Homelessness Prevention Trailblazer

The principles and practice of the multidisciplinary team

Dr Chris Parker & Chloe Harrison, Active Inclusion Service, Newcastle City Council

Background

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

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

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

There are three primary aims of the multidisciplinary team:

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

Introduction

In this report, we present the key principles that have emerged from the team's work over the course of their initial 18-month pilot. Many of these principles are common in descriptions of health and welfare services. However, they are rarely accompanied by clear examples of their practical applications. Therefore, for each of the five principles outlined, we have provided practical examples from within the team's work. These principles were determined in collaboration with the team over the course of the pilot. Each were present in some form in the formative month the team spent together building the foundations of their work at the start of the pilot. The final list of principles were discussed and agreed at the team's fifth periodic review process. The practical examples that accompany each principle were identified from reflective discussions with the team before being validated and developed in review workshops with both the team and the pilot's steering group. Both the principles and the practical examples are interconnected in the team's overall way of working. Therefore, some examples may be highlighted as representative of more than one principle.

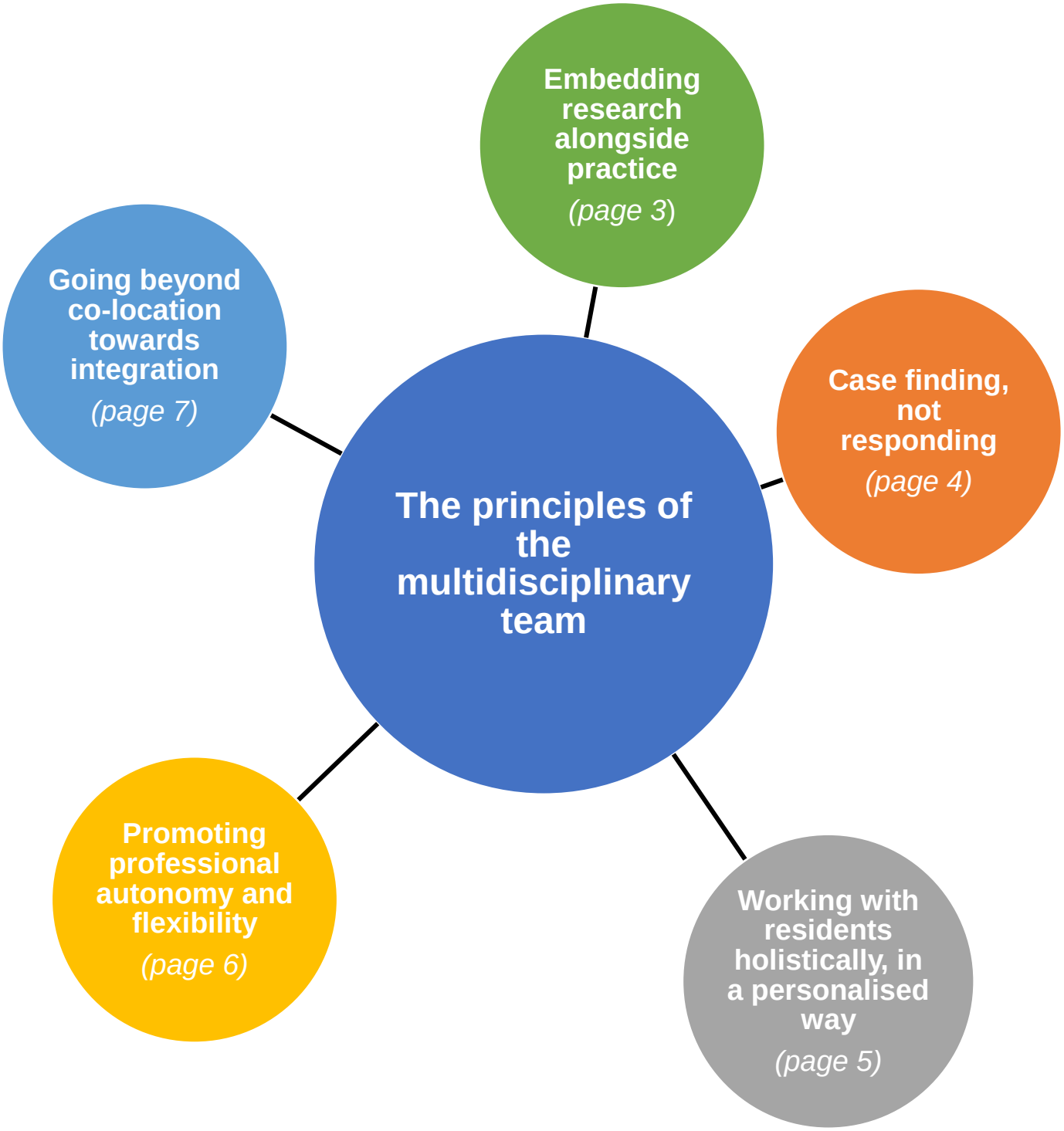
A comprehensive report that covers the learning that has emanated from this pilot more broadly is available separately.

[1] The arms' length management organisation responsible for managing council housing in Newcastle

Overview of the principles

Figure 1 (below) displays the five principles of the multidisciplinary team. The related sections provide a brief definition of the principle, some reflections from the team and an overview of the practical examples in the team's work.

Figure 1 – The principles of the multidisciplinary team



Embedding research alongside practice

Since the pilot's inception, a key aim of the multidisciplinary team has been to capture the learning from the team's ways of working and to contribute to evidence on the issues that residents are experiencing and the challenges they face to inform local and national policy and practice.

To meet this aim, a researcher was embedded with the team and a review process was established. This process involves a number of stages and culminates in quarterly reports that explore the team's work with residents and own perspectives on working in a multidisciplinary way. The review process was designed to be sufficiently structured to capture broad trends related to the challenges faced by residents, and sufficiently flexible to explore these in more depth. At each stage, the team are involved in data collection and analysis to help to embed research alongside practice, encouraging the team to think about the service they are delivering, as well as the systemic and structural context they are working in. As a result, the project is broadly guided by an action research approach, with research and practice complementing one another.

Elliot et al. (2016)[2] describe action research as *"an open-ended cycle of identifying a problem, imagining, then implementing a solution, evaluating the experience with a focus on both the problem and the solution, then changing practice(s) according to what has been learned, and so on"*.

The team's approach to capturing learning is described in more detail in their summative report, that details learning over their initial pilot period. Below are some of the team's reflections on embedding research alongside practice and some practical examples of how they have done so.

"I've really enjoyed it … it gives you a better understanding of the wider issues for residents in Newcastle"

"I've really liked the fact that we have the individual stories, but we have data, neither can stand on its own, one has to support the other"

"It has been interesting to be in a team where we're not afraid of failing. Normally learning always has to be so positive and focused on outcomes but here we also value finding out what doesn't work"

Practical examples from the team's work

- **The team's process for capturing learning** – this process involves quarterly reflective discussions and team review workshops that focus on drawing out trends, which are explored in more depth by members of the team. This also involves capturing residents' subjective perceptions of their situation through a face-to-face survey to bring a greater degree of residents' voice to the team's learning
- **Case identification and in-depth screening** – the team use a range of available data to systematically build a picture of a household's situation, allowing them to develop a personalised approach to establishing engagement and supporting that particular household
- **In-depth case reviews** – the team conduct small scale research projects focused on particular areas identified through the team's process for capturing learning, such as Newcastle City Council's Sustaining Tenancies process and the extent, nature and impact of Children's Social Care involvement across their cases
- **Informing national policy and practice** – the team have used their learning to contribute to national policy by providing evidence to a range of actors including parliamentary committees, government departments and international organisations such as the United Nations

[2] Elliot, M., Fairweather, I., Olsen, W., & Pampaka, M. (2016). *A dictionary of social research methods*. Oxford University Press.

Case finding, not responding

Case finding approaches are most commonly used in preventative health interventions and are focused on proactively identifying and targeting support to people at greatest risk[3]. Case finding is *"a systematic method typically used to identify individuals who are at high risk"* (Ross et al., 2011[4]). The authors also highlight that to ensure that an intervention is cost-effective, it is crucial that resources target the individuals at highest risk. Case finding approaches are much less common in welfare services, or those focused on homelessness prevention. When the Ministry of Housing, Communities and Local Government (MHCLG) launched the Homelessness Prevention Trailblazer fund, they explicitly highlighted that Trailblazer authorities should:

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

The multidisciplinary team do not take referrals, instead they proactively identify residents they think may be at risk of homelessness in the future.

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

"Through screening, we have a broader picture of the individual, so we can know what they may need to become more stable"

"With the targeted approach we can tailor our letters and calls to the resident … and I think that's worked for engagement because it's personal to them rather than just a standard letter"

Practical examples from the team's work

- **Working with partners to identify residents who are at greater risk** – the team have worked with Your Homes Newcastle (YHN) to identify tenants living in the outer west / north of the city affected by the "bedroom tax" and YHN tenants affected by the benefit cap. The team have also worked with Newcastle City Council's Energy Services team to identify residents who have integrated needs and may be at greater risk of homelessness
- **Using predictive analytics to identify residents who may be at risk** – the team have worked with Policy in Practice to develop and test the use of predictive analytics to identify private tenants and families who may transition onto Universal Credit and may be affected by the two child limit
- **Case identification and in-depth screening** – the team use a range of available data to systematically build a picture of a household's situation, allowing them to develop a personalised approach to establishing engagement and supporting that particular household

[3] Summers et al. (2017). *A qualitative study of GP, nurse and practice manager views on using targeted case-finding to identify patients with COPD in primary care.* NPJ primary care respiratory medicine, *27*(1), 49.

[4] Ross, S., Curry, N., Goodwin, N. (2011) *Case Management: what it is and how it can be best implemented.* Kings Fund

Working with residents holistically, in a personalised way

The Royal College of Nursing[5] describe person-centred approaches as *"focusing care on the needs of the person rather than the needs of the service".* Beresford (2011)[6] notes that "*person-centred support is a worthwhile and wise goal for social care policy and practice – seeking to fulfil each person's different wants and needs and shared human and civil rights"*. In turn, Harris and White (2018)[7] describe a holistic approach as one that seeks to understand people in the context of their whole lives and treats people as citizens with rights rather than dependent people in need of services. van den Pol-Grevelink et al. 2012[8] note that working in a personalised way improves the quality of the care from the perspective of those receiving it and enhances job satisfaction for practitioners. However, Hewitt-Taylor (2015)[9] note that working in this way is not easy and many services struggle to achieve it. With reduced budgets and increased demand, they argue that a person-centred approach is increasingly difficult. *Ibid.* note that a personalised approach works best if workers are given sufficient time and resources to really focus on individuals and develop a personalised approach that is appropriate to each case. They highlight that a person centred-approach is inhibited by a lack of multi-agency working, which in turn limits the information available to develop such an approach. For this team, *working with residents holistically, in a personalised way* means considering the needs, circumstances and priorities of a household in how they approach and support them, rather than considering only what can be done within the remit of their particular specialism. The practical examples show some of the ways we have established structures to allow the team to work in a more personalised and holistic way.

"What's different is we don't have a set agenda for our work or an attitude of we know better. We work around what the resident needs"

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

"The client is at centre of it, it's not being done to them, they get to choose what they get support with … and you pull in people who could assist"

Practical examples from the team's work

- **Adapting their approach to the resident** – through their in-depth screening the team utilise a combination of different methods (home visits, text messages etc.) to establish engagement with the resident. As they continue to work with them, they will meet them at times and locations suitable for them and focus their support on priorities agreed with the resident
- **Completing more holistic assessments of a household's situation** – in addition to their case identification screening (see previous section), the team complete an initial questionnaire with residents after they have established engagement. This incorporates aspects related to each of the team's specialisms, rather than each team member just focusing on their own
- **Personalised handovers** – team members are able to make personalised handovers to other specialists in the team and work in conjunction with them to resolve integrated needs. This limits the possibility for engagement to be lost when residents are referred between services

[5] Royal College of Nursing - https://rcni.com/hosted-content/rcn/first-steps/what-person-centred-care-means
[6] Beresford, P. (2011). *Supporting people: Towards a person-centred approach*. Policy Press.
[7] Harris, J., & White, V. (2018). *A dictionary of social work and social care*. Oxford University Press.
[8] van den Pol-Grevelink, A. et al. (2012). *Person-centred care and job satisfaction of caregivers in nursing homes: a systematic review of the impact of different forms of person-centred care on various dimensions of job satisfaction*. International journal of geriatric psychiatry, *27*(3), 219-229.
[9] Hewitt-Taylor, J. (2015). *Developing person-centred practice: a practical approach to quality healthcare*. Macmillan International Higher Education.

Promoting professional autonomy and flexibility

Much of the discussion of professional autonomy and flexibility is set within debates around professional discretion in social work. Freidson (1994)[10] described discretion as *"of freedom a worker can exercise in a specific context and the factors that give rise to this freedom in that context. Discretion, as freedom, is seen as a key characteristic of professional workers".* Evans (2016)[11] noted that *"Professional discretion has re-emerged as a key issue in current social work. It encapsulates the tension in current policy between the increasing regulation of practice and the need for practitioners' initiative and creativity in policy implementation"*. The multidisciplinary team involves four caseworkers, each with specialisms in different areas. In turn, the team was set up to develop and test new ways of preventing homelessness at an earlier stage, working with residents who face integrated needs. Given this context, applying externally enforced requirements about how the team should identify, approach and support residents would not be viable.

Professional knowledge and expertise in each of their specialist areas was understood as an asset that could only be realised by enabling caseworkers to have sufficient autonomy and flexibility to demonstrate their creativity and initiative. This is not to say that caseworkers are left to their own devices. In turn, the first month of the pilot involved working together to establish the foundations of multidisciplinary working through the collective development of policies, procedures and ways of working. These, alongside the team's review process (see page 4), enable a flexible framework that gives sufficient structure while also promoting professional autonomy.

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

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

Practical examples from the team's work

- **Incorporating resident's priorities** – The team have the flexibility to work to the priorities of residents, balancing these with what they see as the main priorities for support. They do so to help build relationships with residents, which encourages the ongoing engagement that is essential to achieving outcomes that can stabilise a resident's situation in the longer term
- **Open ended support** – the team are able to support residents for as long as required to reach what they feel is a sustainable solution to a resident's issues. The team also have the flexibility to engage with residents in places that are suitable and convenient to them, broadening the opportunities for residents to work with them
- **Coordination function** – the team have a shared coordination function, with each team member undertaking the role on a periodic basis. This shared role removes the managerial aspect of a team leader and enables a more democratic process for making decisions about the team's work
- **Making cases 'inactive' rather than closing them** – the team operate a policy of only 'closing' cases when they have stabilised the resident's situation. If they fail to maintain engagement with a resident, they make the case 'inactive'. They then conduct 'inactive' case reviews on a quarterly basis to try to re-engage those residents

[10] Freidson, E. (1994). *Professionalism reborn: Theory, prophecy, and policy*. University of Chicago Press.

[11] Evans, T. (2016). *Professional discretion in welfare services: Beyond street-level bureaucracy*. Routledge.

Going beyond co-location towards integration

Walter (2000)[12] describes co-location as a broad term that can involve the use of both administrative and case-based approaches, but it also represents a unique approach to service integration that is grounded in shared physical space. Others have stated that co-locating services in shared space disrupts the existing system and affords the opportunity for organisations and individuals to redefine their relations with one another and with those they are supporting, both formally and informally. However, Lawn et al. (2014)[13] argue that co-location does not always lead to integration. They state that, much like a person-centred approach, it works best if practitioners are consulted and involved in the transition. In their evaluation of integrated care pilots, the Department of Health (2012)[14] note that *"Integration is not a matter of following pre-given steps of a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventative care, target resources more effectively or improve the quality of care"*.

For the multidisciplinary team, we have sought to use co-location as part of our efforts to integrate caseworkers from four different but complementary specialisms. However, our experience is that co-location is not sufficient to achieve integration alone. The team's flexible approach guided by their review process (see page 4) enables reflection on the extent to which the team have achieved integration and how they may support residents in a more integrated way as their work develops. Some practical examples of how the team have sought to achieve integration are highlighted below.

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

"We can work with them in parallel – rather than deal with one issue, pass them on … which I think must speed things up incredibly for the resident"

"I think the residents now know they're getting a package, rather than an individual"

Practical examples from the team's work

- **Completing more holistic assessments of a household's situation** – when the team establish engagement with a resident, they complete an initial questionnaire that incorporates aspects related to their specialisms, rather than just focusing on their own. Over time, they have reflected that they have become more aware of the types of information required by other team members in order to support the resident more effectively
- **Subjective perception questionnaires** – the team complete questionnaires with residents to better understand their perception of their situation, allowing better understanding of how housing, finances, benefits and employment-related matters intersect with wider needs
- **Case review meetings** – the team conduct periodic reviews of their cases to explore progress and different approaches, including opportunities for more integrated working. In these reviews the team draw together all available data to determine an integrated support plan across relevant specialisms

[12] Walter.S (2000). *Location, location, location: The key elements and factors involved in the co-location of human services for low-income families* University of California, Berkeley

[13] Lawn, S., Lloyd, A., King, A., Sweet, L., & Gum, L. (2014). Integration of primary health services: being put together does not mean they will work together. *BMC research notes*, *7*(1), 66.

[14] www.gov.uk/government/publications/national-evaluation-of-department-of-healths-integrated-care-pilots