Step-Down and Onwards Accommodation: good practice models and resources

Care and Health Improvement programme

Agenda

12:30 – 12:35	***Welcome and Introductions*** – Chris Rowland, LGA
12:35 – 12:55	***Liverpool Homeless Hospital Inreach/Step up and Prevention*** - Katie Taylor Homeless Health Clinical Project Lead, Mersey Care NHS Foundation Trust
12:55 – 13:15	***BCP Homeless Care Pathway Step Up/Down Beds*** – Kim Fletcher, Senior Housing Practitioner, BCP Council
13:15 – 13:50	***Discussion and operational feedback –*** *Chris Rowland, LGA*
13:50 – 14:00	***Next Steps***
14:00	***End***

Housekeeping

- Mics off please, cameras are optional.
- Next webinar: ‘Step-Down and Onwards Accommodation: good practice models and resources’ is on 14th December 12:30-2pm
- Should you lose connection to the session, please re-join using the same MS Teams link you joined with
- If you have any problems, please contact Fiona Wileman via email - Fiona.Wileman@local.gov.uk
- Please fill out our evaluation form at the end of the session.
- Copies of the slides will be available in the post event email.

Liverpool Homeless Hospital Inreach/Step up and Prevention

The model

- Multi disciplinary In-reach team- clinically led by Specialist homeless GP
- Voluntary and statutory sector as equal partners in the pathway
- Proactively seeks clients in addition to accepting referrals
- Rapid response time
- Weekly hospital MDT review (face to face with patient)
- Working across six sites
- Three adapted care beds for ‘step up’
- Care provider to assist Care Act Assessment and short term stability to support discharge/prevent admission
- Weekly case management discussion which includes the Homeless Mental Health Team, Clinical Project Lead, step up and care providers to identify admission avoidance opportunities, capacity and forward planning to enable effective discharge
- Provides short term aftercare where appropriate with seamless transfer to wider team
- Sits within an integrated pathway for homeless health in the city, directed by One Liverpool plan for Complex Lives

Progress to date

- Service ‘went live’ 1st September 2021
- Recruitment continues with three posts remaining outstanding
- 48 people seen by the service in month one (46 seen by clinical inreach team)
- Case Studies
- Harry’s Story
- MH Homeless Outreach team and Complex lives ICT pathways in place to support safe discharge and admission avoidance
- Shared learning and reflective practice
- Communication across the city has commenced to include a range of providers

Challenges

- IT systems (7 systems in use!)
- Data requirements and BI support
- Timely recruitment for short term posts (other projects also recruiting)
- Benchmarking outcomes and performance with no previous data
- Evidence for longer term funding
- Clinical complexity of patients requiring DOLS, MHA detention
- The nature of homeless people- ‘new homeless’ -more people becoming homeless whilst in hospital than initially expected due to unsuitable housing/different needs due to illness
- Limited appropriate housing stock
- Reduced resources across the system to support discharge, eg: environmental health

Learning and further development

- Continue to develop as one offer for homeless health, wider team including ADDER, extended Homeless Mental Health and Pathways Team
- Experienced team is essential in producing rapid results
- Cultural awareness is essential and a multilingual team makes a big difference to care
- Integrated ‘one stop shop’ approach including relationship with housing options
- Flexible care provision to support crisis prevention
- Reciprocal training and development between project partners working as one team within a psychologically safe environment
- Co located work and meeting space
- Learning from other sites delivering OOHM care would be beneficial
- Opportunity for prevention- just as crucial as discharge
- Co production and feedback from people who have experienced homelessness is essential

Ann's Story....

Ann is a fifty-three-year-old lady who is under the care of the Community Mental Health Team since 2019. Ann has a formal diagnosis of Complex PTSD, has an alcohol dependency and a possible acquired alcohol related brain injury.

Ann is frequently taken to A&E by ambulance due to falls, collapse, and intoxication. Ann's blood results are deranged, and she has recurrent problems with leg ulcers.

Ann is a vulnerable adult and has been assaulted by other members of the community, safeguarding referrals and subsequent investigation have taken place.

Ann exhibits behaviour of concern, which is inappropriate, aggressive and abusive towards others. Ann's behaviours have been challenging to manage in her hostel accommodation and also include police involvement for arson and possession of weapons.

In addition to these behaviours Ann's presents as unable to attend to her self care activities of daily living such as taking medication, attending to her personal hygiene and taking an adequate diet. Ann also has difficulty managing her finances.

Ann presents with paranoid ideation which is longstanding and is often related to hostel staff, Ann is well known within hostel and homeless services.

Ann's Story....

- Ann is placed in a different hostel (step up) which is more suitable for her needs
- Ann is discussed and a plan of care is formulated in Complex Lives MDT (part of the OOHM pathway) This leads to an occupational therapy assessment which identifies difficulties caused through alcohol intoxication and dependence.
- Care act assessment takes place in the community through the community mental health team and is ongoing due to the complexity of Ann's presentation.
- Ann's medication is reviewed by the Homeless GP in partnership with her Consultant Psychiatrist.
- Out of hospital care providers assess Ann and provide a two visit a day support package which includes medication prompts and assistance with ADLs. They are able to provide personalised care for Ann with two regular carers who provide continuity and are building a positive relationship with Ann. This has also reduced pressure on hostel staff and ensures that Ann's wellbeing is monitored and further observation and information is gained to inform further assessment

Homeless Care Pathway
Step Up/Down Beds

14th December 2021

Step Up/Down Provision

- Started in February 2021
- 6 dispersed flats across Bournemouth & Poole
- Utilised hard to let Council and ALMO properties
- 9 people have so far benefitted from this service

Planning

- Service Level Agreement with Housing Landlord Services and Poole Housing Partnership
- Process for allocation agreed with Housing and Hospital colleagues
- Regular meetings in place with Housing Landlord Services and Poole Housing Partnership
- Flats set up with furniture/bedding etc including toiletries, food parcel on arrival

Service Provision

- Lettings Teams assist with sign ups/UC claims
- Housing and Reablement Officers turn the properties around
- Wrap around support includes Reablement and Housing Officers, additional input from dedicated specialist roles such as substance misuse, mental health and adult social care
- Supported with Benefit claims, GP registration follow up medical appointments, prescriptions and planning and accessing suitable move on accommodation

Benefits

- Dispersed self-contained accommodation rather than HMO other shared temporary accommodation
- Use of our own stock

Challenges

- Expectations once in accommodation
- Tenure

Outcomes so far

- No evictions
- 2 moved on to own social housing tenancies
- 1 entrenched rough sleeper had not had housing for 20+ years and now holds social housing tenancy
- 1 reunited with family
- 2 in receipt of MH services
- 2 in receipt of substance misuse services

GLORIA HOUSE HOSPITAL DISCHARGE STEP DOWN SERVICE

Presented by Alan Ferguson
Head of Service

14TH December 2021

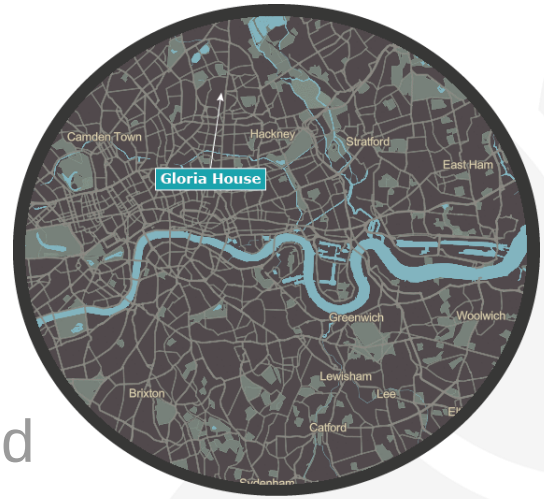
Peabody

Gloria House Step Down Hospital Discharge Service

Peabody

- 150 years experience and expertise
- 67,000 homes across London & the South-East
- We support 16,000 people across our care and support services
- Includes Co-Ordinator's based across 4 Kent hospitals who assist with housing related issues
- Community programmes across London

History and Set Up



- Opened January 2018
- Commissioned by Tower Hamlets CCG and the Royal London Hospital
- Six bed shared house in Hackney with shared bathrooms with modern kitchen, laundry and living room facilities.
- Non-institutional, Psychologically and Trauma informed approach

Purpose

- Support people who are medically fit to be discharged but who have no access to accommodation.
- Client group includes homeless people, people escaping domestic abuse, those with no recourse, mental health, those escaping gang violence and substance use.
- Support offered: Key working/support planning/signposting from resettlement officers

Partnership working

- Pathways Homelessness Team
- Routes to Roots
- Immigration advice services such as Praxis
- Local authority housing departments
- Other Community Services
- DAT/Turning Point
- Weekly MDT

Successes

- **129** people supported since January 2018
- Majority moved on to longer term accommodation through the Local Authority
- Low level of hospital re-admissions while at Gloria house
- Length of stay -6 weeks
- 4% asked to leave due to ASB
- Avoided cost to RLH **£1m +** based on conservative estimates
- High satisfaction levels - Feeling Safe & Overall Experience
- Re-contracted after one-year initial pilot

Deputy Mayor of London's visit

"It's great to see the incredibly positive outcomes this service is able to achieve for its customers. Leaving hospital with nowhere safe to recuperate clearly results in more re-admissions, often due to people returning to un-safe environments. But what this group of partner agencies have realised is the importance of linking health, housing and social care to provide a joined up, practical and successful approach to reducing homelessness."

Sophie Linden September 2019

Challenges

- Small service with one ground floor room
- Customers with mobility issues
- Challenges regarding move-on-NRPF
- Benefit issues
- Based in a different Borough to Tower Hamlets
- Pandemic
- Complex needs customers

The Future

- Continued joint working and integration
- Sourcing properties for new provision
- Wrap pans
- Peer workers
- Tracking customer move-on
- Foulden road-new 6 bed service being developed for LB Hackney

Case Study

- J was homeless, living in his rented black taxicab for nine years following suicide of his wife
- Accident and subsequent spinal surgery meant he could no longer drive and work as a taxi driver. Issues with depression
- Supported by Peabody to find local authority accommodation, register with GP, access benefits and support around his depression

Customer Quotes-Examples

“You have given me my life back, no more homeless days. I was a broken woman, felt like giving up but you have been a blessing in disguise”

“ 5 star service, thank you”

“Thank you for the kindness and professionalism of staff”

Discussion and operational feedback – Chris Rowland, LGA

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