

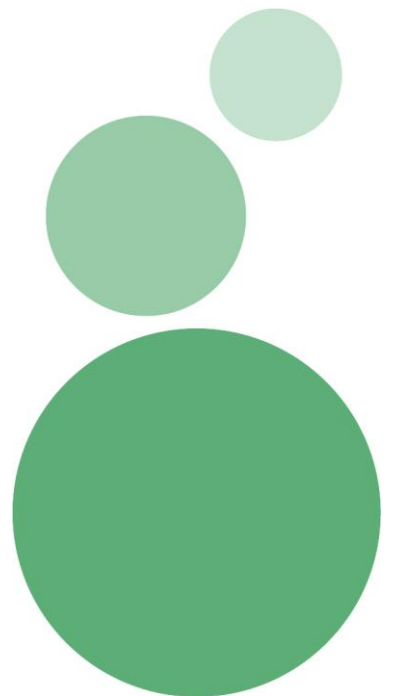


Care Services Improvement
Partnership (CSIP)

ACE Evaluation Interim Report

December 2009

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Executive Summary

The Adults Facing Chronic Exclusion (ACE) programme was established in 2007 as a cross-government collaboration. The Cabinet Office leads the programme in partnership with the voluntary and community sectors, local authorities and health authorities.

A total budget of £6million has been made available over three years to fund 12 pilots located across England. The client groups are varied and the work is mostly delivered by charities and voluntary organisations (only one is delivered by a statutory service, a mental health trust).

The aim of the ACE programme is to test new ways of working with adults facing chronic exclusion to achieve better outcomes for individuals and communities, and whether this can be done more cost effectively than existing approaches. The programme promotes three types of intervention for their clients:

- ‘*system change*’ that effects structural or strategic changes in the delivery of local services and involves changes in their governance and commissioning;
- supporting individuals to move between services - ‘*transition points*’;
- assisting clients to ‘navigate the system’ and find appropriate services.

Evaluation of the ACE Programme

A detailed process, impact and outcome evaluation is answering the principal research question: “*are the ACE pilots succeeding or not in delivering their projected outcomes for service users and themselves, and have they been cost effective?*”

Who are the clients?

There is no universal definition of the ‘chronic social exclusion’. However, the data from the pilots describe the client group as follows:

- a client is most likely to be in his or her 30s;
- the majority are white;
- the gender split is near equal across the programme but pilots tend to support either men or women;
- they are light users of health services;
- 20% of clients across the programme had used temporary accommodation in the four weeks prior to their engagement; and
- tend to be unemployed, long term sick or not working for another reason. But, interestingly, 5% of the clients are *employed*.

Staff skills and experience

A set of professional and social skills are common to the pilot workers: including social skills (empathy, compassion and common sense) and professional skills (negotiating flexibility and creativity).

Previous experience of the pilot workers is important and includes: experience of local agencies, the sector or of being excluded oneself.

There were, however, differing opinions within pilots as to which was more important: skills or experience.

Relationship with clients and local services

In establishing a trilateral relationship between clients, services and pilots, some pilots chose to act as advocates on behalf of their clients. Others supported clients to deal with local agencies themselves. Most pilots adopted both modes of operation.

The pilots reported being better placed than local statutory agencies to spend more time with their clients and to see them more frequently. This allows them to work at the clients' problems and find solutions.

Pilots also considered that they were more likely to take on risk with individuals – although the level of risk varies across the pilots – and help 'normalise' the relationship between client and agency.

Costs of the pilots

The total costs of the pilots in 2008/09 ranged considerably, **from £96,325 to £313,085**. The average total cost was **£193,579**.

As expected, the vast majority of pilots spend most of their budget on staff costs, mainly operational staff. From the six pilots that provided accommodation costs it is concluded that accommodation costs contributed to less than 5% of the total budget costs.

In terms of average hourly costs, the two pilots with lowest hourly costs have more staff than the two pilots with the highest hourly costs. One-to-one meetings are the only type of transactions provided by all pilots: on average each meeting lasts one hour. Group counselling has the greatest variation in terms of length of session, most pilots take between one hour and two and a half hours to complete. The transaction costs of different intervention-classifications differ between pilots, with a one to one session at one pilot costing approximately twice as much as a similar session with another

The configuration of the total staff is dictated by the nature of the intervention and the staff that deliver it. The ratio of operational to non-operational staff also differs substantially between the pilots, as does the number of staff at different levels. This results in a high level of variance in unit costs per hour of activity, from £9.93 to £24.

Changes in clients' use of services

The number of outpatient appointments is increasing over the first 6 months a client is supported by a pilot. While this trend needs to be explored, it appears to be encouraging if it is indicative of clients receiving the services that they require.

However, the observed change in other health service use is small and no trend can be identified.

The use of temporary accommodation is obviously related to clients' circumstances and the pilot's primary objective. Pilots that fit these criteria appear to be influencing the number of days spent in temporary accommodation.

Changes to clients' lives

Overall, clients' well-being scores have increased across the programme after four to six months of engagement. In particular clients reported improvements in their relationship with family and friends; leisure time; housing situation; physical health and mental health. However, they reported less improvement in the areas of their work situation, financial situation, and well-being of their children.

It is particularly noteworthy that:

- most pilots showed an improvement in the average health score after four to six months, with the exception of three;
- there appears to be a steady increase in the receipt of benefits over time;
- clients who are in stable accommodation group maintained this status. However, the average accommodation score for those who were not in that group showed a fluctuating situation; and
- at all pilots clients tend to start their support as 'unemployed' or 'out of work for another reason; and this situation does not change.

Conclusion and recommendations

This report provides further evidence in support of the ACE. Promising as these interim results are, they are of the programme as a whole and have yet to address the principal aim of the evaluation.

It is recommended that that in the remaining months of the evaluation, attention turns to understanding the pilots individually in terms of their costs and outcomes to assess whether the pilots are succeeding or not in delivering their projected outcomes for service users in a cost effective manner.

1.0 Foreword – ACE in Context

In 2007, Hilary Armstrong, then Minister for the Cabinet Office, launched a review to find policy interventions that enable people potentially written off by society to change their lives and fulfil their potential. The resulting report, 'Reaching Out: An Action Plan on Social Exclusion'¹ described the "2.5% per cent of every generation who seem caught in a lifetime of disadvantage and harm". Despite growth in average national income, attainment and outcomes, this group of people had not progressed and in many cases, were deteriorating.

The report announced a Programme of Work to gather further evidence of social exclusion, while meeting that need at a local level. One programme launched was the Adults Facing Chronic Exclusion Pilots (ACE), which were designed to identify people who have chaotic lives and multiple needs, but who do not access support from statutory services.

ACE received funding from the Home Office, Department of Health, Communities and Local Government and the Department for Work and Pensions. Their agreement to fund this work reflects that the ACE client group – with their complex range of needs and issues – use, or try to use a range of public services, each sponsored by different departments. The costs of getting that provision wrong are currently un-quantified, but initial work suggests that the right support can help someone resolve their problems and find employment; while the wrong configuration can see someone with very similar needs go to prison, never resolve their problems and die early.

An initial identification found poor outcomes, observable chaos and lack of engagement characterised the ACE client group. Expressions of interest from organisations were then sought for a range of 3-year pilots that would:

- improve service delivery to the hardest to reach;
- engage with people who are excluded from society; and
- offer individual support during periods of transition.

This approach attracted 229 applications covering groups from people seeking asylum to those over 80 years old and living isolated lives. A shortlist of 20 pilots was produced and this was based on how well organisations demonstrated their ability to:

- identify the client group;
- work collaboratively with local commissioners;
- reduce negative impacts;

¹

Available at:

http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/reaching_out.aspx

(Accessed 19/10/2009)

- show value for money;
- engage with difference and diversity;
- avoid duplication between local agencies.

Following interviews, 12 pilots were selected that together, in the views of all the sponsoring Departments and Cabinet Office, created a programme that:

- would offer wider learning on where systems fail to tackle 'hard to help' people;
- operated in a range of regions and locations (rural, urban, suburban);
- offered new approaches as well as traditional support;
- had local, multi-agency support at a commissioning level;
- could identify hidden need in their communities; and
- worked with a range of client groups who at first seemed very different, but who shared the common issue of poor outcomes and fractured engagement with community support services intended to help them.

Matrix Insight was commissioned to evaluate the ACE pilots. The evaluation is designed to capture the common learning from the Programme. That is a challenging task as:

- there is no common client group or approach to interventions;
- the number of clients supported by the pilots is small, thus rendering a small evidence base;
- the pilot sites share a flexible, changing and adaptive way of working which can be difficult to articulate as core principles.

The resulting evaluation – of which the Annual Report for 2009 follows – attempts to bring findings from this range of work to help inform general service delivery. The idea is that if something is true across all 12 pilots, then it is likely to hold true for many other services and interventions. The evaluation seeks to determine need and the effectiveness of the proposed solutions through an examination of the:

- need identified by the projects;
- mapping the process of delivering engagement, intervention and resolution;
- costing the service against outcomes to determine value for money;
- identifying where the pilots could save other services money.

The resulting findings will provide an evidence base for determining who this group are and what we can do to help. Further public reports will also make suggestions for how local areas can adopt practices used by the ACE pilots to identify better ways of working with people who are everyone's problem, but no-one's responsibility.

*Nick O'Shea
Head ACE Programme*

2.0 Introduction

The aim of the ACE programme is to test new ways of working with adults facing chronic exclusion; to achieve better outcomes for individuals and communities; and to test whether this can be done more cost effectively than existing approaches.

All of the 12 pilots in the programme are working to common principles, but each with a different type of client and method of intervention, which poses a challenge for the evaluation.

The aim of the evaluation: *“are the ACE pilots succeeding or not in delivering their projected outcomes for service users and themselves, and have they been cost effective?”*

The evaluation itself runs for just over three years - it commenced in July 2007 and will be concluded in August 2010 – and comprises

- a process evaluation,
- impact evaluation
- economic evaluation

This report describes how the 12 pilots are working with adults facing chronic exclusion that are common across the programme. It also identifies who are the chronically excluded and what outcomes the ACE pilots are producing for their clients. Service delivery innovation is highlighted, and the report discusses how in its final year, the evaluation will investigate how public services can change to accommodate better the ACE client group. This is the second interim report of the ACE evaluation and is submitted prior to the final report due in August 2010.

2.1 The 12 ACE pilots

The ACE pilots are located across England and work with a varied group of clients. Charities and voluntary organisations deliver most of the pilots and only one is delivered by a statutory service – South West London and St Georges Mental Health Trust. Table 1 describes the 12 pilots; including their name, location, the type of client targeted, the interventions used and the number of staff employed

It is understood that the ACE programme is promoting three types of intervention for adults facing social exclusion.

The first intervention type is the promotion of 'system change'; in other words, effecting structural or strategic changes in the delivery of local services, which might involve changes in governance and commissioning of local services.

The other intervention types relate to operation of local services, namely, supporting a client to move between 'transition points' and providing assistance with 'navigating the system'.

The need for ACE pilots to promote these three types of intervention is based on the findings of the prior research undertaken by Bloor et al (2007) and Schneider (2007). These reports concluded, *inter alia*, that there was a need for services to be re-organised to effectively identify, engage and meet the needs of adults facing chronic exclusion, although there were currently barriers preventing some agencies from so doing. In addition, there was a need to develop and implement pathways of care for the benefit of individuals with complex needs or combinations of needs, and also to engaging people when they are at transition stages between services.

Table 1: The 12 ACE pilots

Name	Location	Type of organisation	Clients targeted	Client needs	Intervention	Staff
St Mungo's – Lifeworks ACE Pilot	London	Charity	Homeless guests in St Mungo's hostels.	Mental and physical health; homelessness.	Psychodynamic therapy, which attempts to engage with clients' unconscious feelings, delivered one-to-one and in groups.	Eight therapists, a Manager and a Clinical Director.
The Employment project – Thames Reach	London	Charity	Those seeking to move from unemployment into work.	Unemployment; low-level mental health difficulties.	Structured training and one-to-one mentoring to encourage skills development and to achieve their employment goals.	One manager and two employment coaches.
Forensic Therapies	HMP Holloway, London	Charity	Female prisoners diagnosed with Borderline Personality-Disorder.	Mental health, especially the risk of self-harm and suicide.	Modified Dialectical Behavioural Therapy, delivered in modules.	Several part-time staff, with two clinical managers.
NOAH Enterprise	Luton	Charity	Rough sleepers with a range of needs who are struggling to access services.	Housing, mental health, physical health, benefits, addiction and crisis episodes.	Practical and emotional support in accessing appropriate services and building relationships.	4 project staff work on the ACE project and are supported by a manager. Other staff may be used when appropriate.
Milton Keynes Link Worker	Milton Keynes	Charity and statutory partnership	Adults with a range of needs who are struggling to access mainstream services.	Housing, mental health, physical health, benefits, addiction and crisis episodes.	Practical and emotional support in accessing appropriate services and building relationships. Volunteers provide ongoing support to clients.	5 (including admin but excluding peer volunteers).
Tyneside Cyrenians	Newcastle	Charity	Adults, often rough sleepers with a range of needs, who are struggling to access mainstream services.	Housing, mental health, physical health, benefits, addiction and crisis episodes.	Practical and emotional support in accessing appropriate services and building relationships through a peer worker.	One manager and 4 project workers.
Connected Care, Turning Point	Bolton	Charity	Engage with community members in order to provide a modified specification for services.	The reshaping of statutory services in order to serve the community's needs more appropriately.	Conducting a 'community audit' using researchers from the community, and presenting this to local commissioners.	One manager; community researchers; and analytical team in London.

Name	Location	Type of organisation	Clients targeted	Client needs	Intervention	Staff
Fairbridge ACE Pilot	Bristol	Charity	Young people aged 19 - 25 years who are struggling to engage in suitable employment, training or education.	Housing, mental health, physical health, self-esteem, benefits, and addiction.	Practical and emotional support to locate services, promote independence and increase confidence, with the goal of finding suitable employment, training or education.	One project worker supervised by a team leader but with active roles from a range of other staff in Fairbridge West.
Inside, Outside – After Adoption	HMP Styal and HMP Low Newton	Charity	Female prisoners who have lost their children to adoption or who are at risk of losing their children to adoption.	Cope with loss of a child and any needs that may have led to the loss of the child (such as alcohol abuse).	1:1 counselling or support to help women through the adoption process and after. Assistance with communicating with birth children and signposting to other services.	Three support workers and three managers (one for each prison project and the overall ACE lead).
Pathways to Inclusion – MCCH	Medway, Kent	Charity	Adults with Aspergers, Autism, learning difficulties or mental health needs.	Locate and access facilities, promote independence and increase confidence.	1:1 support and group activities to target specific needs. For example travel training to enable adults with autism to leave the house independently.	One project manager and two project workers.
New Directions Team, SW London Mental Health Trust	SW London	Statutory	Adults leading 'chaotic' lifestyles.	Support to increase client stability, enabling them to access and engage with mainstream society.	Emotional and practical support to build relationships and locate appropriate services. Steering group of statutory partners to generate system change by promoting service 'flexibility'.	Three project workers, one manager, one admin worker and two strategic managers.
MAZE Project, Calderdale Women's Centre	Women Centre, Calderdale and Kirklees	Charity	Women suffering from domestic abuse or violence.	Increase confidence and promote safety of women and their children.	Enable women to make themselves safe, either through providing support or through work with couples to promote behaviour change.	Four project workers, a team leader, administrator and support from CEO.

2.2 Connected Care

Turning Point's Connected Care project in Bolton has a substantially different mode of operation and is not delivering a service directly to a client group. Rather, the pilot's approach has been to undertake an audit of local service provision and need, and for Turning Point to work closely with local commissioners to re-commission services on the basis of that audit.

The distinct approach of Connected Care is that researchers were recruited from the local community and were trained to undertake the audit with support from the Turning Point's professional research staff. The community researchers may have a deeper 'reach' into the local community and understand the needs of all people who live in a socially deprived area, including those harder to reach individuals who are considered to be 'chronically excluded'. The community researchers also contribute to the pilot's steering group and the commissioning process. The result of this process is that the local agencies will be commissioning a 'social enterprise' to provide an integrated health and social care service. This represents an ambitious approach to effecting local system change and is being brought about in a manner quite different than the other 11 projects.

Given their different approach, Connected Care was not required to provide data on clients or economic data on the cost of service. However, it is participating fully in the process evaluation and senior members of staff were interviewed for the latest round of interviews in September 2009. Given the principal focus of this report is to provide evidence on working with clients, the findings of the Connected Care process evaluation are not provided here, but will be reported in the final report. At that time, the main focus will be on how well system change was effected in Bolton and the interviews with the Connected Care staff will be analysed with reference to interviews with local stakeholders in 2010. Similar local stakeholder interviews will also be conducted in the 11 other pilots at that time.

2.3 Evaluation Methodology

The ACE evaluation is using a **theory of change approach**, where evidence is collected of both changes in outcomes and the causes of these changes. These sources of evidence are combined to understand if outcomes can be attributed to the pilots. This approach was chosen because of the nature of the ACE programme and the type of research questions the evaluation will answer. Data is collected longitudinally, and research methods are designed to be complementary.

Process evaluation

The process evaluation has been designed to answer the following research questions:

1. *How did each pilot perform against its initial plan?*
2. *What are the skills, knowledge and capacity required to offer effective services to the client group? How well did the pilots meet these needs?*
3. *Are the models of working demonstrated by the pilots sustainable and able to be generalised, and if so, in what contexts?*

In addressing these questions, the process evaluation is collecting data through four waves of face-to-face interviews with the pilots' managers, workers, and partners. So far, two waves of interviews have been completed.

The second round of interviews with pilots took place over the summer of 2009 and is presented here. Those interviews were with project managers and workers, and focussed on the skills and human resources that the respondents perceived were necessary to work well with the ACE client group. The interviews also explored the pilots' perspectives of the operational and strategic level relationships with local statutory agencies that were relevant to the pilots, and included questions surrounding how the pilots and agencies establish a working relationship and how they achieve outcomes for the client group. Finally, given the proximity to the conclusion of the programme, the interviews covered the current funding and future funding plans.

The third and fourth rounds of interviews will take place in the winter of 2009 and the summer 2010 with pilot staff and their local agency partners. Those final interviews will focus on, respectively, the pilots' understanding of outcomes and how system change was implemented locally.

Impact evaluation

The impact evaluation is tracking changes over time in the ACE client group's use of services and their employment, accommodation, offending and well being outcomes. A baseline questionnaire is completed when a client engages with a pilot, and then monthly questionnaires are completed until the client leaves a pilot's care.²

An analysis plan has been prepared which sets out the analyses that will draw on the data being collected via the monthly questionnaires. For this part of the study, the impact evaluation will answer the following research questions:

1. *Have the clients of the pilots begun to use services more appropriately than previously?*
2. *Were there common and specific outcomes which relate to local service use?*

These data provide the evaluation with information on:

- client characteristics;
- changes in clients' use of mainstream services; and

² The Turning Point pilot was not included in the impact evaluation because it does not work directly with Adults facing chronic Exclusion.

- changes in clients' subjective outcomes (e.g. well-being) and objective outcomes (e.g. accommodation status) outcomes.

At the beginning of August 2009 the pilots had registered 636 clients and measured changes in outcomes for 298 of these.³ The next year of data collection will aim to lengthen the time period over which clients' outcomes are measured.

Economic evaluation

The economic evaluation builds on the impact evaluation and addresses the following research questions:

- *What impact did the pilots have on cost (including distribution of costs) in relation to the achievement of outcomes and use of services whilst on the programme and progressing on from the programme?*
- *Did the pilots demonstrate that money for services could be allocated to make local or national savings whilst maintaining or improving outcomes?*

The economic evaluation collected information on

- costs of the pilots (from budgets)
- staffing of the pilots (posts and wages)
- unit cost of service delivery (e.g. number of hours spent on one to one meetings).

Additionally we are collecting information on the number of service deliveries (e.g. one to one meetings) that different clients have received. We will use this information to estimate the input of the pilots into the client. From the impact analysis the economic analysis will then take the results describing the impact of the pilots on service use and well-being and compare their outcomes with the inputs that pilots have provided.

³ Defined as measuring changes over two time points or more.

2.4 Findings of the first interim report

Key findings of the first interim report:

- * Pilots were operating with the flexibility and informality required to work with this client group;
- * Pilot workers are committed to working with their clients and had instituted core processes appropriate to those clients and their circumstances;
- * Overall, it was concluded that the programme level theory of change was limited and was hampered by a lack of definition of both the clients and the interventions offered.

The first interim report (January 2009⁴) drew heavily from the process evaluation and began to articulate a 'theory of change' for the programme and its individual pilots. The theory of change is essentially the story of how processes and interventions lead to intended outcomes. For a programme to be successful this theory of change should be coherent and be able to withstand rigorous scrutiny. As part of the development of this theory of change, the report also sought to address whether ACE was a coherent programme or a series of 12 individual pilots.

In examining the programme's theory of change, the first wave of interviews that were conducted in December 2008 began to examine the assumptions behind the pilots and the programme as a whole. In reporting the interim findings of these enquiries, the report examined whether there was a definition of chronic exclusion common to all of the pilots and, further, whether it was possible to formalise the core processes of referral, engagement and assessment for a group of adults who are in character said to be chaotic and difficult to engage. The report also considered whether the interventions that were offered were plausibly addressing the assessed needs of clients and whether they were capable of bringing about a successful outcome.

The January 2009 report found that the pilots were operating with the flexibility and informality required to work with this client group. This was necessary to prevent replicating formal definitions, processes and interventions that would further exclude those who are not engaging with mainstream services. Within that flexibility it was, however, noted that there was no definition of the client group that was common to all the pilots and there was a lack of unanimity on providing interventions that dealt with 'system navigation', 'transition points' and 'system change'.

That report also addressed, to a lesser extent, the question whether the programme had been implemented in terms of the proposed operational processes, management and partnership structures. It found that at a simple level the pilot workers were committed to working with their clients and had instituted core processes that were appropriate to those clients and their circumstances. Some pilots argued that their core

⁴ The submission of this report was delayed from the original submission date of August 2008.

processes should be informal so as to avoid excluding the individual, while others thought that more structured processes were appropriate where the client was living within a structured environment. In recognising the limited extent to which this question was answered, the report recommended that further investigations should be conducted with particular reference to the resources and structures that are in place to support the work of the local pilots.

2.5 Structure of the report

The following three sections of this report provide a detailed account of the findings from the analysis of individual parts of the evaluation to date.

Section 3 examines characteristics of the pilots' clients in terms of their personal characteristics, use of services, and circumstances, using quantitative data to answer the question 'who are the chronically excluded'.

Section 4 explores the operation of the pilots, considering what enables them to meet the needs of the ACE client group.

Section 5 looks at the emerging patterns in the change of service use and outcomes. The report concludes with a discussion of the findings to date together with recommendations relating to the both the management of the programme and the development of the evaluation.

3.0 Characteristics of adults facing chronic exclusion

The previous interim report considered the characteristics of chronic exclusion addressed by the pilots and found that the pilots concurred that chronic exclusion can be characterised by certain core considerations, and that those characteristics fit well with the characteristics demonstrated by prior research in this area (Bloor, 2007; Schneider et al, 2007).

There was not, however, a universal definition of the description of 'chronic exclusion' and in the absence of this the programme suggested that adults could be described by reference to their **relationships, risk factors and resilience** – the '3-Rs'. While these were recognised by all the pilots as applying to their client group, it was evident that they were interpreted differently by each pilot and the report recommended that the programme management issue guidance on their definition. The interim report concluded that guidance on the nature of the clients with whom the pilots should be working would give the programme greater coherence.

Since the January 2009 interim report, both pilots and national stakeholders have asked "who are the chronically excluded?" This section therefore presents empirical data on the gender, age and ethnicity of the clients together with an account of their service use and personal circumstances on engagement with the programme. However, before examining these data it is important to understand the client caseload from which these data are derived and this is presented below.

3.1 How many clients?

As at the 1st August 2009, the eleven pilots included in the impact evaluation have registered 636 clients since the start of the programme. There was, however, quite a range of registered clients within the programme: St Mungo's and Thames Reach had the largest proportion of clients and both registered over 100 clients each. Link Worker had a total of 83 clients registered. The next group of pilots had between 50 and 60 client and these pilots were, Calderdale, Forensic Therapies and Inside Outside. The final group of pilots had between 25 to 40 clients registered in ACE Hub; these pilots were Fairbridge, MCCH, NOAH, SW London and Tyneside.

In understanding these data it should be noted that clients are entitled to ask not to be included in the evaluation or can leave the pilot before two or more questionnaires are completed on them⁵. 304 clients completed only one questionnaire and 44 clients completed no questionnaires.

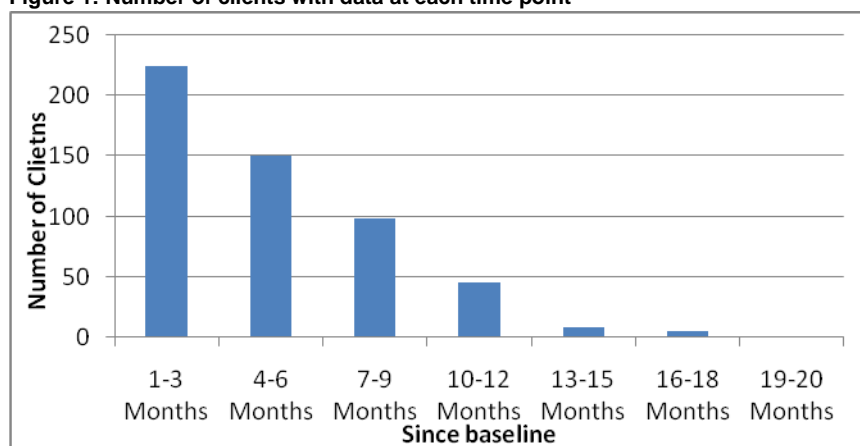
⁵ Clients complete a baseline questionnaire (QA) when he or she starts receiving support from a pilot, and then completes a shorter questionnaire (QB) monthly. Every 6 months or when the client leaves a pilot, the client completes QA again.

Changes in outcomes can be measured for clients where two or more questionnaires are completed and this is available for 288 clients, representing 45% of the registered clients. Within the programme, three pilots have 75% or more of their clients completing two questionnaires: MCCH (76%), SW London (82%) and Tyneside (96%). Calderdale, Fairbridge, Inside Outside, NOAH and Thames Reach all had between 50% and 60% of clients completing two questionnaires. The pilots with the lowest completion are St. Mungo's (16%) and Link Worker MK (33%). Forensic Therapies have only 26% of their clients completing two questionnaires, but they have only just started to enter their data onto ACE Hub.

Questionnaires are completed monthly so the evaluation can measure change over time. The analysis grouped clients' outcomes into three month time periods to make maximum use of the data.⁶ Figure 1 describes the number of clients where data are available at different time points (the time between completing a baseline questionnaire and completing a subsequent questionnaire).⁷ Most clients have changes in outcomes recorded within a time period of six months or less.

This report uses data to describe changes in service use and outcomes within six months as the sample size per pilot becomes too low when longer time periods are used. Thames Reach has the most clients with changes recorded within six months, and Forensic Therapies has measured changes only within one to three months because its intervention lasts approximately six weeks.

Figure 1: Number of clients with data at each time point



Base sample: 288

⁶ Time points are taken at three month intervals after the start of the intervention. If the data from the third month after the intervention is not answered or there is no questionnaire then the second month is used and then the first month. If there is no relevant data from these three data periods then that time point is empty.

⁷

3.2 Who are the clients?

In the first wave of interviews, and reported in the first interim report, the pilots were asked to define chronic exclusion. Consistent with prior research, the pilots concurred that chronic exclusion can be characterised by certain core conditions:

- Chaotic lifestyles;
- Drug/alcohol misuse;
- Homelessness/insecurely housed;
- Inappropriate use of services;
- Lack of employability/employment;
- Lack of engagement with services;
- Learning disabilities;
- Mental illness;
- Offending;
- Physical health;
- Poor education/training; and
- Victimisation and exploitation.

Some pilots focus on a principal condition as the need to address – such as Thames Reach that focuses on increasing employment among the homeless – while other pilots engage with clients presenting with multiple conditions, such as Tyneside that deals with a wider gamut of conditions, for example, homelessness, mental health issues and inappropriate use of services.

This section presents the details of the personal characteristics of the clients – their age, gender and ethnicity - at the point of engagement with the pilots. This information not only provides some basic information on the client group, but it also raises preliminary questions of how the pilots are ensuring equality of opportunity for the use of their services and not further excluding individuals on the basis of race, gender or age. This is a matter that will be explored further in more detail later this year when the evaluation team writes an equality impact report. The views of the Collaborative on this matter will be sought.

Who are the clients?

- * The ACE programme's gender split is near equal but pilots tend either to support exclusively men or women so the split is between projects, rather than within them;
- * ACE clients are most likely to be in their mid-30s;
- * The majority of ACE clients are white, and only 54 clients in number are described as non-white.

Gender

Overall, the ACE programme has a near equal split of men and women: there are 298 male clients and 260 female clients registered in ACE Hub. However, these proportions are not repeated in the individual pilots where most have a majority of male clients:

- SW London: 60% male clients;
- Fairbridge, Link Worker, MCCH and St Mungo's: 70% male clients;
- Thames Reach: 75% male clients;

- NOAH and Tyneside: 79% male clients.

However, two pilots are female only pilots (Inside, Outside and Forensic Therapies, which both operate within female prisons) and females comprise 64% of the clients of Calderdale Maze, a pilot that is open to male partners of victims of domestic violence.

In the process evaluation interviews, the pilots that work with homeless people tended to report that this client group contains significantly more men than women. Contrary to this, the data above show that a large minority of SW London's clients are women (40%). That team includes a female outreach worker which might explain why engagement with this client group is higher than in pilots that work with a similar client groups (Tyneside, NOAH, St Mungo's and Milton Keynes). In these circumstances it is interesting to note that Tyneside have recently employed a female support worker and they hope this will increase their engagement with female clients.

The role of female workers in engaging female clients should not, however, be taken at face value and is worthy of further investigation. Another explanation of SW London's large minority of women might lie in that pilots use of the "chaos index". That index assesses client need on a range of factors including risk of harm to self and others, use of frontline services, use of drugs and alcohol, and social skills. The index can ensure that the pilot engages with a range of clients and does not base referrals on visible criteria such as sleeping rough. Using only visible criteria could exclude homeless women from a pilot because their circumstances can be less visible than those of homeless men.

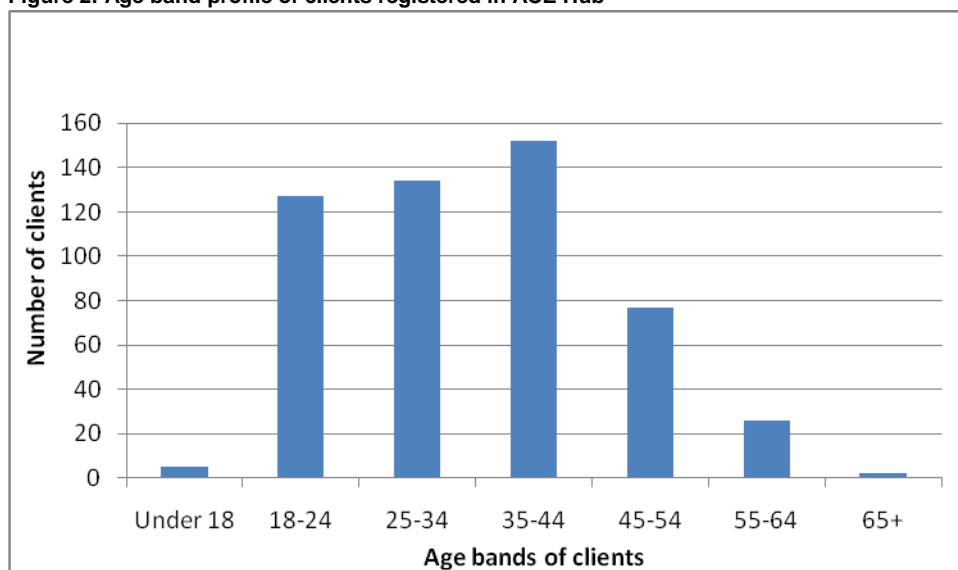
Age

The mean age for the programme is 34. The data presented in Figure 2 indicate the age ranges of the clients engaged by the programme, and shows that the majority of clients are aged between 18 and 54.

The average age of the clients tends to support the view of the Social Exclusion Taskforce that these adults have reached a point in their lives where they can no longer access mandatory provision for young people and are being excluded from, or are not engaging with, provision for adults.

⁸ The number of client under 18 and over 55 are too small to be able to compare against the 18-54 groups, so they will be excluded from any age based analysis in this report.

Figure 2: Age band profile of clients registered in ACE Hub



Base sample: 523

Further analysis of the data shows that six out of eleven pilots worked with clients whose average age was between 18 and 34. Of those six pilots, Fairbridge works with young adults between the ages of 19 and 25, it is to be expected that it was the only pilot to have an average age between 18 and 24 (the mean age was 21). The other projects within this bracket that had a mean age between 25 and 34 were Calderdale, Forensic Therapies, Inside Outside, Link Worker and MCCH.

The other five pilots under review – South London, St Mungo’s, Tyneside Cyrenians, Thames Reach and NOAH – work with clients whose average age is between 35 and 44.

Ethnicity

From the process evaluation, we understand that some pilots recognise that the ethnic profile of their clients may not match the profile of the local area, but cannot explain why this has occurred. This begs the question as to whether ethnic groups within the neighbourhood are being excluded. The Connected Care pilot took active steps to ensure that BME community groups participate in their local audit. As part of the equality impact study to be conducted later this year, we will seek to profile the ethnicity of the local areas and compare that with the ethnicity of the clients.

In the meantime, however, the data provided from the pilots via ACE Hub indicates that the overwhelming majority of clients in the ACE programme are white in ethnicity: only fifty four clients are non-white. Only St. Mungo’s and Thames Reach, have a large minority of non-white clients - 34% and 45% respectively - and both of those pilots are located in London, which may be significant given the city’s ethnic diversity.

3.3 What services do clients use?

What services do clients use?

- * ACE clients are light users of health services. There is little evidence that emergency medical services are being used inappropriately in place of GP services;
- * ACE clients at all pilots tended to visit a GP once a month or less prior to engagement;
- * Clients might use temporary accommodation if the pilot addresses homelessness: 20% of clients across the programme had used temporary accommodation in the four weeks prior to their engagement.

In responding to the interim report's conclusions and recommendations, members of the Social Exclusion Taskforce suggested that there was less concern with establishing a universal definition of chronic exclusion and finding programme coherence. Indeed, it was argued that the very diversity of the client group was a good basis for exploring how pilots respond to diverse needs and understanding what services clients are using (or mis-using) at the point of engagement with the programme. This view reflected not only the concern that the 'chronically excluded' should be accessing services that they might not be receiving, but also that they often use services inappropriately. These insights are vital to planning and commissioning local services. In light of those comments, this section provides a description of the clients' use of services *at the point of engagement with the programme* (details regarding the change in the clients' use of services appears at the end of the report).

The data on use of services at the point of engagement is recorded by the pilots on ACE Hub. When a client first attends a pilot, the pilot records his or her monthly use of public services, for example:

- health services: including GP visits, A&E visits, nights as an in-patient and number of out-patient appointments);
- nights in temporary accommodation;
- nights in a refuge; and,
- instances of calling the fire brigade.

The purpose of recording this information is to provide an indication of the services that clients are using or misusing. This arose from a concern expressed in the *Action Plan for Social Exclusion* that much of the spending on the socially excluded is directed at "*managing the symptoms of exclusion once problems have become entrenched*". In particular, the evaluation is examining a proposition that the chronically excluded are misusing emergency services, including the ambulance and fire services but particularly health services by, for example, resorting to accident and emergency for health care rather than attending a local general practitioner.

Use of health services

In testing that proposition, the data indicate that, at the point of engagement, clients tend to be light users of health services, with little evidence that emergency medical services are being used inappropriately in place of GP services. This is a surprising observation given the chronic health problems of the client group. For example, clients at all pilots tend to visit a GP once a month or less, and use hospital services even less. This finding may relate to the fact that the clients are not accessing or receiving the health care that they require.

While there are examples of heavier users of GP and hospital services these are few, and are not located in one particular pilot. However, a low use of health services is not necessarily virtuous. First, it might suggest that the chronically excluded are not receiving the care they require and to which they are entitled. Indeed, in the first interim report, the pilots described clients that were unable to access the support services they needed despite having both physical and mental health problems. Further discussions with the pilots at the collaborative raised stories of clients who were barred or rejected from health and mental health services, or neither had the ability to access a service nor knowledge of its existence. Fairbridge described how their young clients were unaware of what sexual health services were available, and Tyneside and SW London described clients who could not take action to address their health problems.

Second, even if a small proportion of clients are heavy (mis-) users of health services this might have a large impact on health service costs: just one client misusing medical services can place a large strain on the system and he or she may use more than one service. In light of this point, future economic analysis will consider the overall cost of a client to health provision at a local and national level.

Use of temporary accommodation

Homelessness is a symptomatic problem of chronic exclusion, but was found to vary significantly in incidence. Overall, 20% of clients across the programme had used temporary accommodation in the four weeks prior to their engagement.

Clearly, the use of the temporary accommodation was attributed most closely to those pilots that work with the homeless: about half of the clients had used temporary accommodation at Tyneside (52%) and St Mungo's (55%) prior to engagement.

A minority of clients used temporary accommodation at NOAH (11%), Link Worker (6%), and SW London (26%). Temporary accommodation was barely used by clients of Thames Reach, MCCH, Fairbridge and Calderdale.

For those based in prison, the question was redundant.

Use of other services

Finally, there was a concern that clients might use the emergency services such as the fire service inappropriately or would be users of domestic violence refuges. Analysis of the data showed that the large majority of clients had not called the fire brigade and had not stayed at a refuge in the four weeks prior to their engagement.

3.4 What are the clients' personal circumstances?

What are the clients' circumstances?

- * ACE clients tend to be unemployed, long term sick or not working for another reason;
- * 6% were in voluntary work, training or education;
- * 5% were in employment.

In addition to looking at the clients' service use, the pilots are also collecting data on the clients' circumstances at the point of engagement. Their circumstances are described in relation to their accommodation and employment statuses. Often their circumstances reveal a need which is related to the services they use, and a notable example of this is accommodation status. Clearly this is related to the use of temporary accommodation that was discussed above.

Employment status

ACE clients tend not to be in employment when they start at one of the pilots: 89% of clients are either unemployed, long term sick or not working for another reason. Twenty four clients (6%) were in voluntary work or were either in training or education, and they are evenly spread across the pilots.

However, the data on employment status at the point of engagement also shows that 5% of clients are in employment⁹. Although it might be surprising that 24 clients were *in* employment, this is consistent with the view social exclusion can be described on a range of factors, and not simply indicators such as homelessness or employment. Further, it is not known how secure or skilled the work is that is undertaken by this group of people.

3.5 Discussion

Although the data points to relatively stable conditions for some clients, accommodation status for example, the overall picture is one of exclusion from services and opportunities. In other words, access to services is low, unemployment is high, and clients are described as presenting with a range of needs when they engage with a pilot.

⁹ Either permanent or temporary full or part-time employment.

As suggested earlier in this section, chronic exclusion cannot have a simple definition, such as lack of access to statutory services, but neither can it be considered a condition that is generated just through the individual's actions and attitudes. The January interim report found that although lack of engagement was listed by some pilots as a condition of social exclusion rather than a consequence of it, all pilots have clients who have difficulty engaging with services and this has exacerbated their exclusion.

Given these characteristics of the chronically excluded, it is evident that pilots must both support clients and change the attitudes of statutory agencies to improve access to services. How pilots work innovatively to achieve this is the focus of the following sections of the report and will be pursued in the remaining months of the evaluation.

4.0 Working with clients and partners

Since the last interim report, much work has been undertaken to understand how pilots are working with clients and local agencies. This section examines that work and considers how the pilots are delivered together with their associated costs. Here the focus is not to rate the quality or appropriateness of the services and how they have been delivered, but rather to describe what the pilots themselves have learnt and how they can work trilaterally with clients and local services to bring about changes locally.

4.1 How do pilots work with their clients?

In interview, pilot workers discussed how they support their clients and what it takes to deliver the interventions. Given the diverse nature of the client group, the workers' tasks were described as being involved, varied and unpredictable. Though each pilot is different, workers described the work as demanding and requiring much commitment. The types of activities performed with clients include:

- **One-to-one meetings:** between the worker and the client (and potentially family or an advocate), where problems are identified and plans made;
- **Group counselling sessions:** where a worker meets with two or more clients or their representatives or both in the same session;
- **Supportive accompaniment:** the worker accompanies one or more clients to an appointment or engagement with a public service, employer or other organisation. For example, to health care providers, training session, or a court hearing;
- **Access to services:** The worker arranges for a client to access another service and the worker continues to work with the client. This could be with a housing provider, drug/alcohol support service, health care provider, or training service;
- **Referral to other services:** the worker refers the client to another (external) provider who will then support him or her and this signifies the end of the pilot worker's support to the client; and
- **Support in daily living activities:** here the worker completes tasks on behalf of the client, such as buying him or her some shopping.

Given the diversity of the client group and the services that the pilots offer, it is perhaps not surprising that across the programme of pilots, the staff members come from a variety of backgrounds and experience. Despite this, the pilots' managers and workers did express general requirements when working with the ACE client group and these can be arranged around a number of factors that are discussed below.

4.1.1 What skills and experience are needed?

First, the skills and experience of the staff are important to working with this client group. Personal 'skills' relate to the aptitude and empathy for working with difficult individuals, while staff experience relates to the previous knowledge that the individuals have had of this client group and/or local agencies.

What skills and experience are needed?

Common skills common included *social skills* (empathy, compassion and common sense) and *professional skills* (negotiating, flexibility and creativity).

Experience of local agencies or the sector was important, and one pilot considers that experience of chronic exclusion (homelessness) is important.

There were differing opinions as to which was more important: skills or experience.

Staff skills

Staff at all pilots explained that *personal skills* are required when working with the ACE client group, whether the client group was young adults at Fairbridge or older, homeless men and women at NOAH or St Mungo's. In discussing these personal skills, these included skills in working with the workers considered that the following were important:

- *Flexibility and creativity* in how one works with clients;
- *Listening to the needs* of clients and other service providers;
- *Negotiation and influencing* local service providers;
- *Confidence* to appraise all available support options for clients;
- *Compassion and common sense* in dealing with the clients.
- *Resilience* particularly at those pilots where the managers recognised that the work could be tough.

In interview, pilot workers frequently underlined the importance of **empathising** with the client and having compassion for their situation. This has an important practical application as it helps workers to spot signs of substance abuse, mental health problems, or facilitates the building of trust. In turn this helps to identify a client's needs and some insight into how these are best addressed.

Workers from Tyneside, which is staffed with people who have personal experience of being socially excluded, argued that because they were once in a similar situation to their clients, they have considerable understanding of the clients' problems, needs, and modes of operation; in the words of one pilot worker, "*you can't blag a blagger*".

Staff experience

In contrast, there is no consensus on what staff experience is needed to work with adults facing chronic exclusion. Project workers in half of the pilots considered that experience of the client group as important, but differed on what this experience should be grounded. Some thought that it was either 'essential' or 'desirable' that those working with the client group should have a professional background of working with the chronically excluded or vulnerable (for example, Calderdale and Thames Reach respectively), while others thought that it was more important workers should have been chronically excluded themselves.

Skills versus experience?

For some pilots, hiring staff with experience gained from a substantial professional background was best for working with the ACE client group. Pilot workers from the Calderdale Maze pilot offer support, counselling and signposting to women suffering from domestic abuse, and are drawn from a range of backgrounds that encompasses probation, social work and mediation. Given the complexity of the client group and the nature of service delivery, it was observed that only persons with considerable experience could be expected to deliver the service, in other words, professional knowledge of how probation and social services operated was useful when advocating on behalf of their clients. This view was echoed by a qualified social worker who was employed by the Inside, Outside project and reported

"I think the fact I understand the role of the children's social worker as well gives me a better overall picture of what – well, certainly what should be happening."
(Inside, Outside, Worker)

There were other pilots where the project workers had particular professional experiences that were required to undertake the work of the pilot. For example, in South West London the workers have backgrounds in psychiatric nursing, psychotherapy and drugs and alcohol outreach, and these was thought necessary to meet the needs of the client group. The St Mungo's project workers have psychotherapy backgrounds so the pilot's specific interventions could be delivered.

Of the pilots that valued experience, Tyneside Cyrenians were notable in that the key requirement of a support worker was to have recent experience of chronic social exclusion, including homelessness, substance misuse, and experience of the criminal justice process etc. While it was conceded that such experience alone was not sufficient, the empathy that the workers had with the clients was seen as crucial to spotting the subtle signs of substance misuse or mental health issues. This was considered to be a great difference to mainstream services. In the words of one of the full time members of staff:

“I think they (clients) actually believed in the people they work with and that is a massive thing. It is not to say that people who are not from that background can’t do that, but there are too many that don’t.”

(Tyneside, Manager)

In contrast, other pilots do not draw their project workers from any particular professional discipline, and put greater emphasis on the skills of an individual worker. For example, in NOAH the outreach workers had little previous experience of working with a client group that includes substance misuse, mental illness, homelessness and offending, prior to their employment with the service. However, they put a premium on the skills of boundary setting. Similarly, for Thames Reach, demonstrating the right skills for the job – empowering the client - was more important than specific experience of homelessness or a professional background.

4.1.2 How do pilots work with clients and local services?

How do pilots work with clients and local services?

The ability of managing the relationship between clients and local services is essential.

Most projects advocate for clients, but two encourage their clients to develop their own relationship.

Collaboration with local services was variable and depended on whether pilot workers had previous experience of working at a local service.

The second requirement of working with the client group is, according to pilot workers and managers, the ability to manage the relationship between their clients and local services.

In all but two pilots (Forensic Therapies and St Mungo’s), the workers act as an advocate for a client and removing barriers to the use of services is the major task. Workers described having a network of informal contacts and making efforts to understand the workings of statutory services so they can best advocate for their client.

Collaboration with statutory services was variable. Those that had experience of working within services would know how the system works and how to provide for their clients. Calderdale employs a multi disciplinary team that understands the different services that support victims of domestic violence – police, social services, health and voluntary sector – and understands the context in which domestic violence is set. Similarly, a staff member at the Inside, Outside project believed that his previous position as a social worker was beneficial in working with social services on behalf of his client.

Workers who did not have this experience knew that they needed to gain an understanding in some way or begin to see a situation from the perspective of a partner:

“I look back at myself and think well no wonder I was barred from like my Job Centre because I was always kicking off, and - And I'm thinking well, I can understand - I can understand from their point of view, but I can also understand from the client's point of view.”

(Tyneside, Worker)

In these examples, the workers reported that they understood how best to advocate for their clients through the experience they had gained and with support from colleagues. In slight contrast to those pilots, the Milton Keynes Link Worker and Thames Reach pilot explained that they dealt with this issue differently. Both were keen that their clients begin to understand how to engage better with services. The Thames Reach workers aim for their clients to engage with statutory services by themselves, so they assist the clients to act for themselves. Similarly, the Link Worker project in Milton Keynes assists its clients to take increasing responsibility by encouraging him or her to move on and access other services with ‘arms length’ support.

4.1.3 How do managers support their staff?

Staff training and support

It is not possible to define the level of staff training or support that should be provided, but the consideration should be made of:

- * Should workers have relevant job experience or can other criteria be used for hiring?
- * What is the role of the manager and what support should s/he give to staff?
- * What should be the balance between managers and workers?
- * What should be the balance between people with experience/training and those who bring something else?

The workers at the pilots describe working with the ACE client groups as demanding of their skills and resources. Evidence from the pilots that put less emphasis on the importance on previous relevant work experience suggests that individual workers are dependent upon the type and quality of training and management support. For example, the Fairbridge pilot hires young staff with less two or so years of experience but ensures that training courses are available and new staff are trained to work in “the Fairbridge way.”

The role of the manager is evidently more important at pilots where staff experience is less. At some pilots such as Inside, Outside, the workers are geographically isolated from their managers and therefore rely on their own, considerable experience perhaps

more than staff at other pilots where the managers and workers are co-located, such as Thames Reach or Fairbridge.

These observations may seem obvious or simplistic but are important to raise. If the ACE client group should be supported by staff with relevant experience or not will have implications for the cost of services. Again, understanding what is the right balance between management support and the number of staff supporting clients has cost implications, but the right balance will ensure the pilot can understand its clients and partner services. Comprehending both implications will lead the evaluation to a better understanding of how local system change, transition points and system navigation can be achieved.

4.1.4 How do pilots work effectively with local services

How do pilots work effectively with local services?

The pilots are better placed than local statutory agencies to spend more time with their clients and to see them more frequently. This allows them to work at the clients' problems and find solutions.

Pilots are more likely to take on risk with individuals – although the level of risk varies across the pilots – and help 'normalise' the relationship between client and agency.

Interviewees expressed the view that the statutory sector displayed difficulties with working with the ACE client group, difficulties that are overcome by the pilots themselves. The evaluation has identified two differences that could help explain why pilots believe they can meet the needs of the client group when statutory services cannot. These are the **time spent** with individual clients, and the culture of the pilot and its resulting attitude to **risk taking**.

Time spent with individual clients

The pilots explicitly described dedicating time to working with clients that might not be available to statutory services, and this might include undertaking lengthy tasks and actions on behalf of clients. Being permitted to spend this time with clients, the pilot workers reported that they were enabled to understand and address properly the complex needs of individual clients and their behaviour. In the words of one pilot worker:

"This pilot has given us the luxury of being able to take [the client] and ... work intensively and we spend a lot of time working through our heads what was that about, did you see that, did you observe that, what are we going to do about that does that feel right, does it not; how many social workers get that opportunity?"

(Calderdale, Worker)

Pilot staff believed they had more contact with a client which was spent over a longer period. This was recognised to be important as it allowed solutions to complex needs to be found, or even provided time to accompany a client to appointments he or she finds difficult. For example, in Calderdale the pilot workers might accompany a client to a GP appointment. The ability to work intensively with a client in this way allowed the workers to work with the client and their family and address multiple issues, and workers consider working without feeling that there are constraints on time to be important. The MCCCH workers reported that they felt free to undertake tasks with clients that might take time to complete, and the Tyneside workers have sustained engagement with clients over months whereby many motivational and supportive tasks could be completed.

Fairbridge was the only pilot where the workers reported that they perhaps did not have sufficient time to respond properly to their clients' needs. In the opinion of the workers, a 90 minute meeting was at times insufficient to identify appropriate training and courses for the young adult. Similarly, it is known from a previous round of interviews that the Inside, Outside workers considered that gaining access to prisoners for meetings can be difficult and the workers often could not meet clients as frequently as they might like.

Organisation culture and risk taking

It was evident that pilot workers expressed compassion and care towards their clients. The 'ethos' of the pilots is to understand their clients, be patient with them and not to see them as a problem, and interviewees felt that this was lacking in the statutory services. For example, Tyneside described difficulties with job centre staff that had experienced the client groups' behaviour. Of course, statutory agencies are not constituted with such an ethos, and whilst there are certainly helpful and well-meaning workers in the statutory services it is not always possible for them to spend the same amount of time on individual cases than the pilots.

An open mind towards the client group means that engagement with the client may present more risk at the pilots than at statutory services. At Tyneside, NOAH and Milton Keynes workers will engage with clients before their background is fully known and the risk that he or she presents can be fully assessed. However, these pilots claim to be prepared to take on more responsibility and risk than other services. This can be of benefit to the client and the statutory agency, with the pilots being better equipped to engage with the client and 'normalise' the clients' relationships with local service. This was explained by a Milton Keynes worker who reported that:

"We can say to the police, we can say to A&E, if we can work with this person, if we can stabilise them a little bit then you'll see them less and that's what they want, ultimately, because it's their time and their financial constraints on the services. So I think it's easy to sell to people because not a lot of services will be so keen to work with such difficult clients, you know."

(Milton Keynes, Worker)

The pilots rely on the workers judgement, experience and training to identify potential risk. Whether one can appropriately engage with this group without being prepared to take on risk is something for the evaluation to investigate further. However, the benefits of taking on greater risk must be balanced against the nature of the possible harm. For example, a client of one pilot killed a shop keeper when supported by the pilot. Poor information sharing with the police was blamed for this incident.

Willingness to take on risk taking was not, however, prominent in all pilots. Other pilots tend to have clients with less chaotic or risky lives (for example, Thames Reach or MCCH) or engage clients in safer locations (Inside, Outside, Forensic Therapies), and so do not appear to take on more risk than other services.

4.2 Structure and cost of the pilots

How the service delivery is managed and paid for is considered by the process and economic evaluations. At this stage, the evaluation can report some findings on team mix, support and the costs of delivery.

4.2.1 Who delivers the service?

The pilots are using front line staff with various levels and types of experience to work with the ACE client group. As discussed above, workers are complemented and supported by managers and colleagues, so knowing how this is done is important to understanding how the pilots perform and whether the staff composition is appropriate.

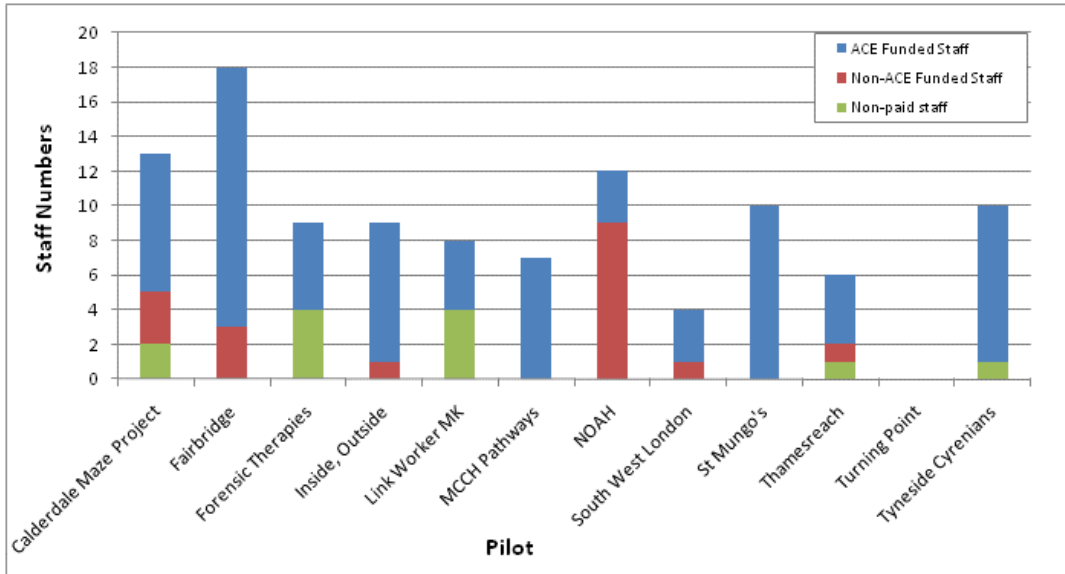
Staff composition

Figure 3 presents the number of the staff at each of the 11 pilots¹⁰ during 2008/09, together with the composition of ACE funded staff, non-ACE funded staff and non paid staff. As the figure shows, most of the pilot sites have a combination of staff, with the exception of MCCH and St.Mungo's who only have ACE funded staff.

Non-ACE funded staff form a substantial proportion of the staff in three pilots (NOAH, Fairbridge and Inside, Outside) while in three other pilots they form a lesser proportion (Thames Reach, SW London and Calderdale). The use of non-paid, or volunteer staff is important at Forensic Therapies and Link Worker Milton Keynes and plays some role in Tyneside, Thames Reach and Calderdale.

¹⁰ No data was collected for Turning Point.

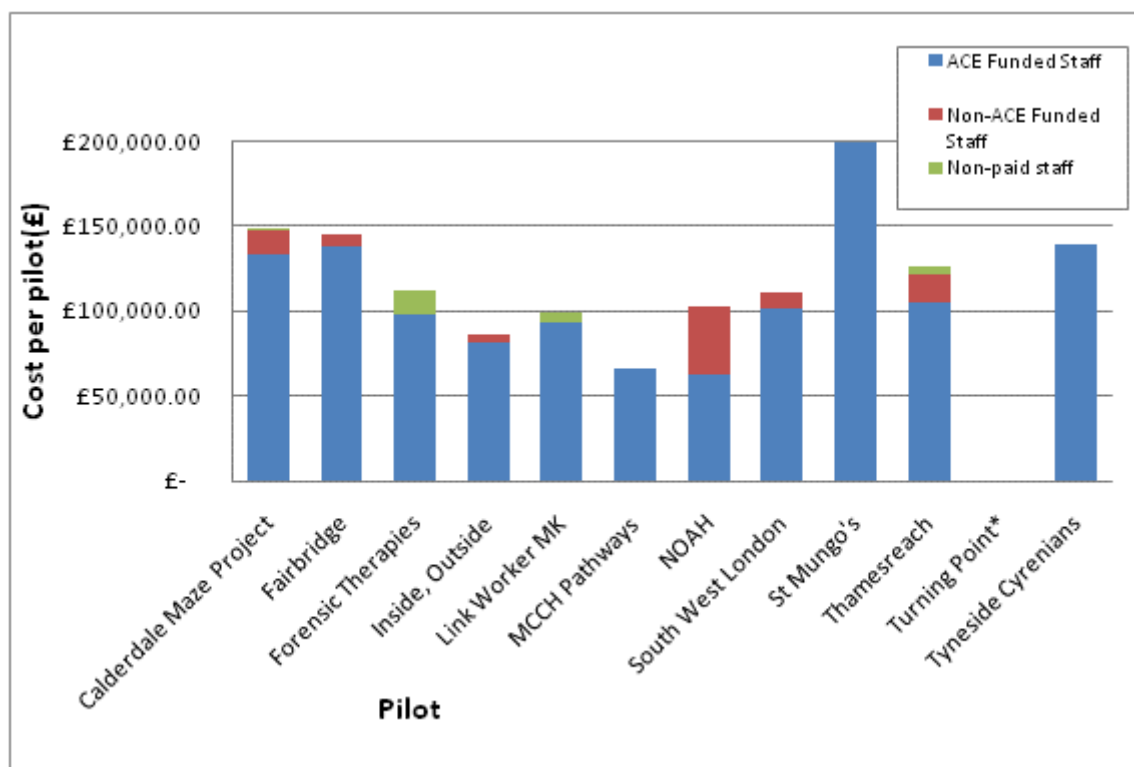
Figure 3: Staff distribution numbers across the pilots.



This distribution, however, is not wholly accurate as some pilots use non-ACE funded staff for only a fraction of their working time. Another perspective on this is to look at the total spending on staff, see Figure 4.

On this view, most pilots are spending the overwhelming proportion on ACE funded staff. Only NOAH is spending a significant proportion on non-ACE funded staff, and it is understood that these costs relate to senior management within the organisation that is running the pilot.

Figure 4: The amount of money spent on the ACE programme for different staff types at each pilot.¹¹



4.2.2 How is the money spent?

How was the money spent?

- * The total costs of the pilots ranged considerably, from £96,325 (Inside, Outside) to £313,085 (St. Mungo's), with an average of £ 193,579 per pilot.
- * As expected, the majority of pilots spend most of their budget on staff costs, mostly on operational staff.

Total cost of running a pilot in 2008/09 was calculated for each, with the exception of Turning Point.¹² The total cost comprises staff costs (operational and non-operational costs); accommodation costs; equipment costs; personal budgets for client expenditure and other administrative costs. The breakdown of the total costs by these categories is shown in Figure 5.

The proportions are indicative of how the pilots spend their budgets and the balance between operational staffing and other costs. However, to understand expenditure it is better to look at the individual budget for each of these costs as presented in Figure 6

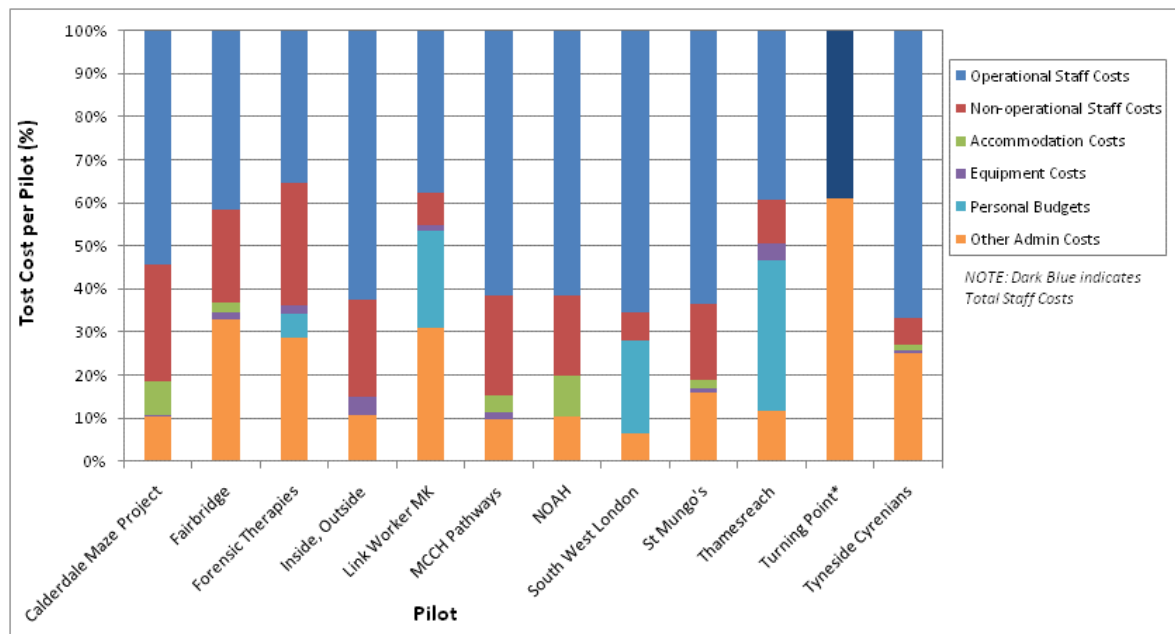
¹¹ This data is not available for the Turning Point pilot.

¹² For this project the staffing costs data had to be taken from the budget, which did not distinguish between Operational and Non-operation staff.

on page 40. As that figure reveals, the total costs ranged considerably, from £96,325 (Inside, Outside) to £313,085 (St. Mungo's), with an average of £ 193,579 per pilot.

Figure 5: The Proportion of the Total cost for each pilots spent on Operational and Non-operational Staff costs; Accommodation costs; Equipment costs; Personal budgets and Other Administrative costs.

NOTE: * indicates no staffing interviews data, so budget staff costs are used instead.



Operational and non-operational staff costs

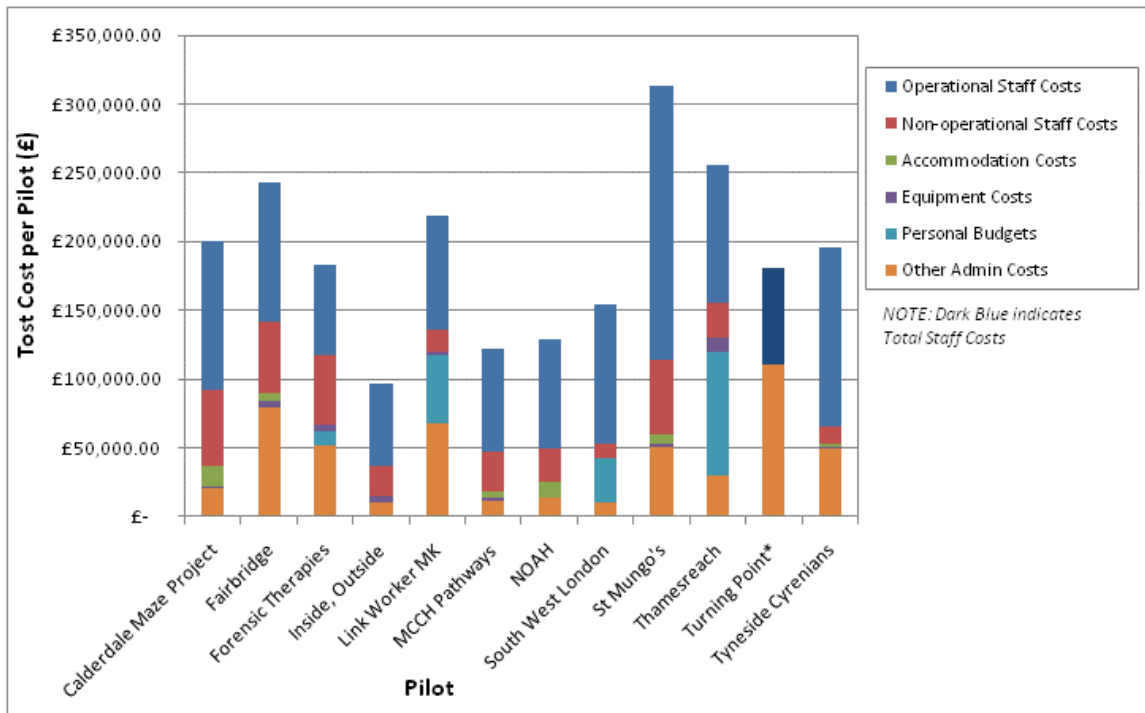
Pilots spend most of their budget on staff costs, mostly on operational staff. Forensic Therapies has the highest proportion of non-operational staff spending. This is because at the pilot non-operational staff tend to be Directors and Managers, and thus their annual salaries are larger than the operational staff. One of the reasons for this is the pilot uses a large number of volunteers in comparison to the other pilots. This can exaggerate the management to operational staff ratio.

Accommodation costs

Six pilots provided information on their accommodation costs in their budgets; these were Calderdale, Fairbridge, MCCH, NOAH, St. Mungo's and Tyneside. In each instance the accommodation costs contributed to less than 5% of the total budget costs. Only two pilots did not provide information for equipment costs, which were South West London and Turning Point. The equipment costs, as with the accommodation costs, contributed to less than 5% of the total budget.

Figure 6: The total cost for each pilots spent on Operational and Non-operational Staff costs; Accommodation costs; Equipment costs; Personal budgets and Other Administrative costs.

NOTE: * indicates no staffing interviews data, so budget staff costs are used instead.



Personal budgets for clients

Four pilots offer personal budgets for clients:

- Forensic Therapies;
- Link Worker +, Milton Keynes;
- New Directions, SW London; and
- Thames Reach.

Each site spent a different proportion of their budget on personal budgets. Forensic Therapies spent about 5% on personal budgets, equating to £10,000. Link Worker and SW London spent 22% and 21% on personal budgets respectively and this equated to £49,000 for Link worker and £33,000 for SW London. Finally, Thames Reach spent £90,000 on personal budgets, which was approximately 35% of their total budget.

4.2.3 What is the cost?

Data on unit cost (2008/09) was collected from every pilot with the exception of Turning Point. These data will be used to evaluate the cost effectiveness of the pilots' work with different clients. In our future analysis we will multiply these unit costs with the number of services that the pilots have recorded for a period and for a certain client.

Before examining the data it is important to note that the unit costs of the pilots can differ for two reasons. Either the *average wage* of the operational staff or the *number of hours* that the pilots put into a service differs significantly. For example one pilot may provide many short one to one meetings while others are focused on fewer but longer interventions. Further, there may be differences in the salary levels of the individual members of staff who provide the service. So an expensive member of staff might overall cost less than a less expensive member of staff if her interventions are shorter and less frequent. Since the business model of every pilot site is different these differences alone are not a measure of efficiency.

Average Hourly Cost

The average hourly costs are set out in Table 2. Again the differences alone are not a measure of efficiency as only a comparison of this input figure with the output can give that information.

Table 2: Average hourly cost for each pilot

Pilot	Avg. Hourly Cost
MCCH Pathways	£9.93
Tyneside Cyrenians	£10.16
Fairbridge	£11.56
Forensic Therapies	£13.31
Link Worker MK	£13.73
NOAH	£14.85
Calderdale Maze Project	£16.15
Inside, Outside	£17.09
St Mungo's	£20.02
Thames Reach	£22.64
South West London	£24.00
Turning Point	Not collected

In terms of average hourly costs, it is interesting to note that that the two pilots with lowest hourly costs, MCCH and Tyneside, have more staff than the two pilots with the highest hourly costs, namely, Thames Reach, St Mungo's and South West London. It appears that the hourly costs for those pilots are higher as they have more operational medical staff (which is highly paid) and team leaders are responsible for fewer members of the operational staff.

Average Unit Cost

Table 3 shows a Count of Average Hours spent by a Case Worker on each occasion for each Transaction per Pilot and the Average Unit Cost for each Transaction per Pilot. The transaction costs are the activities described in section 4.1.

It is clear that one-to-one meetings are the only type of transactions that all pilots undertake and on average each session takes around one hour to complete. Group counselling sessions have the greatest variation in terms of the length of the session, most pilots take between one hour and two and a half hours to complete. However, Fairbridge and Thames Reach's session take longer, six and four and a half-hours to complete respectively. The differences in this category are bigger, again mostly because of differences in the delivery model. Earlier the report discussed how being able to spend generous time with clients meant the pilots could meet the complex needs of the client group. A range of session lengths may reflect different interpretations of how long it takes to address complex needs.

As the number of hours spent is fairly evenly distributed the overall costs reflect the differences in hourly costs that we have calculated above.

Table 3: Count of Average Hours spend by a Case Worker for each Transaction per Pilot

Pilot	Type of Transaction					
	One to one meetings with clients or friends/relatives of clients	Group counselling sessions	Supportive accompaniment	Access to services	Referral to other services	Support in daily living activities
Calderdale Maze Project	1 hour - £16.15	1.1 hours - £17.76	1.6 hours – £25.84	1 hour - £16.15	-	-
Fairbridge	1 hour – £11.56	6 hours – £69.36	2 hours – £23.12	1 hour – £11.56	1 hour – £11.56	-
Forensic Therapies	1 hour – £13.31	1.5 hours – £19.97	-	-	5 min – £1.07	-
Inside, Outside	1 hour – £17.09	2.5 hours - £42.72	-	-	15 min – £4.27	-
Link Worker MK	1.5 hours – £20.60	2.5 hours - £34.33	2 hours – £27.47	2 hours – £27.47	1 hour – £13.73	2 hours – £27.47
MCCH Pathways	2 hours – £19.85	2 hours – £19.85	2 hours – £19.85	1.5 hours £14.89	1.5 hours £14.89	2 hours – £19.85
NOAH	1.5 hours – £22.27	1 hour – £14.85	1 hour – £14.85	1.5 hours £22.27	-	1 hour – £14.85
South West London	50 minutes – £20.00	-	2 hours – £48.01	1.5 hours £36.01	70 min £28.00	1 hour- £24.00
St Mungo's	50 minutes – £16.68	2 hours – £40.04	-	-	-	-
Thames Reach	1 hour – £22.64	4.5 hours – £101.89	-	2 hours – £45.28	1 hour – £22.64	-
Tyneside Cyrenians	1 hour – £10.16	0	1 hour – £10.16	1 hour – £10.16	1 hour – £10.16	1 hour – £10.16

To put these average hourly costs for each pilot into context, data provided by the Personal Social Services Research Unit shows that an adult social worker costs £29 per hour and a social work assistant costs £20 per hour. These costs are not wholly comparable as the PSSRU data is for a type of worker and it is known that the workers in the table above come from a variety of backgrounds. While the PSSRU data provide a higher hourly cost for client contact time, many pilots are providing their service at less cost.

Training and Induction Courses Costs

Only three pilots had an Induction Course, which were Fairbridge, Forensic Therapies and Thames Reach. While for Fairbridge and Forensic Therapies these courses are major interventions where more than 100 staff hours are spent and per participant the costs are nearly £400 or even £1,000, for Thames Reach the induction programme is mostly a longer meeting at the start that costs only about £50 per participant.

4.3 How can local 'system change' be brought about?

This trilateral relationship among project, client, local services is very pertinent to the rationale of the ACE programme, which looks to the pilots to engage clients with services (*system navigation*), to move clients between services and institutions (*transition points*) and to promote new ways of working with local agencies (*system change*). The first interim report found – as the discussion in the section has supported – that pilots were active in system navigation and transition points. However, it found that the pilots' engagement in *system change* was found to be generally lacking. Although system change will be the subject to further investigation, it is clear from the latest round of interviews that pilots are beginning to address local system change and have been able to reflect on some lessons of working with local partners that will bring this about. These preliminary lessons of effecting system change can be arranged around three themes: meeting their partner's requirements, effective partnership working, and establishing responsibility for the chronically excluded.

Meeting their partners' requirements

The pilots are small projects and organisations compared to the statutory services they partner. The good relationships with partners described by pilots are accompanied by an understanding of what that partner is trying to achieve and understanding of their direction, priorities and pressures. Ideally, a pilot should function within these constraints. For example, Tyneside Cyrenians described developing good relationships with important local services. The pilot could then set their service within the strategic direction of the local authority and local health services and was able to demonstrate that its work helped both organisations. This contributed to the pilot receiving post ACE funding.

Effective partnership working

The pilots also need to work jointly with partners so the ACE clients can access services and other available opportunities. The pilots believe that if a service trusts that the pilot is professional and flexible, then clients can access services better. Relationships with mental health services have been difficult for a number of the pilots but Milton Keynes's local Mental Health Trust will generally accept that the pilot's referrals are appropriate. To achieve this level of trust, the pilot took the time to understand the trust's pressures and make accurately targeted referrals. At Calderdale, the workers believe that through building bridges and developing trust they have achieved 'real partnership working'. Partners can otherwise worry that the pilots may

increase their burden rather than help them to provide their services and each pilot may need to develop trust to allay this fear.

Unconstructive relationships can be developed with statutory services, and pilots 'can be seen to be criticising'. Sometimes a pilot and local services will have conflicting views and priorities that are difficult to resolve but an adversarial approach to partner services was found to not work. Rather, a softer approach that understands local position of the service was considered more appropriate.

Most of the pilots report they are receiving more and appropriate referrals now than at the time of the first interim report. The pilots described a process of selling the service to partners and reaching a point where the pilot's service is understood appropriately and inappropriate referrals are reduced. However, pilots such as Milton Keynes and Fairbridge still describe partners referring their unwanted cases to the pilots because there was nowhere else for them to go.

Establishing responsibility

From the perspective of the pilots, partners may not know what statutory responsibility they have to the ACE client group or no one took substantial responsibility until the ACE pilot started. Perspectives and discussions of this issue vary across the pilots and staff but identifying what responsibility a service should take for this client group is fundamental to understanding potential system change and will be investigated further.

4.4 Discussion

The diversity of service-delivery models found across the ACE programme is demonstrated through a range of staffing models. Members of staff have a variety of professional and life experiences according to the different interventions adopted by the pilots. Pilots operating 'programmatic' interventions tend to have staff with a higher level of professional or clinical qualification, whereas 'pragmatic' interventions are more focused on staff's life experience and ability to support clients flexibly. The staff skills required do not vary substantially by pilot. Staff expected to have personal skills whereby flexibility, communication, influence and responsiveness are desirable.

A pilot needs to understand its clients and its partners if it wants to be successful and workers need to act as a conduit between clients and services and establish an effective trilateral relationship. It appears that the effectiveness of this relationship depends on the individual members of staff, but this it is apparent that it is a big requirement to expect workers to readily understand how to work effectively with the their client's *and* a range of statutory services.

Understanding this trilateral relationship is a key to understanding how system change can be effected. An initial, but by no means final, investigation of system change tends to show that pilots must understand the local strategic context and appropriately

position themselves within this, joint working requires trust and understanding between pilots and their partners and an accurate and shared understanding of who is responsible for this client group is needed.

5.0 Measuring change

This section of the report presents the interim outcomes of the work undertaken with the pilots. Changes in outcomes are mainly reported for four to six months after starting with a pilot on the basis that changes in outcomes can be expected within this interval of time. Further a reasonable sample of clients (n=136) is available, which represents 23% of registered clients.¹³

Disaggregating the sample shows that:

- data at four to six months is not available for some clients either because the pilot was unable to collect data or because a pilot has supported a client for less than four months;
- data is available at baseline (engagement) and 1-3 months for 212 (36% of the total) clients; and
- data is available at baseline and 7-9 months for 92 clients (16% of the total).

These latter two groups' outcomes are reported if different to the pattern shown in the four to six months group's outcomes.

This chapter presents how the clients have changed their use of services and how their lives have changed.

5.1 How have clients changed their use of services?

Changes in clients' use of services

The observed changes in health service use are small and no trend can be identified. However, the number of outpatient appointments is increasing over the first 6 months a client is supported by a pilot. This is encouraging as it is indicative of clients receiving the services that they require.

In section 3, the clients' use of medical accommodation services at the point of engagement was presented. This section develops that analysis to show changes in the use of health services and accommodation over time following engagement. When analysing service use it is important to note that the eleven different pilots have different aims and objectives, so with this in mind an increase in service use of one pilot may be seen as an improvement whereas for another pilot it could be seen differently. For example, an increase in the use of hostel accommodation for a pilot (e.g., Tyneside) that is primarily tackling homelessness and rough sleeping is clearly an improvement,

¹³ The number of registered clients is greater than the number who is eligible for the pilots' services. Once each pilot has supplied the information on whether a client was suitable for the pilot, the evaluation can calculate an accurate response rate.

whereas this might not be such a positive trend for clients of a pilot (e.g. Thames Reach) that is primarily seeking to address employability or access to mainstream services.

Changes in access to health services and temporary accommodation are reported.

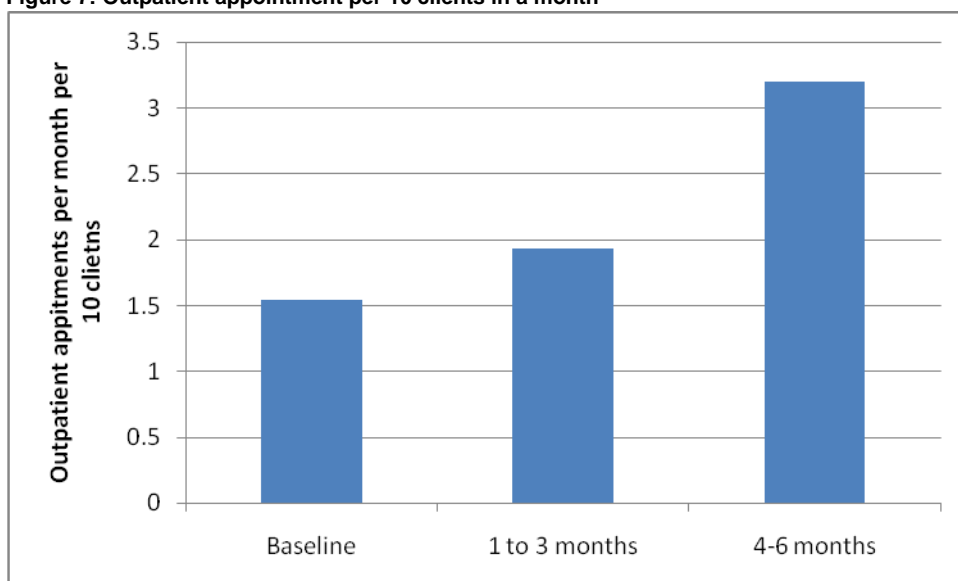
5.1.1 Health services

Earlier, in section 3, the analysis indicated that the clients' use of health services – GP, nights in hospital, attendance at A&E, and ambulance call outs – was low when they engaged with a pilot. Accordingly, when health service use is examined at 3, 6 and 9 month intervals after engagement the observed changes in service use are small and no trend can be identified. For example, between baseline and 4-6 months later, Fairbridge, St Mungo's and Thames Reach have made small increases in the number GP visits but overall the changes – either up or down – are small.

This general pattern in the use of GP services is repeated for other indicators of use of health services, namely, the number of nights spent in a hospital; frequency of attendance at A&E and frequency of ambulance call outs.

An exception to the trends in the use of health services appears when the number of outpatient appointments attended is examined. Figure 7 shows that across the programme, the number of appointments is increasing over the first 6 months a client is supported by a pilot.

Figure 7: Outpatient appointment per 10 clients in a month



Base sample: 136

While this trend needs to be explored with the pilots, it appears to be encouraging if it is indicative of clients receiving the services that they require. If so, then it might be

expected that appropriate use of clinics might result in clients not misusing other services, for example, inappropriate attendance at A&E, ambulance call outs etc. It also suggests that clients are receiving the care that they need – and to which they are entitled – and if this is the case, it is to be welcomed.

On closer inspection, Fairbridge, SW London, Tyneside and (to a lesser extent) St. Mungo's appear to be driving the change in the use of outpatient appointments. This could be a sign that these pilots are successfully getting their clients to access proper health care, whereas prior to the intervention their clients did not receive appropriate treatment. Several of the pilots, such as the three above and MCCH, explain that the increase can be explained by the pilot workers accompanying clients to services and greater confidence within clients to attend appointments.

Contrary to the general process, Fairbridge's clients (who are younger) are visiting their GP more, attending more outpatient appointments, but also increasing their use of A&E. The number of clients this represents is small so conclusions cannot be made, but the pilot explained that they often advise their young adult clients about health services as they can be unaware of what provision is available despite having health problems.

5.1.2 Temporary accommodation

Section 3 also discussed the use by clients of temporary accommodation prior to their engagement with the pilot. In that discussion, it was observed that use of temporary accommodation was obviously related to clients' circumstances (if they were homeless or insecurely housed) and the pilot's primary objective (to tackle rough sleeping and homelessness). As expected, therefore, the SW London and Tyneside pilots – who work with this group of people – appear to be influencing the number of days spent in temporary accommodation. In both pilots the number of days in temporary accommodation rose after 1 to 3 months, and fell between 4 to 6 months. St. Mungo's also had a decrease after 4 to 6 months.¹⁴

In contrast, the Calderdale, Fairbridge and Link Worker pilots, had very few clients in temporary accommodation at the beginning of the intervention for a period of 1 or 2 days - and then this decreased to zero as time in the intervention passed.

The other pilots – Thames Reach, NOAH, and MCCH – did not have any clients who spent time in temporary accommodation during the intervention. Obviously, Forensic Therapies and Inside, Outside are working with women in custody.

¹⁴ The majority of St Mungo's clients did not complete a questionnaire during time point 1 to 3 months, so it is not possible to state whether their clients have increased the number of days that they spent in temporary accommodation, which was observed with SW London and Tyneside.

Case studies:

Tyneside clients had an average of nine days spent in temporary accommodation at the beginning of the intervention. This **rose to 21 days after the first time point** and fell to sixteen after the time point 4-6 Months. Clients in the age band 35-44 tend to have spent more days at each time point in temporary accommodation than clients in age band 25-34.

The clients at SW London spent on average five days in temporary accommodation at the beginning of the intervention. This rose to 11 days after the first time point and then fell to six days after the time point 4-6 Months. Clients who were still in the intervention after 7-9 Months maintained an average of six days in temporary accommodation.

Only the male clients of SW London have used temporary accommodation, and the majority of their clients are from the age band 34-44.

5.2 How have the lives of the clients changed?

How have the lives of the clients changed?

Overall, clients' well-being scores have increased across the programme after four to six months of engagement. In particular clients reported improvements in their relationship with family and friends; leisure time; housing situation; physical health and mental health.

However, they reported less improvement in the areas of their work situation, financial situation, and well-being of their children.

Of particular note:

- * Most pilots showed an improvement in the average health score after four to six months, with the exception of NOAH, SW London and Thames Reach.
- * There appears to be a steady increase in the receipt of benefits over time.
- * Clients who are in stable accommodation group maintained this status; however, the average accommodation score for those who were not in that group showed a fluctuating situation.
- * At all pilots clients tend to start their support unemployed or out of work for another reason and over time this situation does not change

The evaluation is observing changes in different aspects of a client's life since they started their support. These included the client's well-being, mental and physical health, their accommodation and employment status, the benefits they are receiving and finally their criminal activity, if any. The pilots have different aims and objectives and a certain improvement such as in accommodation status, may be a major priority for one pilot but not for another. The data indicate that the pilots may have produced a number of improvements across the aspects mention above. These include well-being

scores, the clients' perceptions of their health, the receipt of some benefits and the number of arrests.

5.2.1 Well-being

In addition to use of services the evaluation also asked a series of questions to rate the well-being of clients: their life overall and eight separate aspects of their lives, namely:

- Relationship with family and friends;
- Leisure time;
- Housing situation;
- Physical health
- Mental Health
- Work situation;
- Financial situation; and,
- Well-being of children.

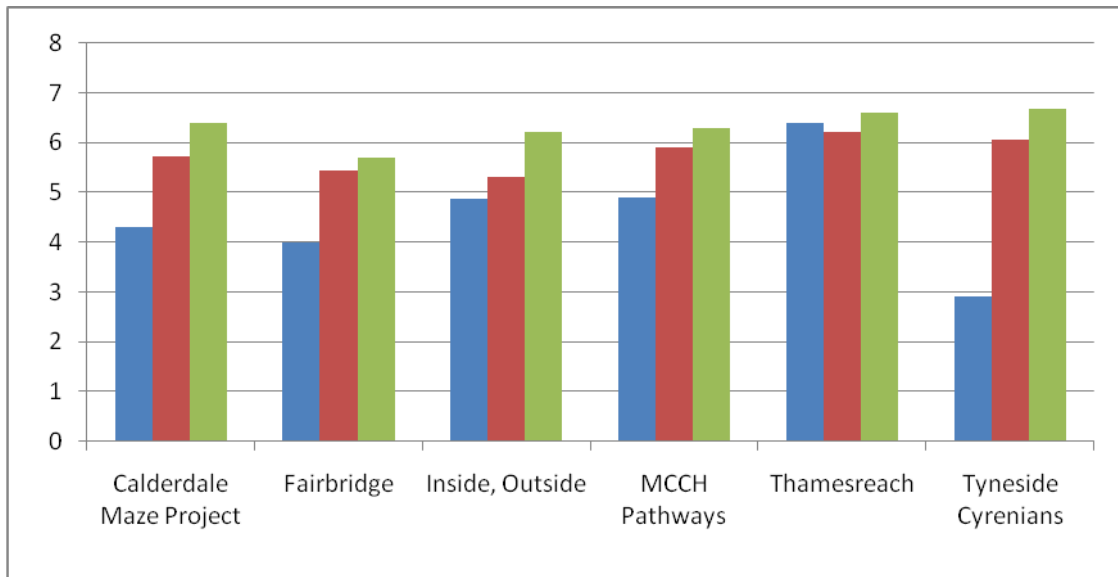
Overall, clients' well-being scores have increased across the programme after four to six months of engagement. However, it was possible to look at changes in well-being scores more in depth in six of the pilots, namely Calderdale, Fairbridge, Inside, Outside, MCCH, Thames Reach and Tyneside Cyrenians¹⁵. The scores for each of these pilots is shown in Figure 8, and it is encouraging to note that those pilots' clients are increasing their overall well-being during the first six months of support¹⁶. With the exception of Thames Reach, the other five pilots improved a mean score of 4 or 5 less at the start of the intervention to a score of around 6 after 4-6 Months (Figure 8).

It is notable that the overall well-being of clients at Thames Reach starts higher than at the other pilots and does not change within six months. Those that had been with the pilot for more than six months began to show a small decrease in well-being (but the sample size is small and conclusions should not be drawn from this).

¹⁵ The remaining pilots were omitted from the chart because the client samples were small.

¹⁶ Clients are asked to rate their 'life as a whole' a score from 1 to 10.

Figure 8: Average for the question “Your Life as a Whole” at selected pilots for four to six months group.



The blue column indicates score at the start of the intervention; red indicates score at 1-3 Months; green indicates score at 4-6 Months.

Base sample: Calderdale = 13; Fairbridge = 10; Inside, Outside = 14; MCCH = 10; Thames Reach= 29 and Tyneside = 25.

The analysis of these data revealed that, for some aspects of their lives - relationship with one’s family and friends; leisure time; housing situation; physical health and mental health - clients reported a similar improvement to that observed for their life as a whole, namely an increase to a score of around six.

For the remaining aspects of their lives, clients reported less improvement in the areas of their work situation, financial situation, and well-being of their children. Unlike the other scores, the scores for these aspects of life did not improve above four: they started at around two rising to an average score of 4 rather than 6.

Forensic Therapies’ intervention lasts approximately six weeks so their clients’ changes in well-being were measured after one to three months. The pilot’s clients do appear to be improving their overall well-being after one to three months, on average from 4 to 6.

5.2.2 Perception of health

The clients were also asked to score their perceptions of their health. Five questions regarding different aspects of mental and physical health are weighted and the resulting scores are combined.¹⁷ A score of one is considered perfect health and any deviation is taken away from one.

Most pilots showed an improvement in the average health score after four to six months, with the exception of NOAH, SW London and Thames Reach. In the case of

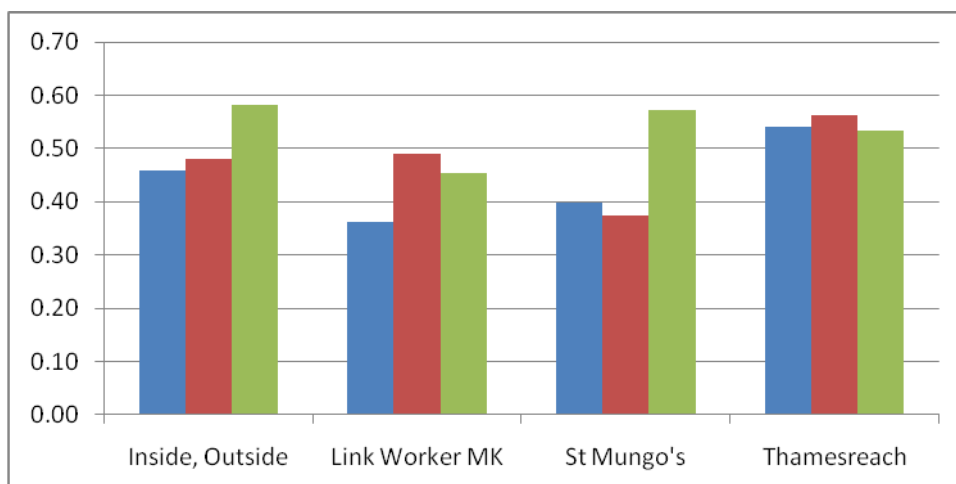
¹⁷ The different aspects of mental health and physical health questioned are: Mobility, self care, performing usual activities, pain/discomfort, and anxiety/depression.

Thames Reach their client's health scores started highest and stayed at that level: see Figure 9.

The pilots that showed the greatest improvement were Link Worker, Inside, Outside and St Mungo's: see Figure 9. It is interesting to note that the majority of pilots who improved their clients' 'health scores' also showed clear improvement in their clients' physical and mental well-being. The only exception was clients from NOAH, who improved their mental health well-being rather than their physical health well-being.

At Forensic Therapies, there was no major change in clients' health scores after one to three months.

Figure 9: Average Health Score at four selected pilots for four to six months group.¹⁸



The blue column indicates score at the start of the intervention; red indicates score at 1-3 Months; green indicates score at 4-6 Months.

Base sample: Inside, Outside = 14; Link Worker = 9; St Mungo's = 11 and Thames Reach= 27.

5.2.3 Receipt of benefits

There appears to be a **steady increase in the receipt of benefits over time**.¹⁹ The majority of the pilots started to increase the number of clients receiving benefits but only for certain types of benefit, namely: Council Tax Benefit, Housing Benefits, and Income Support. As would be expected, a majority of clients at Calderdale received child benefit and the Child Tax Credit.

Council Tax Benefit

Council Tax Benefit (CTB) is a benefit for people on a low income to help them pay council tax. It is paid by the Local Authority and reduces a council tax bill. If a person is getting Income Support, income-based Jobseeker's Allowance, income-related Employment and Support Allowance (ESA) or the guarantee credit of Pension Credit,

¹⁸ The remaining pilots were omitted because they demonstrated no or a small change.

¹⁹ Please note that two pilots, Forensic Therapies and Inside, Outside have clients which are in prison at the start of the intervention and thus can't receive benefits by law.

then that benefit will cover the whole of the Council Tax bill and the beneficiary will have nothing to pay.

At the start of the intervention about 20% of clients were receiving CTB. This increased as clients continued in the programme, which suggests that they are now receiving a benefit to which they were entitled. However, this overall finding must be seen in the context of large variations across the pilot and no clear pattern can be observed.

Housing Benefit and Income Support

As with CTB, a similar pattern of general increase across the pilots was also the case for Housing Benefits and Income Support. Although there were large variations across the pilots and fluctuations between time points, this again suggests that they are receiving assistance to which they are entitled.

Job Seeker's Allowance, Disability Living Allowance and Incapacity Benefit

Job Seeker's Allowance is paid to those who are unemployed, but available and capable for work. Disability Living Allowance provides help with personal care for those physically and mentally disabled. Incapacity Benefit is paid to people who cannot work due to illness or disability. From across the pilots there is little or no increase in the numbers of clients receiving these three benefits.

5.2.4 Number of arrests and crimes

The questions on the number of arrests and crimes committed have proved to be very sensitive and workers had difficulties asking the questions. As a result the number of clients admitting to arrest is quite low (or they were not asked the question). The data available points to a small drop in arrests and no change in offending but these are not meaningful findings.

5.2.5 Client circumstances

The data on client circumstances address accommodation and employment status.

Accommodation

As discussed in section 3.4, there were two groups of pilots: those whose clients were in stable accommodation from the beginning and those that had a mix of clients, some in stable accommodation and those in less appropriate housing or with none.

Table 4 describes the pilots in each group.

Table 4: Accommodation type groups

Stable accommodation	Calderdale MCCH Pathways Fairbirdge Thames Reach
Mixed accommodation	NOAH St Mungo's South West London Link Worker Tyneside

Analysis of the data showed that after four to six months, the clients in the stable accommodation group remained in stable accommodation. In the analysis each type of accommodation was given a score, the higher the score the better the accommodation type. Figure 10 shows the average accommodation score for each pilot in the mixed accommodation group²⁰ and this shows a fluctuating situation.

Figure 10: Average Accommodation Score of four to six months group for the pilots in the mixed accommodation group.



The blue column indicates score at the start of the intervention; red indicates score at 1-3 Months; green indicates score at 4-6 Months.

Base sample: NOAH = 6; SW London = 8; St Mungo's = 11 and Tyneside = 24.

Figure 10 suggest that clients of both NOAH²¹ and Tyneside had improved their accommodation status within four to six months. As can be seen from the Figure 10, a

²⁰ Each client's accommodation type was scored. A score of zero would be roofless or sleeping rough for accommodation or unemployed for employment. A score of five would be home owner for accommodation or working full-time for employment.

²¹ The sample size for NOAH is small (n=6). The pilot has measured accommodation status within 3 months for more clients, and these data also show an improvement in accommodation status.

client's accommodation status starts low – such as sleeping rough – and improves to hostel accommodation or supported accommodation. For Tyneside, this is within one to three months and is maintained thereafter, while NOAH seems to show continued improvement.

In contrast, St Mungo's and SW London's clients on average start with better accommodation and the pilots generally maintain this level, though small fluctuations or a small decrease are shown. A closer inspection reveals that, at both pilots, few clients are recorded as sleeping rough but there is a mixture of accommodation types which do not change over time.

Stability in accommodation type is a good thing, but the pilots in the mixed accommodation group describe clients moving between similar accommodation types, where one is considered considerably better than the next. Accommodation type can tell only part of a client's story when, for example, exploitative relationships in one location can make a move to worse accommodation preferable or clients can be moved between multiple locations though do not change accommodation type.

Employment

At all pilots clients tend to start their support unemployed or out of work for another reason and over time this situation does not change. One potential exception is Fairbridge where the clients are more likely to be in voluntary work or training but this reduced over time. The sample is small (n=10) so can be influenced by a large change in just one client but the evaluation will investigate this finding with the pilot. Encouragingly, Thames Reach and Calderdale are starting to show evidence for improvements in employment status seven to nine months after a client engaged with the pilot.

5.3 Discussion

The data analysed for this report has begun to outline some important trends. The increase in outpatient appointments attended across programme seems particularly important. It may indicate that the pilots can help their clients to access to services from which they have typically been excluded. Improvements in the accommodation status of clients are also indicated as well as better well-being and perceptions of health.

Some encouragement could also be taken from the changes in benefits claimed by clients, though the overall picture is mixed and it is not clear if the pilots are helping their clients to claim the benefits they are entitled to.

Less encouraging are the employment status of clients and the evaluation's measurement of arrests and offending. After six months of support, clients are generally still unemployed or not working for another reason. There are a couple of early signs of employment status improving, and the evaluation will continue to monitor

this movement. The pilots' feedback indicates that not all outcomes are relevant to their work. Further analysis of what outcomes are relevant and how these are achieved may be necessary.

6.0 Interim conclusion and recommendations

The findings presented in this report reveal more about the nature of the ACE client group and the services that they use. To date, this information has been either anecdotal or general: in other words, ACE clients were said to share certain characteristics (for example, living a chaotic lifestyle, homeless, unemployed, mentally ill etc) and were typically either using services inappropriately or not at all (for example, refer to accident and emergency and fire services in appropriately). The data provided in this report, however, provide empirical evidence on the clients and their service use and provides a basis on which to develop an understanding of how services can respond to their needs.

In presenting the data on the personal characteristics of the client group, section 3 of the report found that, overall, there was a roughly even numbers of men and women on the programme and that ACE clients were most likely to be white and in their mid-30's. However, closer examination of the data reveals that most pilots have a majority of male clients, and that most of these are white. The latter finding is surprising particularly since only 54 clients overall are described non-white despite the fact that most of pilots are operating in localities that are known to be either ethnically mixed (for example, inner London) or have a large population from one BME group (for example, Luton). These findings beg the question whether potential clients who are female and/or from the BME community are being further excluded by the very pilots that exist to support them by either not identifying individuals from this group as being excluded or offering a service that is meets their particular needs.

The data also address a central concern of the programme that is to ensure that clients are using services appropriately. This concern was based on a premise that either clients were using services inappropriately (using A&E services for non-urgent medical treatment) or were not engaging with local services (either because they had been barred from using services or did not know how to engage with services to which they are entitled). These matters are of central importance to the programme as it goes to the heart of how services are commissioned and delivered to the socially excluded, and the data that are presented here provide a vital insight into what services clients are receiving on engagement and what services the pilots can provide. For example, the data on health service use are able to clarify that ACE clients on engagement tend to be light users of health services.

Not only do the data give a good description the clients and their circumstances, but they also demonstrate that the pilots are making promising progress towards outcomes. Despite the caveats that are made in the report, the progress on health and accommodation outcomes should be welcomed not just for the programme and the pilots, but the lives of the individual clients. The increase in the use of benefits should similarly be welcomed, if this assumes that this outcome is appropriate for individual

clients and can be read as part of a trajectory of moving clients from worklessness to employment, volunteering, training or education. However, it is of concern that there has been little change in the proportion of those who are unemployed, particularly at a time when the economic conditions are deteriorating and the challenge of finding employment – and even unpaid volunteer posts – is greater.

These promising outcomes have been brought about by the dedicated work of the pilot staff and the interventions that they provide. As expected, the data demonstrate that the main costs are the staff themselves, but that there is a range in the cost of the staff, their skills and experience. However, it is noteworthy that many pilots are apparently providing services at less cost when compared to national data. This is worthy of further investigation as the policy focus addresses how to commission and deliver quality services at a time of fiscal stringency.

In consideration of the importance of the staff to delivering this work, the report has provided an insight into the type of skills and experience that are needed to work effectively with the a challenging group of people and get them engaged with local agencies to obtain the need that they require. Achieving these outcomes depends in part on assisting a client to navigate the system or his or transition between services but also to change how local agencies view the client. Effecting this local system change is a vital part of the work of the pilots, and where such change has been achieved it has reportedly been done by understanding more closely the requirements of the local agencies and how to work in partnership with them, including taking responsibility for meeting the needs of clients.

6.1 Recommendations

This report has provided further evidence in support of the ACE programme and it has been possible to trace how the programme and individual pilots have developed since the previous report, particularly in terms of provision of data, throughput of clients and addressing system change locally. Promising as these interim results are, they are of the programme as a whole and have yet to address the principal aim of the evaluation which is to assess whether the pilots are succeeding or not in delivering their projected outcomes for service users in a cost effective manner. While the findings have demonstrated that data are available from the pilots, the great diversity of the pilots means that it is important to understand in more depth each of the 12 individual pilots within the programme in terms of how it seeks to apply its resources to bring about the changes for individual clients. In other words, understanding the theory of change for each pilot. To this end it is recommended that:

- The evaluation conduct further work on understanding each pilot's perception of the relationship between use of services and outcomes;
- Understand what each pilot considers to be an example of good use of services and outcomes for a client and if this varies by client type;

- Understand each pilot's use of resources and how the time spent on client activity, staff costs brought about beneficial outcomes?
- Report each pilot's use of services and outcomes, informing the analysis with what each pilot considers to be a good and bad for its clients and what the relationship between service use and outcomes is; and
- Report each pilot's causal model, highlight the relationships between variables.

In addition to this work²², the evaluation will also seek to understand the equality issues that were highlighted in section 3.2 and undertake an equality impact assessment on each pilot.

²² This work has commenced and will report in January 2010.