Appendix 1 – Contract Performance

Context to provision

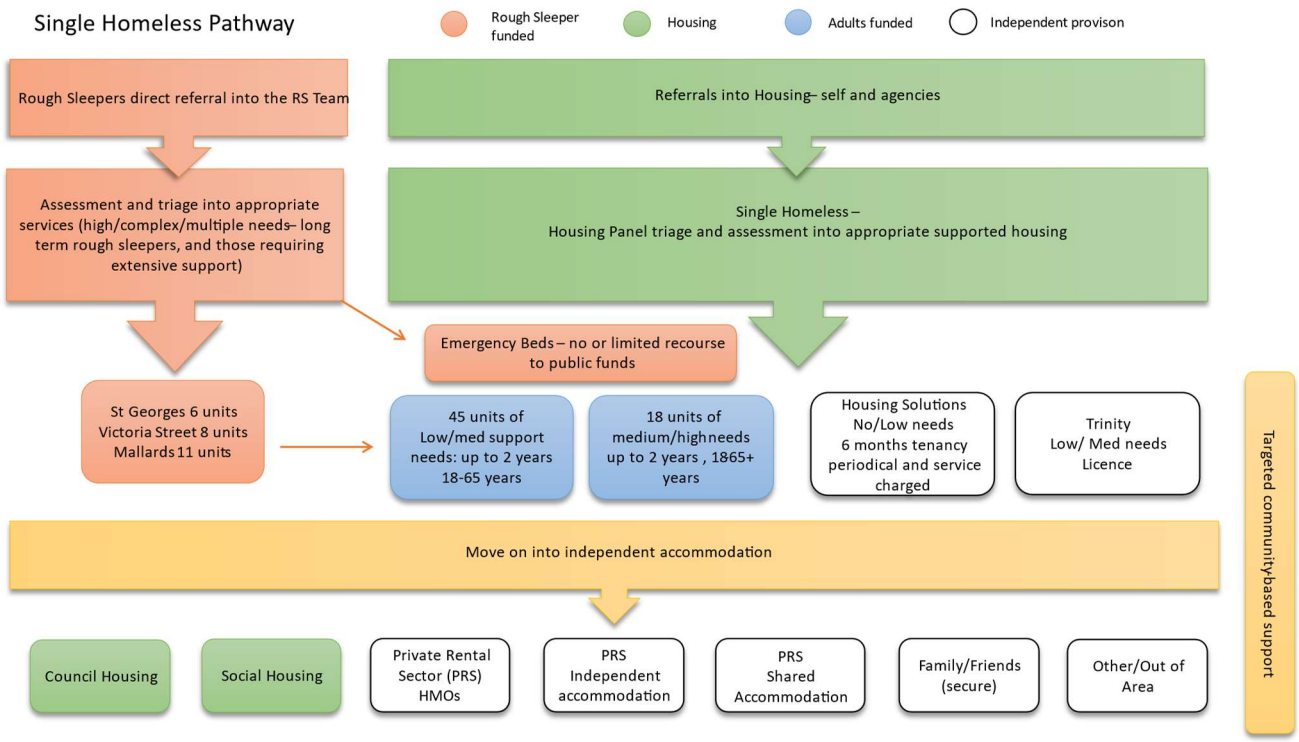
Slough Borough Council currently commissions accommodation -based housing related support services for Slough residents aged 18 to 65. The services support people to acquire and maintain independent living skills and to move into their own tenancy. The services do not include the provision of personal care.

Service users are supported to become active citizens within the community, to access the same opportunities as their peers and to maintain links with the local community, family and friends.

The services take referrals from Slough Borough Council Housing team via the Single Homeless Panel and are targeted at people at risk of, or experiencing homelessness, with various levels of complexity and need.

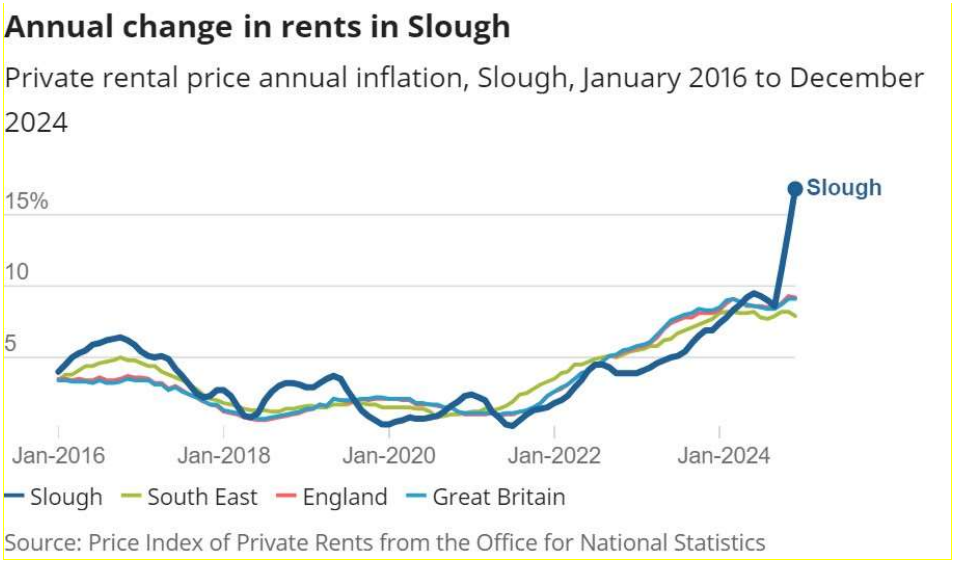
All services are reporting greater numbers of higher risk -including violent and sexual offending. As yet, there is no dedicated probation provision for the single homeless panel to refer into.

People currently sleeping out are supported directly via the Rough Sleeping team, although they do make emergency referrals into current provision.



It should be noted that providers who are tasked with moving people on into independent accommodation are operating within a challenging housing environment. Whilst this a national

experience, move – on to affordable accommodation in Slough has been impacted by a higher than national increase in rent:



The support journey

The overarching aim of the services is to ensure that people have the skills required to support themselves and maintain their accommodation. Support is likely to include the following elements and whilst presented as a list, there is no expectation that individuals will progress neatly from stage to stage, or within any given timescales.

We recognise that individuals may experience a need for multiple elements of support at the same time dependent upon their journey through the service and their ability to respond to unexpected challenges that may arise.

Referral and assessment	The Provider is expected to attend the SBC single person pathway to discuss and accept new referrals as well as updating on those ready to move on, including any individuals being referred into the housing team and why.
Initial entry and crisis interventions	The provider will use trauma- informed practice and strength-based approaches to support the people using their services. This is especially important for those newly entering a service, who are likely to have experienced heightened anxiety, fear and distress in their journey to date, which may also include adverse childhood experiences. New entrants will meet with a

	support worker/coach to settle and allay any immediate fears and concerns. Immediate support needs and interventions are likely to include, but are not limited to: • Physical and/or mental health support, • Suicide Prevention • Family contact • Access to food, clothing, products for self-care and benefits • Criminal justice interventions, • Substance misuse, • Social care interventions, • Behaviour expectations
Stabilising	Building on the trusting relationships established within the entry and crisis intervention phase, the support worker/coach will work with individuals to ensure they are more able to move from reactionary, crisis- style approaches and reactions, to a more secure sense of personal agency with the support of staff. This will be aided by a strength-based support plan, including recognised risks to the individual, co-produced between the support worker/coach and the individual. The format of the plan will be easily accessible and will belong to the individual. The provider will maintain a copy for safekeeping and reference. The areas of support plan activity are likely to include, but are not limited to: • establishing consistent personal boundaries, • managing behaviour • registering / reconnecting with support agencies and primary health services, such as CMHT, Substance Misuse agencies and Probation • Establishing any needs for disability diagnosis – particularly hidden disabilities • Establishing eligibility for Personal Independence Payments • further welfare benefits support and investigation to maximise benefits. • reconnecting with family and friends • Improved self-care and nutrition • Greater ability to manage money • Less chaotic approach to alcohol or drug use • Reduced offending
Longer- term planning and goal setting	The support worker/coach will support the individual to begin to consider next steps and encourage self -identified goals. This will encourage integration into a different support or peer

	network, providing a circle of support once the individual is ready to move on. This are likely to include the following but must be co-produced to take account of strengths and preferences. These are likely to include, but not limited to: • employment, • education, training and volunteering. • hobbies and interests • budgeting skills, • independent living skills, • reconnecting with family and communities The support worker/coach will help the individual to map out the steps needed to reach gaols and will work alongside them to consider any setback or boundaries and how they can be approached. This will also include an element of motivational support, as well as supporting individuals where a change of goal is indicated. The provider will monitor progress towards meeting goals using an appropriate methodology, for example an outcomes star, which incorporates the individuals' view of their progress.
Preparing for move on	Readiness to move on can be indicated at any stage of an individual's journey, regardless of whether it is a sustainable prospect at that time. All elements of the above support can be used to manage expectations, establish skills in resilience and self-advocacy, contributing to an individual's sense of personal agency. In addition to this important indicator, there are skillsets that are needed to ensure individuals have the tools to manage and sustain independent accommodation. This includes but is not limited to: • budgets and affordability - saving for essential items/deposits / cooking on a budget • tenancy support – tenants' responsibilities and priority bills, • tenants' rights, recognising when and how to ask for help • respecting your property – self and others
Post move-on Tapering support	The provider will offer formal aftercare support for up to three months to individuals post-move on who require an element of regular support during their transition into independent accommodation. This can be face to face, via phone or online, dependent on the needs of the individual, and at a frequency determined by need. The tapering service can be an individual approach by each lot provider, but a shared approach between lot providers will be welcomed. Support will be person-centred developing self- advocacy skills and will focus on the presenting need of the individual.

	Interventions may include warm handovers to community support and links to other helping agencies where appropriate or simply be for reassurance Informal 'in-reach' will be provided for those who need occasional support to maintain their independence, with consideration given to those who may want to become peer supporters or volunteers within the setting.
Landlord Liaison (YMCA only)	To combat the current lack of move on accommodation, the provider will develop a private rented sector landlord liaison approach to encourage local landlords to consider their current or future stock for use by those ready to move on. This will include: • developing awareness of the needs of individuals to live in safe accommodation, • the potential to develop small HMOs to provide next step accommodation, and • the potential to develop a 'reassurance 'service for landlords using tapering support to sustain good relationships and response to landlord concerns.

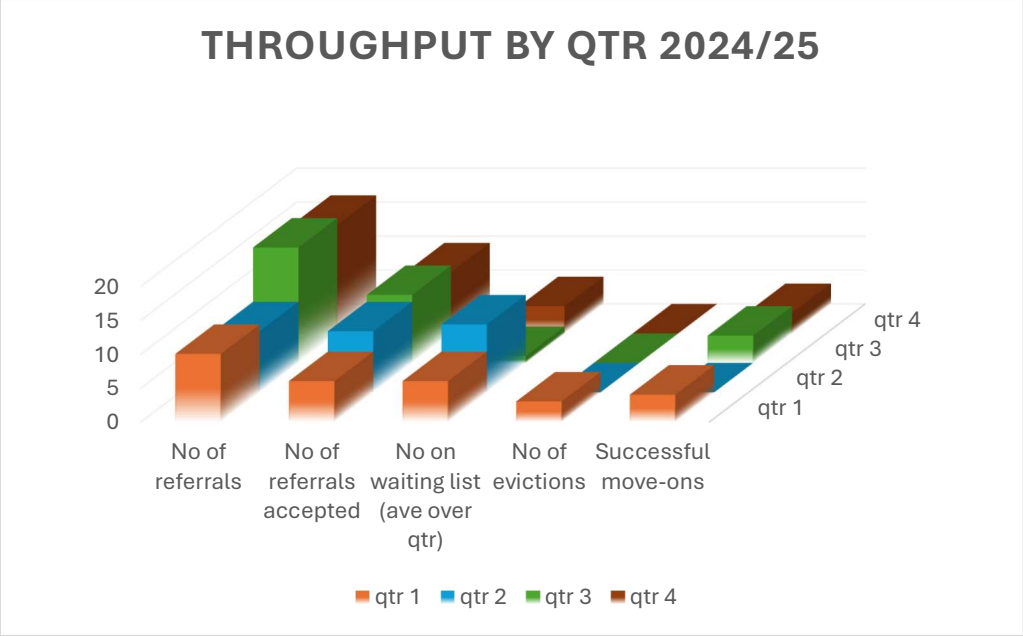
1. **Performance of YMCA for the low to medium needs accommodation for the period 1 April 24 to 31 March 25 – 45 units of accommodation 18-35 yrs**

Low to medium needs include people with support needs around developing tenancy-related skills and who are likely to have some vulnerability relating to age, sex, disability, sexuality, literacy, ethnicity and/or language barriers. These individuals are likely to need a lower ratio of supportive supervision. They are likely to be able to move on within 3 to 12 months.

The lower level needs of this group result in higher 'throughput, people are able to move on quickly freeing up beds for new referrals to be made.

Due to the large number of people accommodated within the scheme, the service is unable to accommodate people with high needs who require greater staff ratios for supportive supervision and to enable a safe environment.

Referrals come directly from SBC single homeless panel.



Throughput – referrals entering and leaving the service over the last 12 months

Total number of referrals received by the service from the single homeless panel	52*
Of those 52:	
Referrals refused by provider due to due to high need and high risk	4
Referrals rejected by the service user post - assessment as did not want to go into YMCA provision	3
Total numbers not engaging with assessment	11
Total number of referrals entering the service	**34**
Total number of evictions over the 12-month period: breaking house rules/not engaging	3
Successful move on into independent accommodation	9: 6 private rented sectors, 2 returned to family home, 1 social housing
Move on into other short-term housing	3: 2 Temporary Accommodation, 1 mother and baby unit

***The 52 referrals from the panel will be made to all providers – not just YMCA- to enable them to balance any risk attached to the referral to the current cohort being supported.**

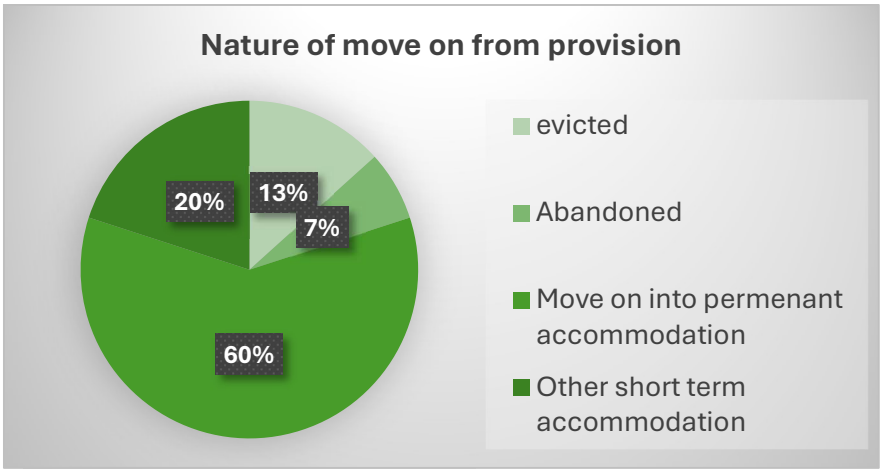
Ambitious indicative KPIs were set out within the specification with the aim of refining the targets over the first 12 months of provision.

As only one bid was received for the contract, ongoing discussions with the provider was entered into concerning the feasibility of their case management platform to report on these targets without it becoming unduly burdensome for staff recording- which ultimately would take time away from support activities.

It was agreed to revert to previous reporting approach as outlined within the contract.

Data for the previous 12 month period

Reporting area:	
Total number of referrals	52
Total number of referrals accepted	48
Total numbers of referrals using the service	34
Total numbers that have moved on successfully	12
Total number who have engaged with substance use services	2 (very low numbers of referrals with substance use issues)
Total number who have engaged with Mental Health services	3 (there are reported issues with the accessibility of MH provision)
Total number who have used the emergency bed	2



2.2 New Initiatives developed in last 12 months and impact:

Initiative	Current impact of initiative
Consultation with residents on how they would like their communal areas to looks and what facilities they would like to see.	The refurbishment is an ongoing project and gym/fitness equipment has been secured which residents are actively using increasing positive engagement with both staff and fellow residents
Partnering with the Slough Power League (football)	Service users at YMCA Chalvey are competing together with other YMCA (Britwell) residents on a fortnightly basis. Residents have expressed that they are thoroughly enjoying this.
Collaborative working with the Refugee Move-On pilot operated by Browns CIC	Early development with 2 refugees supported into independent living

Sourcing private landlords across the county	Improved landlord engagement

2.3 Other successes:

- Resident engagement has improved considerably which is linked to increased referrals from refugees Many residents are engaging together in the lounge area and enjoying the time with each other.
- Improved recruitment to posts

2.4 Main obstacles to success:

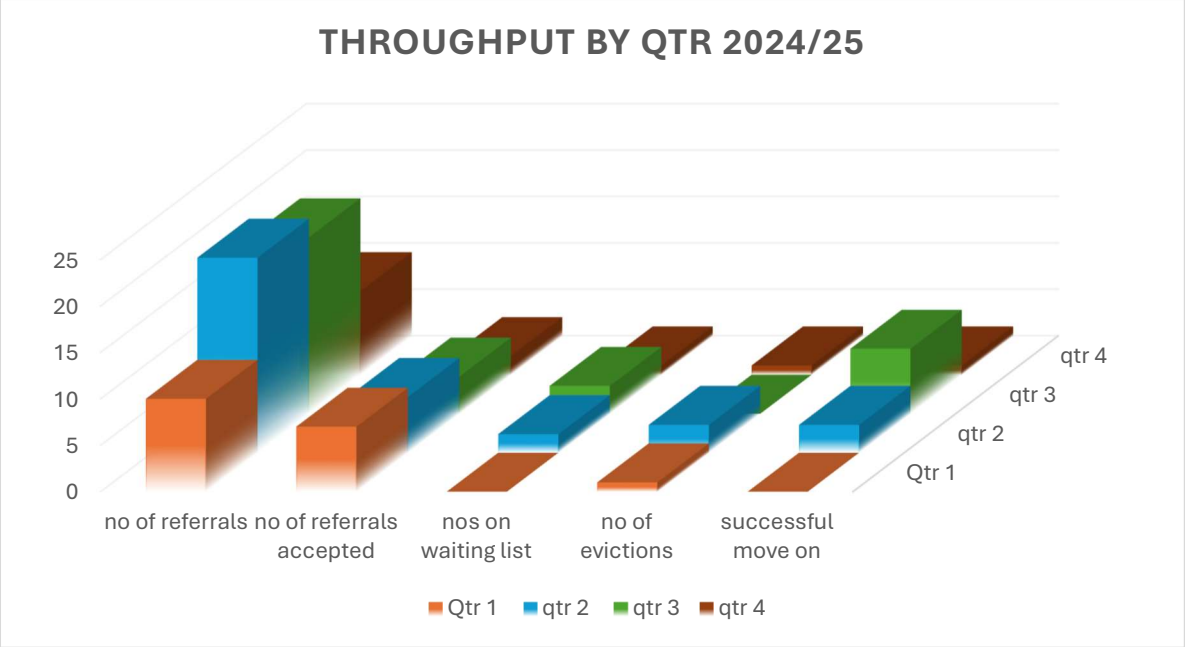
- Some referrals do not want to engage and do not attend assessment therefore have to be removed from the referral list
- Adapting to increase in refugees including non-English speakers.
- Lack of move-on opportunities
- Issues in recruiting
- Unsuitable referrals – too high need or no support needs, outside of age criteria
- Recent issue with Local Housing Allowance entitlement for under 35-year-olds being refused, despite the YMCA qualifying as 'specified' accommodation. People leaving specified accommodation are not subject to the single room LHA rate based on their age (under 35).

2. Performance of Look Ahead for the medium to high needs accommodation for the period 1 April 24 to 31 March 25 - 18 units of accommodation – 18-65 yrs

In addition to developing tenancy-related support needs, medium to high needs include people who have co-occurring issues relating to mental health, substance use, long term rough sleeping, health conditions and sometimes behaviour that challenges. These individuals are likely to need a higher ratio of supportive supervision. They are unlikely to be able to move on without significant support over a longer time period – between 12 to 36 months.

The higher level needs of this group result in a lower 'throughput' - people need more time to become ready to live independently, and so do not move on quickly. This results in fewer spaces becoming free over a 12 month period.

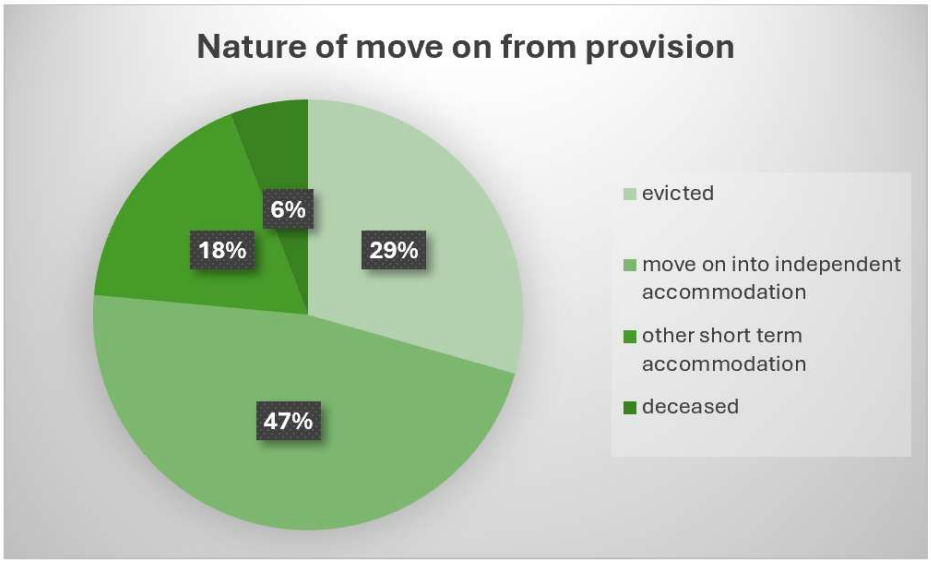
Referrals are made to multiple providers to enable services to make a response based on capacity and risk, therefore reducing the need for the individual to undertake multiple assessments. This is particularly important for those referrals who find it difficult to engage with services.



Throughput – referrals entering and leaving the service over the last 12 months

Total number of referrals received by the service from the single homeless panel	59 *
Of these 59:	
Referrals refused by provider due to high need and high risk related to violent and sexual offending behaviour, unsuitable accommodation and/or repeatedly missing initial assessment	12
Referrals rejected by the service user post - assessment as unsuitable for their needs	20
Total number of referrals after refusals entering the service	**17**
Total number of evictions over the 12-month period: breaking house rules, recalled to prison	5
Successful move on into independent accommodation	8: 5 into social housing, 3 into private rental sector
Move on into other short-term housing	3: 2 into other supported housing, 1 into temporary accommodation

***The 59 referrals from the panel will be made to all providers – not just Look Ahead- to enable them to balance any risk attached to the referral to the current cohort being supported.**



Performance against KPIs (culminative)

target area	Target KPI	met
Service users registered with GP	100%	100%
Service users engaged with substance misuse treatment service where appropriate	100%	100%
Where assessed and appropriate, service users to be offered Hepatitis C testing	60% acceptance	75%
Connections made with a bank for opening current accounts and management of finance	80%	all customers that moved in had already a bank account
Move on predominately private rented accommodation with secure tenancies	80%	total 90% 50% Temporary Accommodation 40% into Slough Borough Council Accommodation

1.3 New Initiatives developed in last 12 months and impact:

Initiative	Current impact of initiative
Partnership with Homeless project in Windsor to extend the agreement with Santander bank to open bank account for customers	The branch has extended the service-to-service users at Look Ahead
Weekly Turning Point face to face drop-in at the hostel to improve engagement	Majority of service users linked in with Turning Point (Substance Use service) All service users have attended Naloxone training - emergency antidote for overdoses caused by heroin and other opiates or opioids (such as methadone, morphine, nitazenes and fentanyl). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties.
access to adult skills courses at local library	2 service users have started language courses through the library
Partnership with No. 22 Counselling Service to give psychologic support to customers	Small uptake at present
Partnership with Job centre	Supports services users threatened with sanctions to address issues
Hepatitis test and treatment workshop	Hep C and Liver Function Testing ongoing at the hostel
Membership for the customers with a local swimming facility	Some engagement noted
Partnership with Slough CVS to get customers into volunteering activities	Early stages of development
GP surgery outreach to hostel	Ongoing Service users are successfully engaging with the service 11 customers successfully had both Covid-19 jabs, facilitate by the hostel GP

1.4 Main obstacles to success:

- Referrals still high needs with very complex needs, referrals with offending behaviour still high (violent and sexual offences most common)

- Some referrals have physical disabilities which cannot be accommodated due to building structure.
- Some referrals do not want to engage and do not attend assessment therefore have to be removed from the referral list
- Adapting to increase in non-English speaking service users and the lack of translation services
- Lack of move-on opportunities