SUPPORT PATHWAY
(RISK, NEEDS & SUPPORT PLANNING)
POLICY & PROCEDURE

Effective from:
24 February 2023

APPLICATION OF THIS DOCUMENT

This document sets out YMCA St Paul's Group's Support Pathway which aims to enable all residents and tenants of the Charity to thrive and eventually live independently within their communities. This is achieved by providing a tailored set of support services and opportunities for increasing self-reliance.

The support pathway outlined within this document also sets out our obligation of being a Supported and Exempt Accommodation Provider.

This Policy applies to all legal entities within the Group.

1. Policy Statement

The aim of this policy is to set out the Charity's core Support Pathway which will:

1.1 Ensure the services (accommodation and support) we offer are fully aligned with the core aims of the Charity.

1.2 Adopt a standardised support framework (Outcomes Star) to map and measure the progress made by the people we work with and the effectiveness of the services we deliver. The Support Pathway is set out in Appendix A and the Outcomes Star model in Appendix B.

1.3 Optimise our accommodation configuration and organisational design to maximise the accommodation capacity, and resources available to be able to support as many people as possible.

1.4 Be collaborative with both resident and housing staff involvement.

2. Objectives

We will ensure that:

2.1 Our residents receive an assessment of their support needs and any associated risks.

2.2 Our residents have individually tailored, up-to-date and regularly reviewed Action Plans and risk management plans.

2.3 Our Support Pathway and associated assessment and support planning procedures are managed by skilled and well-trained staff, place residents' views at the centre and involve other professionals and/ or carers as appropriate.

3. Definitions

3.1 **The Charity:** YMCA St. Paul's Group and all legal entities within the Group

3.2 **Applicant:** a person seeking accommodation with/ supported by the Charity

3.3 **Support Pathway:** sets out a clear pathway from initial referral to planned move on

3.4 **Outcomes Star:** a standardised support framework

3.5 **Inform:** the housing management system used to record all assessments and support records.

4. Scope of Service Offer

4.1 The scope of the Service Offer for the Support Pathway will address all aspects of the challenges a resident may face, and will reflect the ten strands of the Outcomes Star:

1. Motivation and taking responsibility
2. Self-care and living skills
3. Managing money and personal administration
4. Social networks and relationships
5. Drug and alcohol misuse
6. Physical health
7. Emotional and mental health
8. Meaningful use of time
9. Managing tenancy and accommodation
10. Offending

4.2 An individual may need support in one, many or all of these services, which will be delivered in association with an offer of accommodation, or on a floating support basis, either at a YMCA St Paul's Group scheme, or where the young person is living or residing (this applies to Supported Lodgings for example).

5. Referral and Acceptance Criteria

5.1 The Charity will work with individual Local Authorities and other referral agencies to establish a referral process for identifying people who would benefit from following the YMCA St Paul's Group Support Pathway. The Support Pathway will reflect the core mission of the YMCA to support people to live and function independently.

5.2 The acceptance criteria may include:

- Are single (or mother and baby, specific to our mother and baby units)
- Are experiencing homelessness
- Are eligible to be supported via a Local Authority Support Contract, such as Social Services, Homelessness Prevention Team and Housing Solutions
- Have a level of need that can be supported within a balanced caseload
- Require accommodation and/or support whilst based elsewhere
- Personal care package is already in place and is provided by a third-party provider

6. Initial Referral and Risk Assessment

6.1 The Charity will ask applicants to complete an Initial Risk Assessment as part of the referral process which will help determine the applicants support needs, and to assess the level of risk they pose to themselves or others within the YMCA community.

6.2 Staff must utilise our housing management system 'Inform' to collate and complete all support pathway documents. Hard copy documents are no longer in use, however if a applicant / resident wishes to receive a hard copy print out of their documentation, then this can be printed and given to them.

6.3 Comprehensive and reliable information is the basis for all risk assessments and for making an informed decision. We do not use risk assessments to inappropriately exclude residents, but residents can only be accepted into the service when a comprehensive risk assessment has been carried out and we are sure that we can safely manage any identified risks for the protection of the resident themselves, other residents, staff, and the wider community.

6.4 A risk management plan for each risk assessed at a moderate to high level of risk must be collaboratively discussed and documented between the applicant and support worker. This plan must detail agreed strategies to minimise and safeguard against increased risk.

6.5 Applicants, who are risk assessed as having moderate to high risks identified in the risk assessment process, must have a robust risk management plan in place within the first week of residency.

6.6 An initial Outcomes Star, to ascertain a starting point on the Ladder of Change, is to be completed within the first month of residency for all new residents. The applicants who have a designated Social Worker, or other key professional at applicant's request, will engage in a placement meeting within the first 14 days of residency. The risk assessment and Outcomes Star can be developed in conjunction with the placement meeting, with input from the Social Worker.

7. Ladder of Change (Outcomes Star)

7.1 The journey to self-reliance that clients will embark on will be mapped against the Outcomes Star Ladder of Change.

7.2 The ladder has ten steps, characterised as the client being:

Stuck (Steps 1 and 2)	Unable to face the problem or accept help
Accepting Help (Steps 3 and 4)	Accepting help from someone who will sort out the problem
Believing (Steps 5 and 6)	Looking forward and believing that they can make a difference to their life
Learning (Steps 7 and 8)	Looking to making things they want to achieve a reality
Self-reliant (Steps 9 and 10)	Starting to manage without support

7.3 Residents will start on different steps of the ladder for each of the strands of the Service Offer they are being supported on, progress at different speeds, and get off the ladder at different steps. Whilst this is a relatively simplistic approach to mapping what are in reality very complex problems, it provides a framework on which to measure progress and outcomes achieved by the client and also the effectiveness of the service.

8. Support Planning (Outcomes Star Action Plan)

8.1 A tailored Action Plan (also known as Support Plan) will be developed and agreed with each person accepted onto the Support Pathway. The plan will address each strand of the Outcomes Star they need support with.

8.2 Support action planning must be completed in a timely manner to parallel the resident's individual level of risk. Residents with higher levels of risk must engage in action planning within their first month of residency. Residents must be given opportunity to put across their views and comments on their Outcomes Star support plan objectives and goals setting, therefore offering a Person-Centred collaborative approach to their overall support plan.

8.3 Input from other key professionals, such as Social Worker, Medical Professional, Probation Officer, can be drawn upon to support formulation of support objectives. Staff must always seek residents' permission to share personal information unless prior authorisation has been permitted.

8.4 When allocating a Housing Support Officer to a resident, we will aim to meet the preferences and needs of the resident when requested, where possible. For example, someone from a similar ethnic background/ sexuality or gender etc. or if there are any interpreting needs.

8.5 Our residents are wholly and integrally involved with the assessment and support planning/ risk management process and are viewed as the experts on their own circumstances. However, support staff may utilise assessing skills and motivational interviewing techniques to prompt, appropriately challenge, motivate, and explore support options and objectives, and goal setting with residents.

8.6 A tailored package of support will be drawn from across the services and programmes offered by the Charity and will be augmented with third-party support as required. If a resident is not registered with a GP, Dentist or Opticians, or other required healthcare professional, the support staff must support registration with the required professional service as soon as practicably possible. The mix of services delivered to a person will be drawn from the following YMCA service strands:

- Housing, Care and Support
- Education and training
- Health and Wellbeing
- Youth work
- Family work

8.7 The support offered to a person at any point in time will be specific to the step of the Ladder of Change that they are currently on and will help prepare them to move up to the next step of the ladder.

8.8 Information on services offered, including Chaplaincy, 1-1 support, 1-1 counselling, progression team, youth work, health & wellbeing, will be given to residents at the initial assessment and support session.

8.9 Support staff are to encourage residents to engage with the progression team throughout their stay, as to benefit engagement with all key internal support services, and links with external services, such as Employment, Training and Education (ETE) opportunities, health and wellbeing and move on.

9. Rolling Assessment of Needs and Risks

9.1 A rolling review of progress against the Action Plan will be undertaken every at least every twelve weeks, or when circumstances change, or in response to an incident. Ensuring that residents' defined goals are reviewed and updated, and appropriately challenged and encouraged regularly, is integral to their progression.

9.2 Changes of circumstances will be reflected on the Outcomes Star. It is vital that the risk assessment and risk management plan are updated immediately following a serious incident, ASB incident, safeguarding alert, in conjunction with follow up action points that will be documented on Inform. Please refer to our Inform process/ user guide, which can be found on the Housing, Care and Support intranet section and specifically details guidance on the processes and timeframes for such reporting.

9.3 If a resident is resistant to engaging with support planning and or risk management, staff must discuss this with the relevant Housing Manager as soon as possible. Appropriate action, in-line with the Tenure Management Policy and Tenancy Agreement should be taken.

9.4 Support staff must make every effort to engage with and support residents, in an understanding and compassionate way, with awareness of the presenting issues that can be projected or play out with associated lifestyle and past traumas. Every opportunity will be offered to residents to engage in support, prior to potential eviction for non-compliance with support.

9.5 The active management and progress made by each resident will be a key measure of success of the Support Pathway.

10. Accommodation Pathway

10.1 The Accommodation Pathway followed by residents of the Charity is very closely linked to their Support Pathway and is based upon:

- A Tenure Policy that provides flexible, time-limited occupancy agreements that support a pathway to independence as rapidly as possible
- An Allocations and Lettings Policy that reflects the entry criteria of the Support Pathway and maximises the number of units let within them
- A pipeline of Move-on and Resettlement options that enable residents to move along the pathway at the optimum speed.

11. Accommodation Ladder

11.1 The Accommodation Ladder enables the definition of a potential pathway that leads towards independent living and is aligned with the overarching core Support Pathway. Not all of the Charity's projects offer the types of accommodation outlined below, so this section should be used as a guide towards encouraging residents to consider potential move on options:

Step 1	Hostel-based shared-accommodation and support services (catering etc.)
Step 2	Hostel-based self-contained accommodation with lower-level support

Step 3	Hostel-environment or remote semi-independent living
Step 4	Independent accommodation (tenancy)

11.2 To support the above, the terms of the Tenure, and Allocations and Lettings policies ensure that:

- The most appropriate occupancy agreement (licence or tenancy) is used to let accommodation at each step on the ladder
- The terms of each occupancy agreement reflect the temporary nature of the accommodation offered and the goal to support as many people as possible into sustained independent living. The duration of the temporary accommodation tenancies we offer is two years maximum.

12. Move-on and Resettlement

12.1 The availability of a range of move-on and resettlement opportunities and the management of the process will be key to the overall success of the Support Pathway, and will enable a steady flow of support recipients through the service:

- The scope of move on and resettlement pathway application must develop through a collaborative awareness and goal setting and effort between support staff and resident. This process must begin as the resident comes into their second year of residency to enable a year period of exploring and defining accessible move on options. This process will develop capacity within the move-on and resettlement offer and manage individual residents through the process as they approach the point of being ready to move-on. Key professionals involved in the resident's welfare may support move on planning.
- Work with partners to deliver more nomination rights and explore flexible solutions (shared accommodation, cross-generational living etc.).
- Develop the Supported Lodgings offer as part of the broader move-on and resettlement offer, extending its geographical range and the number of potential hosts within the scheme.
- Create and explore internal and external initiatives to secure funds to support residents to move on (deposit, loans etc., into the Private Rented Sector). A realistic approach to move on into PRS, must be addressed and discussed with the resident at all stages of the move on process, and all opportunities to prepare residents for independent living, through support planning must be delivered.
- Funding may come from various sources, such as Leaving Care Grants or external agency donations.

12.2 Enabling residents to move-on as soon as they are ready will be a key measure of success of the Support Pathway. This will in turn increase the throughput of the service, another key measure of success.

13. Independency Health Checks (where commissioned/ funded)

13.1 In some projects the Charity offers a follow-up service upon completion of the Service Pathway, through Independency Health Checks, that will monitor progress of the resident over a two-year period.

13.2 These checks will:

- Ensure that the level of independent living and self-reliance achieved is being maintained
- Provide remedial support and advice where needed, and
- Assess the effectiveness of the service delivered

13.3 Sustainment of independent living and self-reliance will be a key measure of success of the Support Pathway.

14. Data Protection and Information Sharing

14.1 Assessments, support plans, risk assessments and all relevant resident information are securely documented and stored on the housing management system, Inform. Records are accessible to relevant staff only and the resident.

14.2 We will share relevant information with appropriate agencies in line with the most current legislation that governs when and how we can share personal information.

15. Equality and Diversity

15.1 We are committed to treating everyone fairly and will act sensitively towards the diverse needs of individuals and communities and will take positive action where appropriate.

15.2 We make appropriate arrangements where necessary to ensure that residents and clients with distinct communication needs are not unreasonably and disproportionately affected. This could involve providing communications in alternative languages or formats or providing interpretative or transcription assistance where appropriate.

15.3 Residents may have experience of previous negative support services, which could be a barrier to their engagement. This should not be prejudiced against, and every effort must be made to engage residents in an understanding, professionally caring and compassionate way.

16. Staff Training

16.1 We provide staff with support and training in delivering the Support Pathway.

16.2 There is a range of staff training targeted to meet the needs of residents and clients being supported and staff are committed to ongoing professional development.

16.3 If you are unsure about any aspect of the Support Pathway, please speak to your line manager who will support your query with relevant information, coaching and further training.

16.4 We aim to refresh Support Pathway training regularly.

17. Monitoring of the Support Pathway Policy

17.1 We will routinely monitor our performance in implementing this policy and report outcomes to the Executive Team and Performance Committee regularly.

17.2 We will enable residents and clients to scrutinise performance of the Support Pathway Policy and will act upon recommendations about how performance might be improved.

18. Review of the Support Pathway Policy

18.1 We will review our policy every two years to ensure that it is effective and complies with current legislation and good practice.

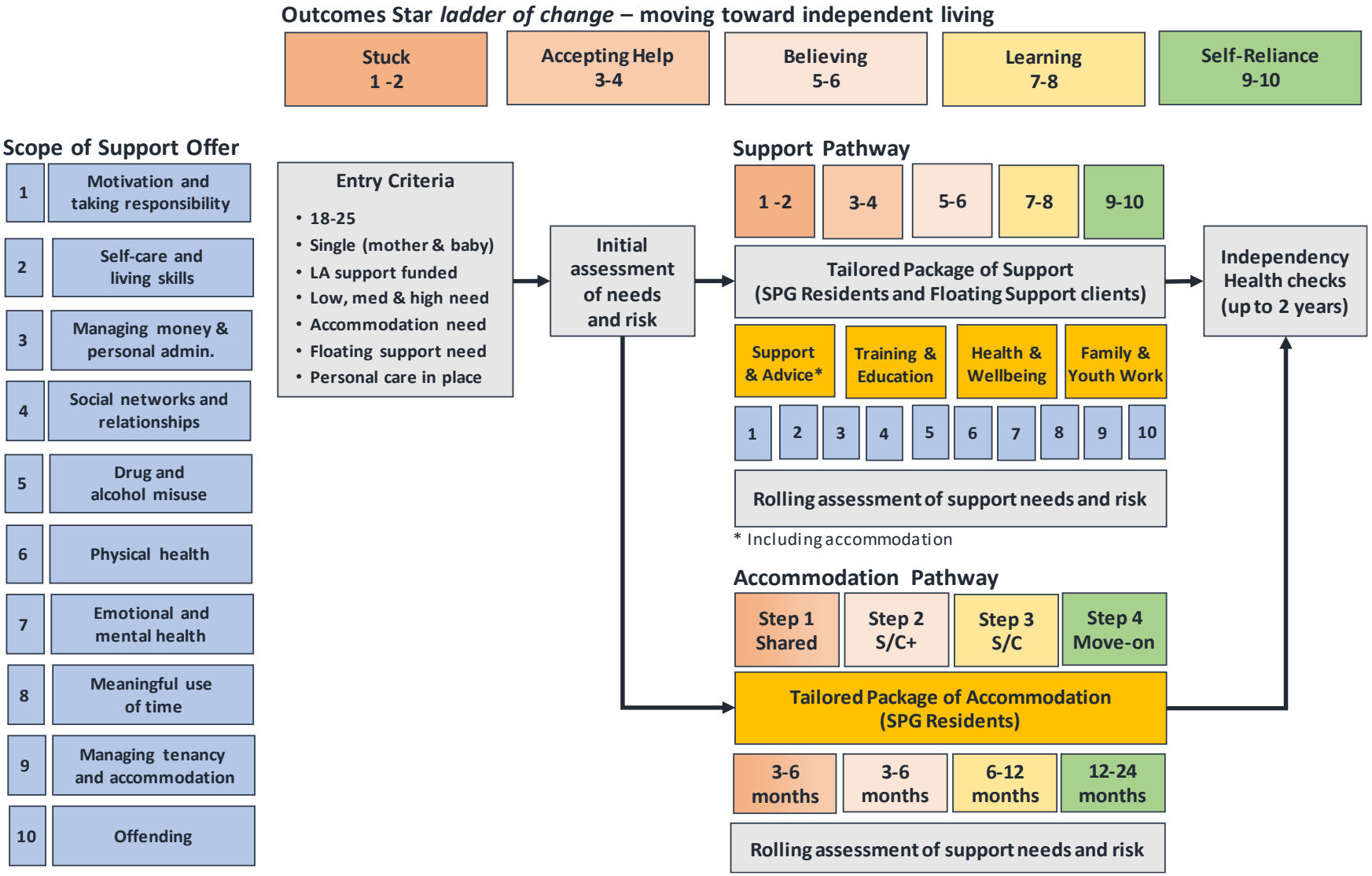
18.2 As an integral part of the review process we will engage with residents in the formulation of the Support Pathway policy, in setting strategic priorities and service standards.

18.3 We will conduct regular contentment surveys with new, current and former residents and clients to seek feedback.

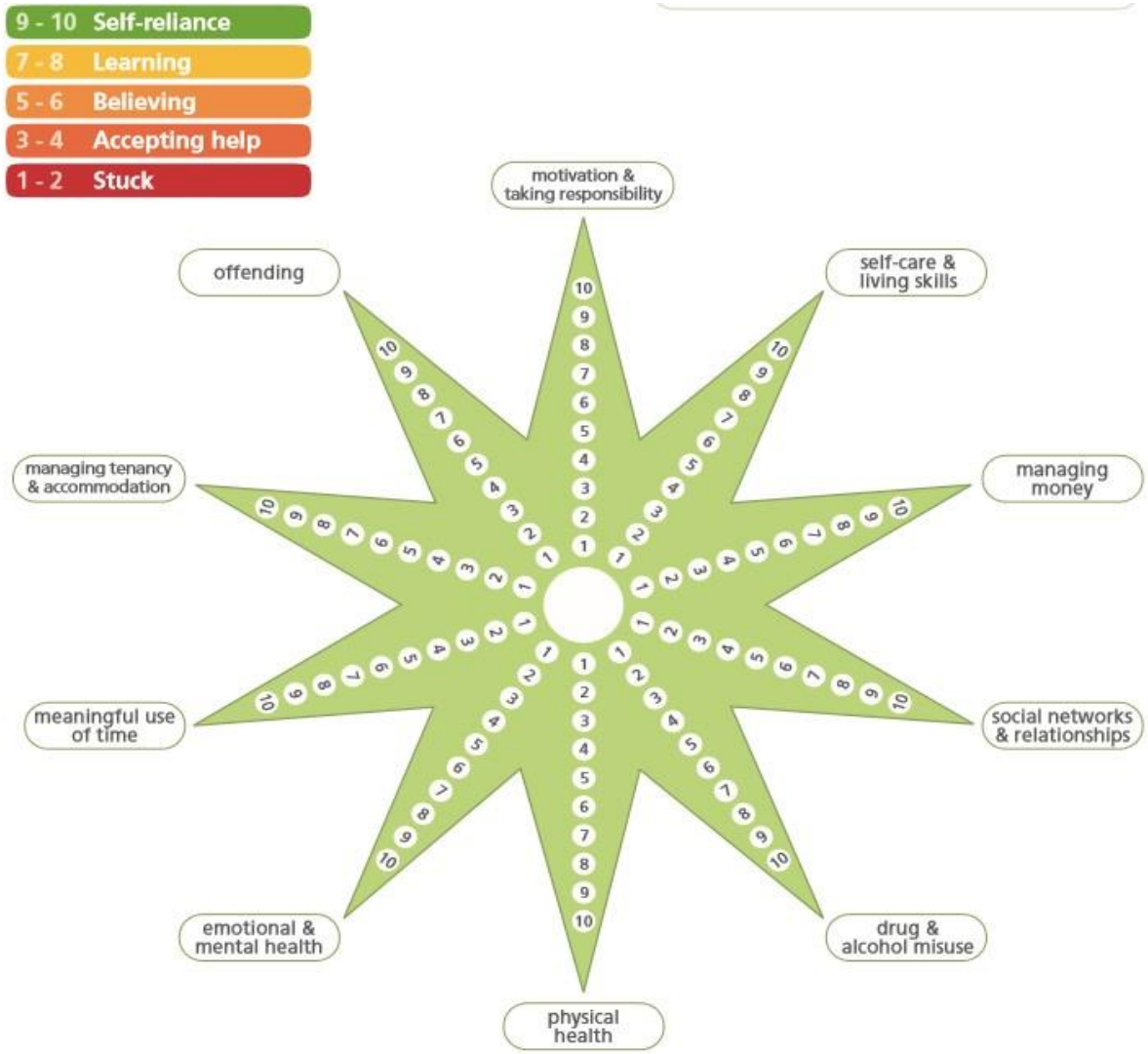
APPENDICES

Appendix A Support Pathway
Appendix B Outcomes Star
Appendix C Risk Assessment Process & Flowchart
Appendix D Non-Engagement Process

Appendix A: YMCA St. Paul's Group Support Pathway



Appendix B: Outcomes Star



Appendix C: Risk Assessment Process & Guidance

Risk, Needs & Support Planning Process

The Charity accommodates residents from diverse and mixed communities and with varied individual needs. The primary aim of this procedure is to identify the nature and extent of residents' support needs and to address those needs through a comprehensive support planning process.

It is recognised that some residents may have multiple support issues, which need to be addressed but may not always be identified at the point of referral. For this reason, the process of identifying resident support needs is as follows:

1. **The purpose of the assessment must first be explained to the resident at referral stage**. The interviewing officer must carry out an **initial assessment** at referral stage using the relevant RESIDENT APPLICATION FORM and RESIDENT RISK ASSESSMENT FORM (these forms must be completed online on Inform). If the referral / risk assessment is being completed in Hard copy version, such as when meeting an applicant without access to a computer or laptop, the notes must be added to Inform as soon as is possible, and the hard copy shredded.
2. Having completed the Initial Assessment, the result (successful or unsuccessful) must be explained to both the applicant and/or the referring agency by telephone or in writing. The Complaints Procedure should be explained to unsuccessful applicants wishing to make an appeal and issued with a copy of the complaints leaflet. Should the referring agency request information from the assessment itself, prior permission must be gained from the applicant.
3. At interview stage, the **Support Pathway Policy & Procedure** should be explained in detail to all applicants, highlighting that it is a condition of their stay with the YMCA that they engage with their support worker, attend key working, resettlement and where provided life skills/ progression and basic skills appointments.
4. All new residents should have an Outcomes Star and goals action Plan completed **within one month** of arrival at the hostel, using the Outcomes Star and goals Plan online. The Outcomes Star Self-Assessment of Needs form should be given to residents at referral or interview stage for completion and residents should be asked to bring this along to their first appointment.
5. Where residents have language barriers, appropriate assistance should be provided.
6. The Outcomes Star and Action Plan should be completed together with the resident in their first key working session. If this is not appropriate, then another appointment must be made to complete the remaining sections. **The Outcomes Star and Action Plan must be completed in full within one month of the resident moving in**. The Self-Assessment of Needs form should be used to assist in the completion of the first Outcomes Star with the staff.
7. After completing each section of the Outcomes Star, the needs identified should be transferred onto the residents Action Plan immediately.
8. As residents make progress through their actions, they should be asked to provide 'evidence' to prove the action taken and place it in the Evidence Section of the residents file (e.g. completed application forms, letters, training information, leaflets/flyers from events attended etc.).
9. Outcomes Star assessments and Action Plan reviews should take place at least every 12 weeks.
10. All action plans must be completed with the resident and signed by both the resident, member of staff and their Line Manager. Residents must be given copies of all completed paperwork either in hard copy or by email.
11. Failed appointments should be recorded, re-appointed and noted in the resident's files.

Risk & Needs Assessment & Support Flowchart

When	Activity	By Whom
Prior to move in	Referral form completed	Referral Agency/ Applicant for self-referrals
Prior to move in	Application form completed	Referral Agency/ Applicant for self-referrals
Prior to move in	Risk assessment & pre-move in interview completed	Relevant Housing staff with applicant
	Resident Moves in	
On day of moving in	Risk Assessment Action Plan put in place	Relevant Housing staff with resident
Within a week of moving in	Outcomes Star Self-Assessment form completed	Resident
Within 30 days of moving in	Outcomes Star assessment completed	Relevant Housing staff with resident
Within 30 days of moving in	Action Plan in place	Relevant Housing staff with resident
Every 4-6 weeks and as needed	Key working sessions/ rolling review of Action Plan	Relevant Housing staff with resident
Every 12 weeks	Outcomes Star and Action Plan formally reviewed and updated	Relevant Housing staff with resident

Appendix D: Non-engagement Process & Guidance

Non-engagement Process

Our residents' needs are of paramount importance and as supported accommodation, the support that is provided is designed to enable residents to successfully move on to independent living. It is therefore important that staff ensure that residents are clear that not engaging with the support provided puts them in breach of their tenancy or licence.

This procedure for support staff and service managers therefore provides guidance in the management of cases of non-engagement by residents. It is however important that when this procedure is to be followed there is clear evidence of the following:

1. There must be an accurate and up to date risk and needs assessment to ensure that changes in support needs are identified.
2. Confirmation (written or verbal) of intention not to engage with support by the individual.
3. Reasons for non-engagement are identified.
4. Accurate record of actions taken to engage with the individual.

Where there is clear evidence of the above, the following steps shall be taken:

Stage 1

a. Staff raises concern and presents evidence of non-engagement to the line manager at supervision meeting, team meeting or any other meeting as might be necessary.

b. The line manager shall arrange a service level meeting within the earliest possible time with the resident and the support staff. Concerns raised and evidence provided by the support staff shall be used as a backdrop for discussion at the meeting.

c. It is important that other agencies involved in the support service delivery to the resident are made aware and involved in all conversations and effort at bringing the resident to engage with support offered.

d. Action plan for engagement and agreed timescale might be agreed at this meeting, and the notes/minutes of the minute should be signed by all participants.

e. Depending on the individual support needs identified, non-formal programmes/activities may be considered/used to encourage engagement.

Stage 2

In the event of the individual failing to adhere to agreed engagement plan from stage 1, the support staff with the knowledge and approval of the line manager might do the following:

a. Review the situation to establish reasons for non-compliance.

b. Issue a non-engagement level 1 warning letter if the individual has failed without good reasons to attend two consecutive support meetings. An example of good reasons would be but not limited to other meaningful engagements, appointments relating to wellbeing, education, employment or training, physical, emotional or mental ill health, etc.

c. Issue a non-engagement level 2 warning letter for the next support appointment missed after the issuance of a level 1 warning.

d. Issue a non-engagement level 3 warning letter if the individual is still not engaging after the level 2 warning was issued.

e. Again, it is important that other agencies involved in the support service delivery to the resident are made aware of the steps taken and involved in all conversations and effort at bringing the resident to engage with support offered.

Stage 3

Where the steps in stage 2 above have been taken with no positive engagement by the resident, the service manager might issue notice of intention to terminate the tenancy or licence agreement if satisfied that:

- The support needs of the resident are still relevant, and likely to present significant risks to the individual and service.

- The resident is clear that the non-engagement constitutes breach to his or her tenancy or licence agreement.

- However, if at the point of issuing or before the expiration of notice to terminate occupancy the resident resumed engagement, the notice is to be set aside, and this shall be replaced by an agreement stating the terms of engagement.

- It is important that other agencies involved in the support service delivery to the resident are made aware of the steps taken and involved in all conversations and effort at bringing the resident to engage with support offered.

Residents should be reminded that they risk losing their accommodation without an up-to-date Action Plan, or for not complying with it. Officers must refer all non-compliance cases to the Housing Manager for decision.