SYSTEM FOR PEOPLE WITH COMPLEX NEEDS

System Specification

1. INTRODUCTION

Plymouth City Council commissions a broad range of statutory and non-statutory interventions for people who have support needs in relation to homelessness and substance misuse and may also have support needs around mental health, offending and risk of exploitation. A large proportion of these presenting needs and behaviours will be underpinned by causes such as experienced trauma (neglect, abuse, hidden harm), family breakdown and disrupted family care, speech and language and special educational needs and disabilities.

These areas of vulnerability and need are acknowledged by professionals as having significant overlap. The consequence of this has an impact on families and communities, with people often leading chaotic lives and having ineffective contact with services.

2. PURPOSE

This service aims to improve the lives of people with complex needs by supporting the whole person to meet their aspirations, whilst also contributing towards national outcome targets in relation to statutory homelessness, children in care and care leavers, drug treatment, reoffending rates, preventing admissions to hospital and urgent care targets.

The purpose of this service is to:

- Enable people to fulfill their potential by resolving underlying issues and causes, the consequences of which are homelessness, substance misuse, offending, mental health and risk of exploitation
- Provide support to enable people to become 'de-assisted', by providing the right support at the right time, reducing the pressure on crisis and emergency services and moving towards independence and wellbeing
- Achieve the goals (the things that matter most to the individuals) through an honest relationship that changes over time as aspirations grow, develop and are achieved.

3. PRINCIPLES

The following are key principles which will be embedded within the service offer:

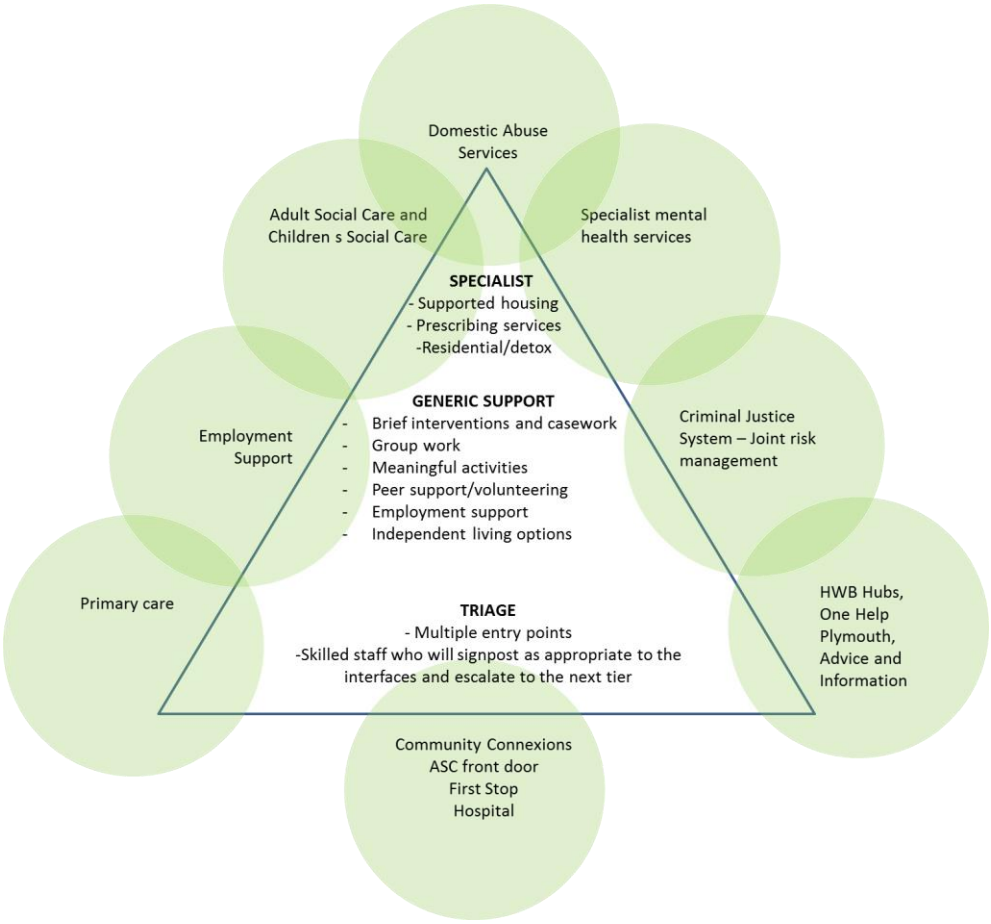
- The person using the service is in control. This is not just about choice but the power to shape and direct their support
- Everything we do acknowledges that everyone is a citizen and we will work to enable them to make a positive contribution to their community
- We will look for opportunities in risks
- We connect ourselves, around and focused on the needs of the person
- We always recognise people's perspectives on the value held in their relationships and networks
- We invest in the priorities, energy, passions and enthusiasm of people
- We aim to increase the understanding and connectedness within a wider community to ensure we reduce isolation
- We involve people with a lived experience and people delivering the service in the ongoing development of services

- We are intelligence-led
- We intervene early where possible
- We believe people have the ability and competence to achieve great things
- We will focus on skills and assets rather than deficits and barriers.

4. SERVICE DESCRIPTION

4.1 Key activity

The service will provide a range of statutory and non – statutory interventions for people who have support needs in relation to homelessness and substance misuse and may also have support needs around mental health, offending and stepping down from care.



The service will:

- Provide integrated care as a seamless system, which feels to the end user as if it's a single service
- Be timely and responsive to changing levels of need
- Effectively share information in the best interests of the person
- Utilise a comprehensive asset based needs assessment
- Support people to keep themselves and others safe, when they are unable to do so for themselves
- Create person centred support plans
- Offer a range of therapeutic interventions that support the whole person through a collaborative "whole systems" approach
- Have multidisciplinary and multi-agency teams (including Primary Care) in co-located settings

- Provide parity of esteem for mental health support
- Have a professional, suitably skilled workforce of generic and specialist roles, with strong leadership
- Have a focus on delivering better outcomes for the population
- Engage with a systems optimisation group, flexing service delivery as required to enable effective systems working.

4.1.1 Triage

This system element will:

- Have multiple points of access into a single support offer which provides a timely, high quality, consistent and comprehensive response
- Have appropriately skilled staff who can triage effectively, performing assessments of need to determine if people require signposting to system interfaces or escalating to generic/specialist support

4.1.2 Generic

This system element will:

- Provide both brief interventions (e.g. advice and information drop in) and on-going casework to people with support needs in relation to homelessness, substance misuse, mental health and offending.
- Deliver a programme of meaningful activities and group work, in a range of settings
- Have access to a range of low level, independent living options including private rented sector landlords willing to let properties to people with complex needs
- Develop and provide peer support and volunteering opportunities
- Support people to seek and maintain suitable education, employment or training opportunities

4.1.3 Specialist

This system element will:

- Provide the appropriate support and treatment for people with substance misuse, including prescribing interventions, vaccinations, testing and inpatient detoxification services
- Deliver sustainable accommodation options (including temporary accommodation) for people with complex needs, including young people (some of whom will be stepping down from care), ex-offenders and mental health. This must include a minimum of 380 supported accommodation units (please note that this contract will pay for support costs only)
- Deliver an outreach service which provides support to rough sleepers and those at risk of homelessness, enabling them to find and maintain accommodation
- Deliver support to complex young people with a history of trauma and work with partners to facilitate a smooth transition to adulthood

4.2 Eligibility criteria

People using this service:

- Will be over 16
- Will have support needs in relation to homelessness and/or substance misuse
- May also have support needs around mental health and offending

- May be stepping down from care, such as residential or foster care.

4.3 Referral routes

People will access the service through a range of routes (this list is not exhaustive):

- Self-referral
- Local Authority
- Third sector organisations
- Criminal Justice System
- Hospital
- Primary care

4.4 Access to the service

The service will have multiple triage access points each providing a high quality, comprehensive, consistent offer.

Whilst we expect everyone to be able to access an element of the service immediately (e.g. triage), demand may exceed supply in some specialist elements of the service. In the event that need overtakes provision then a prioritising system based on highest degree of vulnerability should be put in to operation (as agreed with commissioners).

4.5 Opening times

The level of service user's needs will vary and there will be a requirement to have a tiered level of support in order to respond quickly for successful early interventions, during crisis periods and to encourage movement towards greater independence and stability.

The service will be available flexibly, 7 days a week with sufficient accommodation units staffed 24 hours a day.

4.6 Delivery location

The service will be provided at a range of locations across the city of Plymouth which may include:

- Outreach
- Drop ins
- Building based
- Hubs
- Accommodation settings

5. SYSTEM INTERFACES

This service is part of a wider complex needs system. Agreed interfaces with other system elements include:

Offer from Mental Health to Complex Needs	Offer from Complex Needs to Mental Health
• Rapid access where agreed thresholds / scenarios are met • Expertise and advice readily available from specialist service • Workforce development and training	• Involvement in MDT • Support provided to those experiencing psychological distress who wouldn't meet the threshold of statutory services • Joint case working

• Specialist CPNs appropriately deployed • Joint case working • Shared risk management	
Offer from Employment to Complex Needs	**Offer from Complex Needs to Employment**
• Work readiness/opportunities • Support for employers	• Support around preparation for employment
Offer from CJS to Complex Needs	**Offer from Complex Needs to CJS**
• Shared risk management • Joint problem solving • Information sharing	• Supported accommodation for ex-offenders • Support to prevent re-offending • Information sharing
Offer from Adult Social Care to Complex Needs	**Offer from Complex Needs to Adult Social Care**
• Flexible services such as domiciliary care where required e.g. within the hostel system	• Provide support creatively to reduce costly packages of care
Offer from Children's System to Complex Needs	**Offer from Complex Needs to Children's Social Care**
• Access to supported lodgings for high support young people (dependent on capacity/prioritisation) • Support via the Gateway • Support from young person's substance misuse support service • Support from CAMHs • Support regarding transitions to independence	• Reduction in the use of emergency accommodation • A range of supported accommodation placements including sustainable move on accommodation and step down beds • Streamlined pathway which is needs led • Priority for vulnerable young people • Prevention of homelessness for young people and families
Offer from Health and Wellbeing Hubs to Complex Needs	**Offer from Complex Needs to Health and Wellbeing Hubs**
• Health and wellbeing hubs • Workforce development • Awareness raising • Digital offer • Advice and information • Targeted healthy lifestyle interventions	• Specialist advice e.g. substance misuse • Co-location
Offer from Primary Care to Complex Needs	**Offer from Complex Needs to Primary Care**
• Easy access to IAPT • Homeless outreach GP service	• Locations for homeless outreach service • Support to access health services • Activities relating to health and wellbeing
Offer from Community Connections to Complex Needs	**Offer from Complex Needs to Community Connections**
• Access to professionals telephone line • Support to access advice from Housing Benefit with complex queries • Support with problem solving	• Reduction in the use of emergency Bed and Breakfast • Reduction in Rough Sleeping • Information Sharing

Offer from Domestic Abuse to Complex Needs	Offer from Complex Needs to Domestic Abuse
• Refuge accommodation • Training • Advice and guidance • Perpetrator service	• Support around substance misuse, mental health, homelessness

6. STAFF

The supplier will at all times make available sufficient numbers of suitably skilled staff to deliver the service throughout the year. Specialist accommodation services will need to have access to skilled staff including Community Mental Health Nurses and workers who are able to appropriately manage the needs of high risk ex-offenders.

The service should be provided by appropriately experienced workers (paid staff / volunteers) who have a high level of understanding of the specific needs in relation to vulnerable people with issues around drug /alcohol use, offending, mental health and homelessness. Staff will be skilled in engaging with vulnerable people and ensure that positive support networks are established and maintained.

Support will be provided at flexible times to meet individual need.

Staff will receive planned and relevant training, development and supervision to enable them to fulfil their roles, including (but not exclusively):

- End of life care
- Emotional health and wellbeing/psychological distress
- Needle exchange
- BBV
- Harm reduction
- Risk management
- Needs assessment and support planning
- Relational security
- De-escalation
- Trauma Recovery

The staffing structure will facilitate flexible working across a range of specialisms, tasks and locations dependent on need.

7. SERVICE VOLUMES

The number of people currently using the complex needs system per annum are as follows:

- X number of people accommodated within the single homeless system
- X number of people rough sleeping
- X number of people requiring substitute prescriptions
- X number of High risk ex-offenders being accommodated in supported accommodation
- X number of people being accommodated by the local authority in temporary or emergency accommodation
- X number of young people at risk being accommodated in supported accommodation
- X number of people accommodated within specialist mental health supported accommodation
- X number of people accessing substance misuse day services
- X number of people in drug treatment inpatient services
- X number of people accessing complex needs team
- X number of people accessing floating support/housing related advice and information.

Due to the nature of complexity of need, we anticipate that there is existing duplication across these cohorts.

8. PERFORMANCE

8.1 Key Performance Indicators

TBC

8.2 Outcomes

We recognise that outcomes are created by systems as a whole.

We want to work with provider(s) to measure and reflect on the outcomes that the system is producing, in order to help the system continuously adapt and improve, and to help organisations understand their particular contributions to these outcomes.

The measurement system will need to be adaptive (i.e. it will need to change over the life of the project) and pluralist (it needs to measure in multiple dimensions). In keeping with the principles of Revaluation (http://www.revaluation.org.uk/), value will be gathered in three dimensions: quantitatively, qualitatively and relationally, as networks of people and services.

The provider(s) will work with commissioners as co-evaluators to develop a shared sense of those measures that are meaningful and agree how these outcomes can be measured in a range of different dimensions. This will be on-going work over the lifetime of the programme, as it is likely that currently unknown indicators will emerge throughout the lifetime of the contract.

Through the System Optimisation Group Process, provider(s) will be required to collectively reflect on the outcomes and use these discussions to inform on-going outcome development.

The following outcome indicators are an example of those which will form part of the final service specification.

Wider system indicators which this service will contribute towards:

- Reducing homelessness
- Increasing levels of employment
- Reducing health inequalities
- Increasing levels of substance misuse recovery
- Reducing re-offending
- Reducing A&E emergency attendances
- Reducing the number of hospital admissions and length of stay
- Reducing the number of children with a ‘Child in Need’ status
- Reducing rough sleeping.

Indicators which will measure value within the system:

- People report feeling more connected to people who are important to them
- People report feeling listened to
- People report that they feel more in control of their lives
- The system workforce is happy
- People feel safe

9. QUALITY REQUIREMENTS

- The provider is required to have in place and to operate an effective quality assurance system for ensuring the quality of the services provided and to take any action necessary if the service falls below the standards identified.
- The provider will act on any action plans or risk management plans produced as a result of contract monitoring meetings.
- Quality monitoring visits may be planned or unannounced.

10. I.T. REQUIREMENTS

The provider is required to have:

- I.T system(s) that share information safely and effectively. This can be achieved with a single system, or; a central system which manages information exchange between provider(s') systems, or; systems with sufficient APIs to allow information exchange. The system shall:
    - Meet the user needs of the patient;
    - Comply with the latest data security standards, and;
    - Protect patient confidentiality and privacy, and;
    - Take an 'open first' approach to providing data publically, and;
    - Be able to share data and information with partners.
- A user needs approach to digital service provision should be taken with continuous iterations and improvement to digital service delivery.

11. MANAGEMENT INFORMATION

The provider, at contract monitoring meetings, during regular visits, or via electronic requests, may be required to provide the following monitoring information as required:

- Details of any unmet need
- Referral/signposting source
- Equality data (capture all of the 9 'Protected Characteristics' detailed in the Equality Act 2010)
- Staff numbers
- Staff changes
- Example of literature issued; e.g. information used to promote the service
- Examples of Service User records
- Accident reports
- Details of significant incidents, including those relating to issues of risk or safeguarding, must be communicated to the Commissioning Officer immediately
- Any investigation/disciplinary procedures
- Waiting list details
- Outcome monitoring
- Quarterly returns will be sent to the Strategic Co-operative Commissioning team electronically

- Any other monitoring information as required by the Plymouth City Council Strategic Co-operative Commissioning Team
- Performance monitoring requirements may become more frequent in response to concerns of quality or performance
- Details of length of time accessing the service.

12. CONTRACT MANAGEMENT

The Provider will participate in the on-going monitoring of the contract in line with Plymouth City Council's contract management processes. The performance data above will be required to be reported on a quarterly basis. In addition the provider will be required to inform the local authority of any serious and significant incidents.

13. BUSINESS CONTINUITY

The provider will have a comprehensive business continuity plan in place for the service.