcastle Gateshead Dean had recently been evicted from temporary hostel accommodation and was sofa surfing / street homeless. The most significant problems for Dean have related to his inability to remain in stable and secure housing. This is both through his own behaviours (for example, setting fire to his room) and the inability of housing providers to support him in a meaningful way. In the past two years Dean has been housed in six different temporary or supported housing services, with multiple periods of sofa surfing or street homelessness, and in three different local authority areas.

The critical period for Dean came when he was housed (not by choice) in temporary accommodation in Sunderland. Dean is a Gateshead resident and all his care was in this area. Being housed in Sunderland was a problem as he was out of area to receive the support he had in place, including mental health support. Fulfilling Lives involvement during this period meant that Dean had a Service Navigator to advocate for his continued support from existing services. It also meant that when Dean was evicted from the accommodation in Sunderland, someone was aware that this had happened. Without a Service Navigator it is likely that Dean would have disappeared from services' awareness or continued in his historic cycle of hostel – evictions – rough sleeping – hostel.

During a period of staying at a private hostel in Newcastle, Dean's Service Navigator supported him to access supported accommodation in Gateshead, close to his family and social networks. Again, this has not been without difficulties. However, the Service Navigator was able to advocate on his behalf and, with an offer of taking on some of their support role temporarily, ensure that Dean was able to stay. He has now been in this accommodation for over nine months and has started to engage properly with the support offered, build relationships with other residents and participate in activities such as swimming. Since moving to the new accommodation Dean has reduced his substance misuse and improved his personal hygiene and self-care.

One of the most important elements for Dean has been having no time limits on the support. After one year there had been little change in Dean's needs, despite some more positive periods. He was still unsuitably housed and not engaged with substance misuse support, or mental health support. Had there been a time critical element to supporting Dean then it is likely that the outcomes now being seen would not have been achieved.

Seeing Dean cycle through different accommodations, supporting him through the fallout of evictions and being able to observe patterns of behaviour means the Service Navigator is more attuned to Dean's needs in regard to housing, potential risks and the protective factors needed to support him. This in turn has meant the outcomes for Dean are more likely to be long term and sustainable.

Additionally, the ability of the Service Navigator to adapt his role to reflect the needs of Dean at a given moment has made a difference. When Dean was at risk of being evicted from his current accommodation, the Service Navigator was able to offer additional support to help bridge the gap between Dean's needs and the service provider. This helped to ensure Dean remained in this accommodation. Related to this is the Service Navigators' ability to work across system-constructed boundaries, including geographical boundaries. When Dean was relocated to Sunderland temporarily, unlike many of the other services that he was engaged with, the Service Navigator was able to follow Dean and continue the support offered. This meant that when Dean was evicted from his accommodation in Sunderland he wasn't lost to the system but was immediately linked back in with support in Newcastle and Gateshead.

*Courtesy of Fulfilling Lives Newcastle Gateshead*

## Navigating the system

Frontline staff play a key role not only in navigating the system with beneficiaries, but in opening up access to new services and facilitating improvements in how beneficiaries are treated. Many of the examples of change reported to us by key workers are small scale and may only affect a handful of beneficiaries. However, changing staff cultures, custom and practice are integral to system change. The examples demonstrate how, given the remit and resources to engage with local services and other partners, changes to policy, practice and culture can be achieved.

Frontline staff tell us that building up personal networks with key partners is key to changing access to, and experiences of, services for beneficiaries. Developing relationships with staff from services that beneficiaries are most likely to use allows key workers to contact them directly during the windows of opportunity. For example, one staff member described how they built a relationship with a local police community support officer (PCSO) who would check in on a beneficiary when the key worker was not on duty:

> This PCSO worked really well with us because if he was on shift, he'd call round and do a safe and well check. I could ring him direct. He was the local PCSO for the area, so that was useful.
> **Frontline staff member**

Another key worker has built a relationship with a local landlord who now contacts the project directly when he has available housing. For the landlord, the intensive support offered by key workers gives him extra peace of mind; for the beneficiaries it provides access to other housing options.

One of the key benefits of partnership working of this kind is it can allow frontline staff the opportunity to advocate for tailored access to services. Services have waived triage processes, altered appointment times and changed locations of assessments all in order to meet windows of opportunities for beneficiaries. For example, one beneficiary had a relapse from abstinence between two mental health assessments which meant she was unable to take part in the second assessment that was needed to access support. As the clinician concerned had worked extensively with the beneficiary, the key worker was able to negotiate with them to undertake the assessment without the beneficiary present.

Staff interviewed feel the best way to develop good relationships with services is in person. Explaining the service that projects offer and how it provides navigation and additional support, rather than replacing existing services, is important too. Staff report that at the start of the initiative there was often a lack of understanding and projects were sometimes treated with suspicion.

> When we were first involved, they were a little bit like, 'Who are these lot coming down here saying we didn't do this, or we didn't do that?' Now they can see that we do [what we] say we will do … They know that we will keep them in the loop with everything, be very reactive when they need anything and we will just try and work with them really, really well.
> **Frontline staff member**

Regular communication was also stressed as being of crucial importance. Staff from of the projects explained how they have set up email groups so that any organisation involved in supporting a beneficiary is kept up to date on the service(s) they are receiving. Regular multi-agency meetings are also organised for the same purpose. In order to ensure that partnerships are not reliant on one personal relationship, local teams also share contacts. In some project areas there are plans to roll out IT systems to other agencies working with the beneficiary groups to help develop multi-agency case management.

Partnership working provides an opportunity to challenge the status quo of how services are delivered. It is hoped this will lead to improvements over time. For example, one key worker challenged a hostel on its exclusions policy and this is now being reviewed. In another example, key workers challenged the approach police take with rough sleepers, asking them to take a positive approach, focusing on potential solutions. As a result, an entrenched rough sleeper with a track record of begging was provided with a food voucher by police instead of being arrested. The police now have a positive relationship with the individual who has gone on to undertake volunteering opportunities with the local community wardens.

> Well, actually, you say he's never going to change and he's been like this for such and such a time, but these are the changes he's made so far and could we try this? Maybe

instead of issuing him a warning every time you see him begging, issuing him a food voucher and just see if it makes any difference,' and they embraced that.

**Frontline staff member**

The final case study below, provided by FLIC (Fulfilling Lives Islington and Camden), illustrates some of the frontline worker approaches set out in the first part of this chapter, and gives an example of how a project re-negotiated the terms on which a beneficiary accessed a service. The peer mentor liaised with the treatment service and persuaded them to allow the beneficiary to complete necessary pre-detox work on a one-to-one basis with FLIC rather than the current mandatory group work programme. FLIC are working to build on this small change to make it an option for all who find group work untenable (which is very often those with complex trauma).

**Case study: Jackie**

Jackie was referred to FLIC by her hostel worker at the time, who was concerned about their ability to work with Jackie due to the complexity of her needs. Jackie had come to them from a women's refuge and regularly would mention past traumatic events. Jackie is a heavy drinker and also uses Class A drugs at times, and suffers from acute anxiety, depression and thought disorder. On rare occasions when Jackie was not drinking heavily, she was able to express her desire to have an alcohol detox and move forward in her life. The year before, Jackie had a very negative experience with an alcohol service who had apparently promised her detox and then a move on to her own flat, which had never materialised. As a result she was deeply suspicious of support services and flatly refused to engage with substance misuse support.

FLIC introduced Jackie to Lisa, one of the female peer mentors, to try a different approach. Lisa started accompanying Jackie on walks or going for a coffee and getting to know her. Lisa spoke to her about her own experiences of services, the ups and downs that she'd faced and how eventually she'd found a team who were able to give her the support she needed and had gone to detox and sustained abstinence. Jackie responded well to this informal type of support.

The substance misuse service set out a programme of engagement for Jackie which she would need to engage with in order to get the funding for residential detox. This involved a lot of group work based within the service. Jackie started trying to attend the groups, but due to her anxiety and difficulty expressing herself to others she found them very difficult and would often become very distressed and have to leave the groups early. However, Jackie was engaging well with FLIC and the support provided by a new hostel. When doing arts or wellbeing-based groups she was much more comfortable and she also engaged well on a one-to-one basis when talking about her treatment goals. Jackie had joined the local gym with Lisa, and started attending exercise classes and swimming. Jackie's mental health improved considerably as she began taking part in activities which she enjoyed.

FLIC organised a case conference with Jackie's hostel provider and substance misuse service, and requested that, given how challenging she was finding the designated group work, Jackie's engagement with FLIC could provide an alternative pathway to demonstrating her ability to engage with treatment. It was clear that the traditional pathway was not suited to Jackie's needs and abilities, but her motivation to engage was clear, and the substance misuse service agreed that her external engagement could take the place of the prescribed group work.

Jackie's case went to the funding panel recently and she was awarded funding for a 21 day residential detox. FLIC will support Jackie throughout this and her transition back into the community, and are currently working with Jackie to plan a programme of support and activities for her to engage with once she is abstinent.

*Courtesy of Fulfilling Lives in Islington and Camden*

# 06. Conclusions and next steps

In this final chapter we draw together the key findings from the report and set out some future plans for the evaluation. We link the results back to the aims of the programme as a whole and our aims for the evaluation. In many ways the evidence reported here raises as many questions as it answers. In this chapter we identify issues we plan to explore further as the evaluation progresses.

## Projects have made a good start in reaching those with greatest need

The first aim of the evaluation is to track and assess the achievements of the programme. We can see that the 12 funded projects have made a good start in identifying beneficiaries and reaching those who are disengaged. There does not appear to have been great difficulty in generating volumes of referrals. Although in several instances **criteria for accepting beneficiaries have been refined to ensure referrals are appropriate and to better manage the flow.** It will be interesting to see to what extent the profile of beneficiary needs remains consistent over time or whether this changes as pent-up demand in the system is addressed. However, it is important that we do not place too much emphasis on purely meeting target numbers. A target-driven culture is one of the aspects of the current system that partnerships are seeking to change.

## Continued effort is needed to reach and support 'hidden' beneficiaries

The profile of beneficiaries is in many ways as expected – mainly male, white and aged between 25 and 44. But it is important that projects continue to seek to identify and reach those potential beneficiaries, including women and people from Black and minority ethnic groups, that may be 'hidden' from mainstream services and statistics or are harder to reach. Understanding the particular needs of these groups is also important. A group of peer researchers, supported by the national evaluation team, has chosen to focus their second piece of research on investigating the representation of beneficiaries from ethnic minority groups and how projects are addressing this.

## Few beneficiaries have successfully moved on to date

One of the three aims of the Fulfilling Lives (Multiple Needs) programme is that people with multiple needs are able to manage their lives better through access to more person-

centred and co-ordinated services. For most, **this will not be a quick or easy journey and some may require ongoing support** in some form. We should not be disheartened that only a small number of beneficiaries have successfully moved on from the programme at this stage. It is still too early to draw much in the way of conclusions from the data on those that have successfully moved on – especially as many seem to be the result of inappropriate early referrals. In this report we have focused in particular on the processes and criteria for bringing people on to projects. **In future reports we will explore how and when projects decide it is appropriate to stop working with beneficiaries** or that support is no longer required. We also plan to investigate what 'successful move on' looks like in practice as we expect this will be different from person to person. We hope to be able to track beneficiaries beyond their participation in the programme in order to understand more about onward progression and destinations.

## But there are signs that those on the programme are making progress

There is evidence that **beneficiaries are increasingly accepting help, engaging with services and, crucially, building trusting relationships with projects**. We should also not be surprised if the Outcome Star™ and NDT assessment data shows some early backward movement too – either because early assessments do not identify all needs or as a result of lapses in progress. This is an expected part of the recovery journey and the longer-term nature of the programme and evaluation gives us a ground-breaking opportunity to record and track this.

## Flexible and open-ended support, with a focus on beneficiaries' own priorities, is key

As part of our evaluation we are also aiming to understand what works and the extent to which the Fund's principles are having an impact. We have identified a number of key approaches and interventions that funded projects are taking. We will explore each of these in more detail in future reports, briefings and case studies.

So far **the rate at which beneficiaries are disengaging from projects appears relatively low** (7.5 per cent). This may be an indication that some of the approaches particular to the Fulfilling Lives (Multiple Needs) programme, such as open-ended and persistent support that is flexible and holistic, are having an impact.

We have gathered in this report some valuable insights into what frontline staff think works when engaging and supporting beneficiaries. In particular, **the resources (such as personal budgets) and additional freedoms to allow staff to respond effectively to beneficiary needs** – being spontaneous and making the most of windows of opportunity.

However, at this stage we have little by way of comparison. As additional data from our comparison areas is gathered over the coming years, we will be better able to identify how the programme is distinct from mainstream support and, crucially, whether results are different as a result. This will enable us to meet another of our evaluation aims – to estimate the extent to which achievements are attributable to the projects and interventions.

## There are examples where project staff have facilitated change

Key workers play a key role in navigating the complexities of the current system, but also in improving access to services, and identifying and addressing barriers. We have provided examples in this report of how frontline staff members are working to change the attitudes and approaches taken by local services. **These are often small-scale and piecemeal changes at this stage, but provide a useful foundation** for gathering evidence of impact and learning about effective practice that can be used to influence on a wider scale. This will be critical in achieving the second of the programme aims - services that are more tailored and better connected.

## Difficult systemic barriers remain

There is some improvement in beneficiaries' accommodation over time, although there are also barriers, such as lack of suitable housing and requirements for a local connection, that are difficult to address. **Moving people on from rough sleeping remains a challenge.** We are planning two case studies for the coming year that will explore particular approaches to addressing housing in more detail.

Beneficiaries generally are still struggling with alcohol and substance misuse, and it may be that these issues are addressed at a later stage in beneficiaries' recovery journey. However, **systemic barriers to people with co-existing substance misuse and mental ill health accessing the support they need is a particular concern for projects.**

## Projects have valuable learning around recruiting staff

The national evaluation also aims to explore how projects are delivered, understand problems and share learning. In this report we have highlighted how **seconding staff into projects has potential benefits but can also be challenging**. Projects employing **people with lived experience of multiple needs have found that they can often form relationships with beneficiaries more quickly due to their shared experiences**. It may be useful to explore further the ongoing needs of frontline staff in terms of training, support and development, and in particular, to ensure their own wellbeing when working on potentially distressing cases. This is particularly important

when employing people with lived experience of multiple needs as frontline staff and volunteers.

## There is still much for the evaluation to do

The third programme outcome is that shared learning and the improved measurement of outcomes for people with multiple needs will demonstrate the impact of service models to key stakeholders. We hope this report begins to help address this aim. We know that an important part of demonstrating the impact of the programme is showing the effect on use of public services (such as stays in prison and visits to accident and emergency) and the associated costs. We are working to collect the necessary data in order to assess the costs of people with multiple needs on the public purse and to track how this changes over time and in comparison to those areas that are not receiving funds from Fulfilling Lives (Multiple Needs).

# Appendix 1: Outcome Star™ Journey of Change

When we aggregate scores across the ten issues or average scores across beneficiaries and projects we assign them to the five steps on the journey of change as follows:

- Stuck: total score 10-24 (average score 1.0-2.4)
- Accepting help: total score 25-44 (average score 2.5-4.4)
- Believing: total score 45-64 (average score 4.5-6.4)
- Learning: total score 65-85 (average score 6.5-8.4)
- Self-reliance: total score 85+ (average score 8.5-10.0)

# Appendix 2: Correlation between Outcome Star™ and NDT Assessment

Below we consider the correlation between the two measures – if we were to find a poor correlation then we might have cause to consider either that one was a poor measure for recording wellbeing, or that one was measuring different information to the other. However, Figure 17, which plots the total scores for both measuring systems at the third sampling point, demonstrates a strong correlation between the two. Here the absolute value of the correlation coefficient $r$=-0.691 is high enough to show a strong correlation between the two, with the negative sign indicating that the Homelessness Outcome Star™ score *decreases* as NDT assessment score increases. By eye, we can see from the scatter of the observations in a rough straight line shape that this certainly seems to be the case.

We show the scatterplot with a best-fit line, sandwiched between the two outer estimates at 95% significance level, meaning that we can be 95% sure that the best fit line is in between the two outer lines on below.

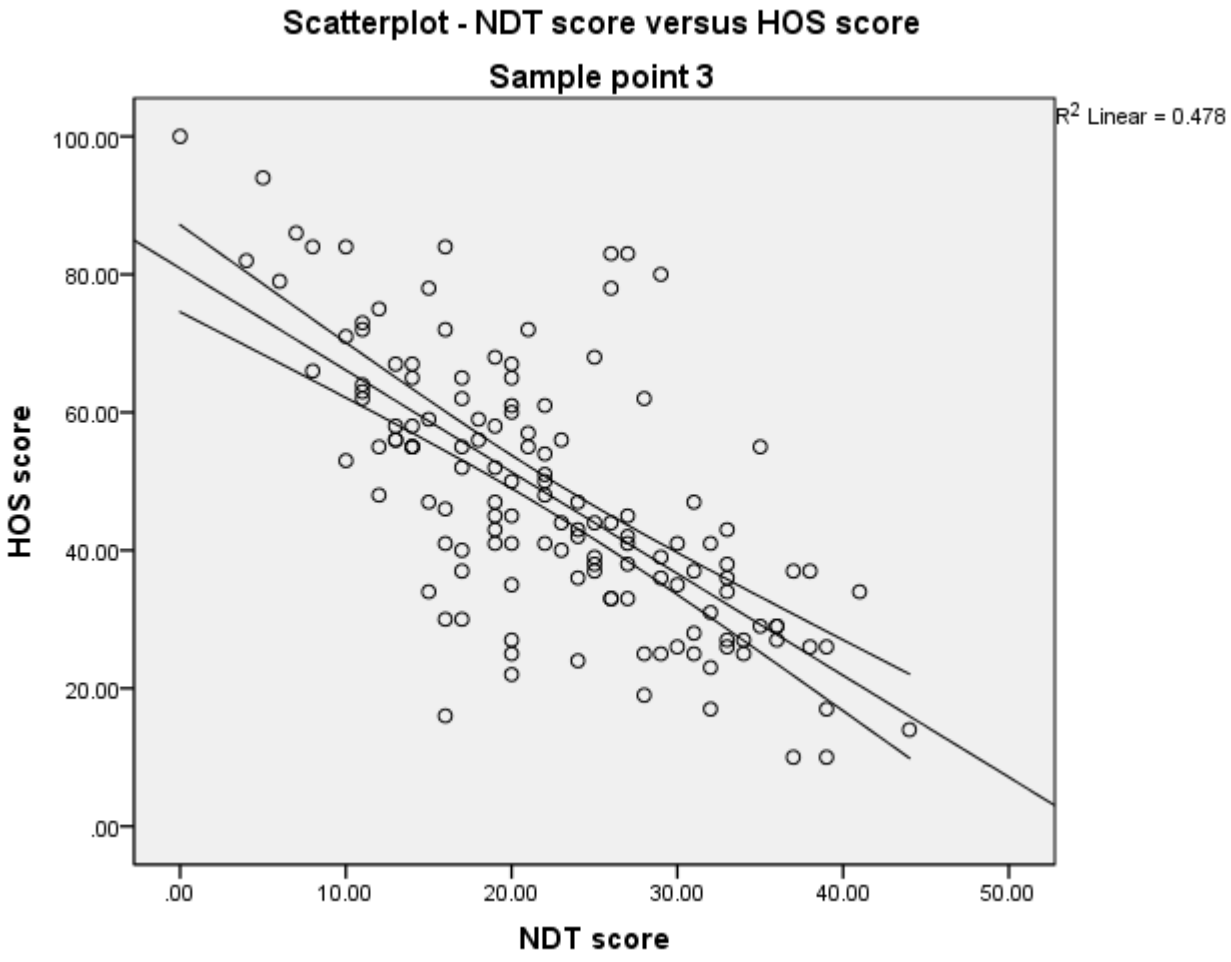


**Figure 17: Correlation between NDT scores and HOS scores at sample point 3 (n=205)**

# Appendix 3: Additional data


**Figure 18: Number of presenting needs of beneficiaries each quarter by project**

| | First reading | Second reading | Third reading |
|---|---|---|---|
| **Total / Overall** | **37.1** | **41.8** | **45.7** |
| Motivation / taking responsibility | 3.53 | 4.11 | 4.39 |
| Self-care / living skills | 3.78 | 4.34 | 4.61 |
| Managing Money | 3.41 | 3.97 | 4.35 |
| Social networks / relationships | 3.34 | 3.70 | 4.09 |
| Drug and alcohol misuse | 3.19 | 3.73 | 4.07 |
| Physical health | 3.85 | 4.15 | 4.45 |
| Emotional and Mental health | 3.07 | 3.62 | 4.04 |
| Meaningful use of time | 2.89 | 3.43 | 3.74 |
| Managing Tenancy / Accommodation | 3.27 | 3.96 | 4.38 |
| Offending | 5.01 | 5.39 | 5.99 |

**Table 3: Homelessness Outcome Star™ average scores: Base - all with at least three complete readings (n=215)**