

Blackpool Fulfilling Lives

Report on the
year five evaluation
2020

**we are
withyou**

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Foreword

Welcome to our final and fifth year evaluation report for Blackpool Fulfilling Lives (BFL), which I am delighted to introduce as Chair of the BFL Legacy Board. At the time of writing the local response to help manage the COVID-19 situation continues.

We have delayed publishing this final BFL evaluation so we could include beneficiary insight into 'the lockdown' and our town wide emergency response and protection to the disadvantaged community. I must at this point also thank The National Lottery Community Fund who provided additional funding and flexibility to allow us to respond so quickly and thoroughly to help people in our town, and as we know, the response is ongoing.

Against the backdrop of a global pandemic response, an evaluation report may seem insignificant, but there is key information and learning for the Blackpool system. The report provides a summary of the demographic characteristics of the people supported by the programme and the impact and outcomes of the BFL intervention with these clients, as well as identifying potential financial savings stemming from that intervention. The report also presents an in-depth review of the findings from a deep dive into the role of the navigator and the navigator model that has been so pivotal to the Fulfilling Lives programme in Blackpool. What probably is more significant, as we reach the final stages of the programme, is the progress towards system change achieved that is highlighted.

The COVID-19 crisis has undoubtedly had a major impact on this last year of the BFL programme, impinging on plans and priorities. What is clear is how positively and effectively the BFL team have responded and adapted to meet the current challenges and continue to support people with multiple disadvantage in Blackpool.

This work has been done collaboratively with partner agencies across the town, demonstrating the strength of the partnerships and relationships that have been built over the last few years.

As we move on to the final few months of the BFL programme it is vital that the recommendations set out in the evaluation report, particularly around retaining a multiple disadvantage strategic partnership, embedding co-production and peer support within the town and retaining the navigator role to work with people who have multiple disadvantage, are carefully considered and, if at all possible, taken forward.



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**Director of Public Health, Blackpool Council
Chair, Blackpool Fulfilling Lives**

Acknowledgements

The evaluation team would like to thank all the BFL beneficiaries, staff and partners who took part in interviews and provided information to inform this report. We are very grateful to everybody for giving their time and for their honest and insightful comments.

This report was co-produced by a team comprising external evaluators, people with lived experience and BFL staff. It was written by Jane Harris (evaluation project lead for Cordis Bright), evaluation team members Caitlin Hogan-Lloyd, Ceri Hutton, Anna Manning and Bill Carroll, with contributions from Bianca Claydon and Helen Mathie from Homeless Link. Research and analysis was undertaken by the Cordis Bright team and peer researchers Patricia Entwistle, Ben Johnson, Johnny McManus, Steven Brown, John Lowther and John Mason, to whom we are extremely grateful. Training sessions for peer researchers were undertaken by the Cordis Bright team together with David Ford and Chris Brill from Expert Link. We would also like to thank Nicola Plumb, LET manager, for her advice and support with organising training and fieldwork, and Jim Devereux, Team Manager Evaluation and Support Services, for providing the programme data and supporting the process of review.





Executive Summary

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Background to the evaluation

Blackpool Fulfilling Lives (BFL) is a partnership between We Are With You (formerly Addaction), the lead organisation, and representatives from a range of statutory and voluntary agencies in Blackpool. It is one of 12 projects across England that have been funded by the National Lottery Community Fund under their initiative to improve the lives of people experiencing multiple disadvantage.

The Lottery's ambition for the Fulfilling Lives programme is that people should benefit from better, more co-ordinated support; that learning from the programme will inform lasting 'systems change', whereby different ways of working are incorporated into mainstream services, and that people with lived experience will be meaningfully involved at all stages of the development and implementation of the programme.

This report sets out the findings of the fifth evaluation of Blackpool Fulfilling Lives. It was originally intended that the report should cover the period from 1st October 2018 to 30th September 2019, but the scope of the evaluation was extended to explore the immediate response to the Covid-19 pandemic and its impact on people experiencing multiple disadvantage in Blackpool.

How the navigator model works

The Blackpool Fulfilling Lives (BFL) navigator model contains many of the characteristics which are common to navigator models more generally, focusing particularly on: proactive outreach and engagement; flexible working in terms of location, time and format; support without time limits or conditions; and small caseloads.

These core characteristics together contribute to the following strengths of the programme:

- **Securing and maintaining engagement or re-engagement** through proactive and persistent outreach, ease of access, flexible support and the help of the Lived Experience Team (LET).

- **Ability to build a trusted relationship with the client**, which is reported to play a central role in facilitating recovery. Small caseloads and the intensive, long-term support provided by navigators enable this.
- **Provision of tailored support to clients that is asset-based**, particularly through the provision of therapeutic activities which help to build the self-esteem of clients and aid improvements in wellbeing.
- **Filling a gap in existing service provision** for people with multiple complex needs who are still struggling to access support, particularly for mental health.

While proving the need for and value of BFL, the need to 'fill in' a gap in provision was also cited as a challenge for the programme. Other services are reportedly reliant on navigators, both to act as a conduit between services and to support clients. Navigators were concerned that the support they provide cannot replace professional mental health support.

Outcomes for BFL clients

The positive nature of the feedback from all interviewees was consistent with that in previous evaluation cycles: members of staff and the Legacy Board reported that they had witnessed improvements in clients across all areas of need as well as in their general motivation and independence.

The clients interviewed also reported improvements in the following key areas:

- **Mental health and wellbeing:** clients highlighted the importance of meaningful activities and having, in their navigator, a person who cared about them in supporting an improvement in their wellbeing.
- **Substance use:** this was one of the most important outcomes cited by clients, particularly those who had stopped using heroin. Clients had been encouraged and supported to engage with substance use services by their navigators and peer supporters, and were supported through relapses.



FIGURE 1: SUMMARY OF COST SAVINGS

SERVICE	CHANGE IN 12 MONTH COST PER CLIENT
A&E ATTENDANCES	-£489.13
NEL ADMISSIONS	-£4,623.77
ARRESTS	-£4,700.00
TOTAL	-£9,812.90

○ **Housing:** clients reported that their living situation had stabilised as a result of BFL staff helping them to find and manage suitable accommodation.

○ **Offending:** a reduction in offending was reported, largely as a result of a reduction in substance misuse.

These changes in wellbeing and situation were reported to have been facilitated by an **increased willingness and ability to engage with other support services** such as mental health, substance use and housing.

Outcome measures

The reported improvements in client wellbeing and need are supported by the analysis of progress made by clients during their time in the programme based on the four outcomes measures used by BFL:

○ **Homelessness Outcomes Star:** measures ten components found to be important in supporting someone to move away from homelessness.

○ **New Directions Team Assessment:** measures ten indicators of multiple need.

○ **Warwick-Edinburgh Mental Wellbeing Scale:** measures seven items of wellbeing and psychological functioning.

○ **Rosenberg Self-Esteem Scale:** measures ten indicators of self-esteem.

Statistically significant improvements in the mean scores for each component and overall were seen for clients across every outcome measure. This suggests that clients have consistently seen improvements in their living situation, risk levels to themselves and others, support need, mental health and self-esteem as a result of their involvement with BFL.

The financial case

To estimate the cost savings from the BFL programme, the evaluation team conducted economic analysis based on administrative data from 'crisis' services for which BFL is likely to have had the most impact on usage: A&E attendances, non-elective hospital admissions (NELs) and arrests. The team applied tariff costs to the service use data and calculated change in use for clients before and after engagement with BFL.

A summary of the cost savings is presented in Figure 1 above. This shows a mean cost saving of **£9,812.90** per client over a 12-month period, as a result of reduced use of these services by clients.

This analysis suggests that BFL has been successful in its aim of supporting people with multiple needs to reduce their use of these 'crisis' services, improving outcomes for the individuals involved and for the system.



While interviewees reported examples of positive changes in practice among professionals and organisations working with people with multiple needs, it was agreed that the extent of the change had so far been relatively modest and relied on a number of committed individuals.

Systems change

What has changed and why?

Some interviewees reported that a greater understanding of multiple needs had developed across services and among commissioners as a result of involvement in the BFL partnership. Partners are also now reportedly working better together within the Legacy Board, in a positive trend continued since the last evaluation cycle. Interviewees were also able to cite a number of examples of good practice within organisations working with people with multiple needs, for example the removal of penalties for late arrival at the Job Centre. However, it was suggested that these changes stopped short of wholesale systems change.

A range of factors were identified as having enabled the progress made, including key individuals within the Legacy Board, a shared mission facilitated by clear communication and effective leadership, and the navigators themselves when working with other agencies. In particular, all staff and stakeholders stressed the importance of the Lived Experience Team. Through attending meetings and panels, the LET have reportedly helped to persuade external services of the need for change and are helping to embed co-production in the Blackpool system.

What has not changed and why?

Overall, there was a consensus that a system-wide shift had not yet been achieved for people with multiple needs in Blackpool. In particular, three areas were identified as still requiring improvement:

- **Service provision:** services, in particular mental health and substance misuse, remain largely unable to support those with multiple needs due to the continued inflexibility of eligibility criteria and appointment systems. This highlights a remaining gap in service provision for people with multiple needs, which BFL is relied upon to fill.
- **Commissioning:** a strategy for addressing multiple needs has not yet been embedded in local commissioning structures, and the commissioning of mental health and substance use services, for example, remains fragmented and siloed.
- **Lived experience and co-production:** while positive progress has been seen, as described above, a number of interviewees felt that co-production was not yet fully embedded into systems and strategies locally. LET members themselves expressed frustration at what could sometimes feel like tokenistic involvement.

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A range of barriers to achieving systems change were cited by interviewees, most of which were structural and included issues around information sharing, differing accountability structures, a lack of capacity, and competition created by limited available funding. Beyond these structural factors, however, stakeholders suggested that the continuing lack of engagement from key partners in health and mental health had limited the progress that could be made in changing the system for people with multiple needs.

Learning from the response to COVID-19

Blackpool successfully responded to the government requirement, issued in March, to house all rough sleepers within 48 hours. The response was seen to have had a range of impacts both on the local system and on BFL clients.

The impact on the system

The local response to COVID-19 was seen to have positively impacted on the system in Blackpool in three key areas:

- Greater multi-agency working among partners including health and mental health, as a result of the need to provide wrap-around support to the people housed. This included more regular and proactive communication between services.
- More flexible working practices in services, for example in changing the frequency of methadone prescriptions.
- Greater understanding of multiple needs and the value of BFL among services involved in supporting the people housed, due to the important role played by BFL in organising support and facilitating communication between services.

Two key criticisms of the response were that a) people with lived experience, and b) specialist services for people with multiple needs, including BFL, were not consulted early enough in the process. This led to avoidable problems for example in the placement of clients. This was in part a result of the necessary speed of the initial response, however, and has reportedly now been rectified, with the LET recently involved in conducting a survey of those housed.



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The impact on clients

COVID-19 and the lockdown had a significant impact on the work of the navigators, limiting the face-to-face work they were able to do with clients and restricting therapeutic activities. Interviewees reported that a number of clients had struggled with the changes, were experiencing feelings of isolation and could not engage effectively with virtual support. The impact varied by client, however, and some found the use of some telephone support helpful. Some clients felt that navigators had even been able to spend more time with them as a result of switching from face-to-face to telephone contact.

Overall, staff were positive that the changes brought about by COVID-19 had helped clients to gain more independence. This reportedly came as a result of their being trusted to manage their own properties, prescriptions and appointments, which clients responded well to.

It was suggested that some might continue to benefit from a more 'hands-off' approach going forward.

The future of services for people experiencing multiple disadvantage in Blackpool

Staff, stakeholders and clients all expressed their concern about the Fulfilling Lives programme coming to an end in March 2021. It was agreed that a gap would be left in Blackpool if at least elements of the current model were not continued. There was consensus that the following key features of BFL should be continued in some form:

- **The navigator model.** There was a strong and widely held view that the project had proved the benefits of the navigator model, and that this should continue. Views differed as to its form and in particular whether it should be an

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independent service or embedded within an existing one. Some suggested that to influence the system the model should be a part of it and so work within an existing service, while others suggested that this would mean navigators would lose their ability to hold the system to account and advocate for people with multiple needs. A hybrid model was suggested, in which navigators would be embedded in a service but with independent management or oversight.

- **The LET.** Many interviewees saw the LET to be an important legacy of BFL and hoped that it would continue, perhaps embedded within an existing voluntary sector organisation.

- **The Legacy Board.** Interviewees suggested that the continuation of some form of strategic partnership with a specific focus on multiple needs was necessary to avoid a loss of momentum around systems change.

Conclusions and recommendations

Stakeholders who participated in the year five evaluation were almost unanimous in highlighting the positive impact BFL has had on beneficiaries and the need to sustain some kind of legacy beyond the lifetime of the project. Many expressed concern that the closure of BFL will leave a significant gap in service provision.

The achievements of Fulfilling Lives

Interviewees also noted that BFL had already secured a legacy for Blackpool through a number of aspects of its work, including:

- The positive changes many people were able to make in their lives with support from BFL.

- The greater awareness of the important role that co-production with people with lived experience can play.

- Building the case for the importance of peer support.

- The experience and knowledge of the challenges facing individuals with complex needs that BFL team members now have.

- The establishment of new professional relationships and the strengthening of pre-existing relationships. This could help to maintain effective partnership working in the future.

- The range of innovative work that has happened over the last five years that would not have been possible without funding from BFL.

- The successful launch of a Housing First project, a partnership between Blackpool Council and Fulfilling Lives. People supported in this way have reported positive outcomes and some have achieved a degree of stability in their lives that they had not thought possible before.

Improving access to appropriate mental health support for people facing multiple disadvantage

The evaluation of BFL and evaluations undertaken in other Fulfilling Lives areas have consistently found that Fulfilling Lives clients experience challenges in getting support from mental health services. There may be a range of reasons for this:

○ Despite NICE guidance on treatment of dual diagnosis¹, which recommends that mental health services should take the lead, services sometimes find it difficult to work with people who have both mental health challenges and issues with substance misuse. Given the high number of people who are affected by dual diagnosis coming through the doors of both mental health and substance use services, staff face a difficult challenge in deciding who should take the lead in a system which still operates in a compartmentalised way.

○ The high demand for mental health services in Blackpool and successive reductions in the budgets of service providers have made it difficult for services to meet the needs of all those with presenting with mental health challenges. While services might wish to operate in a more proactive, flexible, person-centred way, lack of funding acts as a barrier to this.

○ Establishing what works is not easy given the wide spectrum (and combination) of substance use and mental health problems that exist. Where dual diagnosis is associated with greater challenges for practitioners and treatment services it can be marginalising for service users,

despite evidence to suggest that people with overlapping mental health and substance use problems are in the majority not the minority.

Navigators can play an important role both in helping people to access services and in enabling mental health services to better manage the flow of people presenting with mental health needs. Evidence suggests that they can do this in the following ways:

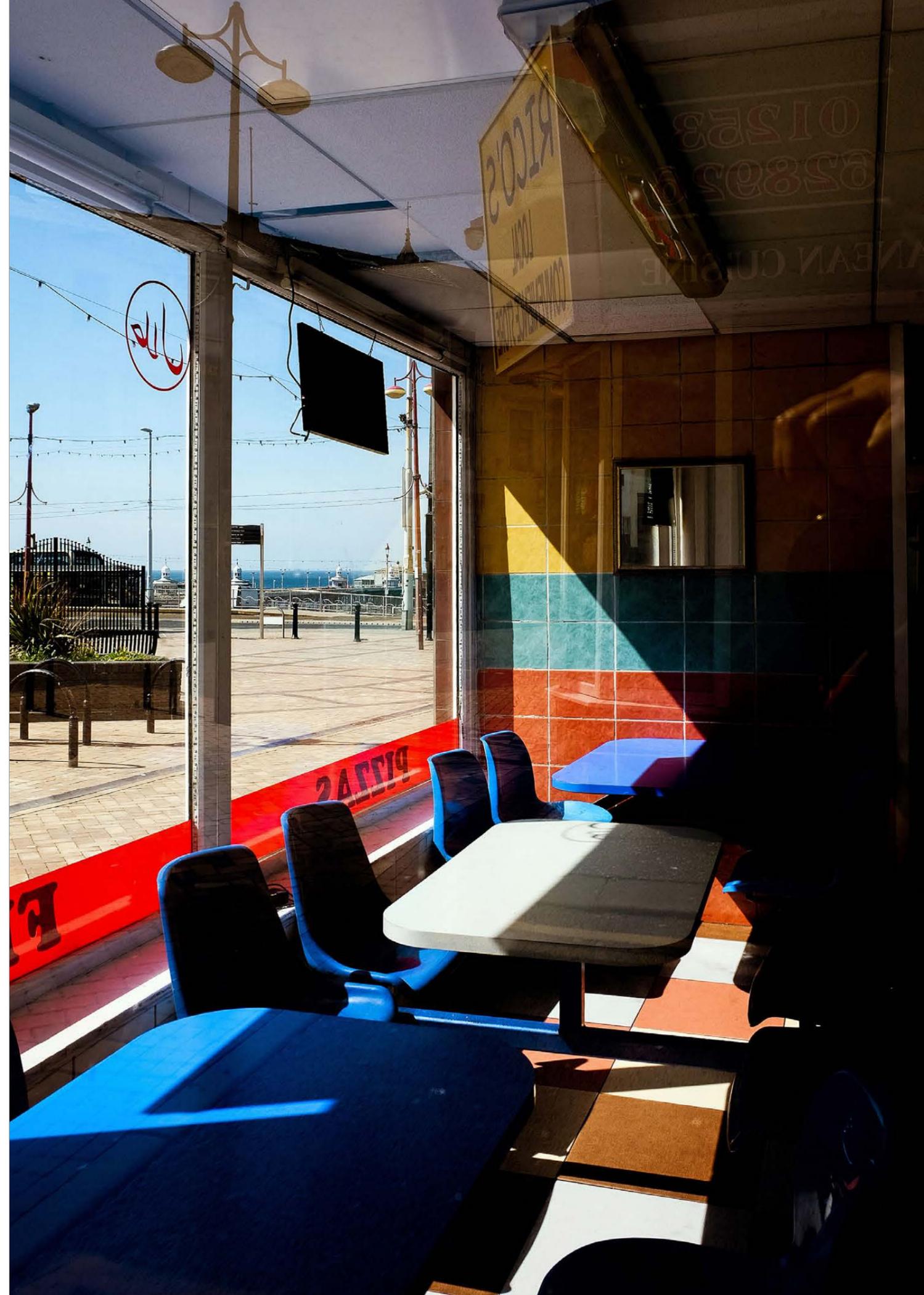
○ By advocating for their clients and helping them to articulate their needs and rights, enhancing the chances that the right decisions are made about their mental health care.

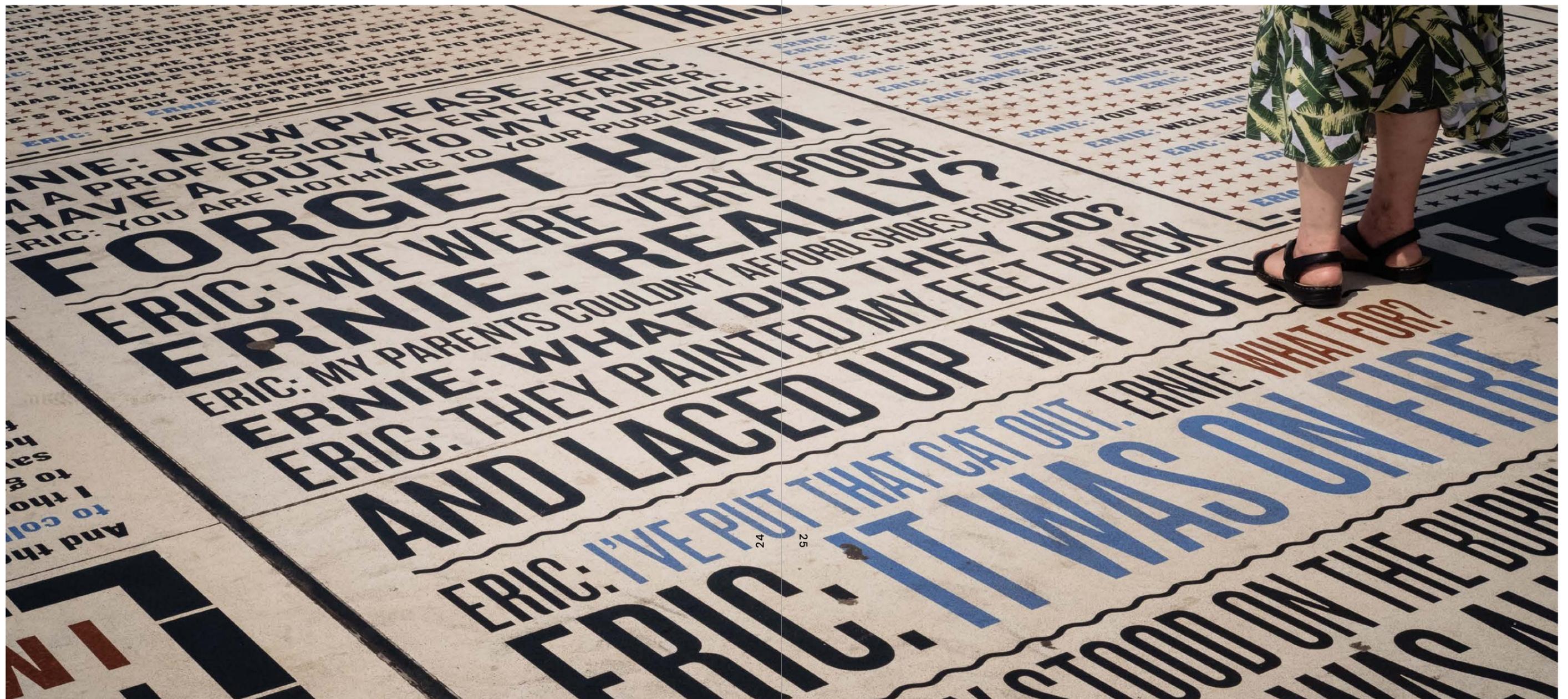
○ Building positive relationships with mental health service providers, helping to develop their understanding of individual clients and the issues that might prevent them from engaging with and benefiting from services.

○ Working with people to address other issues that might be contributing to poor mental health, such as housing, relationships, finances and social connections.

○ Providing practical support to help people engage with services, for example by accompanying them to appointments or supporting them afterwards.

○ Helping clients to access and benefit from peer support.





The recently published Community Mental Health Framework (August 2019)² sets out a new approach in which place-based and integrated mental health support, care and treatment are situated and provided in the community for people with any level of mental health need.

In terms of how this vision is to be realised, the Framework emphasises the role of 'community connectors' (who might also be called 'link workers', 'social prescribers' or 'navigators'). The effectiveness of the navigator model for people experiencing multiple disadvantage has been demonstrated through the experience of

Fulfilling Lives. We suggest that there is a good case for considering the role of a specialist multiple disadvantage or complex needs navigator team, working within a wider team of community connectors to provide the support that would be necessary to ensure that any population-based service arrangements were inclusive for people experiencing multiple disadvantage.

Cost-effectiveness

Fulfilling Lives is cost-effective in that it reduces demand in crucial areas where services are at risk of being overwhelmed (for example, A&E, hospital inpatient beds, criminal justice). The service does not yield cashable savings but does mean that health and criminal justice agencies are more likely to be able to meet the needs of the population without expansion.

2. <https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/>

Recommendations

The impending closure of the project as Lottery funding comes to an end means that our recommendations are focused mainly on taking forward support for people experiencing multiple disadvantage in the future.

1 Retain a multiple disadvantage strategic partnership

The multi-agency partnership that has overseen the delivery of BFL, now the Legacy Board, has been instrumental in raising the profile of multiple disadvantage in Blackpool, building strategic relationships and improving services. The Legacy Board should continue as a strategic oversight group, mirroring the approach taken in the areas which are part of Making Every Adult Matter (MEAM). The national evaluation of MEAM has carried out research into how MEAM partnerships work and has identified the characteristics of effective partnerships³. The report may be a useful source of information to help with thinking about how to configure and run a strategic partnership once BFL has closed.

2 Recognise the importance of co-production and peer support and take concrete steps to embed these in services and support for people with complex needs

Learning about co-production has been at the heart of the Fulfilling Lives programme, but it is not a new concept. There is evidence that co-production with experts by experience leads to improved outcomes and quality of life for people using services; greater satisfaction with using services; increased job satisfaction for people working in services; more efficient services with possible cost-savings, and for society as a whole it means increasing social capital, social cohesion and reassurance about the availability and quality of services (Slade et al 2017)⁴. Recent research by

the national Fulfilling Lives evaluation has found that co-production has helped to bring about systems change in the Fulfilling Lives areas⁵. Similarly, peer support has been a key element of the Fulfilling Lives approach.

Once BFL funding has ended, services in Blackpool would benefit from involving experts by experience in service design and commissioning; continuing to employ people with lived experience in support roles and having a lived experience team to gather intelligence and work with other agencies to improve co-production. A pool of peers who are available to support people experiencing multiple disadvantage (currently being delivered by the LET's 'Peer For You' initiative) would also help to sustain positive outcomes. To this end we recommend that a multiple disadvantage Lived Experience Team be commissioned by a multi-agency partnership and be hosted in an independent organisation with a strong track record in promoting co-production and peer support.

3 Explore possibilities for commissioning a team of specialist navigators to work with people experiencing multiple disadvantage

Navigation helps people connect with services, stay engaged with services, use reactive services less (thus saving money), improve health and wellbeing and achieve socially valued goals, such as making more social connections and enjoying meaningful activities. The evidence base for navigators has been strengthened by the Fulfilling Lives experience. Stakeholders agree

3. <http://meam.org.uk/2020/08/18/year-three-meam-approach-evaluation/>

4. Slade, M., McDaid, D., Shepherd, G., Williams, S. and Repper, J. (2017). Recovery: the Business Case. Nottingham: ImROC.

5. CFE Research (2020). The role of lived experience in creating systems change

5 Continue to manage the transition from BFL

The process of preparing for the end of the BFL service is already underway and the project is now closed to new referrals to ensure that there is time to work with people in a meaningful way before the project ends. Much work has already been done to prepare staff and clients for the transition, although it seems that services with which BFL works are less certain about how they will fill the gap that the end of BFL will leave. Appendix two contains a review of good practice in managing transitions, prepared by Homeless Link. Recommendations on managing the transition are:

- **Continue to liaise with other services about the support people will need after BFL closes. Keep other agencies informed about timescales and schedule joint meetings with clients in preparation for their support from BFL coming to an end.**

- **Work with clients to develop plans for how they want to be supported post-BFL.**

- **Continue to make other agencies aware of the evidence for the effectiveness of the Fulfilling Lives approach and engage them in discussions about next steps.**

- **Put the perspective of people with lived experience at the heart of planning the transition from BFL and any future services that evolve from it.**

- **Use the remaining six months of the project to support other agencies to adopt practices and behaviours that would improve the experience of people facing multiple disadvantage.**

that, in an ideal world, a specialist navigator team would be commissioned to continue to work with people experiencing multiple disadvantage. There is less consensus on how this might work.

For some stakeholders it is important that specialist navigators should operate as a single team, while for others embedding individual navigators into a range of services would be preferable, provided that navigators had access to independent support and supervision. The structure of a navigator team might be determined in part by decisions about where funding would come from and which policy agenda would be best served by employing navigators. These are discussions that need to continue locally, using the evidence set out in this report as a basis for decision-making.

4 Continue to measure outcomes

Consistent measurement of outcomes has been a strength of the Fulfilling Lives programme and has helped the sites and the national evaluation team to demonstrate the value of the approach. In many respects the work that has been done by Fulfilling Lives is an exemplar from which many other voluntary and statutory agencies could learn. It is important that if aspects of the Fulfilling Lives project continue after March 2021, the measurement of outcomes should continue and should be consistent with measuring outcomes for other types of community navigation service in Blackpool.

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1.1 Background to this evaluation

The National Lottery Community Fund has invested £112 million over eight years in local Fulfilling Lives partnerships in 12 areas across England. The programme aims to change lives, change systems and involve beneficiaries. The programme uses co-production to put people with lived experience in the lead and has a strong focus on systems change so that new ways of working can become sustainable.

The vision for Blackpool is that by the end of this project people experiencing multiple disadvantage will be healthier and happier; be identified and engaged in services at an earlier stage; receive better coordinated support with all agencies taking responsibility for their care, and, have access to effective recovery support and improved reintegration. BFL will achieve this vision by enhancing existing services and joint working in Blackpool; 'knitting together' services in new ways and enabling individuals to navigate through health, care and criminal justice systems more easily, and creating sustainable changes to the way services work together.

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Key features of the Fulfilling Lives programme that we know make a difference to beneficiaries include⁶:

- Persistent and ongoing support is essential for people who have previously found it difficult to access and engage with services.
- Complex and entrenched needs take time to address. Fulfilling Lives partnerships are free from the time-limits that restrict some other commissioned services.
- The long-term approach, coupled with small caseloads for workers, means they can build personal relationships based on trust with beneficiaries. This is a key ingredient in providing effective support.
- Partnerships work to provide holistic support and focus on beneficiaries' priorities, rather than working to externally set targets.

The Blackpool Fulfilling Lives project began in April 2014 and is due to end in March 2021. We Are With You (formerly Addaction) is the lead organisation for the programme in Blackpool. The partnership includes representatives from local voluntary and statutory organisations. Statutory representatives include the Police, North West Ambulance Service, Blackpool Council, Blackpool CCG, Lancashire Mental Health Trust and the Probation Service. Voluntary sector representation includes organisations providing mental health services, substance misuse services and support for offenders and people who are homeless.

The work of the project was directed and monitored through a Strategic Board, whose role has now evolved into ensuring a legacy for the project and the embedding of systems change. For this reason it has been renamed 'Legacy Board'.

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This report sets out the findings of the fifth evaluation of Blackpool Fulfilling Lives. It was originally intended that the report should cover the period from 1st October 2018 to 30th September 2019, but the scope of the evaluation was extended to explore the immediate response to the Covid-19 pandemic and its impact on people experiencing multiple disadvantage in Blackpool.

1.2 Evaluation methodology

The evaluation methodology comprised the following activities:

- 1. Interviews with clients:** in-depth semi-structured interviews were carried out with 5 clients, by a group of volunteer peer researchers trained by the evaluation team. The topic guide devised in the first year by the original peer researcher team was updated by the current group.
- 2. Interviews with staff:** semi-structured telephone interviews were conducted with 17 members of the BFL staff team. The interviews focused on the staff members' views on the progress the programme has made in its final year, the outcomes achieved by clients and the programme's legacy.
- 3. Interviews with Legacy Board members:** video interviews were carried out with 17 Legacy Board members, by members of the evaluation

team together with members of the peer researcher team. These interviews focused on the impact of Fulfilling Lives on the system in Blackpool. Two online workshops were conducted in which peer researchers analysed the interview findings and identified key themes for inclusion in the report.

4. Analysis of project data: the evaluation team analysed data about clients received from BFL's Evaluation and Learning Manager. This included the Homelessness Outcomes Star, the New Directions Teams Assessment scores, the Warwick-Edinburgh Mental Wellbeing Scale and the Rosenberg Self-Esteem Scale.

5. Economic analysis of external administrative data: the evaluation team conducted an economic analysis by applying cost tariffs to arrests and hospital admissions data for BFL clients before and after their engagement with the programme.

Two 'deep dives' into the literature have also been conducted by Homeless Link, into two key areas of interest for this year's report: the role of the navigator (embedded in Section 3) and transitions to and from services (included in Appendix B). The methodological approach to the analysis of project and external administrative data conducted by the evaluation team is outlined in full in a separate technical appendix.



A note on COVID-19

All fieldwork conducted as part of this year’s evaluation activity occurred after the announcement of the lockdown in March. This meant that the majority of evaluation activity, including interviews with staff and Legacy Board members, as well as workshops with the peer research group, were conducted virtually. For the most part, we do not feel that this limited the quality of fieldwork, particularly as the peer research group were still able to conduct interviews with the evaluation team over Zoom.

It was felt that client interviews could not be conducted virtually, due to the needs of the individuals involved. A member of the evaluation team therefore travelled to Blackpool and conducted socially distanced interviews, along with members of the peer research team, over two days. The difficult circumstances may explain the lower number of clients taking part in interviews than has been the case in previous years.

1.3 Structure of this report

The report is structured as follows:

- **Section two** provides a summary of the demographic characteristics of people who used the BFL project over the five years since it started.
- **Section three** contains findings from the deep dive into the role of the navigator in a range of settings and outlines the role played by the navigator model in Blackpool.
- **Section four** reviews the impact of BFL on clients, based on qualitative interviews and analysis of the outcome measures used by BFL.
- **Section five** contains an analysis of potential financial savings from the programme based on service usage.
- **Section six** contains an updated review of the progress made towards systems change in Blackpool.
- **Section seven** provides a review of the learning from the response to COVID-19 in Blackpool.
- **Section eight** presents ideas about the future of BFL.
- **Section nine** contains conclusions and recommendations for the project as it draws to a close and for other similar projects in the future.

Fulfilling Lives clients

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7. BFL worked with 530 clients in total. But for 108 of those clients there was insufficient data to allow for comparable analysis. For example, some of these cases were only opened for a relatively short period of time and/or evaluation tools were only completed on assessment and not reviewed.

8. The data cleaning process involved removing data entries in which there were typos or errors. Data were excluded for 3 clients, either because they were duplicate entries or because the end date for support was before or the same as the start date.

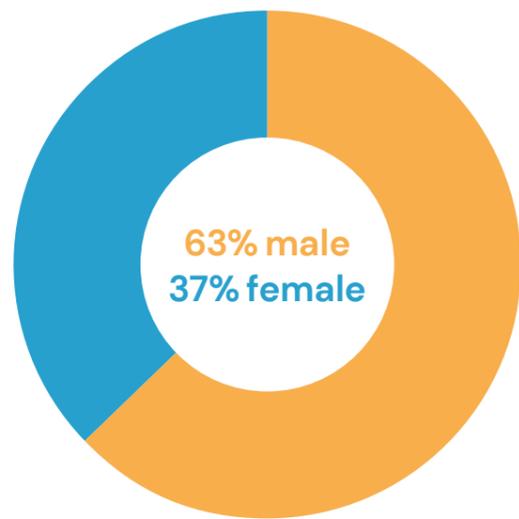
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2.1 Overview

In this section we provide a summarised profile of the clients who have accessed BFL over the full course of the programme. Analysis is based on demography and need. For a more complete breakdown please see the technical appendix.

Useable data were received for **422 clients**^{7,8}, 87 of whom were still engaged with the programme. The average length of support for these clients was **15 months**.

2.2. Demographic profile of BFL clients



Of this cohort, 63% of clients were male and 37% were female. Only **one client reported not being cisgender**⁹.

Of those clients for whom data were collected (47% of the total cohort), **91% reported their sexual orientation to be heterosexual.**

38

The **mean age of client across the programme is 38** but the majority of clients are spread quite evenly between the 26–30, 31–35, 41–45 and 46–50 age brackets.

The majority of clients reported their ethnicity to be White British (89%), **with only 2% reporting that they identified with another ethnicity** (data were not collected for the remaining 9%).

15%

Of the overall cohort, 15% reported that they had a disability.

38

39



2.3. Need profile of the BFL cohort

Only half of the clients for whom data were received were experiencing **homelessness** when they first engaged with the project, while **offending, mental health need, and substance misuse** were experienced by 85%, 87% and 95% of clients respectively. Overall, 85% of clients were experiencing at least three concurrent needs when they first engaged with the project.

Of the total cohort, 7% of clients (29 people) were involved in Housing First.

9. I.e. is the client's gender identity the same as the gender identity they were assigned at birth.

The role and impact of the navigator team

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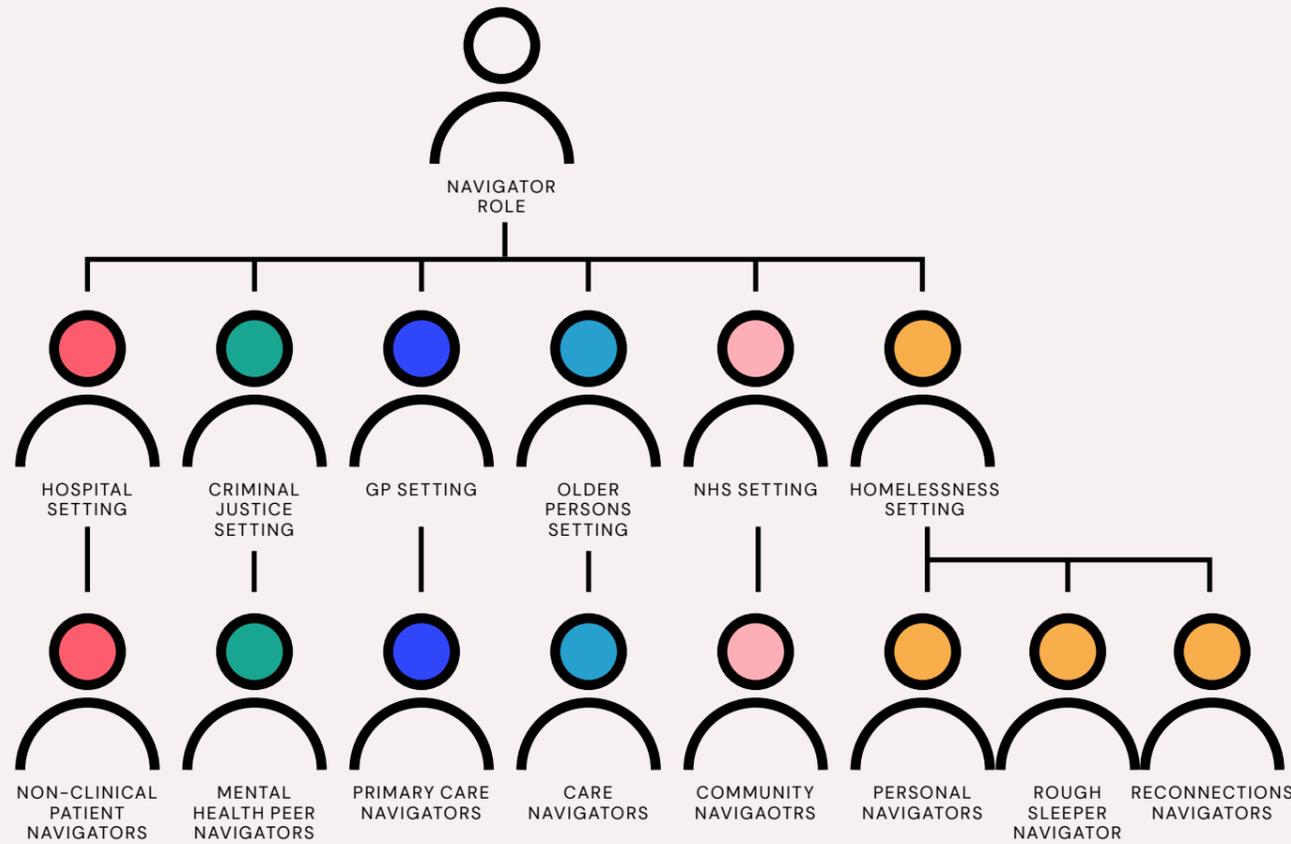
3.1 Introduction

One of the aims of this evaluation has been to draw together evidence about the role and impact of the navigator. This section contains a rapid review of literature on this subject. The literature review considered the following key questions:

1. What is the navigator role?
2. The benefits of the navigator role
3. How navigator roles are commissioned
4. The effectiveness of navigator roles
5. Barriers to effectiveness

We then go on to present and discuss evidence from the evaluation about how the BFL navigator role has worked.

FIGURE 2: THE NAVIGATOR ROLE IN DIFFERENT CONTEXTS



3.2 What is the navigator role?

The following summary explores the themes arising from literature related to the role of the navigator:

- **Connecting individuals to services**
- **Supporting individuals through existing provision**
- **Educating individuals**
- **Addressing needs of individuals**
- **Adopting a flexible approach**

The literature looks at different contexts in which the role exists (see Figure 2). Navigation is vital in supporting individuals experiencing a particular need and it is an approach distinct from other methods of engagement. The need for this type of role is to bridge gaps in services for individuals experiencing multiple needs.

3.2.1. Connecting individuals to services

One of the key roles played by navigators is connecting individuals to different services. For example, a qualitative evaluation of the London Homeless Social Impact Bond (SIB), explores the role of two types of navigators: personal navigators and reconnections navigators. The SIB intervention was designed as a navigator model to provide long-term personalised support for individuals from the street into stable accommodation. Navigators maintain links with the landscape of existing provision so that individuals they support are able to access appropriate interventions (Mason et al., 2017).

Mental health peer navigators, working in a criminal justice setting, provide support by linking individuals to services (Portillo et al., 2017). The individuals supported were returning from prison with diagnosed mental health needs. In practice, this role extended beyond supporting these individuals as it influenced the criminal justice setting and its interaction with the community.

In an evaluation of care navigators, Darnton et al. (2018) note that the care navigators' role is to take time with each person referred, to undertake a holistic assessment and develop a plan. The care navigators support every individual to connect with a large number of services. An evaluation of the service found that the individuals who were supported by the care navigators were older, take more medications, and have higher need. A survey completed by other health professionals found that individuals least likely to benefit from care navigation were younger people with existing access to a good support network.

3.2.2. Supporting individuals through existing provision

Existing provision has been described as difficult to 'navigate'. For individuals experiencing multiple needs or dealing with a challenging time, this added pressure can stop them even attempting to navigate through available services, despite this provision being suitable and needed by the individual. Beyond just connecting individuals to other services, therefore, navigators support individuals to access these services and advocate on their behalf.

Available literature also discusses the role of both the personal navigator and the reconnections navigator as a single point of contact for individuals experiencing homelessness when moving from the street into more stable accommodation, and the services working with them (Mason et al., 2017). Ultimately, the personal navigator and the reconnections navigator act as the key worker of the individual, where a relationship is built to support individuals in entering and sustaining accommodation. Being a single point of contact means the navigators advocate for people who experienced homelessness, advocating with benefit claims, health appointments, and court issues.

MEAM (2018) also explain that rough sleeper navigators should be a single point of contact and build trust with the individuals they are supporting. Rough sleeper navigators enable individuals to successfully engage, or re-engage, with services they would otherwise be excluded from. The focus of the rough sleeper navigator role should not be on developing a new service, but rather on coordinating existing services better.

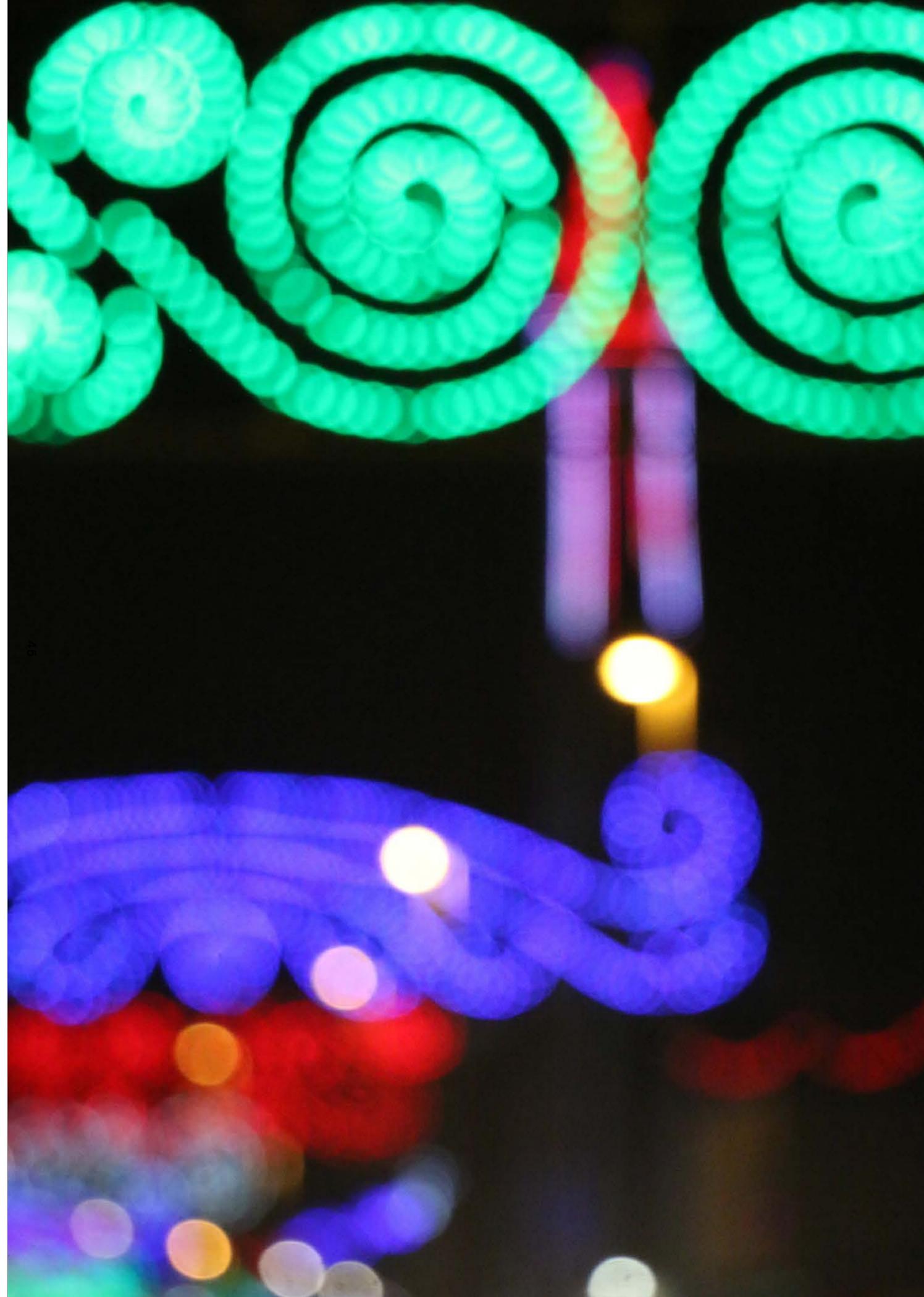
3.2.3. Educating individuals

One of the purposes of a navigator is to educate and inform people, particularly people who are unlikely to be able to access that information easily themselves, about what services might be available to them. Garner et al. (2015) describes the benefits of care navigators approaching patients in Accident & Emergency waiting areas (who had been triaged by the assessment nurse as only requiring non-urgent appointments) to educate and inform them about available local services. These local services included “GP and out of hours services, pharmacies, sexual health services, improving access to psychological therapies and self-care.” This resulted in a 30% increase in individuals leaving A&E without being seen between 2012 (pre-navigators) and 2013 (post navigators), indicating that the individuals may have left A&E to access other, more appropriate, sources of healthcare.

3.2.4. Addressing needs of individuals

Individuals are unique, and by extension so are their needs. A community navigator programme was designed to reduce loneliness for adults with complex depression or anxiety who were using secondary mental health services (Lloyd-Evans et al., 2020). Loneliness and social relationships are often under-addressed in mental health services, and the role of the community navigator addresses this. The programme was delivered in two NHS settings where navigation support has previously not been offered. Adults taking part in the programme were offered a budget, agreed with the community navigator, to use towards social activities and developing networks, depending on the needs of the individual. Similarly, Mason et al. (2017) report using budgets to successfully engage individuals and describe both the personal navigator role and the reconnections navigator role as taking an assertive, tailored approach (rather than deliver any one intervention) in order to provide long-term personalised support to individuals from the street into stable accommodation. A budget would allow the navigators to adopt a personalised approach.

Rough sleeper navigators, funded by the Ministry of Housing, Communities, and Local Government (MHCLG) offer personalised approaches based on the needs of individuals, not the needs of services (MEAM, 2018). The support provided by the rough sleeper navigators builds on an individual’s strength and the support is shaped by understanding how trauma can impact presenting behaviours of individuals.



3.2.5 Adopting a flexible approach

Flexibility is often overlooked in the roles that exist in many agencies delivering services to the public, and the ability to make changes to respond effectively is not always possible. Rough sleeper navigators are described as being confident to act in flexible ways for individuals and call on flexible responses from other services, including statutory and voluntary services (MEAM, 2018). No conditions are, or should be, placed on support.

The health and social care navigator role was developed for health care workers, to help equip staff with the skills to plan and develop new and existing roles for a modern NHS. The role would ensure that the workforce has flexible skills and capabilities to support individuals with long term conditions around self-care (Leveaux et al., 2012). The article describes an example where the health of an individual experiencing multiple conditions improved with taking prescribed medication. The care navigator had worked with both the GP and chemist to be flexible in their response and provide the individual with a dossett box.

Anderson & Clarke (2009) explore a navigation model for individuals with mental health and addiction that was developed by a community-based steering committee. They look at service flexibility and transparent communication, amongst other priorities and principles. The flexible way of working is noted as being adaptable and evolving over time to respond to changes in demographics and demand. The need for a flexible service would meet the priorities of a range of providers, including community, individual, and services.

3.3 What are the benefits of the navigator role?

Benefits of the navigator role identified in the literature are:

- **Improving individuals' awareness and access to other services**
- **Effective liaison with partner agencies**
- **Ability to offer more time to individuals than other roles**
- **Effective mental health support**

3.3.1 Improving individuals' awareness and access to appropriate services

Individuals may not always be aware of their condition or needs, or have awareness of services available to them. Sometimes going through a challenging time will reduce the likelihood of an individual managing well and independently accessing the right information or provision. Macredie et al. (2014) describe how individuals felt the care navigation role helped them to better understand their condition and supported them to increase contact with key services to better manage their condition. Carers of supported individuals felt that after the navigation intervention there was a greater understanding of conditions.

Navigators can also help to ensure that individuals are accessing the most appropriate services. Garner et al. (2015) found that the number of patients attending A&E did not increase significantly between the years that the navigators were in post, compared with rising attendances elsewhere in the country. It is expected that A&E attendance may reduce over time, as more patients interact with navigators and consider more appropriate alternative



services upon receiving information from the navigators.

3.3.2 Effective liaison with partner agencies

Evidence shows how navigator programmes can improve liaison with external agencies.

Garner et al. (2015) explore a non-clinical patient navigator programme, delivered in a hospital setting and commissioned by CCG. Their review highlights that non-clinical patient navigators improved links with GP practices and improved the quality of information received, in this case about enrolment process.

An independent evaluation of care navigators, delivered in the Isle of Wight as part of a system transformation programme, found that other staff working with the care navigators found they helped connect and join up services, and this resulted in the workload of GPs being reduced (Darnton et al., 2018). The care navigator role also improved the knowledge and integration of health, care, and voluntary services in the Isle of Wight context. For example, the care navigators improved the knowledge of GPs regarding their patients as they spent more time with individuals who accessed the GP. The care navigators take a collaborative approach in their work. A survey

revealed that colleagues of the care navigators rely on the service and would really notice a difference if the service were withdrawn. The care navigators effectively linked in with other community roles, for example local area coordinators in the Isle of Wight.

3.3.3 Ability to offer more time to individuals than other roles

Navigator programmes can reduce pressure on other caseloads across different settings. Navigator roles tend to have lower caseloads, giving them increased time to spend with individuals. The additional time this provides for individuals is seen as a valuable benefit of the model. For example, the A&E staff working alongside non-clinical patient navigators felt that the main benefit of the navigators was that they could offer more time to patients to talk through any processes and details of how services work, and provide an important bridge between patients and staff (Garner et al. 2015). The evaluation found that non-clinical patient navigators often spent time with individuals correcting their electronic patient records which resulted in fewer patient records being lost on discharge. Up to date medical information can result in better treatment, which was what 55% of patients wanted as an outcome of their A&E visit.



3.3.4 Effective mental health support

Regardless of the type of setting the navigator role is delivered in, the individuals accessing support often experience additional needs including around their mental health. These are often not met by other roles and navigators across settings have been shown to improve the mental health support an individual receives.

Beneficiaries of the community navigators programme reported that taking part was a positive experience. Other stakeholders felt that it was a useful addition to mental health support (Lloyd-Evans et al., 2020). Individuals identified two key elements to the community navigators programme: the community navigators' focus on moving forward, in contrast to other mental health roles (which often focus more on problems and the past), and the provision of dedicated time and space to focus on social connections. Community navigators were found to support social connectivity; individuals supported by the community navigator role felt more comfortable interacting with others, became more aware of social opportunities locally, and started to attend regular groups and courses. Mason et al. (2017) also highlight how personal navigators coordinated networks of support for individuals who had previously experienced rough sleeping. This included engagement with positive activities and encouraging social networks, as well as coordinating support from services.

Transitioning from prison presents challenges such as reconnecting or connecting with treatment, finding housing, employment, and reuniting with family and friends. Mental health peer navigators worked with individuals released from prison, and for those individuals who had significant mental health challenges, the navigators helped build skills, which resulted in better management of mental health needs (Portillo et al., 2017).

3.4 How is the navigator role commissioned?

While available literature explores different navigator roles in some detail, there is less evidence about how existing programmes have been commissioned or funded. We summarise below three of the main themes to emerge from the literature reviewed.

Multiple sources of funding

Darnton et al. (2018) review a care navigator service originally funded using non-recurrent National Lottery and NHS Vanguard funding – which is now a commissioned recurrent service, funded by three different sources.

Outcomes based commissioning

Mason et al. (2017) explain that the homelessness navigators' delivery began with supporting those from the street into more stable accommodation (sustained outcomes), but then focused on different outcomes in the second year of the role. There are two important features of the outcomes to be used in similar circumstances: the outcomes must have clear evidential requirements and they must be clearly defined. This is to enable commissioners to be certain they are paying providers for the outcomes that have been achieved. Navigators reported that being focused on outcomes provided motivation and focus, as well as a better awareness of needs and progression of the individuals they were supporting. On the other hand, resources were targeted towards individuals who were more likely to achieve outcomes during the final year. However, it was reported that this did not mean that other individuals were neglected entirely. Sustained outcomes required a large amount of support from the navigators.

Commissioning organisations

A number of navigator roles, such as care navigators, dementia navigators, and community navigators have been commissioned by Clinical Commissioning Groups (CCGs). For example, Wellbeing Enterprises Community Interest Company (WECIC) are one of the largest, most established providers of social prescribing – providing financial support to access social activity that is beneficial to individuals. In the North of England, WECIC are commissioned by CCGs to provide navigation support to individuals leaving secondary mental health services.

3.5 How effective is the navigator role?

Available evidence looks at the effectiveness of navigator models in terms of outcomes for individuals, but also in terms of cost savings.

3.5.1 Economic benefits

The North and East London Commissioning Support Unit developed an economic model to evaluate the benefits of the non-clinical patient navigator role, delivered in a hospital setting and commissioned by the CCG. Garner et al. (2015) report an average net monetary benefit of over £160,000 per year for each whole time equivalent navigator. Assessing the economic benefits of navigator programmes does have challenges, and Mason et al. (2017) highlight that the lack of health data limited providers' and investors' understanding of the effectiveness of the intervention, whilst also impacting on the ability to judge cost-effectiveness.

One evaluation focused on six care navigators working in integrated health and social care teams and found that health related quality of life measures improved by 17% for individuals they were supporting. It found that these

individuals needed to use fewer health services, and the project was cost-effective overall (Windle et al., 2010).

3.5.2 Self-improvement of individuals

Evaluations have also explored whether individuals working with the navigators report an improvement across a number of domains. Significant improvements were found in four measures (health status, health confidence, personal wellbeing, and experience). Overall, findings showed that the care navigator role improved individuals' confidence to self-manage, make healthy lifestyle choices, improve safety in their home, reduce social isolation, and improve their quality of life (Darnton et al., 2018).

There is also evidence that holistic support provided by navigators results in individuals addressing their needs (Mason et al., 2017). A particular achievement was that long-standing mental health issues of individuals were diagnosed.

3.6 What are the barriers to the role's success?

Research highlighted the following themes from the literature concerning barriers to successfully delivering the navigator role:

- **Individuals' engagement and expectations**
- **Referrals**
- **Length of support**

3.6.1 Individuals' engagement and expectations

The effectiveness of a care navigator role can be disrupted by the willingness of individuals to



engage as they often declined support or did not feel that they needed any support (Darnton et al., 2018). Lack of success was also found to be due to excessive expectations of individuals being supported. The distinction between dependency and self-management was difficult to manage as individuals assumed care navigators would be around in the long-term, as opposed to supporting them to begin self-management. Mason et al. (2017) worked with individuals from the street who are moving into more stable accommodation and found that those who required the most support had the highest levels of need and often took several months to engage.

3.6.2 Referrals

Darnton et al. (2018) found there were issues around referrals for the care navigators: fluctuating levels of referrals, poor referral situations as a proxy for poor working relationships, and issues with the management of re-referrals. However, the evaluation report revealed that the service received a large number of referrals (averaging 130 referrals per month) and found an enabler to the role's success was to co-produce integrated processes to manage referrals. Also, careful planning is needed at the start of the programme whereby the care navigators engage and communicate with referral partners to explain who and how to refer to the navigator service.

3.6.3 Length of support

The length of support offered by navigator programmes can also be a barrier. Lloyd-Evans et al. (2020) found that some individuals expressed that the community navigator programme was not long enough to address the longstanding nature of mental health needs and loneliness holistically. Community navigators could encourage positive long-term change, but difficulties might not be resolved, according to respondents who participated in the programme. Qualitative feedback concluded that improvements to the role would be to have a longer period of support and more sessions with the community navigator.

For the rough sleeper navigator programme, Mason et al. (2017) identify participants' high levels of mental health needs as a challenge for the final year of delivery. Although there were three years of delivery of the model this was still not long enough to effect long lasting change, especially for those individuals with entrenched lifestyles.

Taylor et al. (2015) also point to a lack of time to fulfil navigation. The primary care navigator role has now been extended to include individuals with other long-term conditions, and not just individuals with dementia.

“The navigator model gave a huge opportunity for people to learn from that model. Intensive work, small caseloads, keep trying with people, work out of hours. That’s what we’ve been asking for in the service sector for so long. So much of it is nine-to-five, one appointment, if you miss it, that’s it.”

Legacy Board member

3.7 How the BFL navigator model works

In this section we outline the key characteristics of the BFL navigator model, and the overarching strengths of the programme that these characteristics combine to create.

3.7.1 Key characteristics of the approach

BFL staff reported that the navigator model and role has evolved over the course of the programme to become more clearly defined and better understood by other services:

“I think it has formed over the years and now it has turned into something which is a model which works.”

Staff member

In line with previous years, staff and stakeholders reported that the navigator model provides the following to clients:

- Outreach
- Support in accessing other services, including triaging to mental health (discussed in section 3.7.3)
- Therapeutic activities
- Practical support
- Emotional support
- Peer support, via the Lived Experience Team (LET)

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Beyond the core activities delivered, the key characteristics of the model were consistently reported by interviewees to include the following:

- Proactive approach, including reaching out to clients to engage or re-engage them.
- Flexible working, in terms of location, time and format.
- Long-term support without time limits.
- Lack of conditions placed on support, meaning that missed sessions do not mean removal from the programme.
- Small caseloads and intensive one-to-one support.

This approach was summarised by one Legacy Board member as follows:

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“The navigator model gave a huge opportunity for people to learn from that model. Intensive work, small caseloads, keep trying with people, work out of hours. That’s what we’ve been asking for in the service sector for so long. So much of it is nine-to-five, one appointment, if you miss it, that’s it.”

Legacy Board member

3.7.2 Strengths of the model

Many of the core characteristics of the navigator model outlined in Section 3.7.1 were also identified by staff, stakeholders and clients as the strengths of the model, that distinguish the Fulfilling Lives approach from that of other services.

Beyond these, four overarching strengths of the programme can be identified, each of which is enabled by a combination of the core characteristics of the model. These are:

- Effective engagement of clients
- Ability to build a trusted relationship with clients
- Provision of tailored support for clients
- Filling a gap in service provision

Engagement

Staff members reported that BFL had successfully reached the people it set out to support and that levels of engagement had been consistently high. This is because of the programme’s focus on the following key areas:

Securing engagement

The programme has a strong focus on engaging clients through proactive and assertive outreach, identifying people in need of help, seeking them out and persuading them to enter the programme.

“I was on the streets and BFL came and found me and got me into Horizon and onto methadone. It must have been back breaking work because me and [my partner at the time] moved around all the time and they had to keep coming to find us.”

Client

Maintaining engagement

Many of the core characteristics of the navigator model were reported to help secure

the continued engagement of clients: small caseloads, a lack of time limits or conditions placed on support, and a flexible approach to delivery. The clients interviewed shared the view that BFL is open and available to those who need it, with one describing the service as “there for you”. This ease of access, particularly the ability to contact their navigator by phone or receive support without having to go into an office, was cited as a key reason for their continued engagement:

“I don’t think they could do anything more. It was really easy to get service, any problems we have we can ring [our navigator].”

Client

Reengagement

When clients do disengage from the programme prematurely, staff reported that measures have been put in place to try to understand the reasons for this and to adapt practices accordingly. Staff also reported a focus on trying to reengage those who drop out of the programme by allowing them to reengage flexibly on their own terms, for example through drop-in sessions. One navigator described a client of theirs who had disengaged from BFL and had eventually been sent to prison. However, following visits from his navigator while in prison he had re-engaged with the programme on his release and had experienced an improvement in his substance use and housing.

For securing and maintaining the engagement of clients with BFL, as in previous years, navigators stressed the importance of patience and persistence, or being prepared not to give up after initial obstacles or failures. Legacy Board members attributed the ability to do this to the small caseloads of the navigators and the ability of Fulfilling Lives to “manage its front door better” than other services.

The Lived Experience Team (LET) were also reported to be crucial in securing and maintaining the engagement or reengagement of clients with the programme. Staff members described the two main ways in which the LET support their work as follows:

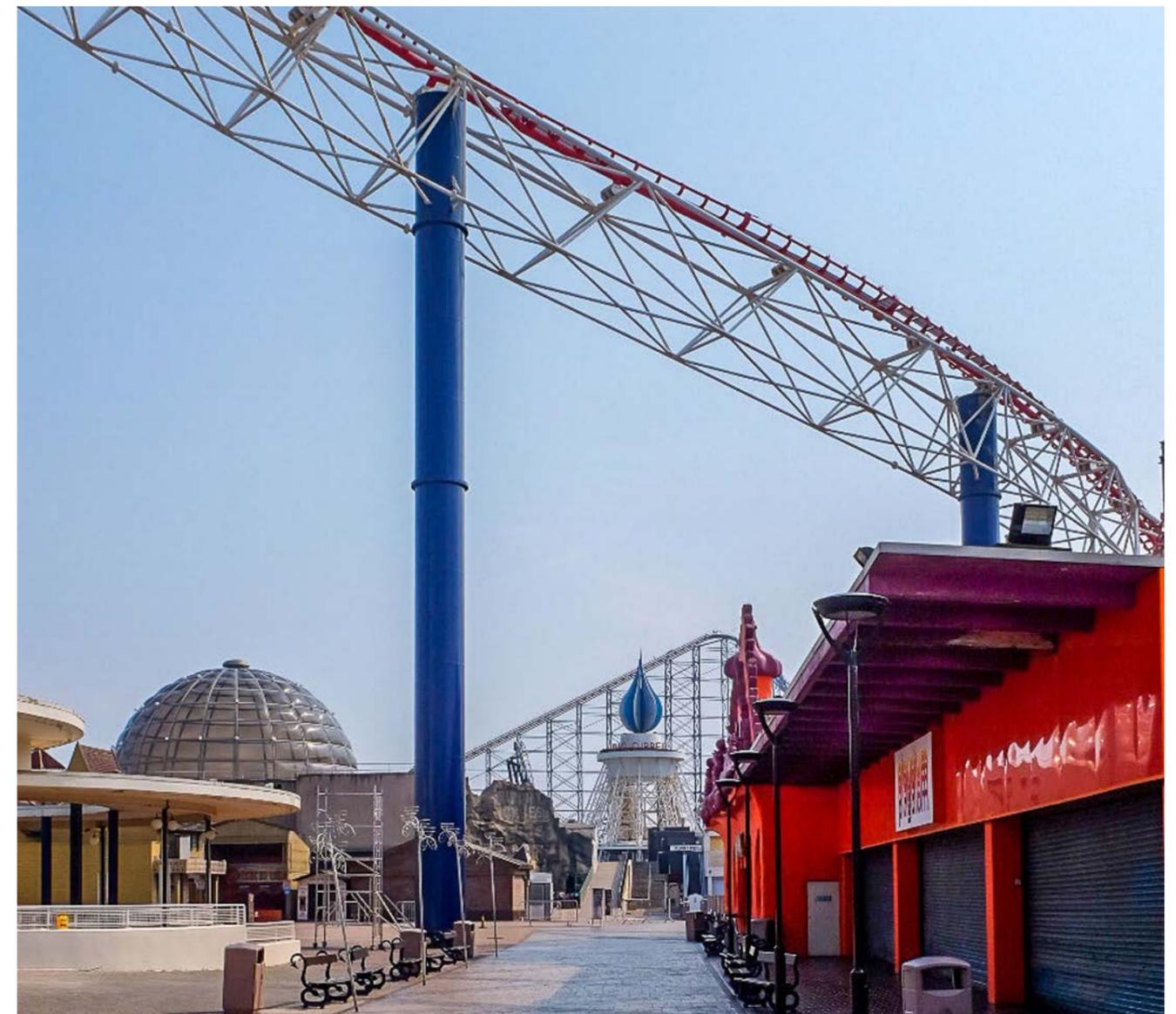
- Assisting navigators to engage with particular clients in a motivational capacity, helping them to continue with their support:

“There’s been times when I have had clients and I wasn’t too sure what to do and I said ‘I think she may need a bit of realisation that recovery is possible’ – that’s massively useful for our clients. The Lived Experience Team are living and breathing proof.”
Navigator

- Following up with clients that had disengaged from BFL to understand the reasons why, and what could have been changed, and feeding this information back to BFL staff. This process was reported to have improved over the course of the programme:

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“We have a more robust lived experience team, more effective in contacting people who have disengaged from the project, and a LET more representative of the type of clients that we work with as well. There’s a system in place now”

Staff member

Trusted relationship

Key to the BFL model is the ability of the navigators to build a trusted relationship with

clients. All clients described a very positive relationship with their navigator, and were clear on the central role played by this relationship in leading to the improvements seen in their lives (discussed in Section 4.2). For example, one client commented:

“[My navigator] is absolutely great, she’s really excellent. She’s helped me so much. She’s different to other workers in other services because she understands me and understands where I’m coming from.”

Client



This view was supported by Legacy Board members, who agreed that navigators were successfully able to build good relationships with clients and so help them to make more progress than other services might be able to:

“I think because there’s more time and understanding because [BFL staff’s] focus is almost getting to know the person and their wellbeing rather than for us, focussing on their drug use or their mental health perspective... If clients are being listened to, they’re more likely to be honest in their responses. It’s more of a relationship-building situation. It’s about a deeper level of understanding than from one service.”

Legacy Board member

Clients and navigators both stressed the importance of this being a long-term relationship, with consistent support provided by one person in order to build up trust. This consistency of support was reported by clients to have been key to making lasting improvements in the areas of substance misuse, offending, and housing, particularly when faced with relapses:

“It’s been excellent. I’ve been involved four to five years. Over the last couple of years Fulfilling Lives has been a constant in my life, getting practical support, getting off drugs and even getting a flat.”
Client

Tailored support

The provision of person-centred and asset-based support that is tailored to each individual client was flagged by staff and Legacy Board members as a key strength of the programme and an important lesson for other services wishing to deliver similar work. The following features of the support were highlighted as being particularly important in allowing for this:

- A robust assessment conducted at the beginning of the client’s journey to ensure that they receive the right support.
- Small caseloads, allowing for this tailored and flexible approach to support.
- The provision of therapeutic activities tailored to the needs of the individual.

Navigators provided examples of clients for whom a bespoke mixture of support and activities tailored to their needs had helped them to increase their self-esteem, which in turn positively affected other aspects of their lives. One navigator, for example, described a client who had disengaged from BFL, but began to re-engage through drop-in sessions and meaningful activities that the navigator helped them to access:

“I arranged for her to go on a woman’s self-esteem day where there was her and another four women. That was massive for her [...] and that helped lift her self-esteem. She ended up going to detox, got off the alcohol, we linked her into women’s service who did a mind fit session building assertiveness – she did a 12-week course there. She started to fly after that, while still engaging in drop-ins and doing therapeutic stuff. She started to go to an art group three times a week. She ended up signing up to college – doing health and social care, she signed up with the LET and now is closed to the service.”
Navigator

to their inflexibility for example with regard to exclusion criteria.

“I think Fulfilling Lives is a really important service, and what it’s shown us is that there has been a gap addressing the needs of people facing multiple needs. It’s brought to light that you need a slightly different approach for people that are potentially the most disengaged from any of the services.”

Legacy Board member

While this was seen as proof of the necessity of BFL, the continued gap in provision for people with multiple needs is also a continuing challenge for the programme, as discussed in Sections 3.7.3 and 6.4.

3.7.3 Challenges and areas for improvement

The main challenge reported by navigators in fulfilling their role was the continued inflexibility in the other services from which their clients require support, and in particular the lack of sufficient mental health provision. Navigators felt that they had to “fill in” for this gap in client’s mental health support, which was a cause of anxiety for several interviewees:

Filling a gap

Due to the lack of conditions placed on the receipt of support, Fulfilling Lives was reported to fill a gap in local service provision for people facing multiple needs. One client reported that they had accessed Fulfilling Lives when social services had “said there was nothing they could do for me and passed me on.”

Other services, on the whole, were reported by staff and Legacy Board members to remain poorly suited to people facing multiple needs, due

“There is a fear because you are not qualified and a mental health worker – what if I say the wrong thing? I get really worried about doing the wrong thing with mental health issues. But because there is such a lack of funds, you have got to run with it really and do the best you can.”

BFL staff member

“It’s a balancing act – you try really hard to engage them and really when you do that you need to be thinking how you disengage from them even if it is two years down the line.”

Staff member

In particular, navigators stressed the “balancing act” that this required, in providing intensive, person-centred support to clients without creating a dependency, and empowering clients to build skills and take control of their own support.

More generally, a number of staff members flagged an over-dependence on BFL, and navigators in particular, to act as a network between services and to fill in gaps in the work they were able to do (this is discussed further in Section 6.4):

“A lot of it was around the dependence which not just clients but other services were having on us. We were filling gaps and picking up agencies’ work they should have been doing”

BFL staff member

“It’s a challenge that sometimes it’s easier for a worker to do something for someone rather than empowering them to do it themselves.”

Staff member

A number of staff members noted that this ability to empower clients was central to the role of the navigator, and that it was not a skill that all outreach workers possessed, stressing the importance of recruiting and training navigators with an appropriate level of skill.

3.8 Supporting transition from Fulfilling Lives

Navigators stressed the importance of encouraging clients to transition away from the service and suggested that this should be planned for from the beginning of engagement.

The findings from a deep dive into the importance of transitions to and from services and how to support them effectively are outlined in Appendix B.

“

There is a fear because you are not qualified and a mental health worker – what if I say the wrong thing? I get really worried about doing the wrong thing with mental health issues. But because there is such a lack of funds, you have got to run with it really and do the best you can.”

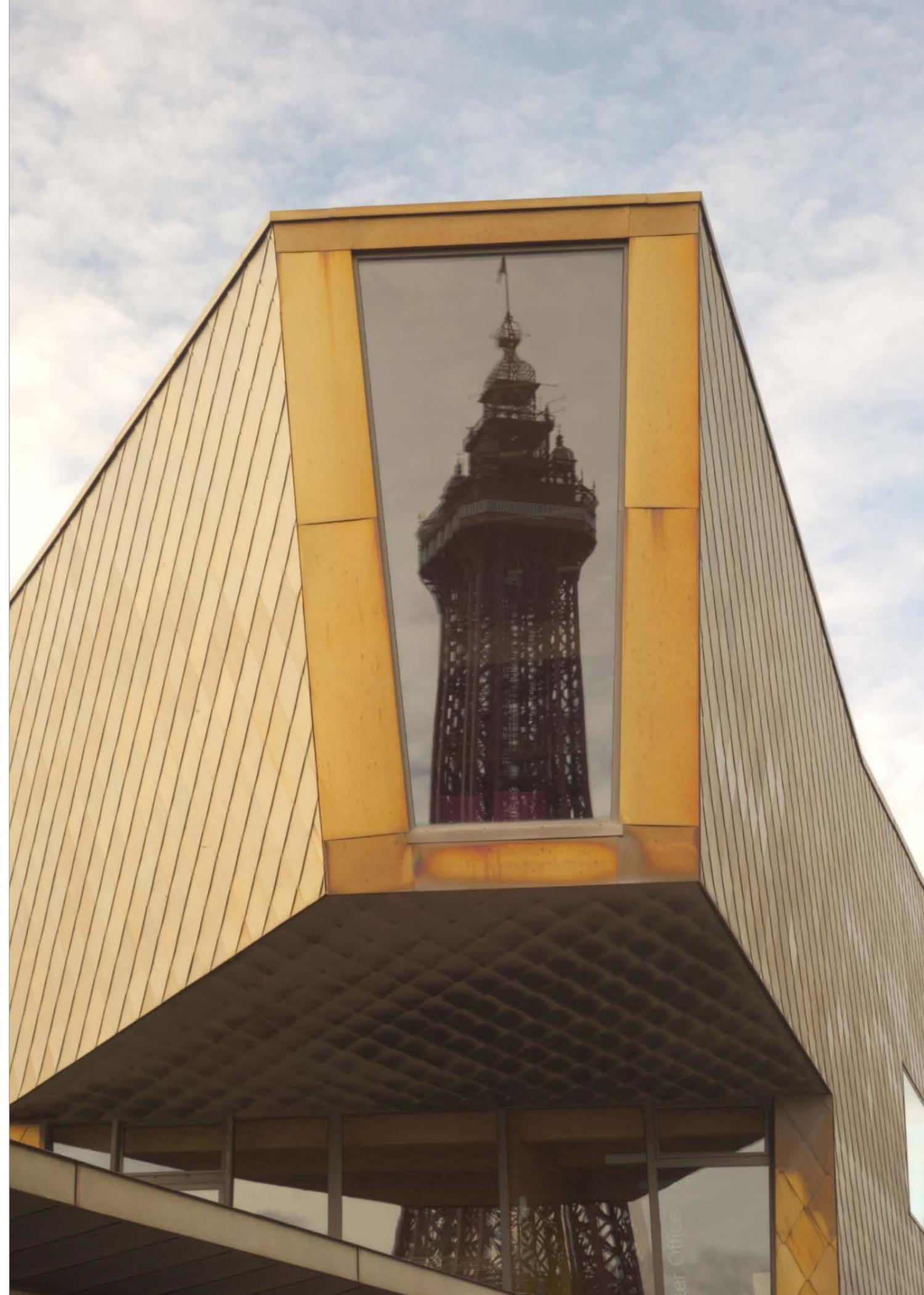
BFL staff member

FIGURE 3: ONWARD DESTINATION OF THE BFL COHORT WHO HAVE DISENGAGED FROM THE PROGRAMME

ONWARD DESTINATION	COUNT OF CLIENTS	PERCENTAGE
MOVED TO OTHER SUPPORT (NOT FUNDED THROUGH BFL)	17	5%
NO LONGER REQUIRES SUPPORT	109	33%
CLIENT DISENGAGED FROM PROJECT	93	28%
PRISON	32	10%
HOSPITAL	6	2%
DECEASED	29	9%
MOVED OUT OF AREA	43	13%
EXCLUDED FROM THE PROJECT	2	0%
OTHER	4	1%
TOTAL	335	100%

3.8.1 Onward destination of clients

A breakdown of the onward destination for the 335 clients for whom data were received and who had disengaged from the programme is outlined in Figure 3. The destinations of the clients varied, with the most common being 'no longer requires support' (33%) and 'client disengaged from project' (28%).



Outcomes for Fulfilling Lives clients

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Introduction

In this section we outline the impact of the Fulfilling Lives programme on clients in Blackpool, as reported in interviews with clients, staff and Legacy Board members (discussed in Section 5.2), and evidenced by the analysis of a range of outcome measures (presented in Section 5.3).

4.2 Impact on clients

The positive nature of the feedback from all interviewees was consistent with that in previous evaluation cycles: members of staff and the Legacy Board reported that they had witnessed improvements in clients across all areas of need as well as in their general motivation and independence.

“There's no doubt that there are people alive in Blackpool now because of the intervention of Fulfilling Lives. There are people in accommodation, jobs, volunteering opportunities, people maintaining abstinence, all of those things as a direct result of Fulfilling Lives. There is loads of evidence of that, but I have also spoken to these people. People [who have been] on streets for 20 or 30 years and for the first time in their lives, living a life that is 'normal'.”
Legacy Board member

Staff members stressed that this progress was in general quite individually defined, noting that some clients experienced “smaller steps” in their journeys that should nevertheless be celebrated as progress, particularly when they displayed signs of clients taking more control over their own support journeys:

“We have to look at small wins. Getting them into a property and them maintaining that property is a win. A client dealing with their own health issues is a win, and phoning the doctor is a win. Making their own appointments is a win.”
Navigator

The views of clients themselves varied as to which aspect of their life had improved the most as a result of BFL, but the most frequently mentioned changes were entering recovery for heroin addiction, improvements in housing situation, and improvements in mental health and wellbeing. Indeed, two clients suggested that if it wasn't for BFL, they wouldn't be here today.

4.2.1 Areas of improvement

A range of improvements were cited by interviewees in the following areas:

- Mental health and wellbeing
- Substance use
- Housing situation
- Offending
- Access to other services

Mental health and wellbeing

All the clients interviewed reported improvements of some kind in how they feel. For example, one client reported feeling happier since being in recovery from heroin addiction. Another client shared feeling more optimistic about getting “back on track” after having “given up on life.” A third client reported that their emotional state had become more stable since being supported by BFL:

“I've been a tearaway and I'm an absolute nightmare at times. I think FL have calmed me down a little bit. I don't know how, but they have.”
Client

When speaking about improvements in their wellbeing, clients highlighted the role that new, positive uses of time and therapeutic activities had played. For one client, this was volunteering with long-term prisoners and caring for their cats; for another this was painting. The importance of therapeutic and meaningful activities such as art, volunteering, or simply going for a walk, in improving the wellbeing and self-esteem of clients was also stressed by staff and Legacy Board members.

Beyond activities, simply having a person who cared about and was kind to the client, in the form of the navigator, was reported to be crucial in making a difference to their wellbeing:

“The improvement in mental health – this is an important point. This wasn't down to mental health services. It was more down to the way people were behaving with those individuals – with simple kindness. We had navigators that really cared and wanted to hear about people's lives and built that rapport. That does a lot when you're trying to improve someone's mental wellbeing.”

Legacy Board member

Whilst they had been beneficial, it was stressed that therapeutic activities and the support provided by navigators should not be seen as a replacement for professional mental health support, which clients still struggle to access.

Substance use

Clients reported positive progress in their substance use and emphasised that this was one of the most important changes to them.

Four of the five clients who were interviewed had previously struggled with substance misuse. All of them reported a reduction in their usage since being supported by BFL, with three no longer using heroin and one scheduled to attend rehabilitation to stop using methadone.

The role played by BFL in these changes, clients reported, was firstly working with clients to prepare them to engage with substance misuse support, and subsequently linking them in with relevant service such as drug and alcohol and rehabilitation, once they were ready. Persistence and outreach were key features of this first element of support provided by BFL, clients reported:

“[My navigator] made me think it would be pointless for [my partner] to be on one [a prescription] and not me; she made something turn around in my head. Other people have been patronising and made us feel like children, but not [my navigator].”

Client

While their substance misuse had improved, clients stressed that this had not been a linear process and that they had experienced relapses. For example, one client, who had been supported for four years, stated:

“The benefits I’ve had from it have been amazing. I’ve had relapses, but I’m now on methadone and cutting down [my methadone use]. But it’s been a roundabout and I’ve had relapses – it isn’t easy.”

Client

Housing

On the whole, clients reported that their living situation had become more stable since beginning work with BFL. Four of the five clients who were interviewed reported having steady housing, whilst one client had been temporarily housed due to COVID-19 but stated that they knew BFL could help them with housing:

“They have helped me with housing, but I’m my own worst nightmare and I keep losing flats because of silly things. [...] I know BFL will help me find somewhere.”

Client

The role played by BFL in their housing situation, clients reported, had been helping them to find and manage suitable accommodation, for example by supporting them to organise deposits or finding accommodation that best met their needs.

“They got us into a hostel at Christmas and now we’ve got a place. When we got the place we were on drugs and now we’re clean we don’t like the place. It’s got slugs coming in. [My navigator]’s going to help us get a different place.”

Client

Offending

A reduction in offending was a common improvement reported by the clients who were interviewed. Three clients reported that they no longer offended, whilst one reported that their offending had only reduced marginally.

For the three clients whose offending had stopped completely, this was tied to their stopping using heroin.

Access to other services

Helping clients to access and improve their relationship with other support services, such as mental health, substance misuse and housing, is a core feature of the BFL programme. To do this, navigators told of reminding clients about appointments and accompanying them if necessary. In particular, navigators reported that they aimed to improve the quality of clients’ interactions with services, not just the frequency. Achieving this goal still poses a challenge to the programme, as discussed in Section 4.7.3, but positive progress has been made for many clients. Indeed, there was a consensus amongst the clients interviewed that their relationships with other services had changed since being supported by BFL.

Firstly, clients reported being involved with a greater number of services since being supported by BFL, such as housing, mental health support and substance misuse services. Clients shared examples of ways in which these services, such as the DWP, had helped to meet their practical needs. In addition, clients reported that they were more eager to engage with support services than before they had been supported by BFL and now felt that they knew where to get help:

“I’ve got more understanding of services and where to go for help. I know there are services out there for people. Four years ago I wouldn’t have had a clue where to go looking for help.”

Client

This view was supported by Legacy Board members, who reported that services had perceived an increase in trust and engagement from clients, as a result of the support provided by navigators:

“I feel that clients trust us more and feel more capable to be honest.”

Legacy Board member

“The clients have definitely benefited from support of navigators, are engaging with services much more than they ever have done in the past – it has definitely proven to be successful.”

Legacy Board member

“

I've been a tearaway and I'm an absolute nightmare at times. I think FL have calmed me down a little bit. I don't know how, but they have.

Client



4.2.2 Impact of demographic factors

When questioned on whether there was a specific cohort of clients that was more likely to respond to the BFL approach, interviewees generally reported that there were no clear predictors and that it often depended on the client's specific situation. However, a number of staff members noted that entrenched homeless rough sleepers with alcohol or drug issues were the least likely cohort to initially engage with support. Some Legacy Board members also suggested that those with certain criminal records may find it more difficult to access housing and so experience improvements in their position.

Some interviewees also reported that younger clients were more likely to engage and remain engaged with BFL:

"I think young people possibly do better, if they stay engaged. Their lifestyle is probably more

able to change and do new things, more flexible. For older people it's harder to do that, particularly for men as well."
Staff member

4.3 Outcomes measures: analysis of reported changes

Four key outcome measures are used by BFL to monitor the progress made by clients during their time in the programme:

- Homelessness Outcomes Star
- New Directions Team Assessment
- Warwick-Edinburgh Mental Wellbeing Scale
- Rosenberg Self-Esteem Scale

For each outcome measure, the evaluation team analysed the reported change in scores for clients between the start of their engagement with the programme and the end, or their most recent assessment if support was ongoing. For more

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detail on the approach to determining sample eligibility and conducting the analysis, please see the technical appendix.

Statistically significant improvements in the mean scores for each component and overall were seen for clients across every outcome measure. This suggests that clients have consistently seen improvements in their situation, need, mental health and self-esteem as a result of their involvement with BFL.

4.3.1 Homelessness Outcomes Star

The Homelessness Outcomes Star (HOS) is a tool made up of 10 components which are found to be important when supporting someone to move away from homelessness, each of which is scored from 1 to 10. The 10-point scale for each component is based on the Journey of Change model, wherein different scores indicate a different stage in the journey, as shown in Figure 4 below¹¹.

Of the cohort eligible for analysis, **a statistically significant¹² increase in the mean score between T1 and T2 was seen for all HOS components** and the mean overall score increased by 12.4 points. 65% of clients reported an improvement in their overall score. Only in two areas, however, 'self-care and living skills' and 'managing tenancy and accommodation', did the change in mean score indicate a change between Journey of Change stages. The change for each component and overall is outlined in Figure 5 below and in graphical form in Figure 6.

FIGURE 4: THE JOURNEY OF CHANGE MODEL

JOURNEY OF CHANGE STAGE	SCORE
STUCK	1-2
ACCEPTING HELP	3-4
BELIEVING	5-6
LEARNING	7-8
SELF-RELIANT	9-10

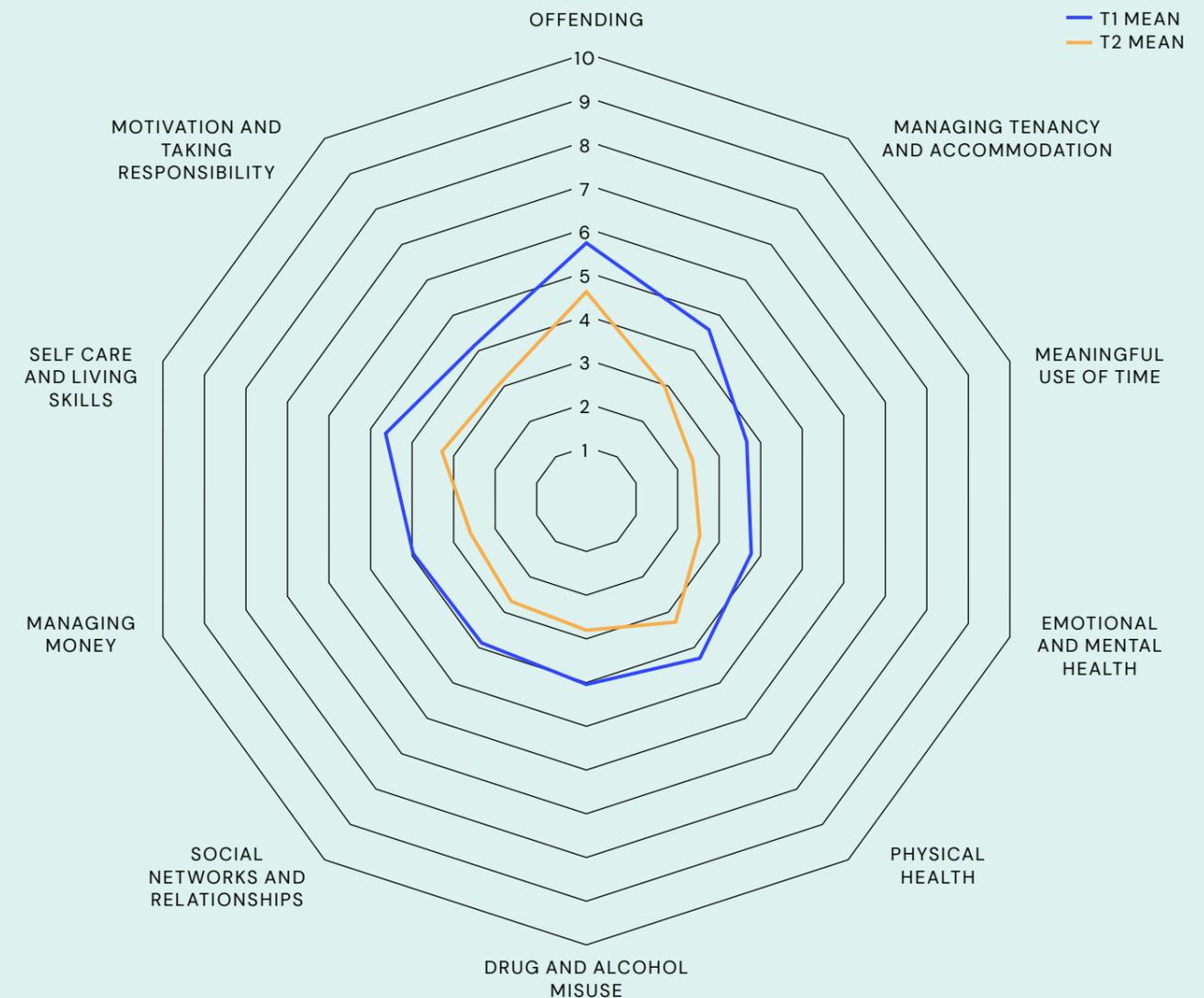
11. Organisation Guide. Outcomes Star. The Star for people with housing and other needs. Organisation. Triangle Consulting Social Enterprise and London Housing Foundation, 2013.

12. Calculated using a two-tail paired two-sample t-test for means.

FIGURE 5: ANALYSIS OF HOS SCORES (N=288). T1 AND T2 MEAN SCORES ARE COLOUR-CODED ACCORDING TO JOURNEY OF CHANGE STAGE (SEE FIGURE 4 FOR KEY).

HOS ELEMENT	DIRECTION OF CHANGE	T1 MEAN	T2 MEAN	CHANGE	P – VALUE ¹³	% WHOSE SCORE INCREASED BETWEEN T1 AND T2
MOTIVATION AND TAKING RESPONSIBILITY	INCREASE	3.3	4.3	+1.0	<0.0001	52%
SELF-CARE AND LIVING SKILLS	INCREASE	3.4	4.7	+1.3	<0.0001	54%
MANAGING MONEY	INCREASE	2.7	4.1	+1.4	<0.0001	57%
SOCIAL NETWORKS AND RELATIONSHIPS	INCREASE	2.9	4.0	+1.2	<0.0001	51%
DRUG AND ALCOHOL MISUSE	INCREASE	3.0	4.2	+1.2	<0.0001	51%
PHYSICAL HEALTH	INCREASE	3.4	4.4	+1.0	<0.0001	51%
EMOTIONAL AND MENTAL HEALTH	INCREASE	2.7	4.0	+1.2	<0.0001	52%
MEANINGFUL USE OF TIME	INCREASE	2.5	3.8	+1.3	<0.0001	56%
MANAGING TENANCY AND ACCOMMODATION	INCREASE	3.1	4.7	+1.6	<0.0001	55%
OFFENDING	INCREASE	4.6	5.7	+1.1	<0.0001	46%
TOTAL HOS SCORE	INCREASE	31.6	44.0	+12.4	<0.0001	65%

FIGURE 6: T1 AND T2 MEAN SCORES FOR HOS COMPONENTS (N=288)

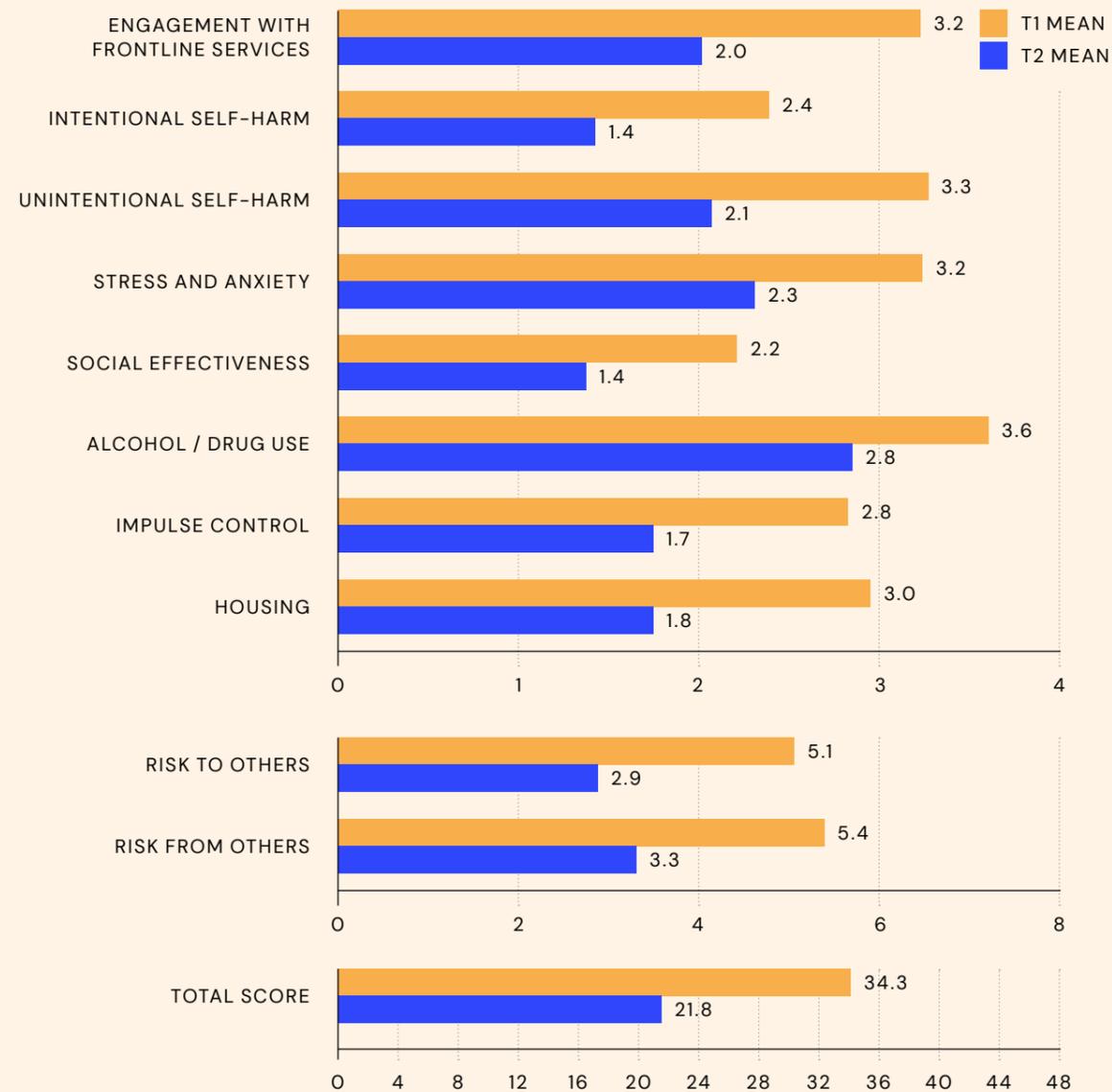


13. If the p value is less than 0.05, we can be reasonably confident that the result is statistically significant at the 95% confidence level. If it is statistically significant, the value is shown in bold. If it is not statistically significant, "NS" appears.

FIGURE 7: MEAN SCORE AT T1 AND T2 FOR NDTA SCALE (N=302)

14. Components are scored from 0 to 4, with the exception of 'risk to others' and 'risk to self', which are scored from 0 to 8 in increments of 2 (i.e. 0, 2, 4, 6 or 8).

15. Calculated using a two-tail paired two-sample t-test for means.



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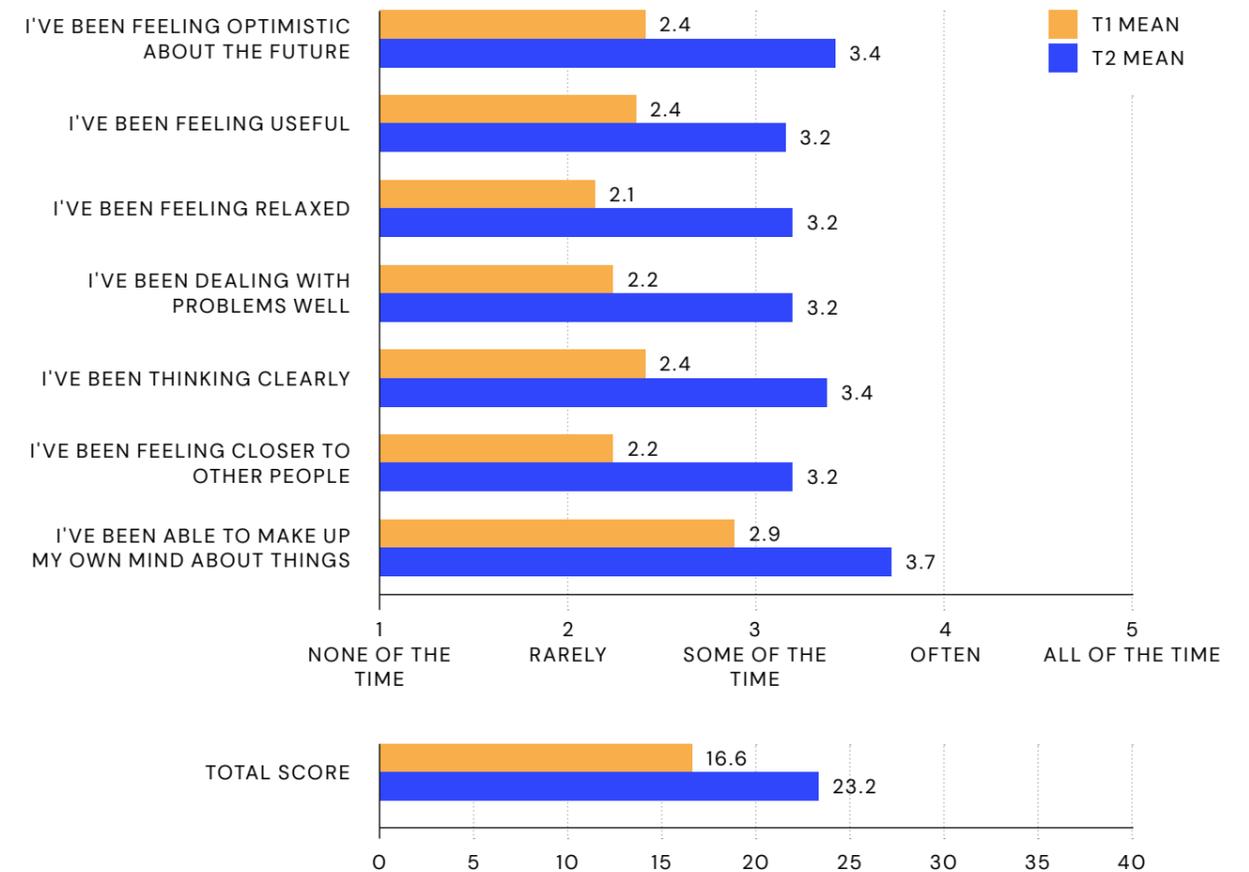
New Directions Team Assessment

The New Directions Team Assessment (NDTA) is made up of 10 components which are indicators of multiple need. A reduction in score indicates a decline in need and represents positive progress¹⁴.

A statistically significant¹⁵ decrease in mean score between T1 and T2 was seen for all NDTA components, indicating a reduction in need. The mean overall total score decreased by 12.5 points. This change is represented graphically in Figure 7 above.

FIGURE 8: MEAN SCORE AT T1 AND T2 FOR SHORTENED WEMWBS (N=99)

16. Calculated using a two-tail paired two-sample t-test for means.



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Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

The shortened Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), used by BFL, is a scale of mental well-being covering seven items of wellbeing and psychological functioning. Items are scored on a one to five Likert scale, where one indicates 'none of the time', and five indicates 'all of the time'.

A statistically significant¹⁶ increase in mean score between T1 and T2 was seen for each component of the shortened WEMWBS, indicating an improvement in wellbeing. The increase in mean score was around 1 for each component, representing a shift from 'rarely' agreeing with each statement to 'some of the time'. The mean overall total score increased by 6.6 points. Figure 8 represents this change graphically.

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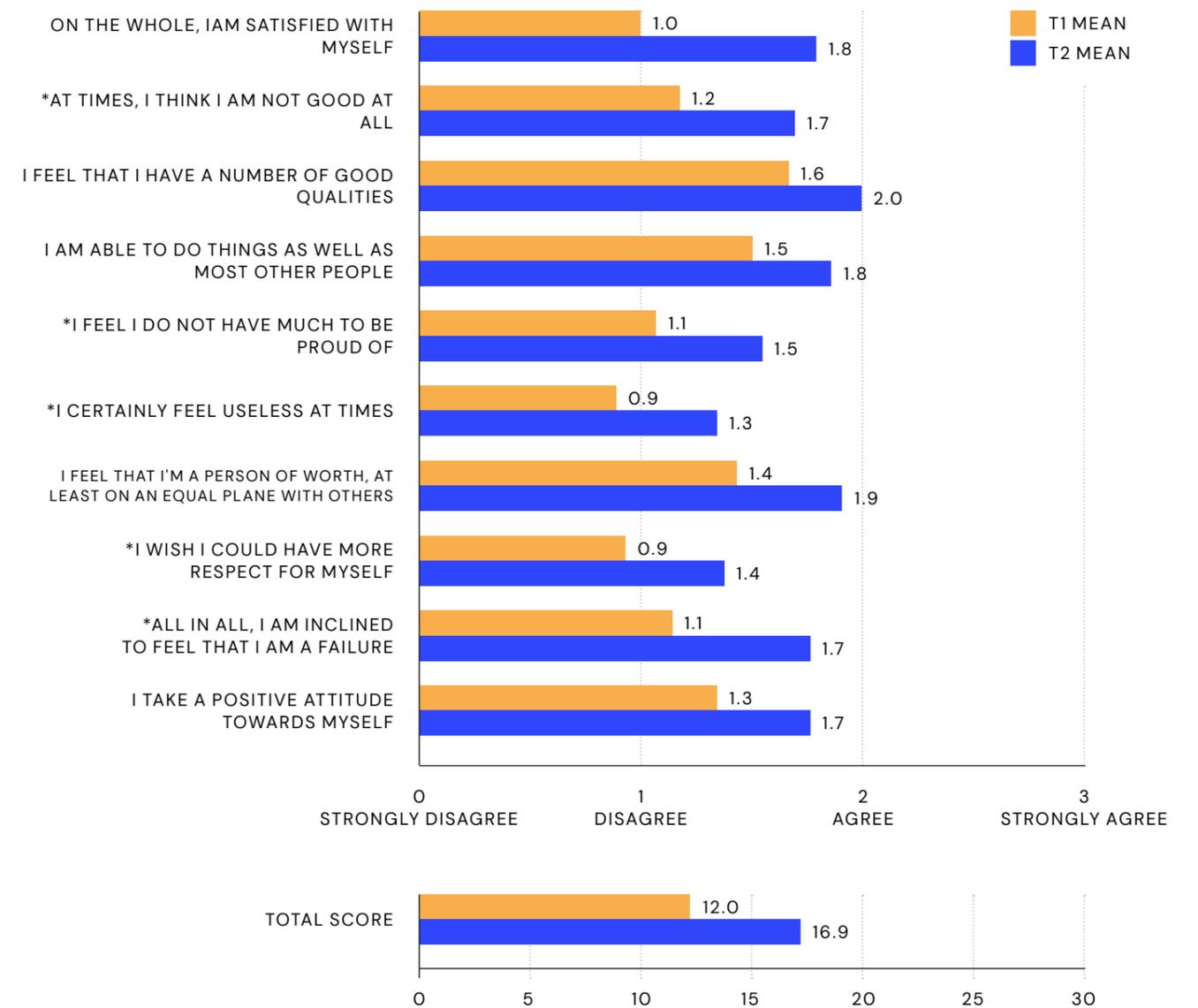
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4.3.4 Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale is a 10-item assessment with items answered on a four-point Likert scale from strongly agree (3) to strongly disagree (0). Four of the items are reversed scored, i.e. strongly agree is scored as a 0 rather than a 3 (these are indicated by asterisks (*) below).

A statistically significant¹⁷ increase in the mean score between T1 and T2 was seen for each component of the Rosenberg scale, indicating an improvement in self-esteem. The increase in mean score was roughly 0.5 for most components, generally representing a shift from disagreeing to agreeing with each statement. The mean overall total score increased by 4.9 points. Figure 9 represents this change graphically.

FIGURE 9: MEAN SCORE AT T1 AND T2 FOR ROSENBERG SCALE (N=89)



17. Calculated using a two-tail paired two-sample t-test for means – see Figure 18 for more details.

The financial case for the Fulfilling Lives approach: service use

5.1 Introduction and methodology

To estimate the cost savings from the BFL programme, the evaluation team conducted economic analysis based on administrative data from services for which BFL is likely to have had the most impact on usage.

Anonymised admissions data for 175 BFL clients¹⁸ at Blackpool Teaching Hospitals NHS Foundation Trust were received from NHS Midlands and Lancashire Commissioning Support Unit. We have focused on A&E attendances and long-stay non-elective hospital admissions (NELs), excluding elective admissions, outpatient appointments and short-stay NELs from the analysis (see Sections 6.2.1 and 6.2.2 for more detail on the analysis approach).

Anonymised arrests data for a cohort of 30 BFL clients¹⁹ was received from Lancashire Constabulary via a serving police officer seconded to the BFL team (see Section 6.2.3 for more detail on the analysis approach).

18. Clients had joined the programme between 2014 and 2019 and had given consent for their records to be accessed and their NHS number passed to the hospital for this purpose.

19. Clients had joined the programme between 2014 and 2019, had been engaged with the programme for at least six months and had a minimum of five arrests recorded during the 12-month period prior to joining BFL.

FIGURE 10: SERVICE USE COST TARIFFS

TYPE OF SERVICE USE	TARIFF	SOURCE / INFORMATION
A&E ATTENDANCES	£166 PER ATTENDANCE	NHS IMPROVEMENT (2018) REFERENCE COSTS 2017/18: HIGHLIGHTS, ANALYSIS AND INTRODUCTION TO THE DATA, NHS IMPROVEMENT, P.5: "A&E ATTENDANCE 2017/18" (£160 WHICH WE INFLATED TO 2019 PRICES).
NON-ELECTIVE ADMISSIONS (NELS)	£3,053 PER EPISODE	PERSONAL SOCIAL SERVICES RESEARCH UNIT (2019), UNIT COSTS OF HEALTH AND SOCIAL CARE 2019: "NON-ELECTIVE INPATIENT STAYS (LONG STAYS)"
ARRESTS	£750 PER ARREST	GREATER MANCHESTER COMBINED AUTHORITY (2019), UNIT COST DATABASE: "ARRESTS – DETAINED".

20. The tariffs used were agreed by Cordis Bright with CFE research as part of the national evaluation of the MEAM Approach, with the aim of ensuring the MEAM Approach evaluation findings were comparable with findings of the Fulfilling Lives evaluation.

This data was used to perform an economic analysis by applying tariff costs to the service use data and calculating change in use for clients before and after engagement with BFL. The data and tariffs used to perform this analysis are outlined in Figure 10 above.

We have attempted to align our tariffs with those used by the national Fulfilling Lives evaluators, CFE, but where possible have sought to use 2019 cost tariffs or to inflate costs to 2019 levels²⁰. Please see the technical appendix for more information on tariffs used and the approach to analysis.

FIGURE 11: ECONOMIC ANALYSIS FOR A&E ATTENDANCES (N VARIES)

21. For T2 figures, this 'total' score is based on mean annual visits rather than the actual number of total visits, as the time period covered by T2 data varies by client. See Figure 12 below for more detail.

22. These figures are based on clients' mean annual A&E visits, rather than their total actual number of A&E visits, as the time period covered by the original T2 data varied by client. This was to enable comparison with T1 data, which covers a time period of 12 months. As such, the 'total' T2 figures were calculated by adding up each

client's mean annual number of A&E visits, to reach a representative total annual number of visits for all clients. The 'mean' T2 figures show the mean of all clients' annual mean number of A&E visits.

23. If the p value is less than 0.05, we can be reasonably confident that the result is statistically significant at the 95% confidence level. If it is statistically significant, the value is shown in bold. If it is not statistically significant, "NS" appears.

SAMPLE	NO. A&E VISITS	T1	T2 ²²	CHANGE	CHANGE IN COST	P VALUE ²³
JOINERS 2014 (N=12)	MEAN	7.7	3.3	-4.4	-£722.28	0.0151
	TOTAL	92	39.8	-52.2	-£8,667.37	
JOINERS 2015 (N=28)	MEAN	3.8	2.0	-1.8	-£306.72	0.0183
	TOTAL	107	55.3	-51.7	-£8,588.15	
JOINERS 2016 (N=13)	MEAN	4.7	1.5	-3.2	-£525.65	0.0051
	TOTAL	61	19.8	-41.2	-£6,833.46	
JOINERS 2017 (N=44)	MEAN	3.3	1.7	-1.6	-£262.21	0.0070
	TOTAL	145	75.5	-69.5	-£11,537.32	
JOINERS 2018 (N=46)	MEAN	5.4	1.3	-4.1	-£679.20	0.0013
	TOTAL	249	60.8	-188.2	-£31,243.24	
JOINERS 2019 (N=32)	MEAN	4.4	0.9	-3.5	-£585.26	<0.0001
	TOTAL	142	29.2	-112.8	-£18,728.21	
WHOLE SAMPLE (N=175)	MEAN	4.5	1.6	-2.9	-£489.13	<0.0001
	TOTAL	796	280.4	-515.6		

5.2 Service use: analysis of reported changes

5.2.1 A&E attendances

The A&E attendance data for the eligible sample of 175 BFL clients are presented in Figure 11 above. A&E attendances in the 12-month period before the client engaged with BFL are compared to the mean number of annual attendances from the point of engagement to 12 months after disengagement, or to the data collection date (28th February 2020) if at this point less than a year had passed since the end of engagement, or support was ongoing.

For the sample as a whole, and each sub-group of clients broken down by the year they joined BFL, statistically significant reductions in mean annual A&E visits can be seen. This means we can be confident that the changes seen for this sample of clients would be replicated for the population of BFL service users as a whole. Across the sample, this reduction was by an average of 2.9 visits per year per client, which is associated with a mean 12 month cost saving of £489 per client. The total²¹ cost reduction associated with reduced A&E visits for the sample as a whole was **£85,598**.

FIGURE 12: ECONOMIC ANALYSIS FOR NELS (N VARIES)

24. This refers to long-stay NELs and is measured in terms of episodes. An episode is defined as an agreed time period during which healthcare is provided to a patient. https://improvement.nhs.uk/documents/3688/1920_NTPS_glossary.pdf

25. For T2 figures, this 'total' score is based on mean annual NELs rather than the actual number of total NELs, as the time period covered by T2 data varies by client. See Figure 13 below for more detail.

26. These figures are based on clients' mean annual NELs, rather than their total actual number of NELs, as the time period covered by the original T2 data varied by client. This was to enable comparison with T1 data, which covers a time period of 12 months. As such, the 'total' T2 figures were calculated by adding up each client's mean annual number of NELs, to reach a representative total annual number of NELs for all clients. The 'mean' T2 figures show the mean of all clients' annual mean number of NELs.

27. If the p value is less than 0.05, we can be reasonably confident that the result is statistically significant at the 95% confidence level. If it is statistically significant, the value is shown in bold. If it is not statistically significant, 'NS' appears.

SAMPLE	NO. NELS	T1	T2 ²⁶	CHANGE	CHANGE IN COST	P VALUE ²⁷
JOINERS 2014 (N=10)	MEAN	3.5	1.4	-2.1	-£6,446.52	NS
	TOTAL	35	13.9	-21.1	-£64,465.17	
JOINERS 2015 (N=25)	MEAN	2.6	1.6	-1.1	-£3,285.39	NS
	TOTAL	66	39.1	-26.9	-£82,134.79	
JOINERS 2016 (N=9)	MEAN	1.0	1.0	0.0	£95.23	NS
	TOTAL	9	9.3	0.3	£857.07	
JOINERS 2017 (N=32)	MEAN	2.4	0.9	-1.5	-£4,704.06	0.0157
	TOTAL	78	28.7	-49.3	-£150,529.90	
JOINERS 2018 (N=26)	MEAN	2.1	0.6	-1.5	-£4,514.06	0.0078
	TOTAL	54	15.6	-38.4	-£117,365.49	
JOINERS 2019 (N=19)	MEAN	3.0	0.5	-2.5	-£7,675.70	0.0013
	TOTAL	57	9.2	-47.8	-£145,838.37	
WHOLE SAMPLE (N=121)	MEAN	2.5	1.0	-1.5	-£4,623.77	<0.0001
	TOTAL	299	115.7	-183.3	-£559,476.66	

5.2.2 Non-elective admissions

Non-elective admissions (NELs) data²⁴ for the 121 clients included in the sample are presented in Figure 12 below, divided by the year of joining the programme.

NEL admissions in the 12-month period before the client engaged with BFL are compared to the mean number of annual admissions from the point of engagement to 12 months after

disengagement, or to the data collection date (28th February 2020) if at this point less than a year had passed since the end of engagement, or support was ongoing.

A statistically significant reduction in the mean number of overall NELs of 1.5 per client can be seen for the sample as a whole, which is associated with a mean 12 month cost saving of £4,624 per client. The total²⁵ cost reduction associated with reduced NELs is £559,477.

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FIGURE 13: ECONOMIC ANALYSIS OF ARRESTS DATA (N=30)

28. If the p value is less than 0.05, we can be reasonably confident that the result is statistically significant at the 95% confidence level. If it is statistically significant, the value is shown in bold. If it is not statistically significant, 'NS' appears.

NO. ARRESTS	T1	T2	CHANGE IN NO. ARRESTS	CHANGE IN COST	P VALUE ²⁸
MEAN	7.9	1.6	-6.3	-£4,700.00	<0.0001
TOTAL	237	49	-188	-£141,000.00	-



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5.2.3 Arrests

The arrests data for the eligible sample of 30 BFL clients are presented in Figure 13 below. Arrests in the 12-month period before the client engaged with BFL are compared to arrests in the 12-month period following the end of the client's engagement.

A statistically significant reduction can be seen in the number of arrests per client. On average, this sample had 7.9 arrests per year per client at T1, and 1.6 at T2, which is associated with a mean cost reduction of £4,700 per client over 12 months. This sample had 188 fewer actual arrests at T2 compared with T1, which is associated with a cost saving of £141,000.

5.3 Conclusion

A summary of the cost savings seen in A&E admissions, NELs, arrests and overall is presented in Figure 14 below. This shows a mean cost saving of £9,812.90 per client over a 12-month period, as a result of reduced use of these services by clients.

This analysis suggests that BFL has been successful in its aim of supporting people with multiple needs to reduce their use of these 'crisis' or 'reactive' services. This implies improved outcomes both for the health and wellbeing of the individuals themselves, and for the system in Blackpool by reducing strain on stretched local services. We can be reasonably confident in attributing this change in service use to the work of BFL, as the programme's clients are generally not consistently engaging with any other support services before working with BFL.

FIGURE 14: SUMMARY OF COST SAVINGS

SERVICE	CHANGE IN MEAN 12-MONTH COST PER CLIENT
A&E ATTENDANCES	-£489.13
NEL ADMISSIONS	-£4,623.77
ARRESTS	-£4,700.00
TOTAL	-£9,812.90



System change for people experiencing multiple disadvantage

6.1 The Blackpool vision for system change

This section is based on six qualitative semi-structured interviews conducted by Homeless Link with key stakeholders in Blackpool on the subject of systems change. Those interviewed were involved in the programme in different ways and worked for a diverse range of services, including the voluntary sector (non-profit organisations), adult social care, the local authority, the lived experience team, and a substance-use service.

“[Systems change] is when all services can treat every individual as an equal, no matter how they present. The individual can present as happy, agitated, frustrated, or erratic, and would still be treated as an equal.”

6.1.1 Systems change in Blackpool

Understanding of “system change”

Interviewees identified two ways of defining “systems change”:

a) A collective definition that focuses on the way services work together. For example, “systems change” might be services having more efficient processes for joint working and information sharing, having trusted assessments so that people only have to tell their story once, and people experiencing services as person-centred rather than inflexible and excessively rule-bound.

b) A definition related to values. In this definition systems change will have happened when individuals are treated with honesty, openness, dignity, trust, and respect. Within the definition related to values, is an element focused on equality:

“The system then, in terms of change, where we need to get to is a system of complete equality between the people who design and deliver services and those who use them.”

Systems change was described as seeing the person, and not the problem. Services would understand that presenting behaviours of individuals are a product of what they have previously experienced.

Linking to the definition related to values is a cultural element. Interviewees explained that systems change would be achieving a system that is easier to navigate through, and part of this is changing the mindsets and cultures of those involved in the system.

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6.1.2 Shared understanding of systems change

The majority of interviewees concluded that there was not a shared language and understanding of systems change before the Fulfilling Lives programme. However, there was overall agreement that language is very important and sometimes the use of language can be a barrier. Systems change includes accessibility, and language plays an important role in understanding what is happening and what needs to be achieved. Without this, there is a higher chance of failure and miscommunication.

“Everyone could have their own different views, dependent on their service and so, it is important to have a universal definition of systems change and the right people at the right level should be involved and should look at the definition themselves.”

Interviewees reported that at the start of the Fulfilling Lives programme the language was not universal:

“There was a lack of clarity around what systems change meant... and there are lots of different ways to describe it”

A general conclusion from interviewees was that a clearer, shared language was developed halfway through the Fulfilling Lives programme.

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6.1.3 The system before Fulfilling Lives

Stakeholders were asked to reflect on what the system was like prior to the introduction of the Fulfilling Lives programme almost seven years ago.

The predominant word used to describe the system during that time was disjointed and there was a lack of joined-up working and multi-agency cooperation. There was a view of a partnership but a common experience of the system, for the interviewees, was that the focus was on delivering performance and meeting the objectives set out by higher organisations. The processes in place were rigid and could exclude those individuals experiencing multiple needs.

A number of interviewees made reference to the system being difficult to navigate:

“[The system] was difficult, and almost impossible, for some individuals to navigate through.”

The system recognised that it needed help, but services were contending with substantial funding cuts and moved to a siloed way of working to manage the impact of funding cuts. The system was uncoordinated and did not involve individuals who used the services in any decisions.

FIGURE 15: PROGRESS MADE AGAINST SYSTEMS CHANGE AIMS

SYSTEMS CHANGE AIM	WHAT HAS CHANGED	WHAT HAS NOT CHANGED
Involvement of people with lived experience	<ul style="list-style-type: none"> o LET offers co-production support to external agencies in Blackpool and routinely attends meetings and panels such as the drug death panels. 	<ul style="list-style-type: none"> o A commitment to co-production is not embedded in strategic planning across the system o LET were overlooked in early response to COVID-19 in Blackpool. o No plans are in place for continuation of the LET.
Commissioning development	<ul style="list-style-type: none"> o Commissioners reportedly have a greater understanding of multiple needs and routinely invite the LET to meetings. 	<ul style="list-style-type: none"> o A strategy for multiple needs has not been embedded into local commissioning structures. o Commissioning of services for people with multiple needs, for example mental health and substance misuse services, remains siloed.
Workforce development	<ul style="list-style-type: none"> o Interviewees reported examples of positive changes in the approach of staff in external agencies to people with multiple needs and areas of good practice, such as in the Job Centre. o Partners within the Legacy Board have a shared understanding of the importance of collaborative working to support people with multiple needs and now work well together. 	<ul style="list-style-type: none"> o Model for continuation of specialist service/interventions around MCN in Blackpool is not yet developed o Services in general remain poorly suited to working with people with multiple needs, for example through rigid eligibility and appointment systems. o Issues around capacity, funding, differing accountability structures and requirements, and data sharing concerns continue to limit the extent to which ways of working can change.
Access to mental health services	<ul style="list-style-type: none"> o A CCG representative is now attending Legacy Board meetings regularly. o Health and mental health services were involved in the provision of wrap-around support for those housed during COVID-19 (see Section 8.2.1). 	<ul style="list-style-type: none"> o Interviewees reported continuing difficulty in accessing mental health provision for BFL clients. o Mental health services continue to have rigid eligibility and appointments systems. o Mental health services have never engaged with the Legacy Board.
Information sharing	<ul style="list-style-type: none"> o Navigators and the response to COVID-19 (see Section 8.2.1) have facilitated the sharing of information between services. o A pilot project has been set up with key partner agencies to share access to InForm (BFL's case management system) for mutual clients, although this has had limited take up so far. 	<ul style="list-style-type: none"> o There is a continued reliance on navigators to act as a liaison between services. o GDPR/data sharing regulations continue to act as a barrier to systems change. o Clients are still required to fill out separate assessment forms when accessing a new service.

6.2 Systems change aims

As outlined in previous evaluation reports, BFL has five key systems change aims, which are outlined in full in Appendix A. A summary of the progress made against each of these aims is outlined in Figure 15 above. A cross-cutting analysis of what has and hasn't changed in Blackpool and why is then presented in Sections 7.3 and 7.4.



6.3 What has changed and why?

6.3.1 What has changed

Staff members reported that systems change in Blackpool had so far been made through individual and small-scale shifts in practice. Some, however, suggested that a greater understanding of multiple needs had developed across services and among commissioners as a result of involvement in the BFL partnership. Some commissioners are now reportedly more receptive to learning about what works for people facing multiple needs, demonstrated by their inviting the LET to meetings.

Partners are also now reportedly working better together within the Legacy Board, in a positive trend continued since the last evaluation cycle. One member of the Legacy Board reported:

“I think after a rocky start, it's probably worth mentioning that, we got to a point where we all understood what needed to happen, and the collaboration that needed to happen... That's been the key thing. It's allowed people to start understanding multiple needs clients from their perspectives, their agencies and what they need to do to change their agencies and the services they've got.”

Legacy Board member

Blackpool stakeholders gave a range of specific examples of how the Fulfilling Lives programme has changed practices in the local system, which are outlined in Figure 16 on the next page.

FIGURE 16: CHANGES TO THE SYSTEM IN BLACKPOOL

SYSTEM REQUIREMENTS	HOW THIS AFFECTS INDIVIDUALS EXPERIENCING MULTIPLE NEEDS	EXAMPLE OF HOW THE SYSTEM HAS CHANGED
Individuals are sanctioned if they are late to Job Centre appointments	Often individuals live far away from the Job Centre and usually their only way of travelling is on foot. Walking can be tiring and to then be late and told your benefits are being sanctioned will cause huge distress and the individual may greet the worker with an outburst	Workers in the system have developed a better understanding of individuals' lives and began to work more flexibly by not making it a punishable if individuals are slightly late to appointments. If an individual is late to an appointment, they are taken to a quiet room and spoken to with dignity
Appointment system	Individuals are less likely to engage with services	Individuals can phone some services directly and meet when it suits them. Services are now less formal and rigid with individuals
Traditionally, individuals experiencing multiple needs have been unable to volunteer for organisations unless they were two years abstinent from drugs or alcohol	Individuals would feel excluded	Barriers have been broken down – these individuals are now considered as volunteers and people are recognising that these individuals have a better understanding of the system
Individuals experiencing multiple needs who do not engage are not supported	Individuals often have chaotic lives, and engaging with a service by directly visiting the service and keeping up with this engagement can be difficult	Navigators have provided a persistent and assertive approach to engagement. This approach has been carried out in the individuals' environment and on the terms of the individuals experiencing multiple needs
Staff using terms such as “they do not engage”	Individuals are seen as a problem and the actual problem is overlooked	Staff are looking at things from a different perspective – the services are not engageable for the individual
Services have very formal, unwelcoming environments	Individuals have felt like they are back in a classroom	Desks have been removed from Probation, for example
The waiting room at Horizons has been improved.		
Individuals waiting for an appointment as staff are running late	Individuals become stressed and agitated. Individuals feel less respected when they are required to be on time to an appointment, are on time, then have to wait.	Staff go down to the reception/waiting area and advise the individual they are running late and ask them if they are ok to wait – individuals feel more respected as a person
Security guards at the services wear a uniform	The uniform reminds the individual of being punished and conflict is felt when the individual enters the service	The Job Centre security guards are no longer wearing a uniform – they are in jeans and t-shirts
Graduates (for example, social care graduates) do not discuss, or learn, during their studies that individuals with lived experience should be seen as partners. Graduates then become part of the system	Individuals are then supported by these graduates, but the graduates are not aware of the importance of co-production	The LET have been going into colleges and teaching people studying health and social care qualifications about the lived experience team and the importance of co-production

6.3.2 Enablers of system change

Interviewees identified a range of factors which have enabled the progress made in systems change in Blackpool.

Lived Experience Team

The LET was consistently identified by staff and stakeholders as a key factor contributing to BFL's impact, and staff members noted that their increasing reach into several other services was affecting system change:

"The LET with their contacts have been able to engage and get them into health services. They've done work with Probation, DWP, Police as well – they've developed a really good reputation across Blackpool. They're definitely affecting system change through this built up reputation."

Staff member

More than being simply an enabling factor, the reach of the LET was reported to represent a change to the system itself, as the involvement of those with lived experience is becoming the norm across services in Blackpool, and within the local authority:

"Absolutely central to everything we do is the lived experience and learning from Fulfilling Lives and embedding that. I'm taking principles of co-production to other colleagues in the council, whenever we're designing any services, not just multiple needs."

Legacy Board member

The work of the team has included:

- Consulting on the commissioning of drug-services, including sitting on interview panels for applicant service deliverers.
- Sitting on strategic boards, including the Legacy Board, the health team, drug and alcohol commissioners, adult social care, and public health commissioners.
- Attending drug death panels.
- Consulting on aspects of support service design, e.g. the foyer/waiting room area of Blackpool's probation office.

Stakeholders stressed the importance of committing the necessary resources to support the LET in their systems change work:

"People who are then being brought into that relationship, the people with lived experience, need significant amount of resource, development, training, recruitment, confidence building... [systems change] needs massive resource and it does not happen by itself"

Stakeholder

Committed individuals

Several key individuals within the BFL partnership were reported to be committed to driving systems change in their organisations.

"It's about who agrees to do work outside of the meeting. There are several colleagues who will do that, and for me that's the sign of a good partnership. If it's just people turning up to find out what [the Chair has] been up to, then that's not a partnership."

Legacy Board member

Shared mission

There was a consensus among Legacy Board members that establishing a shared mission for BFL partners represented positive progress and had served to enable systems change.

Legacy Board members reported that important factors in reaching this shared mission amongst strategic partners had been clear communication, reaching a shared understanding of key terms, and setting realistic expectations as to what could be achieved by BFL in the time period.

"You've got to keep it really simple – create a common understanding about what we mean when we say certain things. When FL started, there was an awful lot of over-promising and under-delivering, was seen as 'cure-all' for Blackpool's problems... We've learned lessons about clear and consistent communications"

Legacy Board member

Board members reported that over the last three years leadership of the partnership had been key to ensuring the clarity of aims, roles and communication necessary for positive progress.

Navigators

Navigators, through their interactions with other services in the system, were reported to have supported progress towards systems change by helping to shift the perceptions of other professionals of people with multiple needs.



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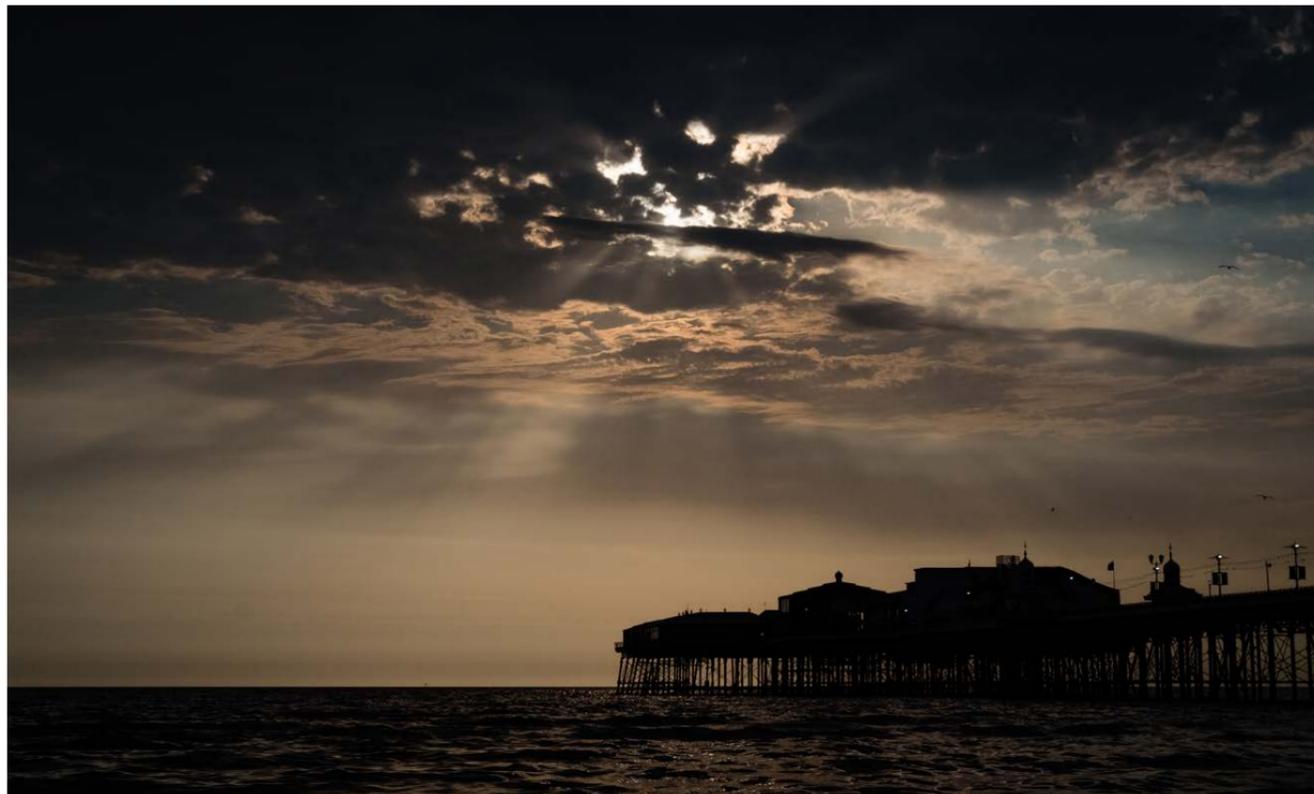
P
CAR PARK
→

Over Bookend
CAR PARK
OPEN
→

Low bridge
15 yds
ahead
4.2m
14'0"

Humps for
300 yds





Outside of Fulfilling Lives

The following factors were discussed by stakeholders in Blackpool as playing an important role in systems change outside of the Fulfilling Lives programme:

- COVID-19 and the lockdown in 2020 has forced services to work in partnership (discussed further in Section 8).
- Austerity has also forced services to rethink how they work. Pressure on services has encouraged creativity. On the other hand, austerity has also led people and services to become risk-averse, and therefore discouraging systems change.
- Legislative changes were mentioned as an external factor that led to systems change. In particular, the Care Act 2014 was mentioned by a number of interviewees.
- Service delivery was discussed in relation to its moving away from being target driven and price-conscious, and this has played a role in systems change.

6.4 What has not changed and why?

6.4.1 What has not changed

While staff and Legacy Board members were able to identify some positive examples of changes to practice and a number of key local stakeholders who were committed to change, the consensus was that a system-wide shift had not yet been achieved in Blackpool. Three areas were identified as still requiring improvement:

- Service provision for people facing multiple needs
- Commissioning for multiple needs
- Lived experience and co-production
- Service provision

The continued reliance on BFL navigators by the rest of the system, to facilitate engagement of clients with multiple needs and communication between services, was cited as proof that systems change has not yet been achieved in Blackpool. In fact, concerns were expressed that when Fulfilling Lives comes to an end and navigators are no longer there, services which have not fundamentally changed the way they operate will not be able to support people facing multiple needs:

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“The worry is, without that emphasis and navigators being there, my fear is that it will just drop off and services will go back to their own ways... Has there been enough systems change for organisations to support people with multiple needs? I’m not as optimistic as I would’ve been.”

Legacy Board member

“Have services realised that multiple complex individuals aren’t all of a sudden going to start coming to services when we leave?”

Navigator

The continued inflexibility of many services in their eligibility and appointments systems was cited by many staff and stakeholders as proof that most services remain poorly suited to supporting those facing multiple needs. Clients are reportedly still being passed back and forth between mental health and drug and alcohol services, for example. One Legacy Board member commented:

“There are still large parts of the system where I cannot see how they’ve changed. I still see people getting appointments for telephone triage for mental health issues, they have no say

over when that appointment will take place. It’s the same thing with substance misuse – if you don’t turn up, that’s a sign you’re not committed. [...] And those are the fundamental things which Fulfilling Lives is meant to challenge and change.”

Legacy Board member

Commissioning

Legacy Board members suggested that the aim of embedding a strategy for addressing multiple needs in local commissioning structures had not yet been achieved, with little change seen in the level of integration of commissioning locally.

“We’re all commissioned by different people. Mental health is commissioned in three different ways, drug and alcohol is commissioned in two different ways. [...] everyone’s working in their own silos from a commissioning perspective, and have their own targets to meet and boxes to tick.”

Legacy Board member

There were mixed views as to the reasons for this. One Legacy Board member reported that the timings of commissioning cycles had meant that there had not yet been an opportunity to implement learning from BFL:

“

Have services realised that multiple complex individuals aren't all of a sudden going to start coming to services when we leave?

“We’ve gotten to the point in Blackpool where we have a good body of evidence of what’s worked. [...] We’ve got all the learning, it’s there to use. Just haven’t had the opportunity to feed into commissioning cycles just yet.”
Legacy Board member

Another Legacy Board member commented, however, that more could have been done sooner to implement a focus on multiple needs in local authority plans.

“There’s a strong partnership there, a well-attended board. But how that links with what’s happening with the local authority I think is quite separate. Longer term planning and next steps – there’s not too much communication. Feeding into local authority plans doesn’t seem to be as good as it could be.”
Legacy Board member

Lived experience and co-production

While a number of staff and Legacy Board members reported that the LET had had a significant impact in Blackpool and was involved in a number of local projects (as discussed above in Section 7.3.2), others suggested that a meaningful commitment to co-production was not yet embedded across the whole system:

“My belief is that in the vast majority of the system, co-production is not happening. It’s still a massive battle to actually bring about co-production into all parts of the system. BFL has given us and shown us what is possible. It’s a start, and it needs to continue.”
Legacy Board member

It was reported that so far, co-production activity has been driven by a minority of committed individuals, rather than buy-in at a wider strategic level.

“The council or the police or NHS have not made a big strategic decision [to embed co-production] – that’s never happened. What we’ve had is key partners saying yes, let’s do this. I see them as the trailblazers – but I would say we are at the start of that process.”
Legacy Board member

Members of the LET themselves expressed frustration at being asked to speak at systems change events and meetings every year, where everyone was seen to talk positively but, as they perceived it, little meaningful action was taken. There was some suggestion among Legacy Board members that the lack of co-production in the local response to COVID-19 regarding homeless people was indicative of this issue (see Section 8 for further discussion).

6.4.2 Barriers to achieving systems change

Staff members reported a number of barriers to effective system change in Blackpool. These largely align to those reported in the last evaluation cycle, explained in part by the fact that most are structural barriers which BFL itself can do little to overcome.

Lack of engagement of key partners

Legacy Board members agreed that, as in previous years of the project, a key challenge faced by the BFL partnership had been the limited engagement of some relevant agencies. As one Legacy Board member stated:

“There are still quite a few groups across Blackpool who work with people with multiple needs who refuse to work in partnership – it’s incredibly frustrating.”
Legacy Board member

As previously, NHS services, and in particular mental health were highlighted as the main examples (although it was noted that the CCG had recently started attending partnership meetings). As noted in Section 7.4.1 above, this lack of engagement has been reflected in a lack of change in practice and continuing difficulty in accessing mental health support for BFL clients.

Competition and protectionism

A number of staff members and stakeholders pointed to a reluctance to embrace change on the part of certain agencies or organisations. Services are competing for funding and consequently are working in a protective way to hold on to their budgets.

Capacity

Stakeholders reported that services are limited in their ability to create change and work more flexibly due to their limited capacity. There is reportedly an increased demand in work locally but fewer people to do it.

“People generally who have struggled with services run at the minute, in terms of their rigidity of approach – [it is] sometimes simply a way of making sure they can deal with the numbers coming through”
Staff member

Accountability structures and requirements

There was some suggestion that, even whilst signed up to a shared agenda, services are constrained in their ability to adapt their approach due to the need to adhere to individual organisational procedures, contractual requirements and targets.

GDPR/ data sharing concerns

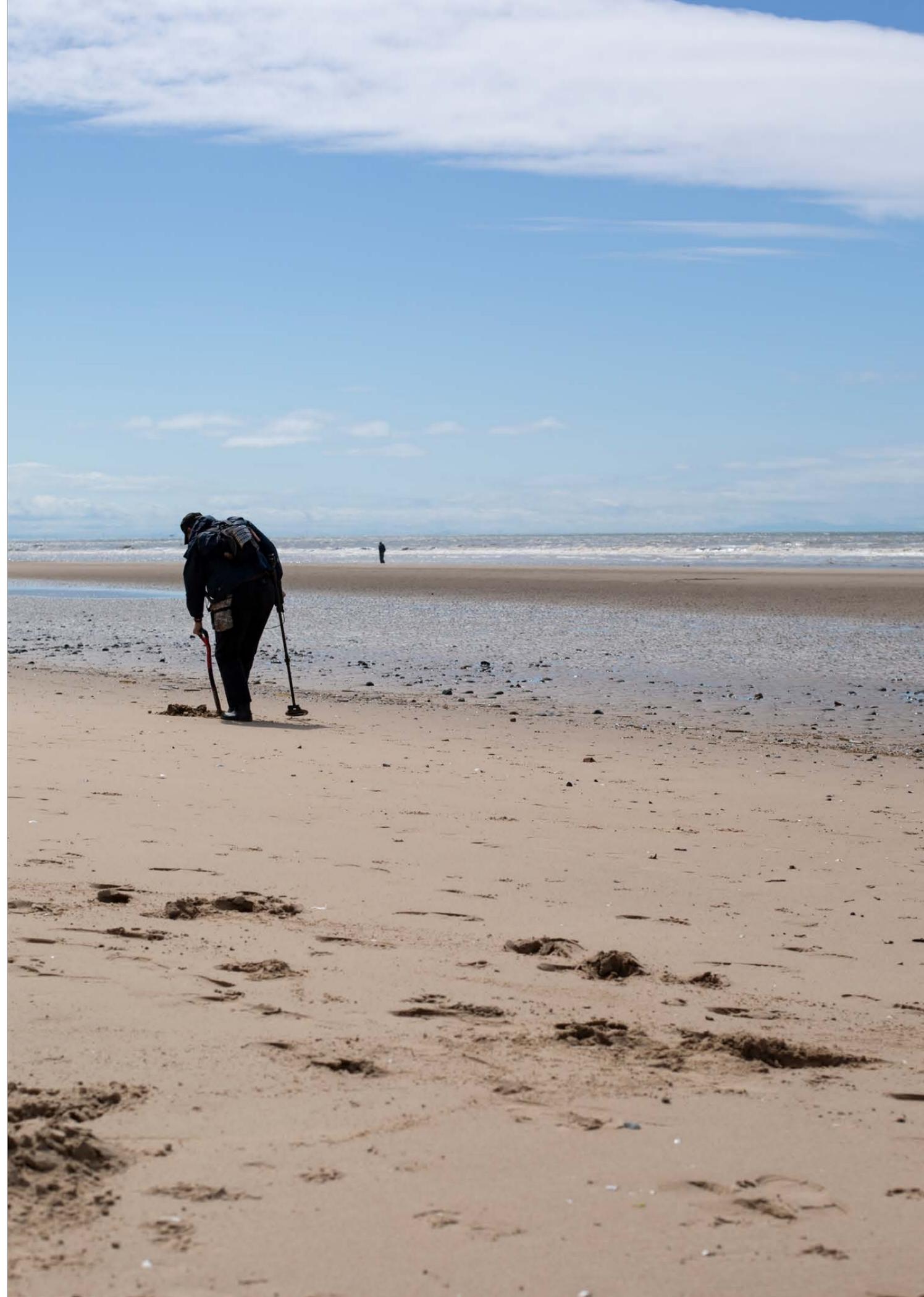
The tension was noted that while clients having to share their stories and fill out assessment forms every time they access a new service is a barrier to engagement, they are also sometimes hesitant at the idea of their information being passed freely between services.

6.4.3 Overcoming barriers to systems change

A number of suggestions were made by Blackpool stakeholders on how to overcome barriers to systems change.

To reduce conflict between services, some interviewees mentioned that recurrent funding, and not just grants, should be given. It was suggested that there should be transparency of how the money and time is being spent. It was also suggested that engagement should be made into a statutory requirement in the form of legal changes:

“Yes the resource still has to follow [legislative changes] but behaviour does change as a result of that. I would love to see a systems change bill passed in this country which both detailed what it was but also gave a statutory obligation on those in power to actually bring about these changes.”



Learning from the response to COVID-19

7.1 The local response to COVID-19 in Blackpool

Blackpool successfully responded to the government requirement, issued in March, to house all rough sleepers within 48 hours. The speed of the response was praised by staff and stakeholders:

“Everyone was accommodated, no matter whether they were from the area or whatever, so from my point of view that was really positive.”

Legacy Board member

The response was directed by the local authority, particularly the public health department and Housing Options. Other services, such as BFL, helped to provide wraparound support to people once they were accommodated.

BFL was also reportedly quick to adapt its practices to continue to support clients, including by providing activity packs to keep people occupied during the lockdown.

We discuss the impact of these changes on the system in Blackpool and on BFL’s clients.



7.2 The impact of COVID-19 on the system

7.2.1 The positive impact

Staff and stakeholders identified three positive ways in which the response to COVID-19 had impacted upon the system in Blackpool, which are discussed in detail below:

- Greater multi-agency partnership working
- More flexible working practices in services
- Greater understanding of multiple needs and the value of BFL

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The impact elsewhere

Cordis Bright was commissioned by the Making Every Adult Matter (MEAM)²⁹ coalition in May 2020 to conduct a rapid evaluation of the changes put in place in response to COVID-19 by systems supporting people facing multiple disadvantage in MEAM areas³⁰.

Many of the findings align with the findings from Blackpool outlined below, suggesting that there has been a degree of commonality in the impact of COVID-19 on systems across the country. In particular, the following key positive impacts were identified in the MEAM areas:

- Improved inter-agency collaboration and partnership working
- Increased sense of community and shared purpose across agencies
- Staff and services working “beyond their remit”
- Swift decision making and staff autonomy
- Reflective practice amongst staff members
- Improved relations with clients
- Increased strategic buy-in
- A more supportive and less punitive approach to enforcement

29. MEAM is a coalition of national charities – Clinks, Homeless Link, Mind and associate member Collective Voice.

30. The full report can be read here: <https://www.cordisbright.co.uk/news/post.php?s=flexible-responses-during-the-coronavirus-crisis>

Multi-agency partnership working

The lockdown period reportedly resulted in greater partnership working between agencies involved in providing wrap-around support for rough sleepers placed in accommodation in Blackpool. The partners involved included Housing Options, Streetlife, substance misuse support and detoxification, health and mental health services, as well as BFL. For example, one Legacy Board member stated:

“It’s definitely strengthened the partnership between Streetlife and other organisations. Housing options are informing Streetlife whenever they place someone in Streetlife’s age range (up to twenty-five), and I can see that carrying on.”

Legacy Board member

More regular and proactive communication between services was reported. This change was largely attributed to the fact that many agencies were working from home and either had more capacity to reach out to other services, or had to

do more proactive outreach by virtue of not being co-located:

“Communication has been so much better with the other services as well – we are getting other services contacting us and giving us much more information than previously. That’s been useful and helpful to get a better picture of what is going on. They are all working from home.”

Navigator

The involvement of health and mental health services in the provision of support for those housed during COVID-19 was cited by Legacy Board members as a particular success. A ‘health bus’ was used to offer wound treatment to those housed, for example, described by one stakeholder as a “fresh approach”. This may provide a template for providing more preventative health care support to homeless people post-COVID-19.

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“The flex seems to have been welcomed by people, and something people don't want to change.”

Legacy Board member

Flexible working

Legacy Board members commented that a key lesson from the response to COVID-19 had been that services had demonstrated the ability to work more flexibly when needed.

“The flex seems to have been welcomed by people, and something people don't want to change.”

Legacy Board member

Changes to methadone prescribing was a frequently cited example of this: to reduce contact, clients whose prescriptions mandated daily methadone pick-ups were instead able to collect their prescription weekly. Legacy Board members reported that the success of this approach had demonstrated that weekly methadone prescriptions may be beneficial for more clients than was previously thought. In response to this learning, it was reported that drug and alcohol services had begun planning to redesign their service model, illustrating a positive instance of a service adapting to meet the needs of its clients.

Understanding of multiple needs and the value of Fulfilling Lives

It was reported by Legacy Board members that the challenges faced in supporting rough sleepers once they were accommodated, with their mental health, substance misuse and behaviour, had given partners a greater understanding of multiple needs and highlighted the challenge faced in supporting them. A key element of this was the need to provide support in addition to housing:

“For Streetlife and BFL, there's a better appreciation from other partners about the support [these services] can offer to people who are vulnerable or have multiple needs. And recognising that just giving someone a roof over their head isn't going to solve their problem. Recognising the value that BFL bring.”

Legacy Board member

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Because of this, a number of staff members noted that the period had led to greater recognition of the value of BFL by partner organisations. In particular, the relationships that navigators or other BFL team members had across services and with clients were deemed to be central to maintaining support for clients during lockdown:

“BFL has bridged a networking gap, and particularly during COVID – it's become apparent to other agencies how valuable we are.”

Navigator

Another navigator noted that this realisation of the value was timely, given that the programme was in its final year:

“I think services are finally realising that we are going in March and they realise they need help working them out. It's so lovely to get a phone call from Housing and asked for advice. [...] I felt we were leaned on by agencies who couldn't get out there”

Navigator

7.2.2 Areas for improvement

Three main areas for improvement in the local response to COVID-19 were identified by staff and Legacy Board members:

- Co-production with people with lived experience of multiple needs
- Involvement of specialist staff and knowledge
- Consistency in approach across organisations

Co-production

There was a shared view that lived experience had been missing in the early response to COVID-19 in Blackpool. Legacy Board members commented that co-production with people with lived experience might have given professionals delivering the frontline response the insight and tools to better communicate with rough sleepers and those experiencing multiple needs.

There were some mixed views as to the reasons for this. One Legacy Board member suggested that the rapidity of the required response did not allow time to consult with people with lived experience:

“I think the pace of the thing was the challenge [...] The lived experience side of things – that can sometimes fall to the wayside when you've got to get things done quickly. A couple of times we would've liked to have involved the [LET] but weren't able to do that right at the start. That's not a negative, it's just reflective of the situation – it was an emergency and things had to move quickly.”

Legacy Board member



On the other hand, some suggested that the lack of consultation with people with lived experience in the response to COVID-19 had revealed the lack of full strategic buy-in to adopting co-production in a way which is not selective or tokenistic. Indeed, one Legacy Board member commented:

“There was no consultation with the Lived Experience Team in that process. It was a completely top-down approach. The fact is that there was a brilliant opportunity for co-production to take place for people facing multiple needs and it was completely wasted. There was no co-production whatsoever. Those senior people in the system still don’t trust people with lived experience. The default mode is we’re the experts, we know best. But they don’t.”

Legacy Board member

Whilst co-production in the initial response to COVID-19 was lacking, this has reportedly improved over the course of the pandemic. For example, the LET was involved in conducting a survey with rough sleepers about their experience of the response to COVID-19. It was also suggested that this learning had been taken on board at a strategic level, with one Legacy Board member with insight into the council commenting: “If there is a second wave in winter, the LET will be heard.”

Involvement of specialist staff and knowledge

Legacy Board members expressed a shared view that specialist support services for homeless people and people experiencing multiple needs (such as BFL) could have been consulted earlier and to a greater extent in the response to COVID-19. As one Legacy Board member noted, “BFL weren’t involved in early discussions and were considered a bit further down the line.”

This resulted in a missed opportunity for the knowledge, skills, and information held by BFL and its staff to usefully inform the response, it was suggested. One example cited by Legacy Board members is that knowledge held by BFL about clients’ needs was not used to inform the approach taken to housing them. It was suggested that this had led to some issues, including evictions, which might have been predicted and avoided:

“I hope other partners will see value of involving BFL in early decision-making about who they place where. And ideally as a result, post-BFL, they might think more. Hopefully will be a lesson learned.”

Legacy Board member

The lack of consultation with BFL about clients’ needs also meant that, as one Legacy Board member reported, the support was being done “to” the client rather than “with” them. The Board member expressed concern that this might lead to a set-back in the empowerment and independence of clients:

“I know it was a crisis, but we had five full years of experience and evaluations telling the system what works for multiple needs, but we had loads of people going out and treating clients like they can’t do anything for themselves.”

Legacy Board member

However, Legacy Board members noted that BFL had become more involved in the response over time, and as stated in Section 8.2.1 above, many staff and stakeholders suggested that the experience as a whole had increased the understanding and appreciation of the programme locally. Overall, the dominant view was also that the response had encouraged independence in BFL clients (discussed in Section 8.3.1).

Consistency in approach across organisations

Legacy Board members suggested that the diversity of organisational policies put in place in response to COVID-19 by support services had made it challenging to respond in a co-ordinated way as a system in Blackpool. This was particularly true of whether face-to-face work with clients continued. It was suggested that this inconsistency would be important to address if the threat posed by COVID-19 was to increase again in winter.



With the crisis, everybody was sort of energised to see how to make the best of it. Hopefully we want to encapsulate that enthusiasm and keep it going forward.

Legacy Board member



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7.2.3 The future

Most of the Legacy Board members interviewed were optimistic that the experience of COVID-19 had refreshed local partners' enthusiasm and ambition for partnership working to support the homeless and people with multiple needs. As one Legacy Board member commented:

"With the crisis, everybody was sort of energised to see how to make the best of it. Hopefully we want to encapsulate that enthusiasm and keep it going forward."

Legacy Board member

A number of staff members, however, expressed concern that services and the system would return to business as usual following the

pandemic, and that the new partnership working and flexibility in provision would not be maintained. In particular, the promise of government funding was seen to have facilitated much of the quick action, which would not continue. Staff were particularly concerned that clients may be returned to the street:

"The concern is the future – they got a lot of people off the street, and did well, but now the worry is of things going back to normal. For example, some people are getting thrown out of services for ASB. It's unrealistic to put someone in a flat and expect them to not need checking on."

Staff member

7.3 The impact of COVID-19 on clients

7.3.1 The positive impact on clients

Most of the BFL clients interviewed reported that they had been well supported during COVID-19 and the lockdown in Blackpool. One couple reported that services had still been able to rapidly respond to meet their needs despite the challenges put in place by the pandemic:

"When [the lockdown] first happened, we were still using ... We told [our navigator] we wanted to get off the drugs. The next week we had a script. There comes a time in a drug user's life when they've had enough. That's when they need the support, not six months later. You need to grab the opportunity when it comes."
Client

In addition, some clients commented that elements of the new ways of working during the lockdown period had been positive and should continue. For example, receiving some support via the telephone had been a positive experience for some, and they suggested that this could replace some but not all face-to-face contacts in the future.

Increased independence of clients

Staff members identified a number of ways in which lockdown restrictions and related changes to support had resulted in an increased autonomy and independence for clients. This included clients managing properties (and other positive outcomes stemming from this management of accommodation), and clients being trusted to manage their own prescriptions due to changes in prescribing practices.

"During lockdown, we gave people enough methadone to kill someone, 700ml, and people took that responsibility well. Lots of learning about how resilient people are. The daily pick-up changing. Having people pick-up methadone every day is demoralising for people. If people can take home methadone once a week, I think that's a massive success."

Legacy Board member

While a number of staff members noted that they had been apprehensive about these changes to support in the initial weeks of lockdown, they found that when clients were afforded the trust to become more independent, they experienced a number of positive outcomes, and a number of staff members reported that drug-related deaths in Blackpool had in fact decreased during this period.

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It's actually given them a bit more independence as well and shown that they have the resilience. [...] Lifts to appointments is an example – one client has been asking 'when can you give me lifts to appointments?' and it's been good for me to say 'you have to do it yourself now'.



In terms of learning from this period, a number of staff members noted that the lockdown had shown that some clients may benefit from a more hands-off approach to support.

7.3.2 The negative impact on clients

Staff and Legacy Board members also drew attention to some of the more negative impacts that COVID-19 had had on clients and local ways of working.

- Clients did not respond well to being isolated
- There was a lack of therapeutic support and meaningful activities for clients
- Many clients found engaging with support remotely difficult
- Navigators had limited time with their clients
- Frontline workers were understaffed, as the majority of navigators had to work from home for health reasons

- Virtual support was found to be less effective in supporting mental wellbeing than face-to-face contact.

All the clients interviewed agreed that being unable to have any face-to-face contact with navigators during the lockdown had been a challenge. The severity of this impact varied by client, however, and tended to be less for clients who were further into recovery than others.

For example, one client whose life reportedly remained fairly chaotic stressed that it had been very challenging to not see their navigator in person for months, contributing to feelings of isolation:

"I felt very isolated. It's been a lonely process. I much prefer to see a friendly face."

Client

The future of services for people experiencing multiple disadvantage in Blackpool

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“I’m scared about what will happen when BFL shuts down next year and where the support will come from.”

Client

8.1 The future

Staff, stakeholders and clients all expressed their concern about the Fulfilling Lives programme coming to an end in March 2021. It was agreed that a gap would be left in Blackpool if at least elements of the current model were not continued.

“We’ve had the project for seven years now. People expected that at the end of the seven years, we’d have sorted everything out and would be in a position where we were just meeting small numbers going forward. But it’s shown that there’s a lot of people with multiple needs in the town, and we’ve not solved it in seven years, and it’ll take us another ten years, and we’ve got to make sure we’ve got the resources and the plans.”

Legacy Board member

One client expressed concern about the future of their support once the BFL project comes to an end:

“I’m scared about what will happen when BFL shuts down next year and where the support will come from.”

Client

This speaks to the issue of a continued ‘failure demand’³¹ in Blackpool (and elsewhere) in which the role of the navigator remains necessary to deal with systemic failures in service provision which fails to effectively engage clients or to work well in partnership.

It was also suggested by stakeholders that the progress made by BFL towards achieving its systems change goals could be lost, as the dissolution of the partnership would lead to a loss of momentum for the multiple needs agenda. This suggests that, without BFL, there is little likelihood of the system in Blackpool progressing to the point at which this failure demand will cease. For this reason, interviewees were clear that the following key features of the programme should be continued in some form:

- The navigator model
- The LET
- The strategic partnership

8.2 The navigator model

“Unequivocally I’d say the navigator system [needs] to continue.”

Legacy Board member

In reflecting on the legacy of BFL, discussion with staff and Legacy Board members generally centred on the subject of the navigator model and how it might continue after Lottery funding ends in March 2021. Consistent with last year’s findings, staff and stakeholders were generally in agreement that the navigator model should continue in some capacity, to prevent a gap in support for those facing multiple needs. Opinions differed, however, on the best way of implementing this. Three main options were identified:

1. Navigators continuing to be employed and managed independently of other support services.
2. Navigators being seconded into another support service(s) or organisation(s) but receiving independent management/oversight.
3. Navigators being embedded into another support service(s) or organisations (s), and receiving management/oversight from that service/organisation.

The majority of staff members (mainly navigators) believed that the most effective way of continuing to deliver this model would be to embed navigators into another service in the sector (option 3). While this was a view less commonly held by stakeholders, one Legacy Board member suggested that the ability of navigators to effect systems change, for example through changing

the culture within support services, would be limited by their being separately employed:

“If doing it again, would we set up a standalone service, not an integrated one? [...] I would integrate it into the system. A big part of Fulfilling Lives is systems change. You can’t do that sat on the outside. It needs to be in it.”

Legacy Board member

Other staff and stakeholders, however, were apprehensive about this approach, fearing that navigators integrated into other services would struggle to retain independence from their host organisation and to hold all support agencies in the system to account equally. It was suggested that staff members might “go native” and be absorbed into those services’ ways of working. As one staff member noted:

“What often happens when somebody from BFL goes to a bigger thing is you get into the machine and one little dot in the machine gets quickly lost.”

Staff member

31 ‘Failure demand’ is a term coined by Jo Wilding in her research: Droughts and Deserts: A report on the immigration legal aid market. 2019. Available: <http://www.jowilding.org/assets/files/Droughts%20and%20Deserts%20final%20report.pdf>



A hybrid model was seen as an acceptable compromise by some, in which navigators are embedded in an existing service, but with external oversight to ensure that they are allowed to continue to focus on those with multiple needs:

“There’s nothing wrong with a hybrid model, to put it [navigator model] within an existing service. It gets the advantage of HR, finance, without having to create its own. But it would need multiagency oversight or steering group to make sure it doesn’t get hived off in a particular direction for the advantage of the host body.”
Legacy Board member

Some staff and stakeholders noted that if the navigator model were to continue, it would require a much leaner model of delivery, due to the challenge of securing funding post-BFL. Interviewees highlighted that there could be a smaller number of navigators, and/or a leaner management structure, than at present, without the infrastructure surrounding BFL.

One staff member reported that the experience during COVID-19 had shown the possibilities for savings in the way the navigators operate:

“We need a cohort of Navigators to go out and do what they do now. The way it’s worked lately, without even needing an office – you can do it on a lot less money.”
Staff member

8.3 The Lived Experience Team

As last year, staff and Legacy Board members expressed their hope that the LET might continue to operate in some form following the end of the BFL programme. Many saw it to be a key legacy of BFL, highlighting the accountability it provides in the system and its role in supporting systems change (see Section 7.3.2 above).

In terms of how the LET might be continued, there was some suggestion that the team should be based in an existing voluntary sector organisation; Legacy Board members suggested Empowerment. It was suggested that this would give the LET access to the leadership and support of an existing organisation, plus the benefit of a voluntary sector organisation’s ability to bid for different types of funding to a statutory sector organisation.

8.4 Strategic partnership

Legacy Board members agreed, as last year, that it would be beneficial to continue some form of strategic partnership with a specific focus on multiple needs. Although board members were uncertain as to what form this might take, there was a shared view that some form of partnership structure would be important in order to maintain the momentum of partnership working and the local focus on improving outcomes for people facing multiple needs. Otherwise, board members reported, the issue is liable to slip down the agenda of other existing groups such as the Health and Wellbeing Board.

“The partnership has worked really well. After the programme, if it can continue in some shape or form that will be an important piece of legacy. People might see each other in various different meetings, but not as a collective focusing on these issues. So that’s a key strength for me and would be great to continue.”

Legacy Board member

However, it was acknowledged that, without funding for positions such as the Chair, it may be challenging to continue the momentum of the strategic partnership structure.

Conclusions and recommendations

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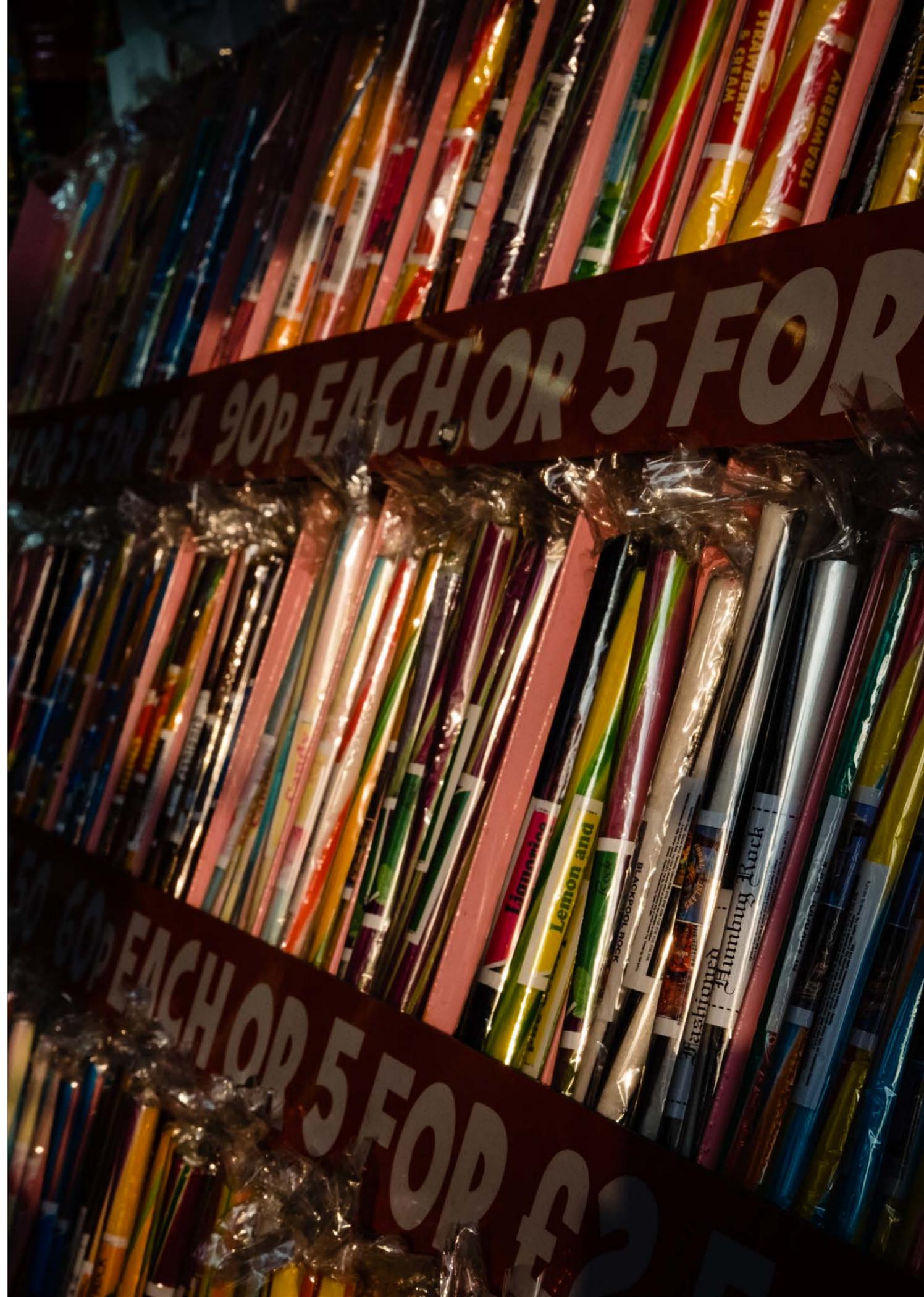
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9.1 Introduction

This evaluation has reinforced many of the conclusions set out in the year four evaluation report; in summary, these are:

- The need for additional support to enable people with complex needs to access and engage with services is not likely to disappear in the near future. It is unrealistic to expect that a project like Fulfilling Lives could have solved problems that have existed for many years, but learning from the project has resulted in some improvements, for example in attitudes towards people with complex needs, the environments in which services are delivered, co-production with service users and people with lived experience, and sharing of information between organisations.
- The navigator model is effective in helping people to make progress in their lives. This year we have drawn together data across a range of measures for all users of the project over five years, and there have been statistically significant improvements on all measures.
- Multi-agency working has improved and become embedded as a default way of working over the life of the project. A partnership approach to addressing complex needs has resulted not only in better outcomes for people using services but also improved morale and job satisfaction for many people working in those services.

These findings are reflected across the twelve sites of the Fulfilling Lives programme. As the national evaluation team has noted, *the substantial investment of Fulfilling Lives is unlikely to be repeated, so it is essential that the learning from the programme informs future commissioning of services*³².





9.2 Conclusions from this evaluation

Stakeholders who participated in the year five evaluation were almost unanimous in highlighting the positive impact BFL has had on beneficiaries and the need to sustain some kind of legacy beyond the lifetime of the project. Many expressed concern that the closure of BFL will leave a significant gap in service provision.

The achievements of Fulfilling Lives

Interviewees also noted that BFL had already secured a legacy for Blackpool through a number of aspects of its work, including:

- The positive changes many people were able to make in their lives with support from BFL.
- The greater awareness of the important role that co-production with people with lived experience can play. Some stakeholders have noted that much more still needs to be done to embed genuine co-production into service planning, commissioning and delivery. However, there are many examples of the influence of people with lived experience have had on the initiatives that have been taken forward, such as the Naloxone training described in the year four report, and on the understanding of agencies across Blackpool of complex needs.
- Building the case for the importance of peer support. As well as the qualitative evidence from Fulfilling Lives, there is now significant evidence for the value of peer support. A Cochrane review of 11 randomised controlled trials found that peer support is associated with similar psychosocial, satisfaction, clinical and service outcomes to those achieved by other professionals (Pitt et al, 2013). A review of the wider literature found

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improved clinical outcomes such as engagement and reduced admissions and symptoms; improved social outcomes such as more friends, employment and community integration; and increased hope, control, self-esteem and confidence (Repper and Carter, 2011).

- The experience and knowledge of the challenges facing individuals with complex needs that BFL team members now have. Navigators come from diverse professional and personal backgrounds and have expertise in different areas, but have built up an excellent understanding of the types of services that people with complex needs might access and the help they might need to do so. They have also developed relationships with those services, supporting them to focus on dealing with issues such as substance misuse, housing or mental health, while navigators work with people to address other needs and issues in their lives.
- The establishment of new professional relationships and the strengthening of pre-existing relationships. This could help to maintain effective partnership working in the future.
- The range of innovative work that has happened over the last five years that would not have been possible without funding from BFL. Whether or not all of the initiatives launched have been sustained, they have all brought people together, helped people who have previously been disengaged from services and social interaction to make positive connections and build self-esteem, and yielded valuable lessons about delivering person-centred services.
- The successful launch of a Housing First project, a partnership between Blackpool Council and Fulfilling Lives. People supported in this way have reported positive outcomes and some have

achieved a degree of stability in their lives that they had not thought possible before. There is a strong case to continue with this approach, on the basis of both the Blackpool experience and national and international evidence. Housing First has become a core element of homelessness policy in much of the economically developed world (Busch-Geertsema, 2016), and has been shown to reduce homelessness and associated costs for people experiencing multiple disadvantage (Padgett et al, 2016). In recent years, the evidence base has been strengthened by large scale studies in Canada (Goering et al, 2014) and in Europe, where findings suggest Housing First predicts greater recovery than traditional service approaches. Outcomes include sustaining housing, fewer psychiatric symptoms and improved community integration (Greenwood et al, 2020; Woodhall-Melnik and Dunn, 2016).

Improving access to appropriate mental health support for people facing multiple disadvantage

According to a recent report by the national Fulfilling Lives evaluation team on access to mental health services for people experiencing multiple disadvantage, almost all Fulfilling Lives clients (93 per cent, n = 3,152) experience mental health problems. These can range from depression and anxiety to severe mental illness. 90 per cent of Fulfilling Lives beneficiaries experience both mental ill-health and substance misuse. There is a very strong association between experience of complex trauma and multiple disadvantage.

Despite this, the evaluation of BFL and evaluations undertaken in other Fulfilling Lives areas have consistently found that Fulfilling Lives clients experience challenges in getting support from mental health services. There may be a range of reasons for this:

- Despite NICE guidance on treatment of dual diagnosis³³, which recommends that mental health services should take the lead, services sometimes find it difficult to work with people who have both mental health challenges and issues with substance misuse. Given the high number of people who are affected by dual diagnosis coming through the doors of both mental health and substance use services, staff face a difficult challenge in deciding who should take the lead in a system which still operates in a compartmentalised way.
- The high demand for mental health services in Blackpool and successive reductions in the budgets of service providers have made it difficult for services to meet the needs of all those with presenting with mental health challenges. While services might wish to operate in a more proactive, flexible, person-centred way, lack of funding acts as a barrier to this.
- Establishing what works is not easy given the wide spectrum (and combination) of substance use and mental health problems that exist. Where dual diagnosis is associated with greater challenges for practitioners and treatment services it can be marginalising for service users, despite evidence to suggest that people with overlapping mental health and substance use problems are in the majority not the minority.

Where the experience of Fulfilling Lives is helpful is in raising awareness of the gaps in

support for people with complex and co-existing difficulties. Where it can also be beneficial is in promoting a language which emphasises the importance of collaboration between mental health, substance misuse and other services. Navigators can also play an important role both in helping people to access services and in enabling mental health services to better manage the flow of people presenting with mental health needs. Evidence suggests that they can do this in the following ways:

- By advocating for their clients and helping them to articulate their needs and rights, enhancing the chances that the right decisions are made about their mental health care.
- Building positive relationships with mental health service providers, helping to develop their understanding of individual clients and the issues that might prevent them from engaging with and benefiting from services.
- Working with people to address other issues that might be contributing to poor mental health, such as housing, relationships, finances and social connections.
- Providing practical support to help people engage with services, for example by accompanying them to appointments or supporting them afterwards.
- Helping clients to access and benefit from peer support.

The recently published Community Mental Health Framework (August 2019)³⁴ sets out a new approach in which place-based and integrated mental health support, care and treatment are situated and provided in the community for

People who have co-occurring drug and/or alcohol-use disorders and mental health needs can also experience discontinuities in their care. This can often be due to a lack of skills or competences, meaning that they can be excluded from drug and alcohol services due to their mental health problems, or excluded from mental health services due to their drug and alcohol problems. This is why this Framework's principle of inclusivity is important; embedding expertise and building skills that provide support for co-occurring drug and/or alcohol-use disorders is a key element of NHS England's Long Term Plan ambition to create "a new community-based offer". People with this expertise should take the lead in establishing formal links and partnerships with statutorily local authority-commissioned drug and alcohol services.

Extract from The Community Mental Health Services Framework for Adults and Older Adults

people with any level of mental health need. In theory, it will enable more and higher-quality care to be provided at a local community level (of 30,000 and 50,000 people, the population of a Primary Care Network's geographical footprint). One of the aims of the new approach is to break down the current barriers between: (1) mental health and physical health, (2) health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care.

The vision for place-based integrated services applies to people irrespective of their diagnosis. The Framework mentions specifically the intention to provide support for those who may be at risk of exclusion from their community, including the following groups who have been supported by BFL:

- People leaving the criminal justice system or people with multiple vulnerabilities frequently in contact with the police
- Rough sleepers

- People with complex mental health difficulties associated with a diagnosis of 'personality disorder'
- People experiencing co-occurring drug or alcohol-use disorders and other addiction problems (see above)

In terms of how this vision is to be realised, the Framework emphasises the role of 'community connectors' (who might also be called 'link workers', 'social prescribers' or 'navigators'), who will be familiar with the local resources and assets available in the community, vary the support provided, based on needs, and assess a person's ability and motivation to engage with certain community activities. The effectiveness of the navigator model for people experiencing multiple disadvantage has been demonstrated through the experience of Fulfilling Lives. We suggest that there is a good case for considering the role of a specialist multiple disadvantage or complex needs navigator team, working within a wider team of community connectors to provide the support that would be necessary to ensure that any population-based service arrangements were inclusive for people experiencing multiple disadvantage.



Cost-effectiveness

Fulfilling Lives is cost-effective in that it reduces demand in crucial areas where services are at risk of being overwhelmed (for example, A&E, hospital inpatient beds, criminal justice). Using data for pre and post service use for clients supported by BFL during all five years of the project, there has been a mean reduction in 'reactive' service costs of £9,813 per person per year. The service does not yield cashable savings but does mean that health and criminal justice agencies are more likely to be able to meet the needs of the population without expansion.

Findings on cost-saving are consistent with previous years and with findings from the national evaluation and other local evaluations. It would have been helpful to have been able to include data on mental health inpatient admissions, which might have increased as people engaged more with services. On the other hand, it is possible that input from navigators would have reduced mental health service usage and costs, in that (a) navigators could triage people who might not need support from services if other issues in their lives could be resolved and (b) navigators could support people to engage more consistently, complete courses of treatment and stick to medication, reducing the chances of readmissions and reactive events.

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9.3 Recommendations

The impending closure of the project as Lottery funding comes to an end means that our recommendations are focused mainly on taking forward support for people experiencing multiple disadvantage in the future.

1. Retain a multiple disadvantage strategic partnership

The multi-agency partnership that has overseen the delivery of BFL and has become the Legacy Board has been instrumental in raising the profile of multiple disadvantage in Blackpool, building strategic relationships and improving services. The Legacy Board should continue as a strategic oversight group, mirroring the approach taken in the areas which are part of Making Every Adult Matter (MEAM). The national evaluation of MEAM has carried out research into how MEAM partnerships work and has identified the characteristics of effective partnerships³⁴; the report may be a useful source of information to help with thinking about how to configure and run a strategic partnership once BFL has closed.

2. Recognise the importance of co-production and peer support and take concrete steps to embed these in services and support for people with complex needs.

Learning about co-production has been at the heart of the Fulfilling Lives programme, but it is

not a new concept. There is evidence that co-production with experts by experience leads to improved outcomes and quality of life for people using services; greater satisfaction with using services; increased job satisfaction for people working in services; more efficient services with possible cost-savings, and for society as a whole it means increasing social capital, social cohesion and reassurance about the availability and quality of services (Slade et al 2017)³⁶. Recent research by the national Fulfilling Lives evaluation has found that co-production has helped to bring about systems change in the Fulfilling Lives areas³⁷. Similarly, peer support has been a key element of the Fulfilling Lives approach.

Once BFL funding has ended, services in Blackpool would benefit from involving experts by experience in service design and commissioning; continuing to employ people with lived experience in support roles and having a lived experience team to gather intelligence and work with other agencies to improve co-production. A pool of peers who are available to support people experiencing multiple disadvantage (currently being delivered by the LET's 'Peer For You' initiative) would also help to sustain positive outcomes. To this end we recommend that a multiple disadvantage Lived Experience Team be commissioned by a multi-agency partnership and be hosted in an independent organisation with a strong track record in promoting co-production and peer support.

3. Explore possibilities for commissioning a team of specialist navigators to work with people experiencing multiple disadvantage.

Navigation helps people connect with services, stay engaged with services, use reactive services

35. <http://meam.org.uk/2020/08/18/year-three-meam-approach-evaluation/>

36. Slade, M., McDaid, D., Shepherd, G., Williams, S. and Repper, J. (2017). Recovery: the Business Case. Nottingham: ImROC.

37. CFE Research (2020), The role of lived experience in creating systems change

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less (thus saving money), improve health and wellbeing and achieve socially valued goals, such as making more social connections and enjoying meaningful activities. The evidence base for navigators has been strengthened by the Fulfilling Lives experience. Stakeholders agree that, in an ideal world, a specialist navigator team would be commissioned to continue to work with people experiencing multiple disadvantage.

There is less consensus on how this might work. For some stakeholders it is important that specialist navigators should operate as a single team, while for others embedding individual navigators into a range of services would be preferable, provided that navigators had access to independent support and supervision. The structure of a navigator team might be determined in part by decisions about where funding would come from and which policy agenda would be best served by employing navigators. These are discussions that need to continue locally, using the evidence set out in this report as a basis for decision-making.

4. Continue to measure outcomes

Consistent measurement of outcomes has been a strength of the Fulfilling Lives programme and has helped the sites and the national evaluation team to demonstrate the value of the approach. In many respects the work that has been done by Fulfilling Lives is an exemplar from which many other voluntary and statutory agencies could learn. It is important that if aspects of the Fulfilling Lives project continue after March 2021, the measurement of outcomes should continue and should be consistent with measuring outcomes for other types of community navigation service in Blackpool.

5. Continue to manage the transition from BFL

The process of preparing for the end of the BFL service is already underway and the project is now closed to new referrals to ensure that there is time to work with people in a meaningful way before the project ends. Much work has already been done to prepare staff and clients for the transition, although it seems that services with which BFL works are less certain about how they will fill the gap that the end of BFL will leave. Appendix two contains a review of good practice in managing transitions, prepared by Homeless Link. Recommendations on managing the transition are:

- **Continue to liaise with other services about the support people will need after BFL closes. Keep other agencies informed about timescales and schedule joint meetings with clients in preparation for their support from BFL coming to an end.**
- **Work with clients to develop plans for how they want to be supported post-BFL.**
- **Continue to make other agencies aware of the evidence for the effectiveness of the Fulfilling Lives approach and engage them in discussions about next steps.**
- **Put the perspective of people with lived experience at the heart of planning the transition from BFL and any future services that evolve from it.**
- **Use the remaining six months of the project to support other agencies to adopt practices and behaviours that would improve the experience of people facing multiple disadvantage.**



Appendix

Appendix A: High level systems change plan

INVOLVEMENT OF PEOPLE WITH LIVED EXPERIENCE	COMMISSIONING DEVELOPMENT	WORKFORCE DEVELOPMENT	ACCESS TO MENTAL HEALTH SERVICES	INFORMATION SHARING
<p>STAGE 1 DEC 2017</p> <p>Work with Revolving Doors Agency (RDA) to develop a model and specification for Service User ENgagement (SUE)/ Co-production and commission an organisation to lead on this</p>	<p>STAGE 1 MARCH 2018</p> <p>Strategic Board members to assist the Partnership Manager in accessing strategic planning forums/decision makers to make the case for a Blackpool wide MCN strategy</p>	<p>STAGE 1 SEP 2018</p> <p>Develop a Community of Practice (CoP) for frontline workers across MCN sections, to Identify knowledge gaps, learning opportunities & key approaches to embed across the city e.g. PIE, TIC</p> <p>Launch a specialist training function, informed by the frontline CoP and Lived Experience Body, to co-ordinate wider workforce development around MCN</p>	<p>STAGE 1 MAR 2018</p> <p>Fully engage with the mental health (MH) sector in Blackpool Fulfilling Lives Partnership Strategic Board and Operational Group and develop co-working arrangements with key parts of the mental health service</p> <p>Organise appropriate mental health training for BFL staff</p>	<p>STAGE 1 SEP 2018</p> <p>Develop a pilot project with a key partner to share access to InForm (BFL;s Case Management System)</p>
<p>STAGE 2 SEP 2018</p> <p>Develop a vibrant lived experience body that feeds into all aspects of the design, development and delivery of BFL</p> <p>Lived experience body works with partners to develop model of support for external agencies around SUE/co-production, including advice, training, consultancy and participation</p>	<p>STAGE 2 MARCH 2019</p> <p>BFL Partnership to work alongside lived experience body, using learning and resources from the programme, to lead on the development of a co-produced Blackpool MCN Strategy, reporting to the Health and Wellbeing Board</p>	<p>STAGE 2 SEP 2018 – MAR 2021</p> <p>Continue to deliver specialist training function</p> <p>Offer short-term placements/shadowing opportunities to external agencies within BFL to share & embed MCN expertise</p>	<p>STAGE 2 SEP 2018</p> <p>Further develop joint working relationships and arrangements including training for BFL staff on 2014 Car Act</p> <p>Embed mental health specialisms within BFL as a link to the wider system.</p> <p>Develop and test referral pathways for BFL into mental health services</p>	<p>STAGE 2 AUG 2019</p> <p>Evaluate pilot and facilitate access to InForm to other agencies</p> <p>Establish a regular multi-agency review meeting around MCN to support information sharing, and co-ordinated interventions, including the involvement of people in their own support planning</p>
<p>STAGE 3 ONGOING TO MAR 2021</p> <p>Lived Experience Body offers SUE/co-production support to external agencies in Blackpool</p> <p>Develop plans to ensure continuation of Lived Experience Body</p>	<p>STAGE 3 MARCH 2021</p> <p>BFL Partnership drives the implementation of the Blackpool MCN Strategy, ensuring continuing SUE</p>	<p>STAGE 3 MAR 2020</p> <p>Develop model for continuation of specialist service/interventions around MCN in Blackpool</p>	<p>STAGE 3 SEP 2019</p> <p>Further develop formal partnership arrangements around service delivery, embedding MCN expertise into mainstream MH services including developing specialist roles within new models of care.</p>	<p>STAGE 3 AUG 2020</p> <p>Support the continuation of multi-agency review meeting around MCN</p> <p>Work with Lived Experience Body to develop a service user led approach to information sharing</p>
<p>SUSTAINABILITY</p> <p>Effective Lived Experience Body is embedded into Blackpool service system and continues to provide SUE/co-production support across the system as required</p>	<p>SUSTAINABILITY</p> <p>Blackpool MCN Strategy continues, driven by and accountable to H&W Board</p>	<p>SUSTAINABILITY</p> <p>Specialist service/interventions for people with MCN form part of wider Blackpool service system</p> <p>MCN traineeships, open to people with lived experience, continue to be offered</p>	<p>SUSTAINABILITY</p> <p>Enhanced ability of MH services to appropriately support individuals with MCN</p> <p>MCN specialist staff embedded in MH services.</p>	<p>SUSTAINABILITY</p> <p>Shared access to InForm re MCN improves coordination of work</p> <p>Service users 'own' their information</p> <p>Multi-agency MCN meeting is part of coordinated practice</p>

Appendix B: Deep dive: Transitions to and from services and how to support this effectively

Introduction

BFL helps people to transition between services and eventually to move from being supported by BFL to accessing other services more independently. Given that the project is due to close in March 2021 and beneficiaries will need support to move on from their engagement with BFL, the evaluation team carried out a 'deep dive' literature review focusing on effective practice in supporting people to move into and out of services. The deep dive considered the following key questions:

- **How are transitions to and from services defined?**
- **What considerations should services take when planning and supporting individuals to transition between services?**
- **Challenges to effective transitions**

How are transitions to and from services defined?

Moving from one provider to another

Transitions can be described as a change. This term can translate and be used in a variety of settings and services that are explored below:

- Inpatient mental health settings to community or care home settings
- Mental health transitions from children and young people's mental health services to adult mental health services
- Discharge from hospital settings
- Hospital settings to care home settings
- Hospital settings to home settings
- Leaving prison to the community

Street et al. (2018) specifically describe a transition as "the process of moving someone from one health service to another; it refers to the coordination, planning and preparation for supporting a person to leave one service and begin attendance at another." Poor and disjointed care during a transition can leave individuals with unsupported mental health needs, individuals can 'fall through the gaps' of services and may be left to navigate independently through complicated service arrangements.

Cause of uncertainty

Guidelines from NICE (2012) discuss how staff focus on the treatment and care provided to the individual in the present. However, when this care comes towards an end, less consideration is given to preparing someone to leave and less consideration is given to the new service that others will provide. Individuals who are transitioning from one form of care to another see the transition as an important part of their experience of care. A transition is seen as a change, and with change comes anxiety and uncertainty. Transitions may be more difficult if it is prompted by the decline of a person's mental health.

What considerations should services take when planning and supporting individuals to transition between services?

Family and carers

NICE (2016) advise that families and carers play an essential part in supporting individuals during transitions. The support network of the individual should be identified and ways should be explored where this network can be involved. Problems can arise when an individual's carers are not involved in planning. Contrarily, Connolly et al. (2009) highlight that relatives can sometimes present obstacles when involved as they see the hospital as providing ongoing care and not themselves and they could have an unrealistic expectation of services' available. Hanratty et al. (2014) report that carers wanted more support and time to voice concerns, especially when transitioning from a hospital to a care home.

Individual needs

When planning transitions and reintegration, community services that address the different needs of the individual should be involved (NICE, 2016). Individuals' rights to information, advocacy, and support should be observed to aid an effective transition. Individuals who experience transitions into and out of mental health inpatient hospital services are vulnerable and often have mental health disorders and so, advocating for their own needs is more difficult.

Transitions between services (when individuals are leaving the hospital setting) could be improved by including follow up care, especially for those individuals with complex needs (Connolly et al., (2009). However, nurses felt this would add pressure to their own workload.

Hanratty et al. (2014) report that discussions about transitions between care settings often did not include individuals' wishes. This was also reported by young people when transitioning from young people's mental health services to services for adults (Street et al., 2018). The young people advised that they felt excluded from important decisions about their care. Guidelines from NICE (2016) highlight that transitions should be taking full account of the individuals' views and needs. Further to this, the guidance highlights that young people should have their transition care and support coordinated by a named worker.

Strength-based approach

Case study 1 – Mayday Trust and the Personal Transitions Service

Mayday Trust deliver a Personal Transitions Service (PTS), a strength-based model for individuals experiencing homelessness and also for those going through tough life transitions, such as leaving prison, psychiatric hospitals or care. Mayday Trust is a registered charity and the PTS is currently available in three locations – Oxford, Northampton, and Westminster.

The idea of the service is to not focus on needs and problems but to build on strengths, aspirations, relationships, and purpose. The transition the individual experiences would be quick and positive, and the individual would have a new community-based network of support around them after engaging with the PTS.

Developing the PTS has resulted in Mayday Trust believing that the systems individuals experience are difficult and do not work for them. Individuals prior to the PTS have often found themselves facing unnecessary barriers and stuck in services, which are sometimes not suitable for their needs.

Peer support

To support sustained recovery, a peer support model has been discussed (NICE, 2016). This model provides an opportunity for social support, and those individuals with long-term conditions have improved wellbeing when they actively work with the peers.

As discussed above, follow up care could improve the transition from a hospital setting but the capacity to complete this was a worry for nurses in the setting. Patients experiencing mental health needs can feel anxious about losing the support of staff when discharged from hospital, the individuals often discontinue treatment, and experience a relapse.

Early transition planning

NICE (2016) emphasises the importance of planning early on the transition process. Singh et al. (2008) highlight that planning should involve a meeting with the individual experiencing the transition and professionals from both services involved in the transition. There should be good information transfer, as well as a period of parallel care where both services involved in the transition work together.

A successful transition includes facilitating recovery through participation, promoting feelings of usefulness, and enhancing an individual's use of time (Turner et al., 2009). Street et al. (2018) found that young people felt their experiences of transition were poor due to lack of planning, limited preparation and inadequate information.

Individuals' past experiences

NICE (2012) highlight that individuals may fear transitions due to previous experiences of loss or rejection. Individuals may fear that a transition will lead to their needs not being met or it may prevent them from accessing services in the future. If a trusting relationship has not been established with the current service/professional they are working with then the individual may be anxious about how they will cope when contact is lost with the service/professional.

'Hump' costs

Closing of services/settings will inevitably incur financial costs (Mansell et al., 2007). Prior to the closure of service, a new service to which individuals can transition to will need to be found and costs will be incurred this way. 'Double' costs can then emerge during transitions from services and these 'hump' costs require careful planning to ensure that individuals are still receiving adequate support and do not 'fall through the gaps' because a service is withdrawn.

What are the challenges to effective transitions?

Developing plans

Providers and wider stakeholders identified the challenge of developing exit plans for individuals as support comes to an end in a programme or service. Mason et al., 2017 describe a navigator programme whose aim was to support individuals to independence, including being able to engage with existing services. A small staff team was retained to support individuals during the final year (a manager and four navigators), but support from the navigator was ended after three years. Individuals who received support from the navigators were reassured that support would be continued as they continued to stabilise.

Planned interaction with the right services

A lack of planned interaction with the right services can make the transition process problematic. For example, individuals leaving prison often lose contact with services. These individuals are unlikely to be registered with primary care services after leaving prison (Social Exclusion Unit, 2002). A lack of planned contact may lead to individuals having chaotic and unplanned interactions with health services when they leave prison (Fox et al., 2014) and individuals may use the emergency department more for problems related to mental health (Frank et al., 2013).

Segregated services and support

Issues can occur when services and support are not integrated and there is a lack of collaborative working (NICE, 2016). This can result in inadequate support for individuals using mental health services, readmissions, and poor care throughout. Inadequate sharing of information between services can also cause issues. NICE (2012) discuss that unnecessary disruption during a transition that may occur if individuals experiencing the transition have to repeat information they have already given due to poor communication between staff in different services.

Rushed transitions

Transitions that are rushed create significant anxiety for individuals, leaving them uncertain about the management of their mental health and sources of further support (NICE, 2016). Transitioning from young people's mental health services to services for adults has been reported by young people as being rushed, poorly planned, and the young people advise that their wishes are often ignored (Street et al., 2018). The young people felt the move seemed abrupt.

Adjustment

Individuals find adjusting from one service to another service difficult, especially when services can be so different from one another and provide different forms of support (NCCMH, 2009). Individuals felt that transitions were abrupt and that they were often required to leave a service before they felt ready. This could negatively impact individuals' attitudes towards future help-seeking.

Recommendations for transitions

The following recommendations are for services and individuals involved in transitions to consider:

1. Individuals' needs can change over time, as can their expectations. Service provision should adapt to this and adopt a flexible approach.
2. Consider that withdrawal and ending of services, or transitioning from one service to another, may evoke strong emotions and reactions in individuals. Therefore, the individual should be involved in the planning process, and arrangements for support should be agreed before the transition.
3. A collaborative environment should be maintained. This will keep any disruption during transitions to a minimum.
4. Assess the resourcing demands of the transition and plan ahead. Forward planning is essential in the success of a transition from one service to another.
5. Communication is important. Clear communication about the individual is required between the services involved in the transition; and direct communication with individuals about preparation and what happens next should occur to reduce any negative impact associated with transitions.



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