

# Independent Evaluation of Changing Futures Multi-Disciplinary Team, Brighton & Hove

Final Report

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## Contents

Acknowledgements.....	4
Executive Summary.....	5
1. Introduction .....	13
1.1. Strategic context in Brighton & Hove .....	13
1.2. Changing Futures .....	14
1.3. Our evaluation .....	15
1.4. Common Ambition and the Peer Support Team as evaluation partners .....	17
2. Description of the MDT pilot .....	19
2.1. Resources .....	19
2.2. Ways of working .....	20
2.3. Referrals.....	21
2.4. Profile of CF MDT clients.....	24
2.5. Monitoring .....	28
3. Learning from implementation.....	30
4. Impact .....	37
4.1. Trust and engagement.....	37
4.2. Safety and Safeguarding .....	40
4.3. Health (mental and physical) .....	49
4.4. Meeting basic needs .....	59
4.5. Housing .....	64
4.6. Self, connection and recovery .....	75
5. Exploring effectiveness .....	82
5.1. Modelling effectiveness in MDT services .....	82
5.2. Challenges in measuring effectiveness in MDT services .....	85
5.3. The Swim Lane Analysis .....	87
5.4. Three levels of measurement .....	90
5.5. Swim Lane Case Studies from Changing Futures Sussex .....	91
5.6. Critically assessing the Swim Lane data.....	95
6. Conclusions and Recommendations .....	98
6.1. Conclusions .....	98
6.2. Recommendations .....	99

## List of figures

Figure 1 - Domains of change identified in the Theory of Change .....	16
Figure 2 - Graph to show personalisation budget monthly spend over time .....	20
Figure 3 - Graph to show referrals to MDT by month .....	22
Figure 4 - Graph to show sources of referrals to MDT .....	23
Figure 5 - Graph to show MDT caseload over time .....	23
Figure 6 - Graph to show percentage of clients by age group.....	24
Figure 7 - Pie chart to show ethnicity of clients .....	25
Figure 8 - Graph to show support needs of clients.....	26
Figure 9 - Graph to show other support needs experienced by those with substance misuses needs.....	27
Figure 10 - Graph to show other support needs experienced by those with offending-related needs.....	27
Figure 11 - Graphs to show average scores for MDT client group against safety-related outcome measures between January 2023 and July 2024.....	43
Figure 12 - Graph to show the health status of CT MDT clients at first return .....	51
Figure 13 - Graph to show health conditions of CF MDT clients at first return .....	51
Figure 14 - Graph to show responses to "I am able to effectively manage my mental health difficulties" .....	52
Figure 15 – Graph to show average score for stress and anxiety over time (NDTA indicators) .....	53
Figure 16 - Graph to show CF MDT client accommodation status from first outcomes questionnaires .....	66
Figure 17 - Housing outcomes of a sample of MDT clients .....	67
Figure 18 - Graph to show average score for housing over time (NDTA indicators).....	68
Figure 19 - Graph to show average score for alcohol/drugs over time (NDTA indicators) .....	77
Figure 20 - Illustrative summary of a Swim Lane for an MDT Pilot service user .....	89

## List of tables

Table 1 - Percentage of clients by number of support needs.....	26
Table 2 - Cross reference of presenting support needs on referral .....	28

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## Executive Summary

### Introduction

This evaluation was commissioned by the city's Health & Care Partnership as part of its Multiple & Compound Needs (MCNs) Transformation Programme. This programme originated from the 2020 MCN Joint Strategic Needs Assessment to deliver on the recommendations. The MCN Transformation Programme is a partnership with the Sussex Changing Futures programme and the local Changing Futures Team pilot service. The city's MCN programme is also a frontrunner for the new Sussex Integrated Care Strategy. The findings from the evaluation will support the Integrated Care Strategy's long-term transformation aims through the development of 13 new Integrated Community Teams across Sussex.

Changing Futures (CF) Brighton & Hove is a multi-disciplinary team (MDT) based within Brighton & Hove's City Council (BHCC) Adult Social Care Directorate. It is funded through MHCLG's Changing Futures Sussex grant and by BHCC. The MDT aims to provide a holistic 'wrap around' service for people with MCN to reduce health inequalities and improve life expectancy. The CF MDT launched in December 2022 and was fully operational by Summer of 2023.

This independent evaluation ran from February 2024 to January 2025, and activities included: MDT staff interviews and observations; development of a Theory of Change; document review; analysis of administrative and monitoring data and case studies; and group and/or individual interviews with 28 professionals working outside of the MDT, focusing on the themes of housing, MARAC, co-occurring conditions, urgent care and safeguarding. The MDT peer support team collected 'stories of most significant change' told by 4 clients and 7 workers, reviewed by Common Ambition (lived experience partner).

The evaluation is structured around the six key outcomes identified within the Theory of Change, i.e., Trust & Engagement, Safety, Health (mental & physical), Meeting basic needs, Housing, and Self, connection & recovery.

### Description of the MDT pilot

Key features of the MDT way of working include:

- Team hosted by Adult Social Care (ASC), with ASC and drug & alcohol services being the most frequent referrers.
- Allocated keyworker(s) – most clients have a mini-team of 2-4 MDT keyworkers.
- Small caseloads – typically 4-7: the MDT's total caseload is around 60.
- Co-location, with restricted working from home.
- Assertive outreach.
- Peer support team.
- Personalisation budget.
- Structures to promote learning, development and communication – regular team meetings, supervision, duty system, and an extensive training offer.

## Learning from implementation

There is strong evidence to suggest the team work well together and are highly supported in their roles. The ability to share information and resolve issues by being in the same room and learning from each other's professional and/or lived experience as a wider team drawn from different parts of the system is highly effective. There is strong emphasis on relationship building to enable holistic wraparound support by drawing on specialisms within the team, whilst minimising the risk of retraumatising service users. Excellent resources have been developed to promote staff wellbeing (e.g. lone worker policy, risk assessments) but some planned development work has been delayed due to lack of capacity in the face of operational demands.

**Recommendation:** The plans to develop a new MCN Integrated Community Team model in Brighton & Hove should build on, incorporate and further develop the trauma-informed/Team around Me model and staff management resources developed by the CF MDT pilot. Approval of the compact agreement between participating agencies should be prioritised so that respective roles and responsibilities are clear, especially in relation to line management and support arrangements for the MDT.

## Impact

### Trust and engagement

The MDT has successfully built relationships with people who have a deep mistrust of services. This takes time, resource, creativity and persistence; the personalisation budget and input from the peer support team have been enablers. Having built this relationship, MDT workers can support clients to engage with health, substance use services, DWP, etc. There is evidence that this eases some of the pressure on professionals outside of the MDT by reducing missed appointments, and providing assertive outreach as an intermediary, or - better still - a member of their own agency.

Co-production has been a key feature of the MDT model and its evaluation – for example, the peer support team has influenced the trauma-informed model of practice and interviewed clients and colleagues for this evaluation, whilst Common Ambition co-produced the design of lived experience research and the evaluation findings. Common Ambition reflected that this helps to build trust in the system at many levels: they have been struck by the fact that they had recommended holistic case coordination several years ago and have been pleased to see it implemented.

**Recommendation:** The design, delivery and ongoing monitoring and evaluation of the Integrated Community Team should be co-produced with lived experience, building on the capacity and skills of both Common Ambition and the MDT peer support team.

### Safety and safeguarding

A key objective of the Changing Futures MDT has been to better coordinate the management of risk for people with MCN, and ultimately to reduce avoidable deaths

(including from drug-related overdose, as highlighted in the recent drug deaths audit) and improve people's sense of safety.

The evaluation has identified examples of individuals' risks being reduced, for example in relation to substance use, self-harm, domestic abuse, or accommodation. There is a slight overall improvement for the MDT caseload in average scores for intentional/ unintentional self-harm and risks to and from others, though these have remained volatile for some.

The MDT provides effective care coordination within statutory safeguarding structures; its location within Adult Social Care, strong leadership from senior management and the Safeguarding Adults Board have been key enablers for this.

This is evidenced by increases in the number of cases progressing to a S42 enquiry, the number of Safeguarding Plans and the number of Safeguarding Reviews for those on the MDT caseload. Meanwhile, there has been a 70% reduction in processing and decision-making for the central team for this cohort, since activity is now handled by the MDT. This approach addresses many issues raised in recent local Safeguarding Adults Reviews for people with MCN. The MDT acts as an anchor between the person and other agencies, modelling trauma-informed practice and highlighting barriers faced by this group, e.g. in relation to having their views represented at the MARAC. The MDT (operationally) and the SAB (strategically) have been able to provide mutual support in relation to system change, working together to establish the Multi-Agency Risk Management (MARM) group. There has been engagement with the Police operationally through safeguarding planning and the MARAC, however community safety partners are still missing from the current model.

**Recommendations:** To increase the supply of safe and suitable emergency accommodation for people with MCN who are particularly vulnerable to abuse and exploitation, including domestic abuse. In developing the Integrated Community Team, consider how gender-specific services for women with MCN might also be better integrated within the city and barriers reduced. Further development needed to engage criminal justice agencies in the model, perhaps via the Community Safety Partnership

### **Health (mental and physical)**

The evaluation confirms the high rate of physical health conditions amongst the caseload, with 58% reporting health problems at or above 'moderate' levels and 43% describing themselves as in physical pain. The most reported physical issues were joint aches/ problems with bones, chest pains/ breathing issues, and mobility problems.

86% of clients reported not being able to manage their mental health difficulties at the outset; 'stress and anxiety' levels show the clearest trend of improvement out of the New Directions Team Assessment Collection (NDTA) indicators.

There are many examples of people being supported by the MDT to access health services in a more timely, planned and effective way, thereby reducing use of crisis services. The proportion of people saying they could access a GP or dentist when they needed one showed a marked increase following MDT involvement.

Access to primary care (via ARCH) and drug and alcohol services (via CGL worker on the MDT) were reported to work reasonably well; however, challenges remain at the interface with secondary health services, (including issues getting information about a person's needs to travel with them through hospital), and mental health services. The level of specialist mental health provision within the CF MDT (originally 1 x Band 6 (increased to Band 7) mental health nurse, and no direct access to psychiatry or psychology) has proven insufficient; case formulation by a clinical psychologist should be built into future models as a minimum; ideally psychiatry and psychology would be integrated into the team to respond to co-occurring conditions holistically. The CF MDT also reports a lack of specialist services for people with MCN with Acquired Brain Injury and/or personality disorder in Brighton & Hove, including access to detoxification.

**Recommendations:** At system level, the CF MDT pilot has highlighted the need for an integrated response to co-occurring mental health, substance use, and underpinning trauma, and for additional specialist social worker input for people with MCN at the hospital. The new MCN Integrated Community Team provides further opportunities to develop the role of health care partners in the care and support of people with MCNs: build in dedicated time from a clinical psychologist for case formulation as a minimum, ideally also include psychiatry in the future ICT and implement Plexus Care Record to facilitate information sharing as a priority.

### Meeting basic needs

There is evidence of the MDT helping to reduce destitution for its clients, by enabling people to access food banks, other community resources, benefits and bank accounts. The MDT's personalisation budget allows immediate needs to be met e.g., for food, drink, bedding, clothing, transport, personal and household items. Individual clients have received intensive practical support, e.g. with moving into a new home.

The MDT's location within Adult Social Care, and the investment which Adult Social Care has made to the programme have enabled the MDT to improve access to care and support for its clients via Care Act Assessments. Twice as many Care Act assessments were carried out for the caseload since joining the CF MDT than in the equivalent period before, and these were more likely to result in services being put in place, ranging from one-off deep cleans, to specialist care home or supported housing placements. There is some emerging evidence of ripple effects from the MDT to wider social work teams and other agencies in relation to the application of the Care Act and Mental Capacity Act to people with MCN.

**Recommendations:** Build a flexible personalisation fund into the budget for the MCN Integrated Community Team. Ongoing work is required to support, educate and challenge locality and hospital social work teams on the use of the Care Act and Mental Capacity Act with people with MCN.

## Housing

Housing is a major issue for almost everyone on the caseload and clients often mentioned housing outcomes as being the most significant change for them due to MDT support. There is evidence that the MDT has helped many of its clients to move out of rough sleeping (in one case after decades), sustain settled tenancies and supported housing placements, move to more suitable temporary accommodation or longer-term supported housing, though housing journeys remain volatile for a significant minority.

Statutory homelessness assessments can be carried out by Homelessness Prevention Officers (HPOs) on the team. It has taken a year to evolve this role and embed the necessary partnerships between the MDT and Housing Services, but HPOs are now well-placed to help clients access housing entitlements and better understand their rights within these processes. The flip side of this is that the MDT hosts social work input for the Rough Sleeping Initiative (RSI)-funded Navigator service.

Accessing suitable accommodation for its clients has been a significant challenge for the CF MDT. Unlike the RSI funded services, the MDT does not have direct access to emergency beds for those sleeping rough. Access has been improved via the development of an 'informal pilot' in which the MDT works closely to support some of its clients in New Steine Mews hostel; and through successfully advocating for the development of new specialist supported housing in Brighton & Hove which can work with people with MCN. There is evidence of stronger relationships between Housing and the MDT (facilitated also by the recent merger of Housing and Adult Social Care), with improved mutual awareness of roles and legal duties.

**Recommendations:** At a strategic level, the pilot has highlighted the need to better join up existing resources (e.g. the RSI Navigator and CF MDT services); develop clear housing, care and support pathways for people with MCN in the city (including formalising the New Steine Mews pilot and properly embedding it in pathways), and consider how the city's Housing First offer might be scaled up as part of the next phase of Integrated Community Team development. The Homelessness Review and Strategy provides an opportunity for this.

## Self, Connection and Recovery

The CF MDT has worked with people to promote recovery outcomes: self-management, relapse resiliency, self-awareness, motivation, and hope. The Peer Support team has been instrumental in this, actively working with 9 people in October 2024 to provide recovery support at their own pace, linking them in with existing resources in the city, and providing lived experience training and development for the rest of the MDT.

Loneliness and isolation are common experiences for people; however, recurring themes in client stories about the impact of CF include people feeling less alone, growing in confidence, independence and self-sufficiency, feeling better able to make choices, reduced stress, managing things better. Clients describe feeling 'content', 'happy', 'excited for the future'. Flexible and consistent support which is relational, non-judgemental and person-led is the key factor in these outcomes; accommodation in which people feel sufficiently safe is also a necessary foundation.

**Recommendations:** Ensure the sustainment of the current ‘wealth’ of community recovery activities in the city and continue to develop the ‘recovery pack’ and training offer being developed by the MDT’s peer support work team.

### Exploring effectiveness

Effectiveness has been monitored by CF for individual clients using cost and cost offset data, measures of ‘system pressure’, and NDTA outcome scoring. Analysis of this data shows that positive outcomes for individuals do not always lead to straightforward reductions in cost and pressures, though there are many examples of these shifting away from emergency service usage to planned community-based treatment, support and care. Supporting the stabilisation of diverse individuals with inter-related support needs and trauma can take years not months, and patterns of service usage can vary considerably during this time.

**Recommendations:** There are positive signs of progress, however, longer-term monitoring of outcomes and patterns of wider service usage across more of the caseload is required.

### Assessment of progress against the JSNA findings

The [2020 \(published in 2023\) JSNA on Multiple & Complex Needs](#) made recommendations in relation to service development and system change for people with MCN. The CF MDT has been able to progress, test and generate learning in relation to many of these. The following table summarises this and identifies remaining gaps and suggested next steps.

Recommendation	Progress/ learning from CF MDT	Gaps and next steps
Information sharing: building trust; establishing processes, developing shared system(s)	The MDT has provided an opportunity to test information sharing within existing systems and understand the practical opportunities and limitations of working across multiple systems.	Implementing Plexus care record should be a priority for the next phase. Early Information Governance discussions are essential in Integrated Team development
Including people with lived experience in service design and delivery	CF MDT has generated significant learning, resource and skill in relation to the delivery and management of peer support work with people with MCN. Co-production with Common Ambition through this evaluation has generated further lived experience insights and capacity-building in relation to evaluation.	Ensure properly resourced peer support is built into the ICT, using models and resources developed in the CF MDT pilot.  Draw on the significant knowledge and expertise of Common Ambition in the design and ongoing evaluation of the ICT model.
Care coordinator for individuals with MCN	CF MDT pilot has tested the implementation of this principle, proposing a small but consistent, multi-disciplinary team around the person, ideally hosted by ASC, as being effective and sustainable.	Finding ways to roll out this small ‘team around me’ model of care coordination to include more people with MCN in Brighton & Hove, e.g. through the combining of resources

Recommendation	Progress/ learning from CF MDT	Gaps and next steps
		in the Integrated Team/ proposed merger of RSI and CF teams.
An integrated approach to co-occurring substance use and mental health	The CF team has highlighted ongoing system barriers and gaps for those with co-occurring conditions and been able to generate further learning about what resources are needed in practice to effectively support them.	Ensure both clinical psychology case formulation to support staff and access to psychiatry and specialist mental health services for people with MCN are built into the design of the ICT. Resources within the HMHT will not stretch wider than their existing caseload. Feed CF learning into ongoing CDP -led system change project on co-occurring conditions
Trauma-informed practice	The MDT has developed and demonstrated the value of trauma-informed ways of working with people with MCN, rooted in social work models of anti-oppressive practice. The pilot has tested what is required to sustain these: lived experience input, training, supervision, regular meetings/ team working, reflective practice, changing language and case recording.	Lasting culture change in wider teams/ services requires ongoing leadership and resource. Roll out training, learning and resources tested and developed by the CF MDT across the wider system, prioritising hospitals/ hospital social work teams, locality social work teams, statutory homelessness teams and the MARAC.
Suitable housing, care and support for people with MCN	Lack of suitable housing has limited the effectiveness of the CF MDT, though progress has been made in the partnerships with New Steine Mews, Filey Care and Support, Housing Options and care providers. The value and lack of gender-specific provision has been confirmed by the evaluation.	Follow evaluation recommendations to formalise, streamline and diversify housing, care and support pathways for people with MCN in B&H, considering how further housing supply combined with Integrated Team support might enable the scale up of Housing First. Ensure the overlap between MCN and homelessness is recognised within the current Homelessness Review and Strategy development.
Gender-informed approach	The evaluation has highlighted the importance of the domestic abuse specialist resource within the MDT and the barriers facing women with MCN in accessing gender-specific/ domestic abuse services.	Importance of designing sufficient specialist gender-informed resource within the Integrated Team, in relation to domestic abuse/ coercive control and child protection/ separation. Ongoing partnerships and development with MARAC, Oasis, Equinox, Women's Centre, etc. towards gender specific integration.
Addressing physical health	The evaluation has confirmed the high level of physical health needs	Further integration between ARCH and the MDT should be explored, e.g.

Recommendation	Progress/ learning from CF MDT	Gaps and next steps
needs of people with MCN	amongst people with MCN. Access to primary care has been facilitated by CF MDT working in partnership with ARCH; however, challenges remain ensuring information about MCN follows people into hospital.	via proposed homeless health hubs. Further conversations with urgent care/ hospital social work teams, ideally with a view to locating a specialist MCN social worker role in hospital

## 1. Introduction

### 1.1. Strategic context in Brighton & Hove

This evaluation was commissioned by the city's Health & Care Partnership as part of its priority workstream, the Multiple & Compound Needs (MCNs) Transformation Programme.

The MCN Transformation Programme is a partnership with the Sussex Changing Futures programme and the local Changing Futures Team pilot service. The city's MCN programme is also a frontrunner for the new Sussex Integrated Care Strategy. The findings from the evaluation will support the Integrated Care Strategy's long-term transformation aims through the development of 13 new Integrated Community Teams across Sussex.

The programme's overall aim is to improve life quality and life expectancy for people with MCN and reduce the resource impact people with MCN have across the wider system. Its vision is for people experiencing MCN to lead healthy, independent lives with value and meaning for them.

#### **Definition of Multiple Compound Needs (MCN)**

People with multiple compound needs (MCN) are defined by the national Changing Futures Programme as experiencing three or more of the following:

- Homelessness
- Mental health
- Substance use
- Current or historical offending
- Domestic Violence & Abuse

The MCN Transformation Programme was informed by evidence gathered in a 2020 Joint Strategic Needs Assessment (published [here](#) in 2023). This established a set of principles of service delivery for people with MCN, including:

- A trauma-informed approach, with implications for staff training
- A service that can meet the different needs of men and women
- The combined level of a person's multiple needs should enable access to services, even if the level of need falls below individual organisational thresholds
- An identified person to be the key point of contact for that client and coordinate a multi-agency response.
- Appropriate support and supervision for staff
- Active engagement/ outreach and easy to access services
- No fixed time limit on support
- Staff with lived experience
- Trusting relationships: helpful, supportive and non-judgemental workers.
- Physical health and housing needs addressed alongside mental health and substance misuse needs

The Changing Futures Multi-disciplinary Team (CF MDT) pilot has been designed to respond to these principles. The pilot became fully operational in the Summer of 2023 after going live in December 2022. The MCN Steering Group undertook an internal thematic review of the service in the autumn of 2023 and presented its recommendations to the MCN Integration and Oversight Board in December 2023 ahead of the external evaluation (see s.1.3 for further details), which started in the Spring of 2024.

## 1.2. Changing Futures

Sussex was awarded a grant of £4.45M in July 2021 as part of the national [Changing Futures Programme](#) (see below) to improve the way that local systems and services work for adults experiencing multiple disadvantage. Changing Futures Sussex is embedded in the three local authority areas in Sussex, and aims to make an impact at individual, service and system levels. In Brighton & Hove, Changing Futures has provided most of the funding for the Multi-Disciplinary Team pilot.

In relation to service delivery, Changing Futures Sussex aims to deliver:

- High quality multi-disciplinary service response across the entire footprint.
- Reduced 'postcode lottery' and more clarity on what 'good' looks like.
- Swifter and safer outcomes for women; fewer preventable deaths and Safeguarding Adults Reviews (SARs) relating to women experiencing multiple disadvantage.
- Clients experience high quality, seamless services and 'no wrong door' for holistic support.
- Clear evidence base developed for interventions.

At its outset in 2021, the Changing Futures (CF) national programme was a £77 million initiative between the UK Government and the National Lottery Community Fund<sup>1</sup> initially intended to run until 2025. More recently, the government has announced an extension of time and budget to the programme, meaning that it is now a 5-year, £91.8 million programme.

Changing Futures aims to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system. The programme is funded through £55.4 million from the government's Shared Outcomes Fund, £10 million from the Ministry of Housing, Communities and Local Government, and £26.4 million in aligned funding from the National Lottery Community Fund. Working with 15 local partnerships across England, Changing Futures is testing new ways of bringing together public and community sector partners to help people change their lives for the better.

The CF programme evaluation Theory of Change monitors outcomes at individual, service and system level:

- **Individual level:** stabilised and improved outcomes for local cohorts of adults experiencing multiple disadvantage.

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<sup>1</sup> Which is itself funded by the UK Government's Shared Outcomes Fund and the National Lottery Community Fund <https://www.gov.uk/government/collections/changing-futures>

- **Service level:** greater integration and collaboration across local services to provide a person-centred approach, and reduced demand on reactive services.
- **Systems level:** strong multi-agency partnerships, governance, and better use of data, leading to lasting systems change and informing commissioning. Learning from evaluation and partnerships between government and local areas improves cross-government policy<sup>2</sup>.

The national evaluation seeks to build an evidence base around impact on individuals, service delivery via system-level changes and value for money.

The most recent interim report<sup>3</sup> identified that 2567 people nationally have received direct support from the programme with numerous and varied referral channels. Smaller caseloads and the CF approach delivered by caseworkers are contributing to effective engagement and trust building with individuals.

The CF approach includes a My Team Around Me (MTAM) model of working that aims to build a 'one team' approach for people who are supported by multiple services. Each team works towards four key objectives<sup>4</sup>:

1. **Client-Led:** enabling multiagency groups to work in person centred and trauma informed ways.
2. **Shared Accountability:** collective safety and support planning, sharing tasks, risk and resources.
3. **Service Continuity:** Staying involved in a one team approach particularly during transitions, making collaborative, preventative and restorative approaches.
4. **Innovative Practice:** Person-centred and trauma informed solutions are enabled, positive risk taking is explored and learnt from.

The national evaluation has found that forms of disadvantage are experienced differently, and to differing degrees, depending on gender e.g., women were more likely to report needs arising from their mental health compared to men. People in contact with the Criminal Justice System (CJS) are more likely to have co-occurring needs, including neurodiversity.

### 1.3. Our evaluation

This independent evaluation was commissioned to help grow and assess the local evidence base and draw learning from this 'frontrunner' pilot to inform the development of a new care and support model for people with MCN in the city. The evaluation ran from February 2024 to January 2025. This final evaluation report will inform the development of an MCN integrated community team (ICT) model via the Health & Care Partnership.

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<sup>2</sup> MHCLG (2023) *Evaluation of the Changing Futures Programme: Baseline Report*. London: The Stationery Office.

<sup>3</sup> MHCLG (2024) *Evaluation of the Changing Futures Programme: Second Interim Report*. London: The Stationery Office.

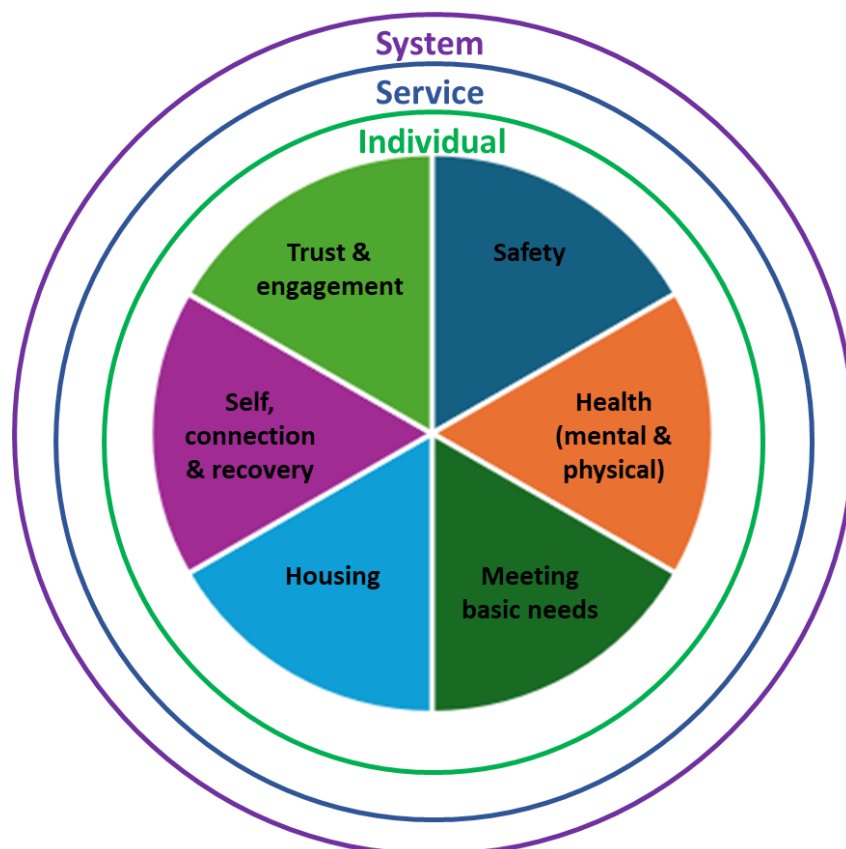
<sup>4</sup> <https://www.changingfuturesbristol.co.uk/what-is-mtam>

At the outset, having reviewed the national CF evaluation Baseline Report and following a familiarisation visit to the MDT service, it was agreed that a Theory of Change (ToC) developed specifically for the MDT was required. This would be used for the pilot but also to test assumptions underlying the Brighton & Hove Health & Care Partnership MCN transformation programme/ integrated community team model<sup>5</sup>.

Evaluators developed a series of outcomes based on learning to date and workshopped these with members of the operational team and strategic leads to develop the ToC. A high-level overview of this was presented to the Oversight Board for further feedback. The ToC design borrowed from the national CF evaluation ToC by using the individual, service and system level focus with measures drawn to correspond with the findings from the CF MDT Thematic Review undertaken by the MCN Steering Group<sup>6</sup>, MCN needs assessment<sup>7</sup> and local strategic planning.

In this report, findings from the evaluation regarding the outcomes, critical success factors and learning from the Changing Futures Multi-Disciplinary Team (CF MDT) pilot evaluation are presented under the following six domains of change identified in the Theory of Change.

Figure 1 - Domains of change identified in the Theory of Change



<sup>5</sup> <https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2024/11/2.3-Integrated-Community-Teams-core-offer-and-implementation.pdf>

<sup>6</sup> Brighton & Hove Changing Futures Multidisciplinary Team Thematic Review, November 2023 (internal)

<sup>7</sup> <https://www.brighton-hove.gov.uk/sites/default/files/2023-04/Adults%20with%20MCN%20Final.pdf>

Evaluation findings are based on engagement with the MDT team and external multi-agency professionals; including through thematic case reviews exploring the interface with Housing, the MARAC, co-occurring conditions and urgent care; with a focus on safeguarding within these. A total of 28 professionals working outside of the MDT were involved in focus groups and/or individual discussions to inform the evaluation. Evaluators conducted secondary analysis of CF return and Eclipse data, and detailed 'swim lane' case studies produced by CF.

#### **1.4. Common Ambition and the Peer Support Team as evaluation partners**

IBA worked in partnership with [Common Ambition](#), a city-wide partnership project which uses co-production to put people with lived experience of homelessness at the heart of improvements to Brighton's homeless health system. Common Ambition and the CF MDT peer support team worked together to plan the collection of 'stories of change' as part of the Most Significant Change<sup>8</sup> methodology which IBA has used extensively in evaluation.

The MDT peer support team collected 'stories of change' told by 4 clients and 7 workers, which were reviewed by Common Ambition, who reflected on what *they* felt was the most significant learning from the stories. These reflections were fed back to IBA in short 'panel' reports. Final reflection sessions were held between Common Ambition, IBA and the Peer Support Team, both to draw out the overall key messages from this strand of the evaluation, and to reflect on the learning from the process.

There are many logistical and ethical challenges in trying to involve people with MCN meaningfully in evaluations and this approach did not necessarily overcome these issues. The Peer Support Workers found that clients often would not have the capacity to sit down and answer questions; some were guarded or said only what they thought people wanted to hear; others do not have the capacity to fully understand what the MDT is offering them or how it fits into the wider system. This meant that it was very difficult to gather unbiased feedback from a truly representative sample of clients within the timescales. Although at the outset they had tried to select people randomly, there were then too many other things to line up before they could interview people. It was however, a positive that the peer support workers were able to carry out these interviews since there is already an established relationship of trust. The peer support team found it difficult to fit this work in around their existing responsibilities, especially given the part-time nature of their roles. A key message is that, for this to be meaningful and to tease out what people want to say, it takes time and space.

Despite these limitations, the peer support team felt that this had overall been a positive experience for them and for some of the people they interviewed. One 'story-teller' in particular was at the right place in their recovery and seemed to really benefit from taking part. They felt heard and this boosted their self-esteem; they are now ready to start delivering some training themselves and this process was an important part of that journey. The team also felt it was useful to capture staff stories alongside those of clients.

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<sup>8</sup> See IBA's microsite SERA for further details: <https://www.seralliance.org>

Similarly, Common Ambition felt the overall approach worked well, despite these challenges. The group have developed their confidence in analysing information and are keen to continue this. At the end of the process, they reflected that it would have been good to hear more about the challenges, to have asked different questions of workers and clients, and not to have attempted the random selection of clients to participate at the outset, since this put more pressure on the peer support workers.

Both partners recommended that to embed lived experience voices in future evaluations, it would be good to explore opportunities for longer term, ongoing feedback, perhaps carried out by an independent body, which can offer capacity to reach more people.

## 2. Description of the MDT pilot

Changing Futures Brighton & Hove is a multi-disciplinary team (MDT) based within Brighton & Hove's City Council Adult Social Care Directorate. The objective of the MDT initiative is to provide a holistic 'wrap around' service for clients facing multiple disadvantages in the local authority area with the aim of reducing health inequalities, particularly around life expectancy. The CF MDT went live in December 2022 and was fully operational by Summer of 2023.

### 2.1. Resources

In addition to the CF national grant, the MDT pilot is part funded by Brighton & Hove national grant as a part of the city's MCN Transformation Programme. At the evaluation outset, CF grant funding was due to end in November 2024, and the hope was that the pilot would eventually transition to an Integrated Community Team model using NHS Sussex Better Care Fund investment and additional national grant awards to Brighton & Hove City Council from MHCLG. CF extension funding for 2025 -2026 was awarded at the end of the evaluation period providing the opportunity to further the ambition of the MCN Transformation Programme using learning from the pilot and evidence from the evaluation.

The MDT is supported by the Changing Futures Programme Team and reports to the MCN Board and Steering Group. The MDT includes the following posts, which are either seconded and funded by CF or directly funded by BHCC:

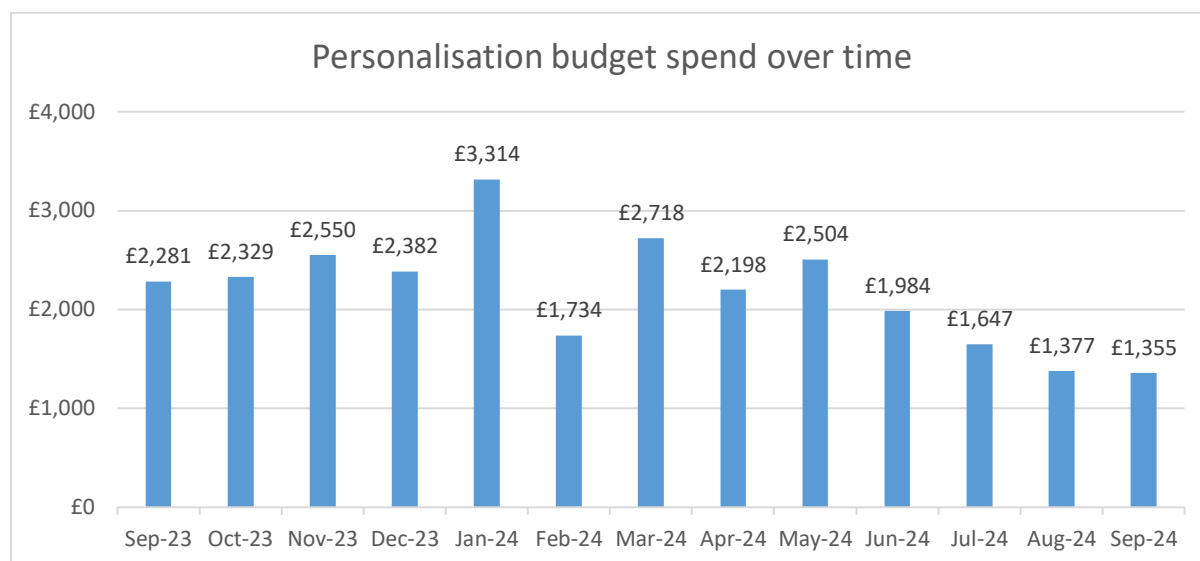
- Operations manager (CF funded and seconded from BHCC Health & Housing)
- Social Workers (two out of seven roles funded by CF with the remaining seconded from BHCC Housing & Health)
- A community Support Worker (CF funded and seconded from JustLife)
- Homeless Prevention Officers (one of two CF funded and seconded / BHCC Housing)
- A Substance Misuse Recovery Worker (CF funded and seconded by Change Grow Live (CGL))
- A Domestic Violence and Abuse Worker (initially through RISE, funded by New Burdens Domestic Abuse funding from BHCC, but then latterly CF funded and employed by JustLife).
- A Mental Health Worker / Clinical Nurse Specialist (CF funded and seconded from Sussex Partnership NHS Foundation Trust (SPFT)), and
- Peer Support Workers (CF funded and seconded by CGL).

The pilot has seen some staff turnover: the Clinical Nurse Specialist left the team relatively early in the evaluation and the post was not filled during the evaluation. Both homeless prevention officer posts became vacant and were recruited in the final stages of the evaluation.

The MDT and its clients benefit from a Personalisation Budget - a separate fund within Sussex CF, set aside to support individual clients flexibly (but within a clear process) to overcome barriers, improve engagement and achieve their goals.

At the end of Quarter 2, 2025, the total personalisation budget spend was £28.4k. This was spread across 17 caseworkers, 339 vendors and benefitted a total of 102 clients. The spend over time is shown below:

Figure 2 - Graph to show personalisation budget monthly spend over time



Details of how this budget has been spent are presented and discussed in section 4.4: Meeting basic needs.

## 2.2. Ways of working

Key aspects of the CF MDT approach include:

- **Allocated keyworker, supported by multiple workers:** each client has a nominated worker, who leads the relationship-building and draws on their own specialism, which is felt to be particularly relevant to the client. However, most clients have at least 2 allocated MDT workers, some as many as 4. This reflects the clients' needs for input from different specialisms but also creates a mini team around the individual, who can support each other and provide cover.
- **Small caseloads:** to enable a person-centred and flexible approach. Typically, each worker has between 4 and 7 on their caseload, to a maximum of 10.
- **Co-location:** the team are co-located in Bartholomew House in central Brighton, and MDT members are not allowed to work from home more than one day a week. This maximises informal interaction between members of the team outside of formal MDT meetings. Each day begins and ends with a 'check-in' and 'check-out' in which those team members present in the office share plans and updates.
- **Assertive outreach:** MDT workers meet with clients outside of Bartholomew House, visiting clients in their accommodation, finding them on the streets via outreach, or meeting them in cafes or community facilities. This is supported by a lone worker

policy and procedure, with the use of a team WhatsApp group as a reliable lone working 'device', and robust risk assessments.

- **Peer support team:** 4 peer support workers each work 2 days per week, overseen by a Team Leader. Typically, they hold a collective caseload of around 13 clients. The peer support workers provide a range of person-led support, including attending health appointments, recovery/ community support groups, and providing advice and training from lived experience perspectives to the rest of the MDT staff team.
- **Regular team meetings:** a weekly formal MDT team meeting in which new referrals and challenges in current cases are discussed, along with staff wellbeing and support. This meeting is also opened up to other Adult Social Care teams for discussion of complex cases. The MDT also has daily group check-ins and check-outs.
- **Regular 1-1 supervision** for each MDT worker: there has also been exploration of the idea of group supervision, but this does not appear to have been implemented during the evaluation period, due to capacity constraints.
- **Recording:** the Adult Social Care Case Note system (Eclipse) is the primary case management system for MDT clients, though members of the MDT also access and record on their 'home' agency's system (where different, e.g. Housing and Healthcare). Plans are in place to implement the *Plexus Care Record*<sup>9</sup> which would enable secure information sharing across health and social care locally both to support case management and evaluation; however, this did not happen during the evaluation period. The MDT has received training and audits on trauma-informed recording.
- **Duty system:** staff and senior managers operate a duty rota to ensure that visits and meetings are covered where the regular keyworker is on leave, triage any nominations, and take responsibility for the MDT WhatsApp group and Teams channel.
- **Location within new Housing, Care and Wellbeing Directorate:** over the course of the evaluation and following a re-structure, the council's housing department has merged into a single directorate with adult services and public health.
- **My team Around Me**<sup>10</sup> adopted as a Model of practice.
- **Staff training** – an extensive and ongoing training offer for members of the MDT

### 2.3. Referrals

Peak referrals took place in December 2022 and accounted for over a third of the total (36%). January 2023 (15%), April 2023 (10%) and January 2024 (14%) also had notable numbers of referrals. At the outset of the pilot, the key partners in the MDT came together to identify the original cohort of clients, based on people accessing existing services, especially where there was statutory work (e.g. Care Act Assessment) outstanding. With hindsight, many of this original cohort had insufficiently complex needs, compared to those whom the service has subsequently supported. As some of these cases were closed, the service was able to open up to wider nominations and was 'inundated with referrals'. The

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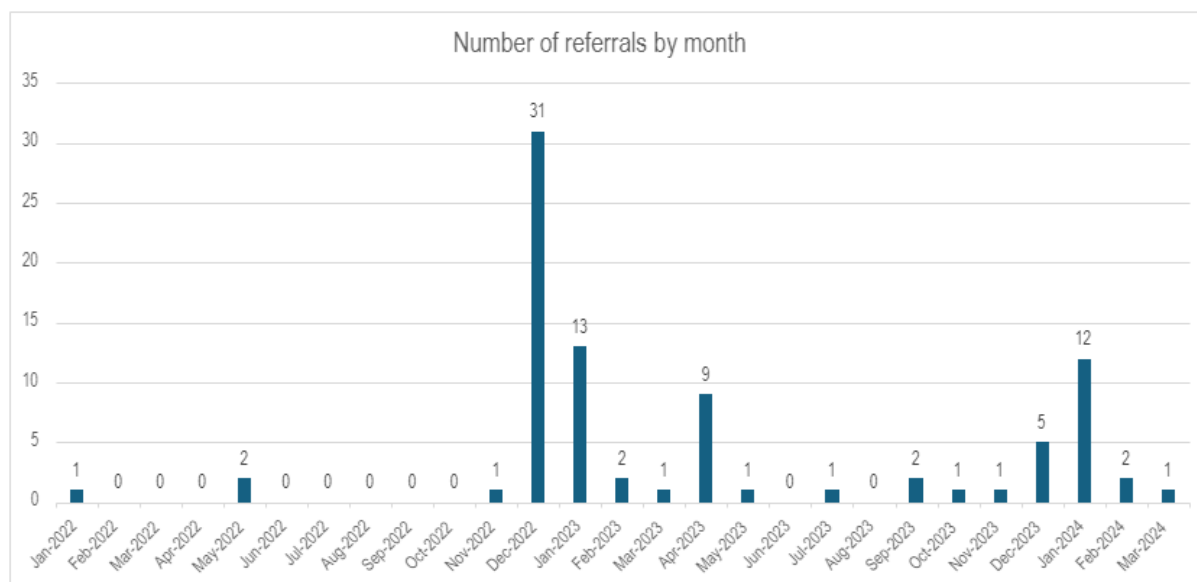
<sup>9</sup> <https://www.sussex.ics.nhs.uk/our-work/our-priorities/digital/plexus-care-record/>

<sup>10</sup> Described above, or in CF Bristol's video: <https://www.changingfuturesbristol.co.uk/my-team-around-me>

MDT continues to receive nominations from other services. These are triaged by the Operational Manager and assessed to check whether they meet the required three out of five needs for the service (as per the CF definition in section 1.1).

The number of referrals over time is shown in the graph below.

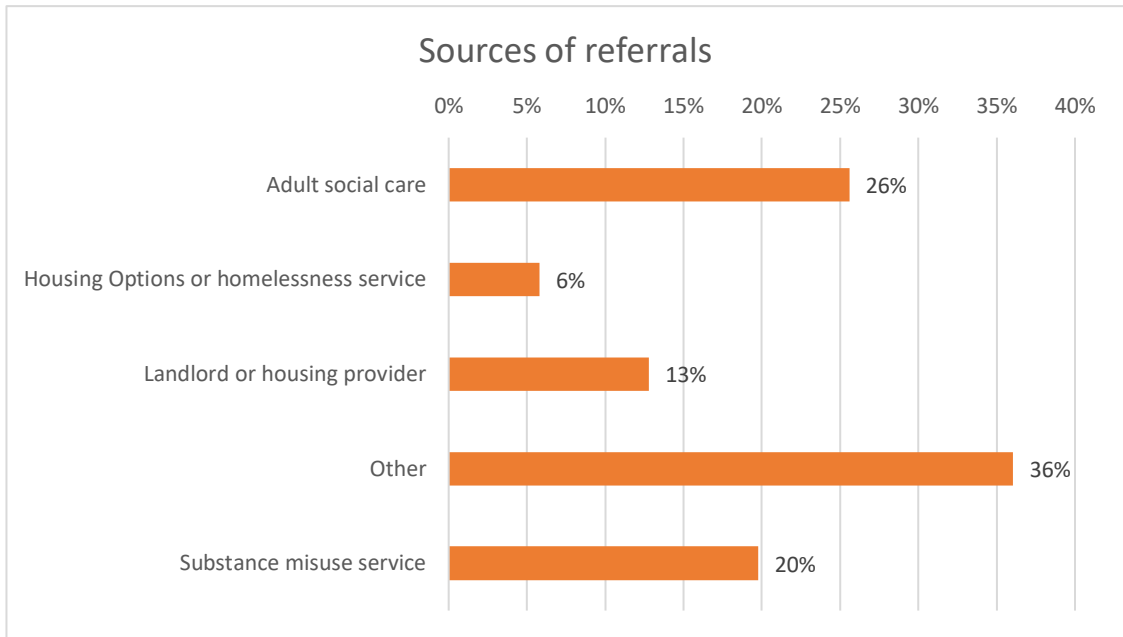
Figure 3 - Graph to show referrals to MDT by month



The graph below shows sources of referrals to the service<sup>11</sup>. As can be seen below, there were two significant sources of referrals – adult social care (26%) and substance misuse services (20%), together accounting for nearly half of referrals. Landlord or housing providers were also a notable source of referrals, accounting for 13% of the total. The range of referring agencies is indicated by the fact that 30% of referrals came from a wide range of agencies, each referring one or two people. These included supported housing providers, outreach, CVS organisations and prisons, police and Victim Support.

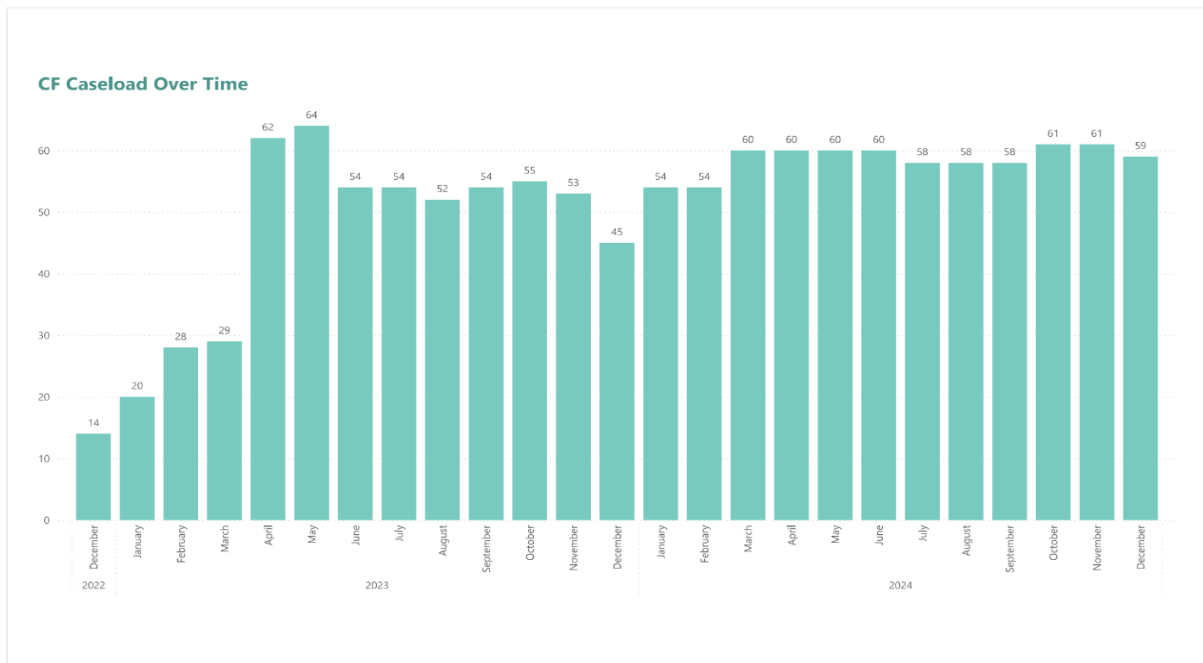
<sup>11</sup> This data was drawn from the Individual Outcomes Reports from quarters ending Feb 23 to Aug 24: referral information was provided for 86 CF client IDs.

Figure 4 - Graph to show sources of referrals to MDT



The graph below shows the total numbers supported in the CF MDT caseload between December 2022 and December 2024.

Figure 5 - Graph to show MDT caseload over time



Source: B&H caseload over time

The maximum number supported across the period was 64, the minimum 14. The average numbers supported across the 25 months was 51, the mode 54. The MDT social workers

also work with 8 RSI Navigator clients at any given time – this is described in more detail in Section 4.5 on Housing.

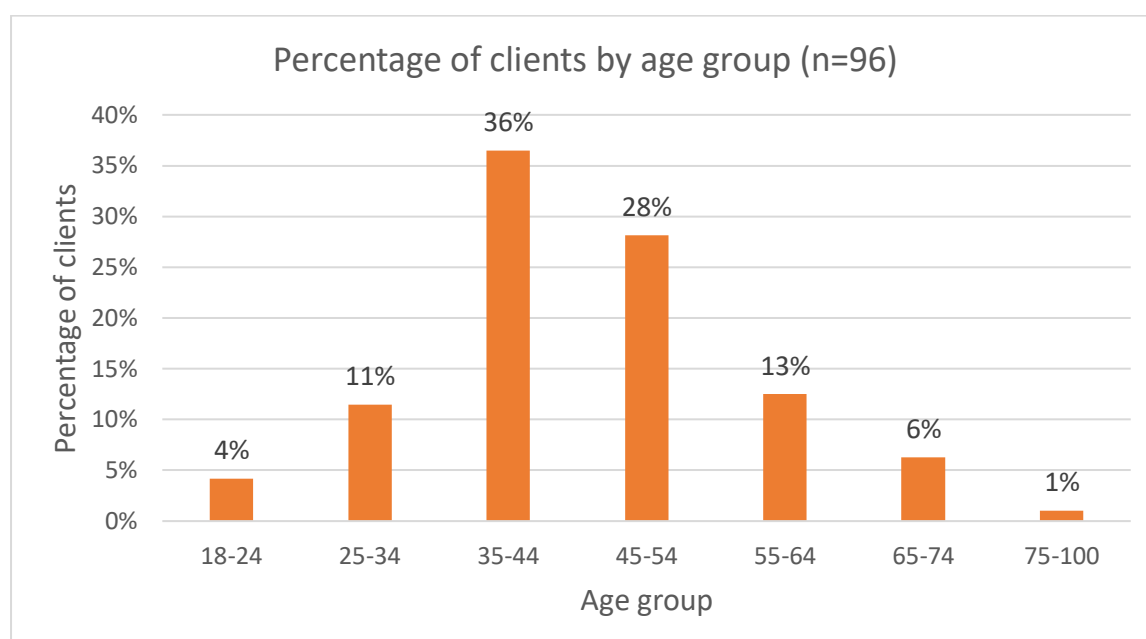
## 2.4. Profile of CF MDT clients

### Demographics

#### Age

Client age groups range from 18-24 to 75-100. Those aged 35-44 are the largest group of clients, comprising 36% of the total, with those aged between 35 and 54 making up almost two thirds (65%) of all clients. A full breakdown can be seen in the graph below.

Figure 6 - Graph to show percentage of clients by age group



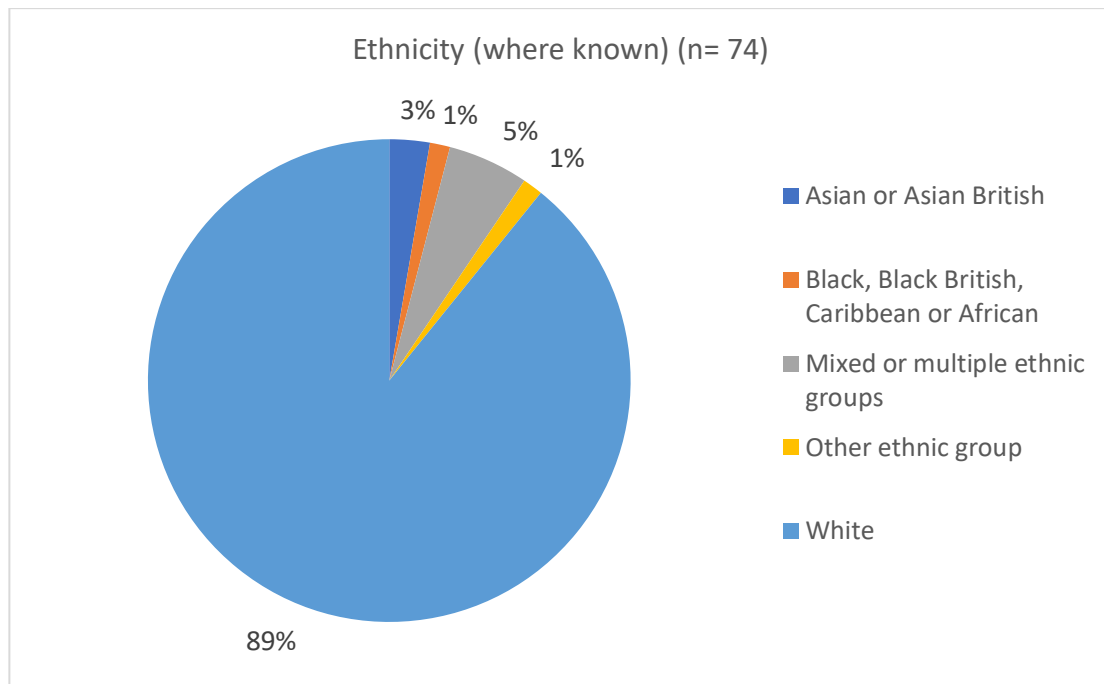
#### Gender

Males comprised the largest group of clients at almost two thirds (63%) (n=96) of the total. Female clients accounted for 36% and non-binary for 1% of total clients.

#### Ethnicity

Ethnicity data was provided for 76% of the client group. Of these, the vast majority were White, accounting for 89% of clients (69% of all clients). The pie chart below shows the breakdown of known client ethnicities.

Figure 7 - Pie chart to show ethnicity of clients



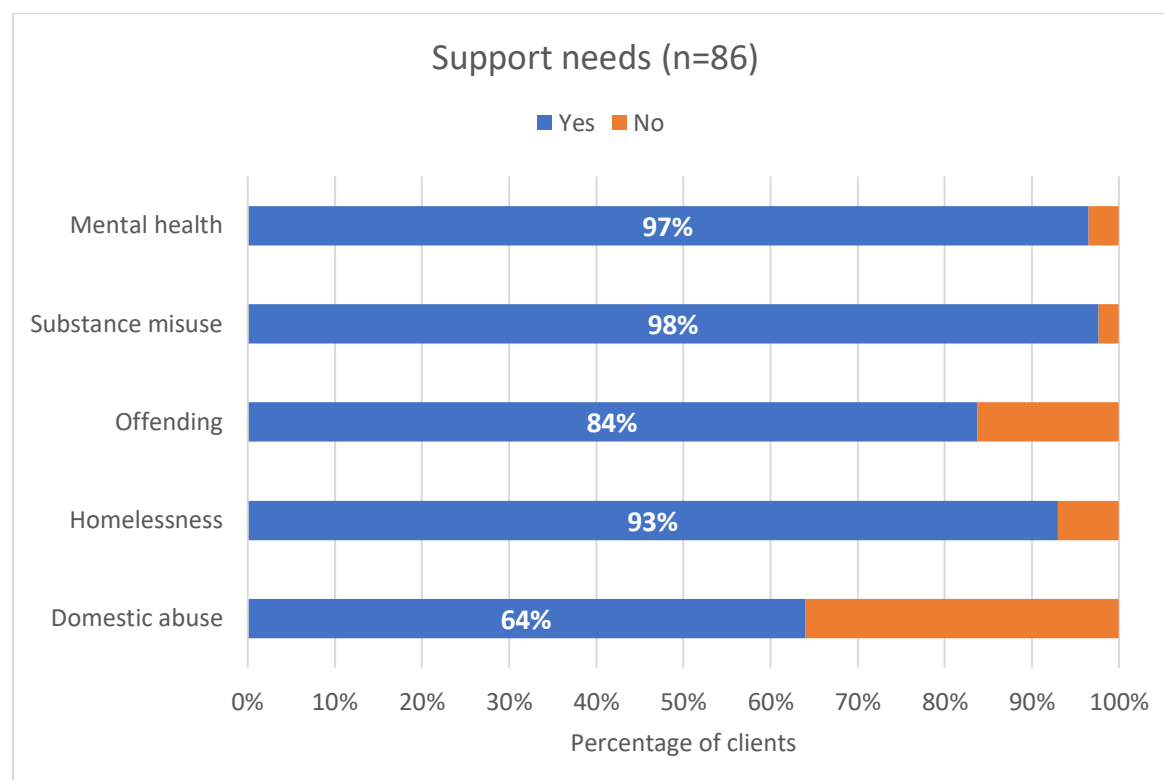
### Presenting needs

Support needs for clients referred to the programme were noted under the following categories, in accordance with the Changing Futures definition and the MDT's referral criteria:

- Domestic abuse
- Homelessness
- Offending
- Substance misuse
- Mental health

Looking at individual outcomes data for 86 clients, we can see that the most prevalent of these is substance misuse, noted for 98% of clients, closely followed by mental health. The percentage of clients referred in each of the categories is shown in the graph below:

Figure 8 - Graph to show support needs of clients



All clients presented with a minimum of 3 of the MCN support needs and almost half of the group had 5 needs.

Full data is shown in the table below:

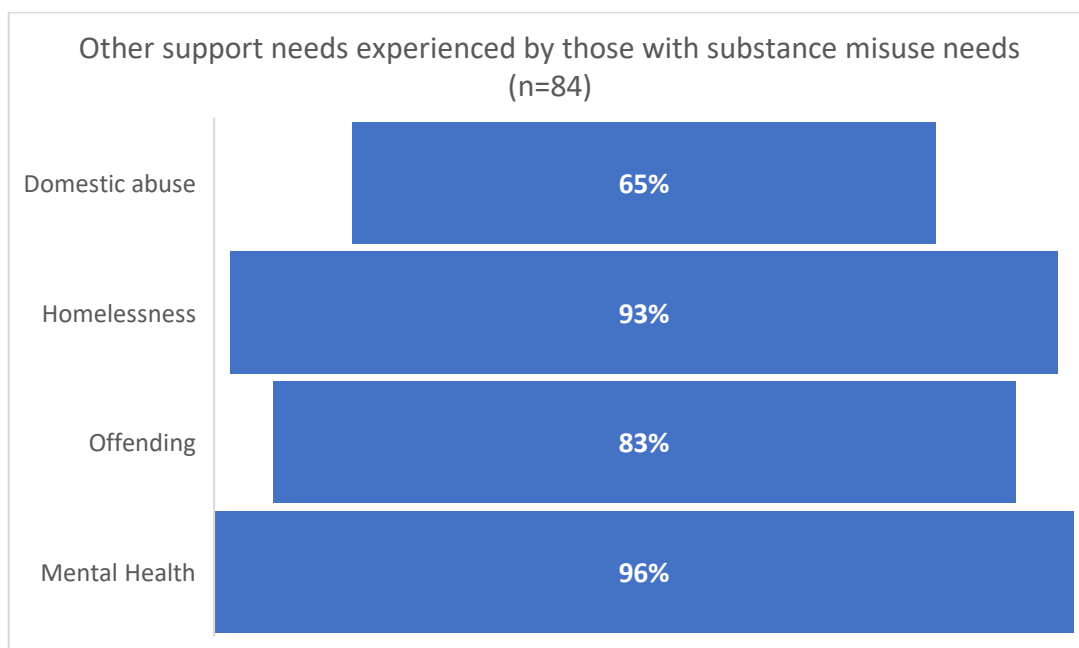
Table 1 - Percentage of clients by number of support needs

	Number of support needs				
	1	2	3	4	5
<b>% of clients</b>	0%	0%	12%	42%	47%

**Substance misuse**

With substance misuse being the most prevalent support need overall, we looked at what other support needs those with substance misuse needs were experiencing. As can be seen from the below, mental health was the most common support need also experienced by those with substance misuse needs, closely followed by homelessness.

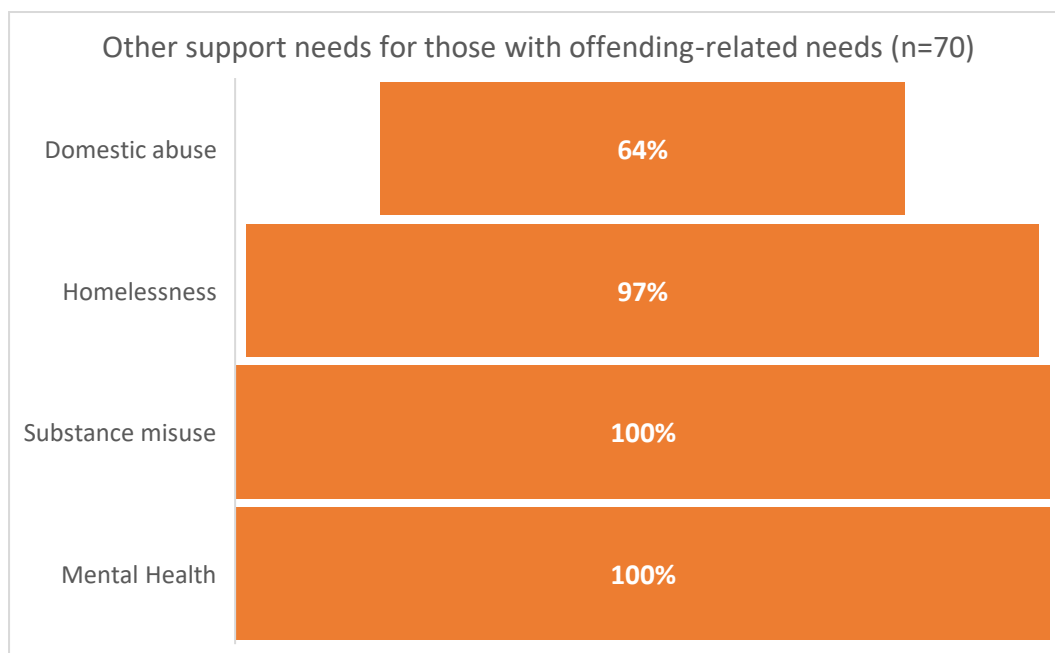
Figure 9 - Graph to show other support needs experienced by those with substance misuses needs



**Offending**

For those clients with support needs linked to offending at referral, co-occurring support needs are shown below. As can be seen from the graph, 100% of those with offending-related needs also had support needs related to both substance misuse and mental health.

Figure 10 - Graph to show other support needs experienced by those with offending-related needs



***Cross reference referral issues***

Below is a table which cross references the presenting support needs on referral for CF MDT clients, as a percentage of the whole client group (n=86). As we can see from the below, the biggest incidence amongst the client group is for those experiencing both substance misuse and mental health, representing 94% of clients.

*Table 2 - Cross reference of presenting support needs on referral*

	<b>Domestic Abuse</b>	<b>Homelessness</b>	<b>Offending</b>	<b>Substance misuse</b>	<b>Mental health</b>
<b>Domestic Abuse</b>	64%	57%	52%	64%	62%
<b>Homelessness</b>	57%	93%	79%	91%	90%
<b>Offending</b>	52%	79%	84%	81%	81%
<b>Substance misuse</b>	64%	91%	81%	98%	94%
<b>Mental health</b>	62%	90%	81%	94%	97%

## **2.5. Monitoring**

Data collection and monitoring is coordinated by a CF Sussex Project Delivery Officer and the Brighton & Hove MDT pilot operational manager. CF data returns are provided to MHCLG (formerly DLUHC) and include data on staffing, caseload detail, demographic information, multi-disciplinary need and multi-disciplinary team work including assessment, safeguarding and progress, MARAC presentations, referrals and housing applications. These are collated across the following CF returns:

- Quarterly Individual Outcomes Return
- Quarterly Outcomes Questionnaires
- Historical Outcomes Questionnaire (not completed during the evaluation)
- New Directions Team Assessment (NDTA snapshot)
- Multiple Needs Audit
- Provider Contract Monitoring
- ReQol (Recovering Quality of Life) Collection – was added from May 2024

The CF Delivery Officer and CF Systems Change Lead developed available data using ‘swim lane’ methodology to map selected client journeys and used system-based multipliers to assess system level cost effectiveness for the CF programme and to inform continuation

post CF funding. The swim lane approach is described in more detail in a CF Sussex methods paper<sup>12</sup>.

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<sup>12</sup> Changing Futures Programme Sussex: Swim Lanes Concept – Project Framework, available: [https://www.changingfuturesussex.org/files/ugd/159251\\_18bee475b7ec4054a04e09c8b55cf48f.pdf](https://www.changingfuturesussex.org/files/ugd/159251_18bee475b7ec4054a04e09c8b55cf48f.pdf)

### 3. Learning from implementation

In this section we explore the learning from several lines of enquiry - a key element being findings from the Most Significant Change activity conducted with the MDT lived experience team, in which stories of change were reviewed by lived experience partner, Common Ambition. These findings are triangulated with evaluators' analyses of operational documents, policies and systems, case studies, interviews with staff and managers, and monitoring reports. In addition to this, evaluators were able to make use of the internal thematic review findings of the service conducted in the early stages of the pilot.

The CF MDT pilot was fully operational around six months after going live in the Winter of 2022. Within that first year, the MCN Steering Group undertook the internal thematic review to:

- Check how well the new multidisciplinary team has bedded in.
- Review how the team works and its focus within the wider MCN system.
- Identify early learning around system challenges and how we can test solutions through the team.
- Support the work to finalise a MCN System Compact Agreement and individual partner MOUs.
- Provide a strong foundation for the external evaluation<sup>13</sup>.

The review reported progress and recommendations to the MCN Integration & Oversight Board informing the next stages of the pilot and the evaluation. Key themes were:

- Less involvement with the pilot from Criminal Justice and Domestic Abuse systems.
- A lack of support for some MDT workers from employing organisations.
- Lack of access to specialist accommodation and mainstream housing.
- The ongoing need to improve access to specialist healthcare and hospital discharge pathways for those with MCN.
- A need to establish a Compact Agreement between the partner organisations.
- An appetite to mainstream continuation funding through long-term investment by local system partners.
- Positive impact on coordination of care, management of complex cases and safeguarding.
- A lack of clarity around role responsibilities, processes and working practices.

The final two bullet points above are mainly addressed by the process learning of the pilot as discussed below, though system challenges remain:

#### ***Compact Agreement***

Key recommendations from the review are largely contingent on the agreement of system partners via the Compact Agreement. The Agreement will ensure effective integrated working during and post CF funding to enable the transition to the Integrated Community

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<sup>13</sup> Brighton & Hove Changing Futures Multidisciplinary Team Thematic Review November 2023.

Team model. At the time of writing, the Compact Agreement was unsigned and in draft form with plans to iterate and finalise alongside the present external evaluation report. In terms of process learning towards this, evaluators found evidence that significant improvements had been made around roles, responsibilities, processes and working practices and including support for the CF MDT workers, though there was still learning to implement and work to do.

### **Duty Process**

The operational team developed a clear and concise Duty Process document highlighting key operational steps to provide continuity and consistency in duty cover and recording practices in following up with nominations. These processes were monitored for compliance and constructive feedback was given where process improvements needed to be made. Positive impacts of the Duty Process are:

- That caseloads are kept under review and where the MDT declines nominations, it makes recommendations for support from other agencies. Declined nominations are then tracked and revisited when capacity allows.
- There is consistent communication between referrers and the team, which supports awareness raising around appropriate identification of MCN cohorts. For example, eligibility criteria require people to have 3 or more out of 5 eligible needs<sup>14</sup> in order access the service. Narrative on all triage decisions is also recorded consistently, including reasons for refusal.
- Relevant key workers are appointed at the time of triage, which includes a lead worker with specialism around qualifying needs in line with the adopted My team Around Me model of Practice (see s. 2.2)

### **Nominations and referrals**

Common Ambition identified a recommendation around signposting to more appropriate support options for nominations not meeting eligibility criteria. The aim of this being to address 'over' support where the '*support threshold is too low*' (CA) but where the nominee is, nevertheless, still in need of support. The CF MDT service has confirmed that this is their standard practice with declined nominations.

Limitations to the caseload capacity is a theme. Striking the right balance in terms of nominations and referrals has been mitigated to some extent by case review exercises, but efforts to increase capacity have been hampered by challenges around the turnover of team members. Early contract monitoring reports state the plan to embed a model of co-working with locality teams to broaden access to Social Workers and thereby bring new nominations forward. The case review in January 2024 allowed the team to close 13 cases and accept 26 new ones (19 keyworker and 7 navigator cases), yet despite this the team was still close to full capacity:

*“social work capacity still remaining as a limiting factor and the increased need for clients to have more than one worker due to the nature of their*

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<sup>14</sup> Substance Use, Domestic Abuse, Homelessness, Mental Health Needs, Criminal Justice System

*needs. This is likely to have had an impact on nominations received via HASC as teams will be aware of the limited SW capacity” (Operations)*

At the time of reporting, the implementation of co-working with locality teams has not developed due to competing priorities placed on relevant staff time. If sufficient resource is not focused towards developing co-working with locality teams, it may pose a risk post CF funding in transforming to the ICT model.

### **Supervision and staff wellbeing**

There is strong evidence to suggest the team work well together and are highly supported in their roles, with regular supervision, daily check-ins and check-outs, and ongoing opportunities to check and reflect resulting from co-location. Nevertheless, there was evidence of competing priorities impacting progress. Efforts to develop a group supervision model via shared practice opportunities with colleagues in Children’s services who use the model, have not yet materialised. Again, this may be a missed opportunity under CF funding conditions to facilitate development cost before transforming to the ICT model.

There are, however, positive efforts towards staff wellbeing evident in the Council wide initiative *BH Healthy Lifestyles* but also in the inclusion of ‘wellbeing hour/ time’ with the MDT team, showing recognition around the demands of the staff roles. One staff member leaving for their own reasons stated that they could not have expected more in terms of support from the staff team.

The Peer Worker team sits within the main MDT and receives an additional layer of support provided by the peer support team leader. There is a strong emphasis on fostering wellbeing within a positive, yet pragmatic, working environment, namely to ‘*cultivate a way of working to combat vicarious trauma and the safe management of triggers*’ (Team Leader). The team has access to support forums including a lived experience network meeting and peer support community of practice - both available on a rota basis - plus access to monthly reflective practice sessions. Team leader support covers supervision on a 4-weekly basis with a focus on matters affecting the teams’ work both in and outside of the role; this externality being an important inclusion expressed by the Peer Worker team themselves.

The whole team is invited, indeed encouraged, to debrief following client contact. This aims to ensure team members are not holding onto aspects of their work which may affect their wellbeing. Time is allocated for ‘pause’ sessions to further debrief and connect with colleagues to share learning and experience. Team and group supervision is regularly provided but is often ad hoc as required/requested. Mindfulness as a ‘trauma-informed grounding exercise’ (Team Leader) during debrief, offers techniques to decompress. Full working pattern flexibility provides agency to maintain personal commitments and recovery, as well as creating opportunities for supporting service users flexibly.

Staff wellbeing is perhaps further evidenced by good staff attendance. Per the most recent contract monitoring reports (Q4 2023/24 to Q2 2024/25), average caseworker sickness absence varied between 0 and 1.4 days per quarter. Annual absence is therefore likely to be lower than that reported by [The state of the adult social care sector and workforce in](#)

[England](#) which suggests 5.3 days per annum as the average number of sickness days for CQC non-residential care workers across England and 5 days per annum across all roles, sectors and services for 2023/24. Peer support worker attendance rates vary between 91-97%.

### **Ways of working**

A key element to the way of working is the Multi-disciplinary Team Meeting. The meeting is scheduled weekly for two hours with the Terms of Reference clearly describing the purpose, membership and agenda. The MDT meeting functions well to support members in terms of sharing their experiences in addition to a daily 'check in and out'. The meeting provides an opportunity for workers to develop their practice through shared learning/ knowledge exchange, which is a recurring theme across all strands of the evaluation, and this was cited as an effective way of working:

*"Most of our clients have multiple workers, so if they have a social worker or a homeless prevention officer or a peer support worker, we are all together sat in the same area so I can ask questions of my peers instantly which cuts out a lot of the chasing that we have to do otherwise, emails ringing people. So being able to problem solve and be solutions focused in the MDT"* (Interview with staff member 'A')

A recommendation coming out of the lived experience review is that *'we should do this way of working more – it works'*(CA) with most workers expressing that their way of working has changed. It is also perhaps important to recognise the legacy workforce development outcomes implicit within this: *'workers can take this into their future roles'* (CA). The ability to share information and resolve issues or concerns in the moment by definition of being in the same room and/or as a wider team from different parts of the system is highly effective and flows through to client level: *'the client only needs one facing point of contact whilst being connected with a wider whole team'* (CA) (this detail is also picked up in the section on holistic care below). Workers are also more aware of their role within the broader system of compared to previous siloed working, and this promotes a sense of connection.

### **Professional development**

There is strong emphasis and commitment to continuing professional development within the CF MDT, and while there is exceptional opportunity within this, there is a balance to be struck. Evaluators identified the recurring theme of competing priorities consistent within this, particularly for the Peer Worker team.

*"Through invitation/involvement in a range of different initiatives, forums, opportunities across the Changing Futures programme the team have expressed confusion/overload [...]. the focus as a team always sharply returns to the operational work with clients. This brings challenges in managing time, prioritising workload [...] The result is a number of unfinished pieces of work that can lose momentum and detract from skills and relational development within the role itself."* (Team leader)

Notwithstanding this observation, training opportunities are of great merit. The Peer Worker team were able to take advantage of or contribute to:

- Reflective practice facilitator training
- A large suite of training on substance use and recovery, including clinical interventions training
- Health Education England training grants were awarded to two peer workers - one for Transactional Analysis and another for Counselling Skills
- Co-produced in house training – workshops which are reflected upon to help determine the next workshop e.g., workshop one: ‘The Risk of Recovery’ and workshop two experience, strength and hope (beginning, middle and end of a recovery journey).

For the whole CF MDT team, a suite of activity / forums and meetings which included training and development opportunities which were cited positively:

*“Worth taking time out of a busy schedule for”*(MH training feedback)

*“This was excellent experience in terms of developing leadership skills and learning more about how the political impacts the front-line work”*  
(Tri-sector Challenge feedback)

Other mention of specific training include:

- Personal safety and de-escalation techniques training
- Suicide Awareness Training
- Reflective practice sessions/ facilitator training

Meetings and forums created potential opportunities for development and knowledge exchange though it is not clear whether trauma informed (TI) training is part of this, though the ethos of TI is consistent and implicit throughout the CF MDT approach.

#### Quarter one:

Meeting/Forum	How often
CGL MDT Meeting	Weekly (2 hours)
MAHHM (Arch)	Bi-weekly (2 hours)
Cuckooing MDT	Monthly (3 hours)
Lived Experience Network	Monthly (2 hours)
CGL Drug and Alcohol Working Group	Monthly (1.5 hours)
Peer Support Principled Ways of Working	Monthly (2 hours)
Out of Area Rehab Panel	Bi-weekly (1 hour)
Supported Accommodation Panel	Monthly (2 hours)
Rough Sleeping Initiative Team Meeting	Monthly (2 hours)
HASC Customer Experience Steering Group	Bi-monthly (2 hours)
Navigator MDT	Bi-weekly (1.5 hours)

**By Quarter two (additional to above)**

Meeting/Forum	How often
MARM triage	Bi-weekly
Hoarding Policy Task and Finish Group	Monthly (2 hours)

**Quarter three in addition to Quarter one**

Meeting/Forum	How often
Oasis Forum – Women who have had children removed	Monthly (1.5 hours)
MH Forum – challenges and opportunities	Monthly (1 hour)
MCN steering group	Quarterly ( 2 hours)

Development of the CF MDT way of working illustrates strong opportunities for collaboration and upskilling almost as a byproduct of working in a multi-disciplinary team perhaps creating greater opportunity for innovation in real time:

*“Working in a team with people at the peak of their career in terms with working with complex cases, it’s been invaluable to gain insight into how to work with people who experience complex needs from the different avenues of practice” (Interview with staff ‘A’)*

**Holistic Care**

The essence of the CF MDT is holistic care, particularly in the development of the My Team Around Me (MTAM) model of practice (s. 2.2). Process learning includes an acute awareness of the additional elements required to support MCN cohorts. There is strong emphasis on relationship building to enable wraparound support by drawing on specialisms within the team rooted in practice which avoids retraumatizing service users. The inclusion of Peer Workers within the CF MDT is crucial to maintaining relationships and trust building with service users. However, where this encounters statutory processes beyond the control of the team, this potentially puts these efforts at risk. System barriers identified through our engagement with rough sleeper teams, highlight the potential risk around undermining relationships due to delays in statutory processing in accessing appropriate accommodation options. This corroborates a staff member observation about how statutory process can hamper efforts to manage continuity for clients:

*“I’ve been surprised by how much the statutory work that they have to go through, that everything has a process, that has surprised me, also the processes within housing. I wasn’t aware of how desperate and how difficult it is – how much of that process is very unstable, hit and miss and that’s made me feel upset for the clients.” (Staff interview)*

There is some tolerance within the model to cushion the effect of this. For example, having one point of contact was cited by the MDT team as having a positive impact on services users’ physical and mental health. Having the same worker throughout the process was also cited as beneficial. Moreover, the team and service users are able to find assurance in the

specialist skills and resource, including information sharing, within the team which they can bring to bear on supporting their clients:

*“Different domains in the [service user’s] life – we then have a team that mirrors that. The team has multiple domains of knowledge and expertise [...] you just can’t hold all of that in one person [...] the team has to mirror the complexity, and the MDT help us to make sense of that complexity”*  
(Staff interview)

### **Safe working**

The wellbeing of workers is functionally validated by the operational tools available to the team to enable safe working practice. The evaluation identified excellent resources by definition of the CF funded programme. A lone working policy and process map was developed early in the pilot and continued to be iterated throughout. Final stages of iteration being reached in the fourth quarter of the evaluation period, perhaps indicating the recurring theme around delays due to capacity. Nevertheless, time investments in developing and testing these during the pilot will inevitably be carried forward as efficiencies in transforming to an ICT model and are therefore assets. The team encountered some technical difficulties in trialling lone working devices and used a workaround to solve this. Risk assessment forms and duty process are another example of excellent resource available to the team.

## 4. Impact

In this section, we present evaluation findings under the six outcome headings of our Theory of Change, considering individual, service and system level impacts.

### 4.1. Trust and engagement

It is clear from the case studies produced by the CF MDT that most clients have previously developed a deep mistrust of services, especially statutory agencies. Many have been excluded or barred from services, many feel let down by previous workers and some have experienced traumatic consequences (such as intensified domestic abuse, traumatic experiences in hostels or the removal of children into care) following engagement with services in the past. Some have told their stories repeatedly to different agencies yet feel they have received little help, some have made multiple complaints, some have avoided interaction with professionals altogether.

*“This client group are so much more distrusting than people I had worked with in recovery services previously – it can take months and months to build a relationship because you represent something that has been so traumatising.” (CF MDT worker)*

#### Individual level

Activities	Outputs	Outcomes	Impact	Measures: data source
<ul style="list-style-type: none"> <li>- Relational person-centred approach</li> <li>- Intensive joint working to build trust over time</li> <li>- Care coordination/ smooth transitions through care</li> <li>- Focus on meaningful (not superficial) engagement</li> </ul>	<ul style="list-style-type: none"> <li>- Increase in meaningful/relational engagement</li> <li>- Fewer instances of losing contact/ being lost in the system</li> <li>- Increase in number of interventions</li> </ul>	<p><b>Improved trust and relationships with services</b> where the individual feels safe to engage</p>	<p>Better overall outcomes for individuals based on receiving the right support in a timely manner</p>	<p><i>Eclipse/ Swim Lane data/ historical ‘bounces’ around the system</i></p>

Given this context, the trusting relationships which the CF MDT has been able to build with its clients should be viewed as a major achievement in their own right – not just a means to an end.

In some cases, a worker from outside of the CF MDT had been able to start this process prior to referring the client to CF, but had been significantly limited in this by time, flexibility and the narrow focus of their role. As one worker explained:

*“Before Changing Futures involvement [the client] would come in to see me and they talked about 30 different subjects and so I would end up having to pick it apart and work out what I need to focus on. But now, with [CF worker] supporting them I am freed to focus on the bit that I need to look at which is substance misuse.”*  
(CGL Drug Worker)

The team’s approach to building engagement is tailored to each person’s strengths, triggers, and preferences. This takes time, resource and creativity and might, for example, include:

- Building on any existing relationships with professionals which are working, so perhaps providing transport and companionship on the way to an appointment and a coffee to debrief on the way home
- ‘Gentle’ text messages to the person
- Being very clear about consent, information-sharing
- Working to the client’s initial priorities, and agreeing not to approach more challenging and sensitive topics until these have been addressed
- Using the personalisation budget to buy coffees and things that matter to the person
- Being able to attend the person’s accommodation and be flexible about timings; coming back another day if the person isn’t in the right frame of mind
- Consistency and persistence: one client expressed gratitude for having a consistent and trusted worker that does not make them ‘feel guilty’ when they feel unable to engage; another person responded well to regular visits at the same time/ day.
- Building in more social visits, perhaps with the peer support team, where the aim is simply to spend some time together.
- Staff being very mindful of not ‘dominating’ the sessions, but going at the client’s pace and giving them space to express themselves.
- For some, it has helped to have a physical list of person-led goals to tick off.

*“Forming meaningful relationships is the service”*  
(Common Ambition, lived experience partner, reflecting on stories from MDT pilot).

### Service level

Activities	Outputs	Outcomes	Impact	Measures: data source
- Assertive outreach - Educating ‘home’ agencies about trauma-informed approach	- Increase in completed assessments - Increase in successful referrals - Fewer missed appointments	<b>Improved engagement with services</b> leading to more appropriate and sustained engagement with services (Health, CJS,	Better overall outcomes for individuals accessing and receiving services	<i>Eclipse</i>

Activities	Outputs	Outcomes	Impact	Measures: data source
- Intensive joint working to build trust over time - Coordination of care/transitions through care	- Fewer short-term open/closed cases due to lack of engagement	ASC, Housing etc.) therefore, services function as intended.		

There are numerous examples of MDT clients being gradually supported to engage with health, substance use, DWP and other agencies as a result of this gradual approach – sometimes for the first time in years.

*“Before it felt very confused and very lonely, I felt like I was battling everything on my own. With Changing Futures, it doesn’t feel like a battle anymore, it’s made everything possible”. (CF MDT client)*

*“I’m really pleased that [CF support] helped me engage with the other services.” (CF MDT client)*

This eases some of pressure on other professionals outside of the MDT by reducing missed appointments, and by working as an intermediary, or better still a member of their own team who can provide assertive outreach. For example, one worker explained that, in their previous role as a mainstream Homelessness Prevention Officer:

*“You’d have a caseload of 60 people, but you might have 3 or 4 people who dominate most of your time, yet you are not able to achieve any real outcomes for them because you are fire-fighting and often getting harassed as you do..... now through CF MDT we have the time and resource to engage these people properly”. (CF MDT worker)*

As we have seen in the last section, resources from the CF programme have acted as key facilitators for being able to work in this way, including:

- Well-supervised peer support workers on the team, acting as role-models and connecting quickly with people; protecting these workers from service-led tasks.
- Pace: caseload allocation between the team small size which allows flexibility, intensity, regularity of support, and consistency

*“I often spend hours at a time with my clients”. (CF MDT worker)*

- Personalisation budget which can be used flexibly in ways that build trust.
- Trauma-informed training and skills, including from lived experience on the team.
- Being able to provide assertive outreach: meeting people for coffee, going to their accommodation, or to appointments with them.
- Having a holistic model – *“all the issues people face are linked; you can’t work on one without also tackling another”. (Common Ambition)*

- Not having a direct accommodation offer for people sleeping rough was felt by some to get in the way of engagement; we discuss this theme in more detail in Section 4.5 (Housing).

### System level

Activities	Outputs	Outcomes	Impact	Measures: data source
Joint working to facilitate 'no wrong front door'	Short-term increase in demand but longer-term decrease in unmet need	<b>Improved engagement with services</b> leading to more appropriate use of services/ services functioning as intended	Improved efficacy and efficiency of the system to better meet the needs of individuals	

Co-production has been a key feature of the MDT model and its evaluation – for example, the peer support team has influenced the trauma-informed model of practice and interviewed clients and colleagues for this evaluation, whilst Common Ambition co-produced the design of lived experience research and the evaluation findings. Common Ambition reflected that this helps to build trust in the system at many levels: they have been struck by the fact that they had recommended holistic case coordination several years ago and have been pleased to see it implemented. This begins to promote trust and engagement at different levels of the system.

*“Importance of the relationship: trust between client and worker, trust between workers, this helps to promote trust in the system”*

(Common Ambition, lived experience partner, reflecting on stories from MDT pilot.)

We discuss in more detail in Section 5 on *Exploring Effectiveness*, the impact which improved trust and engagement has had on CF MDT clients’ usage of wider services. For those who have been newly connected with services, there is a spike in service usage; however, even where this is the case, there is a strong argument that this represents more planned and effective use of services.

## 4.2. Safety and Safeguarding

### Introduction

People with MCN often face high levels of risk resulting from:

- Abuse, assault, and exploitation
- Accidents and injuries
- Overdose, self-harm and suicide.

For example, the Joint Strategic Needs Assessment on Multiple Complex Needs<sup>15</sup> presented local Office of National Statistics data on deaths resulting from one of more of homelessness, mental health and substance use in Brighton & Hove between 2006 and 2017. 108 individuals were identified who had died during this period due to two or more of these contributory factors; the risks were particularly high where substance use overlapped with either mental health or homelessness. Alcohol was a factor in 82% of these deaths; 26% were classified as suicides.

The Audit of Drug Deaths report<sup>16</sup> considered 138 deaths from drug overdose between 2020 and 2023 in Brighton & Hove, of which half were deemed to be accidental. The report highlights the high proportion of people with MCN amongst this group; for example, 83% had a diagnosed mental health condition, and 77% a serious physical health condition. Risk factors included Adverse Childhood Experiences (ACEs), previous self-harm/ suicide attempts, care experience, bereavement and other distressing life experiences – all of which feature frequently for people on the CF caseload. A quarter of those who died were involved in ongoing safeguarding processes.

In the remainder of this section, we consider the impact of the MDT pilot at individual, service and system levels, presenting extracts from the Theory of Change at the start of each, to structure our assessment of the evidence collected during the evaluation.

### Individual level

Activities	Outputs	Outcomes	Impact	Measures: data source
<ul style="list-style-type: none"> <li>-Taking time to build consistent relationships</li> <li>-Non-judgemental, trauma- and gender-informed approach</li> <li>- Understanding of mental capacity (including executive function)</li> <li>- Use of safeguarding processes to</li> </ul>	<ul style="list-style-type: none"> <li>- Increase in risk disclosure by individuals</li> <li>- Individuals engaged in safety planning</li> <li>- Women experiencing domestic abuse engaged in safety planning</li> <li>- Decreased risk to individuals</li> </ul>	<p><b>Improved safety</b> through risks being identified and better managed through safety planning, and provision of appropriate housing, care and support.</p>	<p>Better overall outcomes around feeling and being safer. Fewer injuries resulting from abuse/ assaults, preventable accidents, housing-related ill-health</p>	<p><i>Use self-reporting as well as safeguarding plans held on Eclipse. Moves to safer/ more supported accommodation .</i></p>

<sup>15</sup> Brighton & Hove Council (2023) Adults with Multiple Complex Needs in Brighton & Hove 2020 – full report, available to download from: <https://www.brighton-hove.gov.uk/adults-multiple-complex-needs-brighton-hove-2020-full-report>

<sup>16</sup> Brighton & Hove Council Public Health Team (2024) Audit of Drug Deaths 2024.

Activities	Outputs	Outcomes	Impact	Measures: data source
access resources and convene multi-agency input - Advocacy and support to access housing, support, healthcare, etc				

For individuals, the evaluation has identified examples of risks being reduced, including:

- Fewer accidents and incidents due to stabilisation on substitute and/or psychiatric medication
- Significantly reduced instances of self-harm and suicidal thoughts following engagement with the team
- Target hardening for and safety planning with women at risk of domestic abuse
- Supporting people into accommodation from the streets, or into safer accommodation than they were in previously, for example one individual was supported to move out of a temporary accommodation placement where the level of mould and damp presented a very serious risk to health.

*“It means I’m not sleeping rough; it means I’m not putting myself in danger by being outside anymore. It’s safety more than anything, it’s made me safe, that’s helped me step away from the drugs and alcohol.” (CF MDT client)*

In this quote, access to accommodation has been able both to reduce the risks from being on the streets and from drug and alcohol use to cope with rough sleeping.

An important indicator of the impact of the CF MDT on the safety of its clients is the relatively low number of avoidable deaths which have occurred since the start of operation, given the level of risk and complexity which the service is supporting. At the time of writing, there had been two fatal, accidental overdoses, one by a person who was waiting to go to residential rehabilitation.

Initial analysis of the four safeguarding-related outcomes which MDT has been tracking in its returns to the national CF programme (see fig. 1 below) suggests an overall reduction in the average scores for the MDT client group in each of these areas between January 2023 and July 2024 (higher scores reflect higher levels of risk). The average at the start of the period in relation to unintentional self-harm was 3.0 (*‘High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment’*); by the end of the period, this had reduced halfway (2.58) to the next category (2 = *Definite indicators of unintentional risk to physical safety*).

Feedback from MDT workers emphasises that it can take many months of engagement before people trust the service sufficiently to disclose sources and levels of risk to them, so this is also likely to influence these self-reported measures:

*“There can be a lot of shame around saying whether or not you feel safe – sometimes things are exaggerated or underplayed to get different outcomes”. (MDT worker)*

*“I’ve been working with one person for 9 months – it took 3 months to establish contact – now we meet weekly. Took 6 or 7 months before the domestic abuse discussions began. Getting housed, and getting the place furnished were their priorities and once these were in place, they started to open up about abuse”. (MDT worker)*

Figure 11 - Graphs to show average scores for MDT client group against safety-related outcome measures between January 2023 and July 2024



It is clear from these charts that the average scores in relation to risk continue to be extremely volatile over the relatively short time frame considered in the evaluation; there is also significant variation for individuals over time. This suggests that the MDT is having a positive impact overall in reducing risks and preventing deaths, but that this is not a linear trend across the whole cohort; risks have continued to be high for many of this group during the evaluation period and crises can occur at any time. This needs to be considered in strategic planning and commissioning, including at stepdown from the CF MDT service.

Service level

Activities	Outputs	Outcomes	Impact	Measures: data source
- MDT hosted by Adult Social Care and can initiate, lead and hold safeguarding enquiries and plans, based on better understanding of and engagement with individuals	- More people held within ongoing safeguarding plans - Fewer repeat referrals to Adult Safeguarding Hub. - Better disclosure/ identification of risks - Better implementation of safeguarding and safety plans.	<b>Safety:</b> Improved safety through more effective safeguarding interventions.	Fewer preventable incidents, injuries, assaults, deaths.	<i>Eclipse/ housing data</i>

The MDT provides care coordination within statutory safeguarding structures, and its location within Adult Social Care has been a key enabler for this.

As Research in Practice (2024) highlights, “in adult social care, ‘safeguarding’ is about preventing harm and reducing the risk of abuse or neglect to adults *who have care and support needs*” (p.17<sup>17</sup>). National reviews (e.g., Preston-Shoot & Taylor 2022<sup>18</sup>) have identified common barriers to MCN cases being escalated appropriately to statutory safeguarding processes. These include dismissing care and support needs arising from or alongside substance use as ‘lifestyle choices’, and beliefs that formal safeguarding processes are not relevant because a person has not been formally assessed as having care and support needs under the Care Act, refuses to engage with such assessment or the services offered, or because the funded services which adult social care might put in place following such an assessment are unlikely to be suitable. These themes are also reflected in Brighton & Hove’s Safeguarding Adults Review of James<sup>19</sup>, in which, “*the absence of formal capacity assessments meant there was insufficient understanding of how ABI (acquired brain injury)*

<sup>17</sup> Taylor, G. (2024) Radical Safeguarding Toolkit – Homelessness, Research in Practice

<sup>18</sup> Preston-Shoot, M. & Taylor, G. (2022) “ Learning from Safeguarding Adults Reviews and Fatality Reviews” in Adult Safeguarding and Homelessness: Understanding Good Practice, Jessica Kingsley Publishers

<sup>19</sup> See Brighton & Hove Safeguarding Adults Board: James SAR: <https://www.bhsab.org.uk/2021/05/05/james-sar/>

*was affecting James' substance misuse and vice versa and the implications of this for his capacity to care for himself effectively."*

We discuss in Section 4.4 (Meeting Basic Needs) the progress that has been made within the CF MDT in challenging such assumptions and the role which Care Act assessment plays within the service model. This undoubtedly acts as an enabler to accessing statutory safeguarding processes for CF MDT clients.

Prior to the CF MDT service, we understand that numerous safeguarding concerns were being referred to the council for people with MCN, and this resulted in lots of staff time spent trying to process these referrals, for minimal impact:

*"The same names would in the past be constantly escalated by different agencies – by the time they come to me, risks are really high..... Prior to CF, I was very regularly reading cases escalated to me of people who had been harmed or even died, and we had no team set up to respond to this group in a timely way as we have now with the MDT.....".* (Head of Adult Safeguarding).

By contrast, since CF, the MDT has been able to provide care coordination in safeguarding structures for its clients, alongside intensive work and resources to build and maintain engagement with individuals. This is evident in our analysis of Eclipse data (the Adult Social Care case record system) in which we compared records for the CF cohort for an equivalent period<sup>20</sup> before and after CF intervention. This shows:

- No change in the rate of S42 concern notification (CF MDT reflected that many of these are likely to come from the Police)
- A 70% reduction in Adult Safeguarding Decision-making, suggesting reduced processing by central team, due to safeguarding referrals for this cohort coming straight to the CF MDT.
- 1.5 times as many Adult Safeguarding Enquiry Forms, suggesting that concerns are more likely to move to a S42 enquiry
- 3 times as many Safeguarding Plans, suggesting that these enquiries are more likely to generate a multi-agency plan.
- 5 times as many Reviews of Safeguarding Plans, evidencing the point that the MDT is holding risks in plans, and ultimately reducing further repeat referrals to the Adult Safeguarding Hub (since any further concerns will be directed to the CF team who are holding the plan).

The Head of Adult Safeguarding confirmed that, prior to or outside of the MDT team, it was typically very difficult to engage people with MCN in the planning and reviewing process, where the MDT has been able to maintain engagement in the process with a very high proportion of its caseload.

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<sup>20</sup> NB: We aggregated all Eclipse records over a 29-month period for the CF cohort, then calculated and weighted for average lengths of time before (mean = 18 months) and after (mean = 11 months) individuals' intervention start dates.

**System level**

<b>Activities</b>	<b>Outputs</b>	<b>Outcomes</b>	<b>Impact</b>	<b>Measures: data source</b>
-More effective safeguarding case coordination from ASC - Better joint working around safeguarding for this cohort	- Reduced circling of safeguarding processes -Decreased risk to individuals	<b>Safety:</b> Improved safety for those in receipt of services.	Better overall outcomes as risks better managed	<i>Eclipse/ housing data</i>

A key objective of the Changing Futures MDT has been to better coordinate the management of risk for people with MCN, and ultimately to reduce avoidable deaths and improve people's sense of safety.

There has been a strong focus on MCNs by the Brighton & Hove Safeguarding Adults Board (SAB) in recent years, and on rough sleeping since ministerial direction on this point<sup>21</sup>. It might be a stretch to suggest that this is an impact of the CF MDT, but it would certainly appear that the MDT (operationally) and the SAB (strategically) have been able to provide mutual support and work together in relation to system change (e.g., around the establishment of the MARM, discussed below).

MCN has been a key feature in many of Brighton & Hove's recent Safeguarding Adults Reviews (SARs) and a Thematic Learning Review into the deaths of three local women (2023<sup>22</sup>), all of whom had MCN and were experiencing domestic abuse. The learning from these reviews highlights system gaps and challenges which the CF MDT approach has been able to mitigate for its clients, e.g.:

- Safeguarding concerns not being progressed (e.g., Charlie SAR), sometimes due to difficulties engaging the person (e.g., Oliver SAR)
- Gaps in the application of the Care Act, both in undertaking assessments as well as launching safeguarding enquiries (e.g., Craig SAR)
- Assumptions made in relation to mental capacity (e.g. Craig SAR)
- People with MCN being placed in Temporary Accommodation, or discharged from hospital with minimal support or follow-up (e.g. Charlie)
- Lack of coordination in relation to risk identification and management across agencies (e.g., Craig SAR, Thematic Review)

<sup>21</sup> DLUHC/ DHSC (2024) Recommendations for Safeguarding Adults Boards Regarding Individuals Rough Sleeping.

[https://www.safeguardingwarwickshire.co.uk/images/downloads/Ministerial\\_Recommendations\\_for\\_Safeguarding\\_Adult\\_Boards.pdf](https://www.safeguardingwarwickshire.co.uk/images/downloads/Ministerial_Recommendations_for_Safeguarding_Adult_Boards.pdf)

<sup>22</sup> All downloadable from: <https://www.bhsab.org.uk/safeguarding-adult-reviews-sars/>

- Lack of trauma-informed practice, e.g., a lack of understanding of Craig’s lived experience and trauma, and use of language and assumptions which blamed the women in the Thematic Review for the risks they faced.
- Lack of handover from children’s services to adult social care (e.g. Oliver, Charlie)

The following themes emerge from the qualitative data collected as part of the evaluation as to how the MDT has begun to address these issues at system level, certainly through improving multi-agency coordination and collaboration around its own clients, with some emerging signs of system change in relation to culture and processes.

### *Acting as an anchor between the person and other services’ input*

The local Thematic Review into the deaths of three women highlighted how important it is for someone to ‘anchor’ MCN cases, to follow-up on multi-agency actions (e.g., from the MARAC) and hold other agencies to account. There is also evidence (as described above) of this anchoring role of the MDT in relation to safeguarding planning and reviews. The ability to build trust and engagement (as described in Section 4.1) and to work holistically across issues is a key enabler of this.

*“Changing Futures knit together different aspects of risk, working holistically”* (Professional external to MDT)

### *Trauma-informed practice and language*

The CF MDT has been able to model trauma-informed practice and language in multi-agency meetings. For example, one participant at the focus group exploring the role of the MARAC in relation to MCN observed that Brighton & Hove MARAC uses more trauma-informed and less victim-blaming language than other MARACs and felt this may be a ripple effect of the CF pilot.

### *Educating, engaging and challenging other professionals*

MDT staff explained how they have been able to engage and coordinate the input of other agencies through the statutory safeguarding enquiry, planning and review process. Not only has the *number* of plans and reviews increased for this cohort, but the quality and implementation of these plans was felt to have improved dramatically, with the MDT in place to act as keyworker.

*“Safeguarding plans are really helpful because they mean I can call a statutory safeguarding meeting to discuss risks and can summons other professionals – colleagues see me as keyworker, and the safeguarding meetings are helpful in bringing in criminal justice professionals.”* (MDT worker)

Senior MDT workers also told us how they had educated other professionals in relation to working effectively with people with MCN. Examples include supporting voluntary sector organisations to target their safeguarding concerns for maximum effectiveness; and providing advice to social work teams (i.e., beyond the MDT) in relation to mental capacity and executive function.

### *Working with the MARAC*

The CF MDT pilot and its evaluation has highlighted some of the barriers faced by people with MCN in relation to MARAC processes. For example, Victim Support are contracted to engage with victims of domestic abuse whose cases are to be presented to the MARAC, to represent their voices at the meeting. However, Victim Support does not have the time, skills and scope to engage people with MCN effectively (e.g., engagement is by phone or city centre appointment only), therefore the voices of people with MCN are not represented. The DASH (Domestic Abuse, Stalking and Harassment) assessment form (which initiates referral to the MARAC) can be difficult to use with this client group, due to potentially intimidating language. High turnover of MARAC representatives can result in a lack of confidence, expertise and creativity to identify meaningful actions for people with MCN. The MARAC has stated commitment to tackling these barriers where possible; for example, it is now exploring how CF MDT cases might be identified and the MDT invited to present the voice of the victim at future MARAC meetings.

### *Development of the MARM*

Building on the MDT pilot, the local authority has followed the SAB recommendation to develop a Multi-Agency Risk Management (MARM) group. This provides a forum for multi-agency reflection and problem-solving in complex cases where risks remain high, despite ongoing engagement with the individual and appropriate use of existing relevant multi-agency structures and frameworks. Learning from the MDT has informed design of the MARM Framework<sup>23</sup> and the team plays a key role in both coordinating MARM referrals and follow-up actions. At the MCN Steering Group in February 2025, a healthcare professional commented that:

*“The MARM is great – by the time we refer into it, we have done everything we feel we can but it’s good to come together and really understand what has already been done and whether there are different ways of looking at things”.*  
(Healthcare professional)

### *Limitations, due to resources*

Despite the progress made in developing multi-agency practice and processes to work more effectively to manage risks for MCN individuals, the impact of this work in reducing these risks was felt to be limited by lack of resources, in particular:

- Access to suitable mental health care and support (including for people with co-occurring substance use – discussed in Section 4.3 below), which leaves workers across the system holding high levels of risk.
- Access to safe and suitable emergency accommodation (especially for MCN women). e.g., some people get placed out of borough, or in places where they are at risk of exploitation/ domestic abuse.
- Lack of resources to work with MCN men experiencing/perpetrating domestic abuse.

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<sup>23</sup> Brighton & Hove SAB: Multi-Agency Risk Management (MARM) Framework, 2024:  
<https://www.bhsab.org.uk/multi-agency-risk-management-marm-framework/>

### 4.3. Health (mental and physical)

#### Introduction

As part of its JSNA in 2020<sup>24</sup> Brighton and Hove City Council undertook a research and data analysis exercise which showed that the average life expectancy for people with three or more multiple compound needs is 34 years less than the average adult in Brighton and Hove. Addressing this health inequality and reducing preventable deaths has been a core aim of the MCN Transformation Programme. Work on 'High Intensity Users' in Brighton & Hove has also identified two cohorts which tend to make high intensity use of Accident & Emergency: those who are street homeless or insecurely housed, and those with MCN, including complex emotional needs and/or personality disorder. The CF MDT pilot is working at the intersection between these groups.

Qualitative research carried out by Fuse/ Fulfilling Lives to understand the causes of premature mortality in MCN groups in Newcastle and Gateshead<sup>25</sup> gives us some insights into what is driving this inequality. Fuse found that co-occurring mental health and substance use, self-harm and suicide, lack of access to support, changing drug markets, and risk of overdose during relapse were key causes of death, with wider determinants of health, including poverty and housing, also playing a significant role. System and service barriers – including stigma in seeking help from health services - and a lack of communication between agencies meant that opportunities to intervene preventatively were missed. Researchers were also struck by a common lack of hope, resulting from multiple losses and sometimes desensitisation to death, and compounded by 'transactional' interactions with support services.

At the start of the CF MDT pilot, there was a recognition that there was relatively good access to primary health care for people with MCN in the city, thanks to [ARCH \(Accessible Restorative Community Health\) Healthcare CIC](#), which works with people who are rough sleeping, sofa-surfing or staying in emergency or temporary accommodation. In addition to an accessible GP practice, ARCH also provides health engagement outreach (via Just Life), chairs fortnightly Multi-Agency Homeless Health Meetings (MAHHM) supporting patients with multiple complex challenges, and hosts Common Ambition, a co-produced service improvement initiative. However, there were – and continue to be – concerns that access to and experience of healthcare for people with MCN is far from consistent along the pathway, especially at the interface with secondary health services.

In the remainder of this section, we consider the impact of the MDT pilot on health at individual, service and system levels, presenting extracts from the Theory of Change at the start of each, to structure our assessment of the evidence collected during the evaluation.

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<sup>24</sup> BHCC (2023) JSNA: Adults with multiple and complex needs 2020: <https://www.brighton-hove.gov.uk/sites/default/files/2023-11/Adults%20with%20multiple%20complex%20needs%202020.pdf>

<sup>25</sup> Perry et al (2020) Understanding high mortality rates among people with multiple and complex needs: exploring underlying factors and opportunities for prevention in Newcastle and Gateshead <https://fuse.ac.uk/media/sites/researchwebsites/fuse/Mortality%20and%20MCN%20Report%20Oct2020.pdf>

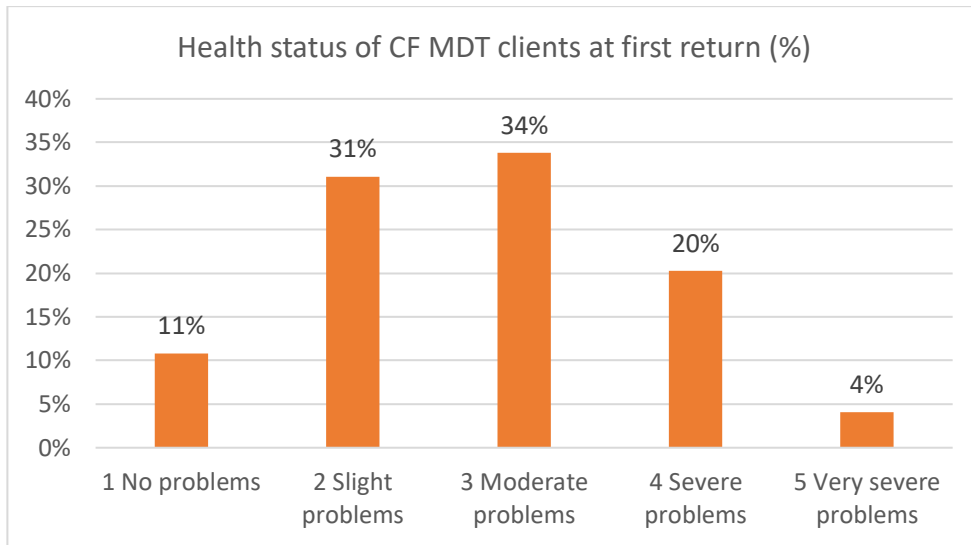
## Individual level

Activities	Outputs	Outcomes	Impact	Measures: data source
<ul style="list-style-type: none"> <li>- Support to attend hospital, healthcare, substance use clinic appointments</li> <li>- Therapeutic &amp; motivational support (from/overseen by MH Nurse/ Drug worker)</li> <li>- Advocating on behalf of individuals to reduce barriers to healthcare</li> </ul>	<ul style="list-style-type: none"> <li>- Accurate diagnoses received</li> <li>- More people access/ stabilise on prescriptions (for substance use/ psychiatric and physical health)</li> <li>- Health promotion interventions received, including harm minimisation, sexual health, contraception, vaccinations, etc</li> <li>- Other treatments (e.g. wound care, outpatient/ elective surgery, dentistry, antenatal care) received</li> <li>-Health conditions are appropriately monitored</li> </ul>	<p><b>Health:</b> access to timely and preventative healthcare</p> <p>Reduction in avoidable health crises</p> <p>Harms minimised</p>	Better health outcomes e.g., mortality, overall, by reducing health inequalities	<i>Eclipse and NHS data for access to treatment, self-reported health improvements</i>

*Health profile of CF MDT clients*

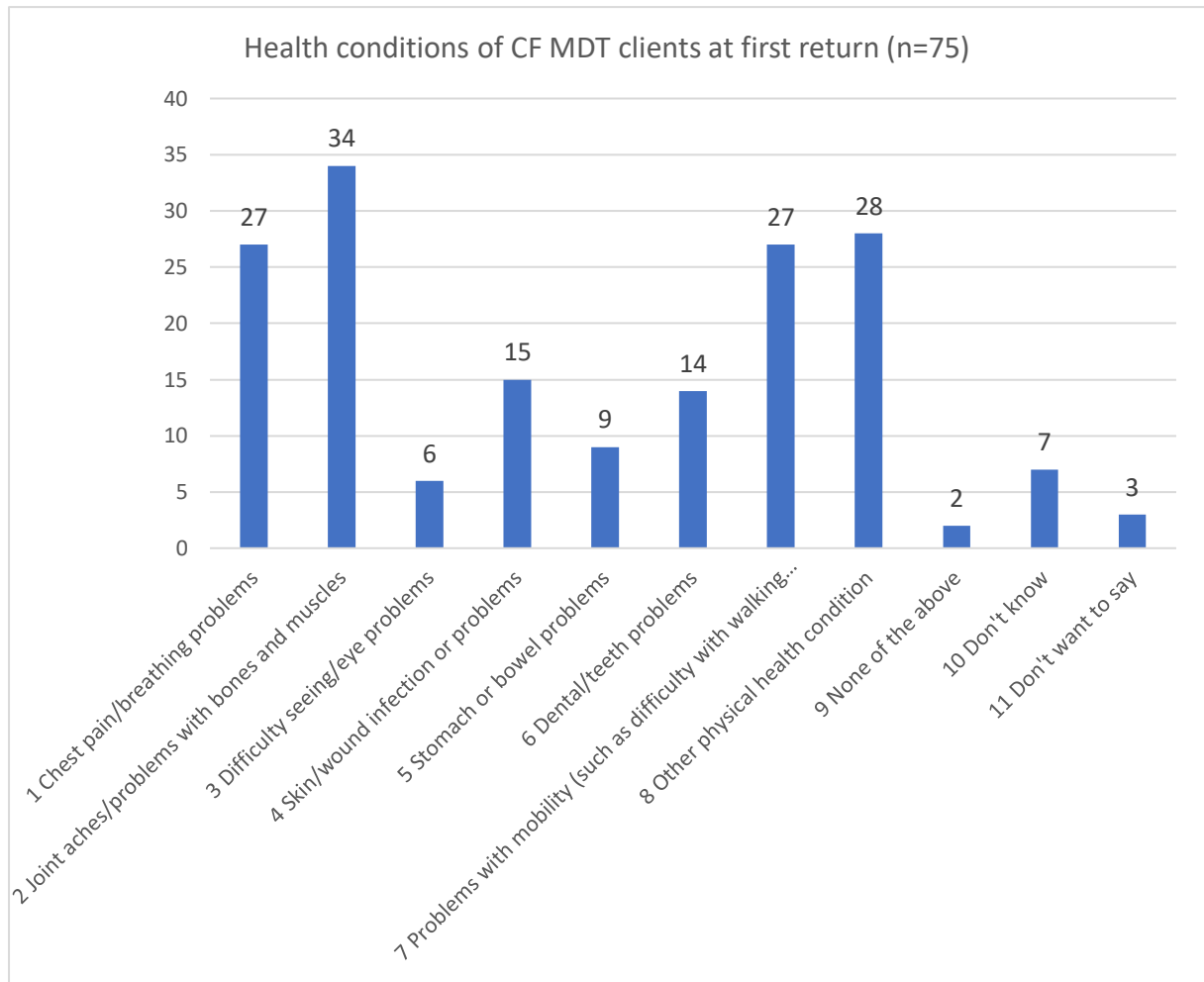
The 'outcome tracker' data collected by the CF MDT workers from individual clients confirms the high level of physical, as well as mental health conditions amongst those on the CF MDT caseload. For example, the self-reported data from the first questionnaire conducted with clients (n = 75) shows that over half (58%) have health problems which are at 'moderate' level or higher, with the largest group describing health problems as 'moderate'.

Figure 12 - Graph to show the health status of CT MDT clients at first return



As the following chart shows, the most reported physical issues were joint aches/ problems with bones, chest pains/ breathing issues, and mobility problems.

Figure 13 - Graph to show health conditions of CF MDT clients at first return

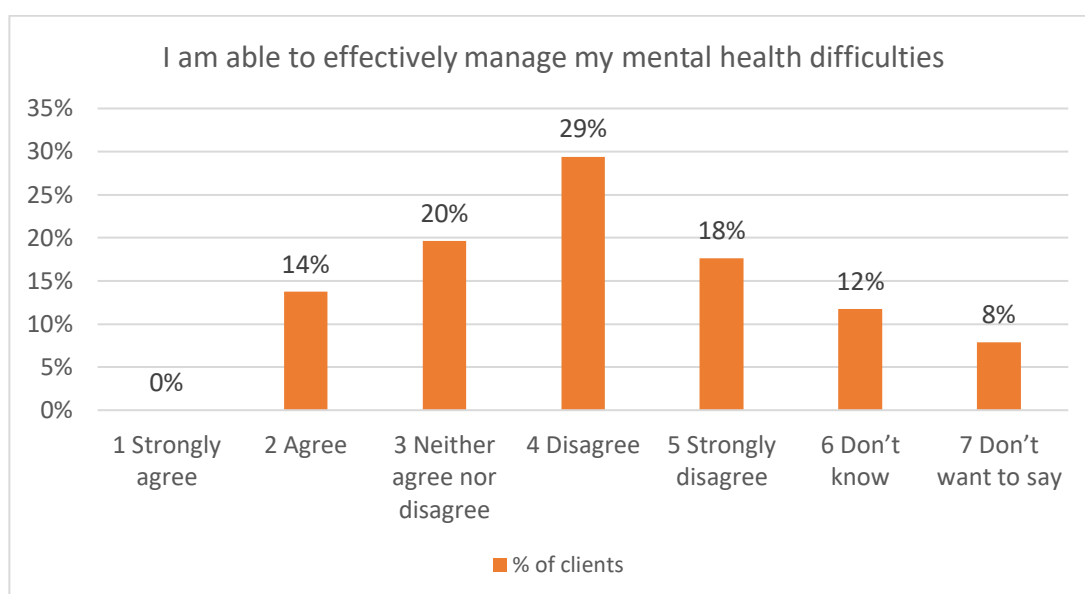


Of the 63 who declared a physical health condition, the average number of different reported conditions was 2.5, up to a maximum of 6.

43% described themselves as being in physical pain; many of the remainder replied that they did not know or did not want to say: only 22% were confirmed they were not in pain.

70% (n = 51) said that they had experienced mental health challenges over the past 3 months; only 6% said they had not. Only 14% of those who replied that they had experienced mental health challenges agreed that they are able to manage their mental health challenges effectively, as the following chart shows:

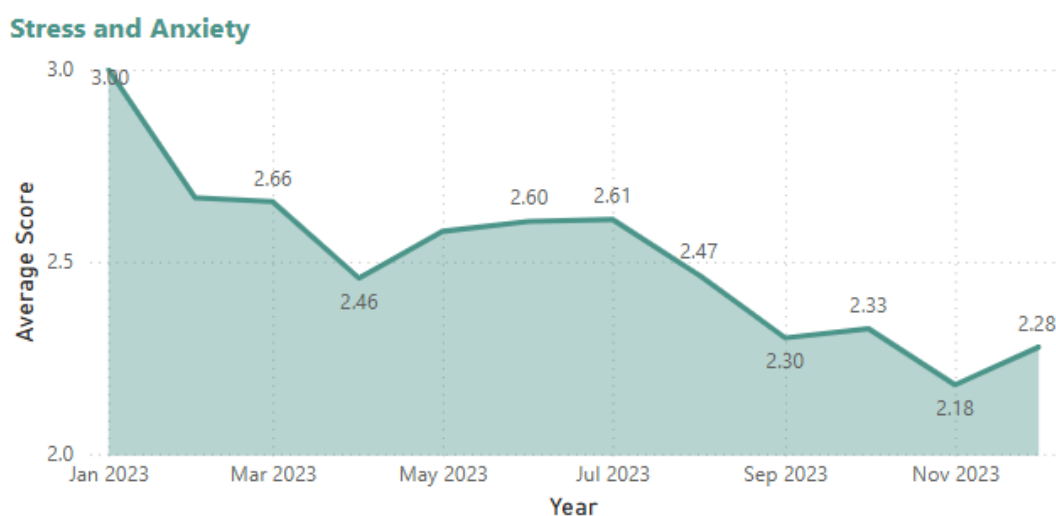
Figure 14 - Graph to show responses to "I am able to effectively manage my mental health difficulties"



### Improvements in self-reported mental health

We would not necessarily expect to see a radical improvement in physical health conditions themselves over the timeframe of the evaluation, and there is insufficient follow-up data to test this with confidence. However, it is notable that 'stress and anxiety' levels show the clearest trend of improvement out of the various aspects monitored by the New Directions Team Assessment Collection (NDTA) indicators. From January 2023 to July 2024, average scores fell from 3 to 2.28 (reaching a minimum of 2.18 in the previous quarter), as the following chart shows. Note that a score of 3 is defined as 'Obvious reactivity; very limited problem solving in response to stress; becomes hostile and aggressive to others'; where a score of 2 is 'Moderately reactive to stress; needs support in order to cope'.

Figure 15 – Graph to show average score for stress and anxiety over time (NDTA indicators)



Key enablers of this impact include: the MH nurse role within the team, who was able to provide direct support to clients experiencing stress and anxiety; emotional support from the whole team, and the continuity and predictability of the support offer.

One of the ‘swim lane’ case studies supplied to the evaluation by Changing Futures Sussex of a client who was at high risk of harm (including self-harm) related to mental ill-health and substance use, continues to experience suicidal thoughts since the MDT support has been in place, but at a much-reduced frequency. Support has included regular visits from CF, ARCH, and carers to support with medication, housing and other needs. This has resulted in a dramatic reduction of both general and mental health admissions and ambulance callouts, which we consider in more detail in the section on Effectiveness.

Given the reference in the introduction of this section to researchers in Fuse/ Fulfilling Lives Newcastle & Gateshead who were struck by a ‘common lack of hope’, there are striking examples of MDT clients regaining their sense of hope through the support they have received.

*“I am excited about my future I want to bring lots of things because I have this future now - magically”.*

### **Improved access to healthcare**

There are many examples of people being supported by the MDT to access health services in a more timely, planned and effective way, thereby reducing use of crisis services. For example, the Just Life Community Support workers provide support to MDT clients to set up and attend healthcare appointments. This includes GP appointments, ante-natal care, routine screening, support to access, adjust and stabilise on psychiatric medication or methadone prescriptions.

*“Arch are great with this client group, but our clients still need support to access, attend, and follow-up after this service..... There might be prescriptions to pick up and so on. We act as a kind of PA almost.” (MDT worker)*

After attending antenatal care appointments initially with one client, who has had traumatic experiences with health and social care professionals, we heard that the client has now built enough trust in the midwives to attend alone.

Comparing the responses to the first and second quarterly outcome questionnaires, suggests an improvement in access to primary healthcare and dentistry services for some clients since joining the CF MDT. Note that, since the first quarterly outcome is not necessarily done at the point where a person joins the service, this data may understate the impact:

- In their first outcome questionnaire, 36% said they had been able to access a GP in the previous 3 months, when they needed to; for those completing a second questionnaire (approximately 3 months later), this had increased to 49%. Most of the remainder said they didn't know (33%) or hadn't needed a GP in this period (5%).
- In their first outcome questionnaire, 11% said they had been able to access a dentist in the previous 3 months, when they needed to; for those completing a second questionnaire (approximately 3 months later), this had increased to 23%. Most of the remainder said they didn't know (41%) or hadn't needed a dentist in this period (23%).

#### Service level

Activities	Outputs	Outcomes	Impact	Measures: data source
- Support to attend hospital, healthcare, substance use clinic appointments - Clients are better motivated and supported to comply with treatment - Advocating on behalf of individuals - Joint working	- Fewer missed appointments - Reduced incidence of case closure/ re-assessment due to lack of engagement - Improved treatment compliance - Fewer presentations to A&E for avoidable/ non-emergencies - Hospital admissions are appropriate - Discharges are better planned	<b>Health:</b> reduce pressure on E&D, facilitate timely and appropriate discharge.	Better health outcomes e.g., mortality, overall, by removing health inequalities	<i>Evidence of relationships with clinicians. Eclipse/ NHS data for treatments HIU data</i>

Activities	Outputs	Outcomes	Impact	Measures: data source
	- Fewer instances of unmet need			

In this sub-section, we focus on the MDT’s partnerships with hospitals, specialist mental health, and drug and alcohol services.

### **Hospitals**

Communication between the hospital and CF MDT was reported to work reasonably well in relation to the discharge of shared clients who have been admitted. However, communication with Accident & Emergency is understandably much more difficult and, certainly at the start of the evaluation, we heard that many people were being kept in Accident & Emergency whilst awaiting a mental health inpatient bed. The MDT also reports challenges getting information (e.g. about mental capacity, or a Methadone prescription) to travel with a person through the hospital system. This was a theme both from the MDT and from the ARCH hospital in-reach team. It was hoped that that some of these issues might be improved with the implementation of the Plexus Care Record system, but that did not happen during the course of the evaluation.

### **Specialist mental health care**

Although the original design of the MDT included one Band 6 mental health nurse, this level of resource has proven insufficient, given the extent of mental health needs within the caseload. Following challenges recruiting to this post (especially given the fixed term contract), it was re-banded to a Band 7, which better reflects the level of autonomy required of the post holder. Although it was possible to recruit to this post, it was not possible to retain the post holder, neither was re-recruitment attempted during the remainder of the evaluation period.

Even when the mental health nurse post was filled, there was no direct access to psychiatry or psychology for the CF MDT. It had perhaps been assumed that this would follow from the nurse post’s location in the Homeless Mental Health Team (HMHT); however, there was no funding from CF to the HMHT for psychological or psychiatric input, only for line management of the nurse’s role, and these resources are limited and under huge demand within the HMHT.

Whilst this has caused some frustration for both MDT workers and the HMHT over the course of the pilot, a clearer understanding of what mental health services can and cannot offer people with MCN does seem to have emerged. There is a recognition that people do need to be ready and willing to engage with medication and/or therapy, and that support around psychological case formulation is perhaps more appropriate in most cases, given the levels of distress and the huge resource of the trusting relationships the MDT has been able to build with its clients. In future service design for people with MCN, it will be vital to build

in and effectively resource certainly clinical psychologist, and ideally psychiatrist input. The HMHT also felt that an additional mental health nurse would have been a great benefit.

In the absence of all these resources for most of the evaluation period, the CF MDT has been able to draw on the HMHT for valued advice and support, both on the phone and through occasional attendance of the HMHT psychologist at MDT meetings for individual clients. The HMHT report that, since this input is currently not formally commissioned or funded, it is no more than they would offer to other agencies working in this space, such as the RSI Navigator team or CGL, and that this support has increased noticeably since the CF MDT nurse left.

The CF MDT also reports a lack of specialist services for people with MCN with Acquired Brain Injury and/or personality disorder in Brighton & Hove.

### **Drug and alcohol services**

The MDT model benefits from a ‘Recovery Coordinator’, who is employed by Change Grow Live (CGL), which runs the [Brighton & Hove Recovery Service](#). This Coordinator acts as a key worker to MDT clients who are also on the CGL caseload, primarily focusing on providing assertive outreach for those who struggle to present at the CGL office base, helping to facilitate their relationship with CGL, and providing motivational support. There are some concerns about the job title and the concept of ‘recovery’ for people with MCN:

*“The idea that linear recovery is achievable for people who are this damaged and disadvantaged only serves to create pressure and shame”. (MDT worker)*

Nevertheless, this model was felt to work well, with the MDT worker having the capacity to visit people on their caseload up to three times a week, sometimes spending ‘hours at a time with them’. Where someone is struggling to get onto a (Methadone) script, the worker might for example go to their accommodation and accompany them on the bus to the CGL appointment, getting a coffee after the appointment to debrief.

The CF MDT – and apparently other local providers in this space – report a lack of specialist detox and rehabilitation facilities in Brighton & Hove and the surrounding area. There is a particular gap for people with Acquired Brain Injury who need detoxification, in a setting where a DOLS (Deprivation of Liberty Standards) could be considered. In a current case, one client is facing a trip to Liverpool for this service.

### **System level**

<b>Activities</b>	<b>Outputs</b>	<b>Outcomes</b>	<b>Impact</b>	<b>Measures: data source</b>
-Joint working/ planning with partner organisations and agencies/	- Increased coordination between NHS and MDT - Health workers more	<b>Health:</b> reduced pressure on crisis healthcare. Better access to healthcare.	Better health outcomes (mortality, inequalities) Efficiencies.	<i>Eclipse or Swim Lane data</i>

Activities	Outputs	Outcomes	Impact	Measures: data source
statutory partners -Awareness raising -Information sharing	confident and trauma-informed in relation to MCNs - Increase in early/preventative/ effective healthcare for this cohort			

In this sub-section, we consider the wider context of healthcare for people with MCN in Brighton & Hove and the extent to which the MDT pilot has been able to influence system change or highlight areas for further development.

### ***Access to mental health care***

It is clear from the MDT pilot that, despite many excellent resources for this client group (such as the Homeless Mental Health Team), the systems for mental health service provision are complex, and people with MCN face additional barriers to access, for example:

- There are different mental health teams at Sussex Partnership NHS Foundation Trust (SPFT) working with people in different housing circumstances - the Homeless Mental Health Team only works with people sleeping rough; where the Assessment & Treatment Service works only with people who are in supported accommodation or have their own tenancy. Whilst there may be many benefits to this arrangement, as discussed in the Housing section, people with MCN are at particular risk of frequent moves between these housing circumstances, and so face an accompanying lack of continuity in their mental health care.
- The Homeless Mental Health Team and its Dual Diagnosis Nurses can provide some outreach, e.g. to day centres, however, they do not have the resource to provide assertive outreach to find an individual in the way that the CF MDT can; whilst they try to be as flexible as possible, they will typically close a case after three missed appointments.
- Adult social care cannot refer directly to the SPFT, referrals must instead come from the person's GP.
- The Haven at Mill View Hospital in Hove provides a dedicated mental health crisis assessment facility, intended to provide an alternative to A&E; however, they cannot accept referrals from people with who are currently dependent on alcohol or Methadone. People also need to be able to make their own way to the facility and home.

- At the start of our evaluation, we heard that there was a huge shortage of in-patient psychiatric beds in the local area, with some people waiting many weeks in A&E or in general hospital settings before being allocated a specialist bed. This is stressful for anyone but can create additional stresses for MCN people, especially where they are also dependent on alcohol or drugs.

### ***Co-occurring mental health and substance use***

Discussions with commissioners of drug and alcohol services as part of this evaluation highlighted the need for an integrated response to co-occurring mental health, substance use, and underpinning trauma in the city. It was recognised that, in the absence of this, each individual agency/ professional group is holding much higher levels of mental health needs and risks than they should be, with particularly concerning impacts on individuals and the housing support workforce.

As part of [Brighton & Hove's Combatting Drugs Partnership](#), a Health Improvement Specialist was commissioned in 2023 to better understand system and service barriers facing people with co-occurring mental health and substance use in the city. This project has involved mapping services, criteria and pathways, a provider survey, the establishment of a Mental Health and Substance Use Steering Group (for governance) and a co-produced lived experience engagement piece with Common Ambition. The project will make recommendations in April 2025 as to how to strengthen pathways, following a multi-agency workshop planned to take place in February/ March 2025. The aims of the workshop will be to identify challenges and good practice for people with co-occurring mental health and substance use and establish a shared vision and priority actions. It will be important to join up the learning from these parallel pieces of work and ensure that the CF MDT perspective is included in the workshop.

### ***Pathways through hospital settings for MCN people***

ARCH Healthcare runs [a hospital in-reach service](#) at the Royal Sussex County Hospital (Sussex University Hospitals Trust). This was an early (2012) example of the [national Pathway model](#), and it aims to identify people in acute settings who are at risk of homelessness on discharge, to make sure they are engaged in treatment, that their basic needs are met, and to try to arrange suitable accommodation for discharge.

Interviews with the Pathway team highlighted frustrations about the minimal impact which the MDT pilot has been able to have on access to social work for people with MCN within the hospital setting outside of the MDT caseload. The Pathways team receives around 400-450 referrals a year, of which only 'a handful' are on the CF MDT caseload, but around 9% are estimated to potentially have Care Act eligibility. For those outside of the MDT caseload, timely access to social workers who understand homelessness and MCN in the context of the Care Act 2014 and the Mental Capacity Act 2005 is reported to be hugely problematic within the hospital setting. This makes it much harder for Pathway to seize the opportunity of hospital admission to put in place the right care, support and accommodation for those with the most compound needs – often this is beyond the remit of Housing alone to resolve. People are discharged to unsuitable accommodation or none, or they discharge themselves

before a solution can be offered. Despite the stepdown offer from New Steine Mews (discussed in Section x Housing), there is a reported lack of suitable housing, care and support to which people with MCN can be discharged from hospital. This has resulted in unsafe discharges (e.g. to rough sleeping or addresses which do not exist) for MDT clients, and others with MCN.

It is clear there was an expectation that the CF MDT pilot – given its location within Adult Social Care – might have improved what was felt to be a disconnect between hospital- and community-based adult social care and created an opportunity to further develop hospital-based social work for MCN people. If anything, this was felt to have further deteriorated – though this is because of increasing resource pressure, not as a result of the MDT pilot.

We sought to explore this theme in more detail as part of this evaluation; however, the limited capacity of hospital managers to engage with service improvement (which has been highlighted in a previous local SWOT analysis) was a practical barrier to this. A meeting with the Lead for the Integrated Discharge Team at the Royal Sussex identified that – were additional social work capacity to be made available in future to work with people with MCN in hospital and to provide training, careful consideration would need to be given to the location of this resource, and to information sharing.

Whilst significant progress has been made in developing operational partnerships and processes, these remaining system challenges at the interface with health services reduce the capacity of the MDT and others working with MCN people to achieve the primary aim of reducing preventable deaths.

#### **4.4. Meeting basic needs**

##### **Introduction**

There is clear evidence that people using homelessness-related support services who also experience three or more primary domains of disadvantage tend to also be living in extreme destitution<sup>26</sup>. As one of the MDT workers commented during our evaluation:

*“People are fighting just to get food”. (MDT worker)*

In this section, we consider the CF MDT’s impact on meeting basic needs, including enabling access to food, benefits, phones, transport and to care and support, through use of the Care Act 2014.

The MDT’s location within Adult Social Care, and the investment which Adult Social Care has made to the programme has enabled the MDT to improve access to care and support for its clients via Care Act Assessments. This contrasts with national research findings which suggest that:

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<sup>26</sup> Sosenko, F., Bramley, G. & Johnsen, S. (2020) Gender Matters: Gendered patterns of severe and multiple disadvantage in England, Lankelly Chase/ I-SPHERE: <https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf>

- People experiencing homelessness have more limited access to Care Act assessments<sup>27</sup>
- Social work roles supporting people experiencing homelessness and MCN have often been at risk from isolation and a lack of ownership by Adult Social Care departments<sup>28</sup>.

### Individual level

Activities	Outputs	Outcomes	Impact	Measures: data source
- Personal budgets used to meet basic needs - Arranging benefit entitlements & bank accounts - Referrals to organisations e.g., foodbanks -Care Act entitlements	- People can eat - People can wash and access clean clothes - Benefits entitlements secured - Those who need care & support receive it	<b>Meeting Basic Needs of the individual:</b> access to food, warmth, hygiene, personal care, etc	Better overall outcomes by addressing wider determinants of health related to alleviating poverty	<i>Personal budget records</i> <i>Care plans</i> <i>Benefit claims</i>

All the individuals supported by the MDT are reliant on benefits, and/or sometimes begging and sex work, as income<sup>29</sup>. At the first outcome tracker questionnaire (usually carried out within the first few months of starting with the MDT), 17 people (24% of the total caseload) said they either did not have a bank account or did not know whether they had one. There is evidence of the MDT helping to reduce destitution for its clients, by enabling people to access food banks, other community resources, benefits and bank accounts.

The MDT’s personalisation budget<sup>2</sup> allows immediate needs to be met e.g., for food, drink, bedding, clothing, transport, personal and household items. Common Ambition also noted how the personalisation budget can open the options available to MDT clients. Data supplied by CF shows how the personalisation budget was spent. The funds are spent under 3 tiers that categorise the spending according to client need. Tier 1 – Addressing immediate needs and promoting engagement - accounted for the majority of the spend

<sup>27</sup> Local Government Association (2022) Care and support and homelessness: Top tips on the role of adult social care:

<https://www.local.gov.uk/sites/default/files/documents/25.207%20Care%20and%20Support%20and%20Homelessness%20AA%20WEB.pdf>

<sup>28</sup> Harris, J. (2023). Evidencing the social work role within responses to multiple exclusion homelessness. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King’s College London. <https://doi.org/10.18742/pub01-151>

<sup>29</sup> Based on their responses to the first outcome tracker questionnaire

(£22.4k). The top 5 categories of spending were: groceries (29%), food & drink (22%), clothing (15%), household (13%) and travel (9%).

*“The personalised budget is amazing for building trust – being able to get something sorted – whether it’s a phone, or a microwave, or whatever on the day – including items for safety as well as wellbeing”. (MDT worker)*

There is evidence of ongoing reflection within the team about how to allocate the personalisation budget fairly between clients and with greatest impact on their safety, engagement, longer-term capacity-building and person-led aspirations.

The focus of the Community Safety workers (employed by Just Life) is on meeting basic needs: this ranges from helping people to complete benefit forms, access food projects or report repairs to a landlord.

The case studies produced by CF demonstrate many examples of practical support for clients. For example, one person<sup>30</sup> with significant mental health and substance use challenges was supported by the team to move from one social tenancy, which was in a very poor condition due to litter, hoarding and lack of hygiene, to another social tenancy, presented as a ‘fresh start’. The MDT provided a range of practical support to facilitate the move and to work with the client to better organise their new property – from help with packing and unpacking, purchasing bins and storage, setting up direct debits for utilities – all with a back-up plan to facilitate a Care Act Assessment if they are still unable to maintain a habitable living environment. The MDT also provided significant support in relation to financial wellbeing, given multiple previous debts. This included helping them to access Money Advice Service support to manage debts and budgeting, making an application for Personal Independence Payment, and a weekly trip to a food bank with the Community Safety Workers to top up on groceries.

### Service level

Activities	Outputs	Outcomes	Impact	Measures: data source
<ul style="list-style-type: none"> <li>- Availability and management of personal budgets</li> <li>- Arranging benefit entitlements and bank accounts</li> <li>- Referral partners/</li> </ul>	<ul style="list-style-type: none"> <li>- Personal budgets are used to fill short-term gaps</li> <li>- People are able to access appropriate benefits</li> <li>- Increase in accepted care packages for this cohort</li> </ul>	<p><b>Meeting Basic Needs of the individual:</b> care package acceptance/ coordination. Reduced pressure on other agencies to meet basic needs.</p>	<p>Better overall outcomes by effectively meeting needs</p>	

<sup>30</sup> B&H Contract Monitoring Report v3, September 2023

Activities	Outputs	Outcomes	Impact	Measures: data source
organisations e.g., foodbanks				

Since the CF MDT is located within Adult Social Care, many of its clients were known previously to Adult Social Care or Children’s Services, some had – for example – been clients of a previous substance misuse social work team sitting within the directorate. Evaluators analysed data from Eclipse (the Adult Social Care case recording system) and compared Care Act activity for clients prior to and after starting with CF. This showed that for the MDT caseload taken as a whole there were:

- 1.5 times as many core conversations (in which relevance of a Care Act assessment is considered) and **2 times as many Care Act Assessments carried out** since joining CF than in the equivalent time period before joining CF. The MDT team reflects that previously people were coming through Safeguarding processes, without a Care Act Assessment having been carried out.
- These assessments were more likely to result in practical outcomes: **3 times as many referrals for care to be authorised and arranged, and 3 times as many referred to brokerage (i.e., for services to be put in place).**

This evidences better use of the Care Act to facilitate outcomes for MCN clients. Interventions have typically included short-term care packages following hospital discharge or deep cleaning interventions, though some people have been placed in specialist residential care homes. Building relationships with care providers who can and will work with this group of people has been a critical success factor to these interventions.

There has also been significant learning and reflection within the team over the course of the pilot regarding how the Care Act applies to this group. The team has moved away from a focus on Care Act assessment primarily as a way of accessing services funded by Adult Social Care to a much broader view:

*“Traditionally, Adult Social Care has focused on assessing for its funded services. We’ve mostly focused on people with care and support needs that might fit our services..... At the start of the MDT pilot, we would close the care coordination element because we weren’t providing a funded service. But now we are working to the principle that everyone in the MDT caseload should have a care and support assessment and this should be reviewed..... none of the actions might be for ASC, but we are sharing and holding that risk.... and if any of these services were to cease, it would be an unmet need.” (MDT manager)*

The inclusion of wider support services was noted as positive practice in a Case Audit carried out by Adult Social Care on a sample Care Act Assessments carried out by the CF MDT. As this focus has shifted, the Care Act assessments carried out by the MDT have moved away from assessing eligibility criteria and have looked more widely at the Act’s wellbeing

principles<sup>31</sup>, considering unmet needs and associated risks, for example of financial abuse. This is a significant departure from standard practice in the locality social work teams where, in the face of huge demand, those with apparent personal care needs are prioritised.

The MDT's social workers have found the process of writing an assessment useful, especially given the multiple needs and systems their clients face:

*"The process of writing an assessment ....gives the time and headspace to gather the information and reflect on how needs might best be met from the whole existing system". (MDT Manager)*

Most of the MDT caseload do not have personal care needs, but some have needed high-cost residential care or specialist supported housing placements due to high levels of risk. The MDT has succeeded in making the case internally for these placements by evidencing the impairments (and hence the Care Act eligible needs) which have often been caused by substance use. Multi-agency and senior management involvement is a key enabler here; by the time the case comes to the panel that makes funding decisions, the mental health team, the Adult Social Care brokerage team (that sources suitable placements) and senior managers have been involved at each step, and everyone agrees the proposed placement is the only suitable option.

The staff team frequently reflects on the balance between the need to prevent crises versus the importance of encouraging people to take responsibility and build their capacity to carry out day to day tasks autonomously. For example, sometimes it is important to invest time to accompany a person on the bus (rather than book a taxi) so they can build up the confidence to make the journey alone in the future.

The team understands that setting out clear parameters for support may be as critical to 'trauma-informed' practice as flexibility and empathy.

*"I don't coddle people – there is a struggle between support and enabling them – I talk about this with [Operational manager] quite a bit - people who are entrenched in the system see this team as Santa – they want us to sort everything out for them – so we have to push back and set boundaries – these are the most vulnerable people, they have slipped through all the nets". (MDT worker)*

*"We might take someone to the pharmacy, but the ultimate aim is to help them to get to a level where they can do that autonomously." (MDT worker)*

The team also describes the need to push back at times against health and other services in light of section 22 of the Care Act, which prohibits the local authority from providing any healthcare services which are the responsibility of the NHS, for example, like providing a taxi for someone to go and collect a prescription.

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<sup>31</sup> See 'Promoting Wellbeing' in DHSC (2024) Care and Support Statutory Guidance <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-1>

## System level

There is some emerging evidence of ripple effects from the MDT to wider social work teams in relation to their practice with people with MCN. For example, locality teams have approached the MDT for advice on mental capacity and executive function. Strong leadership from senior management helps; however, there are barriers linked to stretched resources within Adult Social Care, as flagged in the Learning from Process section. The MDT has also reflected on challenges relating to professional and organisational culture with respect to this client group, with the dominant view in locality teams still tending to be that self-neglect is a ‘lifestyle choice’ and that people with MCN do not fit into Adult Social Care statutory duties and funded services. These misconceptions are highlighted in the national research as common obstacles to the effective use of the Care Act and other statutory powers with people with substance use needs<sup>32</sup>.

The MDT also reports some impact in helping other agencies to better understand the thresholds for the Care Act and to make effective referrals to Adult Social Care. This has included attending weekly meetings at CGL (drug and alcohol services) and working in partnership with the RSI-funded Navigator service (as discussed in the next section).

## 4.5. Housing

### Introduction

Lack of affordable housing is particularly acute in Brighton & Hove. As of November 2024,<sup>33</sup> there were 7,500 households on the city’s housing register and more than 1,800 in emergency or temporary accommodation. Official statistics for the year to September 2024 suggest an average of 89 people identified sleeping rough over the course of a month between October and April, rising to an average of 115 in the months between May and September<sup>34</sup>, evidencing significant seasonal variation. The council is under huge financial pressure<sup>35</sup> and, in 2023, announced its intention to decommission around 100-150 of its 700 units of supported accommodation for people experiencing homelessness.

Given the priority focus on homelessness, and rough sleeping in particular, the development of the MCN integrated community team has focused particularly on these groups. The extent of the overlap between homelessness and MCN has been estimated by a CF audit<sup>36</sup> which, between April and June 2023, identified 539 clients accessing homelessness services in the city who met the CF definition of MCN, representing 54% of the total caseload of

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<sup>32</sup> E.g., Ward, M. & Preston-Shoot, M. (2020) Safeguarding Vulnerable Dependent Drinkers England and Wales, Alcohol Change UK: <https://proceduresonline.com/trixcms2/media/14068/safeguarding-vulnerable-dependent-drinkers.pdf>

<sup>33</sup> BHCC (13 November 2024) ‘How many new homes are needed and where should they be built?’ accessed from <https://www.brighton-hove.gov.uk/news/2024/how-many-new-homes-are-needed-and-where-should-they-be-built#:~:text=There%20are%20more%20than%207%2C500,and%20building%20a%20healthy%20city.>

<sup>34</sup> MHCLG, Rough Sleeping Data Framework, September 2024: <https://www.gov.uk/government/publications/rough-sleeping-data-framework-september-2024>

<sup>35</sup> See for example BHCC (19 September 2024) ‘Report highlights potential budget shortfall’ at: <https://www.brighton-hove.gov.uk/news/2024/report-highlights-potential-budget-shortfall>

<sup>36</sup> Changing Futures Sussex, Multiple Disadvantage Audit Summary, Brighton & Hove, April – June 2023

these services. Mental health needs (affecting 90% of the 539) and substance misuse needs (affecting 89%) were the most reported needs, with 80% experiencing both these needs. Over the course of the evaluation, Safeguarding Adults Boards have been directed by MHCLG to take on greater oversight of the management of risks facing people sleeping rough<sup>37</sup>. The impact of rough sleeping on morbidity and mortality is well-evidenced<sup>38</sup>, so helping people with MCN to secure and sustain suitable accommodation is an essential part of the mission to reduce avoidable deaths.

People with MCN are at particular risk both of being evicted or being unable to move on from temporary and supported accommodation, and of repeat homelessness presentations<sup>39</sup>. A Deep Dive on Rough Sleeping carried out by DLUHC in February 2024 identified a need for BHCC to increase the flow through and out of its homeless pathway into settled housing. The recommendations explicitly mention the need to expand Housing First – a model of support designed specifically for people with MCN. Housing First aims to house people in their own, settled homes as *quickly as possible* and provide them with the support they need to sustain an exit from homelessness.

### Individual level

Activities	Outputs	Outcomes	Impact	Measures: data source
- Homelessness Prevention Officer (but needs more resource/support from Housing) Advocacy and prevention work accommodation - Support to maintain accommodation	People supported into or out of emergency/temporary accommodation	<b>Housing:</b> reduced rough sleeping or acute forms of homelessness. Moves to more suitable accommodation	Better overall outcomes and mortality rates for individuals via improved accommodation	<i>Eclipse data, self-reported health improvements,</i>

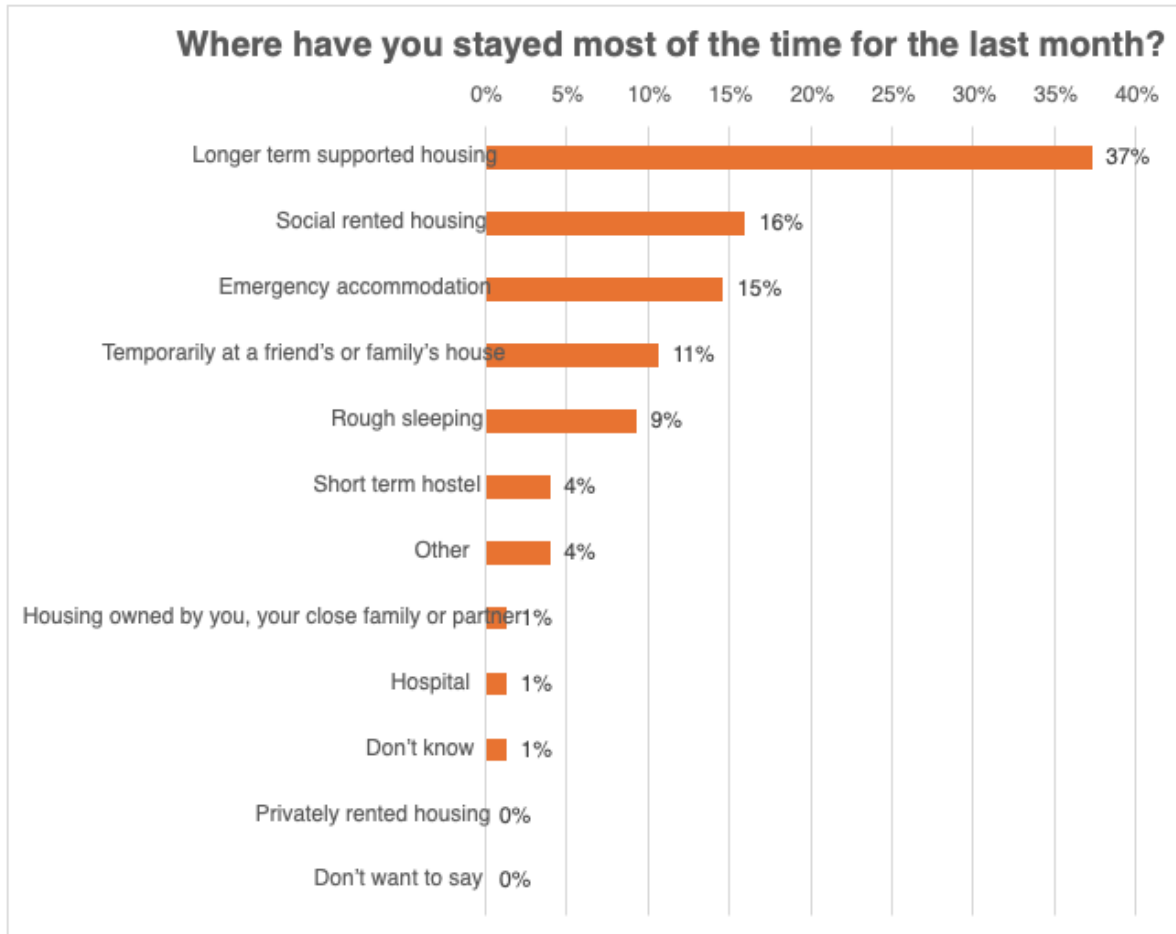
<sup>37</sup> MHCLG/ DHSC (2024) Recommendations for Safeguarding Adults Boards Regarding Individuals Rough Sleeping, [https://www.safeguardingwarwickshire.co.uk/images/downloads/Ministerial\\_Recommendations\\_for\\_Safeguarding\\_Adult\\_Boards.pdf](https://www.safeguardingwarwickshire.co.uk/images/downloads/Ministerial_Recommendations_for_Safeguarding_Adult_Boards.pdf)

<sup>38</sup> White, J. et al (2021) Mortality among rough sleepers, squatters, residents of homeless shelters or hotels and sofa-surfers: a pooled analysis of UK birth cohorts, *Int J Epidemiol.* 2022 Jun 13;51(3):839-846. doi: 10.1093/ije/dyab253. PMID: 34871417; PMCID: PMC9189982.

<sup>39</sup> CFE Research/ University of Sheffield, NECG (2022) 'More than a roof': addressing homelessness with people experiencing multiple disadvantage – Evaluation of Fulfilling Lives, TNL Community Fund: <https://www.tnlcommunityfund.org.uk/media/insights/documents/39More-than-a-roof39-addressing-homelessness-with-people-experiencing-multiple-disadvantage-2022.pdf?mtime=20220311155105&focal=none>

Housing is a major issue for almost everyone on the MDT caseload, with those in more secure tenures typically at risk of eviction on referral. The following chart provides as close to a baseline as is available (i.e. from the first outcomes questionnaires) of the CF MDT’s clients accommodation status:

Figure 16 - Graph to show CF MDT client accommodation status from first outcomes questionnaires



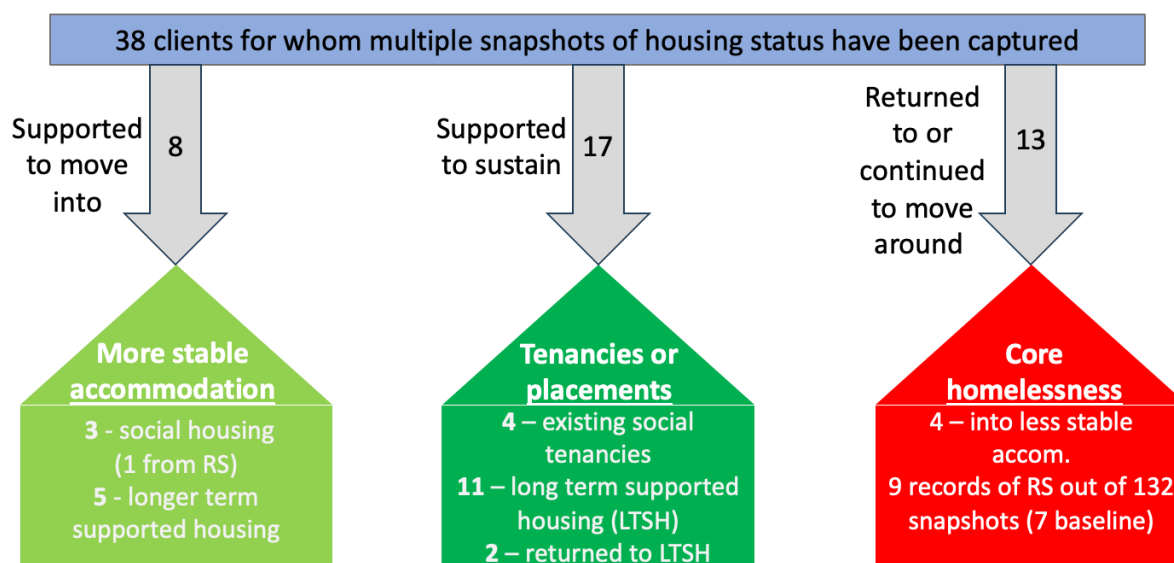
A particular strength of the CF MDT is that rough sleeping is not a requirement for referral; this means that the team can work with people with MCN who have a tenancy but are at risk of losing it and can stick with individuals as they move through housing pathways or drop out of them.

MDT clients often mentioned housing outcomes as being the most significant change for them as a result of their support from the MDT. Outcomes have included not having to sleep rough, moving “out of horrible accommodation and into a recovery flat” (CF MDT Client) and moving to a more central location in the city, thereby reducing isolation, cost and inconvenience.

*“Working with Changing Futures has meant I haven’t slept rough in over a year. I’ve not been homeless. I’ve had a roof over my head, it’s made a huge difference...”*  
(CF MDT client)

Housing outcomes are tracked for returns to CF, and Figure 17 below shows the housing journeys of the 38 MDT clients for whom multiple snapshots of housing status have been captured. On a note of caution, we cannot be sure that there have not been moves in between the snapshots taken, and it is not always possible to interpret whether a change or sustainment is positive or negative. We have no reliable way of assessing the extent to which this sample is representative of the whole caseload.

Figure 17 - Housing outcomes of a sample of MDT clients



Despite methodological caveats, this data certainly suggests positive housing journeys for many MDT clients:

- 3 people moved into social rented housing (1 directly from rough sleeping, see further discussion of this housing journey below).
- 5 were supported to move from emergency/ temporary/ short-term accommodation to long-term supported housing.
- 4 people were supported to sustain a social rented tenancy, which was presumably at-risk at the point of referral to the MDT.
- 11 people were supported to sustain long-term supported housing, with a further two moving out of one long-term supported housing placement but moving back into another long-term supported housing placement by the final snapshot.

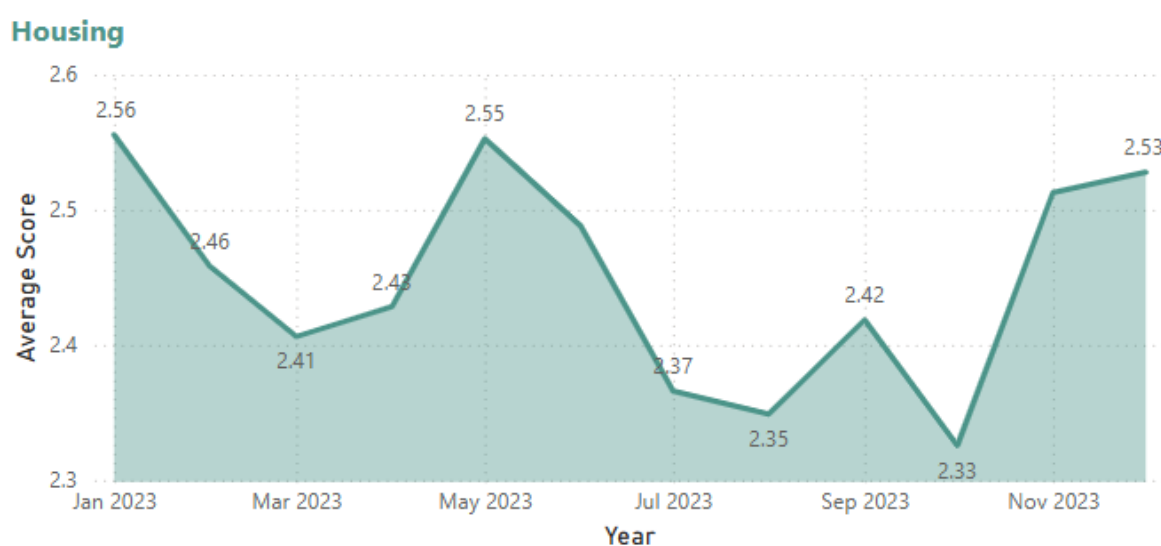
The remaining 13 continued to move between temporary settings (but only 1 of them was rough sleeping at the final snapshot); 4 of them moved to less secure accommodation over the course of the evaluation period.

Out of 132 snapshots taken of CF clients, there were 9 instances in which rough sleeping was recorded as the person's current accommodation status. 7 of these were at the first snapshot taken: 4 of these people did not complete a further snapshot questionnaire; the other three did and were supported out of rough sleeping.

This data shows the overall positive impact of MDT advocacy in relation to housing; however, it also serves to remind us that the housing journeys of people with MCN, even

with CF support, are rarely linear. This is also evident in the average New Directions Team Assessment (NDTA) scores for Housing, which – as the chart below shows - have fluctuated for the overall CF MDT caseload over the course of the evaluation period, though the size of the fluctuation is small, ranging by less than a quarter of a score point during the evaluation period. Note that a score of 2 is defined<sup>40</sup> as “Living in short-term / temporary accommodation; medium to high housing support needs” and a score of 3 is defined as “Immediate risk of loss of accommodation; living in short-term / temporary accommodation; high housing support needs”.

Figure 18 - Graph to show average score for housing over time (NDTA indicators)



A case study was shared by the MDT (and discussed by a focus group of housing professionals) of ‘Tom’, who had been rough sleeping for decades in the city and was now in his 60s. Tom had a historic mistrust of services. He had not wanted to engage in the past with outreach workers and was adamant that he would not move into a hostel or shared temporary accommodation. Over time and by taking a trauma-informed, flexible but intensive approach, his CF MDT keyworker was able to build a relationship with Tom, whilst advocating that a historic *Homemove*<sup>41</sup> application in his name was fast-tracked. Tom was allocated a Band B priority and moved into his flat, with support from the CF MDT to settle in and make the huge adjustments required. The focus group participants identified as critical success factors in this case: the time available to and the approach taken by the keyworker and, given that they were also part of the statutory Housing team and ‘knew some of the internal levers to pull’, their ability to escalate the case to senior management.

<sup>40</sup> Changing Futures NDTA Collection Guidance

<sup>41</sup> Homemove is the choice-based lettings application portal for Brighton and Hove: <https://www.homemove.brighton-hove.gov.uk>

**Service level**

<b>Activities</b>	<b>Outputs</b>	<b>Outcomes</b>	<b>Impact</b>	<b>Measures: data source</b>
- Assertive outreach for statutory homelessness work - Working with housing/ support providers to improve skills with MCN	- Statutory homelessness assessments completed - Barriers to housing reduced	<b>Housing:</b> preventing evictions; reducing use of emergency/ temporary accommodation . Reducing pressure on Housing Team	Suitable housing provides a stable base for effective engagement with other services	<i>Eclipse – housing data including prevention work</i>

***Integrating statutory homelessness processes within the MDT***

A distinctive feature of the CF MDT model in Brighton & Hove is that statutory homelessness assessments can be carried out by Homelessness Prevention Officers (HPOs) on the team. In this section, we consider the significance and value of this for clients and systems and draw learning from the implementation of this aspect of the MDT's work.

Before the Homelessness Reduction Act (HRA) 2017, single people with MCN were typically excluded from statutory homelessness processes<sup>42</sup>, though local authorities funded housing support services to meet the needs of single people who were assumed not to be in 'priority need' under the law. The HRA introduced two new universal duties: a 'prevention duty' and a 'relief duty', giving rights to advice and assessment for *all* at risk of homelessness, as well as those currently experiencing it. However, many barriers remain for those with MCN. Evidence from Safeguarding Adults Reviews (Blood 2022<sup>43</sup>) highlights pinch-points in relation to statutory decision-making for people with MCN, including:

- Whether a person is sufficiently 'vulnerable' to be granted 'priority need' (which means that the local authority has a duty to provide temporary accommodation, whilst assessing eligibility for a 'main duty' to provide longer-term housing), with decisions about physical and mental health conditions sometimes being made by housing departments without proper health and social care input.
- Decisions about whether a person is judged to have made themselves 'intentionally homeless' by leaving their last accommodation, which a person with MCN may be more likely to do, for example in response to real or perceived threats, anxiety or depression and, arguably, reduced mental capacity.

<sup>42</sup> Dwyer, P. et al (2015) 'Rights, responsibilities and refusals: Homelessness policy and the exclusion of single homeless people with complex needs', *Critical Social Policy*, 35(1), 3-23.  
<https://doi.org/10.1177/0261018314546311>

<sup>43</sup> Blood, I. (2022) 'Sustainable Housing' in Cooper, A. & Preston-Shoot, M. Eds (2022) *Adult Safeguarding and Homelessness: Understanding Good Practice*, Jessica Kingsley Publishers

- Whether people with MCN who have experienced domestic abuse and coercive control are identified as such, deemed to be in priority need and offered appropriate and safe services.
- Whether a person who has moved between areas, lost identification, or avoided service contact for many years can demonstrate a 'local connection'.

Additionally, people with MCN experience significant psychological and practical barriers presenting as homeless to the local authority. For example, in Brighton & Hove, there is an expectation that people can and will come into the central office to make a homelessness application, but this is not a psychologically informed environment. Where a person is a client of the CF MDT, the Homelessness Prevention Officer (HPO) on the team can instead outreach to find or visit them elsewhere and work at their pace.

The way in which this function is delivered by HPOs in the CF MDT has evolved over the duration of the pilot. At the outset, two HPOs were appointed within the team, but both found the role challenging and ultimately decided to leave: they were carrying out intensive keyworking with individuals, struggling to find accommodation placements for people who were typically barred from all mainstream options, and were finding it difficult to balance their relational role with the statutory decision-making and paperwork. Furthermore, there was a hiatus in line management for them within the Housing department at this time (amid a major re-structure), and they felt they were the only people within the CF MDT who understood the statutory housing framework.

The posts were vacant for some time and, during this period the restructure was implemented, and Housing and Adult Social Care were merged into the same directorate. These strategic and operational drivers have enabled direct links to be built between the CF MDT Operational Manager and the Housing Options Managers and they have worked together on housing-related applications. These positive relationships helped to build mutual understanding of roles, duties, processes and resources, and CF and the Housing Department worked together to recruit one new and one seconded HPO for the CF MDT.

The new HPO post-holders were interviewed by evaluators at the end of the evaluation, having recently settled into their roles. The HPO caseload has been expanded from the previous model: one worker explained that they are actively working with about 20 MDT clients (13 of whom have a homelessness application open) and they can also provide support to the rest of the team on housing issues. Not acting as keyworkers to clients was felt to make it easier to have more challenging statutory conversations, without jeopardising engagement.

Line management arrangements are in place and appear to be working well, with the HPOs receiving supervision from both the CF MDT and the mainstream HPO team within which they are also located. Working across two case management systems (HomeChoice and Eclipse, the social care system) has been a key challenge of the role; however, the new post-holders seem to have accepted that dual recording is an inevitable consequence of straddling Housing and Adult Social Care for the foreseeable future. Where one post-holder

has been seconded from Housing, they can see the value of now being able to access social care information too:

*“Having access to both systems is so helpful – I don’t have to chase around.... My knowledge of adult social care has massively increased.” (HPO)*

The HPOs identified the following examples of impact from their role:

- Providing an entry point via Adult Social Care/ Outreach for statutory homelessness assessments for people with MCN who would otherwise be unlikely to access these services via the mainstream front door or digital routes.
- Helping clients understand their rights and responsibilities within the statutory homelessness process: *“many have several homeless applications and don’t really understand what they are signing up for”* (HPO).
- Whilst there is a range of direct offers of accommodation in the city for people who do not access statutory homelessness processes, these tend to be one-off and isolated: it is very hard to progress through them to something more secure, especially if you have MCN. However, where the HPOs can support someone through the paperwork and multi-agency working required to reach the Main Duty stage, longer term housing options can open for people.
- Advocacy in relation to the suitability of Emergency Temporary Accommodation (ETA) placements: in the face of budget restrictions and huge demand, the council will typically discharge the first homelessness duty if an offer of ETA is refused. The HPOs can act as an intermediary in such cases, explaining the implications of the refusal to the CF MDT client, whilst also challenging the Housing department in relation to the suitability of the placement, due to MCN and safeguarding risks.

### *Access to supported housing*

Accessing suitable accommodation for its clients has been a significant challenge for the CF MDT. The team does not have direct access to emergency beds for those sleeping rough and must try to lever these via the statutory homelessness route, the RSI team (discussed below), or via wider community and voluntary sector offers in the city. CF clients’ needs and risks mean that these offers are often not suitable; and clients have typically been barred from services in the past. In the early months of the evaluation, we heard that there were frequent debates between Adult Social Care and Housing as to who would pay for spot-purchased emergency accommodation. MDT workers reflected on the negative impact of the delays resulting from these processes on their ability to engage people sleeping rough.

Over the course of the evaluation period, what has been described as an ‘informal pilot’ has developed between the MDT and New Steine Mews (NSM). NSM is a 24-bed mixed gender hostel in Brighton which, partly due to the high number of ground floor rooms in the building, has evolved to become a facility for homeless people with MCN assessed as Care Act eligible, including people being ‘stepped down’ from inpatient settings. Although many people move on from the hostel to residential care, there are limitations to the support which NSM can safely offer – for example, there are only two workers on site overnight.

At the time of our interview with NSM, around half of their residents were CF MDT clients. NSM prioritises CF referrals because the MDT 'stays with the person' and provides ongoing support and development to hostel staff. Feedback from NSM is that they value these relationships:

*"The MDT workers understand the residents and our limitations and challenges because they are in and out of our project. They just kind of pop up". (NSM)*

This partnership was reported to have reduced both refused referrals and unplanned evictions. For example, NSM explained that they had been able to accept a referral of someone for whom the risks were much higher than they might normally have been able to accommodate, because they were reassured that the MDT was involved. The MDT had been very quick to set up health and care workers to come in and provide additional support; they 'understand the urgency'. Similarly, where it was necessary to evict an MDT client (a decision which is not taken lightly), the MDT respected the boundaries of NSM staff, understood and supported their experience and they were able to work together to find a suitable alternative placement, rather than evict someone with MCN to the streets.

Since NSM is an Adult Social Care resource, the hostel cannot refer into the supported housing pathway, unlike the CF MDT. This has meant that the MDT clients have access to a wider range of move-on accommodation than other NSM residents, and the MDT can stay with them as they move to their next accommodation. This way of working has, however, served to highlight the lack of access to ongoing social work review, MDT input and move-on options for the remainder of NSM's residents, who are reported to have similar levels of complexity.

Where MDT clients are struggling to maintain accommodation both at NSM and in other hostels and temporary accommodation settings, additional cleaning and support visits from care agencies or deep cleaning services have been funded by Adult Social Care.

Finding suitable placements for people with higher care needs has been challenging. It has been particularly hard to find placements for people with co-occurring substance use needs and where a Deprivation of Liberty Safeguards (DOLS) arrangement might be put in place to prevent the person leaving the premises during periods where they lack mental capacity and risks are high. At the start of the evaluation period, the MDT had successfully placed some clients in specialist supported housing in London, having had the very high placement costs approved by the Adult Social Care funding panel. Over the course of the evaluation, Adult Social Care has worked with this provider to open a new scheme in Brighton & Hove. The CF MDT has also successfully advocated for one of their clients to move into specialist accommodation on the Brighton & Hove mental health pathway and has received glowing feedback from a care home in relation to the support from and partnership working with the MDT in relation to client placed there.

### *Joint working with the RSI team*

BHCC also delivers a sizeable Navigator service for rough sleepers with MCN, using funding from a different MHCLG pot ([Rough Sleeping Initiative](#), RSI). This service operates alongside

the council’s outreach service and provides a more intensive and relational offer – with many similarities to the CF MDT model of practice - to a ‘priority group’ of around 50 people. The Navigator service has the advantage of being able to access emergency beds in the city, which – as highlighted above - the CF MDT cannot. The RSI funds a social work post to work with the Navigator service, which was initially based in the Navigator service, but this left the social worker isolated from the rest of Adult Social Care and, when the post-holder left, it was agreed that the post would sit within the CF MDT.

This joint working between the two services has taken some bedding in. On the one hand this has been due to logistics: the RSI team would prefer a dedicated social worker on the MDT who can act as a central point of contact for them; but the MDT way of working is to share responsibility for cases between team members so that no single worker is ‘isolated and sitting outside the MDT in a bubble’ – this also helps with staff cover. There have also been ‘teething issues’ due to expectations that the Care Act Assessment process will quickly access additional support for Navigator clients, where this process is long and requires management sign-off.

Despite frustrations in the short term, working through these issues does seem to have enabled the development of stronger relationships between the managers of both teams, increasing mutual awareness of roles, resources and limitations, and prompting system-level conversations about whether these two services might be better integrated in future.

#### System level

Activities	Outputs	Outcomes	Impact	Measures: data source
- Better coordination across agencies/ with providers -Development of clearer accommodation pathways for MCN in B&H	- Fewer instances of homelessness - ASC and Housing better understand each other’s duties	<b>Housing:</b> the cohort is more suitably and safely housed	Better overall outcomes for individuals via suitable housing. Reduced costs resulting from shorter time in ETA, delayed discharges, poor engagement due to housing	<i>CF data, observation, staff interviews – discharge data?</i>

As demonstrated in the previous section, the CF MDT has succeeded in making significant progress over the course of the evaluation in developing partnerships to secure accommodation, with the necessary care and support, for its clients, in a structural context of limited resources. In this section, we consider evidence of a ‘ripple effect’ from this work out to wider systems. We also reflect on areas for ongoing system-level development which have been highlighted by the pilot.

As highlighted above, there is some evidence of a trauma-informed ‘ripple effect’ from CF MDT to the wider statutory homelessness team, partly resulting from individual secondments and the line management arrangements for the MDT HPO, but also from wider challenge from the MDT HPOs to their colleagues, for example in relation to conditionality and housing as a right. Strengthened by the merger, there seems to be a strong sense of shared vision for people with MCN between Housing and Adult Social Care.

*“Each partner has their statutory duty, but as a partnership, we want to improve outcomes”.* (Senior Manager, Housing)

The MHCLG (then DLUHC) Deep Dive highlighted the impact of the closer working between Adult Social Care and Changing Futures on improved awareness of safeguarding, and the use of safeguarding ‘language’ in relation to people experiencing homelessness, though they observed remaining ‘discrepancies’ within some street-based services.

There is significant investment in tackling homelessness in Brighton & Hove, yet there is a recognition of opportunities to better join up and strategically target these. For example, the evaluation has highlighted:

- The risk of duplication between the RSI Navigator service and the CF MDT, and the differential access each team has to social work resource and emergency housing. A Case for Change has recently been produced to merge these two services to combine available resources and expand combined capacity.
- The lack of a clear housing, care and support pathway for people with MCN which:
  - Sets out the various options and which is best targeted at groups with different needs or requirements
  - Stream-lines referral routes into and out of them (for example, New Steine Mews – since they are an Adult Social Care resource - cannot refer into the Homelessness Pathway for move-on)
  - Makes explicit for clients and those workers advocating for them the expectations, criteria, decision-making and appeals, including in relation to timely applications to the housing register.
- There is an existing Housing First offer in Brighton & Hove, currently with approximately 60 places; however, given the low throughput inherent in the model feedback is that this rarely has available spaces. Nevertheless, MDT staff describe good operational relationships with this service. There is an opportunity to consider how the existing support from the CF MDT and from the Housing First service might be integrated to further scale up the offer in the city (as recommended in the Deep Dive). The MDT is effectively already offering a Housing First service – or at least the intensive case management, support and housing advocacy components of it. If a small supply of housing could be made available to the MDT (recognising how challenging this is in Brighton & Hove), Housing First could effectively be scaled up gradually via this route. This approach is being considered by the Northern Ireland Housing Executive, which is keen to scale Housing First and recognises that much of

the model is already being delivered through its Complex Lives MDT approach, if only a dedicated source of housing supply could be levered into the model.

- Another example is provided by Cardiff City Council, which has worked with Registered Providers of Housing to develop new blocks of flats in different parts of the city. These ‘managed blocks’ provide high quality self-contained flats offered as standard general needs tenancies, with rents at Local Housing Allowance level. A housing support worker is on site in the office during office hours, and there is an out of hours concierge service, but intentionally no communal spaces. One block has been used to successfully resettle over 60 people with MCN and long histories of homelessness. Additional packages of support can be commissioned for individuals and flexed over time as needs rise and fall – these include input from the city’s MCN MDT as well as from floating support staff.

#### 4.6. Self, connection and recovery

##### Introduction

In presenting each of the outcomes separately as we have done in this evaluation report, there is a risk that we lose sight of the whole person – the inter-connectedness of the challenges they face, and what matters most to them. In this section, we consider how the CF MDT – and particularly, though not exclusively the Peer Support team - has worked with people to promote recovery outcomes: self-management, relapse resiliency, self-awareness, motivation, and hope.

The way in which national programmes like Changing Futures, local service responses and outcomes measures are designed tends to assume that ‘recovery’ is a linear process, and that, with relatively short interventions, most people – even those with MCN – will want to and can realistically progress to abstinence, or even employment. For example, the MDT includes a ‘Recovery Coordinator’ and Community Support workers, whose job descriptions focus on supporting people into education, training and employment. Yet the case studies produced by the MDT demonstrate the depth of trauma, abuse, and disadvantage which clients of the service have experienced and the huge challenges facing workers in building even their initial trust.

*“Commissioners and government have an idea about what recovery is and how long it should take and assume it’s achievable”. (MDT worker)*

##### Individual level

Activities	Outputs	Outcomes	Impact	Measures: data source
- Building safe and supportive relationships with MDT	-Increase in awareness of mental health/substance use challenges;	<b>Self, connection and recovery:</b> improved emotional and	Better overall outcomes and quality of life	<i>Self-reported (including through Most Significant Change).</i>

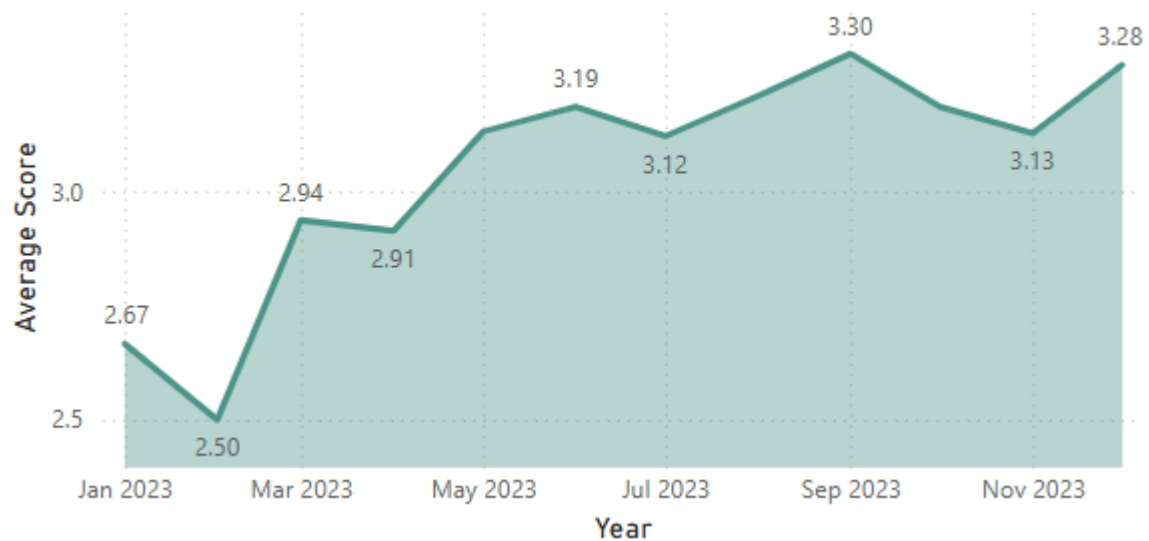
(including peer workers) - Exploring what matters to individuals - Supporting people to take up meaningful activities, re-connect with family	change talk; contemplation of/ confidence to change - Reduced contact/ better boundaries re abusive or unhealthy relationships - Attendances at cafes, groups, libraries, activities, etc - Increased contact in healthy and positive relationships	psychological wellbeing and resilience through positive activities and relationships		<i>Eclipse</i>
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The inter-related nature of people’s challenges is evident from these case studies – people cannot access mental health services because they are using drugs and drinking; but they cannot stop using drugs and drinking because these addictions are a way of coping with past trauma, domestic abuse, homelessness, physical pain and mental health symptoms. For most people, none of the above can begin until they are in accommodation where they feel safe.

It is within that context that we must interpret the NDTA outcome tracker scores which suggests that alcohol and drug use for the MDT caseload on average has worsened slightly over the course of the evaluation period.

Figure 19 - Graph to show average score for alcohol/drugs over time (NDTA indicators)

### Alcohol / Drugs



*NB: Scores 2: Some use of alcohol or abuse of drugs with some effect on functioning; sometimes inappropriate to others; 3: Recurrent use of alcohol or abuse of drugs which causes significant effect on functioning; aggressive behaviour to others*

One reason for this apparent pattern is that it takes time to people to build sufficient trust to speak honestly and openly about their substance use:

*“The longer you work with people, the more they get to trust you – you understand them better, and they are therefore more likely to tell you about risks, the self-harm, the drug use, the domestic abuse, etc. Within 6 months you don’t know all the times they have self-harmed/ used drugs – they often open up to us over the time. You can’t do the work in 18 months – you are just getting the lie of the land”. (MDT worker)*

However, the scores also reflect the fact that reducing drug and alcohol use is not a priority for some people on the caseload at the present time. Even where it is, this is not a straightforward process given the Cycle of Change<sup>44</sup> model (in which cycles of relapse are an inevitable part of change) combined with the ongoing instability and crises which CF MDT clients continue to experience, at least in the first year or two of intervention.

Despite these challenges, in October 2024, 8 out of the 13 people being supported by the peer support workers had expressed a desire to find or maintain recovery from drug and/or alcohol use. The team was working actively with 9 people at different stages of the Cycle of Change to provide recovery support at their own pace. Examples of this have included: taking someone to visit a residential rehabilitation unit and supporting their decision-

<sup>44</sup> Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390-395. <http://doi.org/10.1037/0022-006X.51.3.390>

making and application to attend it; helping another to make an exit plan for when they leave residential rehabilitation; supporting someone to attend 12-step meetings; helping someone to establish boundaries with friends and associates to protect their recovery.

In the three-month period reported in October 2024, the peer support workers attended 26 different recovery/ community support groups with the people they were supporting. These included the Kennedy Recovery Hub, AA/ NA groups, women/LGBTQI-specific groups, CFL 'Speakeasy' group, and groups with more of a focus on creativity and mindfulness.

In addition to these group attendances, we also heard how people being supported to take part in mainstream activities, like going to the cinema, going out for coffee, doing a pottery class, and in some instances, starting to reconnect with estranged family. Moving beyond solely attending service appointments to 'build a life beyond services' is a key part of the vision for the MCN programme in Brighton & Hove. Funds have been used from the 'Wellbeing' tier of the CF personalisation budget for purchases to support personal wellbeing, including art supplies, writing journals, beauty and self-soothing products, cinema trips, etc.

For part of the evaluation period, the peer support team experimented with establishing a peer group space. This was co-produced with those clients with whom they have a good relationship and included a range of activities, from poetry to jewellery-making. Numbers attending were low, but the group successfully created a very safe space for those attending. The group was put on hold while the peer support workers pursued other priorities, such as supporting the lived experience strand of this evaluation and working on developing and delivering training and other products; however, they hope to re-launch this in the future, perhaps including a more formalised peer support group structure.

There are some powerful case studies and personal stories of change from individuals supported by the CF MDT. As Common Ambition reflected, these individuals are at high risk of loneliness and isolation. Recurring themes in client stories about the impact of CF include people feeling less alone, growing in confidence, independence and self-sufficiency, feeling better able to make choices, reduced stress, managing things better. Clients describe feeling 'content', 'happy', 'excited for the future'. A couple of clients described becoming sober/clean whilst receiving support: they valued the regularity of support, help to access complementary therapies, and support to get out and see others or engage with other services when experiencing anxiety.

The quality of the support – relational, non-judgemental, person-led and informed by lived experience – is key to the service being able to create the conditions in which some of its clients have achieved these remarkable outcomes:

*"you can choose your options they're not pushing you..... like giving me a map and I decide which way to take..... look at the world around and what you can do."*

(CF MDT client)

*“I’ve never felt judged by [my worker] in any shape or form, I’ve always felt judged by other workers in some ways. He always reminds me of how well I’m doing even if I go backwards and that’s helping me to see it for myself too.” (CF MDT client)*

Common Ambition, our lived experience evaluation partner, reflected on these client stories of change:

*“[The MDT approach is....] giving you a ladder rather than pulling you out.”*

*“[These clients] learn their own way into recovery, not what someone else thinks they should do....in contrast to some services where you have to follow criteria, do things in a particular way”.*

One case study describes how a person with an extensive history of trauma, homelessness, mental health challenges and substance use was (once settled and feeling psychologically safe in a longer-term supported accommodation project) supported by the MDT staff and peer support team on recovery focused work using a motivational interviewing model. The client commented,

*“It feels really good to focus on who I am as a person, what has always mattered to me, not just the chaos... [Peer Support Worker] is such an inspiration to me, I need that energy around me”. (MDT client)*

However, it is vital to note that this therapeutic work, and the depth of engagement required to underpin it, was not possible prior to the person accessing the accommodation placement. The client said of this placement, which took considerable advocacy from the MDT to set up:

*“This is the first time in years that I have genuinely felt safe, I feel tethered to something that feels like a real home”*

Whilst the MDT intervention does not have a fixed time limit, neither is it intended to go on forever. Common Ambition reflected on the risk of clients building dependence on the team, and this is a real challenge, though one which the team is clearly very aware of and is constantly trying to plan for, both in terms of building people’s capacity to do things for themselves and helping them to develop wider support networks.

*“While [the ongoing social visits from the peer support worker] is still very important to him as he craves social contact, it can’t be sustained long term and we are looking at alternatives to provide this support when CF close his case.”*

(PSW, Peer Support Quarterly Monitoring Report, Q2, October 2024)

**Service level**

<b>Activities</b>	<b>Outputs</b>	<b>Outcomes</b>	<b>Impact</b>	<b>Measures: data source</b>
n/a	n/a	n/a	n/a	

At service level, there are several key facilitators of this model.

Firstly, as we saw in a previous section, the peer support team receives excellent supervision and support, and the service prioritises the ongoing recovery of the peer support workers themselves. Within the structures created by the service (such as weekly peer support team meetings and opportunities to work collectively on projects) the peer support workers have developed considerable mutual support.

*“The team consistently cite the role as a source of stability and inspiration to look at other aspects in their life that they now wish to change”.*

(Peer Support Quarterly Monitoring Report, Q2, October 2024)

Another facilitator has been the integration of lived experience throughout the MDT. The peer support work team have been able to challenge other members of the MDT staff team in relation to how best to support recovery. The impact of this is evident in many of the staff MSC stories.

*“Working with people with lived experience where what was previously abstract information from a client based on what they are willing or comfortable to share with me.”* (MDT worker)

Common Ambition, reflecting on staff MSC stories, commented,

*“Working with people with lived experience has made them realise that they ‘make assumptions a lot of the time’ about what was best for a client but now they no longer do this which has ‘been really humbling’”.*

(Common Ambition (with quotes from MDT staff))

The peer support workers have also run more formal training sessions for the rest of the team, infused with their own lived experience perspectives. One MDT worker commented on their 2-hour session on addiction and recovery:

*“The trauma-informed lens which the workshop took allowed the team to move past general harm-reduction advice and really consider how substance use and addiction impact all areas of someone’s life”.* (MDT worker)

For the peer support team themselves, the experience of delivering training to their professional colleagues promoted a sense of equality across the team, and helped to integrate their experience in the team’s wider practice:

*“Sometimes you feel that lived experience roles, you can feel like the lowest paid add on – it was such a nice feeling to not feel like one of those and that we have an expertise that we were able to share in that workshop”. (MDT PSW)*

The peer support team have also been developing a Lived Experience recovery pack, which will provide an important legacy output from the pilot; though this has had to be put on hold in recent months to make space for other developmental projects, such as the MSC story collection for this evaluation, alongside operational pressures.

### **System level**

A couple of points to make about the system implications and impacts of this work:

- Firstly, it is dependent on a ‘wealth of community recovery activities in Brighton & Hove’, so ensuring the sustainment of this diverse provision is key.
- Secondly, the CF MDT has created a significant legacy resource, including trained and experienced peer support workers, ways of working, resources such as the Recovery Pack and training sessions. It will be important to build on these moving forwards and ensure that they continue to be used and developed within the proposed integrated team model.

## 5. Exploring effectiveness

This section of the report explores the effectiveness of the MDT Pilot. A general discussion of the issues in measuring outcomes for services working with people with multiple and complex needs is followed by an exploration of a swim lane analysis, conducted by *Changing Futures Sussex*<sup>45</sup>. Swim lane analysis<sup>46</sup> provides detailed pictures of service users' journeys through emergency, health, social work and other services, their resource use and records the achievements of the MDT Pilot. This section of the report concludes with a critical assessment of the swim lane approach and its strengths and limitations for measuring the effectiveness of the MDT Pilot.

### 5.1. Modelling effectiveness in MDT services

Service effectiveness and cost efficiency for models using an assertive, person centred, flexible and trauma informed approach of case management, like the MDT Pilot, can be measured in several ways. Techniques for exploring efficiency and effectiveness have evolved in parallel with the rise of broadly similar case management models, including intensive housing related floating support (housing-led services) and various forms of Housing First.<sup>47</sup> These other service models are similarly focused on populations with the same, or very similar, sets of multiple and complex needs (MCN) as the MDT Pilot, i.e. homelessness, current or historical offending, substance misuse, domestic abuse and mental ill health<sup>48</sup>.

Effectiveness for multidisciplinary services for people with MCN tends to be assessed using a mix of the following criteria:

- Increasing efficiency compared to fixed site, usually congregate, supported housing and social care provision. The particular concern here is with fixed site services that are designed to offer short- or medium-term accommodation and support, in which groups of people with MCN become 'stuck' either becoming semi-permanent residents or making repeated stays. This is seen as a significant waste of resources as the 'stuck' people with MCNs are not making sustained gains in their health, wellbeing, social supports or capacity to live independently. Mobile multidisciplinary teams also do not have the capital and maintenance costs associated with fixed site services.
- Addressing support and treatment needs and generating improvements in wellbeing, which can be broken down into:
  - Gains in self-confidence, through esteem support, that generates positive behavioural change and better self-care.

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<sup>45</sup> <https://www.changingfuturesussex.org/>

<sup>46</sup> Improvement Toolkit Academy (2024) [Swimlane Diagrams](#) NHS Wales.

<sup>47</sup> Pleace, N. and Bretherton, J. (2019) [The Cost Effectiveness of Housing First in England](#) Homeless Link

<sup>48</sup> Whereas the MDT Pilot is focused on people with three out of these four sets of treatment and support needs, these other services may not use identical referral criteria, e.g. Housing First might aimed people experiencing homelessness on a long-term and recurrent basis, who tend to have MCN at very high rates, but may not be focused on people a given pattern of MCNs.

- Better access to treatment, support and other necessary services, through informational and practical (instrumental) support.
- Enhancements in social companionship and social capital/participation including friendships, partnerships and community relationships that can also improve health and well-being.
- Residential stability (ending homelessness where it has been an issue).
- Engagement in education, training and/or employment.
- Improvements in mental health.
- (Where applicable) improvements in addiction/alcohol use.
- Improvements in physical health, including limiting illness and disability.
- (Where applicable) reduction/cessation of nuisance/anti-social behaviour.
- (Where applicable) reduction/cessation of criminal activity.
- (Where applicable) cessation of risk of domestic abuse and violence from former partners/family members and others.
- Creating cost offsets for other services, particularly emergency services that have very high operational costs, by reducing or ending *high* frequency contact with those services, including:
  - Accident and Emergency (A&E).
  - Mental health services.
  - Addiction services.
  - Emergency shelters and fixed site supported housing.
  - Refuges and other domestic abuse/violence services.
  - The Police and criminal justice system (especially high frequency of small offences).
  - Reducing or ending ‘revolving door’ patterns of service use that see individuals go into crisis, experience expensive emergency service interventions, stabilise, undergo another crisis and re-enter those services, also known as a ‘frequent flyer’, pattern of service use.
- Reducing the scale and duration of costs to the NHS and social care by:
  - Cutting the frequency and duration of hospital stays by general improvements in mental and physical health, lifestyle, social support, self-esteem and emotional support.
  - Minimising the risks and rates of unplanned hospital admissions.
  - Ensuring discharge from a hospital stay can happen when someone is ready to leave and is not delayed.
  - Maximising treatment and care in the community using primary care and related services, i.e. ensuring treatment and care that does not need to happen in hospital is accessed in the community as much as possible.
  - Prolonging the ‘healthy years’ lifespan of people who might otherwise need long-term support from social care services.

All these different measures combine, in different ways depending on patterns of need, to create what might be termed a four-step model that should arise from a successful service contact by an MDT. When working in an ideal way, a service like the MDT Pilot or a broadly comparable model like Housing First, should deliver this four-step model:

1. Ends a pattern of repeated and/or sustained use of short- and medium-term fixed site supported housing which is not resolving support and treatment needs. This can

include emergency shelters, hostels, supported housing, refuge and other fixed site services in which people with MCN become 'stuck' or caught in a pattern of 'revolving door'/'frequent flyer' use of fixed site services, without their treatment, support and care needs being met or risks including homelessness being properly or sustainably addressed.

2. Significant improvements in mental and physical health, social support, self-esteem, meaningful activity (including but not restricted to education, training and employment), stability in housing, relationships (friends and family) and in the community and (where applicable) reductions in addiction, nuisance and criminality.
3. Marked reductions in unplanned, repeated and ineffective service contact, including expensive emergency health, mental health and (where applicable) criminal justice services and increased planned use of more cost efficient community services.
4. Reduced 'lifetime' costs to the entire social protection and public health system, because by maximising health and wellbeing and the number of 'healthy years' that someone lives, the potential lifetime costs that would be associated with meeting the ever-increasing cost of helping someone with unmet MCNs are either reduced, or do not occur.

This is a broad picture of how MDT teams are supposed to work with people with MCN, which will obviously vary by the pattern of the needs among the people a service is working with and by the specific role ascribed to the service. A Housing First team might be used specifically to support people with MCN who have become stuck or caught in a revolving door pattern in the hostels pathway that is designed to end homelessness and rough sleeping. Equally, an MDT might be used to prevent and reduce homelessness among young people leaving the care system, might be tailored to the specific needs of women with MCN or aimed at preventing homelessness and recidivism among people with MCN leaving prison. These services will need to be tailored to the operational goals.

This means the pattern of referral and the steps involved in what an MDT service provides will vary, by who the service is designed to help and also, as with the Brighton and Hove MDT Pilot, because it will often be engaging with people in different situations and within different patterns of service use. Sometimes an MDT might be helping someone with MCN out of living rough, sometimes it will be helping a person with MCN who has been in supported housing for far longer than they should have been, or it might be someone who has just been evicted, released from prison or discharged from hospital. MDT services are implemented in various ways and are designed to respond flexibly to what can be highly variable situations which people with MCN are facing. However, the core logic of ending patterns of costly emergency service use, bringing a stop to frequent/sustained use of fixed site services like supported housing and improving health and wellbeing in the long term to improve health and social outcomes for each person and minimise future strain on publicly funded services, is a constant in MDT services, including those supported by other MCN programmes.<sup>49</sup>

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<sup>49</sup> Quilgars, D. and Pleace, N. (2018) [The Inspiring Change Manchester Housing First Pilot: Final Evaluation Report](#) University of York.

Using this logic, gains to individual wellbeing and health have multiple beneficial effects that only start with the improvements in mental and physical health for the person receiving a service like the MDT pilot that uses assertive, person centred, flexible and trauma informed approach to case management. Once someone is as well as they can be and in a stable, positive situation in terms of their housing, social support and access to meaningful activity, reductions in resource use and enablement of more efficient resource use happens on two levels. First, there are immediate gains through a shift to community-based treatment and support, which creates greater stability and better outcomes at a much lower cost than repeated, short term, expensive emergency interventions. Second, as just described, the 'lifetime' costs of an individual who would otherwise have faced an increase in the complexity and intensity of their treatment and support needs is reduced. In essence, there is potential for both a long-term and an immediate gain from effective operation of MDT services.

## 5.2. Challenges in measuring effectiveness in MDT services

The potential for MDT services in helping people with MCN is obvious, but there are some challenges in both realising that potential and in measuring the degree to which it is achieved. Arguments that MDT models both enhance health and wellbeing and *cost less* than the usual patterns of repeated and/or sustained use of emergency and fixed site supported housing services are widespread.<sup>50</sup> However, it has been noted that cost savings are dependent on service users having the following characteristics:

- High frequency use of emergency services
- High frequency contact with criminal justice system
- High frequency/sustained use of supported housing and other residential services (such as rehabilitation) which does not result in a lasting improvement in MCN

As soon as these factors are *not* all present the cost saving potential of an MDT is reduced.<sup>51</sup> For example:

- Someone with MCN is not making appropriate use of mental health, health, social care and/or supported housing services at the point of referral to an MDT, nor making high frequency use of emergency services nor involved with the criminal justice system. Some costs will spike as this person is connected to the appropriate support, care and treatment by the MDT.
- Someone with MCN is making use of services, but not high frequency or sustained use, so costs may rise to some degree, at least temporarily, when an MDT starts working with them.
- There is a lived reality of fluctuating needs among people with MCN, causing spikes and dips in associated costs, both in terms of the extent to which they require MDT services and input from other services. Stability and health may increase over time, but the process may be a long one, with their costs fluctuating as needs rise, fall and rise again.

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<sup>50</sup> Padgett, D.; Henwood, B. and Tsemberis, S. (2016) [\*Housing First: Ending Homelessness, Transforming Systems, and Changing Lives\*](#) Oxford University Press

<sup>51</sup> Stanhope, V. and Dunn, K. (2011) The curious case of Housing First: The limits of evidence based policy. *International Journal of Law and Psychiatry*, 34(4), pp.275-282.

- As with any service model, success rates for MDT services in improving stability, health and wellbeing may be high, especially relative to ‘treatment as usual’, but success is not uniform or inevitable. In addition, other factors outside the control of an MDT service may influence results. Not everyone with whom MDT services engage will always be in a better place following that engagement, even though there is strong evidence of generally positive outcomes for these services.<sup>52</sup>
- Early mortality rates for some MDT services working with people with MCN can be high, i.e. people may see gains in health and wellbeing and positive shifts in patterns of NHS and other service use, but longer term gains may not always be attained. This is because people with MCN may have shorter lifespans because of the impacts that unmet treatment, care and support needs may have had prior to their referral to an MDT service.<sup>53</sup>

High volume public services, like the NHS and within the NHS A&E departments and ambulance services, or the Police and criminal justice system may have difficulty in quantifying and realising cost offsets from MDT services. The issue stems from the relative scale of activity associated with people with MCN and the difficulty in tracking what is happening in terms of patterns of service use. By most estimates the numbers of people with MCN are quite small in relation to total population. People with MCN, if they are not receiving the right mix of treatment and support and properly housed, can become high cost, high risk individuals for whom the costs to the State can become very high. If someone is repeatedly arrested and processed, repeatedly uses A&E, experiences multiple emergency hospital admissions and has high frequency contact with mental health and/or addiction services it becomes very expensive to the tax payer very fast. However, the actual numbers of people involved can be relatively small, one attempt at estimation in England reported that the equivalent of 1.5 people per thousand were in a situation in which they were homeless, had a history of offending and of substance abuse (this group would also have high prevalence of mental illness).<sup>54</sup>

What this means in practice is that while people with MCN *may* (but will not necessarily) have high rates of emergency service use and be caught in a revolving door/frequent flyer pattern or stuck in supported housing/homelessness services, they do not represent a very high proportion of total service *traffic*. For example, while people with MCN may have been to A&E more than once as part of the 2.4 million attendances at A&E that happened in March 2024 in England<sup>55</sup>, the great majority of service use was by people who did not have MCN. This means a hospital would not be able to free up significant capacity if an MDT greatly reduced the number of repeat A&E attendances by people with MCN, because the great bulk of people turning up at A&E would still be there.

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<sup>52</sup> Pleace, N. (2023) Complex needs and Housing First in Bretherton, J. and Pleace, N. (eds) *The Routledge Handbook of Homelessness* London, Routledge, pp. 234-243; Nelson, G. (2024) Housing First and Public Policy in Johnson, G. (et al) (eds) *Research Handbook on Homelessness* London: Elgar, pp. 388-405.

<sup>53</sup> Blood, I.; Birchall, A. and Pleace, N. (2021) [Reducing, Changing or Ending Housing First Support](#) Homeless Link

<sup>54</sup> Bramley, G.; Fitzpatrick, S. et al (2015) [Hard Edges: Mapping severe and multiple disadvantage \(England\)](#) Langkelly Chase.

<sup>55</sup> <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/04/Statistical-commentary-March-2024-b64fcb.pdf>

However, cost-based arguments are not the only driver of potential change in how services are organised and work together. For example, an A&E department will be aware of the logistical pressures being put on services and systems and the impacts on staff morale, if say, a small group of people with MCN are using A&E on multiple occasions every year. The NHS can and will invest in services that reduce high frequency use of A&E by people with MCN, improve health outcomes for them and reduce some of the pressure in hugely challenging working environments like an A&E.

If emergency and other services, can reduce pressure on their services, even if there is no tangible saving to operational budgets, they will be willing to support MDT teams that can achieve this. The *capacity* of other services to actively support MDTs, by providing resources and collaboration may however be restricted, in the still ongoing situation of general financial constraint and deep cuts to many public services. This links to a final point which is the impacts that environments can have on MDT services and their effectiveness in working with people with MCN.

An MDT is not a self-contained system, i.e. it is not a welfare state in miniature. All MDTs depend on joint working with other agencies. As soon as those joint relationships are either not functioning well, or one of the partner agencies is experiencing significant resource issues, the effectiveness of the MDT can be compromised. Whenever someone with MCN working with an MDT team cannot access a resource because the partner agencies for the MDT are unable to supply it in a timely fashion, be it access to a social rented tenancy or a series of appointments with a psychiatrist, then there is the potential that an MDT will find performance undermined by factors outside its control. There are risks inherent in MDT models that are reliant on case management, and which do not have direct buy-in from multiple agencies. The Brighton and Hove MDT Pilot retains some reliance on other services to deliver the multiagency packages of treatment, care and support that people with MCN require; as we have seen in previous chapters, access to specialist mental health care and to suitable housing have been challenging.

### 5.3. The Swim Lane Analysis

The Swim Lane analysis summarised and discussed here has been produced by *Changing Futures Sussex*<sup>56</sup>. Swim lane analysis is a detailed examination of the patterns of service use by individuals with MCN being supported by the MDT Pilot. Each 'lane' is a form of service use, e.g. A&E or Adult Social Care, in which activity is tracked over time. Each Swimlane is in effect a large diagram that visualises a service user's journey through their time in using the MDT Pilot, showing the interactions with both the MDT Pilot itself and with other services during that journey. This represents the pattern of total use of services, within and outside their contact with the MDT Pilot, providing a calendar and a map of their service use history. The advantage of this approach is that patterns of service use can be tracked, so to take a basic example, one might explore whether sustained contact with the Brighton and Hove MDT Pilot produced a reduction in certain kinds of emergency service use, like an A&E attendance or ambulance rides and an increase in the

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<sup>56</sup> <https://www.changingfuturesussex.org/>

use of primary care services, like GP appointments, over the course of six months or a year. Similarly, shifts in other forms of service contact, such as with the Police and criminal justice service, emergency mental health services, addiction services and others can be tracked over time, to see if engagement with the MDT Pilot could be linked to shifts in the nature and extent of different forms of service contact.

The *Changing Futures Sussex* Swim Lane model encompasses the following sets of data, which are recorded as brief notes whenever activity takes place under each category. Alongside recording patterns in service use, the Swim Lane model also records shifts in wellbeing (NDTA scores, see below) and records the self-expression ('Voice') of people with MCN using the Brighton and Hove MDT Pilot.

- New Direction Team Assessment NDTA scores ('Chaos Index')
- Changing Futures and Adult Social Care (ASC) Interventions
- Safeguarding Referral (Non Police)
- Domestic Abuse Intervention (MARAC)
- Mental Health intervention
- Drug and Alcohol intervention
- Criminal Justice intervention
- Police contacts
- Ambulance contacts
- Hospital contacts
- Hospital Admissions
- Primary Care use
- Accommodation status
- Accommodation episodes (issues with accommodation)
- Financial / Benefits / DWP
- Service user voice

Figure 20 below, which is based on work produced by *Changing Futures Sussex*, provides a broad summary of how a Swim Lane approach is applied. As can be seen, this is a complex piece of mapping that details a wide array of patterns of service use over time, while also tracking outcomes. The yellow blocks show clusters of service use, and the columns show those patterns before the use of the MDT Pilot (marked by the blue line) and afterwards. Over time, in this illustrative example, service use has changed, for example there is a marked reduction in contact with the Police and criminal justice system and reductions in hospital use, while engagement with adult social care (ASC) increases significantly and a stable housing situation has been established.



#### 5.4. Three levels of measurement

The Swim Lane approach adopted by Changing Futures Sussex has three core systems of measurement. These can be summarised as follows:

- Cost and cost offsets, i.e. how patterns of expenditure shift over time, so for example a cost can be attributed to someone using the MDT Pilot if their use of A&E reduces and their use of a GP service increases, or if they enter stable housing and stop staying in supported housing. There is both the cost of the intervention, i.e. how much the A&E use or stays in supported housing cost and the cost of moving to a more stable housing situation and using primary care rather than emergency services. This can measure a) whether there is an overall saving and b) whether that saving results from significant cost offsets, e.g. A&E is spending less because someone is now using a GP service, which is less expensive to the NHS as a whole.
- Measures of system pressure, i.e. the intensity and pattern of resource use over time by someone using the MDT Pilot. This provides an alternative way of looking at how patterns of service use are being altered by use of the MDT Pilot. For example, high system pressure points exist when multiple agencies are involved and particularly when high resource emergency services are part of that mix. If someone is creating multiple pressures on multiple systems, e.g. they keep getting arrested, keep using A&E, keep having contact with emergency mental health services and use of the MDT Pilot subsequently reduces the overall level and range of pressure, by helping them shift towards community service use this also shows a positive outcome. The system pressure approach can be useful when it is complex to ascribe accurate estimates of cost to every aspect of someone's service use.<sup>57</sup>
- The New Direction Team Assessment NDTA scores ('Chaos Index')<sup>58</sup> for each service user. While there are some issues in relation to what exactly this type of scoring is measuring and how much should be read into it (see below), it does provide some indication of change over time. If an NDTA score falls, this is likely to signify some positive changes in wellbeing.

If an NDTA score is combined with the cost, cost offset and system pressure measurements, it provides a multi-track system for monitoring what is happening as someone uses an MDT team. This combination of indicators provides a range of data which is a more effective approach than relying on a single indicator or a set of data focusing on just one aspect of the MDT goals.

Again, it is important to note that positive outcomes for individuals will not necessarily lead to straightforward reductions in cost and pressure. One aspect of this is that system pressures may *shift*, more than they reduce in overall terms, so for example emergency service use may stop or be much reduced, but pressures (and costs) for primary and outpatient care increase as a result. Another way of saying this is that as someone using the MDT pilot becomes more stably housed and an assertive, person centred, flexible trauma

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<sup>57</sup> System pressure is measured by recording the frequency of service contact by service type over time.

<sup>58</sup> Also known as the 'Chaos Index' the New Directions Team Assessment (NDTA) score records engagement with frontline services, intentional self-harm, unintentional self-harm, risk to others, risk from others, stress and anxiety, social effectiveness, alcohol and drug use, impulse control and housing situation. A low score indicates improvement, a high score indicates deterioration.

informed approach to case management connects them to the community based treatment, support and care they need, the system pressures move to the *right places* i.e. away from the high cost/system pressure emergency services that cannot sustainably meet their needs.

### 5.5. Swim Lane Case Studies from Changing Futures Sussex

#### **“Fay”**

Fay<sup>59</sup> is a woman in her 40s who began using the MDT Pilot in 2022. Her multiple and complex needs centred on a history of domestic abuse, addiction and a series of difficult and broken relationships with service providers. Her housing situation was precarious, and she was disconnected and had lost faith in many of the services she needed. Engagement with the MDT Pilot centred on working with her to restore connections with domestic abuse, health and mental health services, connect her with GP and other community health services and stabilise her housing situation. Support was also provided around securing better and more suitable housing, practical support in setting up and maintaining a home and connecting her with the services she needed. Over time, the NDTA scores for Fay fell and there were reports that her self-confidence, wellbeing, health and service engagement were improving.

Fay was a success story for the MDT Pilot, but the brief summary above does not convey all the detail in the Swim Lane records for her, which show a slow and complex process of building trust with Fay, ups and downs as her circumstances changed and a sustained and convoluted process of helping her move from a precarious situation to one of greater stability and wellbeing. The MDT intervention was not as straightforward as being a story of a few months of engagement that produced a sudden and consistent gain in wellbeing. Fay’s engagement with the MDT had been positive, but it had required a sustained effort both by the MDT team and by Fay herself.

Fay’s wellbeing and situation had improved, but these gains stemmed from increased service activity and re-establishing links with treatment, care and support that had become broken. Consequently, the cost to the taxpayer of supporting Fay increased in the short and medium term because of the MDT Pilot intervention. Better safeguarding support to reduce risks from domestic abuse, increased use of adult social care services and the costs associated with increasing housing stability meant that during the course of 2022-2024, the costs of supporting Fay had increased from £8k in total spending before the MDT intervention to £19k in total spending following MDT intervention (as at mid 2024). In other words, looking at total spending on Fay from 2022-24, 30% had occurred prior to MDT intervention and 70% afterwards.

System pressures had shifted over the period of the MDT intervention. Fay was receiving more support from services that were enabling her to live a safer, better and more stable life. Emergency service use was trending downwards in parallel with these positive developments. In Fay’s case, system pressure was changing in positive ways, both for her

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<sup>59</sup> Pseudonym

and in terms of a positive shift in where service pressures were concentrated, because both were trending towards her living a better life in the community.

It is important to consider that the ‘lifetime’ costs of Fay to public services had probably been reduced, i.e. if her position had continued to deteriorate, the costs of helping her and dealing with the consequences of her situation were likely to increase. There is evidence of this pattern within homelessness associated with multiple and complex needs, i.e. the longer this situation persists, the more expensive it becomes to resolve later on.<sup>60</sup> As is always the case with evaluation of MDT services, the *human* cost of allowing desperate situations of physical and mental distress and vulnerability to persist must be at the core of how outcomes are assessed. Fay was in a better position with a better future because of the Brighton and Hove MDT Pilot intervention.

### “Ivy”

Ivy<sup>61</sup> was in their early 20s when they began working with the MDT Pilot. Their needs centred around experience of abuse, poor mental health including very low self-esteem, poor social supports and addiction. Contact with mental health services had been erratic and challenging, with complexities in engagement being associated with ongoing, significant, addiction. The MDT Pilot had been working with Ivy since early 2024 and had established regular contacts and facilitated access to suitable supported housing which had increased the level of stability and service contact in Ivy’s life, although their treatment, support and care needs remained acute and a situation of steady improvement and increasing stability had yet to be attained.

The Swim Lane data for Ivy showed the MDT Pilot beginning a process of increasing stability, support and access to services for someone with MCN. The challenges in working with someone with very high and complex needs were illustrated in this case, as Ivy’s needs meant that it was difficult for services to engage, particularly those services that are not designed for people with MCN. There had been gains, but the process was again both quite long and quite complex. Costs in this case were quite difficult to track as elements of emergency service provision were still running alongside the MDT Pilot intervention, i.e. because a shift away from unplanned service use was yet to fully arrive, so some of those costs were being combined with both the cost of the MDT Pilot and the access to services the MDT Pilot was facilitating. Costs for Ivy over the period 2023-24 were high, at around £112k, with £79k (70%) of that expenditure occurring after the MDT Pilot became involved, but again, only some of that expenditure was attributable to the MDT Pilot as unplanned service use was still occurring.

Ivy’s case shows the complexities of working with people with MCN, who can face multiple barriers to services, in this case addiction creating barriers to mental health services (a very longstanding problem in effective service provision for people with MCN). The MDT Pilot

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<sup>60</sup> Pleace, N. & Culhane, D.P. (2016) [Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England](#) Crisis.

<sup>61</sup> Pseudonym.

was making a positive difference, as there was greater stability, but Ivy was at the start of what was going to be a sustained process.

The pattern of system pressures for Ivy reinforced this picture, as a clear trajectory around movement away from emergency services had yet to arrive. Again, when working with people with MCN, elements of positive trends in system pressure will not necessarily arrive in a consistent way. Especially during early service use, there may be small indications of positive changes within broader patterns of system pressure that are yet to shift.

### ***“Ben”***

Ben<sup>62</sup> was in his late 40s and was presenting with challenging behaviour, addiction, mental illness and treatment, care and support needs associated with a brain injury when he was referred to the MDT Pilot. Suicide attempts and sectioning under the Mental Health Act had just occurred when the MDT Pilot began working with him at the start of 2023. Progress through the course of 2023 and 2024 had been limited, Ben was not incurring high costs because he had been evicted or faced prohibitions from many of the homelessness and related services he might be using. Engagement with Ben and finding a suitable trajectory through the MDT Pilot and other services had been challenging.

Progress in this case had been limited to date in some respects but had resulted in a reported shift in use of emergency care, as there had been over 50 visits to A&E and over 50 ambulance calls prior to engagement with the Pilot MDT, which had dropped to much lower levels, reducing spending by £30k. Data on system pressure for Ben clearly reflected these changes, with marked reductions in system pressure being recorded as reductions in A&E attendance were recorded. However, the pressure measurements showed something else, which was that a shift from high frequency emergency service use and towards services that supported residential stability and care, support and treatment in the community, had not yet emerged. Ben was not yet using the right services, i.e. system pressures had simply reduced, rather than having shifted in a positive way from emergency to community services.

### ***“Lia”***

Lia<sup>63</sup> was referred to the MDT Pilot at the end of 2022. She presented with mental health problems, difficulty in regulating emotion and was separated from her children, there was also ongoing addiction and a history of homelessness. She had been arrested and charged with a community sentence, but engagement with Probation had sometimes been problematic even with the MDT support being present. Service use had become more appropriate, but there were ongoing issues with service engagement and total expenditure on Lia had not moved significantly since her engagement with the MDT.

The service pressure data for Lia showed that while she was in appropriate supported housing at the point of her referral to the MDT pilot, she was not engaged with all the community-based treatment, care and support she needed. The Swimlane system pressure

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<sup>62</sup> Pseudonym.

<sup>63</sup> Pseudonym.

data showed insufficient access and use of community services, a sudden burst of contact with the criminal justice system and then a return to the earlier pattern. The challenges of meeting Lia's needs, according to the system pressure data, did not centre on shifting system pressures from emergency service use onto community service use (because high frequency emergency service use was not a constant), but instead in getting Lia suitably engaged with the community-based services she needed.

### **“Leo”**

Leo<sup>64</sup> had presented with alcohol dependency and with alcohol related brain injury at referral to the MDT. There had been repeated contact with NHS services which had been erratic and sometimes difficult. Leo was also arrested and briefly imprisoned during his time with the MDT, which had remained in contact with him while he was in prison and was working to secure a release into suitable accommodation with support. Leo was another highly complex case, with a long history of contact with criminal justice services who presented with challenging needs that could create barriers to service use. His rate of contact with both the criminal justice system and NHS services was frequent and he was someone who had been in a situation of precarity and vulnerability for a prolonged period when the MDT started working with him at the beginning of 2023.

The system pressure data for Leo shows a sudden increase in service use. Data were available for some time before his referral to the MDT Pilot and this clearly showed a sudden and ongoing increase in pressure on services following his brain injury. The challenge and the potential for an MDT intervention centred on enabling Leo to shift from a pattern of high frequency, but also erratic, pattern of contact with services and towards a more stable, community-based situation.

Ben, Lia and Leo showed the challenges and perhaps some of the operational limits that can face MDTs. Determining an upper limit for what it is reasonable for an MDT, even one mirroring the ACT model of Housing First, to manage in terms of effectively supporting people with MCN is difficult. It is not a straightforward as particular combinations of treatment and support needs, or those needs existing a particular intensity, being likely to mean that the use of MDT services is unlikely to be effective. Large, randomised control trials of ACT/ICM versions of Housing First have not established a clear association between levels of need at referral and later outcomes and outcomes for people with extremely high MCNs have often been positive.<sup>65</sup>

### **“Chloe” and “Natasha”**

Fewer details were available on two further cases that the Brighton and Hove MDT Pilot had worked on, both of which showed that the Pilot had the potential to generate significant reductions in public expenditure. Again, while these financial arguments have their place,

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<sup>64</sup> Pseudonym.

<sup>65</sup> Aubry, T., Roebuck, M., Loubiere, S., Tinland, A., Nelson, G. and Latimer, E. (2021) [A tale of two countries: a comparison of multi-site randomised controlled trials of Pathways housing first conducted in Canada and France](#) *European Journal of Homelessness* 15(3), pp. 25-44.

the role MDTs in reducing extremes of human distress is always important in evaluating overall effectiveness:

- Chloe<sup>66</sup> had experienced prolonged and repeated use of acute mental health services, spending some 200 nights in psychiatric beds prior to the engagement with the MDT Pilot. In the 12 months since she had been working with the MDT, admissions into acute mental health beds had dropped to three nights, producing a saving of approximately £78k.
- Natasha<sup>67</sup> had been at risk of living rough following eviction from temporary accommodation when the MDT Pilot arranged a short stay to prevent her living on the street. She had been able to access support and treatment services for abuse and addiction and had secured appropriate housing. A pattern of frequent arrests and frequent use of A&E had been stopped by engagement with the MDT Pilot, and this had resulted in an approximately £80k drop in spending since she had been using the service.

## 5.6. Critically assessing the Swim Lane data

The operational realities of an MDT service working with people with MCN are reflected in the highly detailed Swim Lane analysis conducted by *Changing Futures Sussex*. The data shared with the evaluation team appear to be both a thorough and insofar as possible, accurate record of what has been achieved across a range of cases. There were, according to these data, clear gains and successes around cases where emergency service use, homelessness and wider risks had been contained and controlled by engagement with the MDT Pilot. Equally, the realities of engaging with highly complex and highly vulnerable people, who can, speaking frankly, sometimes be very difficult to work with because of the ways in which their treatment, care and support needs manifest themselves, are also captured by the Swim Lane analysis.

Time is often the crucial factor in evaluating MDT services. These are often complex cases that require long periods of engagement to see sustained and stable improvements in someone's situation and wellbeing. When someone is presenting with hugely challenging MCN, the process of building enough trust to even begin working with them might take weeks in and of itself. The challenges here are complex, so expecting an MDT to show improvements in three, six or even nine months might not be realistic. There will be cases in which there are sudden shifts over a relatively short period of time and others in which the process will be much more prolonged. Progress may often not be steady, with MDT services facing a reality in which people with MCN are less firmly rooted to a positive situation than other people might be, because of their treatment, care and support needs and because of past trauma and ongoing risks of violence and abuse. Someone with MCN who is stably housed and successfully working with appropriate services may be knocked out of that situation by what, from an external perspective, might not always seem like a significant challenge. When Housing First, which in some senses is the progenitor of MDT services that engage with people with MCN who are facing or at risk of homelessness, was first designed,

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<sup>66</sup> Pseudonym.

<sup>67</sup> Pseudonym.

it was built around an assumption that support would be designed in for as *long as necessary*.<sup>68</sup> This model of support being provided for as long as needed stemmed from evidence and experience of meeting the needs of people facing sustained and recurrent homelessness. It was expected that their treatment, care and support needs and their experience of trauma would often take time to address and, in at least some cases, would leave them disproportionately vulnerable when faced with adverse circumstances, even when their experience of homelessness had been ended on a sustained basis.

A strength of the Swim Lane approach is the use of three systems of measurement to record change over time. If costs remain high, the measurement of system pressure can help explain why this is the case, e.g. if someone shifts towards a much more appropriate pattern of service use that is a positive result for that individual and for the system as a whole, because the right costs are occurring in the right places in the system. System pressure data can also, as noted, give another indication of what the total impact is on services when obtaining and estimating overall cost and cost offset data is problematic. If the NDTA index is trending downwards, costs are shifting towards community service use and away from emergency service use (perhaps generating cost offsets in the process) and system pressure data show the same pattern, there is good reason to be confident of progress.

The potential limits of the Swim Lane approach stem from some limits in data collection, in cost estimation and from its complexity. While significant success seems to have been recorded by tracking what sorts of contact had been happening with a whole range of NHS, criminal justice and other services, this may (in the absence of actual data merging across administrative systems across all systems) be an entirely accurate picture. One issue is that all contacts may not be remembered or recorded properly, another is that some aspects of service use, such as engagement with open access homelessness services (including informal/volunteer services) may not be recorded in any formal sense.

The costs presented in the Swim Lane analysis are necessarily based on estimations – estimations from well-regarded sources like PSSRU<sup>69</sup> – but they are nevertheless approximate. This is not a flaw in and of itself, many studies of cost effectiveness rely on such data, but it is probably fair to say that the Swim Lane data are a good impression, but not precise record, of spending and changes in spending.

The other issue here is the complexity of the Swim Lane methodology. *Changing Futures Sussex* has been able to provide pen-picture summaries of each case, but the data on which they are based are highly detailed and complex. Recording almost every service interaction and noting the details is a far superior model to earlier attempts to record improvements using a few, often crude, metrics to measure things like health and wellbeing after service interventions. However, complex data can look ambiguous from a political or policy perspective, as they can often show two steps forward is accompanied by a backward step or convey a lot of interactions that might look messy or confused to an untrained eye. Detail also creates ambiguity in and of itself. For example, a metric that is used to determine if someone is 'stably housed' with a yes/no answer and which uses a definition of holding a tenancy for one year, conveys a very simple, unambiguous message. If one uses, for

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<sup>68</sup> Homeless Link (2017) [Housing First in England: The principles](#)

<sup>69</sup> <https://www.pssru.ac.uk/unitcostsreport/>

example, the French metric of how many nights someone using ACT Housing First has *spent in their apartment* in the last year and say the answer is 250, is that good? Clearly, they are housed *most* of the time, but they are also not using that housing for significant amounts of time, so the answer, while it is actually a better quality and more nuanced measure, is a lot less clear than the answer to having held a tenancy for 12 months being a simple 'yes'.

One final point here centres on the use of the NDTA scale or 'chaos index'. This sort of scoring has been criticised as being imprecise, as much depends on worker judgement, the information they have and relatively narrow definitions of what is seen and recorded as 'positive' and 'negative' behaviour. This can mean, for example, lack of clarity and consistency about the difference between, for example a score of 2 and 3 on the 4 point scales NDTA uses and to uncertainties around whether different workers are recording '2' or '3' with the same understanding of that means.<sup>70</sup> Scales like NDTA might be more useful in relative terms, i.e. they can at least broadly track whether someone is getting better or worse, but they might lack the consistency, rigour and clarity needed to systematically demonstrate effectiveness or compare across cases. Alongside this, there is the question of where and how something like NDTA is defining a 'normal' set of behaviours and responses, both in the sense of 'normal' being a decidedly fluid, culturally and ideologically shaped concept and in expecting people to work to levels of self-reliance and self-care that are not reflective of how most people live, i.e. no-one can always cope with the world on their own.

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<sup>70</sup> See Johnson, G. and Pleace, N. (2016) [How Do We Measure Success in Homelessness Services? Critically Assessing the Rise of the Homelessness 'Outcomes Star'](#) *European Journal of Homelessness* 10 (1), pp. 35-55.

## 6. Conclusions and Recommendations

### 6.1. Conclusions

Fusing a national programme with Sussex-level Health and Care Transformation has required considerable effort from both the Integrated Service Transformation and Changing Futures Sussex: whilst there are clear commonalities, priorities and timescales have also been slightly different. There has been persistent strategic relationship-building throughout the pilot, with pivotal activities such as a multi-agency summit on MCN in November 2024. Support from elected members and senior managers in both Brighton & Hove CC and the ICB has been a facilitator. The Health & Care Partnership has been keen to draw learning from the CF MDT pilot to inform wider transformation, hence commissioning this additional independent evaluation (unlike neighbouring East and West Sussex County councils). At the time of writing, there seems to be strong commitment across systems to sustain and mainstream the CF MDT model within wider systems, which does not always happen following funding from national programmes.

It feels significant that the MDT has been hosted by and benefitted from strong leadership in Adult Social Care, given the unequal access to Adult Social Care by people with MCN highlighted in national research. Considerable learning has been generated around how to use the Care Act 2014 to provide support and safeguarding to this group of people. It has taken a little longer to embed statutory homelessness processes within the team, but considerable progress has been made in this regard over the course of the evaluation period. Where – in other projects evaluated by IBA - intensive case management for people with MCN sits outside of one or both these statutory frameworks, a huge amount of staff effort is spent trying to advocate for people's rights and entitlements.

Despite this progress in partnerships and processes, access to housing remains a key challenge and will require bold thinking in Brighton & Hove's challenging housing market if the investment in care coordination is to have the maximum impact on the lives of people with MCN. The current Homelessness Review and Strategy should create an opportunity to consider how Housing First might be scaled up and potentially integrated within the ICT model.

Mental health challenges are universally present for the CF MDT caseload; yet accessing timely and suitable specialist mental healthcare has proven difficult within the model. Not only are mental health services over-stretched in Brighton & Hove, as in the rest of the country, but it is evident in the evaluation that the narrowly defined clinical approach to mental health within the NHS does not meet the needs of those experiencing co-occurring substance use and underlying trauma. There is a risk that the Mental Health Transformation Programme, with its focus on enriching the neighbourhood offer, may not benefit this marginalised group. Again, this is a national issue; however, there is an important opportunity to begin to develop new social and clinical models for people with MCN in Brighton & Hove if psychology and psychiatry can be integrated within the ICT model moving forwards, to enable a fusing of multi-disciplinary professional and lived experience.

Although there are promising outcomes from the work of the MDT, it is also clear from the evaluation that it takes time, resource and a persistent, trauma-informed approach to build trusting relationships, and stabilise the lives of people who have experienced multiple traumas. No intervention for this group can be seen as a 'quick fix'. Even where recovery outcomes are achieved by individuals, these may be fragile, and timely access to ongoing support at times of crisis is vital. The evaluation has demonstrated the importance of the MDT's flexible, non-time-limited offer, however it is important now to consider – at a service design level – how and to what menu of support options people can be stepped down from the MDT caseload.

## **6.2. Recommendations**

### **Short term priorities for MDT partners:**

- Approve the compact agreement, to clarify commitment to and line management/ support arrangements for the MDT model.
- Prioritise the implementation of Plexus Care Record to facilitate better information sharing between health and social care and enable better monitoring of health service usage for future evaluations.

### **Recommendations for the Integrated Community Team (ICT) Leadership Team:**

- The plans to develop a new MCN Integrated Community Team model in Brighton & Hove should incorporate and build on the trauma-informed/ Team around Me and data sharing models and the resources developed and tested within the CF MDT for the learning, development, supervision and wellbeing of staff.
- Ensure properly resourced peer support is built into the ICT, using models and resources developed in the CF MDT pilot.
- Draw on the significant knowledge and expertise of Common Ambition in the design and ongoing evaluation of the ICT model.
- In developing the Integrated Community Team, consider how gender-specific services for women with MCN might also be better integrated within the city and barriers reduced.
- The new MCN Integrated Community Team provides further opportunities to develop the role of health care partners in the care and support of people with MCNs: it will be important to build into the planned Integrated Community Team dedicated time from a clinical psychologist for case formulation as a minimum.
- Learning from the CF MDT is that it is not sufficient to assume that resources in the Homeless Mental Health team can stretch more widely than that team's current

caseload. Access to psychiatry and specialist mental health services for people with MCN need to be built into the ICT model; embedding psychiatry in the team (rather than trying to refer people to a separate team for specialist mental health support) should help to develop integrated models of care for people experiencing mental distress, trauma and substance use.

- Build a flexible personalisation fund into the budget for the MCN Integrated Community Team.
- Further development is needed to engage criminal justice agencies in the model, perhaps via the Community Safety Partnership. Other key partnerships include: the local Mental Health Transformation programme, the Combatting Drugs Partnership and the Safeguarding Adults Board.

#### **Wider system recommendations:**

- Ensure the needs of people with MCN are addressed within the current Homelessness Review and Strategy development.
- Increase the supply of safe and suitable emergency accommodation for people with MCN who are particularly vulnerable to abuse and exploitation, including domestic abuse.
- At system level, the CF MDT pilot has highlighted the need for an integrated response to co-occurring mental health, substance use, and underpinning trauma. It will be important to ensure that learning from the CF MDT pilot feeds into the ongoing Combatting Drugs Partnership-led system change project on co-occurring conditions.
- The CF MDT pilot has also highlighted the need for additional specialist social worker input for people with MCN at the hospital. Further conversations between health, social care, and ARCH are required to consider how this proposed role might work and how it could be funded; and to consider the balance between specialist resource and learning & development for existing hospital social work teams. Learning from the CF MDT in relation to the application of the legislative framework to people with MCN should inform the design and development.
- Ongoing work is required to support, educate and challenge both hospital and locality social work teams on the use of the Care Act and Mental Capacity Act with people with MCN.
- At a strategic level, the pilot has highlighted the need to better join up existing resources and a Case for Change has been made for the integration of RSI Navigator and CF MDT services.

- Develop clear housing, care and support pathways for people with MCN in the city, these need to take an integrated approach and be designed from a customer journey perspective. At present, these have evolved in departmental silos, with different access to resources by different teams (e.g. the MDT cannot access emergency housing, New Steine Mews cannot refer into the supported housing pathway, etc).
- Consider how the city's Housing First offer might be scaled up as part of the next phase of Integrated Community Team development. Given that the MDT model is effectively providing the flexible support, the priority here would be to consider ways to improve access to housing supply.
- Ensure the sustainment of the current 'wealth' of community recovery activities in the city and continue to develop the 'recovery pack' and training offer being developed by the MDT's peer support work team.
- The evaluation has demonstrated the importance of the MDT's flexible, non-time-limited offer, however it is also clear that stabilisation can be a long process for some with ongoing risks that subsequent crises may de-stabilise people. It will therefore be critical to commission a menu of step-down options from the MDT intervention (and co-produce these with the Peer Support Team/ Common Ambition).

### **Ongoing monitoring and evaluation**

There has been considerable effort invested in monitoring and evaluation within the CF pilot, and it will be important to continue collecting evidence about what is working for whom under which circumstances within the ICT model. The independent evaluation has flagged up learning and areas for development from the CF MDT pilot:

- The co-production of the lived experience strand of this evaluation with the Peer Support Team and Common Ambition using the Most Significant Change methodology has been a positive and has built the evaluation skills of those involved, and generated learning and ideas about possible future roll-out of this approach, which should be built into future monitoring and evaluation where appropriate.
- There are positive signs of progress in relation to clients' effective usage of other services, however the picture is complex and longer-term monitoring of these patterns of wider service usage across more of the caseload is required. This will require simplification of the swim lane methodology to include a more focused collection of indicators.
- Accommodation status should be tracked in the team's recording systems in a way that reports on an individual's housing journey or on the status of the whole caseload can be easily produced.

- The standard national CF measures were not designed with an MDT model in mind, for example, it was not clear whether and how data on referral to other agencies should be recorded (given they were internal to the MDT model in Brighton & Hove).
- Since the first quarterly report may be completed at any point within the first few months of a client joining the MDT, there is not a clear baseline from which to measure subsequent outcomes. Moving forwards, it would be good to develop a consistent way to use referral, triage and initial assessment data to create a baseline for each client, whilst minimising the risk of re-traumatising people or jeopardising trust-building at this early stage of the relationship.
- The MDT decided not to use the historical outcomes paperwork from CF and, whilst the reasoning from this is understandable from a practice perspective (since this could be experienced as intrusive or triggering at such an early stage of engagement), it may be possible to design more creative ways of capturing the pre-baseline position for at least a sample of clients. This might again involve drawing on existing data about them from different systems and considering with the Peer Support Team whether there are more ethical and client-led ways of gathering from clients a picture of the 'before' for some, so as to enable comparison over time. Focusing on collecting a pared back collection of standardised snapshot tools (see below) should help to minimise burden.
- Moving on from the baseline for each client, it would be good to streamline ongoing questionnaire/ indicator collection, reducing the burden on staff and clients, whilst also tightening up the timeframes used. For example, this might include carrying out a bi-annual snapshot, selecting two months of the year (6 months apart) in which a snapshot of all clients is carried out. This should include use of the New Directions Team Assessment (NDTA) and ReQoL-10 measures (see below).
- Where practical and appropriate, the bi-monthly snapshot might include a feedback and review discussion with them, focusing on what has been most significant to them over the past 6 months and exploring their goals for the next period. The process for this should be co-designed with the Peer Support Team.