Subject: Building Resilient Lives: Reshaping Housing Related Support

Report to: Housing & Neighbourhoods Committee 22nd June 2017

Report by: Vicky George Group Manager: Housing Health & Wellbeing

SUBJECT MATTER/RECOMMENDATIONS

This purpose of this report is to provide a short update on the Building Resilient Lives work in particular the development of the locality investment proposal matrix, which Norfolk County Council asked district councils or other lead organisations in localities to complete in partnership.

This report is for information.

1. INTRODUCTION/BACKGROUND

Norfolk County Council (NCC) undertook a consultation exercise on the future funding of housing related support called Building Resilient Lives – Reshaping Housing Related. One of the four recommendations concerned investment of approximately £1.3 million in a new community outreach model that will provide support to both older people and those at risk of homelessness.

NCC produced guidance together with a matrix which localities were asked to complete setting out proposals for reinvesting a share of the £1.3 million. The guidance set out that proposals needed to relate to one or more of the needs that will impacted by the decommissioning of services: older people with support needs, young people including care leavers, people who have been homeless, people who are at risk of homelessness in particular people with serious mental health problems, single parents with support needs. Proposals should be designed to support recovery and independence.

2. DEVISING A LOCALITY INVESTMENT PROPOSAL

2.1 Great Yarmouth's locality board met on 28th March and received a short presentation on the impact of the funding decision and agreed to establish a task and finish group that would complete the investment proposal matrix. The group met in April and the final version of the matrix was agreed by the locality board via email at the beginning of June. A copy of the investment proposal matrix is attached.

2.2 Broadly the proposal sets out the Locality's intention to invest the resource into a provision that will occupy the gap between acute / statutory service provision and the models of early help and prevention that are currently being delivered in the Borough. The proposal sets out the evidence base for this and identifies that provision will need to be flexible to evolve through what the locality view as three phases, recover, stabilise and innovate. The detail of these is set out in the matrix.

2.3 The matrix will now be submitted to NCC who intends to combine it with other evidence and test it with a range of stakeholders to inform the overall approach to delivering edge of care interventions across the County. Evidence based recommendations will then be made to Adult Social Services Senior Management Team which will make the final decision. The aim is to conclude the process by the end July.

3. RECOMMENDATIONS

This report is for information.

4. BACKGROUND PAPERS

Areas of consideration: e.g. does this report raise any of the following issues and if so how have these been considered/mitigated against?

Area for consideration	**Comment**
Monitoring Officer Consultation:	
Section 151 Officer Consultation:	
Existing Council Policies:	Homelessness
Financial Implications:	None – report is for information
Legal Implications (including human rights):	None – report is for information
Risk Implications:	None – report is for information
Equality Issues/EQIA assessment:	None – report is for information
Crime & Disorder:	None – report is for information
Every Child Matters:	None – report is for information

Proposal for interventions to support people on the edge of care / crisis (April / May 2017)

Purpose of matrix

As part of decommissioning decisions made in 2017 about housing support services Norfolk County Council has committed to reinvesting some revenue funding in effective, outcomes based interventions which have a positive impact on people who are on the edge of formal care or crisis. Proposals should relate to one or more of the needs that will be impacted by the decommissioning of services: older people with support needs, young people including care leavers, people who have been homeless, people who are at risk of homelessness in particular people with serious mental health problems, single parents with support needs. Proposals should support recovery and independence.

Proposals should indicate how the investment would reduce demand for formal social care intervention and packages. Where relevant proposals should show how investment would reduce demand for other statutory services.

Completion of matrix

This matrix can be completed by district council leads or by other leads in localities on behalf of a wider partnership.

Process

Currently there are few set assumptions about how the money will be invested. Commissioners will consider information on needs and evidence about what works, alongside locality proposals. This intelligence will be tested at a number of stakeholder workshops to inform the overall approach to delivering edge of care interventions across the county.

Evidence based recommendations will then be made to Adult Social Services Senior Manager Team which will make the final decision. Commissioners may come back to the proposal lead for further discussion and information as part of the decision making process.

Depending on the financial value and nature of the interventions proposed it may be necessary to undertake a procurement process.

Types of proposals

The proposal may be for investment in a new service or for the expansion of an existing service. Alternatively it may not be for a formal service at all, but to enhance existing collaborative / partnership approaches.

Investment

Broadly the amount potentially available for investment in edge of care / crisis interventions is around £1,300,000. If this were to be distributed between 5 proposals (reflecting the 5 CCG localities) this would amount to around £260,000 annually per locality. This is to provide some guidance in developing locality proposals.

A strong proposal would probably need to demonstrate additional investment to the amount required from Norfolk County Council in addition to making a convincing case about the likely effectiveness in achieving outcomes. A strong proposal is likely to show good partnership and support from a range of organisations within the locality or localities that the proposal is seeking to cover, such as making use of existing community networks or infrastructure. The funding will be available to invest from March 2018 at the earliest. Norfolk County Council is likely to seek to make this investment for an initial period of three years.

Please contact Jo Clapham, jo.clapham@norfolk.gov.uk, 01603 224061, if you wish to discuss what is required in this matrix.

Proposal for interventions to support people on the edge of care / crisis (April / May 2017)

1.	**Proposal title**	

2.	**Briefly describe what is proposed (what needs will be met and how will needs be met)? What evidence is that show these needs are a priority?**	The proposal as set out below will evolve through three phases.
		
		• **Recover** – this is about understanding now the current gaps in provision and taking a view on the impact of the funding decision. Once funding ceases there will be a period of recovery while services and client adjust. This is why we state the proposal must be able to flex.
		• **Stabilise** – this is about understanding demand and delivering on the collaborative opportunities that we express in the proposal
		• **Innovate** – this is about exploring and developing models for services that can deliver differently and continue the move from a fixing agenda to one that is about living well. The locality has focused on developing the necessary infrastructure to support people to live well and independently. This allows for innovation to happen and we would want to use this funding to support potential innovation opportunities. Those opportunities would be on an 'invest to save' basis, to ensure ongoing sustainability of a project/ service beyond this funding. We would want to co-produce ideas with key stakeholders in the locality but examples of what we might want to explore initially include:
		  • *Time-banking* – supporting the development of the voluntary and community sector through this innovative approach.
		  • *Home Share* – a scheme that matches Older People with spare bedrooms with people who need accommodation. The benefits include a reduction in social isolation and being able to provide alternative accommodation for people who need it.
		  • *Buurtzorg Model* – very simply put the model establishes neighbourhood teams (in Holland these are primarily nurses) that know the area and the networks that exist and can work across the patch to bring together formal and informal support. Working in this way the focus can be on what the client can learn to do for themselves again, how the service can empower the client and how the service can make itself not needed anymore. Taking this model and embedding it in the local well-being and prevention agenda, bringing in the voluntary sector, could provide a sustainable solution for the future.

		The Proposal The intention is to allocate the resource to a provision that will occupy the gap between acute / statutory service provision and the models of early help and prevention that currently being delivered within the locality. The provision will work with vulnerable people who are on the edge of care or experiencing crisis that will if not appropriately support result in demand on acute frontline services. The provision will form part of the broader offer of information, advice and low level support that is being developed via collaborative working with a range of providers and organisations. This opens up opportunities to use funding and assets that exist across the system for example neighbourhoods that work, social prescribing, GP practices development of care navigator roles as well as linking into voluntary sector provision. There is a recognition that the provision will need to flex to meet changing demand particularly as it will be difficult to quantify with any degree of confidence when and where demand will be experienced once the funding ends. The locality already has in place significant infra-structure to support an integrated solution and it would be prudent both in terms of cost and time to build on this. Building on the connector and navigator roles the proposal will introduce a set of specialist facilitator roles that will provide a ‘hand-holding’ interventionist service. This will be supported by a ‘can do’ budget that can be used to unblock situations where there is no other alternative funding routes. An example could be facilitating decluttering. Specialist facilitator support would be time limited, intensive and delivered on one to one basis. It would intervene and deal with the current crisis situation, build resilience for the future and manage a step-down towards self-help. The provision will blend with and enhance existing early help, prevention and intervention services. We are aware that existing floating support services such as the community

		outreach service regularly attend MDT meetings in support of individual patients and clients providing invaluable information and advice to aid discussion and decisions. Targeted specialist provision is likely to focus on the following cohorts: • Older people, • Single homeless • Young people at risk including care leavers and young parents • People who are at risk of homelessness **Evidence Base** Great Yarmouth has a population of 98,000. The health of people in the borough is generally worse that the England average. Great Yarmouth is one of the 20% most deprived districts/unitary authorities in England and life expectancy for both men and women is lower that the England average. Headline Data for Great Yarmouth • 23% of the population aged 65 or over • 7.1% describe their health as bad or very bad (Norfolk 5.6%) • 10.9% report their day to day activities being limited by long-term conditions or disability. <u>Older people living in sheltered housing:</u> • 812 live alone of which, • 164 are over 85 years old of which, • 112 have a known mental health issue, of which • 11 have safeguarding concerns that are being monitored. • 544 have no support other than the sheltered housing support • 50 are over 85 years old. • 359 identified at risk of social isolation

		114 are over 85 years old • 108 tenants over the age of 85 rely on informal care of which • 9 have a known mental health issue • 92 tenants are visited daily <u>Older people outreach:</u> • 144 older people currently supported • 37 are over 85 years old, of which • 6 have high needs • Source of referrals • 15 p/m adult social care • 10 p/m health • 6 p/m voluntary sector • Activity includes monthly attendance at MDT meetings at Shrublands and regular joint visits with the DWP. There is a growing need to support new tenants in order to sustain their tenancies. This work begins when applications are made for housing from those in housing need, including those who meet the criteria as statutory homeless. The Homelessness Reduction Act will lead to increased demand for services as those in housing need are identified earlier and are supported for a longer period. The supply of social housing has reduced at a time where demand is rising. Along with other local authorities, GYBC are only able to house those in greatest need. In turn, those tenants who are housed, tend to have support needs in order to establish a tenancy, particularly first time tenants. New tenants with mental health issues are being identified as a growing cohort. Ongoing support is required in order to sustain these tenancies.

		Tenancy Support • Referrals currently made for support for tenants entering their first tenancy or where previous tenancies have not been sustained. • High level of referrals for support with mental health issues • Tenants where hoarding is an issue are increasing in number. Housing Options • 95 Statutory Homeless Acceptances • 93 decisions of intentionally homeless leading to support need to secure accommodation • 242 applicants homeless but not in priority need therefore no housing duty however require support to secure accommodation • 53% of households accepted as homeless are lone parents with children, predominantly female. • 48% of households accepted as homeless are where the lead applicant is aged 25 - 44 • 453 Households rehoused in the social sector Homelessness Housing First/Pathway Project – 27 individuals approached for support from a variety of sources both self-referrals and from other agencies. These individuals are generally the more chaotic known to a wide number of statutory and voluntary services and if not currently rough sleeping, their next step would be to rough sleep. They would have all had issues which affect their ability to sustain accommodation on different levels which in turn impacts on the amount of time that needs to be spent with each client. Once the immediate issues have been dealt with such as securing accommodation, the other influencing factors can then be dealt with i.e. engagement with other services. Of the 16 individuals placed in accommodation 10 have sustained their tenancies for over 6 months, 2 have only recently secured tenancies and 4 have failed due to continued behaviours that were not conducive to community living or had a lack of life skills to sustain a safe living environment.

		<u>Early Help Hub</u> Great Yarmouth's Early Help Hub was launched in 2015 to provide better, early support for people in need across the borough. NCC Children's Services, Great Yarmouth Borough Council and Norfolk Police jointly fund a Co-ordinator post to drive early help responses and facilitate a daily collaboration meeting to enable practitioners to resolve issues for people far more quickly and appropriately. • Over 50 organisations are attending collaboration meetings • 72 cases per month, on average are presented to the Early Help Hub Jan-March 2017 • 18% of cases related to housing issues. • 15% of cases were specifically in relation to vulnerable adults/older people. • 14% of cases related to health of which 8% related to mental health. <u>Social Prescribing</u> A social prescribing pilot has been launched from the Lighthouse Medical Practice, predominantly serving Nelson and Central and Northgate wards in Great Yarmouth. The pilot is seeking to engage patients in non-clinical interventions recognising the value of social networks, support services and voluntary sector support. The main beneficiaries have been older people and vulnerable adults. In first month of operation: • over 20 individuals have been linked into Neighbourhoods that Work provision. • 5 individuals have noted better outcomes and an improvement in their wellbeing. Examples such as individuals joining seated exercise classes, bereavement groups, receiving debt advice, being assisted with care needs and volunteering with a local organisation have helped to start to demonstrate the value of a social prescribing approach to avoid costly service intervention. <u>DWP</u> Since the introduction of Universal Credit Full Service in Great Yarmouth DWP are

		finding they are working with more vulnerable people who require help around supported housing services e.g. Home Group, MAP, Anchorage Trust etc. DWP funds support from Great Yarmouth BC and its delivery partner, DIAL, to provide personal budgeting support and digital assistance to help individuals make and maintain their UC claim. DWP is also an active partner in the Early Help Hub described above.
3.	**What is the geographical area for this proposal?**	Borough of Great Yarmouth
4.	**What are the objectives / expected outcomes for the proposed investment? How will the proposal prevent, delay or reduce needs for formal care? How will the proposal reduce people undergoing crisis?**	<u>Older People:</u> • Sustaining independent living, • Reducing social isolation • Prevent, delay or reduce the need for formal care • Facilitating hospital discharge, admission prevention • Preventing breakdown of informal care arrangements <u>Varied Cohorts:</u> • Tenancy sustainment • Homelessness prevention • Hospital admission prevention • Reduced A&E attendance • Appropriate access to primary health. • Addressing hording and self-neglect The proposal will prevent, delay or reduce the need for formal care by intervening to provide intensive short-term support. Working collaboratively across the system vulnerable individuals can be identified and directed to the most appropriate level of support. There will be a cohort of frequent flyers that are known to a range of services so key to this intervention will be collaborative working facilitated through the Early Help Hub. This proposal will add to that blend of specialists. Outcomes will include:

		• Reduced demand on crisis services – social care, housing & health • Supporting people to take greater control of their health • Supporting people to make decisions and develop self-help strategies • Improving mental health including decreasing levels of depression and anxiety • Improving physical health • Improving quality of life and emotional wellbeing • Reducing social isolation • Improving employability and access to employment.
5.	**What is the proposed number of individuals and activities which would be supported through this intervention?**	Based on the model of funding for the community outreach service we estimate that the £260,000 funding could support between **300 and 380 live cases**. The lower amount of live cases allows for the establishment of a crisis intervention budget where a small amount of revenue spending could be needed to unlock an issue. For example decluttering a property. The proposal would be integrated into the broader offer and early intervention type services that currently exist (NTW, social prescribing) and will exist (Care Navigator roles linked to GP surgeries) Activity will be part of place based support and intervention working with partners to provide a service that provides 121 crisis intervention and support for the boroughs most vulnerable residents. Activity will include home visits where necessary to provide tailored support to deal with the immediate issues to enable people to help themselves in the future by connecting them with local support in the community.
6.	**How does the proposed intervention make use of partnerships / collaboration with a range of different organisations?**	The locality has an excellent track record of working collaboratively to deliver the best outcomes for the residents of the borough. This proposal will blend with, complement and enhance the current work within the locality. This proposal will align with social prescribing, neighbourhoods that work, the GP practice care navigator role (funded via transformation monies through STP), enhanced housing management for GY community housing tenants and a range of voluntary sector provision from the specialist advice provided by DIAL to grass roots community groups.

7.	**Is this a new proposal or is the proposal to extend an existing intervention or service or enhance existing community networks / infrastructure? Has a provider or providers been identified? Please give details.**	Proposal is a mixture of new provision that will combine to enhance existing work and provision. As described earlier there is an existing infra-structure that could support the work and has experience of delivering the outcomes being sought. We would see this proposal sitting within our Neighbourhoods that Work programme. Neighbourhoods that Work is a commitment to partnership working in a more effective and joined up way to support communities in Great Yarmouth. This is underpinned through Big Lottery investment to build stronger communities and support the voluntary sector to be more responsive to community needs. The approach is being trialled nationally as a more effective mechanism for supporting people across the voluntary sector. The infrastructure provides support for community development and building social capital and support for individuals with complex needs and those needing support with life-skills. There are 6 existing commissioned providers providing a delivery framework for future targeted investment.
8.	**How will the outcomes be captured and shared?**	The outcomes will be captured and reported on a quarterly basis to the Locality Board.
9.	**Which other organisations have been consulted / involved in making this initial proposal?**	Great Yarmouth Locality Board • Great Yarmouth Borough Council • Norfolk County Council o Responsible Director o Adult Services o Children's Services o Public Health • HealthEast – Clinical Commissioning Group • Head of Integrated Commissioning • Department for Work and Pensions • Police • Fire Service
Investment		

10.	**What funding is required from Norfolk County Council?** **2018/19** **2019/20** **2020/21** **Please give some detail about how it will be spent?**	£260,000 for each of the three years *Staff costs* • New roles (Facilitator) • Support / enhance exiting roles?? *Non-staff costs* • 'Can do' revenue budget • Training & development • Publicity and promotion • Back office costs
11.	**Does the proposal include any match funding? If so please give detail.**	There are no formal agreements about match-funding but as a system the locality board would want to align this funding to other pots of funding within the borough. For example: • NCC place based social prescribing bid £40k • GP Forward View transformation funding for care navigator roles • Big lottery – Neighbourhoods that Work • Future supported housing funding
12.	**Will the proposal depend on any funding which has not yet been secured? If so please give details.**	No
13.	**Is there anything else you wish to add?**	As a direct provider of services GYBC is suggesting that rather than use the small amount of reserves within the outreach budget to pay redundancy for the outreach staff, it is used to make the proposal operational ahead of the March 2018 start date. This would make use of existing skilled staff and mitigate the need for extensive training and orientation. As a locality board we believe that we have described a model that can be funded

		through existing local collaborative arrangements mitigating the need for more formal commissioning processes.
14	**Please give the name and contact details of the lead proposer.**	Vicky George Great Yarmouth Borough Council Vicky.George@great-yarmouth.gov.uk 01493 846369

Please return this completed proposal to jo.clapham@hotmail.co.uk by close of play **31 May 2017**.