CAMPBELL TICKELL

West Midlands Combined Authority

Housing First Research Project

For West Midlands Combined Authority Homelessness Taskforce

Final Report

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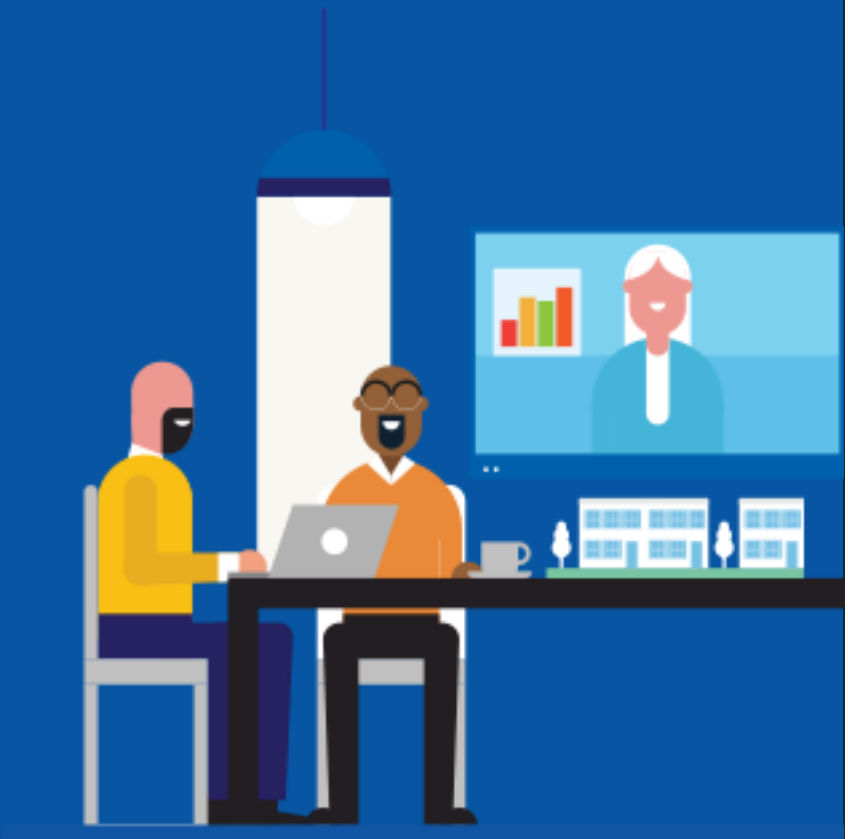

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1. Introduction

1.1 Campbell Tickell has been commissioned by the West Midlands Combined Authority (WMCA) Homelessness Taskforce to undertake an action research project into the Housing First (HF) Pilot sponsored in the region by the former Ministry of Housing, Communities and Local Government (MHCLG) – now the Department for Levelling Up Housing and Communities – DLUHC.

1.2 The scope of the work and the objectives of our research have been to:

a. Facilitate shared learning, focussing on operational issues, across the seven WMCA HF pilot schemes, that will impact on practice in the here and now.
b. Help identify the key elements of an ongoing and sustainable HF programme, both for the seven pilot local authorities and others within the wider WMCA sub-region.
c. Assist WMCA, and individual local authorities, in planning future development of the HF programme after the pilot has come to an end.

1.3 We have achieved these objectives through a three-phase research project, building on the work of each phase to develop the next. Each phase has consisted of field research and data gathering, workshops with practitioners and three interim reports addressing the core issues of:

- Housing access and housing supply.
- Support and case load issues and ongoing need for support of HF tenants beyond the pilot.
- Multi-agency working.

1.4 This report contains a chapter for each of the above issues, followed by a key findings and recommendations section and conclusions. There is a separate Executive Summary.

1.5 The WMCA HF pilot is the largest HF service to have been commissioned in the UK and has provided the opportunity for significant learning about delivering HF at scale and within the relatively short time frame allowed to establish the pilot. The pilot has also developed some great practice innovations and established a sound basis from which the WMCA region can go on to develop HF services in the future.

1.6 The WMCA pilot is the only one of the three national pilots separately commissioned by each local authority, with services designed to address the local context. A further unique feature is the different delivery models utilised, involving services commissioned from the community and voluntary sector, councils and Arms Length Management Organisations (ALMOs).

1.7 All those involved in the WMCA HF pilot services are to be commended for housing and supporting 460 people into tenancies in the first three years of the pilot (to July 2021) with the remaining 40 people (of the 500 target) identified and on track to be housed over the next few months. This being achieved despite the Covid-19 pandemic and significant stresses in the housing, mental health, social care, substance misuse and criminal justice systems. Key innovations and learning points include:

- A best practice model for Local Authority allocation of HF units and a best practice approach to working with registered providers to increase housing access.
- That HF cannot just be seen as a housing solution to homelessness but has to be commissioned using a multi-disciplinary approach which stems across Public Health, NHS and Social Care.
- That access to housing has a close link to the level of support required, the sooner clients are housed the less staff input is needed to manage the caseload. With evidence showing that in the early years of HF a 1:6 ratio would be required but this can taper to 1:7 to 1:8 in later years.
- That waiting times for housing has both a positive and negative impact, the waiting period can lead to people disengaging from the service. At July 2021, 30 individuals, or 7% of the 460 clients, had either withdrawn their consent or lost contact with the service. A further 26 or 6% had either moved away from the area or gone to alternative accommodation. The waiting time for housing however also creates a period of time where the Navigators[1] can build trust with individuals. It also provides space for individuals to come to terms with what taking on a tenancy requires. This period and the relationship building time should be seen as a valuable part of the HF service (rather than a delay before the service can really start) with resources invested in this pre-tenancy work.
- HF is a long-term service model. The approach to supporting individuals, the level of persistence and continued flexibility in working with people, ensuring they can exercise choice, supporting them to try again when things have not worked, finding alternative solutions, and being person-centred at all times while encouraging people to progress have been demonstrated by the pilot as key to sustaining HF tenancies.
- HF, by providing a stable home with intense long term support is the first step to levelling up. It is enabling individuals to create a stable foundation from which their lives can progress. A long term and high fidelity national HF programme presents an opportunity to demonstrate levelling up in practice by ensuring no one (especially our most vulnerable citizens) is left behind.

Solihull Housing First

The Solihull Housing First (HF) service has worked on the principle of person-centred, persistent and tailored support and taking a flexible approach to what each individual client needs to engage with the service. The Solihull HF team began to work with a man, Mr S, who was rough sleeping and who had previously only had minimal engagement with services and refused all offers of support.

On initial engagement Mr S felt Housing First was like all other services and was very hard to engage. Numerous appointments would be arranged, and he would rarely attend and when he did attend, he would provide minimal responses to questions and not engage in

[1] Given that the difference services have different names for their client facing workers, this is the term we have used as a generic term throughout for the worker roles supporting individual clients.

any discussions. Mr S would refuse to travel outside of his known area which was causing great difficulty in getting him to meet with a non-medical prescriber to be able to obtain a methadone script for his heroin addiction.

After numerous contacts with the HF Navigator it became clear that Mr S had a fear of public transport which was the reason why he would not travel out of area. As he could not afford taxis he had no reasonable way of getting to appointments. After several discussions he finally agreed that if a taxi was arranged to collect him on the day of his appointment he would attend. This went ahead as planned; the taxi collected him and took him directly to his appointment with the prescriber, as a result of this he was successfully placed on substitute medication and has remained stable on this since then.

At the beginning of March 2020 Mr S was matched to a Housing First property through Solihull Community Housing – however before being able to set up the pre-tenancy meeting and confirm a move in date the first lockdown for Covid-19 began. The Housing First Navigator still visited Mr S (using Covid safe and PPE measures) and checked in with him daily. A virtual pre-tenancy meeting was arranged and this was followed by the tenancy sign up process being completed by email. The keys for the accommodation were provided to the Navigator and then directly to Mr S.

Mr S moved into his own tenancy during the lockdown period. Since he has moved into his property, he has continued to make positive changes such as furnishing his flat, maintaining abstinence from drug use and staying on his scripted methadone. He no longer sleeps rough and is not street begging.

Mr S has recently requested a reduced number of support hours but still contacts his support worker when he requires the support.

The tailored support from the HF service allows workers to support individuals in alternative ways. Persisting with seeing and contacting this man enabled the HF Navigator to understand that a big barrier for Mr S was his fear of using public transport and the intervention of arranging a taxi helped him to attend an appointment for a methadone script. This in turn stabilised his substance misuse issues to the point where he was able to take up a HF tenancy. The Navigator then worked closely with the landlord and Mr S to ensure that Covid-19 did not impact on his opportunity to move into HF accommodation. Persistence, practical support and a person-centred approach meant that the Navigator was able to build rapport and encourage Mr S to make positive changes. Each positive change has been built on and his need for support is reducing.

1.8 This research was conducted between January 2021 and July 2021. The Department for Levelling Up, Housing and Communities (DLUHC) - formerly the MHCLG - has commissioned its own national evaluation programme of which WMCA's Housing First pilot is a part. We recognise the importance of complementing but not duplicating this national evaluation. Our action research approach has therefore focussed on the current delivery issues faced by the WMCA region pilot and identifying learning for future HF provision in the region.

1.9 We would like to thank all the council officers, registered housing providers, Navigators and managers in each of the services and their partners who have contributed to the research.

2. The WMCA Housing First Pilot

2.1 The WMCA Housing First Pilot received £9.6m in funding from MHCLG (now DLUHC) and consists of eight HF services with a target of housing and supporting 500 clients across seven local authorities:

Birmingham – target to house and support 175 clients. Commissioned as two services operated by Cranstoun and Trident Reach.

Coventry – target to house and support 70 clients commissioned through Brighter Futures.

Dudley – target to house and support 38 clients, commissioned as an in-house Council run service.

Sandwell – target to house and support 49 clients commissioned as a service from Fry Accord.

Solihull – target to house 24 clients, commissioned as a service from Fry Accord.

Walsall – target to house 100 clients, commissioned as a service from Fry Accord.

Wolverhampton – target to house 44, commissioned as a service provided by Wolverhampton Homes the Council's Arms' Length Management Organisation (ALMO).

2.2 The national Interim Process Evaluation Report[2] highlighted that the WMCA pilot began in January 2019 and was in advance of the other two pilot areas of Greater Manchester and Liverpool. It is the only one of the three national pilots that has been separately commissioned by each local authority with each service designed to address the local context. Another unique feature is that there are different delivery models consisting of services commissioned from community and voluntary sector, council delivered and ALMO delivered services.

2.3 The WMCA pilot is the only one that has been commissioned on a 3 +1 + 1 (years) model of funding and is set to run from 2018/19 to 2022/23. One ongoing issue of concern to the WMCA has been the longer-term revenue funding needed to support the clients who would require a longer period of support than the pilot funding allows. We have sought to address this and to model the likely on going need for HF.

2.4 The WMCA HF pilot has been overseen by a Council officer led Steering Group, Chaired by a senior officer from Birmingham City Council. Overall delivery of the WMCA pilot is also overseen by the Delivery Board which is chaired by the Corporate Director for Adult Social Care within Birmingham City Council. The pilot has benefited from regular Psychologically Informed Environments (PIE) reflective practice sessions commissioned centrally for all support staff. These have been used to problem solve and develop different approaches to working with people to maximise the effectiveness of the services. All staff and managers are part of monthly Operational Group Meetings, used to review performance data and share learning.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/946110/Housing_First_first_interim_process_report.pdf

2.5 Key features of the WMCA HF Pilot have been fidelity to the model – with case-loads of between 5-7 clients. On occasions however these levels have been exceeded for short periods of time due to staffing and Covid-19 pressures. The approach to engaging with and supporting individuals has been fundamental to the success of the pilot and is firmly based on persistence, being user-led, providing choices and partnership work with other agencies.

Sandwell Housing First

Mr D had been sleeping rough for a long time after a breakdown in his family life and estrangement. This meant he had no support network. He felt alone and his addiction was escalating; affecting his physical and mental health and wellbeing.

He was in hospital for a few weeks at the beginning of the year very ill. He responded well to treatment and stayed in hospital (rather than discharging himself which was his usual pattern of behaviour) until he was well enough for the hospital to discharge him. On leaving hospital he was housed in a HF property in Sandwell, with a mixture of private and rented properties, with a row of local shop, a pub and on a bus route into West Bromwich town centre. Mr D was very happy with his flat. The challenge for Mr D was to work on his addiction, to keep his tenancy, maintain his health and avoid re-admission to hospital.

At first he found it challenging to comprehend, that he now had a home, and he should be going home every night, rather than staying on the street. The socialising element of his life revolved around other rough sleepers in the town. He stayed out with them and the urge to use drugs, meant he stopped his methadone treatment. He would drop out of contact and all the agencies worked together to find his whereabouts and re-establish contact. The HF Navigator has worked with the substance misuse service and other agencies to ensure Mr D re-establishes his methadone treatment each time he relapses.

The multi-agency work from the substance misuse agency, the Environmental Protection Officer, local Policing, and others meant that the HF service could be both proactive and reactive in a timely manner to any issues that arose or that they were informed of. This persistence and the agencies working together has made Mr D feel secure in the knowledge that there's more than just one person that had his best interests in mind and is willing and able to solve any issue he has.

Mr D received robust support, by daily visits, sometimes 2 or 3 times a day, and telephone calls. Mr D has a peer mentor who has supported him to tidy his flat and maintain its cleanliness, assist in meal planning and cooking healthy, nutritional foods he can freeze, and plan his expenses, using the budget planner that had been completed with him. Navigators have supported Mr D to create routines for himself for example prompting him to go and collect his medication from the Pharmacy. He now has short, medium and long-term goals planned out with the mentor and the support of all HF staff. He engages well and although he has had a recent lapse into drug use he proactively asked the team for help, and was very apologetic and annoyed with himself. The constant support has been key to ensuring he keeps to his goal of reducing his drug intake and progressing with his goals.

3. Housing Access and Housing Supply

3.1 HF services require a steady supply of genuinely affordable housing to succeed. Having the support of local authority (LA), registered provider (RP) and private landlords and the ability to access the right housing units, in the right place at the right time have proven to be key to the success of HF service delivery. In addition the flexibility of landlords and the willingness to house and re-house, or transfer individuals and to work in close partnership with the HF Navigators is also key to successful sustainment of tenancies.

3.2 In the WMCA pilot the key issues identified in relation to housing access and housing supply include:

- Reduction in available lettings during the Covid-19 period compounding an ongoing lack of affordable housing more generally in the region.
- Varying commitments from Registered Providers to provide tenancies for HF clients – which the pilot has addressed through regular and ongoing engagement with local registered providers.
- Competition for available units with exempt accommodation providers.
- The affordability gap caused by the local housing allowance not keeping pace with rent inflation.
- Variable engagement with the private rented sector.

3.3 A key factor impacting on the LA's ability to secure housing units for HF clients and to provide a flexible response to transfers in the level and type of housing available. For example, in Birmingham 85% of the social housing stock is owned by the Council. Some authorities such as Walsall and Wolverhampton have transferred their stock and the council is reliant on housing association, or ALMO provision. The type of stock is also important for example high rise flats with shared entryways and corridors as opposed to street properties, ground floor units or small rise blocks which would work better for HF clients.

3.4 Despite some clear challenges each authority has developed an approach to housing access and supply that has sought to maximise the choice of housing for clients and to transfer clients to alternative units where safeguarding or other issues that put tenancy sustainment at risk have arisen. It can take several moves before a client is able to settle into a tenancy.

3.5 One of the clear learning points from the pilot, is that while there is a long lead in time to establishing a HF service, more time and engagement is needed with landlords to:

- Promote HF with their housing officers (and other relevant staff and managers) so they understand the ethos and clients.
- Explain the available support to clients from the HF Navigators.
- Establish the approach to partnership working with landlords and agree the required flexibilities in processes or procedures to maximise tenancy sustainment so that issues arising can be tackled quickly and jointly within an agreed framework.

- Ensure that pledges of accommodation are established alongside any agreed underwriting of risks to the landlord (such as insurance for any additional repairs costs incurred).

3.6 Research on Social Landlords and Housing First carried out by Homeless Link[3] in July 2020 and subsequent research carried out by the National Housing Federation in December 2020[4] , in addition to the issues above, highlighted the need to engage landlords early on in the planning of HF services. Long term sustainable funding for the required support and a need to adapt nominations and allocations policies were also identified as key.

The period between acceptance and being housed

3.7 A common facet of a number of HF cases was the need for "managed moves" i.e. transfers. There was more than one case where the tenant was at risk of/or being exploited or abused routinely by known associates or other people in the local community. Once this is identified as a problem, then it really requires rapid action and a multi-agency response involving the landlord, Police as well as safeguarding and other agencies to resolve. Before considering this issue as a basis for giving up the tenancy without any alternative being offered, the possibility of a move to a different area or different type of property needs to be explored and has been on many occasions by the WMCA pilot HF services.

3.8 A number of clients had spent a long time waiting for a tenancy to be offered and/or accepted - three months plus was common but several had been waiting considerably longer. Many spent the majority of their waiting time in supported housing. This could work well, as long as this reflected the client's choice. It is important however that this does not come to be seen as the standard route into HF accommodation, as this will then be recreating the staircase / pathway model that HF is designed to replace.

3.9 There are also occasions where this waiting period can undermine the motivation needed to make a HF tenancy work. For example, one client was a frequent offender who was stuck in a cycle of homelessness leading to petty crime leading to a short custodial sentence leading again straight to homelessness. The only way for HF to break into this revolving door syndrome would be for a HF property to be available at the point of their release from custody. Considerable joint work between a landlord, the Navigator and the probation service would be needed to facilitate this kind of rapid response.

3.10 Evidence from a caseload review carried out as part of this research suggests that the location of the property is also really important, and it can be very important to longer term tenancy sustainment to wait until the right property is available. For one client at least, who was still waiting for a HF tenancy, the priority was to find accommodation that was very close to but not on top of their family. As for many clients, close family or other relationships can at the same time be both the basis for a supportive network while also being the source of many of their problems. A property that allows them to maintain the positive impact of

[3] Social landlords and Housing First, July 2020
[4] Experiences of housing associations delivering Housing First Research into how housing associations use the Housing First model and recommendations for delivery, December 2020

family contact while also limiting what can sometimes be the negative impact of these relationships can be key.

3.11 Our research found that an extended period between being accepted on to the HF pilot and receiving a tenancy offer can be an important part of HF rather than simply an indicator of the difficulty in securing housing offers. It is a risky time where people can disengage and be lost to the service. This period of waiting however also provides individuals with the space and time to consider and come to terms with the prospect of taking on the responsibilities of their own tenancy and what that will require.

3.12 It is also a time used by Navigators to build trust with the client. Usually this has focussed on providing very practical assistance such as supporting the client to obtain a birth certificate, make a claim for welfare benefits, and provision of mobile phones and pre-paid sim cards to enable and sustain communication, all of which promote the benefits of engaging with the service and enable Navigators to find out more about individuals and build relationships.

3.13 Not being housed quickly undoubtedly makes it more likely people will disengage and exit the service. Where rapid access to a tenancy is not possible, the provision of rapid access to temporary accommodation once someone has engaged could reduce this. It could also be an important opportunity for the individual to try out their decision to take a tenancy. Anecdotally HF Navigators reported that some clients who had been placed in hotels as part of the 'Everyone In' response to the Covid-19 Pandemic were more able to settle into their HF tenancy once placed, because they had had the period in hotel accommodation to get used to being housed without the pressures of bills or other tenancy obligations.

3.14 In summary the waiting time before a HF tenancy is obtained can mean people disengage. Provision of temporary or supported housing while waiting can help to ensure people do not disengage and enables them to see what being in housing could be like, as long as it does not lead to the recreation of a pathway approach. The waiting period is also a very important part of the process of building the relationship between the Navigator and the person and should be seen as part of the HF service in its own right (rather than as a delay before the HF tenancy and the HF service starts). Building this relationship of trust through practical support while waiting for a HF tenancy is important for subsequent tenancy sustainment. Waiting for the right tenancy in the right location and giving people the time and opportunity to exercise choice is also an important factor in tenancy sustainment.

3.15 Of the 48 clients who exited HF for whom we have data, 23 clients, (47.9%) began a tenancy during their engagement with HF services, but the placement either broke down or they left. The need for rapid access to alternatives where the initial placement breaks down, is important in enabling people to achieve the best housing and support outcome.

3.16 Of those who were housed, the biggest triggers for exiting the service, excluding those who died, were challenges with other residents or neighbours. This was the issue for 6 of the 48, (12.5%). Difficulties with visitors/associates forcing their way into the premises was an issue for 5 people (10.4%) and concerns about loneliness or missing the community of the streets was an issue for 4 (8.3%) of the 48.

3.17 A key learning from this is that the enormity of the transition to their own tenancy for some people needs to be assessed, discussed and planned for with each individual so that they are aware of any risks to ongoing sustainment of the tenancy and plans are developed to support them in dealing with these risks should they arise.

3.18 All HF services demonstrate a high level of commitment to providing flexible and pro-active support to clients. Within the pre-tenancy and move-in phases, this support includes sourcing suitable temporary accommodation (and alternatives where the initial placement has broken down); practical tasks, such as GP registration, establishing welfare benefits claims, securing furniture and connecting to utilities. This support is understood as being vital in helping clients stabilise, supports the development of trusting relationships with staff and creates the opportunity for discussions around transitioning away from the streets.

3.19 One factor that can enable people to settle into their home is the approach taken to furnishing tenancies and turning a flat into a home. Engaging individuals in how the property is furnished, and in the process of securing funding, sourcing furniture and other household goods and ensuring the involvement of HF clients in all aspects of those decisions is critically important in ensuring people are able to sustain their tenancy.

Walsall Housing First

Mr P's mother passed away which led to a decline in his mental health and a diagnosis of borderline personality disorder. He was using Class A drugs and alcohol, he was not scripted and would not engage with services. He became an entrenched rough sleeper for over two years and was living in a tent outside a local supermarket. Some of the staff at the supermarket were supportive of him but eventually the supermarket management advised that he could not stay there indefinitely. A referral was made to Housing First (HF) and Navigator staff went out to meet with him.

The worker explained about the HF service. It was made clear that he would not be under any pressure from the staff, but they would be there to guide him as best they could. Mr P explained why it was so important to him to have accommodation in the area where the supermarket was as it was where he felt safe and away from the Town Centre where old acquaintances would make it difficult for him to reduce his drug and alcohol use. This was explained to the accommodation providers and taken into consideration by them.

Mr P was offered a property in the area of his choice and very happily accepted it. His property was provided with all the essentials. In full discussion and with the participation of Mr P, a starter pack of a microwave, kettle, cups, plates and cutlery as well as pots and pans was provided. Carpets were fitted, bed and bedding delivered on the day of tenancy sign-up along with white goods, and a sofa to ensure Mr P could move in immediately.

The HF Navigator assisted Mr P with his benefit claims to ensure he received the correct benefits he is entitled to and set up payments to ensure his rent is paid directly to the Housing Association to prevent rent arrears. He was assisted in setting up utility billing

accounts in his name and opening up a Walsave Account for benefits to be paid into and Direct Debits to be paid out.

The HF Navigator supported Mr P to engage with the Beacon (drug service) and he is now on a methadone script and registered with a local GP. He was given information and contact details for talking therapy services. The HF Navigators see Mr P on a regular basis to ensure he is coping with things and to address issues as soon as they arise and do not escalate.

Mr P has settled into his flat. He has said he feels safe and comfortable now that he has his own space to call home. He has enjoyed furnishing and decorating the flat to suit his tastes and maintains it well. He takes pride in the fact that he now has a place to call home, he looks after his property and himself.

Mr P's methadone script is slowly being reduced over time, he has not used heroin for over 9 weeks and has massively reduced his use of alcohol. The result of this is that he has rebuilt a relationship with his sister and aunt and he now sees them on a weekly basis.

Mr P has attended talking therapy sessions with the local mental health services to address bereavement, anxiety and depression but in a recent discussion with his Navigator said he does not feel the need for medication as he is not feeling that low, but he knows who to contact and what to do if he has concerns.

In Mr P's words "*It's completely turned my life around, from living in a tent and being distant from my family because of drugs and alcohol to now having my own place and being able to invite my sister round for a cuppa it's fantastic. Having that support there from Housing First and the Beacon really helps, I feel like they've got my life back, even when I've screwed up a couple of times and things have gone badly wrong, they haven't given up on me, they have helped get me back on track, and I can't tell you how much that means to me*".

The available housing options

3.19 The WMCA All Party Parliamentary Group (APPG) submission[5] stated that the "pilot has struggled with housing supply issues (availability, affordability, suitability)." The WMCA region had placed 460 individuals into tenancies. Of these 379 individuals were in tenancies at July 2021. The majority have been housed in Council tenancies, followed by RP tenancies and a very small number into the private rented sector:

	Local Authority		RP		Private landlord		Total	
Birmingham	119	88%	17	12%	0	-	136	100%
Coventry	0	-	32	97%	1	3%	33	100%

[5] The APPG for Ending Homelessness' inquiry into how the Government should expand Housing First services across England (October 2020-July 2021)

Dudley	19	79%	1	4%	4	17%	24	100%
Sandwell	39	85%	7	15%	0	-	46	100%
Solihull	10	83%	1	8%	1	8%	12	100%
Walsall	0	-	76	96%	3	4%	79	100%
Wolverhampton	44	100%	0	-	0	-	44	100%
TOTAL	**231**	**62%**	**134**	**36%**	**9**	**2%**	**374**	**100%**

3.20 We are of a view that the achievements to date are impressive in terms of the numbers of tenancies that have been created in a relatively short timeframe. To provide context the Liverpool City Region Feasibility Study (commissioned by Crisis in 2017)[6] suggested that a realistic timeframe might be to establish 400 units in the first 5 years of large-scale HF implementation. The London Housing Foundation Atlas of Homelessness services in London identified 17 projects, providing support to around 260 people in 2020, the largest services working with 50 people was located in Camden.

3.21 The WMCA pilot has demonstrated that particular problems have arisen when clients expressed preferences for an area where there were fewer housing options available. On the other hand, the APPG submission went on to say that "we know from our experience that if we can get as close as possible, in terms of where people want to live, and match that with a strong support offer, they are more likely to stay and sustain a tenancy. This isn't about being unrealistic about housing options for HF clients, but an exploration of what is it about a particular area that makes it attractive as a place to live and establishing whether this can be found close by."

3.22 This makes it clear that, while there is scope for having an informed conversation with clients about preferences and housing availability, the ability to exercise informed and realistic choice in location and type of housing remains central to the success of HF, even if it can lead to longer lead-in periods to securing a tenancy. It means the tenancy will have a higher chance of success.

3.23 This ability to exercise choice is a first step we believe to enabling people to sustain a tenancy and these conversations, exploring the features that a HF client sees as important in their housing location and type are critical to creating sustainable long-term tenancies. As is their ability to choose how they furnish and decorate their home.

3.24 Another key learning point is the real importance of being able to secure access to a range of housing options provided by a range of landlords, which among other things would increase the choice of areas to live in.

3.25 To date the vast majority of those allocated tenancies have moved into the social housing sector - 97% of those housed have been housed in the social housing sector, with only nine tenancies established in the private rented sector (PRS), in Dudley and Walsall. It may be

[6] Housing First Feasibility Study for Liverpool City Region (2017)

that this is appropriate as social housing is more likely to provide the required level of security and the flexibility in management regimes needed for HF tenants. However we do believe that PRS has a role to play, and has played a role in the development of HF services in areas where housing supply is severely stressed, such as London.

Using the private rented sector

3.26 There could be a number of cases where the client's choice can most easily be met through available private rented accommodation. So, learning the most effective mechanisms for accessing this resource is worth some further investment of time, and relatively little has been done to date in the pilot to address this. Dudley have been looking at how to underwrite landlord's financial risks as part of a range of incentives. There is a considerable body of work in accessing private rented accommodation that could be used to develop a WMCA approach to engaging the private rented sector more directly. This includes:

- Resources invested in building relationships with private landlords and understanding the local private rented sector (PRS) market in each area and the pressures in that market as well as where and what supply is available and its affordability for HF clients
- Funds to cover rent in advance and deposits or deposit guarantees, bonds and insurance or other-underwriting of risks such as damage to property
- Local authority co-operation with regard to local housing allowance administration and access to discretionary housing payments or other funds to support the tenancy
- Clear and ongoing communication with landlords about the support available to HF tenants and a swift response to issues if they do arise
- Incentives to landlords e.g. a one off up-front payment for committing their property, membership of private landlords association, guaranteed fast track of housing benefits payments.

3.27 If PRS is to be part of the mix of housing options going forward then it will require additional funding for rent deposits, guarantees or bonds, insurance or other under-writing or landlords incentives to participate. Each local authority will also need to understand its local market and for example the availability and affordability of one bedroom flats in the right locations and use this to assess the feasibility of using PRS for HF tenancies.

Using Social Housing

3.28 While it is the most used, it is not necessarily easy for HF clients to access social housing. Historically, barriers have existed around previous behavioural problems, arrears and previous failed tenancies that will be endemic to the HF target cohort. One constructive way to address this would be to routinely monitor the extent to which these issues are truly a barrier – how many cases per year are being turned down for these reasons and by whom.

3.29 We found examples of good practice in accessing social housing. The approach to allocation of HF tenancies taken by Birmingham City Council (BCC) we believe is exemplary.

Birmingham City Council – Allocation of Housing First properties

The Council has taken a very sensible approach to the process of allocating properties to Housing First clients, which includes the following aspects:

- The Housing First Navigator informs the Allocations team when a new client is accepted into the Housing First service. An application is not submitted until the Navigator assesses the client is in a position to accept a tenancy if it was offered.
- Two-weekly meetings are held to review all cases that are awaiting a tenancy-offer or are still in the pre-application stage.
- All properties that become available for letting are reviewed first to see if they are suitable for any of the Housing First applicants waiting an offer, before they are advertised for other applicants to bid for through Choice Based Lettings.
- Offers to Housing First clients are made on a direct matching basis. Particular attention is paid to the client's expressed preferences, and wherever possible the Council tries to make use of "low-rise" as opposed to "high-rise" flats.
- There is no formal limit on offers (although they cannot be indefinite).
- The Council does not make offers on a "provisional void" basis to clients – only making the offer when the property is definitely available for occupation – to avoid raising expectations that might not then be realised, or creating delays that may lead to disengagement if the client feels that they have been promised a tenancy and it is taking too long to access this.
- Attention is paid to understand the basis for any refusals and this is used to inform any future offers.
- Properties are held for 7 days after offer to allow the Navigator to work with the client on whether they want to accept it. This time to consider is important.
- The lettings process has been simplified and some of the necessary paperwork is deferred until after the client has settled in.
- All new tenants are offered a 12-week support package to ease their transition to the new tenancy, this is provided in addition to the Housing First support provided by the Navigator.
- Reviews of how the system is working overall are held every 4-5 months involving people across the Council e.g. estate managers and external bodies such as the police. Changes in practice emerge from these meetings.

3.30 The good practice cited above is potentially of national significance in how to make social housing available to support HF. Birmingham City Council has so far allocated 136 tenancies to HF clients using this approach. As one of the largest Councils in the country, and the largest in the West Midlands, Birmingham City Council has more housing resources than some other local authorities. The Council is, like many others, also experiencing high levels of demand and high numbers on its housing waiting list. BCC has however recognised that rough sleeping is unacceptable and has made a commitment to HF as one of the solutions. This commitment includes developing a workable process for enabling HF clients to access social housing.

3.31 The challenge for all Council's looking to establish HF services is how to apply this good practice to their context. Inevitably this is likely to involve looking at how to adapt normal day to day processes to ensure that they work for HF clients.

3.32 Other Authorities in the pilot such as Dudley have worked with HF clients to support them with bidding via the Choice Based Lettings process. Ensuring that all decisions are justified within the Council's overall lettings and allocations policies and any exceptions are agreed in line with the Council's policy framework and related statutory guidance on homelessness.

Dudley Housing First

Ms A has a complex history in relation to housing, she has held several tenancies over a number of years all of which have failed. Ms A has complex mental health issues and has been known to mental health services since the age of 18. While she did access mental health services she did not feel enough support was given to her. Ms A was also a drug and alcohol user and has a difficult relationship with her family which at times was the cause of her homelessness.

Housing First was working with Ms A for two months before suitable accommodation was located through the Choice Based Lettings system operated in Dudley. Ms A was supported to join the Housing Register and to bid for suitable properties in line with Dudley's policies. Support in relation to her alcohol and drug intake and harm reduction, as well as support in accessing services available within the community has been provided by the HF Navigator.

Ms A remained at her accommodation and maintained a successful tenancy from November 2019 to 2020. Ms A decorated the flat and maintained the garden and paid all her bills with the support of Housing First. Ms A abstained from drugs and alcohol for over 8-months and had taken steps to volunteer with the Youth Offending Team as she would like to support others through using her own life experiences. Ms A also compiled a CV and was looking for work in the Security sector, she is a member of a church and has been attending services via Zoom during the Covid-19 lockdown.

Ms A has been engaging well with the HF service throughout but has more recently been suffering with her mental health due to incidents of domestic violence she has experienced from her ex-partner, resulting in a breakdown in mental health. Ms A discussed this with the HF Navigator who in turn contacted her GP and mental health support to address her medication needs and offer additional support during this difficult time.

Due to ongoing domestic violence incidents it was agreed with Ms A that she should be moved to an alternative property. Dudley Council made an exception to its normal policy of tenants being required to have lived in a property for two years before being eligible for transfer for this to be actioned. A suitable alternative property was located and Ms A moved into this second property. With the support of the HF Navigator she settled in and is engaging well; with daily contact via WhatsApp and weekly visits taking place, she is still looking for work and plans to take her first ever holiday.

3.33 Private Registered Providers (Registered Social Landlords) (RPs) also have an important role to fulfil, but in some Authorities, there appeared to be some resistance to participating on behalf of RPs, and some HF clients were effectively "barred" from RP provision due to their previous tenancy history.

3.34 RPs need convincing regarding the risk of taking potentially difficult tenants or that those with a record of failed tenancies can be managed, particularly in the light of concerns about the long-term funding commitment to the HF programme. There is however evidence of good practice in the WMCA – including for example in Walsall where the local authority has engaged RPs by offering to underwrite some revenue losses. We are also aware of a similar approach being taken in Coventry with the HF service underwriting landlord losses.

3.35 Where RPs have worked in partnership with the HF service and established agreed protocols and joint working arrangements this has proved to be effective, demonstrating the need for a partnership approach to increasing the supply and access to HF tenancies.

Citizen – Approach to allocating and managing Housing First tenancies

Citizen owns and manages 30,000 homes for diverse communities across the West Midlands and is a registered social landlord. As part of the organisation's social purpose they were keen to be involved in the WMCA Housing First pilot.

They have made 25 units available for the pilot in Birmingham, Coventry and Solihull and have worked closely with the Housing First Navigators in each area to ensure that the housing and the support are aligned and work together to support Housing First clients to sustain their tenancies.

The units identified were from the organisation's existing stock and were a mixture of 1 bedroom and studio flats. Citizen took the decision to have these units dispersed throughout its stock and to exclude high rise (above 6 floors). Units were identified specifically in areas where the organisation already had a significant footprint.

Care was taken to match the unit to the individual and to ensure that they were at least partly furnished with white goods. This was funded through the pilot and not specifically by Citizen.

From the start Citizen took a partnership approach to their involvement as a Housing First landlord. For example they were involved with the Council in jointly appointing the Housing First Support provider in one of the pilot areas. A senior leader was engaged with the pilot and in introducing the idea of Housing First to the neighbourhood and maintenance teams that would be involved.

Citizen also provided a series of briefings to neighbourhood officers and importantly to its contractors. These briefings addressed the need for flexible neighbourhood management (particularly in relation to anti social behaviour and income recovery) and to working in close partnership with the Housing First Navigators. They provided information to contractors on the types of clients that would be being housed in Housing First properties

and the need for a sensitive approach and they additionally provided guidance on safeguarding in relation to Housing First clients.

The neighbourhood officers and the Navigators met very early on in the pilot and as part of new staff inductions and continue to meet regularly. Citizen has also provided support from their tenancy sustainment teams to Housing first tenants and neighbourhood teams when needed (rather than relying solely on the support provided by the Housing First Navigators). The tenancy sustainment team includes an Independent Domestic Violence Advisor (IDVA) role which has supported tenants to deal with domestic abuse issues when these have arisen.

Inevitably some of the tenants referred to Citizen had previously been evicted by the landlord for serious anti-social behaviour or other issues. Citizen has established reciprocal arrangements with the other social landlords working in the WMCA pilot so that Housing First tenants can have a new start with a different landlord.

Citizen has also actively sought to have Section 106 agreements changed to allow affordable housing to be converted to social rent to facilitate the availability of units to Housing First tenants.

A key learning point from a registered social landlord perspective has been the real importance of building relationships with the Navigators and support agencies from the start and maintaining these on an ongoing basis.

While Citizen and the three local authorities involved are still working on a service level agreement the work of establishing working practices and building relationships has gone on regardless and the final agreement will be based on the practical experience of all partners.

Increasing affordable housing supply

3.36 The need to fund the provision of truly affordable rented accommodation for HF to be successfully rolled out as a national programme goes without saying and the case has been put by many agencies working on HF including Crisis, Homeless Link, and the Centre for Social Justice.

3.37 We know that different models for increasing supply have been adopted across a whole range of contexts in England including the creation of social lettings agencies, private sector leasing, and a range of good practice developed in attracting private landlords to provide housing for homeless and vulnerable people.

3.38 We have not explored these responses and their applicability to WMCA. We are however aware of research being carried out by Crisis to investigate the development of vehicles that could enable the scaling up of HF services across England. There are also examples from elsewhere such as the Y Foundation in Finland, and the Provivienda model in Spain that anyone looking at housing marginalised people can learn from.

Summary of key findings – Housing access and housing supply

1) The research confirms the need for a consistent supply of genuinely suitable and affordable housing for HF clients; that supply can be impacted by a range of factors, including commitment from local registered providers and private rented sector landlords to supply properties and the local LHA rates.
2) There is a need for rapid access to temporary accommodation, i.e. before the HF tenancy starts and alternative long-term accommodation, where the HF property is found to be unsuitable for the client or the tenancy is at risk. This alternative accommodation may include other general needs properties and supported accommodation.
3) Social housing offers greater security and management flexibility than the private rented sector. Although it is important to ensure that previous rent arrears and incidents of anti-social behaviour do not act as barriers for clients to accessing HF social housing tenancies. Reviewing of local Nominations and Allocations policies can help address these issues in part and agreeing protocols around rapid access and transfers, and reciprocal referral arrangements with registered providers is also important.
4) The research highlights that area choice of accommodation for HF clients is highly important, both in terms of promoting client choice and improving rates of tenancy sustainment. Local authorities should therefore seek to develop approaches which maximise realistic choice for HF clients, even where this results in longer waiting times for HF tenancies. Support with furnishing and creating a home and enabling people to exercise choices over these aspects of moving into a tenancy are also important in maximising the chance of tenancy sustainment once housed.
5) Waiting time between clients' acceptance onto a HF scheme and being offered a tenancy is valuable for building trust between Navigator and client, providing practical support and discussing HF tenancy responsibilities. The benefits from this period of support are likely to be greater if clients are in some form of temporary accommodation, rather than still rough sleeping.
6) Our analysis would indicate that the need for rapid access to transfers is an important part of what needs to be negotiated with housing providers as part of the set-up period for a HF service.
7) To date, the PRS has played a minor role in providing HF accommodation/tenancies, in the WMCA and other pilot areas. However, greater use of PRS accommodation has the potential to increase area choice for clients, especially in areas of high housing demand. There is potential to explore PRS utilisation, building on existing knowledge and good practice identified in this research, such as Dudley's underwriting of financial risks for landlords.
8) This research has demonstrated the value of allocating time at the start of HF project implementation to: promote HF and the Navigator model with Housing Officers and other relevant staff; discuss potential changes needed to Nominations and Allocations policies; seek to secure engagement from local registered providers and PRS landlords and establish appropriate partnership arrangements.

4. Case closures and caseloads

4.1 If the supply of housing is the fundamental requirement, the provision of support is what is at the heart of the high level of tenancy sustainment. Understanding more fully the key elements of this support is therefore important to the long-term sustainability of Housing First.

4.2 There are two aspects to this. On the one hand there is the question of the length of time that a client stays with the HF service. Then there is the pattern of staff input required to sustain someone in their tenancy for the duration of the service and the impact of this on caseload management, fidelity to the model and the likely ongoing resource needed to sustain HF tenancies.

4.3 It is part of the fundamental principles of HF that there should be no time limit set on support and caseloads should range between 5 and 7 clients. Nevertheless, understanding the likely drop-off in client numbers and the likely pattern of staff input into open cases are vital to inform the long-term planning for HF services and the likely revenue funding requirements.

4.4 The initial specification for the WMCA HF pilot involved three years of support for each client and with intake over three years (ie: requiring a five-year delivery plan). This rationale assumed that a significant number of clients would "step down" from HF by the end of the pilot, although evidence was not available to accurately predict this figure. It was not possible to predict the actual duration of support needed and part of the learning anticipated from the pilot was the testing of the impact of HF support on individuals and identifying how long they might need support before being able to sustain a tenancy without the intensity of HF support.

4.5 The WMCA APPG Enquiry submission indicates that HF "clients have high levels of dependency resulting in much longer and deeper navigator support than was initially anticipated and modelled when setting up the Housing First programme".

4.6 The Liverpool City Region Feasibility Study[7] undertaken for Crisis in 2017 modelled the scale of HF service required based on a number of assumptions about ongoing demand. These are explored in more depth at sections 5 - 6 of this report.

4.7 The assumptions in the 2017 report were speculative, but the data collected as part of this research has provided an opportunity to reality-test these assumptions and to make some estimate of the likely size of ongoing demand for HF support beyond the end of the pilot in the WMCA area. It should be noted that the approach taken to modelling is not exactly the same and direct comparison of individual elements of the model is not possible, although the conclusions can be compared.

4.8 Our approach to reality testing these assumptions is based on:

a) exploring case closures from the HF programme, to understand demographic patterns, if any, what we can learn about who HF works best for and what kind of additional or

[7] Housing First Feasibility Study for Liverpool City Region (2017)

alternative input could have helped people who left in an unplanned way and whose case was closed, to continue with the service.

b) looking at individual cases being supported in one of the HF pilot areas, Solihull, to understand and model the caseload as a whole in order to identify the pattern of characteristics of the full case load at a particular moment in time.

4.9 This initial analysis has been further developed to:

1) Provide a methodology to predict likely demand for HF over a fixed period of 5 years (after the end of the current pilot).
2) Break the expected caseload down into different categories, define those categories, and use this categorisation to allocate staff input estimates to each category.
3) Combine the two strands of work to project resources needed to meet future demand for HF in the WMCA area.

What can we learn from case closures?

4.10 To understand the reasons behind case closures an online survey was sent to the eight HF providers in the seven local authorities. The survey asked HF teams to provide detailed information relating to all individual service users who had left the service in an unplanned way.

4.11 The term 'unplanned exit' was defined as being people who made an unplanned move or who disengaged from the service; this included people whose cases were closed before they had moved into a HF tenancy. Unplanned exits were grouped into seven categories, in line with the pilot's categories for capturing exits from HF services in the WMCA: lost contact, withdrawn consent, moved away from area, moved to alternative accommodation, long-term hospital stay, imprisonment and death. The online survey generated data on 66 clients who exited HF services in an unplanned way and whose cases were closed.

4.12 Data on those who left HF services at July 2021 identified that 16 people or 4% of the total caseload of 460 died. While 14% disengaged, lost contact, moved away or went to other accommodation, prison, or to a long stay in hospital.

4.13 The analysis of the survey was supplemented with a series of follow-up discussions with service providers to reality check the findings and draw out broader themes. A workshop which discussed findings from the above and sought further insights from providers was also conducted.

Points to note on case closures

4.14 **The demographic and needs profile of those leaving the service is broadly similar to the main HF client profile**. Indicating that there are no specific demographic or needs factors contributing to leaving the service.

4.15 **Of those who left the service in an unplanned way the highest number had diagnosed or undiagnosed mental health issues.** In total, 91.9% of those who exited and for whom we have data had diagnosed or undiagnosed mental health needs. This may indicate that people with mental health needs are more likely to leave the HF services than those without.

4.16 Of those who exited HF, for whom we have data in this area (48 people), 22 clients, **45.8% were offered support with mental health services. Less than half of these clients (45%) actually received support from mental health services**. The most common reason for this was poor engagement with mental health professionals or their GP. The low level of access to mental health services may be a contributing factor to individual's exit from HF services. The research also indicates there is scope to improve access to statutory mental health services – both through increasing overall resources and reducing bureaucracy associated with referral processes. There is also a value in exploring if mental health staff/support can be embedded within a multi-disciplinary approach to delivering a HF service.

4.17 **Those who had a 2-5 year history of rough sleeping were the most likely to exit the HF service in an unplanned way**, this group accounted for 39.7% of exits, followed by 27.6% of people who had slept rough for up to 2 years.

4.18 **Of the clients who died while on the HF caseload, death was as a result of long-term health issues caused by substance or alcohol misuse and entrenched rough sleeping**. For these clients, moving into a HF tenancy provided opportunities for a better quality of life and/or a dignified end of life period. The majority of clients who died (13/15, 86.5%) had HF tenancies at that time. Of these 11 people died in their HF properties, one died in hospital and the remaining person in prison.

4.19 **Of the clients exiting HF, 50% of those for whom we have data had a disability or long-term health condition.** This compares to 24.3% of HF clients at November 2020 with a physical disability.

4.20 **Of the clients waiting for a HF tenancy, 14% disengaged or the service lost contact with them while they were waiting**. Not being housed quickly makes it more likely people will disengage and exit the service. In the absence of a ready pipeline of suitable housing units, the need for rapid access to temporary accommodation once someone has engaged could reduce this attrition.

4.21 **Of the 48 clients who exited HF for whom we have data, 23 clients, (47.9%) began a tenancy during their engagement with HF services, but the placement either broke down or they left**. The need for rapid access to alternatives where the initial placement breaks down, and to supported accommodation, for clients who realise they are not ready or suited for the responsibilities of a HF tenancy is also important in enabling people to achieve the best housing and support outcome for them.

4.22 **Of those who were housed, data indicates a series of triggers for exiting the service, (excluding those who died). A slightly higher proportion of these clients experienced difficulties with other residents or neighbours (12.5%). A slightly lower percentage had challenges with visitors/associates forcing their way into the premises (10.4%), and some had concerns about loneliness or missing the community of the streets (8.3%).** Issues related to the neighbourhood and what is happening around the property were slightly higher as a trigger than continued contact with previous associates from their life on the streets.

4.23 Our data indicates that 27 (56%) HF clients who made unplanned exits from the service were offered emotional support and 24 clients (50%) were offered help to connect to other services. At 52% and 62% respectively, take-up of support in these areas was significantly lower than that around furniture/utilities (which 96% of clients accepted). A smaller proportion of clients making unplanned exits were offered/accepted support around improving links with their local community (37% offered, of which 28% accepted) and relationships with neighbours (27% offered, of which 54% accepted). Lower take-up of these types of support may have contributed to some individuals' exit from HF services.

4.24 In many cases, maintaining engagement and completing requisite practical tasks during the pre-tenancy phase has proved more intensive than envisaged by HF teams, demonstrating that adequate time and resources need to be invested in this phase as part of the overall service.

4.25 The analysis of case closures illustrates that, for a number of clients exiting HF services, HF proved to be not the most effective accommodation option. A small number of clients had support needs which meant they were better suited to a care environment or one with on site and/or 24/7 staff.

4.26 On joining HF services, many clients are 'pre-contemplative' in relation to their housing and other needs and did not have a clear sense of their life goals. Many clients also needed to develop practical tenancy skills, such as financial management, tasks required for tenancy sustainment and dealing with neighbours. There is an understanding that HF clients will initially struggle both practically and emotionally and that HF staff will need to 'hand hold' during the pre-tenancy and move-in process.

4.27 Whilst tenancy skills are recognised as being needed for longer-term sustainment of HF tenancies, significant behaviour change is understood to take place very gradually with HF clients and is not a linear progression. HF tenants can have periods where they are maintaining their tenancy and progressing well. Challenging situations are common and these can impact negatively on an individual's ability to continue their progress and tenancy sustainment. In addition, clients' ability and motivation to make beneficial changes, and manage challenges are likely to be impacted by underlying trauma. However, trauma may not be visible for some time after the tenancy starts, due to clients' poor mental health and/or substance misuse; this makes appropriate interventions more challenging. It also makes the case for HF to be seen as a long term service, where the achievement of moving into housing is the beginning of a recovery process that requires long term tailored, flexible and persistent support.

Coventry Housing First

Mr H is a poly drug user who smokes crack, is an intravenous heroine user and occasionally drinks alcohol. Mr H does engage with the designated drug service and is prescribed methadone by the local pharmacy. Mr H has been diagnosed with Schizophrenia but was very sporadic in his engagement with his GP to maintain good mental health and well-being. Mr H suffers with Deep Vein Thrombosis (DVT) and ulcerated leg wounds due to IV drug use which limits his mobility. Although the wounds were regularly dressed, they did not adequately heal due to Mr H sleeping rough, poor hygiene, poor nutrition and substance misuse. Mr H was regularly bullied and felt vulnerable due to his limited mobility and although he had been provided with emergency accommodation on many occasions for over 5 years, he usually left due to bullying by other service users.

Mr H was housed by Coventry HF service in a property very near to the city centre, local to the support services as he requested and the HF Navigator liaised with the housing association, DWP and the city council in the setup of the tenancy. The HF Navigator completed a community support grant on his behalf to obtain white goods, furniture and other essential items and Mr H has made use of a personalisation budget to make the property into a home.

Mr H can see the benefit of having a safe place to sleep and how it can positively impact his overall well-being. He says that now he has a stable home his next task will be to tackle the drink and the drugs. He would like to return to the building trade eventually, a job he had before he became homeless.

The HF Navigator supports Mr H with keeping track of appointments, prompting him when needed to ensure that he is engaging with services and attending appointments on time. The HF Navigator keeps in touch with the Community Psychiatric Nurse (CPN) and the GP and highlights any concerns around Mr H's mental health that he observes in his interactions with him.

Mr H has also been provided with multiple mobile phones, as these have been lost and damaged on several occasions, to ensure all the services can contact him. The HF Navigator also communicates regularly with the dispensing pharmacy where Mr H receives his methadone and has a good working relationship with Mr H's drug worker, providing him with up to date information on any changes in substance use.

Since being housed Mr H has had periods of increased crack cocaine use which has resulted in an increase in psychotic episodes. Mr H would not engage with support services during these periods and it would take a collective effort from the HF Navigator, drug worker and CPN to ensure Mr H was taking his medication and attending his appointments. Mr H has been hospitalised a couple of times in the last 6 months. It was feared that Mr H legs would have to be amputated as the damage to his legs was severe and didn't appear to be getting better.

As Mr H no longer sleeps rough, bathes regularly and has improved his diet with the help of the Navigator who has supported him with shopping and planning healthy meals, his leg wounds have begun healing and he suffers less pain when walking. This has been a very positive transformation from the time where there were fears his legs would need to be amputated.

The HF Navigator is in regular contact with the drug worker, pharmacist and CPN to ensure Mr H is attending appointments and any concerns around Mr H well-being are shared, so that joint solutions to assist Mr H in continuing to moving forwards can be found and his tenancy can continue to be maintained.

4.28 There are differing views about how to support change and progression for HF tenants, with some viewing client choice as paramount, even if this means little or no change in clients' behaviour/skills and others focusing on the potential for staff to promote change and progression through a persistent, assertive but empathetic and understanding approach, underpinned by trauma informed practice. These differences may impact on outcomes from HF tenancies.

4.29 There are some specific issues around clients with an entrenched life on the street ie: street drinking, drug taking and/or begging. An entrenched life on the street can act as a barrier to engagement with support; these clients are also at greater risk of 'cuckooing'[8]. However, moving away from an entrenched life on the street may require clients to give up their existing social networks and this can be particularly problematic where clients do not see the possibility of replacing these relationships with more positive, non-street-based ones.

4.30 It appears therefore that there is scope for HF services to develop their practice particularly with this cohort to reduce the risk of exits. This could include:

- Having realistic conversations at the pre-tenancy stage about what living in a HF tenancy is likely to be like.
- Identifying the potential for 'cuckooing' within individual risk assessments; working with clients to understand triggers and to develop strategies to reduce risks and increase clients' safety. This might include the possibility of Police support as well the engagement of the local authority adult safeguarding service.
- Providing additional support to help clients develop positive social networks – this is perhaps an area where the role of peer mentoring can have the most significant role to play within HF Services.

[8] 'cuckooing' is used to describe a situation where a vulnerable person has their tenancy taken over by people who pose a threat to the individual and/or who use the tenancy in an anti-social way to the extent that the tenant is put at risk of losing their home.

Case Closure Policy

4.31 It is generally the case that HF services are very loathe to close cases, or to not offer the service to those who meet the criteria. This is in line with the concept of persistence required of HF services but does raise the question of whether there should be limits to this persistence.

4.32 It was clear that a key feature of HF in the WMCA pilot is the persistence of staff in looking to make and maintain contact and demonstrating that the service is there to help when the person is able and willing to respond. It was also clear that motivation was absolutely essential, for people to accept and benefit from the support on offer.

4.33 The reality is however that for some long-term homeless people the motivation to accept the offer of housing and support could take some considerable time to develop, and it is critical that when the window of opportunity arises the relationship with the HF support worker is in place, so that they know where to turn to for assistance in taking their first steps away from their previous street based life. This is the justification for keeping cases open, and continually trying to facilitate contact.

4.34 While it is crucial to avoid returning to any concept of people needing to demonstrate that they are "tenancy ready", before they can be offered a tenancy under HF, it has to be acknowledged that some people are genuinely not currently in a position where they want or can handle a tenancy (even if this is only true in a minority of cases).

4.35 Other reasons why HF may not be the best offer for someone at the time could include:

a) Where they are considered too high a risk to staff because of the unpredictability of violence or abuse that they have demonstrated.

b) Where they are too vulnerable to exploitation by others in an independent tenancy (once all alternatives in terms of security measures, managed moves to a different area, support to manage the situation etc has been explored), such that continuing to live in any independent accommodation is likely to present a serious safeguarding risk for the foreseeable future.

c) Where the individual is deemed to not have capacity to maintain a tenancy.

d) Where their physical and/or mental health will be significantly at risk if they continue living in HF accommodation.

4.36 There is also the fact that some clients have, with the help of HF, achieved a high level of stability in their situation. It is clearly important that this is monitored for some time as experience suggests that this progress can easily unravel.

Wolverhampton Housing First

Ms L is in her late 40's and has a long history of unstable housing and homelessness due to her alcohol addiction. Originally from Wolverhampton, having exhausted all her housing options in the borough, after her last eviction for rent arrears and anti-social behaviour of visitors to her flat, she ended up in homeless in Birmingham.

She spent time sofa surfing, was working as a sex worker to fund herself and was at risk of violence where she was staying intermittently and was very fearful. Ms L was picked up on the streets by an organisation working specifically with sex workers with complex needs and referred to Housing First in Wolverhampton as she wanted to return to her home town and try and rebuild her life, including re-establishing contact with her family.

Ms L had previously held tenancies with Wolverhampton Homes but had lost these due to her use of alcohol and accumulated rent arrears. When she returned to Wolverhampton she was initially placed in a B&B hotel. The Navigator helped Ms L to complete her Universal Credit application, to go on to the Housing Register and to begin bidding for properties through the Choice Based Lettings system, as a high risk of homelessness case. This prioritisation of her case meant she was prioritised for allocation of housing. As Ms L was now on Universal Credit it meant that her income was stable when she was ready to move to her flat.

Ms L discussed her housing options with the Housing First Navigator, and explored the areas she wanted to live in. Her top choice of area was one where there is a high incidence of drug use, after further discussion with the Navigator regarding the risks she would be exposed to in this area and how she might deal with them, she selected a less risky area for her.

After several bids she was successful in being allocated a flat. This was in a property with only one other flat. Luckily the flat was already decorated, however everything else was needed to make the flat into a liveable home.

The Navigator assisted Ms L with getting the flat carpeted, putting in essential furniture such as bed, white goods, TV – this was achieved using Ms L's personalisation budget, a sum available to all Wolverhampton Housing First clients to assist with practical needs. Ms L was also helped by a number of local charities with additional furniture and goods needed. She was assisted to set up her bill payments for utilities, rent and council tax. Ms L was also referred to a local substance misuse organisation so that she would have support to tackle her alcohol addiction issues. Ms L has continued to engage with this support despite her continued alcohol misuse, although she has reduced her use of alcohol and tells the Navigator that she does not want to lose her flat and understands that paying the rent and the bills comes first.

Ms L has been helped to maintain her flat and her commitment to reducing and eventually stopping her drinking by the reconnection with her family. Ms L has older children who are in their 20's and also has grandchildren. They all visit on a regular basis after a long time of not having any contact with Ms L due to her drinking and her way of life. This contact with

her family is helping Ms L to see that she has a lot to gain from focussing on sustaining her tenancy and continuing to build her relationships with her children and grandchildren.

Wolverhampton Housing First service has developed a strong partnership between the council, Wolverhampton Homes, and local charities and organisations so that Housing First clients are prioritised for access and the motivation they have to change is acted on quickly by everyone to ensure the opportunity for change is not lost and people are supported to progress with their lives.

4.37 We set out some general observations that might help HF schemes to develop their case closure policy and suggest the following guidelines:

1) People have right to say directly or clearly through their actions over a period of time that they are not interested in pursuing the HF offer and this should be respected.
2) Safeguarding processes need to be integrated into HF case management processes and sometimes this will mean that decisions have to be taken to seek to withdraw people from a HF tenancy, but other options to resolve the situation should be explored and implemented first. This should include rapid offers of alternative accommodation – in terms of location or type of accommodation.
3) There are limits to how long any individual case should be kept open if they are not responding or using the support being offered, but these cannot be set down in rigid criteria. They should however have to be reviewed on a case by case basis through a multi-agency review mechanism, and wherever possible decisions made in agreement with the client.
4) Where someone chooses to live in supported accommodation, rather than a HF tenancy, this should normally lead to the HF support being suspended, as long as it is expected that this other support will continue for the medium-term.
5) Every effort should be made to ensure that people understand that should they change their mind or their circumstances change, that it will be easy and quick to re-engage the service and open the case again. This may require a need to ensure that there is always the capacity to do this with the caseload.
6) Where cases have been closed there should be some commitment to initiate contact after a time to check that the situation has not deteriorated.

5. Caseloads and modelling of future demand for Housing First

Estimating service demand

5.1 An important consideration when estimating future service demand is that HF is not a traditional 'linear' service model, i.e. one in which there is an expectation the service intervention supports the client towards greater independence/lower service dependency within a given timeframe. In the short-term, recipients of HF services are likely to experience periods of increasing need for interventions, as well as periods of disengagement.

5.2 Estimating the demand for long-term services, as opposed to shorter-term intervention, should rightly be based on population prevalence rather than incidence measures, such as the number of people presenting for assistance in the year. By definition, the prevalence rate has to be derived from research at a particular moment. It therefore needs adjusting to bring it up to date.

5.3 Nationally, there is likely to be a backlog of need for HF services, as people who are long term homeless have been failed by existing service models over a number of years. Addressing this backlog is likely to initially increase service demand significantly. The WMCA pilot (along with the other pilots) is the first substantial attempt to address this backlog, and it is interesting to see whether the demand for services reduces as a result. We present the conclusions of our work on caseload modelling and demand estimation in terms of future caseload requirements in comparison to the caseload size as we near the end of the pilot period.

5.4 Because HF is a long-term service, it makes sense to quantify demand over a longer period than a single year. We have therefore estimated caseload requirements over a five-year period and results are expressed in terms of estimated required average caseload over this period. We do however believe that HF needs to be a long term service offer if it is to support the government's objective of eliminating rough sleeping and ending homelessness. A recommendation made by Lord Kerslake[9].

5.5 This section presents findings from modelling of WMCA HF services caseloads and sets out modelling concepts we consider can contribute to meeting the challenges of future planning for HF, both within WMCA and more widely. We believe these concepts provide a sound basis for drawing conclusions, particularly in relation to implications for staffing levels and future likely on-going demand for HF support. Our modelling also builds on two previously published pieces of HF research[10] and a further unpublished piece of research used with the author's permission.

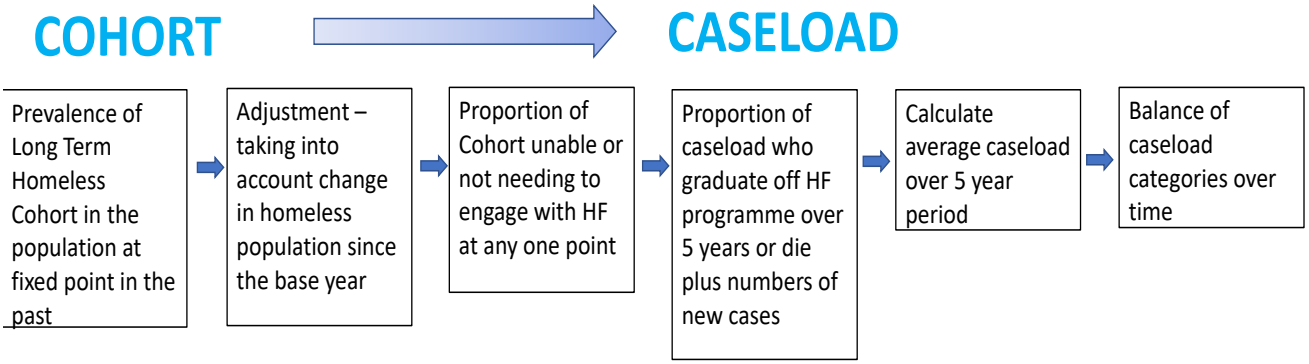
[9] KRSC_Interim_Report_0721.pdf (usercontent.one)

[10] Blood, I., Copeman, I., Goldup, M., Pleace, N., Bretherton, J. & Dulson, S. (2017), *Housing First Feasibility Study for the Liverpool City Region*, London: Crisis.
Blood, I., Goldup, M., Peters, L., Dulson, S. (2018), *Implementing Housing First across England, Scotland and Wales*, London, Crisis.
Blood, I., Burchall, B., Alden, S., Wardle, S., Dulson, S., Hands, C, (2021), *Strategic Needs Analysis: Multiple & Complex Needs in Barnsley*, Manchester, IBA.

5.6 This section sets out the modelling principles and assumptions we have developed and then summarises the findings from the modelling. Appendix 1 is a technical appendix that sets out the modelling process in full.

5.7 In seeking to model the size of future HF caseloads we adapted a methodology, developed in previous research. This is summarised in the following diagram:

Six Steps to HF Caseload Estimates



Methodological Principles / Assumptions

5.8 The modelling aims to estimate the size of the Housing First programme required in the seven WMCA Authorities for the next 5 years. It then aims to translate this into the level of front-line staff resources required.

5.9 It does this by trying to answer the following four questions.

- What is the size of the population cohort that meets the criteria for a Housing First intervention in the WMCA pilot area? We refer to this as the Long Term Homeless Cohort.
- What is the proportion of that cohort that might be able and willing to engage with a Housing First service? We refer to this as the Housing First caseload.
- How much is the long-term homeless cohort size likely to change over the 5 years and what impact will this have on the Housing First caseload?
- What is the average staff to service user ratio needed by Housing First clients and how does this translate into staffing levels required in the WMCA pilot area?

5.10 It is assumed that with this information it is possible to make a reasonable estimate of the level of financial input required to sustain the Housing First programme.

5.11 The following are the key methodological principles upon which our modelling is based. Our principles utilise two related but distinct terms:

- The "***cohort***" is the total population who meet the criteria for a HF service intervention at any one time. Not all the "cohort" however are likely to take up a HF service. For example a cohort could be 100 individuals.

- The "***caseload***" is the proportion of the "cohort" at any one time that may be receiving a HF service. That is the people actually receiving a HF service as a proportion of all those that would be eligible. For example if of the 100 people who meet the criteria, only 70 take up and engage with the service to be counted as an open case, then 70 is the caseload number.

5.12 Being part of the "caseload" takes account of the fact that engagement levels are likely to vary over time. It is also recognised that there is a distinction between an eligible client who is unable to respond to a HF service offer and a client who is a member of the caseload, but who is *currently* disengaged i.e. it is considered possible to re-engage with them. This distinction is important to facilitate the calculation of likely caseloads for resource planning purposes as this needs to include those who are counted as part of the service but are disengaged at any point in time and will require staff input to re-engage.

5.13 To count as a HF case and be part of the caseload there has to be a sense that people could in the near future be able and willing to consider taking on a tenancy that is suitable for them and in line with their expressed choices.

5.14 Housing First is a long-term service intervention which is aimed at a homeless population with multiple and complex needs, who have experienced a cycle of homelessness, tenancy failure and/or disengagement from services. For the purposes of finding a shorthand description that captures the essence of this group of the population, we describe them as the **Long Term Homeless (LTH) Cohort**.

5.15 In principle, all members of the LTH Cohort will be eligible for a HF service at any time. However, in practice only a proportion of the LTH Cohort will be interested in, or able to respond to, the offer of a HF intervention. This reflects a key feature of the LTH Cohort in terms of cycling in and out of homelessness and engagement with services: at any one point some will be housed in other forms of accommodation, hospitalised or imprisoned or be unable/unwilling to engage with any HF offer.

5.16 The main reasons why members of the LTH Cohort might not be able to take up an offer of HF include:

- They have secured their own accommodation and do not believe that they are in need of any assistance to secure alternative housing.
- Their physical or mental health requires them to stay in a medical facility or an environment where their health can be more consistently monitored.
- They are serving a custodial sentence.
- Their current state of mind is such that they are not able or willing to consider an alternative offer or enter into any form of relationship with HF staff.

5.17 Not all offers of HF will be successful (all evidence suggests "success" rates are around 70 - 80%). In addition, people may completely disengage from an HF service, for a number of reasons, some of which have been explored in section 4 above on case closures and illustrated by the case studies in this report.

5.18 All this means the number of potential HF clients at any one time will only be a proportion of the total LTH Cohort. Taking this into account provides the potential ***caseload*** size, ie: all

those that are in a position to take up the offer of HF, in our example above this is 70 out of the 100 possible eligible people.

5.19 The model therefore works out the size of the caseload at the start of the next 5-year period. It then adjusts this for anticipated changes over the following 5-year period. This takes into account the people who move out of the cohort over that period because they successfully graduate from the HF service or because they unfortunately die; and people who newly become long-term homeless over that period. This generates a caseload size at the beginning and end of the five year period and allows for the calculation of the average caseload size over that period.

Findings from the modelling of future caseload and demand

5.20 The assumptions within the model we have used can be improved with more evidence, within this overall framework, but we think the methodology offers a sound basis for future planning of HF services.

5.21 The "cohort" is calculated using the Authority by Authority estimates of the complex needs population experiencing homelessness as contained in the report Hard Edges[11]. This is adapted by using the IBA report on sizing the HF cohort and updated using the trends in levels of homelessness captured by Crisis' Homelessness Monitor[12]. This allows for the creation of high, medium and low estimates of the cohort size by local authority.

5.22 The proportion of the cohort that forms the caseload is based on a piece of very recent and as yet unpublished research undertaken by Imogen Blood Associates (IBA), and this results in an assumption that any one time only 60% of this cohort would engage with HF services. This enables us to calculate the initial caseload.

5.23 Using the Solihull caseload analysis undertaken as part of this research our modelling estimates that 17.5% of the total caseload will "graduate" over a 5-year period. If HF is developed at scale, this figure is a significant number of people who can be enabled to move from long-term homelessness to housing stability.

5.24 Our modelling also demonstrates that 77.5% of the total caseload that engages will need on-going, long term support beyond 5 years. This 77.5% will be sustained in their housing, with all the knock-on savings, which have been estimated[13] to be £1.56 for every £1 spent on HF and the positive consequences that this produces for each individual.

5.25 We have estimated that 5% of the caseload will die, based on the results of the WMCA pilot data at July 2021.

[11] [11] Bramley,G, Fitzpatrick, S with Edwards, J, Ford, D, Johnsen, S, Sosenko, F and Watkins, D (2015*) Hard Edges: Mapping severed and multiple disadvantage (England)*, London: Lankelly Chase Foundation
[12] [12] Fitzpatrick, S., Pawson, H., Bramley, G., Wood, J, Watts, B., Stephens, M., & Blenkinsopp, J, (2019), *The homelessness monitor: England 2019*. Institute for Social Policy, Housing and Equalities Research (I-SPHERE), and The Urban Institute, Heriot-Watt University; City Futures Research Centre, University of New South Wales
[13] https://www.centreforsocialjustice.org.uk/wp-content/uploads/2021/02/CSJ-Close-to-Home-2021.pdf

5.26 Overall, our modelling has resulted in estimates that are broadly in line with the Crisis Liverpool City Region Study carried out in 2017[14] and which was the precursor to the National pilots. Although our methodology is slightly different and exact comparison is not possible, however a broad comparison is possible. The LCR study concluded that 50% of people offered a HR service would still be supported in 10 years time, having first assumed that 20% of the cohort would not accept the service offer, and making assumptions regarding the number of deaths and disengagement. Using the LCR assumptions would mean that of the 100 people in the cohort there would be 40 people still receiving HF support in 10 years time. Our modelling shows the equivalent number receiving a HF services in 5 years time would be 47.

5.27 As it is likely that new people will become long-term homeless over the five year period, we need to also estimate the number of new people that join the LTH Cohort. HF and a prevention approach to homelessness should reduce the rate of inflow into the LTH Cohort and therefore the level of demand for HF, over time but there are questions regarding how to quantify this.

5.28 We have estimated the likely number of new cases requiring a HF service based on recent relevant research and data from Finland's experience of the impact of HF on the long-term homeless population.[15] [16] This has allowed us to assume that 'new entrants' into homelessness and forming part of the LTH cohort would be 13.5% over 5 years.

5.29 Using these data to model the net change over 5 years identifies that, with a permanent HF programme in place, the caseload overall would reduce by 9% over 5 years:

Change Factor	Impact on Caseload Size
People achieving stability and graduating from Housing First	-17.5%
People dying	-5%
Demand as a result of new people entering the Long term homelessness cohort of people	+13.5% * *(based on Finland's research)
NET CHANGE	**-9%**

5.30 If a comprehensive approach to reduce homelessness, and to have a permanent HF programme, such as that adopted in Finland, is followed through, then our modelling demonstrates that the overall demand for HF could reduce over time. It does however need to be a permanent programme.

[14] Housing First Feasibility Study for Liverpool City Region (2017)
[15] Kaakinen, J. (2012), *The programme to reduce long-term homelessness 2008-2011*, Finland, Environmental Administration
[16] *Homelessness in Finland 2020* (2021), The Housing Finance and Development Centre of Finland

5.31 Using the overall methodology to identify the likely size of a WMCA HF programme over the next five years we were able to model the following low/medium/high caseloads estimates:

Local authority	*Estimated Average caseload required over next 5 years (using High, Medium, Low cohort size estimates)*			*Current caseload (as of July 2021)*
	HIGH	*Mid*	*LOW*	
Birmingham	*510*	*332*	*153*	*166*
Coventry	*124*	*81*	*37*	*71*
Dudley	*31*	*20*	*9*	*31*
Sandwell	*53*	*35*	*16*	*76*
Solihull	*25*	*17*	*8*	*21*
Walsall	*59*	*39*	*18*	*103*
Wolverhampton	*82*	*54*	*25*	*48*
TOTAL	***884***	***578***	***266***	***516***

5.32 We suggest the mid-point estimate is the most appropriate to use as a guideline.

5.33 The consistent methodology adopted in this modelling produces very different results for the different Authorities, with a projected increase in caseload for Birmingham, Coventry and Wolverhampton, but projected decrease in the other Authorities. These should be treated as indicative of broad trends rather than as exact figures.

Case load management and staff to tenant ratio

5.34 We carried out a full caseload analysis of the Solihull HF service. This categorised the status of clients and caseload according to the perceived risk to the client's tenancy and wellbeing, using a RED/AMBER/GREEN classification. "**RED**" indicated "serious risk", while **AMBER** indicated a "significant risk" and **GREEN** "no significant risk".

5.35 This categorisation of cases has a number of potential uses:

- To ensure staff caseloads are balanced and equally distributed. Too many of one category or other is more likely to lead to greater stress.
- As a scheme-monitoring tool. While individual cases will change over time, from a scheme point of view it is reasonable to expect the proportion of cases that are "AMBER" or "GREEN" to increase over time.
- Identifying when capacity exists to take on new cases. Using these estimates, we can model likely caseload size and quantify staff input for future planning of HF services.

5.36 The number of hours of direct support provided to clients has been monitored within HF pilot monitoring processes since the beginning of the WMCA Pilot. Using data from monitoring reports, we tested assumptions about the relationship between changes in the

average number of support hours provided and changing proportions of the total caseload that were housed or still awaiting housing:

Date	% of caseload not yet housed	Average monthly support hours per person
November 2020	35%	17
December 2020	31%	16
July 2021	23%	13

5.37 These findings indicate a clear relationship between the average number of support hours per person and the percentage of the caseload that is not yet housed. This suggests that, as the proportion of the caseload that is housed increases over time, the average amount of support required should decrease. This potentially increases the client: staff ratio.

5.38 Findings relating to the proportion of the caseload which is housed and average levels of staff input required indicates the importance of ensuring a ready supply of suitable and affordable housing units, as this will directly impact on the tenant to client ratio and therefore revenue resources needed for future HF programmes.

5.39 For modelling purposes, and based on the case by case review of the Solihull HF service, we were able to link the case status to the level of input and the number of hours required weekly for individual clients depending on their situation:

Case Status		Level of Input	Weekly Support Hours
Housed and stable	GREEN	Fortnightly plus when needed OR limited (in final stages of case)	2.5 hours
Housed and actively engaging	AMBER	Twice Weekly plus when needed	10.5 hours
Housed but not currently using property	AMBER	Weekly plus when needed	7.5 hours
Housed but not engaging	RED	Limited	1.5 hours
Not yet housed and actively pursuing offers	AMBER	Weekly plus when needed	7.5 hours
Not yet housed and currently housed elsewhere	GREEN	Weekly plus when needed OR Limited (depending on where they are housed)	3.5 hours

Case Status		Level of Input	Weekly Support Hours
Not yet housed - not actively engaging	**RED**	Limited (except in very early stages)	1.5 hours

5.40 Taking into account the estimation (based on previous research into Housing First) that 65% of support worker time is spent on direct support, this translates into a 1:6.2 support staff to service user ratio. This closely reflects data generated in actual returns on support time submitted by providers for our research, for this particular ratio of housed / not yet housed clients. It also largely validates this approach as a framework for assessing staff input requirements for actual HF caseloads.

5.41 However, in terms of caseload ratios for future modelling, we suggest treating this ratio of 1:6 as relevant to the first 2-3 years of any HF implementation programme, rising to 1:7 or 1:8 in later years of the programme as more people are housed in HF tenancies. As the WMCA pilot area is already providing HF schemes with some track record it is reasonable to assume that the staff to service user ratio could be 1 to 7 (1:7) for the duration of the 5 year period.

6. Putting together the caseload estimation and staff input calculations

6.1 Putting together the results of these two elements we estimate the amount of support staff required to deliver the HF service to the potential caseloads in each Authority (using the high, medium and low estimates of caseload size set out in para 5.31 above)[17]:

LA	HIGH		MEDIUM		LOW	
	Caseload	Staff Nos	Caseload	Staff Nos	Caseload	Staff Nos
Birmingham	510	73	332	47	153	22
Coventry	124	18	81	12	37	5
Dudley	31	4	20	3	9	1
Sandwell	53	8	35	5	16	2
Solihull	25	4	17	2	8	1
Walsall	59	8	39	6	18	3
Wolverhampton	82	12	54	8	25	4
TOTAL	**884**	**127**	**578**	**83**	**266**	**38**

6.2 We have not sought to translate these estimates into cash terms. There are obviously other factors that influence costs – including such things as management to front line staff ratios, the contribution of specialist staff and levels of overheads, as well as salary levels. There is research by Brotherton and Pleace[18] that did look at the relationship between support hours and overall costs, and this would be a good starting place in undertaking this work. It is however outside the scope of this research report.

6.3 The above table uses a staff to service user ratio of 1:6. In the light of the relationship established between the proportion of clients housed and the hours of support required, it may be reasonable to use a higher ratio – 1:7 or 1:8 in the latter years of a 5-year programme.

[17] These numbers are rounded to the nearest whole number

[18] [18] Pleace, N, & Brotherton, J. (2019), *The Cost Effectiveness of Housing First in England*, London, Housing First England

Summary of key findings – case closure, case loads and modelling future demand

1) The pilot programme has been very successful. However, our cohort estimates would suggest that it has not yet met the full need in the community for people who could benefit from HF. This would suggest a need to increase the caseload slightly. Housing First is a long-term service commitment for the majority of individuals who engage with it, but overall it is possible (based on what has happened in Finland) that over time the numbers of people successfully graduating from the programme could exceed the numbers of new long-term homelessness cases, and therefore the size of the programme could slowly reduce over the 5 years.
2) It would seem that the pilot, has not necessarily removed the backlog of demand for HF in several of the Authorities and ideally an expansion of the scheme is needed in Birmingham, Coventry and Wolverhampton. For the other Authorities a small contraction in the scheme could be possible.
3) Overall, based on the experience of Finland that the numbers of people helped to stability and independence by HF will exceed the numbers of new cases falling into long-term homelessness, if HF continues to be implemented comprehensively and with fidelity as a permanent programme, there could be a reduction in long term homeless numbers, over a five year period, we have estimated this to be 9%.
4) A caseload categorisation methodology is proposed that will serve as an effective caseload management tool, that can monitor the impact of HF and allow for a flexible approach in relation to taking on new cases.
5) Housing First is first and foremost a long-term service. Some people do clearly "graduate" to a level of stability in their tenancies and no longer need the intensive support provided by a HF. In proportionate terms this is likely to be around 17.5% of the caseload that does engage with HF over a 5-year period, although for HF developed at scale this is still quite a significant number of people who can be enabled to move from long-term homelessness to housing stability.
6) Overall, our conclusions are broadly in line with the LCR study, which estimated that 50% of the overall caseload would need ongoing HF support for at least 10 years. With our modelling estimating the 77.5% will need support over five years.
7) Taking into account the variation in staff input required at different stages of someone's journey through HF, suggests that the ideal staff to service user ratio is more like 1:6 initially than 1:5 and this can be increased to 1:7 or 1:8 in latter years.
8) There would appear to be a clear relationship between the proportion of any HF caseload that is housed as opposed to the proportion that is in the "pre-tenancy" phase. The higher the proportion that is housed, the lower the average level of staff input required. This would indicate that resolving the issue of housing supply and ensuring that there is a ready supply of suitable and affordable housing units available will directly impact on the tenant to client ratio and as a consequence the level of revenue resources needed for a HF programme.

7. Multi-agency working

7.1 Facilitating multi-agency working is central to the effective delivery of the HF Model. There are numerous examples of multi-agency working that we have come across in the WMCA, including:

- Multi-agency referral and assessment panels
- Regular multi-agency case reviews
- Shared visits
- Named link people in external agencies
- Effective co-ordination of multi-agency responses to critical support and care needs of HF service users.

Effective multi-agency work

Mr AA was a White British male, with a total of 10 – 15 years rough sleeping history. When the Housing First team met Mr AA, he was living a very chaotic lifestyle. This had resulted in frequent short stays in temporary accommodation, periods of rough sleeping and hospital stays.

Mr AA was dependent on heroin, crack and mamba. He experienced low mood and had periods of anxiety, exacerbated by his substance misuse and history of rough sleeping. However, he did not have a diagnosed mental health problem and was not on medication. He also suffered from endocarditis.

Historically, he found it very difficult to engage with statutory and voluntary sector services. This resulted in a lack of consistency in his support plans.

Mr AA was initially reluctant to engage with Housing First services. The team continued to search for him in well-known local begging and rough sleeper hotspots and also provided him with mobile phones to encourage support and engagement, though he frequently lost these.

Eventually the team was able to carry out a needs assessment with Mr AA. Workers helped him establish welfare benefits claims, including for Personal Independent Payment (PIP).

While waiting for suitable housing to be found Mr AA's health deteriorated rapidly and it was agreed that this meant HF tenancy would not now be the most suitable option for him given his health situation. Shortly after, Mr AA's health started to deteriorate more rapidly. A multi-disciplinary casework meeting agreed the most suitable course of action was to set up a palliative care package. The team liaised with his mother, who agreed to take Mr AA in and support him in his final stages of life. Support provided to Mr AA was emotionally and psychologically informed. Emotional support was also provided to his mother as part of the palliative care package.

The Housing First team ensured multi-agency support was in place, including from: healthcare workers at Health Exchange, CGL's substance misuse team, Birmingham City

Council Adult Social Care. This led to quick and efficient information-sharing and task delegation and ensured he could receive the right level of support for his chronic health situation.

Although Mr AA did not take up an HF tenancy the team's work did ensure that Mr AA did not die on the streets as a rough sleeper and was supported through the multi-agency co-ordination of the Housing First workers to experience a dignified death within his family home.

7.2 A number of specialist posts or partnership arrangements have been put in place or are being considered. The partnership with Good Shepherd in Wolverhampton and SIAS in Solihull, are examples of formal partnerships that look to pool expertise and provide versions of shared care.

7.3 There are also examples of proposals being considered / trialled that the Mobilising HF Toolkit describes in the following way: "At a greater scale it may be beneficial to sub-contract specialised posts to work with HF (e.g. mental health or substance misuse staff). These posts can help to circumnavigate systemic barriers, provide specialist expertise and the ability to lever and broker support from elsewhere within the sector. For example Sandwell has been exploring directly employing psychologist support for staff and clients".

7.4 The Coventry HF service has recently employed a mental health link worker (to be shared with the Rough Sleeping team). In addition to these formal partnerships and specialist posts there is evidence from our discussions with each team that a number of informal relationships are key to ensuring HF clients are able to access mental health and substance misuse services.

7.5 In Coventry the HF service works closely with CGL (substance misuse recovery service) partly because both services are based in the same building. This HF service is also developing the "team around me" approach. This is a structured way of ensuring that multi-agency meetings are as productive as they can be – particularly for those who experience multiple disadvantages and involve a structured approach to discussing each case at multi-agency meetings, with decisions made collectively and individuals allocated responsibility and held accountable for progressing actions agreed.

7.6 One area of external agency co-operation where the WMCA HF pilot has been particularly successful is in relation to working arrangements with the Department of Work and Pensions (DWP). This is explained well in the WMCA APPG submission. "As a result of greater partnership working with DWP, HF teams are notified of changes which may have a detrimental effect on the client … clients are flagged on the DWP systems as vulnerable clients and as a result this helps in creating greater engagement with clients."

7.7 The situation as regards working with mental health services is unfortunately less positive, and in ways that are all too familiar in this arena, a number of services stressed the particular difficulties in accessing mental health services for HF clients, particularly if they suffer from a dual diagnosis (mental ill-health and substance misuse). To an extent this is obviously a resource issue, and to an extent it is a cultural issue – different and somewhat

incompatible ways of working e.g. over the question of missed appointments leading to a suspension of service. The way that people are required to access mental health services through their GP can also be a barrier to receiving appropriate mental health support.

Unplanned Access to Mental Health Services for Housing First Clients

BB is a Black British male, who has spent a total of 5 – 10 years on the streets. He has substance misuse issues with alcohol and cannabis. He has also been diagnosed as having drug-induced psychosis.

The Housing First team helped BB to access temporary accommodation in a hotel and self-contained flat. However, BB found it difficult to sustain this accommodation as he was causing anti-social behaviour. Staff also contacted DWP to support AB, as he was potentially a victim of fraud.

When he was referred to Housing First, it was immediately apparent that BB required intervention from mental health services. BB's mental health appeared to deteriorate rapidly and his engagement with Housing First became very poor. Housing First staff made contact with Mental Health services and Adult Social Care to arrange support. However, BB seemed to lack capacity to understand support workers' interventions.

Housing First then arranged a multi-agency meeting to discuss concerns about BB's mental health. Housing First staff were advised BB needed to access mental health services - via his GP, hospital or Police detention under S136 of the Mental Health Act. However, it was evident that by this point BB was not engaging with Housing First due to his poor declining mental health. He was therefore unable to visit his GP with his Housing First worker. Similarly, BB would not wait for emergency services to arrive – he would either disappear or refuse assistance and walk away.

Shortly after this, BB committed an unprovoked assault. He was arrested and subsequently admitted to a psychiatric hospital out of area. He therefore never began a Housing First tenancy. Housing First staff have continued to periodically check on BB's progress. However, it is apparent that he is likely to be in hospital for a considerable time. He has therefore exited the Housing First service.

A more flexible approach to accessing mental health support for BB, for example through a mental health practitioner engaging with him alongside the HF worker with who he did have contact, may have enabled BB to begin to address his needs. Requiring BB to attend a GP surgery, or to attend hospital willingly or via a section, does not appear to have been the most appropriate response for BB, given his declining mental health and possible capacity to understand the support on offer. Consequently he was admitted to psychiatric hospital via the criminal justice system, rather than any planned way.

7.8 This experience is a common finding in research looking at people with complex needs and rough sleeping, that it is not helpful to simply set out the problem. It is important instead to try and seek understanding of the perspective from mental health practitioners and see if there any ways to address their concerns and adopt practices that would effectively recognise and mitigate these.

7.9 It is however likely that full resolution will require a degree of system change, and in this respect the initiative of Birmingham in working with the Mental Health CCG is particularly interesting. This is explicitly looking at ways to improve access to services for people with a complex range of needs, who nevertheless do not meet the threshold for individual services.

7.10 The HF cohort is likely to have a particular preponderance of social care needs, with significant levels of health problems. 105 clients accepted on to the programme were categorised as having a physical disability. Of clients within the unplanned exits group, at least 42% (20 people) had needs around their physical health and at least a third (16 people) were referred to Adult Social Care services.

7.11 There have been a number of concerns expressed about effective working arrangements with social care services, including some suggestions that HF clients are not accessing their rights to social care assessments and therefore not receiving appropriate social care support.

7.12 It is possible that the issue is around clients not reaching the necessary threshold for accessing individual services, but where the totality of their condition would justify interventions that they are not currently entitled to. This requires further fundamental and systemic change. It also confirms the need to see HF as not just a homelessness response that falls within the remit of housing. We believe that HF should be seen as a Public Health intervention for rough sleepers with complex needs – in the same way that public health approaches to gang violence have been proven to work.

7.13 A Public Health approach has six broad criteria:

- It is focussed on a defined population
- It is established with and for communities
- It is not constrained by organisational or professional boundaries
- It is focused on generating long term, as well as short term, solutions
- It is based on data and intelligence
- It is rooted in evidence of effective practice

Such an approach we believe should be underpinned by a multi-agency commissioning strategy and plan. Our recommendations around this are set out later in this section.

7.14 Multi-agency working is a key component of HF success. To assist in the development of robust multi-agency arrangements and ensure that this is as comprehensive as it needs to be, we have developed a way of categorising multi-agency co-operation that can act as checklist to identify gaps in how multi-agency arrangements are working to date and where they need to improve.

7.15 This matrix sets the purpose of the arrangements against the different ways of delivering effective joint working:

Purpose of Multi Agency Working	Mechanisms to improve joint working
Alignment of agency processes and practice.	Joint operational protocols. Regular multi agency reviews of service delivery.
Access to specialist advice / knowledge to support generic staff in support delivery.	Shared "training" between specialisms. Facility for structured and on going multi-agency case conferences as required – including Team Around Me approaches. Directly employ specialist staff.
Ability to pool client knowledge on individual basis to inform support delivery.	Regular exchange of intelligence. Regular multi-agency case reviews and/or Team Around Me meetings. Joint approach to risk assessment and joint management of shared risks.
Ability to negotiate access to specialist services.	Dedicated Link Workers as routes into services. Designated referral routes.
Ensuring client continues to receive specialist services.	Opportunities for support staff to advocate / procedures for regular consultation over service delivery issues. Flagging clients as being of particular concern in multiple databases.
Informed decision making at key junctures in support delivery.	Joint Assessment procedures. Joint approach to risk assessment and joint management of shared risks. Joint review before decision to withdraw service.
Delivery of short-term shared care across specialisms.	Joint client visits / appointments.
Delivery of long-term integrated care across specialisms.	Integrated teams. Shared case records.

The Commissioning model

Centralised or devolved arrangements

7.16 The WMCA pilot differs from the other two pilot areas in that the services have not been commissioned centrally but have been separately commissioned by each local authority. This has many advantages for piloting a new service, as it provides different approaches simultaneously that can be compared.

7.17 Consideration needs to be given to whether this commissioning model makes sense when the pilot is finished. There are advantages in terms of a flexibility of response, adapting schemes to respond to local circumstances such as different housing markets, and a much greater capacity to evolve and change as required. This approach also means that local people are integrated into local services, communities and service providers.

7.18 Additionally, there can be advantages in having a variety of locally commissioned providers delivering the service. Birmingham City Council pointed out that they felt that the two providers they contracted with complemented each other in terms of strengths and approaches and provided greater choice for clients.

7.19 We would recommend a "mix and match" approach, where some elements of scheme operation are managed / pooled on a sub-regional basis, while a multiplicity of providers are contracted to provide the frontline service locally in each authority. The research has shown that this can work for example the PIE input which is commissioned and delivered centrally.

7.20 The gaps in access to mental health services, dual diagnosis and adult social care could be addressed through a pooled budget approach across NHS, public health and social care with specialist roles recruited to advise across all the separately commissioned services.

Multi-agency commissioning

7.21 The complex needs of HF clients straddle the responsibilities of many statutory agencies, including: health, social care, housing, local A&E departments and Police. Delivering the ambition to meet these needs effectively requires a multi-agency strategy which develops collective ownership of the issue between these services. Developing a multi-agency strategy also promotes effective use of Care Act 2014 S.42 enquiries, thereby increasing safeguarding of highly vulnerable adults who are at risk of abuse or neglect.

7.22 The recent report from the Centre for Social Justice has highlighted the need for a fully multi-agency commissioning approach to scaling up HF. Recommendations included that the Housing First funding programme should[19]:

- Encourage multi-agency commissioning and the use of multi-agency assessment panels to consider individual's eligibility for HF;
- Enable the delivery of both generic HF services and services targeted at particular groups including care leavers, survivors of domestic abuse and prison leavers.

[19] *Close to Home : Delivering a national Housing First programme in England* , 2021, CSJ

7.23 Integrated Care Systems (ICSs) are new partnerships between local authorities, NHS and other partners designed to meet health and care needs across an area. The aim is to plan and co-ordinate services so that traditional divisions are removed so that population health is improved and inequalities between different groups are removed. This also enables a greater focus on neighbourhoods and place - based approaches. There are currently 6 ICSs in the wider West Midlands region[20].

7.24 The Kerslake Commission on Homelessness and Rough Sleeping[21] examines lessons from the emergency response to the COVID-19 pandemic and seeks to understand how progress made can be embedded in the long term. The Commission's report notes how treating rough sleeping as a public health, rather than just a housing issue, has significantly increased engagement from the health sector around rough sleeping. It recommends that ICS and Integrated Care Partnerships focus specifically on tackling healthcare inequalities for people experiencing homelessness and rough sleeping and that ICS plans be fully integrated with all relevant agencies, particularly local authorities, social care, housing, employment and drug and alcohol services.

7.25 We believe the ICS model offers the potential to deliver effective multi-agency commissioning arrangements for HF services, both generic and based around client cohorts, such as prison leavers. We recommend WMCA consider how such arrangements could be developed in the WMCA region, drawing on existing guidance developed by the Healthy London Partnership[22]. This guidance highlights the need for health services to:

- Work in partnership with local authorities to ensure the homeless population receive Care Act and Mental Health Act assessments and S117 aftercare
- Ensure mental health and substance misuse services develop multi-disciplinary dual diagnosis partnership working agreements
- Ensure hospitals (including mental health facilities) have protocols for admission and discharge planning to specifically address the needs of homeless people and which support transition into the community.

7.26 As an interim measure to enhance joint commissioning, we recommend WMCA consider a model involving a core-funded housing service commissioned by the local authority, with integrated add-ons by the relevant agency, such as specialist substance misuse or mental health support commissioned by Public Health or Mental Health Trusts. We additionally recommend WMCA considers how to enhance use of personal budgets for HF clients, as a means of providing flexible bespoke support to promote tenancy sustainment and progression towards independence.

[20] Birmingham and Solihull, Black Country and West Birmingham, Coventry and Warwickshire, Hereford and Worcestershire, Shropshire, Telford & Wrekin, Staffordshire and Stoke on Trent.
[21] https://www.commissiononroughsleeping.org/
[22] *Healthcare and people who are homeless. Commissioning guidance for London* (Healthy London Partnership, 2016)

7.27 The WMCA HF pilot has the unique benefit of the WMCA Homelessness Task Force, this provides an opportunity for developing a multi-agency commissioning approach for HF.

Performance Management

7.28 For future commissioning of HF services, there are a number of measures that could be established and monitored. These will inevitably be based on local context and overall aims of the service. *We would suggest that the key performance measures for future HF services could be a balance of the following*:

- **Levels of tenancy sustainment** – although in reality this is only meaningful on a longer-term basis. The impressive achievements of HF services are most effectively shown by the length of time that so many tenancies are sustained, and by definition it is only possible to show this once the scheme has been going for a length of time.
- **Other measures of individual progress** – which have to acknowledge the non-linear nature of changes achieved – more a focus on the proportion of time when things are going well rather than abrupt changes. These could be related to some of the original measures used to prioritise access to HF in the first place e.g. the Chaos Index.
- **Wellbeing measures** such as those being used in Coventry.
- **Some indicators of levels of community integration**. This is the area of greatest challenge, where some creative thought is required.
- **System-wide indicators** – such as levels of rough sleeping, as well as factors such as numbers turned down by landlords due to previous behavioural problems, arrears and previous failed tenancies and by which landlords.

Summary of key findings - multi-agency working and commissioning

1) The research confirms that robust and comprehensive multi-agency working plays a key role in sustaining HF tenancies. The WMCA pilot has demonstrated the value of a number of successful arrangements, including: multi-agency case review, co-located services and also pooled funding, to enable specialist support and/or cross-authority working.
2) There have been some specific partnership successes, including arrangements with DWP, which have improved engagement with HF clients. The research illustrates the benefits of specialist mental health and substance misuse posts, especially when commissioned at scale, as this enables some systemic barriers to multi-agency working to be circumvented.
3) The research also evidences that HF is not able to address all of these systemic barriers and that some structural barriers remain in relation to social care and mental health services, especially for clients with a dual diagnosis. While HF has circumvented some barriers it has not been able to effect systemic change.
4) The WMCA example demonstrates there are benefits to adopting a devolved approach to commissioning HF services, including greater potential to adapt to local circumstances and changing capacity needs as well as to make best use of the local neighbourhoods and their assets to support tenancy sustainment.
5) This research points towards a mixed approach to commissioning, utilising pooled funding in some areas, such as mental health and PIE and a mix of local providers.
6) This research indicates a clear need to view HF as an intervention which is broader than homelessness. Adopting multi-agency commissioning arrangements is potentially beneficial, as this has a proven track record of working well with other complex client groups. There are a number of potentially relevant joint commissioning models, including the new approach being developed by ICSs.
7) Increasing the use of personal budgets will enable HF services to provide flexible bespoke services and support to HF clients.
8) Finally, the research suggests the value of developing additional KPIs to further demonstrate the benefits of HF support. These include:

   a) measuring long-term tenancy sustainment;

   b) clients' progress and well-being;

   c) developing indicators to measure HF clients' levels of community engagement.

8. Conclusion and recommendations

8.1 The WMCA HF pilot is the largest HF pilot ever commissioned in the UK. It has provided an opportunity to examine the key components of successful delivery and to learn from huge amount of the work done by the seven local authorities and the eight providers and all their partners involved in the pilot.

8.2 This report has set out a series of findings under each of the three headings. The report is designed to act as a resource for others wanting to learn from the pilot as well as to provide an evidence base for what has worked, to suggest ways of addressing the challenges encountered and to model how HF services should plan their resources in the future.

8.3 The main successes of the Pilot are:

a) The WMCA pilot has supported 460 individuals with a history of rough sleeping and complex needs to move into a tenancy and is on target to meet its goal of housing 500 people. This has been achieved during the very real challenges of the Covid-19 pandemic. In doing this the pilot is delivering social justice for some of our most vulnerable citizens.

b) The HF pilot is supporting 460 individuals to improve their life chances in the WMCA area. This provision of a stable home with intense long term support is the first step to levelling up for some of the areas most vulnerable citizens. It is enabling people to address issues such as drug or alcohol misuse, to obtain support and treatment with physical and mental health issues, to reconnect with family and build new positive social networks. It is enabling individuals to create a stable foundation from which their lives can progress. A long term and high fidelity national HF programme presents an opportunity to demonstrate levelling up in practice by ensuring no one (especially these vulnerable citizens) is left behind.

c) The WMCA pilot has demonstrated there are benefits to adopting a devolved approach to commissioning HF services, including greater potential to adapt to local circumstances and align with local systems and local population needs.

d) The service has succeeded with individuals that have been failed by services in the past because of the low tenant to staff ratio and smaller case load per staff member. This has allowed staff to spend time gaining the trust of individuals, developing an understanding of their particular issues and findings individual solutions for each person.

e) The key factors in this success has been the persistence of staff, the willingness to find alternative solutions when things don't work and to try and try again to support individuals to address their complex needs and sustain their tenancy. This has been supported throughout and enhanced by the PIE support for staff provided across the pilot area.

f) Practical interventions have also been key, providing mobile phones and credit so that contact can be maintained, assistance with purchasing furniture and other equipment needed to settle into a tenancy, use of personal budgets and access to small sums of money that can unlock someone's engagement with a service or solve their immediate problems.

g) Other factors that have contributed to the success of the pilot has been the commitment to multi-agency working, despite the very real challenges faced by workers in accessing some services such as mental health or social care.

h) Housing access and housing supply issues have also been addressed despite the housing challenges faced by each of the councils. The pilot has developed innovative approaches to accessing council and RP housing that have been specifically designed by the pilot and that other areas could learn from and adopt. Our research has found that the quicker people are housed the less staff time is required to support individuals, going from an initial ratio of 1:6 to 1:7 or 1:8 in latter years.

i) The pilot has also enabled us to develop a model for testing out the assumptions made in the original 2017 Liverpool City Council research on HF. With our model broadly confirming the rates for graduation at 17.5% over a five year programme and continued need for support for 77.5% of people, beyond five years.

j) A proposed approach to caseload management, case closure and staff to tenant ratio's and RAG rating of cases to enable HF services to manage caseloads more effectively has also been developed through our research with the pilot.

Recommendations

8.4 Key findings have been set out at the end of each main section of the report, below we summarise the main recommendations arising from these findings:

1) The waiting time between being accepted on to the HF programme and actually being housed into a HF tenancy is an important part of the service and should be invested in rather than seen as a waiting period before the service begins. In addition to the practical support provided it should be treated as a part of someone's transition from living on the street to taking on the requirements of a tenancy.

2) Rapid access to temporary accommodation could be a useful addition to the pre-tenancy phase, as long as it is the individual's choice and it does not recreate a pathway model.

3) Early engagement with landlords at managerial and housing management staff level is important and time should be invested in developing protocols for joint working that include areas such as rapid access to transfers, reciprocal referral protocols, regular meetings and joint inductions of new staff and underwriting of some core risks.

4) Work should be carried out to increase access to the private rented sector (PRS), this could potentially increase the choice of housing available to HF tenants. It will however require investment of time and money (for landlord incentives, rent in advance, risk underwriting) and will need to be based on the local PRS context for each council.

5) Personal budgets and assistance with turning a tenancy into a home, including support with choosing and purchasing furniture, white good etc is very important for tenancy sustainment.

6) Clear guidelines for case closure policies should be adopted, these should include regular check ins with people to ensure that they are aware that the HF services is there to assist when they are ready.

7) The proposed case load categorisation set out in this report should be adopted and further tested in practice as a way of managing caseload pressures.

8) Future HF services should be commissioned as long-term high fidelity models with a 1:6 ratio in early years, but they can move to a 1:7 or even 1:8 ratio in later years once individuals are housed.

9) Areas of performance monitoring around tenancy sustainment, wellbeing, engagement with the local community as well as system level indicators (such as the quality of multi-agency work) that should be adopted.

10) Devolved commissioning at a local area/council level works and should continue. Commissioning of future HF services should however be at a system-wide level involving social care, health/ Integrated Care Systems (ICS's), Public Health, Police and Crime Commissioners, and others.

APPENDIX 1 - TECHNICAL APPENDIX

1. Outline of Objectives

1.1 The objectives of this study are to:

- Develop a methodology to predict likely demand for HF (HF) over a fixed period.
- Break the expected caseload into different categories and define / describe those categories, and use this categorisation to allocate input estimates to each category
- Combine the two strands of work to project resources needed to meet future demand for HF in the WMCA area.

1.2 In developing this approach, we also build on three pieces of research previously undertaken as follows:

- Blood, I., Copeman, I., Goldup, M., Pleace, N., Bretherton, J. & Dulson, S. (2017), *Housing First Feasibility Study for the Liverpool City Region*, London: Crisis.
- Blood, I., Goldup, M., Peters, L., Dulson, S. (2018), *Implementing Housing First across England, Scotland and Wales*, London, Crisis.
- Blood, I., Burchall, B., Alden, S., Wardle, S., Dulson, S., Hands, C, (2021), *Strategic Needs Analysis: Multiple & Complex Needs in Barnsley*, Manchester, IBA.[23]

1.3 Local authorities are additionally encouraged to undertake their own research along similar lines to that undertaken as part of the Pilot to validate / adapt the conclusions drawn, particularly in relation to the implications for staffing levels drawn from the categorisation of the caseload.

2. Methodological Principles / Assumptions

2.1 The following are the key methodological principles upon which this modelling is based.

2.2 Two important related but distinct terms are used in these principles. The "***cohort***" is the total population who meet the criteria for a Housing First service intervention at any one time. The "***caseload***" is the proportion of the "cohort" at any one time that could be in receipt of a Housing First service. Some of the "cohort", while eligible might not be able to take up the offer of a HF service at that point in time.

2.3 In principle all members of the LTH Cohort should be eligible for a Housing First service at any time, but in practice only a proportion of people in the LTH cohort at any one time will be interested in, or be able to respond to, the offer of a HF intervention. By definition, one of the features of the LTH Cohort is that they cycle in and out of homelessness and in and out of levels of engagement / disengagement, and at any one point some of the cohort will be housed in other forms of housing intervention, while some will be hospitalised or imprisoned and some will be unable or unwilling to engage with any HF offer. This is however within the context of good practice that suggests that all members of the LTH

[23] this is unpublished work that we have been given specific permission by the authors to refer to in this report

Cohort should in a sense remain on the books and receive some form of service – even if this is a simple monitoring role by street outreach as part of a "by name list" / "multi-agency panel approach", whether they are able to respond to a HF offer at that point or not.

2.4 All of this means that the number of potential HF clients at any one time is only a proportion of the total LTH cohort.

2.5 Taking into account this proportion of the revised estimated size of the LTH cohort that are not in a position to accept an HF offer, gives you the potential ***caseload*** size.

2.6 Because HF is a long-term service, it makes sense to quantify the demand over longer periods than a single year. For the purposes of this exercise, we have looked at estimating caseload requirements over a five-year period. Ultimately, the results are expressed in terms of the estimated required average caseload over that five-year period.

2.7 Over any five-year period, it should be possible for a number of people to be so successfully settled that they no longer need the support provided by HF and therefore effectively "graduate" from the LTH Cohort. The other way that people may leave the cohort and therefore the caseload is by dying. The size of the potential HF caseload is therefore different at the beginning of the period and at the end. The average caseload over the period can therefore be derived from the difference between the two figures.

2.8 Levels of engagement can vary both for those who have moved into a HF tenancy and those in the pre-tenancy phase, and can change rapidly or over long periods of time. Levels of engagement can however be low at any time for essentially "positive" and "negative" reasons. The person may simply need very little input from HF at that time, or they may have disappeared or be experiencing some form of crisis that makes them unresponsive.

2.9 We have used the research previously undertaken to identify a six-way categorisation of the caseload, essentially using the following variables:

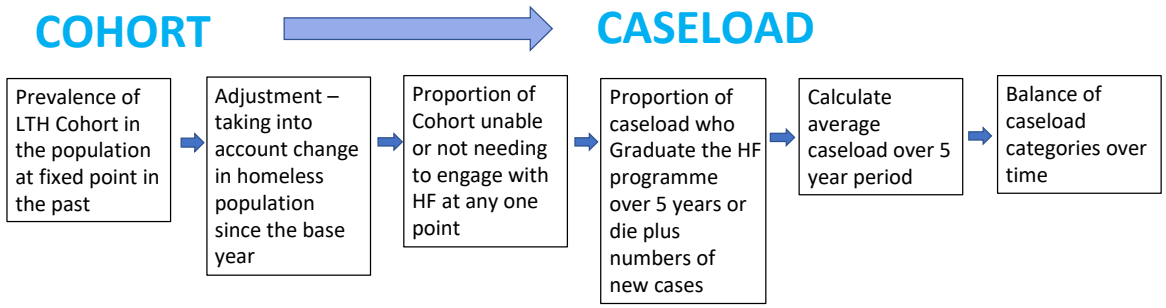
- Whether the person is in the "tenancy" or pre-tenancy phase
- Whether the person is engaging with HF or not
- Whether any "disengagement" is due to positive or negative reasons

2.10 This categorisation and its implications are explored in Section 4.

3. Calculating the size of the Cohort and the Caseload

Overview

3.1 Based on the above modelling principles we have adapted a methodology, previously developed in earlier research, for projecting the size of HF caseload as summarised in the following diagram. It constitutes six steps, as illustrated below.



Six Steps to HF Caseload Estimates

Step One and Two – Sizing the Cohort

3.2 In 2018 Imogen Blood Associates (IBA) undertook work for Crisis that incorporated sizing the cohort for Housing First across the UK .[24] This utilised the ground-breaking research on the prevalence of multiple and complex needs – *Hard Edges*,[25] which allowed for an estimate of the numbers of people with multiple and complex needs on a local authority by local authority basis in 2010/11.

3.3 This has required some interpretation in order to be applied to the modelling here. The total number of core homeless people identified by local authority is calculated from tables in the appendix, and then the nationally calculated proportion that were identified as additionally having an offending history, a substance misuse history and a mental health diagnosis was calculated and applied to these local authority figures. According to Hard Edges the proportion of the homelessness population which has all three needs was calculated as 12.77%.

3.4 However, the IBA research identified that the numbers of people experiencing homelessness in 2010 as calculated in *Hard Edges* could be somewhat of an over-estimation, judged by the results of the annual Homelessness Monitor as compiled by Crisis. The 2019 Homelessness Monitor[26] estimated that the core homelessness figure in England was 120,000 in 2010.[27] The equivalent figure in Hard Edges was 186,000. In the IBA report a range of cohort size estimates were identified, with the Hard Edges homelessness total being the basis for the

[24] Blood ,I, Goldup, M, Peters, L, Dulson, S (2018): *Implementing Housing First across England, Scotland and Wales,* Crisis, London

[25] Bramley,G, Fitzpatrick, S with Edwards, J, Ford, D, Johnsen, S, Sosenko, F and Watkins, D (2015*) Hard Edges: Mapping severed and multiple disadvantage (England)*, London: Lankelly Chase Foundation

[26] Fitzpatrick, S., Pawson, H., Bramley, G., Wood, J, Watts, B., Stephens, M., & Blenkinsopp, J, (2019), *The homelessness monitor: England 2019*. Institute for Social Policy, Housing and Equalities Research (I-SPHERE), and The Urban Institute, Heriot-Watt University; City Futures Research Centre, University of New South Wales

[27] This figure appears to have been revised upwards from that quoted in the IBA research.

high end, and the Homelessness Monitor total being the basis for the mid-point of the quoted range.[28] The low point of the range of estimates took into account additionally some research that estimated that the proportion of the complex needs cohort that had been homeless for more than 2 years was around 30%. This was based on analysis contained in Nations Apart[29] – a Crisis report of a large-scale set of interviews of homeless people. For the purposes of this modelling we have used the IBA mid-point as the high end of the range and kept the IBA low point as the low end of the range. We have the calculated our own mid-point as the half-way level between these two other figures. We have therefore applied a multiplier to the local authority figures from Hard Edges that reflects the ratio between the two core homelessness figures (that quoted in Hard Edges and that quoted in the Homelessness Monitor). This first multiplier was 0.645, and the second multiplier was 0.3.

3.5 The data used by *Hard Edges* is now over 10 years old. As with the IBA research we have used the increase in the size of the core homelessness population as measured by the *Homelessness Monitor* to adjust the numbers and bring them up to date. As already quoted the estimate for 2010 was 120,000. The figure quoted in the 2021 Monitor had grown to 200,000.[30] The rate of increase over the 11 years is therefore 1.66.

3.6 Applying this methodology to the WMCA Authorities participating in the HF Pilot produces the following results in terms of estimated LTH Cohort size:

Local authority	Estimated LTH Cohort Size as of 2021		
	High Point of range	**Mid Point of range**	**Low Point of range**
Birmingham	890	579	267
Coventry	216	141	65
Dudley	54	35	16
Sandwell	92	60	28
Solihull	43	28	13
Walsall	103	67	31
Wolverhampton	144	94	43

Step Three to Five – Sizing the Caseload

3.40 IBA also undertook an influential feasibility study into implementing Housing First at scale in the Liverpool City Region (LCR). This included modelling the volume of service required i.e. the likely caseload. A speculative model was developed to calculate this, and we have used

[28] The low point of the range of estimates took into account additionally some research that estimated that the proportion of the complex needs cohort that had been homeless for more than 2 years. As all of this is speculative, it seems to make pragmatic sense to use the mid-point methodology.
[29] Mackie, P, with Thomas, I., (2014), Nations Apart?: Experiences of single people across Britain, London, Crisis
[30] The 2021 Monitor in fact estimated that core homeless population had shrunk from 220,000 to 200,000, as a result of some of the measures taken during the pandemic.

this research to an extent to test out / validate some of these assumptions, although in fact the methodological approach taken is sufficiently different to mean that it is not possible to compare the results at the detailed level.

3.41 In the LCR modelling it was assumed that 20% of people eligible for Housing First would at any particular point not be in a position to take up a HF offer. Additionally, it was assumed that the following outcomes might occur:

Types of Outcome	Estimated % of customers	Average time over which this outcome will occur
People who withdraw from the Housing First service due to their inability / unwillingness to continue with the arrangement	20%	9 months
People who no longer need the support package offered because of changes in their circumstances	20%	5 years
People who die or whose health deteriorates to the point where they have to move to an enhanced care facility	10%	3 years
People who continue to need the support offered	50%	10 years

3.42 So the study assumed that 20% of the cohort would never be in a position to respond positively to a HF offer. Additionally, a further 20% of the 80% who did accept a Housing first offer, during the first year would also not be able to respond positively to the offer. Applying this modelling to what we are doing here means that this would translate into an estimate that 36% of the cohort at any one time would not be able to (or need to) engage in a HF service. There was however, at the time, no evidence basis to validate these conclusions.

3.43 We now do have access to some evidence, however tentative, through work undertaken this year for Barnsley MBC to validate the estimate of the proportion of the cohort unable to respond to HF at any one time.. As part of a strategic needs analysis of people with multiple and complex needs, the project included estimating the size and profile of this cohort in Barnsley.

3.44 The researchers asked a range of agencies, including Housing Options, the Street Outreach Team, the Police, commissioned support providers, children's services and the Drug & Alcohol Service about all the individuals they currently know of who met a definition of multiple & complex needs and categorising them, if possible, into the following three cohorts:

- **Current priority cohort**: People who are actively homeless (e.g. roofless, in emergency accommodation) with complex needs. These may be people who are banned from your service, or whose needs cannot be met by your intervention or those offered by others.

- 'At risk' group: **Those who are likely to enter the priority cohort (as returners or for the first time):** they may be precariously housed, their current placement may be coming to an end or at risk of failing, their needs may be unmet and worsening.
- People who are not currently on your radar/ trying to access housing and support, but who do tend to re-present to services. They are sometimes known as '**frequent flyers'.** As this can be interpreted as a pejorative term we have used the term '**frequent users of services'.**

3.45 The 122 individuals were broken down by category as follows:

- 30% in the "current priority cohort"
- 20% in the at risk group
- 50% in the "frequent users of services" group.

3.46 Taking a cautious approach to these results however would suggest that maybe the speculative guesstimate that at any one time 40% of the cohort may be unable to engage successfully with a Housing First offer is not too wide of the mark, and therefore in this modelling we assume that 40% of the total LTH cohort is unable to respond positively to HF (although we stress that this does not mean that they should not be receiving a service – just not HF).

3.47 This caseload size is therefore still based on the prevalence of the overall cohort in the population. The factors that can alter this are therefore changes to that prevalence rate. We identified two changes that could take people out of the cohort over the 5-year period being modelled. These were:

- The number of people who may "graduate" from needing support as a result of the stability and independence achieved
- The number of people dying

3.48 Additionally, however, there is the thorny question of new people entering the LTH cohort over the 5-year period. We have sought as part of this research to try and find some evidence from the experience in Finland – where the most comprehensive approach to the introduction of Housing First embedded within a wider preventative approach has been taken.

3.49 As part of the Case Review, we looked at the likely future progress of the 23 current cases. This produced the following conclusions:

Anticipated Future	Number of Cases
Now housed and stable and expected to graduate from HF in next 12 months	5
Likely to remain a HF client for at least the next 3-5 years	13
Never properly engaged or now disengaged for considerable time – case likely to be closed	5

3.50 So out of the total caseload of 23 it is judged that 5 might be closed because they have been disengaged for a considerable time or have never engaged with the scheme – effectively therefore they are a part of the 40% of the cohort not able to respond to the HF offer. They are therefore discounted from these calculations. This effectively means that it is 5 out of 18 cases responding to the HF offer that will probably graduate from HF and effectively no longer be part of the LTH cohort, within about 3.5 years of the scheme starting. However, it is assumed that those cases closed for whatever reason will probably be replaced. This will then mean that a further 11 cases will be opened, but there are only 1.5 years left of the 5-year period. It is possible, based on previous experience, that 2 of those will disengage or never engage effectively (and be discounted from the calculation), while 1 may quickly achieve the level of stability that means they can "graduate". In which case it will in fact be 6 cases out of 27 over the 5-year period that are able to graduate i.e. 22%.

3.51 A note of caution should be struck based on subsequent information provided by Birmingham, although this was not specifically a part of our research and therefore we are unable to fully incorporate it into our modelling. A review of the 140 open cases identified 11 cases whose circumstances were sufficiently stable to "graduate". At that point. We do not have the full range of information to be able to replicate the calculations done for Solihull[31], but this would tend to suggest a lower percentage of the caseload being able to graduate within the 5-year period. It seems right, however, to use this additional intelligence as a basis for moderating the conclusions drawn from the Solihull Case Review. We have therefore reduced the projected graduation rate from 22% to 17.5%.

3.52 Estimating the proportion of people leaving the cohort as a result of death is easier from the results of the WMCA Pilot. The Solihull Case Review was not sufficiently large-scale to test this. On the other hand, our unplanned exits survey identified that 21 people had died in the first 2.5 years of the HF programme. This represents very close to 5% of the total caseload over that period (ignoring the people disengaging).[32]

3.53 Estimating what is a reasonable assumption in terms of the flow of new people falling into long-term homelessness and therefore an increase in the demand for Housing First (and whether this matches the reduction in demand for the previously set out reasons) has always been challenging. The theory however is that a comprehensive programme of Housing First as part of an overall housing-led and rapid response strategy should actually reduce the number of new people falling into long-term homelessness. Finland is perhaps the best place to look to find evidence that this may be truly the case.

3.54 Finland's long-term objective has been to end homelessness for good, and Housing First has been central to their strategy since 2008. At that point long-term homelessness[33] stood at

[31] For example, the Solihull case study review was based on an assessment as to whether they were likely to be able to move off the HF scheme within a reasonable time period, not necessarily immediately. It is unclear as to whether this was the same for the Birmingham review

[32] The LCR estimate of 10% is not directly comparable because it includes people whose health deteriorates on a long-term basis such that they need institutional health care of some kind.

[33] Long-term homelessness is defined as a situation where a homeless person who has significant social or health problems, such as debt, substance abuse or mental health problems, and whose homelessness has been prolonged or is in danger of being prolonged due to a lack of conventional housing solutions and appropriate

3,597 households. By 2019 this had fallen to 961.[34] This includes all those living in temporary accommodation, hostels, institutions, and sofa surfing. Throughout this period around 12,000 Housing First tenancies have been created.

3.55 Getting behind these figures to understand the movement in terms of our concept of the LTH cohort and as a result the potential increase in demand for new HF service delivery takes a degree of interpretation of these figures. We have taken the LTH cohort in this instance to consist of those still defined as long-term homeless AND those living in Housing First tenancies. A report that evaluated the first four years of the Finnish HF programme (2008-2011)[35] identified that 1,500 HF tenancies were created in that period. If the creation of tenancies continued at the same rate in the fifth year, this would suggest that 1875 tenancies were created over a 5-year period beginning in 2008. To be consistent, however, we need to apply our assumptions about the number of Housing First clients who graduate form the scheme or die. This would then mean that the number of HF active cases at the end of the period would in fact be just over 1450. At the same time the number of long-term homeless households outside of Housing First tenancies went down from 3,597 to 2,628. According to our assumption this means that the total LTH population went up from 3,597 to 4,081 (i.e 1453+2628) – an increase of 484 households – this is approximately a 13.5% increase over 5 years.

3.56 The net change in the caseload over 5 years is therefore estimated as follows:

Change Factor	Impact on Caseload Size
People achieving stability and graduating from Housing First	-17.5%
People dying	-5%
Demand as a result of new people entering the LTH cohort	+13.5%
NET CHANGE	-9%

3.57 If this is correct then the large-scale implementation of Housing First will have the effect of reducing the long-term homeless cohort, and over our modelled five-year period the caseload numbers will go down. We therefore calculate the caseload required over the 5 years by taking an average between the projected caseload at the start and the finish of the period. The results for the high, medium and low point range of caseload are as follows:

support services. Homelessness is considered long-term if it has lasted for at least one year or if the individual has repeatedly experienced homelessness over the last three years.

[34] *Homelessness in Finland 2020* (2021), The Housing Finance and Development Centre of Finland

[35] Kaakinen, J. (2012), *The programme to reduce long-term homelessness 2008-2011*, Finland, Environmental Administration.

Local authority	Estimated Average caseload required over next 5 years			Current caseload (as of July 2021)
	HIGH	Mid	LOW	
Birmingham	510	332	153	166
Coventry	124	81	37	71
Dudley	31	20	9	31
Sandwell	53	35	16	76
Solihull	25	17	8	21
Walsall	59	39	18	103
Wolverhampton	82	54	25	48
TOTAL	**884**	**578**	**266**	**516**

3.58 We would suggest that the mid-point estimate might be the most sensible to use as a guideline.

4. Categorising the Caseload

4.1 In the Solihull Case Study exercise, reported on in the second interim report of the Pilot local Research project, the following categories were set out and defined:

	Client Status Category	Definition
1	Housed and stable	The person is satisfactorily housed in Housing First accommodation, is not experiencing any problems which put this situation at risk, and is either happy with their current housing situation or has realistic plans to bring about a change.
2	Housed and actively engaging	The person is housed in Housing First accommodation, but they are either yet to settle in fully, or alternatively they are unhappy with their current accommodation and are looking to move as soon as possible. They are however maintaining contact with Housing First staff and working with them to resolve their difficulties.
3	Housed but not engaging or not living at the property	The person is currently housed in Housing First accommodation, but is either not using the accommodation all or most of the time, or their whereabouts are unknown, and/or they are not responding to Housing First staff's attempts to make contact with them.
4	Not housed but actively pursuing offers	The person is currently not housed in Housing First accommodation, but is actively considering or responding to offers when they are made, and/or is

	Client Status Category	Definition
		in regular contact with Housing First staff over the possibility of moving into Housing First accommodation.
5	Not yet housed and currently housed elsewhere	The person is currently not housed in Housing First accommodation, but has accommodation elsewhere that they are currently happy with and/or seems appropriate to their current needs, and/or they are engaging well with the Housing First staff even though there is no immediate prospect of moving into a Housing First tenancy.
6	Not housed and not engaging	The person is currently not in Housing First accommodation, and is on the streets or living in unsuitable or unsatisfactory accommodation, and/or the engagement with Housing First staff is at best sporadic.
7	Imprisoned/hospitalised	The person is currently in custody or in hospital (on at least a medium-term basis).

4.2 The results for the full Solihull caseload (as set out in the second interim report) were:

Current Status	Number of cases	% of caseload (rounded)
Housed and stable	5	22%
Housed and actively engaging	3	13%
Housed but not engaging or not living at the property	6	26%
Not housed but actively pursuing offers	2	9%
Not yet housed and currently housed elsewhere	4	17%
Not housed and not engaging	3	13%

4.3 The main way in which we hope to use this here, however, is to model the likely caseload size that should be used in relation to future planning, and we explore this in the next section.

5. Quantifying staff input

5.1 The LCR study, already quoted, had set the benchmark for caseload size at a 1:5 ratio between staff and service users. This has since been widely adopted as a more general benchmark for all Housing First schemes – although interpreted in terms of the Pilots as a range of between 1:5 and 1:7.

5.2 This original recommendation did not however take any note of the variation in levels of input for individuals over time. The significance of this was illustrated by a study undertaken by Pleace and Brotherton in 2019.[36] This looked at the difference between the levels of support hours provided at the beginning of a new Housing First case, and the level after 12 months. They found that on average it declined from 32.6 hours per month at Month 1 to 16.1 hours per month at Month 12.

5.3 The number of hours of direct support provided to service users has been monitored as part of the Pilot monitoring processes since the beginning of the Pilot. Examination of a number of the monthly reports indicated that the average number of support hours was changing over time. Initial thoughts suggested that this might be a function of changing proportions of the total caseload that were housed or still awaiting housing. We took three snapshots over time to evaluate the impact of this factor, and the results were as follows:

Date	% of caseload not yet housed	Average monthly support hours per person
November 2020	35%	17
December 2020	31%	16
July 2021	23%	13

5.4 What this suggests is that over time in any large-scale Housing First implementation, as the proportion of the caseload that is housed increases, the average amount of support required should go down and potentially the staff to service user ratio needed may go up.

5.5 For the purposes of our modelling, however, and in trying to provide a caseload management framework that will actually allow one to estimate the number of hours required in relation to the balance in current client status, we have focussed on the November 2020 results i.e. an average of 17 hours per month per individual (or 3.92 hours per week). This is because the balance of cases, when we undertook the review in Solihull, was that 36% of the caseload was not yet housed.

5.6 Obviously, staff time has to be spent on more than just direct support. The Pleace and Brotherton 2019 research based its conclusions on returns from 15 separate Housing First schemes. All the services reported that the bulk of worker time was spent delivering support and case management. The mean proportion of time spent on this was 68% and the median was 64%. For our modelling purposes therefore, we take this to be 65%. Using this proportion to calculate the total level of support worker input implied by the 17 hours per month input quoted in Para 5.3, this would mean that the average staff: service user ratio for the WMCA Pilot was 1:6.25, at that juncture.[37]

5.7 We have tried to get behind this average figure by breaking down the level of input case by case in the Solihull Case Review into the following contact categories:

[36] Pleace, N, & Brotherton, J. (2019), *The Cost Effectiveness of Housing First in England*, London, Housing First England

[37] By July 2021 the equivalent staff to service user ratio was closer to 1:8

- At least twice per week plus when needed
- At least once per week plus when needed
- At least once per fortnight plus when needed
- Limited at the moment
- None at the moment

5.8 For modelling purposes, and based on this case by case review, we linked the following staff contact categorises to the case status categories:

Case Status	Level of Input
Housed and actively engaging	Twice Weekly plus when needed
Housed and stable	Fortnightly plus when needed OR limited (in final stages of case)
Housed but not currently using property	Weekly plus when needed
Housed but not engaging	Limited
Not yet housed - currently housed elsewhere	Weekly plus when needed OR Limited (depending on where they are housed)
Not yet housed - is ready for offers	Weekly plus when needed
Not yet housed - not actively engaging	Limited (except in very early stages)

5.9 We then translated these terms in benchmark number of direct support hours per week as follows:

Case Status	Weekly Support Hours
Housed and actively engaging	10.5 hours
Housed and stable	2.5 hours
Housed but not currently using property	7.5 hours
Housed but not engaging	1.5 hours
Not yet housed - currently housed elsewhere	3.5 hours
Not yet housed - is ready for offers	7.5 hours
Not yet housed - not actively engaging	1.5 hours

5.10 Translating this into the results for Solihull produces the following estimate of the total number of support hours required:

Case Status	Weekly Support Hours	Number of cases	Total Support Hours required
Housed and actively engaging	10.5 hours	3	31.5
Housed and stable	2.5 hours	5	12.5
Housed but not currently using property	7.5 hours	2	15
Housed but not engaging	1.5 hours	4	6
Not yet housed - currently housed elsewhere	3.5 hours	4	14
Not yet housed - is ready for offers	7.5 hours	2	15
Not yet housed - not actively engaging	1.5 hours	3	4.5
TOTAL			**85**

5.11 One of the problems with this kind of approach, and something that definitely needs to be taken into account when this is used to determine whether a scheme has the capacity to take on a new case, is the inherently unpredictable nature of Housing First. Some allowance should always be made to keep spare capacity in case some of the service users experience a crisis and require a significant increase in immediate input. We have therefore added in a further 7.5 hours per week to provide margin to allow for this. The total anticipated input at this point would therefore be 92.5 weekly hours of support. Taking into account the estimation that 65% of support worker time was spent on direct support, this translated into a 1:6.2 support staff to service user ratio. This is very much in line with that generated by the actual returns on support time submitted by providers (as highlighted in para 5.3), for this particular ratio of housed / not yet housed clients. This to a large extent validates this approach as a framework for assessing the staff input requirements for actual Housing First caseloads.

5.12 On the other hand, as has already been demonstrated in Para 5.6 the WMCA HF pilot services are effectively already working at a higher staff to service user ratio to this in terms of direct support. This reflects the fact that these services can now be regarded as "mature" with relatively high numbers of people being housed. It therefore seems reasonable to adjust the ratio to 1:7 specifically for the future WMCA scheme.

6. Putting together the caseload estimation and staff input calculations

6.1 Putting together the results of these two elements we estimate the amount of support staff required to deliver the Housing First service to the potential caseloads in each Authority (using the high, medium and low estimates of caseload size set out in para 3.30)

LA	HIGH		MEDIUM		LOW	
	Caseload	Staff Nos	Caseload	Staff Nos	Caseload	Staff Nos
Birmingham	510	73	332	47	153	22
Coventry	124	18	81	12	37	5
Dudley	31	4	20	3	9	1
Sandwell	53	8	35	5	16	2
Solihull	25	4	17	2	8	1
Walsall	59	8	39	6	18	3
Wolverhampton	82	12	54	8	25	4
TOTAL	**884**	**127**	**578**	**83**	**266**	**38**

6.2 We have not sought to translate these estimates into cash terms. There are obviously other factors that influence costs – including such things as management to front line staff ratios,

the contribution of specialist staff and levels of overheads. The Bretherton and Pleace research quoted did look at the relationship between support hours and overall costs, and this would be a good starting place in undertaking this work. It is however outside the scope of this research report.

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