Annual Report

Fulfilling Lives

Supporting people with multiple needs

Annual report 2017

Key insights from the past year

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April 2018

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.

About this report

This is the third annual report from the evaluation. The report covers:

- An overview of key statistics about people supported by Fulfilling Lives to date and the progress they have made.
- Frontline worker perspectives on two key aspects of working with people with multiple needs: managing caseloads and what successful move-on from the project looks like.

Who should read the report

This report will be of interest to:

- Fulfilling Lives (Multiple Needs) projects and other services working to support people with multiple needs.
- Commissioners, decision-makers and other funders of services to support people with multiple needs.
- Evaluators and researchers working to understand how people with multiple needs can best be supported.

You can find further information and reports from the evaluation at www.mcnevaluation.org.uk

Acknowledgements

The national evaluation team would like to thank the staff of the Big Lottery Fund and the members of the Evaluation Steering Group for their support and advice on this report. We would also like to thank the partnerships, service users, and other stakeholders who have collected data and participated in interviews and discussions.

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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, from for example a keyworker, service navigator or similar.

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 Outcomes 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 Outcomes Star scores are good). An interpretation of Star scores can be found in Appendix 1. The Star should be completed by beneficiaries with support from keyworkers 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.

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. 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 is doubled (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 should be completed by keyworkers 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 and background

About Fulfilling Lives

The Big Lottery Fund (the Fund) has made an eight-year investment of up to £112 million in the Fulfilling Lives: Supporting People with Multiple Needs programme. Around 60,000 people in England experience multiple and complex needs, defined as experiencing at least two of homelessness, reoffending, substance misuse and mental ill health. This not only affects their lives, but leads to significant social and economic costs associated with a failure to effectively support them. The Fulfilling Lives programme funds voluntary sector-led partnerships in 12 areas of England, who 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. They are:

- 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)
- Liverpool Waves of Hope
- Inspiring Change Manchester
- Fulfilling Lives Newcastle Gateshead
- Opportunity Nottingham
- You First (Lambeth, Southwark and Lewisham)
- Voices (Stoke on Trent)
- West Yorkshire – Finding Independence (WY-FI)

The 12 Partnerships

Map by ChrisO modified by User:Xhandler CC-BY-SA-3.0, via Wikimedia Commons

About the 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.

Method

Quantitative data

Quantitative data is collected on beneficiaries from the 12 Fulfilling Lives partnerships and from nine organisations in other areas of the country (comparison group)[1]. Data is collected using a common data framework (CDF) to ensure consistency. The CDF comprises demographic information, the type of support received, Homelessness Outcome Star™ scores and New Directions Team assessments (see Glossary on page 3 for further information). Data is submitted by the partnership to the research team on a quarterly basis. The statistics reported here show the position up to the end of September 2017.

[1] We are gathering comparable data on people with multiple needs from projects based in areas of the country (Bolton, Bournemouth, London, Sheffield and Southend-on-Sea), that are not receiving Fulfilling Lives funding. We will use this to determine what might have happened without the Big Lottery Fund investment (the counterfactual) to better attribute any change to the funding.

CDF data from projects is cleaned and collated in a SQL database. It is then exported into specialist statistical software for analysis.[2] We produced descriptive statistics on beneficiary engagement, their profile, and reasons for leaving. We also explored change over time. We used multivariate regression to explore the individual characteristics that are associated with NDT and Outcomes Star scores at baseline and with change over time. A more detailed description of the regression analysis is provided in Appendix 2.

The data is shared with the national evaluation team on the basis of the informed consent of the beneficiary. 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 of a particular project). Statistics in this report 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.

A baseline NDT assessment should be carried out at the start of beneficiary engagement and Homelessness Outcomes Star scores recorded within two months. This is not always possible however. To ensure baseline data provides an accurate reflection of the beneficiary position when they start with a project, we have only included NDT and Outcomes Star readings that have been completed within the first two months of engagement with the programme or up to one month in advance. We include readings taken in advance of engagement because some projects use the NDT as part of their assessment of beneficiary need before accepting someone onto the programme.

Qualitative data

Alongside the statistical data, we also collect more detailed qualitative information from the projects and their beneficiaries. Telephone and face-to-face interviews were conducted with between one and three staff members from each of the 12 funded projects. Interviews explored front-line staff caseloads and capacity, how and when cases are closed and what positive move-on looks like for their project. We asked to

[2] SPSS and STATA

speak to staff member with responsibility for managing frontline staff, such as team leaders and operations managers, as they were best placed to answer our questions. Interviews took place between December 2016 and February 2017 and were mainly conducted by telephone, lasting between 45 minutes to 1 hour.

Interviews were audio recorded with respondents' permission and transcribed in full. An analytical framework was created in Excel based on our research questions. Summaries of interviewee responses, along with key quotes, were recorded in this framework. This allowed us to identify patterns across projects and differences between them.

The qualitative findings as reported in chapters three and four of this report are therefore limited to the understandings, experiences and perceptions of frontline staff and those who manage them. Further research will be conducted with the projects, their beneficiaries and other stakeholders over the remainder of the evaluation to build upon this evidence base.

During 2017 we also carried out site visits to four of the funded projects (Fulfilling Lives Blackpool, Inspiring Change Manchester, Opportunity Nottingham and Voices) where we interviewed staff, stakeholders and beneficiaries or expert citizens about specific topics. The findings from these visits are reported in other publications – see below.

Related publications

This Annual Report builds on and complements our previous annual reports and other thematic reports and case studies. Other reports published in 2017 include:

- Relationships in recovery. This short report explores the role of relationships from the beneficiary point of view, particularly the relationship between themselves and their keyworker.

- Involving people with lived experience. This is a case study of the VOICES partnership in Stoke-on-Trent and their learning from developing meaningful ways to involved people with multiple needs.

All publications are available to download from http://mcnevaluation.co.uk

02. Reaching people with multiple needs: beneficiary overview

Beneficiary engagement

Up to the end of September 2017 **a total of 2,915 beneficiaries had been engaged on the programme**. Of these, 1,463 were still engaged and **1,452 cases have been closed** for a variety of reasons, for example, because the beneficiary no longer needed support or because they had disengaged. We explore reasons for closing cases in more detail in Chapter 4.

Both beneficiary engagement data and project staff indicate that **beneficiaries are staying with projects for longer than anticipated**.

> *I think [the programme] expected people to be worked with for about six months, and that is not the case. The throughput is, like, eighteen months to two years even [...]*
> **Staff member**

Beneficiaries whose case has been closed spend an average of 11 months with the programme. However, this hides wide variation between individual beneficiaries, with time spent on the project ranging from less than 1 month to over 3 years. Furthermore, these figures only relate to closed cases. **A substantial proportion of beneficiaries remain on the programme two years after first engaging**. Of the 584 beneficiaries who were engaged in the first year of the programme in 2014, 37 per cent were still engaged at September 2017.

Key reasons for this include the number of needs beneficiaries have (see page 11), the time it takes to build a trusting relationship and difficulties re-engaging beneficiaries with services that have previously refused or excluded them. A key barrier to successfully moving beneficiaries on, mentioned by many of the projects, is the lack of appropriate support services and the inadequacy of mainstream services for Fulfilling Lives beneficiaries to move on to – this is explored further in Chapters 3 and 4 (see pages 26 and 52). These issues all contribute to static caseloads and limit the number of beneficiaries that can be supported. Retaining beneficiaries for extended periods of time also risks creating dependency and raises questions about what will happen when

the programme ends. Longer turnaround times and the ability of projects to take on more beneficiaries is discussed in relation to staff caseloads in Chapter 3.

Beneficiary profile

The programme continues to successfully engage those with the most complex needs. Almost all of the funded projects are targeting those with three or four of the identified needs (homelessness, reoffending, substance misuse and mental ill-health). Most beneficiaries (where we know their needs) have at least three of the four needs (95 per cent) and just over half (51 per cent) have all four needs.

We use two key measures to assess beneficiary need and progress – the Homelessness Outcomes Star™ and the New Directions Team (NDT) assessment. See the Glossary on page 3 for further information on these measures.

The average (mean) score on the Homelessness Outcomes Star at the start of engagement is 34 (out of a maximum score of 100). This figure does vary between projects and more work needs to be done to understand reasons for this. The average (mean) NDT score at the start of engagement across all beneficiaries is 31 (out of a possible 48). Again, there is substantial variation between projects.

We held a seminar on the NDT assessment in June to help ensure staff across projects take a consistent approach to scoring the NDT. As part of this we explored possible explanations for the variation between projects. Some projects set a minimum score required to access the programme. Minimum scores are set to help ensure the project supports those with the highest level of need and / or to manage the level of referrals accepted. It was suggested that scores may sometimes be inflated in order to ensure a particular case is accepted. It was also suggested that people with lived experience of multiple needs working in frontline roles may score the NDT lower than those without, as their relative perception of risky behaviour is different given their lived experience – they may be less likely to view certain behaviours as high risk. Again, further work is needed to understand the precise combination of factors that result in variations in baseline scores between projects.

We can explore NDT and Outcome Star scores further by looking at mean scores for each component part. Figure 1 below shows the average score for each criteria on the NDT assessment. Risk to and from others are double weighted and so generally will score higher than other criteria. The average score for risk from others is higher than risk to others. The score for risk from others indicates that there is probably occurrence of abuse or exploitation, highlighting how vulnerable beneficiaries are. Of the other criteria, drug and alcohol abuse scores most highly, indicating drug or

alcohol dependence. Social effectiveness has the lowest score (lower level of need), indicating marginal social skills, sometimes creates interpersonal friction and is sometimes inappropriate.

Figure 1: Average (mean) baseline NDT scores by criteria (n=2,040)

Figure 2 provides a similar breakdown for the Outcomes Star scores. The area that beneficiaries are least likely to need support or assistance with is 'offending'. Beneficiaries may be less likely to admit to offending behaviour at the start of engagement. Areas where beneficiaries are most likely to require support are meaningful use of time and emotional and mental health. Beneficiaries at the outset of their journey with Fulfilling Lives will often be leading chaotic lives and 'meaningful use of time', whilst critical to recovery and progression, generally occurs later in the journey once immediate needs such as housing are met.

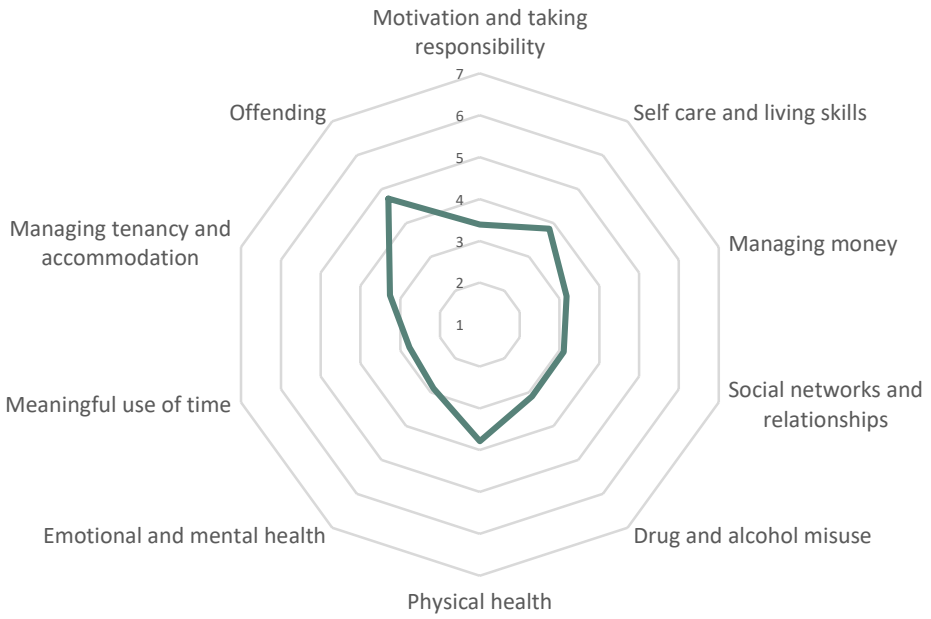

Figure 2: Average (mean) baseline Homelessness Outcomes Star scores by area (n=1,786)

Multivariate regression was used to explore how different beneficiary characteristics may be related to the levels of need at the start of engagement.[3] This analysis shows that age is negatively associated with the NDT score - as the age of the beneficiary increases the NDT score decreases. Being BME[4] is also negatively associated with the NDT score (less likely to have a high NDT score). This indicates that among Fulfilling Lives beneficiaries younger and white British beneficiaries have higher levels of need as measured by the NDT. In particular, older beneficiaries have lower levels of intentional self-harm, risk to others, better impulse control and lower housing support needs. Being female is positively associated with the NDT score – they are more likely to have a higher NDT score and thus higher levels of need. Women have higher needs in relation to self-harm (both intentional and unintentional), risk from others and stress/anxiety. Substance misuse has the largest effect on NDT scores – on average an individual with a substance misuse need at the start of engagement has an overall NDT score 4.31 points higher than someone without substance misuse.

[3] The details of this regression analysis and full tabulated correlates are presented in Appendix 2.
[4] Non-white British ethnicities were aggregated into one group due to small sample sizes.

The Outcomes Star measures slightly different things from the NDT. Our analysis shows that on the Outcomes Star age is associated with higher levels of need relating to self-care and physical health, but offending is less problematic. As with our analysis of the NDT scores, being BME is associated with better overall Outcomes Star scores, and in particular better scores for motivation, substance misuse, physical health and meaningful use of time. Sex has little effect on Outcomes Star scores, although women have better scores for managing accommodation.

The results of the regression analysis provide interesting insights into the different characteristics and needs of Fulfilling Lives beneficiaries. The analysis reported here are headline findings only at this stage. More in-depth work will be undertaken with this data, as well as using qualitative interviews to explore potential explanations for the findings above.

Beneficiary progress and outcomes

Analysis of change over time has shown significant improvements. **Beneficiaries who have remained engaged on the programme for approximately two years show a clear reduction in risk and need** as measured by the NDT assessment. For those with complete scores both at baseline and roughly two years later (between 22 and 26 months, n=283) average (mean) NDT scores drop from 32.8 to 22.4. This shows that, on average, beneficiaries are moving away from high risk and need levels. For reference, a score of around 12 would indicate more minor concerns and that the beneficiary has developed coping and social skills.

On the Homelessness Outcomes Star, there is an increase from an average (mean) score of 33 to 44.6 (n=221). On the journey of change (see Appendix 1) this indicates beneficiaries are moving from recognising they need help to accepting it. This change, while positive, is still some way from being 'self-reliant'.

The average changes on both the NDT and Outcomes Star scores indicate that while **positive change is occurring, progress is slow and beneficiary needs remains high for many**. Projects suggest that initially rapid progress is made with beneficiaries but then tends to plateau out. Further analysis is needed of NDT and Outcomes Star scores to explore these perceptions further.

Looking at component parts of the scores helps to illuminate where most and least progress has been made. Figure 5 shows NDT scores for each criteria at start and approximately two years on. Proportionately, least change has happened in regard to reducing risk of intentional self-harm (including long term destructive behaviour whilst aware of risks), alcohol and drug abuse, and social effectiveness. The first two

criteria are clearly connected and substance misuse in particular can take longer to address than some other needs. Greatest change has occurred in addressing risk to others and engaging with services.

Figure 5: Mean NDT assessment scores by criteria at start of engagement and approximately two years later (n=283)

Looking at Outcomes Star scores, progress is broadly similar across most areas. Most progress has been made on offending and managing tenancy and accommodation. Projects will often focus on addressing housing needs in the first instance, and several are piloting a Housing First[5] approach.

[5] Housing First is an internationally evidence-based approach, which uses independent, stable housing as a platform to enable individuals with multiple and complex needs to begin recovery and move away from homelessness. See http://hfe.homeless.org.uk/about-housing-first for further information. Our 2016 Annual Report indicated that Fulfilling Lives Camden and Islington, Inspiring Change Manchester, Fulfilling Lives Newcastle and Gateshead and Voices (Stoke-on-Trent) were all exploring the use of Housing First as an approach.

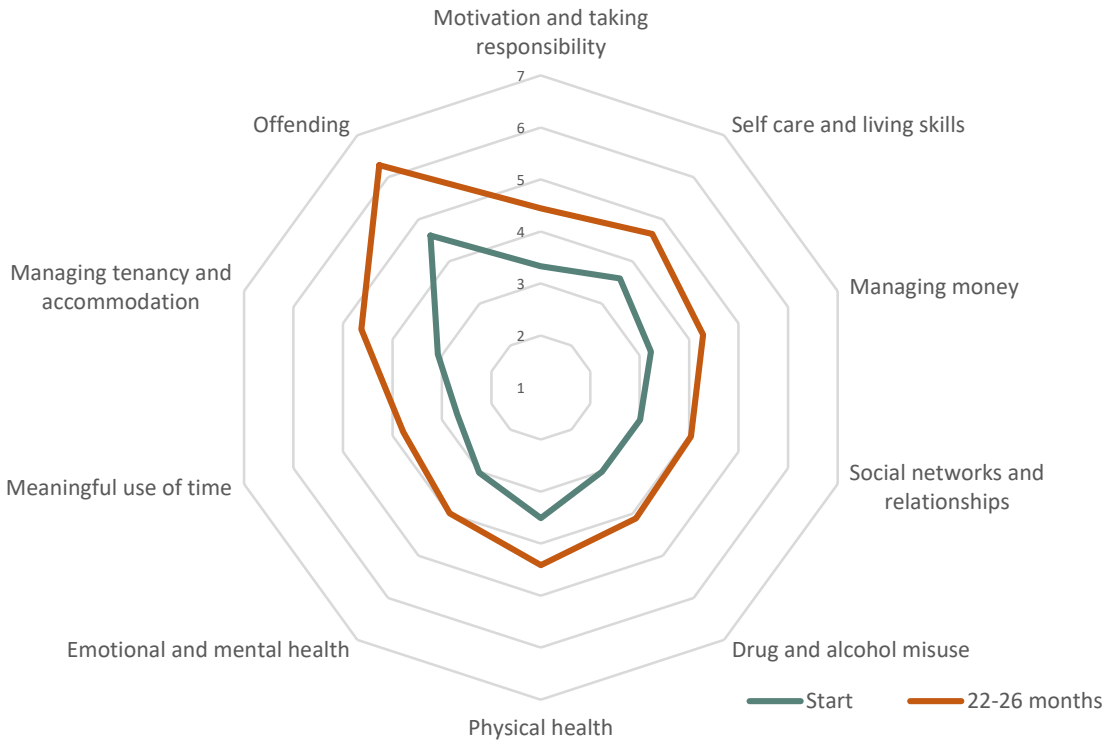

Figure 6: Mean Homelessness Outcomes Star scores by area at start of engagement and approximately two years later (n=221)

Looking at average scores and overall trends is likely to hide nuances in individual journeys and variations between projects. There is more to be done to understand beneficiary progress and how this varies according to different beneficiary characteristics and the support they receive.

03. Frontline perspectives: Managing caseload complexity

Introduction

Our evaluation findings to date[6], as well as other literature on supporting people with multiple needs[7] highlight the importance of building a trusting relationship between keyworker and service user. However, service users often find it difficult to trust professionals due to prior negative experiences with services.[8] Lack of trust can also be attributed to past traumatic experiences. As a result, trusting relationships are likely to take time to develop.[9] Many of the Fulfilling Lives projects were based on the theory that providing staff with smaller caseloads would allow them the necessary time to provide more personalised and better quality support, which in turn would lead to better outcomes. This theory is supported by other evidence that high or heavy caseloads, due to limited resources and high demand, can damage the quality of care provided.[10] A recent evaluation of family intervention projects suggests that intensive support from keyworkers with small caseloads is effective for individuals and families with multiple and complex needs.[11] However, what was considered to be a low caseload was not clearly defined by many projects at the onset.

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[6] CFE Research (2016) *Fulfilling Lives: Supporting people with multiple needs – Annual report of the national evaluation* http://mcnevaluation.co.uk/wpfb-file/fulfilling-lives-multiple-needs-evaluation-annual-report-2016-pdf/

[7] Diamond, A. Adamson, J. Moreton, R. and others (2014) *Multiple and Complex Needs – a Rapid Evidence Assessment* http://mcnevaluation.co.uk/wpfb-file/fulfilling-lives-multiple-complex-needs-rapid-evidence-assessment-pdf/

[8] Rosengard, A. Laing, A. and Hunter, S. (2007) *A Literature Review on Multiple and Complex Needs* Scottish Executive Social Research http://www.gov.scot/Resource/Doc/163153/0044343.pdf

[9] Macias Balda, M. (2016) Complex Needs or Simplistic Approaches? Homelessness Services and People with Complex Needs in Edinburgh. In *Social Inclusion* Vol 4, No 4 pp 28-38 https://www.cogitatiopress.com/socialinclusion/article/view/596

[10] Anderson, S (no date) *Complex Responses: Understanding poor frontline responses to adults with multiple needs: A review of the literature and analysis of contributing factors* Revolving Doors Agency http://www.revolving-doors.org.uk/file/1796/download?token=pZa0cCm3

[11] Hoggett, J. and Frost, E. (2017) The troubled families programme and the problems of success. *Social Policy and Society* 1-2 https://doi.org/10.1017/S1474746417000148

Caseload levels

At the time of the staff interviews, frontline staff **caseloads across the programme ranged from 6 to 15**. Table 1 overleaf shows estimated caseload ranges for each project. Caseload levels vary by project and job role; less experienced staff such as trainees and assistants generally have smaller caseloads than more senior and experienced staff. Different job roles also provide different levels and types of support. Across the 12 projects, the different keyworker roles provide varying levels of support. Some projects focus on guiding beneficiaries through the system, securing and co-ordinating the package of support services beneficiaries need (service coordinator role). In others, the keyworker role is more focused on providing that support themselves (support worker role). Where the emphasis lies is likely to impact on the level of caseload that is manageable. We include in the table whether the keyworker role is predominantly that of support worker or service coordinator (or both) – this is based on information collected from projects for our 2016 annual report. The evidence from interviews suggests providing service coordination is not necessarily any less time-consuming than providing support direct to beneficiaries (this is explored later in the report). The reality is that there is often some degree of overlap between the two types of role.

Caseloads of organisations that are part of our comparison study (see page 7) range from 8 to 25 clients per keyworker. As a further comparison, a recent report on the Housing First approach by Homeless Link suggested that the average caseload of traditional floating support workers is in the range of 20 to 40.[12] In this regard Fulfilling Lives projects have substantially lower caseloads than other types of support for people with multiple needs. However, staff interviewees generally agreed that **the optimal caseload for working with people with multiple needs was between six and ten beneficiaries. Half of the projects at the time appeared to have caseloads that exceed this**. Interviewees generally felt a caseload of between six and ten was needed to ensure that beneficiaries receive the level of support that they require at a level that workers can maintain. We plan to further our understanding of this by exploring whether lower caseload levels are associated with improved beneficiary outcomes and progression.

[12] Homeless Link (2016) *Housing First in England: The Principles* Homeless Link http://www.homeless.org.uk/sites/default/files/site-attachments/Housing%20First%20in%20England%20The%20Principles.pdf

Project	Support workers or Service coordinators	Role	Actual caseload levels	Suggested optimum caseload
Birmingham	Support workers	Lead workers (newer staff have a smaller caseload)	10 – 12	6 to 8
Blackpool	Service coordinators	Navigators	12 – 16	10
		Assistant navigators	5 – 6	
Bristol	Service coordinators	Navigators	12 – 14	Max. 15
Camden & Islington	Both	Link worker	8 – 12	6 - 8
Lambeth, Lewisham & Southwark	Service coordinators	Keyworkers	7	12 - 14
Liverpool	Support workers	Support workers	6 – 8	6 - 8
Manchester	Service coordinators	Engagement worker (Assistant workers have a smaller caseload)	15	10
		GROW trainee	3 – 6	
Newcastle & Gateshead	Service coordinators	Navigator Level 1	10	10 - 12
		Navigator Level 2	6	
Nottingham	Both	Personal Development Co-ordinators	7 – 15	4 - 8
South East	Support workers	Specialist workers	8 – 9	8 - 9
Stoke-on-Trent	Service coordinators	Service Coordinators	7	7 - 10
West Yorkshire	Service coordinators	Navigators	9 - 12	10

Table 1: Actual and suggested optimal caseloads for different roles across projects.

The caseload levels in Table 1 generally relate to the number of beneficiaries requiring intensive support from the Fulfilling Lives project. By intensive support we mean providing frequent and holistic support on a variety of complex needs. This might

involve regularly supporting a beneficiary to prepare for and attend a medical, housing or criminal justice appointment and advocating on the beneficiary's behalf in order to secure support for them. Providing intensive support can sometimes mean staff spend a full day or longer on a particular case. The Fulfilling Lives programme targets those with the most complex needs who are disengaged from services. As a result we expect all beneficiaries to require intensive support at some point in their journey.

Interviewees highlighted that support is often at its most intense at the start of beneficiary engagement as they are likely to have multiple pressing needs, be particularly chaotic and getting the necessary services in place can take a great deal of time and effort. As a result, newer cases may take up more of a keyworker's time. Once a support package is in place and immediate needs (such as housing) addressed, the need for intensive support should, in theory at least, reduce. However, more intensive work may also be required at other times, for example, if the beneficiary faces a crisis, relapse or change in circumstances such as being discharged from hospital.

As beneficiaries progress along their recovery journey, develop trust with staff and engage with services, the support required from projects often reduces. Beneficiaries requiring less intensive support may be supported by more junior staff members, trainees or peer mentors under the supervision of a keyworker/navigator. Peer mentors are individuals with lived experience of multiple needs who use this to support others. Peer mentors can provide empathetic understanding of beneficiaries' experiences, help to build trust and act as positive role models.[13] The role of a peer mentor differs across the programme but often focuses on providing a beneficiary with emotional support and encouraging them to build social relationships and take part in activities. In some instances peers will support beneficiaries to attend appointments too. In some projects beneficiaries supported by peer mentors are not considered to be part of the active caseload for a frontline worker.

Projects may also have inactive or dormant cases on their books. For example, in West Yorkshire, navigators have an average of 9 to 12 active cases but a further 14 to 16 inactive cases assigned to them at any one time. A key feature of Fulfilling Lives projects is a commitment not to sign-off, exclude or give-up trying to work with a

[13] Robinson, S. (2017) *Relationships in Recovery* CFE Research http://mcnevaluation.co.uk/wpfb-file/2017-relationships-in-recovery-final-pdf/ Terry, L and Cardwell, V. (2016) Understanding the whole person: Part One of a series of literature reviews on severe and multiple disadvantage. Revolving Doors Agency. http://www.revolving-doors.org.uk/file/1845/download?token=3jprn2sc

beneficiary. Instead, some cases become inactive or dormant. This can include beneficiaries who:

- are not currently actively engaging with their keyworker/navigator but still require support – these cases may become active when the individual is ready to re-engage
- have progressed through recovery and are now in training or undertaking volunteering – these beneficiaries are often kept on the caseload as experience has shown they may still relapse during the later stages of recovery, or
- are in prison or hospital for a relatively short time.

Case closure and the impact of keeping cases open for longer is explored in more detail in Chapter 4.

Factors affecting caseloads

Only a third of projects stated that their caseloads have remained stable since they began. **Caseload levels and the amount of work that a particular case generates can also change rapidly** - for this reason caseloads are generally expressed as ranges in Table 1.

The key factors that affect caseload levels reported by interviewees are difficulties in recruiting and retaining staff, higher than expected numbers of referrals and longer turnaround times. The workload generated by cases is also affected by the complexity of cases, changes in levels of beneficiary need and wider system failings and frustrations. In this section we explore some of the key factors that affect caseload levels, with suggestions for tackling these explored later in the chapter.

Staff vacancies

> *We've only ever had a very short period of time where we've been at staffing capacity…*
> **Staff member**

Not having a full complement of staff was a major reason for increased or higher than ideal caseloads in several projects. Reasons given for high levels of staff turnover and difficulties filling vacancies include:

- Availability of career progression opportunities in the local area
- A shortage of experienced workers

- Demanding and stressful nature of the work
- Navigator roles within the programme require a different way of working to mainstream services and some staff find that the role is not for them.[14]

Given the nature of the role, recruitment and retention can be challenging. There is a risk that staff working with high caseloads of chaotic people become demotivated, sick with stress or leave. Some projects are employing temporary 'bank staff' to support their teams in the interim. In addition, senior managers are also taking on cases to help ease capacity. While these provide interim solutions, they are not necessarily sustainable and are arguably not the best way to provide the kind of personalised and consistent support that we know beneficiaries value.[15]

To address capacity issues some projects are also looking at recruiting additional staff. However, projects have finite resources and there is a limit to how far staff numbers can be extended, particularly as larger staff teams have implications for the infrastructure needed to support them (such as line management).

High demand

> *We could take on billions of [keyworkers], if we did that, we'd have endless amounts of clients. Longer-term, it wouldn't really solve the issues. We're taking up the lack of capacity in the system.*
> **Staff member**

Caseload levels have increased as more referrals are generated due to the programme becoming better known among local services. However, demand for some projects exceeds their original projections. System failures and austerity are also perceived by many of the project staff interviewed to have increased demand for support from the programme.

There has historically been a lack of robust evidence as to the size of the population with multiple needs. Challenges in measuring the scale of the problem include a lack of consistent definitions of multiple and complex needs and the fact data on the different

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[14] The Fulfilling Lives way of working can be a culture shock for some in the sector who are used to working in a more process-drive way with clear parameters. Further information on this topic can be found within the South East Partnership case study: http://mcnevaluation.co.uk/wpfb-file/the-role-of-specialist-womens-workers-sep-case-study-pdf/

[15] Robinson, S. (2017) *Relationships in Recovery* CFE Research http://mcnevaluation.co.uk/wpfb-file/2017-relationships-in-recovery-final-pdf/

areas of need of rarely joined up. The Hard Edges[16] report, published after the projects began, took important steps in providing a statistical profile of multiple needs, but also acknowledges that some groups (such as women and minority ethnic groups) may be under-represented in the analysis. Projects relied on the best available data when planning their service and staffing models. Three years into the programme **the demand for support in some cases is exceeding initial estimates**. This suggests that the number of people with multiple needs is larger than originally estimated.

> *I don't really think it was recognised just how many people out there met the threshold for this service within the city.*
> **Staff member**

Interviewees also felt that the austere public funding environment is affecting demand for support from the project. While there is evidence which suggests that increases in rates of homelessness have been linked to reductions in government welfare spending in the past[17], further evidence is needed to support a link between austerity and demand for support from Fulfilling Lives. Some project staff felt that mainstream services do not always provide the level of support required and this increases the workload for Fulfilling Lives staff. This includes services not having sufficient flexibility in how services are delivered to appropriately support those with the most entrenched needs but also a perception that services did not always follow-through with their commitments to provide support.

> *Other agencies [are] putting a lot on us, [they] say they'll deal with it and a lot of the time that's not true.*
> **Staff member**

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[16] Bramley, G. and Fitzpatrick, S. (2015) *Hard Edges: Mapping severe and* multiple disadvantage Lankelly Chase Foundation http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/

[17] Loopstra, R. Reeves, A. Barr, B. Taylor-Robinson, D. McKee, M. and Stuckler, D. (2016) The impact of economic downturns and budget cuts on homelessness claim rates across 323 local authorities in England, 2004-2012. in *Journal of Public Health*, Vol 38 Issue 3 pp 417-425 https://doi.org/10.1093/pubmed/fdv126

Pressure to reduce support for people is said to create additional burdens for Fulfilling Lives projects that deal with the consequences and are picking up the lack of capacity elsewhere in the system.

The remit of the programme was to engage, support, advocate and navigate beneficiaries through the system, and to improve the way the system works. It was not designed to provide services directly. If mainstream services expect the programme to pick up their most complex cases, this will inevitably impact on workloads. This also highlights the importance of addressing wider service provision and systems change if the programme is to leave a sustainable legacy. Otherwise, once the programme comes to an end it is unclear where the necessary support for those with multiple needs will come from.

Longer turnaround times

As discussed in Chapter 2, beneficiaries are spending longer with projects than originally anticipated. While some projects anticipated keeping beneficiaries on their caseload for indefinite periods of time, others based their staffing and caseload models on assumptions about turnaround times. The extended length of time beneficiaries spend on the programme has meant that some projects risk increasing the caseloads of their frontline team. Some projects have decided to focus on increasing the throughput of beneficiaries, thus reducing the time they are with the programme. In order to do this, staff focus on engaging a beneficiary with mainstream service provision as soon as possible and work to ensure they have less reliance on the project.

There are risks with this approach. Beneficiaries may not build sufficiently strong relationships with mainstream service provision – particularly where staff have less time for beneficiary contact than Fulfilling Lives. Moving an individual on from a project too soon could lead to the need to re-engage with Fulfilling Lives. However, just six per cent (91) of all closed cases have been re-opened to date, which suggests this is not routinely happening. Also, focusing on achieving rapid throughput appears to replicate the target-driven culture of the current system – a key barrier to achieving a person-centred approach that the programme aims to address. We explore the some of the issues relating to closing cases and moving beneficiaries on to other support in chapter 4. But it will be useful to continue to explore further the timescales involved in supporting beneficiaries, the factors that affect this and the barriers and enablers to successfully moving beneficiaries on. Further analysis is needed to determine the extent to which moving beneficiaries on to mainstream services more quickly is effective.

Complex and time-consuming cases

Whether a caseload is high or at an optimum level there are still factors that make managing them challenging and add to the overall workload generated by a particular case. The beneficiary journey is rarely linear. Both inactive and low level support cases can revert to needing intensive support, which in turn affects caseloads. **Projects can see manageable caseloads quickly become unsustainable when inactive cases re-engage or a low level support case hits a crisis**, for example, by losing their housing, being arrested or experiencing an episode of domestic abuse or violence.

Demand for support from beneficiaries can vary on a case by case and week by week basis and can require extended periods of time from keyworkers ranging from a few hours to a whole week. Several projects highlighted the importance of having sufficient capacity to be able to meet these varying demands and that it was not always possible to plan ahead. **Staff often need to spend extended periods of time with a beneficiary.**

> *Clients don't necessarily need frequent appointments during the week, but they probably need really long appointments, so we need to have the capacity to possibly spend half a day or a whole day with one person.*
> **Staff member**

Projects gave a range of examples of instances where individual cases required extended and/or intensive support, often without much in the way of warning. This encompassed deteriorations in mental health (including being suicidal), worsening physical health, being evicted or threatened with eviction, arrest and attendance at court.

> *A decline in physical health, mental health, someone suddenly having no money, someone being threatened by drug dealers, all of that is pretty normal.*
> **Staff member**

Projects also reported high demand for attending appointments alongside beneficiaries. This is a key part of building trust and engagement but also of advocating on behalf of beneficiaries. Accompanying beneficiaries to hospital, treatment centres or court is often very time-consuming and can involve a substantial amount of travel time. One project highlighted the challenges of supporting beneficiaries who were placed in temporary housing outside of the project area where transport options were limited. Travel time can be particularly substantial for projects covering wide geographical areas.

Our district is quite large geographically. […] So, if you make four trips across the district, that's your 100 miles quite easily done.
Staff member

The lack of capacity and co-ordination elsewhere in the system is also said to add to the workload and the time needed to support individual cases. An important part of the keyworker role, especially those providing service coordination, is negotiating access to services for beneficiaries. This can be particularly time consuming.

The conversations with services, getting services to pick up the phone, to answer emails, going to places. That is a big proportion of the service coordinator's time.
Staff member

Gaining access to GP services, accessing mental health assessments, securing suitable housing and problems created by delayed or cancelled benefit payments were all mentioned as issues that can take a considerable amount of time to deal with. For example, one interviewee outlined some of the challenges in supporting a beneficiary with mental health problems to make a benefits claim:

When she actually finally got the letter to go for a medical […] it was over on the other side of [the city] on a Saturday morning. […] When [the staff and beneficiary] got there, the assessment team doing the medicals were so busy, that the staff said, 'Look, we've overbooked, we have booked in fifteen people, we can only see ten, you're going to have to go, we will send you another appointment.'
Staff member

Managing and supporting service users with transition, for example leaving prison, being discharged from hospital or being evicted, also often makes major demands on staff time, especially if it happens at short notice or before the beneficiary is ready, as illustrated by the example given below.

Yesterday then, for example, this is why I didn't get home 'til half past six, we had a lady that was discharged from a psychiatric hospital […] back to a flat that had no electricity. […] This poor woman, who's given a taxi back to [location], no money because her benefits have stopped because she's been in hospital for three weeks, no furniture in the flat, no electricity in the flat,

terrified of the flat because the door was kicked in the last time she was in there.
Staff member

Negative attitudes of some service providers and a tendency to pass responsibility were also reported to create challenges. Some projects spoke of how their staff were often called upon to support other services manage beneficiary behaviour.

Sometimes, with the chaotic behaviour, it's all about negotiating with other agencies, and helping other agencies to manage that behaviour. […] If somebody's up at A&E, for example, and kicking off, our staff are asked to go up to help keep them calm. So, that can be six, seven hour stint up at the hospital.
Staff member

One example shows how taking steps to empower beneficiaries can also be time-consuming as they face the additional barrier of stigma when engaging with service providers. In this instance, the beneficiary had spent a long time on the telephone trying to arrange a period of extended support from their GP after moving out of the area. Getting nowhere, the keyworker took over the call and resolved the problem almost immediately.

Other than the stigma, I failed to see how the two interactions were different… that's the kind of effort that is having to be put in, to overcome problems that the system is creating by just passing people around.
Staff member

Again, the challenges faced by projects emphasise the importance of the work they are doing to address local systems barriers, including supporting wider workforce development to ensure staff in a range of healthcare, housing and criminal justice services are better able to support people with multiple needs. The examples given also highlight more general inefficiencies in services that affect all who use them and not just people with multiple needs.

Impact of higher caseloads

The following section examines how higher than ideal caseloads of complex or demanding cases can affect staff, beneficiaries and management processes.

Impact on support for beneficiaries

Higher than optimum caseloads limits a project's ability to provide flexibility, responsiveness and full and holistic support to their beneficiaries. Time for each individual becomes restricted and in most projects the decision is made to prioritise those cases that are the most urgent, complex or in need, often at the expense of contact time with other beneficiaries.

> *[When dealing with urgent/complex cases] it can take up to a week or two of your time, so that means a lot of your other beneficiaries you kind of put on the backburner.*
> **Staff member**

> *[When prioritizing cases] those clients who may be reasonably stable, doing alright but not particularly thriving, but not about to get evicted, not in immediate crisis, they can maybe get neglected and stuck if your attention is always on firefighting.*
> **Staff member**

This can mean that, in some instances, beneficiaries are unable to see their assigned keyworker. In turn, this may prolong their recovery journey or in some cases, see them disengage entirely. Our report Relationships in Recovery[18] explores the importance of maintaining consistent keyworker relationships. In the report we highlight how a close relationship with their keyworker helps beneficiaries to grow in self-confidence and reflect on negative behaviours. As stated earlier, trusting relationships can take time to develop and changes in keyworker could delay this important process further.

The Relationships in Recovery report also describes how beneficiaries value the fact Fulfilling Lives keyworkers take time to listen and get to know them. They contrast this with other services where they saw less of staff. Other research also highlights the importance of specialist staff having more time for empathetic listening.[19] Having this

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[18] Robinson, S. (2017) *Relationships in Recovery* CFE Research http://mcnevaluation.co.uk/wpfb-file/2017-relationships-in-recovery-final-pdf/
[19] Bilton, H. (2009) *Happiness Matters: Homeless people's views about breaking the link between homelessness and mental ill health* London: St Mungo's https://www.mungos.org/publication/happiness-matters-homeless-peoples-views-breaking-link-homelessness-mental-ill-health/

time is a key feature of Fulfilling Lives, and it is important that it is not sacrificed due to high workloads.

According to projects, **the type of support that can be offered also changes when caseloads increase – it becomes less person-centred and more akin to 'generic floating support'**. Staff are unable to provide non-urgent support or assist beneficiaries to make meaningful use of their time and to engage in longer-term, low level support – which they all agree is vital to recovery.

> *Unfortunately when staff are trying to manage their diaries, if they've got to prioritise what would be so detrimental to a client if they didn't attend. Well actually would it be really detrimental if they weren't available to support them to an NA (Narcotics Anonymous) group? No. So unfortunately, what we feel we were originally intended to be able to do, we don't feel like we're achieving that 100 per cent just because of the demand for service.*
> **Staff member**

Consequently, beneficiaries may disengage if they feel services are not fully supporting their needs. This then limits the ability of the programme to evidence how providing a different model of support is more effective than mainstream services.

> *If we can't offer the intensive support because the caseloads have gone higher they won't engage.*
> **Staff member**

A particular concern for some projects is that when a beneficiary experiences an emergency or crisis they will not be engaged enough to request help or the staff will not have enough time to be able to address it sufficiently. Consequently, they are less able to manage risk or reduce instances of harm.

Engaging new referrals can also be affected by large caseloads. Most referrals must be 'found' through outreach. This can take a considerable amount of time, walking around the area and making enquiries. If a project is at or over capacity, the time to do this may simply not be available. This could affect a project's ability to reach those who are the most disengaged from services.

Impact on staff health and wellbeing

Working with this complex and needy group of beneficiaries is demanding and stressful, and staff are at risk of 'burn out'. **There may be an increased likelihood**

that staff working with high caseloads of chaotic people become sick with stress or leave.

> *[The] result of the early experience of increasing the caseloads as people came on board [was] reflected in our staff turnover, which was high in the early days. We lost a lot of people in the first twelve months.*
> **Staff member**

High staff turnover creates a vicious circle, where caseloads for remaining staff increase as beneficiaries are assigned to them. This also affects the ability of staff to build long-term relationships and trust with beneficiaries. Morale of the team can be dented and this may negatively affect feelings about the job and beneficiaries.

> *It means… staff will become tired and frazzled and potentially burnt out. When people get like that, obviously we've seen it occasionally within our own team, you start to get negativity about the job and about the client group creeping in.*
> **Staff member**

High turnover also affects managers and working long hours is clearly bad for maintaining a good work-life balance.

> *So, since June [I have] been responsible for 12/13 staff members, that's not sustainable….I've had to write off however many hours of flex…the impact that has on my family life…my children, never being at home.*
> **Staff member**

One project stated that higher caseloads restricted staff ability to gather and validate data for the evaluation. Collecting robust data is important in order to provide evidence to commissioners and policy-makers and projects need to ensure that there is sufficient capacity to ensure this is not side-lined.

The impact of high and changing caseload levels on staff turnover and morale, as well as client engagement and recovery, means that projects must continually find ways to manage caseloads and staff capacity. The following section examines some of the ways projects are addressing this.

Managing caseloads

In order to address the challenges outlined above projects implement a number of approaches to help manage staff capacity and balance caseloads; this includes frequent reviews of caseloads and beneficiary needs, prioritisation and tiered support offers.

Reviewing caseloads

Reviewing caseloads is key to managing staff capacity. The frequency with which projects do this varies from daily to quarterly. Levels of need, chaos, risk and engagement are assessed and recorded in a variety of ways, including points and traffic light systems. This allows projects to see how complex or demanding a keyworker's caseload is. One project strongly advocated for daily reviews as circumstances can change rapidly:

> *This [monitoring system] changes daily. Staff will come in from seeing a client and will say, 'Look, I need to put as much aside this week as possible. This person's in crisis. They've had a huge relapse.' It might be that if [the keyworker has] just been allocated a new referral the day before and haven't yet done anything with it yet, we'll swap it over to someone else.*
> **Staff member**

Some projects will assign keyworkers on the basis of who they feel a beneficiary will get on best with. This can be positive in relation to relationship building and the ability for staff to work closely with specific areas of mainstream services. However, this can lead to imbalanced caseloads. One project found this resulted in some staff members having higher caseloads, or more complex caseloads.

> *When we analyse[d] people's caseloads…we were like, 'Oh look, he's got the long-term entrenched homeless people with alcohol issues.' Another worker had lots of women who had personality disorders who were very chaotic. Someone else had a caseload that was mainly young people….some of the team may work with a slightly easier caseload, but actually, that isn't that fair.*
> **Staff member**

Reviewing caseloads allows projects to reassign beneficiaries if necessary and one option for some is to reduce the level of support for those beneficiaries who no longer require intensive support. Providing lighter-touch support, for example from a peer mentor, is used by some projects to create a phased transition from the programme.

Tiered support

In order to balance the needs of the beneficiaries with staff capacity a number of projects provide a tiered support offer. Beneficiaries with less intensive support needs, although still assigned to a specific worker, may receive support from a peer mentor or through access to a drop-in centre/hub. The drop-in centres/hubs provide access to support from trained staff but also essential social opportunities thus minimizing isolation.

> *It means that people are interacting with positive peer groups… people are getting that social interaction with a counsellor on hand as well. So, if they do have problems, there are people there that we've commissioned in to provide counselling and coaching for them too.*
> **Staff member**

As noted in our Relationships in recover report[20], reducing social isolation and providing positive peer relationships helps beneficiaries start to develop their own support systems outside of services. This is important in encouraging beneficiaries to become self-reliant and move towards leaving the programme.

Reviewing referral processes

The main response to dealing with higher than anticipated demand has been to review referral processes. This has led to changes such as introducing screening, amending eligibility criteria and instigating a pause on new referrals.

In some areas the senior management team have reviewed the criteria for acceptance onto their project in order to prioritise individuals with the highest levels of need. Projects generally adopt some simple criteria for acceptance onto the programme. These include meeting the Big Lottery Fund definition of multiple needs, not engaging with services and minimum scores on the New Directions Team (NDT) assessment. At least two projects have raised the minimum NDT score required in order to ensure caseloads remain manageable.

Some of the high demand for the programme stems from inappropriate referrals – people who may already be engaged with services or do not meet project criteria. Some

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[20] Robinson, S. (2017) *Relationships in Recovery* CFE Research http://mcnevaluation.co.uk/wpfb-file/2017-relationships-in-recovery-final-pdf/

projects explained how referrers will often provide incomplete or over-exaggerated detail on referral forms in a bid to secure acceptance onto the programme. To address this issue some projects have introduced screening procedures whereby a team member reviews referrals before they are submitted to the referral committee or panel. Requesting further detail from referral agencies can often help to reduce inappropriate referrals.

> *Quite often we'll receive a referral and there'll be poor information on there, as easy and basic as our form is. Especially agencies that are trying to squeeze through inappropriate referrals. They'll be a bit vague and hazy. [We'll go back to the referrer and say] 'We need more information on this, this and this. Can we clarify this?' and they've never got back to us.*
> **Staff member**

Most projects have an open referral system, where referrals can be made at any time. However, in order to deal with demand a few have implemented a stop on accepting new referrals on to the programme for a period of time. This allows staff time to work with current caseloads and reduce beneficiary support needs where possible. Where projects do not want to completely turn away people who meet the criteria, waiting lists are created. However, one project reflected that waiting lists are not helpful because they are unable to find those referred once there was space on the programme.

> *Last time we had the waiting list…it was really apparent how [it] absolutely doesn't work. The clients, they don't wait. They disappear, they go to prison, one of them died.*
> **Staff member**

It is important to make the most of windows of opportunity to engage beneficiaries when they are open to change and support. Placing someone on a waiting list means this often narrow window may be missed.

A small number of projects have never had a completely open referral process but only accept referrals at particular times. This was intended to help control the flow of referrals and manage staff caseloads. For one of the projects this been an effective way to manage demand - once they hit capacity with staff caseloads referrals are only opened up when there is space. Another project using the approach has been short staffed and so has not necessarily benefited as much.

Managing referrals through placing stops on new referrals or having specific referral windows appear to offer effective ways of managing caseload sizes to ensure they

remain manageable. However, the fact that such mechanisms are required further supports the suggestion that demand is greater than what the projects are able to meet. It is not clear what happens to those potential beneficiaries that are in need of support but do not get referred because projects are closed to new cases.

Staffing model solutions

Projects have used a number of different staffing models to address high or challenging caseloads, these include: support from peers with lived experience of multiple needs, traineeships and doubling up on keyworkers.

Peer support

Peer mentors offer a way of boosting staff capacity as well as providing empathetic support for beneficiaries. In some areas, peer mentors support keyworkers by undertaking less demanding tasks, freeing-up keyworker capacity to work on the more complicated elements (paperwork, initial liaison with services). For example, in one project each navigator is assigned a full-time peer mentor with lived experience. The peer mentor does not have their own caseload but supports the navigator. The level and type of support provided varies according to where the mentor is on their own recovery journey. Not all will have the skills or confidence to work directly with beneficiaries and so are more likely to provide administrative support. Typically peer mentors will support beneficiaries that are less chaotic.

> *[They help out] with phone calls, benefits and stuff where it's meeting people for a coffee, case finding and stuff like that. So it can free the navigator up to do the more complex stuff.*
> **Staff member**

One project recruited two managers – one to oversee keyworkers and the other peer mentors. This provided flex in the management structure to cover leave and sickness. However, as peers and keyworkers work together with the same beneficiaries, the project has found it was more efficient for a manager to receive views from both the keyworker and the peer on cases. The project is considering reviewing the management arrangements based on this learning.

Lived experience traineeships

Some projects provide opportunities for people with lived experience to become trained keyworkers. Although they have much smaller caseloads than keyworkers, **projects have found trainees useful in increasing team capacity**. Trainees are typically assigned less chaotic/lower risk beneficiaries to work with. As the programme

has developed trainees have asked to work with more chaotic beneficiaries and projects have begun to provide this opportunity.

Traineeships also provide valuable development opportunities to people with lived experience, a key principle of the programme. However, it should also be noted that a few projects have learnt that **trainees require considerable levels of support from staff and having too many trainees can adversely affect capacity.** As a result, one project is reducing the number of trainee roles they provide.

> *We've realised that they need a lot more intensive support. We haven't been treating them as well as we should have done, in terms of the level of training and support that they've been given. The caseloads have been high, they've been having to just muck on and get on straight away. So, we've recognised that they need more support and better management than they've been getting. So, it's going to be four, and then it's going to be three.*
> **Staff member**

Doubling up keyworkers

A potentially promising approach from at least a couple of projects is assigning beneficiaries a secondary keyworker as well as their lead keyworker. This has a number of benefits for both the beneficiary and managing capacity. Beneficiaries have two keyworkers who they will know and build a relationship with – both will understand their case and needs. If one keyworker is unavailable, the beneficiary will be less likely to have to deal with someone they do not know. From an operational point of view, managers have two staff members who can work with a beneficiary; this provides them with resource to cover sickness, training, annual leave etc. as well as providing flex in staff caseload capacity and helps to manage risk in the most complex cases. Additionally, from the keyworker's point of view, they have a peer to discuss the case with; they can share ideas and consider approaches.

> *They've all naturally got another navigator who they work alongside within their organisation, and I think they get a lot of peer support from one another.*
> **Staff member**

Supporting staff

A variety of training and support options are offered to assist frontline staff, increase their resilience and reduce 'burn out', thereby enabling the team to work at capacity.

Training and support offered includes:

- **Helping to understand chaotic individuals and ways to work with them.** This might draw on coaching and counselling skills and how to work with people with a mental health condition.
- **Clinical supervision.** Many projects provide clinical supervision for staff. This is particularly important where a beneficiary has been abusive or passed away.
- **Solution-focused practice.** Some projects provide independent practitioners to help staff uncover ways to work through difficult challenges presented by beneficiaries.
- **Speakers from other services.** Other service providers explain their offer to frontline staff. This has been particularly helpful in increasing the confidence of staff who may feel they have to solve all the beneficiary's problem alone.
- **Daily 'flash' meetings**. A meeting where staff discuss workload/plan for day. They can highlight risks, request support and prioritise cases.
- **Group reflective practice.** Some projects provide peer support, reflective practice groups and communities of practice where staff can share challenges and successes and reflect on the work they are undertaking.

It is evident that maintaining the desired lower caseload levels can be difficult to sustain. As explored above, a number of different approaches are being used across the programme to address this. Given the proportion of beneficiaries remaining on project caseloads, it is also important to examine the factors that influence positive move-on from the programme and barriers to closing cases. These issues are explored in the following chapter.

04. Frontline perspectives: Moving on

Introduction

In our 2016 annual report we identified the need to investigate what successful 'move-on' looks like. This chapter takes the first step in addressing this. It provides an overview of the different destinations of beneficiaries that have left the programme to date and explores which we can take as positive. It summarises the outcomes and behaviours that projects use as indicators that beneficiaries are ready to move on. The chapter also explores the extent to which there is a clear end point for Fulfilling Lives beneficiaries.

Reasons for closing cases

50 per cent of all beneficiary cases have been closed and not subsequently re-opened. Projects universally identify the destinations 'moved to other support' and 'no longer requires support' as positive destinations. Figure 7 below shows that, of those whose case has been closed, **35 per cent moved on to positive destinations** ('no longer requires support' and 'moved on to other support'). **A similar proportion (32 per cent) were closed because the beneficiary disengaged.**

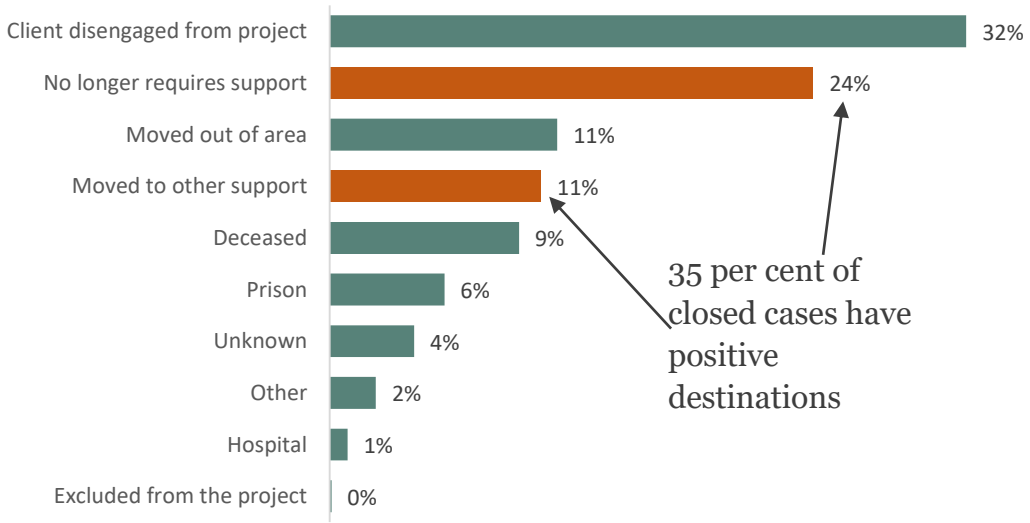

Figure 7: Destinations as a proportion of closed cases (n=1,452)

Although this Chapter is primarily concerned with positive move-on, it seems pertinent to begin with a short digression to other key reasons for cases being closed.

Exclusion and disengagement

In contrast to other mainstream support, projects explicitly seek to avoid excluding service users due to disengagement or behaviour. Fulfilling Lives projects seek to engage individuals who are not currently engaged with services and indeed, are often aimed at those who are routinely excluded from other services.[21] Projects take steps to manage risky behaviour in order to keep working with service users. For example, if projects have concerns about the risks posed by a beneficiary they may avoid conducting meetings in person, ensure more than one worker is present or only meet in a secure environment such as a probation office. While approaches such as this are not unique to Fulfilling Lives, the reluctance to exclude beneficiaries or close cases is a notable feature of the programme.

> *I've closed face-to-face contact for the time being, because the risk issues were just too far beyond [acceptable], but we've still retained consent from that client to carry on doing some [...] co-ordinator work, in terms of making sure the right services are involved with that individual. [...] We really try not to [close face-to-face contact], because that's just what the rest of the system does in lots of ways.*
> **Staff member**

To date, only one case has been recorded in the data as 'excluded', although two projects gave examples during interview of instances when a service user had been excluded due to extreme behaviour that threatened the safety of staff.

One of the most frequently applied reasons for closing cases is because the beneficiary disengaged, accounting for just under one-third (32 per cent) of closed cases. This emphasises the challenges of working with people with multiple needs. Projects are targeting the hardest to engage and will not always succeed in doing so.

[21] CFE Research (2016) *Fulfilling lives: Supporting people with multiple needs – annual report of the national evaluation 2016* http://mcnevaluation.co.uk/wpfb-file/fulfilling-lives-multiple-needs-evaluation-annual-report-2016-pdf/

Cases are closed due to disengagement if they consistently refuse support or after engaging for a period of time cease to do so.

> *If they're really hard to engage with and we've maybe seen them once, we'd still take them onto our caseload. Obviously, the fact they're really hard to engage makes them seem quite appropriate for us. A couple of cases, we've had to close them because we've just not been able to find the client again.*
> **Staff member**

While projects will endeavour to try to engage and work with a beneficiary for as long as is required, they will also respect a beneficiary's decision if they repeatedly say that they do not wish to engage. Frontline workers will often ask permission to check on a former beneficiary (or individual who has been referred but not yet engaged with the programme) from time to time. This allows staff to monitor the welfare of beneficiaries and to remain available should they be ready to engage in the future.

As explored in chapter 3, projects will typically have a number of inactive or dormant cases, including beneficiaries who are not currently engaging. The length of time that projects allow cases to remain dormant due to non-engagement varies.

> *We do leave people open for a long time. Something like six months of trying to find them and chase them around.*
> **Staff member**

Re-engagement

Disengagement does not necessarily mean the end of a beneficiary's journey with a project. Projects will ensure, where possible, that disengaged beneficiaries are aware that support remains available. All projects state that beneficiaries can re-engage at any time. This opportunity to re-engage, despite a lack of consistent engagement previously, is a unique aspect of the Fulfilling Lives programme. When a beneficiary re-engages they do not have to go through the referral and full assessment process again. Projects retain information from the previous engagement and update their records accordingly. This means that beneficiaries only have to tell their story once. Beneficiaries can be reticent to (re)engage with more mainstream services where they have to repeat their personal stories over and over as part of multiple assessments and referral processes, often because doing so is traumatic for them.

To date, 92 beneficiaries have re-engaged with the programme after having their cases closed – just 6 per cent of all closed cases. Of these, 52 are still currently engaged. Of

those who have subsequently returned to projects, 36 per cent left with a positive destination and 42 per cent disengaged.

Other reasons for closing cases

To date, six per cent of closed cases have the beneficiary destination as prison. Decisions to close cases if a beneficiary is given a prison sentence generally depend on the length of the sentence. A short period in prison can be seen by Fulfilling Lives projects as an opportunity to remove a beneficiary from their chaotic lifestyle and a crucial time to engage them. As a result, some projects will accept referrals and complete assessments of beneficiaries in prison and will continue to work with beneficiaries if they receive a prison sentence.

Similarly, projects generally do not close cases when a beneficiary is admitted to hospital - only one per cent of closed cases have hospital as their destination. The exception is if a beneficiary is admitted to hospital for an extended stay, for example to receive treatment for long-term psychiatric needs. In cases like this, a destination of hospital can be seen as a positive outcome if this means the beneficiary is receiving the most appropriate care for their needs. Hospital may be the most appropriate place for their long-term support:

> *She's now in a psychiatric hospital and has been for a number of months. We have signed her off. […] she's now engaged with mental health services and… they are the appropriate service to manage this lady.*
> **Staff Member**

'Moved out of area' might also be positive, if it means service users are moving to be reunited with friends and family and distancing themselves from negative influences. 11 per cent of closed cases and 5 per cent of all beneficiaries have been closed because they have moved out of the project area. Some projects provide bridging support to services in the new area if the move is planned with them – the provision of ongoing support is an important aspect of a successful move to another area. Conversely, moving out of area can be negative. Some beneficiaries engage for a time, state that they are leaving the area and are not heard of for months, only to return later seeking to re-engage.

What does successful move-on look like?

While destinations can be positive or negative depending on the circumstances, **projects agreed that the key indicator of positive move-on is that it is a *planned* move-on.** While there are often standardised benchmarks/thresholds set for acceptance onto a project, this is not the case for successfully moving on from a

project. However, interviewees consistently highlighted some concrete indicators of readiness to move-on that generally relate to improvements in the four core areas of need and include maintaining stable accommodation, reduced use or abstinence from alcohol and/or drugs, not offending and having the confidence and motivation to engage with services with minimal support from projects staff.

> *If somebody is maintaining tenancy, and they're stable, they're okay, they have got a means to use their time, there is no rent arrangements, that would be time for us to move away for them.*
> **Staff member**

The Homelessness Outcomes Star™ and New Directions Team (NDT) Assessment (see Glossary) are part of the mix of information used by projects to understand when a beneficiary might be ready to move on. Projects use these measures as an indication of progress:

> *We're looking at progress with the Outcomes Star and the NDTs, so if progress is being made in the right direction, they will be having that conversation about somebody moving on. We wouldn't move somebody on from the project, who we're still working with, if the NDT score wasn't moving in a positive direction.*
> **Staff member**

However, there is no fixed score that means it is time for a beneficiary to move on. Projects do not solely rely on these tools to assess a beneficiary's readiness to move on.

> *There are people on our current active caseload who would score quite low on the NDT but that we still don't feel would necessarily manage without our ongoing support. So yes, we would look at that but it certainly wouldn't be a deciding factor in any way.*
> **Staff member**

Those who move on to positive destination showed greater improvements in NDT and Outcomes Star scores. For those who moved on to positive destinations we observe an 45 per cent improvement in Homelessness Outcomes Star scores, from a mean average of 37 to 53.6 (n=244). This indicates beneficiaries moving from recognising the need for, and accepting, help to believing that they can make a difference in their own lives and taking responsibility. For those who disengaged, the change between baseline and the final reading is 16 per cent, from 31.9 to 37 (n=154). This indicates beneficiaries recognise that they need help, but rely on others to sort things out (see Appendix 1). It is also worth noting that those who disengaged had a

slightly lower average initial Outcomes Star score compared to those who moved on to a positive destination.

The NDT scores also show that those who move on to positive destinations experience a greater degree of change, with scores improving (reducing – lower scores are more positive on the NDT assessment) by 40 per cent from 30.7 to 18.6 (n=272) compared to those who disengage, whose scores improve by 20 per cent from 31.6 to 25.4.

Figure 8 below shows how mean Homelessness Outcomes Star scores have changed for those who moved on to positive destinations. Most progress has been made in managing tenancy and accommodation and social networks and relationships. Although proportionally offending and physical health have improved least, average scores were higher to begin with.

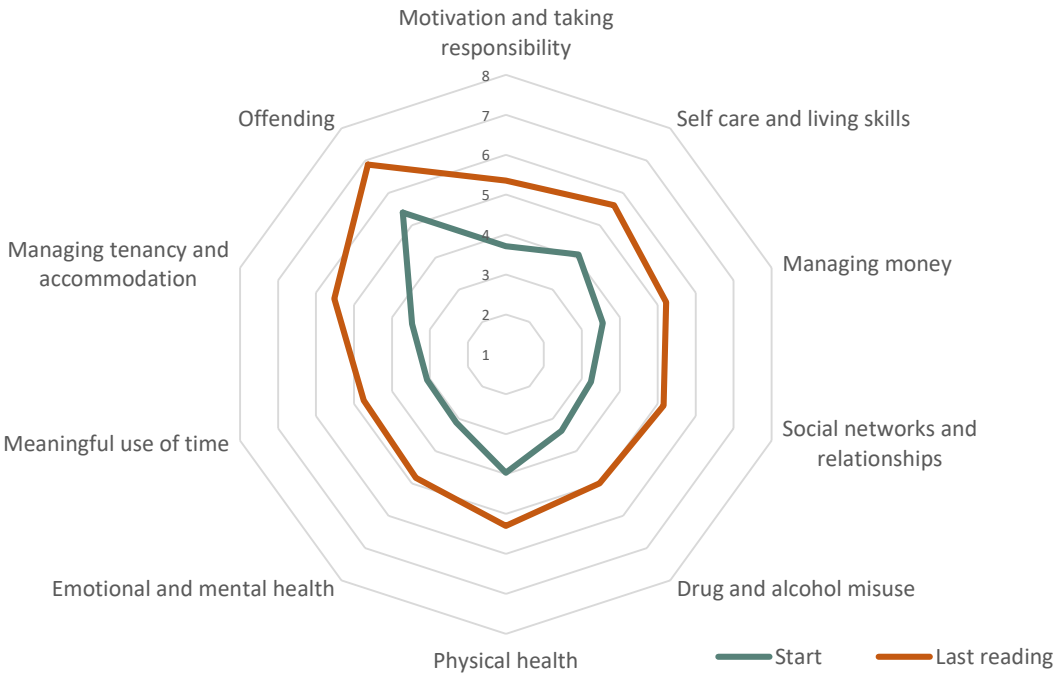

Figure 8: First and last mean Homelessness Outcomes Star scores for those with positive destinations (n=244)

Figures 9 compares proportional change across the ten areas for those who moved on to positive destinations with those who disengaged. As well as showing the higher proportional changes for those with positive destinations, the colour coding shows where most and least progress has been made for each group. Both those who

disengaged and those who achieved a positive move on made most progress with managing accommodation and less with physical health. Perhaps unsurprisingly, **those who disengaged made least progress with motivation**. It is notable too that those who move on to a positive destination made most progress with social networks and relationships while this was one of the least improved areas for those who disengaged. This further supports our findings that **positive social activity and relationships are important in achieving successful outcomes.**[22]

	Positive destinations	Disengaged
Motivation and taking responsibility	44	8
Self-care and living skills	37	22
Managing money	47	18
Social networks and relationships	59	10
Drug and alcohol misuse	48	16
Physical health	33	9
Emotional and mental health	55	21
Meaningful use of time	55	17
Managing tenancy and accommodation	59	28
Offending	28	14

Figure 9: Percentage change in Outcomes Star scores between start and final reading for those with positive destinations and those who disengaged

Figure 10 shows a breakdown of mean NDT scores at the start and the final assessment for beneficiaries who progressed to positive destinations. As with Outcomes Star scores, proportionally, most progress is made with housing. Supporting beneficiaries to access accommodation is often a key priority on engagement and reflects the belief that housing is integral to providing a stable environment from which a person can work on their other needs.

After housing, most progress has been made on engagement with services. This was also highlighted by project staff as a key indicator of beneficiaries being ready to move on. For those projects where keyworkers fulfil a co-ordinator role (see page 18) the ultimate aim for them is to engage beneficiaries with mainstream services. This is explored further below.

[22] Robinson, S. (2017) *Relationships in Recovery* CFE Research http://mcnevaluation.co.uk/wpfb-file/2017-relationships-in-recovery-final-pdf/

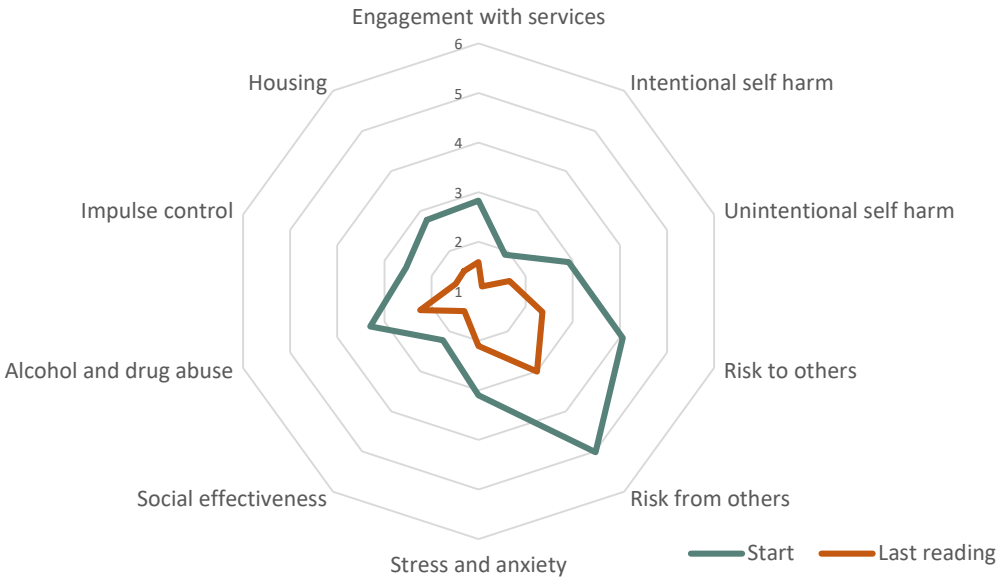

Figure 10: First and last mean NDT scores by criteria for those with positive destinations (n=130)

Figure 11 compares percentage improvement (reductions in NDT score) between those who disengage and those who move to positive destinations. Less progress for both groups is made with alcohol and drug abuse. Those who disengaged progressed least in engagement with services while those who moved to positive destinations made relatively high levels of progress on this criteria.

	Positive destinations	Disengaged
Engagement with services	-44%	-9%
Intentional self-harm	-41%	-17%
Unintentional self-harm	-43%	-18%
Risk to others	-42%	-28%
Risk from others	-40%	-23%
Stress and anxiety	-32%	-18%
Social effectiveness	-33%	-17%
Alcohol and drug abuse	-32%	-12%
Impulse control	-41%	-23%
Housing	-46%	-23%

Figure 11: Percentage change in average NDT scores between start and final reading for those with positive destinations and those who disengaged

Final Outcomes Star and NDT scores for those who have moved-on to positive destinations indicate that beneficiaries need to be motivated, be taking responsibility for their recovery, demonstrate reduced risk and be engaging with services in order to progress from Fulfilling Lives to the next stage in their journey. This is in line with the experiences of project staff. It would be useful to further explore how NDT and Outcomes Star scores relate to other observed changes that projects highlight as indicators of readiness to move on, such as maintenance of stable accommodation and reducing offending.

Interviewees across projects highlighted the importance of beneficiaries taking ownership of their journey as an indicator of readiness to move on. Signs that a beneficiary was taking ownership include:

- attending appointments on their own
- making appointments
- engaging with services – in particular key services such as probation and healthcare, and
- their ability to manage with reduced / light-touch support.

> *Well, in my head, […] part of our job is always to get them to the services that provide the specialist support, and to get them engaging in that willingly and autonomously.*
> **Project staff member**

Relying less on projects is a key indicator of when a beneficiary is ready to move on. Or as one staff member put it:

> *It almost feels like you stop doing your job and they start doing it. That's ultimately the indicator you get.*
> **Project staff member**

Projects also highlighted the importance of beneficiaries engaging with more therapeutic services and activities which help to build their capacity for self-care and resilience; for example substance misuse support groups, gardening, social events and drop-in light touch support sessions which often occur in coffee houses. This type of support provides service users with the ability to be aware of their own support needs and knowledge of how to get support. It also enables beneficiaries to engage with wider social and support groups that provide them with the opportunities to create, build and expand their own stable network of support around them – something required to transition them away from services.

Other important indicators of a beneficiary's readiness to move on include disassociating from risky behaviours of the past and displaying basic life skills such as managing money, paying bills and buying food and clothing.

> *They're coming [up] with a plan [and] they're not having these payday binges on drugs and booze or giving it all away.*
> **Project staff member**

Definitions of 'success' and readiness to move-on are also linked to the model of support provided by funded projects. As briefly discussed in Chapter 3 (see page 18) projects adopt one of two broad approaches to providing keyworker support. Some very clearly provide navigation only, guiding beneficiaries through the system, securing and co-ordinating the package of support they receive from other providers. Others provide more of a focus on providing support for beneficiaries too. Those projects that focus purely on navigation, readiness to move-on is about the extent to which a beneficiary engages independently with other services. For these projects, the aim is to successfully transition beneficiaries to mainstream services. For those projects that also provide support, readiness to move-on is also about someone needing less intensive support. For these projects, 'moved to other support' is more about the beneficiary accessing lighter-touch types of support such as peer mentoring, volunteering and educational opportunities.

Staff interviewed were keen to highlight **the importance of understanding the specific goals and desires of the beneficiary**; if a project is too focused on achieving a pre-defined outcome (like many mainstream services) they argued this would simply replicate the system that had already proved ineffective for this cohort. **Success will vary from person to person and in different contexts.** 'Success' for some could be a meaningful use of time, such as enrolling in college or becoming a peer mentor. For others, a significant change and sustainable improvement may be more about reducing harm or negative behaviours.

> *She's not presenting at A&E either. She might go one or two times a month, which is out of the ordinary for the general population but she used to go 20, 30 times.*
> **Project staff**

Some projects highlighted the need to also capture 'soft' outcomes and change in terms of increases in positive behaviour as well as decreases in negative behaviour.

Speaking to some of the service managers, their view is that some of the softer outcomes [...] should be looking at measures that are about increase. So, about increased understanding of issues for themselves, increased independence, increased perception of their own health and wellbeing, their own state of mind, all of those things.
Project staff

Is there a 'Journey's End'?

The term 'recovery' suggests a definite end point or journey's end, whereby a beneficiary will no longer offend, be substance free, have good mental health and stable accommodation. However, **some beneficiaries have needs for which they will always require support**, for example, physical disabilities or mental health diagnoses, or are so ill that they require palliative care.

In many cases, **success is about developing strategies, resilience and understanding to effectively manage a need**. Interviewees cautioned against expecting all beneficiaries to be able to achieve outcomes such as maintaining employment or independent living.

You know, we know, we're not going to cure people and we're not going to turn out a whole bunch of accountants and social workers from this, but you know that they're stable, they're happy.
Project staff member

Positive outcomes may be more about ensuring beneficiaries can and do access appropriate care and treatment. An important achievement for projects is making beneficiaries' lives more comfortable, helping them to be stable, happy and have an improved quality of life, even if ongoing care is required.

We had somebody before that owns his own accommodation, really unwell, years and years of drinking, and just prayed on by everyone [...] he's just been moved into residential care, and he absolutely loves it there. He's got a specific role helping out in the kitchen, we didn't know he had any interest in food, or cooking, absolutely loves it there. [...] the big thing of course should be, he's not in prison, and he's in appropriate accommodation.
Project staff member

Sadly, for some, there is no real prospect of improvement. One project in particular highlighted they have not insignificant numbers of beneficiaries with a terminal diagnosis.

> *Many people come to us with life limiting conditions. [For example] COPD […] they come to us dying with that sentence looming over them. I think we've a little bit become, for some people, almost like a bit of an end of life care. They're dying. Nothing can be done so no script for methadone, no mental health diagnosis, their organs are failing.*
> **Project staff member**

The perceived high-risk and chaotic lives of such beneficiaries means mainstream palliative care is not accessible to them. 'Success' for these cases is providing the most comfortable end possible.

Sadly, 137 beneficiaries have died since the start of the programme (5 per cent of all beneficiaries). However, this is not necessarily the end of project involvement. A few projects said that their frontline staff were next of kin for some beneficiaries - this highlights the extent to which some beneficiaries are alone, without the usual social or family supports many of us rely on. It also emphasises the important role that the projects play in beneficiaries' lives. When a beneficiary dies project staff can be responsible for making funeral arrangements, notifying agencies and sorting out the beneficiary's affairs. Staff may also attend the funeral, which is seen as important to help with their own closure.

> *So, three out of the five individuals that have passed away most recently, my staff have been their next of kin. [These beneficiaries] literally have nobody… so, that end date isn't reflective [of the end of our involvement].*
> **Project staff member**

How long does it take?

Beneficiaries whose case has been closed spend an average of 11 months with the project. Average time spent on the programme before leaving is now longer than reported in our 2016 report and is likely to extend as the projects continue. However, this hides wide variation between individual beneficiaries, with **the length of time spent on the project ranging from less than 1 month to over three years (38 months)**.

Figures 12 and 13 below show the distribution of time on the programme for those with positive destinations and those who have disengaged or whose destination is unknown.

In both cases, time spent on the programme is skewed towards shorter periods of engagement (most beneficiaries in both cases leave within 12 months). Those who move to a positive destination are more likely to stay on the project for over two years (13 per cent) compared to those who disengaged (5 per cent). However, given projects' reluctance to close cases as a result of disengagement, it may be that cases were dormant for some time rather than actively engaging.

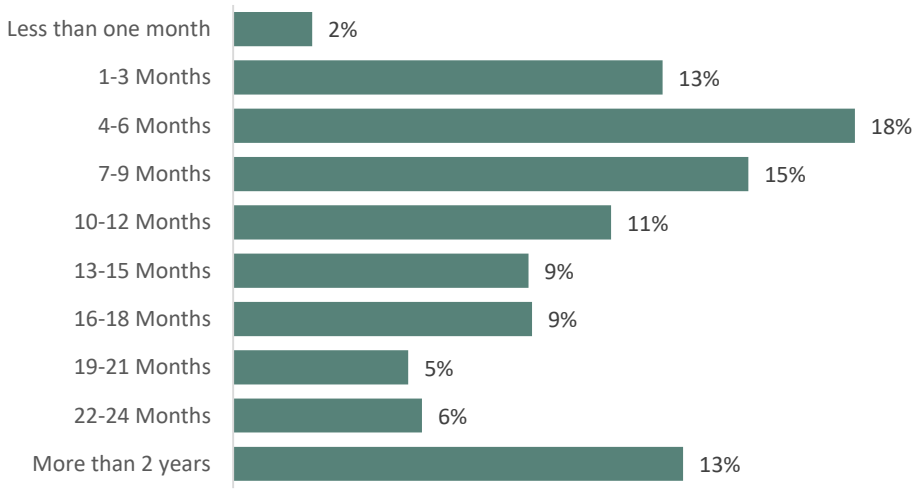

Figure 12: Time spent on the programme of beneficiaries who left with a positive destination (n=526)

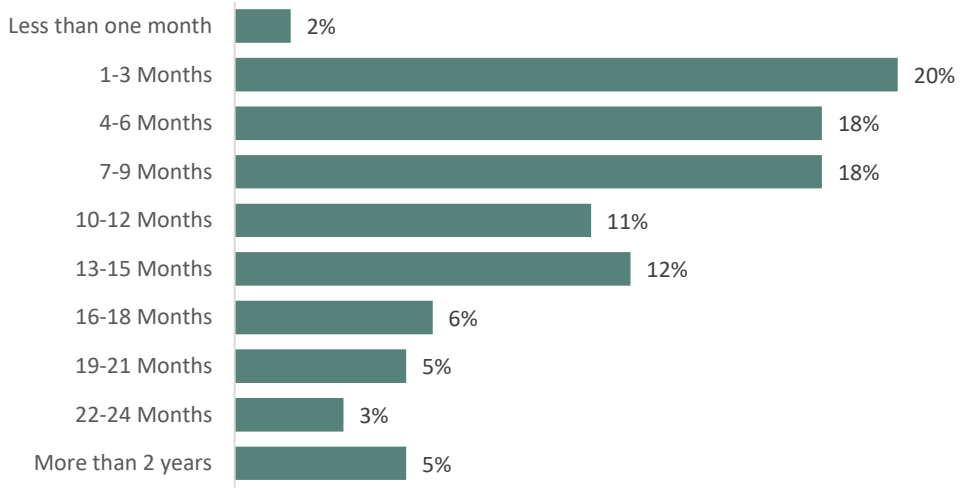

Figure 13: Time spent on the programme of beneficiaries who disengaged (n=482)

This illustrates what projects told us – that **the time it takes to move someone on can vary hugely and depends on the service model as well the individual**. It would be useful to carry out further analysis of the profile of beneficiaries whose case has been closed to understand whether those who are enabled to move-on relatively quickly have different needs to those with whom projects need to work for longer.

Negotiating a successful move-on

While the journey towards a fulfilling life can be a lengthy one, and for some there will be a need for ongoing support, the Fulfilling Lives programme is a finite one. Some projects are acutely aware of this and seek to agree personal goals or outcomes that define when they will stop working with a beneficiary at the start of their engagement. This decision is often made between the beneficiary and their keyworker and ratified by the keyworker and a multi-disciplinary review panel. Deciding at what point in their journey a beneficiary will move on means that, in project models that navigate to other services, beneficiaries are not given a false impression that support is open-ended. Agreeing the outcomes that beneficiaries are working towards in this way helps to ensure the recovery journey is person-centred and holistic with the beneficiary having a key role in deciding what success means for them. The agreed outcome(s) are then built into a personalized development plan for the beneficiary.

Success often relates to the achievement of individual goals. However, diagnosis and prognosis for beneficiaries can change. Addressing a presenting issue(s) may mean that others come to the fore.

> *We've got one lady that we worked with for two years. Chaotic, drug taking, antisocial behaviour, homelessness, mental health. […] We got her to a point where she was drug free, alcohol free, living in her own accommodation, no longer engaging in antisocial behaviour but, when all of that was taken away from her, her mental health came to the fore. All of this other stuff had been masking this really serious mental health problem.*
> **Staff member**

It is necessary to frequently re-assess goals and achievements and all the projects undertake regular reviews with the beneficiary, their keyworker and their multi-disciplinary team.

Handling transition from the project needs to be done carefully and in itself will take time. Projects highlighted how suggesting to a beneficiary that they may be ready to move-on is often met with anxiety and this can trigger relapses.

[…] we haven't had one person yet say, 'Brilliant. I'm so glad I no longer need your support.' It's met with all kinds of anxiety, and it could be that that process takes three to six months.
Staff member

Projects generally take a phased approach to move-on; support and contact time are gradually reduced.

This 'move on' that we've mentioned is, sort of, a tester run […] It's reducing the amount of contact we have with a person, so initially it might be, 'Well, we're not going to see you this week and we'll phone you in two weeks instead of every week,' and if that went well, then they stretch the time between contact.
Staff member

Peer mentors are often used to help with this important transition, providing lighter-touch support and friendship to beneficiaries. Peer mentors help to integrate beneficiaries socially so that they can begin to build their own support networks outside of the programme. These are a key part of ensuring a sustainable recovery for people with multiple and complex needs.[23]

Barriers to moving on

Of the 92 beneficiaries that had re-engaged, 33 had previously been closed with positive destinations (moved to other support, no longer requires support). One project that had re-engagements of this nature explained beneficiaries had required short, minimal additional interventions before they left the project again. Something had knocked their confidence and they needed some extra support before they felt able to continue their recovery without the project again. In contrast, another project had experienced re-engagements after navigating beneficiaries to mainstream services that had subsequently been withdrawn, reduced or were otherwise insufficient to meet the needs of the beneficiary.

I think sometimes what happens is, that wrap around services have been created and then sometimes those services drop off, and we don't always find out about that […] until [the beneficiary] comes back to us. […] what they're

[23] Terry, L. and Cardwell, V. (no date) *Understanding the whole person: part one of a series of literature reviews on severe and multiple disadvantage.* Revolving Doors Agency http://www.revolving-doors.org.uk/file/1845/download?token=3jprn2sc

doing is, they're just pulling out […] The support provider doesn't let us know that they're thinking of closing the case, they just close the case and then all the wheels of the bus fall off.
Staff member

A key barrier to successfully moving on beneficiaries mentioned by many of the projects is the lack of appropriate support services and the inadequacy of mainstream services for Fulfilling Lives beneficiaries. These were often said to lack the necessary flexibility and longevity of support that was required. This is a particular issue for projects seeking to navigate service users to mainstream support rather than providing that support. The relatively low levels of re-engagement following positive move-on so far shows that projects are not frequently supporting beneficiaries into other services only for them to return at a later date. Rather, the inadequacy of wider support means that projects are simply not moving beneficiaries on at the rate that might otherwise be possible. This limits the number of beneficiaries who can be supported, risks creating dependency and raises questions about what happens when the programme ends.

A lack of affordable and suitable housing can also present a barrier to moving beneficiaries on. Appropriate housing is considered essential for stability and maintaining a tenancy an indicator that someone might be ready to move on. This appears to be more of an issue for some areas than others. For example, the South East has reported the lack of supported housing in both Eastbourne and Hastings as a considerable barrier to move-on for their beneficiaries.

Systemic barriers to successfully moving beneficiaries on underlines the importance of the work projects are doing to affect local systems change, so that the wider support provision works effectively alongside Fulfilling Lives. We also explored this perception in chapter 3. It may be useful to explore further the extent and nature of this particular barrier to successful-move and how and where projects have successfully addressed this through local partnership working. Some projects are looking at this as part of their local evaluation work.

We just recently started doing some work around, 'What are barriers to closure, and are cases staying open because there are no clear service pathways or housing pathways for people?' Is it, literally, because we're doing that, kind of, maintenance, holding work, because there just isn't the system or the service in place to support them?
Staff member

An important part of the move-on process is ensuring that other support services understand the beneficiaries' needs and the importance of maintaining ongoing support.

> *Make sure that all the services are engaged […] if the other services involved have an excuse to disengage, then obviously they will. So, you've got to persuade [services] that it's their involvement that's keeping that stability the way it is, and that without it, the [beneficiary] will be back in A&E before you know it.*
> **Staff member**

One project has been piloting a way of smoothing beneficiaries' transition to new services (or keyworkers). Staff create a document for each beneficiary that includes information on what support has worked well for them and what does not. The document can then be taken by the beneficiary to any new professional relationship. Initial signs have shown that this has helped to make the departure of a staff member or the end of engagement with a service as positive as possible. This is particularly important as many beneficiaries may have negative experiences of the loss of relationships or services being withdrawn.

> *So many clients have had such negative experiences and endings at a loss and so few positive examples of good relationships that if we can do anything to get them to experience those things in a positive way, then that feels like… a really good learning experience…*
> **Staff member**

05. Conclusions and promising practice

In this report we have summarised the key findings from the national evaluation of Fulfilling Lives: Supporting people with multiple needs in 2017. This includes data collected on beneficiaries up to September 2017 and discussions with project staff about two important aspects of their work with people with multiple needs: managing caseloads and determining when someone is ready to move on from the programme.

There continues to be high demand for the support provided by Fulfilling Lives projects. To date, projects have engaged 2,915 people, most of whom have experienced three or four of the key needs of homelessness, substance misuse, mental ill health and offending.

In some cases, demand for support is exceeding initial estimates, with some suggestion that the number of people with multiple needs is larger than originally estimated. Projects also attribute part of the demand to mainstream services not having the resources or flexibility to adequately support people with multiple needs.

Beneficiaries are staying longer with projects than anticipated. There is a wide variation in the length of time beneficiaries spend on the project before leaving, ranging from less than one month to over three years. A substantial proportion of beneficiaries remain on the programme two years after first engaging.

High demand and static caseloads contribute to sometimes higher than ideal staff workloads. High levels of beneficiary need also contribute to workloads. As measured by the NDT assessment beneficiaries have greatest need relating to risk from others and drug and alcohol abuse. Areas where beneficiaries need most support as measured by the Outcomes Star are meaningful use of time and emotional and mental health.

Staff often need to spend extended periods of time (half or whole days) with a particular beneficiary - sometimes because the beneficiary has hit a crisis, but also because supporting people to access key services (healthcare, housing, benefits and so on) can be particularly time-consuming. Projects report high demand from beneficiaries to accompany them to appointments and highlight instances of inefficient service coordination and delivery that also impacts on the time it takes to support beneficiaries. It is clear that projects supporting people with multiple needs require staffing models that are flexible enough to cope with sudden changes in demand. Lower caseload levels is one way of enabling this.

There is broad agreement across projects that a caseload of between six and ten people with high levels of need is the ideal in order to provide the type of flexible and personalised support required. Higher than ideal caseloads can mean that projects prioritise the most urgent and in-need at the expense of other important but less urgent work. This includes supporting those with lower levels of need (those who are further along in their recovery journey, have their basic needs met and are engaging with services) to take part in the kind of social activities that are likely to help them sustain their recovery. Those who achieve a positive destination are more likely to have progressed further in developing social networks and relationships than those who disengage from projects.

High caseloads also affect staff wellbeing and can increase turnover. Approaches adopted by projects to effectively manage caseloads include regular reviews, tiered support offers, using peer mentors and trainees and assigning two staff members to each case. Peer mentors and trainees with lived experience can help boost team capacity as well as providing valuable opportunities for people with lived experience. However, trainees in particular require considerable levels of support.

Some projects have taken steps to manage the overall number of cases. This includes controlling referrals through raised thresholds and pauses, and encouraging increased throughput of beneficiaries. The risk with the latter approach, and in providing less personalised and holistic support, is that services become no different from the target-driven services the programme is aiming to challenge. This in turn may risk service-users disengaging and limits the opportunity to effectively evaluate the benefit of small caseloads, person-centred and holistic support.

Beneficiaries who are still engaged on the programme after around two years show a clear reduction in risk and need. Least change has happened in the related areas of reducing risk from intentional self-harm and alcohol and drug abuse. Greatest progress has been made in reducing beneficiaries' risk to others and in engaging with services – the latter being key to supporting beneficiaries to progress and an important indicator of readiness to move on.

Half of all beneficiary cases have been closed and not subsequently reopened. Just over a third of those who have left the Fulfilling Lives programme have moved on to positive destinations. A similar proportion disengaged. While projects aim to avoid closing cases due to disengagement, the nature of the beneficiary group is such that this is sometimes unavoidable.

Those who moved on from the programme to a positive destination showed greater improvements in NDT and Outcomes Star scores than those who disengaged. Those

with positive destinations made most progress on average in managing their tenancies and accommodation, social networks and relationships and engagement with services. Those who disengaged had made least progress with motivation and intentional self-harm. Both groups showed lower levels of progress with alcohol and drug abuse.

While positive change is occurring, progress is slow and beneficiary need remains high for many. Services agree that beneficiary destinations 'no longer requires support' and 'moved to other support' are generally indicative of positive outcomes for beneficiaries, but notions of what constitutes 'success' are wider than this and less clear cut. A move to hospital or residential care can be a positive outcome, while for a few the programme provides a comfortable and dignified end of life. Definitions of success are personalised and will vary from person to person. While some beneficiaries will progress to independent living and work this is not an outcome that all can achieve. Some will always need support and success in these cases is more about accessing and engaging with appropriate services.

The lack of universal outcomes that represent the journey's end presents a challenge for evaluating and commissioning services on the basis of achieving a narrow set of fixed outcomes. However, there are outcomes and changes in behaviour that projects all identify as indicators of readiness to move-on from the projects. These include maintaining stable accommodation and reducing dependence on drugs/alcohol. Engaging with services independently and requiring less support from staff are particularly important indicators of progress.

A lack of a clear point at which beneficiaries are expected to move away from the intensive support provided by Fulfilling Lives potentially risks creating dependency and may contribute to static caseloads. Some projects address this by agreeing goals with the beneficiary at the start, although these often shift and develop. Moving beneficiaries onto mainstream support services can be challenging if these are not sufficiently flexible or long-term, which can also contribute to beneficiaries staying longer with projects. Understanding successful transitions is key to understanding how the Fulfilling Lives project can attempt to be sustainable. Several of the projects are due to end sooner than others (Liverpool Waves of Hope for example is due to end in 2019); it will be useful to understand the steps these projects are taking to ensure sustainability of provision and how beneficiaries are transitioned to other support once the programme comes to an end.

Promising practice

Below we use our findings to set out some recommendations for different audiences. We describe this as **promising practice** as in many cases, further research and analysis would be useful to help strengthen the evidence base for the recommendations.

For services supporting people with multiple needs

- **Small caseloads** of between six and ten beneficiaries per keyworker allow time for providing the kind of holistic, personalised and flexible support that people with multiple needs want.

- Staffing models need to **build in sufficient flexibility** to allow keyworkers to spend extended periods of time with beneficiaries to address crises, accompany them to appointments and advocate for them with key service providers.

- Consider ways to mitigate the impact of beneficiaries changing or being supported by an **unfamiliar keyworker**. This could include assigning two keyworkers to each beneficiary.

- Develop **lighter-touch support mechanisms** for those further along the recovery journey, but who still need support to engage and avoid relapses.

- Explore ways for beneficiaries to get support and encouragement from **people with lived experience of multiple needs**.

- But ensure sufficient **support and training** can be provided and monitor caseloads to ensure peer mentors or similar are not overburdened.

- Consider ways to **make re-engagement with support easier** – for example, by retaining and re-using needs assessments and asking permission to stay in touch.

- Enabling service users to **take part in social activities and celebrations** can be an important part of the recovery journey, helping to develop friendships, motivation and a positive self-identity.

- **Addressing housing need and ability to maintain accommodation** early on is likely to provide a sound basis for future progress.

- Consider ways **to support staff wellbeing**, such as providing clinical supervision, group reflective practice or engaging independent support to work through challenges.

- Develop ways to **phase transition** from intensive to lighter-touch support and to ensure hand-over to other services is as smooth as possible.

For funders and service commissioners

- People with the most entrenched and complex needs may require **extended periods of engagement** (12 months or more) with services to build trust and begin to engage with wider support.
- Person-centred support requires development plans focused on an **individual's own goals and needs**. Do not expect success to be the same for all beneficiaries.
- Consider progress and success indicators that encompass **beneficiary engagement with services** and management of conditions and / or their own recovery.
- **Build in flexibility** to address changing diagnosis and prognosis.
- Bear in mind that some may **require palliative care or ongoing support**.

Appendix 1: Outcome Star™ Journey of Change

When we aggregate scores across the ten issues or average scores across beneficiaries and projects we relate 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: Regression analysis

We used multivariate regression to explore the individual characteristics that are associated with NDT and HOS scores at baseline. The regression is of the form:

$$Y_i = \alpha + \beta_1 Age_i + \beta_2 Sex_i + \beta_3 Race_i + \gamma_1 H_i + \gamma_2 O_i + \gamma_3 S_i + \gamma_4 MH_i + \varepsilon_i \quad (1)$$

Where *Yi* represents the outcome measures for individual *i*, which include the NDT and HOS summary scores as well as the constituent items. *Age* is age in years; *Sex* is a dummy variable where 1 is female, and 0 is male; *Race* is a dummy variable where 0 is British and 1 is non-British. The next set of variables are dummy variables representing the specific needs of the individual - *H* is homelessness, *O* is offending, *S* is substance misuse and *MH* is mental health. ε is the stochastic error term.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	Total	**Engagement**	**Intentional Self Harm**	**Unintentional Self Harm**	**Risk to others**	**Risk from others**	**Stress and anxiety**	**Social effectiveness**	**Alcohol/ drug abuse**	**Impulse control**	**Housing**
age	-0.037**	-0.001	-0.016***	0.005**	-0.026***	0.003	0.001	0.003	0.005***	-0.006**	-0.007***
	(0.017)	(0.002)	(0.003)	(0.002)	(0.005)	(0.005)	(0.002)	(0.002)	(0.002)	(0.003)	(0.002)
sex	1.977***	0.055	0.218***	0.266***	-0.165	1.545***	0.080*	-0.081	0.068	0.023	-0.031
	(0.366)	(0.044)	(0.055)	(0.050)	(0.106)	(0.110)	(0.043)	(0.049)	(0.045)	(0.059)	(0.047)
race	-2.434***	-0.188***	-0.233***	-0.275***	-0.379***	-0.644***	-0.157***	-0.107*	-0.171***	-0.160**	-0.120**
	(0.474)	(0.057)	(0.071)	(0.065)	(0.137)	(0.143)	(0.055)	(0.064)	(0.058)	(0.076)	(0.061)
hlns	1.530***	0.147***	-0.041	0.135**	0.051	0.175	0.066	0.005	0.126***	0.051	0.817***
	(0.385)	(0.046)	(0.058)	(0.053)	(0.112)	(0.116)	(0.045)	(0.052)	(0.048)	(0.062)	(0.050)
offd	3.060***	0.145***	0.068	0.132**	1.355***	0.119	0.209***	0.189***	0.189***	0.467***	0.187***
	(0.457)	(0.054)	(0.069)	(0.063)	(0.132)	(0.138)	(0.053)	(0.061)	(0.056)	(0.073)	(0.059)
subs	4.311***	0.391***	0.200	0.636***	0.646**	0.532*	-0.060	0.145	1.380***	0.190	0.252**
	(0.916)	(0.109)	(0.138)	(0.126)	(0.265)	(0.276)	(0.107)	(0.123)	(0.113)	(0.147)	(0.118)
mthl	1.393**	-0.136*	0.510***	-0.059	0.246	0.276	0.391***	0.198**	-0.086	0.258**	-0.205**
	(0.671)	(0.080)	(0.101)	(0.092)	(0.194)	(0.202)	(0.078)	(0.090)	(0.083)	(0.108)	(0.086)
Constant	22.917***	2.386***	1.880***	1.878***	3.404***	3.298***	2.513***	1.656***	1.654***	1.952***	2.296***
	(1.479)	(0.176)	(0.222)	(0.203)	(0.429)	(0.446)	(0.173)	(0.198)	(0.182)	(0.237)	(0.191)
n	2,027	2,027	2,027	2,027	2,027	2,027	2,027	2,027	2,027	2,027	2,027
Rsq	0.064	0.022	0.055	0.039	0.074	0.104	0.023	0.011	0.085	0.028	0.132

Table 2: Correlates of NDT score at Baseline

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	Total	Motivation & taking responsibility	Self care & living skills	Managing money	Social networks & relationships	Substance misuse	Physical health	Emotional & mental health	Meaningful use of time	Managing tenancy & accom.	Offending
age	-0.046	-0.004	-0.017***	0.005	-0.008	-0.000	-0.032***	-0.001	-0.002	-0.001	0.015**
	(0.037)	(0.005)	(0.006)	(0.005)	(0.005)	(0.005)	(0.005)	(0.004)	(0.004)	(0.005)	(0.007)
sex	0.351	-0.023	0.128	0.009	0.010	0.057	-0.164	-0.027	-0.054	0.211*	0.203
	(0.804)	(0.100)	(0.123)	(0.108)	(0.104)	(0.112)	(0.118)	(0.087)	(0.090)	(0.115)	(0.151)
race	2.124**	0.355***	0.203	0.094	0.102	0.375***	0.346**	0.161	0.347***	0.041	0.101
	(1.031)	(0.128)	(0.158)	(0.138)	(0.133)	(0.144)	(0.151)	(0.112)	(0.116)	(0.148)	(0.193)
hlns	-5.473***	-0.460***	-0.542***	-0.524***	-0.255**	-0.531***	-0.258**	-0.318***	-0.360***	-1.153***	-1.071***
	(0.845)	(0.105)	(0.129)	(0.113)	(0.109)	(0.118)	(0.124)	(0.092)	(0.095)	(0.121)	(0.158)
offd	-6.105***	-0.469***	-0.329**	-0.437***	-0.468***	-0.394***	-0.214	-0.386***	-0.416***	-0.576***	-2.415***
	(0.982)	(0.122)	(0.150)	(0.132)	(0.127)	(0.137)	(0.144)	(0.107)	(0.110)	(0.141)	(0.184)
subs	-9.428***	-0.720***	-0.837***	-0.844***	-0.315	-2.297***	-1.413***	-0.497**	-0.528**	-0.628**	-1.348***
	(2.050)	(0.254)	(0.313)	(0.275)	(0.265)	(0.286)	(0.301)	(0.223)	(0.230)	(0.293)	(0.384)
mthl	-1.461	-0.059	-0.017	-0.059	0.034	-0.065	0.110	-0.811***	-0.185	0.053	-0.461
	(1.505)	(0.186)	(0.230)	(0.202)	(0.194)	(0.210)	(0.221)	(0.164)	(0.169)	(0.215)	(0.282)
Constant	54.645***	4.969***	5.913***	4.549***	4.223***	6.000***	6.711***	4.695***	4.062***	5.051***	8.473***
	(3.270)	(0.405)	(0.500)	(0.439)	(0.422)	(0.456)	(0.480)	(0.355)	(0.367)	(0.468)	(0.612)
n	1,610	1,610	1,610	1,610	1,610	1,610	1,610	1,610	1,610	1,610	1,610
Rsq	0.055	0.027	0.024	0.023	0.013	0.056	0.044	0.028	0.023	0.064	0.123

Table 3: Correlates of Outcomes Star scores at Baseline

This report was researched and written for the Big Lottery Fund by CFE Research and the University of Sheffield.

Published by: CFE Research, Phoenix Yard, Upper Brown Street, Leicester, LE1 5TE

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