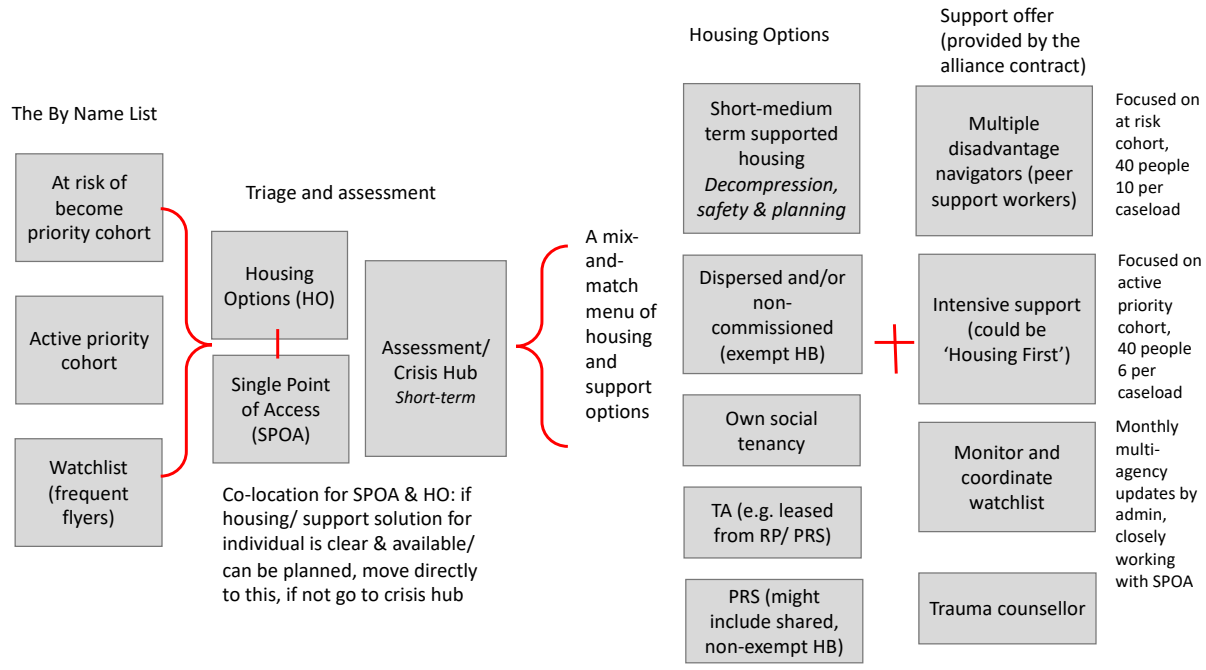
IBA's recommendations for re-commissioning from the findings of the multiple and complex needs review

The different strands of this research have identified some common themes: the lived experience interviews highlighted a number of examples of people experiencing system limitations which adversely affected their outcomes, and the length of time it takes to access the right sort of help. Through the By Name List exercise, the research has identified a substantial cohort of people experiencing severe and multiple disadvantage whose needs are generally not being well-met by the current offer – this may be due, in part, to 'single issue' services, or an inability to engage with the support on offer, periods of relapse which the services are not necessarily designed to flex around. Some have 'burned their bridges'; others have been able to access settled housing, but are now finding this difficult to sustain. The volume, and variety of reasons people fail is itself a powerful illustration of the case for systemic change.

We found evidence that, although the commissioned services are performing well in many ways, they could also be seen to be operating as 'islands' within the wider system. Our recommendation is to bring together some of the examples of good practice we have observed into one coherent offer catering for people with multiple issues and with more psychologically informed services.

Whilst we recognise that the housing and support commission cannot in itself overcome all the barriers which this group face, we nevertheless see some real potential to kickstart a more effective complex needs pathway through the housing and support re-commissioning process.

Fig 1: Illustration of potential pathway:



In order to establish and embed the new pathway, our recommendation is that the current contracts are recommissioned, ideally to an alliance of providers, with a number of clear **principles underlying delivery**:

- This **contract would effectively oversee the By Name List cohort**, working with the priority cohort (we think around 40 people at any given time) and with the at risk/ repeat flyers (probably in the region of a further 110 individuals). This means that the identification of the cohort, the delivery of services to them and the outcomes achieved (e.g. successful engagement, sustainable tenancy, etc) can be co-ordinated and actively monitored with some degree of confidence.

- It provides a commissioned pathway for this cohort, with **a clearly defined case management ethos and model, which retains accountability for the cohort** (whether or not they are staying within a particular building, or whether time limits have been exceeded, etc).

- The 'pathway' refers to movement through (and potentially back and forth between) different models of case management, based on current risks and needs, and does not imply a linear progression through particular buildings or providers. At the moment, service delivery is still buildings-led rather than strictly person-led – the researchers identified examples in which suitability for the offer of a service was led by the question of whether an individual will 'fit into' the available vacancies (and whether the risks can be managed within the support contract attached to that building). A person led approach would ask what someone wanted and then try to provide it. While there is never likely to be an unlimited choice, there are some principles about where power lies, and having the right to make decisions about

issues that affect people. The **proposed *model* is person-centred in design (as well as in the style of practice)** since the housing and support offer is flexible, and responsive to the needs, resources, preferences and risks of the individual. Responsibility for flexing the offer and finding solutions is 'held' by the case worker, giving permission for actions, rather than an expectation that the worker and the service user must follow a prescribed process.

- Whilst we recommend some ongoing accommodation-based provision, that which remains needs to be **very clear about its function within the wider pathway and this needs to be expressed in strengths-based and trauma-informed terms.** The move from large hostel settings to smaller settings has already taken place; however more could potentially be done – especially in the over 25s service – to increase the therapeutic offer. Even in the most well-run services it is challenging to avoid institutionalised practice. Reframing supported accommodation as a valuable part of any offer will require a review of the language and ethos underpinning current provision. For example, Beevor Court moves from a place where people 'are assessed' to a place of safety, decompression and stabilisation from trauma. Engagement is recognised as being the responsibility of the staff, not how the person conforms, therefore allowing sufficient time for this relationship to be developed forms an important part of any meaningful change. In this environment, people are supported to look at the options for ongoing housing and support which might be available to them, including amongst their own family and friends as well as within services, and plan for their next steps. It is not enough simply to change the terminology, this requires good staffing levels and a clear structure/ culture/ vision and appropriate access to multi-skilled and specialist professionals, and to both therapeutic and peer support. Not everyone will want or be able to access this service, and doing so should not be a requirement to access further housing/ support. The **therapeutic, peer and planned support can be flexibly provided across the whole pathway,** rather than just to those currently in Beevor Court.

- The full range of other (supported) housing options should be considered for individuals, with **careful matching of individuals to places, looking at location/ building/ residents and considering strengths and interests as well as risks and 'problems**'. A floating/ wraparound support offer follows the individual as and where needed, including into non-commissioned or their own tenancy – this follows the person, not the building. In this model, support becomes relational, and more equal. This might then take the form of a walk-and-talk, or a meeting in a coffee shop or accompanying the person to look at an area they might live in/ an appointment/ exploring an interest, etc, moving away from institutions with offices and noticeboards and staff with bunches of keys wherever possible. One of the immediate advantages of this shift is to free up resources which are tied up in 24/7 staffing for smaller congregate settings, where others with needs which are probably at least as high are in non-commissioned supported housing with a weekly welfare check – or even in an out-of-area Bed and Breakfast.

- There is a clear need for **women-only spaces and gender-specific service offers which is not currently being met.** Around 30% of the 'priority cohort' in the BNL

exercise are women and this may be the tip of the iceberg, since women are more likely to remain hidden. We recommend that – as a rule of thumb - around 30% of bedspaces, support offers, etc are designed in such a way that women's needs can be safely and effectively met (e.g. in shared accommodation which is women-only, in self-contained accommodation, with access to female workers/ peer support workers).

- Access and triage into the pathway will be key. If the pathway can be successfully commissioned from an alliance of providers, we believe it makes sense for **a Single Point of Access (SPOA) function to also be commissioned from that alliance.** This highly skilled post needs to build relationships to support information sharing and **2-way referrals with non-commissioned providers** (who may also be members of the alliance) as well as into commissioned services. The SPOA will work **very closely (possibly including co-location) with the Housing Options team**.

Resources:
Our initial sense is that the commissioned pathway team will (in addition to management) require around 14 FTE posts (4 x peer navigators, 7 x Intensive/ HF workers, Admin (or outreach type role) to monitor people on the 'watchlist', SPOA, Trauma counsellor plus management costs. Please note, we are suggesting this as just one scenario in which an alliance of providers might propose delivering against this model, not a rigid requirement in the specification.

If commissioners are serious about a trauma-informed system, we would recommend that minimum requirements in relation to training, learning & development (both for staff directly delivering commissioned services, but also for non-commissioned services) should be included, along with IT/ data systems/ information sharing considerations, and lived experience input into design and performance management/ evaluation. Getting the right balance between quality and cost will be key (we heard from one provider that they had recently included a Trauma-informed Counsellor in a proposal which they then lost on cost).

Within the accommodation based services it is important that the therapeutic value is not lost. While many providers have adopted a concierge/ security model, this could lend itself to a contradictory message in a trauma informed environment. A skilled team providing 'reactive support' i.e. staff who are available to actively engage, promote safety and stability and respond to ad hoc needs for support within the short-medium term building-based supported housing offer. Those living in supported housing could also access planned and personalised support from any one of the types of support from the 'menu'.

Risks
There are a number of risks here:

- Re-commissioning too quickly or too prescriptively without sufficient dialogue with existing commissioned and non-commissioned providers, peer mentors and people with lived experience. It takes time to grow a successful alliance, to establish shared values and build trust; to enable innovative solutions to surface. It would be better to pause/ enter a transitional period in the re-commissioning cycle in order to create

the space for this to happen than to rush it and end up with more of the same, enforced partnerships, damaged relationships, etc

- That this commission becomes the 'complex lives team' and creates yet another silo, with all the risks of gatekeeping, labelling, etc that can accompany this, especially within a context of stretched resources. This is not easy to mitigate, but the key seems to lie in:
    - Being clear from the outset about how this contract fits into the wider systems, where accountability lies and escalating blockages relating to individual cases and wider strategic learning to the operational/ strategic panels of the Safer Barnsley Partnership or, where risks are high and no services are succeeding in engaging with an individual, to the Adult Safeguarding Board.
    - Ensuring that the contract is connected – operationally as well as strategically - to the range of relevant preventative and proactive activities going on across the borough, e.g. to Public Health's work to identify and target those making repeat suicide attempts, those known to Community Policing but not yet to Housing Options (are or should some of this cohort be on the peer support navigators' radar?), young people coming through the Future Directions Panel, etc.

There are a number of questions to be ironed out:

1. **Does this contract incorporate commissioning for younger people as well as for adults over 25?**

Specialist younger people's projects are essential within this pathway. However, there are conversations to be had with providers regarding whether it is feasible/ desirable to include these as discreet projects within an alliance or whether these should be commissioned separately, with requirements for integration and communication (especially around transitions) with the wider pathway included in this specification. The current supported housing offer from Centrepoint is clearly valued by many young people and includes offers such as a therapeutic team, linked into CAMHS which align well with the vision set out here. We also heard that this congregate model did not work for others.

There may be advantages (both in terms of the streamlining of resources and the seamlessness of the offer) to including the current community support element of the young persons' contract within this wider alliance contract. This may also become clearer depending on whether or not there is appetite for joint commissioning of a specialist offer for the youngest cohort (including those leaving, or close to local authority care) and where this should sit in the proposed pathway.

2. **Is the 'Intensive Support' team actually 'Housing First'?**

Not necessarily. The two are different: intensive support in this model could apply to people not yet housed, or who are in non-commissioned housing. Housing First incorporates intensive support when required, but is quite distinct, having a number of elements which must all be present, all of the time, for it to be Housing First.

However, the potential advantages of including HF within the pathway are that:

- the Housing First offer would be embedded within the wider case-managed complex needs pathway, which reduces any disconnect from other services (and creation of a silo)
- The Housing First principles have relevance to this cohort across the whole pathway,
- Making it a distinct element of the contract ensures that it is targeted on the right people.

This model potentially recognises that some people need a more intensive offer, some or all of the time (and there may be movement between the less and more intensive offer and back) but that everyone will benefit from the principles of maximising choice, active engagement, strengths-based practice, etc.

There is a risk is that Housing First becomes diluted, or that low fidelity services are assumed to be Housing First. In our experience this can be mitigated by having a specific management function focused on delivering a high fidelity model, which, in turn, will deliver the positive outcomes with respect to tenancy sustainment that it has delivered in numerous services both here and internationally.

Another risk arises from how the contract is presented: it will be important to ensure that the capacity and experience to deliver such a contract is a competitive process - whether and how this is included within an alliance will take some time to negotiate.

If the service is going to be labelled 'Housing First', it is essential that it should have:

- Buy in from housing providers, so that individual choice and careful matching to properties is maximised;
- Appropriate levels of planning (what the principles look like in practice), and training and support for delivery teams; and
- A commitment from the local authority and its partners that ongoing funding will be secured to support a non-time-limited support offer.

3. What is the crossover with the Housing Options-led Covid Recovery Plan and this pathway?

The two systems should and do align but are they one and the same? The cohort and systems for the multiple and complex needs cohort and those for statutory homelessness clearly overlap but neither are fully contained within the other. A similarly structured and principled rapid re-housing pathway for wider homelessness would be our recommendation for the homelessness system, but further low-level and preventative elements will clearly be required within this wider offer. For example, a responsive and preventative floating support offer which can provide 'short sharp' interventions (e,g. around financial and practical issues) is essential to the functioning of the wider system, but should not be funded from the complex needs pathway. Likewise, there may be individuals who should appear on the at risk or 'watchlist' for the complex needs pathway, who are not (yet) on the Housing Options radar.