MEAM

MEAM Approach evaluation: year 2 report

July 2019

CordisBright

COMMUNITY FUND

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1 Introduction

1.1 About the MEAM Approach

The Making Every Adult Matter (MEAM) coalition is formed of the national charities Clinks, Homeless Link, Mind and associate member, Collective Voice.

In 2013, MEAM developed the MEAM Approach, a non-prescriptive framework to help local areas design and deliver better coordinated services for people facing multiple disadvantage[1]. It is currently being used by cross-sector partnerships of statutory and voluntary agencies in 26 local areas across England.

The MEAM Approach includes seven core elements that should be considered by all local areas, but it does not prescribe a particular way in which these elements should be achieved. Most local areas using the MEAM Approach provide specific support for people experiencing multiple disadvantage, often via a team of "coordinators". However, the MEAM Approach also supports local areas to challenge and change local systems and services so that they work more effectively and sustainability for people experiencing multiple disadvantage.

There is no central funding available for local areas using the MEAM Approach, instead the local partnerships must come together to fund and deliver the local work. The "critical friend" support provided by MEAM is free of charge to the current MEAM Approach network members, as it is supported by a grant to MEAM from the National Lottery Community Fund.

More detail about how the network developed over time is included in section 2.7 of the year 1 (scoping) report. The development of the current MEAM Approach network has been broadly successful. Only three areas have left the network due to local funding issues or the ability of areas to convene a suitable partnership to take forward the work. Membership was also expanded earlier than expected in November 2018 to include six new areas. MEAM has been working to fill geographical gaps in coverage, particularly in the North East of England and the Midlands.

1.2 About multiple disadvantage

People facing multiple disadvantage experience:

> *"a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives".* [2]

[1] MEAM (no date) The MEAM Approach www.meam.org.uk/the-meam-approach
[2] MEAM (no date) About multiple and complex needs http://meam.org.uk/multiple-needs-and-exclusions/ [Accessed 19/06/2019]

It is estimated that in England 58,000 people face problems of homelessness, substance misuse and offending in any one year. Within this group, a majority will have experienced mental health problems. These figures are based on service-use data. Women are under-represented in these figures, but despite this face significant and distinct challenges which need to be met. Similarly, people from black, Asian and minority ethnic communities experience a range of social inequalities which contribute to their experience of multiple disadvantage.

1.3 This report

This is the year 2 report for the longitudinal evaluation of the MEAM Approach. The evaluation is being delivered by Cordis Bright, an independent and specialist research and consultancy organisation. The evaluation takes place over five years between 2017 and 2022 and will assess the impact of the MEAM Approach on people facing multiple disadvantage as well as on local systems.

This report includes client level data from year 1 (April 2017 to March 2018) and year 2 (April 2018 to March 2019), but it is important to recognise that the majority of local areas only started working with individuals during year 2.

Year 2 evaluation field work took place from December 2018 to February 2019. As a consequence, many interventions and approaches were in the early stages of implementation at the time of the evaluation.

Cordis Bright and MEAM did not expect to have collected large-scale data at this stage, or to have evidenced the impact of the MEAM Approach on system-level outcomes, which are likely to take longer to both achieve and evidence. Future years of the evaluation will seek to explore these system-level outcomes in more detail.

The report draws on:

- Anonymised client-level data for 373 clients[3] from 14 MEAM Approach areas[4]. (This cohort is described in the section below.)

[3] This is the number of clients who consented to have their information shared with the evaluation, and for whom we then received that information. The total number of past and present clients to have been supported (and therefore the proportion of clients consenting to share data with the evaluation) is not currently known. This will be reported in the year 3 report. However, it is known that an estimated 360 clients were being supported by interventions developed using the MEAM Approach at the end of year 2. (This is likely a conservative estimation – for more information see section 2.3.3 in the methodology annex.) This is not directly comparable to the number of clients included in the evaluation because the evaluation cohort can contain clients who have ended their support during the evaluation period, as well as those who continue to be supported.

[4] As noted above, there are currently 26 areas in the network. Of these, six areas are new and joined the network in November 2018, and as such their data is not included in the year 2 evaluation report. Of the remaining 20 areas, 17 were delivering interventions developed using the MEAM Approach in year 2. One further area left the network during year 2 but had been submitting client-level data to the evaluation prior to leaving and therefore is included in the analysis in this report. There are therefore 18 areas from which the evaluation could have received data; we received data from 14 areas. The methodology annex includes a full breakdown by local area of the client-level data included in the analysis.

- Qualitative consultation (via interviews and/or focus groups) with:
    - 27 clients and 29 staff from five MEAM Approach areas.
    - Programme leads in 20 MEAM Approach areas.
    - 8 members of MEAM coalition staff.
- An e-survey of staff in local areas, which received 211 responses from 19 MEAM Approach areas.
- 18 case studies about the experiences of individual clients, provided by nine MEAM Approach areas.

1.4 Profile of the evaluation cohort

Below we briefly describe the profile of the cohort of 373 clients for whom data was received. This includes only the clients who consented to their data being shared with the evaluation, and for whom data was collected and then shared. We do not assume that the profile of the clients in the evaluation cohort is similar to that of the whole cohort of clients supported by the local interventions. The evaluation cohort is described in greater detail and further commentary is provided in the methodology annex. In summary:

- The mean age of clients at the start of support was 38, with 50% of clients aged between 30 and 45.
- Women make up one third of the cohort, and men two thirds. Two clients identified as transgender.
- 95% of clients described their sexual orientation as heterosexual.
- 92% of clients identified their ethnicity as British, and 98% had UK nationality.

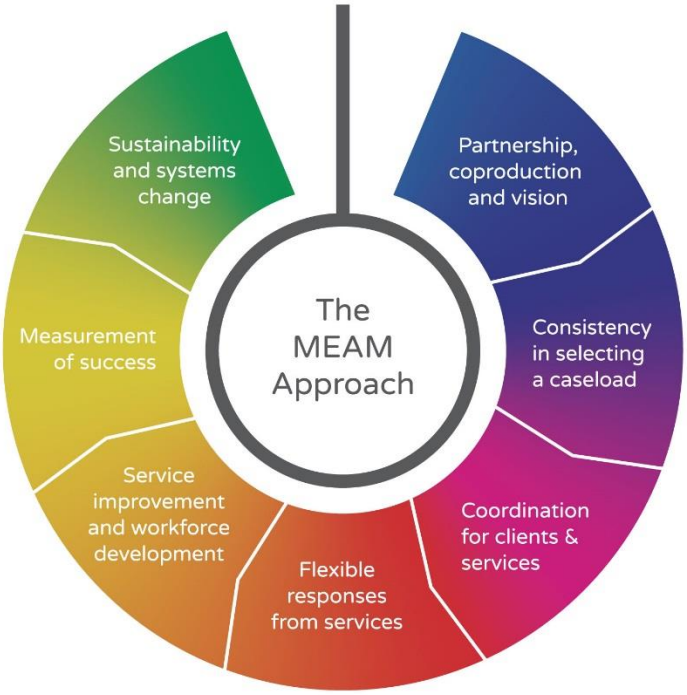
1.5 Further information

More information on the MEAM Approach, the network and the approach to the evaluation can be found in the previous evaluation reports, including:

- The live evaluation framework, produced in March 2018.
- The year 1 (scoping) report, produced in March 2018.
- The year 2 mid-year report, produced in October 2018.

These are available here: http://meam.org.uk/the-meam-approach/meam-approach-evaluation/

Figure 1: The MEAM Approach



Source: The MEAM Approach website[5]

[5] MEAM (no date) The MEAM Approach www.meam.org.uk/the-meam-approach

2 Overview of key findings

2.1 Key findings

The evaluation has highlighted nine key findings from the second year of the work. These are shown in Figure 2.

Figure 2: Key findings from the year 2 evaluation of the MEAM Approach

Individual wellbeing

1. Individuals are achieving goals that are important to them.
2. Individuals are showing improvements in key areas of their lives.
3. Individuals are improving their accommodation situation, with a significant reduction in rough sleeping.

Efficient use of resources

4. Emerging evidence suggests potential reductions in unplanned service use.

Better services and systems

5. Individuals are being supported to access, engage and remain engaged with services.
6. Local areas are delivering better coordinated interventions.
7. Local interventions developed using the MEAM Approach are delivering more flexible support that people need/want. However, the extent to which wider local systems are more flexible is currently limited.
8. Local areas are increasingly focused on involving experts by experience but there is still significant work required to move towards co-production.

Benefits of the MEAM Approach network

9. Being involved in the MEAM Approach network helps local areas design and deliver local interventions.

2.2 Enabling factors and system-level challenges

The evaluation has also identified a number of enabling factors and system-level challenges. These findings are emerging and should not be considered a comprehensive list; we will explore these further in future years of the evaluation. The enabling factors and system-level challenges are described in greater detail throughout the report. In summary:

Enabling factors

- Clients are supported, motivated and informed by a **multiple disadvantage coordinator**.
- More **stable accommodation** provides a platform for progress towards other goals.
- Improved **accessibility and flexibility of GPs** increases engagement with primary care.
- **Co-located services** enable better coordination of support for clients.

System-level challenges

- Limited accessibility, suitability, availability and flexibility of **mental health services.**
- Limited range and supply of longer-term **housing options** in the local area.
- **Developing specialist services** could preclude or inhibit wider system change.

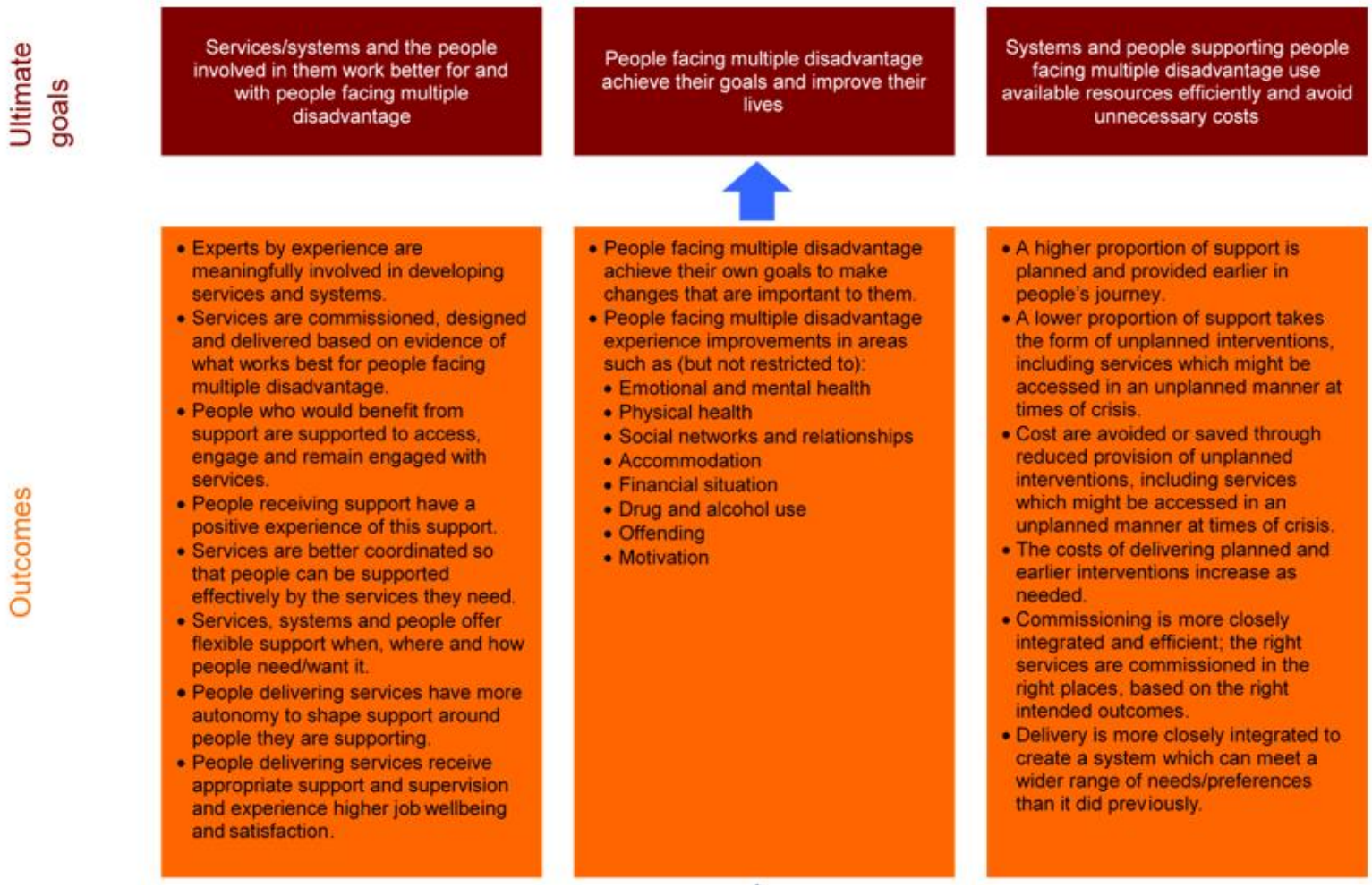
3 Evaluation methodology

3.1 Theory of change

The theory of change for the MEAM Approach evaluation was developed collaboratively during the scoping phase of the evaluation, with input from MEAM, Cordis Bright, local areas participating in the MEAM Approach network, experts by experience and the National Lottery Community Fund. It represents a shared understanding of the aims and core elements of the MEAM Approach. The evaluation takes the theory of change as a starting point for exploring whether the MEAM Approach is achieving its goals and intended outcomes.

Figure 3 summarises the ultimate goals and outcomes of the MEAM Approach, as outlined in the theory of change.

Figure 3: Ultimate goals outlined in the MEAM Approach theory of change



3.2 Summary of evaluation methodology

Figure 4 provides an overview of the methodology used in the year 2 evaluation. A more detailed description of the methodology is included in the methodology annex.

The evaluation aims to explore the implementation and impact of local work in 26 MEAM Approach areas. This work is varied and innovative, involving multi-agency and multi-stakeholder approaches which seek to promote systems change in a highly complex environment. The evaluation aimed to take account of this complexity by taking a collaborative approach to developing and delivering the evaluation. In practice, this meant that we worked collaboratively with MEAM, local areas and experts by experience to:

- Determine the evaluation questions.
- Develop an evaluation framework which outlined how we would address the key evaluation questions.
- Implement the evaluation methods.

It also meant that we designed, discussed, agreed and finalised all evaluation approaches and tools with key stakeholders before they were used in the field.

A research group including eight experts by experience and five members of the Cordis Bright team played a key role in the design and delivery of the evaluation. More information about the group and its role is included within the methodology annex.

Although the evaluation seeks to be as robust as possible within the resources available, there are nevertheless some key challenges and limitations to the evaluation and these are outlined in the methodology annex. The proposed next steps in the evaluation also seek to address challenges where possible and these are discussed in chapter 8.

Figure 4: Summary of year 2 evaluation methodology

4 Outcome area 1: Individual wellbeing

4.1 Overview

This chapter is about the personal changes that individuals are making to their lives. It focuses on the goals which people facing multiple disadvantage set themselves, as well as changes in aspects of their lives, such as accommodation, emotional and mental health, physical health, social networks and relationships, financial situation, drug and alcohol use, offending, and motivation.

4.2 Key finding 1: Individuals are achieving goals which are important to them

> *"The life that I have now compared to the life I had before I was in the [MEAM Approach intervention] is two totally different things. I've got my place, I've got a bit of money, a few nice things, you know, before I had nothing."*
>
> Client, local area D

Most of the 27 clients interviewed reported that the support they had received from interventions developed using the MEAM Approach had enabled them to achieve, or make progress towards, their personal goals. This was also the view of the majority of staff in local areas which had begun working directly with clients. Local staff members explained that understanding clients' personal goals and supporting them to achieve these was the central consideration of any support provided. They also noted that progress was greater than it would have been without support provided through MEAM Approach interventions.

Clients frequently expressed that being able to live *"a normal life"* was their key overarching goal. The definition of what constituted *"a normal life"* varied from person to person but common aspects included:

- Stable accommodation.
- A reliable income.
- A sense of routine, including (re) connecting with hobbies and/or becoming involved in education, volunteering and/or employment.

Enabling factor

Both clients and local staff described the importance of multiple disadvantage coordinators in supporting individuals to make progress towards their goals. Coordinators acted as motivators in encouraging clients to engage with services, and also ensured that clients were informed about the services and opportunities available to them.

"It built my confidence up being with them, being under support with them, it built my confidence up massively, because I was stuck, I didn't know what to

do, and then when I got advice and shown a better path of what my life could turn out like, which I wanted it to be, then my confidence went sky high then. I jumped at that chance."

Client, local area A

Further information on the role of a coordinator in a MEAM Approach area, and the support required from the wider system to make these roles possible, is available on the MEAM website: http://meam.org.uk/the-meam-approach/coordination/ and via this briefing http://meam.org.uk/wp-content/uploads/2018/10/Briefing-on-navigators.pdf

4.3 Key finding 2: Individuals are showing improvements in key areas of their lives

Client-level quantitative data (collected via the Common Data Framework (CDF) for the evaluation) and qualitative feedback from clients and local area staff provides evidence that local interventions developed using the MEAM Approach are supporting clients to achieve improvements in key areas of their lives.

For example, Figure 5 summarises a comparison of first and most recent Homelessness Outcomes Star (HOS) scores for the 66 clients[6] who had complete recorded entries at two or more points in time. It indicates that in all 10 outcome areas:

- The average score on the journey of change increased between the first completed Star and the most recent completed Star.
- The proportion of clients who moved forward by at least one stage between their first and most recent Star was greater than the proportion who move backwards by at least one stage.

In addition, in all ten outcome areas fewer clients were rated as "stuck" (i.e. a rating of 1 or 2 out of 10) when their most recent Star was completed, when compared to their first Star. This means that more clients had moved into stages where they were accepting help, increasing the likelihood of them being in a position to make progress in relation to the outcome area.

[6] These 66 clients came from six network areas. Many of the network areas only started delivering during year 2, therefore reducing the timeframe for (and likelihood of) areas returning data at two time points for clients. It is anticipated that in future reports the valid sample for this analysis will include better representation from across all the network areas.

Figure 5: Proportion of clients moving between Homelessness Outcomes Star Journey of Change stages between time 1 and time 2, and the average size of change (N=66. Darker cell shading indicates areas with higher proportions of clients or larger sizes of change. Lighter cell shading indicates areas with lower proportions of clients or smaller sizes of change).

Area	Moved forwards		Stayed the same	Moved backwards		% change in number of clients who were "stuck"
	% of clients	Average size of change	% of clients	% of clients	Average size of change	
Motivation	36%	2.5	42%	21%	-1.9	-12%
Self-care	44%	2.5	33%	23%	-2.8	-14%
Managing money	36%	2.8	45%	18%	-1.7	-17%
Social networks	38%	2.5	47%	15%	-1.9	-14%
Drug and alcohol misuse	38%	2.8	47%	15%	-2.1	-18%
Physical health	35%	2.1	45%	20%	-2.5	-6%
Emotional/ mental health	44%	2.5	41%	15%	-2.2	-23%
Meaningful use of time	36%	2.2	50%	14%	-2.0	-11%
Managing tenancy/ accommodation	45%	3.3	33%	21%	-2.6	-21%
Offending	38%	3.2	42%	20%	-2.3	-11%

Similarly, a comparison of New Directions Team Assessment (NDTA) scores for 87 clients[7] who had complete recorded entries at two or more points in time found that the average score in all areas was lower (improved) at the most recent completed NDTA. In all areas of the NDTA, the proportion of clients who made positive progress was greater than the proportion of clients who regressed.

Qualitative feedback from interviews with clients and local area staff provided examples of individual clients who had progressed in a range of key outcome areas, including accommodation, motivation, financial situation, substance misuse, offending behaviour and – to a lesser extent – social networks and relationships, physical health and mental health and emotional wellbeing.

Some outcome areas were recognised by clients and staff as longer-term goals, which they had therefore not yet achieved. The main examples of this were improving social networks and relationships (including reconnecting with family) and becoming involved in education, training, volunteering and employment.

Evidence of progress in relation to mental health and emotional wellbeing was less straightforwardly positive than evidence in relation to other outcome areas. The comparison of Star scores at two points in time indicated that 44% of clients moved forward at least one stage on the journey of change in relation to emotional and mental health. However, only 20% of clients scored 6 or upwards for their most recent Star score, which was the lowest among all the outcome areas. Interviews with clients and staff suggested that it was more challenging to support clients to achieve improved mental health, and that this was in part due to the accessibility, suitability and availability of mental health services.

System-level challenge

The accessibility, suitability and availability of mental health services was consistently identified as one of the biggest challenges in local areas. In particular, staff reported difficulty getting buy-in from mental health services to attend multi-agency meetings, a lack of flexibility from mental health services in how they work with people facing multiple disadvantage, and a shortage of provision to suit the needs of clients who have mental health issues and are using drugs and/or alcohol. Clients' eligibility for support from mental health services was also perceived as a significant challenge, with some mental health services refusing to treat people with personality disorder diagnoses or with needs deemed to be below the threshold for access to support.

"We haven't really had the mental health side of things come to the table at the meetings. But a lot of the clients have mental health needs - we would really benefit from their input into things."

A homeless outreach officer

[7] These 87 clients came from 8 network areas. It is anticipated the valid sample for this analysis will include better representation across the network areas in future reports as local delivery and data collection matures.

4.4 Key finding 3: Individuals are improving their accommodation situation, with a significant reduction in rough sleeping

> *"I got to the stage where, what was I going to do? They weren't going to help me and that was it. What could I do? I spent three years on a friend's sofa, ill, before I got [my coordinator] involved in everything and then it just was quick. Within six months I think I was in my home."*
>
> Client, local area A

Improved accommodation status was one of the most widely achieved outcomes for clients supported by interventions developed using the MEAM Approach. It was also one of the most highly-valued improvements by the majority of clients who were interviewed.

Enabling factor

Housing was consistently highlighted by clients and local staff as a vital factor in giving clients the stability to make improvements in other aspects of their lives.

"If I've got somewhere stable to live, you know, I can start doing the rest of my goals, but if I'm out on the streets or sofa-surfing, it's not going to happen."

Client, local area E

Figure 6 summarises client-level data (collected via the CDF). It shows that in a sample of 116 clients[8] the proportion of clients without accommodation or in less stable forms of accommodation reduced substantially between the time of their initial contact with interventions developed using the MEAM Approach and the end of the most recent quarter in which data was available for them.

In particular, there was a significant reduction in the number of individuals sleeping rough, with 49% of clients sleeping rough when they first engaged and only 9% sleeping rough at the end of the most recent quarter for which data was available. This decrease is statistically significant at the 99% confidence level, meaning that we can be confident that the reduction in rough sleeping has not happened by chance[9]. Equally, there was a considerable increase in the proportion of clients in supported accommodation under a licence agreement (i.e.

[8] This is the number of clients whose CDF data a) contained at least two quarters of complete and valid accommodation data and b) included their accommodation status at the time of their initial contact with interventions developed using the MEAM Approach. These 116 clients came from 9 network areas. As with the HOS and NDTA analysis above, it is anticipated that the valid sample for this analysis will include better representation from across all the network areas in future years as local delivery and data collection matures.

[9] Based on a chi-square goodness of fit test. The 99% confidence level means that there is a 99% chance that the fall in the number of people rough sleeping is **not** due to chance.

without the security of a tenancy)[10]; only 2% of clients were in this type of supported accommodation when they first engaged, compared to 41% at the end of the most recent quarter for which data was available.

Figure 6: Client accommodation at beginning of support period and at end of most recent quarter, and the net change (N=116)[11]

Accommodation grouping[12]	Accommodation type	Proportion of clients		
		Initial accomm.	Most recent accomm.	Net change
Rough sleeping	Rough sleeping	49%	9%	-41%
Family and friends	Living with family/friends	10%	6%	-4%
In accommodation (temporary or license i.e. no tenancy agreement)	Night shelter	1%	2%	1%
	B&B/private hostel	4%	4%	0%
	Emergency or assessment bed within a service	7%	2%	-5%
	Supported accommodation (licence)	2%	41%	39%
In accommodation (long-term supported, with tenancy agreement)	Supported accommodation (tenancy)	5%	3%	-3%
In accommodation (own or shared tenancy, with or without floating support)	Own tenancy (social housing)	13%	18%	5%
	Own tenancy (private rented)	3%	9%	7%

[10] This increase was also statistically significant to the 99% confidence level, based on chi-square test. The confidence level should be interpreted with caution due to low cell counts – see section 2.3 in the methodology annex for more information.

[11] The average gap between clients' initial accommodation (reported at start of support) and most recent accommodation (at the end of the most recent quarter of data returned to the evaluation) was 14 months.

[12] These groupings have been agreed with CFE Research to ensure that future analyses of accommodation use within the national MEAM Approach and national Fulfilling Lives evaluations are comparable.

Accommodation grouping[12]	Accommodation type	Proportion of clients		
		Initial accomm.	Most recent accomm.	Net change
	Own tenancy (owner occupier)	0%	0%	0%
	Shared tenancy	1%	1%	0%
Prison	Prison	4%	4%	0%
Other	Other	1%	2%	1%
Not given	Not given	1%	0%	-1%

This finding is supported by consultation with clients, local area staff and MEAM staff, who highlighted that many clients have been supported into accommodation, or more stable forms of accommodation. They provided examples of clients accessing some form of accommodation relatively quickly once they engaged with interventions developed using the MEAM Approach.

System-level challenge

Staff in most local areas in the MEAM Approach network reported that the limited range and supply of longer-term housing options in their local area meant that it was difficult to find suitable accommodation to match the longer-term needs and preferences of all clients. This was echoed by clients who took part in interviews.

"I get clients who too often get stuck because there's nothing for them outside of existing accommodation provision. I can only take people so far."

A social worker

A small number of areas provided examples of more innovative solutions to housing for people facing multiple disadvantage. For example, one area had managed to gain funding for two 'training flats', which allowed clients to test whether a tenancy would be suitable for them. Some also discussed the use of Housing First models in their area, which was often described to be a positive change to clients' pathways to suitable accommodation.

Local Area A: Training flats

Two clients described positive experiences of accessing training flats before moving on to longer-term accommodation.

"[My key worker] got me into a hostel. Then he got me into the first ever training flat there was. I stayed in that for about three nights. I was the first

successful person to stay in the training flats without being evicted. Since I managed to do that, I got my own council place."

Client, local area A

"I was living on the streets for about four years. Going from being on the streets for four years, to somebody saying, 'Here's keys, enjoy it.' It's just, like, wow. You, kind of, end up living in this little place. You just want to make it nice, you know. Half of me wanted to prove to everybody, 'I can do this.' At the same time, I was so grateful for being given the opportunity. You don't want to fail. You want to say, 'Look, thank you so much. I'm going to embrace this and, you know, take it on-board.' It was such a great help, turned my life around completely."

Client, local area A

5 Outcome area 2: Efficient use of resources

5.1 Overview

This chapter is about how services are delivered/commissioned in MEAM Approach areas and the associated costs. It examines clients' use of planned and unplanned services and how this changes as they engage with interventions developed using the MEAM Approach.

5.2 Key finding 4: Emerging evidence suggests potential reductions in unplanned service use

Client-level data (collected via the CDF) suggests that interventions developed using the MEAM Approach may lead to reductions in some unplanned service use by clients. However, at this stage of the evaluation, data is only available to enable comparisons of service use for a relatively small number of clients. This finding should therefore be treated with caution and will need to be verified or modified in future years of the evaluation.[13]

Figure 7 compares service use data at a client's first quarter (i.e. the quarter that they first started receiving support from interventions developed using the MEAM Approach) and fourth quarter of involvement for clients for whom data on the use of a service was available at both quarters. It indicates that:

- There were reductions in the mean incidence per client of A&E attendance and mental health admissions in a client's quarter 4, when compared to a client's quarter 1.
- There were increases in the mean incidence per client of non-elective acute admissions, arrests and prison stays over the same period.

[13] None of the identified changes are statistically significant to the 95% confidence level.

Figure 7: Change in use of services from quarter 1 of involvement with MEAM to quarter 4[14]

Type of service use	Direction of change	Sample size	Valid sample as % of eligible clients[15]	Total number of interactions		Mean incidence per client			% clients with at least 1 interaction	
				Q1	Q4	Q1	Q4	Change	Q1	Q4
A&E	↓	44	25%	58	40	1.3	0.9	-0.4	20%	34%
Non elective acute admissions	↑	61	35%	51	62	0.8	1.0	+0.2	18%	13%
Mental health admissions	↓	61	35%	115	86	1.9	1.4	-0.5	7%	8%
Arrests	↑	59	34%	30	33	0.5	0.6	+0.1	29%	32%
Prison	↑	58	33%	468	556	8.1	9.6	+1.5	26%	26%

[14] The difference in sample sizes for different types of service use data is due to the fact that we excluded people for whom no data was provided for the service in question. The number of network areas represented in each service use type sample varies from four to five areas. It is anticipated that in future reports we will be able to present analysis of service use based on a sample that is more representative of all the network areas, once delivery and data collection is more established across the network.

[15] Please see methodology annex for information about how the total number of eligible clients was calculated.

Local area staff reported an increase in planned support. The majority acknowledged that an initial increase in service use was vital for clients who had previously been unable to access the support they needed, and that service use was only likely to decrease in the longer term – i.e. two to three years after the start of support. This mirrors previous evaluations of MEAM Approach areas, which found that changes in service use did not stabilise until the second year of interventions.

> *"You notice an increase in service use initially whilst they're finally accessing the help they need, but it then begins to level out and decrease."*
>
> Manager of a local hostel

With regards to the cost of service provision, local area staff and MEAM staff emphasised that it was too soon to establish whether the MEAM Approach is delivering reductions in service use costs, and this mirrors findings from previous MEAM Approach evaluations. However, local areas did provide examples of efficiencies in the local system, such as reduced duplication of effort across services. Future evaluation reports will look in more detail at the 'cost-benefit' of interventions developed using the MEAM Approach.

Enabling factors

The MEAM Approach suggests that flexible service responses from a wide range of local agencies are critical to supporting individuals facing multiple disadvantage.

Local areas reported that improved access and more flexible support from GPs was a key enabling factor in increasing planned healthcare for individuals and reducing incidents of unplanned or emergency care. Local areas had achieved this in a range of ways including: designated GPs or GP practices for homeless clients, GP practices offering in-reach into hostels, offering longer appointment slots for clients being supported under the MEAM Approach, and extending weekend and evening provision.

A number of local areas discussed effective signposting/support at the point of hospital discharge as being an important factor in coordinating a client's care, and avoiding a *"revolving door"* whereby clients who were recently discharged from hospital return within a short period of time.

There may also be other factors which are enabling increased levels of planned engagement with services, and thereby contributing to reductions in unplanned service use. However, these were not reported during this year's evaluation.

6 Outcome area 3: Better services and systems

6.1 Overview

This chapter is about wider services and systems in local areas and how they may be changing to work better for people experiencing multiple disadvantage as a result of the area using the MEAM Approach.

6.2 Key finding 5: Individuals are being supported to access, engage and remain engaged with services

> *"Things have changed. I think that a lot of clients would face a brick wall because they weren't working on specific things (e.g. can't access housing because they're drinking). But now when we make a referral and we say that they can have continuous support from us, more services are more willing to engage with them."*
>
> A coordinator, working with people experiencing multiple disadvantage

78% of local area staff who completed the evaluation E-survey reported that as a result of the MEAM Approach, clients were being supported to access, engage and remain engaged with services (N=211). Where local areas had a defined cohort of clients, there was strong evidence from staff and clients that these clients were supported to access and remain engaged with key services. This included ongoing engagement with a multiple disadvantage coordinator, as well as access to other services, such as housing, benefits, health and substance misuse services. However, at this stage it was not clear that improved access and engagement extended beyond the cohort of clients receiving direct support via interventions developed using the MEAM Approach.

> *"We would be doing better if it was a way of working across services in general not just for the 15 people in the cohort."*
>
> A local area MEAM coordinator

Where there was not yet a defined cohort of clients, it was more difficult to find strong evidence of how well people had been supported since the introduction of the MEAM Approach.

Enabling factor

In most cases, improved access and engagement from services centred on clients working with a multiple disadvantage coordinator. Often, direct engagement with this worker was the main form of support and engagement in which a client was involved. Clients emphasised their positive experiences of support from coordinators, noting in particular that:

- They felt promises made to them were fulfilled, which helped to re-build trust in services.
- Coordinators offered a consistent presence and were available when clients needed them, which was better than what they had experienced with other services.
- Coordinators were friendlier and offered a more equal partnership than they had experienced elsewhere.

"Anything happens, anything goes wrong, the first person I ring, after if I need to ring 999, is [my coordinator]."

Client, local area A

Clients did not comment directly on any of the strategic and operational structures which have been developed in local areas as part of the MEAM Approach and which play a role in making this support possible. However, these structures are discussed in key finding 6.

6.3 Key finding 6: Local areas are delivering better coordinated interventions

73% of local area staff who completed the evaluation E-survey reported that as a result of the MEAM Approach services were better coordinated to support people effectively (N=211). Responses to a separate survey question rating the extent to which different types of activities are conducted at a multi-agency level locally are summarised in Figure 8.

The most prominent and frequent example of improved coordination of services, which emerged in both survey responses and qualitative consultation, was the use of multi-agency "operational group" meetings to plan and deliver support for clients. Whilst aspects of this multi-agency working were already in place in some local areas, there was a consensus that using the MEAM Approach is helping to *"cement"* good practice.

In addition, many local areas also described progress they had made in establishing multi-agency strategic groups. These are intended to provide senior-level oversight of the MEAM Approach work and a commitment to tackling strategic-level challenges to improving local services and systems. In some cases, it was expressed that the use of the MEAM Approach had helped to get services and commissioners to collaborate face-to-face in a way that previously hadn't happened.

"I think what it's done with our strategic group, it's got people round the table who wouldn't previously have been around the table. I wouldn't have been to any meetings where housing and DWP would have both been present."

A local strategic lead

There has been less success in increasing coordinated approaches to applying for funding, and the co-location of services. Co-location was not an aim in all local

areas and evidence is not strong enough at this stage to suggest that it should be an aim everywhere. However, the minority of local areas which had been able to achieve a level of co-location reported a positive impact on the coordination and flexibility of support.

Enabling factor

Staff in local areas D and E described how sharing a working space with other statutory services led to better coordination of support, with improved communication and cooperation. In local area E, the multiple disadvantage coordinators shared a space which included a community police officer, a social worker, and local housing representatives. In local area D, one coordinator described how working within a local authority building had provided their intervention with greater legitimacy, and thus made encouraging flexibility from other services easier.

"We've done a lot of work building relationships with partner agencies and getting them involved with our meetings and seeing our clients' issues, and how they can work with them constructively. We are seeing that change, it's slow in drugs and mental health, but I've seen a big change in the council, and being based in this building has made a huge difference. Before the service was based elsewhere people saw us as separate, but now being in this building, and [our team lead] setting up good relationships and single points of contact we're in a better position to badger people or workers who've worked with a client."

A multiple disadvantage coordinator, Local area D

Figure 8: E-survey responses to the question "To what extent do organisations share activities with other organisations serving people experiencing multiple disadvantage?" (N=198. Darker cell shading indicates activities with higher proportions of sharing between organisations. Lighter cell shading indicates areas with lower proportions of sharing between organisations)

Activity	Extent of sharing between organisations (% of respondents)				
	Not at all	A little	Some-what	Consid-erably	Very much
Commissioning of services	14%	21%	29%	26%	11%
Record keeping and management of information systems data	11%	23%	27%	25%	14%
Staff training	8%	19%	33%	27%	13%
Initial assessment forms	14%	15%	34%	25%	12%
Ongoing assessment of service users	6%	15%	28%	33%	17%
Development of support plans	6%	22%	32%	29%	12%
Participation in multi-agency groups or committees	1%	3%	15%	38%	42%
Case conferences or case reviews	1%	6%	16%	33%	17%
Applications for funding	17%	22%	29%	27%	5%
Workspaces	19%	26%	30%	26%	5%

6.4 Key finding 7: Local interventions developed using the MEAM Approach are delivering more flexible support that people need/want. However, the extent to which local systems are more flexible is currently limited.

Clients who are being supported by local interventions developed using the MEAM Approach are receiving more flexible support than they did previously. This has improved the quality of clients' experience of support. However, the bulk of this flexibility was manifest within direct support from multiple disadvantage coordinators or through these coordinators advocating for flexibility from other services on a case-by-case basis, rather than flexibility being the norm across the relevant services and agencies.

> *"We're still reliant on MEAM workers forging flexibility on a case by case basis."*
>
> A local area service manager

The flexibility and advocacy from multiple disadvantage coordinators took a number of forms, but mainly included:

- Outreach and flexibility in where they meet with clients.
- Flexibility on the length and frequency of contact and a reduced emphasis on fixed appointments.
- Accompanying clients at appointments with other services.
- Providing feedback to other services on clients' progress in place of appointments.
- Providing assurances around the level of support in place for clients in order to help secure them access to accommodation or other services.

Clients provided numerous examples of situations in which services were more accommodating following advocacy by a coordinator.

> *"Things like Jobcentre and the hospital and the doctors and all that lot, they tend to listen to other people rather than me, you see, so that's why, quite often [my coordinator] will go, he'll come because if you've got someone there that's, sort of, official, they tend not to just fob you off."*
>
> Client, local area E

There were also examples of mainstream services offering a more flexible and personalised response for individual clients and, in a smaller number of instances, adapting processes or practices to enable them to work more effectively with clients experiencing multiple disadvantage. However, this flexibility was not consistent across all local areas or all services, suggesting that the extent to which the MEAM Approach is resulting in wider system flexibility is still limited at this stage. The barriers to accessing mental health services

described in key finding 2 provide an example of the limited system flexibility within which the coordinators often work.

Both local areas and MEAM staff are committed to developing more flexible responses across systems and see this as an important focus of their work. They recognise and are seeking to overcome the challenges to this, which include limited resources, skills and/or confidence within partner organisations, competing local or organisational priorities, and the need to promote culture change in order to increase openness to less established working practices. It is important to recognise that it will take time for local areas to tackle such challenges. Therefore, this type of system-wide flexibility is only likely to be achieved or to become evident in the evaluation at a later date, once local work using the MEAM Approach is embedded in local areas.

> *"I think that people aren't used to out of the box thinking, but sometimes these systems that they are used to do not work for these clients. People get quite scared of it. It's a tick box system for a lot of services."*
>
> A coordinator working with people facing multiple disadvantage

System-level challenge

The increased flexibility and person-centred support delivered or facilitated by multiple disadvantage coordinators is improving the experience of support for clients who work with a coordinator, and is a contributing factor in improved outcomes for these clients. This represents positive progress in the roll-out and implementation of the MEAM Approach.

However, the MEAM Approach is also focused on changes to wider systems in local areas to enable the system as a whole to work more effectively with and for people experiencing multiple disadvantage. This will require a continued focus on strategic, system-level changes to deliver better support and must remain a key ambition of all MEAM Approach areas.

Staff in a number of local areas explained that stakeholders in other services can sometimes see a multiple disadvantage coordinator as the solution to all support for clients experiencing multiple disadvantage, rather than reflecting on the ways in which these wider services could be adapted to offer better support themselves.

In most local areas, scaling up and delivering multiple disadvantage coordinator interventions to all clients who might benefit from improved and more flexible support would not be feasible or sustainable within the available resources. This is especially true given that individual clients are likely to require support and input for relatively long periods, meaning that throughput in these services could be low. Therefore maintaining a focus on wider system change is crucial to the longer-term success of the MEAM Approach and its capacity to deliver improved outcomes for everyone experiencing multiple disadvantage.

6.5 Key finding 8: Local areas are increasingly focused on involving experts by experience but there is still significant work required to move towards co-production

There is evidence to suggest that local areas are increasingly focused on involving experts by experience in their work. However, in most local areas, further work is required to move towards fully co-producing responses to multiple disadvantage. Local areas recognised the potential value of closer involvement of people with lived experience of multiple disadvantage in both designing and implementing interventions developed using the MEAM Approach. In general, local area staff expressed an appetite for increasing the involvement of local experts by experience and were able to provide examples of planned or existing work with people with lived experience.

Most of these examples were within the 'doing for' (middle) section of the ladder of co-production (outlined in black in Figure 9). Examples of such engagement and consultation work in local areas include:

- Organising weekly, fortnightly or monthly meet-ups through informal events such as brunch clubs, and therefore providing a forum to discuss ideas for service improvements and provide peer support.
- Peer mentor schemes whereby clients have the opportunity to meet and talk with people with lived experience of multiple disadvantage.
- Providing opportunities for clients to give presentations to service managers about their experiences.
- One-off consultations with clients on specific issues.
- More formalised co-production groups or meetings:

> *We've got a panel of 8-10 experts - they meet monthly, and we focus the meetings on a particular topic and then bring the relevant service along. They come up with arguments, and then take them to the elected members.*
>
> Local area programme support lead

  For example, in one area the co-production group (which is chaired by experts) co-developed a response to the draft housing strategy and presented recommendations in cabinet to the scrutiny committee.

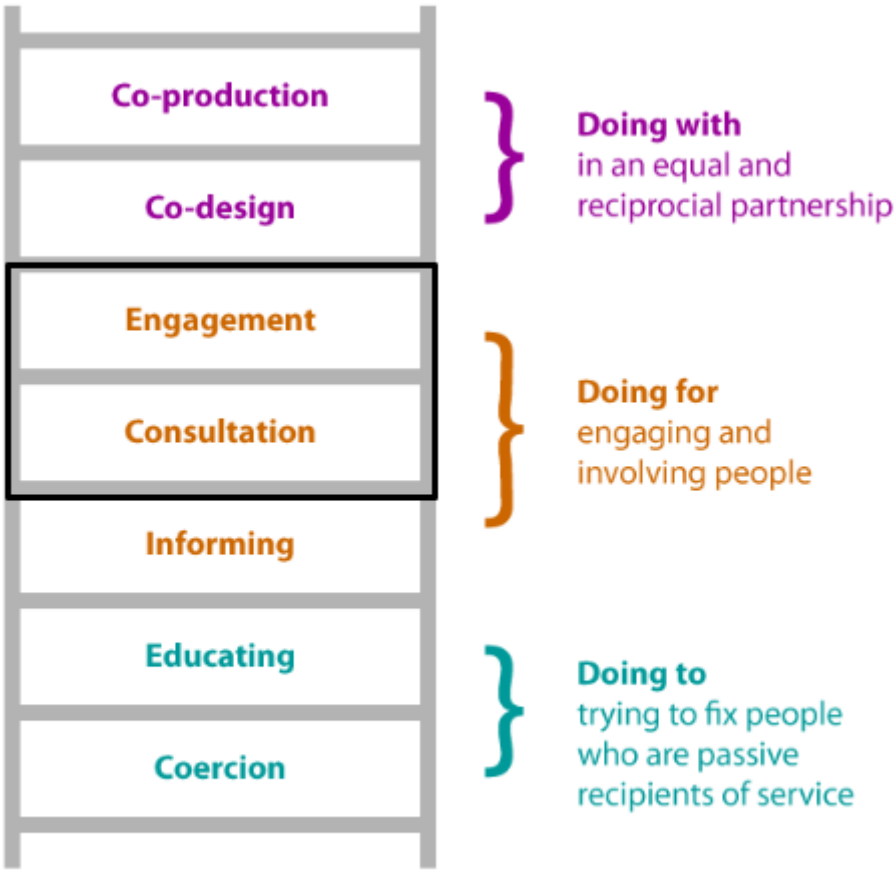
In a small number of local areas, the level of co-production is moving above the middle area of the ladder into the 'doing with' section. Below we describe some examples of co-design and co-production that fall within this section of the ladder:

- In one area a group of people with lived experience sit on the "complex needs strategic board" and deliver frontline coordination. They are therefore in a position to link up the frontline work with the work of the coproduction group and strategic board. Recommendations from the experts, and barriers

identified operationally, are considered by the board to identify long-term solutions.

- Another area has a working group consisting of professionals, people with experience of accessing support and allies. This group has been asked to contribute to the re-commissioning of supported mental health accommodation and the council's approach to citizen engagement. The group is now focusing on proactively changing the things they are collectively passionate about such as better availability of information at the housing options service and trauma informed training for staff.

Figure 9: The co-production ladder



Source: Think Local Act Personal

The MEAM involvement coordinator provides specific support to three areas in the MEAM Approach network at any one time, and has so far offered support to five areas in total. This support focuses on enabling areas to develop and implement improved co-production within their local systems and services. Working with individual areas also provides opportunities for the involvement coordinator to build an increased understanding of what works locally in terms of implementing co-production or progressing towards it, as well as challenges and how these have been tackled. This understanding can then be shared with the

rest of the MEAM team and with local areas, to support them in their own local work around co-production.

In addition, the MEAM staff team is committed to modelling co-production in its own work and has taken steps to ensure that the support it provides to local areas is co-produced. A specific theory of change has been developed by the involvement coordinator and some aspects of MEAM support have been co-produced from the very early stages of development. This includes the learning hubs, which take place regularly for MEAM Approach areas.

7 Benefits of the MEAM Approach network

7.1 Overview

This section covers the views of local areas on the support provided to them by the MEAM team, and the opportunities available to them to share ideas and good practice with other areas in the MEAM Approach network.

7.2 Key finding 9: Being involved in the MEAM Approach network helps local areas design and deliver local interventions

There were two main ways in which being involved in the MEAM Approach network enabled local areas to make progress in their local work. First, MEAM regional partnership managers acted as an advocate for the MEAM Approach and provided advice and support. Second, being involved in the network provided opportunities for local areas to share good practice and learning with other areas involved in the network.

7.2.1 Input from regional partnership managers

The majority of local areas reported that they were in regular contact with their regional partnership manager, describing their strong knowledge of the sector and the input and challenge they offer as highly valuable.

> *She's very responsive, always available. She's helped me lead a workshop involving different agencies. She turns up to regular meetings to help get MEAM off the ground and develop the strategic team.*
>
> A Local area lead for the MEAM Approach

Contact was most frequent and consistent during the initial phases of a local area joining the network. The specific support offered to each local area was determined by structured Support Action Plans which were developed and agreed by the regional partnership managers and key local stakeholders. Some of the main ways in which regional partnership managers supported local areas were:

- Support to build local partnerships and to set up strategic meetings.
- Attending strategic and operational meetings.
- Providing tools and templates to support implementation.

> *"[They have] shared documents and checklists to see if we want to use them and adapt them, to prevent us needing to work from scratch."*
>
> Local service coordinator working for a voluntary sector organisation

- Offering advice and challenge and acting as a sounding board for local programme leads.

7.2.2 Opportunities to share good practice and learning with other areas in the network

> *"I really value the best practice side of it and the links [MEAM have] facilitated with other partnerships. We went up to [one local area], and we're linking with [another local area] to understand how they do things and get specific help on potentially similar situations."*
>
> Local area commissioning and research officer

The primary ways in which MEAM connected local areas with information about good practice were:

- Developing and delivering regional learning hubs to bring together local areas to discuss key topics and themes.
- Facilitating training, workshops and national events on topics such as co-production and system flexibility. In particular, local areas valued opportunities to attend regional or local training.
- Providing email updates about the progress of the MEAM Approach nationally, and examples of good practice in local areas.
- Connecting local areas with one another, to promote exchanges of learning.

Some local areas reported organising their own collaboration with other areas in the MEAM Approach network. This included ad-hoc discussions taking place over the phone, visiting other local areas to observe implementation, or more regular, formalised networks.

Appetite for additional support from MEAM

Local areas highlighted four ways in which MEAM could help them further:

- Increasing the emphasis on local or regional events, rather than central events (e.g. in London), which require longer travel.
- Additional training opportunities.
- Support to establish an open forum to share experiences and ideas with other local areas.
- Support to obtain funding for local work and to evidence the impact of existing local work.

In many cases these issues have been addressed since the evaluation fieldwork took place. Examples include MEAM staff providing specific training on Trauma-Informed Care, offering regional reflective practice sessions and supporting local areas with funding applications relating to the MHCLG Rough Sleeping Initiative and Rapid Rehousing Pathway fund, as well as Public Health England and NHS England programmes around mental health and multiple disadvantage.

8 Next steps for the evaluation

The next steps for the evaluation will be discussed and agreed with MEAM, the evaluation steering group and the expert by experience research group. We anticipate being able to explore the 'cost benefit' of the MEAM Approach in the year 3 report. Two other key areas for consideration are streamlining and improving data collection under the CDF and focusing on specific approaches and themes within the evaluation in future years. These are discussed further in sections 8.1, 8.2 and 8.3.

8.1 Economic evaluation

We intend to include analysis on the 'cost-benefit' of the MEAM Approach in the year three report. This will be based on the client-level service use data collected via the CDF. We intend to work with CFE Research to ensure that our evaluation findings are comparable with the national evaluation of the Fulfilling Lives programme. For example, this is likely to include categorising data in the same way and using the same unit costs when calculating the economic costs of service use.

8.2 Streamlining and improving CDF data collection

We plan to review the CDF and approaches to collecting data, in order to ensure that the process is as feasible as possible for local areas whilst also providing robust data for use by the evaluation.

Increasing the number of data returns, the number of clients included in data returns and the completeness of the data set produced via the CDF would enable more robust analyses to be conducted to understand the impact and outcomes of using the MEAM Approach in local areas. Examples include being able to:

- Apply more rigorous baseline criteria for time 1 Homelessness Outcomes Stars, NDTAs and service use data.
- Use data on clients' service use in the 12 months prior to support as a baseline, rather than relying only on data from the first quarter of their engagement with support.

8.3 Focusing on specific approaches and themes

During year 2, the evaluation sought to identify overarching themes and findings. In years 3-5 it may be useful to focus resource on specific themes or topics of interest, while continuing to provide analysis on individual wellbeing and economic impact. As an example, we could focus work specifically on the impact of the MEAM Approach on local systems. A decision on the focus for year 3 will be taken following discussion with MEAM and the evaluation steering group.

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