AnalyticsCambridge

Out of Hospital Care Models Programme for people experiencing or at risk of homelessness

Challenges, Outcomes and Good Practice

May 2022

Prepared for the Local Government Association

Report is produced by: Analytics Cambridge Ltd, CB1 9XR
Company Number: 07697095
Phone: +44 (0)7547 132551
E:mail: richard.potter@analyticscambridge.co.uk
http://www.analyticscambridge.co.uk/

CONTENTS

Figures

Tables

With many thanks to those who have made contributions, who include:

Matthew Ayres, Elizabeth Biswell, Finola Carey, Rhian Clugston, Monica Connolly, Dr Michelle Cornes, Joanne Dickinson, Hannah Donnelly, Abigail Dowdeswell, Tom Downard, Lydia Duncan, Jennifer Everitt, Sarah Feeley, Grace Heggs, Cameron Hill, Ellie Hobart, Elizabeth Keat, Paul Kelly, Alma Kemp, Ijaz Khan, Kathryn Kinder, Gill Leng, Andrea Mason, Colin Morrison, JJ Nadicksbernd, Joe Nguyen, Saba Rai, Scott Riley, Naomi Robinson, Chris Rowland, Sharon Stephens, Katie Taylor, Catherine Tayeh, Jane Wilson.

1 Introduction

1.1.1 This report shares good practice from the Out of Hospital Care Models programme for people experiencing or at risk of rough sleeping.

1.1.2 Within this a £16 million fund was established for 18 pilots to help end the cycle of homelessness and hospital readmissions by providing temporary accommodation, care and support.

1.1.3 This report gives examples and information provided by 15 pilots (listed in Appendix 1). In the Out of Hospital Care Models programme for people experiencing or at risk of rough sleeping there are an additional three pilots[1] who have had a more targeted focus on mental health. This is covered in an accompanying report[2].

1.1.4 The models have many components. Lead local authorities were named as the place to where funding would be paid on behalf of the partnership. The proposals were asked to name organisations who would be involved. These included other Local Authorities; Sustainability and Transformation Partnerships or Integrated Care Systems; Clinical Commissioning Groups; secondary and primary care provider partners; voluntary, community and social enterprises; and housing provider partners. Liverpool gives eight partners, Bristol six. For Leeds 18 are named and for North West London there are 35. The pilots are named here by geography.

1.1.5 The experience of the pilots, from Liverpool to London, Bournemouth, Christchurch and Poole to Cambridgeshire comes from differing places with different services and networks established. There are different geographies and local structures between hospitals and local authorities. Some are based on one local authority and one hospital, for North West London there are eight local authorities and eight major acute sites.

1.1.6 This report explores the development and experience of the Models for each pilot site, celebrating successful outcomes and exploring challenge. It is there to help others work together towards the same objective "*to end the cycle of people leaving hospital to return to the streets and then being quickly readmitted to hospital*[3]".

1.1.7 The Models are in different stages of development. The report gives examples some of the different activities which the pilots were implementing, which can take different lengths of time and there can be different challenges faced.

1.1.8 The information here is from a number for sources: presentations made by the pilots to quarterly assurance meetings; interviews with 12 pilots, and information others have provided.

[1] Brighton, Cornwall and Oxford

[2] Out of Hospital Care Models Programme for People Experiencing Homelessness, Challenges, Outcomes and Good Practice for those with funding on Mental Health Support

[3] https://www.gov.uk/government/news/fund-to-help-end-cycle-of-homelessness-and-hospital-readmissions

1.1.9 The report gives examples of:

- Objectives for the models and the areas they focus on
- Challenges they have faced and action taken to overcome these
- How outcomes have been shown
- Learning and good practice they have developed and can pass on

1.1.10 If you would like to explore some of the examples in more detail those who have offered to do this are listed in Appendix 2.

1.1.11 Parallel work is being carried out by Kings College London: the evaluation of the Out-of-Hospital Care Models programme for people experiencing homelessness[4]. Results and tools will be published as they become available.

[4] https://www.kcl.ac.uk/research/oohcm-evaluation

2 Objectives and focus

2.1.1 The Out of Hospital Care Models for those experiencing or at risk of rough sleeping bring differing organisations together in different places. One tool to start with can be a vision[5], an end goal that:

- Is easily understood by all stakeholders (short, memorable, no jargon)
- Describes a desirable future state, not how to get there
- Has implicit benefits arising from the transformation to the future state
- Is compelling and motivating – engages hearts as well as heads

2.1.2 One example is North East London's Integrated Care System's[6] vision "*to sustainably and meaningfully improve the quality of health and life for rough sleepers and those at risk of rough sleeping*".

2.1.3 Objectives give focus, and those from Bournemouth, Christchurch and Poole are set out as:

- Timely transfers of care from hospital will improve
- Attendance and admissions to hospital will reduce
- Re-admissions to hospital will reduce
- Access to primary care services will be improved
- Reduction in health and care inequalities for people rough sleeping or vulnerably housed
- Increase in moves to sustainable accommodation with no return to the street
- Positive customer experience with multi-disciplinary team support

2.1.4 Nottingham gives expected outcomes to focus on:

- Reduce delayed discharge from Nottingham University Hospital for those with complex case histories
- Reduce the barriers for rough sleepers to receive treatment that would normally be offered in the community/at home by providing an alternative option
- Provide rough sleepers with an opportunity to finish a course of treatment which would be challenging to deliver whilst rough sleeping or homeless
- Reduce the risk of rough sleepers presenting at Emergency Departments for treatable medical problems prior to admission and post hospital discharge
- Reduce the hospital length of stay for patients who are medically fit but unable to be discharged due to housing need

[5] Department for Business, Innovation and Skills (2010), Understanding Programmes and Programme Management, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/31978/10-1256-guidelines-for-programme-management.pdf

[6] Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups, https://www.england.nhs.uk/integratedcare/what-is-integrated-care

2.1.5 Outcomes are supported by metrics by which they are measured and baselines to start from. The North Central London partnership have looked at aspects of homelessness through data from local authorities and the numbers admitted to hospitals. As well as rough sleepers these also have estimates of the people at risk of homelessness (sofa surfing[7]).

Table 1 Approximate number of rough sleepers and people experiencing homelessness in North Central London, by local authority, January 2021

	Rough sleepers (estimated)	Number of people in settings (homeless)	Total
Barnet	7	172	179
Camden	45	1006	1051
Enfield	19	280	299
Haringey	10	801	811
Islington	11	597	608
TOTAL	**83**	**2660**	**2948**

Table 2 Homeless hospital admissions by acute health Trust, North Central London

Homeless hospital admissions by Trust	2018/2019	2019/2020
North Middlesex University Hospital NHS Trust	135	112
Royal Free London NHS Foundation Trust	226	253
University College London Hospitals NHS Foundation Trust	349	337
Whittington Health NHS Trust	159	151
Other	8	10
Grand Total	**877**	**863**

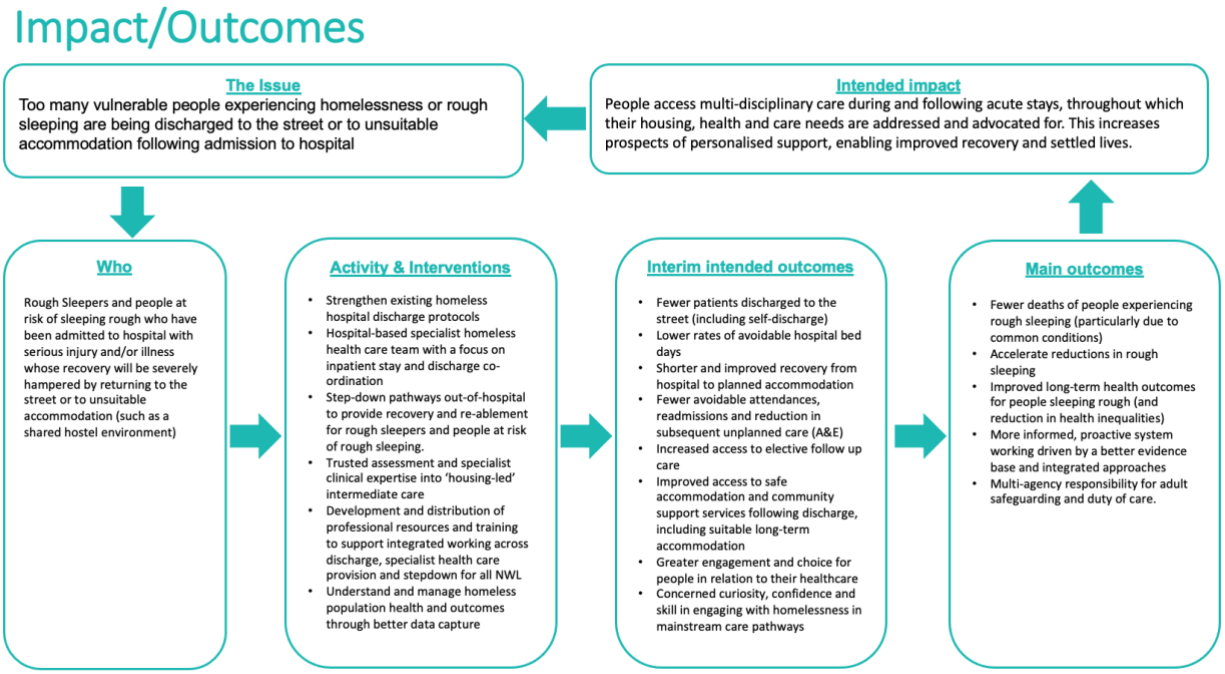
Table 3 A&E attendances and re-attendances, North Central London, 2017

	Number of A&E attendances (1 year)	*A&E re-attendance rate (7 days)*	*Number of hospital admissions (1 year)*	*Re-admission rate (30 days)*	*Average length of stay (days)*
UCLH	3771	20.4%	602	18.3%	4.1
Royal Free	971	57.8%	234	9.4%	3.1
Barnet	277	48.7%	81	9.9%	2.2
Chase Farm	25	40%	4	0%	0.5
North Middlesex	606	7.4%	133	11.2%	4.2
Whittington	684	Not known	102	Not known	3.1
TOTAL	**6334**	-	**1156**	-	-

[7] Crisis (2019), It was like a nightmare – the reality of sofa surfing in Britain today, https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/types-of-homelessness/it-was-like-a-nightmare-the-reality-of-sofa-surfing-in-britain-today/

2.1.6 The pilots move from the objectives to demonstrate the actions and impact of implementing the models. North West London have a diagram showing the issues, outcomes and the activity to achieve these.

Figure 1 Diagram showing issues and activity, North West London



2.1.7 An important element of the models has been the roles of local partner organisations and working together, bringing their skills and expertise to provide wraparound care and support. Birmingham put together a diagram to illustrate the partners involved in their model in an integrated multi-agency homeless team.

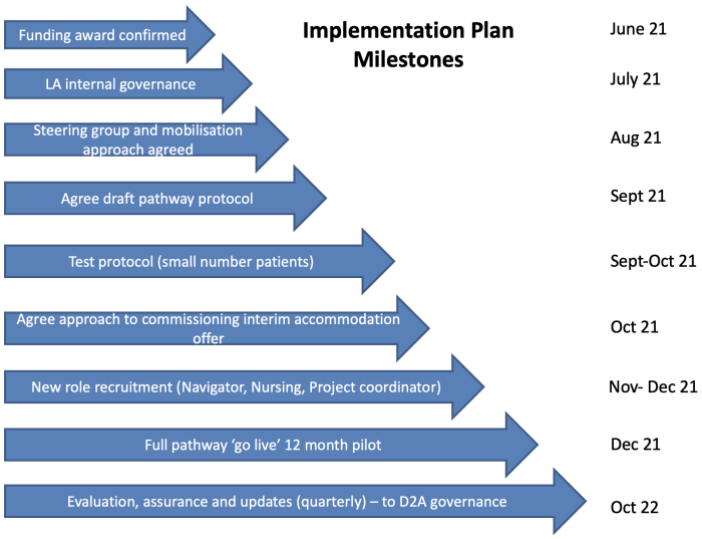
Figure 2 Differing teams needed, Birmingham

2.1.8 An integral part of achieving the objectives can come through mapping the pathways, ensuring that frontline staff have the correct information to facilitate the appropriate response. This is demonstrated in Bolton's Out of Hospital homeless discharge protocol.

Figure 3 Out of Hospital homeless discharge protocol, Bolton

2.1.9 Having identified the outcomes and action needing to be taken, the pilots were asked to show the implementation timetables, as the diagram by Nottingham does.

Figure 4 Implementation plan milestones, Nottingham



2.1.10 From their experience, South West London gave the advice: "*don't underestimate what is needed to set something up from scratch. For example, the time it takes to recruit: advertise, interview, and carry out employment checks*". If good relationships and similar priorities are already established then these can be used when funding becomes available.

3 Challenges and how they were overcome

3.1.1 Moving from the objectives to implementing them comes with challenges. Some of these can be anticipated, with the table from Liverpool as one example (more detail is given in Appendix 3, Risks and mitigation, Liverpool).

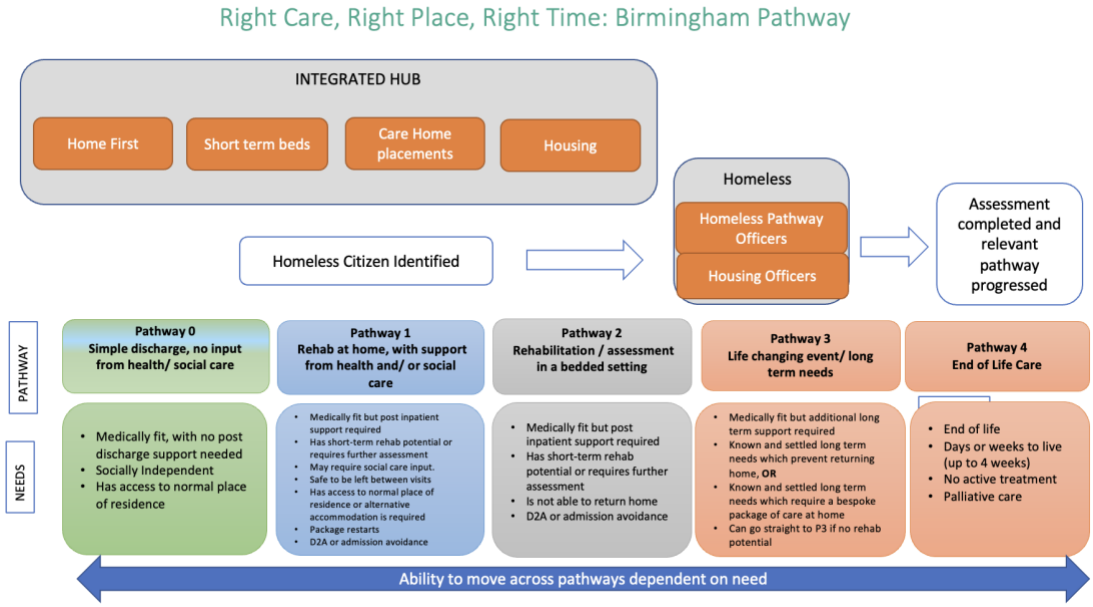
3.1.2 The pilots have given information on the challenges they face and how they are overcoming these. Around three quarters of the challenges come under the headings:

- Accommodation: finding the right approach to help the discharge of the homeless from hospital
- Communications: between organisations, within organisations and with service users
- Data: improving how organisations work together
- Identifying the needs of the homeless: from the complexity of need
- Recruitment: taking on additional staff

3.2 Accommodation

3.2.1 Challenges under the heading "accommodation" were identified by two thirds of the pilots. Birmingham produced a diagram to show the range of accommodation and interaction with the needs of the homeless.

Figure 5 Showing housing options and discharge pathways, Birmingham



3.2.2 For North Central London it was challenging to secure accommodation provision for those who had been deemed likely to have No Recourse to Public Funds (NRPF[8]) and where accessible accommodation was required. In response to this they provided NRPF discharge guidance and training, access to appropriate housing, undertaking a mapping of resources and reviewing the commissioning options for accessible accommodation, case management, and the identification of housing related issues which would impact on safe hospital discharge.

3.2.3 In the Cambridgeshire and Peterborough pilot, the housing provided in Peterborough was fully furnished. But helping the homeless needed more than this: "*living in a house can be scary for people who have been homeless*". What helped was to be in housing for a six week period and learn how to live as close to normal as possible. The project was able to provide a dedicated resource unit which could visit four times a day, set goals and see that the client worked to these.

3.2.4 North East London are using learning from Gloria House[9] and Mildmay[10] to refine a step-down model. A network of three step-down accommodation units is being developed: one in each integrated care partnership. These will provide shared support and capacity for the North East London system. They include 6 bedded medium support unit models:

- Supported by link workers – who identify rough sleeping inpatients and support transition to relevant longer term housing workers, ensuring timely assessments
- Trauma informed
- Capacity co-ordination between sites
- Encompassing those with no recourse to public funds (NRPF)

[8] An explanation of No Recourse to Public funds is available through the Home Office https://homeofficemedia.blog.gov.uk/2020/05/05/no-recourse-to-public-funds-nrpf/

[9] https://www.peabody.org.uk/news-views/care-support-news/2019/sep/deputy-mayor-sophie-linden-visits-peabody-hospital-discharge-service

[10] Step-Down Homeless Medical Care Pathway, https://www.mildmay.nhs.uk/homeless-pathway

3.3 Communications

3.3.1 The need for good communications is broad and takes many forms - between organisations, within organisations, and with service users. South West London worked to have external support as one way of increasing awareness.

Figure 6 Getting wider publicity for new programme, South West London

It was one of the most enlightened evenings I had spent, listening to the doctors and nurses whose job it was to provide this wonderful medical-social thinking. I shall write further about the Pathway programme because it is this sense of enlightened emergency support that we need to concentrate our efforts on.

Emergency help should be effective, efficient and take people out of the emergency. Giving people medical treatment in the crisis of homelessness should be seen as getting them a step away from emergency.

I have banged on about prevention for so long and believe in it fully. But that does not mean we can ignore the emergency of current times. We have to provide the best of emergency support in a way that helps people move away from it.

On so many occasions I would see people in doorways with heavily bandaged legs, arms or head; it seemed the biggest of anomalies, one that needed to be addressed.

St George's and Pathway have begun to address that. And the good news is that Pathway is spreading out to hospitals all over the country. I hope we can all get behind their thoughtful and profoundly inspirational work.

John Bird is the founder and Editor in Chief of The Big Issue.
@johnbirdswords

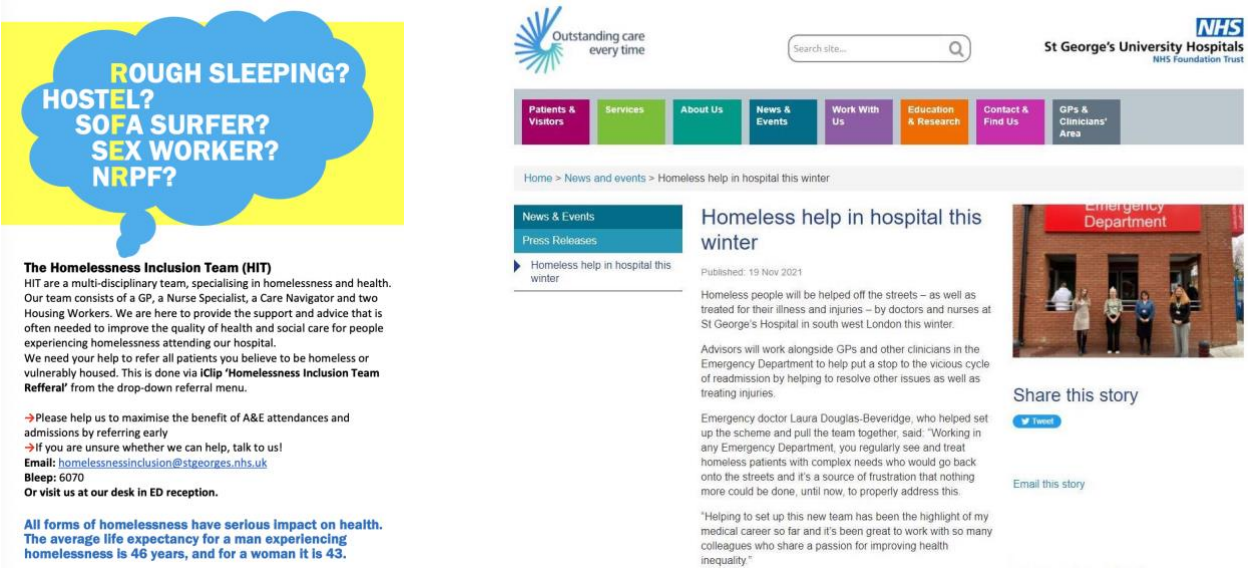
This article is taken from The Big Issue magazine. If you cannot reach your local vendor, you can still click HERE to subscribe to The Big Issue today or give a gift subscription to a friend or family member. You can also purchase one-off issues from The Big Issue Shop or The Big Issue app, available now from the App Store or Google Play.

FROM THE MAGAZINE, HOMELESSNESS, JOHN BIRD, PATHWAY, SHARE

3.3.2 Half the pilots identified that communication was a challenge. For Salford (as with many pilots) this was "*raising awareness of the service within the trust*." In Oldham it was described as a "*lack of understanding of the Homelessness services*".

3.3.3 There are many other examples of pilots addressing this challenge: attending meetings; producing posters and accessible information on internal or external websites; and personal stories in staff newsletters.

Figure 7 Raising awareness of the Homeless Inclusion Team, South East London



3.3.4 One pilot reported that case conferencing can be time consuming and there can be a tendency to predict the outcome of discussions. The risk of this can be mitigated by having a co-produced model with frontline staff. Staff from the hospital integrated discharge team, community specialist services and housing attend a mobilisation *steering group* and are taking the lead on establishing a cross agency team meeting to debrief and discuss how the pathway could work better.

3.3.5 Access to a person with knowledge and who can do things is seen as a key resource for communication. For Bolton, ward staff don't always have the time to be ringing housing options as they are often having to ring multiple times. This will change as the Bolton Council Rough Sleeper Outreach Team now have a duty number that professionals can ring 9am – 5pm, Monday to Fridays and the number will be publicised to the Integrated Discharge Team and all wards.

3.3.6 Communications between agencies can support the identified needs of the homeless. Liverpool give the example of a person with a terminal illness, who wanted to go home but couldn't – the landlord had changed her lock, the home had no electricity, there were rats. The team worked with environmental health and supported her so she could return home: "*Hospital in reach Colleagues acted as a point of contact to coordinate actions from across the systems, a team member physically attended the property so that the patient could gain access and took pictures as the environmental health department had limited capacity to do so and to wait would have caused further delay. The team also contacted the landlord directly to ensure that access remained and provided practical support such as a mobile phone for the patient to use to contact her family and offered support and basic provisions such as clean pyjamas and toiletries. The team contacted the Macmillan nurses and ensured that they were aware of her situation and support needs and continued to provide outreach support in the community with review from the specialist homeless nurse on discharge*".

3.4 Data

3.4.1 The engagement of different organisations leads to problems accessing and sharing computer systems. Liverpool reported seven different IT systems that would need to be used[11].

3.4.2 Bolton colleagues were unable to update the hospital Electronic Patient Record (EPR) system: it was only available as a read-only system in the community. They had to rely on staff to enter visits on the system and this couldn't always be done. They have now completed process mapping for the EPR and should be on the first roll out for the community access.

Figure 8 Community Team moving to new Electronic Patient Register, Bolton, article in Trust magazine

Our Community Teams are now in the early stages of moving onto our new Electronic Patient Record (EPR).

Also known here at Bolton as Allscripts, it will mean that patient's details are easy to find and ensures staff have access to the most accurate and up to date information.

This will also be a huge boost to patient safety by providing patients with efficient, coordinated care and making it easier for teams to work together and share patient records. All of this will improve what the patient experiences.

As part of the project, the Homeless and Vulnerable Team have been working hard behind the scenes to complete process maps for their service.

This allows us to see how EPR can fit for each team, offering a great opportunity to shape and design our services with the exciting benefits and improvements from digital technology.

For our Homeless and Vulnerable Team, who work with some of the most vulnerable people in Bolton, access to EPR will improve how different disciplines communicate with each other and promote enhanced Multidisciplinary Team (MDT) working for patients.

Stacey Leigh, Clinical EPR Project Manager, said: "There is a positive feeling across the division for this transition over to EPR and I am really looking forward to working with everyone throughout this process."

3.4.3 The Bristol pilot had struggled to get data about the health needs of homeless people and also secondary data usage data. The Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group business intelligence team is working with them to access secondary usage data sets.

3.4.4 As shown in Figure 2 Birmingham had identified that one of the skills they needed was a data analyst/intelligence post. The role is in place to ensure that there is coordination and development of the data locally to provide a better system-wide understanding, including monthly project reporting, dashboards and reporting for the Department of Health and Social Care.

[11] The seven systems are – 2 systems for the acute trust, one to make referrals (ICE) and one to record notes (PENS); GP and primary care trust use EMIS to record clinical notes; Mainstay records hostel and homeless service info.; Mental health trust uses RiO to record clinical info, Whitechapel housing charity uses their own system to record data, Local Authority uses Liquid Logic to record information.

3.5 Identifying the needs of those experiencing or at risk of rough sleeping

3.5.1 South West London felt that nurses, GPs and other clinical and social care professionals might not feel able to recognise who is homeless, and that training helped them make referrals. A challenge identified by Oldham (and other pilots) was that some staff have a lack of understanding of the homelessness services. A hospital might not know that Social Services' support is not classed as a public fund for immigration purposes and so can be accessed by a person who is subject to the 'No Recourse to Public Funds' (NRPF) condition[12].

3.5.2 Healthy London Partnership carried out a snapshot survey which highlighted issues impacting on timely and safe discharge for people experiencing homelessness. It demonstrated the wide range of complexity of need, often including a combination of physical health, mental health, addiction, housing and social care factors. Despite being deemed fit for discharge, many needed continued specialist case working, a period of rehabilitation, and in-reach support or specialist accommodation.

3.5.3 Leeds record how they seek to overcome this: "*we are working with people who have often presented in crisis and chaos, sometimes the risks have been high. We have had weekly multi-disciplinary team meetings, case managements, robust risk management and have utilised the City's exceptional risk forum to discuss several cases. Our approach has been very trauma informed, trying to understand the person's story, what leads their behaviour, how we can engage them in the most creative and therapeutic way.*"

3.5.4 South East London has seen strong benefits and experienced value by introducing Red Cross resettlement workers in the hospitals: "*they are a seamless link and follow the patient from discharge planning all the way through to settling in to move on accommodation*". There is the need for the flexible use of short term accommodation. There had been concern that hospitals would send people with complex requirements to the hotel[13], thereby long length of stays which would lead to using up the allocated funding for hotel beds quickly: "*we set strict acceptance criteria to mitigate against this including not accepting clients with no recourse to public funds. By assessing clients on a case by case basis, we have found that we could accept some NRPF clients where it was clear that a plan had been developed for a move on solution*."

3.6 Recruitment

3.6.1 Seven of the pilots reported the challenge of recruitment. For the programme this was partly due to the fixed term contracts as a result of time-limited funding. The exact problems differed, as did the solutions found.

---

[12] For example, "Supporting European Economic Area (EEA) nationals who are destitute or at risk of homelessness Guidance for local authorities", https://www.nrpfnetwork.org.uk/-/media/microsites/nrpf/documents/guidance/factsheet-eu-settlement-scheme.pdf?la=en&hash=4B47BC7030DB7A459877902127FDAB93E7D9DE84
With some EEA nationals unable to access benefits, local authorities will need to consider whether statutory duties are engaged to provide accommodation and financial support when a person or family are destitute or at risk of homelessness. Any increase in demand for this 'safety-net' support will give rise to significant pressures on local government, and people who do not qualify for such assistance may be at risk of rough sleeping.

[13] There was a long-standing relationship with the London Hotel Group who had provided Bed & Breakfast accommodation for similar projects in the past.

3.6.2 It took time for Birmingham to finalise and develop their recruitment programme. The initial timeline and the identified number of staff required were in place. The main issue around recruitment was the limited 12-month fixed term contracts - against a vibrant employment market. Birmingham "*took time to get this right*" using secondment of staff and money to back fill posts to make this possible.

3.6.3 South East London were only able to fill one of the three posts they advertised. They are looking into the possibility of using an agency locum social worker and whether a voluntary sector organisation they are working with can provide an interim resource.

3.6.4 Liverpool also found that flexibility helped and were able to use bank staff initially to support staff already engaged in the project.

3.6.5 South West London had good applicants for the posts they advertised. This came from the significant effort that was put into the recruitment process, for example with senior managers engaging with the process and raising awareness.

4 Measuring and informing on outcomes

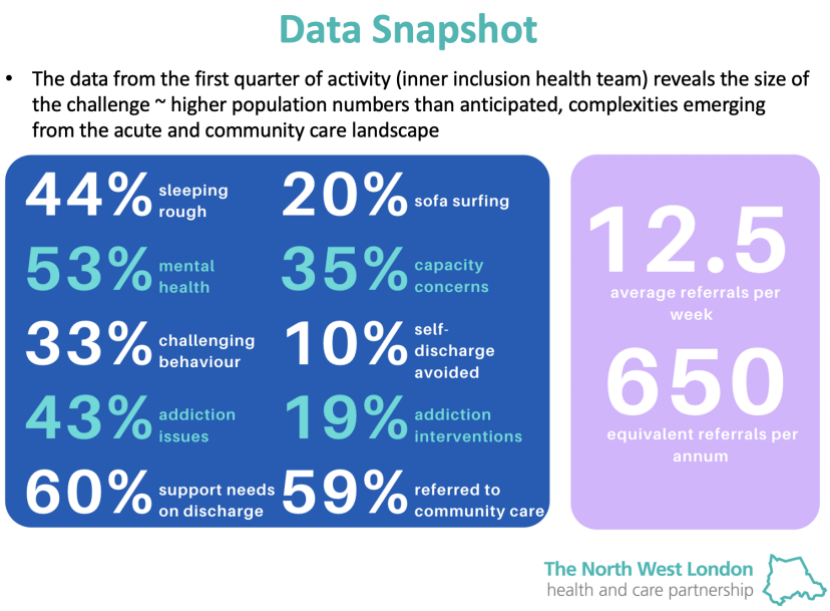
4.1.1 Given the differing sizes of the pilots and differing times they were able to start up their models, this report is not about the size of the numbers. The focus is on *how* the outcomes were reported. The examples are extracts rather than full reports.

4.1.2 South East London give the following information:

- 112 hotel bed nights have been used between 31/12/21 and 21/2/22
- 112 hotel bed nights = 112 NHS bed nights released at acute hospitals.
- £26,000 has been saved by the NHS by not having to accommodate these patients in hospital beds (based on a cost of £295 per bed day)
- 94% of all referrals received are Pathway 1 and 6% were Pathway 2. No referrals for Pathway 0 or Pathway 3 have been received.
- 40% of the referrals were received from Southwark homeless or rough sleepers, 15% from Lambeth and 10% from Lewisham. These proportions are likely to be skewed due to the phased mobilisation with King's College and Guy's and St Thomas' hospitals mobilising first.
- 35% of the cases managed are for white people, 25% for Black- African, 10% Black – other and 5% with a mixed ethnic background
- 30% of cases were sleeping rough at the point of hospital admission
- 90% referrals to the service have been accepted.

4.1.3 North West London use a graphic as one aspect of showing activity.

Figure 9 Data snapshot from North West London



4.1.4 Although numbers have an important role in measuring the impact of the programme, many pilots have provided case studies to bring a human element to outcomes achieved through the programme. One from South East London and one from Liverpool are given as examples.

Case study, South East London

60 year old male. Frequent attender at Kings College Hospital, St Thomas' and University Hospital Lewisham attended the Lewisham Emergency Department (ED). He was admitted for pneumonia which was quickly resolved and due to safeguarding concerns. He is vulnerable due to having cognitive impairment.

The temporary accommodation he was in prior to ED has been taken over by others.

Kings Health Partner (KHP) Homeless Health team intervened following a referral from Lewisham ED. A prolonged hospital admission was avoided by undertaking an initial assessment to check that he could safely be accommodated in hotel accommodation and then subsequently moving him there.

Occupational Therapy (OT) assessment then took place in the short term resettlement hotel accommodation. The OT making a recommendation of a move to a more supportive environment, as opposed to the previous temporary accommodation.

KHP Homeless Team contacted the Southwark Council Housing Navigator Team at the earliest opportunity who have expedited a referral to an appropriate hostel.

He has been supported by the Red Cross Resettlement workers with settling in to the hotel and with shopping.

Positive feedback received from the service user and his next of kin. They were both extremely grateful for the support provided.

Case study, Liverpool

I would like to express my sincere thanks to all the staff and volunteers at the Whitechapel centre for their invaluable assistance this year.

Like many others I lost my job during the pandemic and was struggling with my rent and bills. Having rented a 2 bed flat while in employment and housing benefit would only cover a portion of this I was looking for somewhere affordable while keeping my landlord informed of my intentions.

In August this year I fractured my spine in an accident and spent 5 weeks in hospital. While I was there I was evicted and my possessions were removed.

The hospital recommended the Whitechapel centre and from day 1 the support I received was truly incredible. They visited me regularly to update me and give me encouragement.

On my discharge in September they found me some excellent temporary accommodation while continuing to look for something permanent. They helped me retrieve my belongings while helping with transport, food and toiletries. After only 4 or 5 weeks they had secured me a lovely 1 bed flat. They also allocated me a support worker to help me move and settle in as I still struggle with my injuries and also a welfare officer to ensure I claim the right benefits.

I honestly don't know how I would have got through this without their help and would like to thank everyone at the centre for their support. They do amazing work and always with a smile on their faces. Particular thanks to Stephen, Rob, Dave, Michelle, Maureen, Russell and John as they have been looking after me personally but the whole team have my eternal gratitude.

Part of their vision is to help people find a route out of homelessness, maintain a home and achieve their individual potential. They have, without a doubt, helped me with the first 2 objectives and I know they will continue to support me and help me achieve my potential once I am fit again. I plan to offer my time to the centre either as a volunteer or as a staff member as soon as I am able.

5 Learning or good practice

5.1.1 The pilots have provided examples of lessons they have learnt; what has and hasn't worked, and advice they would like to pass on to others from their experiences. These are related to the challenges and what was done to overcome these.

5.2 Accommodation

5.2.1 For South East London, one example of good practice has come through the availability of short term resettlement accommodation and the resettlement support workers - leading to a dramatic shift away from needing to discharge people from hospital onto the streets towards more person-centred solutions. The provision of short-term accommodation provides 'breathing space' for any challenges to be resolved i.e. allocation of temporary accommodation by the council. Birmingham similarly values step-down accommodation which provides a safe testing space for individuals who are bordering on residential care, and allows appropriate assessments to be completed in an independent living facility.

5.2.2 Leeds give the importance of flats in therapeutic housing units which normally accommodate people with mental health difficulties. People have been placed in either short-term or longer-term arrangements, with a robust case management and care planning system around them so they can achieve individualised goals.

5.3 Flexibility

5.3.1 Oldham and Liverpool both refer to the benefits and importance of being flexible to achieve *no discharge to street* and *no extended stay*: "*the service must be responsive and flexible to the needs of the individual and system*".

5.3.2 For Liverpool flexibility comes through:

- The use of emergency provision as last resort
- Good links with housing options service
- Timely accessible referral and assessment which means no delay in actions which support discharge
- Escalation to senior leads if necessary to support systems working
- An experienced team to ensure awareness of all avenues for discharge

5.4 Partnership

5.4.1 The models are built from a differing organisations and people working together. Liverpool see that "*relationships and local knowledge are essential*" and that shared intelligence supports outcomes. In Leeds there has been "*a multiagency approach across health, housing, adult social care, mental health, third sector and accommodation providers*". For North Central London "*the biggest success has been collaboration and the understanding of roles*." Salford name the value of reducing silo working.

5.4.2 Bristol gives an example as "*building links with services to support people when they are discharged, such as SUST (the Substance Use Support Team), a floating support service that supports people with substance use needs to engage*". Oldham valued "*enhanced partnership working with drug and alcohol support services*."

5.4.3 There are many different ways for what is needed and what can be achieved. In North Central London there were "*governance meetings including Public Health & Housing*". For Salford there was "*having a presence in multi-disciplinary teams*."

5.4.4 Nottingham strengthened the formality and consistency of their approach to multi-agency case conferencing for hospital discharge cases where the individual is experiencing homelessness.

5.5 Integration

5.5.1 Partnership is working together, for some of the services provided there can be greater benefits from combining these. The accessing and sharing computer systems forms one element.

5.5.2 Birmingham highlight the integration of teams and shared office space, with the Homeless Pathway Team as part of the discharge hubs and sharing space with Complex Discharge Nurses and Social Workers proving a real asset.

5.5.3 In South East London there are strong benefits and value from introducing Red Cross resettlement workers in the hospitals. They support people with transitioning to accommodation (which could be the short-term accommodation as part of this project or a longer-term accommodation option). They are integrated into the King Health Partners Homeless Health Team and work closely with the NHS staff.

5.5.4 In North West London the view is that integrated working needs to come earlier in the care episode – so there is clarity about what needs to be achieved and who has responsibility for each task. Blended teams energise staff with cross fertilisation of skills and knowledge.

5.6 Training

5.6.1 Bournemouth, Christchurch and Poole see a "*change in culture – the education of hospital staff around housing processes and available services, identifying on admission and information required for statutory process.*"

5.6.2 Bolton note that "*better in-reach into the hospital has helped to educate staff about our service and the facilities available in Bolton for our homeless patients. This has helped to reduce self-discharges which can be unsafe with patients leaving without medications or a discharge address*."

5.6.3 Bristol held workshops with Homelessness Accommodation Pathway Providers to identify barriers to engagement & service gaps.

5.7 Understanding the needs of the homeless

5.7.1 Understanding the needs of the homeless is given as a key element of good practice. Healthy London Partnership expresses this as "*seeing the complexity of needs, even when medically optimised*." In Liverpool "*listening to lived experience is key to delivery and development*."

5.7.2 Nottingham saw that "*there was a clear difference in the effectiveness and partnership approach for cases in which the individual was already known to community homelessness nurses and support workers, and these frontline staff were able to attend the case conference. The discussion about the individual is person-centred, pragmatic but also looked at the 'window of opportunity' presented in terms of engagement and readiness to access services like detox."*

5.7.3 In Cambridgeshire there was a challenge with homeless people who had a dog in their care, reducing options for suitable accommodation. In Peterborough they worked with the Housing Association and also the Dogs Trust[14] so that there was housing which could work - food and bedding for dogs could be provided.

5.7.4 The examples from the pilots introduce and illustrate ways to meet the objective of ending the cycle of people leaving hospital to return to the streets and then being quickly readmitted to hospital. Their experience is for others to adapt to where they are. Further information from the pilots can be provided from the contacts given in Appendix 2.

[14] https://www.dogstrust.org.uk/rehoming/

Appendix 1. Pilots in the Out of Hospital Care Model programme for people experiencing homelessness

Pilot	Leading local authority
Out of Hospital Care Model – Birmingham	Birmingham City Council
Our Dorset	Bournemouth, Christchurch and Poole Council
Healthier Together Bristol, North Somerset and South Gloucestershire	Bristol Council
Cambridgeshire and Peterborough	Cambridgeshire County Council
Greater Manchester Health and Social Care Partnership	Greater Manchester Combined Authority, projects in Bolton, Oldham and Salford
Humber, Coast and Vale	Kingston Upon Hull City Council
West Yorkshire and Harrogate Health and Care Partnership	Leeds City Council
Cheshire and Merseyside Health and Care Partnership	Liverpool City Council
Nottingham and Nottinghamshire	Nottingham City Council and Mansfield District Council
North Central London Partners	Islington London Borough
North West London	Kensington and Chelsea Royal Borough
Our Healthier South East London	Lambeth London Borough
South West London Health and Care Partnership	Kingston upon Thames Royal Borough
North East London Health and Care Partnership	Newham London Borough
Pan-London Model	Healthy London Partnership[15]

Note: there are three additional pilots - **Brighton**, **Cornwall** and **Oxford** - who were provided with additional funding to support addressing mental health. A summary of their work is provided in an accompanying report.

[15] Note: Healthy London Partnership partners include the NHS in London, Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers, the Greater London Authority, the Mayor of London, Public Health England, and London Councils. https://www.healthylondon.org/

Appendix 2. Contacts for further information

Pilot	Leading local authority	Name of contact	Email
Out of Hospital Care Model - Birmingham	Birmingham City Council	Sarah Feeley	Sarah.Feeley@birmingham.gov.uk
Healthier Together Bristol, North Somerset and South Gloucestershire	Bristol Council	Jennifer Everitt	Jennifer.Everitt@bristol.gov.uk
Cambridgeshire and Peterborough	Cambridgeshire County Council	Kathryn Kinder	kathryn.kinder@serco.com
Greater Manchester Health and Social Care Partnership	Bolton Council for project in Bolton	Joanne Dickinson	Joanne.Dickinson@boltonft.nhs.uk
West Yorkshire and Harrogate Health and Care Partnership	Leeds City Council	Elizabeth Keat	ekeat@nhs.net
Cheshire and Merseyside Health and Care Partnership	Liverpool City Council	Katie Taylor	Katie.Taylor@merseycare.nhs.uk
Nottingham and Nottinghamshire	Nottingham City	Naomi Robinson	naomi.robinson2@nhs.net
North Central London Partners	Islington London Borough	Jane Wilson	jane.wilson19@nhs.net
North West London	Kensington and Chelsea Royal Borough	Cameron Hill	cameron.hill1@nhs.net
Our Healthier South East London	Lambeth London Borough	Kenneth Gregory	kennethgregory@nhs.net
South West London Health and Care Partnership	Kingston upon Thames Royal Borough	Matt Ayres	Matthew.Ayres@stgeorges.nhs.uk
North East London Health and Care Partnership	Newham London Borough	Abigail Dowdeswell, Ellie Hobart	abigail.dowdeswell@nhs.net ellie.hobart@nhs.net
Pan-London Model	Healthy London Partnership	JJ Nadicksbernd	jj.nadicksbernd@nhs.net

Appendix 3. Risks and mitigation, Liverpool

Risk	Mitigation
Stakeholder and partner buy-in	Early engagement in bid development; Programme Board made up of key stakeholders to oversee delivery; Programme Management role includes stakeholder management, communication; alliance delivery model with strong clinical and system leadership
Recruitment of key posts	Pre-planning with delivery partners to ensure timely recruitment, use of secondments to create opportunities
Complexity of current funding streams/systems	Funding and outcome mapping matrix; strong programme management; delivery alliance model; effective governance and ownership by joint commissioning
Failure to secure delivery partners with track record	Work with existing experienced partners/providers in developing the bid; partners are aligned where expertise lies
Failure to deliver to timescales	Effective programme management; ongoing engagement with partners to understand individual milestones; use governance structures to problem-solve if issues
Sustainability due to 1 year funding	Balance of activity to focus on system change rather than recurrent interventions; analyst capacity to focus on data for business/system change case; effective governance; tracking of outcomes and efficiencies across all parts of the system (health, housing and social care)
Fragmented service delivery across multiple partners	Develop a Standard Operating Procedure (SOP) for the programme with clear roles and responsibilities; programme management to align partners; regular formal and informal opportunities for communication, skill sharing etc.