Public Health England

Protecting and improving the nation's health

South East Framework to Support COVID-19 Transition Planning for Multiple Exclusion Homelessness

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Contents

Introduction

Building on the opportunities that have arisen through the COVID-19 pandemic to address multiple exclusion homelessness and the wider determinants of health for people who sleep rough in the South East; the South East Homelessness and Health Network established a task and finish group to develop a transition framework to support local systems as they develop their recovery plans.

Following Dame Louise Casey's call to action to get 'Everyone In' in March, local authorities, with their local partners, have put in place unprecedented emergency accommodation, health and care arrangements for large numbers of people who sleep rough, hidden homeless and other multiple excluded homeless on a scale that has not been seen before. For many, this has meant access to healthcare, substance misuse services and mental health services in a sustained and more joined up way than ever before, but it has also highlighted the fragmentation and complexity of our systems in enabling effective and appropriate support, care and accommodation to those who are multiply excluded.

We have an opportunity now to act and address this fragmentation and complexity and ensure that no one returns to the streets. In addition, we must not forget those people who did not go into emergency accommodation, may find themselves newly homeless or new to the street as a result of the pandemic and / or due to pre pandemic challenges – no-one must be left behind.

What's the purpose of the framework?

The purpose of the framework is to provide local systems with a set of guiding principles, which can then be used to develop transition / recovery plans for people who are homeless. They have been developed by a task and finish group made up of members from the network across the South East and have built on those agreed in London and the transition framework produced by MEAM.

Development of this framework has been supported by the South East ADPH group, who recognise the significant adverse outcomes experienced by people who are homeless and the extreme inequalities faced by them in their local areas. They are keen to ensure that this vulnerable group are not missed out as system recovery plans are developed.

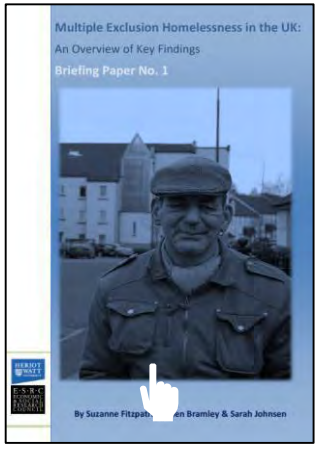
How to use it

- Bring together a group of key stakeholders, e.g. health, housing, public health, criminal justice, voluntary and community sector, social care and local businesses (using existing mechanisms, where these exist)
- Use the principles to decide where you feel you were pre-COVID-19, where you feel you are currently and where you want to be as a system / local area
- Agree aspirational level and prioritise actions to achieve
- Use this to inform / develop your work plans and mobilise wider conversations
- If you identify areas pre COVID-19 and currently where you see yourself as being silver or gold, please share those examples with us for wider learning across the SE network

Who experiences multiple exclusion homelessness?

Continued

Who experiences multiple exclusion homelessness?



What is Multiple Exclusion Homelessness (MEH)?
Fitzpatrick, S et al describe MEH as; 'People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)'.

LGA / ADASS have recently published an adult safeguarding document, which also talks about this. Their main point is that multiple exclusion homelessness is *'quite probably people with care and support needs, who may well also be experiencing abuse and neglect (including self-neglect),'*

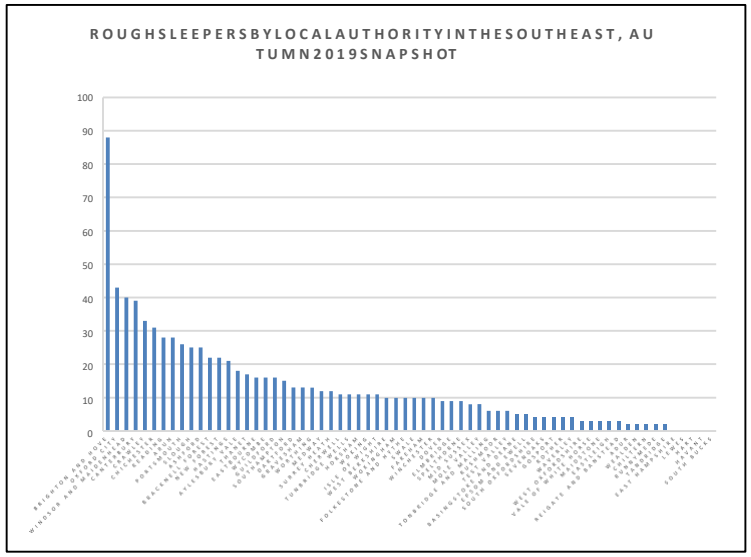
Why do people become homeless?
The reasons why people street sleep or become homeless are many and the way in which these interact is complex. Exposure to significant trauma (especially in childhood) lies at the heart of multiple exclusion homelessness.

The life course of Multiple Exclusion Homelessness?
Pathways into MEH is impacted by experiences throughout our lives, which increase the likelihood of us experiencing homelessness and other issues such as mental health and substance misuse.

Those things that happened early seem to contribute to commencing on a MEH pathway and then experiences in the mid to later phases seemed to confirm transition. Later, more official forms of homelessness were not part of the original set of causes, but the result of sequence of events, which are more likely to have started with combinations of the kinds of factors that occur in the earlier phases of the pathway.

Continued

Who experiences multiple exclusion homelessness?



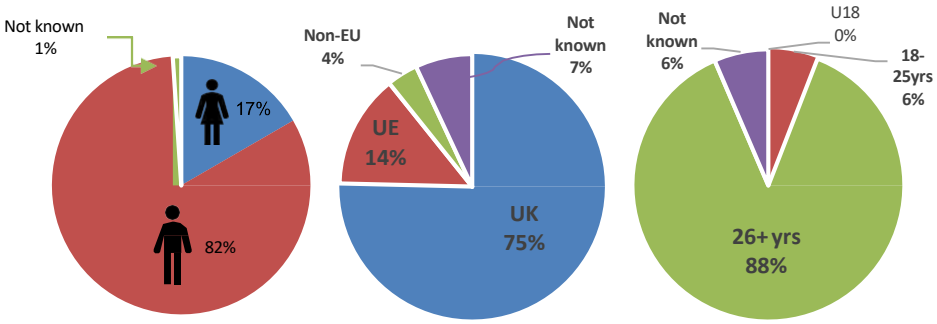
What's the scale of homelessness?

The Ministry of Housing and Local Government (MHCLG) have estimated that around 15,000 people who sleep rough have been housed during COVID-19, which is higher than the national MHCLG rough sleeper count. In excess of 3,666 people have been accommodated in the South East, but this is likely to be an underestimate of the true number of people brought in as result of the call to action.

Rough sleeper count 2019:

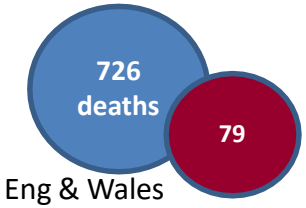
- England: 4,266
- South East: 865 (minus Milton Keynes)

The counts also give us a snapshot of some key demographics for the South East, which are highlighted below:



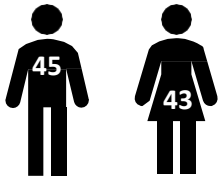
8,830 households were in temporary accommodation at the end of December 2019 in the South East (includes 691 households in Milton Keynes).

Mortality: In 2018



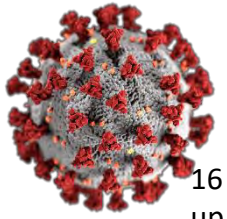
Eng & Wales

South East



Average age at death

2 in 5 deaths were related to drug poisoning



16 deaths in Eng up to 26th June

Some of the health needs:

- 20% had no alcohol, drugs or mental health needs
- 42% alcohol misuse needs
- 41% drug misuse needs
- 50% mental health needs

The Principles at a Glance

Principle 1: A multiagency, system wide approach is prioritised and embedded into the local place to ensure that there is an integrated approach in place to enable a joined-up response to transition, recovery and future planning.

Principle 2: A multiagency partnership / collaborative approach is further prioritised to reduce fragmentation, enabling individualsto have their needs met in a more joined up way and reducing opportunities for them to fall between services.

Principle 3: Structures are developed locally and regionally to support cross-sector leadership around transition and drive the development and implementation of ambitious transition plans.

Principle 4: Nurturing and developing the workforce to sustain and capitalise on the high levels of passion and knowledge that exists within it to reduce burn out and enhance capacity to support across sectors is vital.

Principle 5: That everyone in emergency accommodation (and others who need it) has a full assessment of their strengths, aspirations, needs, health, housing, finances and entitlements to inform an ongoing support plan.

Principle 6: That mechanisms are put in place so that people facing multiple disadvantage can help shape their transition plans and their longer-term future, with a focus on providing what people want and need.

Principle 7: That every person who is homeless, at risk of homelessness or is currently in emergency accommodation, has had a full health assessment from a health professional and has been referred for health and social care to meet any unmet needs; ensuring registration with a GP (if they choose to do so) to enable access to the full range of primary care services.

Principle 8: Where there are difficulties accessing health care, proactive collaborative working arrangements and shared decision making is in place across housing, public health and third sector with health to identify and address those gaps.

Principle 9: No-one who has been placed in emergency accommodation in response to the Covid-19 pandemic is asked to leave that emergency accommodation without an offer of support to end their rough sleeping.

Principle 10: Continued protection from Covid-19 is provided for those who need it, using a cohorting approach of care, protect and prevent.

Multiagency Partnerships / System Wide Approaches

Multiagency partnerships are crucial in ensuring that the needs of those experiencing multiple disadvantage are met due to the multiple and overlapping issues they face, which results in many falling between the gaps in our complicated infrastructures and systems.

Principle 1:
A multiagency, system wide approach is prioritised and embedded into the local place to ensure that there is an integrated approach in place to enable a joined-up response to transition, recovery and future planning.

Key features underpinning the principle:

- Enhanced interagency collaboration and response
  - ✓ Providers and commissioners
  - ✓ Health inc. mental health
  - ✓ Housing
  - ✓ Substance misuse
  - ✓ Criminal justice
  - ✓ Social care
  - ✓ Public health
  - ✓ Voluntary and community sector
  - ✓ Local businesses
- Willingness to be flexible / responsive
- Improved / quicker decision making, which enables autonomy at all levels
- Both strategic and action focused
- Insight led – people with experience of multiple disadvantage at the heart

Where were we?
Where are we?
Where do we want to be?

Practice Examples

Principle 2:
A multiagency partnership / collaborative approach is further prioritised to reduce fragmentation, enabling individuals to have their needs met in a more joined up way and reducing opportunities for them to fall between services.

Key features underpinning the principle:

- Individual needs are assessed and identified
- Individuals are effectively engaged in the process of change (not assuming everyone is ready for behaviour change)
- Key services / partners involved in partnership as outlined above to reduce fragmentation

Principle 1: A multiagency, system wide approach is prioritised and embedded into the local place to ensure that there is an integrated approach in place to enable a joined-up response to transition, recovery and future planning.	**Bronze** • No multiagency partnerships in place locally to address multiple exclusion homelessness • Fragmented system wide approach – may be some activity in some areas e.g. substance misuse service engagement across the system, but limited to service level and not embedded	**Silver** • Limited multiagency partnerships in place, with some key stakeholders, but not formal partnership and limited engagement from all key agencies • Some system wide approaches in place e.g. primary health care in place across the system with clear pathways in place between acute and community services, but this is not fully embedded and lacks integration with social care and other services	**Gold** • Full multiagency partnership in place, with clear terms of reference and lines of accountability and all key stakeholders engaged • System wide approaches are embedded across the system e.g. MEAM • Approaches are psychologically informed ensuring that there is a good understanding of behaviour techniques, which are embedded across all services • A system wide review of the cross-sector flexibilities has been conducted exploring what should be kept, what is needed to achieve this and what further flexibilities may be required
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐
Principle 2: **A multiagency partnership / collaborative approach is further prioritised to reduce fragmentation, enabling individuals to have their needs met in a more joined up way and reducing opportunities for them to fall between services.**	• Limited involvement of individuals in their options and ongoing support. Quick move-on is prioritised and individuals are not appropriately supported during and after	• Individuals have access to some key services e.g. mental health, primary care and substance misuse, but these are not fully aligned • Multiagency approaches are not fully embedded	• Support is in place before someone moves from emergency accommodation, which moves with them, ensuring continuity of care. An integrated approach with health and care to facilitate this and secure access to services, with mechanisms to involve people throughout
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐

Leadership

Strong, positive leadership locally has to be in place to enable and influence local decision making processes. This needs to be at a variety of levels, with those in operational and support roles being fundamentally important in stimulating and driving change; and those in more strategic positions being crucial in unlocking some of the barriers that may exist to wider multiagency and system wide working. Covid-19 provided the stimulus for people to act quickly and decisively, but are the mechanisms and structures now in place to take this further as we move in to transition and what happens next?

Principle 3:

Strong senior strategic leadership to enable local buy in and positioning of the transition plan to maximise impact is crucial, with structures developed locally and regionally to support cross-sector leadership around transition and drive the development and implementation of ambitioustransition plans.

Key features underpinning the principle:

- Senior strategic leader identified who is able to influence, drive and oversee the local response, ensuring that there is local buy in from across the system – this will enable diverse organisations to express a common set of goals and purpose
- Strategic oversight group in place which focuses on the needs of inclusion health groups / homeless populations and is multiagency / cross sector. This group would drive the development and implementation of any transition plans and ensure the system is held to account for action against that plan – this could be the Health and Wellbeing Board or other existing group, if appropriate
- Data and intelligence led approach in place to support decision making and identify needs
- Enable collaborative, rather than competitive commissioning for these types of complex areas

Principle 4:

Nurturing and developing the workforce to sustain and capitalise on the high levels of passion and knowledge that exists within it to reduce burn out and enhance capacity to support across sectors is vital.

Key features underpinning principle:

- Leaders help to foster a safe, supportive, no blame approach
- Staff given green light to 'flex' the system to enable the best outcomes for individuals
- Shared vision and goals across the system help to ensure staff are able to work to a common objective

Where were we? Where are we? Where do we want to be?

Practice Examples

Principle 3: **Structures are developed locally and regionally to support cross-sector leadership around transition and drive the development and implementation of ambitious transition plans.**	**Bronze** • Lead identified within system • No formal structure in place to support cross-sector leadership, but informal arrangements may be in place • Transition plans being developed, but lack system / cross sector buy in • Lack of cohesion across local system	**Silver** • Senior lead in place and developing environment for change • Semi-formal cross sector leadership arrangements in place • Transition plans in development with lines of accountability being agreed to enable buy in across the system • More co-ordinated approach in place, ensuring that LA housing leads, public health, social care and health are connected • Data and intelligence processes are in development, but not yet embedded	**Gold** • Overarching senior system lead in place (public health led) and driving change within the local place • Clear commitment from cross-sector leaders that this is an opportunity to take a system-wide approach • Formal cross sector leadership arrangements in place to enable discussions • The local system is fully aligned, with housing, public health, social care, health and other key stakeholders fully engaged and maximising implementation of the plan • Data and intelligence fully embedded and used to inform decision making / identify and address needs • Ambitious transition plans developed with clear lines of accountability in place
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐
Principle 4: **Nurturing and developing the workforce to sustain and capitalise on the high levels of passion and knowledge that exists within it to reduce burn out and enhance capacity to support across sectors is vital**	• Limited capacity within the system to adapt and sustain focus on developing the workforce • Training and development of the workforce is limited in scale and breadth • There is limited evidence of workforce planning in this area	• Workforce plans are in development, but have not been fully implemented • Training needs have been identified, but a comprehensive programme to address these is not yet in place • Support for those working with the homeless is developing, such as peer support, coaching etc.	• A multiagency workforce plan is in place and is being implemented; it cuts across sectors and enables shared ownership of the actions within it • Training and development needs have been identified and there is a multiagency training programme in place to meet these • Coaching, mentoring, peer support networks etc. are available for staff across sectors to access
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐

Co-creation / Co-production

Those with lived experience should be at the heart of decision making and planning. Understanding what people want and need and then enabling them to be part of the discussions to determine the solutions is crucial if we are to capitalise on the opportunities afforded to us by this pandemic.

Principle 5:
That everyone in emergency accommodation (and others who need it) has a full assessment of their strengths, aspirations, needs, health, housing, finances and entitlements to inform an ongoing support plan and identify unmet needs.

Key features underpinning the principle:

- Everyone has access to a holistic assessment, with full health assessment to ensure that as a minimum they are:
  - Registered with a GP
  - Have their health needs checked (including mental health and substance misuse needs), noted and a plan put in place for ongoing care where applicable
- Everyone has an opportunity to discuss their aspirations, strengths and what they need to enable them to achieve these
- Everyone has a clear personalised plan developed with them

Principle 6:
That mechanisms are put in place so that people facing multiple disadvantage can help shape their longer-term future through being at the heart of decision making within local systems.

Key features underpinning the principle:

- People with lived experience are supported and encouraged to be involved in the development of transition plans through being a central part of partnership groups / or providing individual input if they do not want to participate in larger groups
- Peer mentors / advocates developed as a way of supporting people to get involved
- Shared decision making is central to enabling shared power and inclusion
- The development of a formal group or network comprising people with lived experience / peer mentors is prioritised to ensure that people who are homeless are able to contribute to the decision making and design process

Where were we? Where are we? Where do we want to be?

Practice Examples

Principle 5: That everyone in emergency accommodation (and others who need it) has a full assessment of their strengths, aspirations, needs, health, housing, finances and entitlements to inform an ongoing support plan and identify unmet needs.	**Bronze** • Assessment process in progress/ starting imminently but inconsistent and not holistic • Using traditional deficit-based approaches	**Silver** • Consistent assessment process in progress or starting imminently, utilising person-centred and strength-based approaches • OR assessment process in place using traditional deficit-based approaches and limited choice/ collaboration with individuals	**Gold** • Full holistic assessments in place for everyone that needs one, with key information recorded and used to inform the development of personalised plans • Strength based approaches adopted by skilled staff, ensuring people feel they have choice and control over their plans
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐
Principle 6: That mechanisms are put in place so that people facing multiple disadvantage can help shape their longer-term future through being at the heart of decision making within local systems	• People with lived experience have limited involvement in developing and shaping transition plans • There are limited mechanisms in place to support their involvement	• People with lived experience have some involvement in developing and shaping transition plans, but this is not yet fully embedded • There are some mechanisms in place to support involvement e.g. peer mentor programmes emerging etc.	• People with lived experience have a central role in partnerships and are supported to enable them to engage effectively – a group is established and they are formally consulted in the creation and review of services • Mechanisms are in place to involve people facing multiple disadvantage in shaping current support, in the development of transition plans and in the development of future relevant services / plans
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐

Health

There is a fundamental need for us to ensure that the physical and mental health needs of those who are homeless are appropriately identified and that mechanisms are in place to enable them to access the services they need to meet their needs.

Principle 7:

That every person who is homeless, at risk of homelessness or is currently in emergency accommodation, has had a full health assessment from a health professional and has been referred for health care to meet any unmet needs; ensuring registration with a GP (if they choose to do so) to enable access to the full range of primary care services.

Key features underpinning the principle:

- Full health assessment process developed and implemented – needs to be developed jointly with health, housing, social care, those with lived experience and other key stakeholders
- Appropriate GP services are in place to effectively support the needs identified – this may require commissioning specialist primary care services for those who are homeless
- Primary Care Networks should consider how they can support those who are homeless, ensuring that they are able to access registration, that pathways are in place between acute, community and primary care when emergencies occur etc.
- GP registration is prioritised and individuals are supported to register
- An understanding that developing the relationships locally with key NHS practitioners and managers through personal liaison is extremely valuable in enabling access and helping to make service more available for people who are homeless

Where were we? Where are we? Where do we want to be?

Practice Examples

Principle 8:

Where there are difficulties accessing health care, proactive collaborative working arrangements and shared decision making is in place across housing, public health and third sector with health to identify and address those gaps

Key features underpinning the principle:

- Links back to the multiagency partnerships principle – strong multiagency collaboration in place to ensure individuals do not fall through the gaps
- The needs of those who are homeless are understood and the partners collaborate to discuss, develop and where necessary commission appropriate services to meet their needs – joint commissioning and / or pooled budgets may be considered to enable this to happen and reduce fragmentation
- Appropriate, accessible, timely, flexible and quality services, with clear pathways in place to improved outcomes

Principle 7: **That every person who is homeless, at risk of homelessness or is currently in emergency accommodation, has had a full health assessment from a health professional and has been referred for health and social care to meet any unmet needs; ensuring registration with a GP (if they choose to do so) to enable access to the full range of primary care services.**	**Bronze** • A partial assessment of health needs has been undertaken and there is awareness amongst all agencies supporting those who are homeless of the general and specialist health services that are available for this population in the local area	**Silver** • A full assessment of health needs of every homeless person has been undertaken by a health professional and people supporting homeless are making every contact count in facilitating registration with a GP and access to screening and immunisation, health checks, urgent health care and treatment for long term conditions	**Gold** All those who are homelessness are registered with a GP, have had a full health assessment by a health professional, all have personalised health care plans in place and there is evidence that all care plans being implemented
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐
Principle 8: **Where there are difficulties accessing health care, proactive collaborative working arrangements and shared decision making is in place across housing, public health and third sector with health to identify and address those gaps**	• Health commissioners and providers responsible for all of the health needs identified are proactively working with housing, public health and third sector colleagues to address these gaps	• There are written plans approved by health organisation corporate management (e.g. CCG Board) and funding has been secured to address any gaps. There is a process to review these plans as further health needs are identified	• There is access to health care for the homeless population (multiple excluded group) and this meets full assessments of their health needs by a health professional. There is evidence from homeless people that the health care provided is the right care, delivered at the right time and in the right place.
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐

Accommodation and Support

Local systems were tasked with accommodating rough sleepers and others with urgent housing needs at very short notice and successfully brought in several hundred across the South East, but much of the accommodation is time limited and has utilised hotels, B&Bs and other such properties during the lockdown to enable sufficient capacity. It has, however, also provided us with a unique opportunity to engage with some individuals, for whom a home was not available pre Covid-19.

Principle 9:

No-one who has been placed in emergency accommodation in response to the Covid-19 pandemic is asked to leave that emergency accommodation without an offer of support to end their rough sleeping.

Key features underpinning the principle:

- Clear commitment to ensure that everyone is accommodated permanently
- Clear commitment to ensure returns to temporary accommodation and night shelters are avoided
- Clear commitment to ensure trauma informed and strengths based approaches embedded are used to support and engage with individuals as transition plans are developed
- Autonomy and genuine choice (as far as possible) underpins support
- Where navigator roles exist, there needs to be clarity about their role descriptions and must include clear feedback loops regarding on the improvements their efforts have afforded

Principle 10:

Continued protection from Covid-19 is provided for those who need it, using a cohorting approach of care, protect and prevent.

Key features underpinning the principle:

- Continued triage and assessment arrangements in place to identify those needing shielding; at high risk; and those with Covid-19 symptoms
- Identification of specific accommodation that may be required depending on the local context to support those who may require shielding; or in the event of an outbreak for example.

Where were we? Where are we? Where do we want to be?

Practice Examples

	Bronze	Silver	Gold
Principle 9: **No-one who has been placed in emergency accommodation in response to the Covid-19 pandemic is asked to leave that emergency accommodation without an offer of support to end their rough sleeping.**	• Not applying housing-led principles i.e. restrictions and barriers/ people needing to prove they are "housing ready" OR limited progress understanding/ identifying appropriate pathways	• Collaborative partnerships started exploring provision and move-on work whilst they await outputs of needs assessment. Looking at a few options/ tenures but yet to explore a full range of options	• Collaborative partnership in place working towards a clear understanding of the required pathways and support models (housing first, permanent housing with floating/ resettlement support, permanent supported housing and residential care etc.). Exploring all options and tenures, coordinating procurement and making best use of existing provision. Move-on work ongoing where appropriate and sustainable • Clear, navigator type support available to help people access key services e.g drug and alcohol services and mental heath services and psychologically informed approaches are embedded within these • Clear commitment in transition plans that no-one will leave the emergency setting they're in without appropriate permanent accommodation in place and the support they need to keep it
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐
Principle 10: **Continued protection from Covid-19 is provided for those who need it, using a cohorting approach of care, protect and prevent.**	• Limited provision in place to identify those requiring shielding; those at high risk; those with symptoms	• Triage and assessment processes planned, but not fully embedded • Protection from Covid-19 is integrated in to personalised plans as part of assessments process	• Clear triage and assessment process in place to identify Covid-19 protection needs as part of holistic assessment • Accommodation needs considered in relation to those and factored into to transition plan / personalised plans where possible
Where were we before Covid-19?	☐	☐	☐
Where are we now?	☐	☐	☐
Where do we want to be / get to?	☐	☐	☐

Practice Examples – Home

- **Basingstoke and Deane MEAM Approach**
- Surrey Multiagency Group
- Portsmouth
- Southampton
- Brighton and Hove
- Reading
- Groundswell
- Shropshire
- London

Basingstoke and Deane MEAM Approach

Making Every Adult Matter

Multiagency Partnerships / System Wide Approaches

For an overview of the programme click here.

One of the key aspects of their approach is in relation to psychologically informed environments and trauma informed approaches, which support this. They have developed peer mentor programmes and particularly focused on the leadership skills needs, appropriate organisational structures to support them and the remuneration packages that need to be in place to underpin this for effective delivery.

Practice Examples

Basingstoke and Deane MEAM Approach
Surrey Multiagency Group
Portsmouth
Southampton
Brighton and Hove
Reading
Groundswell
Shropshire
London

Surrey Multiagency Group

Multiagency Partnerships / System Wide Approaches

The Surrey Homeless Multi-Agency Group (MAG) was established to support the homeless population during
the COVID-19 pandemic and to also rethink the ways support is provided in the longer term.

The Homeless MAG has oversight of the Homeless Response to COVID by all agencies represented. Issues arising around access to primary care, mental health or substance misuse is reviewed by this group with the aim of identifying how existing provision can provide a solution. Where this is not be possible, issues can be escalated via the RCG. It works collaboratively with the housing managers across all 11 Boroughs and Districts to monitor the number of suspected or confirmed cases.

This collaborative approach will continue to provide support into recovery and beyond. MAG is well placed to bring together different partners who will provide flexible ongoing support to those who are newly placed in long term accommodation. The MAG's recovery plan currently aims to cover the following issues

- Significant gaps in high support accommodation
- Need for specialist outreach
- Development of earlier intervention
- Further development of mental health and substance misuse pathways
- Ensuring appropriate primary care access

Practice Examples

Basingstoke and Deane MEAM Approach
Surrey Multiagency Group
Portsmouth
Southampton
Brighton and Hove
Reading
Groundswell
Shropshire
London

Portsmouth

Multiagency Approaches / System Wide Approaches

Portsmouth embedded the needs of those with multiple disadvantage in to their Health and Wellbeing Board pre Covid-19, which ensured that key senior leaders were engaged from the outset. Some examples from their work relating to:

Health

Towards better health *project/service innovation/system change* - Portsmouth City Council Public Health & East Shore Partnership working with the Society of St James

Project ran from early 2020 providing health care for the homeless through the Cities support services, this work continued into the national lockdown and call to get 'everybody in' **The Towards Better Health** project aims to provide a health interventions (which alleviates the ongoing associated risk of homelessness and rough sleeping), to bring GPs, physical and mental health nurses closer to people at risk of rough sleeping, by conducting weekly surgeries, drop-ins and in-reach in the homeless day centre and main homeless hostel - this work was and is delivered in the two main emergency housing provision sites occupied by over 220 residents.

Contact - Alan Knobel Public Health Development Officer, Portsmouth City Council
publichealth@portsmouthcc.gov.uk

Continued

Practice Examples

Basingstoke and Deane MEAM Approach
Surrey Multiagency Group
Portsmouth
Southampton
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Shropshire
London

Portsmouth

Health

Vaping harm reduction initiative *project/service innovation* - Portsmouth City Council Wellbeing Team

After a successful business case was made, ongoing pilot work was and is delivered in the two main emergency housing provision sites occupied by over 220 homeless residents. Approximately 85% of homeless people currently smoke tobacco, with up to 50% wanting to stop , although a significant proportion find this difficult with mainstream stop smoking services and products. Vaping is now a common and effective method to quit smoking. The Wellbeing service acquired vaping starter kits, with additional liquid and required accessories, for homeless clients residing within the hotel and Hope House Hostel.

There are a number of issues linked to smoking for this group and the accommodation:

- Residents go outside of the hotel on a regular basis to smoke, breaching social distancing guidelines and congregating outside the hotel.
- Residents of Hope House are currently leaving the hostel to smoke, also breaching social distancing guidelines.
- Smoking causes poor lung health, with smokers approximately 2.5 times as likely to need treatment in an ICU or to die from COVID-19,compared to non-smokers . However improvements in lung function can occur quickly. The need to quit smoking is highlighted by the #QuitforCovid campaign.
- Smoking poses a fire risk within the hotel as residents are tempted to smoke in their rooms. There have already been cases of residents covering the smoke detectors in their rooms in order to smoke, increasing the risk of serious fire.
- The management of smoking within the hotel, and potential smoking related evictions are an issue.

Contact - Alan Knobel Public Health Development Officer, Portsmouth City Council
publichealth@portsmouthcc.gov.uk

Continued

Practice Examples

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Portsmouth

Health

TB and Blood Born Virus testing - project/service innovation - Portsmouth City Council Public Health & East Shore Partnership

- Innovative approach to screening for BBVs and liver damage , for homeless clients residing within the homeless hotel and Hope House Hostel. (*A link to webinar presentation is to be added*)

Contact - Alan Knobel Public Health Development Officer, Portsmouth City Council
publichealth@portsmouthcc.gov.uk

Co-creation / Co-production

Rapid Participatory Appraisal - The Portsmouth homeless population during COVID-19 *qualitative research piece/report* Portsmouth City Council Public Health & Integrated Wellbeing Team

The research aims to explore the lived experiences of Portsmouth homeless people who are currently residing in the IBIS budget hotel (purposed for homeless people with higher needs) who have been placed there as an emergency response to COVID-19

We believe that the emergency housing provision provided by Portsmouth City Council to the homelessness people of Portsmouth has provided a unique opportunity to understand this population group better and to work on finding solutions that will meet their needs. We hope that our research will help you better understand the successes and failures of the current emergency provision and the impact it has had on our homeless population.

Contact - Paul Hudson & Rob Anderson Weaver Public Health Practitioners , Portsmouth City Council.
publichealth@portsmouthcc.gov.uk

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Southampton

Multiagency Approaches / System Wide Approaches

Strong multi agency working arrangements were already in place across housing, health and commissioning. These links have been strengthened and collaboration has extended into neighbouring local authorities as a result of work around the pandemic. Multi agency working was and remains multi-faceted:

- **Between providers and service settings** (primary health, mental health, substance misuse, domestic violence, and prisons). Ensuring pathways were robust and collaborative ways of working have highlighted the benefits from having a dedicated homeless health care provision.

- **Between professional settings** existing good links between housing, providers, primary healthcare and commissioning have been extended to include Public Health and neighbouring authorities a lot more. Our cross-border work evolved from several roots:

- A local Southampton response to Covid 19 saw the development of a Protecting our Vulnerable Residents forum. This fed into the LRF structures
- The Integrated Care System also developed responses to Covid 19, developing local Hubs to respond to the outbreak. The Hubs covered hospital discharge, PPE, infection control and other key areas.
- Strong provider engagement and local system discussions.

- Over a matter of weeks the various structures started to link up and form a more coherent method of engagement and cross agency working and collaboration, resulting in

- Daily multi agency 'panel' meetings (virtual) to discuss all placement options across all homeless settings
- Local provider system calls (weekly reducing to fortnightly) to ensure preparedness & planning for outbreak (PPE, staffing, infection control, shared knowledge & guidance, support etc)
- Weekly forums connected (linked representation & agendas) across LRF, Hampshire and within Southampton

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Leadership

The leadership shown was much more about the characters of the individuals involved. The champions who forge links, relationships and build the momentum for change. In Southampton, there were a few people in different settings who started to engage in a dialogue around the issue of homelessness and Covid 19. This included the housing lead, the healthcare lead, the commissioning lead and a public health representative. Through discussion between these people and with providers, the existing multi agency working arrangements were built upon and merged with the Covid 19 response structures, not only locally (Southampton) but wider across pan Hampshire (to include Portsmouth and IOW) and regionally (SE).

Co-creation / Co-production:

Southampton had a strong collaborative approach prior to the Covid pandemic:

bringing providers, housing and commissioning together to respond to system issues. Examples have been End of Life Care, responding to TB cases where there is NRPF and more recently, responding to MHCLG annual short term funding bids.

Responding to the pandemic has resulting in additional partners being brought to the discussions, such as public health colleagues and neighbouring authorities. Already having an integrated commissioning team in place, enabled prompt and timely discussion across a wider range of issues such as Covid Care pathways, access to PPE, infection control support.

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Accommodation:

Southampton found itself to be reasonably well placed in regards to accommodation. Existing relations with local small hotels/ B&B's facilitated a prompt response and avoided the use of large hotels. This was led by the housing team, while commissioning (from integrated health and care perspective) looked at the options for Covid Protect and Covid Care. Following collaborative discussions it was agreed to pursue the Covid Care & Protect (light) model currently in place in Southampton using University accommodation.

From the outset, "move on" planning has been a key consideration. A number of people are already moving into and through the existing homeless pathways. As the situation settles, there has already been a reduction in the number of hotel/B&B places used. There is also a commitment that no-one will be returned to the street. There is a small number of evictions as a result of very extreme unacceptable behaviours.

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Brighton and Hove

Multiagency Partnerships / System Wide Approaches

In response to the Covid crisis and the 'Everyone In' mandate, Brighton & Hove established a multi-agency lead meeting, chaired by the Director of Public Health, to lead on responses. This meeting has ensured delivery of accommodation, infection control, health and support services. (See embedded MoU with membership, and the protocol agreed by the group to further update the work of the group). This group built on existing joint working relationships and enabled a rapid cross sector response to the crisis. Contact details for more information.

Contact: Emily Ashmore – Brighton and Hove Council
emily.ashmore@brighton-hove.gov.uk

Leadership

The Director of Public Health has taken a lead role in the response to Covid-19 in Brighton and Hove in relation to those experiencing multiple disadvantage, as illustrated in the above example.

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Multiagency Partnerships / System Wide Approaches

Partners used a cross sector approach to engage with those who had no recourse to public funds. Many of the client group had never engaged with services and had slept rough, occupied unidentified squats or within tented encampments. Rough sleeping initiative funding was repurposed and existing charitable sector support and expertise was pooled.

NHS commissioned outreach services assisted with health checks, registering with GPs and prescription exemptions; local council and faith groups have provided food parcels and helped with accommodation. Reading's support approach has three stages (more detail can be found here):

Stage 1 – triaging and obtaining ID;
Stage 2 – settled status application;
Stage 3 – expert immigration advice.

Contact: Jo Slotwinska – Reading Borough Council
Joanna.slotwinska@reading.gov.uk

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Groundswell

Co-creation / Co-production

Groundswell have been undertaking research throughout the pandemic to try to gain an understanding of the impacts of Covid-19 on the lives of those experiencing homelessness and multiple disadvantage.

It seeks to use this understanding to enable the voices of those with lived experience to be included in the decision making processes at local and national levels.

Updated briefings are published approximately fortnightly; click on the picture and sign up.

Practice Examples

- Basingstoke and Deane MEAM Approach
- Surrey Multiagency Group
- Portsmouth
- Southampton
- Brighton and Hove
- Reading
- Groundswell
- **Shrewsbury**
- London

Shrewsbury

Co-creation / Co-production

Webinar – *access here and link to a piece in the guardian regarding their work below*

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Accommodation

The London Partnership produced a briefing designed to help understand the options available for sourcing accommodation and support solutions for all people sleeping rough or at risk of sleeping rough in the immediate circumstances of June 2020. It covers sourcing accommodation and support, both interim and longer term, and considers how this may be funded within current resources. Link to London Partnership accommodation guidance can be found here.

Acknowledgments and Resources / References (not already in document)

Acknowledgments: A small task and finish group, made up of colleagues from the SE Homelessness Network, was established to develop this framework tool, led by Emma Seria-Walker (PHE SE). PHE SE would like to thank them for lending their expertise and experience to the development and review of this framework: Sandy Jerrim, Hannah Gaston, Alan Knobel, Rob Anderson-Weaver, Vee Hutcheson, Kate Holborn, Sarah Kilvington, Emily Ashmore, Anna Perkins, Jason Mahoney, Karen Simmonds, Debbie Kennedy, Sian Smith, Nick Hanson-James

The King's Fund has published a Covid-19 focused document on 'Going above and beyond' in relation to health and care for those who are homeless and set out 10 key points.

The RSA has developed a framework on health and care post-covid, which can be accessed here.

Access a range of Covid-19 resources, examples of practice and information from across England on the NHS Future Collaboration Platform's *'Homeless and Inclusion Health'* group pages.

FutureNHS Collaboration Platform

COVID-19 information in multiple languages: https://www.doctorsoftheworld.org.uk/coronavirus-information/

COVID-19 information, resources and tools from Homeless link: https://www.homeless.org.uk/covid19-homelessness

COVID-19 resources and information from MEAM: http://meam.org.uk/covid-19-resources/

COVID-19 resources and information from the Faculty for Homelessness and Inclusion Health - Pathway (Healthcare for homeless people): https://www.pathway.org.uk/blog/covid-19-coronavirus-homelessness

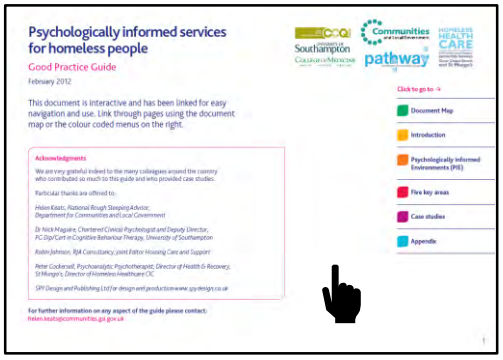
COVID-19: guidance for commissioners and providers of hostel services for people experiencing homelessness and rough sleeping: https://www.gov.uk/government/publications/covid-19-guidance-on-services-for-people-experiencing-rough-sleeping/covid-19-guidance-for-commissioners-and-providers-of-hostel-services-for-people-experiencing-homelessness-and-rough-sleeping

Continued

Groundswell Homelessness & COVID-19 Self-Assessment Tool https://groundswell.org.uk/covid19-selfassessmenttool/

Acknowledgments and Resources / References (not already in document)

Further resources


Psychologically informed services for homeless people

Good Practice Guide

February 2012

This document is interactive and has been linked for easy navigation and use. Link through pages using the document map or the colour coded menus on the right.

Acknowledgments

We are very grateful indeed to the many colleagues around the country who contributed so much to this guide and who provided case studies.

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Peter Cockersell, Psychoanalytic Psychotherapist, Director of Health & Recovery, St Mungo's, Director of Homeless Healthcare CIC

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For further information on any aspect of the guide please contact:

Click to go to →

Document Map

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Psychologically informed Environments (PIE)

Five key areas

Case studies

Appendix

This is an excellent resource as a starting place for thinking about psychologically informed approaches / environments and gives some examples of good practice in this regard