Market Engagement Session 21.04.21

Feedback

Following the Market Engagement session on 21st April 2021, Detailed notes were taken from each breakout group – the summary below highlights the main discussions and issues, collated from all groups. Questions that arose during the session, both in the message boards and in the group discussions, are have been collated and an FAQ (Frequently Asked Questions) will be published on the supplier portal

1. Proposal for tiered level service – cluster model with progressive step down to move-on.

- Pros and cons of the proposed model
- Would this work better with a single provider for each quadrant or other arrangement?
- How well can providers deliver flexible accommodation and services?
- What would providers' workforces (skills) need to adapt to this new model?
- Hospital discharges – D2A and standard DToC what does 'good' look like?

Complex service	• An MDT approach is critical to robust, positive risk taking, assessment and management and must be focused on joint positive risk taking • The new model could help prevent people being placed in unsuitable settings. This is a current feature when IE is full, and StoI providers have to decline referrals. • Additional clinical support helps very well in other services, particularly where the psychologist on site provides training for staff. • Developing a flexible model could involve a lot of work and staff would need up-skilling • Crossing Health boundaries can be a problem, which should be taken into account when determining localities for services • With High support, night awake is not always necessary as it could build dependency issues • Full buy-in is critical for an MDT approach to work, it really helps to share common practice tools e.g. assessment templates
Discharge to Assess (DtoA)	• Would need to ensure discharge to assess (D2A) placements do not become an extension of hospital beds
Single provider per quadrant:	**Pros:** • Similar approaches seem to work and should help secure good move-on outcomes • Single provider should enable quicker access to the services **Cons:** • 2 or 3 specialist type providers could work better if they work together to agree best placements for individuals • Finding properties is a challenge, working by quadrants could limit options to rehouse • Could make it hard to find the right accommodation for the individual

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General	• The model needs to be backed up by strong housing management • Tender timings are a challenge as will need to bring on new properties (existing properties may take up to 9mths, new properties may take up to 18mths) • Success of the model will depend on the whole system working really well with good communication • Would like to see where the demand lies across the areas • MH recovery isn't linear, how people migrate through the tiers needs to be clear • The model would require closer working with community resources and Care Co's committing to greater involvement with the services • Maintaining contact with people as they progress out of the pathway is an important aspect of sustaining recovery
	2. Sustainable Move on • How do we overcome the challenges of limited move-on options? How do we ensure move-on is sustainable? • Any examples of good practice/solutions? • What's needed to better engage private landlords to be able to access private accommodation options?
Private Landlords	• To be able to access private rented accommodation, clients need: rent deposit; often a guarantor; reassurance re: tenancy sustainment risks due to MH • Local councils do not all provide deposit schemes across the county • The cluster model may support better relationships to develop with local landlords • A point of contact for support should help reassure landlords • LA nominations system could perhaps be rolled out as a quota arrangement to private landlords • Properties are available - there was experience in the group of working with private landlords which really helps with the guarantor set up
Property development	• Landlord providers can invest and make properties available for the support • Some HAs lease properties from private landlords – one organisation had 3 year leases, another 6 years. 3 years was considered too short term for move on.
Sustaining recovery	• Sustaining continuity of support from the point of move-on is difficult, but a critical feature. Unsure whether this should be provided from scheme or from elsewhere • MH Floating Support would support sustainable recovery, as it needs to be assertive, have a point of contact and be flexible to prevent relapses/crises • Some organisations work with investor partners for housing development, which can be developed for move-on • There are other approaches to consider along the lines of a Housing First type model • Peer support e.g. a move on buddy, really helps to support sustainable move on, reference was made to the current tenancy sustainment pilot service • Also critical to sustain contact through resettlement with the provider for agreed short term time to prevent relapses • Tenants need to be linked to any community assets available in their new homes at the earliest possible point
General	• Establishing any duty of housing rights needs to be started at the beginning of the pathway

	• Important to manage client expectations, some aren't prepped to the type and standard of housing available to them • Dedicated link and move on workers would help to build relationships with landlords and LA's to help match people to the right kind of property
	3. Community assets • Most commonly used services – what are current working arrangements with providers? • How can these key partner services be involved from the point of referral, particularly D&A services? • What's needed to ensure that drug and alcohol and other support services are engaged at the point of discharge into the accommodation?
Collaborative support planning	• Collaborative care plan from referral stage is needed with the right professionals involved in MDT • Assessments at point of discharge needs to engage all services • Currently referral information is very sketchy and hard to assess • A shared support plan challenges different commissioning routes for D&A and MH – greater co-ordination and leadership needs to develop in the organisations • Sometimes clients are already referred to appropriate services (D&A) by EPUT on placement, others haven't been so the provider needs to support referrals • MDT approach would help greatly at the earliest point • 3 way communication is needed between client/Service/Provider
Community links	• Community assets aren't evenly available across the county • Drug and Alcohol (D&A) services do visit clients regularly where many have Direct Payments • There can be a problem accessing MH services with Drug and Alcohol • Community Hubs would be useful where a variety of services are on offer for the clients to tap into on one visit – 'speed dating' type events could help.
General	• Staff need training in D&A • Covid-19 has changed the way people are supported, which has proved to be very successful in some cases, not so in others • These are all personal journeys and need to be tailored