West Midlands Combined Authority

Rough Sleeping Initiative 2020/2021

May 2021

Key Achievements & Learning Report

Introduction

West Midlands Combined Authority (WMCA), through the work of the Homelessness Taskforce, secured £581,400 of Rough Sleeping Initiative (RSI) funding, for the region in 2020/2021. This funding to the WMCA from Ministry of Housing, Communities and Local Government (MHCLG) was awarded in addition to RSI funding allocated to individual Local Authorities.

The primary objective of RSI funding is to:

- Help people sleeping rough off the streets;
- Help those who have moved off the streets to successfully progress away from rough sleeping; and
- Prevent those in crisis, and at imminent risk, from sleeping rough.

Bringing a region wide perspective, the WMCA Homelessness Taskforce sought to **add value** and complementary outcomes to the work of Local Authorities and wider partners to **prevent and reduce rough sleeping** across the region.

To ensure relevance and strategic fit, the Homelessness Taskforce and Rough Sleeper Task Group, with Local Authority Lead Officers, identified the following **priority areas of need** where service gaps existed or there was potential to enhance existing services; as well as opportunities for additional value in undertaking work across the region rather than in any single Local Authority:

1. **Certain Health issues** - including dual diagnosis (mental health and substance misuse) – which result in difficulties to sustain accommodation.
2. **Women** - vulnerable, rough sleeping and other precarious situations, not feeling safe in provision, needing a bespoke, intensive support and accommodation offer.
3. **Intensification of support** - recognising that the support needs of some individuals are beyond current risk management levels, however with additional resource, individuals could be appropriately supported into accommodation and to remain in accommodation.
4. **No Recourse to Public Funds (NRPF)** – working within legal parameters to arrive at solutions for individuals from abroad for whom legal restrictions mean there are significant constraints on what help can be given, recognising the needs and opportunities to connect to migrant services, legal advice and employment pathways.

The Homelessness Taskforce and its partners were clear that in addressing the identified priority areas of need, the RSI funding would be used to invest in activity across the region that would contribute to clear pathways away from and out of **crisis** – a central point of focus for the wider work of the Taskforce.

Investment

WMCA received £581,400 for investment from MHCLG and undertook an open tender process and sought submissions from relevant organisations, to deliver outcomes through bespoke, innovative, flexible and effective proposals across 6 Lots:

A. Provision of accommodation/intensification of support to enable people who sleep rough to access and maintain accommodation.

B. Women specific service provision to prevent and resolve rough sleeping crisis, especially where abuse or exploitation may be a factor.

C. **Provision of support to those with problematic status in the UK impacting rough sleeping, including temporary accommodation as a pathway to resolving status and rights, return to country of origin or into work.**

D. **Outcome focused, spot purchase fund available to organisations to enable individual solutions for people sleeping rough, allowing flexible, personal planning and delivery.**

E. **Developing Psychological Approaches, placing clinical psychology at the frontline, working directly with identified people sleeping rough and in support of outreach services.**

F. **Local plan of outreach and accommodation pathway – in geographically more removed/suburban /unserved areas, enabling local service mobilisation.**

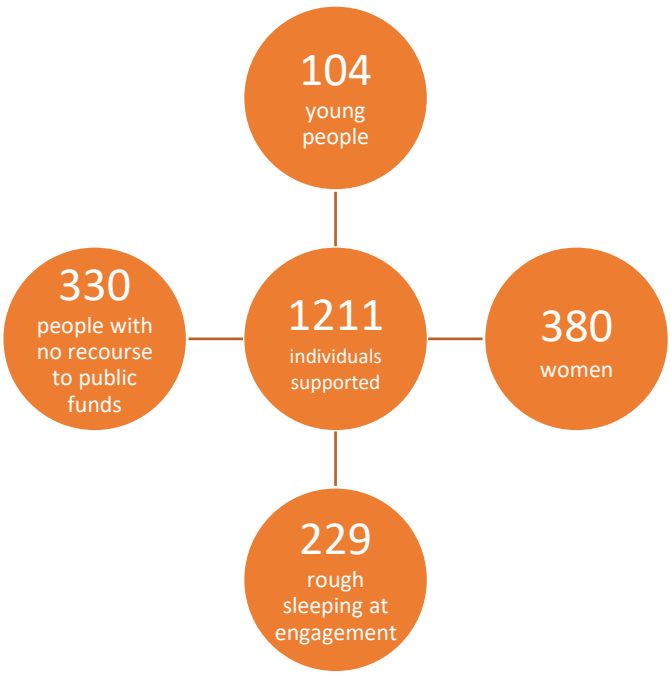
In total, WMCA commissioned 14 organisations to deliver 21 projects across the 6 Lots that focused upon the need for each person rough sleeping or at risk of rough sleeping in the region to be identified, engaged with, known and have an agreed plan.

A central component of each individual project was to ensure collaboration and joining up of local services, especially around **prevention** and to complement the concerted work across the region of Local Authorities and wider partners, including initiatives such as Housing First.

In addition, WMCA invested part of the RSI funding to develop a new Faith & Communities Development Officer role for the region to work with faith, community and smaller scale voluntary groups to provide some level of coordination of services, greater integration with Local Authority and statutory pathways, create meaningful offers away from the streets and support upskilling and safe practice amongst volunteers and groups

Achievements

Individuals supported:



Impact of Interventions:

Intervention/Impact	Individuals supported
Emergency accommodation spaces provided	208
Temporary accommodation spaces provided	246
Long-term accommodation spaces provided	144
Number of unique individuals supported into short-term accommodation	318
Number of unique individuals supported into long-term accommodation	183
Number of unique individuals supported through RSI funded services (non-accommodation)	504
Number of unique individuals supported to reconnect to another area	71
Number of unique individuals supported into employment, or employment focused services	65
Number of unique individuals connected to other support services e.g. Drugs and Alcohol	236
Number of unique individuals directly supported through PIE activity e.g. supported into or to sustain settled accommodation	88
Number of unique individuals supported by RSI funding in other ways not included above	150
Number of unique individuals sustaining engagement over 3 months	165
Number of unique individuals sustaining engagement over 6 months	43

The graphic and table above highlight that through the RSI investment we enabled organisations to reach 1211 unique individuals with a range of outcomes.

Faith & Community Groups

Following an initial coproduction session to understand the training needs of groups; over the year, our Faith & Communities Development Officer has delivered 5 training and engagement events covering a variety of topics including homelessness awareness, impact measurement, governance and accountability, assisting individuals with no recourse to public funds, trauma informed care and strengths based approaches – reaching 80 volunteers and staff working in faith and community groups.

We also invested in 6 small-scale innovation projects to develop and test new interventions and ways of working. So far, 17 unique individuals have been supported through these projects through meaningful activity aimed at improving digital inclusion and wellbeing. It is anticipated that once groups funded through the second application window have completed their projects, that 50 individuals will have been supported.

Learning

A key part of any programme like RSI is capturing and sharing the learning that the projects we invest in generate, whether that be learning about what works well or what should be avoided in the future.

As well as tracking data on outcomes and outputs we asked providers for case studies that illustrated presenting issues and challenges, and we also asked them to reflect on their own learning as part of that process. A detailed analysis of the case studies and some examples are attached in the appendices below.

In this section of the report we set out the main learning points that the providers and we have captured to date.

Cross cutting learning

Logistics through Covid-19 and the subsequent response has had an impact on how providers were able to both mobilise and then deliver services. It is worthy of note that, almost without exception, providers managed to overcome the challenges of starting new projects, such as recruitment of staff, really well. They also rose to the challenge of redesigning critical elements of their project delivery to ensure that it was Covid safe and yet still delivered. This is to the credit of frontline staff and project managers across the programme.

RSI activity across the region demonstrated the importance of considering the **resilience and skills** needed by frontline staff and managers and was supported through the **PIE** element of the programme. This included a combination of training and reflective practice sessions alongside individual consultancy and case management, taking psychological knowledge and skills to frontline teams, supporting engagement and trauma-informed practice.

The case studies and feedback from providers indicates that a significant number of the people they have been supporting had **complex and multiple support needs** e.g. long-standing substance misuse and mental health issues. They are also likely to have experienced multiple exclusions from services or in the case of those in the NRPF cohort (see below) to have been exploited and not able to seek help with complex issues.

A significant number of those helped have ongoing **physical health challenges** as well as the mental health concerns noted above.

For the women who have been helped through the RSI programme there is a disproportionate *(in comparison to the whole population)* number who are either fleeing **domestic abuse** or have experienced domestic abuse in the recent past. Many will have experienced ongoing abuse whilst rough sleeping.

Overall, our assessment is that the projects we have invested in have reached those most in need and at highest risk of rough sleeping.

Client group specific learning

As we note above the **Covid-19** pandemic has had an impact on not just those seeking help, see note below on NRPF) but also on how services can respond to need. Providers reported that the 'Everyone In' approach was very helpful in bringing people in off the streets and opening up new opportunities to engage with people and encouraged a fluid approach to joint working between some agencies.

It also created challenges as some critical delivery partners did reduce the services they offered, certainly during the early stages of lockdown. For example, getting appointments or support from some agencies became far more challenging than usual.

It has been accepted that **the experience of women** who rough sleep is significantly different to that of men. As yet we are not able to fully articulate the extent or nature of all the differences, but it is clear from the literature and from the experience of the projects we funded across our RSI programme that those differences do exist.

For example, women are less likely to sleep rough in the same places as men, they are often at much greater risk of exploitation and are more likely to be the victims of abuse. The projects funded under the WMCA RSI programme have identified the lack of a clear pathway for women and assess that there is high risk of women falling between services.

The projects we funded in 2020/2021 have overcome some of these hurdles and the learning to date confirms the need for a gender specific trauma informed response going forward. That work is being used by the same providers to help co-create the foundations for a more robust pathway for women in the coming year.

One of the unforeseen impacts of the pandemic response, in particular 'Everyone In' has been the high numbers of people who have been supported that have **No Recourse to Public Funds** (NRPF). It is fair to say that the numbers of people who are in the NRPF cohort has been much larger than was expected. This is partly due to the impact that the pandemic, and the policy response, had on sectors of the economy that rely on exploitative work practices.

The projects we funded made a major contribution to supporting people in this cohort with outcomes ranging from helping people to reconnect with their home nation through to enabling people to find both work and settled accommodation.

There have been significant challenges for providers and Local Authorities as the pressure to move people on from 'Everyone In' accommodation intensified at the same time as work was ongoing to help those who still did not have settled status.

The work of many of the projects has continued to highlight the need to increase the focus of investment on **prevention of homelessness** wherever possible. This has been reflected nationally and the RSI 2021/2022 prospectus has created space for greater investment in prevention focused projects.

Testing new approaches

Through the RSI investment we have been able to help providers test out new approaches and roles. For example, one provider used the RSI investment to test out the impact of a worker who could engage with people in accommodation with **disrupted sleep and activity patterns**. Working with people during the late evening and night to help re-establish routines to support motivation and energy for engagement. This role enabled service users to engage more effectively, and the evidence suggests that it reduced unplanned moves.

Finally, it is worth noting that despite the disruption caused by the pandemic we have been able to get some critical work with **Faith and Community Groups** underway, undertaking and providing a range of training and awareness raising sessions, running an innovation fund and engaging groups in the first steps towards a refocusing on prevention.

Conclusion and Next Steps

Overall, our assessment is that the WMCA RSI Programme achieved what it set out to do, in particular adding value to the work of Local Authority partners and in developing region wide initiatives. The work carried out by those supporting people with no recourse to public funds is a good example of the former and the Faith and Community Groups work is a good example of the latter. The feedback from partners indicates that the investments did add value to local work, added much needed capacity and in some cases stimulated innovation.

Providers of all sizes and configurations were required to change the way they delivered their services as a result of the Covid-19 pandemic and the public health response to that. Whether that be the work of the team delivering Psychologically Informed Environment (PIE) training and support having to use remote

learning techniques and tools instead of face-to-face training or the work of those offering drop-in services having to reconfigure those services quickly to be Covid safe.

The feedback from providers was that this was a very challenging time and there had to be some rapid redesign of how services were delivered. Credit is due to all those who rose to that challenge and helped to deliver some important outcomes for very vulnerable people in the community.

Throughout the process we kept a focus on investing in outcomes rather than in outputs which may well have helped to encourage providers to be flexible about how they delivered services in order to achieve outcomes in a rapidly changing environment.

Looking forward and building on the work done to date the intention for the upcoming round of RSI funding is to start to build in an increased focus on prevention of rough sleeping, it is early days in that process and we feel this is the natural next step for the Taskforce to take as prevention of all forms of homelessness is central to the work of the group.

For RSI 2021/2022 the intention is to continue to invest in a number of the projects from 2020/2021 and in all these cases we have collaboratively refocused providers outcomes to include a mix of embedding the positive work already done. In some cases, we have introduced elements of system change, for example the work on designing and testing a discrete pathway for women at risk of rough sleeping.

Some of the projects we funded have now gone on to be funded by the relevant Local Authority, either through their individual RSI programmes or from mainstream funding.

We are also seeking new investments in two areas of work, firstly developing and launching a region wide resource with Street Support. Secondly investing in innovative projects to help those at risk of returning to rough sleeping to develop sustainable social networks that reduce the risk of a return to the streets.

Further Information	
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Appendix 1: Case Study Review & Analysis

Case Study Review	In gathering case studies from our delivery partners commissioned as part of the WMCA Rough Sleeping Initiative Programme 2020/2021, we wanted to extract some of the more personal narratives of the individuals supported and gain a qualitative understanding of the key emerging issues, barriers that may have been faced and key learning that could potentially be used to inform plans for 2021/2022 and the type of services commissioned. The anonymous case studies received from delivery partners have been analysed and emerging themes discussed in the below report.
Key Stats	A total of 25 detailed case studies were received, of which: • **11 were women, and 14 were men** • **10 individuals had no recourse to public funds** (1 of these was female and 9 were male) • 4 individuals were supported under Lot A – Provision of accommodation/ intensification of support • 6 individuals were supported under Lot B – Women specific service provision • 6 individuals were supported under Lot C – Provision of advice/ support to those with problematic status • 6 individuals were supported under Lot D – Outcome focused, spot purchase fund • 3 individuals were supported under Lot F – A local plan of outreach and accommodation pathway in geographically more removed/ suburban/ unserved areas.
Emerging Themes	**<u>Multiple and Complex Needs</u>** • **Relationship breakdown:** The majority of those reported had experienced family fallouts/ relationship breakdowns, with a high number of **women fleeing from domestic violence** and other forms of abuse. Perpetrators of domestic abuse had often ensured that women were isolated from and could no longer resort to depending on their family networks. • For young people experiencing relationship breakdowns amongst families, this meant that they were no longer able or welcome to stay at their family homes. • **Addiction:** Many rough sleepers had addictions/ substance misuse issues. These ranged from alcohol addiction to heavy drug use (crack cocaine, heroin, marijuana and MAMBA). These individuals required a great deal of support from specific services tailored to help them overcome these addictions, sometimes requiring prescribed medication from GPs to alleviate withdrawal symptoms. • **Mental Health Issues:** Most clients had mental health issues for a variety of reasons (i.e. as a result of experiencing childhood trauma). These mental health issues varied from person to person but included experiencing severe anxiety, depression, delusional behaviour, suicidal thoughts, psychotic episodes and aggressive outbursts. The wide range of presenting mental health issues demonstrates the need for staff in homelessness services to be trained in recognising these and understanding the best approaches to support. • **Learning disabilities:** Some clients also had lifelong learning disabilities, such as autism and Asperger's syndrome meaning that they found it harder to understand new or complex information, to communicate with people unknown to them or to cope independently. The level of support needs for these individuals is high and requires experience. • **Physical Health Issues:** As well as mental health issues, some clients were also experiencing physical health issues, disabilities or long-term medical conditions requiring regular medication. This meant that it was essential they were registered with health services and their accommodation and support needs had to be adapted to care for them.

	• Furthermore, these long-term medical conditions (i.e. diabetes, cancer) made them vulnerable and at higher risk of Covid-19 – so it was essential that these individuals were safely accommodated. • Such mental and physical health challenges often prevent individuals from being able to commit to full-time employment. • **Financial hardships:** Unsurprisingly, most of the individuals presenting were facing financial struggles, often having lost their job, accruing rent arrears, debt and many had faced evictions and were either rough sleeping or at imminent risk. They were unaware of the public funds available to them and needed support and guidance with housing and benefits application processes.
Barriers/ Challenges	• **NRPF:** Those with no recourse to public funds had no means of obtaining funds to support themselves and thus had no options but to sleep rough. This was often alleviated when services were knowledgeable and able to support individuals into emergency accommodation whilst seeking legal advice and applying for status within the UK. Nonetheless, for a few NRPF clients there are few immediate options other than accommodating them currently as part of the response to the public health emergency. • Of these NRPF individuals, a common challenge was the **language barriers** experienced. These then also limited their options for employability if they were not fluent English speakers. • **Lack of trust in professionals:** Clients worked with were initially very reluctant to trust service professionals, partly due to reporting being let down in the past by them. This often led to a lack of cooperation or willingness to engage with services for support. • **Chaotic lifestyle:** Individuals also led very chaotic lifestyles, and some are very entrenched rough sleepers. This can make it extremely difficult to get them to stay engaged and keep in touch/ locate them. • Many interact with unhelpful social networks which can make it hard for them to break out of engaging in dangerous behaviour (selling drugs or phones that have been provided by services to maintain contact, stealing, sex work) or **relapsing** in their addictions. If these social networks are not replaced with more positive ones, then the risk is that individuals will go back to interacting with unhelpful networks in order to feel a sense of belonging. This can lead to services feeling less willing to provide items if they feel the user will lose/ sell them or refuse to engage with support offered to them. The services who were supportive and encouraged making alternative social circles and activities to occupy them found increased engagement. • **Lack of face-to-face contact due to Covid-19:** Lots of delivery partners reported that the loss of ability to maintain regular face-to-face contact with clients was detrimental as individuals with multiple and complex needs benefit most from personal face-to-face interactions and support. • Additionally, most people experiencing homelessness do not have the resources to engage in virtual support sessions (i.e. laptops, smartphones), so unless services are willing to provide these then these people will lose out on essential support. • Though some organisations have managed to work around the lockdown and organise Covid-safe face-to-face interactions, these were not as frequent as they would have been pre-Covid. Others have had to adapt to the new restrictions and modify services to make them operational from a distance. • **Delays/ closures to services caused by Covid-19:** Lots of services that homeless services rely on to alleviate rough sleeping for clients were either shut or at limited capacity/ had less staff resourcing due to the pandemic. This had a negative impact on all clients but especially those with NRPF and/or mental health issues.

	• These changes caused delays in receiving required documentation, such as ID or passports for those with no recourse to public funds, which then led to lags in receiving public funds and status giving the right to work in the UK. • Likewise, delays in support services, such as Citizens Advice and mental health services meant that clients were unable to acquire the vital support needed to improve their circumstances. • For example, some consulates/ embassies were only open in London, meaning services had to fund clients to travel and also assist in their travel by a key worker due to their health needs and to ensure their safety. • **Improvements needed in health services, especially Mental Health services:** Delivery partners reported challenges in accessing mental health services such as finding MCN workers during lockdown, long waits in mental health services and gaining appointments often leading to delays in essential support and in some circumstances lead to individuals dropping out or losing contact with services. • In addition, some support workers felt that they did not have enough knowledge of some of the mental health issues they were presented with, triggers and coping techniques to efficiently support clients, meaning that in one case an ambulance had to be called for emergency mental health support and engagement with client was then lost. • Additionally, working with emergency and social care teams has been a challenge. For example, there is a lack of step-down support for **hospital discharges** and services are often given little warning of handovers so have less time to prepare and support individuals. A better process is needed that does not leave clients at risk of unsafe placements.
Insights/ Learning	• **Meeting basic needs initially helps to builds trust in services:** Services stressed the importance in meeting basic needs for clients, such as providing them with food as an engagement tool, as well as safe accommodation, and essential items such as clothing really helps to build trust and understanding in clients, and this then allows services to extend their capacity to engage and resolve other more complex needs. • **Building trust is essential:** Making regular contact with clients, being patient, providing reassurance and specific support and building rapport was essential in securing successful outcomes for those who often have a lack of trust in services. • Once a trusting relationship is established, clients are more likely to trust in services and be honest about their circumstances (i.e. provide their real names, family circumstances, if they are in debt or have relapsed) which is a key element in helping clients off the streets and to better their circumstances. • **Flexible hours:** Staff being available and flexible around client's needs is another important way of building positive relationships with clients and ensuring sustained engagement. For example, for those with substance addictions, ensuring appointments were in the morning when they were less likely to be intoxicated. • Similarly, where appointments for healthcare/support needs are missed, ensuring that these are rebooked and perhaps accompanying them to ensure they are supported and likely to attend. • **Collaboration with night/day staff is essential:** Informing and updating all staff that are working with a client on their circumstances is essential. For example, some organisations have an online IT system in which they update all information on that client each day so that when passing over to night staff they are aware of all updates and can engage with the client in a relevant way. This helps the client feel worthwhile and understood and increases trusting relationships.

	• **Meaningful activities such as social clubs and courses are hugely beneficial:** Social clubs and activities that draw on hobbies were found to be a great way to build trust and engagement in services (e.g. cookery and games nights). Additionally, enrolling clients onto courses is a great way to make best use of time where delays to ID applications and opportunities for employment may occur. • They have also been described as extremely helpful in enhancing confidence and employability skills. • **Continued support is often needed to sustain outcomes:** as clients often have multiple and complex needs, continued support once clients have moved on and been accommodated is often key in maintaining progress. • **Joint working across agencies:** Most of the case studies received reiterated the point that becoming more aware of the different agencies in their area and the support services that are available has been invaluable in getting the right support that is unique and tailored to each individual that presents to services. • Services are hoping that in developing partnerships between organisations, they will be better equipped to deal with future homeless presentations.

Appendix 2: Case Study 1

Describe the person's story at the point you started working with them.	CF is a young person aged under 25 years old, South American national with no recourse to public funds. He had no status in the UK, he had limited English and had been sleeping rough, he had recently come to the area.
What were the presenting issues when you started working with them?	He was sleeping rough and we needed to provide emergency accommodation due to Covid-19, we also needed to have options available to him as someone with NRPF.
What work did you do alongside the person?	CF was assisted with contacting the Home Office and registering an application for asylum. While this application was initially processed, we assisted CF with temporary accommodation via our Registered Providers supported accommodation project, he was placed in an emergency room.
What changes and outcomes have you and the person achieved so far?	We required somewhere safe for CF to remain while the Home Office processed the application and arranged the initial interview which would hopefully lead to an offer of NASS accommodation. As CF had no recourse to public funds, we also offered support via access to food parcels and support with his application and contact with the Home Office.
What are the person's chances of sustaining any changes and outcomes they have achieved?	CF engaged with the Registered Provider whilst temporary accommodation was provided. The outcome achieved was an offer of support including accommodation via the Home Office.
How have you helped to ensure this person has continued to engage with services?	This service was provided due to Covid-19 and implications of CF rough sleeping during this period. He continued to engage so that accommodation would be provided until the Home Office accepted his application for asylum and offered support.
What barriers did you encounter in helping the person? *Structural and /or personal.*	The accommodation offered would not usually be offered to an applicant with NRPF. Therefore, the delay in the Home Office accepting an application and not providing support including accommodation immediately does put people at risk. There was a two-week delay in the Home Office interviewing CF and subsequently offering full support and accommodation. Under normal circumstances CF would have had no support during the two-week delay.
What learning or new insights have you had as a result of the work?	Assisting customers to make asylum claims. Usually he would have been referred to the migrant centre, but during Covid-19 and places being closed it was easier for the homeless team to make the call while the customer was present. This demonstrates all the additional work by a homeless service and the support offered all customers that make contact and approach the service.
Do you feel this learning would change the way you	This was a good outcome for this young person, and it demonstrated that we have good services and working relationships with our partner agencies. The

work with a person in a similar situation needing support in the future?	Registered Provider supported CF while he was accommodated and made sure that he was safe.

Appendix 3: Case Study 2

Describe the person's story at the point you started working with them.	MW is 29 years old and is a known to the service as a rough sleeper, he has been someone that we have supported throughout the years and have been encouraging to take up accommodation. He has a history of adverse housing, offending and drug misuse.
What were the presenting issues when you started working with them?	MW came through to the service this time following a discharge from hospital. He had been in hospital for 7 weeks. He was now using a wheelchair and required accommodation that was adapted. Due to his care and support needs multiple services were required to be in place and jointly working.
What work did you do alongside the person?	We had been working with MW providing an outreach service as he was a rough sleeper, we then referred him to the Housing First project following his imminent discharge from hospital. Furthermore, due to his care and support needs Adult Social Care were and are still involved. MW was placed in temporary accommodation while suitable accommodation was sourced. This was more difficult due to his disability and care and support needs that meant that he required an adapted property. TA required OT and adult social care assessments before he was placed so this was a longer process and less suitable properties available.
What changes and outcomes have you and the person achieved so far?	MW is now engaging with Housing First. He is receiving support, for drug misuse and his disability. He has now moved from temporary accommodation into a property that will be long term and suitable for his needs and furnished.
What are the person's chances of sustaining any changes and outcomes they have achieved?	Through our assessment we hope that MW can continue with engagement with all services and the Housing First team, this will enable him to maintain his current tenancy. There are multiple services supporting MW, this will hopefully enable him to manage his drug misuse and access all support that he requires to maintain this accommodation.
How have you helped to ensure this person has continued to engage with services?	MW was identified as requiring intensive support – this has been provided via Housing First. He also now has care and support provided by Adult Social Care; this is provided 4 times per day. The fact that MW was in hospital for a period gave opportunity to put in place support services and access to Adult Social Care. Although the discharge happened quickly for someone with such needs, we managed to organise the services that were required.
What barriers did you encounter in helping the person? *Structural and /or personal.*	This was a complex case, as MW was discharged from hospital and required an adapted property. The complexities included his care and support needs that required Adult Social Care to be involved from discharge, through to temporary housing and continue while permanently housed. The homeless team took the responsibility of coordinating this. The discharge gave limited time for the homeless team to secure suitable accommodation and that is why TA was used.

	This was hotel accommodation and before he could be placed provisions via social care needed to be in place, which included aids/adaptations and a care package. For MW there was a barrier to housing (due to an adverse history) and there were further barriers due to the current discharge process and lack of step-down provision.
What learning or new insights have you had as a result of the work?	Hospital discharge is often a difficulty for HPRT, as there is little warning and subsequently some customers have multiple needs that need assessing before suitable accommodation can be found. We have been trying to work with the local hospital and Adult Social Care to look at the issues and try and consider suitable solutions. The discharge process is still something that we are working on with agencies that need to be involved in this process.
Do you feel this learning would change the way you work with a person in a similar situation needing support in the future?	We will continue to work with the discharge team and Adult Social Care and try and look at a better discharge process, looking at such cases, at the difficulties that arise. We do need a better process in place so that customers are not roofless with multiple needs. We have been trying to establish a better discharge process that does not leave customers at risk of an unsafe placement. A work in progress!

Appendix 4: Case Study 3

Describe the person's story at the point you started working with them.	H aged 19 had been sleeping rough under a bridge on a canal for approx. 3 weeks. Prior to this H had been sofa surfing since becoming estranged from his family aged 16. H has a diagnosis of Asperger's and depression, he was not in receipt of any benefits, had no bank account, no ID and no mobile phone. He was also not engaged with any other services.
What were the presenting issues when you started working with them?	H was initially reluctant to engage with the outreach team. The team went out to the canal bridge every day for 2 weeks, quite often taking him breakfast. He was also provided with a mobile phone and credit so that he could call the team at any point if he wanted help (both funded via Lot D). Slowly H started to respond to the team and the team were able to encourage him to access the Youth Hub and support to obtain accommodation.
What work did you do alongside the person?	H was accompanied to the Youth Hub and supported to complete a Housing Needs Assessment. He was then accommodated in the services direct access accommodation, supported to access other support services, obtain ID and taken shopping to buy essential items (both funded via Lot D). He was also supported to apply for Universal Credit and open a bank account. Once settled H was then referred to the Employability team.
What changes and outcomes have you and the person achieved so far?	H still remains in direct access accommodation and his Progression Coach is now working closely with him to identify a long term move on option for him. H is now registered at a doctors, has a bank account, is in receipt of Universal Credit and has a birth certificate as a form of ID. H has also recently completed our You Can course and obtained a Level 1 qualification. He has also been supported to create a CV.
What are the person's chances of sustaining any changes and outcomes they have achieved?	H engages positively with support and we have seen his confidence increase a lot over the last 2 months. He is really keen to now find full time employment and is actively seeking work. Although apprehensive to move out of the direct access accommodation, which provides 24-hour support, we are confident that he will continue to move forward positively when he moves in to long term accommodation with support from the Lead Worker service.
How have you helped to ensure this person has continued to engage with services?	We were able to use the WMCA RSI funding to help build a relationship with H, whether that was to buy breakfast during initial engagement or buy his mobile phone so he could keep in regular contact. So that H was able to access the You Can project he was provided with a laptop. This ensured he was able to complete distance learning and also keep in contact virtually with his Employability Coach.
What barriers did you encounter in helping the person? *Structural and /or personal.*	There were challenges engaging with H in the beginning which we believe were mainly down to lack of trust. In the initial stages H also gave us the wrong name for himself which only came to light when trying to apply for this ID and register him at the doctors. It took some time building a trusting relationship with him

	before he was able to share with us that the name he had provided was incorrect.
What learning or new insights have you had as a result of the work?	Being able to use food as an engagement tool worked well in the beginning to try and build up our relationship. Also being able to take H shopping to buy essential items and clothing of his choice made him feel valued. This also supported with relationship building rather than handing over a bag of donated secondhand items.
Do you feel this learning would change the way you work with a person in a similar situation needing support in the future?	This case study is a clear example of how the outreach team work with all young people in similar situations where possible. We know that having access to funds as an engagement tool as above is beneficial and works.