
PREVENTING HOMELESS **OUT-OF-BOROUGH** **PATIENTS FROM** **ROUGH SLEEPING**

A REPORT ON THE TOWER HAMLETS
'ROUTES TO ROOTS' APPROACH



After the accident there was no way I could have returned to my previous house. But everyone was so supportive and never gave up on me. My housing situation is worked out now and my health is improving as well. I really wouldn't be here without you. Thanks so much to everyone for all their help.

'Routes to Roots' Service user

The value of this project in preventing rough sleeping is that each homeless patient is provided with advice and support to find appropriate accommodation rather than leaving them with no option but the street. This support is offered at a point when patients are able to be discharged from hospital but often are still recovering from a physical illness and are struggling with other needs. The 'Routes to Roots' project is a lifeline for many. It makes good sense for both the patient and our wider community.

Kath Dane

Tower Hamlets Street Population Lead

Uniquely in London the Tower Hamlets Housing Options Support Team (HOST) has recognised that more than half of the homeless people in their local hospital will not have a local connection. As a result they have specifically commissioned a service to support the Pathway team in working on the complex housing elements of their situation, both during the admission and after leaving hospital. This synergistic approach considerably improves the outcomes for patients. It multiplies the value of the NHS investment in the Pathway team and has made a considerable contribution to developing an integrated approach in Tower Hamlets that involves primary care, secondary care, social care, housing and the voluntary sector in working with homeless people according to their need rather than excluding them from any help because of a lack of local connection."

Dr Nigel Hewett
OBE MB ChB DCH DRCOG FRCGP

Medical Director Pathway

LIST OF REGULAR ABBREVIATIONS:

- CCG** (NHS Clinical Commissioning Group)
- DCLG** (Department of Communities and Local Government)
- ESA** (Employment and Support Allowance)
- FACS** (Fair Access to Care Service)
- GLA** (Greater London Authority)
- HOST** (Tower Hamlets Housing Options Support Team)
- JSNA** (Joint Strategic Needs Assessment)
- LRT** (London Reconnections Team)
- MDT** (multi-disciplinary case conferencing meeting)
- NHS** (National Health Service)
- NIHR** (National Institute of Health Research)
- NLOS** (No One Living on the Streets)
- PRC** (Providence Row Charity)
- PRS** (Private Rented Sector)
- RLH** (Royal London Hospital)
- THFS** (Tower Hamlets Floating Support Service)
- UCLH** (University College London Hospital)

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FOREWORD

This report shows how we are leading the way in tackling homelessness. In working closely with the Royal London Hospital and other local authorities in and out of London, we have had a hugely positive impact on these peoples' lives, and helped to find options for them.

In producing this report, we want to ensure that other local authorities read through our approach, learn from it, and help us to tackle homelessness.

John Biggs
Mayor of Tower Hamlets

INTRODUCTION

Tower Hamlets ‘Routes to Roots’ service addresses one of the perennial challenges facing many of the capital’s hospitals – the struggle for Hospital Discharge Teams to source a rehousing option for homeless out-of-borough patients.

For many homeless people in hospital, recovery from an acute health episode is also a time when they may be able to detox, have a period of relative stability whilst on ward and where they can be open to meaningful dialogue about change with health and social care professionals – in the hope of getting their life back on track. Without tangible rehousing choices this rehabilitative momentum is easily lost. The ‘Routes to Roots’ service provides a realistic way home that enables the recovery process to continue, empowering homeless people to further rebuild their lives.

‘Routes to Roots’ builds on the hospital discharge prototype spearheaded by the Pathway Charity at University College London Hospital (UCLH). It works with patients approaching the end of their hospital stay, identifying where and in which borough their local connection lies, and then supporting the patient to return to their home borough on discharge to access housing options. It also assists patients from abroad to reconnect to their country of origin

where appropriate and where this is the patient’s preference. The service is conceived, led, and facilitated by the London Borough of Tower Hamlets Housing Options Service who are also the main funders.

This report is aimed primarily at local authorities, health professionals and NHS Clinical Commissioning Groups (CCG), and the voluntary sector. It provides an overview of why Tower Hamlets commissioned the ‘Routes to Roots’ service, how it works, what it has achieved to date and suggests how to replicate the model and its principles in the local hospital in other boroughs.

The difference ‘Routes to Roots’ makes to clinical outcomes for homeless people is more holistic care, more robust discharge planning and reduced likelihood of failed discharges and readmission to hospital. This helps improve the healthcare of homeless people after discharge from hospital. Patients are more likely to have support in place, be more hopeful for the future and therefore are more likely to take better care of their physical and mental health. Patients can also be assisted with GP registration if needed to support their ongoing and future health and care needs.

Dr Peter Buchman

Clinical Lead Pathway Homeless Team
at RLH

CONTEXT

Homeless people experience some of the worst health in our society and are heavy users of acute health services. Homeless people have poorer health outcomes than the general population, and their average age of death is 30 years below the national average.¹

Most of our society takes for granted having somewhere to go when we leave hospital. However, research in 2012 found that more than 70 per cent of homeless people were discharged from hospital back onto the street, without their housing or underlying health problems being addressed.² This result is damaging to those individuals and also a drain on the public purse.

In May 2013 the Government invested £10 million in a national Homeless Hospital Discharge Fund. Voluntary sector organisations, working in partnership with the NHS and local authorities developed projects across the country to improve hospital

discharge procedures for people who were homeless. The projects' evaluation focused on outcomes and learnings for the local homeless population. Most of the London projects highlighted the need for reconnection work for out-of-borough patients with one project reporting that 50 per cent of their work was focused on reconnection. Some projects utilised housing link workers, others outreach teams while some involved peer navigators to concentrate on reconnection for out-of-borough patients.³

1 Bethan Thomas, 'Homelessness Kills: An analysis of the mortality of homeless people in early twenty-first century England', (Crisis, 2012)
2 'Improving Hospital Discharge and Admission for People who are Homeless', (Homeless Link and St. Mungo's, 2012)
3 Unpublished research finding from the Homeless Link evaluation study. For the published study, see 'Evaluation of the Homeless Hospital Discharge Fund', (Homeless Link, 2015)

BACKGROUND TO THE PROJECT

Tower Hamlets Housing Options Service is committed to ending rough sleeping. Traditionally, Tower Hamlets has been one of the boroughs in London with the highest number of rough sleepers. In recent years, new policies and remodelled services have been effective in significantly reducing the number of individuals in Tower Hamlets spending a second night on the street and bringing those who are street entrenched into accommodation.

Tower Hamlets Housing Options Service is currently developing a new 'no first night out' approach with partners, supported by funding from the DCLG and the GLA to reduce rough sleeping in the borough to zero.

The borough's commitment to ending rough sleeping meant it took an active role in late 2011 when a Pathway Homeless Team was established at the local general hospital, the Royal London Hospital. The Pathway Homeless Team was funded by the National Institute of Health Research (NIHR) and the Pathway Charity and based on the homeless hospital discharge model pioneered at UCLH.

The new Pathway Homeless Team held a weekly multi-disciplinary case conferencing meeting (MDT) with key

partners including Tower Hamlets Housing Options Service, hospital staff and social services and voluntary sector partners. Consequently, a clear and effective pathway was developed for patients that had a local connection to the borough. This had a positive impact on local rough sleeping numbers.

However, there was no local housing provision within Tower Hamlets for those whose local connection was to another borough and who could safely return to their home area.⁴

The impact on the Medical Discharge Team at the hospital of not having 'Routes to Roots' was that clinical staff – doctors and nurses from the Pathway Homeless Team – were spending large amounts of time completing housing and benefits applications for out-of-borough homeless hospital patients without adequate capacity or expertise to do so. There was also no capacity to accompany patients to appointments at housing departments on hospital discharge and nobody to follow them up in the community to make sure that they engaged with the community support services they had been referred to (Floating Support, social services, etc). It also meant that the Pathway Homeless Team had little opportunity for feedback on outcomes for homeless patients after discharge.

Dr Peter Buchman

Clinical Lead Pathway Homeless Team
at Royal London Hospital

⁴ The means by which a 'local connection' can be derived is set out in homelessness law at s.199, Housing Act 1996. Those people who can not return to their home area for safety reasons are supported by the existing Tower Hamlets pathway as are people who are unable to establish a local connection to Tower Hamlets or to anywhere else.

The inter-borough referral provisions within the homeless legislation were considered too slow and unpredictable to help people access housing options in their home area. For example, there was no guarantee the individuals would meet the statutory tests to trigger the referral provisions. Inter-borough referral also placed a high administrative and financial burden on the referring local authority.

Meanwhile there could be housing options that the person qualified for in their home borough, which they might in the interim have been able to readily access.

From the patient's point of view the statutory approach delays resettlement to the home area. In the best case a succession of multiple moves in short-term emergency accommodation would be needed. Where social care packages are involved an added layer of logistical complexity enters the frame with the transfer of care between boroughs not always seamless, with the potential for service gaps.

Another approach was needed given the Council was not prepared to risk patients sleeping on the streets on discharge from the hospital. The Housing Options Service, as the sole partner with a rehousing brief at the MDT, took the lead in developing what was to become the 'Routes to Roots' initiative.

Initial steps involved training up the Pathways Homeless Team nurse to present clients directly for statutory assessment to their housing options service back home. It quickly became apparent how resource intensive and housing specialist this work was,

routinely taking the nurse into unfamiliar professional territory and out of the clinical setting where their skills and experience were most needed.

Tower Hamlets Floating Support Service (THFS) took on the development of the service and scored a number of successes. As the geographical scope of the work was not in keeping with the mainly in-borough brief of THFS, and as the service demand continued, it was clear that steps were needed to place the service on a more formal footing.

As a result since 2013, the Council has commissioned Providence Row to deliver the service. Providence Row already had experience of reconnecting rough sleepers who attended their day services, and a decision was made to build on their experience.

The benefit to the hospital of 'Routes to Roots' is that together with the Pathway Homeless Team, planning to facilitate as safe a discharge as possible can begin long before the day of discharge. Workers with detailed knowledge of the housing & benefits system can submit applications while the medical and surgical teams are treating the patient's acute illness. Patients are therefore less likely to be stuck in a hospital bed they no longer require while awaiting a safe discharge plan. Patients also have a skilled advocate who can meet them on discharge if required and accompany them to housing departments or to a safe discharge destination. The patient is less likely to be readmitted unnecessarily because arrangements have broken down (or worse still not made in the first place).

Dr Peter Buchman

Clinical Lead Pathway Homeless Team
at Royal London Hospital

WHAT IS ‘ROUTES TO ROOTS’?

‘Routes to Roots’ is precisely that – a route back to resources in the patient’s own area – whether this is statutory, third sector or private sector provision, or support from friends and family. It is not necessarily a route to Council housing and the service has no accommodation provision of its own. When it comes to local authority presentations, clients are subject to the same assessment criteria as homeless people in their home area with no special privileges given or expected.

The key aims of the service are:

- prevent rough sleeping and homelessness by helping clients to access housing in a safe area where they have a local connection
- improve health and wellbeing among homeless adults, leading to reduced instances of mental-ill health, poor physical health and substance misuse, and acute hospital admissions
- resettle effectively so as to prevent future homelessness
- improve the financial situation of clients through advice and support to achieve appropriate financial support.

Key performance indicators for the service in 2015-16 are:

- work with 65 to 75 referrals per year
- 90 per cent of referrals assessed for service eligibility and decided upon within one working day; 100 per cent within two working days
- local connection determined within two working days in 50 per cent of cases; 90 per cent within five working days
- 80 per cent of patients supported to sign up to a reconnection plan
- 100 per cent of housing option referrals made to relevant local authority (where appropriate)
- a minimum of 48 successful housing outcomes via destination Housing Options team or supported into own option
- 75 per cent of these are sustained beyond six months.

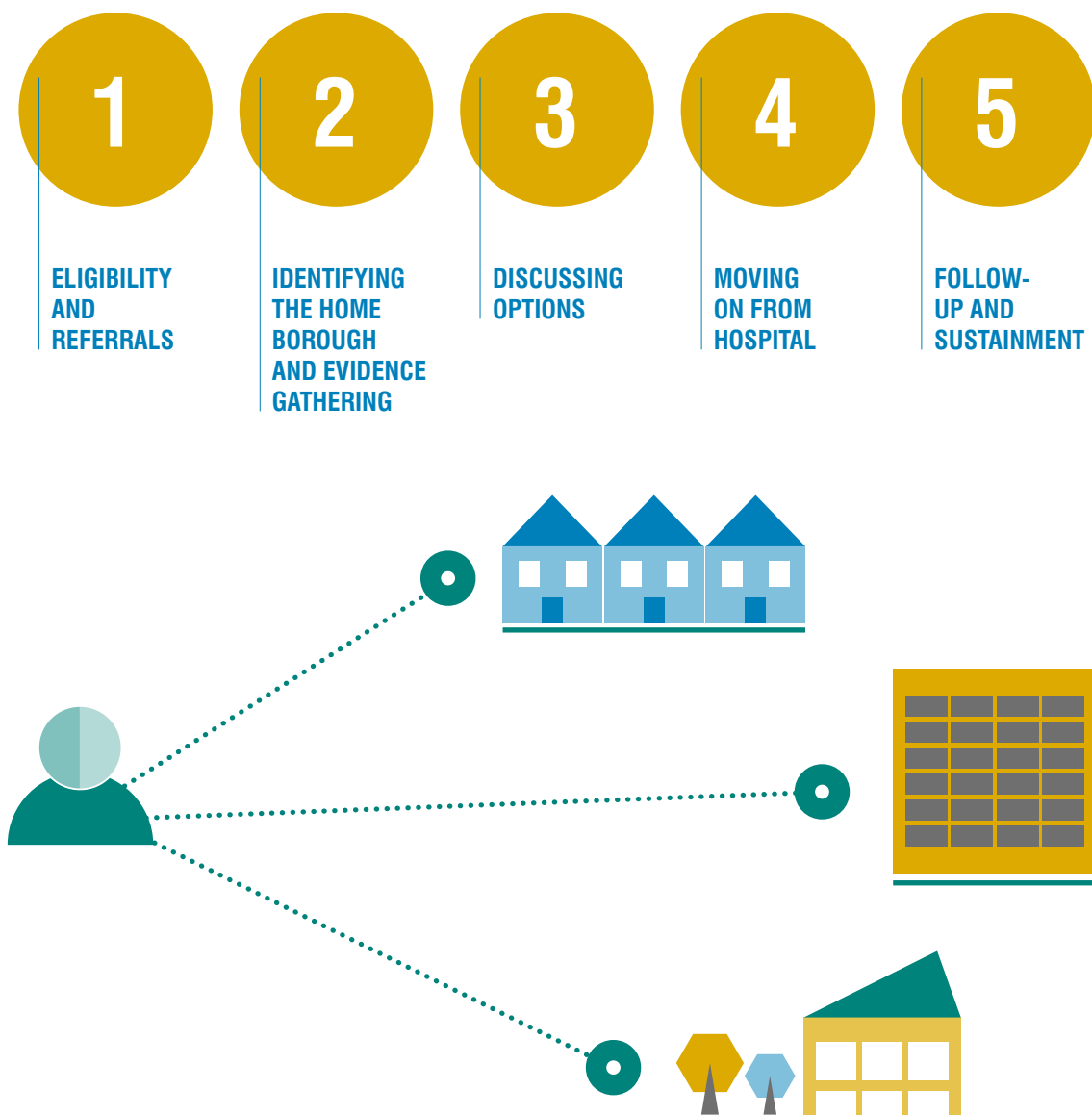
Resettlement targets around GP registrations, benefit interventions amongst other targets are currently in development.

HOW DOES IT WORK?

THE SERVICE MODEL

The 'Routes to Roots' model encompasses the technical knowledge of the Council's Housing Options Service with the voluntary sector's outreach capacity and person-centred service model.

The 'Routes to Roots' model has five elements, each of which is examined in more detail below:



1

ELIGIBILITY AND REFERRALS

Access to the service is open to all homeless RLH patients with a non-Tower Hamlets local connection. This includes single person households as well as family-sized households.

Referrals will be accepted to help people return to their roots whether in or out of London. The service has a reach across the UK and has a budget to cover travelling expenses. The service is not available to those with 'no recourse to public funds'. Tower Hamlets will offer these clients international reconnection or alternatively a referral will be made to Tower Hamlet's social services team.

Patients who have no local connection to any borough or patients for whom it is unsafe to return to their home borough are not eligible for the service and these patients will be dealt with by Tower Hamlets Housing Options Service directly.

MDT partners all work to ensure referrals are made at the earliest possible opportunity, though short notice referrals do occur. RLH staff get cases moving forward in terms of medical evidence gathering and referrals into NHS services.

Referrals are received during the weekly MDT case conferencing meeting. Referrals can also be

made in between meetings via completion of a short form which can be emailed.

Responding to referrals quickly is important and during the first 18 months of the project 80 per cent of referrals were visited and assessed on a ward either the same day or by the end of the next working day.

A key challenge sometimes is the length of time it takes to get referrals – the process is elongated; referrals come from a range of hospital departments to the Hospital Pathway team, who then vet referrals and then send to us.

Will Norman

'Routes to Roots' Manager

The lack of notice for hospital discharge is still a challenge and is caused by suboptimal communication and lack of joined-up working within the overstretched and busy acute hospital environment. To improve things would entail better communication and a better understanding of the challenges faced by homeless patients on discharge by the hospital team. It would also entail a more holistic view than just discharging as soon as possible. A better understanding is needed that criteria for fitness for discharge may at times be different for homeless and housed patients. The Pathway Homeless Team tries to advocate for this vulnerable group with doctors, nurses and therapists, on the wards, as well as with hospital managers.

Dr Peter Buchman

Clinical Lead Pathway Homeless Team
at RLH

2

IDENTIFYING THE HOME BOROUGH AND EVIDENCE GATHERING

The team apply a criteria common in Housing Options to establish where a patient's local connection lies, namely, the area where the patient is employed or has immediate family in permanent residence or where they themselves have resided for six out of the preceding 12 months or three out of the last five years.

This is straightforward in many cases, especially where patients have been in stable housing up to the point of hospital admission or the housing breakdown is relatively recent.

The typical presenting scenario is patients being unable to advocate a return back to their hosts or tenancies or existing accommodation being inaccessible, for example, due to deteriorating health and mobility.

In other cases the work will be more complex. This will be particularly the case for individuals who have lived itinerantly for some time and who have a slender grasp on the details of dates and addresses in their housing history.

The challenges are further multiplied in the hospital setting where for example patients are at different stages of recovery and not always cogent – whether due to their immediate condition, underlying cognitive impairment, substance

issues, or due to the clinical treatment being administered to them. Often they may also not have direct access to their personal documentation, nor be mobile enough to travel to access it.

The work in these cases is painstaking and unglamorous. Where it will clearly require a presentation to the home area

The main skills you need when conducting an interview at a patient's bedside are: compassion, patience, listening skills.

Paulina Gudalewicz

'Routes to Roots' Adviser

The characteristics of this client group are unique as they are often complex and not straightforward, making obtaining information complicated and challenging — they may not be motivated, coupled with physical or mental health.

Will Norman

'Routes to Roots' Manager

Empathy and a consideration for the client and their medical conditions are important skills when conducting assessments but a strong knowledge of housing and homelessness is also essential, in particular, knowledge of the legal duties a local authority has and local connection protocol.

Stephanie Ratcliffe

'Routes to Roots' Advisor

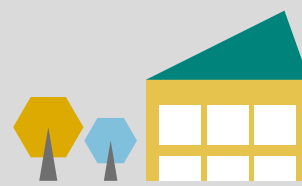
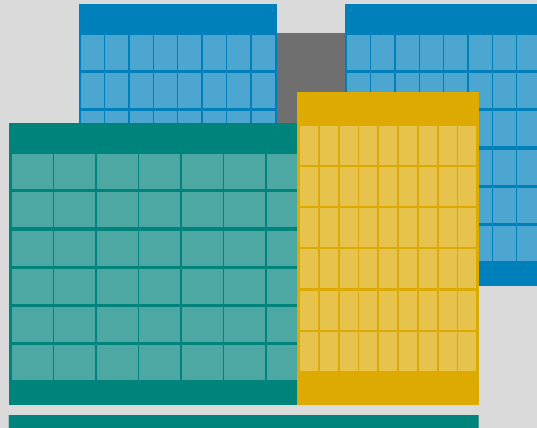
2

housing options service, it involves assembling a case to meet the homelessness statutory criteria.

This includes:

- collecting ID and sourcing official documents
- collating and evidencing address histories
- tracking down relatives.

Cases are assembled from what can sometimes be loose scraps of knowledge, tenuous leads, confused, incomplete and contradictory shreds of information collected at the bedside of the homeless person. Such work is crucial as insufficient documentary evidence and unaccounted gaps in address histories are common barriers preventing vulnerable people accessing statutory housing. Applying for birth certificates as a form of identification is standard practice in such cases.



3

DISCUSSING OPTIONS

Importantly the service promotes choice and control – returning home is offered as an option rather than an imposition.

Early assessments are undertaken to give patients time to think about their options and choices without having to do so under pressure. Service take-up is thus entirely voluntary. Reassurance is given and requests are answered promptly so people can focus on their physical recovery rather than worry about where they will sleep in a few days' time.

Much of the work in this stage can involve talking to patients about the barriers of returning home and dispelling fears. The service is on hand to reflect and review with the homeless person on the challenges and obstacles associated with returning back to a place that may have ambivalent associations and memories.

One of the critical success factors is that staff from the voluntary sector are impartial. Being independent, Providence Row staff are not identified with a statutory service, whether that be the housing options

team, the hospital or a social work department. Hence they can explain what is and isn't a realistic option persuasively. Workers engage intensively with clients using a person-centred approach so that choice and control remains with the service user.

Patients uncertain or nervous about returning to their home area or presenting to a council service are provided with assurances that the service will be there to accompany them and remain on-hand to help them.

4

MOVING ON FROM HOSPITAL

There are a range of homelessness prevention and housing options solutions employed by 'Routes to Roots'. The team will negotiate for patients to stay with friends and family; they will also undertake tenancy rescue work and involve occupational therapists to order and install home aids and health adaptations to properties. They will also work with the home borough to access housing options, for example, arranging for patients to have assessments for sheltered housing and residential care. This involves making housing option referrals for the patient prior to discharge and securing a timely response from the home area.

The team also facilitate international reconnections for EU nationals. They will discuss the option with the patient who if interested will then have their case raised with the London Reconnections Team (LRT) who make the necessary travel arrangements. Either a 'Routes to Roots' adviser or LRT worker can travel with the patient, or both can if required.

Where homelessness cannot be averted, the service presents patients to their home council for emergency assistance under the homelessness legislation. As previously mentioned the team will submit supporting documents such as evidence of local connection, proof of homelessness and medical evidence.

Importantly the service will accompany patients to office interviews and also to emergency accommodation to help people settle in. The service will accompany people to locations in London as well as elsewhere in the UK. Such presentations can involve spending long days in council offices which can be physically taxing and stressful for the homeless people concerned. They may still be recuperating and may have spent a long period out of the community whilst staying in hospital and therefore may have limited stamina for the demands of the on-the-day office presentation.

All cases are subject to statutory assessment. There is no guarantee that the homeless person will be deemed to meet the statutory threshold by the local authority to provide emergency accommodation. Where it is appropriate the service will undertake advocacy on behalf of the homeless person to facilitate statutory housing assistance. Where the criteria are met, challenges may still be faced due to the lack of availability of appropriate emergency accommodation. A common challenge where the patient has mobility problems is that there is no ground floor or lifted accommodation available on the day.

4

Once accommodation has been sourced the team will request social care packages, and also liaise with the hospital to put in place community nursing visits that may be required. They will accompany the homeless patient to the accommodation (again this may be outside of London). They will also purchase basic household items such as plates and basic cooking utensils like a saucepan as these may not always be provided as part of the emergency accommodation. This on-the-day work is an essential part of re-settlement, addresses vital safeguarding and the person's basic human needs in such a situation.

For those that have no available accommodation, the 'Routes to Roots' service has no housing provision of its own to offer. There are several cases where patients have been re-admitted to hospital following an unsuccessful housing options presentation, even though they have no medical need to be in hospital. The hospital have also stepped in on occasion to pay for bed and breakfast accommodation and the deposit and rent in advance for private rented accommodation for those where there were serious concerns but no prospect of re-admission.

There have also been cases where the 'Routes to Roots' service have brokered last minute overnight stays with a friend or relative, or access to one of London's seasonal winter night shelters providing a place to sleep for the night typically in a local church hall.

When I began working on the 'Routes to Roots' project I noticed a real lack of consistency in responses to homelessness across different boroughs. A strength of the project has been that it builds relationships with local authority staff across London to ensure patients get the best outcome possible as quickly as possible.

Some councils have been very responsive but we still have ongoing challenges. For example, the time it takes from initial presentation to getting an appropriate housing outcome. We work closely with other agencies including hospital staff, occupational therapists and social workers to ensure the process runs as smoothly and timely as possible.

Stephanie Ratcliffe

'Routes to Roots' Adviser

The first time I presented a client to Housing Options outside Tower Hamlets I was taking a client to [council in London] and it took ages to get through to the right person. I was surprised how much time was wasted just to find the right person. Some councils have been very responsive. We still have ongoing challenges though when it comes to finding emergency accommodation on the day we present, or when ground floor accommodation is needed for someone in a wheelchair.

Paulina Gudalewicz

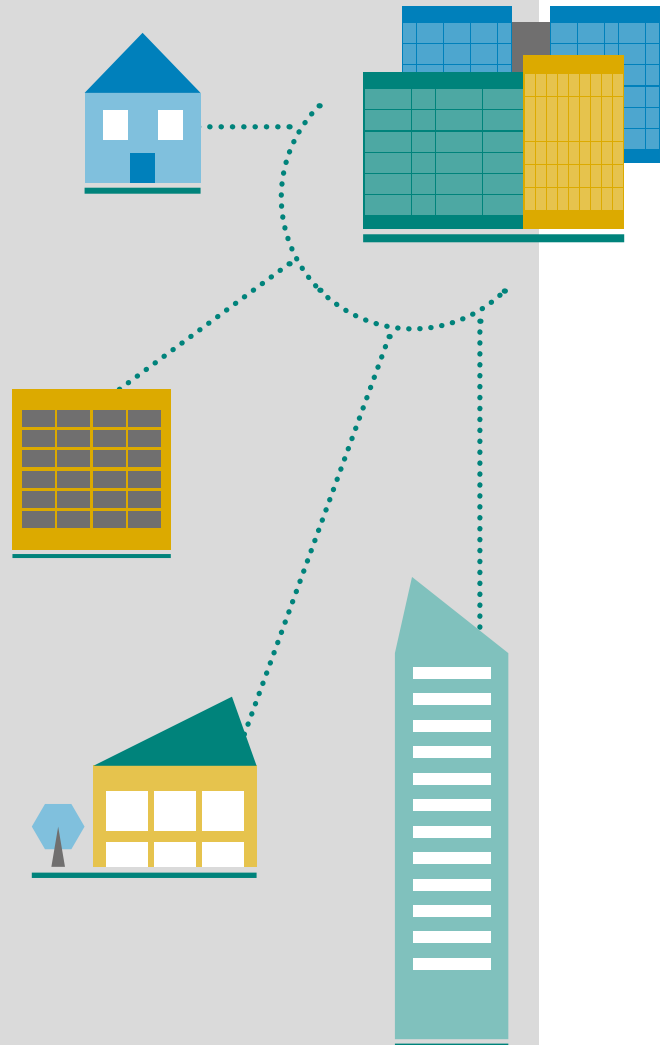
'Routes to Roots' Adviser

5

FOLLOW-UP AND SUSTAINMENT

One of the most important stages in the model is ensuring the move is sustained. The focus of this stage is 'linking in' the client to local services to aid resettlement. The added value of having 'Routes to Roots' delivered by a voluntary sector provider is evident here as hospital social workers do not have the capacity or remit to extend the discharge process into this stage. Voluntary sector knowledge and expertise to manage individuals' expectations is also critical.

Sustainment starts on day one and can include attending the tenancy sign up, assisting on move-in day, helping clients to buy essential household items, and helping apply for grants, referral to local food banks, and other charitable projects. The team will also help people register with a GP, and with benefit claims. Trust built between the homeless person and the service means people will often make use of the service for several months after resettlement and during this time the service undertakes handovers with their local equivalents in the home area such as floating support.



1

CASE STUDY:

ANDREW

Andrew was referred to the service by the Hospital Pathway Team. He had renal failure and also had mobility problems. The 'Routes to Roots' Adviser assessed him as having a connection with London Borough of X. The 'Routes to Roots' Adviser also identified an outstanding Employment and Support Allowance (ESA) claim had not been finalised and took this matter up on the same day.

The housing options service in London Borough of X was phoned the next day. Medical information was requested and the 'Routes to Roots' Adviser provided this. Two days after referral to 'Routes to Roots' Andrew was discharged from RLH and supported to present to Housing Options at his home local council.

At the meeting it was confirmed verbally that a housing duty would be owed to Andrew. However the council did not have a suitable property to meet his needs. He needed

level access ground floor accommodation but all that was available was a hostel and no suitable Bed and Breakfast accommodation was available.

The Housing Options Manager called '999' and Andrew was admitted to a local hospital in borough X. The 'Routes to Roots' adviser applied for social services assistance for Andrew, but he was assessed as not meeting the Fair Access to Care Services (FACS) criteria.

In the meantime the 'Routes to Roots' adviser supported Andrew to claim statutory sick pay since it transpired he was technically still in employment. They contacted his employer and arranged a meeting to sign papers, closing his employment and the transfer of monies owed.

Five days after the initial presentation to the home local council, their Housing Options team found a suitable unit for Andrew in sheltered housing. The

'Routes to Roots' adviser obtained a copy of his birth certificate as this was needed as identification.

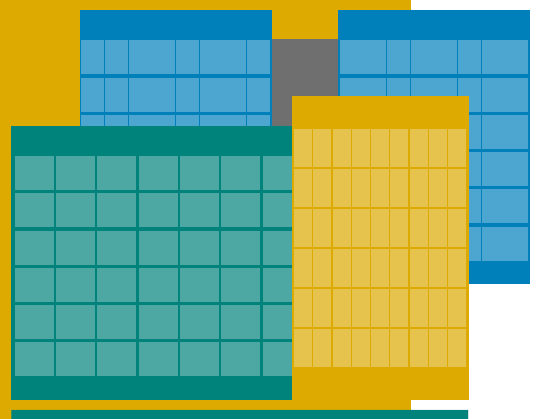
By this time he was staying temporarily with a relative. The adviser purchased a mobile phone and phone credit for him to ease communication and an Oyster card. These costs were split between 'Routes to Roots' and the RLH.

Several days later he received the keys and moved in with food and hygiene products also paid for by 'Routes to Roots' and the hospital. A referral was immediately made by the 'Routes to Roots' adviser for floating support and shortly after the adviser also submitted an application for funding for white goods and other items for resettlement.

They contacted the mobile support worker (from the sheltered accommodation) and the council's Housing Benefit outreach worker to brief them on A.'s support needs in order to effect a seamless handover. A

package of care was then set up with the adviser providing a briefing on his support needs. It was agreed that Adult North Community Team would follow-up the floating support referral.

A fortnight later all parties met at Andrew's flat. He was informed about what support he can expect from his worker. Housing Benefit papers were completed and signed.



2

CASE STUDY:

OHID

Ohid's case was referred to 'Routes to Roots' and they established that the local connection was with the London Borough of Y. Borough Y were contacted and sent a Housing Options officer to the hospital to complete a housing options assessment.

The officer confirmed verbally that the council would be needing to secure temporary accommodation for Ohid pending further enquiries.

Three weeks later, when he was ready to be discharged, the adviser contacted Borough Y to book an appointment. Borough Y said they were unable to provide accommodation due to a lack of information about his address history. A list of addresses had been provided but Ohid had a brain injury which meant recollection was poor.

The adviser provided evidence of his brain injury and problems with his memory but the council

was not prepared to change its opinion.

The discharge from hospital was consequently delayed for a fortnight as 'Routes to Roots' worked with the RLH. Given the pressure to release the bed, the hospital decided to pay for private rented accommodation for him through a letting agency in Ilford. He was placed originally in Thurrock but then moved within this same agency to Ilford where he now rents a room in shared accommodation.

DEMAND AND OUTCOMES FOR THE ‘ROUTES TO ROOTS’ SERVICE

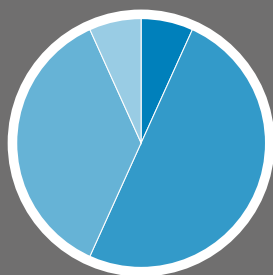
The following is a breakdown of clients who were referred to the service in 2014-15 and what was achieved.

Altogether, the service dealt with 74 referrals in 2014/15, and the team succeeded sometimes with very limited notice of discharge to undertake an assessment in each case.

There were nine referrals for people who were already known on CHAIN, the London Rough Sleeper database (five UK nationals and four EU nationals).

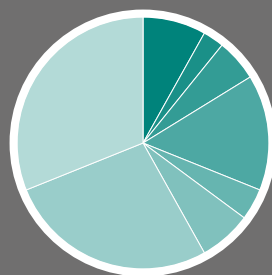
DEMOGRAPHIC PROFILE OF SERVICE USERS

THE AGE RANGE OF SERVICE USERS WAS:
 (THE SERVICE USERS WERE PREDOMINANTLY MALE – 67 MEN; 7 WOMEN)



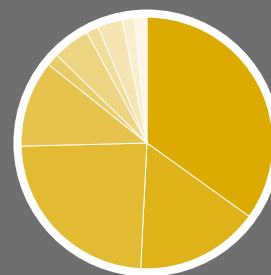
UNDER-25	5
25-44	37
45-64	27
65 AND OVER	5

THE ETHNICITY PROFILE WAS AS FOLLOWS:



ASIAN BRITISH	6
ASIAN OTHER	2
BLACK AFRICAN	4
BLACK BRITISH	11
BRITISH	3
MIXED RACE BRITISH	5
WHITE BRITISH	20
WHITE EUROPEAN	23

THE SUPPORT NEEDS FOUND IN THE CLIENT GROUP WERE AS FOLLOWS:
 (WITH SOME RECORDING MORE THAN ONE)



ALCOHOL	22
DRUGS	10
MENTAL HEALTH	15
MOBILITY	7
LITERACY	1
COGNITIVE IMPAIRMENT	3
LEARNING DIFFICULTIES	1
DV	2
GAMBLING	1
OFFENDING	1

WHERE WAS THE HOME BOROUGH?

The team were able to identify a local connection for every one of the 74 clients, except for four people who didn't want to work with the service.

51 of the 74 clients (69 per cent) had a local connection to another London borough. These 51 people came from 20 London boroughs in all and from as far afield as Richmond and Bexley. 41 per cent of the London cohort came from two of the neighbouring boroughs – Hackney (11) and Newham (10).

Only six came from out-of-London boroughs – Cambridge (one), Essex (two), Coventry (one), Broxbourne (one) and Wycombe (one).

The remaining 13 had no UK local connection and these were all Eastern European nationals.

OUTCOMES

The service made referrals to the home Housing Options service in 37 cases with sometimes positive, sometimes negative and sometimes inconclusive or significantly delayed responses.

Reconnection efforts resulted in getting 36 of the clients back into housing through a wide variety of avenues:

- 11 were offered temporary accommodation (TA) by their home council
- one received permanent council housing
- one received sheltered housing
- one was accepted on their home council Private Rented Sector (PRS) scheme
- one was admitted to residential care by the home borough
- two were assisted into hostels by their home area
- one was supported by the home borough to access the GLA 'No One Living on the Streets' (NLOS) hub
- four had an international reconnection
- four were assisted to sustain and return to their PRS tenancies
- two were assisted to access a hospital discharge bed at Hackney Mare Street
- six were mediated back to friends and family
- two were returned to hospitals in their home area.

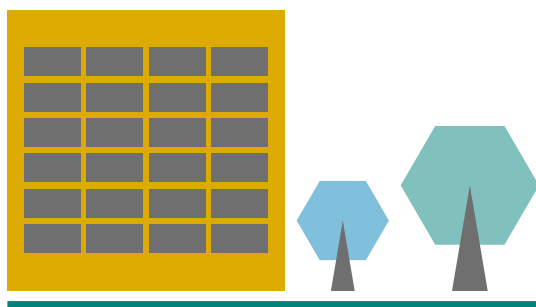
ROUGH SLEEPING POST-DISCHARGE

Of the nine CHAIN verified rough sleepers referred to the service in 2014-15, four have had a further bedded down encounter post-discharge (in other words have been met by an outreach team sleeping on the street). This was a single encounter in three cases; in the remaining case the person was seen twice. These encounters on the street all were within three months of being discharged by the hospital. Five did not sleep rough again after using the 'Routes to Roots' service.

Of those with no rough sleeping history prior to referrals to 'Routes to Roots', none of them slept rough post-discharge.⁵

REDUCING UNPLANNED HOSPITAL RE-ADMISSIONS

The number of patients who were discharged by the Royal London Hospital but who then had to be subsequently readmitted was very low amongst the Routes to Roots client group. Hospital records show there were only two patients in this category who, after being referred to the Routes to Roots service in 2014-15 and discharged, had a further admission at the Royal London Hospital. In both cases they were back in the hospital within less than 28 days of having been discharged.



The difference 'Routes to Roots' makes to clinical outcomes for homeless people is more holistic care, more robust discharge planning, and reduced likelihood of failed discharges & readmission to hospital. This helps improve the healthcare of homeless people after discharge from hospital. Patients are more likely to have support in place, be more hopeful for the future and therefore are more likely to take better care of their physical and mental health. Patients can also be assisted with GP registration if needed to support their ongoing and future health and care needs.

Dr Peter Buchman

Clinical Lead Pathway Homeless Team
at RLH

⁵ Data on post-discharge rough sleeping among the 'Routes to Roots' 2014-15 cohort is based on checks of CHAIN in June 2015 on each of the 74 individuals in the cohort.

COSTS AND RESOURCES

Tower Hamlets Housing Options provides funding of £35,000 per annum.
The Marie Celeste Samaritan Society makes an annual contribution of £23,000.

SERVICE COSTS 2014-15

1.6 FULL TIME EMPLOYED STAFF (SALARY AND ON COSTS)	£44,395
STAFF TRAINING	£425
TRAVEL COSTS	£462
CLIENT ID AND DOCUMENTATION COSTS	£182
EMERGENCY RESETTLEMENT ITEMS (E.G. BEDDING, POTS AND PANS)	£153
IT AND EQUIPMENT COSTS (INFORM LICENCES, TELECOMS)	£364
WORKPLACE PROPERTY CHARGE	£4322
OVERHEAD ALLOCATION	£5235
TOTAL	£55,538
COST PER SERVICE USER IN 2014/15	£750

PROJECT

LEARNING

Challenges in the early days of the service mainly involved problems obtaining statutory homeless assistance from the home borough. Staff inexperience and lack of confidence in navigating the administrative systems of Housing Options departments as well as not having a detailed working knowledge of the law were the main barriers that had to be overcome through formal legal staff training.

Getting through to Housing Options services or obtaining responses once referrals are submitted remains an occasional problem. Nationally or regionally agreed timescales for responding to referrals would help overcome these problems.

Short notice hospital discharges impact on the ability to make an intervention. One of the 2014-15 'Routes to Roots' cohort was referred at too short notice for an effective intervention to be made, and they subsequently had a further rough sleeping experience. Instances of cases hampered by discharge on the same or the following working day, however, are relatively few.

Lack of appropriate emergency statutory housing on the day of homelessness remains a major challenge, particularly where ground floor or wheelchair accessible

accommodation is needed. The service has responded practically to the immediate challenge of resettling people into flats with no basic equipment by purchasing these goods with them on the day of homelessness, providing the money where necessary.

The absence of equivalent support services in the borough to effect a handover has meant cases remaining in the "Routes to Roots" caseload longer than was necessary.

For me, the key to ensuring the success of the project is credible partnerships with local authority housing teams. I don't see any benefit to taking an adversarial approach with housing options teams, but that does rely on us sharing the same objective – to avoid street homelessness. Where we have working relationships and named workers to communicate with we resolve problems quicker which benefits all parties.

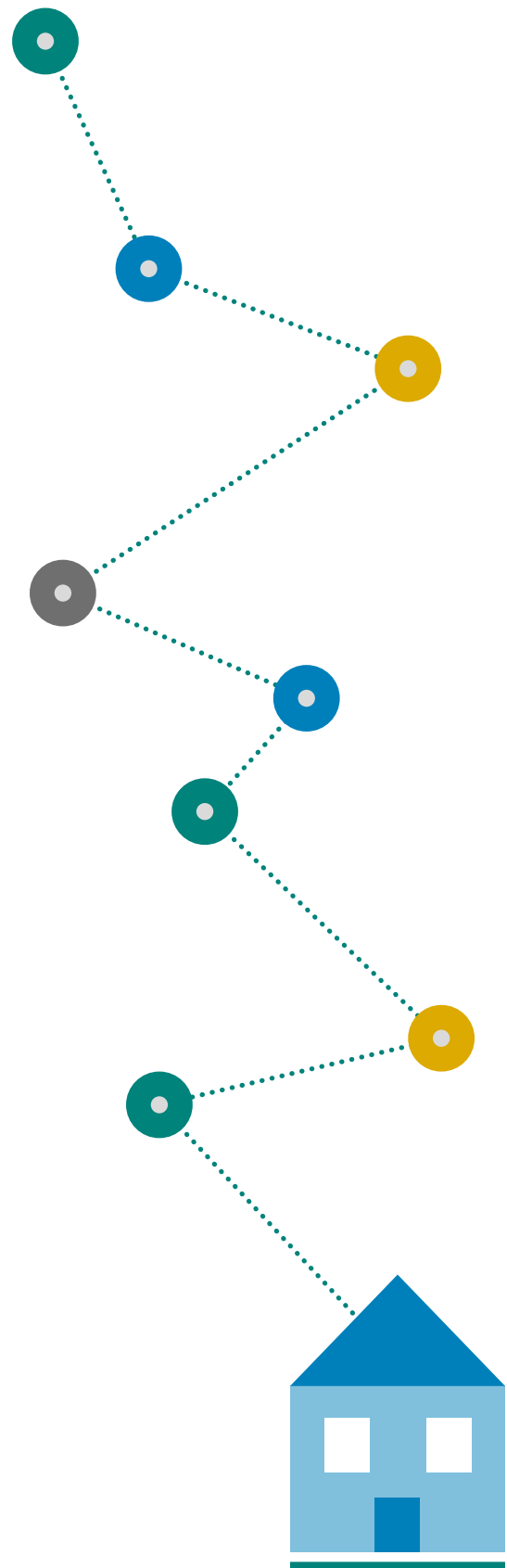
Promoting the benefits of the project and disseminating the practice will be important next steps. My aspiration for the project is that when a 'Routes to Roots' adviser contacts a Housing Options team, the local authority officer at the other end knows exactly what to do next. It seems likely that resources will remain under pressure for the foreseeable future, but the best way to mitigate this is the efficient use of the resources that exist.

William Norman

'Routes to Roots' Manager

The following are critical to the success of the Tower Hamlets 'Routes to Roots' approach:

- a Hospital Homeless Pathways Team or a sympathetic discharge planning team
- early referrals to the project. Because of the pressure on beds, early engagement is key
- clinical involvement for instance for navigating hospital systems and providing up-to-date medical evidence
- early contact with the home borough and excellent case preparation and communications
- putting the leg work into gathering evidence so a full case can be presented at first contact
- comprehensive knowledge of homelessness prevention and housing option solutions
- comprehensive homelessness law training for staff, including case law and coaching on how to present a competent case
- follow-up and sustainment.



REPLICATING

THE MODEL

The Routes to Roots approach can provide an important rehousing avenue in the hospital discharge setting for out-of-borough homelessness patients. It has a place in an area's homelessness and rough sleeping strategy. It feeds into Joint Strategic Needs Assessment (JSNA) work and vulnerable adult safeguarding and health and well-being goals. It contributes to relieving pressures on acute and unplanned admissions at the local general hospital. The approach can also be adapted for use in other health settings.

The basis for a project is:

- a demonstrated need for managed discharge for hospital patients with a local connection to another borough
- a willingness for a number of agencies to work together to tackle the problem.

The 'Routes to Roots' service returned a clear saving for Tower Hamlets as a whole based on 2014-15 figures. A business case can be formulated based on projected savings against a range of costs:

- staffing costs of undertaking homelessness prevention and sourcing housing options
- staffing costs of processing homeless applications, with potentially lengthy investigations of priority need, intentional homelessness, and s198 inter-borough referrals, including reviews and costs of legal challenges
- emergency temporary accommodation, including housing management and eviction costs
- Housing Benefit for temporary accommodation
- temporary accommodation rent write-offs
- social services care packages
- residential care placements
- delayed hospital discharge, unplanned local hospital re-admissions and repeat use of local A&E
- hospital funding of emergency B&B and PRS
- local rough sleeping services.

Depending on client numbers, a sub-regional worker that can be pooled across several hospitals and/or a cluster of local authorities may be a cost efficient approach. (In Tower Hamlets the data shows a high number of clients were from two neighbouring boroughs).

The work is suited to local homelessness charities and day centres and could be carried out by either a peer advocate or an outreach worker, whether from a street outreach, floating support or welfare advocacy background. For homelessness statute reasons, the model is not suited for delivery by a local authority. Experience would counsel against using clinical resources such as a Discharge Nurse to undertake homelessness prevention and securing housing options since success depends on Housing rather than Health expertise. The Discharge Nurse or other clinical expertise rather is essential in the model for navigating the hospital system, reporting discharge dates, imparting medical knowledge and supplying rapid up to date medical evidence and liaison with occupational therapists and social care.⁶

Providence Row wanted to take on this work because it prevents people from becoming homeless and alongside this, at a time when their health is poor and they are very vulnerable, supports long term physical recovery. For other day centres interested in replicating this approach, I suggest making a link to hospitals with Accident and Emergency admissions and speaking to those responsible for the timely discharge of patients. I also recommend investing in in-depth training in housing regulations for those frontline staff involved.

Pam Orchard

Chief Executive, Providence Row

From a resource point of view, the RLH MDT report that the service is performing an important role in reducing delayed discharge, as this was often the case with significant move-on barriers for discharge teams, consuming the time and energy of doctors and nurses fruitlessly arguing with Housing staff. Time and energy which is now better spent employed in clinical care.

Dr Peter Buchman

Clinical Lead Pathway Homeless Team
at RLH

6 For further reading on producing a business case, see 'Why Invest? From hospital to home: improving hospital admission and discharge for people who are homeless', (Homeless Link, 2015)

FURTHER **INFORMATION**

The partners to this project welcome interest from other local authorities, hospitals and other organisations exploring establishing similar arrangements in their own area. Tower Hamlets itself will be trialling new features of the project as part of its tri-borough work through the DCLG Single Homelessness Fund and GLA No First Night Out work in 2015-16.

To get in touch, please email
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- 'Routes to Roots' workers, Stephanie Ratcliffe and Paulina Gudalewicz
- Pam Orchard, CEO, Providence Row
- Dr. Peter Buchman, Clinical Lead Pathway Homeless Team at RLH
- Dr. Nigel Hewett, Medical Director Pathway, OBE MB ChB DCH DRCOG FRCGP

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Jenkins Duvall and Kath Dane helped with preparing an early draft of this report.