Agenda Item No: 5

Homelessness and Housing Related Support

To:	Adults and Health Committee
Meeting Date:	12th December 2024
From:	Executive Director Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	KD2024/035
Executive Summary:	This paper provides an overview of how the County Council is investing resources and working with partners to deliver essential support for the rising numbers of those with often complex support needs who are experiencing homelessness. The report highlights the positive impact this service has been having with the people being directly supported. To support the continuation of this work we are seeking an extension of the existing contracts which are facilitating the delivery of this support.

Recommendation: The Committee is recommended to:

a) note the County Council's contribution to investing in a system-based approach to delivering support services to address the needs of those who are experiencing homelessness, and how this positively impacts this group of people.

b) approve a 2-year extension to the existing contract in line with current terms and conditions at a total value of £4,582,926 (£2,291,463 per annum) from 1st April 2025. This value will be adjusted for any future inflationary uplifts, awarded at the Council's discretion, as agreed through the business planning governance process.

c) delegate the authority to award the subsequent extension period to the Executive Director Adults, Health and Commissioning, in consultation with the Chair and Vice Chair of the Adults and Health Committee.

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1. Creating a greener, fairer and more caring Cambridgeshire

1.1 The continued delivery of these services supports the following Cambridgeshire County Council ambitions:

1.1.1 **Health inequalities are reduced.** The services provide vital support to people in Cambridgeshire who are experiencing homelessness. The services provide tailored support to help people who are struggling with to maintain their accommodation for a range of reasons including addiction, poor mental or physical health. These services help people to engage in support and treatment in a way that works for them with the aim of reducing the health inequalities that the homeless population often experience.

1.1.2 **People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.** Services help ensure that this group of people have access to safe accommodation where they can access the support they need to begin to make lasting improvements that will help them to gain confidence to live independently and achieve their goals.

1.1.3 **People are helped out of poverty and income inequality.** The services help to ensure that people have access to a stable income by enabling access to benefits as well as opportunities to develop skills that will aid them in accessing employment in the longer term.

2. Background

2.1 The number of people presenting as homeless continues to rise across the country. In Cambridgeshire we are seeing a rise in number of people approaching local district councils for support and to declare themselves homeless as well as those seeking to access Housing Related Support (HRS) services commissioned by the Cambridgeshire County Council (CCC). As people who find themselves homeless may regularly transition in and out of support services it remains difficult to calculate exact demand figures across all districts of the county. However, we do know the greatest demand for these services is presenting within Cambridge City and Fenland and the current model and level of investment in HRS reflects this. The impacts of homelessness, and particularly rough sleeping, are well documented. With this in mind, the current HRS Service was developed in 2020 in partnership with District Councils, Public Health, the Cambridgeshire Domestic Abuse and Sexual Violence Partnership, local providers and people with lived experience. The services seek to ensure that effective, preventative support and accommodation options are available to support people experiencing homelessness, and wherever possible to transition into a more permanent accommodation arrangement through helping to address and manage the reasons for this.

2.2 The HRS service commissioned by CCC plays an integral part of the local systemwide, preventative offer to support those experiencing homelessness. These contracts are complemented by an in-house Housing First service. Housing First aims to support those with the most complex needs for whom other interventions have not succeeded. Often these will be people with a history of repeat rough sleeping and homelessness, who find it hard to engage with any structured support approach. Whilst delivery of Housing First sits

outside of this contractual arrangement, it operates as part of the same pathway. The Housing First approach is jointly funded by CCC and central government rough sleeper funding with a total additional investment of £673k being used to operate the approach.

2.3 Housing Related Support (HRS) services provide dedicated staff who are able to deliver specialist support to individuals to enable them to develop independent living skills and maintain their accommodation. The support provided is tailored to meet the specific needs of each person with key examples including support to develop life skills and/or manage issues such as addiction, mental health issues and emotional wellbeing. The ultimate aim of these services is to help people to:

- Move on to fully independent living
- Feel part of their community
- Make informed decisions and choices
- Be actively involved in training, education or employment
- Engage with other relevant agencies and services
- Manage their own health and wellbeing

2.4 The funding provided for HRS services is focussed on delivering the support within a service. District Councils support with other costs such as rent or service charges through the use of housing benefit, which they administer. They also provide funding to deliver the statutory homeless functions which sit with them, such as, housing advice, assessing homelessness applications and providing access to temporary accommodation. Alongside this they also offer some discretionary services such as rent deposit schemes or helping people to clear historical rent arrears.

2.5 The Council commissioned a new co-produced model in 2020 to reflect best practice and better meet current and future needs. At the time there was extensive engagement with people with lived experience. As those experiencing homelessness are often a seldom heard group, we worked directly with the County's Counting Every Adult Team to enable us to link with their established co-production group to ensure meaningful engagement. Feedback from this engagement suggested that the reliance on shared hostel accommodation was not able to meet the wide range of needs presenting in an effective or outcome focused way. To ensure that the redesign took account of any national good practice, we also had conversations and meetings with Homeless Link, a national membership charity for organisations working with people who are homeless.

2.6 In co-production with these groups, District Councils and local providers, we sought to move away from reliance on a traditional 'hostel' model. Instead, we worked as a local system to develop a wider range of more flexible solutions that are able to respond effectively to a range of needs and demands. For example, ensuring that all contracts introduced appropriate spaces and support to meet the specific needs of homeless females who will often have experienced abuse and violence.

3. Main Issues

3.1 The services commissioned in 2022, adopted the new co-produced model resulting in;

- a move away from a focus on using ‘hostel’ type accommodation towards a more place-based approach
- ensuring a trauma informed approach to support
- a ‘Hub and Spoke’ type model that can deliver more localised solutions
- flexibility for community based ‘spoke’ units able to offer more self-contained spaces as an alternative to shared ‘hostel’ type accommodation and to provide increased ‘move-on/step-down’ opportunities for those moving through a journey out of homelessness
- an ability to meet identified support gaps e.g. support and accommodation specifically for homeless females in meeting the priorities set out in the Council’s Domestic Abuse and Sexual Violence Strategy
- simplified referral routes and a more coordinated approach to referrals
- Better access to supporting services including Drug and Alcohol Support Service commissioned by Public Health, support for mental health and employment support.

3.2 The development of this model is being shaped, delivered and progressed in two phases:

Phase	Deliverable	Timescale
1	Development, delivery and embedding of the new model outlined in paragraph 3.1 by locally commissioned providers detailed in paragraph 3.6	First contract phase (2020-2025)
2	Development of a Cost Benefit Analysis Tool and more systematic tracking of individual outcomes	Second contract phase (2025-2027)

3.3 These services have a significant impact on the ability of people to achieve improved outcomes across all areas of their lives and ultimately enable them to secure and sustain long term accommodation. The preventative nature of these services also supports the Council in managing the demand for statutory social care services. Case studies are collected from the services on an ongoing basis to evidence the difference that they are making to the individuals who use them. Some examples of these can be found at Appendix A. Overall the case studies help to demonstrate how the services positively impact on key aspects of peoples’ lives, such as:

- Regaining choice and control over their everyday lives
- Tenancy sustainment
- Improving self-esteem and self-confidence
- Being able to better manage issues they may be experience around drugs, alcohol, mental health and physical health
- Setting goals for the future
- Moving towards economic stability

3.3 Physical and mental health challenges are two of the key areas contributing to the reasons someone experiences homelessness and those accessing HRS services require immediate support with. For example, between April 2023 and March 2024, the HRS services assisted 113 people to access mental health services, 143 people to access specialised drug and alcohol support, 233 to access or engage with general health care services and 53 people were supported to engage in paid employment. These outcomes will prove integral to creating

a local support network to enable these people to increase their independence and ability to retain permanent accommodation.

3.4 The model and investment are also supporting local HRS providers to manage a significant increase in demand for these support services within the context of a rising complexity in need. Overall, services have seen a 14% increase in the number of referrals received since the contract started and the number of adults with complex needs[1] being supported by services has increased by 27% from 89 being supported at the end of 2022-23 to 122 at the end of 2023-24.

3.6 Table one below provides an overview of the providers and services operating within each District area across Cambridgeshire. The number of units represents the level of temporary accommodation available within service, with the HRS Services wrapping around the person residing within each unit. Lot 1 is delivered by an established Fenland based charitable provider. Lot 2 is a partnership of providers which includes larger organisations as well as local charitable organisations.

<table>
<tr><th>Lot</th><th colspan="2">Provider</th><th>Service</th><th>Units</th></tr>
<tr><td>Lot 1 – Fenland</td><td colspan="2">The Ferry Project</td><td>The Ferry Project</td><td>37</td></tr>
<tr><td rowspan="9">Lot 2 – Cambridge</td><td rowspan="9"><u>Riverside Group</u> are the lead Provider and contract holder, but work with the other Providers and Partners listed to deliver the contract.</td><td>Jimmys Cambridge</td><td>Jimmy’s Assessment Centre and move on units</td><td>24</td></tr>
<tr><td>Jimmy’s Cambridge</td><td>451 Newmarket Road</td><td>6</td></tr>
<tr><td>Riverside Group</td><td>Willow Walk</td><td>20</td></tr>
<tr><td>Riverside Group</td><td>222 Victoria Road</td><td>54</td></tr>
<tr><td>CHS Group</td><td>Corona House</td><td>6</td></tr>
<tr><td>Cambridge Cyrenians</td><td>Dispersed and Move-On Houses</td><td>73</td></tr>
<tr><td>Cambridge Cyrenians</td><td>Jubilee Project</td><td>10</td></tr>
<tr><td>Change Grow Live (CGL)</td><td>Street Outreach & Homeless Prevention Offer</td><td>Variable</td></tr>
<tr><td>Wintercomfort</td><td>Learning and Development (excluded adults)</td><td>Variable</td></tr>
</table>

Table 1: List of commissioned Adult HRS services

3.8 Based on current service capacity, the average annual cost of each unit is £8,582 (£165.00 per week). However, in reality prices will vary across the provisions to reflect the differing levels of support being provided. Due to the transient lifestyle and engagement in services by people accessing these services, systematic tracking of performance is challenging. However, we are confident that the data reflected in paragraph 3.4 and 3.5 reflects delivery across the service.

[1] For this contract complex needs are defined as someone who has three or more of the following; history of repeat homelessness, substance misuse, mental health issues, domestic abuse, contact with the criminal justice system.

3.9 Wider impact:

In addition to the services provided within these contracts, providers also use grant funding, charitable means and their own volunteers to deliver a range of additional services which users of contracted services can benefit from. These include things such as access to onsite mental health support, counselling, art therapy, cookery classes, smoking cessation interventions, social activities, additional options for move-on accommodation, assistance with furnishing a new home and initial resettlement support for those moving on.

3.10 To ensure a more robust approach to evidencing wider benefits, providers are working with commissioners to develop and implement a new Cost Benefit Analysis (CBA) Model across all HRS Services to better understand the real value added. The model is based on the nationally recognised 'Manchester Model'[2], and will help to demonstrate the wider impact of HRS services in delivering savings to the public purse by preventing, or reducing higher cost interventions needed from other public sector services. Some initial testing of the model is being undertaken with the aim of it being piloted within these contracts from January to March 2025, and then fully implemented from April 2025.

3.11 Details of extension request:
The report is seeking extension approval for all the services detailed in table 3.2. The contracts for Lots 1 and 2 were procured following Adults and Health Committee approval in June 2021. The committee approved the award of a 7-year contract (3+2+2). The initial contracts for both Lots end on the 31st March 2025 and this is the first request to extend for an initial period of 2 years. It should be noted that there is a standard 6-month break clause built into the contract for these services which means the Council holds the right to vary or terminate arrangements should they not deliver to expectations, outcomes or value for money requirements during the next extension period.

The value of the requested contract extensions are set out below.

Lot	Annual Value
Lot 1 – Fenland	£278,036
Lot 2 – Cambridge	£2,013,426
Total per annum	**£2,291,463**
Total for 2 year extension	**£4,582,926**

Table 2 – Annual values

The contract value for Lot 2 includes the following contributions from Public Health and Cambridge City Council who are both partners within the current contract arrangement.

Third Party	Contribution per annum
Cambridge City Council	£395,000
Public Health	£182,000

Table 3 – Third Party contribution per annum.

[2] Research: Cost Benefit Analysis - Greater Manchester Combined Authority

4. Alternative Options Considered

4.1 The alternative options that were considered alongside this recommendation are outlined in the table below.

Option	Rationale
Let the contract expire	Whilst these are non-statutory services, they are supporting some of the most vulnerable residents in Cambridgeshire. Ceasing these services would lead much poorer outcomes for this group and would generate increased levels of economic disadvantage, increased health inequalities and divert people into higher cost crisis and statutory services.
Re-tender the services	The original decision to allow a contract period of up to 7 years was to enable providers to make the changes needed to move towards the new model of service delivery. Providers have made good progress in this area and are continuing the develop the services. The contract is delivering good outcomes for individuals and there is a good working relationship between the council and the providers. Re-procurement would be costly, divert provider and council resources away from service delivery and lead to disruption for service users.
Deliver the support in-house	The providers of these services are specialists in their fields. Their comprehensive knowledge and understanding of homelessness and housing is an essential element of the support they deliver. As third sector agencies they are often able to also access additional resources and grants which are not available to statutory services. Many of those supported by these services also have a reluctance to approach or work with statutory services, therefore an in-house option would be more likely to deter people from accessing the support they required.

5. Conclusion and reasons for recommendations

5.1 By commissioning these services the county is supporting the commitments made within its strategic ambitions and is helping to deliver positive outcomes for some of the most vulnerable residents of Cambridgeshire, many of whom have complex needs, are economically disadvantaged and socially excluded.

5.2 Providers have proactively worked with the Council to align with the new model and current monitoring data is demonstrating the very positive impact that the services are having, as well as the difference they are making to the lives of individuals.

5.3 By supporting individuals within these services, the Council is also helping to prevent people's needs from escalating to a level where they would require crisis or higher need services, thus increasing pressure on statutory services and resources.

5.4 Extending the contracts will allow the council to continue working with the providers and wider partners to deliver further improvements and innovations, starting with the planned implementation of the new Cost Benefit Analysis approach will also help to evidence the wider benefits of the service.

6. Significant Implications

Report authors should evaluate significant implications using the sub-headings below. Each specific implication must be signed off by the relevant officer within the Council (or external advisors) and included in the table below for the Executive Director to review before the final report is submitted to Democratic Services (who will delete the table) for publication.

You will also need sign off by the Corporate Clearance Group (CCG) at the relevant CCG meeting.

Further guidance and a checklist containing prompt questions are included at Appendix 1.

6.1 Finance Implications

What are the finance implications?
Please see section 3.9 of the report

6.2 Legal Implications

What are the legal implications?
No legal implications identified.

6.3 Risk Implications

What are the risk implications?
These are highlighted in Sections 2.1, 3.3 and 4.1

6.4 Equality and Diversity Implications

What are the equality and diversity implications?
These services support significant numbers of people experiencing multiple disadvantage, rough sleeping and repeat homelessness. Removal or reduction of these service would impact on their access to support and lead to much poorer outcomes for them and contribute to increased rough sleeping.

6.5 Climate Change and Environment Implications

What are the climate change and environment implications?
None identified.

7. Source Documents

None

Appendix A – Case studies

Example One

Name of provider and service:

The Ferry Project

Contact person for any queries:

Keith Smith

Client identifier (e.g. initials, code etc):

LM

Background/Crisis/Issues (Where was the client before, what was the situation that led to them needing this support service, what needs are you supporting them with?

LM is a 44-year-old lady who was referred to our service following on from a discharge from Hospital.

Client had been smoking heroin heavily prior to admission and had been taken into hospital.

Client was admitted to hospital with Liver swelling, and was treated for Sepsis, thrombocytopaenia and heart failure.

Her Mobility was severely impaired due to acute swelling in both of her legs and was unable to walk without the use of crutches.

Client had been staying with her son however due to overcrowding could not return there.

Client had been known to our service historically and had successfully enjoyed a sustained period of both work and managing her tenancy.

This came to an end after approximately 2 years as she returned to substance misuse.

Whilst LM does have family connections in the area these cannot always be relied upon as a trusted network of support.

Her drugs misuse historically has meant she has served custodial sentences and has been abused sexually.

Actions/Support (what have you done to support them and how have you helped them access other support?)

Client has been supported to register with local drug recovery service and has been assisted with booking and attending appointments.

We liaise weekly with LM's assigned recovery worker on progress and updates.
At time of writing LM has been abstinent totally on drugs misuse since discharge from hospital and appears to be enjoying this abstinence and the support she is receiving.
LM attributes her determination to successfully recover from misuse to recently becoming a grandmother and sees this as a responsible role.

LM has engaged well in her health recovery, and this can be visibly seen in her improved mobility and general presentation.

Client is assisted with booking medical appointments and attending them where appropriate.
Whilst many of her medical conditions will be lifelong by providing this support, we are able to ensure that her needs are met as best as they can be.
Evidentially we have provided support to gain asthma inhalers, non-opiate pain killers to under pin her drug tests at recovery services in addition to support with ordering other medication.

From a financial perspective we have supported LM in maximising benefits by putting in for both PIP and WCA considerations and her journey will be health orientated.

LM has displayed that she can when abstinent from Drugs misuse budget and manage her income and expenditure well.

LM also is upskilling on her spoken English by attending weekly ESOL courses.

Comments (what difference or impact has the service made to the person's life? Have any potential scenarios been prevented or delayed as a result of support received e.g. hospital admission, recall to prison etc?)

Criminal convictions have been avoided, thanks to hub staff intervention.
Engagement with the appropriate health services has been coordinated, meaning LM may recover in the future, or there may be a way to manage her symptoms long term.

Street homelessness was prevented by managers and the key worker agreeing to bring LM back into a supported living environment and work in a bespoke way.

Pressure from the DWP has been eased, meaning LM will not be forced back into employment while so unwell; there were many risks associated with that scenario.

LM may see an increase in her income if the PIP and WCA applications are successful.

LM now has an identifiable pathway back to accommodation and can receive our support for a prolonged period.

LM has been able to build a solid relationship with her key worker and is able to be open and honest about challenges she faces.

Example Two

HRS Monitoring Case study template

Name of provider and service:

CHS Group – Corona House

Contact person for any queries:

Client identifier (e.g. initials, code etc):

AR

Background/Crisis/Issues (Where was the client before, what was the situation that led to them needing this support service, what needs are you supporting them with?

AR moved into Corona House after a period of homelessness. She had a difficult family background, resulting in her being taken into care as a child and through her late teens and twenties, experiencing nearly a decade of unstable housing with periods of homelessness, living in hostels and living in her partners' homes. AR received a diagnosis of EUPD shortly before moving into Corona House, she experienced extreme emotional states that she felt completely overwhelmed by, and this appeared to have contributed to her housing situation. AR had also self-medicated since her mid-teens, with alcohol and later cocaine, and to this day, is reliant on cannabis to regulate her mood. AR had been unable to work, had difficulty trusting others including professionals, and difficulties with regulating her emotions and behaviour. She had a court date coming up because of an incident resulting in two charges of assaulting a police officer.
AR found all relationships challenging due to her past experiences and emotional health needs. She has tendencies to view others and their actions as good or bad and therefore found it difficult to accept honest mistakes and occasions when things might not turn out the way she imagined they would.
This resulted in intense relationships that could be stormy and disruptive; hurtful for those in them and difficult for others witnessing the disruption. A's friendships

and intimate relationships were fraught with arguments, cold wars and sometimes physical violence. Several times at Corona House, A's partner was banned for several months due to the severe disruption caused by their incidents of conflict. AR was good at looking after her flat and kept it very clean and tidy. She had pets that were very important to her and took good care of them. She did not like having debts but found budgeting an enormous challenge. She felt she needed to collect items for her future to feel safe, and thus shopped compulsively. This also meant that she had to be very organised in her flat – because there was very little space remaining!

She was very anxious about interaction with others, and needed support with phone calls, appointments, attending activities etc.

While living at Corona House, A had a stroke resulting in partial sight loss and brain injury impacting her memory and concentration and causing regular fatigue and headaches. This also led to her being diagnosed with a heart condition and a decision to carry out heart surgery in the near future. This was a devasting blow for her as a young woman (26 years old) and her mental health deteriorated as a result of this for a period of time. A was angry at what had happened to her and keen to place blame somewhere. This resulted in many episodes of extreme anger towards health professionals and staff at Corona House.

Following her stroke, A did not feel confident to go out alone and required staff or a friend/family member to go with her to the shops and all appointments. The stroke also delayed her moving on, so she lived at Corona House for around one year with significantly increased support needs, particularly as she felt she could not do things independently.

Actions/Support (what have you done to support them and how have you helped them access other support?)

- **Support to access and attend courses and activities:** A enjoyed coming to some of the Corona Community sessions and would come if a member of staff she trusted would be there with her. A also undertook a few online courses whilst at Corona House. Some of these were completed as part of her probation requirements.
- **Referrals to financial support and foodbank vouchers:** A struggled to make her money last and frequently needed some support planning her spending or accessing grants to top up her income.
- **Support to make and access medical appointments:** A had many health issues before she had the strokes, including asthma and IBS. The stroke caused lots of health complications and A had various teams she had to meet with and required staff to attend these appointments with her.
- **Support to manage reminders for medication and appointments: T**he strokes affected A's capacity to remember details and she needed help to diarise appointments and remember to look at her calendar.
- **Support to access legal aid and communicate with the courts:** This was with regards to the assault case.
- **Referral for a free laptop**
- **Funding for a punchbag to support emotional regulation:** This was accessed through the CHS support fund.

- **Support with social interactions:** A would regularly show us text messages and get support with how to respond and reflect on what was reasonable in her relationships.
- **Support to apply for a provisional driving licence**
- **Support with relationships and boundaries**
- **Support with claiming benefits**
- **Support with managing sexual health and contraception**
- **Funding to get bike mended**
- **Support with moving on to permanent independent accommodation**

Comments (what difference or impact has the service made to the person's life? Have any potential scenarios been prevented or delayed as a result of support received e.g. hospital admission, recall to prison etc?)

Corona House and the support offered provided A with a stable home for the first time since she was 16. A was supported and worked hard to manage and regulate her emotions; at times it was extremely difficult for A and the staff team to manage her outbursts, but over time she learned to deal with her fluctuating emotions well. This helped her to cope with moving on from Corona House which had really become a safe haven for her and to move into permanent independent accommodation, avoiding the revolving door of homelessness that she had previously experienced. A was very devoted to her pets and has now got 5 cats and a dog.

When A had her stroke the support that was offered prevented her needing hospital admissions, staff managed and supported her with all her appointments, helping with travel to keep her numerous appointments.

When A moved in, she was involved with the courts and probation, staff supported her through the entire process, dealing with her high anxiety and emotional regulation, which then prevented her becoming involved in any more altercations and further involvement with the criminal justice system