Newcastle City Council

Homelessness Prevention Trailblazer

Multidisciplinary team

Summative review

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Contents

Executive summary

Background and purpose *(section 1.1)*

On 17 October 2016 the Prime Minister launched a new Homelessness Prevention Programme, announcing that Newcastle was one of only three national 'early adopters' for the Homelessness Prevention Trailblazer part of the programme. As part of our Homelessness Prevention Trailblazer programme, we have developed and appointed a multidisciplinary team who started working together on 9 October 2017.

The team is comprised of the following specialist caseworkers:

1. **Housing** – secondment of an Income Recovery Officer from Your Homes Newcastle (YHN)
2. **Welfare rights** – outposting of a Welfare Rights Officer from Newcastle City Council
3. **Debt and budgeting** – outposting of a Debt Advisor from Newcastle City Council
4. **Employment** – loan of a Work Coach from Jobcentre Plus

There are three primary aims of the multidisciplinary team:

- To deliver integrated casework on housing, financial and employment issues for residents facing certain issues or changes in circumstances, or where existing services aren't designed to meet the intensity of support required
- To provide infrastructure support to help services and organisations to adapt to meet the challenges of a reduced welfare state and to strengthen our local system
- To capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice.

This report presents the learning captured during the multidisciplinary team's initial pilot to 29 March 2019.

The structural context of the team's work *(section 1.3)*

Poverty

Bramley and Fitzpatrick's (2018) seminal article underlined the centrality of poverty in determining an individual's risk of homelessness. The authors argue that their findings both reinforce the need for policy action on homelessness and highlight opportunities for targeted preventative interventions for high risk groups. The North East has among the highest number of deprived areas and the Index of Multiple Deprivation shows that Newcastle is among the 20% most deprived English local authority areas. In turn, over a fifth of Newcastle's population live in areas that are among the 10% most deprived in the country (Casla et al., 2018)[1].

Austerity

Local authorities experienced a 49% reduction in government funding for local authorities in England in real terms between 2010 and 2018 (National Audit Office (NAO), 2018). The level of cuts has varied significantly between local authorities. As a general rule, the higher the level of deprivation, destitution, and severe and multiple disadvantage, the more severe the cuts (Hastings et al. 2015, 2017). Watts et al. (2019) find that Newcastle is one of the very worst affected local authorities in England, with real cuts of 32% or £461 per head between 2010 and 2018. Newcastle City Council (NCC) (2018) estimate a £327 million reduction in its budget by 2022-23.

[1] See section 5.3.1 for an overview of how the households the multidisciplinary team are working with are largely clustered around the 10% most deprived areas

Welfare reforms

Since 2010, the UK government have undertaken unprecedented changes to the welfare system (NAO, 2015). Beatty and Fothergill (2016) estimate that between 2010 and 2021, £27 billion a year will be lost from benefit entitlements, equivalent to £690 a year for every adult of working age. As with local authority budget cuts, Newcastle is among the worst affected of the core cities by welfare reforms (Watts et al. 2019). Newcastle City Council estimate an annual loss of £122 million in working age benefits amongst 40,000 Newcastle residents by the end of 2022-23 (Munslow, 2018). Although the scale of the reductions to welfare benefits is significant, it is also important to recognise the intensity of the rate of these reforms and the role of particular reforms in impacting residents in Newcastle. The removal of the spare room subsidy (commonly referred to as the "bedroom tax") and the benefit cap are both reforms that have had a significant and lasting impact on residents in the city. Newcastle is also the first of the Core Cities to have the Universal Credit 'full service' in all our jobcentres. Watts et al. (2019) described this as contributing to a triple burden of challenges in homelessness prevention for the city (alongside the overall impact of the welfare reforms and local authority cuts).

Debt

Parallel to austerity and the welfare reforms, there is also evidence to suggest that more people are experiencing problem debt in the UK. The NAO (2017) estimated that 8.3 million UK residents are in problem debt. The Trades Union Congress (TUC) (2018) identified that unsecured debt per household rose to £15,385 in the third quarter of 2018, which is up £886 on a year earlier and at a record high. In turn, unsecured debt as a share of household income is now 30.4% – the highest it's ever been, and above the level it reached in 2008 ahead of the financial crisis (27.5%). The combination of these factors creates an extremely challenging context for the team's work, underpinned by poverty and compounded by austerity, welfare reforms and growing personal debt.

Methodology *(Chapter two)*

An action research informed approach (Section 2.1)

Since the pilot's inception, a key aim of the multidisciplinary team has been to capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice. To do so, research was embedded alongside practice using an action research informed approach. Such an approach highlights the importance of partnership and participation between research and practice and, therefore, between researchers and practitioners.

The team's periodic review process (Section 2.2)

The team's periodic review process was developed during the team's first month together (October 2017) in which they established the foundations for their work (see section 3.1). This process was developed through a participative approach involving both the specialists working on the team and the researcher aligned to the project. The review process involves a number of stages and culminates in quarterly reports that explore the team's work with residents and own perspectives on working in a multidisciplinary way (see figure 1 in section 2.2). At each stage, the team are involved in data collection and analysis to help to embed research alongside practice, encouraging the team to think about the service they are delivering, as well as the systemic and structural context they are working in.

The summative review methodology (Section 2.3)

The summative review of the team's work took place between March and May 2019 and drew together key learning from the pilot to provide direction for the next phase of the team's work,

funded through Newcastle City Council's Life Chances fund. The review was designed by the embedded researcher with input on each aspect from specialists on the team and the team's Steering Group. It drew on a variety of data sources and methods, combining data that has been systematically captured through the team's periodic review process with a case review, a telephone survey with residents, and reflective one-to-one interviews with team members.

The team's approach *(Chapter three)*

Establishing the foundations (Section 3.1)

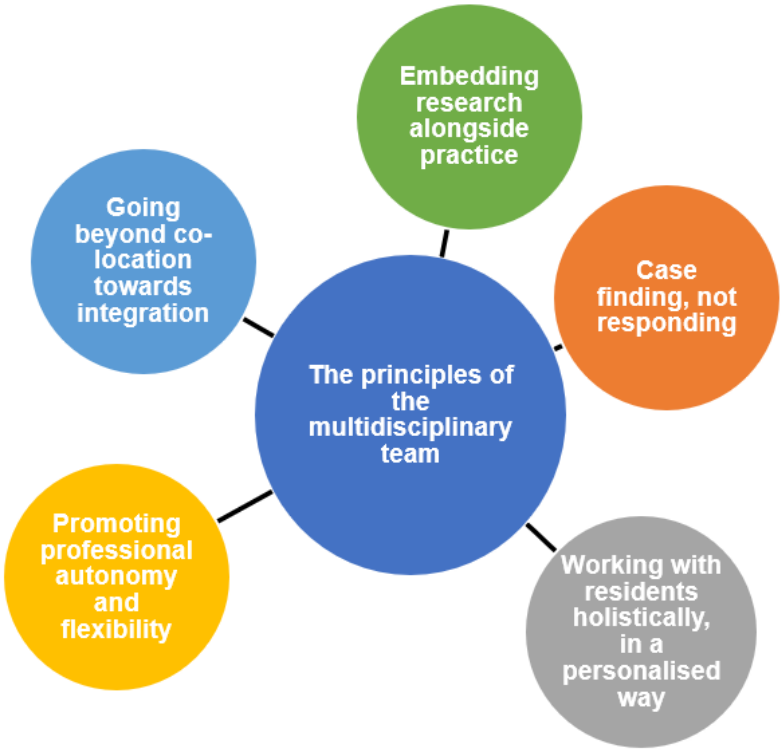
The team undertook a month-long induction process, based around workshops and team development activities. Over this period, the team established a foundation of agreed policies, protocols and processes to support engaging and working with residents in a safe and effective manner. The importance of this period in guiding the team's work was emphasised in the team's reflections on multidisciplinary working.

Matrix management arrangements (Section 3.2)

The multidisciplinary team drew together practitioners from four different specialisms and three different organisations. As the project was a pilot, it was not sensible to seek to replace current line management responsibilities, particularly as one of the specialists was on loan from the Department for Work and Pensions (DWP) rather than being seconded. Therefore, a matrix management system was established where individual specialists retained their current line management within their respective organisations but the direction of the work they undertook was determined by the aims of the pilot.

The team's principles (Section 3.3)

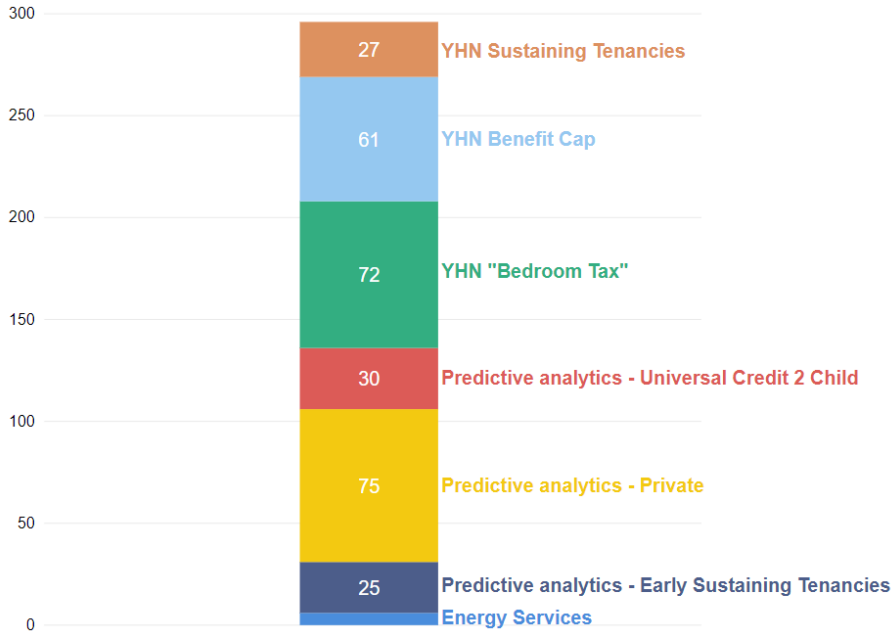
There are five principles that guide the team's work. These principles had their origins in the team's first month together but were only formalised towards the end of the pilot period, in line with the team's inductive approach to capturing learning. These principles are outlined below and described in more detail in a separate document available as part of a suite of reports and resources developed through Newcastle's Homelessness Prevention Trailblazer.



Identifying residents *(Chapter four)*

As highlighted within the principles above, the multidisciplinary team do not take referrals, instead they proactively identify residents they think may be at risk of homelessness in the future. Case finding is *"a systematic method typically used to identify individuals who are at high risk* (Ross et al., 2011). Case finding approaches are much less common in welfare services, or those focused on homelessness prevention. However, targeted preventative interventions for groups of residents at higher risk of homelessness are suggested by Bramley and Fitzpatrick (2018). In turn, as they launched the Homelessness Prevention Trailblazer fund, the Ministry of Housing, Communities and Local Government (MHCLG) explicitly highlighted that Trailblazer authorities should *"collaborate with other services and / or use data to identify at-risk households and target interventions well before residents are threatened with the loss of their home".*

The team have identified 296 households, establishing seven routes into the team by working with partners and by testing the use of predictive analytics.



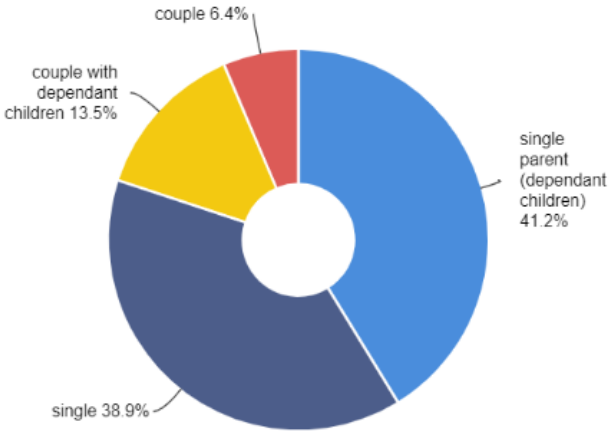
Understanding residents better *(Chapter five)*

On a weekly basis, between five and ten cases were selected from the routes outlined in the previous section. It is important for the team to adapt their methods of engagement to the needs of residents. Therefore, in-depth screening is undertaken by each member of the team on their respective databases to offer a detailed overview of each resident. Once the screening has been completed, the cases are discussed at a weekly case identification meeting where the team share information and determine how they will seek to establish contact and engagement from the resident and develop a provisional plan of work that could be done with them.

Household composition (Section 5.1)

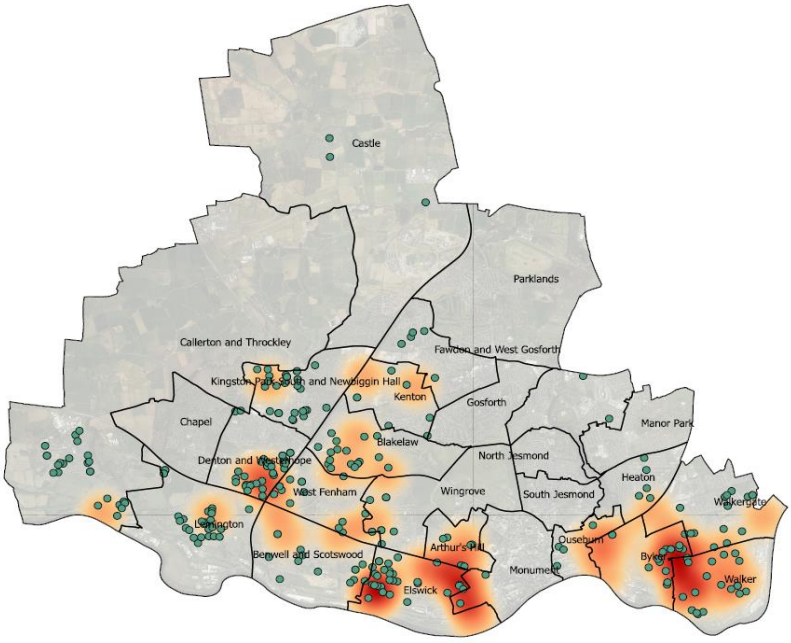
The majority of households approached by the team were either single parents or single adults without dependant children. The high proportion of households that have a female as their main resident is perhaps surprising given that the population of people who are homeless is often male dominated. Targeting female residents was not an explicit goal of the multidisciplinary team but can be partially explained by the targeting of residents affected by the benefit cap (see section 4.1.1) and the Universal Credit 'two child limit' (see section 4.1.2). Each of these routes were

predominantly orientated towards single parent households. All of the single adult households through the benefit cap route and 90% of those identified through the Universal Credit 'two child limit' were female, in line with the prevailing trend that single parent families tend to be headed by a female.



Deprivation (Section 5.3.1)

The team did not specifically intend to target households in the most deprived areas. Nevertheless, there is a clear correlation between the households approached by the team and the areas of Newcastle with the highest levels of deprivation.



Debt, deductions and Discretionary Housing Payments (Section 5.3.2)

Although poverty may be the dominant structural factor in determining risk, there are also intermediary factors that are essential when seeking to identify and ameliorate the risk of homelessness. In their first periodic review, the multidisciplinary team identified a trend among the residents they were working with. They noticed that many residents seemed to be locked in a cycle of debt, deductions and Discretionary Housing Payments (DHP)[2].

[2] DHP is a discretionary scheme that allows local authorities to make monetary awards to people experiencing financial difficulty with housing costs.

For many of the households in the benefit cap and “bedroom tax” routes, the effect of their rent shortfall on their arrears had been minimised by DHP awards. As a result, it is reasonable to assume that the level of arrears would be significantly higher if it was not for this ‘sticking plaster’ (Watts et al., 2019). The vast majority (67.6%) of residents identified by the team had received at least one DHP at the time of screening, with 15 residents receiving four or more awards. National DHP funding has dropped significantly in 2019-20. Given the importance of DHPs in preventing residents with significant shortfalls falling into homelessness, this policy change is particularly concerning. As a whole, these factors begin to demonstrate how significant structural changes brought about by the welfare reforms can lead to a significant and very tangible risk of homelessness.

Additional needs (Section 5.3.4)

The information collected by the team through their integrated triage and casework approach has revealed a high degree of variation and complexity amongst the lives of the residents they are working with. In total, 65.5% (n=194) of the residents identified by the team had some form of additional needs, beyond the specialisms of the multidisciplinary team.

The most common types of need identified were mental health issues and having previously been a victim of harassment or abuse, which were present for 20.9% and 20.6% of residents respectively. The next most common need was previous Children’s Services’ involvement, which was present for 15.9% of residents.

Relationships (Section 5.4)

In their summative case review, the team were asked to identify whether residents received positive financial, practical or emotional support from family or friends. Overall, there was a relatively low level of positive support available to residents supported by the team. However, where it was available it was often vital to the ongoing stability of residents’ situations.

During the in-depth screening process, the team identified additional needs that were present among known, close relationships[3] of the residents they had identified. The most commonly identified challenge was having previously been a perpetrator of harassment or abuse (most often domestic abuse). There was also a high level of NEETs[4] in households identified by the team.

Establishing contact with residents *(Chapter six)*

The team’s case finding approach is informed by their case identification screening. Through screening a variety of databases, the team are able to build a clearer picture of a household and question whether their case finding approach has directed them to the right residents. The team then adopt an approach to engagement that is guided by principles of being clear and honest in communications, flexible in their approach, coordinated across each of their specialisms, and persistent in their attempts to engage residents.

The team established contact[5] with the majority of residents they approached (57%). This proportion actually increases to 64.5% when we discount those residents who the team were still attempting to contact at the time of the review or those that they decided not to contact after their in-depth screening process.

[3] Non-dependant relationships include residents’ siblings, adult children, partners and ex-partners, as well as friends or associates

[4] NEET refers to young adults aged between 18 and 25 years old who are not in employment, education or training

[5] Broadly categorised as where the team have made contact, agreed with the resident that they would be willing to work with the team and booked a follow-up appointment

Inactive case reviews (Section 6.1.1)

As highlighted in the above principles, the team seeks to be coordinated and persistent in their attempts to establish contact. A key aspect of this approach is the use of inactive case reviews. The team operate a policy of only 'closing' cases where they have stabilised the resident's situation. If they fail to maintain engagement with a resident, then they will make the case 'inactive'. They then conduct 'inactive' case reviews on a quarterly basis to avoid the resident missing out on support.

What it took to establish contact (Sections 6.2.2 and 6.3)

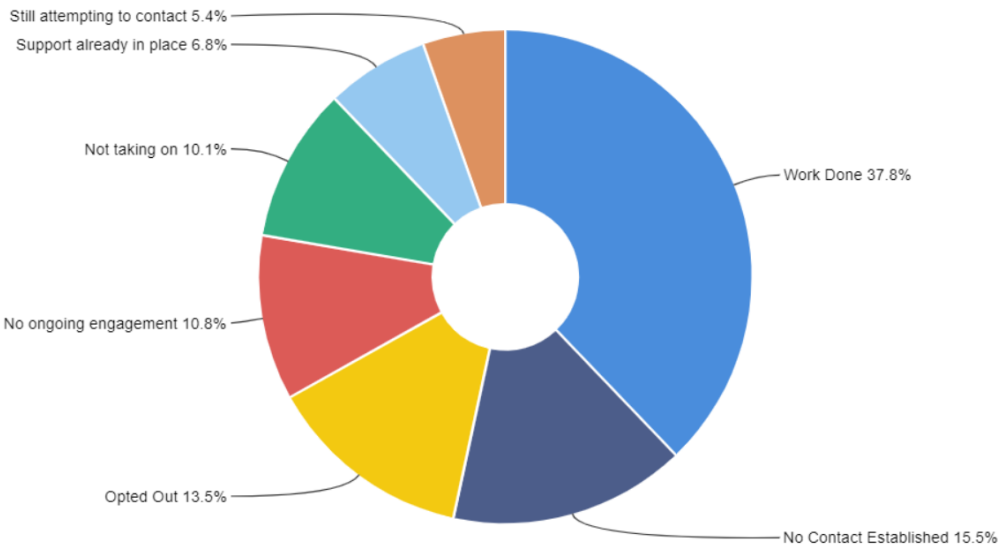
An average of four attempts were made before establishing contact with residents, with a maximum of 21 attempts made to a single resident. In turn, figure 19 shows that for the majority of residents (66.6%) more than three different methods were used by the team prior to establishing contact.

Both residents and the team identified the team's flexible and persistent approach to establishing contact as an important factor in establishing contact. The offer of home visits was also prominent in responses of each. Team members also stressed that home visits were not only important in establishing contact but also in retaining engagement and in supporting residents.

Supporting residents *(Chapter seven)*

Retaining engagement (Section 7.1)

It is important to explore rates of establishing contact to evaluate the efficacy of the team's case finding approach. However, it is also important to differentiate between where the team have established contact and where they have been able to retain engagement for a sufficient period of time to allow them to stabilise a resident's situation. As such, at their summative case review, the team classified cases according to the extent to which they had been able to retain engagement with residents. More detail on each of these categories is available in section 7.1. The team have been able to retain engagement to the point of 'work done' for 40% of residents (n=112). In addition, they have started work but not been able to retain engagement with an additional 11.4% of residents (n=32).



Case length (Section 7.2)

Of all of those cases where the team were able to establish contact and do some work with, the average (mean) case length was 177 days. At the end of the initial Trailblazer pilot period, the team's longest case was 544 days (and is still active at the time of writing).

Reflections of multidisciplinary working *(Chapter eight)*

A key aim of the multidisciplinary team is to test integrated, multidisciplinary working. Therefore, it is important to establish the key benefits of multidisciplinary working, as well as the key challenges faced by the team. These were captured through one-to-one interviews with individual specialists from the team.

The benefits (Section 8.1)

When asked what had worked well in supporting residents, all four specialists emphasised the **holistic nature of the team's work** and the support they offered to households. All four specialists reported that they felt that they had **more professional autonomy** in this role than their previous role, albeit to differing extents. When asked, specialists highlighted that this **greater autonomy had enabled them to adapt their approaches** to establishing contact and retaining engagement to individual residents, by trying different methods that in previous roles they would not have been able to employ (e.g. home visits[6]).

Specialists also noted that this **professional autonomy, alongside working in an integrated multidisciplinary approach, allowed them to be more holistic in the way they supported residents**. Specialists consistently highlighted that they felt working in a multidisciplinary team has **enabled professional development**, as well as improving the service they offer to residents. Specialists articulated this in a number of ways but consistently highlighted the importance of working with specialists from other disciplines which enabled knowledge transfer. This, in turn, allowed specialists to develop their skills in other areas.

The facilitators (Section 8.2)

There was a number of facilitators highlighted by the team's specialists, each of which stressed the importance of developing structures that allowed for **an inductive way of working**. All of the specialists emphasised the importance of being able **to spend their first month together establishing the foundations for how they would work together**. This helped to promote a shared ownership of the direction of the team's work and allowed them to get to know each other as professionals and people. This was essential for **establishing a shared culture within the team through developing a mutual trust between specialists and with the embedded researcher**.

As this structure was co-produced by the team it contributed to a more integrated approach based around individual households. However, some specialists also recognised that integration did not come immediately but had to be worked at over time. The team's process for capturing learning allowed structures to be reviewed and improved.

Their perspectives also reveal that, like being part of designing the service, **the team enjoyed being involved in research that informed their practice**, and vice versa. The team's reflections revealed how this **research-informed approach encouraged a more democratic orientation to their work and helped develop a 'safe' environment** in which specialists felt that they could voice their opinions without fear of 'being wrong'.

[6] See section 6.3 for a discussion of the value of home visits in engaging and supporting residents

The challenges (Section 8.3)

Although the team's reflections on multidisciplinary working were overwhelmingly positive, they did also highlight some challenges that they have faced over the Trailblazer pilot period. Two specialists noted that **working within a small team** sometimes posed challenges to integrated working. They suggested that it may be desirable to develop a larger team, either by extending the number of disciplines or by having more than one specialist from each discipline, or both.

Another challenge highlighted by specialists was **balancing caseloads over time** and between specialists. To mitigate this issue, one specialist suggested staggering more than one route at a time, each with a different focus so that the team had a mechanism for balancing caseloads if they became unevenly distributed.

Working across a number of databases also brought challenges for this review in sourcing and triangulating all of the available evidence related to households' circumstances and the team's work. If the team are to continue in the long-term, more integrated databases incorporating different services would be an important enabler of better multidisciplinary working.

Outcomes *(Chapter nine)*

'Headline' outcomes (Section 9.1)

The majority of the residents that the team have identified face significant financial challenges[7]. The link between these financial challenges and homelessness is largely mediated by a resident's ability to pay their rent. Therefore, to demonstrate the impact of the team's work we looked at the change in the rent balance of the residents identified by the team, looking at whether residents have reduced their immediate risk of homelessness by reducing arrears or increasing credit on their rent accounts. Of course, changes to rent balances can be fleeting and do not necessarily indicate affordability in the longer term. Therefore, the team also looked at the difference between the amount residents receive through benefits for their housing costs and their rent (their rent shortfall) and their eligible rent as a percentage of their remaining income. Both of these measures allow for greater interrogation of the extent to which the team have been able to stabilise a resident's situation and reduce their risk of homelessness. The figures below outline the outcomes for those residents who the team have been able to work with (the 'work done' category).

Although indicative rather than definitive, the 'headline' findings presented above broadly suggest that the team have reduced the risk of homelessness for those households they have been able to work with. These findings have a bittersweet tone to them. They show that the team's work is effective in reducing the risk of homelessness but for those that the team were unable to engage,

[7] See sections 1.3 on the context of the team's work and section 5.3.1 and 5.3.2 for the financial challenges faced by the residents they have identified

the risk of homelessness has persisted and even worsened (see section 9.1). For more detail on the outcomes achieved in individual domains, see section 9.2.

Integrated outcomes (Section 9.3)

Through analysis of the summative case review data, it was possible to explore the extent to which the team had gained outcomes across the four domains of their work (housing, finance, benefits and meaningful activity/work).

This analysis revealed that the team gained outcomes across more than one specialism for 84 different households. Outcomes across two specialisms had been achieved for 51 different households, outcomes across three specialisms had been achieved for 29 households and outcomes across all four of the team's specialisms had been achieved for 4 households. Integrated outcomes were most commonly achieved across the "bedroom tax" and benefit cap routes, with these two routes being the only ones to include households for whom the team have achieved outcomes across all four domains.

Influencing policy and practice *(Chapter ten)*

National policy and practice (Section 10.1)

A key aim of the pilot was to *'capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice'*. This report is the culmination of the team's attempts to capture the learning from their work over the pilot. Throughout the pilot, the team have sought to influence local and national policy and practice. They have done so by combining quantitative data with the stories and perspectives of individual residents to demonstrate the challenges of those people they have identified, approached and supported, sharing these with policy makers and decision makers to evoke progressive change in the systems and policies that influence these residents' lives.

The team have supported submissions made to three parliamentary inquiries during their pilot. In addition to submitting evidence to inquiries, the team have also taken opportunities to highlight the challenges faced by the households they support to government departments, intergovernmental bodies and other practitioners and policy makers. Details of the team's work influencing national policy and practice is outlined in section 10.1.

Local policy and practice (Section 10.2)

As well as seeking to influence national policy and practice, the team recognise that local policy and practice also has a significant role in determining the circumstances in which residents live. The team have sought to influence local policy and practice in two key ways; by conducting 'in-depth case reviews' (see section 2.2.2) that focus on specific issues that have emerged through their periodic review process, and by providing infrastructure support to other professionals. Details of the team's work influencing local policy and practice is outlined in section 10.2.

Final discussion and conclusions *(Chapter eleven)*

The team sought to identify, approach and support residents at greater risk of homelessness at an earlier stage. What they found was a majority of residents living in precarious, complicated and burdensome circumstances that have been worsened by welfare reform policies since 2010. What they also found were some successes and failings with the local system in the way residents with integrated challenges are supported.

The team have made an important and sometimes vital impact on the lives of many of the households they have supported. However, for those the team could not make contact or retain engagement with, there is evidence to suggest that their situations worsened. In turn, although the team stabilised the situations of many, they were not often able to remove the shortfalls most households had between their housing costs and the entitlements they received to pay these costs.

The structural context in which the team work is one underpinned by poverty and informed by national policies of welfare reform and austerity that are regressive in their approach to supporting people out of poverty. As demonstrated at various points in this report, triggering an income shock by reducing welfare benefits to residents in vulnerable circumstances doesn't incentivise them to start work when their original issues still exist (Dwyer et al., 2018). That income shock only serves to add complexity to what can already be complex lives. It also diverts the costs to other publicly funded organisations who are subsequently providing advice and support to prevent and respond to the increased risks of financial hardship and deprivation. Due to this, it is our belief that the UK's welfare system is no longer an effective safety net to protect against hardship and chronic deprivation.

In this context, one team can only do so much through direct support, they cannot move households out of poverty or reverse the impact of welfare reforms. However, they can seek to make a more significant difference by combining practice, research, policy and advocacy. This helps to develop a deeper understanding of each household's circumstances and promotes more compassionate and empathetic responses to the challenges they face. The team have highlighted the consequences of failings in national and local policies and, in line with an action research approach, they have sought to influence progressive change. The team have done so with the lived experience of those residents living with these consequences, and the professionals supporting them, at the core of their approach.

1. Introduction

1.1 – Background and purpose

On 17 October 2016 the Prime Minister launched a new Homelessness Prevention Programme, announcing that Newcastle was one of only three national early adopters for the Homelessness Prevention Trailblazer part of the programme, which is "a fresh government approach to tackling homelessness by focusing on the underlying issues which can lead to somebody losing their home". This public service transformation programme lasted from January 2017 to March 2019 and focused on the prevention of homelessness at an earlier stage by working with a wider group of residents at risk to help them before they reach crisis point.

As part of our Homelessness Prevention Trailblazer programme, we developed and appointed a multidisciplinary team who started working together on 9 October 2017. The team is aligned to the Active Inclusion Newcastle partnership aim of supporting residents to have a stable **life** – somewhere to **l**ive, an **i**ncome, **f**inancial inclusion and **e**mployment opportunities – and includes disciplines that provide specialist information, advice and support to contribute to delivering this aim. The team is comprised of the following specialist caseworkers:

1. **Housing** – secondment of an Income Recovery Officer from YHN
2. **Welfare rights** – outposting of a Welfare Rights Officer from Newcastle City Council
3. **Debt and budgeting** – outposting of a Debt Advisor from Newcastle City Council
4. **Employment** – loan of a Work Coach from Jobcentre Plus

There are three primary aims of the multidisciplinary team:

- To deliver integrated casework on housing, financial and employment issues for residents facing certain issues or changes in circumstances, or where existing services aren't designed to meet the intensity of support required
- To provide infrastructure support to help services and organisations to adapt to meet the challenges of a reduced welfare state and to strengthen our local system
- To capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice.

1.2 – Structure of report

The remainder of this report is structured within 11 chapters. The remainder of chapter one provides a brief summary of relevant literature related to poverty, austerity, welfare reforms and personal debt to provide important context for the team's work. Chapter two then outlines the methodological strategy that has informed the team's approach to capturing learning and their work more broadly, before detailing the methodology that informed the team's summative review, at the end of their initial Homelessness Prevention Trailblazer funded pilot. Chapter three briefly outlines the team's ways of working, emphasising the importance of having a formative period together to begin developing a shared culture. Chapter four describes how the team identified residents using a 'case finding' approach, including their reflections on testing the use of predictive analytics. Chapter five outlines how the team used 'in-depth screening' to develop a personalised approach for establishing contact with and supporting residents. This chapter also presents a profile of some of the characteristics and circumstances of the households the team have identified. Chapter six explores how the team have established contact with residents and discusses the extent of their success in doing so. Chapter seven describes how the team have supported residents, building on the principles discussed in chapter three before chapter eight presents the team's own perspectives on multidisciplinary working, using their previous roles as

the main point of comparison. Chapter nine then highlights the outcomes the team have achieved with residents across their specialisms, as well as looking at the overall impact of the team's work on resident's financial situations. Chapter ten focuses on the latter two of the team's primary aims by highlighting how they have sought to influence positive change in policy and practice on a local and national level. Finally, chapter 11 discusses the key findings from the pilot as a whole before providing conclusions on the extent to which the team have achieved their aims.

1.3 – The structural context of the team's work

This section looks briefly at the structural context of the team's work, primarily focusing on those factors that contribute to increasing the risk of homelessness among certain groups. Section 1.3.1 highlights the centrality of poverty in determining the risk of homelessness before sections 1.3.2 and 1.3.3 highlight the compounding effect of the welfare reforms and austerity on households living in relative poverty. Finally, section 1.3.4 looks at the rise of personal debt in the UK.

1.3.1 – Poverty

Bramley and Fitzpatrick's (2018) seminal article underlined the centrality of poverty in determining an individual's risk of homelessness. In particular, they highlighted the importance of childhood poverty as well as the wider impact of broader labour and housing market contexts. An increasingly prominent aspect of the housing market context in England is the sharply rising numbers of individuals made homeless from the private rented sector (Assured Shorthold Tenancy), with a 400% increase from 2009-10 to 2016-17 (Fitzpatrick et al., 2018; 2019).

Bramley and Fitzpatrick (2018) argue that their findings both reinforce the need for policy action on homelessness and highlight opportunities for targeted preventative interventions for high risk groups. In a small way, this project seeks to develop targeted preventative interventions for groups of residents we have identified as at higher risk of homelessness (see chapter four for an overview of how we identified residents).

The North East has among the highest number of deprived areas and the Index of Multiple Deprivation shows that Newcastle is among the 20% most deprived English local authority areas. In turn, over a fifth of Newcastle's population live in areas that are among the 10% most deprived in the country (Casla et al., 2018)[8]. 19.9% of households in Newcastle are workless (compared to the UK average of 14.5%) (HM Revenue & Customs, 2016). Further, levels of child poverty are significantly higher in Newcastle than the national average with 29.1% of dependent children in Newcastle living in low income families (compared to the UK average of 19.9%).

In addition to this already challenging context of poverty, reductions in public spending and welfare reforms have also had a significant impact on residents in Newcastle, as well as the services that support them.

1.3.2 – Austerity

Local authorities experienced a 49% reduction in government funding for local authorities in England in real terms between 2010 and 2018 (NAO, 2018). Central government departments have not been immune to cuts either, the Department of Work and Pensions experienced a reduction in spending of 31% between 2010-11 and 2015-16 (NAO, 2015), at the same time as delivering unprecedented welfare reforms described in the next section.

In turn, the level of cuts has varied significantly between local authorities. Perhaps the most striking trends are that, as a general rule, the higher the level of deprivation, destitution, and

[8] See section 5.3.1 for an overview of how the multidisciplinary team's cases are largely clustered around the 10% most deprived areas

severe and multiple disadvantage, the more severe the cuts (Hastings et al. 2015; 2017). Watts et al. (2019) find that Newcastle is one of the very worst affected local authorities in England, with real cuts of 32% or £461 per head between 2010 and 2018. Newcastle City Council (NCC) (2018) estimate a £327 million reduction in our budget by 2022-23.

The scale of the cuts to local authority budgets is great, particularly in Newcastle. In providing evidence to the Housing, Communities and Local Government Committee (2019) Professor Tony Travers from the London School of Economics highlighted that the scale, intensity and the long time period over which the reduction in local government spending has taken place is without parallel in modern times. The next section outlines a similar picture in relation to the extent, intensity and scale of the welfare reforms across the UK, and in Newcastle in particular.

1.3.3 – Welfare reforms

Since 2010, the UK government have undertaken unprecedented changes to the welfare system (NAO, 2015). Beatty and Fothergill (2016) estimate that between 2010 and 2021, £27 billion a year will be lost from benefit entitlements, equivalent to £690 a year for every adult of working age. As with local authority cuts, the authors also highlight that, as a general rule, the more deprived the area, the greater the financial loss. As with local authority budget cuts, Newcastle is among the worst affected of the core cities by welfare reforms (Watts et al. 2019). Newcastle City Council estimate an annual loss of £122 million in working age benefits amongst 40,000 Newcastle residents by the end of 2022-23 (Munslow, 2018). Given the evidence outlined above, it is perhaps unsurprising that Watts et al. (2019) note that Newcastle appears to be receiving among the greatest impacts across the core cities for the combined impact of the local authority cuts and welfare reform (£838 per capita, around £2,100 per household).

Although the scale of the reductions to welfare benefits is significant, it is also important to recognise the intensity of the rate of these reforms. Between January 2014 and December 2018, Newcastle City Council have identified over 120 important benefit changes that have affected residents in the city (NCC, 2019). Although no single household will be affected by all of these reforms, the scale and frequency of these changes places greater pressure on residents (and the services supporting them) to identify, understand, and transition. Since 2010, there has also been an "expansion and intensification of welfare conditionality", placing greater responsibility on claimants to move towards employment (Dwyer et al., 2018). However, the Welfare Conditionality Study found that this was largely ineffective in facilitating people's entry into or progression within the paid labour market over time.

In addition to the overall scale and rate of reform, particular reforms have also had a significant impact in Newcastle. At 31 March 2019, there were 2,380 residents affected by the removal of the spare room subsidy (commonly referred to as the "bedroom tax") across the city[9]. In a qualitative study of the impact of the "bedroom tax" in Newcastle, Moffatt et al., (2015) found that it has increased poverty and had broad-ranging adverse effects on health, wellbeing and social relationships within this community. At 31 March 2019, there were also 244 households known to be subject to the benefit cap in Newcastle[10]. Newcastle City Council argue that the benefit cap can place some vulnerable residents at risk of homelessness and destitution. In their report from the re-opened benefit cap inquiry, the Work and Pensions Committee (2019) recognised *"the work that many local authorities are doing – often at the expense of their own resources – to identify and support capped households is a vital tool in mitigating some of the hardship the cap creates".* They also highlighted concerns that the benefit cap disproportionately impacts households the

[9] https://newcastle.gov.uk/sites/default/files/Council%20Tax/SSSC%20March2019.pdf
[10] https://newcastle.gov.uk/sites/default/files/Council%20Tax/Bencap%20claims%20March%202019.pdf

DWP itself has recognised (through its own assessment) face barriers to moving into employment and are, therefore, not required to look for work. Childcare and health problems were noted as the major barriers to entering work for these individuals.

Newcastle is also the first of the Core Cities to have the Universal Credit 'full service' in all our jobcentres. The Universal Credit 'full service' was introduced at Newcastle City Jobcentre in May 2016, at Newcastle East Jobcentre in February 2017 and at the now closed Newcastle West Jobcentre in March 2017 (Horton, 2018a). As of 11 April 2019, there were 19,327 people on Universal Credit in Newcastle, according to official Universal Credit statistics[11]. Watts et al. (2019) described this as contributing to a triple burden of challenges in homelessness prevention for the city (alongside the overall impact of the welfare reforms and local authority cuts).

1.3.4 – Debt

Parallel to austerity and the welfare reforms, there is also evidence to suggest that more people are experiencing problem debt in the UK. The National Audit Office (2017) estimated that 8.3 million UK residents are in problem debt. They also highlighted that many residents face challenges managing their money, estimating that four out of ten people in the UK cannot manage their money well day to day. There was also evidence that more people are falling into personal debt, with a 19% increase in the proportion of reported debt problems relating to debts owed to government between 2011-12 and 2017-18.

The TUC (2018) identified that unsecured debt per household rose to £15,385 in the third quarter of 2018, which is up £886 on a year earlier and at a record high. In turn, unsecured debt as a share of household income is now 30.4% – the highest it's ever been, and above the level it reached in 2008 ahead of the financial crisis (27.5%). Between 2016 and 2018, 21% of those residents who worked with Newcastle City Council's debt advisors were identified as having 'unsustainable budgets'.

The rise in personal debt and residents with unsustainable budgets is worrying, but not particularly surprising. Welfare reform and austerity measures have disproportionately affected the poorest people in society, further reducing their income and the support services available to them. It is reasonable to assume that many of these individuals will be forced to take on personal debt to make up the difference between their living costs and their income. However, evidence presented later in this report (section 5.3.2) shows how this has led many households into greater precarity. The next chapter looks at the methodology used to collect and analyse the data contained in this report, as well as describing the team's overall approach to capturing learning.

[11] http://dwp-stats.maps.arcgis.com/apps/MapSeries/index.html?appid=f90fb305d8da4eb3970812b3199cf489

2. Methodology

This chapter outlines the methodology used to capture learning from the team's work over the course of their Homelessness Prevention Trailblazer funded pilot (9 October 2017 to 29 March 2019). Section 2.1 briefly describes the 'action research' approach that informed the methodology before section 2.2 outlines the formative process that was used to capture learning throughout the pilot, informing the team's approach throughout. Finally, section 2.3 describes the methods used to complete a summative review of the team's work at the end of the pilot period.

2.1 – An 'action research' informed approach

Since the pilot's inception, a key aim of the multidisciplinary team has been to capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice (see section 1.1). To do so, research was embedded alongside practice using an action research informed approach. In action research and this pilot, research and practice are intended to complement one another. Elliot et al. (2016) describe action research as *"an open-ended cycle of identifying a problem, imagining, then implementing a solution, evaluating the experience with a focus on both the problem and the solution, then changing practice(s) according to what has been learned, and so on"*. Kemmis et al. (2013) particularly highlight the value of an action research based approach in bringing together action and reflection, theory and practice. In turn, they highlight the importance of partnership and participation between research and practice and, therefore, between researchers and practitioners. Particularly important to the approach is the concept of reflexivity, thinking consistently about the bidirectional relationship between cause and effect.

This pilot seeks to identify and test new ways of preventing homelessness at an earlier stage by focusing on the underlying issues that lead to people becoming homeless. In turn, the team are working within a period of unprecedented change to both the welfare system and public spending (see section 1.3). Therefore, a reflexive approach that focuses the interconnected factors that may lead a resident to be at risk of homelessness was essential to the team's work. Further, as the team come from different specialisms, partnership and participation in determining shared, multidisciplinary responses to residents' interconnected issues was also vital.

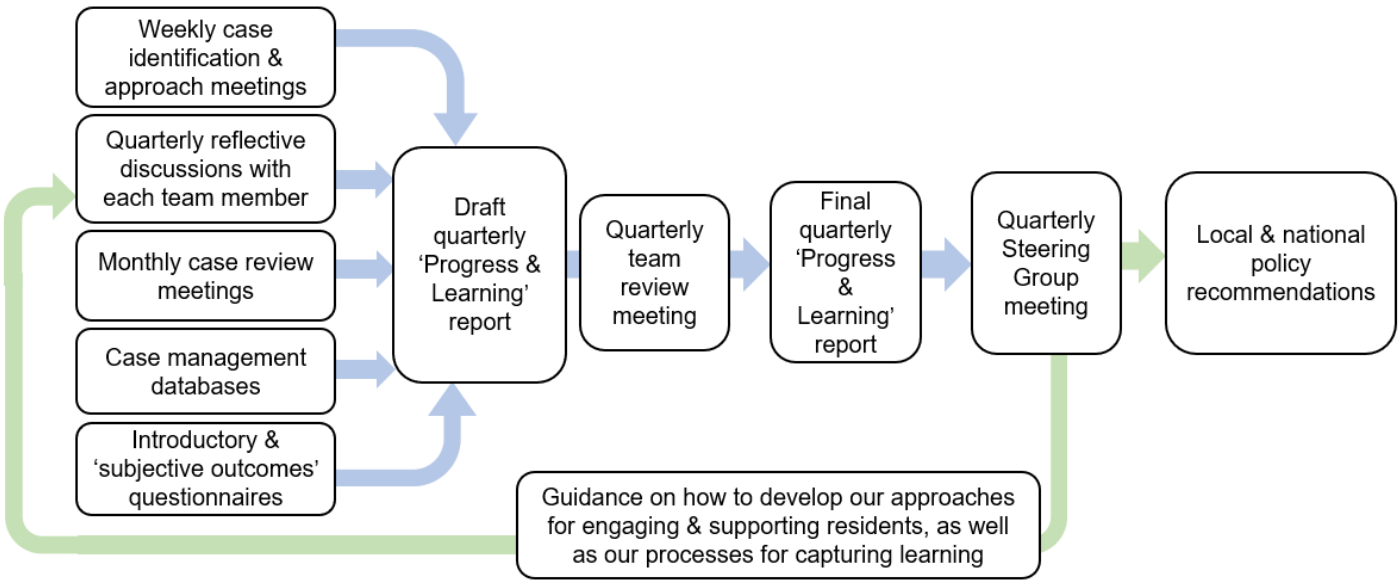
2.2 – Process for capturing learning

Research is embedded alongside practice in a number of interconnected ways in the multidisciplinary team's work. At the centre of this is the team's periodic review process.

2.2.1 – Periodic review

The team's periodic review process was developed during the team's first month together (October 2017) in which they established the foundations for their work (see section 3.1). This process was developed through a participative approach involving both the specialists working on the team and the researcher aligned to the project. The review process involves a number of stages and culminates in quarterly reports that explore the team's work with residents and own perspectives on working in a multidisciplinary way (see figure 1). The review process was designed to be sufficiently structured to capture broad trends related to the challenges faced by residents, and sufficiently flexible to explore these in more depth. At each stage, the team are involved in data collection and analysis to help to embed research alongside practice, encouraging the team to think about the service they are delivering, as well as the systemic and structural context they are working in.

Figure 1 – The team's periodic review process



2.2.2 – In-depth case reviews

The team's periodic review process allows the team to highlight trends that require further exploration. To explore these trends, the team conduct small scale research projects focused on particular areas identified through the team's process for capturing learning, such as Newcastle City Council's Sustaining Tenancies process and the extent, nature and impact of Children's Social Care involvement across their cases. In these research projects, the specialists work alongside the researcher to establish the parameters of the review, conduct secondary data analysis of relevant databases and develop in-depth case histories for comparison to identify themes and trends that may illuminate ways to improve the support offered to residents in Newcastle. These case reviews are written into short reports that are reviewed and disseminated through the team's Steering Group or other relevant channels. As part of the suite of reports and resources developed through Newcastle's Homelessness Prevention Trailblazer programme, a short guide to conducting in-depth case reviews has been developed and is available on our website at www.newcastle.gov.uk/homelessnesspreventionforprofessionals.

2.3 – Summative review

The summative review of the team's work took place between March and May 2019 and drew together key learning from the pilot to provide direction for the next stage of the team's work, funded through the Life Chances fund. The review was designed by the embedded researcher with input on each aspect from specialists on the team and the team's Steering Group. It drew on a variety of data sources and methods, combining data that has been systematically captured through the team's periodic review process with a case review, a telephone survey, and reflective one-to-one interviews with team members.

2.3.1 – Summative case review

The summative case review took place between 26 March and 5 April 2019 and systematically reviewed the outcomes for all 296 residents that the team had approached over the course of the pilot.

The team seek to work with residents in a holistic way, focusing on housing, financial, benefits and employment related support whilst also appreciating that work in these areas will inevitably involve

touching on other areas of residents' lives, including supporting other members of the household. The team also seek to work with residents until they feel that their situation has been stabilised, with some cases lasting over the entire course of the pilot (and beyond). As a result, there are a range of possible outcomes that can be achieved with households. Residents also face different circumstances, and cannot all achieve the same outcomes, making it difficult to define and measure success across residents.

As this is a pilot there was not sufficient time or capacity to develop a single database that would be able to meet the needs of each specialism represented on the team. In turn, each team member also needed to retain links with their respective specialisms, using the databases aligned to their specialisms to provide updates on cases and feed into wider review structures. The result of this is that the outcomes associated to each resident are disparately recorded in different locations according to the work done and the specialist who supported them.

In order to capture the wide range of outcomes possible, key outcome domains were first identified, relevant sub domains were then identified, and composite measures were used to measure success in that particular domain. For each individual resident, the team then systematically discussed and recorded the outcomes related to each domain using Microsoft Excel. The outcome domains, sub domains, composite measures and data used can be found in appendix 2.

2.3.2 – Reflective discussions

An important aspect of capturing the learning from the pilot was to capture the team's reflections on the benefits and challenges of multidisciplinary working. During each periodic review period, the team had reflective discussions with the embedded researcher exploring these benefits and challenges. The notes from these discussions were transcribed and analysed to identify themes in the team's perspectives.

During the summative review, each specialist took place in a longer, more in-depth one-to-one interview with the researcher. The interviews focused on broad topics such as 'engaging residents', 'supporting residents', 'the multidisciplinary approach' and 'next steps' and open questions were used to encourage the specialists to lead the discussion. The researcher also prepared summaries of key points made by each specialist during periodic reflective discussions to use as prompts during the interview. The interviews were audio recorded to ensure accuracy in quotations and notes were transcribed into discussion summaries. These summaries were reviewed and validated by the relevant specialist to ensure that they were a fair reflection of the interview. These summaries were then used as the basis for establishing the key themes that form the structure of chapter eight of this report.

2.3.3 – Telephone survey with residents

To supplement the summative case review and capture residents' perceptions of the team's work, a short telephone survey was devised. The telephone survey was developed over a number of iterations in conjunction with the specialists on the team. Closed survey questions explored residents' retrospective perceptions of the impact of the team's work on their housing, finances, welfare/benefits and jobs/other work-related activity, as well as reflecting on the impact on their overall wellbeing. After each closed question, the resident was asked to give the reasons for their response, allowing more clarity on residents' perceptions.

The survey was carried out after the summative case review in late April and early May 2019. As the survey focused on the impact of the team's work, only those residents who the team had worked with were incorporated into the sample. In total, 112 residents were approached to take

part in the survey by a research assistant who was not directly associated to the team prior to the telephone survey, allowing a degree of independence. Each resident was approached on at least three occasions and there were 28 completed responses (25.0%). Residents' responses were recorded using Microsoft Forms and, where possible, were later incorporated with 'residents' perception' questionnaires that were carried out with 51 residents at the start of their engagement with the multidisciplinary team to allow for comparison over time[12]. There were comparable responses for 12 residents.

2.3.4 – Analysis

Once each aspect of the summative review had been completed, the results from each were consolidated into a number of spreadsheets including; residents' perception data from initial surveys carried out by the team and the summative telephone survey, demographic and needs-related information and case-related data for each household drawn from final periodic review data, and outcomes data from the summative case review. These spreadsheets were drawn together into a single model using Microsoft Power BI to allow for comparison across different sets of data. Further descriptive and comparative analysis was also conducted using Microsoft Excel.

As described in section 2.3.2, the data emanating from one-to-one interviews with the team were thematically analysed separately.

[12] Residents' perception questionnaires were carried out by team members at the start of their engagement with a resident and explored residents' perception of their situation across each of the team's specialisms, as well as asking about the reasons they engaged with the team and their hopes for working with the team

3. The team's approach

This chapter explores the team's overall approach to identifying, engaging and supporting residents. Section 3.1 describes how the team used their first month together to establish a foundation of policies and procedures that informed a shared way of working that has been later formalised into a set of principles described in section 3.3.

3.1 – Establishing the foundations

Before the team started to provide direct support to residents it was essential to establish the foundations of agreed policies, protocols and processes to support engaging and working with residents in a safe and effective manner. In turn, as this project is designed to test new ways of working, it was essential to establish a strong evaluative framework around the team's work. To establish these foundations, a month-long induction process was designed, based around workshops and team development activities. This process ran alongside more general induction activities, such as shadowing and training. During the month, the team focused on a number of essential areas including:

- Reaching consensus about previous challenges and expectations for cooperative working
- Defining and agreeing pathways into the multidisciplinary team
- Developing a safe 'lone working' policy
- Agreeing how to engage with and retain the engagement of residents
- Agreeing how to contact residents
- Capturing learning from the work of the multidisciplinary team
- Defining the team's 'infrastructure support' function
- Co-designing the team's 'joint working' processes

The importance of this period is emphasised in the team's reflections on multidisciplinary working (chapter eight).

3.2 – Matrix management arrangements

The multidisciplinary team drew together practitioners from four different specialisms and three different organisations. As the project was a pilot, it was not sensible to seek to replace current line management responsibilities, particularly as one of the specialists was on loan from DWP rather than being seconded. Therefore, a matrix management system was established where individual specialists retained their current line management within their respective organisations, but the direction of the work they undertook was determined by the aims of the pilot. A matrix management document was developed to encourage clarity among line managers and specialists and each of the respective line managers were also asked to join the pilot's Steering Group, so they could contribute to the direction of the project and take learning back to their organisations.

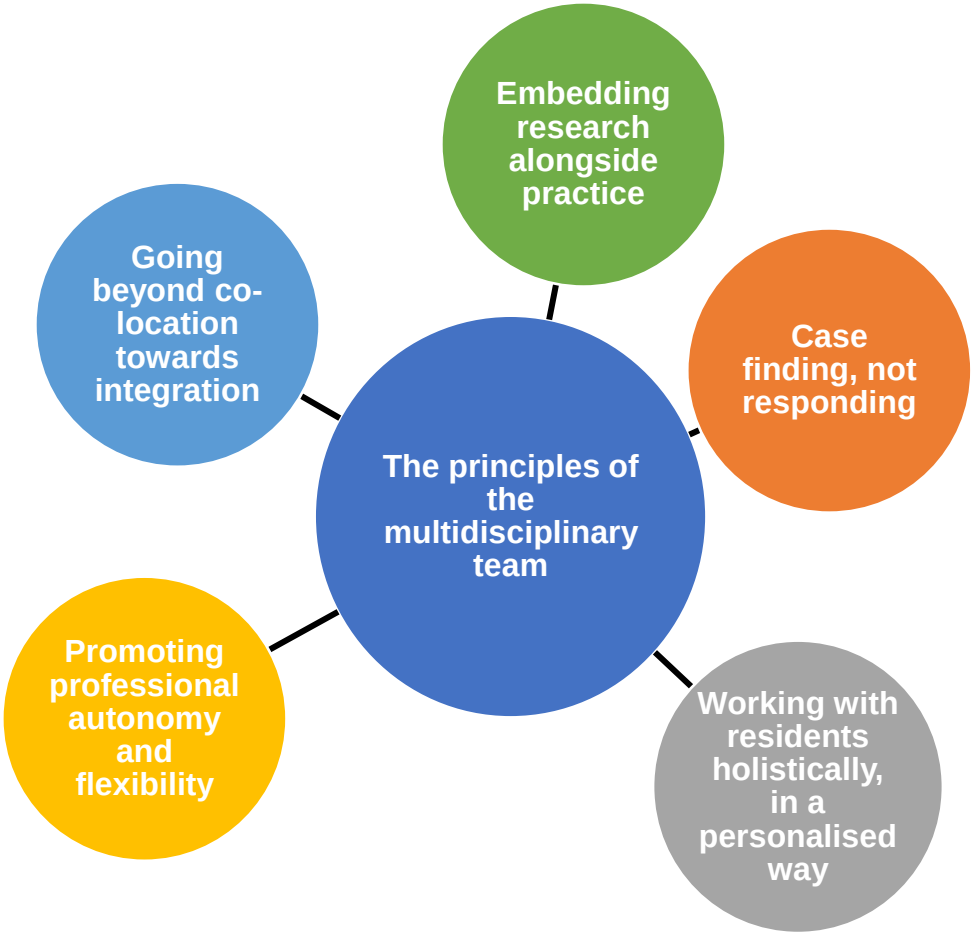
As part of the matrix management arrangements, a coordination function was established. The purpose of this function was to support the multidisciplinary team to maintain routines and to provide a dedicated contact for the generic developmental aspects of the team, including support in capturing the learning from the team's work and incorporating it into future developments and ways of working. The coordination function was be carried out on a rota basis, to support routines, provide clarity and avoid needing to seek volunteers, nominate individuals or send 'whole team'

requests for responsive and time-specific areas of work. The function was also reviewed at regular intervals at the team's operational review and planning meetings to ensure effectiveness.

3.3. – The team's principles

The principles that guide the team's work were determined in collaboration with the team over the course of the pilot. Each were present in some form in the formative month the team spent together building the foundations of their work at the start of the pilot. The final list of principles was discussed and agreed at the team's fifth periodic review process. The principles are displayed in figure 2 but a separate report is available that describes each principle in more detail and provides practical examples from the team's work. Throughout the remainder of this report, examples of and outcomes associated to each principle will be discussed.

Figure 2: The principles of the multidisciplinary team



4. Identifying residents

As highlighted within the principles above, the multidisciplinary team do not take referrals, instead they proactively identify residents they think may be at risk of homelessness in the future. Case finding is *"a systematic method typically used to identify individuals who are at high risk* (Ross et al., 2011). Case finding approaches are much less common in welfare services, or those focused on homelessness prevention. However, targeted preventative interventions for groups of residents at higher risk of homelessness are suggested by Bramley and Fitzpatrick (2018) (see section 1.3.1). In turn, as they launched the Homelessness Prevention Trailblazer fund, the MHCLG explicitly highlighted that Trailblazer authorities should:

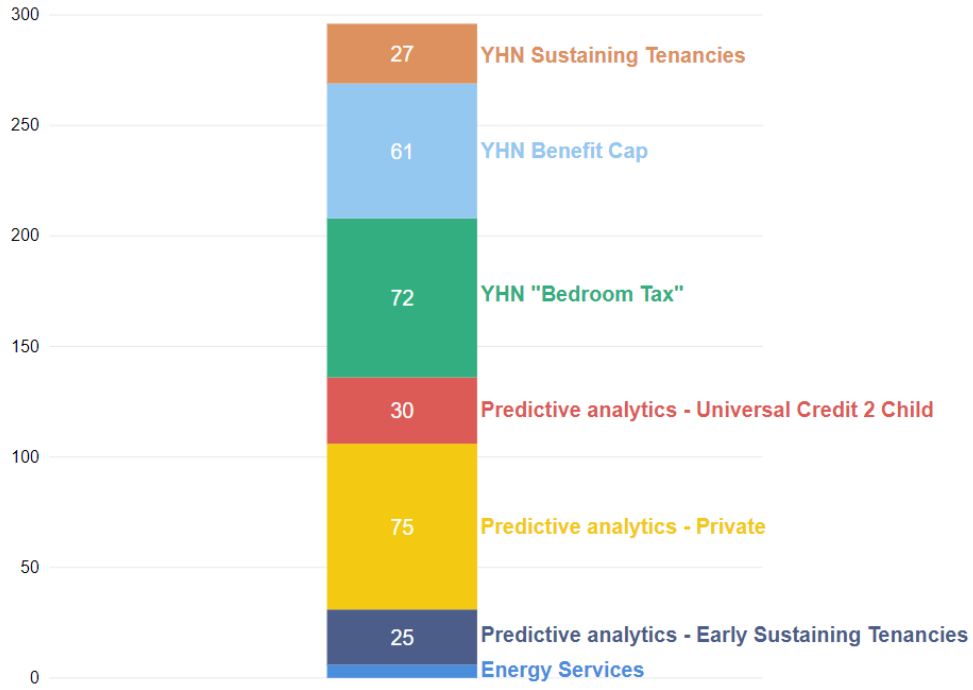
"collaborate with other services and / or use data to identify at-risk households and target interventions well before residents are threatened with the loss of their home"

This chapter outlines how the team have identified residents who may be at greater risk of homelessness through seven different 'routes'. These routes can be broadly split into two categories, according to the approach taken to identified residents who are at risk. Section 4.1.1 focuses on how we have worked with partners to identify residents at greater risk and section 4.1.2 looks at how the team tested the use of predictive analytics developed with Policy in Practice to identify residents.

4.1 – Routes into the team

Figure 3 displays the distribution of each of the routes into the multidisciplinary team before the following sections provide more detail on each.

Figure 3: the routes into the multidisciplinary team



4.1.1 – Working with partners

YHN "bedroom tax"

The first route was YHN tenants affected by the removal of the spare room subsidy (commonly referred to as the "bedroom tax") in the outer west area of the city. This area was selected

because the Housing Specialist in the multidisciplinary team was seconded from the YHN Outer West Hub, allowing strong working relationships to be quickly established.

The initial dataset consisted of 695 tenants impacted by this welfare reform. This represents around 12% of the 5,806 YHN tenancies in the outer west area, and around 29.2% of the 2,380 residents affected by the "bedroom tax" across the city, according to the most recent statistics from Newcastle City Council (March 2019). Therefore, the team underwent a process of segmenting and prioritising which tenants should be targeted first.

1. Tenants in receipt of a Discretionary Housing Payment (DHP) were segmented from the original dataset. Additional prioritisation was then applied to tenants who had received repeat DHPs, and those who had DHPs which ended sooner. The rationale employed by the team was that they would attempt to find out more about why these tenants had received repeat DHPs and to find more sustainable solutions to their issues.
2. Tenants were then prioritised if they faced multiple issues across the specialisms of the team. By prioritising those residents with multiple needs, the team hoped they would be best able to test integrated ways of working.

At the end of the initial pilot, the team had approached 72 of these residents to offer support.

YHN benefit cap

The second route through which the team identified cases was YHN tenants affected by the benefit cap, with the initial dataset consisting of 69 tenants. This represents around 28.5% of the 244 households known to be affected by the benefit cap across the city, according to the most recent statistics from Newcastle City Council (March 2019). These tenants had previously been approached and/or supported by YHN Advice and Support Workers (ASWs) and were categorised as 'red' by YHN, indicating higher levels of complexity. In order to prioritise which of these tenants to target first, the team segmented the tenants by RAG rating them according to their risk of homelessness, using established criteria used in the benefit cap project (see appendix 1). Each of the datasets were also screened by Newcastle City Council's Early Help team to determine whether there was an active 'Early Help Plan' in place for any of the households in either dataset. For those where there was an active plan in place, the multidisciplinary team paused engagement until after a joint arrangement could be determined with the Early Help team.

At the end of their pilot, the team had approached 61 of these residents to offer support.

Energy Services

In August 2018, the team established a temporary route into the team from Newcastle City Council's Energy Services team. Energy Services had been working with the Crisis Support Scheme to identify a small number of residents who had requested support with their utilities but may have additional needs that would benefit from integrated support provided by the multidisciplinary team. Energy Services had previously attempted to contact these residents but without success. It was decided that, as this was a small number of residents, the team would carry out in-depth screening to determine whether it was appropriate to approach these households.

At the end of their pilot, the team had approached six of these residents to offer support.

YHN Sustaining Tenancies

In May 2018, the multidisciplinary team began contacting residents at various stages of YHN's 'Sustaining Tenancies' process. The team received weekly reports of single residents (those without dependant children in their household) in this process. The team then prioritised those

residents according to their perceived risk of homelessness, approaching those deemed to be most at risk.

At the end of their pilot, the team had approached 27 of these residents to offer support.

Figure 4 – In-depth case review of the 'Sustaining Tenancies' route

After approaching 18 of these households, the team began expressing concerns about the extent to which this route met their overall purpose of preventing homelessness at an earlier stage. As a result, the team designed and conducted an in-depth case review (see section 2.2.2) focused on the first 18 households approached by the multidisciplinary team through the 'Sustaining Tenancies' route between May and September 2018.

The review was guided by two key questions:

1. Does the 'Sustaining Tenancies' route meet the purpose of the multidisciplinary team in preventing homelessness at an earlier stage?
2. What are the opportunities for earlier intervention for this group of residents?

The review was conducted in October 2018 and concluded that the route did not meet the purpose of the team as they were approaching residents at too late a stage to avoid an immediate threat of homelessness. The team also identified a number of opportunities to improve the Sustaining Tenancies process, which were discussed by senior members of staff at YHN and Newcastle City Council.

4.1.2 - Using predictive analytics

In April 2018, the multidisciplinary team began to identify residents who may be at risk of homelessness using predictive analytics developed with Policy in Practice, using Homelessness Prevention Trailblazer funding. The analytics are based on a range of local data including Housing Benefit, YHN rent, Council Tax arrears and Reduction Scheme, and Discretionary Housing Payment (DHP) data. This data is analysed against estimated changes in inflation on household goods and services and expected welfare reforms to predict which residents may be at risk of homelessness in the future. The team access this data through an interactive dashboard that allows them to segment the data in various ways.

Before approaching these residents, the team wrote a method statement for approval by Newcastle City Council's Information Governance Officer to confirm that they had a legal basis to use this method of identifying and approaching residents, as well as ensuring that their approach was sufficiently transparent and understandable to residents.

Private tenants

In June, the team established their first criteria of residents who were categorised as being 'at risk of financial crisis' by Policy in Practice's dashboard, were in private tenancies, had Council Tax arrears, and were not in receipt of a DHP. They began to approach these residents on 10 July 2018. At the end of their pilot, the team had approached 75 of these residents to offer support.

Earlier opportunities in Sustaining Tenancies

In December 2018, the team established their second route using predictive analytics, identifying residents who were identified as being in relative poverty (less than 60% of median national income) through the predictive analytics, were YHN tenants, and had between one and 15 months of rent arrears, based on the most recent update from Policy in Practice at August 2018. The team have so far approached 20 of these households to offer support.

Universal Credit and the 'two child' policy

The team had initially planned to use the dashboard to identify residents who were at risk of being impacted by the 'two child limit'. In January 2019, the government made more announcements about Universal Credit, including that they have decided not to go ahead with the planned 'retrospective' extension of the 'two-child limit' in Universal Credit for children born before 6 April 2017, which was due to be introduced on 1 February 2019. However, families with three or more children could still be affected by Universal Credit from 1 February 2019 because they will no longer be able to make new claims to 'legacy' benefits and will be signposted to claim Universal Credit instead. Therefore, the team decided to use the dashboard to identify residents who may struggle with this transition. From 5 February 2019, the team began to approach residents who:

- have three or more children – prioritising those with the most children
- are currently on 'legacy' benefits – therefore, may be required to claim Universal Credit if they experience a change in circumstances
- are affected by the benefit cap – therefore, they are likely to already be in financial difficulty
- are private tenants – therefore, they are less likely to be offered support by their landlord

At the end of the pilot, the team had identified 30 of these residents to offer support.

5. Understanding residents better

5.1 – In-depth screening to determine an approach

On a weekly basis, between five and ten cases were selected from the routes outlined in the previous section. It is important for the team to adapt their methods of engagement to the needs of residents. Therefore, in-depth screening is undertaken by each member of the team on their respective databases to offer a detailed overview of each resident. The team screen a range of databases including:

- YHN Northgate database
- Newcastle City Council's (NCC) Revenues and Benefits Northgate database
- NCC's Welfare Rights AIMS database
- NCC's debt & budgeting AIMS database
- NCC's Social Care Totalview database
- NCC's Active Inclusion Gateway web-based portal

Following their first quarterly review, the team amended their screening process to avoid collecting unnecessary and out-of-date information on the residents they are approaching. The team now base their screening around set relevant areas rather than capturing and discussing all the information available to them. Sufficient flexibility is allowed in this approach for caseworkers to still note information that may not sit within one of their specialist areas but that they deem to be relevant to their approach to the resident.

Once the screening has been completed, the cases are discussed at a weekly case identification meeting where the team share information and determine how they will seek to establish contact and engagement from the resident and develop a provisional plan of work that could be done with them. The remaining sections in this chapter present data captured from the team's case identification meetings. This data has been captured, analysed, presented and discussed at each of the team's periodic reviews to better understand the challenges experienced by residents and inform how the team can work to better support residents in a holistic and personalised way. First, section 3.2 outlines demographic information related to the households identified by the team.

5.2 – Household composition

The demographic information displayed below relates to all 296 households identified by the multidisciplinary team.

Figure 5 – Household composition of multidisciplinary team cases

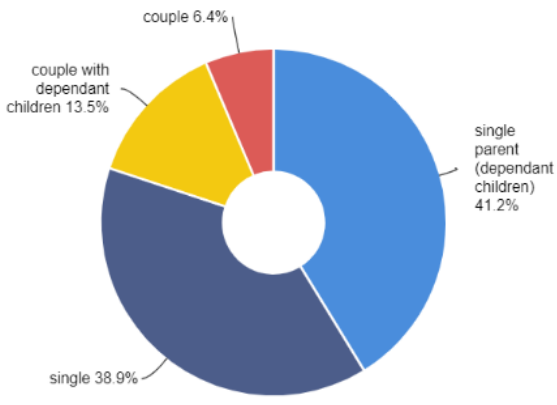
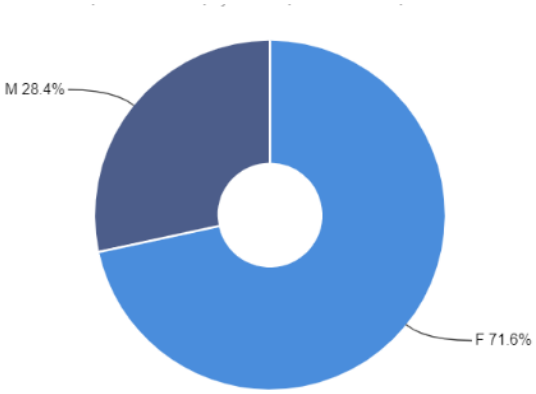


Figure 6 – Gender of main resident across multidisciplinary team cases

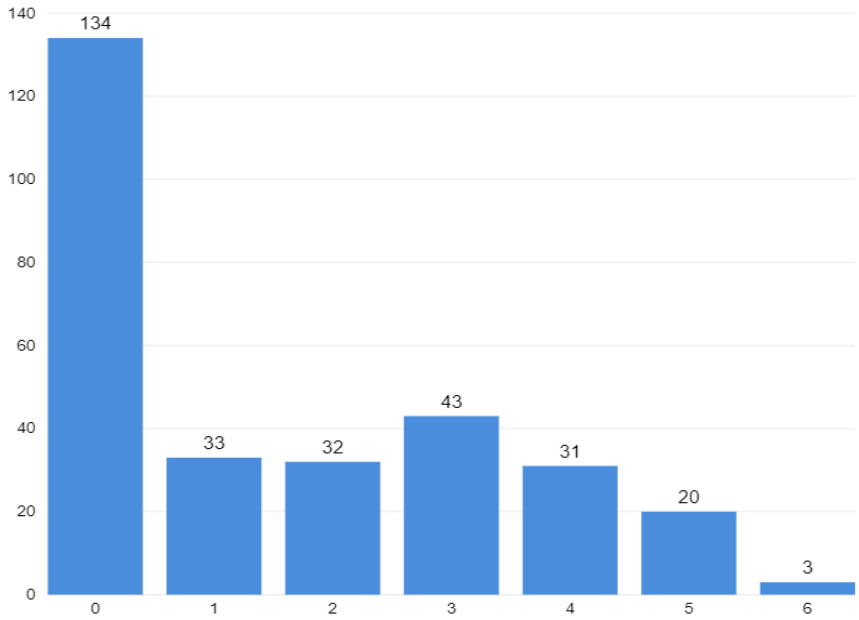


As displayed in figure 5, the majority of households approached by the team were either single parents or single adults without dependant children. This is unsurprising when we consider that two of the routes were focused on the “bedroom tax”, a reform that primarily affects single adults and the benefit cap, a reform that primarily affects single parents[13]. More broadly, it is also logical to assume that households that only contain a single adult are more likely to face financial difficulty than households with two parents (and, therefore, two potential sources of income).

The high proportion of households that have a female as their main resident is perhaps surprising given that the population of people who are homeless is often male dominated. Targeting female residents was not an explicit goal of the multidisciplinary team but can be partially explained by the targeting of residents affected by the benefit cap (see section 4.1.1) and the Universal Credit ‘two child limit’ (see section 4.1.2). Each of these routes were predominantly orientated towards single parent households. All of the single adult households through the benefit cap route and 90% of those identified through the Universal Credit ‘two child limit’ were female, in line with the prevailing trend that single parent families tend to be headed by a female.

Figure 7 (below) displays the number of dependant children in each household at the point at which the team conducted screening. It is important to note that a significant minority of residents identified by the team have children who have been removed from their care (see section 5.3.4), so do not feature in this analysis. Excluding those who have no children, the most common number of dependant children is three, with a third of those households with dependant children having four or more in the household. Given the financial challenges identified in section 5.3 and later in this report and the prominence of childhood poverty in determining the risk of homelessness (see section 1.3.1), there is an imperative to alleviate the financial strain on these households.

Figure 7 – The number of dependant children across households identified by the multidisciplinary team



[13] The latest statistics available from the DWP show that 70% of households affected by the benefit cap are single parent households.

5.3 – The challenges faced by residents

This section outlines some of the key challenges faced by residents who the multidisciplinary team are supporting. Section 5.3.1 begins by demonstrating that many of the residents that the team have identified, approached and supported live in deprived areas of Newcastle.

5.3.1 – Deprivation

Figure 7 – Households who the multidisciplinary team are working with mapped against 10% most deprived areas in Newcastle

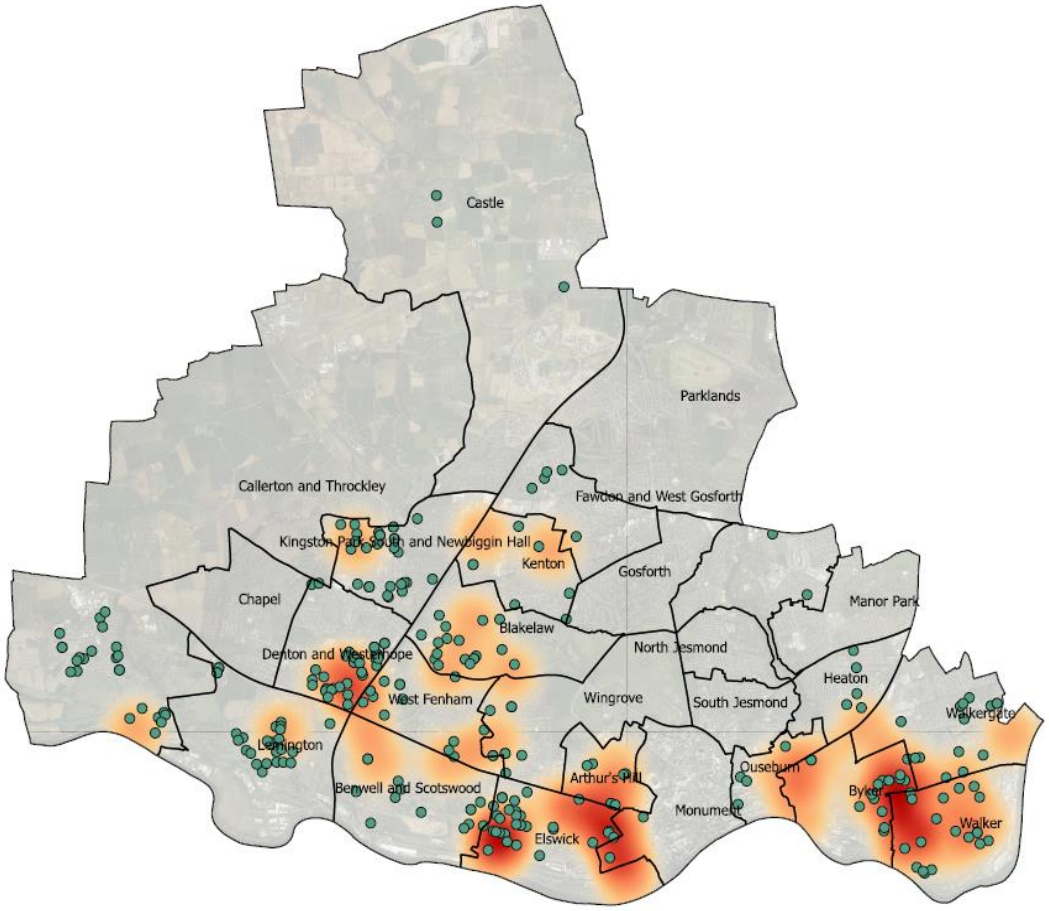


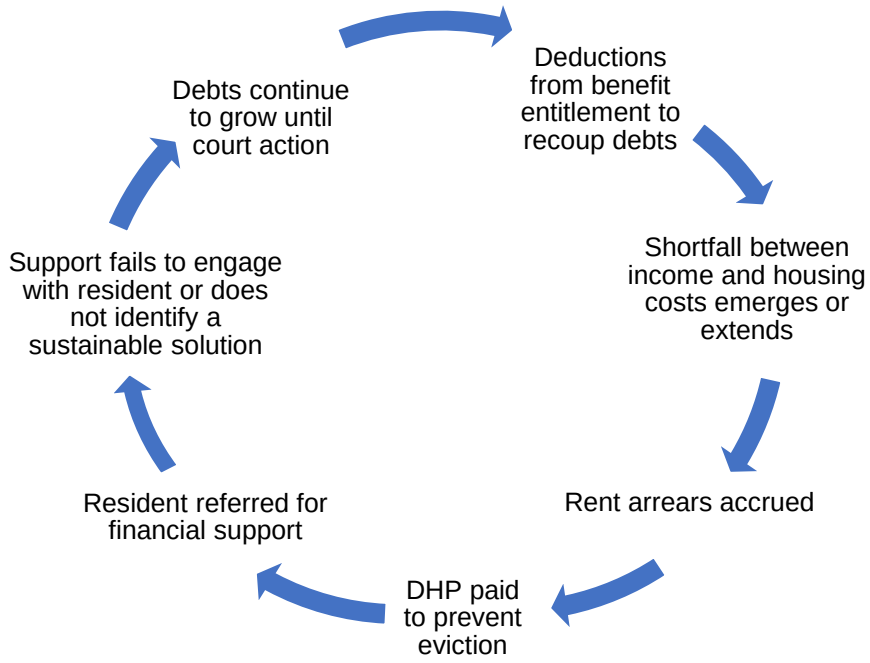
Figure 8 (above) displays the households approached by the multidisciplinary team (as rounded icons) overlaid on a heat map of the areas in Newcastle that are among the 10% most deprived in England[14]. The team did not specifically intend to target households in the most deprived areas. Nevertheless, there is a clear correlation between the households approached by the team and the areas of Newcastle with the highest levels of deprivation. When we consider the centrality of poverty in determining an individual's risk of homelessness, this evidence suggests that the team's case finding approach has directed them towards those residents at greatest risk. Although poverty may be the dominant structural factor in determining risk, there are also intermediary factors that are essential when seeking to identify and ameliorate the risk of homelessness. The following section focuses on the financial situations of the households identified by the team, at the time of screening.

[14] The heat map corresponds to example postcodes for the 38 Lower Super Output Areas (LSOAs) that are in the top 10% most deprived areas in England according to the Index of Multiple Deprivation 2015.

5.3.2 – Debt, deductions, DHPs

In their first periodic review, the multidisciplinary team identified a trend among the residents they were working with. They noticed that many residents seemed to be locked in a cycle of debt, deductions and DHPs[15]. Figure 9 displays this cycle before it is described in more detail below.

Figure 9 – The cycle of debt, deductions and DHP



Across the residents identified by the multidisciplinary team, there was an average rent shortfall of £35.63 a week[16]. Excluding those households from the Energy Services route (of which there were only six), the households identified through the benefit cap route had the highest average rent shortfall of £56.10 per week. These rent shortfalls can make it significantly more difficult for residents to pay their rent, in turn contributing to the accrual of rent arrears[17]. As there is no centralised repository of rent arrears data for households in the private rented sector, it was not possible to ascertain levels of arrears for private tenants. However, of those residents where data was available, there was an average £507.44 of rent arrears. For many of the households in the benefit cap and "bedroom tax" routes, the effect of their rent shortfall on their arrears had been minimised by DHP awards. As a result, it is reasonable to assume that the level of arrears would be significantly higher if it were not for this 'sticking plaster' (Watts et al., 2019). The vast majority (67.6%) of residents identified by the team had received at least one DHP at the time of screening, with 15 residents receiving four or more awards. Between 2011-12 and 2017-18, Central Government allocation of DHP funding to local authorities in Great Britain rose from £30 million to £166.5 million[18]. Over the same period in Newcastle, spending rose from £94,326 to £1,169,857[19]. National funding has dropped significantly in 2019-20 to £153.5 million, with a drop to £932,043 in

[15] DHP is a discretionary scheme that allows local authorities to make monetary awards to people experiencing financial difficulty with housing costs.
[16] Rent shortfalls were calculated by comparing residents gross rent to their receipt of housing benefit/ housing element in Universal Credit
[17] The change in rent arrears and rent shortfall from screening to the end point of a case are both highlighted in section 9.1 of this report.
[18] https://researchbriefings.files.parliament.uk/documents/SN06899/SN06899.pdf
[19] https://www.gov.uk/government/publications/housing-benefit-subsidy-circulars-2019

Newcastle. Given the importance of DHPs in preventing residents with significant shortfalls falling into homelessness, this policy change is particularly concerning.

Beyond rent arrears, many residents supported by the team also experience other forms of debt. These debts are increasingly recouped through deductions from benefit entitlements. 56.4% of residents identified by the team had deductions from their benefits for various debts. On average, residents identified by the team have £25.94 deducted from their benefit entitlement on a weekly basis. Among the residents who had deductions, this worked out as an average of 11.3% of their household income after housing entitlement. There have been a number of concerns raised about the rate at which deductions are taken from Universal Credit in particular, including from Newcastle City Council and Your Homes Newcastle (Horton, 2019). For ten residents the team identified, they had deductions of more than 30% of their income after housing entitlement and for two residents this rose to over 50% (50.3% and 56.5% respectively). Of these two residents, the team established contact and worked with one.

Case study 1 (appendix 3) presents the story of one resident who the had significant deductions from their benefits and was supported holistically by the team

As a whole, these factors begin to demonstrate how significant structural changes brought about by the welfare reforms can lead to a significant and very tangible risk of homelessness. Particularly concerning is the reduction in DHP allocations that are, at present, stopping a significant number of households from becoming homeless. Findings from subjective perception questionnaires also suggest that this brings a significant amount of stress to residents. Figure 10 and 11 (below) present the responses of 51 residents who took part in a survey exploring their subjective perception of their situation at the start of the team's engagement with them. The findings begin to demonstrate the emotional stress and precarity brought by resident's financial situations. Particularly striking is the extent to which many residents were relying on family members to support them. Findings in section 5.4.1 suggest that relatively few residents supported by the team have access to positive financial, practical or emotional support from family or friends. In turn, it could be argued that the financial support offered by family or friends may bring additional strain to these relationships.

Figure 10 – Do you find it stressful to manage your finances?

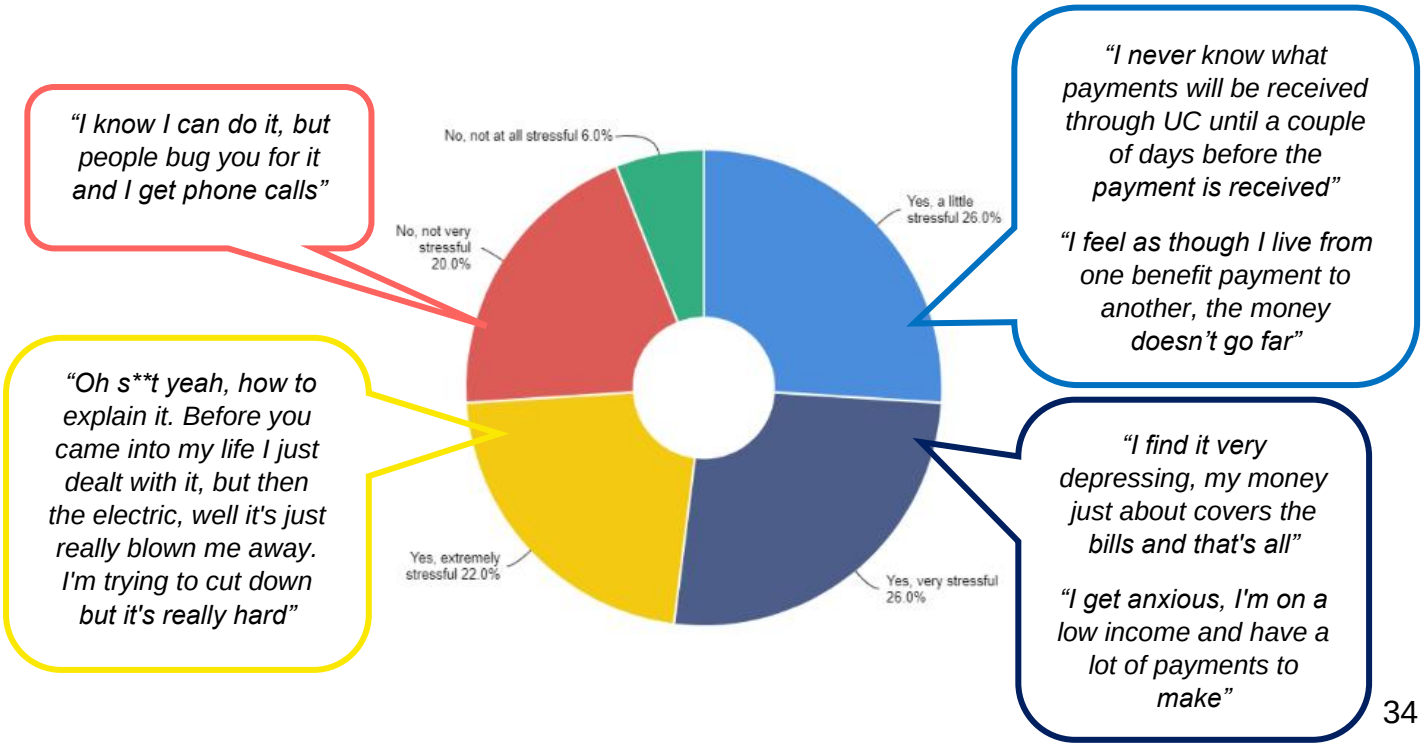
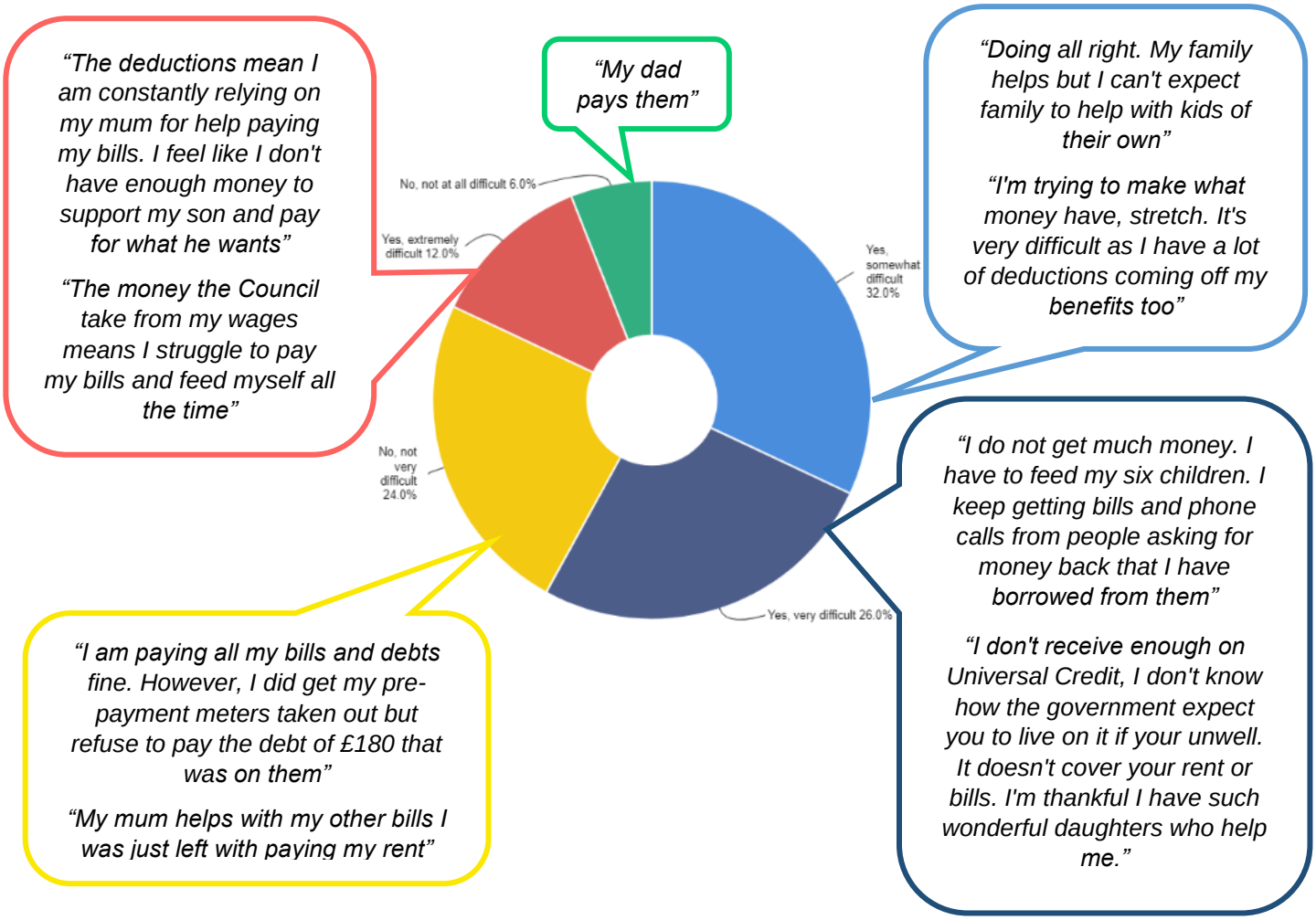


Figure 11 – How difficult do you find it to meet payments on your bills?



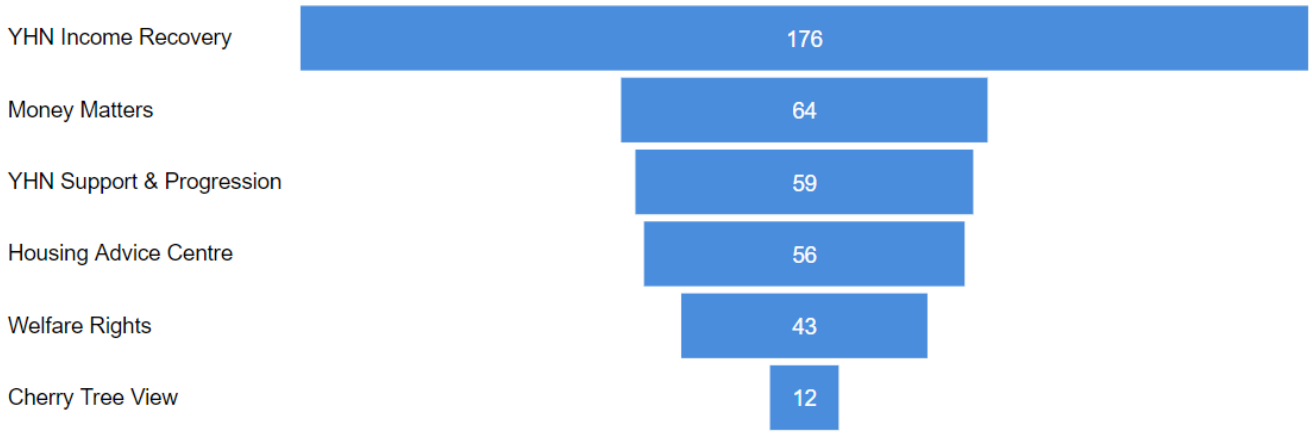
The next section explores the extent to which these residents had previously engaged with services prior to being identified by the multidisciplinary team.

5.3.3 – Previous service involvement

Figure 12 (below) displays the extent to which residents identified by the team had previously engaged with relevant support services. The data that informs the analysis was populated by members of the team, as part of their in-depth screening process. As such, it is subject to some level of human error. In addition, where the Housing Advice Centre (HAC) is noted, this refers to residents who have presented at HAC for any reason (not necessarily because they wished to make an application under homelessness legislation). Cherry Tree View (CTV) relates to both those residents who have been in statutory temporary accommodation over the last two years and, to a lesser extent, residents supported by CTV's preventative outreach function.

The figure highlights relatively high levels of engagement with YHN Income Recovery Officers, which is not particularly surprising given that four of the team's routes focused explicitly on YHN tenants and the majority of residents identified by the team faced significant challenges paying their rent. However, given the significant financial challenges outlined in the previous section, it is perhaps surprising that the rates of engagement with the council's debt and budgeting team (Money Matters) (21.6%), the council's Welfare Rights (14.5%) and YHN's Support and Progression team (19.9%) are relatively low.

Figure 12 – Previous service involvement within the last two years among residents identified by the multidisciplinary team



The next section focuses on the additional needs identified among residents during the team's in-depth screening process. These additional needs extend beyond the specialisms of the team and of the services outlined above.

It is important to capture the wider issues households may be facing in order to develop a more holistic and personalised approach to both establishing engagement and supporting them (see section 3.3). Findings from reflective discussions with the team outlined in their fourth periodic report highlighted the importance of considering the households' wider situation as this could not be decoupled from work on debt, budgeting, benefits, housing or employment support. The following quotes begin to demonstrate the relationship between the household's wider physical and mental health needs and their benefit entitlement, or their capability to undertake administrative tasks such as budgeting, managing their benefits, and making appointments.

"Just in my first meeting with you it has been a great help. I didn't know that I could claim DLA for my daughter. She was diagnosed two years ago with her condition and I attended a lot of meetings for her but not one person mentioned that I could get extra financial support until [specialist] came to my house"

"I suffer with bad depression and I get confused and stressed very easily"

These administrative tasks have arguably become more important due to welfare reform measures for a number of reasons. The rapid rate of benefit changes, an increased focus on conditionality, and a shift of responsibility to the claimant for making and maintaining benefit entitlement all privilege those with less needs and more capabilities (see section 1.3.2).

5.3.4 – Additional needs experienced by households

The information collected by the team through their integrated triage and casework approach has revealed a high degree of variation and complexity amongst the lives of the residents they are working with. The needs identified in the following sections have been drawn from many databases, through an in-depth screening process. Where the team have been able to, they have confirmed these needs with residents upon initial contact. Only those needs verified by some level

of supporting evidence are reported in the sections below. In total, 65.5% (n=194) of the residents identified by the team had some form of additional needs, beyond the specialisms of the multidisciplinary team. Of those residents who did experience additional needs, they most commonly experienced only one or two additional needs. A significant minority of residents (16.9%) experienced three or more additional needs. However, it is important to highlight that these needs are only those identified during screening and do not include those identified after the team had established contact with residents. In turn, once household size is accounted for, there is little difference between the extent of additional needs across each of the routes into the multidisciplinary team.

Figure 13 - Number of households experiencing additional needs

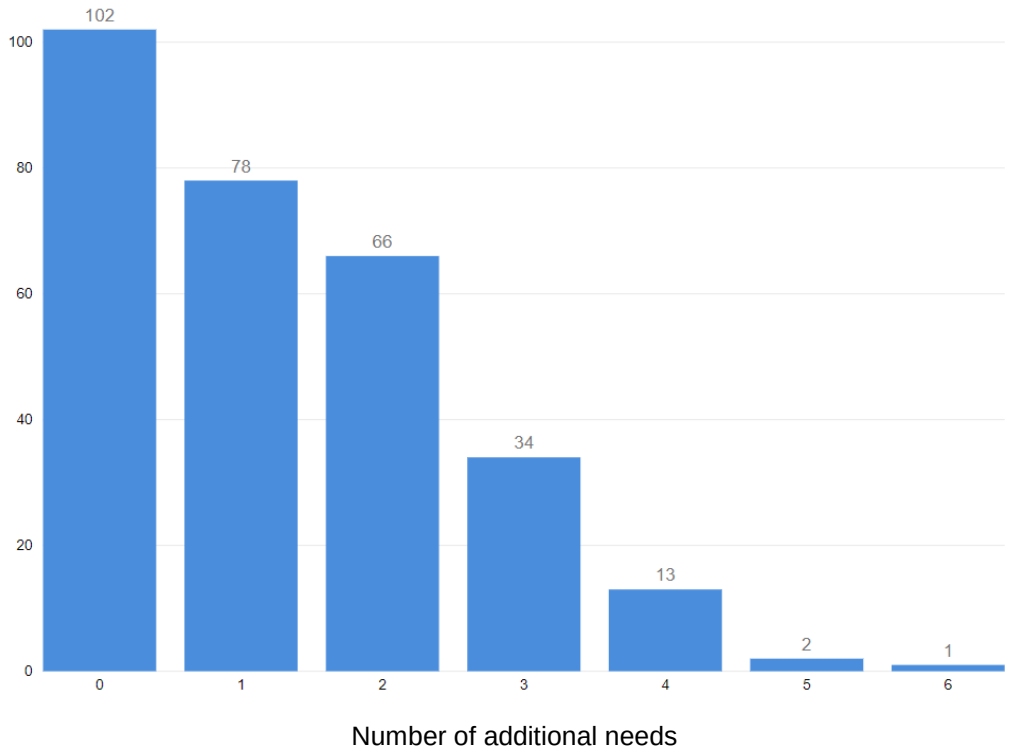
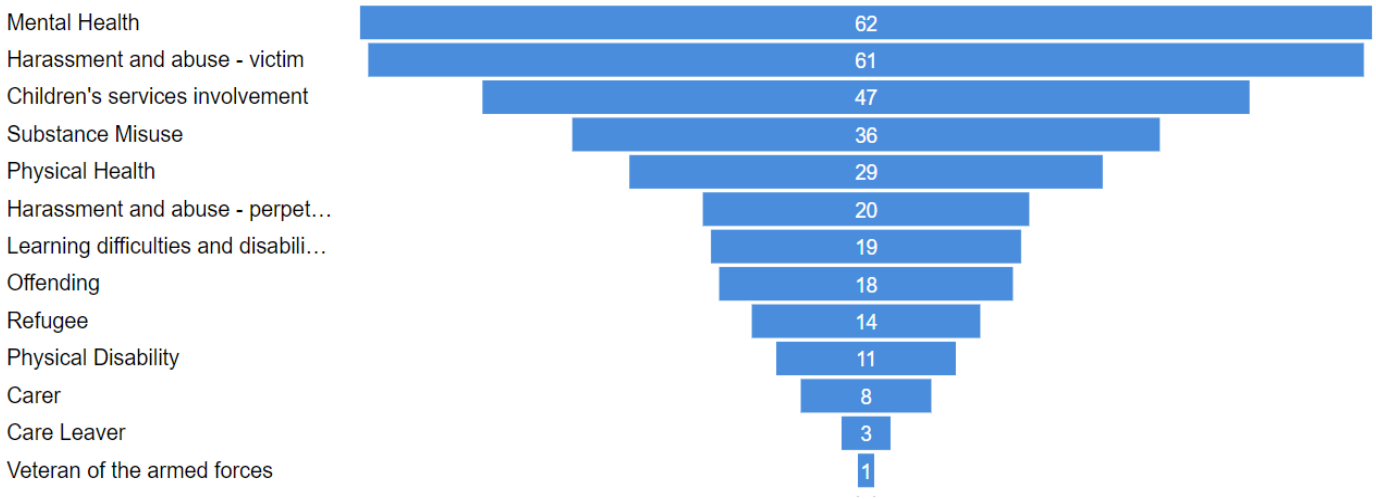


Figure 14 (below) displays the types of needs identified among households during the team's in-depth screening process. The most common types of need identified were mental health issues and having previously been a victim of harassment or abuse, which were present for 20.9% and 20.6% of residents respectively. The next most common need was previous Children's Services' involvement, which was present for 15.9% of residents. More detail is offered on each of these top three additional needs in the following sections.

Figure 14 – Additional needs identified among residents during in-depth screening process by type of need



Mental health

Although exact diagnoses were not available for all 62 residents who were identified as experiencing mental health issues, it was possible to identify some broad trends among the types of mental health issues experienced by residents. The most common mental health issues experienced were related to anxiety, agoraphobia and depression which were consistently experienced together by residents. However, there were also other forms of mental health issues present in the histories of residents identified by the team including post-traumatic stress disorder (PTSD), schizophrenia, perinatal depression and bi-polar disorder. These mental health issues cannot be decoupled from support on housing, debt or employment. Part of the team's reflexive approach (see section 2.1) involves an understanding of the bi-directional nature of these factors. Problems such as mental health issues can influence an individual's ability to manage their financial situation or find work. In turn, worsening housing or financial situations can also have a significant impact on an individual's mental health.

Case study 2 (appendix 3) presents the story of one resident who presented with significant mental health issues at the time the team established contact with her. Her story demonstrates the importance of a holistic and personalised approach to supporting residents with mental health issues

Harassment and abuse

All but one of the 61 residents identified as having been victims of harassment or abuse were survivors of domestic abuse. This trend correlates with the high level of perpetrators of harassment and abuse identified among known relationships of residents (see section 5.4). Fleeing domestic abuse is a longstanding cause of homelessness. In turn, previous experience of domestic abuse is a significant risk factor for homelessness (Bramley and Fitzpatrick, 2018). For the residents identified by the team, previous experience of harassment and abuse was predominantly experienced by single parents (62.3%). As many of these households were also affected by reforms such as the benefit cap, they are further disadvantaged after having survived domestic abuse. 32.7% of the households who had experienced domestic abuse had also experienced Children's Social Care involvement. In turn, 51% of those who had experienced Children's Social Care involvement were single parents (see figure 14). These findings are only drawn from a relatively small sample and should be treated with caution. Nevertheless, they do suggest that at least among the residents identified by the multidisciplinary team, there is a

correlation between domestic abuse, single parent households and Children's Social Care involvement.

Children's Social Care involvement

The multidisciplinary team are currently conducting an in-depth case review exploring the incidence and influence of Children's Social Care and Early Help involvement across their cases. Although the review has not yet concluded, it is possible to identify some key emerging trends from the first wave of this review, which looked at 47 households identified as having either Children's Social Care or Early Help involvement in the past. Although the team's direct remit does not include Children's Social Care, their holistic approach to supporting households necessitates close working with Children's Social Care.

Figure 15 – Overview of Children's Social Care (CSC) involvement across multidisciplinary team cases

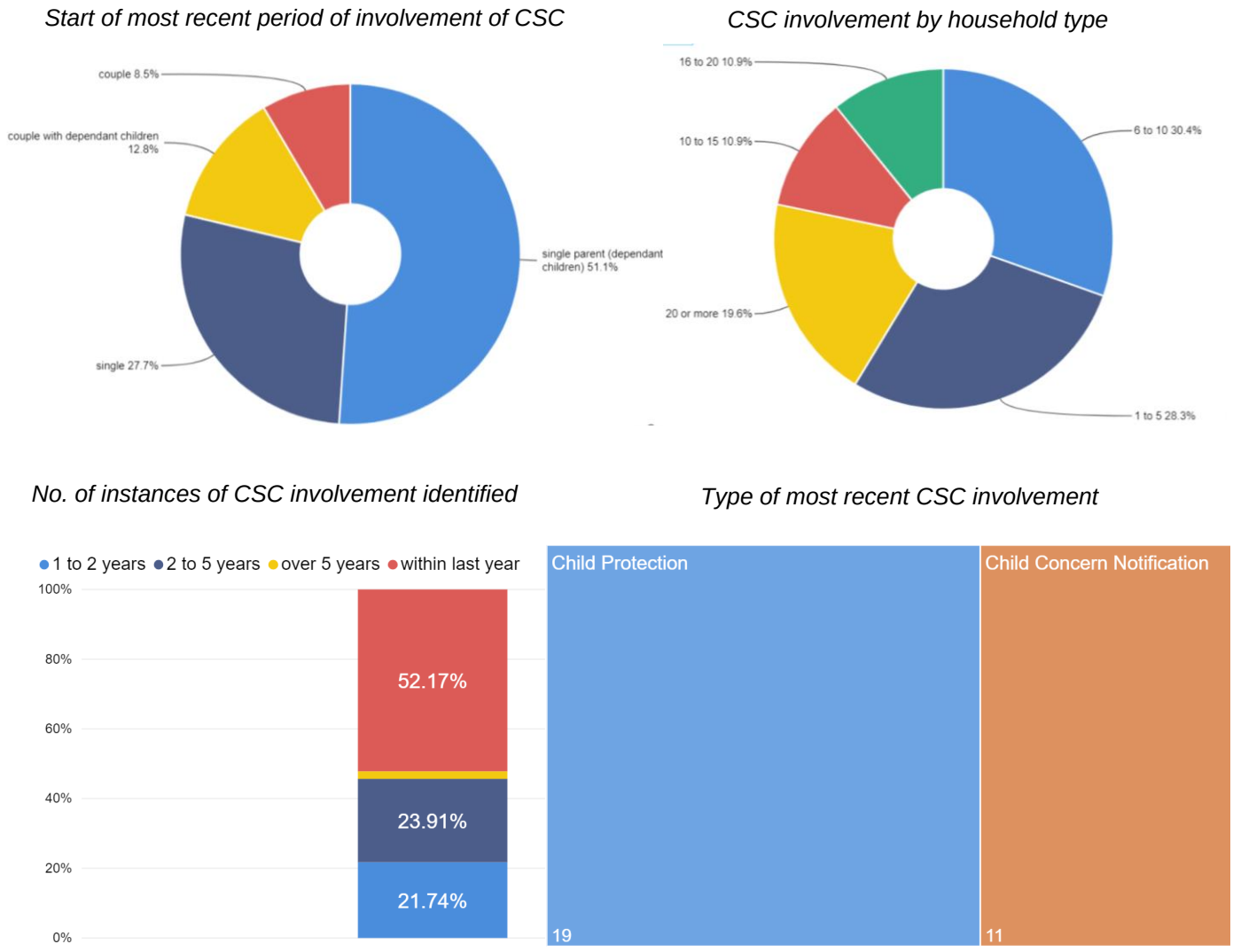


Figure 15 (above) shows some of the key findings from the first stage of the in-depth review into Children's Social Care involvement among households identified by the multidisciplinary team. They reveal that the vast majority of cases (71.7%) have had more than five periods of Children's Social Care involvement. In addition, the majority of cases (52.17%) had periods of involvement that started in the last year. These findings indicate that many issues have persisted over time and remain present in the lives of households at the point at which they were identified by the team.

Figure 15 also indicates that recent involvement has predominantly been orientated towards more serious involvement, with child protection being the most common type of involvement. However, Child Concern Notifications were also common. More detailed findings from this in-depth case review will be published in a report at a later date but case study 3 presents one example of the interaction between the work of the team and Children's Social Care.

Case study 3 (appendix 3) presents the story of one resident who was supported by the team throughout (and following) child protection proceedings that ultimately resulted in her losing custody of her children. The case study poses questions about the support available to residents immediately after their children have been removed. Case study 6 (appendix 3) presents the story of another resident who was supported by the team in conjunction with colleagues from Early Help and Children's Social Care.

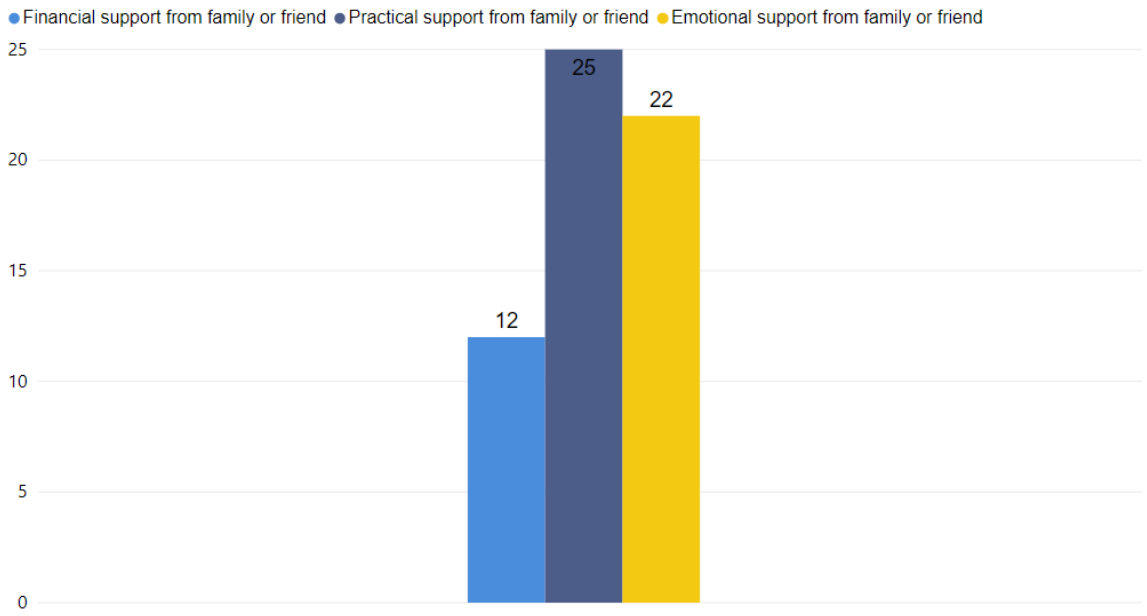
5.4 - Relationships

As the team aim to support households in a holistic way, it is important for them to offer support in the context of residents' wider relationships. Throughout the course of the pilot, these relationships have either posed challenges or provided essential support to residents, or both.

5.4.1 – Positive support from family or friends

Figure 16 displays the support available to residents from family or friends as identified by the team at their summative case review (see section 2.3.1). As such, this data only relates to the 112 residents the team worked with (see section 7.1) and the team were able to select more than one type of support if it applied to the household. Nevertheless, it gives some insight into the extent and type of support available to residents from their social networks. Overall, it shows a relatively low level of positive support available to residents supported by the team. The most common form of support available was practical support and this was only identified as being available to 22% of residents the team had worked with. Only 10.7% of residents were identified as having access to financial support.

Figure 16 – Support from family or friends for residents supported by the team – as reported by team members



However, the numbers shown above do not show the quality and vital nature of support offered by some residents. The following quote is from the mother of the resident who is the focus of case study 2 (appendix 3). It begins to demonstrate the level of emotional and financial strain of supporting a daughter with significant mental health problems prior to the team's involvement.

> *"I was keeping her for 18 months after her ESA stopped, gas, electric, paying her "bedroom tax" … for years I'd been trying to get help for her, banging my head against the wall with all of them… It's traumatic, the whole situation"*

Among others, the team also supported two residents who received considerable care from their family members due to significant learning disabilities, as well as other issues. In turn, each resident was living in a tenancy that they had succeeded from their parents. As a result, each of these residents was deemed to be 'under-occupying' their property and were subject to the "bedroom tax". These tenancies were close to the family members who acted as appointees and carers, so it was not desirable or sensible for them to move to a smaller property. As a result, the team worked closely with family members to stabilise each residents' financial situation as much as possible. Figure 17 (below) highlights the work done by the team with one of these residents, Charlie (pseudonym).

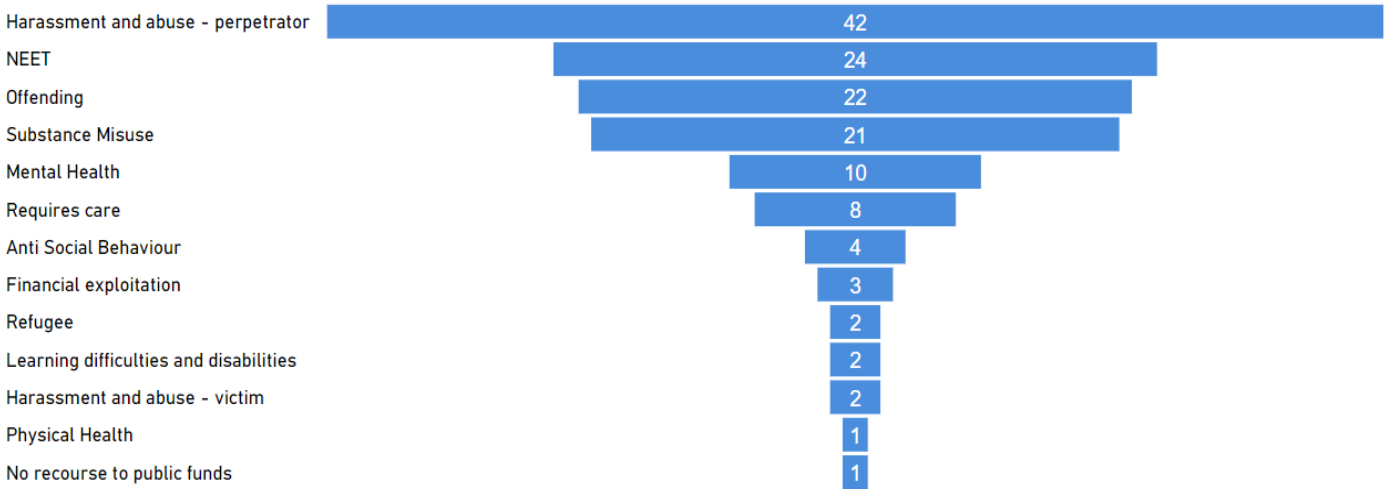
Figure 17 – Working with family to support residents

Context	Work done
Charlie is a 62 year old single male who was diagnosed with schizophrenia over 30 years ago and has learning difficulties, diabetes, osteoarthritis and a recently diagnosed significant heart condition	The team worked with a Primary Care Navigator to gain medical evidence to support a PIP claim
He lives alone in a 'succession tenancy' two-bedroom YHN tenancy, where he was born and the only home he's ever lived in. He is affected by the "bedroom tax' and has a rent shortfall of £11.62 per week, which has led to rent arrears and being at risk of eviction	While this was being considered, the team supported Charlie to maintain his ESA award, to add the income-based top-up that he was missing out on (resulting in a backdated award of £3,357.74), to get a DHP to clear his rent arrears and cover his rent shortfall (reducing his risk of homelessness) and have carried out other work to reduce his expenditure on essential items such as water
The team established contact with Charlie through a phone call then home visit, when he gave permission to speak to his sister for a fuller picture of his health needs. The team liaised with her throughout providing their support	His ESA secured £10,060.02 over a year (including backdated amount). The team are also awaiting the outcome of a PIP claim (at the time of writing this report). This allowed Charlie to afford the shortfall caused by the "bedroom tax" and stay in his

5.4.2 – Additional challenges posed by known relationships

During the in-depth screening process, the team identified additional needs that were present among known, close relationships[20] of the residents they had identified. Figure 18 displays these needs and highlights that the most commonly identified challenge was having previously been a perpetrator of harassment or abuse (most often domestic abuse). It is important to note that as the team's screening process incorporates accessing 'Total View' social care records (see section 5.1) there is a chance this system may increase the possibility of these needs being identified. There was also a high level of NEETs[21] in households identified by the team. As the team began working with these households they also identified that many of these NEETs were not claiming benefits or were not contributing to household costs. However, residents were still subject to non-dependant deductions[22] placing them under increased financial strain.

Figure 18 – Additional needs presented by known relationships of residents identified by the multidisciplinary team



As the team seek to support households holistically, they may also support residents' relationships. Figure 19 (below) highlights one such case, where, in order to stabilise his financial situation, the team supported Mark's brother, who is alcohol dependent.

Figure 19 – Holistic support with residents and their relationships

Context

Mark is a 50 year old male resident who was identified through the YHN "bedroom tax" route. He had a rent shortfall of £31.41 a week because he was deemed to be 'under-occupying' by two bedrooms

Soon after the team identified Mark, his brother moved in with him. His brother has several chronic health problems resulting from drug misuse and alcoholism and Mark is unofficially caring for him. When his brother moved in, his under-occupation charge was replaced by a non-dependant charge.

After two unsuccessful phone calls, the team established contact by attending the resident's Jobcentre Plus appointment after liaising with his Work Coach

[20] Non-dependant relationships include residents' siblings, adult children, partners and ex-partners, as well as friends or associates

[21] NEET refers to young adults aged between 18 and 25 years old who are not in employment, education or training

[22] http://england.shelter.org.uk/housing_advice/benefits/housing_benefit_deductions_when_living_with_non-dependants

Figure 19 continued

Work done

Mark's brother requires 24-hour care, so Mark felt unable to return to work. An agreement was reached with the Work Coach at the Jobcentre to remove all conditions from his Jobseeker's Allowance Claimant Commitment, except a requirement that he works with the multidisciplinary team

The team made a PIP claim for Mark's brother in March 2018. This was awarded in July 2018 and was backdated. Once this was awarded, the team could claim Universal Credit with the Carer's element for Mark so that he no longer has a requirement to find employment and can spend his time caring for his brother

In June 2018, the brother's ESA claim was closed because he failed to attend an assessment. It transpired that his letters from the DWP were being sent to his previous address

The Employment Specialist was able to check the DWP's systems and, although his address had been changed at the beginning of March when she had notified ESA Maintenance, they had failed to remove a correspondence address. The Employment Specialist sent an internal email asking her colleagues to rectify this error

5.5 – Conclusion

This chapter has highlighted how, through their in-depth screening process and subjective perception questionnaires, the team have been able to better understand the residents they have identified, approached and supported. Section 5.2 looked at the demographic make-up of these households and highlighted that the majority were either single adults or single parents. This section also highlighted that many of the households identified by the team had dependant children. The high proportion of children in these households is a sobering finding when we consider the range of challenges these households face and we consider the prominence of childhood poverty in predicting the risk of homelessness (as well as a wide range of other negative life outcomes). Section 5.3 highlighted and described the challenges faced by residents starting by showing that the majority live in amongst the 10% most deprived areas in England. Section 5.3.2 showed how many residents are trapped in a cycle of debt, deductions and DHPs, related to significant shortfalls between their rent and housing-related benefit entitlement and bringing significant emotional stress. Section 5.3.3 highlighted relatively limited service engagement with housing, debt and welfare rights services and section 5.3.4 described the range of additional needs faced by residents. Most prominent amongst these were mental health issues, Children's Services' involvement and being victims of harassment and abuse. Finally, section 5.4 indicated that many residents lack positive social relationships but also highlighted that where they are present, they provide vital emotional, practical and financial support.

6. Establishing contact with residents

This chapter presents the team's approach to establishing contact with residents before exploring the extent to which this approach has enabled success. Section 6.3. concludes this section by drawing on the reflections of the team and residents to ascertain 'what worked' in establishing contact.

6.1 – A personalised, flexible approach

As highlighted at the start of chapter 4, the multidisciplinary team do not take referrals, instead they proactively identify residents they think may be at risk of homelessness in the future. The team have used this pilot to test different approaches to case finding. The team's case finding approach is informed by their case identification screening. Through screening a variety of databases, the team are able to build a clearer picture of a household and question whether their case finding approach has directed them to the right residents.

The team's attempts at engagement are guided by their 'engagement and retention' protocol which was established in the first month of the pilot (see section 3.1). This protocol is guided by a number of principles determined by the team:

- All attempts at engagement should be **clear and honest**, setting out realistically how we aim to support the resident in terms they understand
- Our engagement with residents should be **flexible** to each individual's circumstances. For example, this means allowing the resident to have choice over how we contact them, and where we meet them
- When we engage with residents, we should do so in a **coordinated** manner, ensuring that we communicate with the resident as a team and we avoid duplication
- We should be **persistent** in our attempts at engagement and retention with residents. This means giving residents numerous chances to work with us, and having no fixed end point to our attempts at engagement

6.1.1 – Inactive case reviews

As highlighted in the above principles, the team seeks to be coordinated and persistent in their attempts to establish contact. A key aspect of this approach is the use of inactive case reviews. The team operate a policy of only 'closing' cases where they have stabilised the resident's situation. If they fail to maintain engagement with a resident, then they will make the case 'inactive'. They then conduct 'inactive' case reviews on a quarterly basis to avoid the resident missing out on support. Similarly, if the team fail to establish contact with a resident they will seek to re-engage at their quarterly inactive case review. Any residents who have explicitly opted out of support will not be contacted again.

These inactive case reviews are rooted in a situational understanding of residents. Residents may not feel able to engage with the team at a given point in time because of a wide range of personal and environmental factors. Trying to establish contact at a different point in time is a way to give residents another opportunity to engage with support that we believe will be of benefit to them, rather than excluding them from support because at a particular moment in time they did not pick up the phone or answer the door.

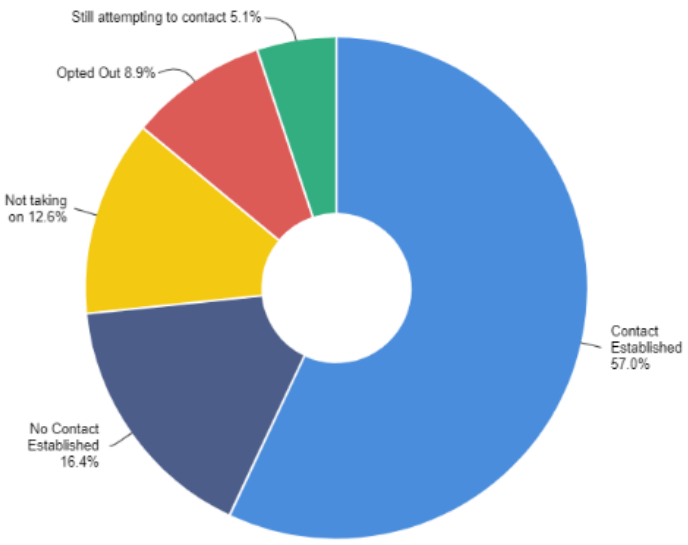
The rates of establishing contact presented in section 6.2 include 17 residents who the team established contact with following an inactive case review. Although these numbers are relatively low, that is still 17 more residents who through organisation and persistence we have been able to offer support to.

6.2 – Rates of establishing contact

Figure 19 (below) shows the extent to which the multidisciplinary team have established contact with the residents they have identified. The team established contact[23] with the majority of residents they approached (57%). This proportion actually increases to 64.5% when we discount those residents who the team were still attempting to contact at the time of the review or those that they decided not to contact after their in-depth screening process. Where the team have decided not to take a case on, this is where they have determined that the resident did not require support as they were clearly financially stable or being supported by another organisation. There were only 16.4% of residents for whom the team were unable to establish contact with at all. Perhaps most interesting is that less than 9% of residents opted out of support. It may be assumed that as the team are proactively contacting residents there may be a higher proportion of residents who opt out. The small number of these residents suggests little resistance from residents to this approach.

As case finding approaches are rare in welfare and homelessness services (see chapter four) it is difficult to find a point of comparison for these rates. However, as the team were proactively contacting these residents unannounced and many had previously been identified as 'difficult to engage', it can be argued that this is a high success rate.

Figure 19 – The rates of establishing contact for residents identified by the multidisciplinary team



6.2.1 – Variations by route

Figure 20 (below) explores how these rates of establishing contact varied between routes into the multidisciplinary team. The highest rates of establishing contact were among residents identified through the benefit cap, "bedroom tax" and Energy Services routes. A key point to draw from figure 20 is that the team had significantly less successful in establishing contact with residents identified through the use of predictive analytics. There are a number of important caveats to this point though. Firstly, in two of the predictive analytics routes the team were still seeking to establish contact with a high proportion of residents. Secondly, the predictive analytics routes did broadly focus on private tenants, who may have less experience of engaging with support services and are, therefore, less willing to engage. In turn, in reflective discussions the team highlighted a lack of data available for private households during their in-depth screening process. As a result, the team had less information on which to develop a personalised approach for the household.

[23] Broadly categorised as where the team have made contact, agreed with the resident that they would be willing to work with the team and booked a follow-up appointment

This may partially explain why the team also decided not to take on a greater proportion of residents from these routes. In their fourth periodic review, the team looked in-depth at the 'predictive analytics – private tenants' route and identified some inaccuracies with the financial information (see figure 21 below).

Figure 20 – Rates of establishing contact by route into the multidisciplinary team

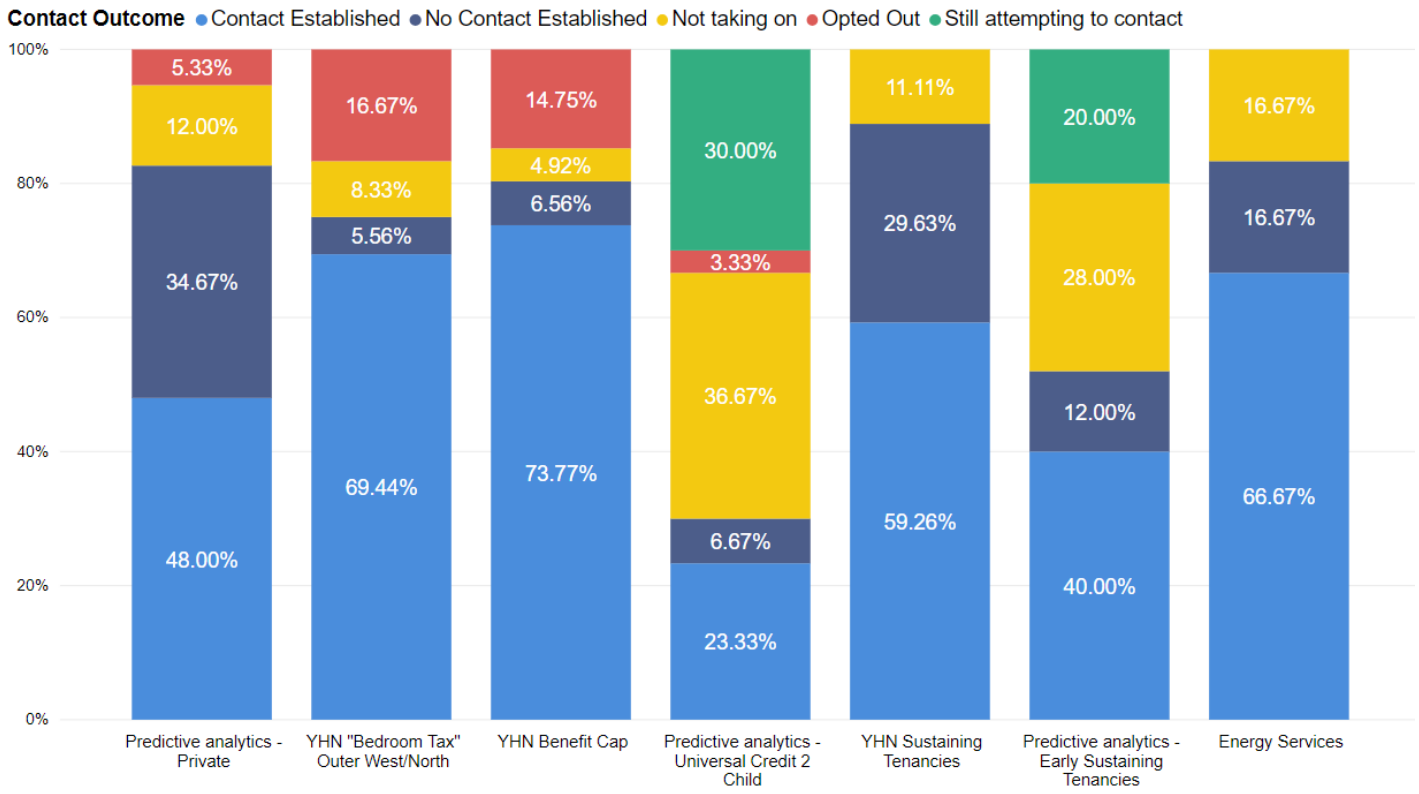


Figure 21 - Using predictive analytics to identify residents who may be at risk of homelessness in the private rented sector - Comparative analysis of income and expenditure

In their fifth periodic review, to test the efficacy of using predictive analytics to identify households who may be at risk of homelessness in the private rented sector, we carried out a comparative analysis of financial assessments on the dashboard, with those completed by the team. The multidisciplinary team established engagement with 35 of the 75 households they approached through the 'predictive analytics for private tenants' route. Of these 35, the team carried out complete financial assessments (of income and expenditure) with 15 households. We were able to compare the financial assessments of the team with those on the Policy in Practice dashboard, used to identify residents. **The results of this comparative analysis revealed a high degree of variation.** There was only one case where the income, expenditure, and surplus/deficit were within £50 of those undertaken by the team (within £60 for income). All figures presented are monthly.

Figure 21 continued

Of the monthly income and expenditure figures for these 13 households on the dashboard:

Income	Expenditure	Income v Expenditure
Two assessments of income were **within £1** of those undertaken by the team	Three assessments of expenditure were **within £50** of those undertaken by the team	Two assessments placed the surplus or deficit between income and expenditure **within £50** of assessments undertaken by the team
On average assessments of income were **£71.61 under** those carried out by the team	On average assessments of expenditure were **£159.60 over** those carried out by the team	On average assessments of surplus or deficit were **£235.38 below** those carried out by the team
Assessments of income ranged from **£745.17 under** and **£1,147.17 over** assessments carried out by the team	Assessments of expenditure ranged from **£445.19 under** and **£2,065.42 over** assessments carried out by the team	These assessments ranged from **£918.25 under to £1,050.00 over** assessments completed by the team

It is important to recognise the limited scale of this comparative analysis, which explored only 13 cases. Nevertheless, there was considerable variation between financial assessments carried out by the team and those that underpin the categorisation of financial risk on the dashboard. In these 13 cases, **the dashboard seems to underestimate income and overestimate expenditure** but, as yet, we are unable to determine any pattern in these differences as individual assessments vary widely. The team will now explore individual cases with Policy in Practice to identify reasons for these differences and conduct a wider comparative exercise on households identified through other 'predictive analytics' routes.

6.2.2 – What it took to establish contact

The value of the team's flexible persistent approach to engagement is demonstrated when we consider the number of attempts made prior to establishing contact with a resident. An average of four attempts were made before establishing contact with residents, with a maximum of 21 attempts made to a single resident. In turn, figure 22 shows that for the majority of residents (66.6%) more than three different methods were used by the team prior to establishing contact. Figure 23 shows that the most common method that was successful in 'getting over the line' in establishing contact was a phone call to a resident. However, home visits also featured prominently. Qualitative evidence from the team and residents presented in section 6.3 demonstrates the importance of home visits to the team's work. Case study 3 highlights the value of a persistent and flexible approach and home visits in particular.

Figure 22 – The number of methods employed prior to establishing contact

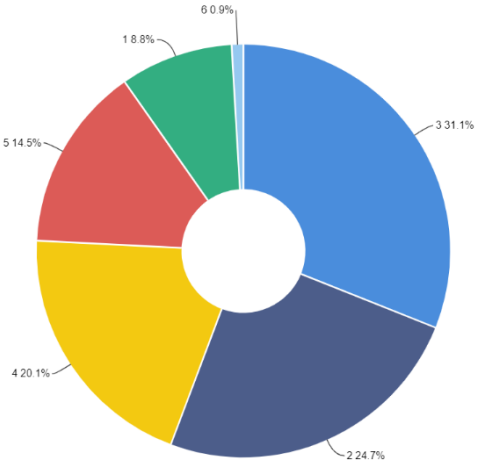
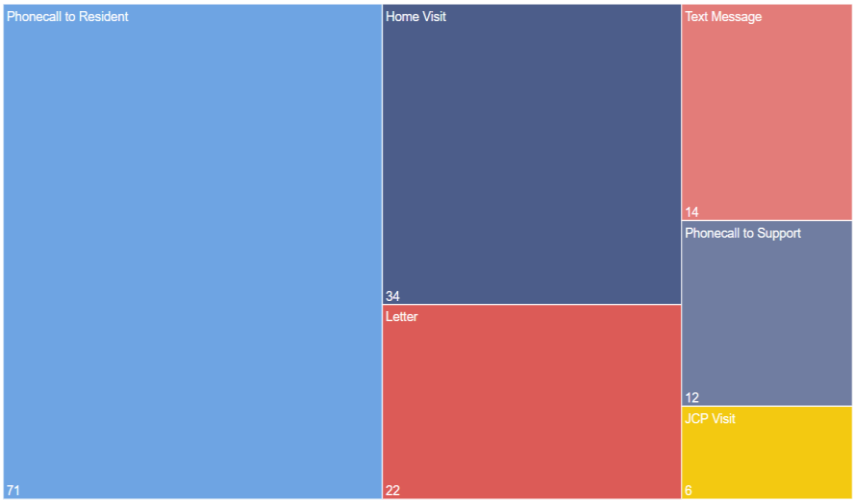


Figure 23 – The types of methods used to establish contact



Case study 4 (appendix 3) focuses on the benefits of a persistent and flexible approach to establishing engagement as well as the importance of maximising opportunities for support.

6.3 – Reflections on establishing contact

6.3.1 – The residents

51 residents responded to the team's structured questionnaire focused on residents' own perception of their situation. The first question residents were asked was the open question *"Why did you agree to meet with us after we contacted you?".* In individual reflective sessions, each of the specialists in the multidisciplinary team were also asked what they think has worked well in establishing contact with residents. As highlighted in the fourth periodic 'progress and learning' report, the team's flexible and persistent approach to establishing contact was an important factor in why those residents agreed to meet with the team after initial contact, with 18 residents making specific reference to this. The offer of home visits was again prominent among the responses of residents, with eight residents noting this as a reason why they agreed to meet with the team.

"I received the first letter you sent me so was expecting your call. You also offered to come and see me at home"

"You could come to the house. I find it difficult to go to places due to my anxiety, but I was also sick of burying my head in the sand"

"I wanted help and support with the benefit cap and you offered to do a home visit. Due to my anxiety and the fact that I have two young children I struggle to make appointments that are not at home"

The team's fourth periodic report also highlighted that many residents agreed to meet with the team because they already felt that they were struggling, either generally or with a specific issue.

The same trend continued this quarter with 38 (75%) noting that they felt that they required support.

"I wanted to know if I could qualify for free school meals for my daughter and if my partner's payments towards our Council Tax arrears could be reduced."

"To do with looking at the mobility side of PIP [Personal Independence Payment], and the Council Tax arrears and I thought 'ooh' perhaps someone could take a look at that"

"Just for help"

"I just had to, I needed to"

6.3.2 – The team

Persistence and flexibility to enable personalisation

In summative reflective discussions with the team, a number of themes converged to explain what the team felt worked well in establishing contact with residents. All team members referenced the importance of being persistent and flexible in their attempts at establishing contact. One team member noted that in their previous role there was an underlying ideology that if residents didn't respond then they didn't want any help. Whereas, in this team, there is a shared expectation that they do everything that is reasonably possible to establish contact. At different points, each team member also highlighted the importance of establishing shared ways of working during their first month together in building this expectation.

"We're quite pushy with our attempts, which has been more successful… sometimes there are other factors at play, which is why they don't engage initially"

Another team member noted that the in-depth screening process was a key part of this. Doing the screening and discussing cases with other team members gave the team a fuller picture of the challenges they face. They went on to note that this promotes a sense of urgency as they are more aware of what could be done to improve a resident's situation. Another specialist noted that home visits can increase feelings of empathy:

"It definitely makes you more empathetic … A budget can be abstract but when you go to their house and actually see what the money buys it's different, especially when they're mentally not very well"

Finally, two of the specialists also highlighted the importance of lower caseloads in enabling greater autonomy and flexibility in their work. In previous roles, team members reflected that due to high caseloads and more strictly defined roles, they were less mobile and less able to adapt their approach to the resident.

"In my previous role there was always loads of cases waiting, so if that resident didn't engage, you moved on"

The value of home visits

The value of home visits in establishing contact are apparent in section 6.3.1 within the perspectives of residents. They highlighted that contact was often established through a phone call, but it was the offer of a home visit or meeting at another convenient location that was the deciding factor in gaining a first meeting with residents.

"We can go to them – some residents find it difficult to travel, live quite far out and can't afford the travel [costs], or don't want to leave their home because of physical or mental health problems"

Each team member also stressed that home visits were not only important in establishing contact but also in retaining engagement and in supporting residents. In particular, specialists noted that home visits made it much more likely that you would be able to get the paperwork required for housing, debt, benefits or employment-related work because you weren't relying on the resident knowing what you wanted and remembering to bring it in to an appointment. One team member summarised the perspectives of others by saying:

"Home visits are the best thing ever, we could rarely do these before. You get more engagement because you're actually there. It also helps you get what you need from them, get a better understanding of them, lets you see the condition of the property and just makes it all faster"

6.4 – Conclusion

This chapter has focused on the team's approach to establishing contact with residents before exploring the extent to which this approach has enabled success. Section 6.1 described the team's personalised, flexible and persistent approach Section 6.2 presented evidence that demonstrated the persistent and flexibility of the team's approach and highlighted how it has contributed to establishing contact with 60% of the residents that have approached[24]. However, it was also apparent that rates of establishing contact varied across routes, with those routes identified using predictive analytics bringing less success. The lack of available data to inform a personalised approach and the higher proportion of private tenants in these routes were both cited as possible explanations for this difference. Finally, section 6.3 explored the reflections of residents and specialists on the team to provide further support for a flexible and persistent approach. Home visits were identified as a particularly valuable method in both establishing contact, retaining engagement and supporting residents.

[24] Excluding those the team decided 'not to take on'

7. Supporting residents

Chapter eight focuses on the team's reflections on the multidisciplinary approach, providing more detailed qualitative evidence of the culture that informs the team's approach to supporting residents. The outcomes that have emerged from the multidisciplinary team's work over the course of their Homelessness Prevention Trailblazer funded pilot are then outlined in chapter nine. Before then, chapter seven outlines some of the key characteristics of the team's cases. Section 7.1 looks at the extent to which the team retained engagement with residents after having initially established contact. Section 7.2 then looks at the varying time spent supporting residents before section 7.3 looks at the extent to which more than one specialist was involved in a case.

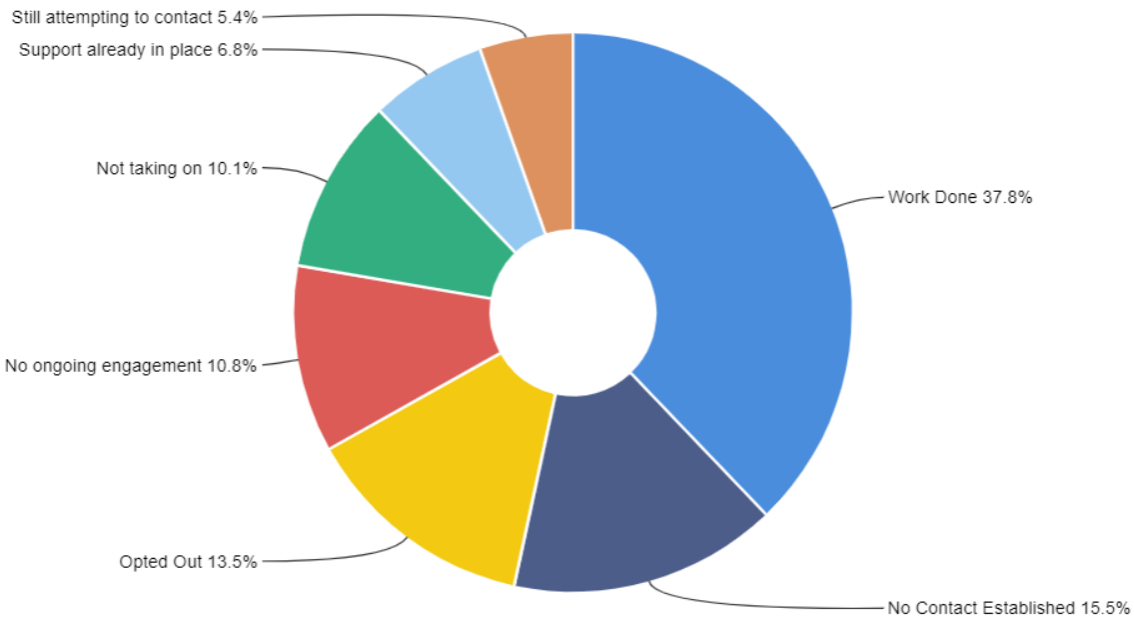
7.1 – Retaining engagement

It is important to explore rates of establishing contact to evaluate the efficacy of the team's case finding approach. However, it is also important to differentiate between where the team have established contact and where they have been able to retain engagement for a sufficient period of time to allow them to stabilise a resident's situation. As such, at their summative case review, the team classified cases according to the extent to which they had been able to retain engagement with residents. Cases were organised according to the following categories:

- **Work done** – the team have retained engagement for a sufficient period of time that they are able to complete a significant amount of work to stabilise their situation
- **No ongoing engagement** – where the team have started work to stabilise a resident's situation, but they have not been able to retain engagement with them for whatever reason. They may still have been able to achieve some short-term outcomes with these residents
- **No contact established** – those residents the team have been unable to establish contact with at all
- **Opted Out** – residents who either immediately opted out of support or opted out at an early point in their engagement with the team
- **Not taking on** – cases that the team have decided not to take on at initial screening or at initial contact with the resident
- **Support already in place** – residents who the team have identified as already being supported by another service or services
- **Still attempting to contact** – residents who the team were still attempting to establish contact with at the end of the pilot period

Figure 24 (below) displays the proportions of residents associated to each category demonstrating that the team have been able to retain engagement to the point of 'work done' for 40% of residents (n=112). In addition, they have started work but not been able to retain engagement with an additional 11.4% of residents (n=32). The outcomes presented in chapter 8 relate to these two groups of residents.

Figure 24 – Retaining engagement with residents



7.2 – Case length

Case length is determined by the number of days between the date that the team first engaged with a resident and the date at which the team recorded it as 'closed'. As the team work with residents for as long as required to stabilise their situation, it is important to capture case length. This allows exploring the differences between different cases, and the reasons for these differences. Of all of those cases where the team were able to establish contact and do some work with, the average (mean) case length was 177 days. At the end of the initial Trailblazer pilot period, the team's longest case was 544 days (and is still active at the time of writing this report). To better understand how case length differs across residents supported by the team, cases were split into quartiles:

- **Quartile 1** *(lower quartile)* – 1 to 52 days
- **Quartile 2** – 53 to 146 days
- **Quartile 3** – 147 to 259 days
- **Quartile 4** *(upper quartile)* – 260 to 545 days

These quartiles were used to explore variations in outcome achievement, as highlighted in chapter 8. For now, it is interesting to note that at least a quarter of the cases the team worked with lasted over eight months, showing that for some residents the work required to stabilise their situation can take a considerable period of time.

Case study 5 (Appendix 3) presents an example of the work required to stabilise one resident's situation over 344 days before the case was closed.

8. Reflections of multidisciplinary working

A key aim of the multidisciplinary team is to test integrated, multidisciplinary working. Therefore, it is important to establish the key benefits of multidisciplinary working, as well as the key challenges faced by the team. Originally the team were asked to complete reflective diaries to consider the benefits and challenges associated to this different way of working. However, over time it became apparent that these diaries were not the best method for encouraging team members to reflect on integrated working and the work of the multidisciplinary team more broadly. Therefore, in their fourth periodic review process, a different approach was trialled by carrying out individual reflective discussions with individual team members. In each periodic review, themes were drawn out of these discussions before being validated and consolidated through a workshop with the team. During the summative review, each specialist took part in a longer, more in-depth one-to-one interview with the researcher (see section 2.3.2). This section draws primarily on these interviews, supplementing with findings from previous discussions where shared themes have been established.

8.1 – The benefits of multidisciplinary working

8.1.1 - Holistic and personalised working

When asked what had worked well in supporting residents, all four specialists emphasised the holistic nature of the team's work and the support they offered to households. Specialists articulated this in similar ways, with each focusing on going beyond their specialism to support the household in other areas of their lives:

> *"We can do as much as we can and we're always willing to do new things"*

> *"We do things that aren't in our defined role to help the resident. We'll liaise with social services, police, go through DWP to find more information. Previously, I would have just made a simple referral without liaising or following up. Now, none of us think that's something we want to do … We take more ownership"*

For three of the specialists, this represented a significant departure from their previous roles, where they would have been primarily focused on their own specific area of work.

> *"Previously, I would be focusing on why the person wasn't paying at that time, rather than understanding the underlying reasons they can't afford to pay"*

> *"now we're focusing on the big problems and the little problems, formerly I would have thought 'that's not my job or its not appropriate for me to think about that"*

However, one specialist was more used to working in a holistic way, having previously worked in a role that had a wider remit. The same specialist specifically highlighted the value of identifying and working towards the priorities of individual households. She stated that even if what they wanted support with didn't match up with the team's priorities, it was still important to respect what the resident wants. Further, she saw it as pragmatic to work to residents' priorities in order to establish engagement and a relationship with them. Another specialist also highlighted the importance of developing relationships to enable a more personalised approach. She particularly noted that the

autonomy and flexibility available to specialists in the team was an enabling factor in allowing them to build relationships with residents:

> *"We have had the time to build a relationship with the resident and it's more led by them"*

8.1.2 - Promoting professional autonomy and flexibility to enable personalisation

All four specialists reported that they felt that they had more professional autonomy in this role than their previous role, albeit to differing extents. One specialist noted that in their previous role, their work would have been quite micro-managed and was largely target driven, whereas another noted that in this team there was a culture of "let's try it and run with it". Since its origins, this pilot had been focused on testing new ways of working and specialists felt that this had infiltrated the culture of the team. When asked, specialists highlighted that this greater autonomy had enabled them to adapt their approaches to establishing contact and retaining engagement to individual residents, by trying different methods that in previous roles they would not have been able to employ (e.g. home visits[25]). This theme also emerged during the team's fourth periodic review process, where one specialist noted:

> *"In this team, we have the flexibility and autonomy to keep on trying and trying to engage the resident on their terms"*

Specialists also noted that this professional autonomy, alongside working in an integrated multidisciplinary approach, allowed them to be more holistic in the way they supported residents. As they had done in their fourth periodic review, specialists highlighted the value of being able to make quick and personalised handovers to other team members rather than referrals to other services. In particular, they referenced the trust already established by other team members as a key factor in enabling a positive handover.

> *"when we get a referral from another team member, the trust is already there and residents only have to tell their story once. We can introduce the other specialist by name, as a person rather than as just a professional … It's a handover rather than a handoff."*

> *"Gaining knowledge and more insights into the other disciplines and using this knowledge when dealing with the residents. Being able to immediately pass a resident to the most suitable team member to help with a particular issue, avoiding a delay which could exacerbate the problem"*

8.1.3 - Integration as a means of enabling professional development

Specialists consistently highlighted that they felt working in a multidisciplinary team has enabled professional development, as well as improving the service they offer to residents. Specialists articulated this in a number of ways but consistently highlighted the importance of working with specialists from other disciplines enabled knowledge transfer, which in turn allowed specialists to

[25] See section 6.3 for a discussion of the value of home visits in engaging and supporting residents

develop their skills in other areas. In the team's fourth periodic review process, the balance between 'generalist' and 'specialist' was discussed. Team members were positive about working in a more holistic way with residents, they reflected on the value of both more generalist work that eased pressure on residents in the short-term, and more specialist work that tried to find longer term solutions. One specialist noted that this way of working was more challenging than her previous role, which was quite formulaic and less varied. However, she saw this challenge as a positive thing, noting that "there was always something new to learn or consider with the cases". As discussed further in section 9.2.4, perhaps the greatest change in role came for the Employment Specialist. As the majority of residents had no or limited work-related conditionality, the Employment Specialist's role became primarily focused on facilitating important liaison and advocacy with colleagues at Jobcentre Plus and the DWP more widely. Given the scale and pace of change in the benefits system and the reduced capacity within DWP (see section 1.3.3), this role was vital to supporting benefit claims, debt solutions, correcting inaccuracies in entitlement and ensuring that conditionality was appropriate to the circumstances of residents. The Employment Specialist highlighted that an essential factor in this work was the in-depth knowledge of cases that being integrated within the multidisciplinary team brought.

"It helps to have four sets of eyes on a case … we've all got a unique way of looking at a problem and talking through them makes you think a bit differently"

"My capabilities have increased by finding out information about each other specialism. We've all picked up on each other's specialisms … It comes from discussion around specific cases"

"we're becoming more generalist, but don't get me wrong, it's not like we're making cups of tea, it's still all related to the specialisms of the team"

The specialists' responses highlight the importance of not simply working alongside other disciplines. What was important being integrated with those disciplines:

"It's the team's case, not an individual's case"

As highlighted in the next section, a key catalyst that enabled integration was the team's person-centred approach, which provided an axis for the team to develop their integrated responses around the needs and circumstances of individual households.

8.2 – Factors promoting integrated multidisciplinary working

There was a number of facilitators highlighted by the team's specialists, each of which stressed the importance of developing structures that allowed for an inductive way of working. The structures have sought to use co-location as part of our efforts to integrate caseworkers from four different but complementary specialisms. However, our experience is that co-location is not sufficient to achieve integration alone. The team's flexible approach guided by their review process enables reflection on the extent to which the team have achieved integration and how they may support residents in a more integrated way as their work develops. The following sections outline three consistent themes that emerged from discussion of the factors that promoted integrated, multidisciplinary working.

8.2.1 – Establishing the foundations

All of the specialists emphasised the importance of being able to spend their first month together establishing the foundations for how they would work together (see section 3.1). Specialists reflected that the structured approach to this period allowed them to develop a series of shared policies and protocols to determine their ways of working. Specialists reflected that they enjoyed and valued being involved in the design of the service, which helped to promote a shared ownership of the direction of the team's work.

"It was interesting to actually have an opportunity to participate in the design of the service"

"Looking back now we didn't appreciate it at the start but the first month together was really important. That we have been able to work without a team leader is testament to that work. We developed a shared way of working through developing policies and procedures"

However, the specialists also emphasised how this period allowed them to get to each other as professionals and people. This was essential for establishing a shared culture within the team through developing a mutual trust between specialists and with the embedded researcher. Specialists also highlighted that good recruitment played an important role in developing this mutual trust. Their reflections also indicate that simply co-locating staff is not sufficient to achieve integration between staff from different disciplinary specialisms. Time and effort must also be committed to producing shared ways of working and mutual trust between colleagues. As highlighted in sections 2.1 and 8.2.3, encouraging and enabling partnership and participation between researchers and practitioners is a central aspect of the action research approach that underpins the team's work.

"You chose well with the team, we all have a similar work ethic"

"We got the opportunity to get to know people, which allowed us to get into the personal stuff and get an understanding of the people in the team. It's always a pressured environment at the start of new projects and it needed to be facilitated. If we didn't have that time in a room giving our opinion and having nowhere to hide, I don't think it would have worked. It made a huge difference. Doing this at the beginning also allowed us to be involved in the design of the team. It made us feel like we were invested in this piece of work"

"previously, you could even be sitting two rows from [other service] and technically be working on the same case but because your roles and tasks are segmented you aren't actually working together and residents can easily fall through the gap"

8.2.2 – Designing a structure that enables flexibility

As highlighted in the previous section, the team's first month together was spent developing a framework of policies and protocols, informing shared ways of working. The team's reflections revealed that developing this framework created a structure for their work. As this structure was co-produced by the team it contributed to a more integrated approach based around individual households.

> *"At the start we had to work towards integration, there was a checklist of others' areas in our introductory questionnaire that we developed in the first month, now it's more habit to consider everything, not just our own specialism"*

However, some specialists also recognised that integration did not come immediately, it had to be worked at over time. The policies, protocols and associated meetings provided a blueprint, but greater integration came through embedding research alongside practice. The team's process for capturing learning allowed structures to be reviewed and improved. It also allowed the team to share learning between themselves and with others, adapting their approach as they learned more about residents. Doing so contributed to greater integration between specialists by providing a flexible approach that develops through shared learning.

> *"The case identification and review meetings and inactive case reviews … they allow for more integration because they're based around the needs of the household. They also allow us to find out why they haven't engaged and what we could differently … the structure is in place to allow for flexibility like a change of approach"*

Two specialists also highlighted the way in which the process for capturing learning also provided scrutiny. However, they were keen to highlight that this scrutiny was not seen in a negative light.

> *"The research gives us a structure that allows for flexibility … it brings accountability through the reviews and the ability to prove things. We see the work we do as snapshots in periods of residents' lives. We appreciate the context more so we're not frightened of it."*

> *"The reviews are useful but I don't necessarily look forward to them, they bring scrutiny … They also act as a catalyst for things to happen, I don't get the sense that they are an opportunity for a boss to tell you off, they're part of a process of finding the answer together"*

8.2.3 – Embedding research alongside practice

As discussed in the previous section, the team's action research approach provided a structure through which the team could review and develop their work further. The focal point of the teams' action research project was the households they identified, approached and supported. Specialists highlighted how this culture was established at the beginning of the pilot. Their perspectives also reveal that, like being part of designing the service, the team enjoyed being involved in research that informed their practice, and vice versa.

The team's reflections revealed how this research informed approach encouraged a more democratic orientation to their work and helped develop a 'safe' environment in which specialists felt that they could voice their opinions without fear of 'being wrong'. Two specialists reflected that in their previous role you may be less likely to share your opinion for fear of showing yourself up among colleagues from the same discipline. As the team all come from different disciplines there was less reluctance to discuss different approaches.

"From the start, we were expected to make our opinions heard. We have a culture of testing and learning, it's like an open-ended question, which makes it interesting and we're part of the research … It also links to being a 'safe' way of working, where there's no rights or wrongs. It's nice to be part of a team where we're not afraid of failure, finding out what doesn't work is valuable too. I really like that we have the stories, but we also have the data and we need both … Having a researcher aligned to the team have been central to this, helping to articulate the work"

"The fact that we've all come from different disciplines … it's engendered a way of working where we're much more open to asking each other for advice and support and I don't think in our previous roles we would have had the flexibility to do that"

8.3 – The challenges of multidisciplinary working

Although the team's reflections on multidisciplinary working were overwhelmingly positive, they did also highlight some challenges that they have faced over the Trailblazer pilot period. Some of these challenges, such as 'balancing caseloads' and 'working in a small team' were related more specifically to the team's work. Others such as 'limits of a multidisciplinary approach' related more to the context the team worked in, highlighting that this context is not wholly conducive to developing an integrated, multidisciplinary approach.

8.3.2 – Working in a small team

Two specialists noted that working within a small team sometimes posed challenges to integrated working. They each used the example of being in the office by themselves and fielding questions from residents about specific aspects of casework. As the team operate a flexible approach to engagement with residents, individual team members are often out of the office. The team have an 'at a glance' spreadsheet which each of them can access to give quick updates to residents. However, this does not contain detailed information on casework, which is contained in individual databases. The challenge of working on fragmented databases is highlighted further in section 8.3.4. Although not specifically related to multidisciplinary working, this challenge was arguably exacerbated by working with specialists from other disciplines. Section 8.1.3 discussed how practitioners felt that they were developing knowledge and skills in other areas, but this could not replace specialist disciplinary knowledge. As a result, one specialist suggested that one way to improve the team further would be to increase the capacity of the team to include two of each specialism.

"It can be challenging when you're the only one in the office and residents call with questions. You can try to calm residents down but its difficult to give advice right then when you're not a specialist [in that area]"

8.3.3 – Balancing case loads

Another challenge highlighted by specialists was balancing caseloads over time and between specialists. Specialists reflected that at times caseloads became uneven, with some specialists taking on more cases than others. The team have been testing different routes for identifying residents who may be at risk of homelessness. As a result, it was not always possible to ascertain the detailed picture of the work that each resident would present with until they conducted their in-depth screening. Once screening had been undertaken, it sometimes became apparent that groups of residents had needs related to one disciplinary area but not in others. For example, section 9.2.4 highlights some of the challenges in identifying residents that were both at risk of homelessness (and, therefore, facing significant challenges) and those ready to be supported to move into employment. One specialist also reflected that cases may build up over time, as although specialists only had a certain number of cases in which they were 'lead', they also worked on many others, in line with the team's holistic and integrated approach. As sections 9.2.2 and 9.2.3 highlight, debt solutions and gaining benefit entitlements also took considerable time. As more complex cases lasted longer periods of time, caseloads built up for certain specialists. However, these specialists did reflect that they didn't feel alone in managing their caseloads, with other team members keen to support at times of greater demand. To mitigate this issue, one specialist suggested staggering more than one route at a time, each with a different focus so that the team had a mechanism for balancing caseloads if they became unevenly distributed.

"they are often uneven, maybe we could look at staggering routes … it would also be good to be able to pause routes. Having said that, we are all keen to help each other with caseloads, there's no hesitation to step in"

"you might only have x amount of cases but you have your fingers in many cases and we don't close cases so people pop back up with serious issues"

8.3.4 – Fragmented data systems

Section 8.2 discussed the structures that the team had developed to facilitate integrated working based around a greater understanding of the circumstances of the households they support. However, the team consists of specialists from four different services and three different organisations. As such, they each work on different case management databases, each with different recording and reporting functionalities. The team's holistic approach also means that they also need to feed into additional information systems such as those in Children's or Adult Social Care. As the team were established as a time-limited pilot it was not possible to develop and test a single database for all of the team's work. Even if this had been possible, it would not have been wholly conducive to multidisciplinary working, as the team would still have had to record updates on the databases aligned to their respective specialisms. If they had not done so, they would have been working in isolation from the wider system of support in the city. The challenges fragmented

data systems brought for capturing learning and outcomes from the team's work are discussed briefly in section 2.3.1. However, it also brought challenges for integrated casework. Chief among these challenges was duplication of recording, with updates recorded in more than one place to ensure that the team and wider services were all sufficiently aware of progress with cases.

"it would be easier to have everything [case recording] on a single database"

"It would be useful to have an admin function to help put people onto the databases particularly if cases are stored in multiple places"

8.3.5 – The limits of a 'multidisciplinary' approach

The challenges related to fragmented databases overlap with challenges faced in developing a holistic approach to supporting residents in a context that is not wholly conducive to this type of working. The team's holistic approach was necessarily bounded by their four disciplinary specialisms. As demonstrated throughout this report, within these four specialisms the team were able to develop more integrated approaches to supporting residents. However, when a household's needs extended beyond these specialisms the team faced greater difficulty in facilitating a truly holistic response. This is not to say that the team were not able to work with households with additional needs, but it required a great deal of extra time, effort and resilience on the part of specialists. In particular, the team highlighted the challenges of navigating mental health and Children's Social Care systems, each of which had distinct protocols, thresholds and points of focus that did not always align with those of the team. Case studies 2, 3 and 6 reveal complexity added when trying to work holistically with households that had additional needs, both in the support given and the nuanced nature of outcomes achieved.

"Dealing with wider protocols, like safeguarding, and being told that they won't take it, that feels hard because where do you go next? The resident wants help from you but there's other bits of help you can't give them so you can't give them all they need. You're left in a situation where you're almost hoping that something goes wrong with them because that's the only way they'll get support"

8.4 – Conclusion

This chapter sought to establish the key benefits and facilitators of multidisciplinary working, as well as the key challenges faced by the team. The themes outlined throughout the chapter were drawn from the team's own reflections. These reflections were primarily drawn from one-to-one interviews conducted with team members at the end of the pilot.

The team's reflections emphasised that working in an integrated, multidisciplinary way allowed for a more holistic approach to support based around the needs and circumstances of individual households. They also noted the importance of professional autonomy and flexibility in enabling greater personalisation in the way they approached and supported households. Finally, the team felt that being integrated with other professionals from other disciplines allowed for professional development through knowledge exchange between specialists.

The team's reflections also revealed that these benefits did not emerge spontaneously, but were facilitated by a structured, yet inductive approach. The blueprint for this approach was developed in the team's first month together when they co-produced a foundation of policies and protocols.

They also used this period to get to know each other and started to develop a shared culture within the team. This culture and the team's way of working was nurtured by the team's process for capturing learning, which provided structured opportunities to review and further develop their work through shared understanding.

Finally, section 8.3 focused on the challenges of multidisciplinary working. Some of these challenges, such as 'balancing case loads' and 'working in a small team' were related more specifically to the team's work. Others such as 'limits of a multidisciplinary approach' related more to the context the team worked in, highlighting that this context is not wholly conducive to developing an integrated, multidisciplinary approach.

9. Outcomes

As discussed in section 2.3.1, the team seek to work with residents in a holistic way, focusing on housing, financial, benefits and employment-related support whilst also appreciating that work in these areas will inevitably involve touching on other areas of resident's lives. As a result, there are a range of possible outcomes that can be achieved with households. Residents also face different circumstances, and cannot all achieve the same outcomes, making it difficult to define and measure success across residents.

During their summative reflective discussions (see section 2.3.2) the multidisciplinary team reflected on what constitutes 'success' for the residents they have supported. One specialist noted that at the summative case review, it felt like a success when there were outcomes across all four specialisms that make up the team. At their fourth periodic review, reflective discussions with the team highlighted the importance of outcomes that were personalised to the situation of the resident they were supporting. They also highlighted the importance of sustaining outcomes, whilst recognising the difficulty of doing so when faced with such significant structural challenges. In their summative discussions, the same themes emerged with each specialist noting that what constitutes success can differ substantially between residents, depending on personal circumstances, social relationships and structural constraints. In turn, sustainability was a key theme across specialists' perspectives. Ultimately, one specialist summed up the perspectives of others by noting:

> *"helping residents to at least be more stable than they were"*

The outcomes highlighted through the remainder of this chapter demonstrate that, for many residents, the team have gone far beyond this rather modest goal. However, their modesty demonstrates an appreciation of the context in which they operate and the extremely significant challenges that many of the residents they support experience in their lives (see sections 1.3 and 5.3).

The remainder of this chapter looks at the range of outcomes the team have achieved with residents over the course of the Homelessness Prevention Trailblazer pilot period. Section 9.2 explores outcomes across the four domains the team work in as well as looking at the impact of the team's work on residents' wellbeing. First, section 9.1 explores some 'headline' outcome measures for the team's work, including a comparison of the rent accounts for residents the team have supported and those they have not[26].

9.1 – 'Headline' outcomes

Before exploring the outcomes achieved across individual outcome domains (see section 2.3.1 and appendix 2), this section looks at some 'headline' outcomes associated to the team's work. As outlined in earlier sections, the vast majority of the residents that the team have identified face significant financial challenges[27]. The link between these financial challenges and homelessness is largely mediated by a resident's ability to pay their rent. Section 9.1.1 focuses on the change in the rent balance of the residents identified by the team, looking at whether residents have reduced their immediate risk of homelessness by reducing arrears or increasing credit on their rent accounts. Of course, changes to rent balances can be fleeting and do not necessarily indicate affordability in the longer term. Therefore, sections 9.1.2 and 9.1.3 look at the difference between

[26] See section 7.1 for the categorisations used to organise the cases the team approached

[27] See sections 1.3 on the context of the team's work and sections 5.3.1 and 5.3.2 for the financial challenges faced by the residents they have identified

the amount residents receive through benefits for their housing costs and their rent (their rent shortfall) and their eligible rent as a percentage of their remaining income. Both of these measures allow for greater interrogation of the extent to which the team have been able to stabilise a resident's situation and reduce their risk of homelessness.

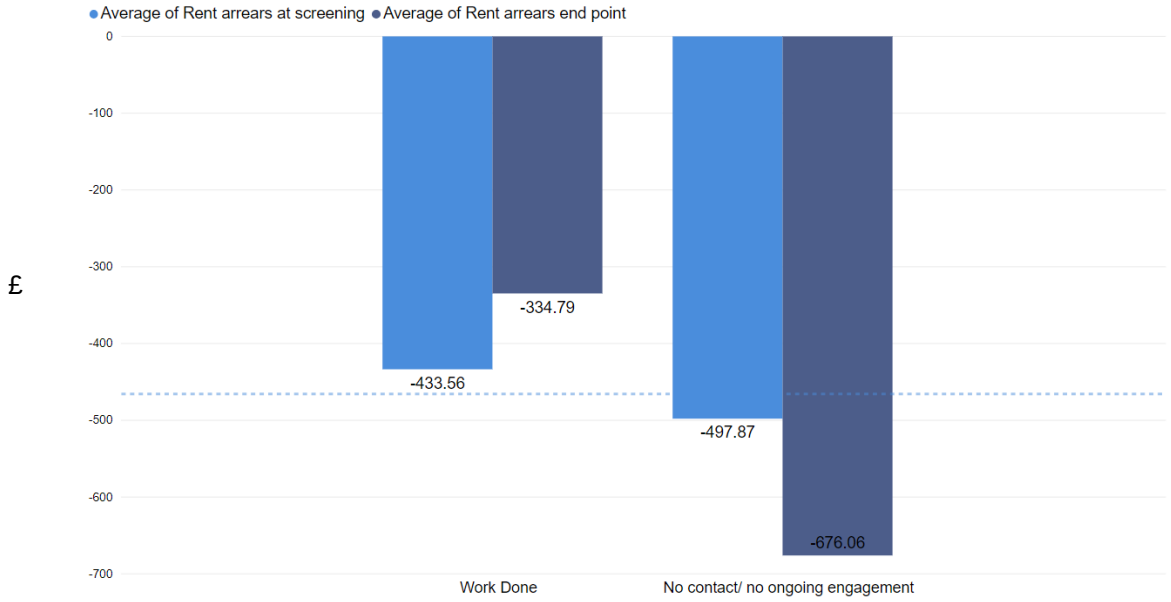
For each of the measures discussed in sections 9.1.1 to 9.1.3, the 'start point' is defined as the point at which the team conducted their in-depth screening of the household. For 'work done' cases that had been closed, the 'end point' measure was taken at the point at which the case was closed. For 'work done' cases that were still active and all other cases, the 'end point' measure was taken when the summative case review took place. As a result of the differential time periods over which change was measured, the findings in each of these sections should be treated as indicative, rather than definitive. In turn, as described in section 7.1, cases were categorised in a number of different ways, with significant differences in the number of residents in each. To aid clarity and limit issues associated with drawing inferences by comparing averages of significantly different sample sizes, each of the following sections compare the residents categorised as 'work done' (n=112) with those who the team had 'no contact/no ongoing engagement' (n=117)[28]. Cases categorised as 'support already in place', 'not taking on' and 'still attempting to contact' were excluded from the analysis.

9.1.1 – Change in rent arrears

As discussed in section 5.3.2, there was an average of £507.44 of rent arrears among the residents identified by the team, indicating a high and relatively imminent risk of homelessness. Figure 25 (below) shows that the multidisciplinary team supported residents in the 'work done' categorisation to reduce arrears by an average of £98.77. In contrast, the arrears for those residents in the 'no contact/no ongoing engagement' categorisation increased by an average of £178.19. These findings indicate that where the team have been able to sufficiently support a household, they have been able to reduce their risk of homelessness (albeit not eliminate it). In one case, the team were actually able to reduce one resident's arrears by £3,743.89 from £4,454.68 at screening to £710.79 at the 'end point'. However, these findings also indicate that those residents who the team have been unable to either establish contact or retain engagement with continue to live in precarious situations, with an ever increasing risk of homelessness. As the team adopt a case finding approach, it is important to acknowledge a responsibility to both those residents they have worked with and those they have not been able to support. Yet, this acknowledgement must also come with a recognition of the limitations of a single team in achieving and retaining engagement with a wide range of residents.

[28] Including cases categorised as 'no contact established, 'no ongoing engagement' and 'opted out'

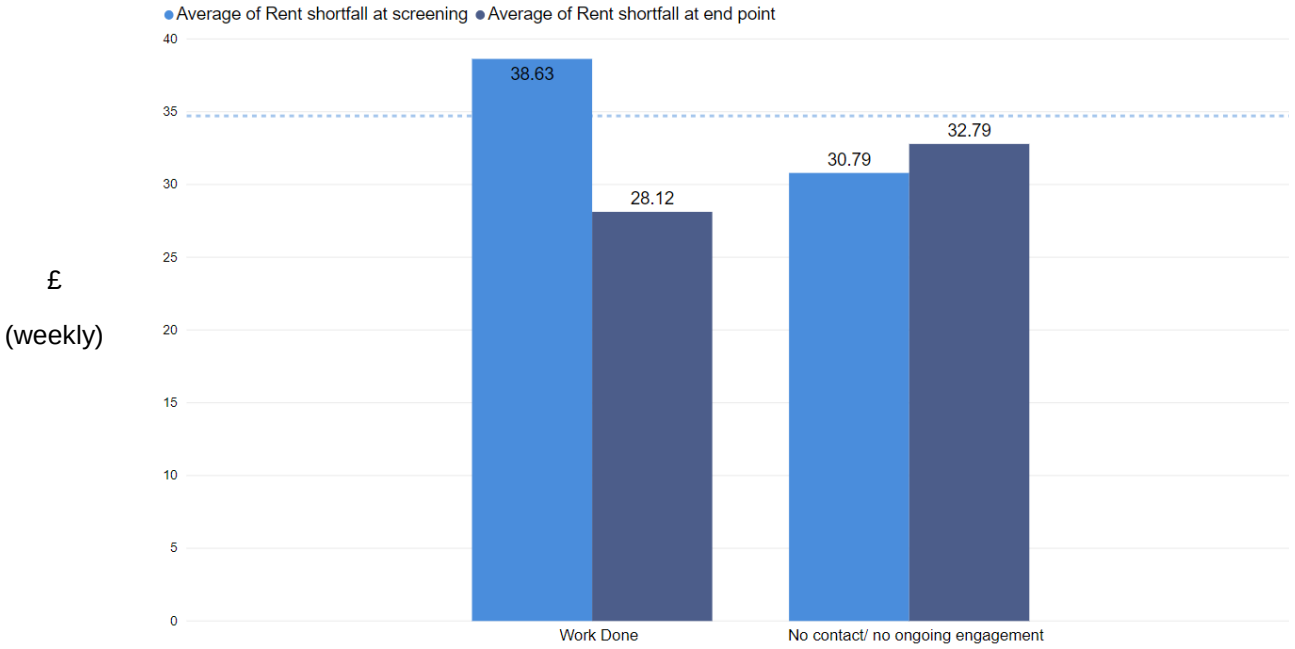
Figure 25 – Change in rent balance at screening and end point



9.1.2 – Change in rent shortfall

As mentioned in the introduction to this section, rent shortfall is an earlier indication of the affordability (or lack thereof) of a household's housing situation and consequently their risk of homelessness. Rent shortfall refers to the difference between the entitlement a household receives to cover their housing costs and their actual housing costs. Figure 26 (below) shows that for those residents the team have been able to sufficiently support ('work done') they have reduced household's shortfall by £10.51 a week. In contrast, the rent shortfall for those residents who the team were unable to establish contact or retain engagement with have increased by £2 per week. These findings broadly mirror those outlined in section 9.1.1, indicating that the team have not only been able to mitigate residents' risk of homelessness in the short-term by reducing arrears but also stabilise their situation in the longer term by reducing their rent shortfall.

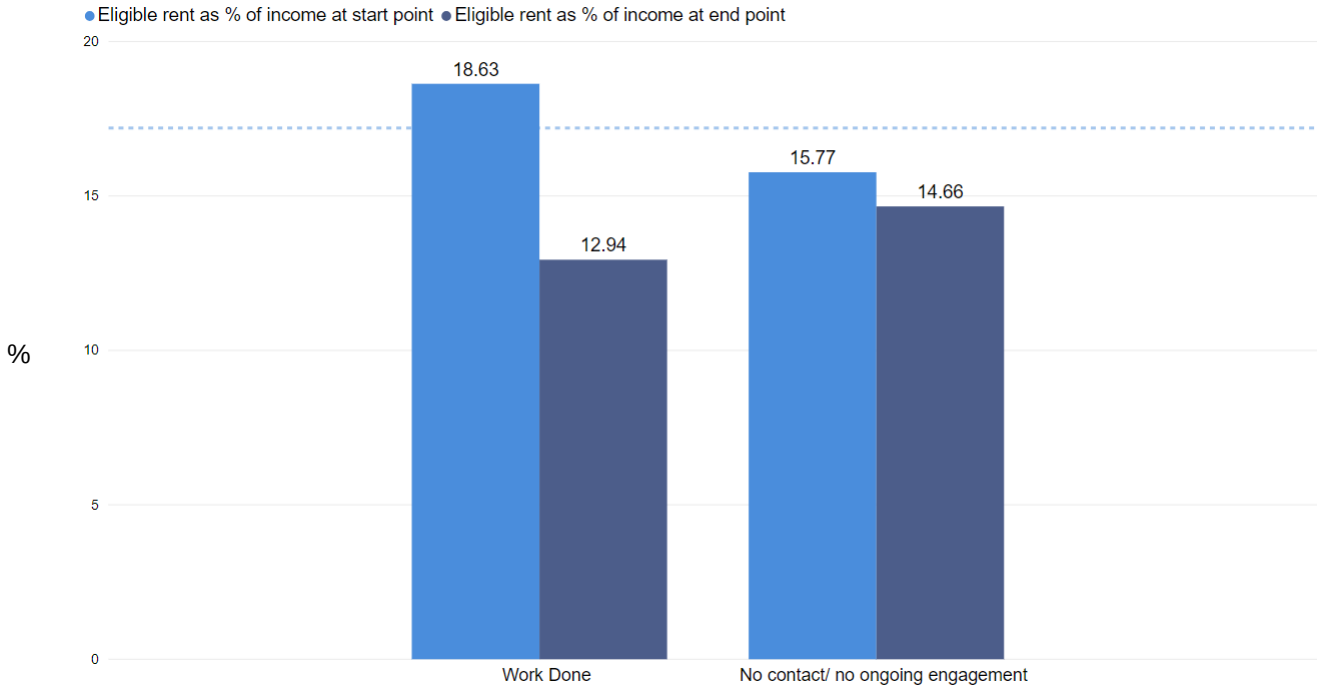
Figure 26 – Change in rent shortfall at screening and end point



9.1.3 – Eligible rent as % of income

Another measure of the extent to which the team have supported residents to stabilise their situation is by looking at how much their eligible rent (the rent they have left to pay after their housing entitlement) is of their remaining income (after housing entitlement is discounted). Figure 27 shows the change in eligible rent as a percentage of income from screening to 'end point'. The findings reaffirm that the team have been able to stabilise the financial and housing situations of those residents they have sufficiently supported ('work done'), reducing the proportion of additional income spent on topping up housing costs by an average of 5.69%. The proportion of additional income spent on housing costs decreased less for those households who the team did not establish contact or retain engagement with by 1.11%.

Figure 27 – Change in eligible rent as a percentage of income at screening and end point



9.2 – Outcomes across domains

The findings in section 9.1 indicate that the team have been able to reduce the risk of homelessness for those residents they have been able to work with. This was evident both in more immediate terms through the reduction in rent arrears and the longer term by reducing the proportion of income households were spending on their housing costs. This section now focuses on the outcomes the team have been able to achieve within each of the individual domains that constitute the specialisms of the team. Section 9.2.5 also explores the extent to which the team have been able to make a difference to the wellbeing of residents, drawing on the perspectives of the team and a sample of residents supported by the team. The findings throughout this section draw on both the summative case review (see section 2.3.1) and telephone survey (see section 2.3.3).

9.2.1 – Housing

The findings in section 9.1 could be broadly interpreted as 'housing' outcomes. This section focuses on other housing-related outcomes related more to the quality, location and security of housing that are essential components of building a greater sense of home.

Figure 28 – Housing-related outcomes

18 households were supported to gain free **furniture and white goods** to a total of **£13,741.65**, with up to **£2,296.10** of goods gained for one particular household

For **15** of these households, replacing the furniture pack they were renting from their landlord meant they were **no longer affected by the benefit cap**

11 households were supported to move property so they could be **closer to work, education or social networks**

5 households were supported to move **away from potential risk of harm or harassment**

The vast majority of furniture and white goods were gained through Supporting Independence Scheme (SIS) awards[29] funded and administered by Newcastle City Council after the removal of the Social Fund. Although the overall numbers were low in comparison to the number of households supported, they had a significant impact by taking 15 households under the benefit cap by reducing their expenditure on rented furniture. In turn, the majority of the team's work focuses on keeping residents in their homes by stabilising their financial situation. However, for a minority of residents, the team's work focused on first supporting them to move to a new property. Figure 32 highlights one such case where a household was supported to move closer to social networks after having previously moved because they were fleeing domestic abuse.

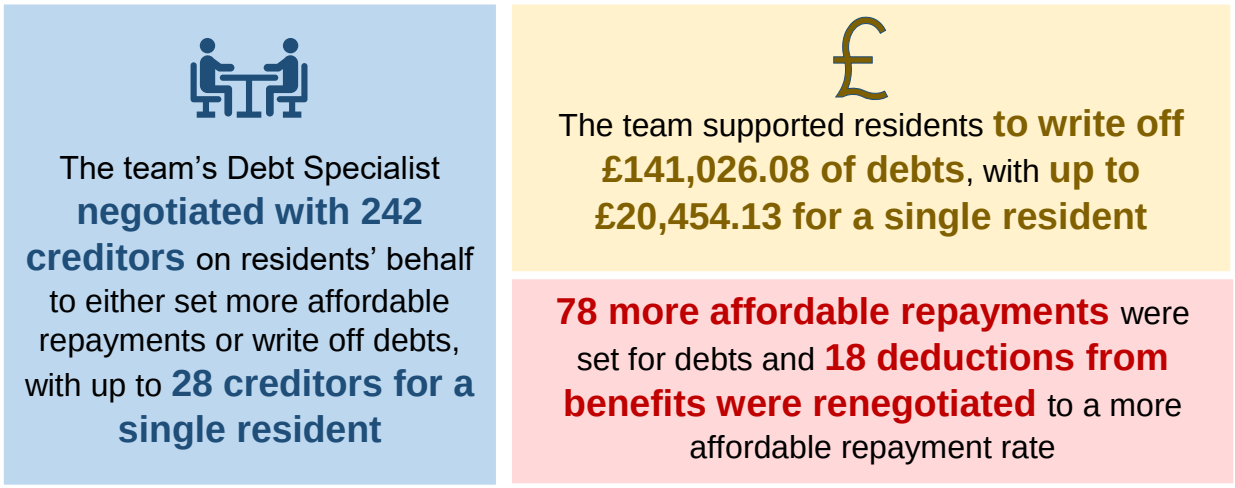
Findings from the summative telephone survey also indicate the team's work may support residents to feel more settled in their home. When asked '*since working with the team, do you feel more or less settled in your home?',* the vast majority (81.5%) of respondents noted that they feel slightly or much more settled in their home since working with the team.

9.2.2 – Finances and debt

Supporting residents with debt and budgeting represented a key part of the team's work over the course of their pilot. Figure 26 shows the key debt-related outcomes from this work.

[29] The Supporting Independence Scheme (SIS) replaced the Community Care Grant element of the Social Fund on 1 April 2013

Figure 29 – Debt-related outcomes



The £141,026.08 of debt written off has been accrued across just 19 residents supported by the team, with an average of £7,422.43 written off per resident. The most common debt solution employed by the team was a Debt Relief Order (DRO), used in 11 of the 19 cases, with write-off requests making up the majority of the remaining 19 and 1 bankruptcy. These outcomes were distributed relatively evenly across different routes. When compared against the case length quartiles, it becomes clear that debt write-off is a solution that takes considerable time and ongoing engagement. 15 of the 19 cases where debt was written off lasted over 147 days. When we look at the amount of creditors the team's Debt Specialist negotiated with, it becomes clear to see why these outcomes can take such a significant period of time and effort. One DRO involved 28 different creditors, which meant gaining, organising and submitting information across a wide range of debts. As highlighted in section 6.3.2, home visits were essential in gaining sufficient evidence of debts in order to include them within a DRO. On average, the Debt Specialist negotiated with over four creditors for each resident; for eight residents they negotiated with 14 or more creditors. As a result, by renegotiating repayments or writing off debts the team are able to remove a significant burden and stressor from residents.

Alongside the more specialist debt work undertaken by the team, the team have also provided budgeting support to help residents manage their finances. As the majority of residents face significant financial challenges underpinned by poverty and exacerbated by welfare reforms, budgeting support is essential to limit the possibility of them falling back into debt. The team provided budgeting support to 88 households, with more intensive budgeting support offered to 36 households. This more intensive budgeting support can be differentiated as when the team have actively developed weekly budgeting plans and other resources with households to help them manage their money as efficiently as possible. In their summative review, the team reflected on their perception of how effective their budgeting support had been across these 88 households. In the majority of cases (64.4%), the team felt that budgeting support had a positive impact. In the remaining cases, the team did not feel that they could definitively state that the support had made a positive difference because the household had been unable to follow the budget.

Figures 30 and 31 display the responses of the 28 residents who took part in the summative telephone survey (see section 2.3.3). They support the idea that the team's work around debts and budgeting have enabled residents to feel more financially stable, in turn reducing stress related to bills and financial management.

Figure 30 – Do you feel more or less financially stable since working with the team?

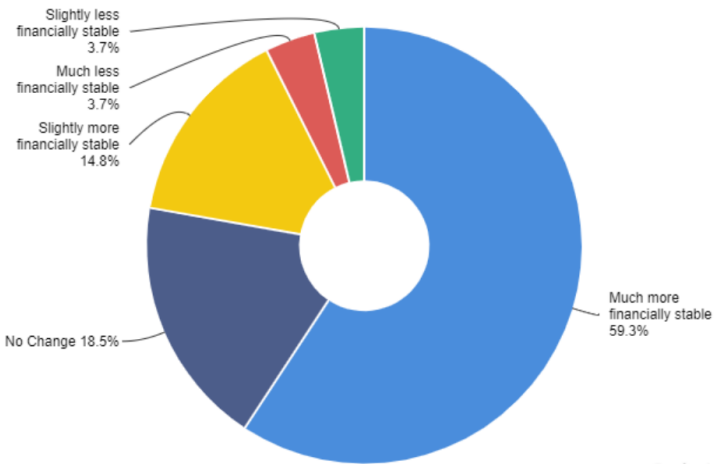


Figure 31 – Do you find paying your bills more or less stressful since working with the team?

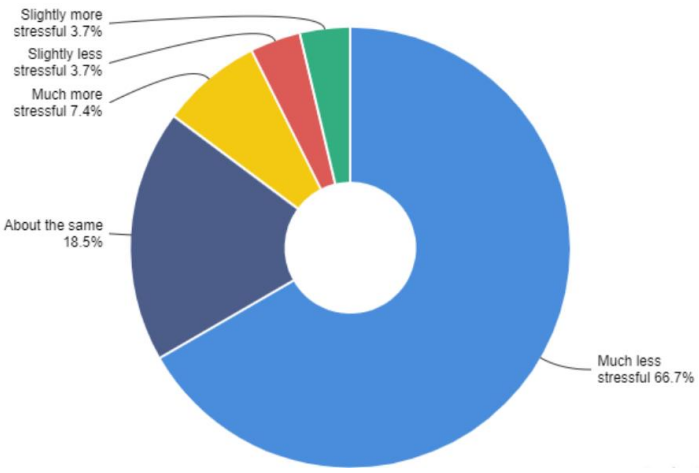


Figure 32 – A case study of debt and budgeting work

Context

Lucy is a 27 year old resident with five dependant children

Lucy was affected by the benefit cap, leaving her with a rent shortfall of £55.16 per week

The team established contact with Lucy after a letter, two phone calls, two text messages and an unannounced home visit in January 2018

They worked with her for 136 days

Work done

To stabilise Lucy's situation in the short-term the team made a successful application to **the SIS to replace her furniture pack** and reduce her rent by £31.65 a week. The team also completed two DHPs while they worked towards longer term solutions

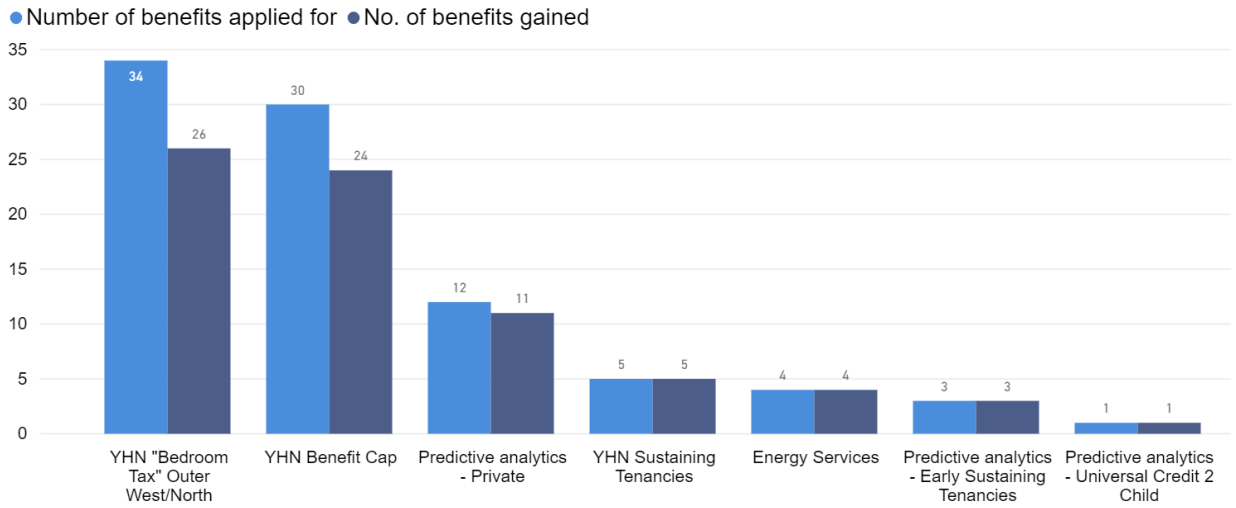
The Debt Specialist supported Lucy to **write off £15,689.20 of debts across 18 different creditors**. She was then given intensive budgeting support to help her manage her improved finances. The team felt that this had a very positive impact as she is maintaining the budget

Lucy moved into her current home after fleeing violence from her ex-partner. The team also supported her to move closer to her family

9.2.3 – Benefits

As well as reducing expenditure through housing, debt and budgeting work, the team's work also focuses on increasing income. The primary way in which the team increase residents' income is through gaining additional benefits, which the household were entitled to but were not receiving. Figure 33 shows some of the key welfare benefit-related outcomes from the team's work.

Figure 33 – Benefit-related outcomes



£

The team gained **£288,960.81 in additional benefit entitlement** for households (annually), with up to **£27,002.74 for a single household**

79 residents were given **advice or support around their benefit entitlement**

In total, the team applied for additional benefits for 89 different entitlements for 46 different households and gained 74 of these entitlements across 34 households. The household that was supported to gain £27,002.74 is outlined in more detail in case study 6 in appendix 3.

The quality of supporting evidence played an important part in determining whether benefit claims were successful or unsuccessful. The Welfare Rights Specialist required and gained supporting evidence from medical professionals for 41 households. The team focused on supporting evidence in their second periodic review, highlighting variations in the quality of supporting evidence for Personal Independence Payment (PIP) claims. The specialist rated 61.1% of the evidence she gained as useful or very useful in supporting the claim. The team have since written a briefing paper on medical evidence, which has contributed to attempts to develop a more consistent approach to gaining medical evidence across the city.

Some of the benefits claims submitted by the team were initially unsuccessful. The team then supported residents to make mandatory reconsiderations and appeals, which can take considerable time and effort. In her summative reflective discussion, the team's Welfare Rights Specialist noted that in her previous role many of the residents she supported would not have met the threshold for direct support. In turn, many would have struggled to maintain engagement or act independently on the advice given without additional support. As the team have less of the constraints associated to large caseloads, they can work with residents for as long as required and offer more personalised support. Therefore, the Welfare Rights Specialist had more autonomy and flexibility to pursue even borderline claims, reconsiderations and appeals. Although they were not all successful, there were still a significant minority of cases where the team were only able to gain entitlements after reconsiderations and appeals. 14 mandatory reconsiderations were made, with

seven of these successful. Eight appeals were made for households, with three of these being successful.

These findings begin to demonstrate why gaining benefit entitlements took considerable periods of time, with 67.5% of these cases in the upper quartile, lasting over 260 days.

9.2.4 – Employment and meaningful activity

The majority of residents supported by the team had no or limited work-related conditionality. Given that the Welfare Conditionality study identified an "expansion and intensification of welfare conditionality", placing greater responsibility on claimants to move towards employment (Dwyer et al., 2018) across the UK, it is reasonable to note that the residents supported by the team were not close to employment. In their subjective perception questionnaire, the team asked residents about their thoughts on employment. 73% of the 51 residents who responded said they were like to be in employment if circumstances were right. When asked what circumstances would need to change, residents highlighted that their health would need to improve, and / or their childcare commitments would need to reduce. Many residents also noted that they would then need to upskill to have a reasonable prospect of gaining meaningful employment:

"My anxiety and depression is really bad. I have a fear of going out of the front door and I don't know why. I've spoken to my GP and have been referred to Talking Therapies. At the moment I can't even imagine being ready and able to work"

"I would like to think about work once my children are in school and my mental health is better"

"Some days I'm brilliant, some days I'm not. I worked full time until I had [son]. I was a hairdresser and I worked in ASDA for 9 years. I can't do hairdressing now cause I'm on morphine. My work coach offered me an IT course, and I wanted to do it, but I had a funny turn and couldn't go. I don't need to see him now until next year"

"If I could work in a trade I'm competent in, like engineering, it's all I've known since I was 17 except for the army, then yes. But I can't do computers and IT and all that. If my health was as it was before I wouldn't be on employment benefit at all. I even worked for YHN picking up the rubbish cause there was no other jobs you know. It was YHN that helped me get on the employment benefit, I didn't even know there was such things"

For these reasons, the work of the Employment Specialist in the team has primarily focused on ensuring that the Claimant Commitments of residents are appropriately suited to their circumstances. The Employment Specialist liaised with Jobcentre Plus over conditionality for 39 different residents. In addition to these cases, in their summative discussions team members reflected on the importance of the Employment Specialist's role in being able to provide accurate and up-to-date information on residents' benefit claims as well as being to speak directly to colleagues in the DWP to highlight administrative issues or gain essential evidence for benefit claims and debt solutions. Liaison work mainly focused on either Claimant Commitments (generally around relaxing requirements in line with our more in-depth knowledge of residents' situation), engagement (changing appointment times and frequency based on knowledge of the resident's situations), checking deductions, and correcting incorrect information that has led to inaccurate decisions on benefit entitlements (see figure 18 for a case study of the value of this

work). Team members specifically stressed the importance of having an Employment Specialist who both had the experience of being a DWP employee and the in-depth knowledge of individual cases brought by being integrated with the team. Two team members noted that this was the key difference between this type of role and 'point of contact' type roles who did not have the same level of understanding of residents' circumstances.

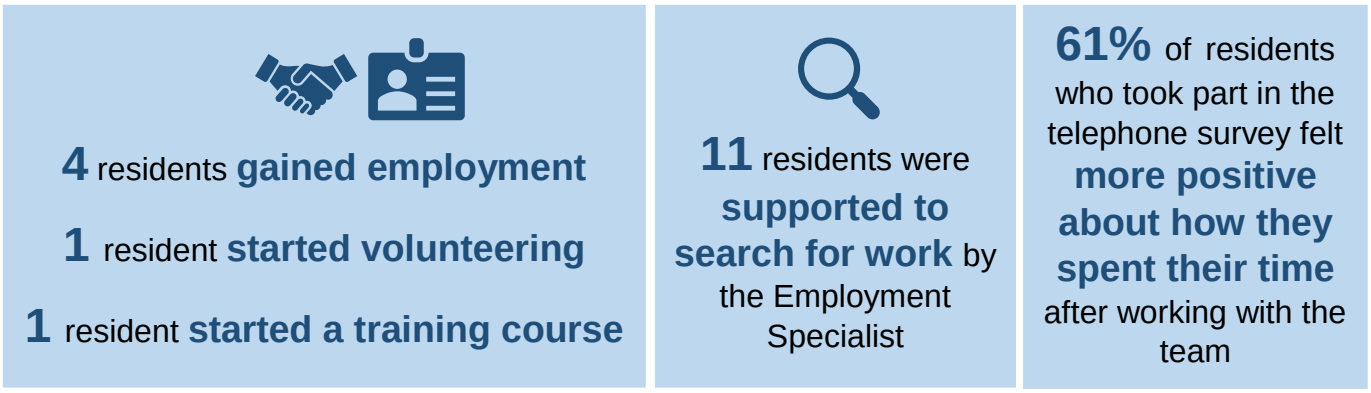
> *"It's essential to have [Employment Specialist's] role on the team. She has access to all the databases and can resolve issues really quickly as well as providing a way in to the JCP. She understands residents' issues too though, which is really important … she needs to understand them to explain clearly to the DWP and she needs to understand the DWP to feedback to us."*

The Employment Specialist herself noted the difference between her role and a broader 'point of contact' type role:

> *"It's very different from a point of contact role as we have access to that wider knowledge informed by a wider understanding … we can help to identify issues with residents and advocate for them. It's related to helping JCP and residents understand their rights and responsibilities around their benefit entitlement. It won't be the only job for a point of contact, they won't be close to the team or the residents and don't have the knowledge of the other specialisms to understand how they fit together. The info we have is far richer and it helps our knowledge of resident to allow for effective advocacy based on an individual's needs."*

Nevertheless, in this context there are still some positive outcomes related to employment and meaningful activity, as displayed in figure 34.

Figure 34 – Employment-related outcomes



9.2.5 – Wellbeing

This section draws on the perspectives of those who participated in the summative telephone survey[30] to explore the extent to which residents supported by the team feel any more positive about the team's support or their lives more broadly.

[30] See section 2.3.3 for an outline of the methodology used in the telephone survey

Figure 35 – Do you feel more or less positive about your life since the team started working with you?

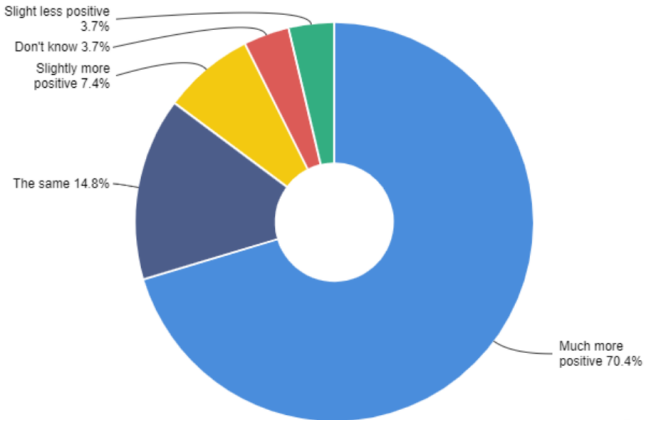
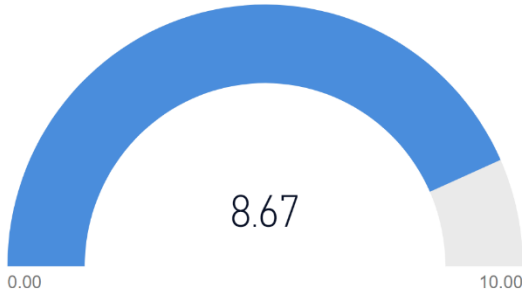


Figure 36 – Generally speaking, would you say that working with the team has been a positive or negative experience?



Figures 35 and 36 provide some evidence that the team have been able to bring about a general improvement in residents' perception of their situation and their wellbeing more broadly. It is important to note that the questions are not representative of a validated psychometric measure of wellbeing and should be treated with some caution. However, when asked for their reasons for their responses, it becomes clear that for some residents, the team's support has made a substantial impact on their lives:

"Very positive, because of the outcome of everything that has been done. [specialist] has been fantastic, all the work that she's done, she's helped with safeguarding as well, her health as well."

"They are an amazing team for people like myself who struggled and didn't know that help was available"

"Because if it wasn't for her I wouldn't be here today. I had no cooker or nothing. I would be dead if it wasn't for her, you probably can't put that in your box can you?"

"It'd all been building up and building up and it was getting me upset and now it's not"

Although these quotes demonstrate a very positive picture, they are all from residents that the team have been able to support for a sufficient period. The telephone survey did not involve residents who the team had been unable to establish contact or retain engagement with. Findings in section 9.1 indicate that residents the team were unable to establish contact or retain engagement with are now at greater risk of homelessness. As a result, we can infer that the wellbeing of these residents has at very best remained the same.

9.3 – Integrated outcomes

In the introduction to chapter 9, it was highlighted that 'success' for the team may be defined as where the team have achieved outcomes across all four specialisms that make up the team. In turn, one of the team's primary aims is to deliver integrated casework on housing, financial and employment issues, supporting the idea that outcomes in more than one of these domains would indicate 'success'. This section briefly explores the extent to which the team gained outcomes across more than one of their specialist areas. Through analysis of summative case review data, it

was possible to explore the extent to which the team had gained outcomes across the four domains of their work (housing, finance, benefits and meaningful activity/work – see appendix 2). Only outcomes that related to reduced expenditure, increased income, or direct advice and support (for example around budgeting or benefits) were included in this analysis.

This analysis revealed that the team gained outcomes across more than one specialism for 84 different households. Outcomes across two specialisms had been achieved for 51 different households, outcomes across three specialisms had been achieved for 29 households and outcomes across all four of the team's specialisms had been achieved for four households. As highlighted in section 2.3.1, the majority of households would not have needs across all four of the team's specialisms. Employment outcomes in particular were less common across households, for the reasons given in section 9.2.4, limiting the possibility of gaining outcomes across all four domains further. These outcomes should also be taken in the context of those households the team have been able to sufficiently support ('work done'), rather than all those residents the team initially identified.

Figure 37 (below) explores the distribution of integrated outcomes across different routes into the team. This figure reveals that integrated outcomes were most commonly achieved across the "bedroom tax" and benefit cap routes, with these two routes being the only ones to include households for whom the team have achieved outcomes across all four domains. In turn, when figures are adjusted to account for the number of households in each route, these two routes also had the highest proportion of integrated outcomes.

Figure 37 – Outcomes achieved across the four domains of the team's work by route into the team

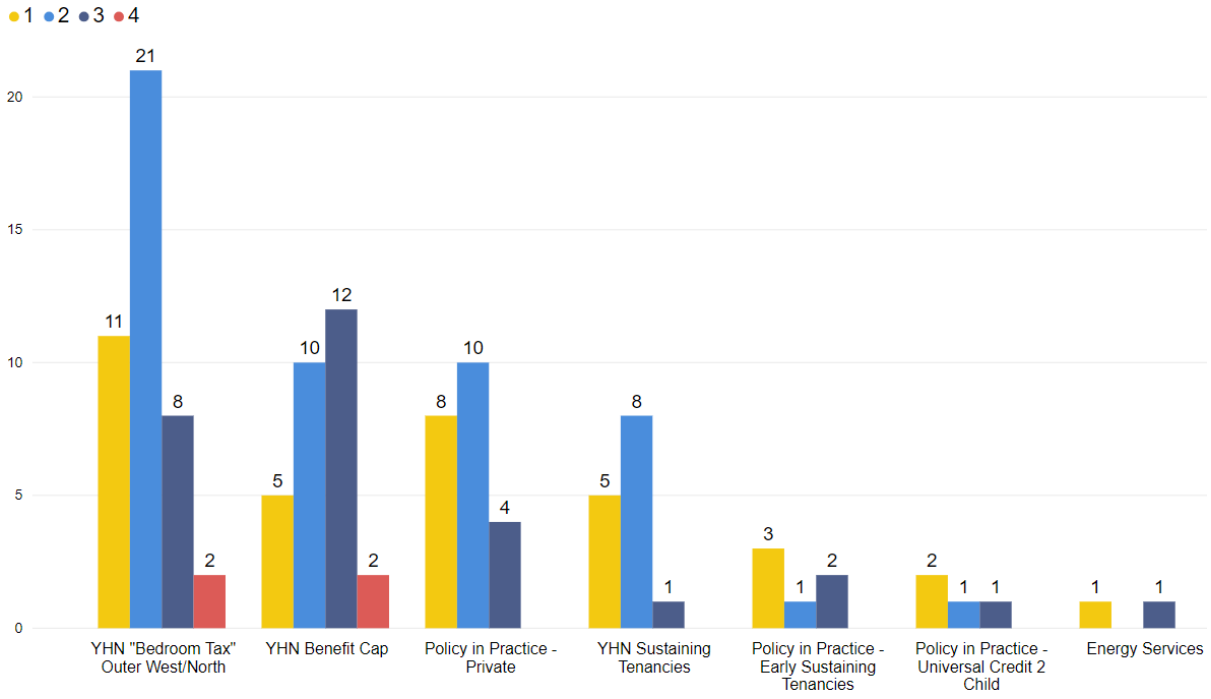
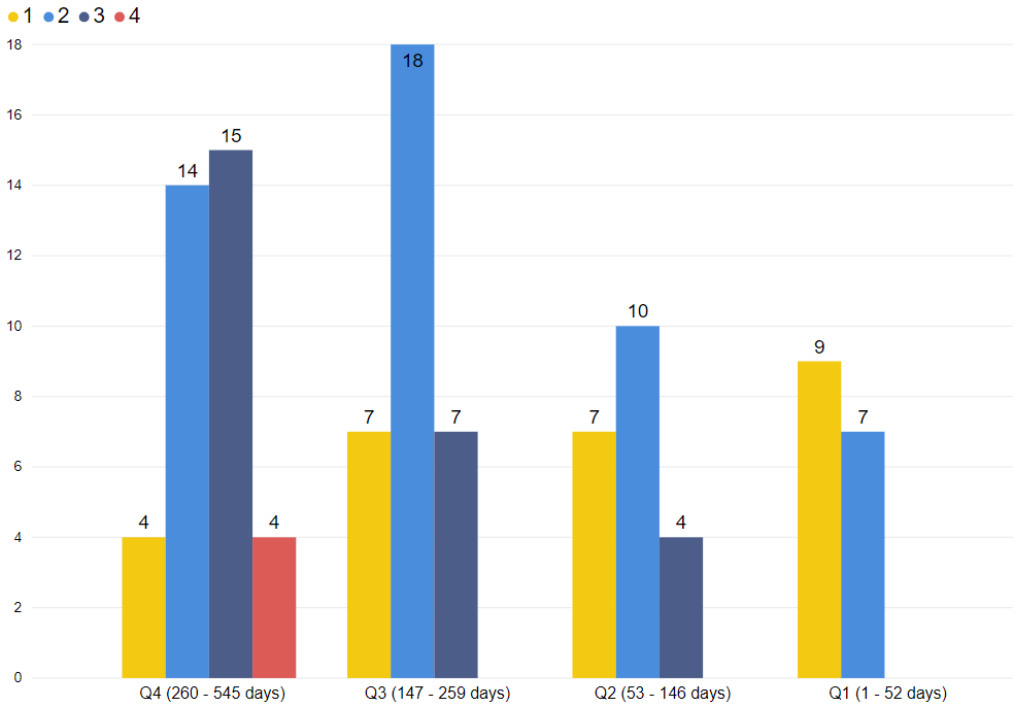


Figure 38 looks at the distribution of integrated outcomes in relation to case length[31]. Perhaps unsurprisingly, integrated outcomes were mainly clustered among longer cases (Q3 and Q4), with

[31] 13 households were excluded from this analysis as there was not sufficient information available on case length

the majority of cases where outcomes were achieved across three domains and all of the cases where outcomes were achieved across four domains present in the upper quartile of case length.

Figure 38 – Outcomes achieved across the four domains of the team's work by case length quartile



These findings indicate that achieving outcomes across multiple domains takes time, even within an integrated multidisciplinary model. They also suggest that the most complex cases, which require work across all four domains require long-term support to stabilise their situation. This suggestion is reaffirmed when we consider that a proportion of the cases in the upper quartile are still active (at the time of writing this report).

Case studies 5 and 6 (appendix 3) give the stories of two residents who received integrated support from the team across more than one specialism. Each of these cases are in the upper quartile of case length (260 to 545 days).

9.4 - Conclusion

This chapter has focused on the outcomes achieved by the multidisciplinary team with the residents they have been able to support. Section 9.1 highlighted some 'headline' outcomes that specifically looked at the extent to which the team have reduced the risk of homelessness for the residents they have worked with, using those who they did not establish contact with or did not maintain engagement with as a point of comparison. Although indicative rather than definitive, the findings broadly suggest that the team have reduced the risk of homelessness for those households they have been able to work with, whereas that same risk has increased for the comparison group. These findings have a bittersweet tone to them, they show that the team's work is effective in reducing the risk of homelessness but also show that for those that the team were unable to engage the risk of homelessness has persisted and even worsened.

Section 9.2 revealed more about how the team have reduced the risk of homelessness for the households they have worked with, covering outcomes across individual domains of housing, finances and debt, benefits, employment and wellbeing. Finally, section 9.3 looked at the extent to which the team have achieved integrated outcomes for households, revealing that they have been most able to do so with more complex cases, that have also lasted the longest amount of time.

10. Influencing policy and practice

Section 1.3 of this report discussed the challenging structural context in which many residents live, and in which the team aim to achieve sustainable outcomes. Section 5.3 then explained how this structural context of poverty, austerity and the welfare reforms has led many residents into debt and increased risk of homelessness. Welfare reform and austerity policies have largely compounded the deprivation many already lived in, rather than relieving it. These sections highlighted failings in the local and national state in how they contribute to the accumulation and management of debt, which can increase the risk of homelessness.

Chapter 9 has revealed that even within this context, the team have achieved some very positive outcomes for residents, stabilising the situation for many. Nevertheless, the extent to which a single team can overcome challenges of a structural nature on an individual level is inevitably limited. Therefore, a key aim of the pilot was to *'capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice.'* This report is the culmination of the team's attempts to capture the learning from their work over the pilot. Throughout the pilot, the team have sought to influence local and national policy and practice. They have done so by combining quantitative data with the stories and perspectives of individual residents to demonstrate the challenges of those people they have identified, approached and supported, sharing these with policy makers and decision makers to evoke progressive change in the systems and policies that influence these residents' lives.

Section 10.2 will focus on how the team have sought to influence and improve local policy and practice. First, 10.1 focuses on the team's attempts to influence national policy and practice.

10.1 – National policy and practice

An appreciation of structural context has been key to the team's work since they began working together. The team's first two routes were focused on households affected by the "bedroom tax" and benefit cap. As a result, they could not avoid appreciating the dominant influence of national government welfare policy on the incomes of residents in Newcastle.

The team have sought to constructively highlight the consequences of the UK government's welfare and public spending policies since 2010. They have done so by providing specific examples of where these policies have failed to meet their aim and instead disadvantaged households already living in difficult situations by taking money away from them and the services that support them, as well as adding complexity to their already complex lives through the pace and scale of the welfare reforms. There are two main ways in which the team have sought to influence national policy and practice; by supporting submissions to parliamentary inquiries and by taking opportunities to highlight the challenges faced by the households they have identified, approached and supported.

10.1.1 – Supporting submissions to inquiries

The team have supported submissions made to three parliamentary inquiries during their pilot. Of particular value in these inquiries was including residents' own perception of their situation by using quotes captured through the team's subjective perception questionnaire.

- **August 2018 – Universal Credit consultation:** The experiences and learning from the team were used to inform Newcastle City Council's response to the Social Security Advisory Committee's consultation on proposals to move existing claimants in receipt of a working age income-related benefit to Universal Credit

- **September/October 2018 – Re-opened benefit cap inquiry:** The experiences and learning from the team were used to inform Newcastle City Council and YHN's joint response to the Work and Pensions Committee's re-opened inquiry into the benefit cap (September 2018), which resulted in being called to give oral evidence to the Work and Pensions Committee on 31 October 2018
- **December 2018 – 'Welfare Safety Net' inquiry:** The experiences and learning from the team were used to inform Newcastle City Council and YHN's joint response to the Work and Pensions Committee enquiry which resulted in being called to give oral evidence to the Work and Pensions Committee on 13 February 2019

10.1.2 – Highlighting the challenges faced by residents

In addition to submitting evidence to inquiries, the team have also taken opportunities to highlight the challenges faced by the households they support to government departments, intergovernmental bodies and other practitioners and policy makers:

- **February 2018 – HM Treasury:** The team presented their approach to prevention to the Deputy Director of Strategy, Planning and Projects and his team
- **March 2018 – MHCLG Trailblazer Case Study:** The team contributed to a three day evaluation of our Homelessness Prevention Trailblazer on behalf of MHCLG, through which they drew out good practice in early homelessness prevention
- **July 2018 – House of Lords:** The team presented at an event focused on 'preventing vulnerability' hosted by Lord Bird at the House of Lords
- **October 2018 – FEANTSA visit:** The team presented their approach to FEANTSA who identified it as best practice in early prevention that they were keen to share internationally
- **November 2018 – UN Special Rapporteur on Extreme Poverty and Human Rights:** The team presented evidence to Professor Alston and his team on the impact of austerity and the welfare reforms on poverty in the city
- **May 2019 – FEANTSA Policy Conference:** Presented the team's approach and outcomes to the FEANTSA European Policy Conference, which brings together practitioners, researchers and policy makers from across Europe

10.2 – Local policy and practice

As well as seeking to influence national policy and practice, the team recognise that local policy and practice also has a significant role in determining the circumstances in which residents live. The team have sought to influence local policy and practice in two key ways; by conducting 'in-depth case reviews' (see section 2.2.2) that focus on specific issues that have emerged through their periodic review process and providing infrastructure support to other professionals.

10.2.1 – In-depth case reviews

The team have conducted three in-depth case reviews, each of which have focused on a specific issue.

- **July 2018 – Personalised DHP recommendations:** the team developed a methodology for making personalised DHP recommendations for residents affected by the benefit cap. They used this methodology to develop recommendations to Newcastle City Council's Revenues and Benefits department for the residents they supported and repeated the process at the start of the following financial year
- **November 2018 – 'Sustaining Tenancies' review:** conducted an in-depth review of the Sustaining Tenancies process through the lens of residents supported by the

multidisciplinary team, which has provided a catalyst for a wider review of the process. See figure 4 in section 4.1 for more details of this review

- **February 2019 – Medical evidence paper:** the team have written a briefing paper on medical evidence, which has contributed to attempts to develop a more consistent approach to medical evidence across the city

- **March 2019 (ongoing) – 'Children's Social Care and Early Help Involvement review:** conducting an in-depth review of the interrelationship between the team's work and Children's Social Care and Early Help. See section 4.1 for some initial findings from this review

These reviews have sought to promote and improved understanding of the interrelationship between local policy and the lives of individual households. They have also sought to demonstrate the interdependencies of different disciplines and organisations in preventing homelessness and promoting stable lives for residents in Newcastle.

10.2.2 – Infrastructure support

One of the team's primary aims is *'to provide infrastructure support to help services and organisations to adapt to meet the challenges of a reduced welfare state and to strengthen our local system'.* Section 10.1.2 has highlighted how the team sought to meet this aim by developing in-depth case reviews to improve local policy and practice on a broader level. This section focuses on how the team have provided infrastructure support to individual organisations, services and practitioners across the city. The team have offered infrastructure support to 14 practitioners across 13 different services including Welfare Rights, Cherry Tree View (statutory temporary accommodation), Supported Employment, YHN and Adult and Children's Social Care. The support has ranged from liaison with Jobcentre Plus or DWP to benefits advice and training.

Case Study 2 (appendix 3) provides an overview of the range of work done by the team with mental health professionals to understand the complex housing and financial situation of a resident they were supported. After the team's Welfare Rights Specialist wrote a detailed review of her work with the resident to date to the Consultant Psychiatrist in charge of the ward the resident had been placed on, she received a very positive reply from the Consultant Psychiatrist:

"Thank you so much for your detailed account of your involvement with [the resident]. It really has enlightened us as to how complex her case has been and also how much you have inputted to try and resolve the situation. I apologise that you were under the impression that we were being critical regarding your involvement. It looks like you have done your utmost as far as I am concerned. Sometimes our frustration with external agencies derives not so much from criticism as lack of understanding as to why (there) is no progress in issues."

Although it is only related to one particular case, this quote demonstrates the value of working collaboratively and of taking the time to clearly and comprehensively communicate with colleagues from other disciplines. Doing so helps to promote shared understanding which reduces conflict and confusion for the resident being supported.

11. Final discussion and conclusions

This report has presented the learning captured from the work of the multidisciplinary team over their initial pilot period, funded through the Homelessness Prevention Trailblazer programme. Chapter one began by giving a brief description of the Newcastle's Homelessness Prevention Trailblazer and the role of the multidisciplinary team within the programme. The primary aims of the team were outlined, which focused on delivering integrated casework to residents where existing services aren't designed to meet the intensity of support required. The pilot also aimed to provide infrastructure support to these services and capture learning from the team's work to inform local and national policy and practice. Chapter one concluded by outlining the structural context of the team's work, highlighting the centrality of poverty in determining the risk of homelessness and the compounding effect of the welfare reforms and austerity.

Chapter two outlined how the team have formatively captured learning throughout the course of the pilot. Section 2.3 then covered the methodology used in the summative review at the end of the initial pilot. For both the formative and summative process, an action research approach underpinned the methods used, bringing together action and reflection, theory and practice as well as emphasising the importance of partnership and participation between research and practice. Chapter three then gave a brief description of the team's wider approach to delivering integrated and holistic support to residents. The importance of establishing a foundation of shared policies, protocols and ways of working before starting casework was underlined, as were the team's matrix management arrangements. Chapter three concluded by describing the five principles that guide the team's work. These principles had their origins in the team's first month together but were only formalised towards the end of the pilot period, in line with the team's inductive approach to capturing learning.

Chapter four outlined the team's 'case finding' approach, detailing how they have identified 296 households by working with partners and by testing the use of predictive analytics. The in-depth screening process that the team operate is key to their case finding approach. This process also produced much of the data presented in chapter five, which focused on the personal and systemic challenges faced by households identified by the team. Chapter five provided a link between the structural context described in chapter one and the increased risk of homelessness experienced by households identified by the team. In particular, a cycle of debt, deductions and DHPs was described, in which many households are trapped in precarity primarily caused by welfare policies since 2012 but also by systems that can compound this precarity, rather than relieving it. Section 5.3 then showed how many households identified by the team also present with additional needs, outside of the team's specialisms. These needs both added complexity to the team. Finally, section 5.4 focused on the support offered by the friends and family of residents supported by the team, as well as the additional challenges they can also bring.

Chapter six described how the team drew together information gathered through their in-depth screening process to develop an approach to establishing contact with households that was clear and honest, flexible, coordinated and persistent. Although there is a paucity of comparable data to establish the success of this approach, it is the belief of the team and the team's Steering Group that their 60% rate of establishing contact was a very positive outcome. It was important to differentiate between establishing contact with residents and retaining engagement for a sufficient period of time to untangle often complex situations and provide a greater degree of stability to households. Chapter seven briefly described how the team categorised cases after establishing contact and gave an overview of how long different cases lasted.

Chapter eight focused on the team's own reflections on their approach to multidisciplinary working using data collected through one-to-one interviews with each specialist. The team's reflections emphasised that working in an integrated, multidisciplinary way allowed for a more holistic approach to support based around the needs and circumstances of individual households. They also noted the importance of professional autonomy and flexibility in enabling greater personalisation in the way they approached and supported households. Finally, the team felt that being integrated with other professionals from other disciplines allowed for professional development through knowledge exchange between specialists. The team's reflections also revealed that these benefits did not emerge spontaneously, but were facilitated by a structured, yet inductive approach. The team also highlighted some challenges associated to multidisciplinary working. Some of these challenges, such as 'balancing case loads' and 'working in a small team' were related more specifically to the team's work. Others such as 'limits of a multidisciplinary approach' related more to the context the team work in.

Chapter nine looked at the outcomes achieved by the team. Although indicative rather than definitive, the 'headline' findings presented in section 9.1 broadly suggest that the team have reduced the risk of homelessness for those households they have been able to work with. These findings have a bittersweet tone to them. They show that the team's work is effective in reducing the risk of homelessness but also show that for those that the team were unable to engage, the risk of homelessness has persisted and even worsened. Section 9.2 revealed more about how the team have reduced the risk of homelessness for the households they have worked with, covering outcomes across individual domains of housing, finances and debt, benefits, employment and wellbeing. Finally, section 9.3 looked at the extent to which the team have achieved integrated outcomes for households, revealing that they have been most able to do so with more complex cases, that have also lasted the longest amount of time.

Chapter nine revealed that even within an extremely challenging context, the team have achieved some very positive outcomes for residents, stabilising the situation for many. Nevertheless, the extent to which a single team can overcome challenges of a structural nature on an individual level is inevitably limited. Chapter ten detailed how the team have combined quantitative data with the stories and perspectives of individual residents to demonstrate the challenges of those people they have identified, approached and supported, sharing these with policy makers and decision makers to encourage progressive change in the national and local systems and policies that influence these residents' lives.

The final sections of this report provide final conclusions on the value of the team and their approach, areas for improvement and the team's next steps for development.

11.1 – The value of the team and their approach

The team sought to identify, approach and support residents at greater risk of homelessness at an earlier stage. In doing so, they found a majority of residents living in precarious, complicated and burdensome circumstances that have been worsened by welfare reform policies since 2010. What they also found were some successes and failings with the local system in the way residents with integrated challenges are supported. Most importantly, what they found in most cases were residents exercising incredible resilience, grace and humility given the frustration many of them felt. Many of these residents were trying to get on with their lives but were also incredibly glad of some support to help them feel more stable.

The team have made an important and sometimes vital impact on the lives of many of the households they have supported. Working in an integrated way with specialists from complementary disciplines has been central to this, as has the adoption of an inductive approach

informed by an action research methodology. This approach has enabled sufficient flexibility to adapt according to improved understanding of the circumstances of the households supported. The importance of the positive impact made by the team is amplified when we consider that the team have proactively identified many households who had previously been labelled as particularly complex or difficult to engage.

The team made contact with the majority of the households they approached and retained engagement over significant periods of time with many. Doing so allowed the team to work with many residents to untangle often extremely complicated situations and bring more stability to their lives. However, for those the team could not make contact or retain engagement with, there is evidence to suggest that their situations worsened. In turn, although the team stabilised the situations of many, they were not often able to remove the shortfalls most households had between their housing costs and the entitlements they received to pay these costs.

Central to the team's approach is an appreciation of context. As outlined in the introduction to this report, the structural context in which the team work is one underpinned by poverty and informed by national policies of welfare reform and austerity that are regressive in their approach to supporting people out of poverty. As demonstrated at various points in this report, triggering an income shock by reducing welfare benefits to residents in vulnerable circumstances doesn't incentivise them to start work when their original issues still exist. That income shock only serves to add complexity to what can already be complex lives. It also diverts the costs to other publicly funded organisations who are subsequently providing advice and support to prevent and respond to the increased risks of financial hardship and deprivation. Due to this, it is our belief that the UK's welfare system is no longer an effective safety net to protect against hardship and chronic deprivation

In this context, one team can only do so much through direct support, they cannot move households out of poverty or reverse the impact of welfare reforms. However, they can seek to make a more significant difference by combining practice, research, policy and advocacy. This helps to develop a deeper understanding of each household's circumstances and promotes more compassionate and empathetic responses to the challenges they face. The team have highlighted the consequences of failings in national and local policies and, in line with an action research approach, they have sought to influence progressive change. The team have done so with the lived experience of those residents living with these consequences, and the professionals supporting them, at the core of their approach.

In summary, the team have tested a new approach that combines research and practice with the aim of providing holistic, multidisciplinary support to households facing integrated challenges and informing national and local policy and practice. The learning captured from their initial pilot indicates that this approach has been successful in meeting these aims, but also emphasises the limitations in the capacity and scope of a single service in bringing about sustainable change in the face of such a challenging structural context.

11.2 – Areas for further development

Although this report suggests that the pilot has been successful in meeting its aims, it also highlighted some areas for further development. The team's approach to establishing contact and retaining engagement has allowed the team to proactively engage (and maintain engagement) with households previously categorised as difficult to engage. However, for those households that the team failed to engage, their situations seem to be worsening. It isn't sensible to suggest that the team could engage 100% of the households they identify, but it is important that these

households receive support to prevent them from becoming homeless. Therefore, the team should further develop their inactive case review process to limit the number of households that they fail to engage with.

The team have also sought to embed research alongside practice by employing an action research informed approach. Key to this approach has been access to and analysis of various databases to develop a clearer understanding of the needs of individual households. However, the team highlighted that working across a range of databases also has its shortcomings. Foremost among these shortcomings was the need to duplicate information to keep specialists in the team and colleagues from other services aware of progress. Working across a number of databases also brought challenges for this review in sourcing and triangulating all of the available evidence related to households' circumstances and the team's work. If the team are to continue in the long-term, more integrated databases incorporating different services would be an important enabler of better multidisciplinary working.

They also suggested that it may be desirable to develop a larger team, either by extending the number of disciplines or by having more than one specialist from each discipline, or both. In relation to this, the team highlighted some challenges for ensuring caseloads remained balanced across specialisms and suggested staggering routes into the team as a potential solution. This will be a particularly important consideration if the number of specialisms on the team is extended.

11.3 – Next steps for the team

The team have made considerable process from their origins as four specialists from different disciplines, services and, in most cases, organisations. They have created shared ways of working underpinned by co-designed policies and protocols, which have been developed into five overarching principles that guide the team's work. These principles have been refined through an inductive process for capturing learning informed by an action research approach that brings research and practice together. Most importantly, they have proactively identified 296 households at greater risk of homelessness, establishing contact with over 60% and providing holistic support to 40% of these households. The outcomes described in this report and the case studies outlined in appendix 3 show the positive difference made for these households but also emphasise that many of the structural and systemic problems that have contributed to their challenges persist, limiting the scope for truly sustainable outcomes.

In their report on homelessness prevention in Newcastle, Watts et al. (2019) recommended that the work of the multidisciplinary team is extended. Therefore, it is positive to note that the team have secured additional funding from Newcastle City Council's 'Life Chances' fund to continue their work until 30 September 2020. This funding enables the team to incorporate Early Help support in their model by seconding a colleague from Newcastle City Council's Early Help team. This will allow the team to expand their range of specialisms and offer more holistic support to the households they identify and approach.

This summative report will provide a resource for the team to continue their efforts to inform the national and local systems and policies that influence these residents' lives. In turn, the team will be a key part of a review of corporate debt being undertaken by Newcastle City Council and YHN. The team will undertake the casework element of this review, using their action research informed approach to inform the development of a corporate debt policy that shifts the focus from collection to connection (Munslow, 2019). This is a particularly positive next step for the team as it allows them to combine research and practice in a way that not only makes a difference to the lives of individual households but also has a tangible opportunity to influence local and national policy on how we relate to households with problem debt.

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Appendix 2 – Outcome domains used in the summative review

Outcome domain	Sub domain	Composite measure	Data source	Stage of review
Housing	Property type and standard	Supported to remove “bedroom tax”?	WR AIMS	Summative case review
		Supported to stop overcrowding?	Casefiles/ notes	Summative case review
		Helped to obtain furniture or white goods?	WR AIMS/Debt AIMS	Summative case review
	Location	Supported to move away from potential risk of harm/harassment?	Casefiles/notes	Summative case review
		Supported to move closer to social connections/ work / support?	Casefiles/notes	Summative case review
	Affordability	Comparison of rent shortfall at screening and end point	Case identification notes/’at a glance’ spreadsheet/ R&B Northgate/casefiles	Summative case review
		Comparison of housing costs as % of total income at screening and end point	Case identification notes/’at a glance’ spreadsheet/ R&B Northgate/ casefiles	Summative case review
		Change in rent arrears at screening and end point	YHN Northgate	Summative case review
	Ontological security	Resident’s reflection on whether they feel more settled in their home?	Telephone interviews	Telephone interviews
		Comparison of subjective perception on sense of control over housing (if baseline est.)	Subjective perception questionnaire/ Telephone interviews	Telephone interviews
Finances	Debts	Debts written off (type of debt, amount written off, no. of creditors, debt solution used)	Debt AIMS	Summative case review
		Setting more affordable repayments for debts (change in repayment rate, no. of creditors)	Debt AIMS	Summative case review
		Weekly deductions from benefits	Casefiles	Summative case review

		No. of deductions from benefit entitlement renegotiated to a more affordable repayment rate	Debt AIMS/ WR AIMS/ Casefiles	Summative case review
	Increasing income	Gained a Discretionary Housing Payment (DHP) award?	Debt AIMS/ WR AIMS	Summative case review
		Was a successful Housing benefit claim made for the household?	Debt AIMS/ WR AIMS	Summative case review
		Was a successful charity grant application made for the household?	Debt AIMS/ WR AIMS	Summative case review
		Was a successful child maintenance claim made for the household?	Debt AIMS/ WR AIMS	Summative case review
	Reducing expenditure	Gained a Northumbrian Water Support Plus Scheme award?	Debt AIMS/ WR AIMS	Summative case review
		Gained a Council Tax Reduction?	Debt AIMS/ WR AIMS	Summative case review
		Gained a Crisis Support Scheme award?	Debt AIMS/ WR AIMS	Summative case review
		Gained Support for Mortgage Interest (SMI)?	Debt AIMS/ WR AIMS	Summative case review
	Managing money (budgeting)	Has budgeting advice been offered to the household?	Debt AIMS/ WR AIMS/ casefiles	Summative case review
		Has intensive budgeting support been provided to the household?	Debt AIMS/ WR AIMS/ casefiles	Summative case review
		Retrospective subjective account by team of impact of budgeting support	Team's reflection	Summative case review
		Retrospective subjective account of resident of impact of budgeting support	Telephone interviews	Telephone interviews
		Comparison of subjective perception on finding it stressful managing finances	Subjective perception questionnaire/ Telephone interviews	Telephone interviews
Benefits	Benefit entitlements	Supported resident to make application for benefit entitlement? (type of benefit entitlement)	Casefiles/ WR AIMS	Summative case review

		Gained benefit entitlement (type of benefit entitlement, amount gained annually)	WR AIMS	Summative case review
	Helped with transition to changes in welfare system	Supported to prepare for possible transition onto Universal Credit?	Casefiles/ WR AIMS	Summative case review
		Supported with transition to benefit with greater work-related conditionality?	Casefiles/ WR AIMS	Summative case review
		Has the resident been given benefits related advice?	WR AIMS	
	Advocacy work	Supported resident with mandatory reconsideration?	Casefiles/ WR AIMS	Summative case review
		Supported resident with appeal on benefit entitlement?	Casefiles/ WR AIMS	Summative case review
		Supported resident with capability for work assessment?	Casefiles/ WR AIMS	Summative case review
Meaningful activities / Work	Employment	Does the resident have any work related conditionality linked to their benefits?	Case identification meeting notes/ 'at a glance' spreadsheet	Summative case review
		Have we given support for searching for work? (note type of support e.g. CV written, help with job search)	Employment Specialist – recording spreadsheet	Summative case review
		Has the resident gained employment? (note contract type)	Employment Specialist – recording spreadsheet	Summative case review
		Liaised with Jobcentre around claimant commitment?	Employment Specialist – recording spreadsheet	Summative case review
	Volunteering	Has the resident started volunteering? (role, place and number of hours)	Employment Specialist – recording spreadsheet	Summative case review
	Education and training	Has the resident been supported to access any training courses?	Employment Specialist – recording spreadsheet	Summative case review
		Has the resident been supported to gain any qualifications?	Employment Specialist – recording spreadsheet	Summative case review

	Social activities	Has the resident been supported to access any other social activities that may be of benefit (e.g. mother and child activities etc.?)	Casefiles	Summative case review
	General sense of wellbeing	Team's subjective reflection on change in wellbeing for resident over course of support	Team's reflections	Summative case review
	General sense of wellbeing	Resident's reflection on whether they feel more or less positive about their life since working with the team	Resident's reflection	Telephone interviews
	Domain wellbeing	Resident's reflection on whether they feel more or less positive about relevant domains of their life since working with the team	Resident's reflection	Telephone interviews
Health	Physical health	Has the resident been supported to access health related support?	Casefiles	Summative case review
		Have we supported to resident to get adjustments to their property, additional equipment or additional funds to help them manage their health issues?	Casefiles	Summative case review
	Mental health	Has the resident been supported to access mental health support?	Casefiles	Summative case review
		Have we supported to resident to get adjustments to their property, additional equipment or additional funds to help them manage their health issues?	Casefiles/ WR AIMS/ MM AIMS	Summative case review

Wider circumstances to be captured and considered

Circumstance type	Circumstances	Data source	Stage of review
Personal factors	Additional needs identified during screening (household)	Formative analysis of case identification meeting notes	Final data from periodic review

	Whether the resident receives positive support from a family member/ friend? (financial, emotional, practical)	Case identification meeting notes/ team's reflections	Summative case review
	Additional needs identified for known relationships (non dependant)	Formative analysis of case identification meeting notes	Final data from periodic review
	Does the resident care for any children with learning disabilities/ physical disabilities or who have Special Education Needs?	Case identification meeting notes/ Team's reflections/ WR AIMS	Summative case review
Structural factors	Welfare reform affected by (type of welfare and financial impact of reform)	WR AIMS/ case identification meeting notes	Summative case review
Case related factors	Length of time worked with case	Formative analysis of 'at a glance' recording	Final data from periodic review
	Whether case is active/ inactive?	Formative analysis of 'at a glance' recording	Final data from periodic review
	Reason for 'end point' (if inactive)	Formative analysis of 'at a glance' recording	Final data from periodic review

Appendix 3 – Case studies

Case Study 1 – Deductions

Introduction

This case study highlights the team's work with Tim (pseudonym), who at the time of screening had among the highest levels of deductions from benefits of all residents identified by the team. The case study demonstrates how the team were able to make Tim's situation more stable but also serves as a reminder of how long this work can take and how it won't necessarily result in a completely sustainable solution.

Context

Tim is a 46 year old single man living in a private tenancy. He was identified through the 'predictive analytics for private tenants' route

Tim had deductions from his Universal Credit entitlement of £67.57 a week at the time of screening, representing 50.3% of his weekly income after housing element was discounted. He also faced a rent shortfall of £18.72 per week. His eligible rent was 26% of his income after housing element at the time of screening

Although no additional needs were identified during the team's in-depth screening process, it became apparent that Tim suffers from depression and is seeing a psychologist for support with this

> *"I do suffer with depression and stuff like that – it's an ongoing thing"*

Establishing contact

The team discussed Tim's situation at their case identification meeting on 29 May 2018. It took the team two months to establish contact with him, with 11 different attempts made using three different methods of establishing contact. The most common method used was liaising with support providers to ensure that the team were able to complement rather than interrupt the work of other support providers such as Tim's psychologist and Newcastle Futures, who were offering employment support

The team had identified during their initial screening that there were warnings suggesting that no home visits should be undertaken because Tim had a dog that could be protective and aggressive.

Work Done

Tim's case was still active at the end of the Trailblazer pilot period (29 March 2019) having lasted 304 days at this point and in the upper quartile for case length

The team made a successful application for a Discretionary Housing Payment (DHP) for £18.72 per week until 31 March 2019, covering the full shortfall of Tim's rent and stabilising his situation while they sought longer term solutions

The team's Debt Specialist supported Tim to set a number of more affordable repayments for his debts. This included negotiating with the Council Tax team at Newcastle City Council to stack all of Tim's accounts on one attachment of benefit order. This means that Tim could pay the accounts back one at a time rather than paying them at the same time

"They managed to help us sort out Council Tax and got me confidence up a bit"

The Debt Specialist also negotiated for Tim to move onto the Northumbrian Water Support Plus Plan, which means that he received a reduction on his bill of £185 a year and help towards paying his arrears

At the same time as the Debt Specialist was providing support, the team's Welfare Rights Specialist supported Tim to apply for a Personal Independence Payment (PIP). Tim had been turned down for PIP in the past and but has multiple health problems. The Welfare Rights Specialist reflected that in her previous role she may not have submitted an application for Tim, because there was a strong likelihood his claim would be turned down again. In December 2018 Tim was awarded PIP at an enhanced rate for mobility. This resulted in an additional £3107.00 annually with a £375.57 backdated payment, helping to increase Tim's income significantly

Although his rent shortfall remained the same, the multidisciplinary team were able to increase Tim's income, meaning that his eligible rent was reduced from 26% of his income at screening to 12% at end point. However, the team then gained a DHP to cover the full shortfall of £18.72 per week for five months while they continue in their work to help stabilise Tim's situation. A telephone interview revealed that the team's work not only reduced the financial burden on Tim but allowed him to feel more positive about his life. As a result of the team's work, Tim's deductions were reduced by 45.4% to £36.92 a week.

""When I first heard about this, I wasn't sure, I'm a stubborn person, I have to do stuff myself, the girls have been amazing, I cannot praise them high enough"

Case Study 2 – Additional needs (mental health)

Introduction

This case study presents the team's work with Tina (pseudonym). It highlights the additional complexities that are added to the team's work when they are supporting residents who have needs that extend beyond their specialisms. However, it also highlights how essential it is for these additional needs to be considered when supporting on housing and financial matters, as well as emphasising the need for close working between health and homelessness prevention services. Finally, the case study demonstrates how the holistic nature of the team's support also extends to resident's relationships. Tina's case study is intersected with the words of her mother, who took part in a telephone interview at the end of the Trailblazer pilot period.

Context

Tina is a 37 year old single female. She was identified through the 'YHN "bedroom tax"' route. She was 'under-occupying' by one bedroom, which left her with a rent shortfall of £11.85 a week

She has had significant mental health problems, with multiple diagnoses including bi-polar, post-traumatic stress disorder, alcohol-related psychosis and an acquired brain injury from a road traffic accident when she was a teenager. She has been **sectioned twice** before and was last **discharged by the Community Mental Health Team (CMHT)**. She was **not eligible for support from the CHMT** due to her issues being believed to be "alcohol-related"

Tina was referred to the **council's Welfare Rights team in 2016** after her ESA ended because she did not attend multiple medical assessments. She was also referred to **Money Matters in 2010** for debt issues.

The resident's mother was the key contact and provider of support, but she was not the resident's appointee

Establishing contact

The team discussed Tina's situation at their case identification meeting on 27 November 2017. At the end of the Trailblazer pilot period the case was still active and had lasted for 477 days

The team determined that the best approach was to contact the resident's former Community Practitioner Nurse (CPN). The CPN noted that she was not involved with the case and did not wish to be.

The Welfare Rights Specialist (WRS) got in contact with the resident's mother and arranged a joint home visit with her

During the initial home visit (December 2017) the WRS became increasingly concerned that the resident was acting in a delusional and paranoid manner. She was also concerned by the lack of food, heating, or electricity in the property. The resident's mother became very distressed after the visit, noting the level of stress she felt she was under

Initial work done

The WRS determined that no ESA appeal had been lodged and that a PIP renewal was due. The resident and her mother were not aware of how to submit these and they had received conflicting advice from the Department of Work and Pensions (DWP). In the meantime, the team's Debt Specialist made a **Crisis Support Scheme application** to cover the costs of utilities and food in the short-term

The WRS made a **safeguarding referral to Adult Social Care** asking for a **Mental Capacity Assessment** (MCA), with a view to establishing an appointeeship to help manage the resident's financial situation. However, the team were notified in January 2018 that she had failed her MCA, confirming the level of her mental health difficulties and a need for ongoing intensive support with managing her finances

A **referral was also made to Tina's GP, requesting a referral to the Community Mental Health Team (CMHT)** in December 2017, but this was not accepted as she did not meet their criteria. Due to the high level of concern expressed by the WRS, Safeguarding agreed to send out a Social Worker in early 2018

The team had tried to re-engage the resident with the Community Mental Health Team (CHMT) or her Community Psychiatric Nurse, but each refused the referral as she did not meet their criteria. The team also sought to gain medical evidence from the resident's GP to re-establish her Employment and Support Allowance (ESA) and to gain evidence for Council Tax exemption, and PIP renewal. However, **the GP surgery declined the request for evidence** and noted that there would be a cost of £50 for medical records

In hospital

The resident was **sectioned under the Mental Health Act** at the end of March 2018. The WRS sought a **corporate appointeeship to stabilise the resident's financial situation while she is in hospital, ready for when she is discharged**. However, the hospital ward also wished to establish a corporate appointeeship and had concerns about the amount of time that the resident was without money. They sought to make their own application for an appointeeship to establish a source of disposable income for the resident during their stay. After the WRS provided a detailed account of the situation to the Consultant Psychiatrist who thanked the WRS for the clarity she provided and agreed not to interrupt the more sustainable focus of the team's appointeeship

Tina's daughter was living with Tina's mother, who is her full-time carer. Children's Social Care are involved in relation to Tina's issues. In turn, Tina's mother is also a foster carer for two children. The team continued to liaise closely with her throughout the course of support

The corporate appointeeship was granted in June 2018. The team were then able to re-establish her ESA payments at £6,611.80 a year and get a backdate of payments of £9,313.20. The WRS also applied for Personal Independence Payment (PIP). The Debt Specialist also wrote off £376.24 in Council Tax debt and arrange for her to be granted an exemption to Council Tax, reducing expenditure by £1,208.45 a year. These measures allowed Tina's rent to be paid while she was in hospital, giving her the chance to move back home when she was ready to leave hospital

Moving back into the community

Tina was discharged from hospital on a Community Treatment Order in May 2019 with ongoing support from a CPN from the CMHT and a mental health social worker. The WRS reflected that Tina looked significantly better and the Consultant Psychiatrist was very pleased with her recovery. The Consultant was keen to stress that the difference between earlier periods of disconnection with services and now is that she does now have underlying mental health diagnoses, that earlier discharges were based on her alcohol use, but that this shouldn't recur now that they know about the diagnoses

Tina did not wish to stay in her property so before she was discharged, the hospital staff been helping Tina to bid for properties in North Tyneside. However, this would mean that Tina would be living away from her support networks and would be outside of the remit of her current corporate appointeeship. After the team explained these circumstances to these staff they were able to establish an agreement that they would encourage Tina to search for properties in Newcastle

At the end of the Trailblazer period the team were continuing to support Tina, the WRS was able to make a personal handover to the team's Housing Specialist to provide Tina and her mother with intensive support to search for appropriate properties, which were close to her family and support networks

"[it's been] very positive, because of the outcome of everything that has been done. [specialist] has been fantastic, all the work that she's done, she's helped with safeguarding as well, Tina's health as well ... because her bills are paid directly, she doesn't have the responsibility of paying her bills, she has an appointeeship now who does that now. She had no gas, electric or food before"

Case Study 3 – Additional needs (Children's Social Care)

Introduction

This case study explores the work done by the multidisciplinary team with Alex (pseudonym). The team have worked with Alex since November 2017 and continue to do so. Alex's story was presented in both the team's first and second periodic reviews and highlights the significant challenges the team can face in supporting a household with financial, benefits, housing and employment-related matters in the context of complex, challenging, and changing personal circumstances. In particular, Alex's story highlights the team's work in supporting residents after children have been removed.

Context

The team first identified Alex through their 'red' benefit cap route for YHN tenants on 28 November 2017. At the time, Alex was 43 year old mother and lived with her five dependant children (aged 14, 13, 11, 8, and 6). Her weekly housing benefit receipt had been capped at 50p, reducing this receipt by £88.09.

The resident had received three Discretionary Housing Payments (DHP) and had moved from her previous YHN tenancy as she was a victim of anti-social behaviour in the community. This move was facilitated through a direct let because the property had been left unkempt and damaged, and she had accrued £843.30 in rent arrears.

Approach and initial work done

An Early Help Plan had been established due to concerns about neglect, after some of the children had disclosed that they had no heating and did not have enough money for food. The team liaised with Early Help to develop a joint plan for supporting the household.

Alex was provided with intensive budgeting support by the Debt Specialist but was not able to maintain the budget set. Actions were also taken to stabilise her financial situation the short to medium-term (DHP completed, referral to Energy Services, 50% reduction in water bill with Northumbrian Water)

Update in April 2018 – moving into temporary accommodation and child protection procedures

In their second periodic review, the team provided an update on Alex and her children, highlighting that their situation had worsened.

Alex was now subject to child protection procedures, under the category of neglect, and had moved into temporary accommodation at Cherry Tree View (CTV) after a threat of violence. There were further reports of neglect, drug use, and one child had attempted self harm.

The multidisciplinary team continued to provide intensive support around the resident's housing and financial needs

Case study 3 continued

April – September 2018 – Supporting the household while in temporary accommodation

April to September 2018 - Alex and her children were residing in CTV, the Child Protection Plan still continued, and during this period various efforts were made by the Housing Specialist to see the client to discuss budgeting support. However, Alex was consistently reluctant to discuss her spending and vague on the information she provided. The team continued to seek to ease the financial reduction brought about by the benefit cap.

May 2018 - a letter was received from the GP regarding a potential Personal Independence Payment (PIP) application, which stated that she had been assessed previously as not having learning disabilities. However, in light of the team's concerns the GP re-referred her to the Community Learning Disability Team. Applying for PIP was postponed as the client did not attend an appointment with this team. At present the client has still not requested this assessment. A fifth DHP was awarded for a further 4 months at 100%. In August the DHP expired, a sixth DHP was then completed beginning of September, but refused on the grounds that Alex had no intention to return back to her substantiate address. This also prompted her Housing Benefit claim to be cancelled. This meant the client was eligible to cover her full rent costs of £82.65.

October 2018 – January 2019 – supporting Alex to transition after the removal of her children

October 2018 - In October, the resident's children were placed under the care of the local authority. The oldest and the youngest of the children were placed with separate foster parents. The middle child was placed in specialist care following repeated allegations to Social Services that he was both the victim and perpetrator of sexual assault.

Alex returned to her YHN tenancy after she was asked to leave CTV following the removal of her children. The Housing Specialist supported her to make a claim for Universal Credit. Alex was now under-occupying and affected by the "bedroom tax" so a 'direct let' was agreed to move to a more suitable accommodation.

Alex was also in receipt of Child Benefit and Child Tax Credits, so the Housing Specialist supported the resident to inform HMRC and DWP of these changes, avoiding a benefit overpayment. Alex's Housing Benefit payments were also reinstated. A sixth DHP application was made and was awarded for the full amount lost through the "bedroom tax". This payment also cleared the client's rent arrears at the time.

November 2018 - Alex was supported to move into a one bedroom property through a 'direct let'. This meant that her full rent was now being covered by Housing Benefit. The Housing Specialist Trailblazer assisted the client to complete a change of address form for Housing Benefit entitlement.

December 2018 - Alex attended appointment with Housing Specialist to discuss further financial support. She disclosed multiple deductions coming off her benefits leaving her with £91.52 per fortnight. At the time of writing this report, the Housing Specialist is working with the Employment Specialist to determine the exact nature of these deductions so they can be negotiated to a more affordable repayment rate.

Case Study 4 – Persistent and flexible approach to engagement

Introduction

This case study highlights the work done by the multidisciplinary team to support Steph (pseudonym). The case study highlights the importance of persisting in attempts to support residents and maximising the opportunities there are to support them. Steph's case study is intersected with her own words, captured through our subjective perception questionnaire to illuminate the reasons why it took so many attempts to establish engagement with her.

Context

Steph is a 39 year old single mother of five dependant children aged between one and 13 years old. She also has three non-dependant children aged 16 and over who live independently, one of whom is currently in prison.

Steph is a YHN tenant and who is not currently working. She is in receipt of Income Support, Child Benefit and Child Tax Credit totalling £390.28 per week. Steph is subject to the Benefit Cap and her Housing Benefit has been capped at £0.50 per week leaving her to pay £98.83 per week rent, which is 25% of her total income.

A persistent approach to establishing contact

The team tried to contact Steph 15 times over two months before they could sit down with her to identify ways they could support her:

23 November 2017: the team sent an initial contact letter to Steph

27 to 30 November 2017: the team sent two text messages to Steph and tried to call her twice

4 December 2017: the team conducted an unannounced home visit to Steph's address. She answered and said that she needed help with budgeting and debt but it was not a convenient time. She gave the team her new telephone number and asked them to call her to arrange an appointment. The team called her on 4 December but there was no answer, so they sent her a text message offering support with budgeting and debts

5 December 2017: the team called her but there was no answer, so they sent her a text message offering support with budgeting and debts. The team also sent her a letter, explaining the support they could offer

11 December 2017: the team called Steph but there was no answer, so they sent her a text message offering support with budgeting and debts

2 January 2018: the team sent Steph another letter to explain that they intended to conduct a home visit on 8 January

8 January 2018: the team carried out their second home visit. Steph again reiterated that she would like support but it wasn't a convenient time, so they re-arranged to come back on 16 January 2019

16 January 2018: the team established engagement with Steph and highlighted a number of areas in which could offer support

Case study 4 continued

A persistent approach to establishing contact (continued)

The number of attempts the team made to establish engagement with Steph may seem excessive. In turn, some services may believe that Steph does not want support. However, after establishing engagement, the team's Debt Specialist was quickly able to ascertain that there were good reasons why Steph had struggled to engage before this point:

> *"Due to my anxiety and depression I worry about everything; the rent, the Council Tax, the house, the kids … I feel that I have no control over anything and sometimes just ignore everything as a way of coping … I wanted help and support with the benefit cap and you offered to do a home visit. Due to my anxiety and the fact that I have two young children I struggle to make appointments that are not at home"*

Maximising the opportunity to stabilise a resident's situation

> *"I manage with what I get but it would be nice to be a little richer … I just take what I'm given, I don't really check what benefit I'm on and why. People keep talking to me about UC and I'm not sure if I'm supposed to be on that now or not"*

Short term mitigation

The team completed a Supporting Independence Scheme (SIS) application to replace the goods in Steph's furniture pack (2 x wardrobes, 3 x chest of drawers and a double mattress). These actions reduced her rent by £10.71 per week (£556.92 per year) with an award of only £765.11.

The team completed an application form for Discretionary Housing Payment (DHP) to cover the shortfall in her rent. However, this was refused as, at the time, she had a surplus on her rent account.

The resident had a debt to Provident of approximately £1,500. After doing intensive budgeting work with the resident, the Debt Specialist contacted Provident and negotiated an affordable repayment rate on the account of £5 per month. Steph also had deductions from her Income Support for water rates arrears, Council Tax and a Magistrates' Court Fine totalling £20.90 per week. Unfortunately, these could not be reduced.

Offering advice and keep a 'watching brief' after losing contact

Steph's youngest child is two, so she has no specific work-related conditionality for another three years. The team reassured her that she was on the right benefits and discussed her future plans once her youngest child is able to go to nursery and she advised that she would like to speak to an employment specialist closer to the time.

The team 'failed to maintain engagement' with Steph after her initial appointment despite three phone calls (14 February 2018, 22 March 2018 and 26 April 2018) and two letters (17 January 2018 and 8 February 2018). However, after the credit on Steph's rent account ran out in March 2018 the team got back in touch and managed to submit another application for DHP. This was successful, and the fund agreed to pay her rent in full until 31 March 2019 at a total cost of £4,278.04.

Case Study 5 – The time taken to stabilise

Introduction

This case study highlights the work done by the multidisciplinary team to support Rob (pseudonym). This was one of the team's longest cases, taking almost a full year (344 days) before they felt that they had stabilised his situation.

Throughout the case study, Rob's case study is intersected with his own words, captured through our subjective perception questionnaire to highlight the wider impact on emotional wellbeing that is brought about by the work of the team.

Context

"If I could work in a trade I'm competent in, like engineering, it's all I've known since I was 17 except for the army, then yes. But I can't do computers and IT and all that. If my health was as it was before I wouldn't be on employment benefit at all. I even worked for YHN picking up the rubbish cause there was no other jobs you know. It was YHN that helped me get on the employment benefit, I didn't even know there was such things"

Rob is a 55 year old single man who lives in a YHN tenancy and was identified by the team through the "bedroom tax" route for YHN tenants in the 'Outer West and North' of the city. He is deemed to be 'under occupying' his home by one bedroom, meaning his housing benefit receipt is reduced by £10.71 per week. At the time that the team identified the resident, they had already had 3 DHP payments, this was covering the shortfall caused by the under-occupation charge ("bedroom tax") of £10.71.

Rob had previously served in the army, worked in the mining industry abroad and more recently worked for YHN up to April 2016. Due to health issues, he could no longer work in industries that he had experience in.

Getting in contact and establishing engagement

The team conducted in-depth screening on the household before discussing the most appropriate way to approach Rob at their case identification on 5 December 2017.

The team's Welfare Rights Specialist sent him an introductory letter, made two phone calls, sent two text messages, and made two home visits. Engagement was established with Rob at the second home visit on 21 December 2017.

The home visit

*"Oh s**t yeah, how to explain it. Before you came into my life I just dealt with it, but then the electric, well it's just really blown me away. I'm trying to cut down but it's really hard … Mine's a battle at the minute, that I'm having to take money from my kids to keep me going and I'm behind with certain things. If I didn't have my kids, well it's a bit shit you know, when they're having to put money in your account … I would have sold the car but I need it, I'm helping my mam and I need it for myself too"*

At the initial home visit, Rob disclosed that he would like to move to a one-bedroom property but was struggling to find one in his local area. He does not feel that he can move out of the area because he cares for his mother who has COPD.

Case study 5 continued

The home visit (continued)

The Welfare Rights Specialist also identified that Rob had significant breathing difficulties due to working in the mining industry abroad but did not have a diagnosis. Rob was also struggling with around £3,000 of electricity debts. The Welfare Rights Specialist referred him to Energy Services for support with these and Energy Services managed to support the resident to move onto a cheaper tariff.

"I didn't know I was entitled to anything more than I was getting … I just knew I was on employment benefit, I had no understanding that there was anything else out there I could get. I just took it at face value that's all I was entitled to. I didn't know the Tax Credits were saying they were still paying me and I was missing out on my employment benefit. I had no knowledge of it until you brought it to my attention. One end doesn't know what the other's doing"

Rob was in the ESA Support Group but was receiving £54.26 a week less than he should have been. The team's Employment Specialist was able to liaise with the DWP to determine that this was because they mistakenly thought he was receiving Working Tax Credits (WTC). This error had continued from previous employment for YHN, which had ended, alongside his WTC payments in 2016. While they sought to remedy this issue, the team made a successful application for a fixed term DHP payment for the resident.

In August 2018, the resident gained £6,549.96 in backdated ESA payments for the error in deductions dating back to 2016. The resident used this payment to initially pay £2,000 off his electricity bills. The resident's ESA award also increased by £2,821 per year.

Helping Rob get the Personal Independence Payment he is entitled to

"I would just like to get more stable until they find out if there's a cure for this COPD and asbestos thing, I don't think there is one"

After undergoing tests at hospital, the resident was diagnosed with COPD in May 2018. The Welfare Rights Specialist advised him to order forms to make a claim for Personal Independence Payment (PIP). The claim forms arrived in June 2018 and the claim was submitted in the same month, but with only relatively limited supporting medical evidence. The resident's PIP claim was initially turned down in October 2018 and he noted that the reason he was given was that he could walk more than 20 metres. After a mandatory reconsideration was submitted by the Welfare Rights Specialist he was awarded PIP daily living and mobility at £1,177 per year in December 2018.

Case Study 6 – Combining benefits, debt and budgeting work

Introduction

This case study highlights the work of the team to support Linda (pseudonym). The case study highlights the relatively high degree of Children's Social Care involvement among the households being supported by the team and the challenges posed by the residents' known relationships. This case study also emphasises the need to work closely with wider partners to develop more sustainable solutions. Finally, the importance of budgeting support to foster independence to avoid reliance on ongoing support and to ensure that the solutions provided by the team are sustainable.

Context

Linda is a single female resident living in a YHN tenancy with six dependant children

Linda is affected by the benefit cap with her Housing Benefit capped at 50p per week, leaving her with a rent shortfall of £87.96 per week.

Establishing contact

The team had initially attempted to contact the resident in February 2018 with no success. They placed notes on each of their databases to state that they had been trying to contact Linda

Working with wider partners

In April 2018, the resident was referred to Welfare Rights by the Intensive Family Support Worker for support with non-priority debts. This referral was redirected to the multidisciplinary team. The Welfare Rights Specialist identified that the resident had an appointment with a YHN Advice and Support Worker (ASW) to complete a DHP and so arranged to attend this appointment. The Welfare Rights Specialist established contact with the resident at this meeting on 5 May 2018

The team established through the YHN ASW and Children's Social Care that the resident had a pattern of seeking additional sources of funds from different support services. The team discussed the case and invited the Intensive Family Support Worker to meet with them to agree a more holistic approach to working with the family

Short term mitigation

It was agreed with the YHN ASW that the multidisciplinary team's Housing Specialist should make a DHP application for the resident to stabilise her situation in the short-term. The Housing Specialist checked in regularly with the resident to ensure she understood and was making rent payments before the DHP went through

Case study 6 continued

Debt and budgeting work

Between May 2018 and October 2018, the Debt Specialist has conducted several home visits with the resident. She has agreed smaller repayment arrangements for a combination of 11 non-priority debts. However, the resident has been reluctant to return the items she bought on credit through Brighthouse, which prevented the Debt Specialist from seeking a Debt Relief Order. During these visits, the Debt Specialist also agreed a budgeting plan that breaks down what needs to be paid each day through a practical visual aid and timetable. She continues to support the resident to stick to this budget

Benefits work

Between April 2018 and September 2018, the Welfare Rights Specialist collated supporting evidence for DLA claims for two of the resident's children, which were successful. This allowed the resident to claim Carer's Allowance and additional premiums on Child Tax Credits for both children, giving the family an exemption, which removed the benefit cap. This meant that the family are now £445.00 per week better-off than prior to the team's involvement (excluding money saved through debt repayments)

Despite a couple of large backdated benefit payments, the resident has taken out a further Moneywise Credit Union loan against the team's advice. In turn, the resident's children are now again subject to a Child Protection Plan due to suspected neglect