West Northamptonshire Health and Wellbeing Board

A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Jeffrey Room, Guildhall, Northampton, NN1 1DN on Monday 11 December 2023 at 9.30 am

Agenda

1.	**Apologies for Absence and Notification of Substitute Members - Chair**
2.	**Notification of Requests to Address the Meeting - Chair** The Chairman to advise whether any requests have been received to address the meeting.
3.	**Declarations of Interest - Chair** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
4.	**Chair's Announcements - Chair** To receive communications from the Chair.
5.	**Minutes of previous meeting 28th September** (Pages 5 - 14) To confirm the Minutes of the meeting of the Board 28th September
6.	**Voluntary Sector Spotlight - Re:store - Anya Willis** (Verbal)
7.	**Live your best life domains: Employment that keeps them and their families out of poverty:** (Presentations) • Health Skills and employment data – Sally Burns • Delivery Plan and Scorecard – Sally Burns • Debt and money advice – Belinda Green • West Northamptonshire PLACE Vision – Louis Devayya • Adult Learning – Teresa Humpage • Anchor Institution – Sadie Beishon

8.	**Better Care Fund Quarterly Report - Ashley LeDuc** (Pages 15 - 40)
9.	**Joint Health and Wellbeing Strategy Delivery Plan and Scorecards - Sally Burns** (Presentation)
10.	**Local Area Partnerships Update** (Verbal)
11.	**Children and Young People Needs Assessments: - Racha Fayad** (Pages 41 - 68)
12.	**Any Other Business - Chair** (Verbal)
13.	**Close meeting - Chair**
14.	**Reports for information:** (Pages 69 - 316) • Suicide Prevention Strategy Action Plan • Rough Sleeping Needs Assessment

West Northamptonshire Health and Wellbeing Board Members:

Councillor Matt Golby (Chair)

Councillor Fiona Baker
Dr Jonathan Cox
Sally Burns
Colin Foster
Russell Rolph
Colin Smith
Dr Andy Rathbone
Professor Jacqueline Parkes
Dr Philip Stevens
Dr Santiago Dargallonieto
Heidi Smoult
Miranda Wixon
Chief Superintendent Rachel Handford
Councillor Jonathan Nunn
Anna Earnshaw
Naomi Eisenstadt
Stuart Lackenby
Toby Sanders
Michael Jones
Councillor Wendy Randall
Wendy Patel
Dr David Smart
David Maher
Robin Porter
Carella Davies

Information about this Agenda

Apologies for Absence
Apologies for absence and the appointment of substitute Members should be notified to cheryl.bird@westnorthants.gov.uk prior to the start of the meeting.

Declarations of Interest
Members are asked to declare interests at item 2 on the agenda or if arriving after the start of the meeting, at the start of the relevant agenda item

Local Government and Finance Act 1992 – Budget Setting, Contracts & Supplementary Estimates
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Queries Regarding this Agenda
If you have any queries about this agenda please contact Cheryl Bird, Health and Wellbeing Board Business Manager via the following:

Tel: 07500 605450
Email: Cheryl.Bird@westnorthants.gov.uk

Or by writing to:
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Northampton
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WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD
Minutes of the meeting held on 28th September 2023 at 1.00 pm
Venue: Council Chamber, The Forum, Towcester

Present:

Councillor Matthew Golby (Chair)	Cabinet Member for Adults, Health and Wellbeing, West Northamptonshire Council
Anna Earnshaw	Chief Executive, West Northants Council
Chief Superintendent Rachael Handford	Northamptonshire Police
Cllr Fiona Baker,	Cabinet Member, Childrens and Families, West Northants Council
Hannah Scanlon - substitute	Office Manager, LMC
Michael Jones	Divisional Director, EMAS
Miranda Wixon	Chair VCSE Assembly
Naomi Eisenstadt	Chair, NHS Northamptonshire Integrated Care Board
Polly Grimmett - substitute	Director of Strategy, Northampton General Hospital
Sally Burns	Director of Public Health, West Northants Council
Sean Carter	Strategic Manager for Safeguarding and Quality Assurance, Northamptonshire Childrens Trust
Stuart Lackenby	Deputy Chief Executive, West Northants Council
Toby Sanders	Chief Executive, NHS Northamptonshire Integrated Care Board

Also, Present

Alex Copeland, Chief Executive, Hope Centre
Annapurna Sen, Public Health Physician Health Protection, West Northants Council via Teams
Cheryl Bird, Health and Wellbeing Board Business Manager
Chloe Gay, Public Health Specialist, West Northants Council
Chris Holmes. Chief Executive, Northamptonshire Sport
Deborah Mbofana, Public Health Principal, West Northants Council
Declan Ryan, Senior Lecturer Exercise Physiology, University of Northampton
Emilie Vasasour, LAP Project Lead
Jackie Brown, Northamptonshire Sport
Julie Curtis, Assistant Director PLACE Development, West Northants Council
Justine Horrocks, LAP Project Lead
Michelle Grimwood, LAP Project Lead
Peter Cox, Head of Sport Leisure and Culture, West Northants Council
Peter Jones, Chair, Northamptonshire Sport
Rachael Byrne, LAP Project Lead
Sarah Hayle, Chief Executive, Community Law Service
Scott Bradley, Head of Science, University of Northampton

55/23 Apologies

Carella Davies, Chief Executive, Daventry Volunteer Centre
Cllr Jonathan Nunn, Leader, West Northants Council
Cllr Wendy Randall, Labour Group Leader, West Northants Council
Colin Foster, Chief Executive, Northamptonshire Childrens Trust
Colin Smith, Chief Executive, LMC
David Maher, Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust
David Peet,
David Smart, Chair Northampton Health and Wellbeing Forum
Dr Andy Rathborne, Primary Care Network
Dr Philip Stevens, GP, Chair Daventry and South Northants GP Locality
Dr Santiago Dargallonieto, Chair, Northampton GP Locality
Heidi Smoult, Chief Executive, Northampton General Hospital
Professor Jacqueline Parkes, Professor in Applied Mental Health, University of Northampton
Rebecca Wilshire, Director of Childrens Services, West Northants Council
Robin Porter, Assistant Chief Fire Officer, Northants Fire and Rescue
Russell Rolph, Chief Executive, Voluntary Impact Northamptonshire

56/23 Notification of requests from members of the public to address the meeting

None Received.

57/23 Declaration of members' interests

None received.

58/23 Chairs Announcements

David Peet will replace Nicci Marzec as the Office of Police Fire Crime Commissioner representative.

59/23 Community Training Partnership

The Chief Executive, Hope Centre introduced the formal launch of the Community Training Partnership (CTP). This partnership is a collaboration between West Northants Council (WNC) and Community Law Services. The CTP will host courses aimed at front line workers, helping those in the community who may be struggling or facing hardship.

The Chief Executive Community Law Service advised the CTP is delivering bite sized virtual sessions, with 10 sessions delivered so far and 18 more scheduled before Christmas. Currently 370 people have signed up through the CTP portal. The courses cover a wide range of topics such as mental health, substance misuse, debt advice and benefits. 100% of attendees have rated the tuition as excellent or good, 100% said the courses were valuable to their job and 89% said it improved their ability and confidence in making effective referrals.

RESOLVED that all are asked to consider the training needs of their front-line workers and promote the CTP across West Northamptonshire.

60/23 Minutes and actions from the previous meeting 27th July 2023

RESOLVED that:

- **The minutes from the previous meetings held on the 27th July were agreed as an accurate record.**
- **Findings from the Homelessness Needs Assessment are awaiting final approval before being circulated to the Board.**

61/23 Better Care Fund Quarterly Report

The Deputy Chief Executive advised there is a statutory requirement for the Better Care Fund (BCF) to submit performance against the BCF Plan on a quarterly basis through this Board. The submission template has only just been received and must be submitted before the 31st October. The Deputy Chief Executive requested that delegated authority be given to the Chair to review the performance report on behalf of the Board, before submission by the 31st October. Currently submission dates for performance against the BCF Plan do not correlate with Board meetings dates, these will be reviewed for 2024 to try and get an alignment.

RESOLVED that:

- **The Board agreed to give delegated authority to the Chair to review the BCF Quarterly Performance Report before submission.**
- **The BCF Quarterly Performance Plan to be presented at the next meeting.**

62/23 Live your best life domains: Opportunities to be fit well and independent:

The Chair advised the Live Your Best Life (LYBL) thematic theme for this meeting is Opportunities to be fit well and independent, focusing on the active lives element of this ambition.

The Public Health Principal gave an overview of physical activity and highlighted the following:

- Physical activity is not just about gyms and leisure centres, it incorporates everyday activities such as gardening, housework and walking. Creating active lives is about getting people more active, as 1-6 deaths can be related to a person being inactive.
- The benefits of undertaking physical activity can also include community cohesion, social networks, volunteering, feeling of belonging to the community and increasing levels of social trust.
- National guidance is for adults to have 150 minutes moderate exercise or 75 minutes vigorous intensity activity each week. For children it is an average of 60 minutes a day physical activity.
- 60.4% of the adult population across West Northamptonshire completes 150 minutes+ activity a week, 10.7% are fairly active 30-149 minutes a week, 28.9% of individuals undertake less than 30 minutes activity a week.
- Although trends for physical activity for West Northamptonshire have increased, they are still below the national and regional averages. Activity rates for children are above the regional and national averages.
- People from low-income households are 20% less likely to be active than those from higher income households.
- Over 50% of adults aged 75+ are inactive, which is a challenge due to an ageing population. It is important to encourage physical activity early in life with the aim that this will continue throughout the life course, helping to achieve the best possible health and

wellbeing outcomes for older people and supporting them to stay independent for as long as possible.

- Disabled adults are almost twice as likely as non-disabled people to be physically inactive. People from ethnically diverse communities are half as likely to be active as those from white British backgrounds.
- Promotion of physical activity as a positive behaviour, impacts most of the LYBL ambitions, as well as supporting interventions towards emerging priorities across the Local Area Partnerships (LAPs).
- Local champions can be upskilled to deliver activities and clubs in the community, which could help reduce anti-social behaviour. Well Northants Community Workers can assist with identifying local champions and Northamptonshire Sport (NSport) train volunteers as well as assisting in the building of networks and community clubs in deprived areas.
- There are challenges about how to work together to share outcomes.
- A Physical Activity Pathway review is being conducted in collaboration with NHS Northamptonshire Integrated Care Board.

The Chief Executive NSport gave an overview of the Active Lifestyles Framework and highlighted the following:

- NSport is one of 42 active partnerships established across the country by Sport England with the aim to get more people active. NSport became a charity in 2020.
- United in Movement, is a 10 year strategy launched by Sport England in 2021 and places inequalities at the heart of Sport England's strategic view. Using a systemic PLACE based approached from the ground up, working with local communities to create the interest in physical activity at the heart of communities.
- The Department for Culture Media and Sport have released their strategy, 'Get Active'. This Strategy concentrates on groups in society that need additional help and support, with more resource shifted towards these cohorts to help overcome the barriers they face in being active. Sport England are required to allocate a third of their budget to working with these groups, with a target being set for 2.5 million adults and 1 million children being moved from inactive to active by 2030.
- The Active Lives Survey is commissioned annually by Sport England where 180k people nationally, including 1k in Northamptonshire are surveyed on their physical activity.
- The Active Lifestyles in Northamptonshire Framework is a countywide strategy and will be facilitated and driven by NSport, with shared ambitions and measures to track progress of the strategy.
- The shared ambition of the Framework is that by 2028, healthy active lifestyles will be an integral part of all people's lives in Northamptonshire, irrespective of background, race, age, gender or geography.
- The Framework highlights 6 enablers of physical activity through a life course, as activity in younger years, might not be suitable for when people are older.
- There is good work taking place in schools and early years settings to encourage activity.
- A good environment will help make activity choices easier such as cycle lanes, tracks, parks, leisure centers with bespoke easy to access opportunities that suit current lifestyles, as circumstances in people's lives are constantly changing.
- Integrating physical activity into services, systems and places will make it easier to be active on a daily basis, as well as communicating consistent messages about the benefits of an active lifestyle to enable sustained behaviour change.

The Head of Sport, Leisure and Culture gave an update on the development of the WNC Active Lives Strategy and highlighted the following:

- The core purpose of developing this strategy is to increase activity in residents, with the initial challenge to ensure this is connected to the countywide Framework.

- A working group will start the mapping process before the co-production work begins. Part of the initial work will be to look at mitigating the fear that physical activity is unachievable for some people.
- There is a need to have safe and clean streets, as well as accessible green spaces to encourage physical activity.
- A wider determinants of health 'Active Lives' workshop was held including representatives from Public Health and Communities and Opportunities Teams. At the workshop attendees were asked 'how can we connect on a personal level and on a workplace level to create more active lifestyles;. The key messages from the workshop were that active lives plays a key role in the shaping of place, with a need to create more opportunities for people to be active. The workshop discussed the assets and infrastructures already in place, and the ability to improve on these and create better spaces for people to be more active, including improved engagement.
- The aim of the Active Lives strategy is to combine the work partners are completing rather than working in silo, being underpinned by an evidence base.
- The aim is to reach people who don't understand the benefits of increased physical activity and create organisational behaviour change within WNC, by influencing system change and connecting how partners work together.

The Board discussed the presentations and the following was noted:

- Concerns were raised about how sport is taught in schools, as not all children enjoy these experiences and could dissuade children from participating in physical activities during their life course.
- Providing information on standing and sitting for long periods of time can help with the promotion of being active and mobile to live happier healthier lives.
- There is a need to consider how activity can ease social isolation and loneliness. Carers are a big support network who can encourage those they care for to be more active.
- Integrated Care Systems have a 4th aim 'helping the NHS to support broader social and economic development'. There is a need to consider this more ambitiously about how Board members as employers can support their workforce to become more active during and out of work.
- There is a need to maximise opportunities to enable patients within local hospitals to undertake activities to build their strength, as well as those in communities with long term conditions where physical activity could help manage their condition.
- The VCSE Assembly are creating a Sports Thematic led by the Chief Executive NSport, with the aim for this work to be embedded into the LAPs.
- Organisations will need to consider how they can contribute to each element of the Framework.

The Chief Executive NSport gave an overview of NSport's PLACE approach and highlighted the following:

- Through data and intelligence mapping 7 hotspots were identified across Northamptonshire, NSport have a place lead working 2 days a week in each hotspot.
- This is an asset based approach with 4 elements, insight, identify, connect and mobilise, working with communities to build trust, suggesting ideas and opportunities for these communities.
- Measurement of success is via a Hotspot Maturity Matrix, whether residents were feeling more confident about physical activity, and are more clear about how they could be more active in community areas.
- Some of the learning is understanding the characteristics of these local areas, working in smaller population areas of between 4k-20k and to recruit local champions.
- The next steps is to continue to work with the existing hotspots, consider new hotspots and how they can align with other projects such as Well Northants.

The Senior Lecturer Exercise Physiology gave an overview of the Active Quarter and highlighted the following:

- The Active Quarter started as a partnership of early adopters, to encourage residents to use the local green spaces and is currently focusing on the South of Northampton Town centre.
- The aim of the Active Quarter is to bring residents together to enjoy outdoor space, by using a partnership approach to understand the mutual benefits for health, economic growth, tourism and education
- Public Health England recognise the value of green space in local communities for health and wellbeing. A sense of belonging and pride in the community is also crucial to improved wellbeing.
- Access needs to be prioritised to those communities that are experiencing unequal access.
- The World Health Organisation has a Urban Green Spaces brief for action, which contains recommendations for a whole system approach, ensuring that green space feeds into all services.
- There is a need to understand the needs and wants of residents in designing interventions and green spaces, which will be more sustainable when incorporating stakeholders from different sectors.
- Natural England (2023) Green Infrastructure Framework provides a process journey for local authorities to follow, which the Active Quarter partnership is using to guide strategic planning.
- Community and elected member partnerships are being built upon to ensure there is 'end-user' representation, a strategy for the Active Quarter will be co-produced, so decision-making is informed by community wants and needs.
- The aim is to focus on the top 20% most deprived communities, ethnic groups, women and girls and those suffering disabilities who tend not to use green spaces and live within a 15 minutes' walk of a green space.
- There are the following ambitions:
  - PLACE - the core infrastructure within the area, looking at the physical access to green spaces such as trails, tracks and rights of way; cycling and walking; seating; use of the lakes. A 3km walking route has been created in Delapre Abbey in conjunction with NSport funded by University of Northampton (UoN) as a research project to help local people to explore their green spaces. More table tennis tables and benches have been added at UoN Waterside Campus. Audits have been completed around the Brackmills estate to assess access for cycling and walking.
  - Identity - communication, marketing, information and messaging required to create an identity, perception, sense of civic pride and shape a place. £5k of funding has been received to develop a website for the Active Quarter. There is a need for residents to get involved and have a shared responsibility in developing green spaces within the town. A map has been developed to help identify what opportunities that are available in the area.
  - People - the way people use the place and engage in activities set up within the area. The Thriving People Social Prescription project has been developed at Delapre Abbey funded by Arts Council England. The National Academy for Social Prescription and Natural England are using the Delapre Wellbeing Hub as an exemplar of sustainable partnership working to deliver programmes. UoN conducts interviews with those visiting Upton Country Park, Hunsbury Hill and Delapre Abbey to find out why they used these spaces. There will be an online consultation around cycling and walking social prescription programme launched once the footpaths are upgraded. The findings from the consultation will be fed back into the community. There will be a co-produced 'Thriving Communities' Social Prescribing project in partnership with the General Practice Alliance.
- The next steps are to:

- Redevelop 19th Century stable block at Delapre Abbey to a Wellbeing Hub. Northamptonshire Community Foundation are establishing a Active Quarter Fund that local groups can bid into to support local projects that promote activity, wellbeing and connecting communities.
- Develop a suite of research that provides Active Quarter partners with evidence base intelligence.
- Align the Active Quarter with the local Integrated Care System, Health & Wellbeing Forums and LAPs.
- Align the Active Quarter with WNC strategic plans, such as Sport and Leisure, Community Safety and Community Engagement, Regeneration, Economic Growth, Parks and Open Spaces, and Highways.

RESOLVED that:

- **An update on being active will be brought back to a future meeting.**
- **The Board endorsed 'Move Northamptonshire' as the key system-wide Framework for active lifestyles, physical activity and sport across the county.**

63/23 Joint Health and Wellbeing Strategy

The Director of Public Health gave an update on the Joint Health and Wellbeing Strategy (JHWBS) and highlighted the following:

- The Health and Care Act 2022 requires all Health and Wellbeing Boards to develop and deliver a Joint Local Health and Wellbeing Strategy.
- The engagement process in development of the Strategy has included elected members sessions, WNC Cabinet, communities and residents.
- Feedback from the final public consultation has been incorporated into the Strategy, making the document more accessible and strengthened the references to active travel.
- The Strategy articulates how this Board will improve the health and wellbeing of residents in West Northamptonshire, as well as focusing on health inequalities.
- The Strategy aligns with the Integrated Care Northamptonshire (ICN) Strategy, and NHS Northamptonshire 5 Year Forward Plan and how this can be delivered at a place level by focusing on the wider determinants of health.

RESOLVED that:

- **Delivery plans for the Joint Health and Wellbeing Strategy to be presented at the next meeting.**
- **The Board endorsed the final Joint Health and Wellbeing Strategy.**

64/23 Local Area Partnership Project Leads

The Assistant Director PLACE Development advised 4 LAP Project leads and 2 LAP administrators are now in post, with one further LAP Project lead to start in October. The LAP Project Leads will create a delivery plan for each LAP to understand the need in their communities and identify health inequalities which will underpin the JHWBS and ICN Strategy. Chatty Cafes are now being introduced into LAP areas, with some walking groups becoming a spin off from some of these.

RESOLVED that the Board the Board noted the update.

65/23 Health Protection Committee Annual Report 2022/2023

The Public Health Physician Health Protection gave an update on progress of the Health Protection Committee 9 strategic priorities agreed in 2022 and highlighted the following:

- Immunisation
  - There has been decline in childhood vaccinations including seasonal flu vaccination in 2- and 3-year-olds, preschool boosters, and HPV in 12–13-year-old females, which were below national targets.
  - Seasonal flu vaccination local coverage reduced in all adult cohorts apart from pregnant women. In addition, Shingles and all seasonal flu adult cohorts, except over 65s, were below the national targets.
  - The system will be supported to increase uptake in the childhood and adult immunisation programmes across the county area, maintaining COVID-19 vaccination rates, as well as a measles elimination plan.
- Screening
  - There was a drop in the take up of cervical screening amongst 24–49-year-olds.
  - Cervical and Breast screening did not meet the national targets.
  - The uptake of Bowl screening dropped, but has met the national target.
  - AAA and diabetic eye screening are below the national targets.
  - The system will be supported to increase uptake in the screening programmes across the county area.
- Infection, Prevention and Control
  - There was an increase in C Diff rates in both Acute hospitals.
  - There was a small increase in Syphilis diagnosis rate during the year.
  - The System will be supported to:
    - Continue delivery of consistent IPC compliance, risk assessment and training in high-risk settings. Care homes, nursing homes and SEND schools.
    - Reduce rates of C Diff in both Acutes.
    - Contribute a further reduction in the diagnosis rates of Syphilis.
    - Contribute to initiatives and measures that support the reduction of COVID-19 cases, including good COVID-19 vaccination uptake.
- Tuberculosis (TB)
  - There was a reduction in starting timely treatment within 4 weeks for TB.
  - The number of TB cases offered HIV test is lower than the national average.
  - The system will be supported to:
    - Improve proportion of people starting treatment within 4 months of diagnosis.
    - Deliver the countywide latent screening programme to people from high-risk countries who have lived in the county for the last 5 years.
- Blood Borne Viruses
  - HIV testing rates are lower than the national average. Late diagnoses of HIV is above the national and regional averages.
  - There was a rise in hospital admissions due to Hepatitis B related liver disease/cancer, and a reduction in people entering drug misuse treatment accepting Hepatitis B vaccination.
  - Increase in Hepatitis C (Hep C) rates, and mortality rate from Hep C related liver disease / cancer remains higher than the regional and national averages.
  - The system will be supported to:
    - Maintain improvements to HIV testing and diagnoses to prevent the increase in late diagnoses rates and to support achieving regional and national averages.
    - Improve Hepatitis B vaccination uptake in people under substance misuse treatment.
    - Support work that contributes to reducing hospital admissions due to Hepatitis B and Hepatitis C

        - ❖ Prioritise follow up care of people newly diagnosed with Hep C to contribute to reducing mortality rates from Hep C related disease/cancer
        - ❖ Reduce rates of Hep C.
- Environmental Health
    - ➢ Mortality due to air pollution is higher than national and regional averages.
    - ➢ The system will be supported to carry out an air quality health needs assessment to identify issues in poor air quality areas.
- Outbreak Management
    - ➢ The System will be supported to:
        - ❖ Update and localise the systemwide outbreak management plan which are sufficiently resourced.
        - ❖ Review the MoU between LHRP partners and the local authorities, to include the management of cross border incidences.
- Training and Campaigns
    - ➢ Continue to work with organisations and groups representing high-risk groups, delivering education and media campaigns that improve immunisation and screening across the system, and deliver professional updates to the workforce.
- Addressing Health Inequalities
    - ➢ Continue to address inequalities by engaging with groups with poor health and social outcomes in deprived areas, high risk populations and those experiencing inaccessibility.

The Board discussed the update and the following was noted:

- Administering of COVID19 and flu vaccinations have been brought forward due to the rise in COVID19 cases. There will be a wellbeing campaign to promote the uptake of vaccinations and the Outbreak Management Plan is being refreshed. Infection Prevention Control are working with lots of different settings to minimise risk.
- There are some highly urbanised areas of West Northamptonshire where there are concerns about poor air quality.
- Work is taking place in Northampton Central LAP on high rates of CPOD rates.

RESOLVED that the Board noted the progress against the priorities endorsed the recommendations contained within the Health Protection Committee Annual Report.

66/23 Any Other Business

The Northamptonshire Care Record has now gone live, which will enable information to be shared appropriately with clinicians in different settings across the county.

There being no further business the meeting closed at 3.30 pm.

WEST NORTHANTS
Health and Wellbeing Board
live your best life

West Northamptonshire Health and Wellbeing Board Action Log

Action No	Action Point	Allocated to	Progress	Status of Action

Actions completed since the 28th September 2023

Action No	Action Point	Allocated to	Progress	Status of Action
270723/02	Feedback from the Homelessness Needs Assessment to be circulated to the group	Rhosyn Harris	On the agenda 11th Dec	Completed
280923/01	The BCF Quarterly Performance Plan to be presented at the next meeting.	Ashley Leduc	On the agenda 11th Dec	Completed
280923/02	Delivery plans for the Joint Health and Wellbeing Strategy Delivery Plan to be presented at the next meeting.	Sally Burns Karen Spellman	Circulated 29th September	Completed
280923/03	Presentations from the meeting to be circulated to the Board	Cheryl Bird	Circulated 29th Sept	Completed

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

11th December 2023

Report Title	**BCF Quarter 2 Update**
Report Author	**Michael Hurt, Better Care Fund Service Manager, West Northants Council**

Contributors/Checkers/Approvers		
Other Director/SME	Stuart Lackenby	1st December 2023

List of Appendices

Appendix A – BCF Quarterly return

1. Purpose of Report

1.1. Health and Wellbeing Board to approve quarter 2 update (prior approval of chair for submission)

1.2. To update the Health and Wellbeing Board on the progress of the BCF

2. Executive Summary

2.1 The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

2.2 The policy framework, published on April 4th, 2023, confirmed the conditions and funding for the BCF for 2023/25.

2.3 The BCF plan and schemes for 2023/25 were submitted and approved as complying with the conditions of the 2023/25 grant on 28th June 2023.

2.4 The regional BCF lead asked to put forward the WNC BCF submission as a national exemplar.

2.5 The Health and Wellbeing Board are required to approve the BCF Quarter 2 Return (prior approval of the chair sought for submission).

3. Recommendations

3.1 It is recommended that the West Northamptonshire Health and Wellbeing Board:

a) Approve the Quarter 2 submission

b) Note the BCF update

4. Report Background

4.1 BCF national reporting for 2023/24

The national conditions for the BCF for 2023 to 2025 are:

1. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
3. implementing BCF policy objective 2: providing the right care, at the right place, at the right time
4. maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

4.2 Until now, WNC was required to submit fortnightly BCF returns and monthly BCF returns. From 11th December, the returns will be monthly. Each quarter, a further report with more detail is required. This report is for the quarter 2 submission. Quarter 3 will include additional data requirements and will be required to be submitted at the end of January 2024.

5. Issues and Choices

5.1 There have been some issues about timely and accurately recorded data. NHS brokerage is now being delivered by WNC in a joint approach. However the correct coding wasn't always being applied and therefore numbers were reported lower than anticipated. In the short term, averages based on expected activity were used and later corrected. These issues seem to have been resolved now.

5.2 Falls were higher than planned activity in Q1 with 541 reported falls vs 431 planned. There are plans to have a better coordinated approach across the system and how to best manage performance against BCF and other targets associated with injurious falls of people 65+. Public Health are leading a group that involves commissioners, occupational therapy and assistive technology leads. The work will focus on upstream falls prevention initiatives.

5.3 All other areas are on track.

5.4 Reviews of schemes are taking place and a Health Equity Assessment Tools (HEAT) are being completed for each scheme as it is reviewed.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 Please see appendix A for the breakdown of schemes and the financial allocation.

6.2 **Legal**

The council constitution makes provision for working groups to undertake activity on behalf of the board.

6.3 **Risk**

6.3.1 None.

6.4 **Consultation**

6.4.1 No consultation was required.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 The report has not been considered by Overview and Scrutiny.

6.6 **Climate Impact**

6.6.1 There are no known direct impacts on climate because of the matters referenced in this report.

6.7 **Community Impact**

6.7.1 There were no distinct populations that were affected because of the matters discussed in this report, however those that access care and health services more frequently than the general population were impacted more by any improvements associated with activity undertaken.

7. Background Papers

7.1 As per appendixes

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Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	West Northamptonshire
Completed by:	Ashley Leduc
E-mail:	ashley.leduc@westnorthants.gov.uk
Contact number:	07912 891860
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: West Northamptonshire

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	
Confirmation of National Conditions	
National Conditions	**Confirmation**
1) Jointly agreed plan	Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes

If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:

Checklist
Complete:
Yes
Yes
Yes
Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: West Northamptonshire

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	220.0	220.0	220.0	220.0	241.5	On track to meet target	We have increased our 2hr UCR Capacity to mitigate increase in demand but this is through non recurrent funding at this stage which can make recruitment challenging. Failure to recruit coupled with unplanned rise in covid / flu sickness would impact delivery	Extended use of remote monitoring joint solution across healt and social care; increase in support roup provision for persons living with complex long term conditions	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.0%	95.0%	95.0%	95.0%	94.33%	On track to meet target	None	Additional workers have been put in place to undertake meet and greets with patients which has supported more people to return home. This is in addition to the Home based discharges services built into the BCF	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,739.7	541.2	Not on track to meet target	None	We have funded and implemented use of Riazer Chairs across several care homes and trained LA reablement staff in their use supported by guided clinical decsion making App. This is proving to significantly reduce	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				470		On track to meet target	Please note: This indicator is cumulative Population within scorecard Q1 (79/77,713*100,000) = 102 Q2 (177/77,713*100,000) = 228 Num/Dom within plan is as follows	Through BCF Funded schemes, specifically ASC Discharge Funding, we have built additional capacity to support reablement and recovery opportunities for more people. This has enabled us to maximise home	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				81.8%		On track to meet target	Q1 = 85.3% (81/95*100) Q2 = 73.9% (147/199*100) Improvements to Num/Dom are beginning to show for Q2.	Through BCF Funded schemes, specifically ASC Discharge Funding, we have built additional capacity to support reablement and recovery opportunities for more people. This has enabled us to maximise home	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: West Northamptonshire

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
We have continued to carefully monitor and review our initial plan against actuals and found this to be generally on track. There have been some changes to demand profiles as result on industrial action and we have	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
Our profiles already factored in for seasona variation and we believe that we will remain on track against these.	Yes
Capacity:	
We are focusing on increasing our proactive care approaches to better support known patients living with complex long term conditions to reduce frequency of escalation and conveyance. This will include further 50 p	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
There is little change from the figures provided in the previous return.	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Our capacity concerns relate to workforce, both our ability to commit to recruiting to permanent posts against non-recurrent funding sources and second risk of covid / flu wave increasing staff sickness levels short ter	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
There is a data blip relating to reablement performance in July which presents a low metric outcome. We are investigating this issue and will correct once error identified. We are working to maximise our Northamptor	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
We are committed to removing delays across our bed base and minimising exit delays from P2 provision will support greater flow along with reducing length of stay. We will continue to improve our productivity to further mitigate.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Complete:

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: West Northamptonshire

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	-6	-6	-6	-6	-6	-6	-6	-6	-6	-6
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Capacity - Hospital Discharge		Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing				
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	1625	1607	1654	1567	1615	153	158	158	143	158	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	281	287	292	282	287	281	287	292	282	287	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	69	71	71	66	71	63	65	65	60	65	0	0	0	0	0

Checklist

Complete:

Yes
Yes
Yes
Yes

Demand - Hospital Discharge		Prepopulated from plan:					Please enter refreshed expected no. of referrals:					
Pathway	Trust Referral Source	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	**Total**	**1625**	**1607**	**1654**	**1567**	**1615**	**153**	**158**	**158**	**143**	**158**	
	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1625	1607	1654	1567	1615	153	158	158	143	158	Yes
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**281**	**287**	**292**	**282**	**287**	**281**	**287**	**292**	**282**	**287**	Yes
	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	281	287	292	282	287	281	287	292	282	287	Yes
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Short term domiciliary care (pathway 1)	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**69**	**71**	**71**	**66**	**71**	**69**	**71**	**71**	**66**	**71**	Yes
	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	69	71	71	66	71	69	71	71	66	71	Yes
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	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes

Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**52**	**50**	**53**	**50**	**51**	**52**	**50**	**53**	**50**	**51**	Yes
	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	52	50	53	50	51	52	50	53	50	51	Yes
	(blank)											Yes
	(blank)											Yes
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: West Northamptonshire

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:					Checklist Complete:
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	Monthly capacity. Number of new clients.	25	25	25	25	25	25	25	25	25	25	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	534	552	560	506	560	555	584	592	534	592	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	15	15	15	15	15	15	15	15	15	15	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	25	25	25	25	25	25	25	25	25	25	Yes
Urgent Community Response	534	552	560	506	560	555	584	592	534	592	Yes
Reablement & Rehabilitation at home	15	15	15	15	15	15	15	15	15	15	Yes
Reablement & Rehabilitation in a bedded setting	3	3	3	3	3	3	3	3	3	3	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	Yes

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

11th December 2023

Report Title	**Children and Young People Health Needs Assessment**
Report Author	**Racha Fayad – Public Health Principal**

Contributors/Checkers/Approvers		
Other Director/SME	Sally Burns, Director of Public Health	1st December 2023

List of Appendices

Appendix A – Children and Young People Health Needs Assessment Summary

1. Purpose of Report

1.1 The purpose of this HNA is to provide a snapshot of the health and wellbeing needs of children, young people aged 0-19, and up to 25 where there's a statutory responsibility and their families.

1.2 The report captures what are the current needs of this population across WNC, highlight the existing offer provided by the council whilst also understanding the impact of COVID-19 pandemic and the cost-of-living crisis on children and their families. The objectives of the health needs assessment report is to:

1.3 The objectives are to:

- Review the current model of 0-19 services delivery across WNC and NNC
- Identify opportunities to improve, integrate and re-align local provision to better meet the needs of this population
- Make recommendations to commissioners and policy makers based on the findings and conclusion of the HNA to develop more effective and efficient services, reduce inequalities and help meet the national targets for the HCPO programme

2. Executive Summary

2.1 This health needs assessment takes a life course approach to children and young people's lives and is divided into 7 main chapters starting with Demographics, Maternal and Infant Health, Early Years, Primary School age, Secondary school age, Transition to Adulthood and Engagement and Insights. The following recommendations are based on the findings of the health needs assessment and consultation and engagement that was undertaken with stakeholders, children, young people, and their families earlier in May-June 2023.

2.2 These findings (see below in Recommendation section) will inform the future commissioning of the 0-19 services across WNC and NNC particularly after the split into two unitary authorities and will provide us with a snapshot of the needs across both areas.

3. Recommendations

The key strategic findings of this health needs assessment are:

1- In reviewing the 0-19 service currently provided as a county-wide offer, there has been recognition of the need to develop a new service model and service specification with a greater emphasis on a whole family approach, reflecting the need of making prevention and early intervention everyone's business to support children, young people, and their families with a focus on existing universal services.

2- There is a wide variation in the needs of children and young people across WNC and NNC as shown by the epidemiological data. The 0-19 service must ensure that resources (including workforce) are targeted to meet the needs of children and families most in need, whilst at the same time maintain universal offer. This also include working on a locality basis, aligning with local area partnerships, and restructuring the service workforce to increase capacity and meet the needs identified.

3- Lack of early help services across WNC and NNC. This was identified as the underpinning cause of many significant gaps identified through this health needs assessment. It also means that services are being overwhelmed dealing with complex cases and crisis due to the lack of prevention and early intervention practice across the system. The need to invest in early help and preventative services was evident across the HNA and the stakeholder engagement to prevent the escalation of need and embed prevention and early intervention approach across our integrated way of working across the system.

4- Improve partnership working, join up and integration across the system to meet the needs of children, young people and their families living in West Northamptonshire and North Northamptonshire. It was clear from the stakeholder consultation that partnership working across the system have improved in the last 2 years, however it still needs to be more integrated. This includes making decisions on commissioning for new services, the co-location of services, improved understanding of services, closer relationships, and information sharing.

5- The development of clear pathways of support for services available for children, young people and families was highlighted as being unclear. It was agreed that support pathways for children and families should be accessible and easy to understand and navigate. It was also agreed that we need to map the existing service provision alongside the referral pathways to enable the workforce and frontline workers to signpost appropriately.

4. Report Background

4.1 The foundations for virtually all aspects of human development – physical, intellectual, emotional, and social – are established in early childhood. It is therefore important that every child can have the best start in life. Building resilience and reaping the maximum benefits from education are important markers for good health and wellbeing throughout life (Source: Marmot Review, CMO Report 2012).

4.2 Since April 2015 local authorities became responsible of commissioning of the school nursing service, health visiting and the family nurse partnership programme. These services deliver the 0 – 19 Healthy Child Programme (HCP), which is the universal clinical and public health programme for children and families from pregnancy to 19 years of age.

4.3 The Healthy Child Programme (HCP) is an evidence-based, universal, clinical, and public health programme for children and families from pregnancy to 19 years of age. The HCP provides a universal offer and enables the identification of any difficulties or issues a family may encounter at an early stage to receive the support needed and prevent issues from escalating. The HCP programme is delivered by school nurses and health visitors while working in partnership with health professionals, Sure Start children centres, schools, and range of voluntary, community sector organisations. The objectives of the HCP are to:

- Identify and treat problems early
- Help parents to care well for their children
- Change behaviours which contribute to ill health
- Protect against preventable diseases

4.4 This health needs assessment (HNA) provides a focus on the health and wellbeing of all children and young people aged 0-19 and up to 25 for children with special educational needs and disabilities (SEND) living across West Northamptonshire and North Northamptonshire. This includes the mapping of the current service provision, and identification of gaps in support or service provision. The aim is to offer a strategic review of the health needs of children, young people, and families across West Northamptonshire council (WNC) and North Northamptonshire council (NNC). The results of this health needs assessment will inform our future commissioning decisions across both unitary councils particularly after the disaggregation and influence service configuration and development for residents of WNC and NNC.

5. Issues and Choices

5.1 The following methods were used to inform this health needs assessment:

- **Literature Review** – A literature review of national and local evidence was carried out by a public health officer to inform this HNA. Findings are summarised at the beginning of each chapter.
- **Epidemiological** – A wide variety of data sources have been used to inform this HNA. The Office for National Statistics (ONS) and Office for Health Improvement and Disparities (OHID) Fingertips data. Local data have also been used and supplied by our system partners where available. Limitations in finding data have also been noted.
- **Surveys** - Three surveys were undertaken in March-April 2023 to gather insights into the health and wellbeing of children and young people, and their families. The surveys were targeted at parents and carers, primary and secondary school staff and stakeholders and wider partners.
- **Semi-structured Interviews** – 32 semi-structured interviews were undertaken with stakeholders including Maternity services, ICB senior executives, Northamptonshire Children's Trust (NCT) colleagues, 0-19 service provider, Strong start, Local Authority public health and Education colleagues and Voluntary community sector organisations. The key themes were identified using a thematic analysis and are summarised in the Engagement and Insight chapter.
- **Public Engagement** – WNC and NNC have commissioned Free2Talk in partnership with HomeStart Daventry and south Northants and NHFT participation to deliver a series of engagement workshops with children young people aged 0-19 and their families, as well as stakeholders and wider system partners. More than 120 children and young people, and 68 stakeholders were engaged throughout these workshops. A copy of the full engagement report can be found in the appendix.

6. Implications (including financial implications)

6.1 Resources and Financial

There are no financial implications at this stage. This report will inform our commissioning intentions for 0-19 services moving forward.

6.2 Legal

There are no legal implications arising from the proposals.

6.3 Risk

We will be having a detailed workshop on the recommendations and emerging findings of this Children and young people health needs assessment report where we will be discussing the risks

6.4 Consultation

Included in Section 5

6.5 Consideration by Overview and Scrutiny

This report has only been shared with ELT

6.6 **Climate Impact**

None

6.7 **Community Impact**

To be discussed at the dedicated workshop

7. Background Papers

None

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West Northamptonshire Council

CYP Health Needs Assessment – Update and Emerging Findings

November 2023

Racha Fayad – Public Health Principal

West Northamptonshire Council

Children and young people/0-19 Health Needs Assessment

Emerging Findings and Recommendations for WNC

Purpose

The purpose of this HNA is to provide a snapshot of the health and wellbeing needs of children, young people aged 0-19, and up to 25 where there's a statutory responsibility and their families.

The report captures what are the current needs of this population across WNC, highlight the existing offer provided by the council whilst also understanding the impact of COVID-19 pandemic and the cost-of-living crisis on children and their families.

Underpinning this Health needs assessment report is a life-course approach which describe the importance of the best start in life and recognises the importance of prevention and early intervention to tackle any emerging issues in young person's life.

The HNA will provide an epidemiological overview of the needs of 0-19 (up to 25 for SEND) population, describing the population demographic and other key measures. The objectives are to:

- **Review the current model of 0-19 services delivery across WNC and NNC**
- **Identify opportunities to improve, integrate and re-align local provision to better meet the needs of this population**
- **Make recommendations to commissioners and policy makers based on the findings and conclusion of the HNA to develop more effective and efficient services, reduce inequalities and help meet the national targets for the HCPO programme**

Methodology

The following methods were used to inform this health needs assessment:

- **Literature Review –** A literature review of national and local evidence was carried out by a public health officer to inform this HNA. Findings are summarised at the beginning of each chapter.
- **Epidemiological –** A wide variety of data sources have been used to inform this HNA. The Office for National Statistics (ONS) and Office for Health Improvement and Disparities (OHID) Fingertips data. Local data have also been used and supplied by our system partners where available. Limitations in finding data have also been noted.
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Chapter 1: Demographic – WNC

- West Northamptonshire has a population of **425,726 and is the 13th largest authority** in England and the **5th largest in the East Midlands.**

- West Northamptonshire is also the **8th most densely populated authority** in the East Midlands, with an average of 309.1 usual residents per square kilometre.

- Of this figure, 24.8% of the population were between the ages of 0-19 in 2011.
  In 2021, 101,056 were between the **ages of 0-19, or 23.7%** of West Northamptonshire's population.

Whilst the population of 0-19s has grown in real terms, the proportion of 0-19s vs the total population of West Northamptonshire has fallen. This CYP/0-19 health needs assessment currently underway will investigate further the causes of this decline in proportion, typical causes include an increase in adult migration, or a fall in births

- WNC' population has become increasingly diverse since the 2011 Census. **White British as a proportion** of the total population has fallen from **83.96% to 75.1% in 2021**. The 5 most populous non-White British ethnic groups are: Asian/Asian British (5.2%), Black/African/Caribbean/Black British (4.8%), mixed multiple ethnic groups (2.8%), other ethnic groups (1.1%).

Chapter 2: Maternal and Infant Health

- There were **4,647 live births** in West Northamptonshire in 2021,significantly higher than East Midlands and England.

- Between 2019-21 there were **58 stillbirths in West Northamptonshire**. Whilst the rate of 4.2 per 1,000 was similar to the East Midlands rate of 3.8 and the England rate of 3.9, the stillbirth rate fell in West Northamptonshire between 2018-20.

- **22.5% of women** were recorded as **being obese in early pregnancy** in 2018/19 in Northamptonshire.

- **11.3% of women who gave birth in West Northamptonshire were smokers** at the time of delivery in 2021/22, which was 479 mothers. This was similar to the East Midlands average of 11.8%. Although the proportion of women smoking during pregnancy has fallen from 12.3% in 2020/21.

- Estimates for West Northamptonshire suggest that between **466 and 932 mothers experienced perinatal mental health problems in 2021.**

- Nearly **6 out of 10 babies (58.8%) were totally or partially breastfed at 6-8 weeks** in West Northamptonshire in 2021/22, which was 2,551 babies. A total of 41.2% were not breastfed – 1,784 babies. The proportion of babies breastfed at 6-8 weeks was significantly higher than the averages for North Northamptonshire (46.6%), East Midlands (49.6%) and England (49.2%).

Recommendations for Maternal and Infant Health Chapter

Recommendations for West and North Northamptonshire Council for Maternal and Infant Health
1. Improve partnership working and data sharing between midwifery, health visiting, and GP services
2. Work with maternity services and existing providers to address Healthy pregnancy including the high levels of women smoking during pregnancy to be referred into smoking cessation services, support women who have been identified as obese to be referred into the dietetic service as per NICE guidance.
3. Ensure there is a universal service that provides a wrap-around support for women, pre-natal, during pregnancy and post-natal embedded within the Family hubs across both unitary councils.
4. Adopt the principle of Making Every Contact Count (MECC) to improve the health promotion messages during pregnancy, raise awareness about the existing commissioned services available for a new parent to improve access to such services when needed.
5. As a system we should be working towards a better integration between maternity services and early years services to ensure pregnant women and new parents can access the right support at the right time when needed. We need to ensure there is a handover pathway between maternity services and healthy visiting service to optimise the continuity of care
6. More consultation is needed with “hard to reach” women who are not accessing our services, and where language is a barrier to ensure their voices are heard and they get the right support where needed

Chapter 3: Early Years (0-5s)

- **97.5% of babies** in **West Northamptonshire received a face-to-face NBV from a Health Visitor within 14 days of birth** in 2021/22, which was significantly higher than the averages for the East Midlands (92.4%) and England (82.7%). In 2021/22, 98.5% of babies received a 6-8 week review, significantly higher than the East Midlands (91.1%) and England (81.6%); at 12 months, 77.4% of babies received a 12 month review in West Northamptonshire, significantly higher than the East Midlands average of 70.1% but significantly lower than England (82.0%).
- Apart from the DTaP/IPV booster and MMR (two doses) by age 5, **vaccination coverage among 0-5 year** olds was generally high in 2021/22.
- **49.6% of 2 to 2½ year olds received a health visitor review** in 2021/22, significantly lower than the East Midlands and England.
- **96.4% of 2 to 2½ year olds received an ASQ-3** in 2021/22, significantly higher than the East Midlands and England.
- **78.3% of 2 to 2½ year olds met the expected levels of development across all five domains of the ASQ-3** in 2021/22.
- **22.1% of five year olds suffered from tooth decay** in 2021/22, similar to the East Midlands and England
- **65.8% of children achieved a good level of development by the end of Reception** in 2021/22, similar to the East Midlands and England.

Recommendations for Early Years Chapter

Recommendations for West and North Northamptonshire Council for Early Years (0-5s)
1. Improve outcomes related to the 'Good level of development for 2-3 years old' through prioritising the 2-2.5 years mandated health check undertaken by 0-19 health visiting service, and providing advice, guidance and support to the early years and childcare sector so that more children are ready for school.
2. Invest in the early year's infrastructure across WNC and NNC by working closely with the current children centres, rolling out the family hubs programme and ensuring integration across 0-5 services and early help. While "early help" does not mean "early years", the over representation of 0-5s at Specialist Help levels suggests that there are significant number of children 0-5 whose needs are not being identified early enough. The ultimate goal is to increase the role of early intervention and prevention – current early intervention services could be supporting more families.
3. Prioritise working towards integration at local level by working with system partners such as Health and ICB, developing resilience, and ensuring we have sufficient capacity in the system, to reduce inequalities, particularly for disadvantaged groups and young children
4. There is a huge opportunity for both unitary councils to redesign their 0-19 service models, and 0-5 universal services in light of the presenting data in this health needs report to better meet the needs of early years children and their families
5. Ensure the provision of consistent information across the system on all early year's services including infant feeding, introduction to solid foods and portion sizes, with additional levels of support in response to need, to enable the healthy growth of all infants and children. The aim is to ensure families with under 5s children know where and when to access services when they need it.

Chapter 4: Primary School Children (5-11)

- **19.6%** of Reception and **35.9%** of Year 6 students recorded as overweight or obese in 2021/22, statistically lower than England and East Midlands.
- **50%** of 5-16 age group recorded as active in 2021/22, similar to England and East Midlands. **26.4%** of 5-16 age group recorded as less active in 2021/22, similar to England and East Midlands.
- **Significant increase in percentage of active children from** pre/during COVID-19 pandemic recorded in 2021/22.
- **14,431** pupils eligible for free school meals of which **79%** were reached in the last issuing period. **22.9% of 5-16 population eligible for free school meals**, similar to the national average of 23.6%.

- **Asthma** emergency admissions at a crude rate of **179.0** per 100,000, statistically similar to England and significantly higher than East Midlands.
- **Diabetes** emergency admissions at a crude rate of **29.8** per 100,000, statistically similar to England and East Midlands.
- **Epilepsy** emergency admissions at a crude rate of **47.0** per 100,000, statistically significantly lower than England and similar to East Midlands.

Recommendations for Primary School Children Chapter

Recommendations for West and North Northamptonshire Council Primary School Age Children (5-11)
1. Review and audit the role of the school nursing service and shift the service towards Health improvement. School nursing service has a focus on statutory duty, and the increased demand on safeguarding across Northamptonshire has meant that the service spent less time on health improvement. There is a need for a system discussion to re-imagine the role of school nursing and expand the breadth of work to include youth workers and Voluntary and community sector organisations to meet the gaps in service provision for primary school age children.
2. Develop a whole system approach to improve children and young people emotional health and wellbeing by integrating the school offer (including MHSTs, PSHE, Healthy Schools etc.) with the community offer (e.g. REACH) to provide a universal emotional health and wellbeing for children and young people.
3. Develop a Tier 2 school and community-based family weight management initiatives linked to NCMP data as part of a system-wide approach to address healthy weight. Furthermore, implement universal and targeted approaches that address inequalities and align with Physical Activity to engage the whole family, not just young people. Within this actively promote physical activity clubs available after school and in the community.
4. Upskill the frontline workforce with the adequate training to ensure children and young people are provided with health education and self-management tools to continue to reduce accidents in the home. Ensure promoting accident prevention information using culturally specific language in public areas and settings where children and families might attend such as schools, GP clinics, youth clubs etc.

Secondary School Children (11-18) Chapter

- **31,879** young people **aged 10-15 years**
- **Average attainment 8 score (48.6)** exceeded that of the East Midlands region (47.5) and fell just below the England value of (48.7) in 2021/22.
- **The secondary school exclusion rate** (**0.04%)** was lower than the East Midlands region (0.046%) and England (0.052%) rates for Autumn term 2021/22
- **Persistent disruptive behaviour was most common reason for exclusion at 27.3%** also a high % of drug and alcohol related exclusions at 13.6% (the England value was 5.6%).
- Northamptonshire NHS Foundation trust received around 500 CAMHS referrals per month in 2018, **recently referrals are above 1,000 per month** (there were 1,165 referrals made in January 2023). Many referrals result in DNA appointments.
- **Age 10-14 self-harm rates were significantly better than England**. By age 15-19 rates were significantly worse than England. Girls rates by 10-15 were highest of all East Midlands regions and **28th highest** of the all England table.
- **629** Children in Care for year end 2022
- **Highest rate of age 15-24 substance misuse admissions** in East Midlands (**127.4 per 100,000**) for period 2018-2020. Significantly higher than region and England. Further analysis shows girls admission rates were **166.3 per 100,000**.

Recommendations for Secondary School Chapter

Recommendations for West and North Northamptonshire Council Secondary School Age Children (11+)

1. Emotional health and wellbeing
   - Further work is needed to understand and address the gaps in low level support, including how to better manage low level need to prevent needs escalating and reduce demand on specialist services. This includes identifying how we better align with universal services, Early Help and the CAMHS Front Door.
   - Develop youth services and youth clubs across Northamptonshire (WNC and NNC) to provide young people with safe spaces where they can connect with trusted professional outside of school hours.
   - As stated in the previous chapter, the need to review and audit the role of school nursing service and shift the service towards Health improvement. There is a need for a system discussion to re-imagine the role of school nursing and expand the breadth of work to include youth workers and Voluntary and community sector organisations in order to meet the gaps in service provision around emotional health and wellbeing support and other identified health priorities.
   - Review existing information and develop easily accessible resources for children, young people and their families as well as health, education and care professionals on how to promote mental wellbeing and how to access support if needed.

2. Substance Misuse, Drugs and Alcohol
   - Work with the providers to ensure there is equitable access to substance misuse, drugs, and alcohol services with the aim of integrating, and exploring a redesigned model that offer a blended service delivery within community, youth settings.
   - Work with schools to provide information to parents on how they can approach conversation with young people around substance misuse, drugs, and alcohol.
   - Provide MECC training to encourage discussions with young people around the use of alcohol, drugs, and substance misuse.
   - The need to work and co-produce with young people an approach to inform our targeted messages and strategies to address the increase in alcohol, substance misuse and drugs consumption among young people

3. Education
   - Prioritise education needs assessment to understand and gather more information on inequalities including attainment, attendance, and exclusion in schools.
   - Work with secondary schools and explore ways how young people could be supported through transition stage around stress and anxiety.
   - Commission the SHEU (School Health Education Unit) survey and utilise the data to inform our thinking and future commissioning intentions for services aimed at 11+

Transition to Adulthood (16+) Chapter

- **75 hospital admissions for alcohol-related conditions among under 18s** in 2018/19 – 20/21. The admission rate of 27.2 (per 100,000 under 18) was similar to the East Midlands and England.

- **165 hospital admissions due to substance misuse among 15-24 year olds** in 2018/19 – 20/21. The admission rate of 127.4 (per 100,000 aged 15-24) was significantly higher than the East Midlands and England.

- **225 admissions to hospital among 15-19 year olds due to self-harm in 2021/22**. The hospital admission rate was 934.9 (per 100,000 aged 15-19), significantly higher than the East Midlands and England.
- **2020 estimates for 18-24 year olds show there were 813 adults with a learning disability**, 1,046 at a higher risk of an alcohol-related health problem, 2,500 dependent on drugs.

- **91% of care leavers aged 17-18 were in suitable accommodation in 2021/22** compared with 83% of care leavers aged 19-21; 28% of care leavers aged 17-18 were not in education, employment or training compared with 35% aged 19-21.
- **2.3% of 16-17 year olds were not in education, employment or training (NEET) in 2021**, significantly lower than the East Midlands and England.
- **13,602 17–24-year-olds were estimated to have either a possible or probable mental health disorder in 2021**

Recommendations for the Transition to Adulthood Chapter

Recommendations for West and North Northamptonshire Council for Transition to Adulthood (18-25)
1. The need to co-produce the redesign of some services involving young adults such as youth offer and other health services with young people to ensure they are involved in the participation and engagement exercises. The aim is to get their buy-in into to a service model that will be easily accessible and available for young people across WNC and NNC
2. The same recommendation to develop a whole system approach to address emotional health and wellbeing that was listed in the previous chapter also apply here
3. Co-location has come up across the previous chapters as an effective way to increase uptake of appropriate services. This also applies to young adults and co-locating some services as sexual health, emotional health, and wellbeing etc. to be offered from community venues and youth clubs where young people attend after school.
4. Review young people's Substance misuse, drugs and alcohol services offer to ensure a flexible, responsive, and coordinated service is available to meet the needs of young people who use a range of substances. This in line with co-producing the offer with young people.
5. Many of the recommendations in this chapter cross over with the recommendations identified in the previous chapters, however the key message is to include flexibility in the age restriction on services to incorporate young adults into young people services, early intervention, adaptation of current service models to better meet the needs of young adults, and upskilling health and care professionals with knowledge and skills to recognise and address young adults' needs.

Engagement and Insights Chapter - Recommendations

Semi-structured Interview with Stakeholders across the system- The main themes that were highlighted are:

- **Integration and join up** – the most prevalent themes were about the lack of integration and join up across services available for children and young people. We have a good range of commissioned services for children; however, services tend to work in silos.

- **Leadership, Commissioning and Communication** – lack of awareness of all the existing services for children and families across Northamptonshire among system wide partners. As a system, children and young people should be considered a strategic priority and we should develop a joint system-wide commissioning intention plan to commission any future services. This will help with developing appropriate pathways between services, avoiding duplication, and using resources more efficiently.

- **Prevention and Early Intervention** – another most prevalent theme was Early Help; how do we work as system together to deliver Early Help and identify any emerging issues at the earliest point to be able to intervene and prevent the issue from escalating to crisis level. This includes working as one system to complete Early Help assessment and deliver a universal early help service.

- **Youth Offer** – the need to develop a youth offer for young people across WNC to provide them with safe space after school where they can spend their time safely, happily and develop trusted relationships with professionals (youth workers).

- **Funding** – Resources should be directed and invested towards Children and young people services as this is where the greatest impact can be achieved to prevent any future ill-health in adulthood.

Engagement and Insights Chapter - Recommendations

Surveys – Parents and Carers

The three most important considerations for parents/carers to help and support them looking after their children's health and wellbeing are:

- Timely and ease of access to services
- Being listened to, heard, and understood when raising any concern
- A directory of what services are out there and how to get the help when needed

Surveys – Professionals and Stakeholders

When asked about what they would like to improve for 0-19 health and wellbeing services as professionals, the most prevalent themes were:

- A robust and effective early help team that supports families and the practitioners who are working to support these families
- Joined up services and referral pathways - integrated assessment process across a range of 0-19 services so the young person is at the heart of process rather than being made to fit processes.
- More integrated approach - services are still too separate and working in silo. We need a shared understanding of CYP outcomes and how all services are working together to achieve this. Greater emphasis on partnership working with CYP and families to meet needs at individual, service, and strategic levels.

Engagement and Insights Chapter - Recommendations

Surveys – School Staff (Primary and Secondary)

- When asked about what improvement for health and wellbeing services they would like to see as professionals in the next 5 years, respondents said:
- Central directory of support services so that schools can be clearly signposted to services when needed.
- Capacity increased across the board so that when help is needed, it is readily and promptly available.
- Early help and support services accessible for young people when they need it

Engagement and Insights Chapter - Recommendations

Public Engagement workshops completed by Free2Talk, HomeStart and NHFT Participation team

The following recommendations align to the discussions in the workshops:

- Strategic resourcing of early help and preventative services to enable long term, consistent trusted relationships to be built in safe and accessible services at times when children and young people can access them
- Development and communication of clear pathways of support
- Co-production and improving the services and systems' knowledge of children and young people
- Improving health knowledge and education
- Skilled and knowledgeable practitioners' training
- Quality of systems to safeguarding children and young people needs auditing and developing across the Integrated Care System.

Summary Recommendations for the CYP Health Needs Assessment for WNC

The key strategic findings and recommendations of this health needs assessment are:

1. **In reviewing the 0-19 service currently provided as a county-wide offer, there has been recognition of the need to develop a new service model and service specification with a greater emphasis on a whole family approach, reflecting the need of making prevention and early intervention** everyone's business to support children, young people, and their families with a focus on existing universal services.
2. There is a wide variation in the needs of children and young people across WNC and NNC as shown by the epidemiological data. **The 0-19 service must ensure that resources (including workforce) are targeted to meet the needs of children and families most in need, whilst at the same time maintain universal offer.** This also include working on a locality basis, aligning with local area partnerships, and restructuring the service workforce to increase capacity and meet the needs identified.
3. **Lack of early help services across WNC and NNC. This was identified as the underpinning cause of many significant gaps identified through this health needs assessment**. It also means that services are being overwhelmed dealing with complex cases and crisis due to the lack of prevention and early intervention practice across the system. The need to invest in early help and preventative services was evident across the HNA and the stakeholder engagement to prevent the escalation of need and embed prevention and early intervention approach across our integrated way of working across the system.

Summary Recommendations for the CYP Health Needs Assessment for WNC

4. **Improve partnership working, join up and integration across the system** to meet the needs of children, young people and their families living in West Northamptonshire and North Northamptonshire. It was clear from the stakeholder consultation that partnership working across the system have improved in the last 2 years, however it still needs to be more integrated. This includes making decisions on commissioning for new services, the co-location of services, improved understanding of services, closer relationships, and information sharing.

5. **The development of clear pathways of support for services available for children, young people and families was highlighted as being unclear**. It was agreed that support pathways for children and families should be accessible and easy to understand and navigate. It was also agreed that we need to map the existing service provision alongside the referral pathways to enable the workforce and frontline workers to signpost appropriately.

West Northamptonshire Council

Thank you

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

11th December 2023

Reports for information

Reports Titles	**Annual Review Suicide Prevention Strategy -Henna Parmar** **Rough Sleepers Needs Assessment – Rhosyn Harris**

List of Appendices

Appendix A – Annual Review Suicide Prevention Strategy
Appendix B – Suicide Prevention Action Plan
Appendix C – Rough Sleepers Needs Assessment

1. Purpose of Reports

1.1. The attached reports are for Board members to review and will not be discussed during the Board meeting.

2. Executive Summary

2.1 The refreshed all-age, county-wide Northamptonshire Suicide Prevention Strategy and Action Plan for 2022-2025 was launched in September 2022. This is the first annual review of the action plan to ensure our local suicide prevention work remains aligned to national guidance and relevant to local need. The updated action plan highlights the key achievements made since the launch and also provides detail on what to expect over the next year.

2.2 The Housing and Communities Team and Public Health jointly commissioned an independent assessment of the need of people sleeping rough, including the current customer journey, existing accommodation and support. The initial findings were presented to the Board at the meeting on the 27th July 2023. Appendix C is the completed needs assessment.

3. Recommendations

3.1 Board members are asked to note the reports.

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Annual Review 2023

Northamptonshire Suicide Prevention Strategy 2022-2025

Northamptonshire Suicide Prevention Steering Group
September 2023

Introduction

This report highlights the key findings from the first annual review of the refreshed Northamptonshire Suicide Prevention Strategy 2022-2025 and corresponding action plan.

The refreshed strategy and action plan was launched in September 2022 and the delivery is being coordinated by the Northamptonshire Suicide Prevention Steering Group. This report will review the progress in implementing the action plan and recommendations for further actions to ensure this area of work remains updated and relevant to local need.

Background

Suicide is defined as the deliberate act to intentionally end one's life (1). The effects of a suicide can be devastating, and the impact felt by many – including family, friends, neighbours, employers, colleagues, professionals, and the wider community. People bereaved by suicide are also more likely to experience poor mental health and have an increased risk of suicide themselves.

In Northamptonshire, around 60 people take their own life each year. As a partnership, we believe that every death by suicide is one too many. Each of these deaths can potentially be prevented, therefore suicide prevention is a priority for everyone. This strategy and action plan aims to reduce suicide and self-harm in Northamptonshire, through a whole-county, all-age approach.

In line with the newly published *Suicide Prevention in England: 5 year cross sector strategy (2023)* (2) following on from the *Preventing suicide in England: fifth progress report (2012)* (3) , the partnership is taking a cross-system collective approach to suicide prevention. The suicide prevention strategy for England identifies eight priorities to contribute to reducing suicide and self-harm. This strategy is aligned to these priorities, which are:

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Partner agencies on the Northamptonshire Suicide Prevention Steering Group were instrumental in developing this strategy. These agencies are committed to working together to deliver this strategy.

The Northamptonshire Mental Health, Learning Disability and Autism Population Health and Prevention Pillar (adults) and the Children and Young People Collaborative Mental Health and Emotional Wellbeing Work Programme (children and young people) maintain strategic oversight of the implementation of the strategy. Progress and outcomes are reported through the Mental Health, Learning Disability and Autism Collaborative and to the North Northamptonshire and West Northamptonshire Health and Wellbeing Boards.

Review of Priorities

This section will review the strategy action plan against the aims and objectives set out to be completed and/or in progress by the first year following the strategy launch. There are several actions that are set out in the strategy action plan that are yet to begin, please view the full updated action plan document for details.

Below is a summary of our headline achievements since September 2022.

Priority 1: Reduce the risk of suicide in key high-risk groups

What we set out to do…	What we achieved…	What we plan to do…
Coordinate a countywide prevention campaign aimed at groups identified at high-risk of suicide	Local high-risk groups have been identified from a deep-dive audit on local data – these include substance and/or alcohol misuse; self-harm and/or previous suicide attempts; adverse events in childhood; relationship breakdown; illness (mental health condition); illness (physical health condition); debt/financial problems.	Develop and deliver a campaign plan aimed at reducing the risk of suicide for these identified groups.
Coordinate a campaign for World Suicide Prevention Day (10th October 2023) with key partners	Coordinated the 'Take a Break' sofa campaign with NHFT, across various locations across North and West Northamptonshire. The aim of the campaign was to encourage passers-by to stop, sit and talk, to help to raise awareness of suicide prevention and the services that can provide support, as well as reducing stigma around suicide and self-harm. This was a successful campaign, and it was followed up by a visit to the University of Northampton for World Mental Health Day October 2023.	Continue to develop and deliver future campaigns for World Suicide Prevention Day, World Mental Health Day and support other key dates/events.

Deliver a suicide prevention training programme to upskill primary care and frontline staff in the early identification of risk factors	A mental health and suicide prevention training framework has been developed and delivery has begun. This includes the development of mental health awareness and suicide prevention training for primary care (general practices, pharmacies, and dental practices) and bespoke advanced suicide mitigation training.	Continue to develop and deliver the mental health and suicide prevention training framework.
		Review induction processes for West Northamptonshire and North Northamptonshire Councils to incorporate suicide prevention training for all staff.
	A pilot support package for West Northamptonshire Council's Customer Service Teams' call handlers was developed to increase awareness of suicide prevention and available services, and to increase resilience and support for staff.	The pilot support package will be reviewed and updated ahead of rolling out across all teams with call handlers in North and West Northamptonshire Councils.
Continue to monitor suicide data and intelligence to maintain our understanding of high-risk groups and inform trends and emerging issues	A report has been developed following a deep-dive audit on local data. Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly. Links with local safeguarding partnerships have been established.	Data and intelligence will continue to be collected and monitored. Findings from the audit and Mental Health Joint Strategic Needs Assessment (JSNA) will be used to enhance understanding of all-age high-risk groups.
Explore opportunities to enhance intelligence on local suicide from across the suicide prevention partnership	Opportunities to access additional data sources are explored regularly.	Opportunities to enhance intelligence on local suicide from across the suicide prevention partnership will continue to be explored.
Explore solutions that enhance the development of protective behaviours and suicide prevention	A Psychoeducation and Respite pilot for Mental Health Carers was completed and evaluated. The Specialist Perinatal Mental Health and Maternity Mental Health service has been expanded in line with Long-Term Plan ambitions. An Emotional Coaching Pilot initiative for parents/carers of children with suicidal ideation was implemented, monitoring and evaluated.	Expand the Improving Access to Psychological Therapies (IAPT) Talking Therapies Service and Individual Placement and Support (IPS) Services in line with Long-Term Plan ambitions.

Priority 2: Tailor approaches to improve mental health in specific groups

We said we were going to…	Achievements	Future actions
Improve partner and public awareness of local mental health services targeted to identified priority groups	A map of local mental health services is in development.	Develop and deliver a campaign plan aimed at reducing the risk of suicide for identified groups.
Analyse intelligence to improve understanding of local mental health services and service users	A report has been developed following a deep-dive audit on local data. Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly. Links with local safeguarding partnerships have been established. Opportunities to access additional data and intelligence sources are explored regularly.	Findings from the audit, real-time surveillance system and Mental Health JSNA will continue to be analysed and used to enhance understanding of local mental health services and service users.
Monitor trends in data and intelligence to inform priorities	Analysis of local and national data has contributed to the identification of local high-risk groups.	Data and intelligence will continue to be collected and trends will continue to be monitored to inform priorities.
Sign up to the Prevention Concordat	There is Northamptonshire system-wide sign up to the National Mental Health Prevention Concordat since November 2022.	Suicide prevention priorities are being delivered within the Prevention Concordat Action Plan.
Maintain delivery of the Wave 3 Transformation Programme	The NHS Wave 3 Transformation funding was used to deliver STORM training for staff working in hospitals, to produce and distribute Protect Cards, and provide a 24/7 digital support offer to 250 residents in the county.	An alternative 24/7 digital support offer will be funded from 2024. There will be continued delivery of STORM training and distribution of Protect Cards. The funding will contribute to the campaign plan.
Strengthen and enhance response to people with suicidal ideation/ self-harm making transition from Children and Young People to Adult Pathways	There has been expansion and alignment of the 16-25's Enhanced Support Service model. The Mental Health Transitions Strategy is currently in development.	The alignment of the Enhanced Support Service with the Care Leavers Team to create a Community of Practice for young people transitioning from children and young people to adult pathways is in progress.

Priority 3: Reduce access to means of suicide

We said we were going to…	Achievements	Future actions
Work with partners to prevent public places being used for suicide	A map of locations has been developed to identify priority locations.	Asset owners of priority locations will be engaged with to create action plans with opportunities for mitigation.
Engage with partners and retailers to influence policy change to reduce access to certain means of suicide	Data and intelligence have been evaluated to identify local means of suicide.	Partners and local retailers will be engaged with to explore opportunities for changes to existing policies.
Continue to monitor existing suicide data and intelligence sources to inform emerging methods and local trends	A report has been developed following a deep-dive audit on local data. Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly. Links with local safeguarding partnerships have been established.	Data and intelligence will continue to be collected and monitored to inform of emerging methods and local trends.

Priority 4: Provide better information and support to those bereaved or affected by suicide

We said we were going to…	Achievements	Future actions
Work with emergency service partners to explore opportunities to better support staff involved with suicide intervention	Research on available postvention support has been completed. A contact list of key emergency service partners is in development.	Local emergency service partners will be engaged with to undertake a needs assessment of existing postvention support and use research to adjust and enhance current service provision.
Coordinate a countywide suicide prevention package to support educational establishments	A support package for all educational establishments in Northamptonshire has been developed to support in the event of a suspected death by suicide in a school community, including postvention and prevention information launched in February 2023.	The support package is to be reviewed on an annual basis and reshared with educational establishments with key updates. Similar support packages will be developed offering information and guidance around self-harm and online harms.
Explore opportunities to develop intelligence and data on bereavement services and those bereaved by suicide	A monitoring system for the bereavement services has been established and is reported on regularly.	The monitoring system will be explored and evaluated by bereavement service partners, using the findings to enhance and develop the available bereavement support.

from across the suicide prevention partnership		
Embed the local Bereavement Real-Time Referral Pathway	A local bereavement real-time referral pathway has been embedded.	The bereavement referral pathway will be reviewed regularly.

Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

We said we were going to…	Achievements	Future actions
Develop a local Media Framework to support responsible reporting of suicide	A local media reporting framework has been developed and shared with local media partners.	There will be continued engagement with local media partners to promote the framework and support cooperative and transparent working partnerships.
Establish a local media monitoring system	A local monitoring system has been established, with support from communication colleagues when reporting concerns arise.	The established local monitoring system will continue to be used and developed as appropriate.

Priority 6: Support research, data collection and monitoring

We said we were going to…	Achievements	Future actions
Undertake an audit of Coroners cases to enhance our understanding of the local situation	A report has been developed following a deep-dive audit on local data.	The audit will continue on a regular basis.
Continue to work with partners to maintain the Northamptonshire Suicide Real Time Surveillance System (RTSS)	Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly.	Work with partners will continue to maintain the Northamptonshire Suicide Real Time Surveillance System (RTSS).
Develop an escalation protocol for suspected suicide cases	An escalation protocol has been developed and is followed when actions have been identified to reduce further impact.	The established escalation protocol will continue to be used and developed as appropriate.
Support the development of the Mental Health JSNA to inform future actions	The Mental Health JSNA is currently being developed.	Recommendations for future consideration will be identified once the Mental Health JSNA has been developed.

Explore opportunities to develop intelligence and data sources from across the suicide prevention partnership	Opportunities to share and receive relevant data and intelligence are explored regularly.	Opportunities to develop intelligence and data sources from across the suicide prevention partnership will continue to be explored.

Priority 7: Reducing rates of self-harm as a key indicator of suicide risk

We said we were going to…	**Achievements**	**Future actions**
Improve awareness and understanding of services offering support for self-harm in Northamptonshire	A map of self-harm services and support has been developed.	Actions are currently underway to improve local data and intelligence on self-harm. Next steps will then include working with partners to promote services and support to identified groups.
Develop a pilot Self-Harm Real Time Surveillance System (SHRTSS) which will provide an insight into those who self-harm but do not present to primary or secondary care services	Development of this pilot was stopped due to challenges around data sharing. Actions are currently underway to improve local data and intelligence on self-harm.	Work with identified partners to identify recommendations for future consideration within this Strategy.

Key Recommendations

The Suicide Prevention Strategy for England 2023 to 2028 (2) was recently published.

To ensure the Northamptonshire Suicide Prevention Strategy remains relevant to local need and updated with national guidance, the following additions have been made to the local action plan. Please view the updated action plan published alongside this review for further details.

Objective	Action
8.1 Continue to develop suicide prevention plans in Northamptonshire following local need	8.1.1 Restructure of the Northamptonshire Suicide Prevention Steering Group in line with NICE guidelines
	8.1.2 Complete a map of Northamptonshire's mental health pathways to identify barriers to access
	8.1.3 Develop a self-harm support package for educational establishments in Northamptonshire
	8.1.4 Develop an online harms support package for educational establishments in Northamptonshire
	8.1.5 Review the pilot support package for call handlers in the WNC Customer Service Team for improvements and roll out to call handler teams across the county
	8.1.6 Embed formal processes with Adult and Children and Young People safeguarding boards to support with suicide cases
	8.1.7 Commission a 24/7 all age digital support offer for residents of Northamptonshire
8.2 Continue to develop suicide prevention plans in Northamptonshire following the national suicide prevention strategy guidance	8.2.1 Explore data and trends for people with autism/ASD/ADHD/ learning disabilities to inform the development of campaigns and future work
	8.2.2 Work with local domestic abuse services to support awareness and understanding of mental health and suicide prevention

Conclusion

The refreshed Northamptonshire Suicide Prevention Strategy and Action Plan for 2022-2025 was launched in September 2022. Since the launch there have been several key achievements.

Some of these achievements include a deep-dive data project to improve understanding of local high-risk groups and the launch of a support package for educational establishments in Northamptonshire in the event of a suspected death by suicide in a school community. There is a Mental Health and Suicide Prevention Training framework underway, mapping of means of suicide to make the county safer, and a pilot resource in place to support call handlers when a caller presents in mental health crisis.

Suicide prevention remains everyone's business. Now more than ever efforts from all partners are required to ensure our county feels safe and supported.

In September 2023, the England Suicide Prevention Strategy for 2023 to 2028 was published. National guidance and local data have informed the annual review and key recommendations for the county-wide, all-age strategy and updated action plan. The updated action plan reflects on the actions set out following the first annual review. This area of work will continue to be reviewed annually to ensure suicide prevention remains updated and relevant for local need.

Priority 1: Reduce the risk of suicide in key high-risk groups Completed actions for Priority 1 include: 1.3.1, 1.3.3, 1.3.4, 1.4.1, 1.4.2, 1.5.1, 1.5.2, 1.5.3, 1.5.5, 1.5.6, 1.5.7. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
1.1 Coordinate a countywide prevention campaign aimed at groups identified at high-risk of suicide	1.1.1 Coordinate a prevention campaign, with partner agencies, targeted at reducing suicide in all-age high-risk groups and raising awareness of local suicide prevention services and support	Summer 2023 – Winter 2024	Amber: **Action in progress** Local high-risk groups have been identified and a campaign plan will be developed and delivered.	- Campaign Evaluation - Suicide Indicators - Suicide Prevention Campaign - Co-Production Insight Reports	Lead agency: - Public Health North Northamptonshire Council (NNC) and Public Health West Northamptonshire Council (WNC) [Public Health Consultant] Supporting agencies: - Lived Experience - Northamptonshire Healthcare NHS Foundation Trust (NHFT) [Suicide Prevention Lead] - Northamptonshire Integrated Care Board (ICB) [Programme Manager, Mental Health, Learning Disabilities & Autism (MHLDA) Collaborative] - Suicide Prevention Steering Group (SPSG) Partners - SPSG Partner Communication Teams - WNC and NNC Drugs Related Death Panel [Public Health Consultant]

1.2 Deliver a suicide prevention training programme to upskill primary care and frontline staff in the early identification of risk factors	1.2.1 Identify appropriate primary care and frontline staffing groups and undertake a training needs assessment. Design and deliver a suicide awareness and mitigation training programme using a tiered/stepped approach.	Summer 2022 – Summer 2025	Amber: **Action in progress** A mental health and suicide prevention training framework has been developed and delivery has begun. This framework will continue to be developed and delivered.	- Delivery Plan - Staffing Groups - Suicide Indicators - Training Needs Assessment - Training Programme - Sessions Delivered - Number of Attendees - Training Evaluation	Lead agencies: - Northamptonshire Adult Learning [Learning for Wellbeing, Mental Health, and Learning Support Lead] - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agency: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative]
	1.2.2 Explore opportunities to incorporate suicide prevention in staff induction and training programmes of all suicide prevention partners	Summer 2023 – Summer 2025	Amber: **Action in progress** A pilot support package for West Northamptonshire Council's Customer Service Team's call handlers was developed. This package will be reviewed and rolled out to all teams with call handlers across NNC and WNC. Induction processes are currently being reviewed to incorporate the most appropriate suicide prevention training for staff at NNC and WNC.	- Support Package - Package Evaluation - Induction Processes - Staff Feedback	

	1.2.3 Support key organisations to explore their policies in supporting staff who experience a suicide amongst their caseload and/or are experiencing severe low mood or anxiety	Winter 2023 – Winter 2025	Grey: **Action has not started**	- Policy support - Postvention staff support	Lead agencies: - Public Health NNC and Public Health WNC [Public Health Consultant] - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] Supporting agencies: - SPSG Partners
	1.2.4 Align Suicide Prevention Strategy to Northamptonshire Health and Care Partnership (NHCP) People Plan to develop approaches to system wide training of all staff in Compassion-Focussed/ Trauma-Informed care	April 2023 – Summer 2025	Amber: **Action in progress** Action has been amended. Design a trauma-informed approach to be applied across the Mental Health Crisis Pathway, with an aim to roll out more widely.	- Production of Trauma-Informed Approach - Suicide Indicators	Lead agency: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] Supporting agencies: - North and West Northamptonshire Health & Wellbeing Boards - Population Health Management Programme
1.3 Continue to monitor suicide data and intelligence to maintain our understanding of high-risk groups and inform trends and emerging issues	1.3.2 Use the findings from the Mental Health Joint Strategic Needs Assessment (JSNA) to enhance the understanding of all-age high-risk groups	Winter 2024	Grey: **Action timescale has not begun** The countywide Mental Health JSNA is currently in development.	- Coroner's Audit Report - Mental Health JSNA - RTSS Intelligence - RTSS Quarterly Reports - Safeguarding Partnership Outcomes - Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Coroner's Office [Coroner's Office Manager] - Northamptonshire Police - Northamptonshire Safeguarding Adults Board - Northamptonshire Safeguarding Children Partnership

1.5 Explore solutions that enhance the development of protective behaviours and suicide prevention	1.5.4 Strengthen dual needs policy (mental health & substance misuse) via new 'access-to-care' protocols, information sharing agreements, and partnership working models	Summer 2024	Amber: **Action in progress** The strengthening of the dual needs policy is in progress.	- Production of Standard Operating Procedures - Service User Feedback - Staff Feedback	Lead agencies: - Change Grow Live [Lead Nurse] - NHFT [Community Mental Health Teams (CMHT) Lead] Supporting agencies: - MHLDA Outcome Based Pathways Pillar - NHFT [Suicide Prevention Lead]
1.6 Align the Strategy with health inequalities workstreams across Northamptonshire	1.6.1 Engage with the Equalities Enabler Group and explore opportunities to align key areas of work	Winter 2024	Amber: **Action in progress**	- Meeting Minutes - Aligned Work Plan	Lead agencies: - Public Health NNC and Public Health WNC [Public Health Consultant] - NHFT [Project Manager Equalities Lead] Supporting agency: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative]

Priority 2: Tailor approaches to improve mental health in specific groups Completed actions for Priority 2 include: 2.2.1, 2.2.3, 2.2.4, 2.2.5, 2.3.1, 2.4.1, 2.5.1, 2.5.2, 2.5.3, 2.7.2. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
2.1 Improve partner and public awareness of local mental health services targeted to identified priority groups	2.1.1 Identify and map Northamptonshire mental health services working with all-age priority groups identified in the Strategy and pathways	Autumn 2022 – Winter 2024	Amber: **Action in progress** A map of local mental health services is in development and will be tailored to priority groups and shared through a campaign plan.	- Mental Health Services Campaign - Campaign Evaluation - Self-harm and Suicide Indicators - Service and Pathway Map	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Children and Young People Collaborative - Lived Experience - NHFT [Suicide Prevention Lead] - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - SPSG Partners - SPSG Partner Communication Teams
	2.1.2 Coordinate a communication campaign for mental health services targeted to all-age priority groups	Autumn 2023 – Winter 2024	Amber: **Action in progress** Local high-risk groups have been identified and a campaign plan will be developed and delivered. These groups include: - Substance/Alcohol Misuse - Self-Harm - Previous Suicide Attempt(s) - ACEs (Adverse Childhood Experiences) - Relationship Breakdown - Illness (Mental and Physical Conditions) - Debt/Financial Problems - Autism - LGBTQIA+ - Domestic Abuse - Gypsy, Roma and Traveller Communities - Rural Communities		

2.2 Analyse intelligence to improve understanding of local mental health services and service users	2.2.2 Review outcomes from the Mental Health JSNA for future consideration	Winter 2024	Grey: **Action timescale has not begun** The countywide Mental Health JSNA is currently in development.	- Self-harm and Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Coroner's Office [Coroner's Office Manager] - Children and Young People Collaborative - Northamptonshire Police - Northamptonshire Safeguarding Adults Board - Northamptonshire Safeguarding Children Partnership - SPSG Partners
2.3 Monitor trends in data and intelligence to inform priorities	2.3.2 Work with partners to enhance data and intelligence sources on mental health in specific groups	Summer 2025	Grey: **Action timescale has not begun**	- Self-harm and Suicide Indicators - Data Reports	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - SPSG Partners
2.4 Sign up to the Mental Health Prevention Concordat	2.4.2 Represent suicide prevention priorities within the Mental Health Prevention Concordat Action Plan	Summer 2022 – Summer 2025	Amber: **Action in progress** Prevention Concordat Action Plan is currently being delivered.	- Prevention Concordat Action Plan - Prevention Concordat Application	Lead agencies: - Integrated Care System Partners - Public Health NNC and Public Health WNC [Public Health Consultant]

2.6 Strengthen and enhance response to people with suicidal ideation/ self-harm across Place-Based Community Mental Health Teams	2.6.1 Enhance & embed Suicide Prevention Best Practice into delivery models for Place-Based Community Mental Health Teams (aligned to principles of biopsychosocial, personalised, needs-led care & removal of Care Programme Approach)	Winter 2023 – Summer 2024	Grey: **Action timescale has not begun**	- Delivery Plan - Production of Standard Operating Procedures - Service User Feedback	Lead agency: - NHFT [CMHT Lead] Supporting agencies: - MHLDA Outcome Based Pathways Pillar - NHFT [Suicide Prevention Lead] - Public Health NNC and Public Health WNC [Public Health Consultant]
	2.6.2 Strengthen the links between Place-Based Community Mental Health Teams & Crisis Pathway to ensure fluid boundaries and continuity of care for people with suicidal ideation	Winter 2023 – Summer 2024	Grey: **Action timescale has not begun**	- Delivery Plan	Lead agency: - NHFT [Community Mental Health Teams Lead] Supporting agencies: - MHLDA Acute & Crisis Care Pillar - NHFT [Crisis Pathway Lead] - NHFT [Suicide Prevention Lead]
	2.6.3 Implement Core 24 (Crisis Response) standards across all acute hospital and community settings, to facilitate compassionate/ responsive models of care & aftercare to all those in crisis	Winter 2023 – Summer 2024	Grey: **Action timescale has not begun**	- Implementation of Mental Health Ambulance Model - Service Level Data (Core 24 Standards) - Service User Feedback	Lead agency: - NHFT [Crisis Pathway Lead] Supporting agencies: - MHLDA Acute & Crisis Care Pillar - NHFT [Suicide Prevention Lead] - NHFT Patient Experience Group

	2.6.4 Align mental health response to the Northamptonshire Care Record to enhance quality and timeliness of care and treatment via digital innovations	Winter 2023 – Summer 2024	Grey: **Action timescale has not begun**	- Delivery Plan - Service Level Data - Staff Feedback	Lead agency: - Northamptonshire ICB [Digital Lead] Supporting agencies: - MHLDA Acute & Crisis Care Pillar - MHLDA Outcome-Based Pathway Pillar - NHCP [Digital Strategy Lead]
	2.6.5 Review existing provision for service users presenting with suicidal ideation and work with partners to design and implement viable pathways, processes, and protocols	Winter 2023 – Summer 2024	Grey: **Action timescale has not begun**	- Pathway Review - Updated Process and Protocols	Lead agencies: - NHFT [Suicide Prevention Lead] - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Children and Young People Collaborative - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Service Users

2.7 Strengthen and enhance response to people with suicidal ideation/ self-harm making the transition from Children and Young People to Adult pathways	2.7.1 Accelerate Transition Workstream, including involvement from suicide prevention leads in development of Transitions Strategy	Summer 2023 – Summer 2024	Amber: **Action in progress** The Mental Health Transitions Strategy is currently in development.	- NHCP Transitions Strategy - Pathway Plan Documents - Pillar Updates	Lead agency: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] Supporting agencies: - Children & Young People (CYP) Collaborative [Programme Lead] - MHLDA Collaborative Programme - NHFT [Suicide Prevention Lead] - NNC and WNC Relevant Teams - NNC Health & Wellbeing Board and WNC Health & Wellbeing Board - Northamptonshire Children's Trust

	2.7.3 Align Enhanced Support Service with Northamptonshire Children's Trust Care Leaver Teams to create Community of Practice for young people transitioning from Children and Young People to Adult pathways	Summer 2023 – Summer 2024	Amber: **Action in progress** The alignment of the Enhanced Support Service with the Care Leavers Team to create a Community of Practice is in progress.	- NHCP Transitions Strategy - Pathway Plan Documents - Pillar Updates	Lead agency: - Youth Works [Chief Executive Officer] Supporting agencies: - CYP Collaborative [Programme Lead] - MHLDA Collaborative Programme - NHFT [Suicide Prevention Lead] - NNC and WNC Relevant Teams - NNC Health & Wellbeing Board and WNC Health & Wellbeing Board - Northamptonshire Children's Trust - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health NNC and Public Health WNC [Public Health Consultant]

	2.7.4 Review existing provision for service users presenting with suicidal ideation and work with partners to design and implement viable pathways, processes, and protocols	Winter 2023 – Summer 2024	Grey: **Action timescale has not begun**	- Pathway Review - Updated Process and Protocols	Lead agency: - NHFT [Suicide Prevention Lead] Supporting agencies: - Public Health NNC and Public Health WNC [Public Health Consultant] - Children and Young People Collaborative [Programme Manager] - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Service Users

Priority 3: Reduce access to means of suicide Completed actions for Priority 3 include: 3.2.1, 3.3.1, 3.3.2, 3.3.3, 3.3.4. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
3.1 Work with partners to prevent public places being used for suicide	3.1.1 Work with transport partners and the emergency services to create a Northamptonshire map of priority suicide risk locations and structures	Autumn 2022 – Autumn 2024	Amber**: Action in progress** A map of locations has been developed to identify priority locations. Asset owners of priority locations will be engaged with.	- Suicide Rates at Priority Locations - Suicide Risk Location Map - Mitigation Plans	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - British Transport Police [Harm Reduction Team] - Coroner's Office [Coroner's Office Manager] - East Midlands Railway [Emergency Planning Manager] - Highways England [Midlands Road Safety Coordinator] - KierWSP [Head of Customer and Communications] - Network Rail [Community Safety Manager] - NNC and WNC's Place Planning Teams - Northamptonshire Police - Northamptonshire Fire and Rescue
	3.1.2 Work with partners to explore opportunities for mitigation at high-risk locations	Winter 2024 – Summer 2025	Grey**: Action timescale has not begun**		

3.2 Engage with partners and retailers to influence policy change to reduce access to certain means of suicide	3.2.2 Engage with partners and local retailers to explore opportunities for changes to existing policies	Summer 2024 – Summer 2025	Grey**: Action timescale has not begun**	- Retailer Policy and Practice - Self-harm and Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - NNC and WNC's Trading Standards Teams - Northamptonshire Retailers

Priority 4: Provide better information and support to those bereaved or affected by suicide Completed actions for Priority 4 include: 4.3.1, 4.5.1, 4.6.1. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
4.1 Coordinate a campaign to improve partner and public awareness of suicide bereavement services available in Northamptonshire	4.1.1 Identify and map Northamptonshire suicide bereavement services	Winter 2023	Grey: **Action timescale has not begun**	- Bereavement Service Users - Campaign Evaluation - Service and Pathway Map - Suicide Bereavement Campaign	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Child & Adolescent Bereavement Service [Service Coordinator] - Service Six [Chief Executive] - SPSG Partners Communication Teams - Survivors of Bereavement by Suicide (SOBS) [Chief Executive Officer]
	4.1.2 Create and deliver an awareness and promotion plan of suicide bereavement services	Winter 2023 – Winter 2024	Grey: **Action timescale has not begun**		

4.2 Work with emergency service partners to explore opportunities to better support staff involved with suicide intervention	4.2.1 Engage with emergency service partners and undertake a needs assessment of existing postvention support for staff. Agree adjustments that complement and enhance existing service provision	Autumn 2022 – Autumn 2025	**Amber: Action in progress** A contact list of key emergency service partners is in development. Next steps will involve engaging with each to undertake a needs assessment.	- Emergency Service Staff - Postvention Support Analysis - Postvention Service Usage - Postvention Service Evaluation	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - British Transport Police [Harm Reduction Team] - East Midlands Ambulance Service [Senior Manager for Quality] - Northamptonshire Police - Northamptonshire Fire and Rescue Service [Prevention, Safeguarding and Partnerships Manager]

4.3 Coordinate a countywide suicide prevention package to support educational establishments	4.3.2 Work with partners to maintain the package and explore opportunities to develop and enhance it	Summer 2022 – Summer 2025	Amber: **Action in progress** The support package is to be reviewed on an annual basis and reshared with educational establishments with key updates.	- Education Postvention Service Map - Educational Establishment Package - Package and Service Evaluation - Self-harm and Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Children, Families and Education Team - Education and Skills Team - Educational Psychology Service - NHFT [CAMHS Clinical Lead Nurse] - NHFT [Suicide Prevention Lead] - Northamptonshire Children's Trust - Reach Collaborative - NNC and WNC's Safeguarding in Education Teams - Service Six [Chief Executive Officer] - SPSG Partners Communication Teams - University of Northampton [Free2talk Lead]

4.4 Work with commercial organisations to shape postvention support	4.4.1 Engage with relevant commercial organisations, review existing practice, and identify areas requiring development	Winter 2023 – Winter 2024	Grey: **Action timescale has not begun**	- Self-harm and Suicide Indicators - Postvention Support Guidance	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Commercial Organisations - SPSG Partners
4.5 Explore opportunities to develop intelligence and data on bereavement services and those bereaved by suicide from across the suicide prevention partnership	4.5.2 Work with partners to explore and evaluate further intelligence and data sources, including practical support, and use the findings to enhance and develop the available support	Summer 2023 – Summer 2024	Amber: **Action in progress** Next steps involve bereavement service partners exploring and evaluating the monitoring system and using the findings to enhance and develop the available support.	- Additional Intelligence and Data Sources - Postvention Support Data - Self-harm and Suicide Indicators	Lead agencies: - Child and Adolescent Bereavement Service [Service Coordinator] - Service Six [Chief Executive] - SOBS [Chief Executive Officer] - Coroner's Office [Coroner's Office Manager] Supporting agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - SPSG Partners - Public Health NNC and Public Health WNC [Public Health Consultant]

	4.5.3 To evaluate the sustainability of the pilot Northamptonshire Support After Suicide (N-SAS) service	Winter 2023	Amber: **Action in progress** Awaiting update on the evaluation from the leading agency.	- Evaluation Report	Lead agency: - Kelly's Heroes [Chief Executive Officer] Supporting agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health NNC and Public Health WNC [Public Health Consultant]

Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour Completed actions for Priority 5 include: 5.1.1, 5.2.1. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
5.1 Develop a local Media Framework to support responsible reporting of suicide	5.1.2 Develop and sustain good working relationships with local media organisations to support cooperative and transparent working partnerships	Ongoing	Amber**: Action in progress** Continued engagement with local media partners to promote the framework and support cooperative and transparent working partnerships.	- Established Relationships with Media Organisations - Evaluation of Reporting - Media Framework - Self-harm and Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Local Media Organisations - Northampton Samaritans [Director] - SPSG Partners Communication Teams

Priority 6: Support research, data collection and monitoring Completed actions for Priority 6 include: 6.1.1, 6.1.2, 6.2.1, 6.3.1, 6.5.1. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
6.4 Support the development of the Mental Health JSNA to inform future actions	6.4.1 Support the development of the Mental Health JSNA and identify recommendations for future consideration within this Strategy	Winter 2022 – Winter 2024	Amber: **Action in progress** The Mental Health JSNA is in development. Identifying recommendations for future consideration will begin once each chapter of the JSNA is completed.	- Mental Health JSNA - Recommendations and Action Plans	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - SPSG Partners
	6.4.2 Support the identification and delivery of recommendations for the CYP Mental Health JSNA chapter	Winter 2023 – Winter 2024	Amber: **Action in progress** The CYP chapter of the Mental Health JSNA has been completed. Recommendations are currently being identified and will be detailed in an Action Plan.	- CYP Mental Health JSNA Recommendations and Action Plan	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - SPSG Partners

Priority 7: Reducing rates of self-harm as a key indicator of suicide risk Completed actions for Priority 7 include: 7.1.1. For details, refer to Appendix A.					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
7.1 Improve awareness and understanding of services offering support for self-harm in Northamptonshire	7.1.2 Work with partners to promote self-harm services and support to identified groups once mapping is complete	Summer 2022 – Winter 2024	Amber**: Action in progress** Actions are currently underway to improve local data and intelligence on self-harm. Next steps include working with partners to promote services and enhance engagement with identified groups.	- Data on Service Users - Self-Harm Services and Support Map	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - SPSG Partners - Services Offering Self-Harm Support
7.2 Improve data and intelligence of self-harm in Northamptonshire	7.2.1 Work with identified partners to develop a picture of self-harm data and intelligence in Northamptonshire	Winter 2022 – Summer 2025	Amber**: Action in progress** Actions are currently underway to improve local data and intelligence on self-harm. Next steps include working with partners to expand this picture.	- Self-Harm and Suicide Indicators - Self-Harm Data Report - Self-Harm Recommendation Report	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - Northamptonshire ICB [Programme Manager, MHLDA Collaborative]
	7.2.2 Work with identified partners to identify recommendations for future consideration within this Strategy	Summer 2024 – Summer 2025	Grey**: Action timescale has not begun**		
7.3 Support the development of a self-harm pathway for children and young people	7.3.1 Support the development of a self-harm pathway for children and young people	Winter 2023 – Summer 2025	Amber: **Action in progress**	- Self-Harm Hospital Admission Data - Self-Harm Indicators - Self-Harm Pathway	Lead agency: - Northamptonshire ICB [Transformation Manager Children and Young People Mental Health] Supporting agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health NNC and Public Health WNC [Public Health Consultant]

Priority 8: Additional Actions from 1st Annual Review 2023					
Objective	**Action**	**Timescale**	**RAG Status**	**Outputs**	**Stakeholders**
8.1 Continue to develop suicide prevention plans in Northamptonshire following local need	8.1.1 Restructure of the Northamptonshire Suicide Prevention Steering Group in line with NICE guidelines	Winter 2023 –Summer 2024	**Grey: Action timescale has not begun**	- Membership List - Data Sharing Agreement	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - Northamptonshire ICB [Programme Manager, MHLDA Collaborative]
	8.1.2 Complete a map of Northamptonshire's Mental Health Service Pathways to identify barriers to access	Spring 2024 – Spring 2025	**Grey: Action timescale has not begun**	- Service Pathways Map - Self-harm and Suicide Indicators	Lead agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - NHFT [Suicide Prevention Lead] - Public Health NNC and Public Health WNC [Public Health Consultant] - Local Area Partnership Leads NNC and WNC Supporting agencies: - Identified SPSG Partners

	8.1.3 Develop a self-harm support package for educational establishments in Northamptonshire	Summer 2023 – Summer 2025	Amber: **Action in progress** The package is currently in development.	- Educational Establishment Package - Package and Service Evaluation - Self-harm and Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - Services Offering Self-Harm Support - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - NHFT [Suicide Prevention Lead
	8.1.4 Develop an online harms support package for educational establishments in Northamptonshire	Spring 2024 – Summer 2025	Grey: **Action timescale has not begun**		Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - Services Offering Self-Harm Support - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - NHFT [Suicide Prevention Lead

	8.1.5 Review the pilot support package for Call Handlers in the WNC Customer Service Team for improvements and roll out to Call Handler Teams across the county	Autumn 2023 – Spring 2024	Amber: **Action in progress** The review of the package is currently underway.	- Evaluation of Package - Self-harm and Suicide Indicators	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - WNC Customer Service Team - NNC and WNC Teams with Call Handlers
	8.1.6 Embed formal processes with Adult and Children and Young People Safeguarding Boards to support with suicide cases	Spring 2024 – Spring 2025	Grey: **Action timescale has not begun**	- Safeguarding Processes	Lead agency: - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - Northamptonshire Safeguarding Adults Board - Northamptonshire Safeguarding Children Partnership

	8.1.7 Commission a 24/7 all-age digital support offer for residents of Northamptonshire	Winter 2023 – Winter 2024	Amber: **Action in progress** The provider of a 24/7 digital offer is currently being changed.	- Clinical Insight Reports - Service User Data	Lead agencies: - Mental Health Innovations [Head of Commissioned Partnerships] - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: -Northamptonshire ICB [Programme Manager, MHLDA Collaborative]
8.2 Continue to develop suicide prevention plans in Northamptonshire following the National Suicide Prevention Strategy guidance	8.2.1 Explore data and trends for people with Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), and/or learning disabilities to inform the development of campaigns and future work	Spring 2024 – Spring 2025	Grey: **Action timescale has not begun**	- Learning Disability, ASD and ADHD Indicators - Campaign Plan	Lead agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health NNC and Public Health WNC [Public Health Consultant] Supporting agencies: - Identified SPSG Partners - Relevant local services
	8.2.2 Work with local domestic abuse services to support awareness and understanding of mental health and suicide prevention	Spring 2024 – Summer 2025	Grey: **Action timescale has not begun**	- Domestic Abuse Indicators - Support Package	Lead agencies: - Public Health NNC and Public Health WNC [Public Health Consultant] - Northamptonshire Domestic Abuse service - Voice Northants - Eve Supporting agencies: - Identified SPSG Partners

Appendix

Appendix A

Find below the completed actions following the 1st annual review of the Suicide Prevention Strategy Action Plan 2022-2025. These actions are not represented in the Updated Action Plan above.

Priority 1: Reduce the risk of suicide in key high-risk groups				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**
1.3 Continue to monitor suicide data and intelligence to maintain our understanding of high-risk groups and inform trends and emerging issues	1.3.1 Evaluate the findings from the Coroner's Audits	Autumn 2022	**Green: Action complete** A report has been developed following a deep-dive audit on local data. The audit will continue on a regular basis.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Coroner's Office [Coroner's Office Manager] - Northamptonshire Police - Northamptonshire Safeguarding Adults Board - Northamptonshire Safeguarding Children Partnership
	1.3.3 Evaluate findings from the local Real Time Surveillance System (RTSS)	Ongoing	**Green: Action complete** Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly. Data and intelligence will continue to be collected and monitored, with an escalation protocol in place to highlight if actions are required to reduce further impact.	
	1.3.4 Establish and embed links with local adult and children and young people safeguarding partnerships to enhance intelligence through shared learning	Ongoing	**Green: Action complete** Links with safeguarding boards have been made with the agreement of collaborative working when appropriate.	
1.4 Explore opportunities to enhance intelligence on local suicide from across the suicide	1.4.1 Work with partners to establish additional sources of data and intelligence	Ongoing	**Green: Action complete** Opportunities to share and receive relevant data and intelligence are explored regularly.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agency: - SPSG Partners

prevention partnership	1.4.2 Align Suicide Prevention Strategy with Mental Health, Learning Disabilities & Autism Equalities Enabler Group and Population Health Management Programme	Summer 2022	**Green: Action complete** The Suicide Prevention Strategy and Action Plan is aligned to these areas and updated on at regular meetings.	Lead agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - MHLDA Equalities Enabler Group - Population Health Management Programme
1.5 Explore solutions that enhance the development of protective behaviours and suicide prevention	1.5.1 Implement, monitor and evaluate Emotional Coaching Pilot initiative for parents/ carers of children with suicidal ideation	Winter 2022	**Green: Action complete** The Emotional Coaching Pilot initiative has been implemented and is being monitored. There is a growing evidence base that this intervention is successful, and a post-meta-analysis questionnaire showed increased parental ability to recognise, manage and support child's emotions post completion of the course.	Lead agency: - NHFT [0-19 Team] Supporting agencies: - Children and Young People Collaborative - NHFT [CAMHS Clinical Lead Nurse] - NHFT [Suicide Prevention Lead] - Public Health NNC and Public Health North WNC [Public Health Consultant]
	1.5.2 Monitor and evaluate Psychoeducation & Respite pilot for Mental Health carers	Winter 2022	**Green: Action complete** This pilot was completed and evaluated in an outcomes report published in July 2023. The pilot showed positive improvements to the wellbeing and mental health of carers, but also highlights the increasing number of carers presenting at a point of crisis.	Lead agencies: - Mental Health Northamptonshire Collaborative Lead - Northamptonshire Carers [Chief Operating Officer] Supporting agencies: - MHLDA Population Health & Prevention Pillar - Northamptonshire MIND [Chief Executive Officer]

	1.5.3 Expand Improving Access to Psychological Therapies (IAPT) Talking Therapies Service in line with Long-Term Plan ambitions, and implement Long-Term Conditions (Physical Health) pathways into the model	April 2025	**Green: Action complete** Completed. All planned investment has been allocated to service lines. LTC Pathway has been implemented. There is some financial reconciliation to be done across all MH pathways, but this is an internal exercise and should not affect the fact that we did as we planned to do for 1.5.3	- Pillar Updates Service Level Data (Access & Outcomes)
	1.5.5 Expand Individual Placement & Support (IPS) services in line with Long-term Plan ambitions to assist with SMI to obtain and maintain employment	April 2024	**Green: Action complete** This was completed. As with 1.5.3. IPS investment has been made. The service is not yet meeting its access targets and we feel this will require more investment in 2024-25 to deliver access to 696 services users per year (KPI). However, also worth mentioning that additional investment has gone into NHS Talking Therapies services to provide Employment Advisors that work alongside psychological therapists for people who have common mood disorders linked to employment concerns	- IPS Expansion Plan - Service Level Data (Access & Outcomes)
	1.5.6 Expand access to Specialist Perinatal Mental Health and Maternity Mental Health service in line with Long-Term Plan ambitions (to 10% of live birth rate). Incorporate assessment & signposting for perinatal partners	April 2023	**Green: Action complete** Access to Specialist Perinatal Mental Health and Maternity Mental Health service has been expanded in line with Long-Term Plan ambitions.	Lead agency: - NHFT [Specialist Perinatal Service Manager] Supporting agency: - NHFT [Suicide Prevention Lead]

	1.5.7 Investigate viable solutions with partners and providers for future consideration	Ongoing	**Green: Action Complete** Viable solutions with partners and providers are investigated regularly.	Lead agencies: - NHFT [Suicide Prevention Lead] - Public Health Northamptonshire [Public Health Consultant] Supporting agency: - SPSG Partners

Priority 2: Tailor approaches to improve mental health in specific groups				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**
2.2 Analyse intelligence to improve understanding of local mental health services and service users	2.2.1 Analyse existing sources of data and intelligence and identify issues for future consideration	Ongoing	**Green: Action complete** Existing sources of data and intelligence are analysed regularly.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Coroner's Office [Coroner's Office Manager] - Healthy Minds Healthy Brains Pillar - Northamptonshire Police - Northamptonshire Safeguarding Adults Board - Northamptonshire Safeguarding Children Partnership - SPSG Partners
	2.2.3 Review findings from the Real Time Surveillance System and Coroners Audits to inform understanding of mental health services and service users	Ongoing	**Green: Action complete** A report has been developed following a deep-dive audit on local data. The audit will continue on a regular basis. Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly. Data and intelligence will continue to be collected and monitored, with an escalation protocol in place to highlight if actions are required to reduce further impact.	
	2.2.4 Establish and embed links with local safeguarding partnerships and review findings to inform understanding of mental health	Ongoing	**Green: Action complete** Links with safeguarding boards have been made with the agreement of collaborative working when appropriate.	

	2.2.5 Work with partners from across the suicide prevention partnership to explore opportunities for access to additional sources of data and intelligence to inform analysis of services and service users	Ongoing	**Green: Action complete** Opportunities to access additional data and intelligence sources are explored regularly.	
2.3 Monitor trends in data and intelligence to inform priorities	2.3.1 Analyse existing sources of data and intelligence to inform local groups for prioritisation for mental health improvements and issues for further consideration within this Strategy	Ongoing	**Green: Action complete** Analysis of data has contributed to the identification of local high-risk groups, with continued regular analysis of existing data sources.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agency: - SPSG Partners
2.4 Sign up to the Prevention Concordat	2.4.1 Coordinate sign up to the Prevention Concordat	Summer 2022	**Green: Action complete** There is Northamptonshire system-wide sign up to the National Mental Health Prevention Concordat since November 2022.	Lead agencies: - Integrated Care System Partners - Public Health Northamptonshire [Public Health Consultant]
2.5 Maintain delivery of the Wave 3 Transformation Programme	2.5.1 Continue delivery of STORM™ training	Summer 2023	**Green: Action complete** STORM™ training has continued to be delivered to clinical staff.	Lead agency: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - NHFT [Suicide Prevention Lead] - SPSG Partners
	2.5.2 Coordinate subscription to Stay Alive app	Summer 2023	**Green: Action complete** The Stay Alive app was subscribed to, with no cost implication, and included local signposting information.	
	2.5.3 Coordinate production and distribution of Protect Cards through partner channels	Summer 2023	**Green: Action complete** Protect Cards were produced and continue to be distributed to relevant audiences.	

2.7 Strengthen and enhance response to people with suicidal ideation/ self-harm making transition from Children and Young People to Adult pathways	2.7.2 Expand the model of 16-25's Enhanced Support (wrap around) service and align to the wider transitions workstream in 2022-23	Winter 2023 – Summer 2024	**Green: Action complete** The expansion and alignment of the 16-25's Enhanced Support Service model has been completed.	Lead agency: - Youth Works [Chief Executive Officer] Supporting agencies: - Healthy Minds Healthy Brains Pillar - MHLDA Outcome-Based Pathways Pillar - NHFT [Clinical Lead Nurse Child and Adolescent Mental Health Services (CAMHS)] - North Northants and West Northants Council's Leaving Care Teams - Public Health Northamptonshire [Public Health Consultant]

Priority 3: Reduce access to means of suicide				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**
3.2 Engage with partners and retailers to influence policy change to reduce access to certain means of suicide	3.2.1 Evaluate data and intelligence to identify local means of suicide for prioritisation	Summer 2022	**Green: Action complete** Data and intelligence have been evaluated to identify local means of suicide.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - North and West Northants Council's Trading Standards - Northamptonshire Retailers
3.3 Continue to monitor existing suicide data and intelligence sources to inform emerging methods and local trends	3.3.1 Evaluate the findings from the Coroner's Audits	Ongoing	**Green: Action complete** A report has been developed following a deep-dive audit on local data. The audit will continue on a regular basis.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Coroner's Office [Coroner's Office Manager] - Northamptonshire Police - Northamptonshire Safeguarding Adults Board - Northamptonshire Safeguarding Children Partnership - SPSG Partners
	3.3.2 Evaluate findings from the local Real Time Surveillance System	Ongoing	**Green: Action complete** Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly. Data and intelligence will continue to be collected and monitored, with an escalation protocol in place to highlight if actions are required to reduce further impact.	

	3.3.3 Establish and embed links with local safeguarding partnerships	Ongoing	**Green: Action complete** Links with safeguarding boards have been made with the agreement of collaborative working when appropriate.	
	3.3.4 Work with partners to explore opportunities for access to additional sources of data and intelligence to inform analysis of suicide methods	Ongoing	**Green: Action complete** Opportunities to share and receive relevant data and intelligence are explored regularly.	

Priority 4: Provide better information and support to those bereaved or affected by suicide				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**
4.3 Coordinate a countywide suicide prevention package to support educational establishments	4.3.1 Work with partners to map existing postvention services and carry out a needs assessment and gap analysis on the current position. Use the results of the needs assessment and gap analysis to identify and coordinate essential service and information requirements, to develop a comprehensive package which will provide support to the affected community	Summer 2022 – Autumn 2022	**Green: Action complete** A support package for all educational establishments in Northamptonshire has been developed to support in the event of a suspected death by suicide in a school community, including postvention and prevention information.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Children, Families and Education Team - Education and Skills Team - Educational Psychology Service - NHFT [CAMHS Clinical Lead Nurse] - NHFT [Suicide Prevention Lead] - Northamptonshire Children's Trust - Reach Collaborative - Safeguarding in Education Team - Service Six [Chief Executive Officer] - SPSG Partner Communication Teams - University of Northampton [Free2talk Lead]

4.5 Explore opportunities to develop intelligence and data on bereavement services and those bereaved by suicide from across the suicide prevention partnership	4.5.1 Work with partners to devise a monitoring system to provide intelligence on Wave 3 support bereavement services	Summer 2022 – Summer 2023	**Green: Action complete** A monitoring system has been established and is reported through the MHLDA Data Lab.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Child and Adolescent Bereavement Service [Service Coordinator] - Coroner's Office [Coroner's Office Manager] - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Service Six [Chief Executive] - SOBS [Chief Executive Officer] - SPSG Partners - We Mind and Kelly Matters [Chief Executive Officer]
4.6 Embed the local Bereavement Real-Time Referral Pathway	4.6.1 Work with partners to evaluate existing referral pathways for local bereavement services, and devise solutions to develop and embed the pathways across the system	Summer 2022 – Summer 2023	**Green: Action complete** A local bereavement real-time referral pathway has been embedded; review of this pathway will remain ongoing.	Lead agencies: - Northamptonshire ICB [Programme Manager, MHLDA Collaborative] - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Child and Adolescent Bereavement Service [Service Coordinator] - Service Six [Chief Executive] - SOBS [Chief Executive Officer] - SPSG Partners - We Mind and Kelly Matters [Chief Executive Officer]

Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**

5.1 Develop a local Media Framework to support responsible reporting of suicide	5.1.1 Work with local media organisations to produce a framework that provides guidance on reporting and includes the promotion of prevention and sources of support, to encourage good standard practice and minimise impact on communities	Autumn 2022 – Summer 2023	**Green: Action complete** A local Media Reporting Framework has been developed and shared with local media colleagues following World Suicide Prevention Day September 2023.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Local Media Organisations - Northampton Samaritans [Director] - SPSG Partner Communication Teams
5.2 Establish a local media monitoring system	5.2.1 Develop a local system to monitor reporting of suicide and self-harm across local, regional, national, and social media channels. Review outcomes and identify recommendations for adjustments to existing practice	Winter 2022	**Green: Action complete** A local monitoring system is in place, with support from communication colleagues when reporting concerns arise.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Northampton Samaritans [Director] - SPSG Partner Communication Teams

Priority 6: Support research, data collection and monitoring				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**
6.1 Undertake an audit of Coroners cases to enhance our understanding of the local situation (audit since last audit) Annual audit ongoing	6.1.1 Complete an audit on closed Coroners cases between September 2018 and April 2022. Analyse findings and identify findings and recommendations for future consideration	June 2022 – October 2022	**Green: Action complete** A report has been developed following a deep-dive audit on local data.	Lead agencies: - Coroner's Office [Coroner's Office Manager] - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - SPSG Partners - We Mind and Kelly Matters [Chief Executive Officer]
	6.1.2 Commence an annual audit programme to maintain intelligence	June 2023 onwards	**Green: Action complete** The audit will continue on a regular basis.	
6.2 Continue to work with partners to maintain the Northamptonshire Suicide Real Time Surveillance System (RTSS)	6.2.1 Monitor and analyse data from the SRTSS and identify findings and recommendations for future consideration	Ongoing	**Green: Action complete** Local real-time surveillance data is collated on suspected deaths by suicide and is evaluated regularly.	Lead agencies: - Coroner's Office [Coroner's Office Manager] - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Northamptonshire Police - SPSG Partners

6.3 Develop an escalation protocol for suspected suicide cases	6.3.1 Establish a Suicide Prevention partnership protocol to undertake a timely review relating to suspected suicide cases which require escalation following notification via the RTSS	Summer 2022	**Green: Action complete** An escalation protocol has been developed and is followed when actions have been identified to reduce further impact.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - Co-opted SPSG Partners - NHFT [Suicide Prevention Lead] - Northamptonshire ICB [Programme Manager, MHLDA Collaborative]
6.5 Explore opportunities to develop intelligence and data sources from across the suicide prevention partnership	6.5.1 Work with partners to maximise opportunities for access to existing intelligence and data and look for additional opportunities to increase sources utilised	Ongoing	**Green: Action complete** Opportunities to develop intelligence and data sources from across the suicide prevention partnership will continue to be explored.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - SPSG Partners

Priority 7: Reducing rates of self-harm as a key indicator of suicide risk				
Objective	**Action**	**Timescale**	**RAG Status**	**Stakeholders**
7.1 Improve awareness and understanding of services offering support for self-harm in Northamptonshire	7.1.1 Produce a map of current self-harm services and support available in Northamptonshire to enable prioritisation and identify areas for future consideration	Summer 2022 – Summer 2024	**Green: Action complete** A map of self-harm services and support has been developed.	Lead agency: - Public Health Northamptonshire [Public Health Consultant] Supporting agencies: - SPSG Partners

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West Northamptonshire Council

People sleeping rough or at risk of sleeping rough: needs assessment

Final Report
Version: 14 July 2023

West Northamptonshire Council

Contents

West Northamptonshire Council

0. Executive Summary

Introduction

This mixed methods research was completed over four months between February and May 2023

The refreshed Health and Wellbeing Board (HWB) under the new unitary council arrangements recognises the significance that settled, good quality housing, and tailored support to meet individuals' needs, can have on reducing health inequalities and improving life chances. **This has made homelessness & reducing rough sleeping a high priority for the HWB and the wider 'system'.**

The Council's Public Health and Housing Services have therefore commissioned PPL, in conjunction with Homeless Link, to conduct this research, which has two fundamental parts:

a) **an independent assessment of the needs of people sleeping rough**, at risk of rough sleeping for the first time and those who are at risk of returning to rough sleeping, within West Northamptonshire. 'Needs' is defined as physical and mental health needs as well as accommodation and support needs

b) **review the current customer journey, including existing accommodation and support**, identify gaps and make recommendations on maximising service provision, including new operating models and approaches, to inform a new commissioning framework for supported accommodation and services for this cohort

In-scope cohort for this needs assessment

1. **People at immediate risk of sleeping rough with very minimal prior experience** (requiring emergency prevention work)
2. **People currently sleeping rough** (official count definition)
3. **Rough sleepers placed in "off the street accommodation"** intended to last for 6 months or less (hostels/ TA placements/ shelters/ winter provision/ hotels/ refuges/ other assessment bed settings)
4. **Rough sleepers currently 'sofa surfing'** or in other insecure, short-term arrangement
5. **People in medium/ long term accommodation** (intended to last > 6 months e.g. Single Homelessness Pathway, social housing, PRS AST) with a history of rough sleeping, and are **at high risk of rough sleeping again**

Approach & methodology

Collation and analysis of quantitative datasets

Over 23 data requests were made to various stakeholders in the system. Cost effectiveness analysis and financial modelling were completed based on financial and demand data received.

Stakeholder engagement with professionals working in the system

A series of 1-2-1 interviews and focus groups were organised with professionals across the local system, as well as extensive wider engagement with a broader range of stakeholders. A multi-agency steering group was established to support the work.

Engagement with people with lived experience

Homeless Link completed a series of interviews and focus groups in four different locations to gather insights into rough sleepers' health needs and experiences of access to health and care services; and the single homelessness pathway.

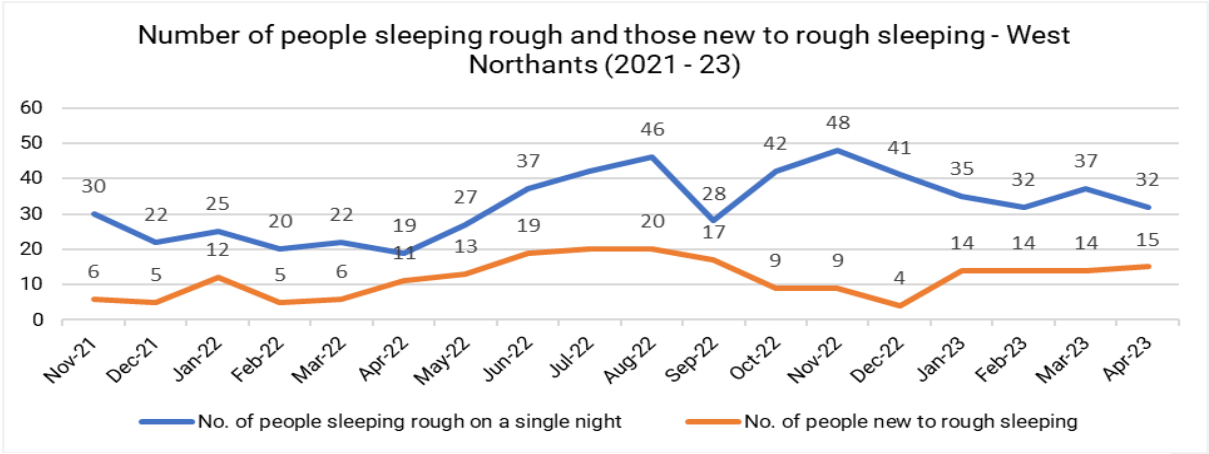
Desktop review of best practice and existing evidence base

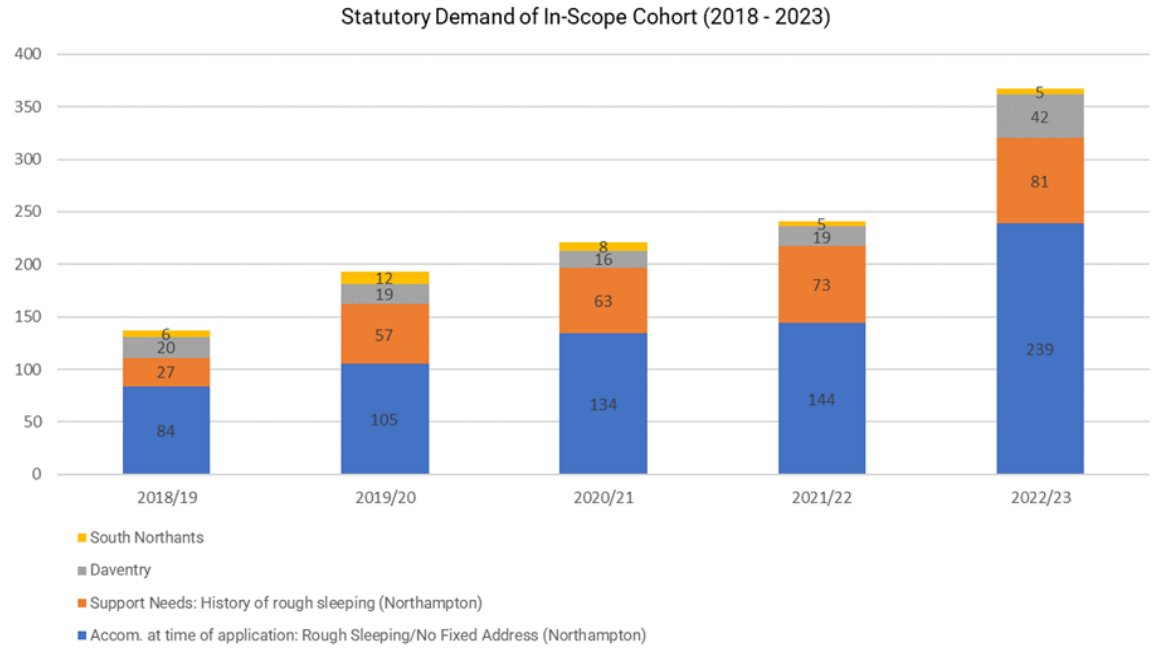
An extensive review was completed and findings summarised at relevant points in the full report.

Current Trends & Demand

Demand has remained relatively consistent in recent years, although statutory homelessness data shows a growing number of people rough sleeping or with no fixed abode at the time of their application

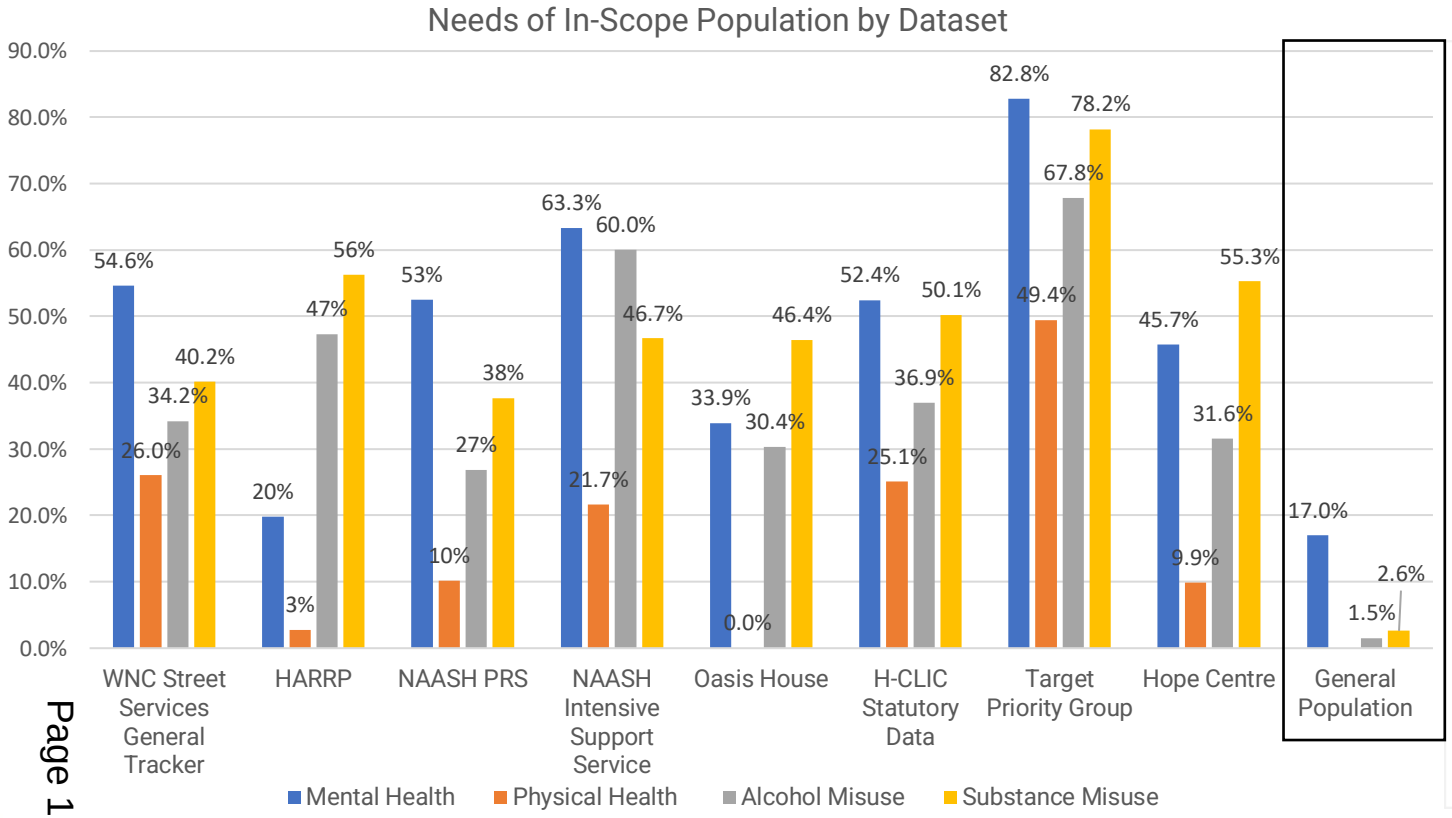
- The top right chart shows a calculated figure of people who have slept rough during the last 18 months in West Northants, based on **monthly DELTA returns to Government**. It is a casework figure compiled by outreach teams and other service providers and covers both those understood to be sleeping rough on a single night each month; and people who are understood to be new to sleeping rough during that month, within the authority
- The numbers in the bottom right graph are a sub-section of overall **statutory homelessness demand (H-CLIC)** to reflect our in-scope cohort. They include those whose accommodation at the time of a statutory homelessness application was "Rough Sleeping" or "No Fixed Abode" and/ or those with a "History of Rough Sleeping" support need. The data shows an increasing growth in demand through this period with **706 households in total recorded since 2018/19 as Rough Sleeping or No Fixed Address (NFA) at the time of application**, while a further 301 had a history of Rough Sleeping listed as a support need
- Data received from the **General Tracker used by the Street Services Team**, which records and maintains contact and progress of individuals, contained **n=968 records over the period since recording began (1st January 2021)** to March 2023. 222 records were last updated between January - March 2023 highlighting some kind of activity or status update for around a quarter (23%) of individuals on the tracker. 217 people on the tracker were last presented to the weekly Multi-Agency Assessment Panel in 2021, 225 people last presented to Panel in 2022, and 29 between January-February 2023.
- Throughout the **Everyone In** response period during the pandemic (March 2020 – March 2021, when local authorities were required to accommodate people sleeping rough and those in accommodation where it was difficult to self-isolate, regardless of entitlement) the **authority accommodated 195 people (160 men and 35 women)**

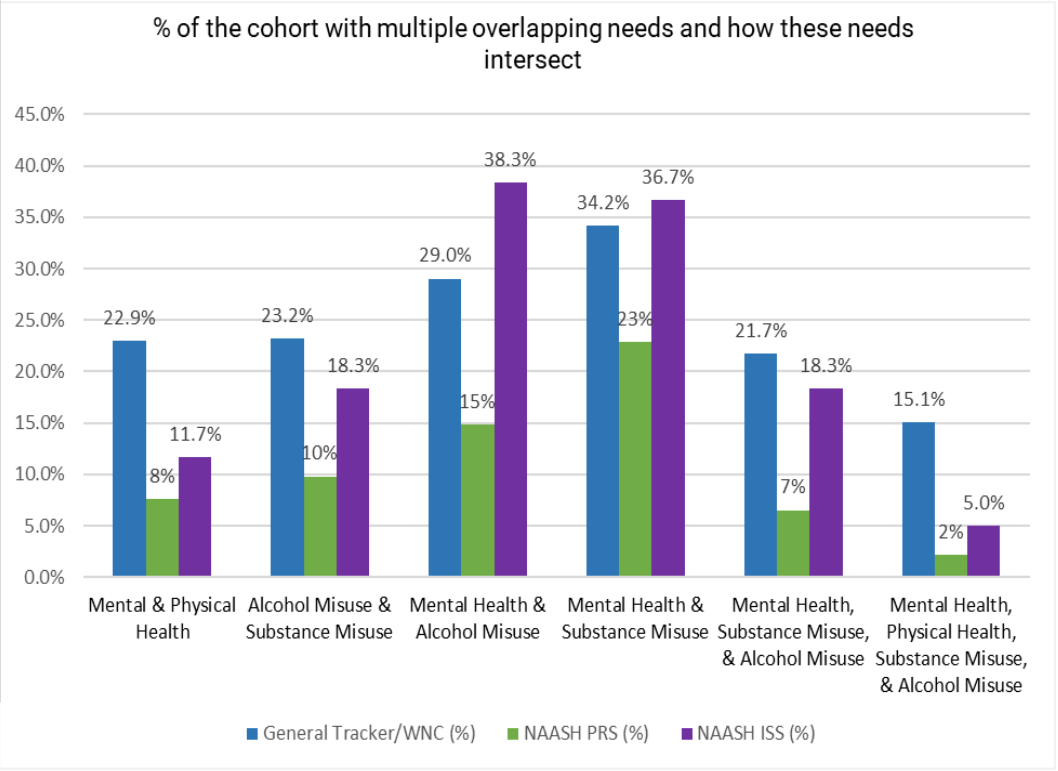




Prevalence of Need: Summary (1/2)

Looking at the needs of those who use the Council's homelessness services across the datasets, the proportion of different need profiles is summarised below, with a focus on Mental and Physical Health needs, and Alcohol and Substance misuse – the needs recorded most widely across organisations and the datasets received (bottom left). Although timescales vary, and so direct comparison is not possible, **it is still apparent that mental health and substance misuse are areas of particularly high need within the local population; and far higher than the general population.** Multiple and coexisting needs are also common in this population, and the bottom right chart illustrates how these needs interact across three of the core datasets where this could be analysed.

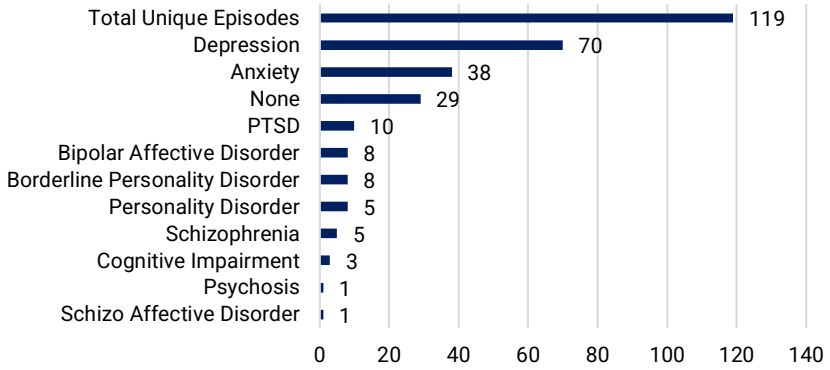


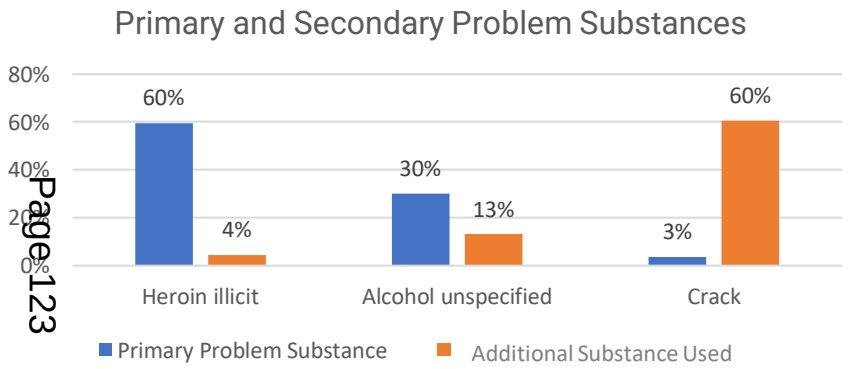


Prevalence of Need: Summary (2/2)

The below graphs contain 2-year snapshot data from the **Northampton Homeless Treatment Team's (NHTT)** records, and outline in more detail the mental health and substance misuse needs of the service users working with the team. **230 service users across the 2-year period reported under the team as rough sleeping or at risk of rough sleeping, and worked within structured treatment.**

Support Needs: Mental Health Diagnosis – NHTT-CGL data (18th April 2021-2023)





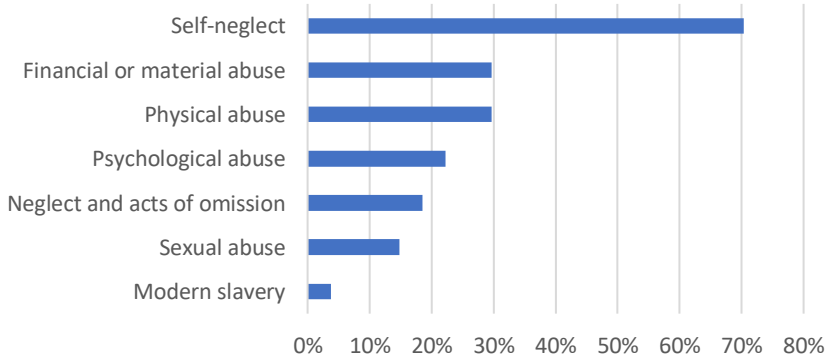
There were **64 individuals (11%)** present on both the Homelessness panel and **Adult Social Care** datasets; indicating some interaction with Adult Social Care. **18 of these individuals (28%) have experienced three or more different types of social care interactions.** 14 **Mental Health Act assessments** have been completed since Dec 2020, with 6 resulting in section 3 (treatment order), 4 in section 2; and 4 in no further action. In total, **72 safeguarding concerns were reported since December 2020.** 45 (63%) of these were categorised as an "Alert", with 27 (37%) categorised as "Enquiry" and resulting in an investigation.

51 individuals (9% of our cohort) had initial contacts logged with Adult Social Care since Dec 2020

14 individuals have had a Care Act Assessment

8 individuals have received packages of care

Safeguarding Enquiries since Dec 2020 (n=27): Types of abuse



Lived Experience Voice

A selection of quotes have been selected from the lived experience research to illustrate key points and findings

[GP Access] "They just, they were, I'm very, quite complicated. I've got PTSD, I've got everything, I've got quite a lot of problems so like they, they, they weren't very understanding at all with my mental health"

"I have been able to see a dentist, but it was too late. The damage from drugs on my teeth… there is nothing they can do for free and I cannot afford treatment"

[GP Access] "If you say call in the morning and you don't get through, you know, you don't get through with the line because it's constantly engaged…And it is only when they tell you can call between eight to nine . . . when you get through to make an appointment they say it's all places are full"

"It feels like they care here [HAARP]. They don't want you to leave if they think you're gonna fall into pieces as soon as you leave. Within 48h of going to the Hope centre for the first time, I was in here [HAARP] and I enter rehabilitation as well. I got medication to start my addiction withdrawal and S2S as well"

"Had to wait perhaps 6 months to finally see a therapist for my mental health problems. 6 months! Thankfully I am not suicidal as I would be dead by now. So much can happen in 6 months"

"Once I got a room in the shared house, I felt like all the support I received stopped in one go. I was further away from the town centre, my friends, and no one was checking on me. I didn't get on well with the house mates. I could not do it and started using [drugs] again until I was evicted (….) drug dealers came to the house and that was it (…) back to the street."

"I think sometimes they are not clever, they put alcoholics and drug addicts with people that just got clean. It can't work!"

Professional Voice

A selection of quotes have been selected from the engagement with professional stakeholders to illustrate key points and findings

"Jump through so many hoops - prove that they've engaged. prove, prove, prove"

"From what I see in people's record the support for this cohort, the substance misuse and mental health side is a catch 22 with services not addressing one with the other being present"

"Where rough sleepers are housed also baffles me, as they will put them in hotels in the middle of nowhere when pharmacy is so far away. They want to be around services they require and where they feel safe. They haven't got money for travel and are begging to make money, so money on travel is not possible. If you think about it like this, they are dependent on the drugs and alcohol, so this is the priority need for them over a travel card."

"When people get stuck - they get angry, they use more, they go back onto the streets."

"Admitted a lady to crisis house - was doing really really well. Discharged at night for smoking cannabis. 10pm at night. She was a vulnerable woman and slept rough that night"

"Other agencies we engage with to support this cohort are all working towards the same outcomes however there is a gap in primary and secondary care."

"If we can get them housed quicker, we can organise pick ups for medication and get them better quicker."

"it is 50/50 with whether they come or not"
"won't go to GPs and struggle to show up to pre-booked appointments or to even make an appointment"

Analysis of Current Service Provision | Health & Social Care

We have reviewed current provision against published standards, and the needs identified in the assessment

Key areas of strength and positive practice

- Development of the Northampton Homeless Treatment Team is in line with published standards, recognising the need for specialist homelessness multidisciplinary teams across sectors, and the importance of longer contact times in developing and sustaining trusting relationships. It could be developed further in both size and scope
- Recognition that more effort and targeted approaches are often needed to ensure that health and social care for people experiencing homelessness is available and accessible. The NHTT and dedicated Homelessness Mental Health Practitioner (HMHP) are taking health and social care services to people experiencing homelessness by providing outreach care in non-traditional settings, such as on the street, day centres (Hope Centre) and providing in-reach to some supported accommodation settings (e.g. Oasis House, HARRP Trinity, St. John's Winter Provision)
- Street Services Team working closely with NHTT (including via a drug and alcohol outreach worker) to offer collaborative, assertive outreach to start and maintain engagement with health and social care for people experiencing homelessness; including multi-agency assessments
- Collective effort across agencies to support GP registration at Maple Access if needed, often at the start of engagement to facilitate access to primary care
- Homelessness Mental Health Practitioner has had a positive impact, able to bridge the gap with mental health trust, facilitate mental health diagnoses and care and case management from the appropriate service
- Dedicated housing officer (Hospital Discharge Transitions Officer) working closely with a named hospital coordinator at Northampton General (and with inpatient mental health settings) to flag and address accommodation needs on discharge and support transition between settings (same with prison and care leaver transitions)

Key gaps and opportunities

- Despite its status as the default practice to register with, Maple Access is currently unable to offer enhanced or targeted services to single people who are homeless; generating a number of primary care access issues for this cohort
- Likewise, despite some limited targeted provision; access to primary care dental services is another widely reported issue
- Access issues and dedicated service provision for those with dual diagnosis (co-occurring mental health and substance misuse needs). Although the NHTT and dedicated Homelessness Mental Health Practitioner work closely together 'in a dual diagnosis way', there are widely reported access issues to mainstream mental health services; and no dedicated dual diagnosis workers, joint clinics, formal protocols and partnership working agreements for people experiencing homelessness etc.
- Although there is ongoing work to improve pathways into mental health services for this cohort (supported by the HMHP), there are still a number of access issues linked to the rigidity and lack of flexibility; with no dedicated protocols that recognise the access barriers for this cohort
- A few locations (e.g. Hope Centre) have the makings of a 'one stop shop' for all services to facilitate holistic assessments and wraparound support which is a positive, but these don't currently contain the full complement of services and agencies required. There is a real opportunity to upscale and coordinate this provision with drop-ins, 'open-door' services etc. that people can self-refer to and access (even after any initial support ends)
- There are no intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community, but who do not need inpatient hospital care e.g discharged from hospital (step-down care) or referred from the community who are at acute risk of deterioration and hospitalisation (step-up care).

Key Recommendations | Health & Social Care

Alongside these specific recommendations, there is a clear need articulated by health and social care professionals for more stable accommodation outcomes for this cohort. This would enable the appropriate care and support to be better coordinated, and provides the focus for the remainder of this report

1. To ensure routine **access to primary care**, the enhanced and targeted services for people experiencing homelessness should be reinstated at Maple Access. This might include dedicated GPs, drop-in clinics, in-reach and 'satellite clinics' in local settings etc.

2. The early work of special care dentistry to **increase access to dental treatment** for this cohort should be continued and expanded

3. Ensure **mental health services** have working agreements and tailored eligibility criteria in place for people experiencing homelessness, the agencies that support them and the specialist mental health provision for this cohort. This should facilitate enhanced and easy access to treatment, including a willingness to work around relatively high rates of non-attendance at appointments

4. Alongside the integration of mental health and drug and alcohol services within the NHTT, ensure mental health services and substance misuse and alcohol services have multi-disciplinary **dual diagnosis** partnership working agreements, formal protocols and easy referral pathways in place for people experiencing homelessness. This should encourage a 'no wrong door' attitude

5. Develop **intermediate care services** with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care e.g discharged from hospital (step-down care) or referred from the community who are at acute risk of deterioration and hospitalisation (step-up care).

6. As well as the outreach and in-reach provision, upscale and coordinate provision for this cohort with **co-location and a 'one stop shop'** of all relevant services at an accessible location; with drop-ins, 'open-door' services etc. that people can self-refer to and access

7. The NHTT could benefit from expansion in size to function as the locality's **integrated and multidisciplinary homelessness team** (e.g. additional lead nurse, more recovery workers and lower caseloads/ more contact time is likely to be more cost effective); and in scope in the following opportunity areas:

- Dedicated mental health social worker and/ or specialist homelessness social worker role within outreach undertaking Care Act 2014, Mental Capacity and Adult Safeguarding assessments (acting as Safeguarding Lead)
- Dual diagnosis workers
- Mental Health and psychological professionals in addition to the current NHFT provision given the high prevalence of need e.g. MH practitioners, psychologists, psychiatrists
- Pharmacists are part of local homelessness multidisciplinary teams in other locals areas, and/ or additional prescriber capacity dedicated to this cohort
- Physical rehabilitation (such as occupational therapy and physiotherapy)

8. There is limited interaction between strategic commissioners across sectors, and **joint commissioning for people experiencing homelessness**. Utilise the local strategic governance forums to develop shared strategic priorities for funding and explore the significant opportunities for greater collaboration and commissioning outlined in this report e.g. Housing First. Commissioners across sectors should review and co-ordinate service specifications for retendering, and move towards alignment of commissioning cycles

Current Single Homelessness Pathway | Summary

(Early) identification of people at risk/ sleeping rough

Outreach workers (inc. x1 drug & alcohol)
Undertake outreach sessions, provide housing advice surgeries, visit local services. Caseload: 15 at one time. Continue to support clients after they have moved off the street into accommodation, where necessary.

Navigators
Support those with higher needs through their journey, with freedom to innovate and use personalised budgets. Emphasis on resettlement and sustainment. Caseloads up to 15.

Transition Officers (x3)
Co-located in hospital, probation and leaving care teams.

Triage Officers (x4)
Council first point of contact. Decide whether to refer cases to the Single Homelessness Team (non-priority need).

Single Homelessness Advisor
Triages cases referred in (non-priority presentations). Support case set up in Jigsaw case management system. Work with single people before they reach crisis point.

Weekly multi-agency assessment panel

Comprises various support services and supported accommodation providers, who:

- Meet to discuss new and existing homeless referrals, accommodation voids, arrange assessments and share relevant information.
- Aim to identify the appropriate housing and support pathway for individuals being referred.
- Referrals completed by members of the Street Services Team who 'present' the case. All individuals must meet local connection criteria and be eligible for assistance

Meetings, a chance to:

- Raise any concerns with current residents in the pathway
- Discuss any support available in order to prevent evictions where possible.
- Conclude with an agreed plan and confirmation of who will carry each action out

- There will be cases presented at Panel but then removed / not housed typically (but not exclusively) because:
  - They were considered to have stopped engaging with the service
  - They refused accommodation
  - WNC accepted a main housing duty
  - They were considered to have 'behavioural issues'

Short term/ temporary/ insecure accommodation

Short-term, transitional supported accommodation
Circa 499 units across the core provision, from 10 providers. Two of these providers (HARRP* and NAASH) receive 100% of their referrals from Panel. All providers have a contact at WNC from the Street Outreach Team.

NSAP / RSAP Properties
Additional 35 NSAP / RSAP Properties with x3 Tenancy Support Officers (Northampton Partnership Homes) and NAASH support for x3 dedicated units for women involved in sex work. Placed directly from the street or SWEP. Self-contained 1-bed flats for occupation for up to 2 years, to achieve move on to general needs social housing.

Temporary Accommodation
Some individuals placed in temporary accommodation (nightly paid, B&Bs, hotels etc.) under a statutory s.188/s.193 duty. Limited designated support for these households.

St John's Winter Provision
25 unit, 24/7 staffed student accommodation during SWEP and between Dec/ Jan and 31 March.

Accommodation for Ex-Offenders (AfeO)
Coordinated by NAASH. Provide accommodation in the private rented sector for up to 2 years following release from prison, with x2 tenancy support officers, landlord incentives and personalisation budget.**

Secure/ settled/ long term accommodation

Social Housing
Main move on option currently available. Move on protocol with NPH (after 6 months stay) and number of providers. NPH Housing Support Service offer tenancy sustainment to those that need it, including those who have experienced rough sleeping. Also provide a resettlement service for prospective tenants to ease transition, 6-weeks of resettlement work. Caseloads of circa 1:25. There is also an RSI-funded Tenancy Sustainment Officer (Social Rent) supporting people's housing application and resettlement, encouraging positive engagement; and building relationships with social landlords.

Private Rented Sector
Currently not used as a move on option. Social Lettings Agency Manager and 2 PRS focused posts within the statutory service. Recently (late 2022) landlord incentive offer enhanced. Stated intention to use for those in the pathway with arrears and to support PRS move on with rent in advance or top-up; alongside support from the TA team. Not yet materialised

Long-Term Supported Accommodation
Evidence of some individuals placed in long term supported accommodation under a health/care-led and funded response.

*Although HARRP Trinity was originally conceived as first stage assessment hub provision; this has not often been achievable and is therefore included here.

The project has accommodated 38 people; with a target of 40 to end of March 2023. As at end Feb 2023, 4 people had successfully moved on from AfEO. Also transitional accommodation **(Community Accommodation Service – CAS3) providing temporary accommodation for up to 84 nights for homeless prison leavers and those moving on from Approved Premises (CAS1) or the Bail Accommodation and Support Service (CAS2), and assistance to help them move into settled accommodation.

Current Pathway | Accommodation-Based Support

Due to data limitations, a number of assumptions have been made to estimate the current number and balance of support needs to enable comparison against the existing provision within the pathway. There is currently significant unmet need in the higher intensity support categories

Current Need for Accommodation & Support (circa. 716 – 801 single households)

No/ low	Medium	High/ Complex	Very High/ Specialist
300 - 340	300 - 340	106	10 - 15
40 – 45%	40 – 45%	14%	1-2%

VS.

Current Provision within the Single Homelessness Pathway (circa. 534 units)

Low	Low/ Med	Med	Med/ High	High/ Complex
124	296	37	37	40
23%	55%	7%	7%	7%

Categories of Support

Level of need/ support	Description
No/ low	• People who are newly homeless and/or have less significant health, care or support needs • Want/ need only some support to know how to manage a tenancy. Can foresee being able to do this eventually on their own
Medium	• People who have a significant or repeat history of rough sleeping and/or have health, care and support needs best met through supported accommodation, or ideally a housing-led placement with sufficient floating support i.e. met by mainstream support services in the community • Dealing with issues, most often addiction, and requiring support until stable
High/ Complex	• Long-term rough sleepers, and those requiring extensive support through supported accommodation with high-level on-site support or Housing First (ideal) • Need intensive support, likely to continue to need this indefinitely, but doesn't necessarily require 24-hour on-site provision
Very High/ Specialist	• Want and need 24-hour on-site support for the rest of their lives • Needs so complex that independent living within the community is not possible or preferable for whatever reason (safety, risk to self or others, choice), and for whom shared, supported accommodation is the preferred housing option

Additional unmet need identified:

- Tailored specialist/ dedicated accommodation and support provision for women is limited but already recognised as a target area
- Lack of provision for high-risk cases from providers in the current pathway
- Those with "No recourse to public funds" struggle to access current "first stage" accommodation outside of Winter Provision
- There are a number of care leavers with complex needs relying on unsuitable TA as the right provision isn't available currently
- There is limited provision outside of Northampton town; with those from rural areas often struggling to access the pathway

Reshaping the Pathway | Case for Change

- There is **strong operational and multi-agency support** taking place at an individual level within the pathway, and this should be recognised and successes celebrated.
- The current supported accommodation system is supporting some people out of homelessness and into more settled housing; but these constitute a significant minority (a maximum of 8% since January 2021). It is **not functioning as a coherent and effective response system** that follows "what works" to sustainably end people's homelessness. There is therefore a **need to reshape the current single homelessness pathway**.
- Alongside this, there is **significant unmet need and key gaps in the current provision**; with reliance on a select group of supportive and collaborative providers.
- A **number of providers are not Registered Providers**, causing issues with housing benefit subsidy loss and threatening the ongoing viability of key elements of the current provision.
- As seen nationally, there has been a **steady increase in Supported Exempt Accommodation**. This is **linked to the lack of wider oversight of the accommodation and support provided** across the 500+ units, and central coordination of everyone that is placed and accommodated within the pathway.
- There have been some small movements to a more housing-led response, the shift away from night shelter provision prompted by the pandemic and the NSAP/ RSAP properties. However, the **"treatment first" philosophy is still prevalent**, alongside **language around "tenancy/ housing readiness"**.
- The ongoing review of the statutory service found that **single applicants presenting through the single homelessness pathway are not receiving full homeless assessments** and in many cases are not receiving a decision on why they are not in priority need. Adjusting accountabilities so the Street Services Team have more capacity to focus on the cases with the highest need and prevention work for this cohort would be beneficial.
- Work to **access the private rented sector for settled move on** from the pathway is **underdeveloped**, leaving social housing as the sole move on route which has its own access issues.
- It was reported in the focus groups that there are a **limited number of Service Level Agreements (SLAs)** in place currently and that the pathway would benefit from these and other operational policies and frameworks that everyone should be expected to sign up to and follow. This would also facilitate the **transparency for service users on how the pathway works** and what they can expect.
- Finally, the **level and richness of data on the pathway and its performance has significantly improved** since January 2021. The need for a **dedicated case management system** is widely acknowledged to support operational staff, strategic roles and partners going forward.

Reshaping the Pathway | Target Future State

West Northants should **work towards a clear local pathway into settled accommodation** that includes **rapid assessment of need and eligibility**, **rapid rehousing into an appropriate settled home,** and **referral into long- or short-term support services** where needed. This should include a **longer term / general direction of travel away from shared, supported accommodation**. This is especially relevant for people with low or no support needs as it is not an outcome- or cost-effective form of accommodation. The components of the reshaped pathway are outlined below.

Common Goal + Data-Led Framework (Source: Centre for Homelessness Impact/ DLUHC)

'Rough sleeping is ended if it is prevented or is otherwise rare, brief and non-recurring'

Prevent
P.1 – Number of new people sleeping out (an absolute figure, as a rate per 100,000 population, a proportion of all people sleeping rough)
P.2 – People discharged from institutions with no settled accommodation identified

Rare
R.1 – The number of people sleeping out on a single night, expressed as: an absolute figure, as a rate per 100,000 population

Brief
B.1 – The length of time between the first time someone is identified sleeping rough and moving into 'off the streets' accommodation
B.2 – The length of time between a person's first contact with outreach services and moving into 'long-term' accommodation

Non-Recurring
NR.1 – The number of 'returners' of people seen sleeping out again after being successfully supported into accommodation, expressed as: an absolute number, a proportion of the number of people who are successfully supported into accommodation
NR.2 – The number of people experiencing 'long-term' rough sleeping (an absolute figure, as a rate per 100,000 population, a proportion of all people sleeping rough)

Provision and accessibility of affordable permanent housing stock for people experiencing homelessness
Targets (permanent mainstream housing) informed by evidence on the scale of homelessness and included in strategic housing market assessment (SHMA). All registered providers of mainstream social housing set an annual guideline target for the minimum proportion of social lettings to homeless nominees; and report on their performance providing settled homes for homeless people

Housing-Led Principles and Whole System Approach

1. People have a right to a home
2. Flexible support is provided for as long as it is needed
3. Housing and support are separated
4. Individuals have choice and control
5. The service is based on people's strengths, goals and aspirations
6. An active engagement approach is used
7. A harm reduction approach is used

These should provide the shared framework and understanding of 'quality'.

Features (Following the evidence of what works)

Continuation of Current Features

- Assertive Outreach Service
- Navigators
- Personalised Budgets
- Targeted interventions at key transition points (e.g. institutional discharge, leaving care etc.)

Amending of Current Features

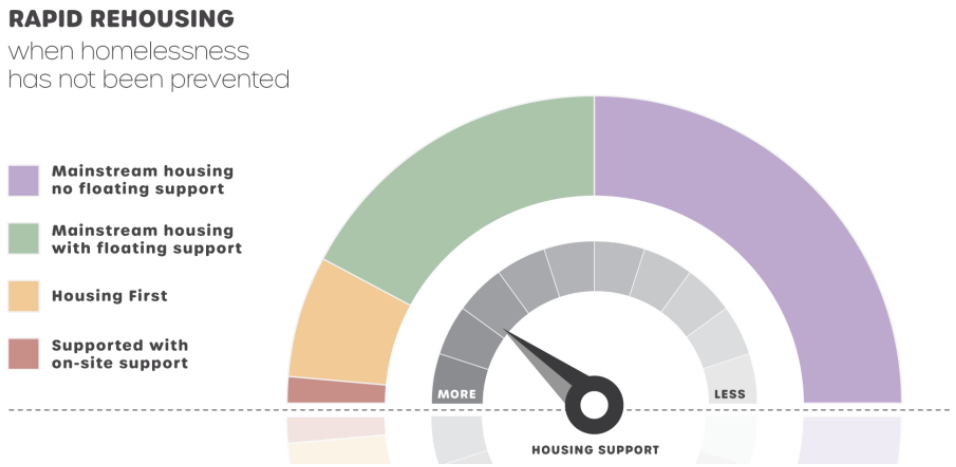
- Rapid Assessment/ Somewhere Safe to Stay Hub
- Move On Provision
- Reconnection
- Prevention
- Short Term/ Transitional Supported Accommodation
- Long term/ Mainstream Supported Accommodation
- Supported Lettings/ Floating Support
- Data System & Sharing

New Features

- PRS Access
- Housing First

Reshaping the Pathway | Housing-Led Approach

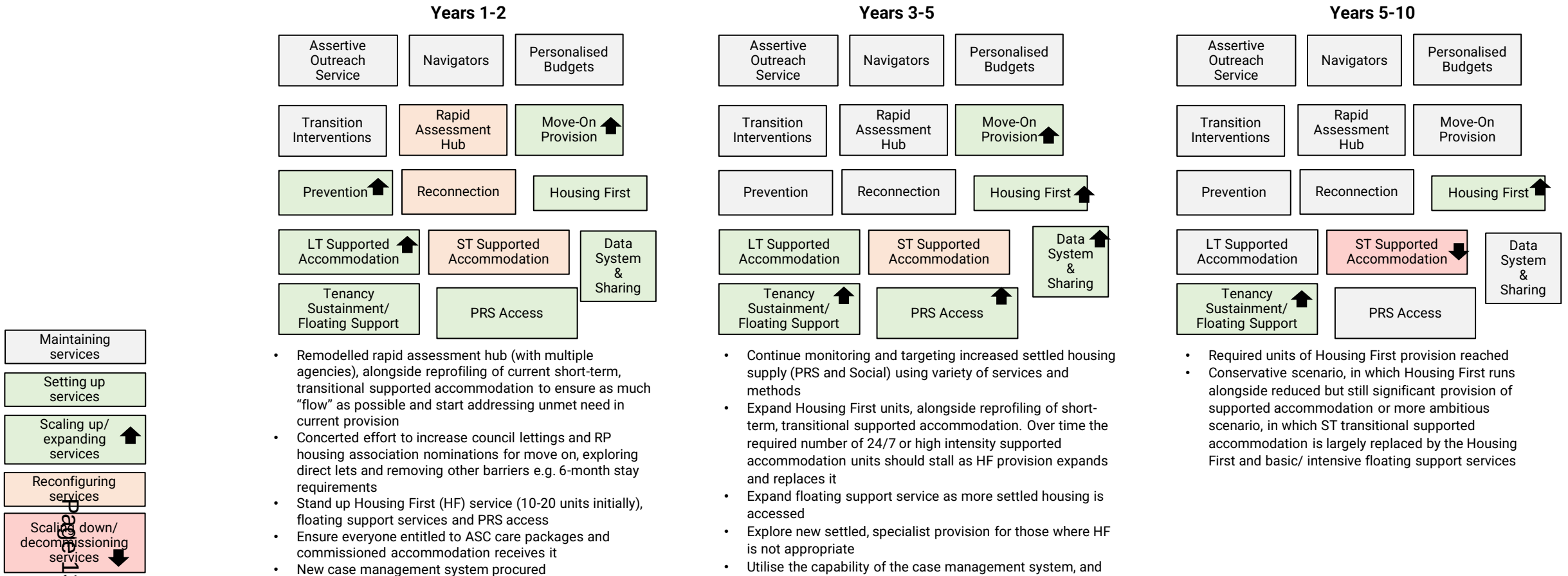
- For people that experience homelessness and have support needs, **"Rapid Rehousing"** or **"Housing-Led"** means **to resettle people in mainstream housing as quickly as possible, with the floating support they need to make it work**. The approach **seeks to minimise the amount of time spent in temporary accommodation and the number of transitions** a person has to make before they move into a permanent home.
    - Within this group, there are a smaller number of people that need intensive floating and 'wrap around' support, as provided by the Housing First approach. And a smaller number of people that need a different housing option, with support on-site.
- Research indicates that the **Housing First approach** is **most cost-effective for individuals experiencing multiple disadvantages**. These are individuals with long or repeated histories of homelessness and other multiple, often interconnected, needs. Individuals are likely to have had repeat contact with services who have found it difficult to engage and support them effectively. Many Housing First projects have started with just ten individuals in the first year. The only condition placed on the individual is a **willingness to sustain a tenancy**. There is no requirement that they demonstrate a 'good' housing history or meet any 'tenancy ready' requirements, as long as they are willing to try.
    - Only a relatively small number of single people experiencing homelessness need Housing First; however, a **housing-led approach** recognises that the principles underlying the Housing First model can and **should benefit all those who are experiencing or at risk of homelessness**.
    - Housing-led is a **whole system approach**, which seeks to **apply the principles of Housing First model** to all those experiencing or at risk of homelessness



Source: Policy Position. The future role of supported housing to prevent and respond to homelessness in Scotland (2021)

Reshaping the Pathway | Transition

A high-level route to transition to the new pathway, progressively meeting the housing-led principles and reprofiling the existing provision



- Remodelled rapid assessment hub (with multiple agencies), alongside reprofiling of current short-term, transitional supported accommodation to ensure as much "flow" as possible and start addressing unmet need in current provision
- Concerted effort to increase council lettings and RP housing association nominations for move on, exploring direct lets and removing other barriers e.g. 6-month stay requirements
- Stand up Housing First (HF) service (10-20 units initially), floating support services and PRS access
- Ensure everyone entitled to ASC care packages and commissioned accommodation receives it
- New case management system procured

- Continue monitoring and targeting increased settled housing supply (PRS and Social) using variety of services and methods
- Expand Housing First units, alongside reprofiling of short-term, transitional supported accommodation. Over time the required number of 24/7 or high intensity supported accommodation units should stall as HF provision expands and replaces it
- Expand floating support service as more settled housing is accessed
- Explore new settled, specialist provision for those where HF is not appropriate
- Utilise the capability of the case management system, and start to develop system wide performance data

- Required units of Housing First provision reached
- Conservative scenario, in which Housing First runs alongside reduced but still significant provision of supported accommodation or more ambitious scenario, in which ST transitional supported accommodation is largely replaced by the Housing First and basic/ intensive floating support services

Cost Effectiveness Modelling | Existing and newly arising need

In order to assess the likely cost of reshaping the single homelessness pathway, it is necessary to understand the scale of additional support needed, the cost of providing this support, and how this compares to the costs of current support provision received by those whose support offering would differ under the reshaped provision. **We have estimated there are 761 individuals with a current need for settled accommodation. This is for our in-scope cohort and therefore excludes other forms of homelessness e.g. most statutory homeless households.**

Not all of these individuals will require the same support; this will depend on their support needs and the length of time that they have been homeless. In this model, we consider a scenario in which West Northants offers five broad categories of support: (i) housing first; (ii) long term congregate housing with housing first-style support; (iii) intensive floating support; (iv) basic floating support; and (v) transitional supported accommodation. We have also estimated the number that just have a need for accommodation (i.e. no support) but are currently waiting in the pathway.

In order to understand how need for support will change over time we also need to project newly arising need in each year. This has been identified on the basis of newly arising demand (i.e. new to rough sleeping or new to the pathway via the panel) in the last full year of data we have. **In summary, this implies that each year there are approximately 330 individuals with newly arising need**. As the level of support individuals need is typically higher for those who have been homeless for a longer period of time, we assume that a lower proportion of those with newly arising need require high levels of support. Additionally, we assume that 10% of individuals are not at a position to accept support in any given year meaning that total additional newly arising demand is 297. This yields the estimates bottom right of newly arising demand for each level of support. **We have currently modelled newly arising demand remaining constant over time**. The figure for those requiring transitional supported accommodation each year (and hence the target residual stock) is based on each new entrant requiring an average of 6 months before permanent settled housing is sourced and accessed.

Estimated existing need

	No.	%
Total requiring Housing First	106	14%
Total requiring long term congregate housing	11	1%
Total requiring intensive floating support	320	42%
Total requiring basic floating support	259	34%
Total requiring transitional supported accommodation	-	-
Total requiring independent, general needs tenancy (no support, but housing access)	65	9%
Total need	**761**	**100%**

Projected newly arising (annual) need

	No.	%
Total requiring Housing First	15	5%
Total requiring long term congregate housing	3	1%
Total requiring intensive floating support	116	39%
Total requiring basic floating support	163	55%
Total need	**297**	**100%**
Total requiring transitional supported accommodation	165	-

Cost Effectiveness Modelling | Scenarios and costs

As well as the human and moral case, there is an economic imperative to tackling homelessness; with housing-led interventions the most cost-effective way to do this

The table to the right shows the total cost of three scenarios modelled over the next ten years, both housing support costs and costs incurred to the wider public sector of homelessness (specifically those with an unmet need for accommodation and support).

In the first two scenarios, housing-led provision is expanded to meet unmet need (the difference between cumulative demand and units of provision available i.e. the number of people without accommodation and support) by the end of Year 10. From Year 11, there will be enough Housing-Led units to meet cumulative demand. The difference between the two scenarios is the rate at which short term, transitional supported accommodation is scaled back as housing-led provision is scaled up. The third scenario represents a continuation of the "as is" pathway provision, albeit with an increased move on and flow to settled housing.

In order to estimate the cost of providing the proposed support we multiply estimated need in each year by unit costs of providing each level of support to a person. These only include support funding/ costs (and exclude housing costs) as this is the focus of comparison. The unit cost used for calculating wider public sector costs was £4,251, the average reduction in public spending from avoiding homelessness per person per year (Pleace & Culhane, 2016).

Key Conclusions

- **When faced with current and future demand, the current homelessness provision is likely to incur substantial and increasing cost of homelessness to the West Northants public sector**
- It is when analysing the whole public sector costs of homelessness that the cost effectiveness of Housing-Led provision is most stark. As our analysis showed, an additional investment of £19.5m (Scenario 1)/ £14.4m (Scenario 2) over the next ten years in Housing-Led transition would reduce forecasted public spending on homelessness by £89.6m (Scenario 1)/ £83.9m (Scenario 2). A cost benefit ratio of £1 to £4.59/ £5.83
- This is due to the "year on year" nature of the benefit. By sustainably and quickly ending people's homelessness with secure housing, multiple years of future homelessness are avoided (and the costs, morbidity and mortality that come with this). In contrast, the continuation of the current provision (even with an increased 'flow') is unlikely to be able to keep up with the cumulative demand, whilst remaining less effective and flexible
- **This highlights the economic imperative for the whole system to pool budgets, jointly commission and invest in Housing-Led approaches to tackling homelessness**

Scenario (Years 23/24 – 33/34)	Total Cost (Housing-Led Units & Access)	Total Cost (Short Term, Transitional Supported Accommodation)	**Total Scenario Cost (Housing + Homelessness Services^)**	**Total cost of scenario's unmet need to wider public sector**	**Total Scenario Cost**
(1) Scale up required housing-led units. Retain current transitional supported accommodation until there is no unmet need for accommodation & support (achieved end of Year 6)	£23.7m	£18.5m	**£42.2m**	**£9.5m**	**£51.7m**
(2) Scale up required housing-led units. Gradually reduce current transitional supported accommodation to achieve target units end of Year 6	£23.7m	£13.4m	**£37.1m**	**£15.2m**	**£52.3m**
(3) "As Is" with significantly improved move on rates from current short term, transitional supported accommodation. No investment in housing-led units	£0	£22.7m	**£22.7m**	**£99.1m**	**£121.8m**

West Northamptonshire Council

1. Background

Introduction & Overview

National Legislation & Policy

National Picture

Introduction & Overview

Tackling homelessness and rough sleeping is an increasing priority for the local health, care and housing system

In line with national government policy, **West Northamptonshire Council (WNC) is committed to ensuring that rough sleeping within the local area is prevented where possible; and is rare, brief and non-recurring when it does happen**. The formation of the Council in April 2021, and the Integrated Care System, have facilitated joined-up working at both a strategic and operational level across health, public health, adult social care and housing.

The refreshed Health and Wellbeing Board under the new unitary council arrangements recognises the significance that settled, good quality housing and tailored support to meet individuals' needs can have on reducing health inequalities and improving life chances**. This has made homelessness & reducing rough sleeping a high priority for the HWB and the wider 'system'.** WNC's Housing Service secured funding from the Government's Rough Sleeper Initiative 2022-25 programme. The funding award requires the Council to establish a commissioning framework for services in the short term and start preparing for the delivery of services beyond 2025. This research will inform the development of this framework.

WNC's Public Health and Housing Services have therefore commissioned PPL, in conjunction with Homeless Link, to conduct this research, which has two fundamental parts:

a) **an independent assessment of the needs of people sleeping rough**, at risk of rough sleeping for the first time and those who are at risk of returning to rough sleeping, within West Northamptonshire. 'Needs' is defined as physical and mental health needs as well as accommodation and support needs

b) **review the current customer journey, including existing accommodation and support**, identify gaps and make recommendations on maximising service provision, including new operating models and approaches, to inform a new commissioning framework for supported accommodation and services for this cohort.

This research is intended to help ensure that services address the physical and mental health, social care and wellbeing inequalities for those who experience rough sleeping and street homelessness.

This work also supports WNC's Corporate Plan's (2021-25) "Improved Life Chances" priority which includes tackling homelessness with "nobody forced to sleep rough in West Northamptonshire". It also provides evidence that contributes to a number of the ambitions within the Integrated Care Northampton Strategy (2022 – 2032), as shown to the right. West Northamptonshire's Housing Strategy (2022 – 2025) also contains priorities to "have a consistent approach to the letting of social housing across West Northants" and "tackling homelessness and rough sleeping in a way that delivers positive long-term outcomes for each individual.

Project Context & Scope

Now is an opportune time for a dedicated needs assessment for people at risk of, or experiencing, rough sleeping

There has always been a need for local systems to strategically assess the health and care needs of people experiencing homelessness, and develop the appropriate service provision in response. As an "inclusion health" group, people experiencing homelessness are often socially excluded, experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma); and stigma and discrimination. They are not consistently accounted for in electronic health databases, which makes them effectively 'invisible' in health and care needs assessments.

A number of policy changes have recently aligned to further build the case for a dedicated needs assessment for this cohort:

- **NICE guideline NG214 (Integrated health and social care for people experiencing homelessness)** was published in March 2022, issuing national guidance on providing joined-up health and social care services for people experiencing homelessness. A key recommendation for commissioners is to "conduct and maintain an up-to-date local homelessness health and social care needs assessment and use this to design, plan and deliver services according to need"
- **Following the Health and Care Act 2022, Integrated Care Systems (ICS)** across the country have developed their initial strategies. Statutory guidance includes a section on "Groups who can be under-represented in assessments of need", referencing people experiencing homelessness in this category. Local systems are encouraged to "identify opportunities for research where there are gaps in evidence, either of health and care need or gaps in how those needs might be effectively met". The ICS strategy guidance also cites **housing and homelessness services as examples of "health-related services" that could be better integrated with the health and care sector**
- The cross-government **"Ending rough sleeping for good" strategy** was published in September 2022. There are commitments to "support partners within the new Integrated Care Systems to develop joined-up local strategies that bring together housing, homelessness and healthcare.
- **Updated guidance for Health and Wellbeing Boards**, published in November 2022, also references the needs of people experiencing homelessness and rough sleeping

This research has therefore been commissioned at an opportune time for the Council. The text box to the right summarises the cohort in-scope for this needs assessment, with a focus on people at risk of, or who have experienced, rough sleeping; as opposed to all forms of homelessness (e.g. families within temporary accommodation).

In-scope cohort for this needs assessment

1. **People at immediate risk of sleeping rough with very minimal prior experience** (requiring emergency prevention work)
2. **People currently sleeping rough** (official count definition)
3. **Rough sleepers placed in "off the street accommodation"** intended to last for 6 months or less (hostels/ TA placements/ shelters/ winter provision/ hotels/ refuges/ other assessment bed settings)
4. **Rough sleepers currently 'sofa surfing'** or in other insecure, short-term arrangement
5. **People in medium/ long term accommodation** (intended to last > 6 months e.g. SH pathway, social housing, PRS AST) with history of rough sleeping, and are **at high risk of rough sleeping again**

Approach & Methodology

This research was conducted between February – May 2023, using the following approach and methodology

1. Collation and analysis of quantitative datasets

- Over 23 data requests made to various stakeholders in the system, outlined below.
- Cost effectiveness analysis and financial modelling based on financial and demand data received.

Hospital Trust (Urgent/ Secondary Care)
Primary Care
Council (Outreach/ Street Services)
Council (Housing Options)
Police
Substance Misuse Services
Council (Public Health)
Mental Health Trust
Council (Adult Social Care)
Children's Trust
Probation
Social Housing
VCSE – Support Providers
VCSE – Accommodation-Based Support Providers
DWP

2. Stakeholder engagement with professionals working in the system

A series of 1-2-1 interviews and focus groups were organised with professionals across the local system to gather their insights into rough sleepers' health needs and experiences of access to health and care services; and their experiences of the single homeless pathway.

This included:

- 13 scheduled 1-2-1 interviews
- 3 focus groups, attended by frontline and operational staff; attended by 16 individuals from 6 different organisations
- Multiple formal and informal conversations with a wide range of individuals within the local system, identified mostly via 'snowball' sampling

3. Engagement with people with lived experience

Homeless Link completed a series of interviews and focus groups in four different locations to gather insights into rough sleepers' health needs and experiences of access to health and care services; and their experiences of the single homeless pathway.

This included:

- 9 interviews organised at the Hope Centre on 3rd of April 2023
- 3 interviews and a focus group, attended by 5 people, held at Trinity House Homeless Assessment Rapid Resettlement Pathway (HARRP) on 24th of April 2023
- 4 interviews organised at the Women's Centre (C2C Social Action) on 25th of April 2023
- 1 focus group, attended by 3 people, held at NAASH main office on 25th of April 2023

4. Desktop review of best practice and existing evidence base

An extensive review was completed and findings summarised at relevant points in this report.

National policy context (1/2)

Successive Governments have put in place initiatives to tackle rough sleeping. **The Conservative Manifesto (2019)** committed to ending "the blight of rough sleeping by the end of the next Parliament" through an extension of the **Rough Sleeping Initiative** which began in 2018, Housing First, and using local services to meet the health and housing needs of people living on the streets. The Government's **'Everyone In' programme** to assist rough sleepers through the Covid-19 crisis was hailed as one of the most effective responses to the pandemic. The sector was keen to build on its success to achieve the Government's **target of ending rough sleeping by 2024**.

A refreshed strategy, **Ending Rough Sleeping for Good**, was published in September 2022. It focuses on a "four-pronged approach" of prevention, intervention, recovery and ensuring a joined-up transparent approach. The strategy was co-signed by eight department ministers showing a growing recognition of the "whole system" nature of the issue. It includes:

- **Rough Sleeping Initiative** ~ the government's flagship programme to drive the manifesto commitment to end rough sleeping. Funding to help provide emergency beds, off-the-street accommodation and wrap-around support
- **Single Homelessness Accommodation Programme** ~ new funding seeking to deliver up to 2,400 homes by March 2025, including supported housing and Housing First accommodation
- **Rough Sleeping Drug and Alcohol Treatment Grant** ~ Since 2020/21 the Rough Sleeping Drug and Alcohol Treatment Grant has provided £50 million for substance misuse treatment services for people sleeping rough or at risk of sleeping rough
- **Housing First pilots** ~ extending Housing First Pilots in the West Midlands, Manchester, and Liverpool
- **Transparency and data-led framework** ~ New data framework to measurably end rough sleeping with new monthly returns required from local authorities from the 1 May 2023. The Government will publish quarterly data setting out how they and partners are delivering on the overall mission.

The **NHS Long Term Plan (2019)** includes a commitment to "invest up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to **specialist homelessness NHS mental health support**, integrated with existing outreach services." The Government's **"From harm to hope: A 10-year drugs plan to cut crime and save lives"** was published in December 2021, with a focus on delivering three strategic priorities: break drug supply chains, deliver a world-class treatment and recovery system; and achieve a generational shift in demand for drugs. It includes commitments to:

- transform the system so that providing trauma informed care becomes the norm, and complex needs (such as homelessness) are recognised and responded to
- work with NHS England to explore opportunities for better commissioning to make sure that there is locally joined-up service provision between specialist mental health services and substance misuse services for people with co-occurring issues, including those experiencing rough sleeping
- extend work to provide specialist treatment and recovery services to people sleeping rough and offer help to people whose ability to engage in treatment is hampered by their need for support with their housing

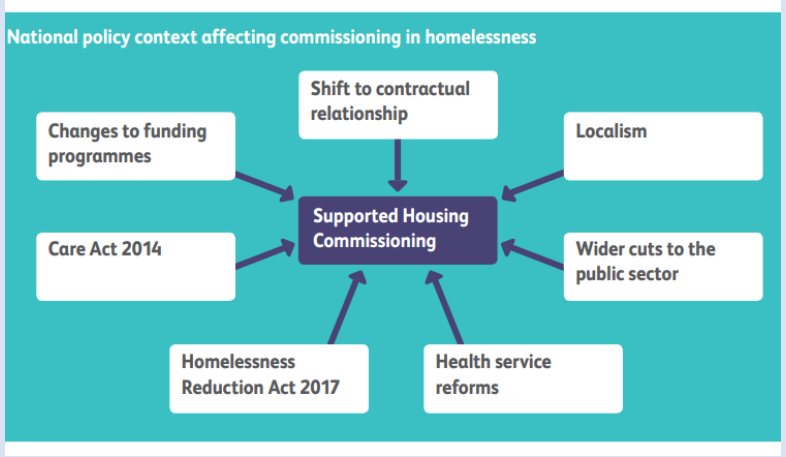
Invest £53 million over the next three years to fund a menu of housing support options which will improve the recovery outcomes for people in treatment and reduce the flow of people into homelessness and rough sleeping – including funding housing support workers to work within treatment services. Alongside this investment, build the evidence base on the housing related need for people dependent on drugs and alcohol and the most effective interventions.

National policy context (2/2)

There has been recent change in policy attention around **supported accommodation,** which describes a range of housing types, such as group homes, hostels, refuges, supported living complexes and sheltered housing. Residents receive support to help them live independently. **Exempt accommodation** is a type of supported housing where certain Housing Benefit provisions which limit claimants' entitlement to defined local levels do not apply. This means Housing Benefit may cover the full amount of rent charged by providers. It is defined as "accommodation provided by a county council, housing association, registered charity or voluntary organisation where that body or person acting on their behalf provides the claimant with **care, support or supervision.**"

There are concerns at the growth and under-regulation of the specified exempt sector. The Levelling Up, Housing and Communities Committee (LUHC) describes the system of exempt accommodation as "a complete mess" in a report published in October 2022. It found good providers, but in the worst cases there's evidence of "exploitation of vulnerable people" and landlords who are making "excessive profits" from high rents paid for by Housing Benefit. Government action has included the following:

- In October 2020, the Government published **"Supported housing: national statement of expectations"** setting out a vision for the planning, commissioning and delivery of supported housing for the first time
- Also in October 2020**, five pilots were established in Birmingham, Blackburn, Blackpool, Bristol, and Hull** to improve quality enforcement, oversight, and value for money in the sector. They focused on short-term, non-commissioned exempt supported accommodation. An independent evaluation of the pilots was published in April 2022
- In March 2022, then-Minister Eddie Hughes issued a written statement setting out **Government plans for supported exempt housing**. They include introducing minimum standards of support; changes to Housing Benefit regulations to clarify the definition of care, support and supervision; **new powers for local authorities to better manage their local supported housing market and "ensure rogue landlords cannot exploit the system"**
- Legislation has since been introduced via a Private Member's Bill, and is backed by Government. At the date of this report, the **Supported Housing (Regulatory Oversight) Bill** is awaiting the Lords Committee Stage. The bill includes a number of changes and would:
    - require local authorities in England to review supported housing in their areas and develop strategies
    - give local authorities power to create local licensing schemes for exempt accommodation



Wider factors affecting the national policy context

Source: Blood et al (2020), A traumatised system: research into the Commissioning of Homelessness Services in the last 10 years

Relevant statutory frameworks (1/3)

Housing Act 1996 > Homelessness Reduction Act 2017

The Homelessness Reduction Act (HRA) 2017, which came into force on 3 April 2018, placed new duties on local authorities to intervene at earlier stages to prevent homelessness, irrespective of whether or not an applicant has 'priority need' or may be 'intentionally homeless'. Priority need includes vulnerability arising from disability. Vulnerability means significantly more vulnerable than ordinarily vulnerable as a result of being rendered homeless. The comparator is the ordinary person if made homeless and not an ordinary actual homeless person (Hotak v Southwark LBC [2015] UKSC 30).

The new HRA duties include providing free information and advice on preventing and relieving homelessness to all residents. Local authorities have a duty to carry out an assessment in all cases where an eligible applicant is homeless or threatened with homelessness. This should identify what has caused the homelessness or threat of homelessness, the housing needs of the applicant and any support they need in order to be able to secure and retain accommodation. Following this assessment, the housing authority must work with the person to develop a personalised housing plan which will include actions (or 'reasonable steps') to be taken by the authority and the applicant to try and prevent or relieve homelessness. The Act also introduced a "Duty to Refer" on specified public bodies to refer households they believe are, or may be at risk of, homelessness to a local housing authority.

Despite the widening of statutory rights introduced by the HRA, local authorities in England still do not have a duty to secure accommodation for all homeless people. However, the **Homelessness Statutory Code of Guidance**, of which local authorities must take due regard when exercising their functions under the Act, references specific considerations in relation to applicants who are (or are at imminent risk of) sleeping rough and owed the relief duty; including:

a. working with other agencies and/or commissioned services to ensure rough sleepers are aware of, and have support to seek, housing assistance from the authority and in the provision of appropriate accommodation and/or support;
b. if the authority does not have reason to believe that the applicant may have a priority need and has not therefore provided interim accommodation under section 188(1), the use of discretionary powers to secure emergency accommodation to prevent nights on the streets, taking into account the risk of harm applicants may face
c. if using discretion to enquire into whether an applicant has a local connection, remembering that normal residence does not require a settled address and may include periods sleeping rough

Relevant statutory frameworks (2/3)

Care Act 2014

Assessment for care and support: Section 9 Care Act 2014 requires single and upper tier local authorities to assess a person who appears to have needs for care and support, regardless of the level of need. Where the authority is satisfied on the basis of a needs assessment (that a person has needs for care and support), it must determine whether any of the needs meet the eligibility criteria (section 13). Such needs may arise from physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. These are needs that many people experiencing multiple exclusion homelessness have. If the needs are urgent, care and support can be provided before an assessment is completed. The authority is under a duty to meet the adult's needs for care and support which meet the eligibility criteria, if the adult is ordinarily a resident in the area or present and of no settled residence.

Safeguarding enquiries: Section 42(1) sets out the circumstances in which the local authority (under section 42 (2)) must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom. This duty to make enquiries is triggered where an adult who has needs for care and support (whether or not the authority is meeting any of those needs), is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Relationship with housing

Section 23 (Care Act 2014) seeks to clarify the boundary between care and support and housing legislation. The lack of suitable accommodation puts health and wellbeing at risk. Suitable accommodation is one way of meeting a person's care and support needs. However, where a local authority is required to meet a person's accommodation needs under the Housing Act 1996 (as amended by HRA 2017), it must do so. Where housing is part of the solution to meet a person's care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014.

Case law has also established that a need for accommodation on its own is not a need for care and support and local authority adult social care departments must consider if care and support needs are accommodation related. It is difficult to conceive of situations in which homelessness does not have a significant impact on an individual's wellbeing. All of which would suggest a required focus on how the provisions in the Care Act 2014 relating to care and support are being implemented with respect to people who are homeless.

Mental Health Act 1983

Accommodation may be provided for those who are eligible for after-care (section 117). Judicial and Ombudsman decisions continue to remind local authorities that financial charges for mental health after-care services cannot be imposed and that these arrangements must continue for as long as mental health needs endure.

Relevant statutory frameworks (3/3)

Mental Capacity

A local authority cannot accept a homeless application made by a person who lacks mental capacity. Decisions about a person's mental capacity must be made with reference to the Mental Capacity Act 2005. The Court of Protection can authorise a deputy to make a homeless application on behalf of a person who lacks capacity. The deputy can decide whether to accept an offer of accommodation and enter a tenancy agreement on behalf of the person whose interests they represent.

No recourse to public funds

Many individuals who are subject to immigration control have no entitlement to public housing and there are restrictions on most welfare benefits. This includes homelessness assistance. However, access to other publicly funded provision may still be available, including health (NHS General Practice – GP services) and adult social care. Some individuals with no recourse to public funds may be given assistance under the Care Act 2014 provided that their needs for care and support have not arisen solely because of destitution or the physical effects, or anticipated physical effects, of being destitute. Provision can include accommodation owing to the individual's need for care and attention.

National Picture (1/3)

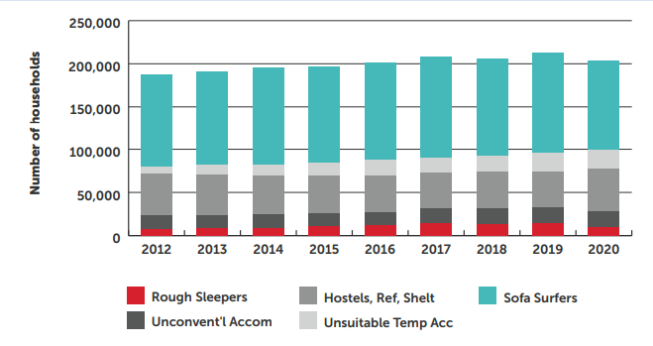
All forms of homelessness have risen since 2010, and are forecast to continue doing so, despite some recent decreases in rough sleeping in particular

Rough sleeping snapshot in England: autumn 2022 (DLUHC)

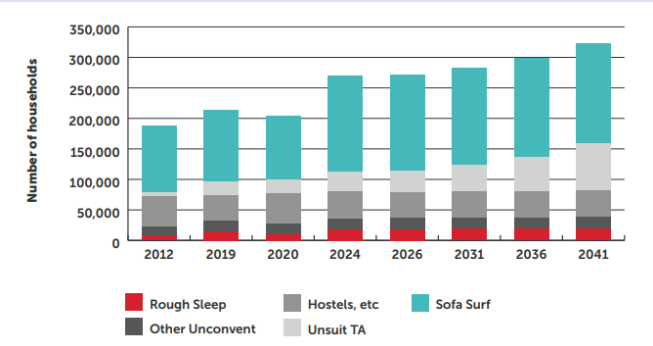
- The number of people estimated to be sleeping rough on a single night in autumn 2022 is 3,069, which **after 4 years of decreases has risen for the first time since the peak in 2017**
- The number of people estimated to be sleeping rough on a single night in autumn 2022 is down 28% from 2019 which was before **COVID-19 related measures** which may have reduced people's risk of rough sleeping, particularly in 2020
- The number of people estimated to be sleeping rough on a single night in autumn 2022 is up by 626 people or 26% from 2021. It is down 35% from 2017, but is **up 74% since 2010 when the snapshot approach was introduced.**

The Homelessness Monitor: England 2022 (Crisis)

- The Homelessness Monitor series is a longitudinal study providing independent analysis of the homelessness impacts of recent economic and policy developments in Great Britain
- **The general trend picture is that core homelessness numbers (pre-COVID-19) were on a gradually rising trajectory**. The overall numbers rose by 14% between 2012 and 2019. There were rises in each component between 2012 and 2019, apart from hostels etc., with the largest percentage terms increase between 2012 and 2019 being for unsuitable temporary accommodation (194%) and rough sleeping (85%)
- **The number of core homeless households are projected to grow further in England**, particularly in London, unless policy steps are taken to correct this negative direction of travel
- Statistical modelling indicates that the **most effective policies for reducing core homelessness** include: rehousing quotas for core homeless groups in the social rented sector; increasing the Local Housing Allowance rate; raising the level of Universal Credit payments; expanding Housing First interventions; and maximising the use of prevention tools by local authorities. Such policies in concert **could reduce total core homelessness by 34% in England**



Core homelessness estimates by category, England 2012-2020 (Crisis, 2022)



Baseline projections of core homelessness by category, England 2012-41 (Crisis, 2022)

National Picture (2/3)

Homelessness is predictable, but not inevitable.

Causes of Homelessness and Rough Sleeping: Rapid Evidence Assessment (MHCLG, 2018)

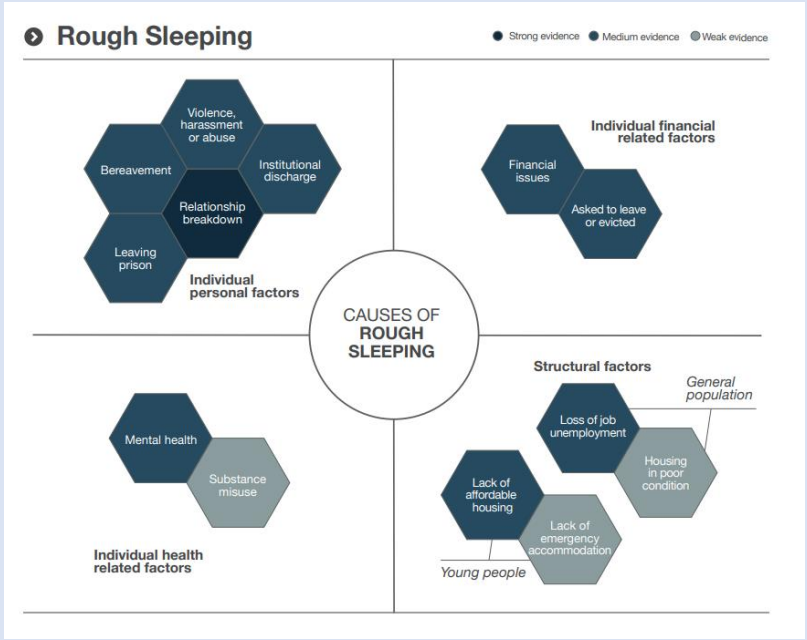
Most research divides the causes of homelessness into **structural and individual factors**, though there is criticism of this established categorisation. Recent literature uses a hybrid approach which acknowledges that structural factors create the conditions within which homelessness occurs and people with personal problems are more vulnerable to these adverse social and economic trends than others. In terms of important causes of overall homelessness, papers often cite **affordability of housing, relationship breakdown and poverty**. While there is recognition that some causes of homelessness do interact, there is limited detail on how a set of causes interact or any dynamic effects of different causes on homelessness

In terms of the causes of homelessness across the three different types of homelessness (statutory homelessness, single homelessness and rough sleeping), research indicates that structural factors are more important in explaining family homelessness. **People sleeping rough are more likely to have individual factors contributing to their reasons for being homeless (e.g. mental health and relationship breakdown).** Some **incorrectly interpret these individual factors as issues of personal agency** (i.e. the individual is culpable).

Homelessness in the UK: who is most at risk? (Bramley and Fitzpatrick, 2017)

This study demonstrate that **poverty, particularly childhood poverty, is by far the most powerful predictor of homelessness in young adulthood**. Health and support needs, such as serious drug use, also contribute to homelessness risks, but their explanatory power is less than that of poverty. Social support networks are a key protective 'buffer', but again the link with homelessness is weaker than that with material poverty. **Where you live also matters**, with the odds of becoming homeless greatest in higher housing pressure areas, but these additional 'area' effects are considerably less important than individual and household-level variables.

In the UK at least, **homelessness is not randomly distributed across the population**, but rather the odds of experiencing it are systematically structured around a set of identifiable individual, social and structural factors, most of which, it should be emphasised, are outside the control of those directly affected.



Source: MHCLG/ Alma Economics (2018)

White male	Mixed ethnicity female
Relatively affluent childhood in rural south of England	Experienced poverty as a child
	Brought up by a lone parent
Unproblematic school career	
Graduated from university at 21	Left school or college at 16
Living with parents at age 26	Living as a renter at 26
	Spells of unemployment
No partner	No partner
No children	Own children
Predicted probability of homelessness by age 30: 0.6%	Predicted probability of homelessness by age 30: 71.2%

Source: Bramley & Fitzpatrick (2017)

National Picture (3/3)

The sector is losing capacity as a result of sustained underinvestment

2021 Annual Review of Support for Single Homeless People in England (Homeless Link)

Whilst there is evidence that homelessness may be increasing across England, the review shows that levels of homelessness provision for single households is continuing to decline. This includes:

- The **number of accommodation providers for single people experiencing homelessness has dropped every year since 2010**, down 1.9% from last year, to 893. This is a 38.9% decrease from 2010
- The number of day centres is down 1.7% from last year to 173, a 7.5% decrease from 2010
- The **number of bed spaces** has decreased by 0.4% from last year to 32,184, a **decline of 26.3% from 2010**.At the same time, funding has been relatively stagnant, with 59.6% of accommodation providers and 51.0% of day centres saying their funding was the same as the previous year. A further 19.2% of accommodation providers and 22.5% of day centres said their funding had declined.

While service capacity has declined, the fallout from the COVID-19 pandemic appears to be pushing more people into homelessness. Worryingly, when asked about changes to homelessness amongst different groups over the past year, in every case respondents were more likely to indicate there had been an increase in those experiencing homelessness than to say there had been a decrease. This includes:

- 42.9% of accommodation providers supported more people experiencing homelessness for the first time;
- 30.7% saw more people currently in low paid jobs (including zero hour contracts); and
- 29.5% saw more people who had recently lost their job.

Local authority spending on homelessness (WPI Economics/ St. Mungo's/ Homeless Link, 2020)

A report, commissioned by St Mungo's and Homeless Link, examined changes in local authority expenditure on homelessness-related services over the past decade. The findings, based on local authority revenue outturn data, show that despite a number of funding announcements from Central Government targeting specific areas of homelessness, **local authority expenditure on homelessness-related services has reduced significantly as compared to expenditure ten years ago**; in 2008/9, £2.9 billion (in current prices) was spent on homelessness-related activity, while in 2018/19, £0.7 billion less was spent. **The expenditure on single homelessness (single households referring to those without dependent children, including multi-adult households) has been particularly impacted by reductions in spending**, as prior to the HRA, most single households were not owed a duty. This is not to say that prior to the HRA, work to prevent and relieve homelessness was not done outside of the statutory duty; Local authorities deploy a range of approaches and support services outside of the statutory framework to help those who are homeless, or at risk of homelessness. However, their capacity to do this has been significantly challenged. **In 2018/19, nearly £1 billion less was spent on support services (Supporting People, prevention and support) for single homeless people than was spent in 2008/9.**

Summary of key datasets used in this report

When presenting local level data in this report, a combination of datasets were obtained across key services and accommodation providers for our in-scope cohort. These core datasets have been utilised in various sections at various points, and have therefore been introduced and summarised here for ease:

- **WNC's General Housing Tracker** (n=968 over the period from 1st January 2021 to March 2023) & **Panel** data are the main records collected and maintained by the Council's Street Services Team. They seek to maintain an up-to-date account of everyone the team comes into contact with, and those referred and discussed at the weekly multi-agency panel
- WNC's Homelessness Case Level Collection (**H-CLIC**) dataset, provided from the council and standard homelessness statutory data collection
- Data from local supported accommodation providers:
  - Keystage Housing's Homeless Assessment Rapid Resettlement Pathway (**HARRP**)
  - Northampton Association for Accommodation for Single Homeless (**NAASH**) Private Rented Service (**PRS**) and Intensive Support Service (**ISS**)
  - Midland Heart's **Oasis House.** There are still outstanding questions around this dataset, provided during a data gathering exercise by the Homelessness Strategy Team towards the end of 2022. It has been included for completion but should be viewed with this in mind
- The Target Priority Group (**TPG**) identifies individuals who have been seen sleeping rough in two or more years out of the last three, or in two or more months out of the last 12
- Data from the Northampton Homeless Treatment Team (**NHTT-CGL**)
- Hope Centre (**Hope**), support provider and day centre

It is important to note that these are total datasets across different timespans, with small numbers of overlapping individuals across each of them accessing different services, at different times, in different circumstances. They still provide valuable insights into the characteristics, demographic profile, and needs of those people who access and use WNC's services.

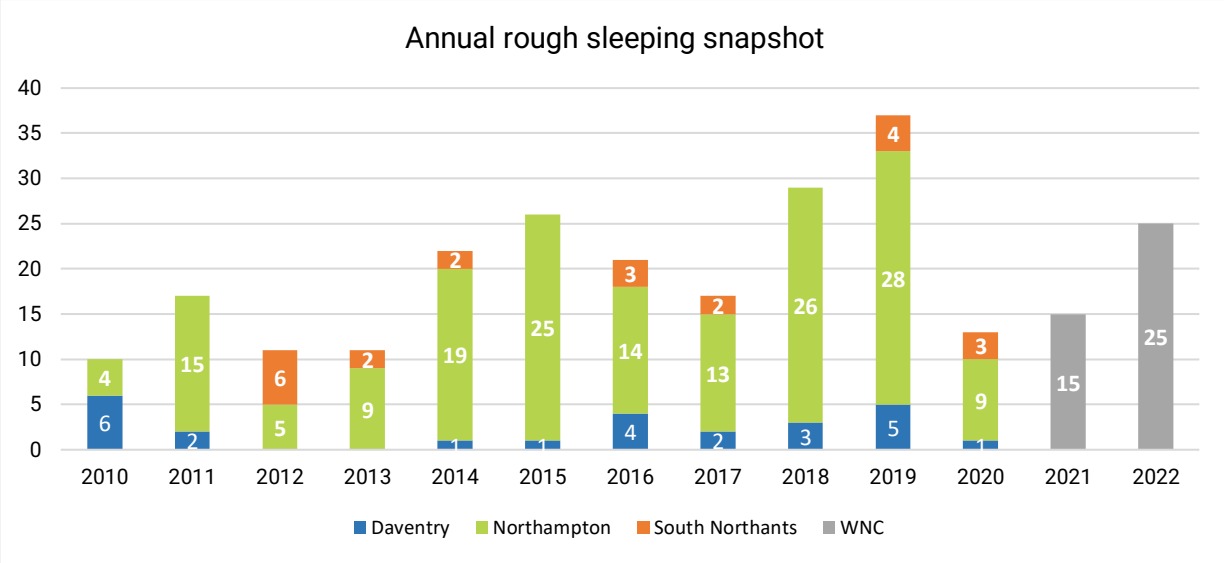
West Northamptonshire Council

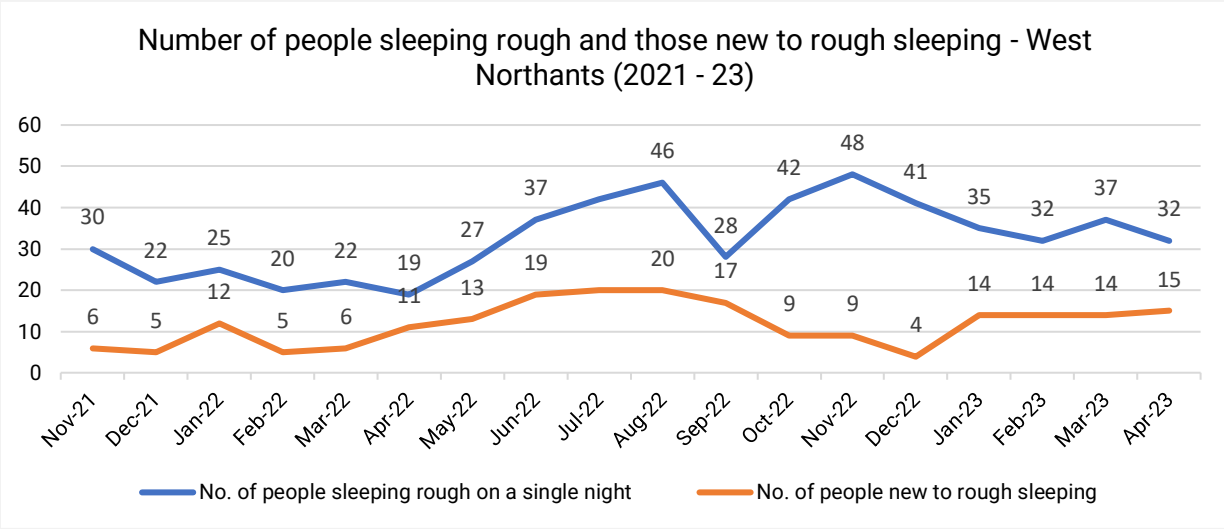
2. Local rough sleeping and single homeless population

Current trends

Local demand (1/2)

- **Overarching trends in rough sleeping in West Northants:**
  - Top right, the chart shows the estimated number of people sleeping rough on a single or 'typical' night in West Northamptonshire, an annual rough sleeping snapshot submitted to government.
  - This reflects the changing structure of the estimates, from prior to 2021 being split by Daventry, Northampton and South Northants, but since represented as one figure under WNC. Overall, the numbers of rough sleepers have fluctuated since 2010, peaking in 2019 (37), decreasing significantly in 2020 to 13 and rising again. Between 2021-2022, there was a 67% rise in the number of rough sleepers to 25. Figures are influenced by the Everybody In response to the COVID-19 pandemic.
  - The bottom right chart shows a calculated figure of people who have slept rough during the last 18 months in West Northants, based on monthly DELTA returns. It is a casework figure compiled by outreach teams and other service providers and covers both those understood to be sleeping rough on a single night each month; and people who are understood to be new to sleeping rough during that month, within the authority.
  - Between November 2021 and April 2023, the number of people sleeping rough on a single night within each month varied, with peaks in August 2022 (46) and November 2022 (48)
- **Street Services Team:** Data received from the General Tracker contained n=968 records over the period since recording began (1st January 2021) to March 2023. 222 records were last updated between January - March 2023 highlighting some kind of activity or status update for around a quarter (23%) of individuals. 217 people on the tracker were last presented to Panel in 2021, 225 people last presented to Panel in 2022, and 29 between January-February 2023.
- **Panel:** Between 1st January 2021 and March 2023, the total number of referrals to Panel was 580 (some individuals may have multiple entries), with an average age of 36 at referral. The primary reason for homelessness was cited as friends and family not being able to or not being willing to accommodate the individual, with many people sofa surfing at the time of Panel (28%).
- **Everybody In:** Throughout the Everyone In response period (March 2020 – March 2021, when local authorities were required to accommodate people sleeping rough and those in accommodation where it was difficult to self-isolate, regardless of entitlement) the authority accommodated 195 people (160 men and 35 women)

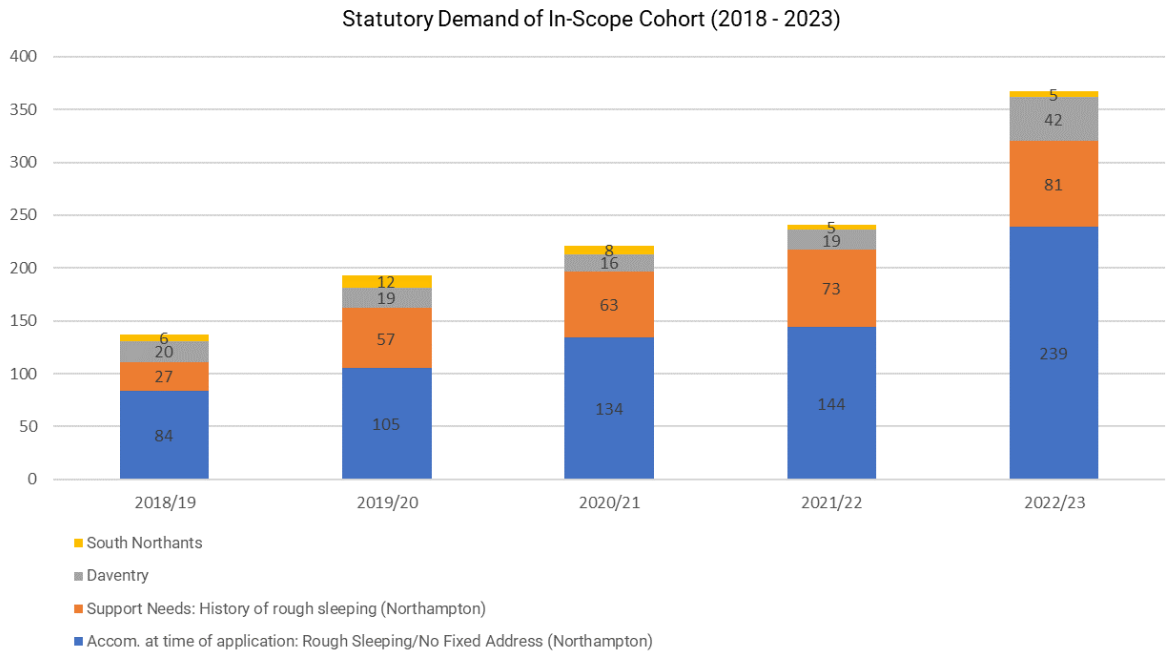


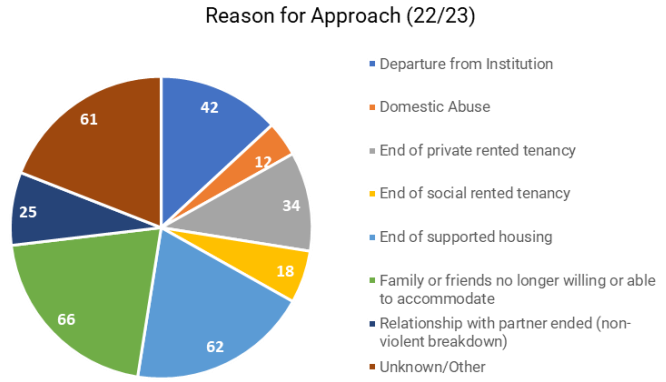


Local demand (2/2)

Statutory/H-CLIC Data:

- The most up-to-date Homelessness Case Level Information Collection (H-CLIC) dataset was received from WNC, providing a view of demand from the statutory service from April 2018 – March 2023.
- This provides a face value cohort as a measure of demand and presentations, even though several individuals re-presented during this period.
- **The numbers shown are a sub-section of overall statutory demand to reflect our in-scope cohort**. They include those whose accommodation at the time of a statutory homelessness application was "Rough Sleeping" or "No Fixed Abode" and/ or those with a "History of Rough Sleeping" support need .
- The data shows an increasing growth in demand through this period. **706 in total were recorded as having an accommodation at the time of application that was either Rough Sleeping or No Fixed Address (NFA), while a further 301 had a history of Rough Sleeping**.
- Of the 706, 388 (55%) were owed a Relief Duty, 216 (31%) had no duty owed detailed, and 93 (13%) were owed a prevention duty
- Although the dataset is imperfect, it provides a strong representation of demand from the statutory service, the growing complexity of cohorts as histories of rough sleeping and repeat homelessness develop and become entrenched





Summary of current evidence: demographics

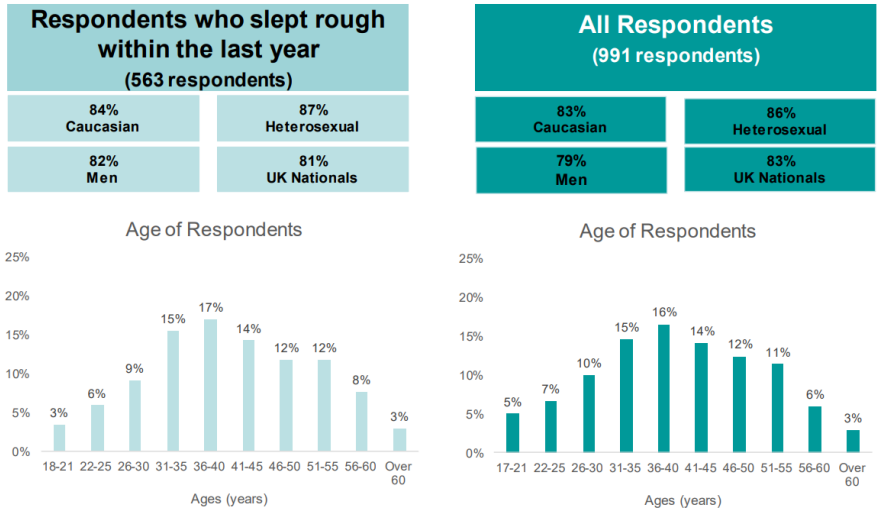
The figures to the right outline the broad demographics of people that experience rough sleeping.

There is increasing evidence showing that the cause of **women's homelessness**, and trajectories they take through it, tend to differ from those of homeless men, and, for multiple reasons, women who experience rough sleeping also experience increased vulnerability (Health matters: rough sleeping, 2022). Evidence has shown that women who experience rough sleeping also experience higher rates of mental ill-health. These women are also more likely to experience sustained or repeated rough sleeping.

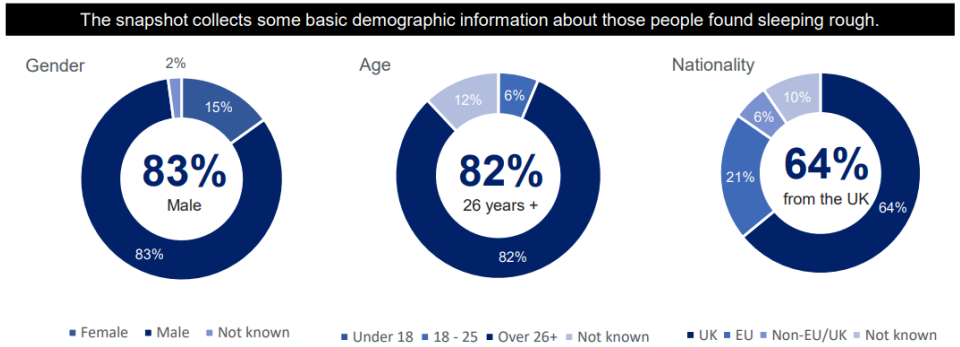
Women who experience rough sleeping are more likely than men to have experienced traumas, including self-harming and domestic violence. Despite not always being a direct cause of homelessness, evidence has shown that experience of domestic violence and abuse is very common among women who become homeless. Women who sleep rough also tend to make themselves less visible in order to stay safe, by moving at night or concealing themselves or their gender. As a result, information about them and their needs is less well known than for men.

EU citizens living in Britain are almost twice as likely than the general population to experience the worst forms of homelessness and are almost three times as likely to experience rough sleeping (Crisis, 2021). The causes of homelessness for EU nationals are similar to those experienced by the wider population, but they are compounded by restrictions that limit the support that some EU citizens can access.

LGBTQ+ people are more likely to experience homelessness than their peers (Centre for Homelessness Impact, 2022a). LGBTQ+ people are often more likely to encounter overlapping experiences of social exclusion (i.e.. institutional care, substance use) that will in turn increase the likelihood of them experiencing homelessness. Young people who are LGBTQ+ are more likely to enter foster or residential care, and young people who are care experienced are also much more likely to be impacted by homelessness than their peers. Many LGBTQ+ people experience mental health challenges, particularly as young people. These challenges are associated with adverse economic outcomes and in turn, with homelessness.



Source: Rough Sleeping Questionnaire, MHCLG, 2020

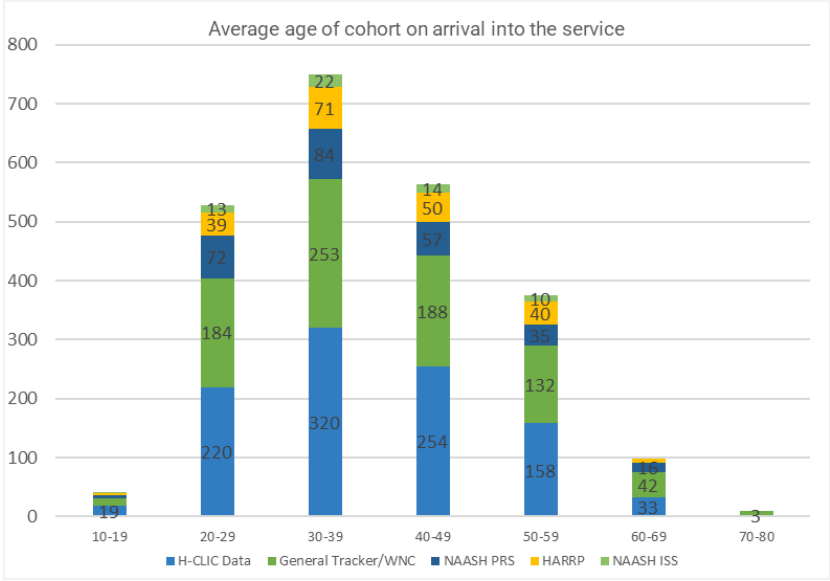


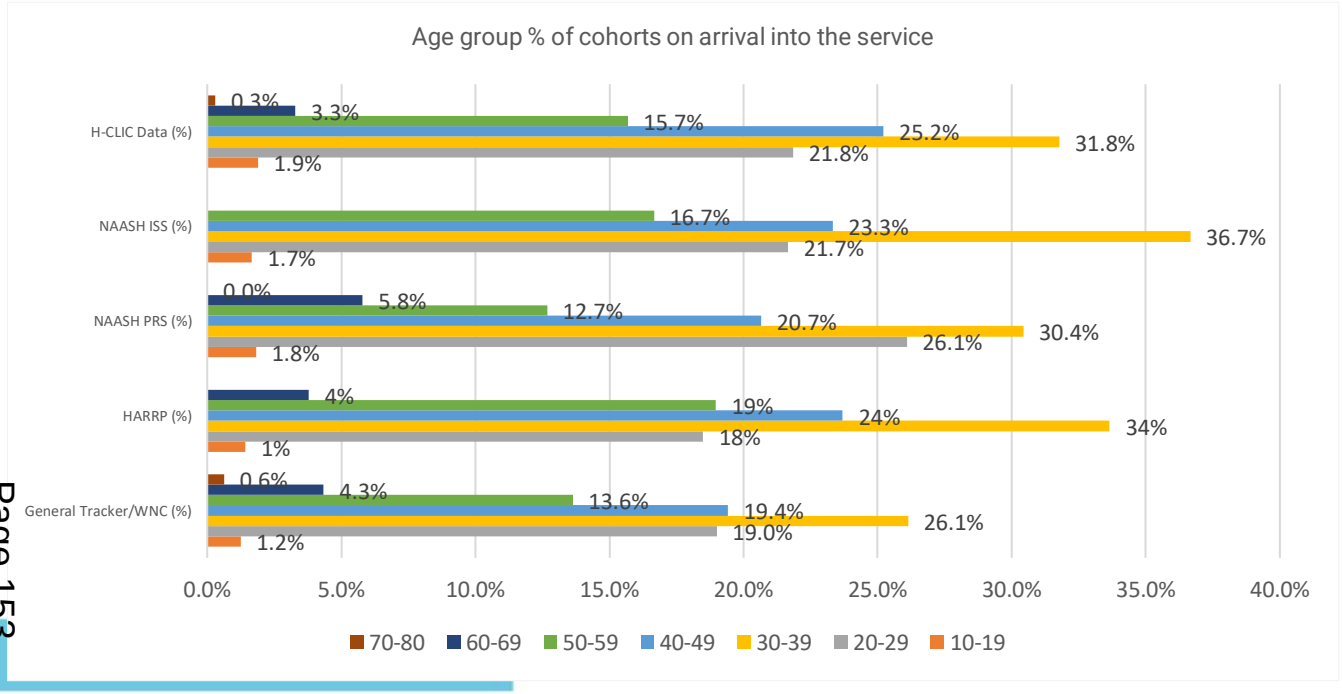
Source: Rough sleeping snapshot in England: Autumn 2022, DLUHC

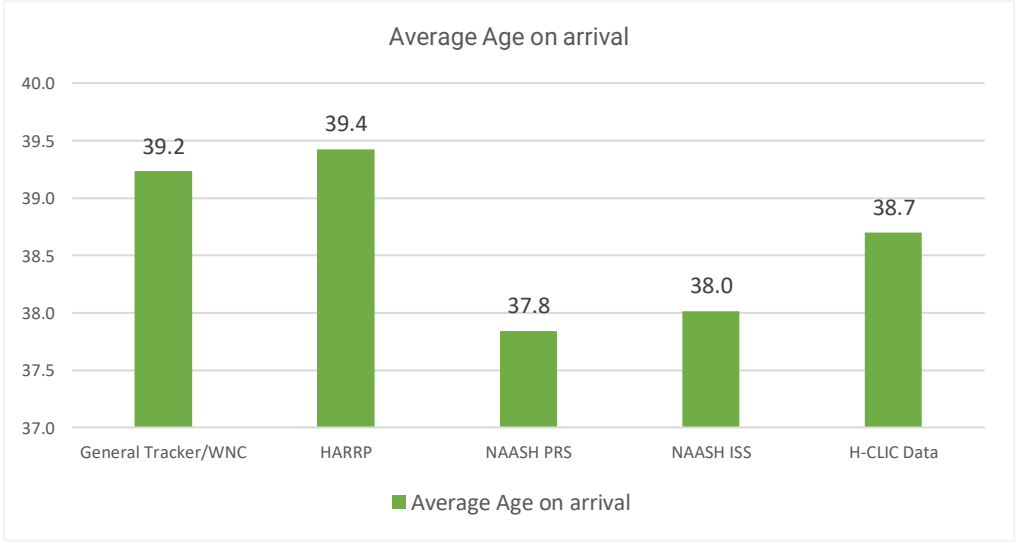
Local demographics (1/4)

Understanding our cohort and local demographic characteristics: Age

- Using data from across WNC's General Tracker, HARRP data, NAASH PRS, and H-CLIC Data, age profiles across the datasets show a high proportion of 30-39 year olds across the services.
- Smaller numbers of people access services from older (50-59, 60-69, 70+) and the very youngest (10-19) age groups, but a more diverse cohort can be seen in the largest datasets from H-CLIC and the General Tracker.
- The age groupings across these cohorts also provide interesting insights, with fewer older people using the NAASH ISS and a higher proportion (26.8%) of 20–29 year olds accessing NAASH PRS, despite a higher proportion of those between 60 – 69 (5.9%).



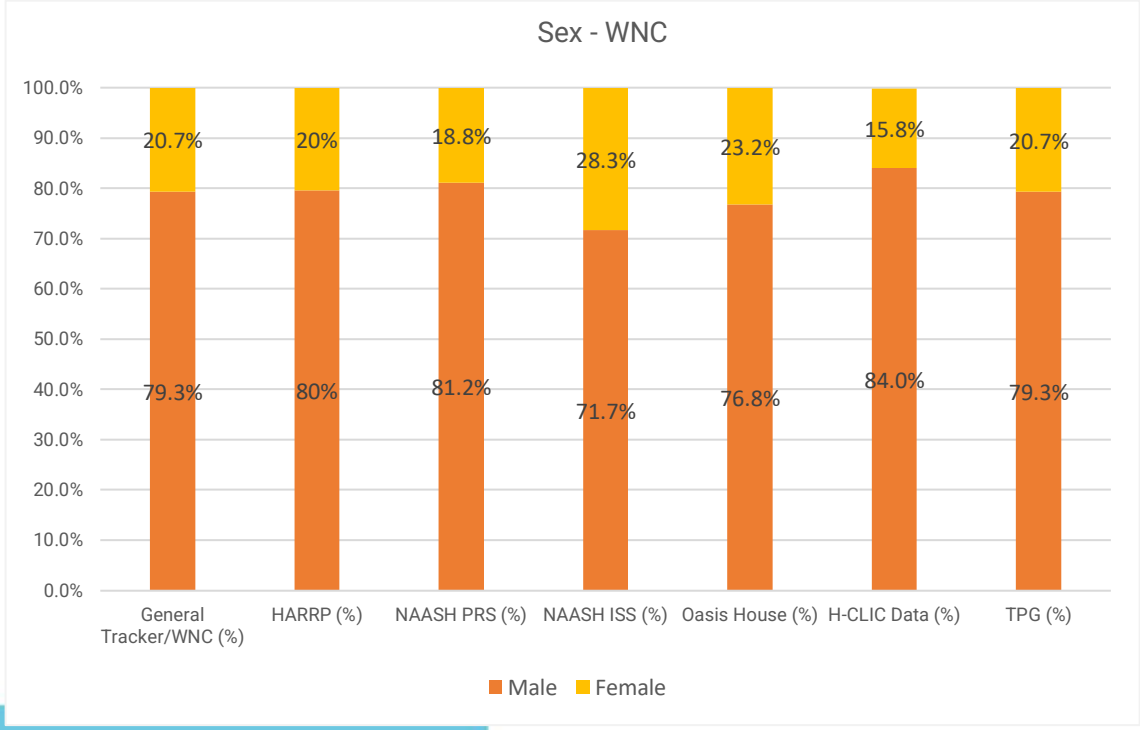




Local demographics (2/4)

Understanding our cohort and local demographic characteristics: Sex and sexual orientation

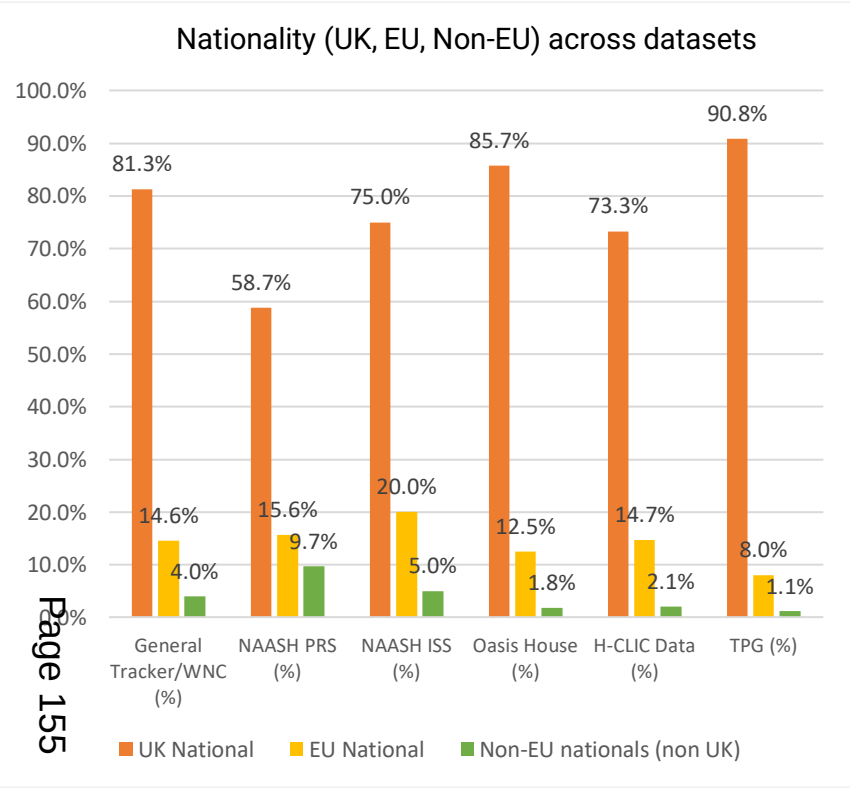
- As shown, most people sleeping rough in West Northants have been male across datasets from a range of services and providers shown in the bottom left chart, averaging 78.8% across each of these cohort. There are, significant differences across these cohorts, reflecting the different services and cohorts/needs they serve. NAASH's ISS in particular has a much larger proportion of female service users, >5% higher than the second highest female cohort, Oasis House (23.2% female), and >12% higher than the lowest proportion of women in the H-CLIC data (15.8% female).
- Although as highlighted above, LGBTQ+ people are more likely to experience homelessness than their peers (Centre for Homelessness Impact, 2022a), prevalence of LGBTQ+ is only visible in the two largest datasets (General Tracker and H-CLIC data), and even here in very low numbers with no openly gay (male) individuals in the General Tracker. This may reflect a discomfort in service users expressing their sexuality, with a large number, 75 or 7%, of service users preferring not to say in the H-CLIC cohort.

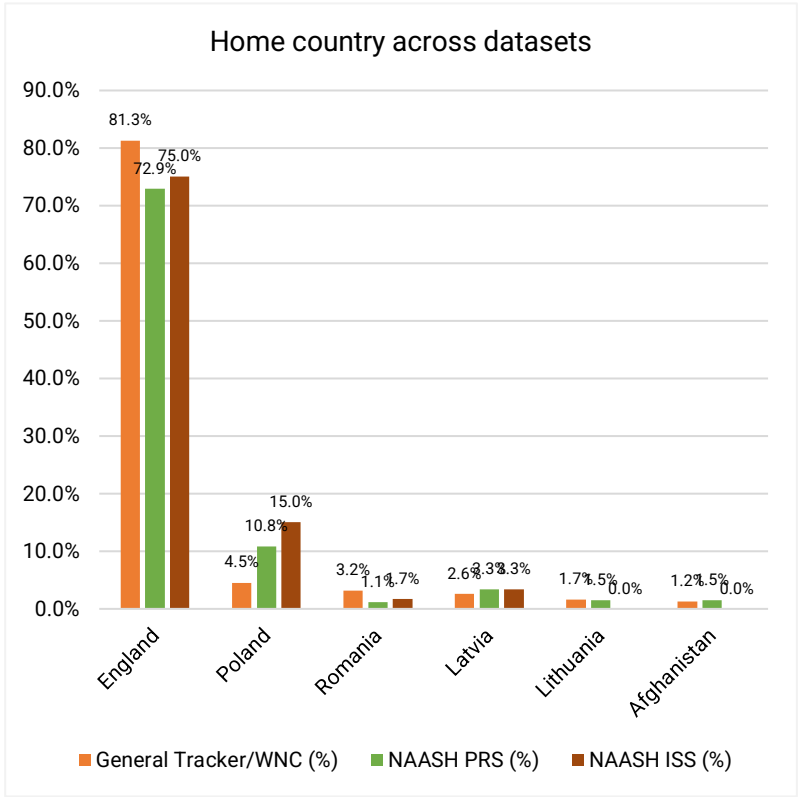


Sexuality/Sexual Orientation				
Sexual Orientation	**General Tracker/WNC (2020-23)**	**General Tracker/WNC (%)**	**H-CLIC Data (2018-23)**	**H-CLIC Data (%)**
Heterosexual	950	98.1%	813	81%
Transgender	4	0.4%	1	0%
Bisexual	3	0.3%	6	1%
Lesbian	2	0.2%	6	1%
Gay	0	0.0%	5	0%
Plus +	1	0.1%	2	0%
Applicant Prefers not to say	0	0.0%	75	7%
Unknown	8	0.8%	99	10%

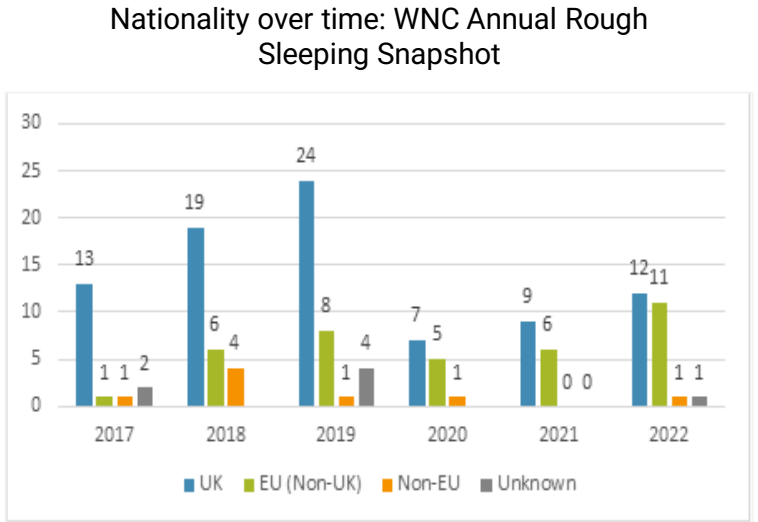
Local demographics (3/4)

- Across those cohorts with data points that detail nationality and home countries, the diversity in the people who use homelessness services in West Northamptonshire is clearly illustrated, with 34 home countries listed in the WNC General Tracker dataset, 23 in the NAASH PRS, and 9 in NAASH ISS.
- The majority of those who use WNC services are UK nationals and across the cohorts, over 70% of people detail England as their home country, alongside significant representation from those who detail Poland as their home country, alongside Romania, Latvia, Lithuania, and Afghanistan.
- The variation in datasets is also telling, with the lowest proportion of UK Nationals in the less intensive NAASH PRS service at 58.7%, versus the Target Priority Group (TPG) with 90.8% UK nationals.
- A large proportion of our in-scope cohort are White (81%), with diversity within this group across British (670/66%), Other (132/13.1%), Irish (8 or 0.8%), Gypsy/Roma (4 or 0.4%), Turkish, Irish Traveller, and Greek. There is also significant representation from Black or Black British, Mixed groups, with some representation from Chinese, and Asian or Asian British groups.





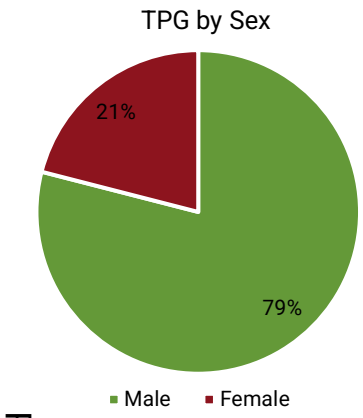
- In terms of overall demographics, the bottom right chart taken from the annual homelessness snapshot for WNC in 2022 shows a gradual increase in the number of people from the European Economic Area (EEA).

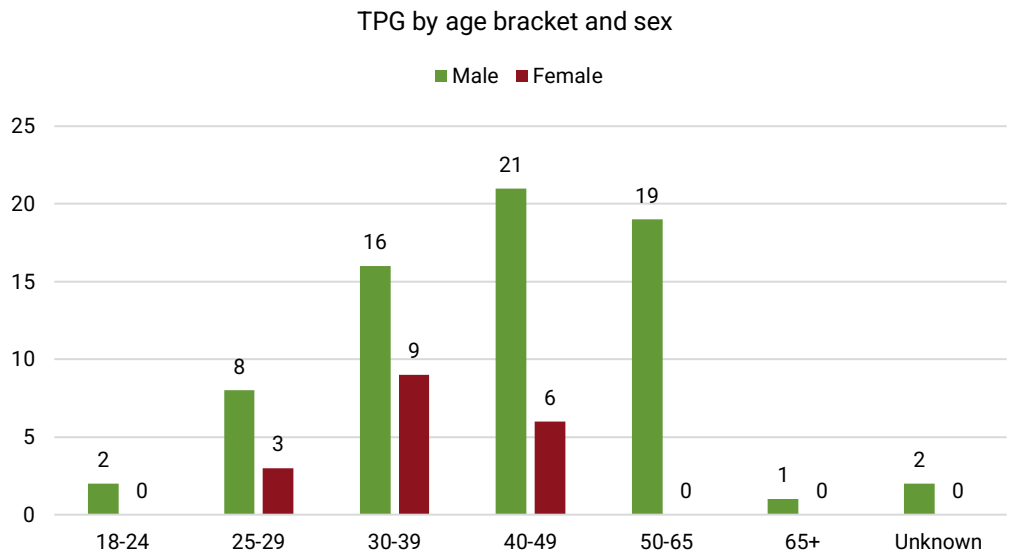


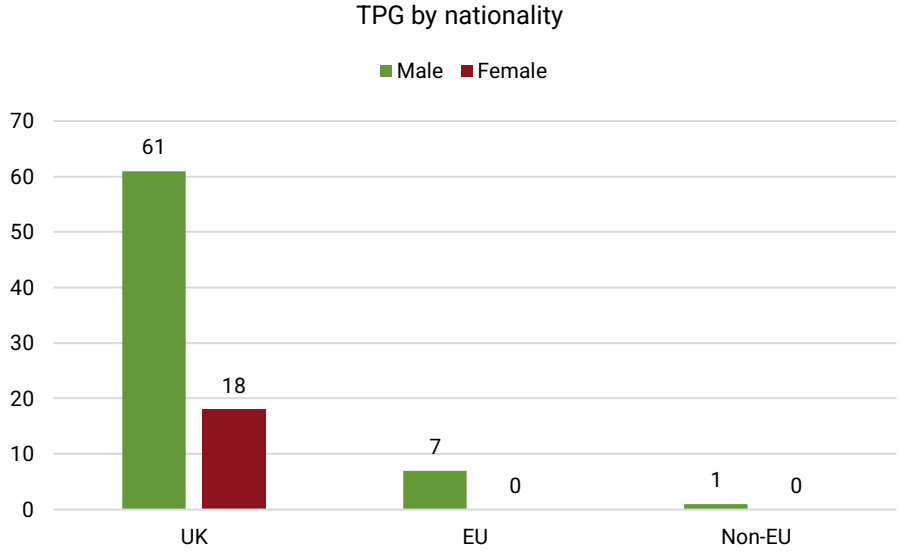
Local demographics (4/4)

Target Priority Group (TPG):

- The Target Priority Group (TPG) identifies individuals who have been seen sleeping rough in two or more years out of the last three, or in two or more months out of the last 12
- As of February 2022, West Northamptonshire's TPG was 91 people, of which 5 have subsequently died, leaving 86 people.
- 21% of the cohort are female, all UK nationals. There were no women in the 18–24-year age range and the oldest women were in the 40-49 year age range.
- The majority of men were aged between 25-49 years, with 19 between 50-59 years, and 2 between 18-24 years of age. 60 men are UK nationals; 7 are EU nationals and 1 a non-EU national.







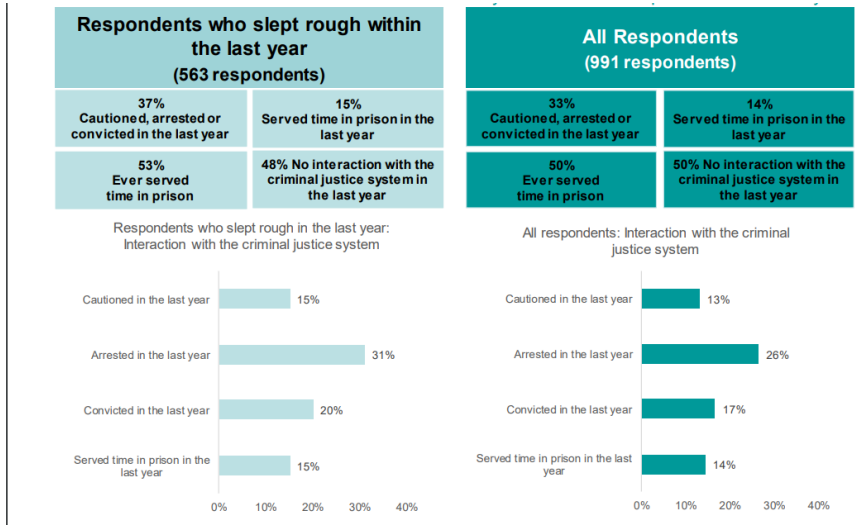
Summary of current evidence: overlaps with other 'at risk'/ inclusion health groups

Data quality in the correlation of **care experience** and homelessness is patchy, but it is possible to piece together a picture from multiple sources of data. Approximately 10% of people sleeping rough in London in 2018 were in care as a child (Ministry of Housing, Communities & Local Government, 2018).

Households who are **discharged from prison, hospital or local authority care** are at a high risk of experiencing homeless and, in particular, are at risk of street homelessness. Among the three key groups discharged from institutions, people leaving prison and young people ageing out of local authority care are the most numerous, with people who have served time in prison particularly overrepresented among those who are street homeless (Centre for Homelessness Impact, 2022b). However, there is a substantial overlap between these groups. The numbers of people who are experiencing homelessness and were previously in local authority care or prison have been increasing over recent years, while numbers for hospital discharge remained fairly stable.

The Rough Sleeping Questionnaire (2020) shows that 12% of people surveyed had left a hospital or a prison. Of the people in London experiencing street homelessness, in the second quarter of 2021, 35% were people leaving prison and 9% were people leaving care. People leaving prison or care were also more likely to have long term experiences with street homelessness. In 2021 Q2, 33% of those living on the streets in London were prison leavers, compared to 15% of those who were new to the streets. For people leaving care, it was 11% of those living on the streets compared to 4% of those who were new.

People discharged from institutions tend to have long experiences of street homelessness and be part of the 'stock' rather than the 'flow'. People leaving prison who become homeless are also more likely to have other negative outcomes. Firstly, they are significantly more likely to reoffend. Those experiencing street homeless are the most likely (67%), followed by those in temporary accommodation (54%) and permanent housing (43%). Also, a large proportion of prison leavers remain unemployed upon release which may play a role in homelessness and other negative outcomes.



Source: Rough Sleeping Questionnaire, MHCLG, 2020

Local overlaps with other inclusion health/ "at risk" groups

Women who have been involved in sex work:

- **Council:** Data from WNC's General Tracker indicated varying levels and types of need in the homeless pathway identified by the service (n=968 over the period from 1st January 2021 to March 2023). Of these, 18 (2%) are currently involved in sex work, a further 10 (1%) are at risk, and 4 (0.4%) have in the past but aren't currently.
- Of those 18 who are currently, 7 are housed in supported accommodation (across Oasis House, Orbit, HARRP, and NPH), 8 have No Fixed Abode, 1 in is in Temporary Accommodation (and being supported by Adult Social Care, CGL and Good Load) and 2 have an unknown housing status. 14 of these have at risk tenancies.
- Of those 10 who are at risk, 6 are housed (across NPH, Oasis House, NAASH and HARRP), 1 has No Fixed Abode, and 3 are unknown. 5 are also in at-risk tenancies.

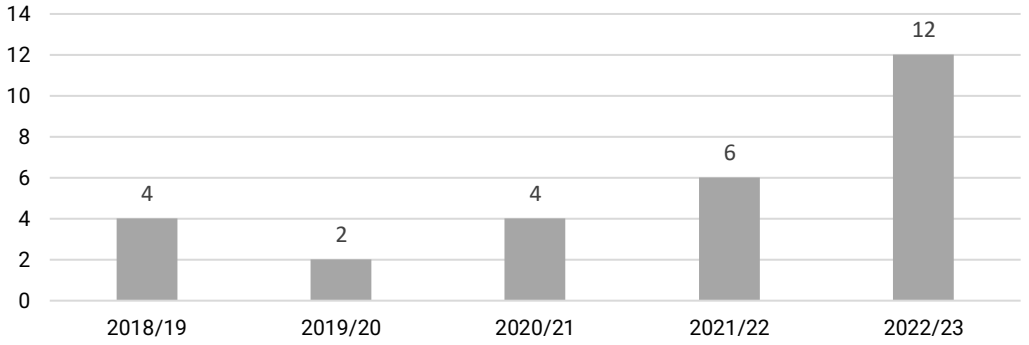
Domestic Abuse:

- Domestic abuse features as a reason for approach in the H-CLIC dataset, increasing significantly in number, or recognition in the data, over the last year.
- Domestic abuse is mentioned as a physical need in the NAASH PRS and ISS datasets, with four cases and one case detailed respectively across these datasets, and two cases are mentioned in the HARRP data.
- There isn't a clear and exclusive category for recording those that are currently or who have previously experienced domestic abuse, which could be an area to improve to ensure consistency and clarity in the recording of cases in this category.

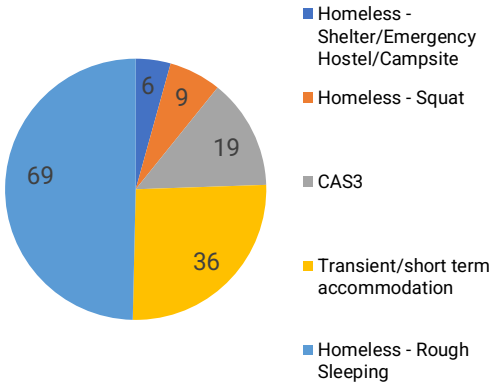
Offending/Probation:

- Data from Northamptonshire Probation Delivery Unit provides an insight into those from our in-scope cohort from West Northamptonshire on probation without stable accommodation between April 2022 – March 2023.
- It shows that **139, or 13% of all people on probation that were managed by the Northampton team between April 2022 to March 2023, were without stable accommodation**, with 19 of these in Community Accommodation Service Tier 3 (CAS3) temporary accommodation for prison leavers, 69 homeless and rough sleeping, 6 homeless and in shelter/emergency hostel/campsite, 9 homeless in a squat, and 36 in transient/short-term accommodation.
- This is reflected in the datasets from NAASH PRS (52 or 19%), NAASH ISS (15 or 25%), and Oasis House (7 or 12.5%) that detail Offending Needs within their cohort

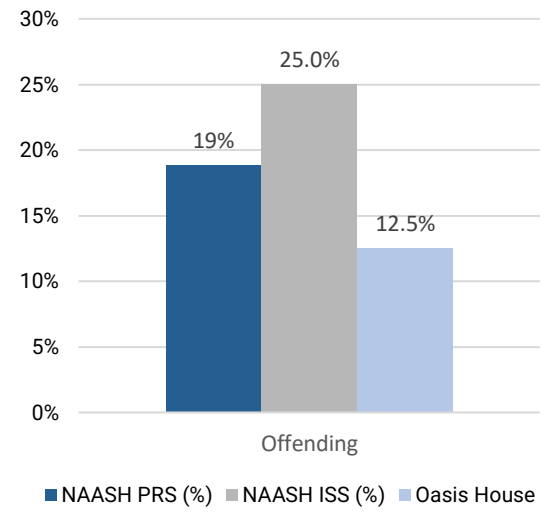
Reason for Approach "Domestic Abuse" – In-Scope H-CLIC Data (2018 - 2023)



All people on probation without stable accommodation (Northampton: April 2022 - March 2023)



Offending needs: NAASH PRS, ISS, Oasis House



West Northamptonshire Council

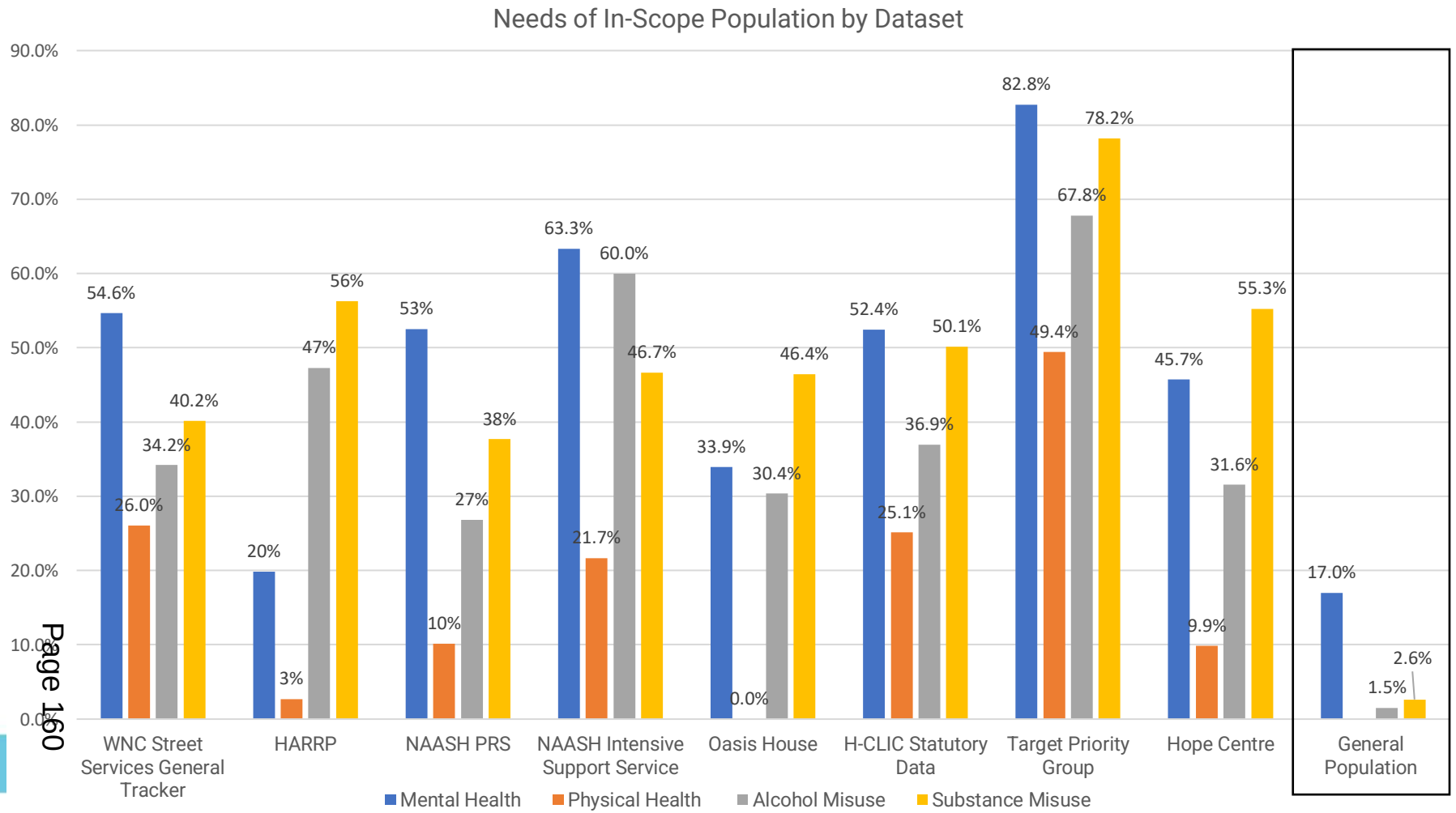
3. Prevalence of Need

Overall Summary of Need

Physical Health & Mortality | Mental Health | Substance Misuse | Social Care | Service Access, Utilisation & Engagement | Wellbeing & Preventative Healthcare | Practical / Other Needs | Multiple & Co-Existing Needs

Overall Summary of Need

Looking at the needs of those who use WNC's homelessness services across the datasets, the proportion of different need profiles were compared, with a focus on Mental and Physical Health needs, and Alcohol and Substance misuse – the needs recorded most widely across organisations. Although timescales vary, and so direct comparison is not possible, **it is still apparent that mental health and substance misuse are areas of particularly high need across West Northamptonshire.**



- Across all datasets, Mental Health, Alcohol Misuse, and Substance Misuse needs are highly prevalent.
- In the largest and most broadly representative datasets, WNC's General Tracker and H-CLIC, >50% have a Mental Health need, >40% have a Substance Misuse need, and >35% have an Alcohol Misuse need.
- Data from more intensive services, such as NAASH ISS, reflect much higher levels of needs than this baseline, with 63% and 60% of the cohort presenting with a Mental Health and Alcohol Misuse need, respectively.
- The highest levels of need can be seen in the Target Priority Group (TPG), where physical health needs are also prevalent (49.8%), as well as extremely high levels of need across Mental Health (82.8%), Substance Misuse (78.2%), and Alcohol Misuse (67.8%).

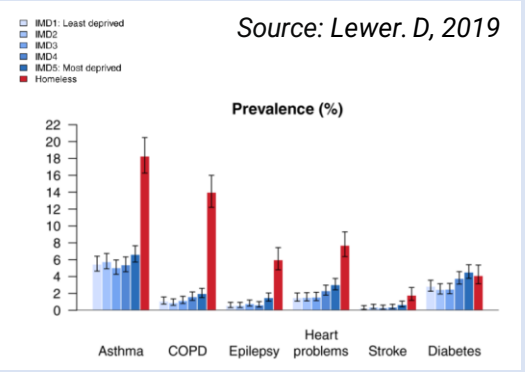
Summary of Current Evidence | Physical Health & Mortality (1/3)

Comparable data shows that almost all long-term physical ill-health needs are more prevalent in the homeless population than in the general population.

Physical health:

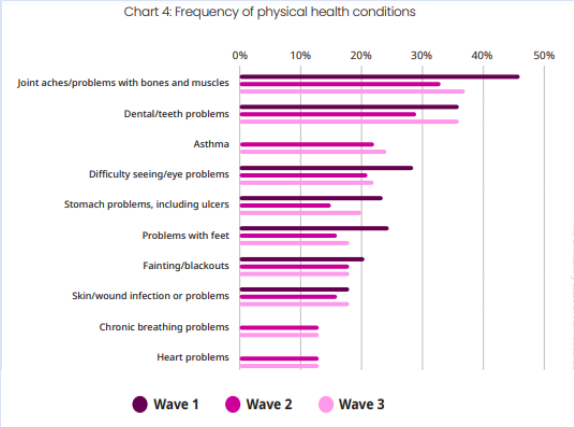
- There is a higher prevalence and incidence of **cardiovascular disease** as well as risk factors for people experiencing homelessness in the UK compared to people who are housed (Banerjee. A. Nanjo. A, 2020).
- Whilst it is widely understood that those in deprived areas of the UK experience poorer health outcomes than those in less deprived areas, a study of people living in London and Birmingham found the reported **prevalence of several chronic diseases is far higher for people experiencing homelessness**.
- As shown in the graph taken from the study, **asthma**, **COPD**, **epilepsy**, **heart problems** and **stroke** were reported to be significantly higher amongst those experiencing homelessness compared to the housed population, including those living in the most deprived areas (Lewer. D, 2019).
- The prevalence of **infectious diseases**, such as tuberculosis, HIV and hepatitis C, is **significantly higher in the rough sleeping population** than in the general population.
    - There is an increased risk of HIV and hepatitis C virus among people who inject drugs (PWID) who are or have recently experienced homelessness or unstable housing when compared with PWID who are more stably housed (Arum C, 2021).
    - People experiencing homelessness in the UK have been found to have higher rates of latent tuberculosis (TB) (Aldridge RW, 2018) and an association has been found between people who have experienced homelessness and higher TB risk (Nguipdop-Djomo P, 2020).
    - Data on TB in England is collected on the presence or absence of four social risk factors (SRF) which are known to increase the risk of TB and these include experiencing homelessness.
    - Available data for 2016-2019 showed a rise in the percentage of cases that were recorded in those experiencing homelessness although this dropped again in 2020 (UK Health Security Agency, 2021).
- As shown overleaf, other health conditions with an increased risk include **musculoskeletal disorders** and **chronic pain**, **skin** and **foot problems**, **dental problems** and **respiratory illness**.
- Slightly more people are **diagnosed with a physical health problem *after* they experience homelessness**.
    - 56% of respondents in Homeless Link's "Unhealthy State of Homelessness 2022" report received a diagnosis after becoming homeless. Field (2019) found that the most recorded diagnosis at admission to hospital for people experiencing homelessness were mental and behavioural disorders, external causes and their consequences. External causes and their consequences included assault, road traffic collisions, poisoning, head injuries and fracture.

Source: Lewer. D, 2019



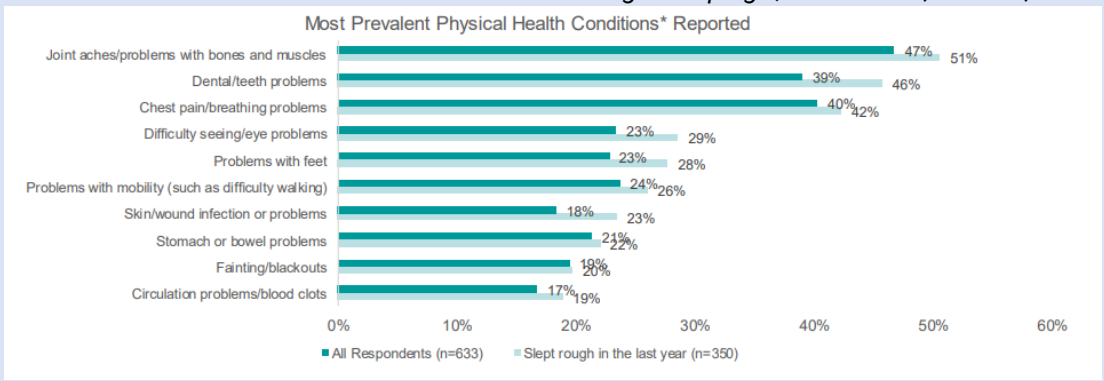
Summary of Current Evidence | Physical Health & Mortality (2/3)

Physical health, continued:



Source: Homeless Link, 2022

Source: Rough Sleeping Questionnaire, MHCLG, 2020



- The British Liver Trust explains that risk factors for liver disease include alcohol use and Hepatitis C and there has been found to be a **high burden of chronic liver disease amongst people who experience homelessness** (British Liver Trust, 2022), (Hashim, 2021).
    - Liver disease has been found to account for a higher percentage of deaths (13.8%) amongst people experiencing homelessness when compared to people living in the most deprived areas (2.7%) (Aldridge RW, 2019).
- People experiencing homelessness have been found to have **greater need for oral healthcare** than the general population (NHS England and NHS Improvement, 2021).
    - Oral health varies across the national population and disproportionately impact socially disadvantaged groups and individuals such as those experiencing homelessness (Public Health England, 2022).
    - Peer led research in London found that the experience of homelessness has a negative impact on a person's oral health and the oral health of participants in the study was significantly worse than the general population (Groundswell, 2018). 30% of those in the study were currently experiencing dental pain with bleeding gums, holes in teeth and abscesses common. 17% had lost teeth following acts of violence and 15% had pulled out their own teeth. 27% had used alcohol to help them deal with dental pain and 28% had used other drugs.

Summary of Current Evidence | Physical Health & Mortality (3/3)

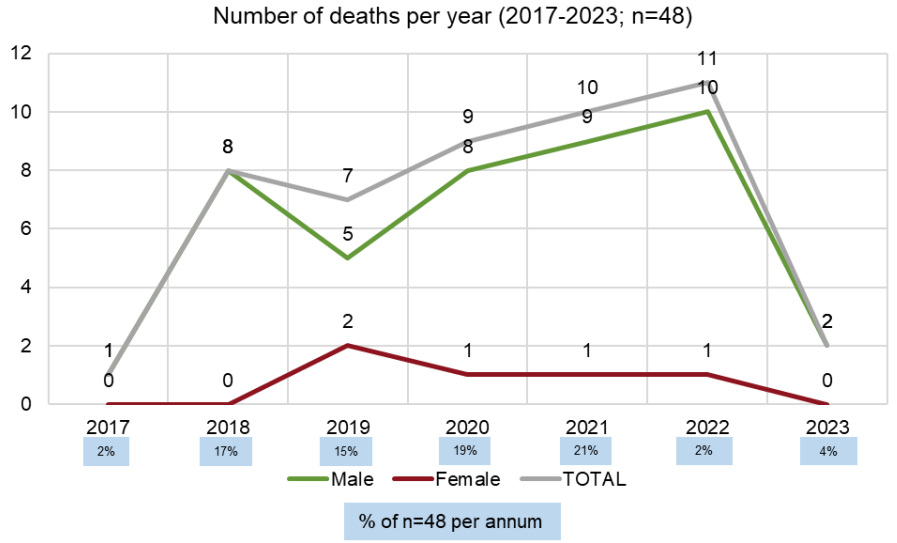
Mortality:

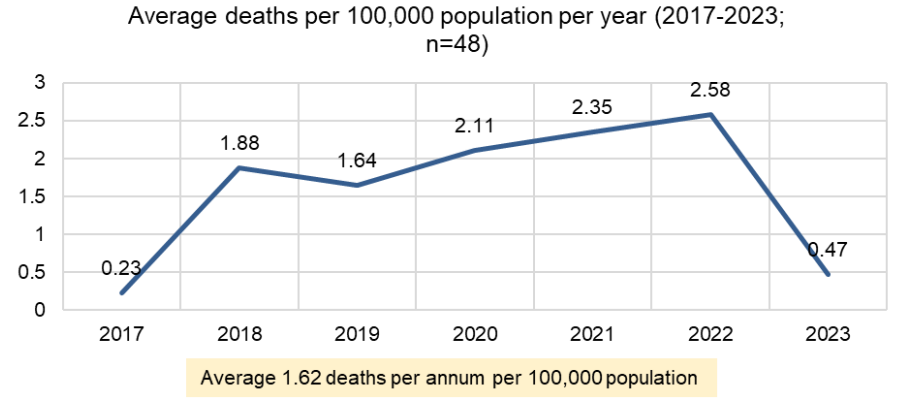
- People who experience rough sleeping over a long period are, on average, more likely to die young; with an **average age of death of 47 years old** and even lower for homeless women at 43 years old, compared to 77 years old for the general population (74 years for men and 80 years for women) (Crisis, 2012). It is important to note that this is not life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation.
- It has been estimated that around **35% of people who die whilst sleeping rough die due to alcohol or drugs (ONS, 2021)**, compared to 2% in the general population. Almost 2 in 5 deaths of homeless people were related to drug poisoning in 2021 (259 estimated deaths; 35.0% of the total number), consistent with previous years. There were an estimated **99 (13.4%) suicide-related deaths** and **71 (9.6%) alcohol-specific deaths**.
- A recent study (Aldridge RW, 2019) investigated the **causes of death** for a large group of people admitted to hospital in 17 sites across England (Aldridge RW, 2019). It was found that whilst external causes of death such as **drugs**, **alcohol** and **suicide** are considerably more prevalent in the homeless population than for those living in socially deprived areas, this was also the case for deaths from respiratory, cardiovascular and digestive system diseases.
- A study of “Pathway” teams in the UK which offer specialist hospital care coordination for people experiencing homeless found that **many deaths of homeless individuals are due to treatable conditions** such as **heart disease**, **pneumonia**, and **cancer** (Field, 2019).
- Fifty reviewed patients died within one year of discharge with an average age of 52 years at the time of their death. Analysis of data from the national child development study and 1970 British cohort study provides further evidence that **exposure to any type of homelessness in early adult life can increase the risk of overall mortality** (White.J, 2021).

Local Data | Physical Health & Mortality

Data from various organisations in West Northamptonshire clearly indicates increased physical health need in the in-scope population, and increasing rates of mortality.

- *Council:* Data received from WNC's Housing Service indicated varying levels and types of need in the homeless pathway identified by the service (n=968 over the period from 1st January 2021 to March 2023). There were **high levels of physical health need (252, 26%)**, particularly in the **male** homeless population
- In the WNC Housing Service dataset, an analysis of deaths of homeless, or recently homeless, single people in Northampton was provided (2017-March 2023), indicating 48 deaths over this period. Of these, 11 (23%; 10 male) were due to unspecified, underlying health issues, and 8 (17%; 7 male) due to heart attacks.
- As shown to the right, the number of deaths per year has been rising (data for 2023 only covers January-March and not the full year)





- *Panel:* Similarly in the Panel data over the period of January 2021-March 2023, of 580 individuals, **137 (24%; 115 male) had a physical health need**.
- *Housing Providers:*
  - **NAASH's PRS data** shows **28 or 10% of the cohort** were classified as having a physical health need.
  - **NAASH ISS,** the more intensive service, shows a higher level of physical need with **14 (22%) having physical health needs**.
  - **Hope Centre** data provided for January-March 2023 showed just 30 individuals out of 167 on record (**18%**) have a physical health need.
  - Data was not received regarding dental and oral health, or around specific long-term conditions and diseases
- *Target Priority Group (TPG):* Of the 87 included in the TPG, **43 (49%) have a physical health need**. Of these, 34 are male and 9 female.
- *H-CLIC Data (2018 – 2023)*: 25% had a physical health need or disability.

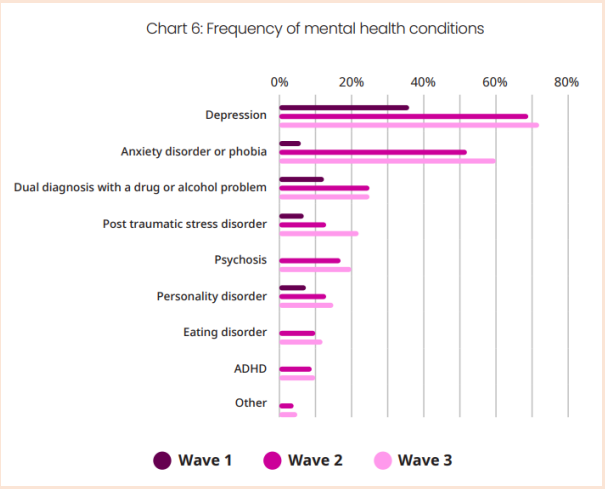
Summary of Current Evidence | Mental Health (1/2)

Mental health problems are highly prevalent in the homeless population, with particularly elevated rates of depression and anxiety.

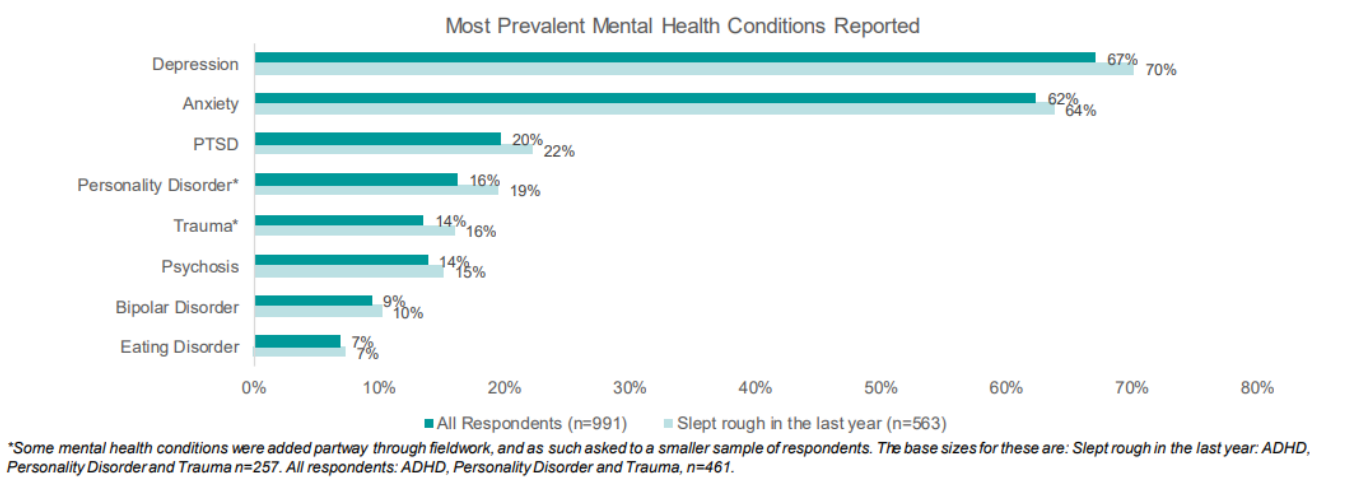
Prevalence and diagnosis:

- Although people who experience homelessness may have a range of conditions, most prescribing activities in specialist GP services have been found to relate to mental health and substance use, possibly suggesting under diagnosis and under treatment of other long term health conditions (Khan A, 2022).
- The latest Homeless Health Audit data (Homeless Link, 2022) found that **82% of respondents** reported they have a **mental health diagnosis** – a rise from 45% in a previous audit. This appears to be much higher than the general population as identified via a survey of GP patients nationally in which 12.3% reported having a mental health condition (NHS England, 2022).
    - Of those reporting a mental health condition in the audit, **72%** reported that this **condition predated their experience of homelessness**. This suggests that mental ill health predates homelessness and can then be further exacerbated by the experience of homelessness.
- Evidence has shown that, compared with the general population, **common mental health conditions** (such as depression, anxiety and panic disorder) are **over twice as high among people who experience homelessness**, and **psychosis is up to 15 times as high** (Health matters: rough sleeping, 2022).
    - In one study, people experiencing homelessness were more than **twice as likely to report problems with anxiety**, compared to those who were housed in the most deprived areas (Lewer. D, 2019).
    - An overview of studies conducted in seven western countries including the UK showed that prevalence of diagnosed mental health problems are higher among people experiencing homelessness, with 23.1% having a personality disorder, 12.7% having a psychotic illness, and 11.4% having major depression, among other diagnoses (Centre for Homelessness Impact, 2022c).
    - A recent Scottish study looking at the relationship between homelessness and health showed that someone experiencing homelessness has **5 to 20 times more mental health admissions** than someone not experiencing homelessness.
        - This compares with UK data suggesting that fewer than 1% of the general population has a psychotic mental health illness, with about 4% reporting post-traumatic stress disorder (PTSD) and 3% with diagnosed depression (Mind, 2021).
- As shown above and also overleaf, **depression** and **anxiety** are the most prevalent mental health conditions experienced by individuals who are homeless or rough sleeping.

Source: Homeless Link, 2022



Summary of Current Evidence | Mental Health (2/2)



Source: Rough Sleeping Questionnaire, MHCLG, 2020

Situation and engagement:

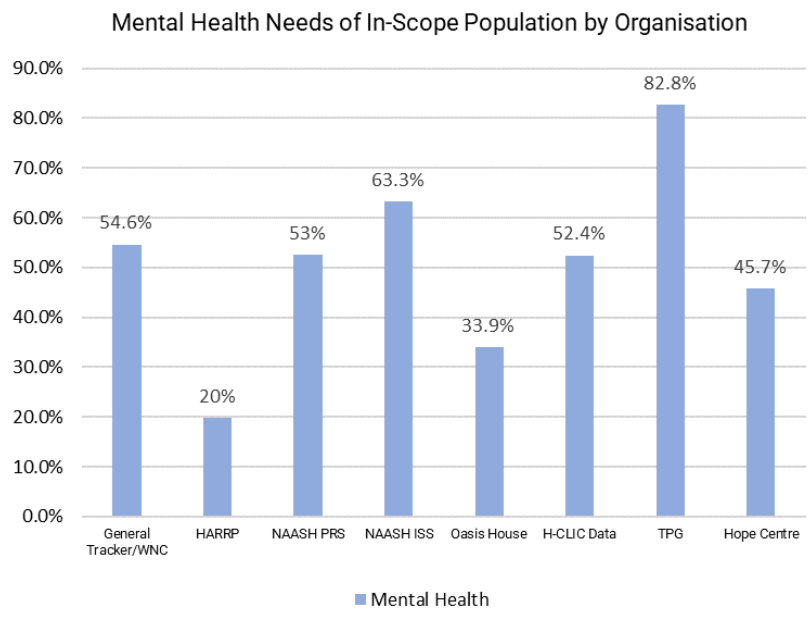
- Evidence suggests that **mental ill-health can make moving off the streets and into accommodation more challenging**.
    - Research has shown that people are around **50% more likely to have spent over a year sleeping rough** if they are also experiencing mental ill-health (compared to those who do not have mental health needs) (Health matters: rough sleeping, 2022).
- Field (2019) found that the **most recorded diagnosis at admission to hospital** for people experiencing homelessness were **mental and behavioural disorders**, external causes and their consequences. Mental and behavioural disorders included **alcohol intoxication or withdrawal**, **self-harm**, **suicidal ideation**, or **depression**.
- Analysis of data from the National Confidential Inquiry into Suicide and Safety in Mental Health found that people experiencing homelessness, who died by suicide between 2000 and 2016, who had recent contact with mental health services, were **more likely to have acute and chronic substance use** than patients in stable accommodation. They were also **younger**, more likely to be **male** and **less likely to be supported by a crisis team** (Culatto P, 2021).

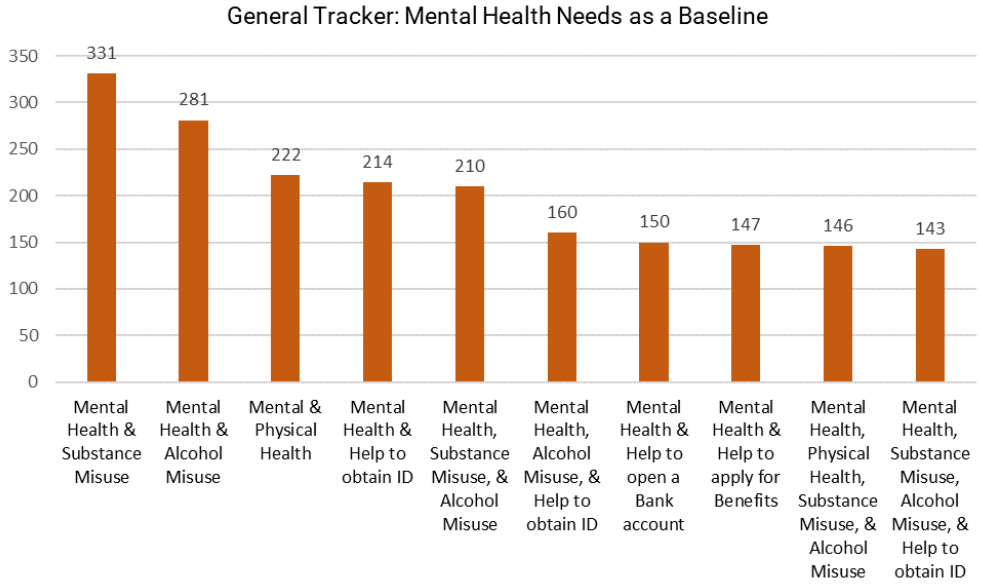
Local Data | Mental Health (1/5)

Data from various organisations in West Northamptonshire clearly indicated high mental health need in the in-scope population, with rising rates.

Local Data: Mental Health as a core need across Council, Provider, and Service data:

- Across every dataset, Mental Health needs have stood out as a core baseline across the in-scope population that use WNC's services.
- It provides a baseline of need, and a strong evidential base upon which better services can be built from. These needs feature in every dataset that has been assessed, but are particularly prominent amongst those in the highest intensity service such as NAASH ISS, as well as the WNC's Target Priority Group, as seen in the graph below.
- The graph on the bottom right uses data from WNC's General Tracker (n=968), and shows Mental Health need as a baseline to illustrate the extensive overlap and interrelation with many other needs.

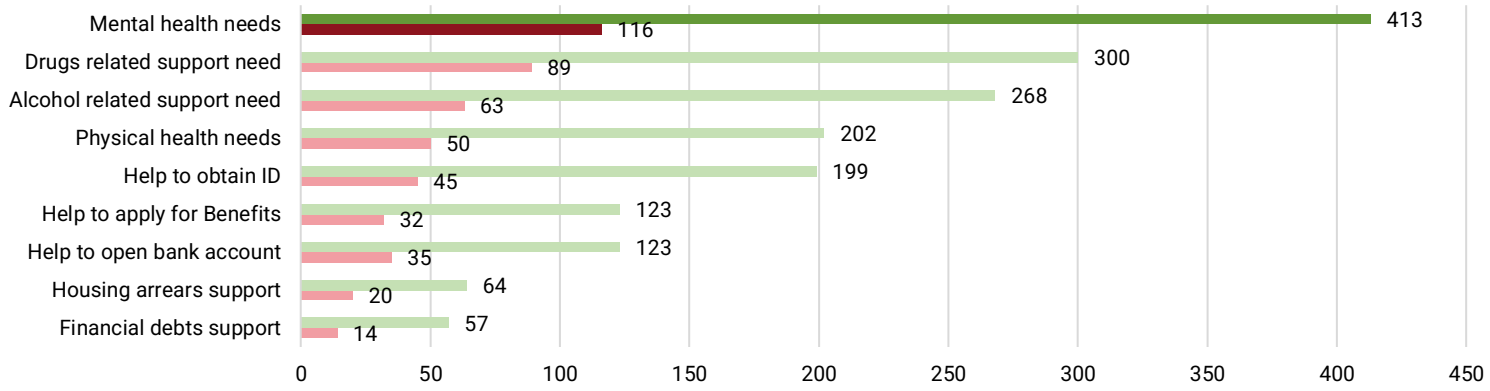




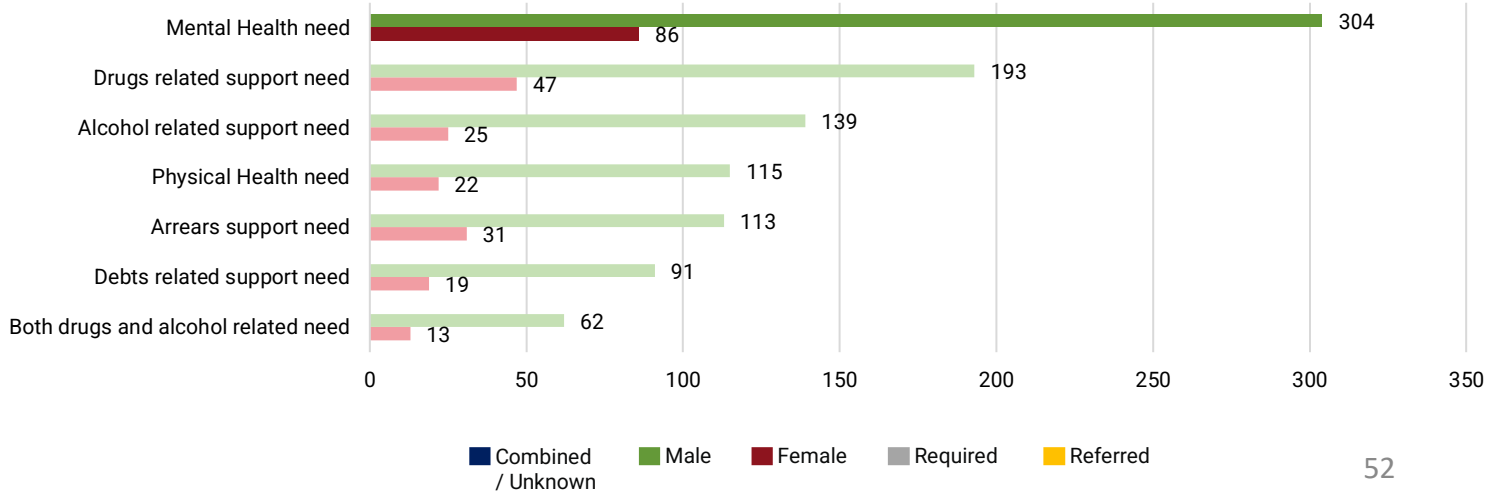
Local Data | Mental Health (2/5)

- **General Tracker:**
  - Mental Health is the most prevalent support need documented.
  - **529 (55%)** of individuals presented with Mental Health needs, with **high prevalence in the male homeless population** (413, representing 78% of the mental health need and 43% of the overall cohort).
- **Panel:**
  - *Panel*: Similarly in the Panel data over the same period, of 580 individuals, **390 (67%)** had a mental health need, again **mostly male** (304 - 78% of mental health need cohort, 52% of the whole cohort).
- **Target Priority Group:**
  - WNC's Target Priority Group (TPG) represents the cohort with the highest need profile overview, with mental health the need of highest prevalence in this group.
  - 72 of the 87 included in this cohort (83%) have a mental health need. Of these, 56 are male and 16 female.
- **H-CLIC Data (2018 – 2023):**
  - Within the H-CLIC data, 52% had a mental health related need,

WNC Housing General Tracker; Analysis of needs – Male vs Female
(January 2021-March 2023; n=968; Yes only answers)



Needs of those on Panel – Male vs Female
(2021-2023; n=580; Yes only answers)

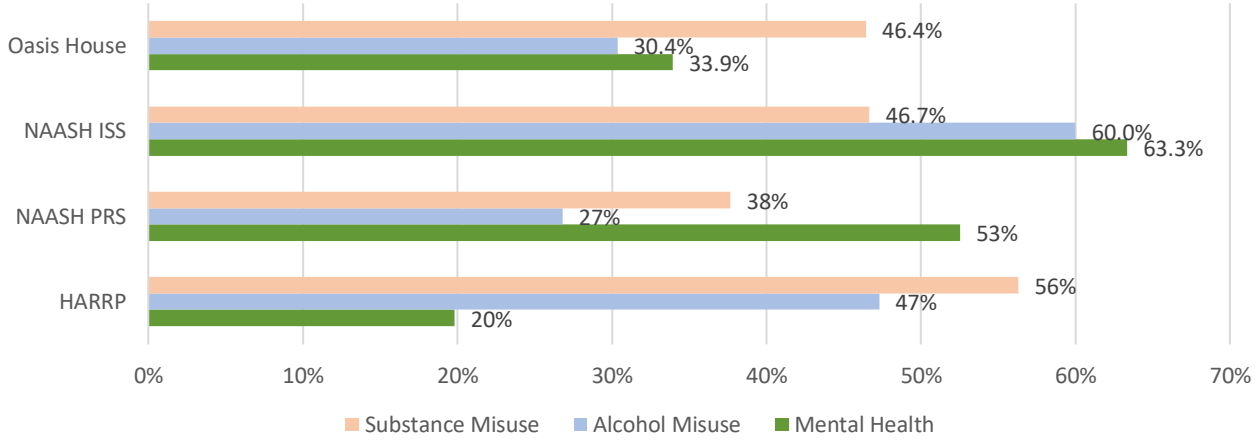


Local Data | Mental Health (3/5)

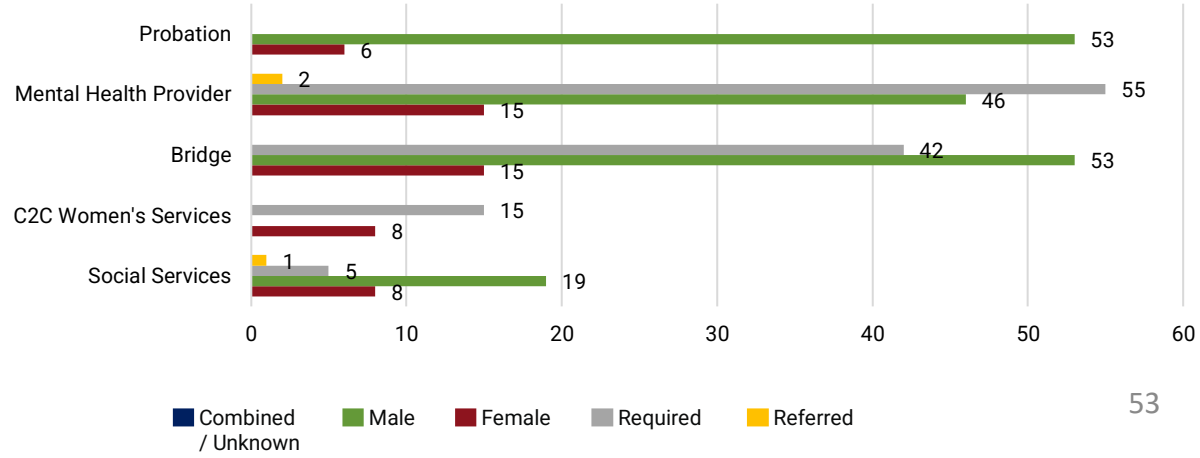
Accommodation Providers:

- **NAASH ISS:**
  - The most prominent support needs are **mental health (38, 63% of the cohort**), amongst a high prevalence of other needs, such as alcohol and substance misuse.
  - It reflects the high intensity nature of this provision.
- **NAASH PRS:**
  - Mirroring the ISS cohort, mental health needs are the most prominent in the NAASH PRS cohort: **145 (54%) of those who accessed the service have a mental health need.**
- **HARRP:**
  - Within the recorded cohort who have used the service between its opening in November 2020 and the end of March 2023, (n=211), **29% worked with mental health support from a mental health provider.** However, **55 individuals (26%) still required mental health support according to the data record**.
  - Total historical HARRP data (n= 242) highlights mental health as **a significant primary need**, with 44 (20%) of past users and 8 (30%) of present users presenting with this primary need.
  - These mental health needs were shown to increase by 14% to 64 service users when they exit the service, illustrating how needs can change over time.
- **Oasis House**:
  - From the data available, 33% of those accommodated in Oasis House present with mental health needs, combining again with high levels of substance misuse and alcohol misuse needs for those who use the service.

Mental Health Needs of Population by Housing Provider



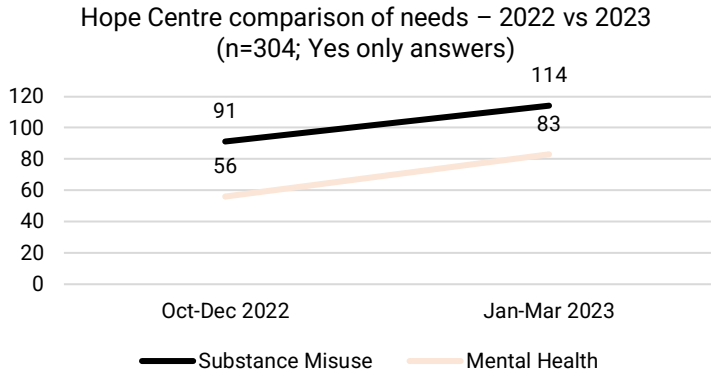
HARRP: Guests working to address their needs – Male vs Female (2021-2023; n=211; Yes + Required + Referred answers)

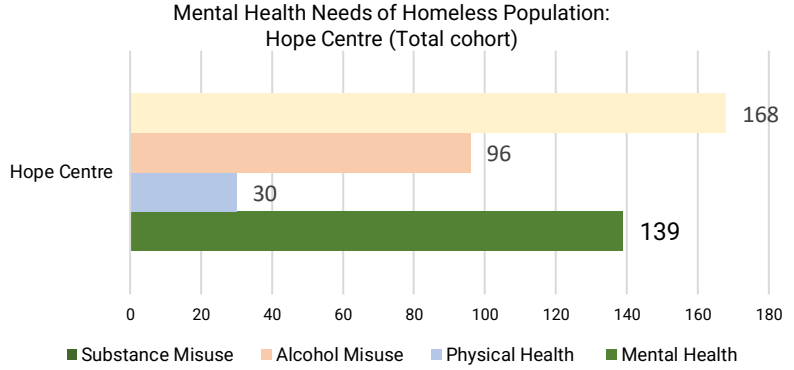


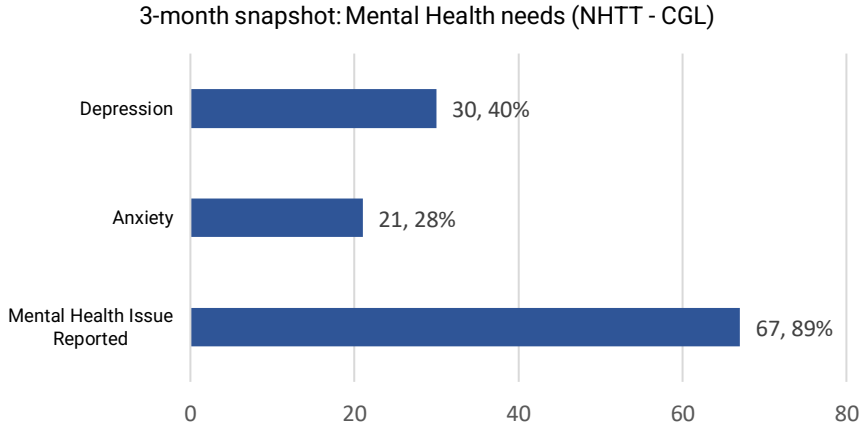
Local Data | Mental Health (4/5)

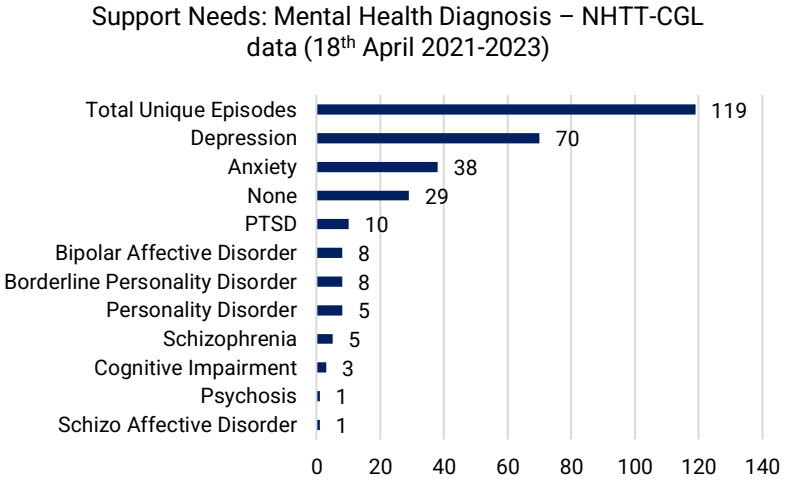
Support providers:

- **Hope Centre:**
  - Data indicates that the **level of mental health need** has increased from October-December 2022 to January-March 2023 (from 56 individuals to 83; a **48% increase**).
  - Looking at the cohort in the round, mental health needs are highly prevalent – **46% of the cohort overall.**
- **NHTT-CGL:**
  - Providing a 3-month and 2-year snapshot of the service users working with the team, prevalence of mental health needs were very high with 67 or 89% presenting with mental health needs in the 3-month snapshot – only 8 reported no mental health need.
  - With some overlap with the Total Unique Episodes, the chart to the right shows the distribution of mental health diagnoses in this cohort.
  - A majority of the cohort received a diagnosis of depression, followed by anxiety. This is echoed in the 3-month snapshot data from 18th February-April 2023, where 30 people had depression-related support needs, and 21 had anxiety-related support needs.



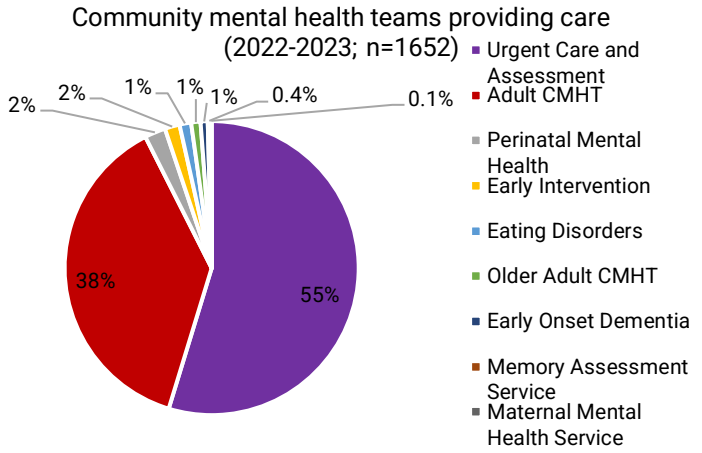


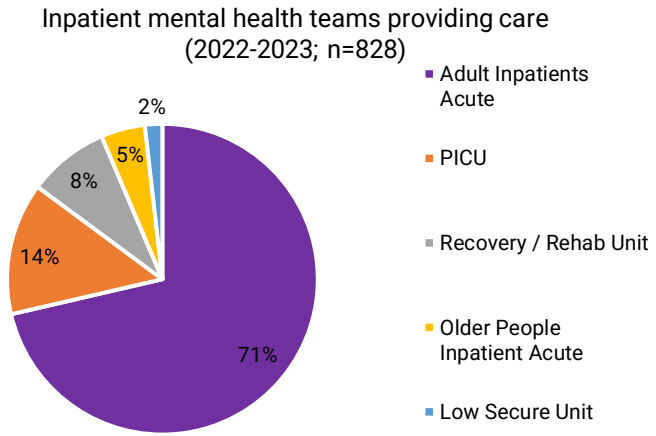




Local Data | Mental Health (5/5)

- *Secondary care*: From 30th April 2022 to 31st March 2023, **1,652 individuals** have been under the care of the **community mental health teams** under Northampton Healthcare NHS Foundation Trust (this is therefore a wider geographical coverage than West Northants).
  - **55%** of this homeless cohort ("homeless" accommodation status indicator) have been under the care of the **Urgent Care and Assessment Team**, and **38%** under the **Adult Community Mental Health Team (CMHT)**.
  - Over the same time period, **282** have been under the care of the **inpatient mental health teams** in Northamptonshire. **71%** of this homeless cohort have been under the care of the **Adult Acute wards**, and **14%** in **Psychiatric Intensive Care Units (PICUs)**.
  - These distributions by team for Community and Inpatient settings are illustrated on the right.
- *Suicide*: The Northamptonshire Suicide Prevention Strategy 2022-2025 sets out priorities and actions to reduce the number of local lives lost to suicide.
- The recent Northamptonshire Coroner's Suicide Audit Report: Public Health Northamptonshire Council (March 2023) indicated that of the 225 cases audited, 4 (2%) had homeless / pending eviction cited as their crisis triggers.
  - Other triggers included relationship breakdown (48, 21%), **mental illness (38, 17%)**, physical deterioration (29, 13%), debt / financial problems (27, 12%), work stress (10, 4%), current contact with criminal justice system (6, 3%), recent abuse / being a victim of violence (6, 3%), and redundancy (5, 2%). These triggers have been found to be areas of need within the homeless population itself through other datasets.
  - In the WNC Housing Service dataset, an analysis of deaths of homeless, or recently homeless, single people in Northampton was provided (2017-March 2023), indicating 48 deaths over this period. Of these, 4 (8%), all male, were due to suicide.





Summary of Current Evidence | Substance Misuse

Evidence suggests that drug and alcohol use can cause homelessness, but it also shows that the experience of homelessness can also lead to substance use.

Context and Prevalence:

- It has been estimated that around **35% of people who die whilst sleeping rough, die due to alcohol or drugs**; compared to 2% in the general population (ONS, 2021). Almost 2 in 5 deaths of homeless people were related to drug poisoning in 2021 (259 estimated deaths; 35.0% of the total number), consistent with previous years.
- Substance dependence can be both a cause and consequence of homelessness. Those who are dependent on drugs or alcohol may struggle to retain accommodation due to financial difficulties, problems with behaviour or family relationship breakdown.
- Homelessness can also be the route to substance dependence. Even with street homelessness, there is often an **unclear pattern of cause and effect**, as whilst substance misuse can be a contributory cause of homelessness, it often develops and worsens as a direct consequence of sleeping out. One survey conducted among a group of people experiencing homeless had substance use as the cause of homelessness for only 5% of the survey cohort (Centre for Homelessness Impact, 2021).

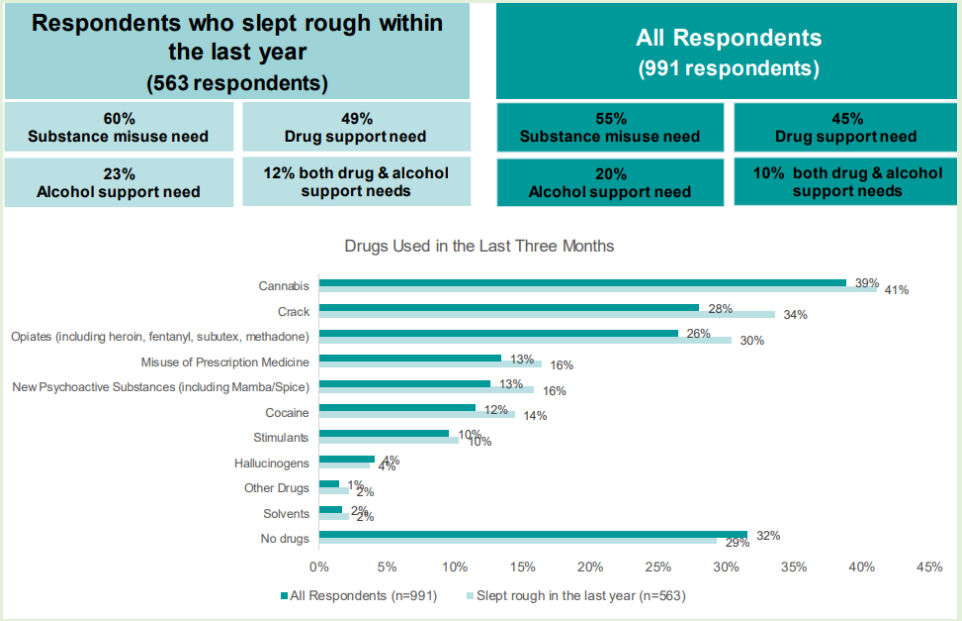
Access:

- Access to health and substance use services can be **challenging**, often due to **negative past experiences**, **discriminatory services**, **healthcare costs**, and other **administrative barriers**. This can lead to delayed treatment or even no treatment.
    - St Mungo's (2018) estimated that in 2018-19, about 12,000 people in England who were street homeless did not receive vital drug or alcohol treatment.
- **Lack of care for substance use issues** can contribute to other health problems.
    - There is evidence showing an **increase in diseases like Hepatitis-C and HIV**, most likely caused by drug use (Lewer et al, 2017).
    - The **rates of injected-related health issues are higher in the population experiencing homelessness** than compared to the general, drug-using population in the UK.
- **Poor access** to care also contributes to higher death rates in the homeless population due to drug use.
- The **length of homelessness** is also connected to alcohol or drug support use.
    - More than a third of people who experience intermittent and long-term street homelessness had substance or alcohol support needs but that proportion is much lower among those who are new to the streets (alcohol 15% and substance 14%) (CHI, 2021).
- Over half (**54%**) of people experiencing homelessness report having **used drugs in the last year** (Homeless Link, 2022) which is far higher than estimates for the general population (8%).
- **Treating drug dependence as a long-term condition** has been recommended (Department of Health and Social Care, 2021).

Summary of Current Evidence | Substance Misuse

Substances used:

- According to the 2020 Rough Sleeping Questionnaire (Ministry of Housing, Communities & Local Government), the mostly commonly used substance was **cannabis** (41% of those who has slept rough in the past year, n-563), followed by **crack**, and **opiates**. This is shown to the right.
    - Almost 2/3rds of the respondents who had slept rough in the year before had used drugs in the 3-months prior



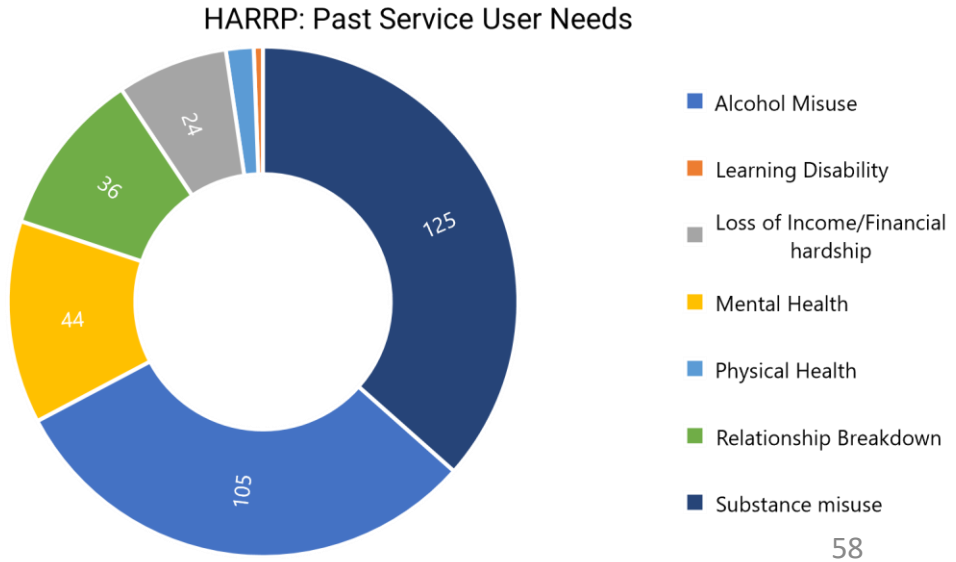
Source: Rough Sleeping Questionnaire, MHCLG, 2020

Local Data | Substance Misuse (1/4)

- *Council:* Data received from WNC's Housing Service indicated varying levels and types of need in the homeless pathway identified by the service (n=968 over the period from 1st January 2021 to March 2023).
  - **Drug (389, 40%)** and **alcohol (331, 34%) related support need** represented, after mental health**, the next two highest areas of need**. In both cases, there were particularly high rates of need in the **male** homeless population.
  - For drug-related support needs, 300 men were identified (representing 77% of drug-related need and 31% of the whole cohort).
  - Similar figures were seen for the male population with alcohol-related support need (268, representing 81% of the alcohol need population, and 28% of the whole group).
- In this dataset, an analysis of **deaths** of homeless, or recently homeless, single people in Northampton was provided (2017-March 2023), indicating 48 deaths over this period. Of these, **10 (21%) were due to alcohol** and another **10 (21%) due to drugs**, primarily male in both cases.

- *Panel:* Panel data from 2021-2023 (n=580) shows similar trends with 240 having a **drug-related support need (41%)**, 164 having an **alcohol-related support need (28%)**, and 75 having **both drugs and alcohol related needs (13%)**. In all cases, a vast majority are **male**.

- *Housing providers:* Data contained within the Keystage Housing HARRP Trinity Needs Assessment (collected as of the end of March 2023, with some as of April 2023) shows that **alcohol misuse and substance misuse are the needs most commonly found on entry**.
  - **Alcohol misuse** is recorded as a **primary need for 105 (47%) past service users**, with **substance misuse a primary need for 125 (56%) past service users** – both were the most frequent needs for all three cohorts (1, 2, and 3 primary needs). This is shown to the right.
  - This trend is mirrored in **current service users**, with **alcohol misuse a primary need for 20 (74%)**, and **substance misuse a need for 14 (52%)**, of current service users – with both of the most prevalent needs for all three cohorts (1, 2, and 3 primary needs).

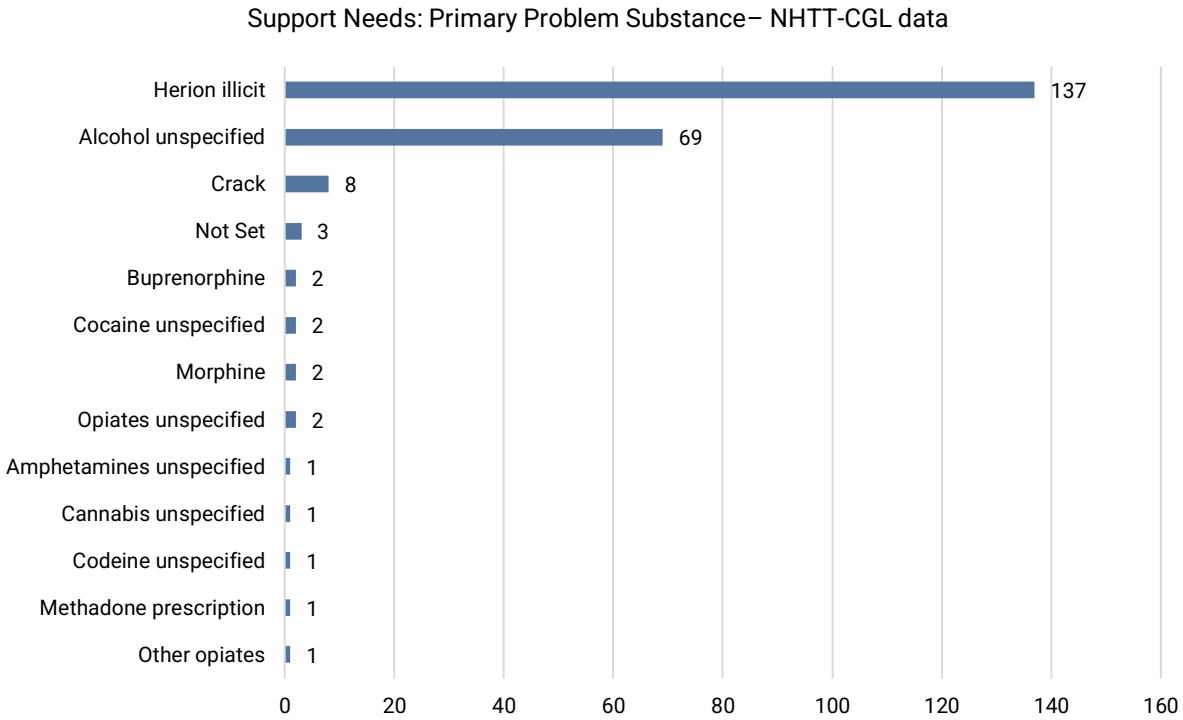


Local Data | Substance Misuse (2/4)

- NAASH Intensive Support Service (**ISS**) data indicates that, after mental health, the **second most prominent support needs are for alcohol abuse (36, 60% of the cohort), followed by substance misuse (28, 47%)**. Similarly in NAASH Private Rented Sector (**PRS**) data, **alcohol abuse and substance abuse were the third most prevalent areas of need** (after mental and physical health), with 74 individuals (27% of the cohort) and 52 (19% of the cohort) with related needs, respectively. This is shown on page 53 [MH section].

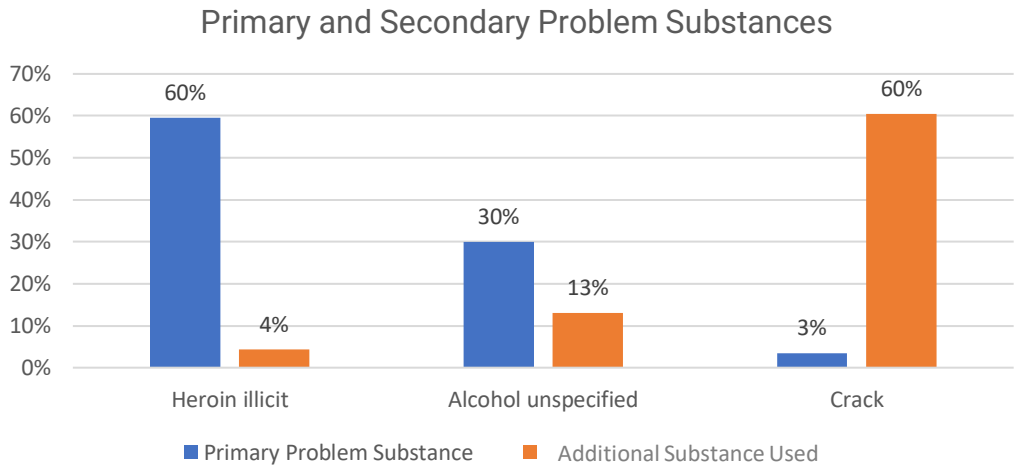
- *Target Priority Group (TPG)*: Of the 87 included in the TPG, **59 (68%) have an alcohol-related need**, of which 45 are male and 14 female. **68 (78%) have a drug-related need**, other which 51 are male and 17 are female.

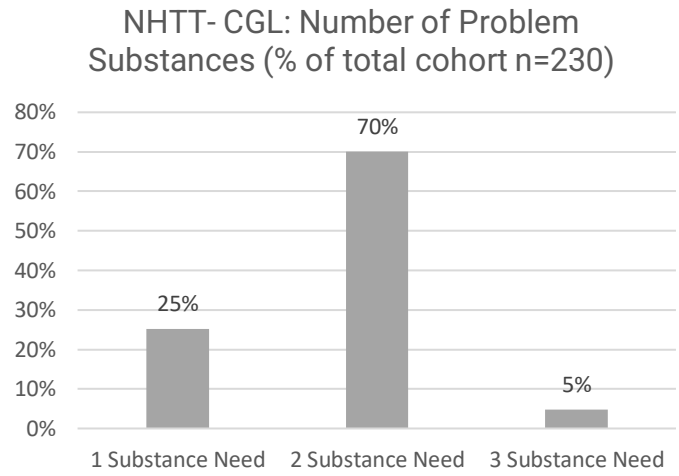
- *Support providers*: Hope Centre data indicates that the **level of substance misuse need** of their service users has increased from October-December 2022 to January-March 2023 (from 91 individuals to 114; a **25% increase**). This is shown on page 54 [MH section
- *H-CLIC/ Statutory Data (2018 – 2022)*: 37% with an alcohol related support need, 50% drug related
- *Primary care*: Of the 149 registered as homeless with Maple Access Partnership Surgery, **29 (19%) are recorded with a substance misuse problem**, of whom **23 (79%) are male, aged 41-50**.
- *Data provided by NHTT-CGL* shows a 2-year snapshot from 18th April 2021-2023. 230 individuals reported as rough sleeping or at risk of rough sleeping were engaging with the service.
    - The distribution of primary problem substances is noted in the data, with **heroin** being the most prevalent (137, 60%), followed by **alcohol** (69, 30%). This is illustrated to the right.
    - This is echoed in the 3-month snapshot data from 18th February-April 2023, in which 49 people have a heroin related substance misuse support need, followed by 21 alcohol-related needs.

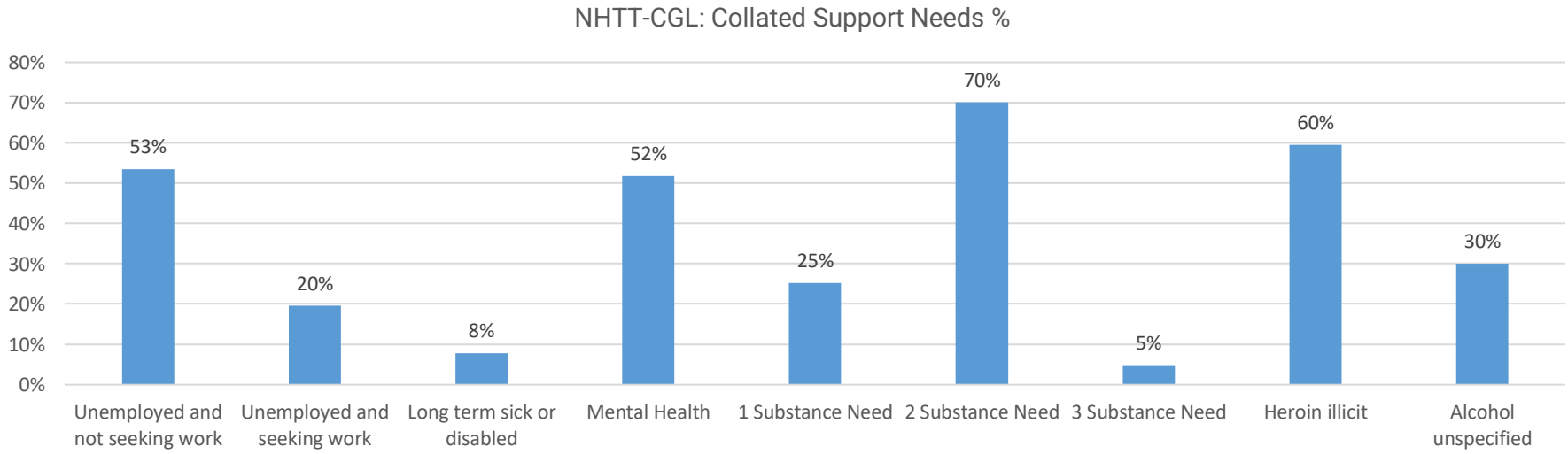


Local Data | Substance Misuse (3/4)

- *Data provided by NHTT-CGL cont*.
- The large majority (75%) of this cohort have more than one substance support need, with 70% (161) individuals displaying two problems substances, and 5% (11) presenting with 3 problem substances.
- When breaking this down into the three largest problem substance types, in this cohort – Heroin, Alcohol, and Crack – you can see the large prominence of crack as a 'secondary' problem substance for 60% (139) of the total cohort.
- As the bottom chart shows, these dependencies combine with and compound circumstances and needs across employment, sickness, and mental health – highly prevalent across the 230 services users reported



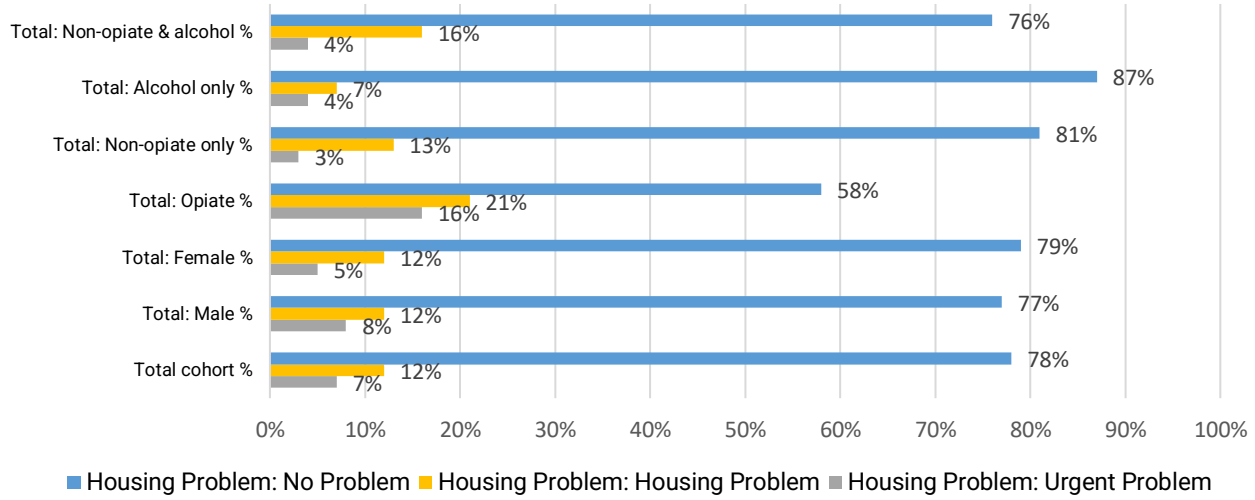




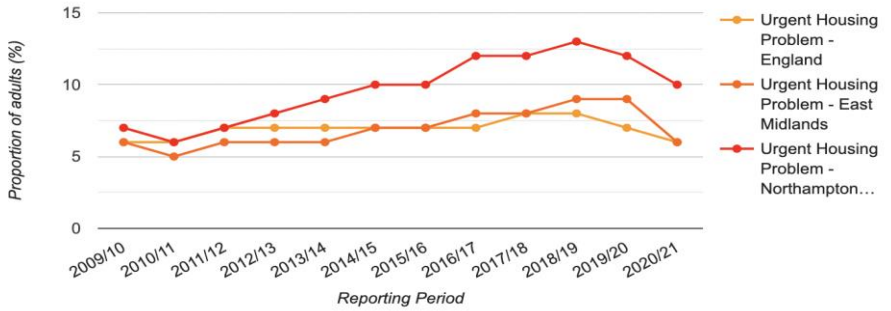
Local Data | Substance Misuse (4/4)

- **NDTMS data analysis:**
  - For the reporting period of 2021/22 across WNC, data from the National Drug Treatment Monitoring System (NDTMS) shows that out of those 915 new presentations over the period:
    - 65 or 7% of them had an 'Urgent' Housing Problem, a further 110 or 12% had a Housing Problem, and 710 or 78% had No Housing Problem.
    - Male and female groups provides another interesting comparison, with far more male presentations – 630 or 69% of the total new presentations during the period
    - Amongst the 285 new female presentations (31% of the total), Urgent Housing Problems were less significant in number and percentage, with only 15, or 5%, of their cohort compared with 50, or 8%, of male presentations.
    - Housing problems are most prevalent and urgent amongst the Opiate cohort, with 35 or 16% facing an Urgent Problem and a further 45 or 21% facing a Housing Problem.
    - This mirrors trends seen in the 2023 Northamptonshire Drug and Alcohol Needs Assessment. From 134 deaths registered in Northamptonshire between 2019 – 2022, 71% were male and deaths were concentrated in the most deprived areas of Northampton, with 63% of illicit drug deaths occurring in the 30% most deprived areas in Northamptonshire.
    - The number of new presentations to adult substance misuse services taken from the 2023 Substance Misuse Needs Assessment shows demand over time (graph bottom right)

NDTMS Data: Housing Problems across cohorts



Number of new presentations to adult substance misuse services with an urgent housing problem



Summary of Current Evidence | Social Care (1/3)

Evidence suggests that homeless populations have higher levels of disability, premature aging and frailty, and are more susceptible to exploitation.

Disability:

- Research has consistently found **higher levels of physical disabilities and health conditions within households affected by homelessness**.
    - In MHCLG's Rough Sleeping Questionnaire (2020), **48%** respondents had a **long-standing physical impairment, illness or disability**, 16% a learning disability, 12% ADHD and 4% Autism.
    - In Homeless Link's Health Needs Audit (2022), **63% reported having a long-term illness or disability compared to 22% of the general population**. Considering all disability categories, an analysis of single people experiencing homelessness reported a disability prevalence rate of 34% (CHI, 2023).
- An annual review of support for single homeless people in England reported that on a single day in 2021, 13% of day centre clients and 13% of accommodation provider clients had a learning disability (Homeless Link, 2021).
    - These figures are considerably higher than the estimated 2% in the general population.
    - In 2018, a novel research study estimated **prevalence of autism** in the caseload of a UK homeless outreach team at **12.3%** (Churchard et al, 2018).
    - Further research in 2019 estimated autism prevalence in a sample of people using homelessness services at **18.5%** (Kargas et al, 2019).
    - These estimates are significantly higher than the 1–2% general population estimate suggesting autistic people are at acute risk of experiencing homelessness.
    - Given the sensory processing and social difficulties associated with autism, **current provision is likely to be unsuitable**. The research also suggests that autistic people experiencing homelessness may **not have a clinical diagnosis**.
- Research consistently suggests that **cognitive and neurodevelopmental conditions**, including **traumatic brain injury**, **autism**, and **ADHD** are **overrepresented in homeless populations**.
    - There is an association between Traumatic Brain Injury (TBI) and poorer reported health as well as suicidality and suicide risk (Stubbs J. L., 2020); and the **lifetime prevalence of moderate to severe TBI** has been found to be around **ten times higher amongst people experiencing homelessness** (than estimated for the general population).
- An inpatient audit took place over one week in February 2022 in hospitals across London (Nguyen et al, 2022). It was a detailed investigation of the health, care, support and accommodation needs of people identified as being homeless who were in hospital.
    - Of the 104 people reviewed, more than half (54.7%) were believed to have care needs.
    - There were concerns about cognitive impairment and/or aspects of mental capacity in 30.2 per cent and significant safeguarding concerns were present in 29 per cent including domestic violence, "cuckooing" and self-neglect.

Summary of Current Evidence | Social Care (2/3)

- **Premature aging and frailty**, defined by the British Geriatrics Society, the Royal College of General Practitioner, and Age UK as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves', are **common among people experiencing homelessness with severe and multiple disadvantage (NG214)**.
    - Care and support should be based on **assessed need**, not biological age.
    - **Flexibility in the eligibility criteria** could prevent the situation from escalating and help people to receive support earlier, leading to better outcomes.
    - NICE Guideline NG214 states the need to ensure that people experiencing homelessness who are assessed as frail and in need of social care and support get **long-term care packages**, including **residential care** or **supported housing**, irrespective of their age.

Workforce and models of care:

- There is evidence to suggest that **social workers and social care workers feel ill-equipped to support people with housing-related needs** (Simcock & Machin, 2019)
    - A Kings College London study (Martineau et al, 2019) has evidenced inconsistent and often inadequate responses to Multiple Exclusion Homelessness where social workers do not have expertise in and/or are not an accessible component of homelessness outreach working.
    - Those social workers who are striving to drive good practice are often isolated and unsupported in their work.
- The Out of Hospital Care Models programme and other initiatives provide evidence that **people experiencing homelessness have more limited access to Care Act Assessments (LGA, 2022)**.
    - Whilst not everyone who is sleeping rough or living in a hostel will have care and support needs, as defined by the Care Act 2014, and be eligible for adult social care and/or adult safeguarding, there is considerable overlap. However, research (Mason et al, 2017) has observed the impact of financial austerity on the capacity of Adult Social Care departments to absorb the workload arising from recognition of the care and support needs, and safeguarding concerns of people sleeping rough.
    - Research (Whiteford & Simpson, 2015) has also highlighted that resource scarcity can lead to unlawful gatekeeping and the exclusion of people who are homeless from care and support.

Summary of Current Evidence | Social Care (3/3)

- As Safeguarding Adult Reviews (SARs) identify, **people sleeping rough and in temporary accommodation are at risk of financial and physical abuse, and exploitation**.
    - They often have **multiple physical and mental health problems**, and not infrequently **die as a result of chronic ill-health** and the effects of **long-term substance misuse and mental ill-health**, including **suicidal ideation**.
    - Adult safeguarding is not just the responsibility of adult social care. Reviewing homelessness cases, a **lack of Care Act and Mental Capacity Act assessments** is often found, despite significant mental and physical health; and substance misuse needs (LGA, 2020).
    - Some SARs report a **failure to recognise care and support needs**.
    - There was some evidence to suggest a **reluctance to see the person's needs as anything other than a housing matter**.

Local Data | Social Care (1/3)

- *H-CLIC Data (2018 – 2023):* Within the H-CLIC data, 6% had a learning disability listed on their statutory homelessness application (compared to 2% of the general population).
- *Data provided by NHTT-CGL* shows of the 75 service users in-scope and working with the team, 15 (22%) reported a long term disability; similar to national averages

Adult Social Care Data Analysis

The dataset containing individuals presented to the weekly single homelessness pathway panel (n=566) was matched with people on the Adult Social Care database. Panel data started to be captured in January 2021. ASC matched data goes back to December 2020, as this is when the new Adult Social Care database was implemented and data from the legacy system is not possible to include.

- There were **64 individuals (11%)** present on both datasets indicating some interaction with Adult Social Care.
- The types of interactions could include:
  - Initial contact
  - Care Act assessment
  - Provision of services
  - Mental Health Act enquiries
  - Mental Health Act assessments
  - Adult risk management process
  - Safeguarding concerns
- The majority of individuals experienced only one type of interaction (n=30, 47%), with 19 experiencing only initial contacts and 11 safeguarding concerns. A further 16 (25%) experienced two interaction types (14 initial contact and safeguarding concern, 2 MH enquiries and assessments)
- The remaining **18 individuals (28%) have experienced three or more different types of social care interactions.** One individual (see right) had experienced all seven

51 individuals had initial contacts logged with Adult Social Care

14 individuals have had a Care Act Assessment

8 individuals have received packages of care

Snapshot Case Study

One individual represented heavy usage of Social Care services with 22 interactions logged across all seven types since December 2020; including:

- 2 initial contacts
- 3 Care Act assessments
- 3 service packages provided (x2 supported living, x1 home care)
- 5 Mental Health Act enquiries
- 5 Mental Health Act assessments (x1 section 2 outcome, x4 section 3 outcome)
- 2 ARM processes/ plans
- 2 safeguarding concerns (one from NHFT, one from ASC)

Local Data | Social Care (2/3)

Initial Contacts

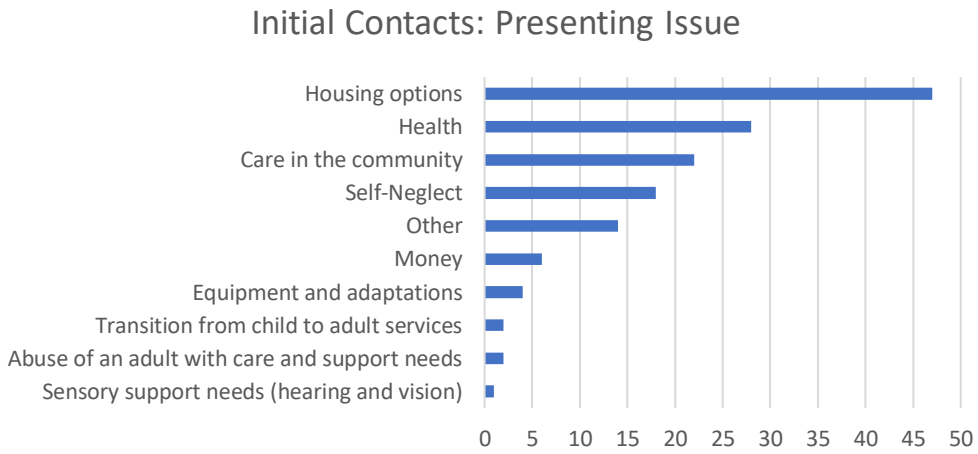
- Of the 51 individuals that have had a contact logged with Adult Social Care, the majority (n=30, 59%) only had one contact recorded, 14 (27%) individuals had two recorded, and 7 (14%) had three or four
- **The outcome of an initial contact was "Information/advice/signposting" in 61% of cases and "Move to conversation 2" in the other 39%** (the service operates the three conversation model, an escalation to conversation 2 is if people are at risk and need something to happen urgently to help them regain stability and control in their life)
- The predominant route of access (94%) was via the community, with a small handful from hospital or prison
- Multiple "presenting issues" are able to be logged with initial contacts. As shown on the right, and perhaps unsurprising given the cohort, "housing options" is the most common presenting issue; followed by health, care in the community and self-neglect

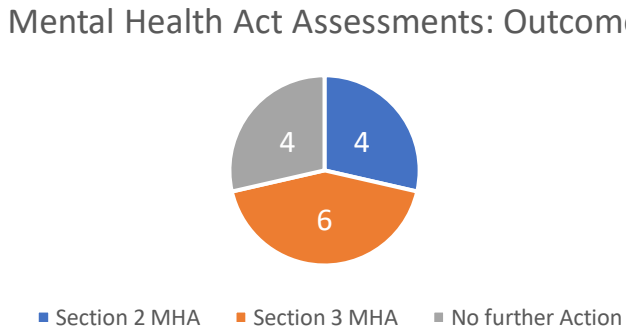
Care Act Assessments & Services

- 13 individuals have received one Care Act assessment, with one individual receiving three
- Of the 16 assessments completed, the majority (n=14, 88%) had needs arising from a physical impairment, mental impairment or illness; with 13 (81%) reporting a significant impact on wellbeing
- The most common outcome of the assessments was "support plan required" (n=11, 69%) with the remaining 5 a mixture of information and advice or low level support
- Of these 11, 6 resulted in a supporting living service, 3 home care, and 2 reablement

Mental Health Act Enquiries & Assessments

- 16 Mental Health enquiries have been made for 7 individuals (3 just one, 4 more than one). 14 (88%) of these progress to a Mental Health Act assessment
- Of the 14, 6 resulted in section 3 (treatment order), 4 in section 2; and 4 in no further action

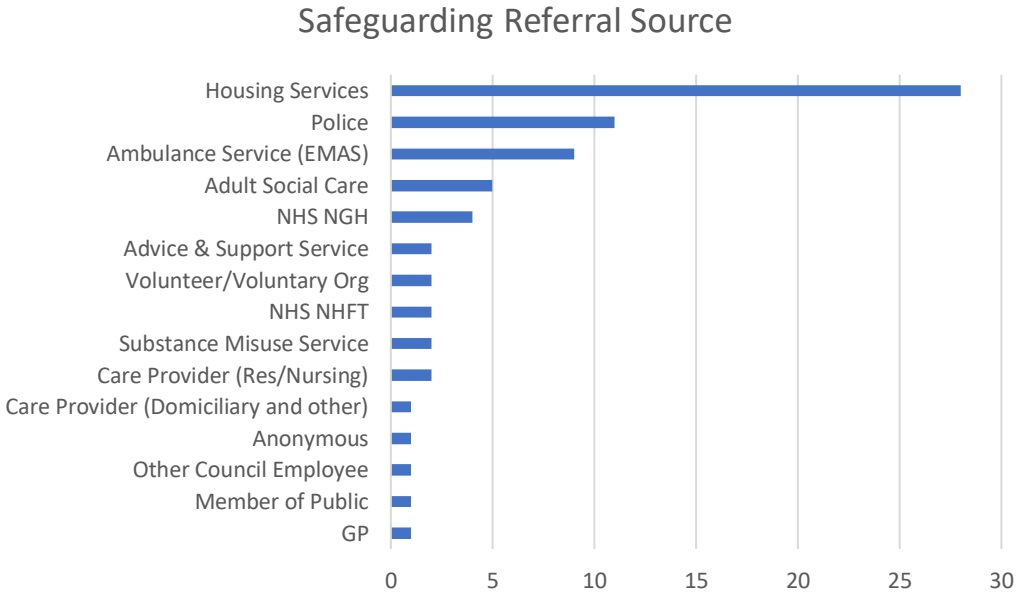


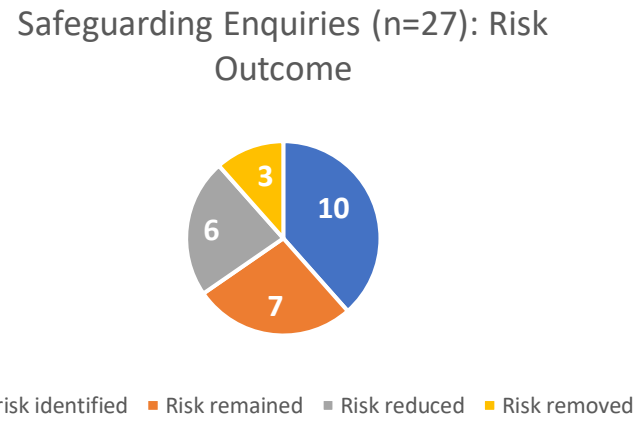


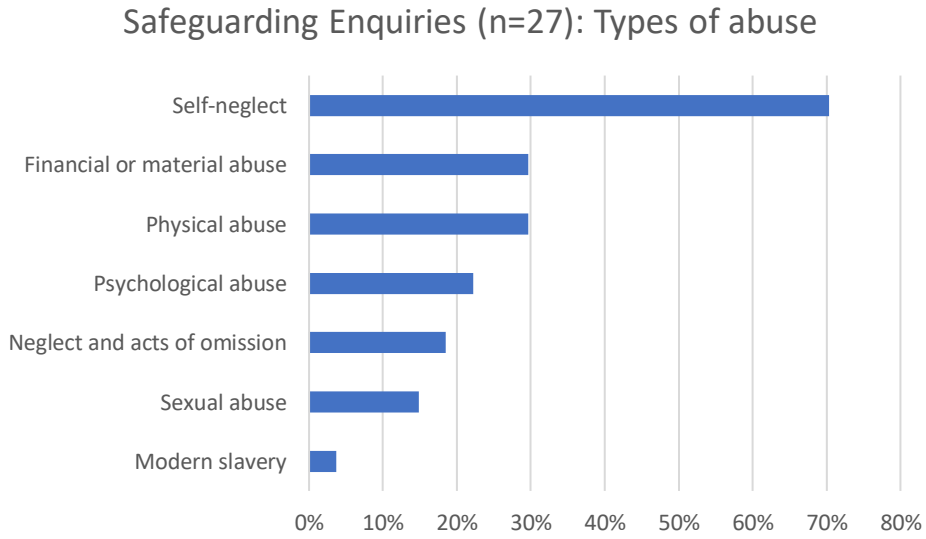
Local Data | Social Care (3/3)

Safeguarding

- 3,940 safeguarding concerns were reported in West Northamptonshire in 21/22, 1.1% of the WN general adult population. 19 safeguarding concerns were raised in the same period for our in-scope cohort, representing 6.6% of those on the panel dataset.
- In total, **72 safeguarding concerns were reported since December 2020.** 45 (63%) of these were categorised as an "Alert", with 27 (37%) categorised as "Enquiry" and resulting in an investigation
- There were 15 different sources of referral with Housing Services the most common (again unsurprising for this cohort), followed by the Police and Ambulance Service (see right)
- For the 27 concerns that reached the enquiry stage, abuse types are recorded with the possibility of multiple entries. Self-neglect (n=19, 70%) was the most common followed by physical abuse and financial/ material abuse (n=8, 30%) (see below)
- For the 27 concerns that reached the enquiry stage, 10 (37%) identified no risk, in 7 the risk remained, 6 the risk reduced; and in 3 the risk was removed





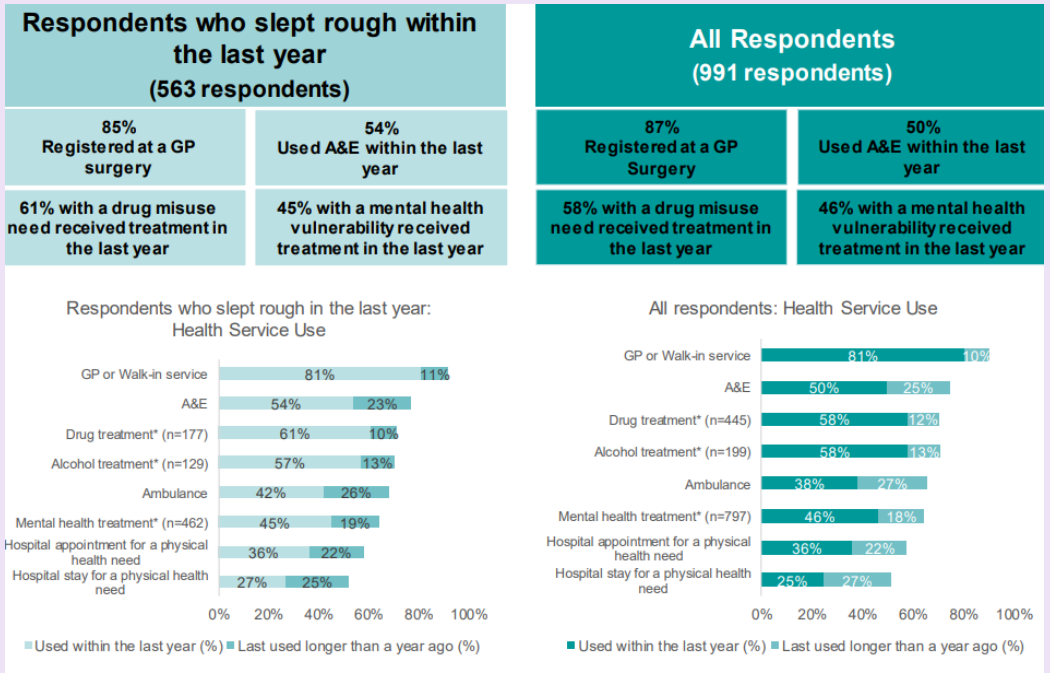


Summary of Current Evidence | Service Access, Utilisation & Engagement (1/3)

Many people who experience homelessness or rough sleeping are refused registration at GPs and other services due to having no fixed abode, and use hospital and emergency care more with longer than average lengths of stay.

Access and admission:

- Access to healthcare for this population is different to that of the general population, with **1/3rd of people who experience rough sleeping not being registered with a GP (Health matters: rough sleeping, 2022)**.
    - Those who are registered may choose not to access the service.
    - Many people who are sleeping rough report being unable to register with a GP practice because they have **no fixed address. 6**% of respondents in Homeless Link's Health Needs Audit (2022) had been **refused registration at a GP/ homeless healthcare service** in the 12 months before responding to the survey.
    - **Dental registration** was also **low at 53%**.
- People experiencing homelessness use **more acute hospital services and emergency care** than the general population. As shown by the Ministry of Housing, Communities & Local Government (Rough Sleeping Questionnaire, 2020; shown right).
    - St Mungo's homelessness charity (2016) looked at the records of people who were homeless, including those sleeping rough, who had used specialist homeless healthcare services. This research found that the **average number of health visits was over 50 in 12 months**.
    - The Department of Health and Social Care (2010) found that people who are **homeless are 3.2 times more likely to have an inpatient admission to hospital than the general population**.
    - Furthermore, **attendance at accident and emergency is at least 8 times higher in the rough sleeping population** than the housed population, and people who experience **both homelessness and alcohol dependency** were found to be **28 times more likely to have emergency admissions to hospital (Health matters: rough sleeping, 2022)**.



Source: Rough Sleeping Questionnaire, MHCLG, 2020

Summary of Current Evidence | Service Access, Utilisation & Engagement (2/3)

- When admitted to a hospital, the **length of hospital stay is usually much longer** because of **multiple unmet needs**.
  - **Barriers to access and engagement with preventive, primary care and social care services** can mean that problems remain untreated until they become very severe and complex.
  - These barriers include **stigma** and **discrimination**; **lack of trusted contacts**; **fragmented, siloed and rigid services**; **strict eligibility criteria**; and **lack of information sharing and appropriate communication**.

Accessing mental health services and barriers:

- The **prevalence of mental ill-health** may also act as a **barrier to engaging with housing services**.
  - For example, people with psychosis, delusional disorders and paranoia may experience mistrust towards street outreach workers and other professionals (Health matters: rough sleeping, 2022).
- The **common requirement to stop using substances before engaging with mental health services** has been identified as one of the key deficiencies in the homelessness system.
- In Homeless Link's Health Needs Audit (2022):
  - **40%** respondents reported that the **level of support they received did not meet their needs**
  - 27% reported they had not received a medical examination or treatment for a physical health condition when it was needed at some point within the last 12 months
  - 37% reported there had been at least one time in the past 12 months that they needed an assessment/treatment for a mental health condition but did not receive it
- In Homeless Link's Annual Review of Single Homelessness Services (2021), **just 10% of accommodation providers reported no trouble accessing mental health services** for their clients.

Summary of Current Evidence | Service Access, Utilisation & Engagement (3/3)

Leaving hospital:

- In the London Homeless Inpatient Audit (2022), **most people (92%) were unable to return to their pre-admission living environments as they were not appropriate, safe or secure for their needs**.
    - Due to a lack of safe and appropriate step-down options, **almost half (44.2%) of people remained in hospital longer than needed**
- **People leaving hospital who are homeless have worse care outcomes** compared to housed people leaving hospital which increases costs of care (Jenkinson et al, 2020).
    - They are more **likely to be readmitted within 30 days** (**17%** compared to 10% of the general population), and **more likely to need an emergency department visit** (**27%** compared to 12%), and **over 50% less likely to get the post-discharge care they need**.
    - People discharged to the streets may **face greater risks if they have a continued medical vulnerability** and **potentially higher levels of mortality**.
    - There are also **opportunities being missed to link people who are street homeless into services when they attend A&E** for treatment but are not admitted as an inpatient.

	A&E	Ambulance	Hospital admission
% used in the last year	48% (50% wave 2)	38% (37% wave 2)	38% (38% wave 2)
Level of use	On average attended 3x more than gen pop	8% used more than 3 times	7% admitted over 3 times
% due to physical health problem/ condition	32%	38%	37%
% due to mental health crises	32%	27%	28%

Source: Homeless Link Health Needs Audit (2022)

Local Data | Service Access, Utilisation & Engagement

Data from various organisations in West Northamptonshire was limited.

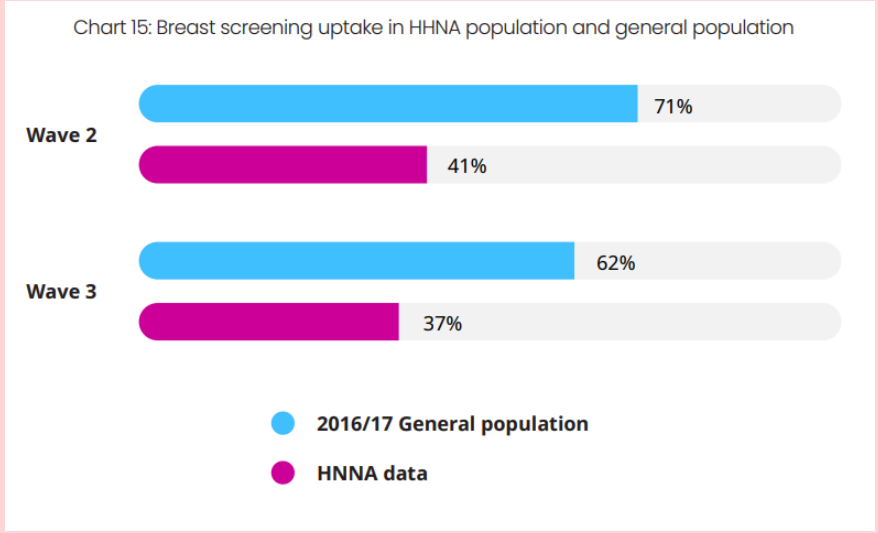
- Limited data is available on service access, utilisation and engagement, but what is available is summarised below.
- *Housing providers:* HARRP report that although **all service users leave registered with a GP**, it is estimated **10% do not have one on entry or have not visited one in years**.

Summary of Current Evidence | Wellbeing and Preventative Healthcare

People who have experienced homelessness are less physically active, have lower rates of uptake of vaccinations and screenings, and smoke more than the general population, putting them at increased risk.

Health behaviours:

- Health behaviours which reduce risk of non-communicable diseases such as (most) cancer and cardiovascular diseases include **not smoking** and **being physically active**. These **health behaviours** have been **found to be lower in people who have experienced homelessness** compared to those who have not (Homeless Link, 2022).
    - One study found that **physical activity levels were significantly lower** amongst participants who had experienced at least one month of homelessness, with 30.7% being classed as inactive compared to 23% in those participants who had not experienced homelessness. The study also found higher levels of smoking amongst those who had experience of homelessness (Smith L, 2019).
- **Higher rates of smoking** were also found amongst those surveyed by Homeless Link in their most recent review of homeless health audits for years 2018-21.
    - This review found that 76% of respondents reported they smoke cigarettes, cigars, or a pipe.
- Homeless Link (2022) also found **reduced uptake of breast screening** compared to the general population in 2016/17, as shown to the right.
- People experiencing homelessness **fare worse on basic wellbeing indicators** than the general population, and **access preventative healthcare at lower rates** than the wider population.
    - This **exacerbates health inequalities** as levels of smoking and poor nutrition affect wider health; and **lower take up of vaccinations and screenings** increase the risk of illness and disease.



Source: Homeless Link (2022)

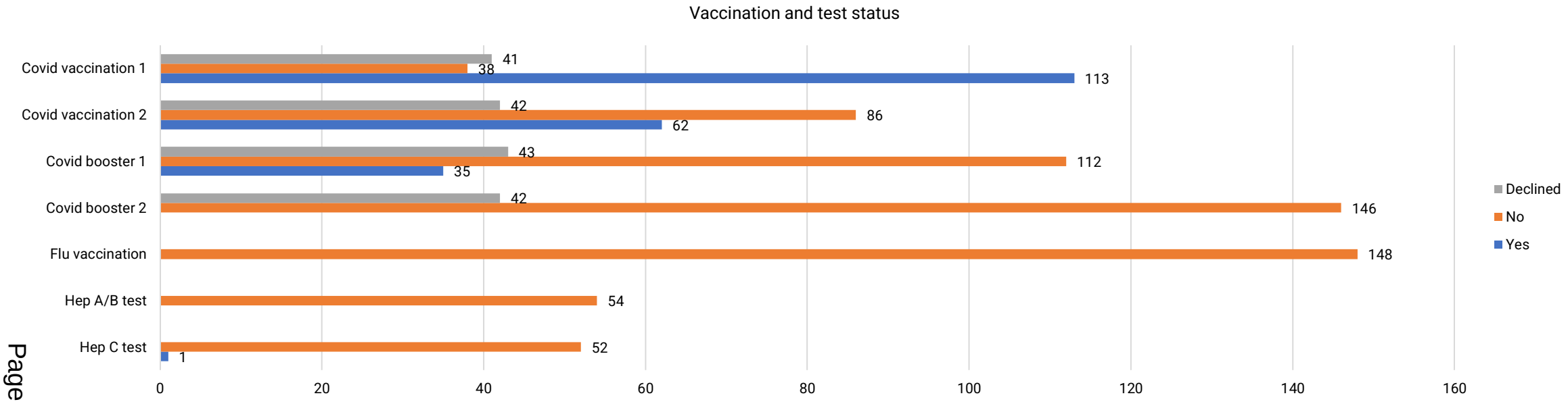
Local Data | Wellbeing and Preventative Healthcare

Data from various organisations in West Northamptonshire was limited, but showed low rates of COVID-19 vaccination, with some declining.

- Limited data has been made available on other aspects of wellbeing and preventative care, or on health behaviours.

Vaccination and health tests:

- *Council:* Data received from WNC's Housing Service indicated varying levels and types of need in the homeless pathway identified by the service (n=968 over the period from 1st January 2021 to March 2023). It also indicates the vaccination status of this cohort, as described and shown below:
- 113 (12%) received the first COVID-19 vaccination, and 62 (6%), their second, and 35 (4%) the first COVID booster vaccination. 1 person received the Hep C test.
- Roughly 4% of the cohort declined the first two COVID vaccinations and the first booster. Reasons for declining are largely unspecified, but where stated, include for personal reasons, being anti-vaccines, or it being against their beliefs.

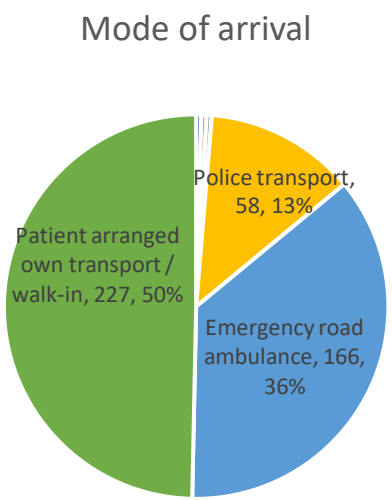


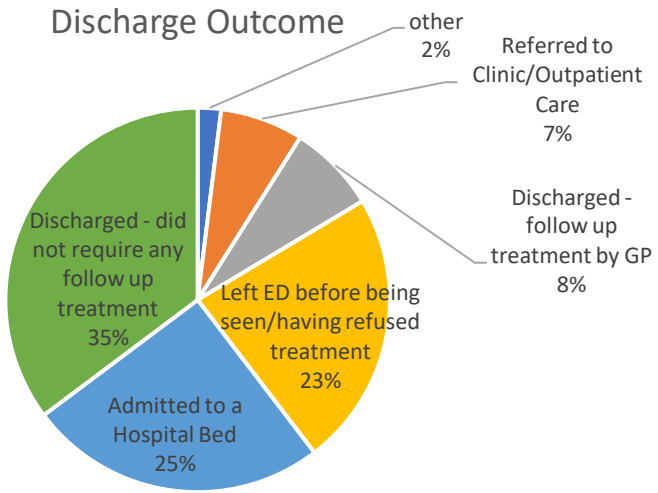
Local Data | Secondary Care – Emergency Department

Data below for the whole population is from SUS and for those with no fixed abode directly from NGH records

- The total date range searched from 01/04/2022 to 28/07/2023 identified 457 attendances for patients with “No Fixed Address”/NFA or c/o Oasis House /c/o Campbell House in Address Line 1 field.
- Looking specifically at the financial year 01/04/2022 to 31/03/2023, 328 attendances occurred for patients in this category, equivalent to around 27 per month or just under one a day.

- 1 in 5 (18%) were re-attenders within 7 days
- Three quarters male and a quarter female (76% and 24% respectively)
- There was no apparent seasonal variation (50% of presentations April to September and 50% October to March)
- Assuming the population with no fixed address in 2022/23 was 367, as per the H-CLIC report, around 1 in 3 people who were homeless at risk of rough sleeping attended ED in Northampton compared with only 1 in 8 members of the general population. People with NFA attending ED were more likely to attend more than once





NGH Adult ED attendances April 2022 – March 2023 (inclusive)	Total	NFA
Individual attendees	58,838	136
Attendances by those individuals	90,020	328
Mean attendances	1.5	2.4
Range of number of attendances in the year per individual	1 to 58	1 to 20

Top 10 Presenting Complaints
1.Mental Illness
2.Unwell Adult
3. Overdose/Poisoning
4. Head Injury
5. Apparently Drunk
6. Wounds
7. Collapsed Adult
8. Falls
9. Foot injury
10. Local Infect/Abscess

Local Data | Practical / Other Needs

Data from various organisations in West Northamptonshire showed a strong need for help to obtain an ID in the population. Support is also needed to help open bank accounts and apply for benefits, and with financial debts and housing arrears.

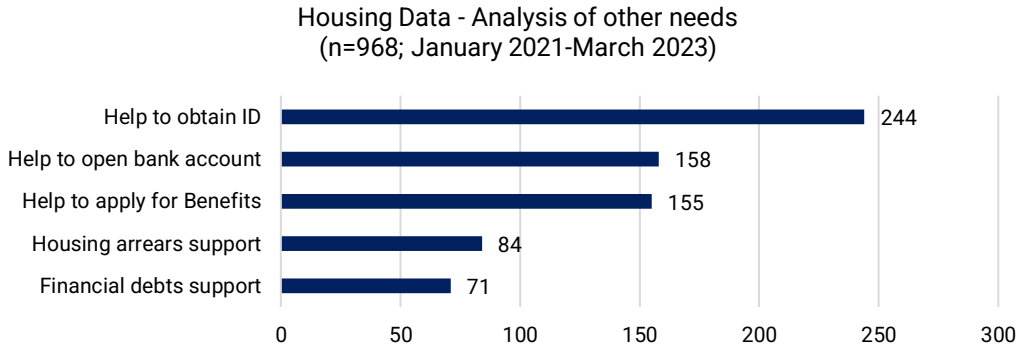
- *Council:* Data received from WNC's Housing Service indicated varying levels and types of need in the homeless pathway identified by the service (n=968 over the period from 1st January 2021 to March 2023). As shown below, this highlighted need in a number of other areas beyond mental health, physical health and alcohol and substance misuse, as previously described. In all areas of need, the need is higher for the male homeless population. Particular **support is needed in helping to obtain IDs (244, 25%)**.

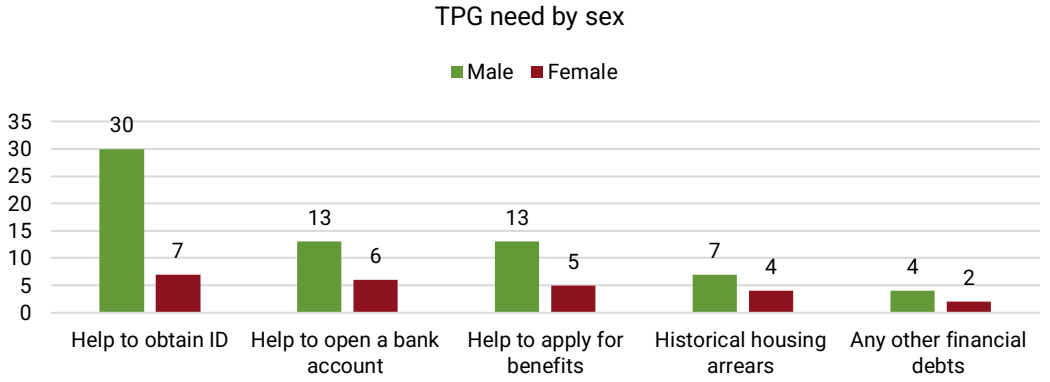
- *Panel:* Panel data reflects similar other areas of need, where 144 out of the 580 cohort (**25%**; 113 male) have an **arrears-related support need**, and 110 (**19%**; 91 male) have a **debts related support need**. This is shown on page 52.

- *Housing providers:* NAASH ISS data indicated that those who arrived in the services (from January 2020) had no Financial Needs, either Housing Arrears or Other debts, whereas those in **PRS** (n=269), 28 (**10%**) had **financial/ housing arrears support needs** and 14 (**6%**) had **financial / other debts**. This is shown on page 53. At HARRP (2021-2023, n=211), 83% have their own bank account; 68% have ID; and all have income, 77% from Universal Credit.

- *Mental health / suicide*: The Northamptonshire Coroner's Suicide Audit Report: Public Health North Northamptonshire Council (March 2023) indicated that debt / financial problems were crisis triggers in 27 (12%) of cases, and work stress (10, 4%) in others.

- *Target Priority Group (TPG):* Of the 87 included in the TPG, the distribution of need is shown in the chart to the right and split by sex. A **majority need help to obtain an ID (37, 43%**; of which 30 are **male**).



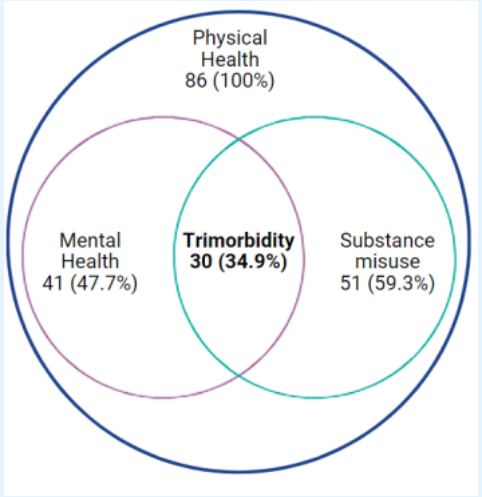


Summary of Current Evidence | Multiple and coexisting needs (1/3)

Homeless and rough sleeping populations often have dual diagnoses, co-occurring mental ill health, substance misuse needs and physical health needs, and multiple vulnerability, but experience many barriers to care.

Dual diagnoses and multiple vulnerabilities:

- People who sleep rough experience some of the most severe health inequalities and report much poorer health than the general population. **Many have co-occurring mental ill health and substance misuse needs**, **physical health needs**, and **have experienced significant trauma** in their lives; resulting in an **increased risk of mortality**.
    - Those with substance use issues often also struggle with **poor mental health**, and **offending behaviours** which can compound the barriers they face. People in **drug and alcohol treatment** who have **mental ill-health** and **housing problems** are also **less likely to successfully complete treatment**.
- **Dual diagnosis of mental health and drug or alcohol problems are common amongst people experiencing homelessness**. People may use alcohol and drugs to **self-medicate** for their mental ill-health, and may also use substances to help with **sleeping**, **pain management** and **cold temperatures**.
    - There is evidence that people experiencing rough sleeping with co-occurring needs find it **challenging to engage with and/or experience other barriers to accessing treatment services (Health matters: rough sleeping, 2022)**.
    - It is not uncommon for **mental health services** to **exclude people because of co-occurring alcohol or drug use**, a particular problem for those diagnosed with serious mental illness, who may also be excluded from alcohol and drug services due to the severity of their mental illness.
    - Surveys indicate that **people who experience homelessness and have multiple needs are often bounced around between care service**s, being told to address their mental health issue before their substance abuse or vice versa.



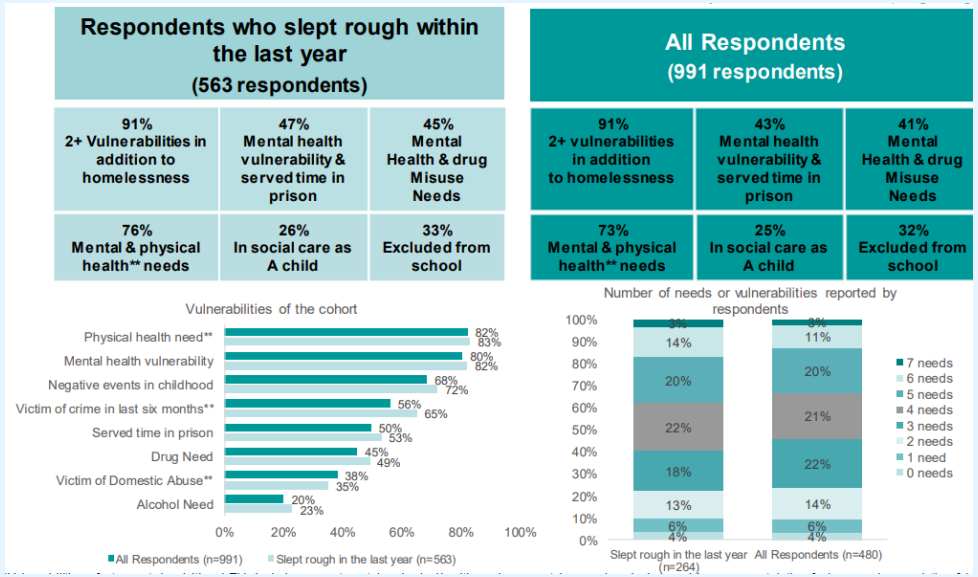
Source: Healthy London partnership inpatient audit (2022)

- **45%** of respondents in Homeless Link's health needs audit (2022) **reported using drugs or alcohol to help them cope**.
    - It is also found **81%** of people with a **mental health condition manage comorbidities** (27% reporting two mental health conditions and 24% three), and **80%** of respondents **with a physical health condition manage comorbidities** (29% of respondents reporting between 5-10 physical health diagnoses).
    - The London Inpatient Audit study (2022) found two-thirds of participants (63.9%) had three or more different clinical issues related to their hospital admission (the most being eight) and one third had tri-morbidity. In MHCLG's Rough Sleeping Questionnaire (2020), respondents reported an average number of 1.9 mental health conditions and 3.2 physical health conditions.

Summary of Current Evidence | Multiple and coexisting needs (2/3)

Source: Rough Sleeping Questionnaire, MHCLG, 2020

- As shown on the right through the MHCLG Rough Sleeping Questionnaire (2020), **96% of those who had slept rough over the previous year has at least 1 vulnerability** in addition to sleeping rough. Some respondents had up to 7 different needs.



'Co-occurring serious mental health problems and alcohol/drug use' (COSMHAD):

- Motivation for, and maintenance of, behaviour change was reported as a central factor for success in community-based services for people experiencing homelessness with 'Co-occurring serious mental health problems and alcohol/drug use' (COSMHAD), with respect for client choice and client involvement in programmes facilitating this. Provision of a more supportive, less intensive approach in residential programmes for people with COSMHAD was found to be a key to success (CHI, 2022a).

Severe and Multiple Disadvantage (SMD) or Multiple Exclusion Homelessness (MEH):

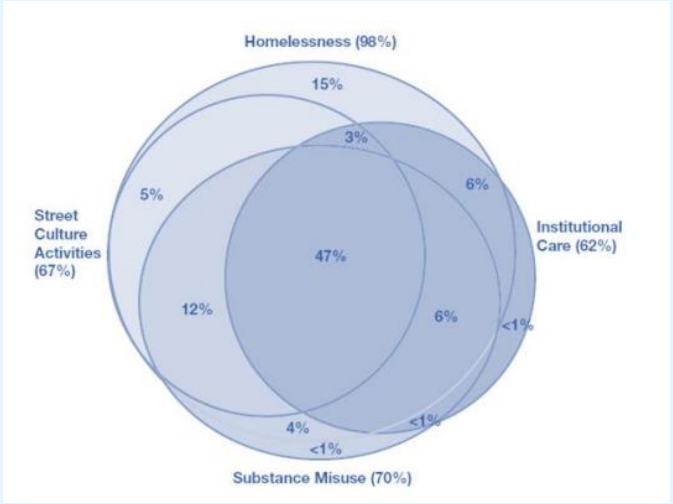
- The study Hard Edges (2015) looked at how issues such as drug and alcohol misuse, poor mental health and offending behaviour are related and found significant overlap in these risk factors.

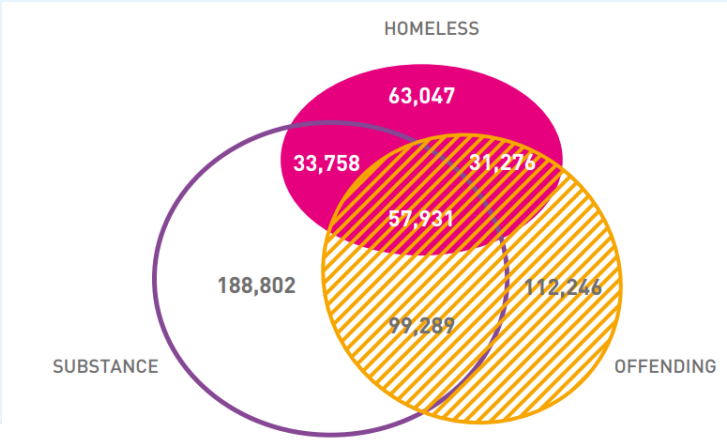
- This is often referred to as **Severe and Multiple Disadvantage (SMD) or Multiple Exclusion Homelessness (MEH).** People have experienced MEH if they have been 'homeless' and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care, 'substance misuse'; or participation in 'street culture activities'. MEH remains under-researched in the United Kingdom, with only one large scale quantitative study having been undertaken. Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse. Those who have experienced early traumatic incidents, including emotional, physical, and sexual abuse, neglect, parental mental ill-health and/or substance abuse; are all at particular risk of entrenched, complex, homelessness in adulthood.

Summary of Current Evidence | Multiple and coexisting needs (3/3)

- A recent study (England et al, 2022) explored a typology of multiple exclusion homelessness and concluded the following:
  - If highest levels of adversity amongst people experiencing homelessness are to be avoided, policy and action must intervene earlier, including in childhood
  - The needs of people reporting highest levels of adversity (roughly 1 in 10 single people experiencing homelessness in GB) are not well met. Effective interventions such as Housing First must be more widely available and further service development and innovation targeted at this group is necessary
  - Greater policy and practice impetus is required to disrupt the enduring nexus of prisons, drug dependencies and homelessness and this may include investment in approaches such as Critical Time Interventions
  - Housing-led responses such as Rapid Rehousing would help address the housing needs of the large proportion of people experiencing homelessness who face relatively few adversities.
  - Moreover, earlier preventative actions to address structural drivers of homelessness such a poverty and unaffordable housing markets would prevent the occurrence of homelessness in the first instance for these individuals.
  - In order to meet the needs of women who face particular forms of MEH, it is essential to address the shortage of appropriate services for women with complex support needs.

Source: Fitzpatrick et al, 2010





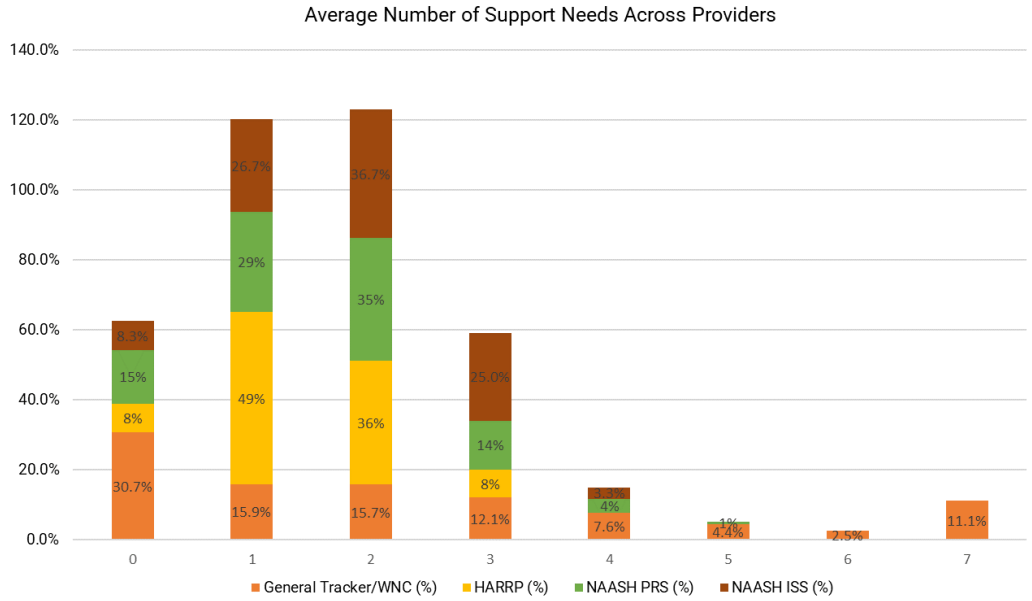
Overlap of SMD domains, England, 2010/11. *Source: Hard Edges (2015)*

Local Data | Multiple & Coexisting Needs (1/4)

Data from various organisations in West Northamptonshire show high overlap of mental health need with alcohol abuse and substance misuse in particular.

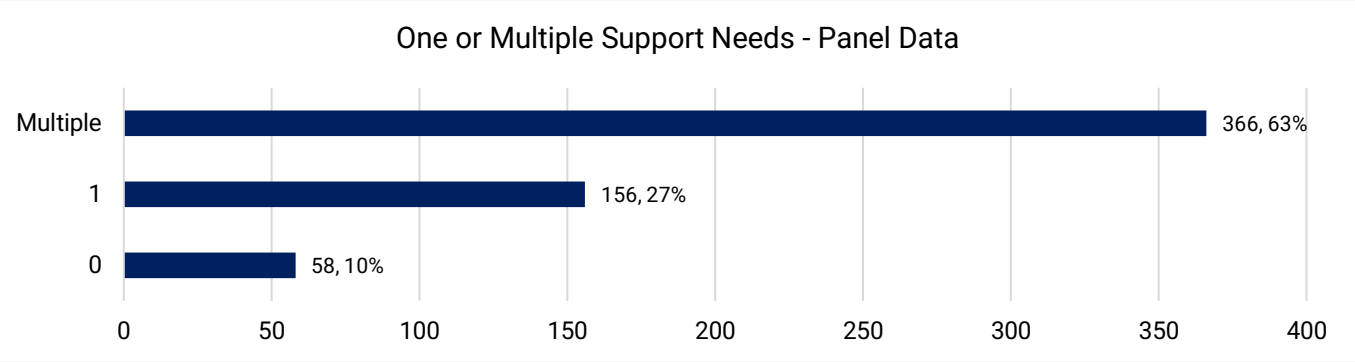
- *Housing Providers:* Data contained within the Keystage Housing HARRP Trinity Needs Assessment (collected as of the end of March 2023, with some as of April 2023) shows that most individuals' risks cannot be contained to one primary need which correlates with over **83% of their past Service Users being classed as having Multiple Exclusion Homelessness (MEH)**.
    - **Needs on entry:** As shown overleaf, of those placements housed in HARRP Trinity between November 2020-March 2023: 53% had 1 Primary Need on Entry; **38%** had a **2nd Primary Need on Entry**; and **8%** had **3rd Primary Need on Entry**.
    - Of those current services users: a **majority (59%) had a 2nd Primary on Entry**, 26% had 1 Primary Need on Entry; and 15% had a 3rd Primary Need on Entry.
    - These needs were across:
        - Alcohol Misuse; Learning Disability; Loss of Income/Financial hardship; Mental Health; Physical Health; Relationship Breakdown; and Substance misuse, with the cohort totals for these needs outlined on page 80.
- Data provided by NAASH **ISS** (n=60) shows that **72% of the cohort has >1 support need overall**. The exact distribution of multiple needs is shown overleaf.
- NAASH **PRS** data shows a similar picture, with **Mental Health and Substance Abuse the highest combination of needs (63, 23%),** followed by **Mental Health and Alcohol Abuse need (41, 15%)**. This is shown on page 81.

- *Panel:* Shown overleaf also, of those on Panel between January 2021 and March 2023 (n=580), **63% were classified as having multiple needs**, and the remaining 27% as having just one need.

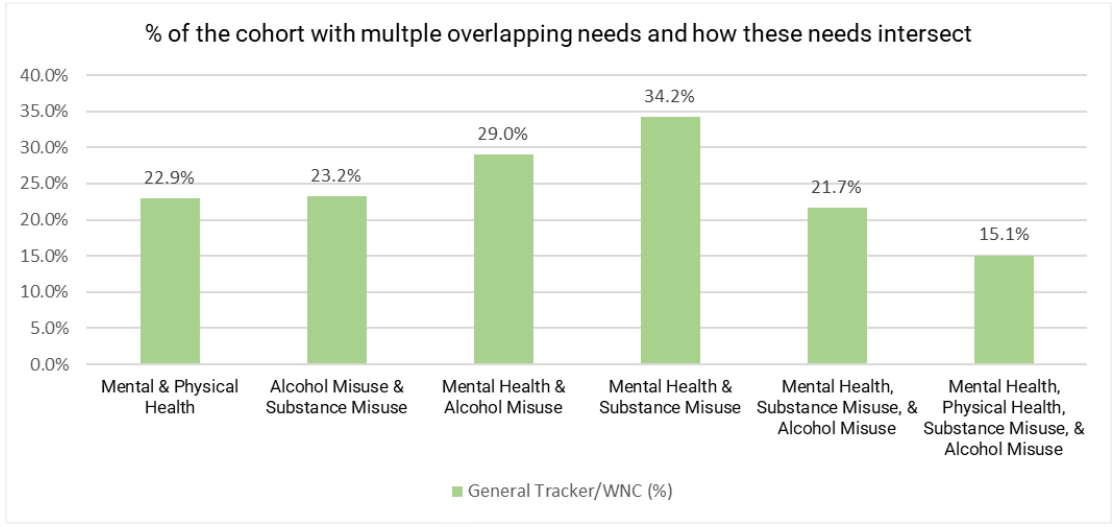


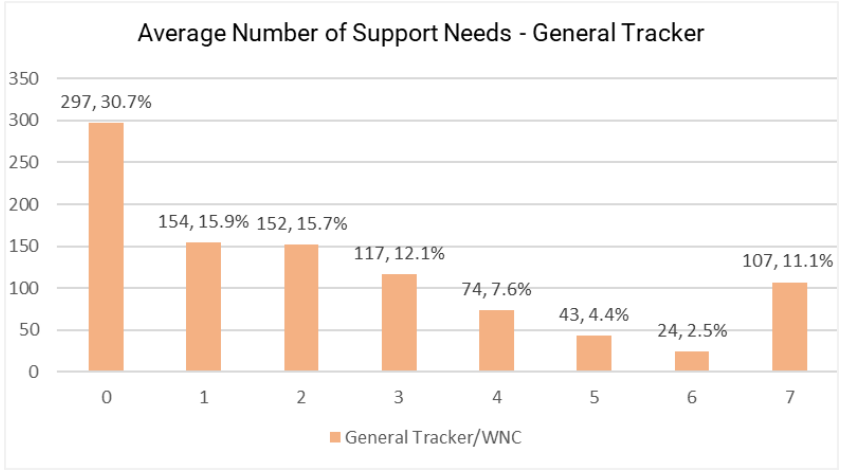
Local Data | Multiple & Coexisting Needs (2/4)

n= 580, Panel data (01/01/2021 – 28/02/2023)



- The WNC General Tracker and Panel data provide the broadest view of multiple and coexisting needs in the in-scope cohort, with a large proportion of each cohort displaying multiple needs - >50% across both datasets.
- These are multiple and complex, as shown in the General Tracker dataset, with 11% of those who use WNC's services displaying 7 different types of need, across Alcohol Misuse, Drug misuse, Mental Health, Physical health, Obtaining ID, Benefits, Housing Arrears, and other Financial Debt needs.
- How these different needs combine and overlap to illustrate the diverse set of complex needs within this cohort, can be seen in bottom graph.

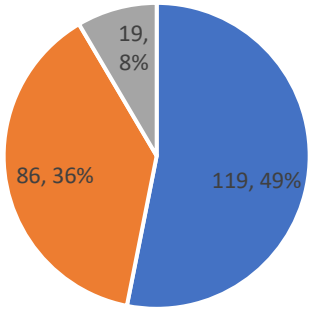




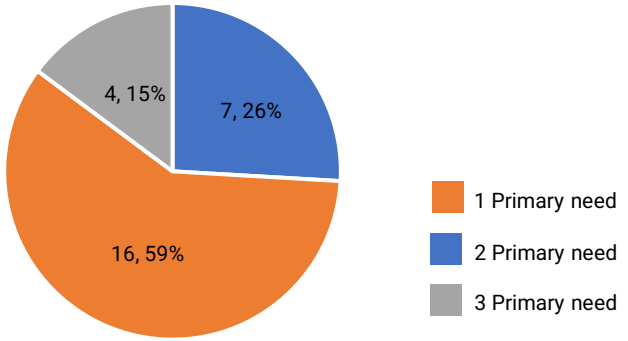
n= 968, General Tracker, data (2020 – 2023)

Local Data | Multiple & Coexisting Needs (3/4)

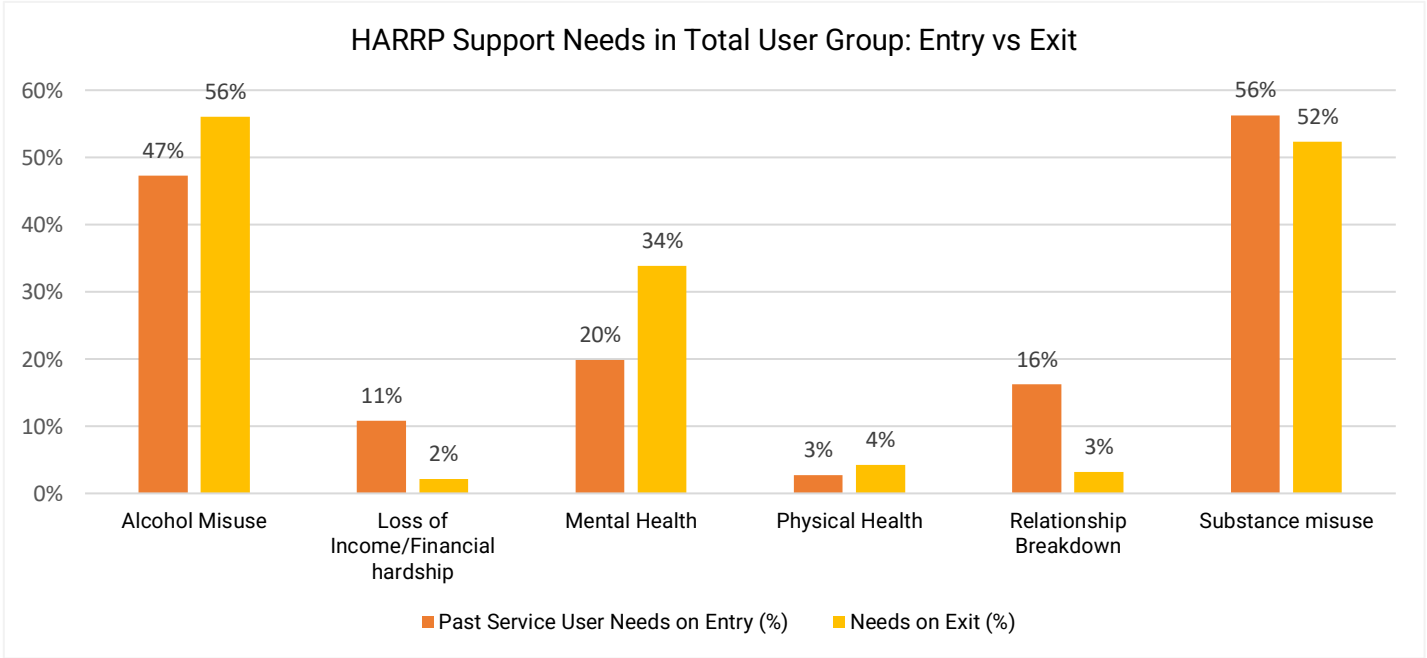
No. of primary needs in past HARRP service users (11/20 - 03/23)



No. of primary needs in present service users – HARRP data

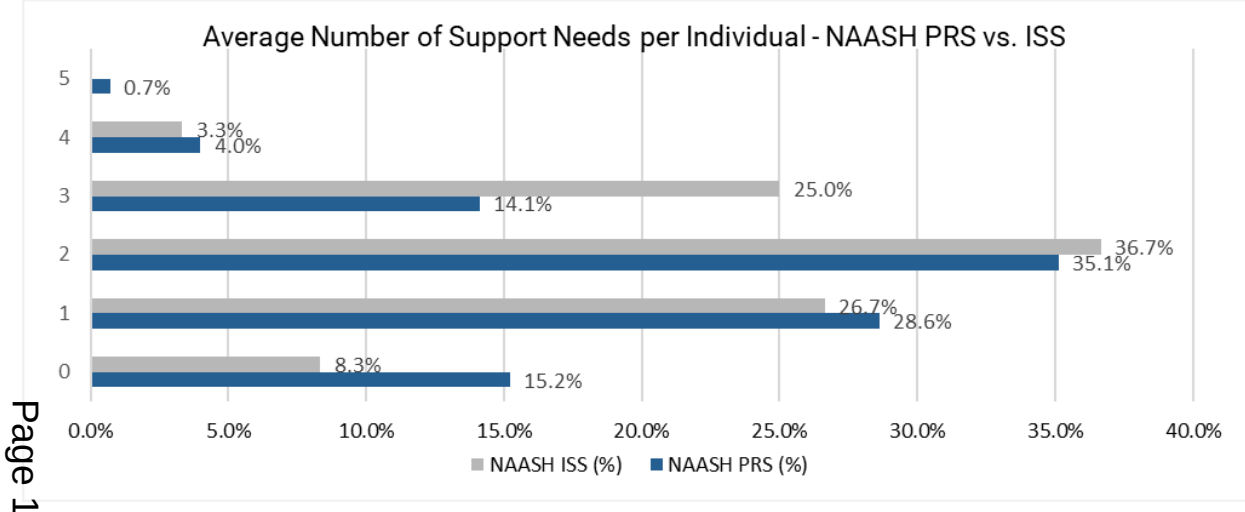


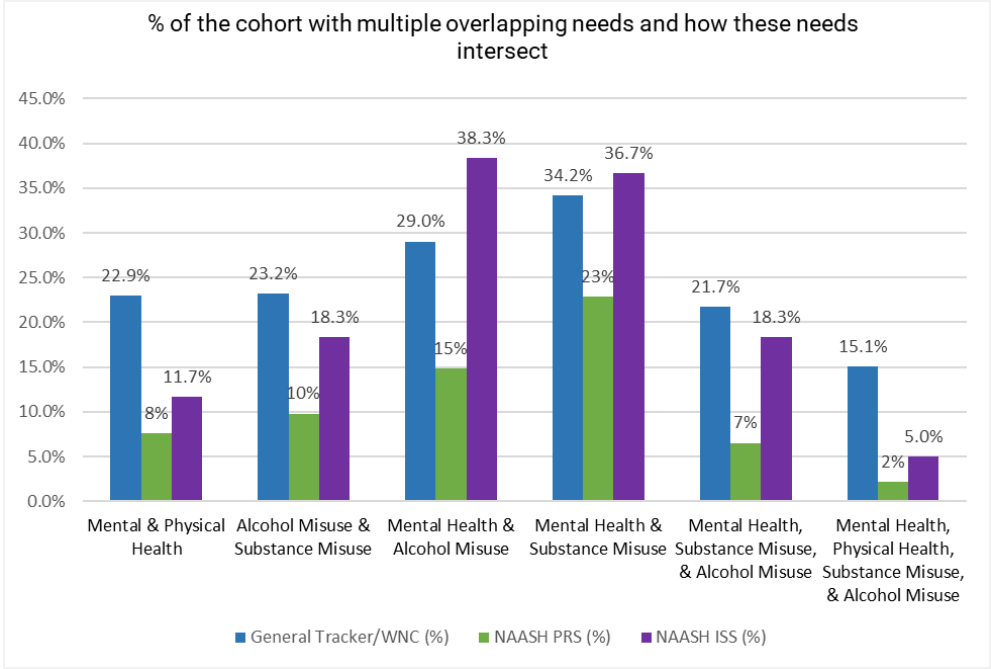
- Taking a closer look at HARRP data provides a secondary view of the complex need profiles of the in-scope cohort – particularly in the 242 placements housed in HARRP Trinity between November 2020 when the service opened, to March 2023.
- 83% of those who have used the HARRP Service during this period were classed as MEH, with only 7% presenting with no support needs at all. Similar trends are witnessed in the 27 current Service Users, where all of the cohort have at least 1 support need.
- The HARRP data provides a unique insight, recording needs of those who have used the service, both on entry and exit and their 'noticeable differences'. This dataset shows significant decrease in needs around Income/Financial Hardship and Relationship Breakdown support, but an increase (14%) in Mental Health needs, with "individuals beginning to address substance misuse and as a result, needing further mental health support for underlying mental health conditions".
- It shows how support needs and the combination of support that those who use the service need can change over time, through the customer pathway.



Local Data | Multiple & Coexisting Needs (4/4)

- Multiple and coexisting needs are visible across the NAASH datasets, both in their larger PRS cohort and smaller ISS cohort.
- The comparison between these two datasets provides an insight into the increase in the complexity of need for those who user the more intensive service, with significantly larger proportions of those who use the ISS service with more than 2 support needs.
- Even in the PRS service, however, there are still a large proportion, and much larger overall number, who have complex and intersecting needs, evidencing the need for support that is adaptable and floats through groups, even in less intensive or supported accommodation.
- When looking at how these needs overlap, there is a much clearer concentration of needs around Mental Health, Alcohol Misuse, and Substance misuse in the ISS cohort when compared to PRS. The graph to the right shows how these needs overlap and compare to data in the General Tracker





West Northamptonshire Council

4. Current service provision

Summary of current evidence: service provision (1/3)

NICE Guideline NG214 (Integrated health and social care for people experiencing homelessness, 2022) states care should be provided through specialist homelessness multidisciplinary teams across sectors; and levels of care tailored according to local needs. Homelessness multidisciplinary teams should act as expert teams, providing and coordinating care across outreach, primary, secondary and emergency care, social care and housing services. Homelessness multidisciplinary teams may include:

- experts by experience
- healthcare professionals with relevant specialist expertise (for example, drug and alcohol treatment, mental health, primary care, emergency care, palliative care)
- social workers
- housing options officers or homelessness prevention officers
- outreach and homelessness practitioners
- voluntary and charity sector professionals
- staff with practical expertise in accessing benefits and entitlements for people experiencing homelessness.

Homelessness multidisciplinary teams should have protocols and systems in place for communication and sharing information to support integrated working within the team and between services. Homelessness multidisciplinary teams should:

- identify people experiencing homelessness through outreach or when they present to health and social care services
- support mainstream providers to identify and refer people to the homelessness multidisciplinary team
- undertake and support assessments for safeguarding, physical and mental health, alcohol and drug treatment needs, and social care, including informing Care Act assessments
- support mainstream providers to ensure safe, timely and appropriate hospital discharge and engagement with onward care

Homelessness multidisciplinary teams should:

- offer person-centred case management by a designated practitioner within the multidisciplinary team and ensure continuity of care for as long as it is needed by the person
- offer wraparound health and social care support that encompasses the person's needs, including: physical health, mental health and psychological support (such as psychological therapies), physical rehabilitation (such as occupational therapy and physiotherapy), drug and alcohol treatment, social care, palliative care, communication support; and practical support, such as help with benefits, housing and referral for legal advice.

Summary of current evidence: service provision (2/3)

The Centre for Homelessness Impact's What Works Evidence Note on Mental Health (2022), found that "given the fact that existing evidence suggests that many of the common interventions to address mental health issues have little or no impact, much more focus should be placed on secondary and primary prevention activities to pick problems up earlier amongst those who are experiencing or at risk of homeless". More work should be done to test targeted mental health interventions within hostels, housing first projects and local authority temporary accommodation. Given that commonly used interventions (e.g. CBT, Intensive Case Management, Assertive Community Treatment, Contingency Management) don't seem to outperform business as usual provision, it will be important to develop and test new models of mental health support aimed at people experiencing homelessness.

Based on the evidence that many people experiencing street homelessness have an underlying mental health vulnerability, screening could be tested within outreach and No Second Night Out services to identify mental health issues amongst those sleeping out for the first time. Rapid access to peer and community support, counselling and psychotherapy should then be provided where this is clinically indicated, alongside housing solutions, in order to test if this is effective in reducing returns to street homelessness and the risk of mental health problems worsening.

Joint mental health and housing services are reported as superior to mental health care alone. A systematic review reported that mental health support with housing had an effect size of 0.67 for a housing outcome. This compared with an effect size of 0.47 for Assertive Community Treatment (ACT), a case management approach which employs a multidisciplinary team to support an individual. Among those with serious mental illness, Community Engagement and Planning (CEP), a coalition approach to plan, co-lead, and monitor training and implementation, reduced poor mental health-related quality of life; but not depression after 12 months. Authors believe factors that contributed to CEP's success included multi-sector collaboration, task sharing, relationship building across sectors, and building staff knowledge and capacity to work with those with mental illness.

Regarding **transitions**, existing evidence suggests that models which coordinate discharge with accommodation and a holistic offer of services – e.g. Critical Time Intervention and 'Re-entry programmes' – can be effective at reducing homelessness and improving other outcomes (CHI, 2022). There are also multiple evidence-based strategies to support people leaving prison, including support for drugs and alcohol use, and restorative justice approaches. We know a lot less about the best strategies to support people ageing out of care. There is promising evidence suggesting that extending the upper age in which people can remain in foster care (i.e. 18 to 21 years) can be beneficial, however, common interventions such as 'independent living programmes', which aim to improve education and employment outcomes for young people leaving care, have little supportive evidence behind them and require rigorous testing.

Evidence strongly suggests that respite care should be available to **people discharged from medical institutions**, providing people with time-limited housing and supportive care which is often embedded in the medical system. People in this cohort should also receive ongoing support once they move into longer-term accommodation. In the London Hospital Inpatient Audit Study (2022), more than four in 10 (45.2%) were projected to need short-term intermediate care/step-down. Appropriate accommodation with a range of additional care and support services (including community in-reach or floating support) was needed to meet patient's complex needs. Less than 1% of inpatients needed 'just' accommodation.

Summary of current evidence: service provision (3/3)

The evidence also highlights the relevance of creating **trauma-informed and psychologically informed environments (PIE)** to improve the acceptability of services. They speak to the importance of the staff or volunteers delivering services understanding the needs of the people they are working with. Equally important is incorporating flexibility into any contacts and service provision to facilitate both access and engagement:

- Good, trusting relationships between clients and staff are identified as key to successful service uptake and implementation through, for example, joint decision making and establishing clear roles and responsibilities
- Employing people with experiences of homelessness when designing and evaluating services
- Ensuring flexibility for direct service delivery staff to meet clients' needs, and varying the intensity of services over time, as required. For example, flexible start times of services or sessions, identifying and addressing small problems when they arise to prevent escalation or varying the duration and frequency of home visits depending on the clients' current level of service need
- Ensuring people have both choice and control when engaging with services, for example joint decision making when it comes to individual plans and accommodation location
- Maintaining contact when they are in the process of exiting a service, ensure a support plan is in place.

Local services (1/2)

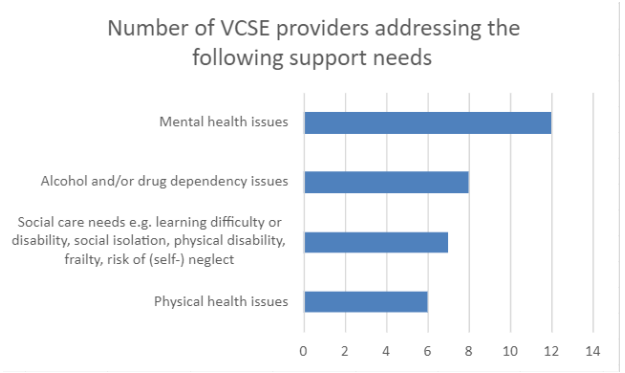
Services provided in West Northamptonshire which are available to support the health and care needs of people experiencing homelessness include (but are not limited to):

1. **Mainstream NHS and other health specific services** such as GPs, secondary care (hospital), primary care, social care – although access issues raised. Public health services like the Sexual Health Outreach Team are increasingly working with more vulnerable people at risk, including those homeless and/ or rough sleeping

2. **Health and well-being support and help to access healthcare are provided by various non-health services.** These include homelessness services, and third sector and other support services. As show in our provider survey (figure)

3. **Targeted services provided to address the specific health and care needs of people experiencing rough sleeping and homelessness**:

a. **Maple Access Partnership GP surgery**, which was established to provide primary care services to a variety of vulnerable groups, including homeless people. Under a GP with special interest in complex mental health needs and substance use, Maple Access previously held a Personal Medical Services (PMS) contract, in addition to the General Medical Services (GMS) contract, to deliver enhanced and outreach offers to vulnerable patients; although this contract has ended
b. **Mental Health Practitioner (Band 6)** funded by NHFT and The Hope Centre, commenced in June 2021. This role works peripatetically to improve access to mental health support and works closely with NHTT, supports a drop in service at the Hope Centre (Crisis Cafes), in-reach support within local provision, delivers customised groupwork, attends MDTs and works with a wide range of partnership agencies. A proposal for expansion (which would add an additional Band 6 MH Nurse) to develop a model around education, supervision, and better work with those who present with mental health needs has been developed for the 2023/24 Health Inequalities Additional Allocation, following the work of a dedicated Task & Finish Group
c. **Northampton Homeless Treatment Team (NHTT).** Initially funded by the Rough Sleeping Drug & Alcohol Grant, which aimed to ensure that the engagement that people have had with drug and alcohol treatment services whilst rough sleeping or in emergency accommodation is maintained as they move into longer term accommodation; and build resilience and capacity in local drug and alcohol treatment systems to continue to meet the needs of this population in future years. The multi-agency, peripatetic team (Council/ S2S/ Bridge) includes the following roles: Drug and Alcohol Treatment Co-Ordinator, PHE Outreach Nurse, Nurse Medical Prescriber, Assistant Psychologist, Drug & Alcohol Recovery Workers; and Drug & Alcohol Outreach Worker. The team also include staff with lived experience of homelessness. The team aims to get people into treatment very quickly and also conducts screening work e.g. blood tests within the community
d. **Hospital Discharge Transitions Officer (within Street Services Team)** – co-located in hospital and also covers discharges from inpatient mental health settings. There is also a nominated "Duty to Refer" Lead to coordinate effective discharge for those at risk of homelessness from Northampton General



Local services (2/2)

4. **Substance treatment and recovery services** – CGL/S2S and Bridge Substance Misuse Programme (recovery). Whilst not exclusively for people experiencing homelessness and rough sleeping, access is provided with people who experience multiple disadvantage in mind.

5. **Community Dental Services (CDS) and Special Care dental services** provide dental care services through referral for people who cannot be seen in general practice (Northampton Healthcare NHS Foundation Trust). There is a drop in clinic once a fortnight at St James Clinic for patients experiencing homelessness, following links made with the Hope Centre. There are plans underway in Special Care Dentistry to reach more of this population and demonstrate need. The Specialist Dental Service offers the clinics with treatments like fillings, tooth extractions, and gum treatments; mobile services (currently visit special needs pupils in schools); and oral health promotion

Local provider survey (1/3)

A survey was distributed to all relevant local organisations as another source of evidence collection for the needs assessment

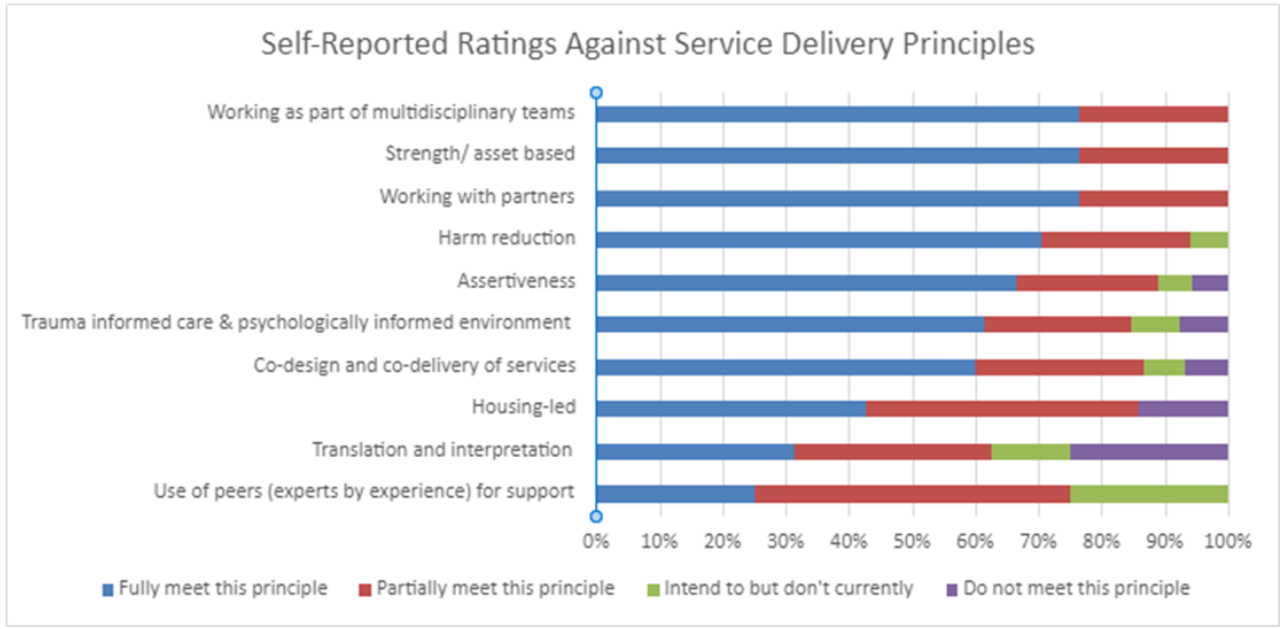
Organisations listed to the right completed the survey (19). Notable omissions include Substance to Solution/ CGL and Northants Mind

- Questions covered:
  - Service overview
  - Who do you help
  - Accessing your service
  - Length of stay/ engagement
  - Type and level of support offered
  - Capacity
  - Delivery principles
  - Public funding
  - Data request

Amicus Trust
Bridge Substance Misuse Programme
C2C Social Action
Changing Lives
Emmaus Village Carlton
eve
Futures Housing
International Lighthouse CIC
Keystage Housing - HARRP Trinity
Lumsden Housing
NAASH
Northampton Hope Centre
Northamptonshire Domestic Abuse service
Pause Northamptonshire
Re:Start at the Lowdown
Richmond Fellowship
Stepping Stones Northampton Ltd
The Salvation Army
Midland Heart

Local provider survey (2/3)

Providers were asked to self-report against service delivery principles outlined in the NICE guideline (NG214)



Principle Definitions:

Housing-led: A Housing-Led or Rapid Rehousing approach to ending homelessness aims to move people into their own homes as quickly as possible and provide them with the support they need to make it work (in contrast to the traditional "staircase model" where people have to prove they are 'tenancy ready'). The approach seeks to minimise the amount of time spent in temporary accommodation and the number of transitions a person has to make before they move into a permanent home.
Working as part of multidisciplinary teams: A multidisciplinary team involves a range of professionals across disciplines as well as agencies working together to assess and support the needs of a person experiencing homelessness
Trauma informed care & psychologically informed environment: Trauma Informed Care (TIC) is an approach to planning and providing services that involves understanding, recognising and responding to the effects of all types of trauma. It emphasises physical, relational and emotional safety, and helps survivors of trauma to rebuild narratives of connection, control and empowerment. Psychologically Informed Environment (PIE) is service provision and practice that takes into account individuals' psychological and emotional needs, and their experiences of trauma
Strength/ asset based approaches: These involve the person who uses services and the practitioners who support them working together to achieve the person's intended outcomes, in a way that draws on the person's strengths. Individuals are also able to exercise choice and control around the service response they receive
Co-design and co-delivery of services: Involving people with lived experience in service design and improvement e.g. directly delivering as part of outreach, providing a user perspective to influence the design and development of services, providing training etc.
Translation and interpretation: Providing translation and interpretation services as required
Use of peers (experts by experience) for support: e.g. role modelling, developing self-efficacy, navigating services, peer advocacy. Also includes supporting the peers to deliver services effectively and maintain their own wellbeing and development
Assertiveness: A proactive and persistent approach that involves repeated contact with people who are initially unable to or unwilling to “engage”
Harm reduction: Recognising that abstinence from substance use and other potentially harmful behaviours is not desirable and/or realistic for many at this point in time, and that these individuals may disengage if pressured into abstinence by professionals. Instead, workers support individuals to set their own goals and develop their own strategies to manage risk

Local provider survey (3/3)

- The self-reported responses highlight that providers think the use of peers/ experts by experience, housing-led responses and translation/ interpretation services are the main service delivery principles not currently being met in full. Although it is only the use of peers/ experts by experience where there is the greatest intention to start applying the principle, if not currently
- The majority of providers self-report that they operate strength/ asset-based approaches and adopt trauma informed care/ psychologically informed environments. This is likely to be the case for some providers but should be read in the context of the wider findings of this needs assessment, particularly the element of “choice” inherent in strength/ asset-based approaches
- Providers were also asked to select which support needs their service addresses. The most common support offered was the following:
    - housing related support/ managing a tenancy (17, 89%)
    - practical and emotional (13, 68%)
    - benefits/ income maximisation (13, 68%)
    - mental health (12, 63%)
    - debts and arrears (12, 63%)
    - access to education, employment and training (11, 58%)
    - substance misuse (8, 44%)
- This ranking is to be expected given the number of accommodation-based providers responding to the survey, however does highlight the number of VCSE organisations with practical expertise in accessing benefits and entitlements for people experiencing homelessness; as well as providing access to education, employment and training
- International Lighthouse are also important to note, providing specialist casework support for non-UK nationals with restricted eligibility. They are one of the only multilingual organisation supporting individuals (a navigator in the SST also speaks Latvian, Lithuanian and Russian) and provide a vital service for this cohort

Analysis of current service provision (1/3)

Current service provision has been reviewed against published standards (NICE NG214 and Homeless and Inclusion Health Standards); and the needs identified in the previous section

Areas of strength and positive practice

- Development of the Northampton Homeless Treatment Team is in line with published standards, recognising the need for specialist homelessness multidisciplinary teams across sectors, and the importance of longer contact times in developing and sustaining trusting relationships
- Recognition that more effort and targeted approaches are often needed to ensure that health and social care for people experiencing homelessness is available and accessible. The NHTT and dedicated mental health nurse are taking health and social care services to people experiencing homelessness by providing outreach care in non-traditional settings, such as on the street, day centres (Hope Centre) and providing in-reach to some supported accommodation settings (e.g. Oasis House, HARRP Trinity, St. John's Winter Provision)
- Evidence of working towards a 'One stop shop' model at the Hope Centre, looking to facilitate everyone working together in a single location. The recent co-location of Adult Social Care teams in all three West Northants housing area teams has been cited as a positive, with further intentions to move to nine community teams working towards more integrated provision and co-location (e.g. health, police, housing etc.)
- Street Services Team working closely with NHTT (including via a drug and alcohol outreach worker) to offer collaborative, assertive outreach to start and maintain engagement with health and social care for people experiencing homelessness; including multi-agency assessments
- Collective effort across agencies to support GP registration at Maple Access if needed, often at the start of engagement to facilitate access to primary care
- Specialist mental health nurse has had a positive impact, able to bridge the gap with NHFT, facilitate mental health diagnoses and care and case management from the appropriate service
- Dedicated housing officer (Hospital Discharge Transitions Officer) working closely with a named hospital coordinator at Northampton General (and with inpatient mental health settings) to flag and address accommodation needs on discharge and support transition between settings
- Specialist casework support for non-UK nationals with restricted eligibility provided by International Lighthouse
- The majority of sectors across the local system either have dedicated professionals working with this cohort, or dedicated "Homelessness leads" in the relevant mainstream services

Gaps and opportunities

- Despite its status as the default practice to register with, Maple Access is currently unable to offer enhanced or targeted services to single people who are homeless; generating a number of primary care access issues for this cohort
- Likewise, despite some limited targeted provision; access to primary care dental services is another widely reported issue

Analysis of current service provision (2/3)

Gaps and opportunities (continued)

- Access issues and dedicated service provision for those with dual diagnosis (co-occurring mental health and substance misuse needs). Published standards state "all mental health services should be ready to work with people with drug and/or alcohol problems in addition to mental health issues. Mental health treatment should still be offered even when the patient does not wish to engage with substance use treatment." Although the NHTT and dedicated mental health nurse work closely together 'in a dual diagnosis way', there are widely reported access issues to mainstream mental health services; and no dedicated dual diagnosis workers, joint clinics, formal protocols and partnership working agreements for people experiencing homelessness etc.
- Linked to this, there is a lack of appropriate mental health respite beds for those experiencing multiple exclusion homelessness and/ or with dual diagnosis, due to restrictive criteria in the Crisis Houses
- Although there is ongoing work to improve pathways into mental health services for this cohort (supported by the dedicated MH nurse), there are still a number of access issues linked to the rigidity and lack of flexibility; with no dedicated protocols that recognise the access barriers for this cohort. This should include enabling people to re-engage with services at the same point as they left, actively supporting re-engagement, flexible appointment times, not penalising for missing appointments, less restrictive eligibility criteria etc.
- Streamlined debt and money advice provision across West Northants has been noted as an opportunity, including a specialist welfare benefits caseworker for those who are sleeping rough or are at risk. Debt and arrears accumulated from stays in supported accommodation was a widely cited issue
- There is significant centralisation of services for this cohort in Northampton town, increasing access issues for those in rural areas
- Although there is evidence of employing people with lived experience of homelessness in local services, and the use of advocates, there is significant scope (and intention) for more co-design and co-delivery of services with people with lived experience of homelessness, as well as encouraging and enabling the contribution of peers (experts by experience)
- Psychologically informed environments and trauma-informed care is an area that would benefit from targeted and collective practice development locally
- A few locations (e.g. Hope Centre) have the makings of a 'one stop shop' for all services to facilitate holistic assessments and wraparound support which is a positive, but these don't currently contain the full complement of services and agencies required. There is a real opportunity (linked to the Rapid Assessment Hub in the reshaping of the single homelessness pathway) to upscale and coordinate this provision with drop-ins, 'open-door' services etc. that people can self-refer to and access (even after any initial support ends), to reduce the risk of becoming homeless again because of unmet health, care and support needs.
- There are no intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care e.g. discharged from hospital (step-down care) or referred from the community who are at acute risk of deterioration and hospitalisation (step-up care).

Analysis of current service provision (3/3)

Service capacity

- Given the high prevalence of need, overall numbers of people experiencing or at risk of rough sleeping in West Northants; and the high caseloads of the NHTT; the NHTT could benefit from expansion in size to function as the locality's integrated and multidisciplinary homelessness team (e.g. a lead nurse, more recovery workers and lower caseloads/ more contact time is likely to be more cost effective); and in scope in the following opportunity areas:
    - Dedicated mental health social worker and/ or specialist homelessness social worker role; within outreach undertaking Care Act 2014, Mental Capacity and Adult Safeguarding assessments (acting as Safeguarding Lead)
    - Dual diagnosis workers (as above). These posts can help to circumnavigate systemic barriers, provide specialist expertise and the ability to lever and broker support from elsewhere within their sector. Specialist posts can share their expertise with the wider workforce through reflective and consultative support. They may also hold a caseload of individuals who need more specialist input
    - Mental Health and psychological professionals in addition to the current NHFT provision given the high prevalence of need e.g. MH nurses, MH practitioners, psychologists, psychiatrists
    - Pharmacists are part of local homelessness multidisciplinary teams in other locals areas, and/ or additional prescriber capacity dedicated to this cohort
    - Physical rehabilitation (such as occupational therapy and physiotherapy)
- The above should also allow the multidisciplinary team to provide and coordinate care across a range of settings (outreach, primary, secondary and emergency care, social care and housing services); ensuring continuity of care for as long as it is needed by the person, as well as supporting transitions in care such as prison, hospital and accommodation moves

Snapshot Case Study – Housing First Pilots

As part of the Housing First Pilot in Greater Manchester, two FTE **Dual Diagnosis Practitioners** were contracted from the local mental health trust, with a view to increasing to four later, to provide specialist mental health provision to individuals. They are also intended to help improve joint working with mental health and substance misuse services, and to help overcome the barriers individuals with complex needs face in accessing support for mental health and drug/alcohol use. In another Pilot (Liverpool City Region), two psychologists have been contracted from a local hospital to work with both individuals and staff, the latter as part of the Pilot's approach to supporting their emotional and wider wellbeing. In common with this Pilot, it is anticipated that these dual diagnosis workers will similarly help negotiate access to specialist mental health services for those being supported. They are not about seeking to replace mainstream services, but instead to improve access to them in the short term while also helping deliver the longer-term system change needed to tackle the barriers faced by Housing First clients.

West Northamptonshire Council

5. Service user and professional experience

Professional experiences

Approach

A series of 1-2-1 interviews and focus groups were organised with professionals across sectors to gather their insights into rough sleepers' health needs and experiences of access to health and care services; and their experiences of the single homeless pathway.

The findings presented derive from:

- 13 scheduled 1-2-1 interviews
- 3 focus groups, attended by frontline and operational staff; attended by 16 individuals from 6 different organisations
- Multiple formal and informal conversations with a wide range of individuals within the local system, identified mostly via 'snowball' sampling

The anonymity of participants is protected in the reporting.

Professional experiences

Multi-Agency Working

- Over the past year, S2S now has representation at many MDTs for CMHTs and UCAT due to the NHTT team
- Whilst the NHTT are able to share information across the different agency systems (with some limitations), individuals in general find themselves having to relive and recount traumatic experiences "over and over"
- Long standing need identified for coordinated case management system. Separated systems between health, social care, and VCSE organisations leading to delays, duplication, and unnecessary barriers between organisations working to the same person-centred outcomes

"Asked and asked for data sharing agreements"

- Professionals highlighted it was often only when you go to an ARMs meeting that all the information on a case is brought together
- Multi-agency working/ safeguarding and collaboration has improved since unification and the pandemic. Still room for improvement but much better

NHTT

"So much to be said for dedicated, consistent support, to provide trust and consistent engagement"

- Positives around dedication to this cohort, adaptable, MDT, info sharing, iterative development of service pathways
- Limitations on access to the prescriber, the general S2S prescriber has allocated hours to NHTT but demand for more and more outreach prescribers who can do more in-reach
- It would be good to have a lead nurse within that team that liaises with safeguarding, GPs hospitals etc.

Primary Care Access

- Trying to engage entrenched rough sleepers, as they have the most complex physical health needs but won't go to GPs and struggle to show up to pre-booked appointments or to even make an appointment. Need a dedicated pathway that bypasses GPs, so they don't have phone and book an appointment when they have already been assessed in the community

"In Scotland they have a gold card, so that once they are assessed by a nurse on the streets they can be prescribed anti-biotics or whatever they need and can use the gold card to collect the prescription and do not have to ring the GP to get an additional appointment. Through this we could have significantly more hospital avoidance for this cohort. "

"Other agencies we engage with to support this cohort are all working towards the same outcomes however there is a gap in primary and secondary care."

Professional experiences

Primary Care Access (Continued)

- GP surgeries difficult to access and struggle for people to get appointments

"Maple access completely changed - don't do outreach anymore"

"Maple Access swamped. Difficult to get appointments and follow ups"

"it is 50/50 with whether they come or not" "won't go to GPs and struggle to show up to pre-booked appointments or to even make an appointment"

"Used up all his credit trying to get a fit note"

- Need more dedicated physical health nurses for the numbers - having primary care who can look at injuries and medical issues, rather than call a GP
- Maple Access have protocol in place with a walk in service for homeless patients and register without address. Will be given a pre-booked appointment if not urgent, and if secondary care needed will be supported with hospital appointments if they do not have phone. The "walk in service" does not seem to be well known but service well represented on ARMs and other multi-agency forums
- Leg infections for this cohort are high, need for a drop in medical hub without barriers or need for appointment e.g. to go for acute leg dressings, giving bloods regularly. Could all link in and work together, need to build on the "one stop shop" model e.g. Hope Centre improving access to a range of services

"I am not a clinician but lots have DVTs from leg wounds and get sepsis"

"We had a patient show up late on Friday and his skin was rotting"

- A little while ago the ICB funded a paramedic: "was short-lived but worked well"

Professional experiences

Dentistry and Oral health

- Really struggle with dentistry: *"isn't a dental facility"*
- Even with the fortnightly drop-in at St James Clinic, reports of still struggling to access e.g. 3 hour wait

Mental Health Services

- Issues with mental health as the primary need (despite recent dedicated roles and pending expansion of these) and current referral pathways for this cohort

"Trying to access mental health services is a nightmare"

"Shut down to mental health, we can't refer in. If something happens have to go back through the GP to access community mental health teams"

"Jump through so many hoops - prove that you've engaged. prove, prove, prove"

- Dedicated respite or different type of inpatient provision needed for this cohort
- Housing navigators embedded in MH teams used previously but funding stopped
- Invaluable having dedicated mental health support (MH Nurse), majority of time spent working with crisis *"but there is not enough provision"*
- Very long wait times e.g. UCAT/ PCAT: *"Julie has to navigate for you"*

Substance Misuse

- Alcohol use a particular issue with people from Eastern Europe, alongside the language barriers.

Adult Social Care

- Acknowledgement there is limited understanding of this cohort across the service: *"Haven't got all the knowledge"*
- One social worker was based in Hope Centre, looking to replace that person
- Issues with ASC supported accommodation providers and willingness to support those with drug and alcohol needs: *"Happier with alcohol"*
- Closer collaboration with housing, working more closer than have ever been: *"Still work in progress . . . yours/ ours and vice versa"*
- Some stated thresholds were very high and, even when eligible need accepted, finding an appropriate provider is sometimes impossible

Professional experiences

Dual Diagnosis

- "Catch 22" of dual diagnosis and service refusal/ back and forth still an issue, despite developing dedicated resources (MH Nurse, NHTT providing *"support on a dual diagnosis basis wherever possible")*. Dual diagnosis leads in all the NHFT teams - dual diagnosis training leads, work with those service users in contact with that team – *"fallen away with the changes in community mental health teams"*
- Potential plans to recruit dual diagnosis worker e.g. attached to NHFT but within the NHTT

"From what I see in people's record the support for this cohort, the substance misuse and mental health side is a catch 22 with services not addressing one with the other being present"

"Some people still don't understand dual diagnosis"

"Mental health services won't see them if they have drug and alcohol issues"

"People's attitudes towards substance misuse is outdated. Needs to be more organisational change with people's mindsets"

"Admitted a lady to crisis house - was doing really really well. Discharged at night for smoking cannabis. 10pm at night. She was a vulnerable woman and slept rough that night"

Hospital Discharge

"Within hospital discharge it would be good to connect with them better, we should be connected in around hospital discharge to ensure we know where people are going, know if there is any further follow up required e.g. for stitches to be taken out. Otherwise we do not know when people are back out on the street and cannot support them."

- Issue with those with mobility problems and securing appropriate TA on discharge (really hard to get ground floor access) leading to inappropriate and unsuitable accommodation and/ or bed blocking while trying to source TA
- Real need for step down provision while this process can be sorted, care can be coordinated and avoid blocking an acute bed (physical and mental health)
- Transition Officer works closely with the Hospital Housing Officer and receives referrals when people are admitted after an initial triage and duty to refer necessary
- Social prescribers are a good link to have and *"worked really well"*

Lived experience voice

Approach

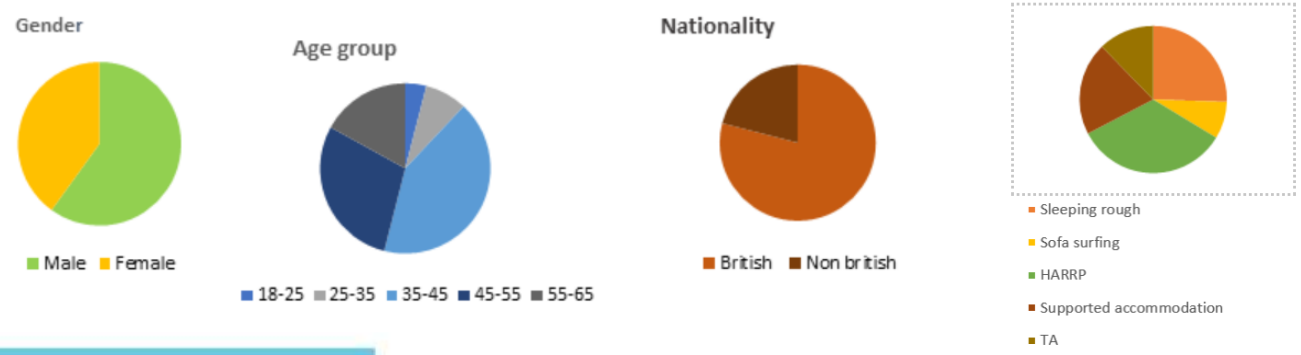
A series of interviews and a focus groups were organised in four different locations to gather insights into rough sleepers' health needs and experiences of access to health and care services; and their experiences of the single homeless pathways.

The findings presented derive from:

- 9 interviews organised at the Hope Centre on 3rd of April 2023. Most interviewees were sleeping rough at the time of the interview.
- 3 interviews and a focus group, attended by 5 people, held at Trinity House Homeless Assessment Rapid Resettlement Pathway (HARRP) on 24th of April 2023. The interviewees were all staying at Trinity House at the time of the interviewees. Length of stay varied from 2 days to 4 months. All interviewees had experienced rough sleeping.
- 4 interviews organised at the Women's Centre (C2C Social Action) on 25tht of April 2023. All interviewees were either on probation or had history with the criminal justice system and had experienced homelessness or rough sleeping.
- 1 focus group, attended by 3 people, held at NAASH main office on 25th of April 2023. All interviewees were currently in one of NAASH supported accommodation and had experienced rough sleeping.

All the participants were provided a gift card to thank them for their time and feedback. Informed-consent procedures were explained at the beginning of each interview and focus groups and after distributing the consent forms. Discussions were tape-recorded with the permission of the participants. The anonymity of participants in the focus groups is protected in the reporting.

Participant Profile



Lived experience voice

Key Points

- Stress and strain of sleeping rough, with participants physical and mental health problems developed as a result of their living conditions.
- Challenges in accessing primary care. Participants described significant barriers to accessing GPs and dentists. This was often due to challenges with inflexible appointment booking systems and long waiting periods to get the support they needed. In particular, issues with *Maple Access* were highlighted.
- Long waiting times for mental health support and limited follow up support. People often felt that the mental health support they received was not timely enough, too limited and lacked follow-up support.
- Evidence of hospital and mental health institutions' discharge to the street with no follow-up support
- An ecosystem of support organisations highly valued and acting as clear conduit / referral points to health and care services. This could be reinforced by more transparency and more joined up working between services to avoid miscommunication and poor information sharing.
- Clear barriers for people with NRPF and no local connection to accessing services, in particular health services, supplemented by lack of information and clarity on their rights and what they need to access support.

Impact of sleeping rough on health

- The stress and strain of sleeping rough came across strongly when respondents were asked whether they thought sleeping rough had impacts on their health.
- Reports of mental health problems were common across the interviews. This includes depression (e.g., in relation to their situation, life conditions and loneliness) but also anxiety and stress disorders directly resulting from the traumatic experience of living in the street. A number of individuals mentioned having been physically assaulted multiple times whilst sleeping in the street, feeling unsafe and developing conditions as a result (e.g., PTSD, epilepsy / seizure).
- Reports of physical health problems were less common, but two issues that were reported were musculoskeletal problems from sleeping outside, and experience of physical attacks. 2 issues of skin infections were also reported.
- Finally, drug and alcohol use was seen as sometimes being a causal factor, often as a response to the experience of sleeping rough and homelessness, a way of coping with the stress, and was occasionally reported as self-medication in an attempt to manage mental health problems.

Lived experience voice

Health and care services review

GP

- The majority of participants were registered to a local GP. Only a few weren't – those were all currently rough sleeping and either relatively new to Northampton (less than 6 months) or could not access GP services because of their immigration status (I.e. NRPF).
- A number of participants mentioned having received support from the outreach team, workers at HARRP Trinity or at the Hope centre to register.
- Most people were registered to Maple Access. Other mainstream GP practices were only accessed by a minority of those we heard from.
- Barriers in accessing Maple Access:
- Participants highlighted that walk-in was not available and that a security guard was '*permanently screening* [the practice] *entrance'*. Several participants mentioned feeling that the presence of security guards was '*intimidating'* and *'anxiety inducing'*.
- Participants mentioned that calling to book an appointment is the only way to see a doctor or a nurse, but that the line is constantly engaged. A couple of participants felt that this was *'discriminatory'* against people experiencing rough sleeping as a number of them do not have a phone number and are struggling to attend pre-booked appointments.
- At least three people mentioned that access and quality of services at Maple Access worsen since Covid-19.

'If you say call in the morning and you don't get through, you know, you don't get through with the line because it's constantly engaged…And it is only when they tell you can call between eight to nine but then when you call at eight the line is busy and about 8.15 or 8.20 when you get through with the phone call to make an appointment they say it's all places are full'

Snapshot case study
P. has a long history of rough sleeping. Last year, the Hope centre encouraged him to join Maple Access GP, he had been with a previous surgery for 10 years with no problem and describes always being able to get help when he needed it at the previous GP. At Maple Access he describes not being able to get into the surgery. He is clear that he does not like bouncers on door and has never heard of this at a GP surgery. He describes it being impossible to get an appointment, and that it does not work for him to ring up in advance. This week he had given up and gone to the hospital to be seen instead. He also describes taking multiple other people to hospital when they also couldn't get into Maple Access to see the GP.

Lived experience voice

Health and care services review

GP (continued)

'It's a bit rubbish because they used to have a mental health nurse'.

'They used to have an asthma clinic, but I haven't had an asthma check for 3 years'.

- Lack of continuity in support received. The opportunity to build rapport with a doctor was an obstacle when they did not have the same doctor, highlighting that continuity with a GP was significantly important for many participants.
- Lack of awareness from staff – Participants talked about the stigma they sometimes felt at the GP, in particular due to of lack awareness and consideration of the other health needs they may be experiencing.

"They just, they were, I'm very, quite complicated. I've got PTSD, I've got everything, I've got quite a lot of problems so like they, they, they weren't very understanding at all with my mental health".

"I mean they're nice, the doctors are nice and pleasant, and I feel like when I go, I think …they're not nasty or anything but when I want help with my issues, especially when it comes to my addiction and my mental health there is nothing they will do.

- A female participant reported feeling uncomfortable during GP examination and needing a chaperone. Unfortunately, she reported that her GP was only able to provide a male chaperon. As a result, she usually refuses examination.

"it's horrible talking to a man. If I have to have a man I have to have someone with me."
•.

Lived experience voice

Health and care services review

Pharmacies

- Access was not an issue for the people interviewed. Rather, most people had positive experiences of using their pharmacy due to ease of access to medication and felt that their needs were addressed.
- Many people explained that their relationship with pharmacy staff was friendly and attentive and contributed to the efficiency of picking up their medication.
- Participants using injecting drugs mentioned being able to access clean equipment easily.

"They have been good. Can't complain. I feel treated well and they don't care if you're going in there for addiction drugs'.

Dentists

- Difficulties in accessing and registering for services was a common theme for people when engaging with dentists. Over half of the participants who expressed the need to see a dentist had not been able see one in the past 12 months. Participants who said that they would like to access a dentist, but were unable to get an appointment, described experiencing ongoing pain and discomfort.
- The issue of registration was highlighted as a key barrier to access.

'You can't get in there despite the big sign saying 'NHS patients' on the building. They are either full or ask for tons of information we don't have.'

- Additional barriers to dental care were often caused by the cost of treatment.

'I have been able to see a dentist, but it was too late. The damage from drugs on my teeth… there is nothing they can do for free and I cannot afford treatment'

Substance and alcohol services

- The large majority of people with substance and alcohol misuse issues had experiences of using substance and alcohol services.
- Overall, most said that the support received was good and appropriate. However, like many other healthcare services, people highlighted that accessing programmes and treatment was couple with long waiting times.
- A couple of participants mentioned being aware that S2S workers were under-resourced and overworked and *'had to much on'* leading to less individualised and bespoke support.

Lived experience voice

Health and care services review

Mental Health Services

- The majority of participants said that had mental health issues, however mental health services had been often inconsistently accessed and experiences described were mixed.
- When prompted on the support received, most of the participants felt that they were not receiving enough support.
- Of those mentioning a poor experience, this was often in relation to the lack of responsiveness and waiting times that they had experienced when accessing mental health support. Some notes that in some instances their mental health had changed or deteriorated in the time they were waiting to receive treatment or support.
- The lack of follow up support and the short-term nature of the support provided was also mentioned as an issue. The limited nature of mental health support also meant that people who had accessed treatment for a period of time were discharged without a simple way to re-enter treatment if their mental health deteriorated.

'I had to wait perhaps 6 months to finally see a therapist for my mental health problems. 6 months! Thankfully I am not suicidal as I would be dead by now. So much can happen in 6 months. It's not serious to have to wait such a long time. My mental health got worst (…) and the therapy was only 10 sessions or something. Perhaps for some it is enough, but I feel like I need something much more long term. In 10 sessions we can't go deep and fix long standing issues'

' I had a few sessions with a mental health doctors but then it stops and I never heard back from them. It felt ad-hoc, detached.'

- Further, some mentioned that support was limited or not appropriate to their needs, especially when offered group sessions or support over the phone.

'So, I know a group session and all that are not for me. I'm not going to get anything from it. I guess I just have to live with it'.

'*I have been in touch with mental health services in the past but I don't find it very useful. They just give me tablets and I don't find it useful'.*

- As per GP registration, participants highlighted the efficiency of the 'ecosystem' of homeless support organisations (Hope Centre, HAARP, NAASH, C2C Social Action etc.) in helping them with accessing mental health services and support.

'I don't know how they do it. I have been trying for months to get mental health support. As soon as I got in here [HARRP], I was on the waiting list. I am very grateful, they work hard to help people'.

Lived experience voice

Other experience and feedback

Hospital Services

- Participants were overall satisfied with their experience of accessing hospital services and appointments, however participants felt that communications between different hospitals and services were inconsistent. Some people mentioned that they visited hospital services and that none of their support services were made aware.
- A couple of participants said that they received multi-agency support whilst they were in the hospital to ensure that their care was joined-up, however this was not the case for a number of people. Two starks illustrations were given by two individuals who described being discharge from hospital / mental health institution with no support and follow-up in place.

Valued Services

- The Hope Centre was repeatedly mentioned as a very important resource for people sleeping rough, sofa surfing and having experienced rough sleeping. A number of people said that they were not aware of its existence at the start of their rough sleeping journey but that they had been made aware of it promptly (by the outreach team, a soup kitchen, a church member). Several people also said that the Hope Centre really acted as a 'gateway' to access other services and support that they were struggling to access alone.

'After a week in the street, someone at the soup kitchen dropped me off at the Hope Centre. When I arrived there, someone quickly went to discuss with me saying 'I haven't see you here before, how are you doing etc.' and advised me on what to do with regards to getting in touch with the council and getting support. Somehow, they helped in getting things moving quickly'

'I come here [hope centre] everyday. It's like a lifeline to be honest, it makes a lot of difference this place does.'

'Without the Hope Centre I don't know what would have happened to me. It's a safe place'

- Similarly to the Hope Centre, participants all described positive experience and opinions of the ecosystem of homeless support organisations, including NAASH, C2C Social Action, Bridge, HARRP. Participants discussed how these organisations helped them to access support and services, sometimes acting as their advocate.
- For female participants, the Women's Centre is a clear source of support, both practical and emotional.

'Number 1: it's female. Number 2: you do get support. Like there's days I come in and I'm not myself and [staff member] picks it up and says you're not yourself today do you want to chat? And usually I come in crying and she cheers me up. I end up going, feeling much better.'

- The outreach team was also seen as supportive and *'doing what they can'*. Most people currently sleeping rough had an interaction with the team and most of them said that the contact was regular. Issues were raised regarding the rough sleepers' verification process

Lived experience voice

Other experience and feedback

Accessing Information

- A common theme was the difficulties in communication and accessible information around what they are eligible for, what is available and how they can access support. Overall, limited knowledge of services, pathways and of their rights combined with low confidence make it difficult for people to negotiate their way into and through services. Again, the role of gateway organisations such as the Hope Centre, are seen as crucial for sharing information.

Communication

- Communication is a significant barrier to accessing health services for people whose first language was not English. The lack of support and access to interpretation and translation services for health-related support was a key issue for the majority of people we spoke to who required communication support. People mentioned that access to translation services was usually arranged for all appointments taking place at the Hope Centre, but that this was not the case at the hospital or the GP.

Joined Up Working Across the Healthcare System

- Many of the people we heard from had multiple health needs and were interacting with many health services simultaneously. In some cases, this led to positive outcomes for people who were receiving specialist, tailored treatment. However, often people described the need for more joined up working between services to avoid miscommunication and poor information sharing.

People with NRPF

- Participants included 2 individuals with No Recourse to Public Funds, currently sleeping rough and awaiting for the regularisation of their status. Both were in contact with the outreach team and able to name their dedicated support worker.
- None of these individuals had seen a doctor or a health worker since starting to sleep rough in Northampton (more than 6 months) and despite clear health issues developed as a result of living in the street (e.g., epilepsy and PTSD, skin infection).

‘ I am in the street because I lost my passport. I do have the right to stay here in the UK as I have settled status but I can prove it until I get my passport back. I have been in the street for 8 months and I can’t access any support’

West Northamptonshire Council

6. Single homelessness pathway

Summary of current evidence | Responses to single homelessness and rough sleeping (1/5)

Traditional responses to rough sleeping and single homelessness:

- The prevailing approach to housing homeless people in the US, Europe and Australia can be described as **'linear'** in nature (Johnsen & Teixeira, 2010).
  - This essentially **involves 'progressing' homeless people through a series of separate residential services**.
  - It is founded on a **'treatment first' philosophy**, with homeless people typically only placed into 'normal' housing when they exhibit evidence of 'housing readiness' (e.g., basic living skills, sobriety, commitment to engage in treatment).
  - Linear or 'staircase' models have been criticised in some contexts because of their **high attrition rates** (i.e., the loss of clients between stages).
  - **In the UK, the linear model is implemented more flexibly than elsewhere, but a 'treatment first' philosophy still prevails** – with most support agencies requiring evidence of 'housing readiness' before placing clients into independent, settled accommodation.
- The primary purpose of **short term / transitional supported housing** is to **address the reasons why an individual cannot or does not want to move into mainstream housing straight away**, with the aim of **preventing their future homelessness**.
  - The **primary outcome measures** are therefore around **the numbers of people sustaining accommodation as an alternative to homelessness in the short term AND then moving into settled housing in the medium term**.
  - The Theory of Change can be summarised in the table to the right (Blood et al, 2023)

Source: Blood et al, 2023. Research into the supported housing sector's impact on homelessness prevention, health and wellbeing

Activities	Inputs	Assumptions	Short-term outcomes	Medium-term outcomes	Impact
Provision of accommodation (with housing management/ supervisory functions to ensure health & safety)	PIE building Appropriate staffing levels, skills & style A range of move-on options is available Staff know of them and there are access routes Clear processes to remove barriers to mainstream housing	Risks can be managed, and a sufficiently 'safe space' created A range of move-on options can be accessed within a reasonable timeframe	Those who would otherwise be roofless are accommodated They sustain accommodation until ready to move to settled housing	Appropriate, settled accommodation is identified and accessed.	Settled housing is sustained
MEASURES			Number accommodated (previously/ otherwise homeless) Number leaving in unplanned way	Proportion moving to more settled and/or suitable housing	The individual does not re-present as homeless in future
			following eviction / abandonment.		
Provision of personalised support to: • Stabilise personal issues • Reduce barriers to housing • Develop positive support networks • Enhance confidence to manage independently	Individual agency and choice is promoted Effective referrals and alternative models available Effective multi-agency partnerships Wider services are accessible to people experiencing homelessness and/or complex needs	Individuals engage Sustainable behaviour change is desired and possible People can access any specialist support they need	Support needs are effectively identified Appropriate support is accessed	Barriers to more independent/ settled housing and risk factors for future homelessness are reduced	Capacity to prevent further homelessness is increased
MEASURES	Support staff assessment of whether those agencies that need to be involved are and how well they are working together?		Engages with / makes more preventative use of support services	• Substance use is stabilised • Mental health conditions better managed • Practical skills/ confidence improved • Pro-social networks developed • Housing barriers (e.g., affordability/ exclusions) reduced	

Summary of current evidence | Responses to single homelessness and rough sleeping (2/5)

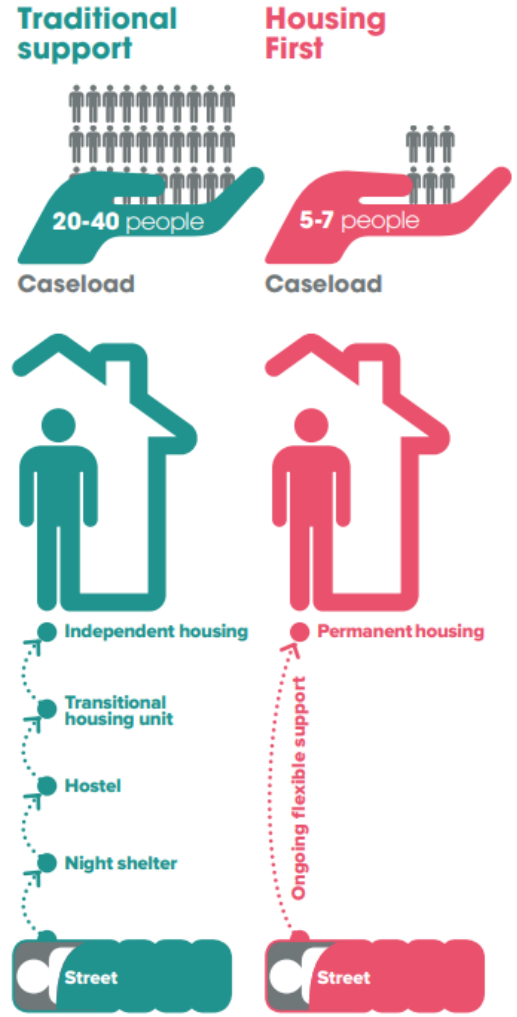
Issues with the traditional response:

- The problems with the traditional response centre around both the principles and philosophy, and the assumptions and practicalities needed to make it work (for example, suitable accommodation with the right level of support, appropriate range of move on options, limited barriers to mainstream housing etc.)
- The latest Annual Review of Support for Single Homeless People in England (Homeless Link, 2021) showed **a lack of move-on options** appears to be **leaving people trapped in homelessness accommodation longer than they need to be**, with 42.9% of providers stating that over 50% of their residents were waiting over six months to move on.
    - The **short term accommodation** is therefore **forced to operate as longer-term** but this is an **unsustainable and insecure solution** to street homelessness.
    - As a result of these challenges and barriers, people with complex needs are at **high risk of frequent evictions**, **getting 'stuck' within the homelessness** system, or **rejecting services altogether** (Blood et al, 2017).
- **Hostels and shelters** (traditional, congregate provision) **protect residents** from many of the risks associated with sleeping on the street, but present their own health-related hazards (Mackie et al, 2017).
    - The onset and/or escalation of **drug misuse** amongst residents is widely reported, the **risk of communicable disease transmission high**, and **deterioration in mental health common**.
    - The management of **antisocial behaviour** is an ongoing challenge for staff.
    - Only a minority of people express a desire to remain in congregate hostels and shelters or supported accommodation in the long term.
    - Concerns about using mainstream hostels and shelters tend to be **particularly acute for young people, transgender people, women and people with complex needs**.

Summary of current evidence | Responses to single homelessness and rough sleeping (3/5)

Evidence of what works:

- Until the development of the Centre for Homelessness Impact (What Works Centre), there were **no reliable tools** to help us identify what we know and what we don't about what works to reduce homelessness.
- Homelessness has been **lagging behind other fields** and **more local evidence is needed**, with **large gaps in the evidence base** around the most commonly used interventions (e.g. hostels); and the **majority of relevant studies originating in the USA**.
- As a response to the issues with the traditional linear model outlined above, Housing-led responses to homelessness are slowly emerging as a policy priority across all three GB nations, marking a major departure from the status quo.
    - In England, there has been an almost **six-fold increase in the capacity of Housing First services across the country between 2017 and 2020 (Homeless Link, 2020)**.
    - The **evidence base on Housing First is exceptionally strong**; far stronger than is true of any other housing-related intervention targeting rough sleepers (Mackie et al, 2017).
    - **Retention figures** (measured in variable ways over different timeframes) range between **60-90%**, and typically coalesce around the 80 per cent mark. This is markedly higher than rates reported for Treatment as Usual (TAU) comparison groups.
    - The Housing First model **bypasses transitional accommodation by placing the most vulnerable homeless people directly from the street into independent tenancies with tailored support, without insisting that they engage in treatment**.
    - Such outcomes fundamentally challenge widespread assumptions that chronically homeless people with co-occurring mental health problems and/or substance dependencies are incapable of maintaining an independent tenancy.
    - The majority of homeless people express a **strong preference for scatter-site Housing First**. There will always be a need for short-term and high-quality emergency provision; and there is a role for supported housing, on either a transitional or long-term basis, when it is provided as a solution outside of a staircase model.



Source: The Principles of Housing First, Homelesss Link, 12 April 2022

Summary of current evidence | Responses to single homelessness and rough sleeping (4/5)

- An international evidence review of what works to end rough sleeping (Mackie et al, 2017) examined a range of different interventions and suggested **five key themes to help underpin the approach taken to prevent and end rough sleeping**:

1. **Recognise the diverse needs of individual rough sleepers** – address each rough sleeper's housing and support needs and their different entitlements to publicly funded support.

2. **Take swift action – to prevent or quickly end street homelessness** – through interventions such as No Second Night Out, thereby reducing the number of rough sleepers who develop complex needs and potentially become entrenched.

3. **Employ assertive outreach leading to a suitable accommodation offer** – by identifying and reaching out to rough sleepers and offering suitable housing as part of the package of support. Where outreach leads to permanent, rather than temporary, accommodation; tenancy sustainment outcomes are better. Second, accommodating rough sleepers in shared or congregate housing appears to be less effective and less desirable than self-contained options.

4. **Be housing-led** – offering swift access to settled housing, including the use of Housing First.

5. **Offer person-centred support and choice** – via a client-centred approach based on cross-sector collaboration and commissioning

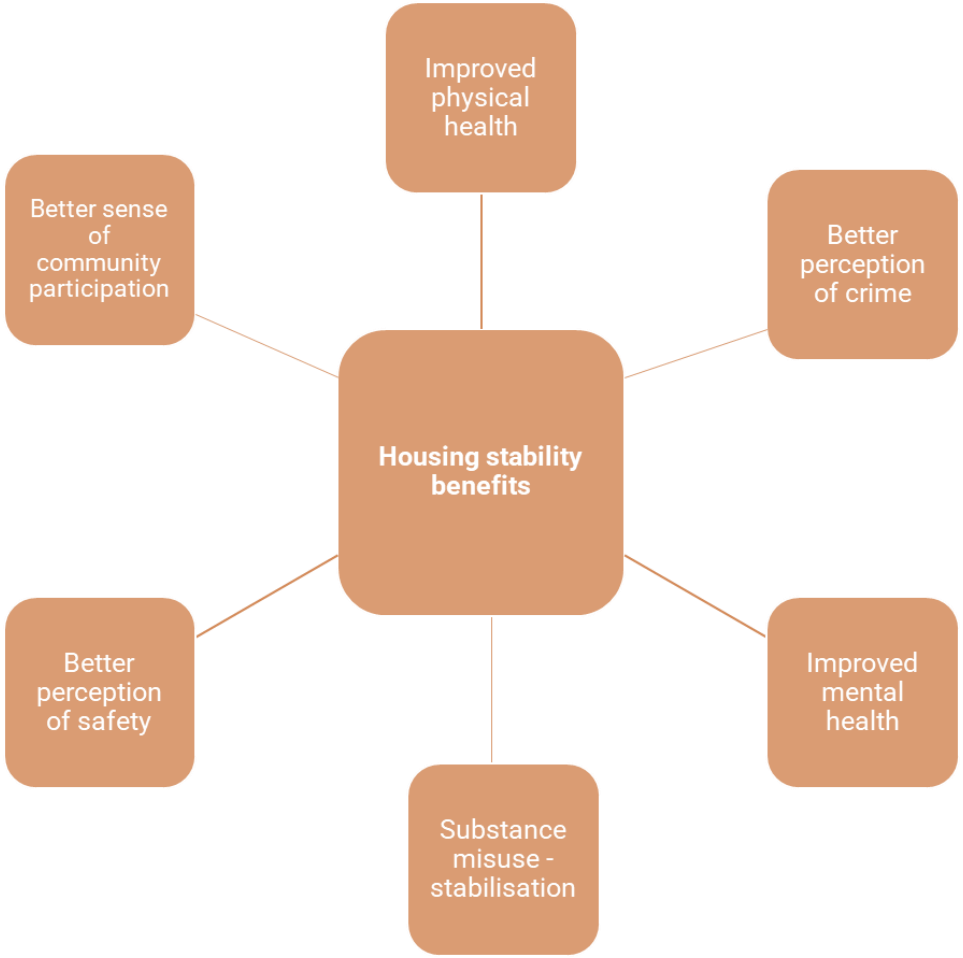
Underpinning all this is the **provision and accessibility of affordable permanent housing stock** for people experiencing homelessness, and support services..

Summary of current evidence | Responses to single homelessness and rough sleeping (5/5)

Housing stability and health/ wellbeing outcomes

- Systematic reviews on the **health effects of improvements in an individual's housing situation** suggest a **promising impact on self-reported physical and mental health**, as well as **perceptions of safety, crime and social and community participation** (Thomson, H. et al., 2001).
    - Some individual studies looking specifically at mental health did see **long-term improvements in mental health associated with better housing**: after being housed for three years, people showed reductions in mood disorders (from 20% to 12%), in anxiety disorders (11% to 5%) and substance use (70% to 55%), although levels of psychotic disorder remained stable (Herbers & Cutuli, 2014).
- Reviews of the evidence around housing interventions suggest neither a positive nor a negative **impact of Housing First (HF) or other supportive housing interventions on substance use**, but it was deemed **potentially helpful for stabilisation**, which is important if the aim is to reduce homelessness (Baxter et al, 2019).
    - This is consistent with other reviews including the Centre for Homelessness Impact's (CHI) review of accommodation-based interventions (2020) which suggest the intervention is more effective in improving housing stability compared to no intervention, but has less pronounced impacts on other outcomes such as improving health.
    - **Housing** might not result in a reduction in substance misuse, especially for people with long histories of homelessness, but it can nevertheless play a **vital foundation for stabilisation in consumption** and result in **fewer episodes of homelessness**.
- Housing First has been shown to have a significant impact on mental health, with 66% of people reporting improvements (Bretherton & Pleace, 2015). There is a 71% improvement in engagement with mental health services plus 80% engagement with meaningful activity (O'Campo et al, 2022).

A Kings College London Study has just been launched titled **"Housing Model Evaluation (HOME): Improvements in health associated with housing-led systems for people experiencing homelessness",** running from 2023-2026. This should be noted and provide additional supporting evidence.



Current Single Homelessness Pathway

Current pathway

(Early) identification of people at risk/ sleeping rough

Outreach workers (inc. x1 drug & alcohol)
Undertake outreach sessions, provide housing advice surgeries, visit local services. Caseload: 15 at one time. Continue to support clients after they have moved off the street into accommodation, where necessary.

Navigators
Support those with higher needs through their journey, with freedom to innovate and use personalised budgets. Emphasis on resettlement and sustainment. Caseloads up to 15.

Transition Officers (x3)
Co-located in hospital, probation and leaving care teams.

Triage Officers (x4)
Council first point of contact. Decide whether to refer cases to the Single Homelessness Team (non-priority need).

Single Homelessness Advisor
Triages cases referred in (non-priority presentations). Support case set up in Jigsaw case management system. Work with single people before they reach crisis point.

Weekly multi-agency assessment panel

Comprises various support services and supported accommodation providers, who:

- Meet to discuss new and existing homeless referrals, accommodation voids, arrange assessments and share relevant information.
- Aim to identify the appropriate housing and support pathway for individuals being referred.
- Referrals completed by members of the Street Services Team who 'present' the case. All individuals must meet local connection criteria and be eligible for assistance

Meetings, a chance to:

- Raise any concerns with current residents in the pathway
- Discuss any support available in order to prevent evictions where possible.
- Conclude with an agreed plan and confirmation of who will carry each action out

- There will be cases presented at Panel but then removed / not housed typically (but not exclusively) because:
  - They were considered to have stopped engaging with the service
  - They refused accommodation
  - WNC accepted a main housing duty
  - They were considered to have 'behavioural issues'

Short term/ temporary/ insecure accommodation

Short-term, transitional supported accommodation
Circa 499 units across the core provision, from 10 providers. Two of these providers (HARRP* and NAASH) receive 100% of their referrals from Panel. All providers have a contact at WNC from the Street Outreach Team.

NSAP / RSAP Properties
Additional 35 NSAP / RSAP Properties with x3 Tenancy Support Officers (Northampton Partnership Homes) and NAASH support for x3 dedicated units for women involved in sex work. Placed directly from the street or SWEP. Self-contained 1-bed flats for occupation for up to 2 years, to achieve move on to general needs social housing.

Temporary Accommodation
Some individuals placed in temporary accommodation (nightly paid, B&Bs, hotels etc.) under a statutory s.188/s.193 duty. Limited designated support for these households.

St John's Winter Provision
25 unit, 24/7 staffed student accommodation during SWEP and between Dec/ Jan and 31 March.

Accommodation for Ex-Offenders (AfeO)
Coordinated by NAASH. Provide accommodation in the private rented sector for up to 2 years following release from prison, with x2 tenancy support officers, landlord incentives and personalisation budget.**

Secure/ settled/ long term accommodation

Social Housing
Main move on option currently available. Move on protocol with NPH (after 6 months stay) and number of providers. NPH Housing Support Service offer tenancy sustainment to those that need it, including those who have experienced rough sleeping. Also provide a resettlement service for prospective tenants to ease transition, 6-weeks of resettlement work. Caseloads of circa 1:25. There is also an RSI-funded Tenancy Sustainment Officer (Social Rent) supporting people's housing application and resettlement, encouraging positive engagement; and building relationships with social landlords.

Private Rented Sector
Currently not used as a move on option. Social Lettings Agency Manager and 2 PRS focused posts within the statutory service. Recently (late 2022) landlord incentive offer enhanced. Stated intention to use for those in the pathway with arrears and to support PRS move on with rent in advance or top-up; alongside support from the TA team. Not yet materialised

Long-Term Supported Accommodation
Evidence of some individuals placed in long term supported accommodation under a health/care-led and funded response.

*Although HARRP Trinity was originally conceived as first stage assessment hub provision; this has not often been achievable and is therefore included here.

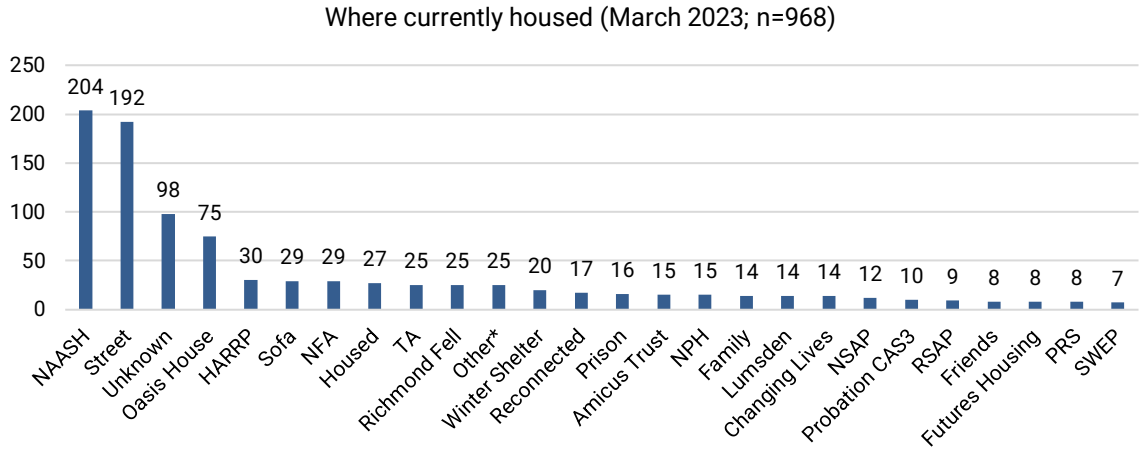
The project has accommodated 38 people; with a target of 40 to end of March 2023. As at end Feb 2023, 4 people had successfully moved on from AfEO. Also transitional accommodation **(Community Accommodation Service – CAS3) providing temporary accommodation for up to 84 nights for homeless prison leavers and those moving on from Approved Premises (CAS1) or the Bail Accommodation and Support Service (CAS2), and assistance to help them move into settled accommodation.

Current Pathway | Demand (1/2)

968 individuals have been added to the general tracker since its conception in January 2021

- *Panel:* The total number of presentations (not unique individuals) to Panel was 580 between 1st January 2021 and March 2023, with an average age of 36 at referral. 18 days on average were spent on Panel before an outcome (either accommodated or removed).
- 99% of those on Panel receive income from some source, primarily Universal Credit.
- **The primary reason for homeless was cited as friends and family not being able to or not being willing to accommodate the individual (160, 28%).**
- **At the time of Panel, most people were sofa surfing (163, 28%) or in HARRP (104, 18%).**
- Over 29 different organisations have been involved with those on Panel, in many cases S2S (151, 26%) and Probation and Police (139, 24%).
- From Panel, many people were accommodated in NAASH (35%), not accommodated elsewhere (18%) or accommodated at Oasis House (15%) and HARRP (7%), among other places (see next slide).

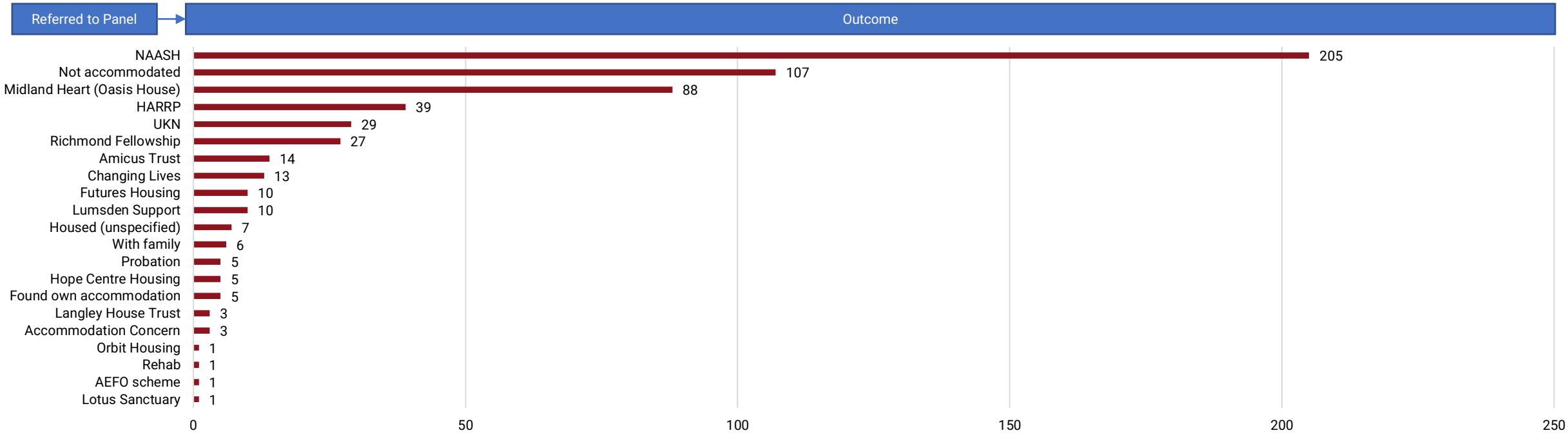
- *Current Housing:* The General Housing tracker shows the distribution of current housing provision across many different categories for the 968 individuals on record, with a majority at NAASH (204; 21%) or on the street (20%).
- Current housing of these individuals started are various times throughout the last few years, going back as earlier as 2008 (this individual is now deceased), with 1 individual having sofa surfed since 2017.
- For a majority (779, 80%), they last bedded where they are meant to be currently housed.



Other includes: ASC/Care Home, Lotus Sanctuary, Supported, Accommodation Concern, Hospital, Langley House, Orbit Housing, at work, The Plough Hotel, Main duty, Midland Hart, Reactivate8 Housing, Housing Register, YMCA, Berrywood, Sanctuary Housing, Hope House, EFEO, Refuge, St Mungo's Shelter, Detox, BASS, Phase Housing, Mayday Trust, Approved Premises

Current Pathway | Demand (2/2)

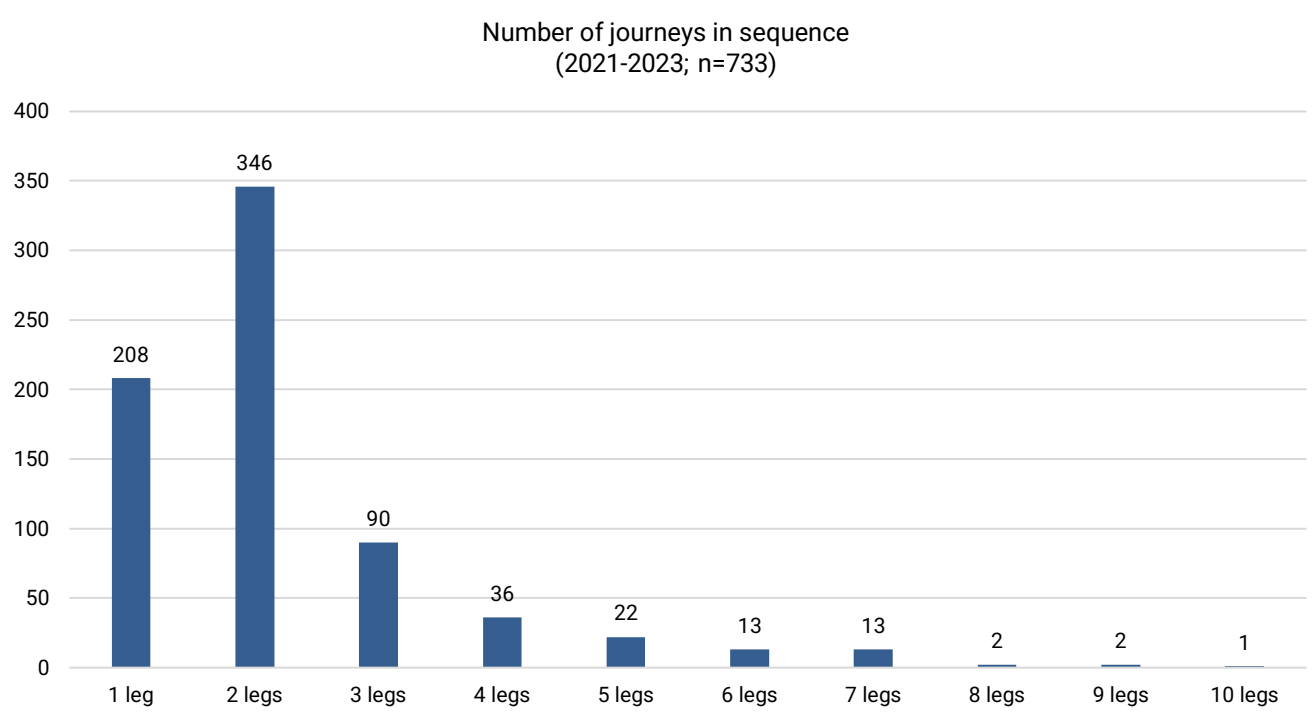
Summary of panel outcomes after referral

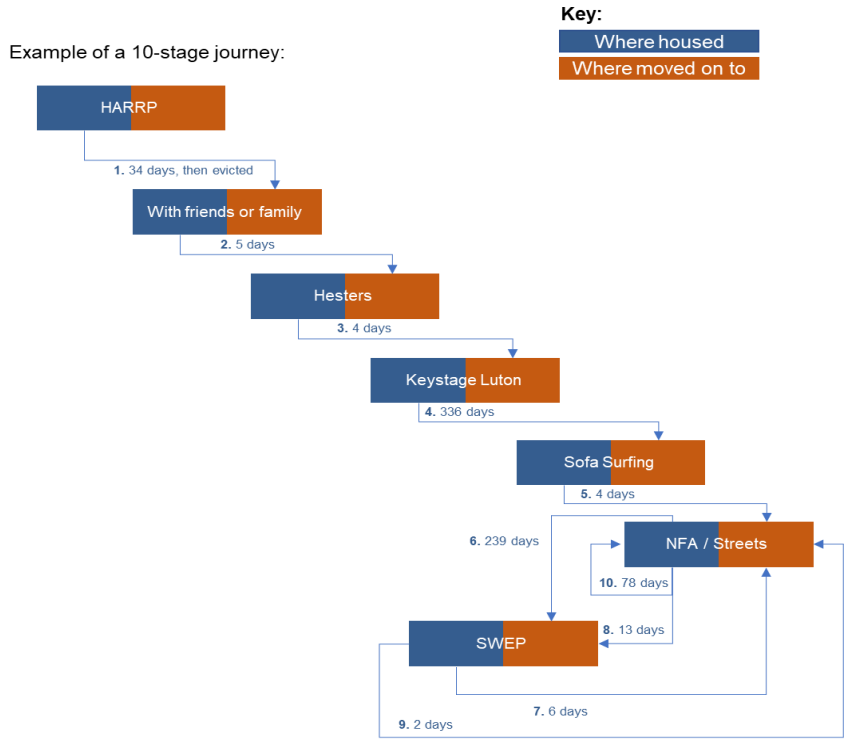


Current Pathway | Movement within the Pathway (1/5)

An additional dataset (Historical housing data) shows varying flows through and journeys once people enter the pathway, and varying lengths. There are often a number of moves in these journeys, but the data is unable to indicate whether these are planned or unplanned.

Using the Historical Housing Data, there are often **a number of different steps and transitions** between where individuals are initially housed and where they are currently, with a majority of those on current record moving to at least 2 places (47%). An example of one individual journey is shown below, which involved 10 separate movements with the individual ultimately still ending up on the streets homeless.

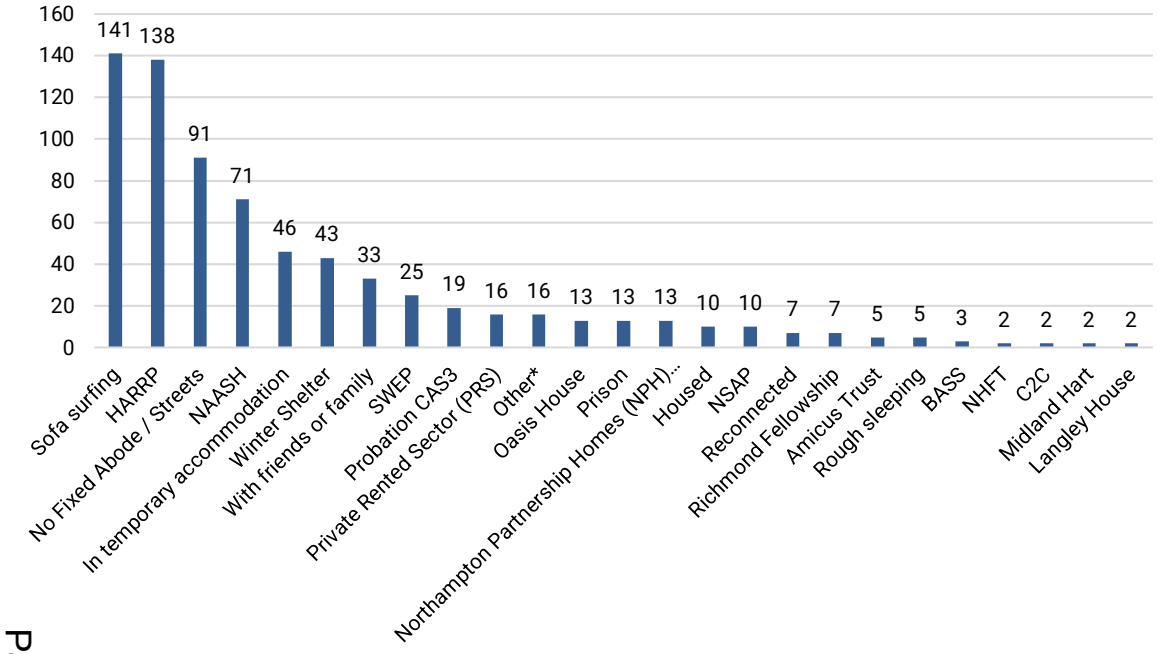




Current Pathway | Movement within the Pathway (2/5)

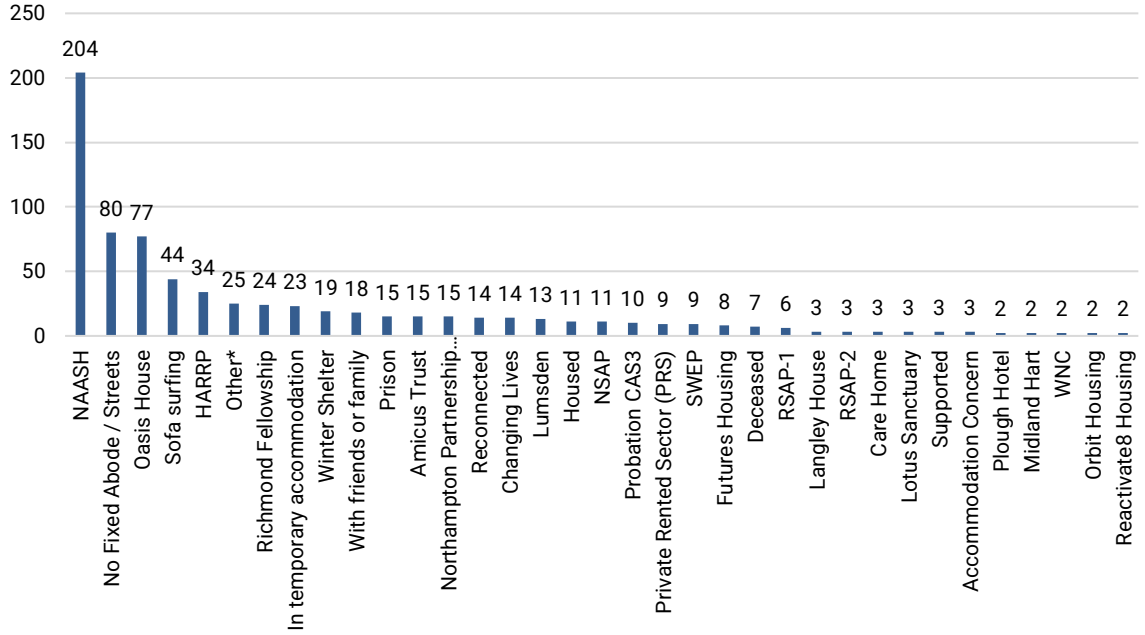
The Historical housing data contained 733 unique records and revealed widespread distribution of accommodation sources, with a **majority (19%) starting their journey sofa surfing**, or in **HARRP** (19%), and **currently being housed in NAASH (28%)**, as shown below and assuming the information is up to date:

Where housed initially (2021-2023; n=733)



Other includes: RSAP-1, Hotels/ Plough Hotel, St Mungo's Shelter. Futures Housing, At work, Approved Premises, ASC Living, Hospital, Supported, Lumsden, Mayday Trust, Care Home, Orbit Housing

Where moved to currently if still within the pathway (2021-2023; n=733)

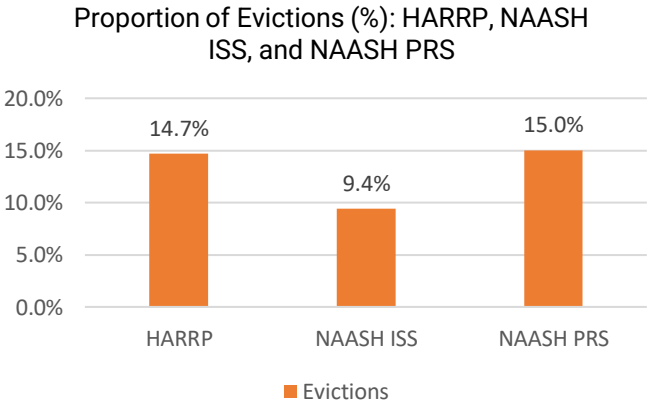


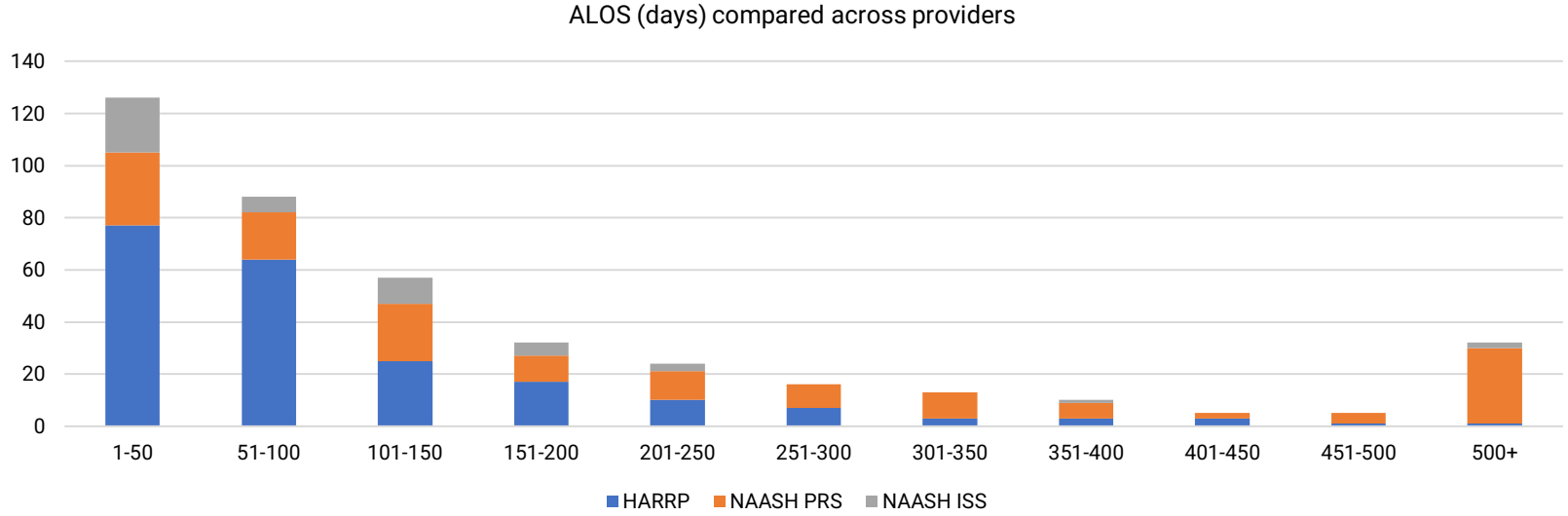
Other includes: Stopped engaging with support, Sanctuary Housing, Evicted, ASC Living, Mayday Trust, Housing Register, Moved OOA, Ignite Care, BASS. At work, Social Care, Unknown, St Mungo's Shelter, Approved Premises, Hospital, Hope House, Phase Housing, Rough sleeping, YMCA, Detox, Homeless Team, Live-in carer job, NHFT

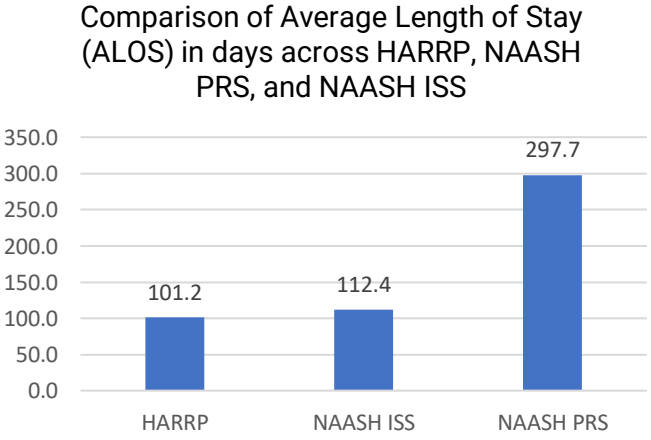
Current Pathway | Movement within the Pathway (3/5)

We are unable to present the average length of stay within the pathway due to data limitations, although assumptions can be made when analysing numbers moved on into permanent accommodation. However, this data is provided for two core providers and reflects the different nature of the provision and its intended role in the pathway.

- The graphs below show a range of statistics detailing the proportion of evictions, average length of stay overall, and average length of stay distributed across additive 50-day periods, from HARRP, NAASH PRS and NAASH ISS.
- Evictions are relatively consistent, around 15%, across the HARRP and NAASH PRS cohorts, but show a slightly smaller proportion, 9.4%, in the more intensive NAASH ISS cohort, although this is a significantly smaller sample size.
- Average Length of Stay (ALOS) across these providers shows a similar trend, with a difference between the outcomes of the cohort in more intensive versus less intensive accommodation/service providers.
- ALOS is highest in NAASH PRS, less intensive supported accommodation, with very similar trends in the HARRP and NAASH ISS cohorts.
- Of the current HARRP cohort, 12/27 have been housed with Trinity beyond the target 28-day period, with the longest stay being 623 days.

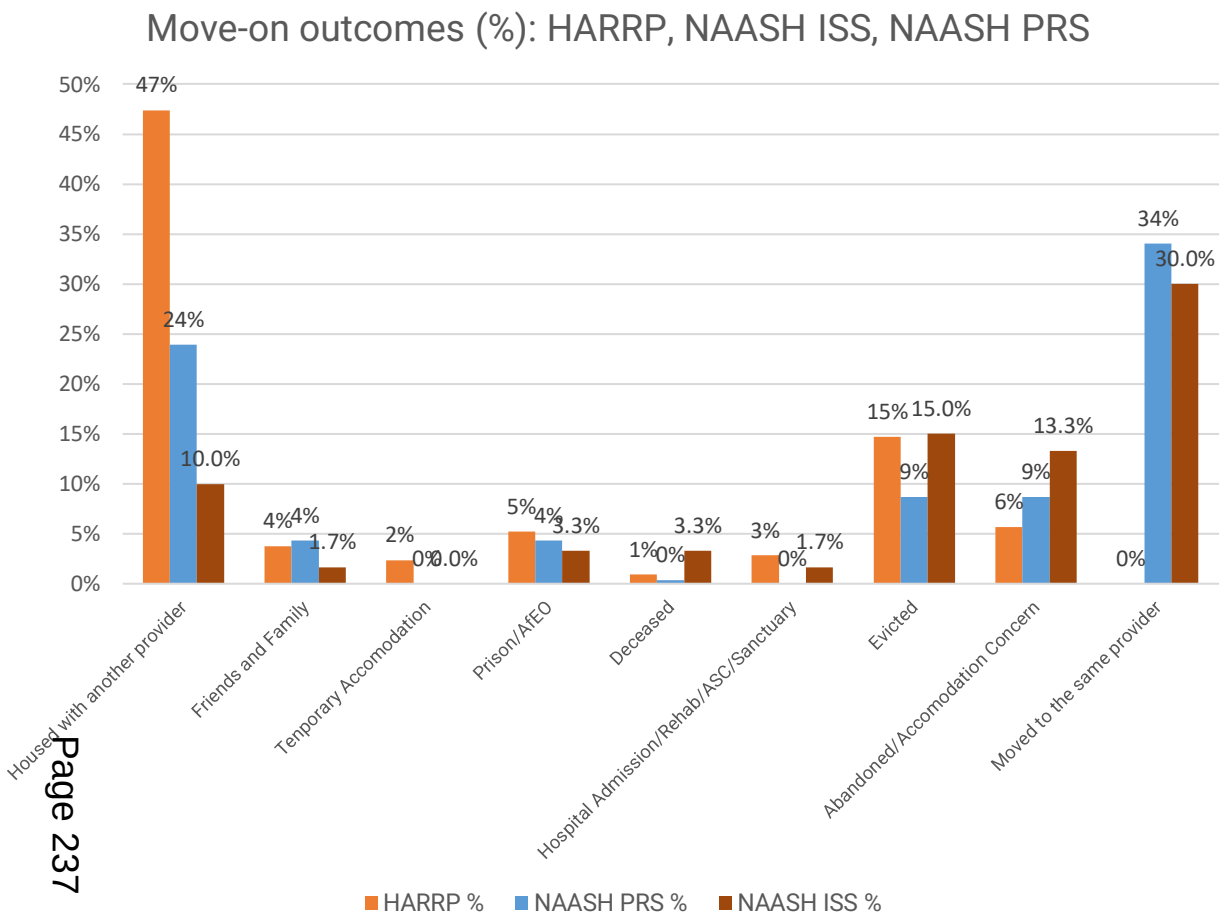






Current Pathway | Movement within the Pathway (4/5)

Across the same data provided by HARRP, NAASH PRS and NAASH ISS; the most frequent outcome when moving from this provision was that individuals were housed with another provider, or moved elsewhere with the same provider.



HARRP :

- Move-ons to other housing providers are dominated by NAASH (44, 41%) and Oasis House (26, 24%).
- Overall, average stay was 101 days, 73 days above the max target stay of 28 days, and only 21% (44 cases) were below the max target stay.

NAASH ISS:

- There are 28 recorded move-ons to other accommodation providers and other positive outcomes. The majority of these (17 or 61% of these positive move-ons) were to NAASH PRS service. The remaining 12 move-ons are spread evenly across a number of providers, and one onto Friends and Family.

NAASH PRS:

- 54 of the cohort were moved-on to other accommodation providers, with the largest number, 16 individuals, **moving into settled NPH social housing**, **10 moved into settled PRS accommodation**, alongside a number of other non-settled provision such as Oasis House (4) and Lumsdens (4) also featuring as destinations. Alongside this, 12 individuals moved to live with Friends and Family.

Current Pathway | Movement within the Pathway (5/5)

A selective sample of case studies from Housing Benefit, chosen to highlight examples of lengthy stays or multiple moves within the pathway

Case Study 1

Background
- The service user is a single male aged 55 and has been in short-term emergency accommodation since around 2013.

Support needs
- Physical health
- Mobility issues

Date of entry:
- 2013

Services / teams accessed
- In receipt of ESA IR, PIP daily living and mobility at the highest levels.

Outcomes
- Accommodation 1: Oasis House from June 2013-September 2014 (Midland Heart)
- Accommodation 2: Berkely House from November-December 2017 (NAASH)
- Accommodation 3: Back to Oasis House from January 2018-February 2022 (Midland Heart)
- Accommodation 4: Moved to a property at the end of February 2022 and currently remains there (Lumsden)

Themes:
- Multiple short-term accommodation placements
- Physical health and mobility issues
- Multiple benefits

Case Study 2

Background
- The service user is a single woman aged 43, in receipt of ESA income related. She has been in short term emergency accommodation since October 2021, she had been in Local Authority accommodation in Northampton

Support needs
- None identified

Date of entering service:
- 2021

Services / teams accessed
- Income-related Employment & Support Allowance (ESA)

Outcomes
- Accommodation 1: Oasis House from from November 2021-December 2022 (Midland Heart)
- Accommodation 2: Short-term property July 2022-September 2022 (NAASH)
- Accommodation 3: Moved to a property in early September 2022 and remains there (Keystage)

Themes:
- Multiple short-term accommodation placements
- Employment & Support Allowance

Case Study 3

Background
- The service user is a single woman aged 57 who is in receipt of basic universal credit and high-level PIP daily living

Support needs
- None identified

Date of entering service:
- 2020

Outcomes
- Accommodation 1: Short-term emergency accommodation since late January 2020 (Lumsden)

Themes:
- Short-term emergency
- Daily support allowance

Case Study 4

Tenant is a single man aged 47 who is in receipt of ESA IR and high level PIP daily care and PIP mobility)

- Accommodation 1: Supported Accommodation in Luton January 2020 to October 2021
- Accommodation 2: Keystage from October 2021 to January 2022
- Accommodation 3: Moved to Oasis House and remains there

Current Pathway | Settled Move On (1/2)

A maximum of 8% of the individuals listed on the general tracker are thought to be in settled accommodation as of March 2023.

- Of the 968 on WNC's general housing tracker, 19 are deceased and a further 98 have unknown whereabouts. Of the 851 remaining, 17 were reconnected but it is unclear where, so have been removed, leaving 834 records. A further 188 are classified as being on the "Street", though other datasets suggests the figure is lower. 646 records remain once these are excluded.
- Of these, a snapshot of the relevant current housing entries is provided:
    - 27 are "housed" in an unspecified location, where the level of risk and degree to which support is provided is unclear. This is despite 18 of these individuals have 1 or more need across alcohol, drugs, mental health, physical health, help to obtain an ID/open a bank account/apply for benefits, and financial debts support.
    - 22 are housed with family or friends: 18 of whom have 1 or more need spanning alcohol, drugs, mental health, physical health, help to obtain an ID/open a bank account/apply for benefits, housing arrears needs, and financial debts support. It is not clear whether the Friends and Family provide support for any of these identified needs, and what their individual risk level is.
    - 13 are housed in NPH, of whom 6 have 1 or more need across alcohol, drugs, mental health, physical health and help to obtain an ID/open a bank account/apply for benefits. NPH does offer support across these areas of need, and so it is likely that need is being met for those housed here.
    - 8 are housed in PRS, of whom 6 have 1 or more need across alcohol, drugs, mental health, physical health, help to obtain an ID/open a bank account/apply for benefits, housing arrears needs, and financial debts support.
    - 5 are with Adult Social Care / in Care Homes, of whom 4 have multiple needs across alcohol, drugs, mental health, physical health, and help to obtain an ID/open a bank account/apply for benefits. It is likely that the care home is able to support these individuals with this level of need.

Using this data, it appears that a maximum of 75/968 people (c.8%) are in potentially settled accommodation; evidencing move on and flow from the pathway is limited. This supports the qualitative research.

Data received from Northampton Partnership Homes shows there are only 26 current housing register applicants accommodated within the pathway and awaiting settled accommodation via the move-on route.

Current Pathway | Settled Move On (2/2)

CORE Social Housing Lettings data shows there were 54 social lettings in 2021/22 to those moving on from hostel/ rough sleeping/ supported housing

CORE Data and social housing:

- The continuous recording of lettings and sales in social housing in England, known as CORE, is a national information source that provides insights into the West Northamptonshire and National picture of new social housing tenants and the homes they rent for the year 2021 – 22
- There were 1322 social lettings in West Northants during the year. When compared to England there were less social lets to single households
- There were more lets to those within statutory temporary accommodation compared to England, however less (4.9% vs. 8.8%) to those moving on from hostels/ rough sleeping/ supported housing

Note: Data still pending from Northampton Partnership Homes

Lettings to social housing in 2021/22 (CORE data)	West Northamptonshire	England
Household Composition		
Single male	19.4%	21.8%
Single female	13.4%	15.9%
Single elder	11.8%	13.8%
Couple	3.6%	2.9%
Elder couple	2.6%	2.7%
Previous Tenure		
Any other temporary accommodation	14.9%	10.0%
Direct access hostel	0.1%	1.0%
Rough sleeping	1.3%	1.8%
Supported Housing	3.5%	6.0%
Homeless		
Yes - assessed by the LA as homeless	24.0%	16.6%
Other Homeless (not found statutorily homeless but considered to be homeless)	4.8%	8.8%
Not homeless	71.3%	74.6%
Household given Reasonable Preference by LA?		
Yes	36.0%	32.5%
No	38.6%	38.7%
Reasonable preference as Homeless	18.3%	11.7%

Introducing categories of need

The below framework for categories of housing-related support need will be used in subsequent analysis. It has been developed from standard and widely used understanding of these categories, including central government submissions

Level of need/ support	Description
No/ low	• People who are newly homeless and/or have less significant health, care or support needs • Want/ need only some support to know how to manage a tenancy. Can foresee being able to do this eventually on their own • Can be assisted through low support accommodation options, or ideally access to housing and short-term floating support i.e. met by mainstream support services in the community • A staff ratio of 1 full-time employee to 15-25 placements may be appropriate for this cohort
Medium	• People who have a significant or repeat history of rough sleeping and/or have health, care and support needs best met through supported accommodation, or ideally a housing-led placement with sufficient floating support i.e. met by mainstream support services in the community • Dealing with issues, most often addiction, and requiring support until stable • Want to manage own tenancy but recognise will need ongoing support, mainly in relation to keeping stable from drugs or alcohol, mental health, or being able to manage running their home • Would typically expect 1 full-time employee for every 8-15 medium-need placements
High/ Complex	• Long-term rough sleepers, and those requiring extensive support through supported accommodation with high-level on-site support or Housing First (ideal) • Need intensive support, likely to continue to need this indefinitely, but doesn't necessarily require 24-hour on-site provision • Typically expect 1 full-time employee for every 5-8 placements • Some of these cases can drop to being a 'medium' level of need potentially over time, for example if substance use stabilised
Very High/ Specialist	• Want and need 24-hour on-site support for the rest of their lives • Needs so complex that independent living within the community is not possible or preferable for whatever reason (safety, risk to self or others, choice), and for whom shared, supported accommodation is the preferred housing option • Likely to be a health- and/ or care-led response

Current Pathway | Existing Provision (1/2)

Units, level and types of support:

- 10 core providers: NAASH, Midland Heart (Oasis House), Keystage (HARRP Trinity), Richmond Fellowship, Changing Lives, Lumsden, Futures Housing, Langley House Trust, Bridge, Amicus. Also have NSAP/RSAP properties (Northampton Partnership Homes)
- Additional accommodation-based units for specialist user groups (C2C, Eve, NDAS)
- Circa 534 units across the core provision, with the following breakdown of support intensity (based on survey responses, nature of support and caseload of support workers)*:

Low	Low/ Med	Med	Med/ High	High/ Complex
124	296	37	37**	40
23%	55%	7%	7%	7%

*Correct as of today, rather than planned changes to the pathway

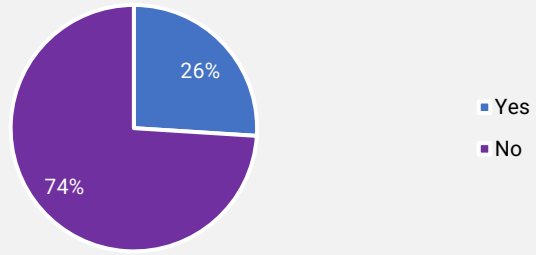
**This includes 32 Lumsden units. They have 126 units in total but estimated they accommodate 27% of our in-scope cohort. Other tenants are likely accommodated via a health/care-led response via their contracts with health and social care. Lumsden provide intensive housing management as landlords; and support is sourced as required. They have 40 independent core hour supported flats over three sites, and 86 tenants over dispersed shared housing with support delivered daily from low to high (inc. 24hr). Our analysis has assumed if they are accommodating someone via the SHP, that on average they are likely to have Med/ High needs that the other pathway providers cannot currently support

	Total Units	Properties	Low	Low/Med	Medium	Med/High	High
Oasis House	58	1	58				
HARRP Trinity	27	1					27
NAASH	192	47		192			
NAASH ISS	18	3				5	13
RSAP2 (NAASH Support)	3	3		3			
Amicus	50	10		50			
Bridge	5	2			5		
CL - Broadmead Court	11	11	11				
CL - Broadmead Court	18	1	18				
CL - Daventry	15	3	15				
CL - Dispersed	22	4	22				
Futures	9	1		9			
Langley House Trust	20	7		5			
Lumsdens	126					32	
Richmond	37	14		37			
NSAP	15	15			15		
RSAP	17	17			17		

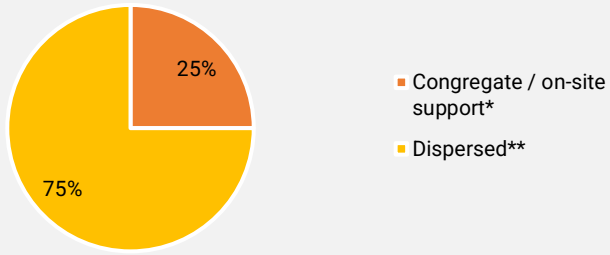
Current Pathway | Existing Provision (2/2)

- Breakdown of 534 units across the core provision:

Provision of 24-hour cover

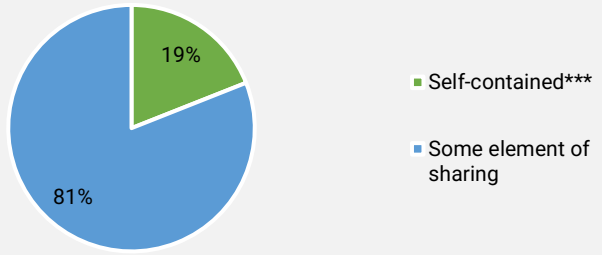


Type of support



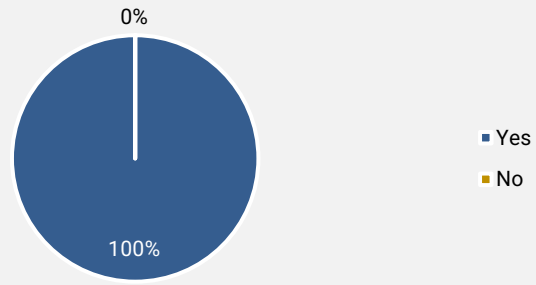
*Congregate/on-site support: >5 people at a single property sharing some facilities; **Dispersed: up to 5 people at a single property

Degrees of sharing



***Exclusive sleeping, kitchen and bathroom facilities

Support tied to accommodation



100% of support is "tied" to the accommodation address i.e. it does not follow the individual if they move out of the accommodation-based service provision/ is not provided independent of the housing

Other key features:

- Mixture of 2-years/ no maximum stay
- 5 female only rooms at HARRP trinity
- High levels of non-commissioned services
- For various reasons and pressures (e.g. mainstream housing affordability), transitional supported accommodation is the default response to single homelessness currently; regardless of support needs and suitability
- Very limited floating support provision available for a person or household within their own tenancy, and in mainstream housing i.e. where there is no need for the tenancy to end if the tenant chooses to no longer receive the support service; or it is assessed that they no longer need it
- Social housing the main/ only option for settled move-on from the pathway. Limited to no use of Private Rented Sector as a settled housing option

Additional findings from provider survey:

- *Eligibility criteria:* Many providers self-reporting no blanket exclusion policy. Where reasons for not supporting someone were shared, most common were unacceptable level of risk (4, 22%) and previous convictions for arson (3, 17%) or sexual offences (2, 11%).
- *Access:* 14 (74%) accept self-referrals, 11 (61%) referrals from partner agencies or professionals, 9 (47%) mention referrals from statutory organisations e.g. local authority, and 6 (32%) specifically mention probation services.
- *Continuity of support:* Respondents citing eviction only as a last resort, usually due to breach of licence agreement and that onward referrals are made. Majority allow individuals to "re-engage" with their service as and when they wish to.
- Main reasons for eviction and / or withdrawing support were arrears (6, 33%), abandonment/ disengagement (5, 28%), acts of violence, illegal activity, ASB, drug use and risk to other service users (all 3, 17% respectively).

Current Pathway | Met and Unmet Need (1/2)

Beyond the general category of support need, the current datasets do not expand on the more detailed nature and severity of these needs. A number of assumptions have therefore been made to arrive at high-level estimates of the current number and balance of support needs to enable comparison against the existing provision

Current Need (circa. 716 – 801)

No/ low	Medium	High/ Complex	Very High/ Specialist
300 - 340	300 - 340	106	10 - 15
40 – 45%	40 – 45%	14%	1-2%

VS.

Current Provision (circa. 534)

Low	Low/ Med	Med	Med/ High	High/ Complex
124	296	37	37	40
23%	55%	7%	7%	7%

- Page 151 outlines the calculation to arrive at total level of need
- The number of individuals with high/ complex needs is based on the target priority group and individuals currently accommodated in high intensity service provision, or waiting for it
- The estimates for very high/ specialist are based on the number of previous individuals accommodated in ASC placements and benchmarks
- The estimates for no/ low and medium are based on the analysis of overlapping support needs in Section 3 in a selection of existing providers. Due to the lack of specific assessment data, assumptions need to be made about the number of coexisting needs and therefore the overall level/ category. This has however been sense checked against similar exercises completed in other local areas

Additional unmet need identified:

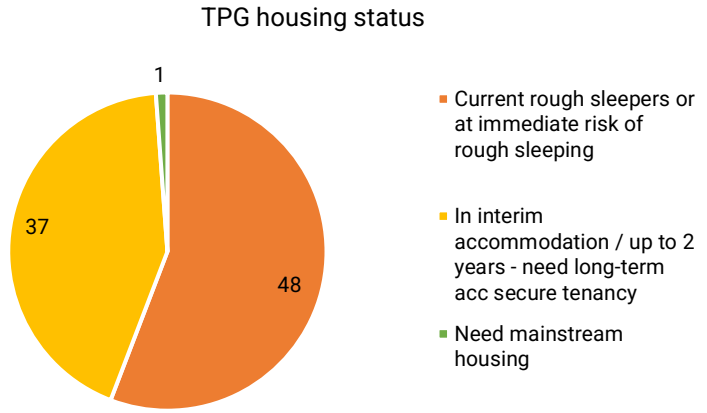
- Tailored specialist/ dedicated accommodation and support provision for women is limited but already recognised as a target area
- Lack of provision for high-risk cases from providers on the Single Homelessness Panel
- Those with “No recourse to public funds” struggle to access current “first stage” accommodation outside of Winter Provision
- Although YMCA Northants are working with NCT to create a new supported housing service for young people aged 18-25, there are a number of care leavers with complex needs relying on unsuitable TA as the right provision isn’t available currently
- Aside from the Changing Lives units in Daventry (low intensity support), there is limited provision outside of Northampton town; with those from rural areas often struggling to access the pathway

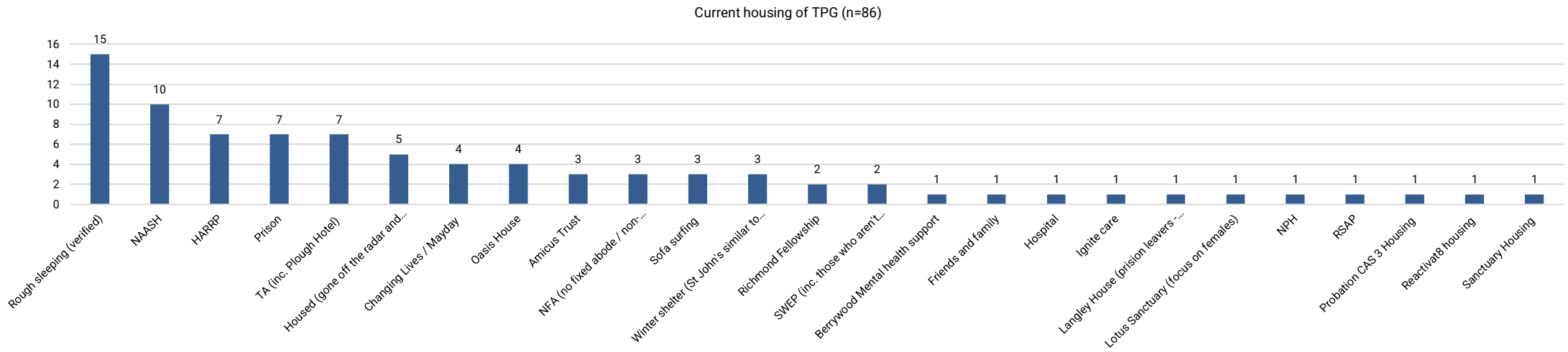
Current Pathway | Met and Unmet Need (2/2)

There are currently a lack of options and appropriate support for those with complex needs/ multiple exclusion homelessness who repeatedly fail to sustain tenancies

Target Priority Group (TPG):

- The TPG comprises of 86 people, predominantly aged 30-39 and a majority male.
- Of these, 56% are current rough sleepers or at immediate risk of sleeping rough; 43% are in interim accommodation for up to 2 years, but in need of longer-term secure accommodation tenancy; and 1% are in need of mainstream housing.
- 74% have multiple complex support needs / dual diagnosis and 91% have experienced multiple exclusion homelessness (MEH).
- Only a **maximum of 24% of this group** are currently in accommodation with the appropriate level of support for their needs
- Most are currently verified as rough sleeping (15/86; 17%) or at NAASH (12%) or HARRP (8%), as shown below.





Current Pathway | Professional Views (1/5)

Professionals engaged as part of our stakeholder interviews and focus groups highlighted areas for improvement, including but not limited to using of Service Level Agreements, earlier referral for at risk people, better service access particularly for those with complex needs, and more move on options.

Overall System

- **Limited use of SLAs** to formalise process and arrangements and ensure "everyone is on the same page" e.g. local connection and people arriving from out of area
- Individuals find themselves **having to relive and recount traumatic experiences** "over and over"
- Concerns around when **grant funding** ends for some key roles, what will happen?
- Many people are being told on the day they are being **evicted**, creating constant **revolving doors** - this pattern **fractures relationships** with people with entrenched street lifestyle

"When people get stuck - they get angry, they use more, they go back onto the streets."

"We are still seeing the same faces 4 and 5 years down the line. Something is failing somewhere!"

"They are doing the rough sleeping and the HRA. They pick up intentionally homeless cases. Come in as priority - put in a hotel - lose the priority duty - then it is main duty, then they lose. Then they put them as discretionary in a hotel."

Providers

- Need greater commitment from some providers to **refer earlier those at risk** of losing supported accommodation
- **Communication and engagement** with some housing providers has increasingly become a challenge: *"who do we contact?"*
- Concerns around **levels of support provided** in some settings and **safeguarding** issues
- View that providers are often not working in a **trauma informed** way
- Concerns with current lack of **oversight of placements** – challenging incentives around places needing to be filled increases potential unsuitability of placements
- **Updated information** about the providers and housing stock available is required to **support customers to make informed choices**
- **Local "anchor" VCSE organisations**, and their flexibility and adaptability, has been praised
- **Housing benefit subsidy loss** affecting the viability of some key provision

Current Pathway | Professional Views (2/5)

Service Access

"People often saying why they don't fit into the category, rather than do."

- Barriers reported with getting people verified as rough sleeping
- Difficulty accessing services for rural areas

Specific Groups

- **Young people coming from custody** and **people with mental health issues** have more issues in accessing longer-term, non-supported accommodation.
- **Care Leavers** – *"don't have a facility for complex cases"*. Housed in temporary accommodation but due to the high needs, **placements are failing** (21-25 year olds).
- **Women** in *"revolving cycle of TA and eviction"*. Example: A vulnerable woman entered the pathway for the first time, and then her needs, particularly related to debt, were escalated. If she had have received some floating support prior to getting to a position of high and complex need, she most likely would not have needed to enter the pathway.
- General view that there is a **lack of accountability and duty of care around groups with no recourse to public funds**.

Influx from Out of Area

- **Street Services Team** are aware of vulnerable people placed in the locality as out of area placements who have been evicted from temporary accommodation - and ended up among the population at risk of rough sleeping within West Northamptonshire.

Current Pathway | Professional Views (3/5)

Responsibilities of the Street Services Team/ Statutory Homelessness Service

"We frequently encounter cases which would constitute priority need status but, often due to multiple exclusion homelessness and historic failures by other organisations, faith in our service is already limited."

"As Outreach workers, we strive to rebuild that trust and work hard to ensure that our clients are heard and seen."

"Within the council getting a diagnosis of priority need for a rough sleeper is hard."

"Where rough sleepers are housed also baffles me, as they will put them in hotels in the middle of nowhere when pharmacy is so far away. They want to be around services they require and where they feel safe. They haven't got money for travel and are begging to make money, so money on travel is not possible. If you think about it like this, they are dependent on the drugs and alcohol, so this is the priority need for them over a travel card."

- **Single applicants** presenting through the single homelessness pathway in Northampton are **not receiving full homeless assessments** and in many cases are **not receiving a decision on why they are not in priority need**.
- **Difficulties accessing statutory rights** under housing and homelessness legislation e.g. priority need.
- Individua**ls who are eligible for temporary accommodation** find themselves at an almost instant disadvantage because **their reluctance to relive traumatic events can be viewed as unwillingness to engage**.
  - These individuals would benefit from **better communication** with the priority need and TA teams in reference to those complex cases already in TA in order to provide a support scaffold and **encourage positive engagement**.

Current Pathway | Professional Views (4/5)

Positive Interventions

"We are an incredibly proud team. We love the work we do, and we are devoted to assisting people off the streets."

- **Personalised budgets** would be a *"real gamechanger"*
- **Specific RSI roles** for rough sleepers, able to take the time and build the trust needed
- **Outreach team** – *"tenacious and committed"*, picking people up and addressing the earliest cases and in their journey. The team see people very quickly, and help them get out as soon as possible.
- Improved **multi-agency approach**
- Importance of **navigators** to support people through the process

Panel

- View from some that prior to the **COVID-19 pandemic** it *"ran seamlessly"*. It has **not fully recovered since then** and the unique role it needed to play during the pandemic response.
- Used to have **closer coordination with more of the providers** and they were only able to take referrals from the Council.
- Need for a **reinstatement of weekly in-person panels**, lasting 60-90 minutes with representatives from the various providers and other services to review all individual cases, was seen as an important way to **build back the connections** and **improve integrated working**.
- Others reported that *"in person, no one shows up"*. **Current attendance is mixed** and *"people have tried to reduce and rush this process"*.
- Council officers complete the housing panel referrals, but **clients** are **asked by some providers** ***"for information over and over again"***.

Need for Consistent Assessment Hub/ Direct Access Emergency Provision

"St John's remaining open for a longer term, or having a similar direct access service, would be a tremendous tool in assisting those experiencing homelessness, rough sleeping and multiple exclusion homelessness."

- **Limited direct access** to services when not using winter provision – *"somewhere to coordinate support and next steps"* would be beneficial
- Having the **round-the-clock accommodation** has proved **valuable** in facilitating a variety of needs assessments, including care needs and substance misuse.
- Had a "No Second Night Out" service some years ago and HARRP has been unable to operate as short-stay provision.

Current Pathway | Professional Views (5/5)

Need for Housing-led interventions

"We have seen a good degree of progress by offering accommodation first and then accessing additional support services."

"Fastest results you've ever seen."

"If we can get them housed quicker, we can organise pick ups for medication and get them better quicker."

- **RSAP and NSAP provision viewed positively**, with people going straight into properties – *"these schemes can be hugely successful with the right level of support and a realistic approach to expectation"*.
- Services can support but **people need a consistent place to stay**, where that support can administered, but **current provisions** are **not long enough**.
- Reported that **less complex individuals** might **have more options**, are **more attractive to housing** providers, and they can **take up valuable space** within supported accommodation.

Move on and ongoing support

"PRS is not an option."

"There isn't that long-term, supported accommodation that people need."

"When people move on the case is closed and there isn't a lot of support"

"'A cog missing in Northamptonshire around moving people on to permanent accommodation or supported accommodation for longer-term support needs."

- **Issue of bed blocking with people ready to move on**, move on pathway (or lack of it) - *"one of the biggest issues"*
- View that people are *"left to it"* when moved on, with **limited resettlement and floating support**. **Re-presentations** for some an inevitability.
- The reality is that for many, they move **from one short-term placement to another**.
- View that there is no point putting people into supported housing if there is no move-on pathway.

Current Pathway | Service User Views (1/5)

Service users engaged as part of our stakeholder interviews and focus groups highlighted areas for improvement, including but not limited to providing better access to all levels of need, better support to access and engage with services, more support from housing providers, and much more robust care for those with no local connection.

Reaching out and getting help

- Most people interviewed had sought support from the council Housing Options since their current experience of rough sleeping / homelessness.
  - Of those, **most were told that they did not have priority needs** and therefore that the council did not have a duty to offer them temporary accommodation.
  - The topic of **'priority need'** was highlighted as an issue and sparked heated conversations in the focus group as **participants often felt they had been misjudged as not being *"vulnerable enough"***.
- Most participants had had **contact with a street Outreach worker** since they had been rough sleeping and most felt that the support they received was **helpful**.
  - Generally, feedback on their support was quite positive with participants often using terms to describe outreach team staff as ***"knowledgeable"***, ***"*professional"** and **"dedicated"**.
  - However, **lack of updates** on their cases and **lack of transparency** in the process were mentioned as problematic. Most participants also felt that, whilst supportive, the outreach team had **limited power on improving their situations**.
- Most participants agreed that a myriad of barriers made them **feel like they had to fit a certain "vulnerable" mould to access support**. It was noted that services were so sparse and the threshold so high that even when people were in dire need, they feel like they need to exaggerate to get any support.
- **Participants with no local connection** were **unclear of the help they could get** (if any) and on how to build a local connection

Current Pathway | Service User Views (2/5)

Accessing the pathway

"As a women, when I sleep in the street, I am worried for my physical integrity. It's rough out there. So I hide! Green sleeping bag under a green bush.. How do you want to outreach team to find me?'"

"Because I slept in my car, they said they could not identify me."

"I don't get it. It's like all the support workers from different services know each other so we are being passed around and they play with us: let's support this one but not this one! I know they want to help most of us, but I don't understand the criteria in terms of priority. I have been sleeping in the street for months and months and I really had to insist to get a place here [at HAARP]. Others get in straight away. Why? His outreach worker is nicer than mine? Did he pay money?"

- Issues around **rough sleeping identification** were mentioned multiple times by participants.
- From discussions with participants, it is unclear how the decision (eligibility and priority criteria) to accommodate individuals within HAARP Trinity is made.
  - **Some participants** testified having **moved quite quickly** (a few days) from the street to the assessment centre, whilst **others testified having had to wait for months**. These individuals were **sharing similar support needs**. Participants also reported the lack of transparency on eligibility and priority criteria to entering the pathway / accessing initial accommodation support.
- Participants currently accommodated within the assessment centre recalled what they had to go through in order to access accommodation support.
  - Overall, all of them either had an **advocate outside of the council** to assist them in getting support or **had to "heavily insist"**. A number were **referred by S2S and health services**, one through their Probation Officer, one slept on the front steps of the council office for 3 months, and another "walked his support to work every morning and every night".
- Participants highlighted a **need for support to be able to effectively engage them**, particularly **at times of crisis** when it can be **difficult to deal with the assessment process and know your rights**.

Current Pathway | Service User Views (3/5)

Assessment centre – Keystage / HAARP Trinity House

"I was impressed how they were able to link me with support services so quickly. I have been clean since I got here and I never could have done it in the street and without support."

- Interviewees were **overwhelmingly positive** about the support received from staff at Trinity House, once they enter the pathway.
  - Almost all commented on the **thoroughness of the initial assessment** and **how efficient the staff were** in creating a good base from which progress can be made: **registering to the GP**, **connecting with specialist support services** etc.
- Participants described the centre as a **good transition place** from the street to a more permanent accommodation base.
- **Length of stay varied** from a participant to another and seem to **depend on clients' readiness and availability of move-on support housing options**.

Supported accommodation

"Once I got a room in the shared house, I felt like all the support I received stopped in one go. I was further away from the town centre, my friends, and no one was checking on me. I didn't get on well with the house mates. I could not do it and started using [drugs] again until I was evicted (….) drug dealers came to the house and that was it (…) back to the street."

"I think sometimes they are not clever, they put alcoholic and drug addict with people that just got clean. It can't work!"

- A number of participants were familiar of the rough sleeping pathway, having been through it and returned to the street after eviction from supported accommodation or abandonment of tenancy.
  - **Eviction reasons** included: **drug use**, **disagreement** with neighbours/housemates and **anti-social behaviour**.
  - A number of participants testified having been evicted from Oasis House in the past.
- When prompted about quality of services in supported accommodation, participants mentioned the **lack of support** provided by the housing providers and the somewhat **difficult mix of people** created in supported shared accommodations.

Current Pathway | Service User Views (4/5)

People with no local connection

"They check in on me and I can go to them if I have a big problem."

"I know I can't get helped being housed for 3 years."

"They came once and they told me to go to the Hope Centre."

"I have to prove that I have been sleeping in the street for three months and then they will help me."

"Apparently I have to be in Northampton for more than 6 months to be considered as 'having a local connection'."

- Participants included 3 people with no local connection(s) and who have been sleeping rough in Northampton for 2 to 5 months. All mentioned having been in contact with the outreach team and two said that the contact was regular. However, none said that they had an assessment.
- Participants were **all unclear regarding their status**, **what they are eligible to** and the **length of stay** they need to reach to get support from Northampton Council and local services.

"The point is they don't send people back to Birmingham and London, they just help them here. But with me, because my local council is next door, they're refusing to help me […] if I'm 100 miles away or 20 miles away, what's the difference?"

"If you are a drug addict, even with no local connection, they would help you. It makes you think I should just go out there and come back and say yeah I'm addicted to alcohol and drug then I know that I will then get the help. But I'm not like that, I'm truthful."

- Participants all estimated that they had a good reason for being in Northampton and for not going where they have a local connection.
  - One person explained that his local council was an adjoining council to Northampton but that he needed a clear break away from the small town they grew up in.
  - Another explained that he had been living in Northampton for a few years 3 years ago and had to come back due to relationship breakdown and work related reasons.
  - **All felt that the 'local connection rule' was inflexible and unfair**. They also felt that it was **not transparent and inequal**.
  - Two participants, separately, shared they were **aware of people with no local connection having received support** due to being *"higher need"*.

Current Pathway | Service User Views (5/5)

People with no local connection, continued

"They knew I was homeless, and they knew where I was, but they didn't come and see me or anything. No one came and check on me once during that bad weather. Not once […] they know you're there. They know I'm a person like anyone else.(…) I know I can't get helped being housed for 3 years, I accept that. That's ok, that's my problem. I've got to work around that. I think things should change a bit on that - but when it comes to being freezing cold and SWEP I think everybody should have the equal opportunities and that's not how the council works it."

- When prompted if they have had **access to SWEP accommodation in colder days**, **none of them recalled having had access**.
  - A participant described being **refused accommodation during SWEP due to his lack of local connection**.

Reshaping the Pathway | Case for Change

- There is **strong operational and multi-agency support** taking place at an individual level within the pathway, and this should be recognised and successes celebrated.
- The current supported accommodation system is supporting some people out of homelessness and into more settled housing; but these constitute a significant minority (a maximum of 8% since January 2021). It is **not functioning as a coherent and effective response system** that follows "what works" to sustainably end people's homelessness. There is therefore a **need to reshape the current single homelessness pathway**.
- Alongside this, there is **significant unmet need and key gaps in the current provision**; with reliance on a select group of supportive and collaborative providers.
- A **number of providers are not Registered Providers**, causing issues with housing benefit subsidy loss and threatening the ongoing viability of key elements of the current provision.
- As seen nationally, there has been a **steady increase in Supported Exempt Accommodation**. This is **linked to the lack of wider oversight of the accommodation and support provided** across the 500+ units, and central coordination of everyone that is placed and accommodated within the pathway.
- There have been some small movements to a more housing-led response, the shift away from night shelter provision prompted by the pandemic and the NSAP/ RSAP properties. However, the **"treatment first" philosophy is still prevalent**, alongside **language around "tenancy/ housing readiness"**.
- The ongoing review of the statutory service found that **single applicants presenting through the single homelessness pathway are not receiving full homeless assessments** and in many cases are not receiving a decision on why they are not in priority need. Adjusting accountabilities so the Street Services Team have more capacity to focus on the cases with the highest need and prevention work for this cohort would be beneficial.
- Work to **access the private rented sector for settled move on** from the pathway is **underdeveloped**, leaving social housing as the sole move on route which has its own access issues.
- It was reported in the focus groups that there are a **limited number of Service Level Agreements (SLAs)** in place currently and that the pathway would benefit from these and other operational policies and frameworks that everyone should be expected to sign up to and follow. This would also facilitate the **transparency for service users on how the pathway works** and what they can expect.
- Finally, the **level and richness of data on the pathway and its performance has significantly improved** since January 2021. The need for a **dedicated case management system** is widely acknowledged to support operational staff, strategic roles and partners going forward.

Reshaping the Pathway | Target Future State

- West Northants should **work towards a clear local pathway into settled accommodation** that includes **rapid assessment of need and eligibility**, **rapid rehousing into an appropriate settled home,** and **referral into long- or short-term support services**, where needed.
- This should include a **longer term / general direction of travel away from shared, supported accommodation**. This is especially relevant for people with low or no support needs as it is not an outcome- or cost-effective form of accommodation.

Common Goal + Data-Led Framework (Centre for Homelessness Impact/ DLUHC)

'Rough sleeping is ended if it is prevented or is otherwise rare, brief and non-recurring'

Prevent
P.1 – Number of new people sleeping out (an absolute figure, as a rate per 100,000 population, a proportion of all people sleeping rough)
P.2 – People discharged from institutions with no settled accommodation identified

Rare
R.1 – The number of people sleeping out on a single night, expressed as: an absolute figure, as a rate per 100,000 population

Brief
B.1 – The length of time between the first time someone is identified sleeping rough and moving into 'off the streets' accommodation
B.2 – The length of time between a person's first contact with outreach services and moving into 'long-term' accommodation

Non-Recurring
NR.1 – The number of 'returners' of people seen sleeping out again after being successfully supported into accommodation, expressed as: an absolute number, a proportion of the number of people who are successfully supported into accommodation
NR.2 – The number of people experiencing 'long-term' rough sleeping (an absolute figure, as a rate per 100,000 population, a proportion of all people sleeping rough)

Provision and accessibility of affordable permanent housing stock for people experiencing homelessness
Targets (permanent mainstream housing) informed by evidence on the scale of homelessness and included in strategic housing market assessment (SHMA). All registered providers of mainstream social housing set an annual guideline target for the minimum proportion of social lettings to homeless nominees; and report on their performance providing settled homes for homeless people

Housing-Led Principles and Whole System Approach

1. People have a right to a home
2. Flexible support is provided for as long as it is needed
3. Housing and support are separated
4. Individuals have choice and control
5. The service is based on people's strengths, goals and aspirations
6. An active engagement approach is used
7. A harm reduction approach is used

These should provide the shared framework and understanding of 'quality'.

Features (Following the evidence of what works)

Continuation of Current Features

- Assertive Outreach Service
- Navigators
- Personalised Budgets
- Targeted interventions at key transition points (e.g. institutional discharge, leaving care etc.)

Amending of Current Features

- Rapid Assessment/ Somewhere Safe to Stay Hub
- Move On Provision
- Reconnection
- Prevention
- Short Term/ Transitional Supported Accommodation
- Long term/ Mainstream Supported Accommodation
- Supported Lettings/ Floating Support
- Data System & Sharing

New Features

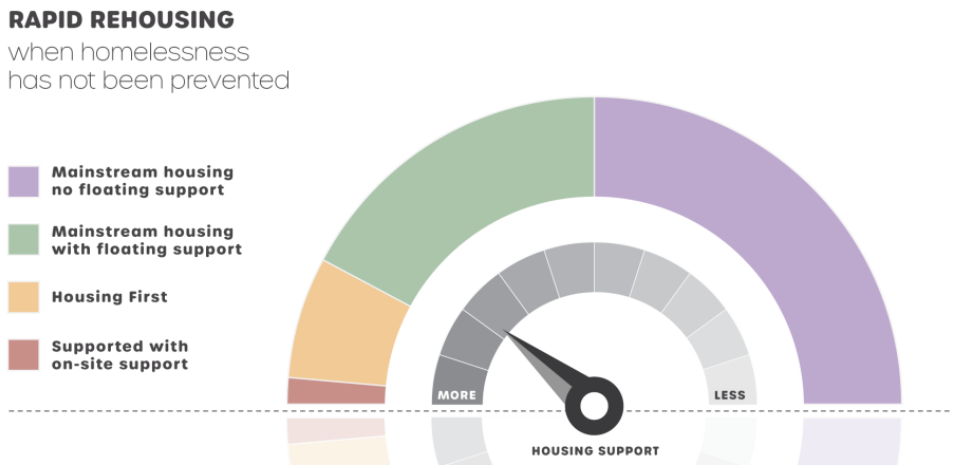
- PRS Access
- Housing First

Reshaping the Pathway | Features

Continuation of current features	Amending of current features	New features
• **Assertive Outreach Service** • **Navigators** • **Personalised Budgets** • **Targeted interventions** ~ at key transition points (e.g. institutional discharge, leaving care etc.)	• **Rapid Assessment / Somewhere Safe to Stay Hub** ~ safe emergency environment away from the street which is open and staffed 24 hours a day, 7 days a week, to anyone who is identified and referred as being at imminent risk (within 24 hours of) or already rough sleeping. Short stay (target 72 hours) with multi-agency coordination. • **Move On Provision** ~ More suitable, consistent, swift and measurable approach to accessing mainstream housing • **Reconnection** ~ The provision of sufficiently intensive and tailored support is a critical ingredient in any successful reconnection e.g. if local connection barriers remain • **Prevention** ~ Free up capacity for more targeted emergency prevention work, identifying the predictable routes people may take in being at risk of or experiencing rough sleeping and identifying them early. Can also utilise floating support services for prevention and better tracking of individuals with the new case management system (see below) • **Short Term/ Transitional Supported Accommodation** ~ initial reprofiling of current units to match current need, prioritising self-contained options over shared or congregate. Over time, a phased transition to housing-led models of support (floating support in mainstream housing) and away from hostels, B&B, and other similar models of shared and supported temporary accommodation. Potential conversion of existing stock to settled supply or long-term specialist supported accommodation. Can retain required amount of high quality, short stay and move-on focussed transitional accommodation whilst people are waiting for a permanent move e.g. waiting for accommodation whilst supported by Housing First service • **Mainstream supported housing with care and support on site** ~ supported housing as a settled housing option for a small number of people who don't want and/or can't sustain a mainstream tenancy, including with Housing First support. Most likely a health and social care led response. Ideally a relatively small 'core and 'cluster' model of self-contained units with communal on-site support • **Supported Lettings/ Floating Support** ~ Range from basic to intensive for people with low/ medium level of need; not tied to accommodation. Alongside swift access to settled housing, will help sustain tenancies in mainstream, self-contained housing • **Data System & Sharing** ~ tool to promote and facilitate shared accountability for case management. Individuals can be tracked through the system, and at system level, flows of people into and out of homelessness can be monitored – this creates the possibility for system-wide performance indicators	• **PRS Access** ~ dedicated staff resource to source accommodation and appropriate landlord offer and liaison. Potential need for social/ local lettings agency • **Housing First** ~ Housing First is rolled out as the default option for homeless adults with complex needs

Reshaping the Pathway | Housing-Led & Whole System Approach

- For people that experience homelessness and have support needs, **"Rapid Rehousing"** or **"Housing-Led"** means **to resettle people in mainstream housing as quickly as possible, with the floating support they need to make it work**. The approach **seeks to minimise the amount of time spent in temporary accommodation and the number of transitions** a person has to make before they move into a permanent home.
    - Within this group, there are a smaller number of people that need intensive floating and 'wrap around' support, as provided by the Housing First approach. And a smaller number of people that need a different housing option, with support on-site.
- Research indicates that the **Housing First approach** is **most cost-effective for individuals experiencing multiple disadvantages**. These are individuals with long or repeated histories of homelessness and other multiple, often interconnected, needs. Individuals are likely to have had repeat contact with services who have found it difficult to engage and support them effectively. Many Housing First projects have started with just ten individuals in the first year. The only condition placed on the individual is a **willingness to sustain a tenancy**. There is no requirement that they demonstrate a 'good' housing history or meet any 'tenancy ready' requirements, as long as they are willing to try.
    - Only a relatively small number of single people experiencing homelessness need Housing First; however, a **housing-led approach** recognises that the principles underlying the Housing First model can and **should benefit all those who are experiencing or at risk of homelessness**.
    - Housing-led is a **whole system approach**, which seeks to **apply the principles of Housing First model** to all those experiencing or at risk of homelessness



Source: Policy Position. The future role of supported housing to prevent and respond to homelessness in Scotland (2021)

Reshaping the Pathway | Principles

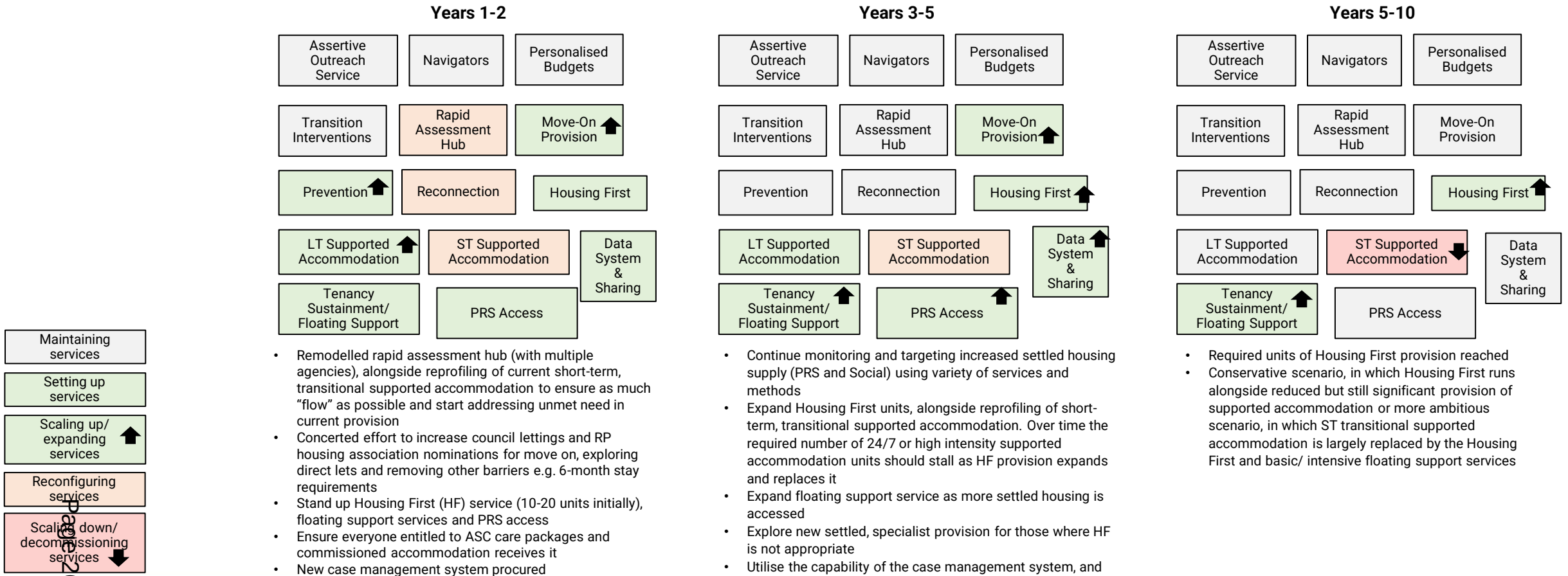
The following table suggests what it might mean to apply each of the Housing First principles to the whole homelessness system

People have a right to a home	Bolstering the supply of affordable housing options and keeping any evictions to an absolute minimum. Removing the conditionality from the system, e.g. so people do not have to first prove they are tenancy ready, thereby earning the right to a home. The system views housing as a human right.
Flexible support is provided for as long as it is needed	Our need for support naturally fluctuates; it is almost impossible to predict exactly how much support an individual will need, around which issues and for how long. Yet support for those experiencing homelessness tends to be commissioned in time-limited blocks; some people experience 'cliff-edges' where support suddenly ends, some may be over-supported at times. Instead, a housing-led system allows for support to flex around a person in their own home when they need it.
Housing and support are separated	This separation means that the housing offer is not dependent on the support offer; so if the support comes to an end, the person does not have to move. Conversely, a person does not have to move into a buildings-based project in order to access support; and the support relationship can stay with a person where they want or need to move. Separating the support from the landlord function can also help to clarify the role of different workers, thereby building better relationships
Individuals have choice and control	Choice is often designed out of the service response to single homeless people: people are 'placed', 'sent', 'signposted' and, if very lucky, 'housed'. Research suggests that increasing a person's sense of choice and control improves their outcomes, and that services are less effective when they are "done to people". Instead, a housing-led system treats people experiencing homelessness as adults and citizens.
The service is based on people's strengths, goals and aspirations	Seeing the person as a survivor, as an individual, as a person, rather than a problem to be managed, and recognising that everyone has strengths. In a housing-led approach, we move from assessments which focus on risks, needs and eligibility to more creative assessments which recognise the strengths, resources and relationships the person brings to the situation and works with them to consider how they can build on these
An active engagement approach is used	Recognising that services are often 'hard-to-reach', and that closing the case of a person who is experiencing homelessness, substance use or mental health challenges because they behave in a way we find challenging is often counter-productive. Instead, professionals are responsible for proactively engaging their clients; making the service fit the individual instead of trying to make the individual fit the service.
A harm reduction approach is used	Recognising that abstinence from substance use and other potentially harmful behaviours is not desirable and/or realistic for many at this point in time, and that these individuals may disengage if pressured into abstinence by professionals. Instead, workers support individuals to set their own goals and develop their own strategies to manage risk. A housing-led approach recognises the harm that comes from all forms of homelessness (especially rough sleeping) and seeks to reduce this by avoiding homelessness or by supporting a person to exit homelessness as quickly as possible.

Source: Blood et al (2020) Housing-led Feasibility Study for Oxfordshire

Reshaping the Pathway | Transition

A high-level route to transition to the new pathway, progressively meeting the housing-led principles and reprofiling the existing provision



- Remodelled rapid assessment hub (with multiple agencies), alongside reprofiling of current short-term, transitional supported accommodation to ensure as much "flow" as possible and start addressing unmet need in current provision
- Concerted effort to increase council lettings and RP housing association nominations for move on, exploring direct lets and removing other barriers e.g. 6-month stay requirements
- Stand up Housing First (HF) service (10-20 units initially), floating support services and PRS access
- Ensure everyone entitled to ASC care packages and commissioned accommodation receives it
- New case management system procured

- Continue monitoring and targeting increased settled housing supply (PRS and Social) using variety of services and methods
- Expand Housing First units, alongside reprofiling of short-term, transitional supported accommodation. Over time the required number of 24/7 or high intensity supported accommodation units should stall as HF provision expands and replaces it
- Expand floating support service as more settled housing is accessed
- Explore new settled, specialist provision for those where HF is not appropriate
- Utilise the capability of the case management system, and start to develop system wide performance data

- Required units of Housing First provision reached
- Conservative scenario, in which Housing First runs alongside reduced but still significant provision of supported accommodation or more ambitious scenario, in which ST transitional supported accommodation is largely replaced by the Housing First and basic/ intensive floating support services

West Northamptonshire Council

7. Cost effectiveness

Summary of current evidence: cost effectiveness (1/5)

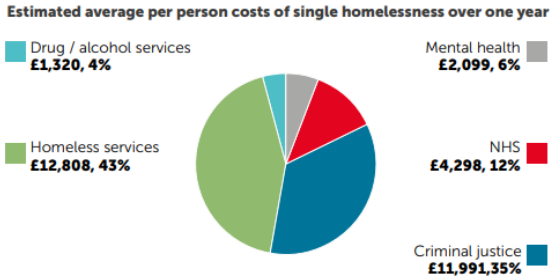
There is an economic imperative to tackle homelessness and the costs of homelessness to society are significant

Prevention is better than cure

The report by Pleace and Culhane (2016), published by Crisis, estimated the total public sector costs of a person experiencing homelessness to be as much as £38,736 per year in England (based on 2019/20 prices). By comparison, the average estimated cost of the preventative services that homeless people said would have stopped their homelessness was £2,263 per person. **On average, it was estimated that preventing homelessness for 1 year would reduce the public expenditure by approximately £10,000 per person**. The pie chart shows where the costs of single homelessness typically fall and hence where the savings might accrue from successful prevention. Given the financial implications of homelessness to society and the far worse health and social care outcomes, most interventions that address homelessness are likely to be cost effective (or even cost saving) from the wider public sector perspective.

Whilst there are significant potential savings for health and criminal justice services, it should be noted that the greatest savings accrue from a reduction in spend on homelessness services themselves. If the funds currently being invested in the system can be used to secure an exit from homelessness into stable housing for more people, it follows that significant savings can be generated for criminal justice, NHS and local authority spending. The negative impact of homelessness on individuals' and public health, and on NHS expenditure has been well documented. For example (and as noted previously):

- Homeless populations experience extreme health inequalities and high levels of mortality and morbidity, particularly in relation to: infections, mental health, cardiovascular and respiratory conditions
- Attendance at accident and emergency by rough sleepers is at least eight times higher than the housed population
- Even being homeless for a short period of time increases long term health risks
- Homeless people have higher rates of hospital admissions and also have longer stays (2 days longer for acute admissions) once admitted than the general population
- Rough sleepers are vulnerable to high levels of abuse and attack, which may result in physical injury and can also lead to anxiety, fear and trauma



Source: Pleace and Culhane (2016)

Summary of current evidence: cost effectiveness (2/5)

Prevention is better than cure (cont.)

There are also clear links between homelessness and the criminal justice system:

- Many prisoners face homelessness on release; meanwhile a lack of accommodation increases the risk of reoffending
- People with no fixed abode are more likely to be remanded in custody or to face custodial rather than community sentences; there has been a sharp increase in the proportion of women sentenced to custodial sentences who are homeless
- Those experiencing homelessness may face enforcement for activities such as begging or street drinking

The longer someone is homeless, the more they will cost the taxpayer. The costs to public services do not end just because a person is in stable housing, however there are cost off-sets for all sectors where people are successfully rehoused. For example,

- For local authorities, a reduction in homelessness presentations, and a decline in spending on housing and support offers that prove ineffective
- For the NHS, there is an increase in planned and preventative use of healthcare, instead of emergency presentations, ambulance call-outs and avoidable admissions
- For the criminal justice system, there is a reduction in repeat offending, short term custodial sentences and frequent arrest/ overnight detention.

NICE Guideline NG214: Integrated health and social care for people experiencing homelessness

- **Economic analysis suggests that reducing caseloads (and thus increasing time spent with clients) for practitioners working with people experiencing homelessness could be cost effective.** Longer contact time is likely to improve engagement with services, help build a trusted relationship and ultimately lead to improved outcomes and sustained recovery. There would also be likely benefits from improved staff satisfaction and retention, and continuity of care. The guideline committee made a research recommendation to better understand the effectiveness and cost effectiveness of longer health and social care contacts for people experiencing homelessness
- **Involving peers in delivering care or support and co-designing services** is already happening in some areas and organisations, particularly in the voluntary and charity sector. It will involve costs in terms of training and support for peers and potential incentives or remunerations; however, **involving peers can reduce pressure on practitioners and therefore result in cost savings**. Evidence on a London-based outreach service to screen vulnerable people for hepatitis C and offer peer support for getting treatment in secondary care was shown to be cost effective
- **Intermediate care** is a multidisciplinary service that helps people to be as independent as possible and provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. **Evidence from several economic studies suggested that it is cost effective and potentially cost saving.** The committee agreed that providing such services would help avoid hospital admissions and ensure safe and timely discharge from hospital and transition to the community. Intermediate care can also prevent or shorten expensive inpatient care and provide appropriate care and support to people in need of more intense support than otherwise provided in the community

Summary of current evidence: cost effectiveness (3/5)

Intermediate Care

In a recent study, Tinelli et al (2022) investigated the cost-effectiveness of three different 'in patient care coordination and discharge planning' configurations for adults experiencing homelessness who are discharged from hospitals in England. As stated in Section 3, compared to people who are not homeless, those experiencing homelessness are likely to be discharged back onto the street, attend Accident and Emergency (A&E) departments six times more frequently, be admitted three times more frequently, stay in hospital three times longer and have unscheduled hospital care eight times more frequently. There are long-standing concerns that people experiencing homelessness may not recover well if left unsupported after a hospital stay. The three configurations in the study were each compared with 'standard care' (defined as one visit by the homelessness health nurse before discharge during which patients received an information leaflet on local services). Findings were complex across the configurations, but, on the whole, there was promising evidence suggesting that specialist homeless hospital discharge schemes are potentially more effective and cost-effective than 'standard care'. Homeless hospital discharge schemes providing access to specialist intermediate care (step-down beds) appear more cost-effective than schemes with no access to intermediate care.

Economic impact of closing the gaps in responses to homelessness and self-neglect

As part of Kings College London's "Strengthening Adult Safeguarding responses to homelessness and self-neglect" study (2023), economic analysis was completed to understand the full costs of the "unmet needs" scenarios leading to harm and/ or death and the subsequent Safeguarding Adults Reviews; comparing these to a "met needs" scenario in the preceding year. When considering the resources to be invested to keep people safe and meet their needs in the last 12 months of the SAR case stories, they found a shift from urgent and emergency care to planned, multidisciplinary and recovery care can be cost saving. Both appropriate and timely (preventative) care are needed. Delayed care is associated with worse health outcomes and higher costs to the system.

Crisis Plan to End Homelessness (2018)

Crisis commissioned PwC to estimate the expected costs and benefits of achieving its plan through different combinations of interventions (solutions) which Crisis has identified are necessary to address and prevent homelessness. Four different categories of benefits that potentially arise from ending homelessness were considered:

- Avoided costs to local authorities through reduced use of homelessness services (e.g. reduced need for spending on temporary accommodation and other housing and support based services for homeless people funded by local authorities)
- Avoided costs to the Exchequer through reduced use of public services such as NHS or criminal justice services
- Increased earnings from increasing the number of people able to work
- Improved wellbeing as a result of homeless people obtaining secure housing

In summary, in present value terms, for every £1 that will be invested in the solutions recommended to achieve Crisis's definition of "ending homelessness", it is estimated that £2.8 will be generated in benefits – this includes cashable savings and wellbeing value. This is an overall benefit-cost ratio of 2.8.

Summary of current evidence: cost effectiveness (4/5)

Housing First

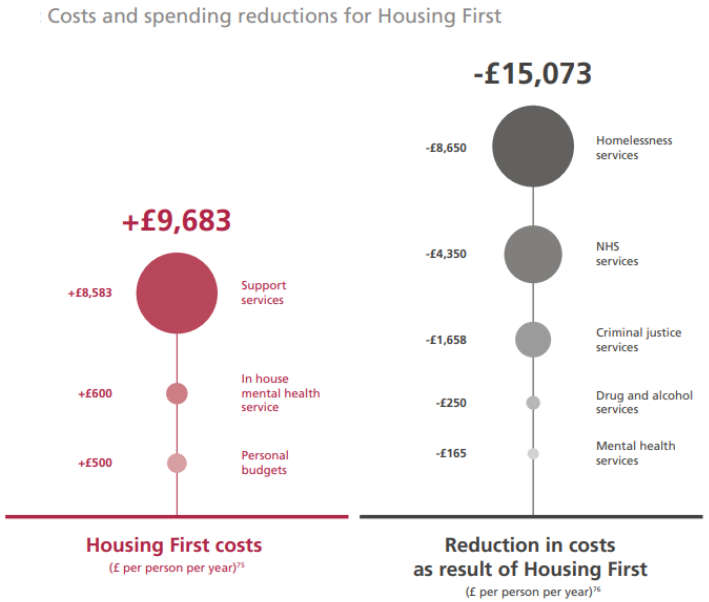
As well as proving a more effective intervention, an additional argument advanced in favour of Housing First is that it is a more cost-effective solution; reducing the financial costs of homelessness to society by reducing long term and repeated homelessness. Using lifetime costs (the total financial costs of a long term or recurrently homeless individual to society during their life) makes the potential savings that a Housing First service might make clearer and shows a cost benefit.

Housing First is not itself low cost, the greatest potential to generate offsets arises when Housing First is focused on people with high support needs who are frequent users of other homelessness services and health services and/or who have frequent contact with the criminal justice system. Where £9,700 is spent on supporting a Housing First client, the taxpayer saves £15,100 (see diagram) i.e. for every £1 spent on Housing First, £1.56 is saved (Centre for Social Justice, 2021).

A York University evaluation (Bretherton & Pleace, 2015) compared the costs of Housing First (£26-40 per hour) to other support options of varying intensities, with the biggest savings found where the approach is compared to high intensity supported housing:

- Scenario 1: Within a year, an individual has contact with an outreach team and then moves into a high support hostel before being resettled and provided with floating support. The cost savings of providing an individual with Housing First instead is estimated at £3048 – £4794
- Scenario 2: An individual is housed and remains in a high intensity supported housing placement for 18 months. If instead they were offered Housing First, the estimated savings are £16,380-19,656.

A report building on this (Pleace, 2019) explored the cost effectiveness of Housing First, drawing on the results of anonymous surveys of 15 Housing First services in England, local authority service commissioners and a group of 29 Housing First service users. It found Housing First tends to cost less than fixed-site services, such as hostels and high intensity temporary supported housing. In part, this is because the level of support Housing First provides to service users tends to fall over time, which means Housing First services can redeploy resources, whereas fixed-site services tend to also have fixed costs. Housing First also tends to have lower daily support costs than fixed-site services. When Housing First is providing 'peak' levels of support during the first month of service use, it still has lower average support costs than fixed-site services.



Source: Centre for Social Justice (2021)

Summary of current evidence: cost effectiveness (5/5)

Housing First (continued)

Housing First can be highly effective and reduce costs for local authorities and homelessness service providers because it often works well for homeless people who are "frequent flyers" in fixed-site services, i.e. people with high and complex needs who make frequent, or long-term, use of existing services, but who cannot exit homelessness on a sustained basis. By providing a way to meet the needs of frequent flyers who become stuck in fixed-site services, Housing First can help reduce long-term and repeated homelessness and the costs associated with it.

NHS emergency service use, including A&E departments and mental health services, can be associated with the "frequent flyer" homeless people with high and complex needs. By ending this form of homelessness Housing First may reduce NHS costs. emerging evidence also indicates Housing First can significantly reduce offending behaviour and contact with the criminal justice system. While only some homeless people with high and complex needs have contact with the Police and Courts, the costs of this contact are very high, indicating real potential for cost offsets (i.e. savings for the criminal justice system due to Housing First).

Housing First will sometimes increase costs, in cases where someone should have been receiving treatment and support, has not accessed any services while homeless, and is connected to the treatment and services they need once they start using Housing First. Using unit costs, the report provides an illustrative example of the annual healthcare, support and criminal justice costs of long term and repeat homelessness (see table). If it is assumed that due to contact with Housing First the same person is not taken to hospital as an emergency admission, but instead sees a GP for an hour in total and attends four outpatient appointments, is not arrested and does not, because they are housed, use supported housing, there is the potential for savings of £17,000 - £20,000 depending on the cost of the Housing First service.

In summary, the greatest potential for cost offsets seems to be in reducing "frequent flyer" contact with homelessness services that are unable to provide an exit from homelessness and significantly reducing contact with the criminal justice system. There is some potential for improving costs and outcomes for the NHS.

Illustrative One-Year Financial Costs of Long-Term and Repeat Homelessness

Seen by ambulance crew and taken to hospital (twice)[1]	£466
Non-elective long stay[1]	£2,716
Outpatient appointments (missed)[1]	£436
Arrested and prosecuted for shoplifting twice[2]	£7,000
Imprisoned for two months[2]	£5,460
Stays in low intensity supported housing for three months (support costs)[3]	£1,274
Stays in high intensity supported housing for five months (support costs)[3]	£7,260
Total	£24,612

Source: Bretherton & Pleace (2015)

Reshaping the single homelessness pathway: estimating existing need

In order to assess the likely cost of reshaping the single homelessness pathway as outlined in Section 6, it is necessary to understand the scale of additional support needed, the cost of providing this support, and how this compares to the costs of current support provision received by those whose support offering would differ under the reshaped provision. In this section we provide estimates of these costs, although these should be taken as indicative rather than precise, given there is uncertainty over how future need will arise and the fact that support should be designed to be flexible to the needs of the individuals who need it.

In order to identify the scale of additional support needed we have first identified existing need for a settled accommodation solution. This has been identified on the basis of:

- starting with the 958 unique individuals listed on the street services general tracker
- removing those deceased or assumed to be in stable housing based on current entry
- removing those with "unknown" current housing status, the vast majority of which have very few recent updates
- reviewing the 192 records with "street" as current housing status. Only 93 of these have been updated since September 2022, so we have removed the other 99

This leaves 661 individuals. However, we know there are roughly an additional 100 individuals accommodated in one of the Single Homeless Pathway's "non-core" providers that aren't listed on the tracker (assuming full capacity). As six months' residence in the area during the past 12 months is required to establish a local connection, we have assumed these individuals will have done this and have therefore included them in the scope of this analysis.

Taking these together, we have identified 761 individuals with a current need for settled accommodation. This is for our in-scope cohort and therefore excludes other forms of homelessness e.g. most statutory homeless households.

Not all of these individuals will require the same support; this will depend on their support needs and the length of time that they have been homeless. In this model, we consider a scenario in which West Northants offers five broad categories of support: (i) housing first; (ii) long term congregate housing with housing first-style support; (iii) intensive floating support; (iv) basic floating support; and (v) transitional supported accommodation. We have also estimated the number that just have a need for accommodation (i.e. no support) but are currently waiting in the pathway.

In order to identify the level of need for each of these types of support, as outlined in Section 6 we have used data on support needs provided by the Council. Given the challenges in mapping support needs onto levels of support required, we have erred on the side of caution, assuming that individuals will require higher levels of support in any unclear cases. As such, the figures to the right should be taken as indicative. As outlined in the next sections, transitional supported accommodation is not a settled solution (and therefore not included in the above table), but units will need to be retained as interim solutions within a housing-led system,.

	No.	%
Total requiring Housing First	106	14%
Total requiring long term congregate housing	11	1%
Total requiring intensive floating support	320	42%
Total requiring basic floating support	259	34%
Total requiring transitional supported accommodation	-	-
Total requiring independent, general needs tenancy (no support, but housing access)	65	9%
Total need	**761**	**100%**

Newly arising need

Projected newly arising need

In order to understand how need for support will change over time we also need to project newly arising need in each year. This has been identified on the basis of newly arising demand (i.e. new to rough sleeping or new to the pathway via the panel) in the last full year of data we have which is March 2022 – February 2023. According to the last full year of data on the Panel, there were 294 presentations. Filtering out for brand new presentations (i.e. removing those that are currently or have previously been accommodated in the pathway) leaves 277. In the same year there were 139 new rough sleepers identified in the monthly Government submissions. Around 13% of these were presented to panel and included in the previous figure. Some of those counted might be in and out of rough sleeping depending on the night, and therefore could be on the panel but listed as an alternative accommodation source (est. 15%). Some of those counted may be engaged by Outreach Services and then contact lost (est. 10%). The additional 62% have therefore been added to the total. Our assumption is that relevant new entrants (i.e. our in-scope cohort) to statutory temporary accommodation are captured in the previous figures which include TA cases.

In summary, this implies that each year there are approximately 330 individuals with newly arising need. As the level of support individuals need is typically higher for those who have been homeless for a longer period of time, we assume that a lower proportion of those with newly arising need require high levels of support. Additionally, we assume that 10% of individuals are not at a position to accept support in any given year meaning that total additional newly arising demand is 297. This yields the following estimates of newly arising demand for each level of support:

	No.	%
Total requiring Housing First	15	5%
Total requiring long term congregate housing	3	1%
Total requiring intensive floating support	116	39%
Total requiring basic floating support	163	55%
Total need	**297**	**100%**
Total requiring transitional supported accommodation	165	-

There is uncertainty as to how newly arising need will develop over the coming years,. We would anticipate that increased prevention activity (as outlined in Section 6) would reduce newly arising demand but this may be offset by increased need as a result of other structural risk factors, such as the cost of living crisis. **We have therefore modelled newly arising demand remaining constant over time** but alternative scenarios can be modelled. The figure for those requiring transitional supported accommodation each year (and hence the target residual stock) is based on each new entrant requiring an average of 6 months before permanent settled housing is sourced and accessed. It is likely that this is an over-estimate if rapid rehousing pathways are sufficiently developed, but also important with regards to choice and control of where people are accommodated (a key principle); and the realities of the housing market. For example, the ongoing evaluation of the national Housing First pilots found the process from initial engagement to moving into a tenancy varied considerably, with some participants being able to move in within 8 weeks and some not being matched with a property for 12 months.

Cumulative demand and housing-led units required

Cumulative Housing-Led Units & Demand

In order to forecast demand for each type of support in each year we combine estimates of existing need and newly arising need with estimates of the expected length of time that support will persist (i.e. whether those receiving support in year 1 will still be receiving it in year 2, year 3, etc.) For housing first and long term congregate housing we assume that 10% of the cohort will exit support in each year, meaning that duration of support will vary between 1 and 10 years. For intensive floating support we assume that 25% of the cohort will exit support in each year, meaning that duration of support will vary between 1 and 4 years. Additionally, we assume that basic floating support will be needed for 8 months. We also assume that 10% of those with need for support in each year will not be in a position to accept it.

Scaling up Housing-Led services takes time, particularly in the first couple of years when standing up new services. We have therefore estimated the increasing number of housing-led units required to meet the cumulative demand **by end of Year 10** (allowing for a gradual start). Until then, transitional supported accommodation will need to continue playing a substantial role (see next page). If the scale up route outlined below is followed, there will be enough Housing-Led units from Year 11 onwards to meet pre-existing and newly arising demand (i.e. cumulative demand). The table shows the target number of individuals receiving each level of support, each year.

	Housing First	Long term congregate housing	Intensive floating support	Basic floating support	**Total**
Year 0 (23/24)	0	0	0	0	**0**
Year 1	10	0	66	63	**139**
Year 2	30	11	210	221	**472**
Year 3	57	16	298	221	**592**
Year 4	81	20	353	221	**675**
Year 5	102	24	374	221	**721**
Year 6	120	24	374	221	**739**
Year 7	135	24	374	221	**754**
Year 8	146	23	374	221	**764**
Year 9	155	23	374	221	**773**
Year 10	161	21	374	221	**777**

Assumption

- Housing-led forms of support require access to settled, mainstream accommodation. If these targets are to be met, it is assumed the appropriate units of accommodation are also able to be sourced
- This is a big assumption, but the intention of this modelling is to show what is needed to meet cumulative demand by the end of Year 10
- These should therefore be viewed as stretch targets

Scenarios: short-term, transitional accommodation

As Housing-Led services are scaled up, it is important to allow sufficient time for them to become operational and effective; and avoid the loss of supported accommodation capacity before they are established. This effectively requires a 'double running' period. The extent of this double running is variable, and the below tables outline two potential scenarios of how short term, transitional supported accommodation stock can be scaled back; whilst Housing-Led services are scaled up as outlined on the previous page. The third scenario provides an "as is" comparator i.e. retaining the existing stock but with improvements in "flow" and move on.

Scenario 1: As housing-led units are scaled up, retain current transitional supported accommodation for longer until there is no unmet need for accommodation & support (achieved end of Year 6)

	Transitional supported (Low)	Transitional supported (Med)	Transitional supported (High)	**Total**
Year 0 (23/24)	288*	236**	40	**564**
Year 1	288	236	40	**564**
Year 2	258	236	40	**534**
Year 3	258	236	40	**534**
Year 4	258	236	40	**534**
Year 5	258	236	40	**534**
Year 6	258	236	40	**534**
Year 7	180	162	40	**382**
Year 8	116	108	30	**254**
Year 9	80	72	15	**167**
Year 10	80	72	13	**165**

Scenario 2: As housing-led units are scaled up, gradually reduce current transitional supported accommodation to achieve target units of 165 by end of Year 6

	Transitional supported (Low)	Transitional supported (Med)	Transitional supported (High)	**Total**
Year 0 (23/24)	288*	236**	40	**564**
Year 1	277	209	40	**523**
Year 2	238	182	40	**457**
Year 3	199	155	40	**391**
Year 4	160	128	40	**325**
Year 5	121	101	40	**259**
Year 6	80	72	13	**165**
Year 7	80	72	13	**165**
Year 8	80	72	13	**165**
Year 9	80	72	13	**165**
Year 10	80	72	13	**165**

Scenario 3: "As Is" with significantly improved move on rates^ from current short term, transitional supported accommodation. No investment in housing-led units

	Transitional supported (Low)	Transitional supported (Med)	Transitional supported (High)	**Total**
Year 0 (23/24)	288*	236**	40	**564**
Year 1	288	236	40	**564**
Year 2	258	236	40	**534**
Year 3	258	236	40	**534**
Year 4	258	236	40	**534**
Year 5	258	236	40	**534**
Year 6	258	236	40	**534**
Year 7	258	236	40	**534**
Year 8	258	236	40	**534**
Year 9	258	236	40	**534**
Year 10	258	236	40	**534**

*Includes 30 AfeO tenancies per year for Years 0 & 1
**Assumes the 58 Oasis House units will provide, on average, a medium level intensity of support; based on support worker caseloads in the 23/24 service specification
^200 people move on from the pathway each year (100 from low needs, 90 from medium, 10 from high)

Scenarios: unmet need across provision

The following tables show the "unmet need" each year, for each type of support for the three scenarios. "Unmet need" in this case is people who have a need for accommodation and support (as calculated on pages 151 & 152), and are not accommodated in one of the Housing-Led (Scenarios 1 & 2) or transitional supported accommodation units (all three scenarios). The calculation is cumulative demand minus the available units. The reason scenario three's unmet need continues to grow year on year is, despite increased move on rates modelled, the flow into the system is still greater than the flow out. As stated previously, Scenarios 1 & 2 have been modelled so that there is no unmet need by the end of Year 10. This means from Year 11 the Housing-Led units and remaining transitional supported accommodation can sustainably match the newly arising need.

Scenario 1: As housing-led units are scaled up, retain current transitional supported accommodation for longer until there is no unmet need for accommodation & support

	Unmet Need (Very High)	Unmet Need (High)	Unmet Need (Med)	Unmet Need (Low)	**Total**
Year 0 (23/24)	14	81	200	134	**429**
Year 1	17	86	250	234	**587**
Year 2	9	80	196	206	**491**
Year 3	6	65	142	148	**361**
Year 4	3	50	88	90	**231**
Year 5	0	35	34	32	**101**
Year 6	0	20	-20	-26	**-26**
Year 7	0	5	0	-6	**0**
Year 8	0	0	0	0	**0**
Year 9	0	0	-18	-22	**-40**
Year 10	0	-13	-72	-80	**-165**

Scenario 2: As housing-led units are scaled up, gradually reduce current transitional supported accommodation to achieve target units by end of Year 6

	Unmet Need (Very High)	Unmet Need (High)	Unmet Need (Med)	Unmet Need (Low)	**Total**
Year 0 (23/24)	14	81	200	134	**429**
Year 1	17	86	277	245	**625**
Year 2	9	80	250	226	**565**
Year 3	6	65	223	207	**501**
Year 4	3	50	196	188	**437**
Year 5	0	35	169	169	**373**
Year 6	0	47	144	152	**343**
Year 7	0	32	90	94	**216**
Year 8	0	17	36	36	**89**
Year 9	0	2	-18	-22	**-38**
Year 10	0	-13	-72	-80	**-165**

Scenario 3: "As Is" with significantly improved move on rates from current short term, transitional supported accommodation. No investment in housing-led units

	Unmet Need (Very High)	Unmet Need (High)	Unmet Need (Med)	Unmet Need (Low)	**Total**
Year 0 (23/24)	14	81	200	134	**429**
Year 1	17	106	406	397	**926**
Year 2	20	121	522	590	**1253**
Year 3	23	136	638	753	**1550**
Year 4	24	151	754	916	**1845**
Year 5	27	166	870	1079	**2142**
Year 6	30	181	986	1242	**2439**
Year 7	33	196	1102	1405	**2736**
Year 8	36	211	1218	1568	**3033**
Year 9	39	226	1334	1731	**3330**
Year 10	42	241	1450	1894	**3627**

Estimated Costings

In order to estimate the cost of providing the proposed support we multiply estimated need in each year by unit costs of providing each level of support to a person, as outlined below. Further details of how these unit costs have been calculated are available in Annex C. Note, these only include support funding/ costs (and exclude housing costs) as this is the focus of comparison. Housing-Led unit costs are traditionally lower than fixed site, as services can redeploy staff, moving support around and, for example, taking on a higher caseload when the support needs of most of the people using the service have lessened. Fixed-site services cannot vary their deployment of support to the same extent e.g. Housing First services can reduce resource use for someone being supported by their staff over time, whereas a hostel, for example, has a fixed number of spaces and a fixed allocation of staff.

Housing-Led Units	
Long term congregate housing	£12,903
Housing First	£9,683
Intensive floating support	£2,588
Basic floating support	£1,242

Transitional Supported Accommodation*	
High intensity	£15,495
Medium intensity	£3,965
Low intensity	£1,931

The average reduction in public spending from avoiding homelessness for a year (per person)**		
Unit Cost	**£4,251**	**100%**
Drug/ alcohol services	£340	8%
Mental health	£510	12%
NHS	£1,020	24%
Criminal Justice	£2,381	56%

*Average based on the costs of a sample of current West Northants supported accommodation schemes
**Pleace, N. & Culhane, D.P. (2016) Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England

Estimated Costings: Housing-led provision

The Housing-Led unit costs yield the following cost estimates in each of the 10 years from the start of provision:

	Housing First	Long term congregate housing	Intensive floating support	Basic floating support	**Total**
Year 0 (23/24)	£-	£-	£-	£-	**£-**
Year 1	£96,830	£-	£170,808	£78,246	**£345,884**
Year 2	£290,490	£141,933	£543,480	£274,482	**£1,250,385**
Year 3	£551,931	£206,448	£771,224	£274,482	**£1,804,085**
Year 4	£784,323	£258,060	£913,564	£274,482	**£2,230,429**
Year 5	£987,666	£309,672	£967,912	£274,482	**£2,539,732**
Year 6	£1,161,960	£309,672	£967,912	£274,482	**£2,714,026**
Year 7	£1,307,205	£309,672	£967,912	£274,482	**£2,859,271**
Year 8	£1,413,718	£296,769	£967,912	£274,482	**£2,952,881**
Year 9	£1,500,865	£296,769	£967,912	£274,482	**£3,040,028**
Year 10	£1,558,963	£270,963	£967,912	£274,482	**£3,072,320**

Estimated costings: three scenarios

The tables below provide a comparison of costings for the three scenarios. The estimates show that the "double running costs" during the housing-led transition, retention of residual stock and scaling units to meet demand mean scenarios 1 & 2 are costlier from a housing support perspective, whilst enabling the support provided to better meet the needs of more individuals.

Scenario 1: As housing-led units are scaled up, retain current transitional supported accommodation for longer until there is no unmet need for accommodation & support

	Transitional supported (Low)	Transitional supported (Med)	Transitional supported (High)	Transitional Supported Total	Housing-Led Total	**Total**
Year 0 (23/24)	£556,186	£935,720	£619,797	£2,111,703	£-	**£2,111,703**
Year 1	£556,186	£935,720	£619,797	£2,111,703	£345,884	**£2,457,587**
Year 2	£498,250	£935,720	£619,797	£2,053,767	£1,250,385	**£3,304,152**
Year 3	£498,250	£935,720	£619,797	£2,053,767	£1,804,085	**£3,857,852**
Year 4	£498,250	£935,720	£619,797	£2,053,767	£2,230,429	**£4,284,196**
Year 5	£498,250	£935,720	£619,797	£2,053,767	£2,539,732	**£4,593,499**
Year 6	£498,250	£935,720	£619,797	£2,053,767	£2,714,026	**£4,767,793**
Year 7	£347,616	£642,316	£619,797	£1,609,730	£2,859,271	**£4,469,001**
Year 8	£224,019	£428,211	£464,848	£1,117,078	£2,952,881	**£4,069,959**
Year 9	£154,496	£285,474	£232,424	£672,394	£3,040,028	**£3,712,422**
Year 10	£154,496	£285,474	£201,434	£641,404	£3,072,320	**£3,713,724**

Scenario 2: As housing-led units are scaled up, gradually reduce current transitional supported accommodation to achieve target units by end of Year 6

	Transitional supported (Low)	Transitional supported (Med)	Transitional supported (High)	Transitional Supported Total	Housing-Led Total	**Total**
Year 0 (23/24)	£556,186	£935,720	£619,797	£2,111,703	£-	**£2,111,703**
Year 1	£534,943	£828,667	£619,797	£1,983,408	£345,884	**£2,329,292**
Year 2	£459,626	£721,615	£619,797	£1,801,038	£1,250,385	**£3,051,423**
Year 3	£384,309	£614,562	£619,797	£1,618,668	£1,804,085	**£3,422,753**
Year 4	£308,992	£507,509	£619,797	£1,436,299	£2,230,429	**£3,666,728**
Year 5	£233,676	£400,456	£619,797	£1,253,929	£2,539,732	**£3,793,661**
Year 6	£154,496	£285,474	£201,434	£641,404	£2,714,026	**£3,355,430**
Year 7	£154,496	£285,474	£201,434	£641,404	£2,859,271	**£3,500,675**
Year 8	£154,496	£285,474	£201,434	£641,404	£2,952,881	**£3,594,285**
Year 9	£154,496	£285,474	£201,434	£641,404	£3,040,028	**£3,681,432**
Year 10	£154,496	£285,474	£201,434	£641,404	£3,072,320	**£3,713,724**

Scenario 3: "As Is" with significantly improved move on rates from current short term, transitional supported accommodation. No investment in housing-led units

	Transitional supported (Low)	Transitional supported (Med)	Transitional supported (High)	**Total**
Year 0 (23/24)	£556,186	£935,720	£619,797	**£2,111,703**
Year 1	£556,186	£935,720	£619,797	**£2,111,703**
Year 2	£498,250	£935,720	£619,797	**£2,053,767**
Year 3	£498,250	£935,720	£619,797	**£2,053,767**
Year 4	£498,250	£935,720	£619,797	**£2,053,767**
Year 5	£498,250	£935,720	£619,797	**£2,053,767**
Year 6	£498,250	£935,720	£619,797	**£2,053,767**
Year 7	£498,250	£935,720	£619,797	**£2,053,767**
Year 8	£498,250	£935,720	£619,797	**£2,053,767**
Year 9	£498,250	£935,720	£619,797	**£2,053,767**
Year 10	£498,250	£935,720	£619,797	**£2,053,767**

Estimated costings: unmet need

The tables below show the cost of the unmet need in each scenario on other public services (using the unit cost on page 156). Whilst this calculation excludes those accommodated in short term transitional accommodation, we know these individuals are not in stable housing and are also likely to incur higher costs on other public services. However, the purpose of this analysis is the comparison of the three scenarios; hence the focus purely on the public sector costs of the "unmet need" individuals.

Scenario 1: As housing-led units are scaled up, retain current transitional supported accommodation for longer until there is no unmet need for accommodation & support

	Unmet Need (Very High)	Unmet Need (Low)	Unmet Need (Med)	Unmet Need (High)	Total
Year 0 (23/24)	£59,514	£344,331	£850,200	£569,634	**£1,823,679**
Year 1	£72,267	£365,586	£1,062,750	£994,734	**£2,495,337**
Year 2	£38,259	£340,080	£833,196	£875,706	**£2,087,241**
Year 3	£25,506	£276,315	£603,642	£629,148	**£1,534,611**
Year 4	£12,753	£212,550	£374,088	£382,590	**£981,981**
Year 5	£-	£148,785	£144,534	£136,032	**£429,351**
Year 6	£-	£85,020	£-	£-	**£85,020**
Year 7	£-	£21,255	£-	£-	**£21,255**
Year 8	£-	£-	£-	£-	**£-**
Year 9	£-	£-	£-	£-	**£-**
Year 10	£-	£-	£-	£-	**£-**

Scenario 2: As housing-led units are scaled up, gradually reduce current transitional supported accommodation to achieve target units by end of Year 6

	Unmet Need (Very High)	Unmet Need (Low)	Unmet Need (Med)	Unmet Need (High)	Total
Year 0 (23/24)	£59,514	£344,331	£850,200	£569,634	**£1,823,679**
Year 1	£72,267	£365,586	£1,177,527	£1,041,495	**£2,656,875**
Year 2	£38,259	£340,080	£1,062,750	£960,726	**£2,401,815**
Year 3	£25,506	£276,315	£947,973	£879,957	**£2,129,751**
Year 4	£12,753	£212,550	£833,196	£799,188	**£1,857,687**
Year 5	£-	£148,785	£718,419	£718,419	**£1,585,623**
Year 6	£-	£199,797	£612,144	£646,152	**£1,458,093**
Year 7	£-	£136,032	£382,590	£399,594	**£918,216**
Year 8	£-	£72,267	£153,036	£153,036	**£378,339**
Year 9	£-	£8,502			**£8,502**
Year 10	£-				**£-**

Scenario 3: "As Is" with significantly improved move on rates from current short term, transitional supported accommodation. No investment in housing-led units

	Unmet Need (Very High)	Unmet Need (Low)	Unmet Need (Med)	Unmet Need (High)	Total
Year 0 (23/24)	£59,514	£344,331	£850,200	£569,634	**£1,823,679**
Year 1	£72,267	£450,606	£1,725,906	£1,687,647	**£3,936,426**
Year 2	£85,020	£514,371	£2,219,022	£2,508,090	**£5,326,503**
Year 3	£97,773	£578,136	£2,712,138	£3,201,003	**£6,589,050**
Year 4	£102,024	£641,901	£3,205,254	£3,893,916	**£7,843,095**
Year 5	£114,777	£705,666	£3,698,370	£4,586,829	**£9,105,642**
Year 6	£127,530	£769,431	£4,191,486	£5,279,742	**£10,368,189**
Year 7	£140,283	£833,196	£4,684,602	£5,972,655	**£11,630,736**
Year 8	£153,036	£896,961	£5,177,718	£6,665,568	**£12,893,283**
Year 9	£165,789	£960,726	£5,670,834	£7,358,481	**£14,155,830**
Year 10	£178,542	£1,024,491	£6,163,950	£8,051,394	**£15,418,377**

West Northamptonshire Council

Summary (1/2)

The table below shows the total cost of the three scenarios over the modelled period, both housing support costs and costs incurred to the wider public sector; specifically those with an unmet need for accommodation and support.

Scenario (Years 23/24 – 33/34)	Total Cost (Housing-Led Units)	Total Cost (Additional Housing-Led Access to Housing)*	Total Cost (Short Term, Transitional Supported Accommodation)	**Total Scenario Cost (Housing + Homelessness Services^)**	**Total cost of scenario's unmet need to other sectors**	**Total Scenario Cost**	**Ratio of £1 Housing/ Homelessness Cost: Other Sector Cost**
(1) Scale up required housing-led units. Retain current transitional supported accommodation until there is no unmet need for accommodation & support (achieved end of Year 6)	£22.8m	£0.9m	£18.5m	**£42.2m**	**£9.5m**	**£50.8m**	**£1 : £0.19**
(2) Scale up required housing-led units. Gradually reduce current transitional supported accommodation to achieve target units end of Year 6	£22.8m	£0.9m	£13.4m	**£37.1m**	**£15.2m**	**£51.4m**	**£1 : £0.30**
(3) "As Is" with significantly improved move on rates from current short term, transitional supported accommodation. No investment in housing-led units	£0	£0	£22.7m	**£22.7m**	**£99.1m**	**£121.8m**	**£1 : £4.36**

*The two housing-led transition scenarios require more units of accommodation to be accessed than scenario 3, an average of 192 additional units per year. A benchmark unit cost of £385 has been used to calculate this additional amount (Source: Blood et al, 2017). This is the cost of providing access to mainstream housing e.g. via a local lettings agency

^It is likely that for the very high/ specialist long term provision; health and care services will fund the care and support costs but for simplicity these have been badged as Housing/ Homelessness costs here

Summary (2/2)

Our analysis has been carried out on the basis of data provided by the Council. Conversations have been helpful in adding assurance over the validity of this data but, in so far as this data is inaccurate or incomplete, the accuracy of our analysis will be limited. That being said, the general conclusions are likely to hold even if the volume of people requiring support differs from what is implied by the information we have been provided; this is because the temporary and supported accommodation currently provided is both expensive and less effective than what would be delivered by a more housing-led approach.

The indicative scenarios used were chosen to help provide the general conclusions outlined below, and additional ones could be explored further if required (e.g. if we retain the same overall financial envelope, how far could we scale up Housing-Led provision?).

Conclusions

- When faced with current and future demand, the current homelessness provision is likely to incur substantial and increasing cost of homelessness to the West Northants public sector
- As the summary of current evidence showed, when comparing the support costs of Housing-Led provision with short term transitional supported accommodation; Housing-Led is a more cost-effective form of housing support in its own right
- However, it is when we analyse the whole public sector costs of homelessness that the cost effectiveness of Housing-Led provision is most stark. As our analysis showed, an additional investment of £18.6m (Scenario 1)/ £13.5m (Scenario 2) over the next ten years would reduce forecasted public spending on homelessness by £89.6m (Scenario 1)/ £83.9m (Scenario 2). A cost benefit ratio of £1 to £4.82/ £6.21
- This is due to the “year on year” nature of the benefit. By sustainably and quickly ending people’s homelessness with secure housing, multiple years of future homelessness are avoided (and the costs, morbidity and mortality that come with this). In contrast, the continuation of the current provision (even with an increased ‘flow’) is unlikely to be able to keep up with the cumulative demand, whilst remaining less effective and flexible
- This also highlights the economic imperative for the whole system to pool budgets, jointly commission and invest in Housing-Led provision to tackle homelessness

Additional Financial Efficiencies

- Although housing costs were excluded from this analysis, there are ongoing instances of housing benefit subsidy loss across some of the specified exempt accommodation within the current pathway. Housing-Led provision is classified as “floating support” and is therefore not specified accommodation that can incur subsidy loss. A transition as outlined in our analysis is therefore very likely to reduce housing benefit subsidy loss
- Increased economic value from a workless claimant entering the workforce and the value of increased wellbeing were not included in the wider public sector analysis but represent additional benefits

As a final note, the modelling does not account for any possible policy changes in relation to levels of Universal Credit, Housing Benefit, Local Housing allowance or central grant provided relating to homelessness. If there was significant change in relation to any of the above, the projections in the financial modelling may be affected.

West Northamptonshire Council

8. Case studies

Case study 1

Source: Homelessness Mental Health Practitioner

Background

The service user is a 31-year old male who resides in Oasis House. They have been experiencing low mood and feelings of hopelessness and suicidal ideation which he had internalised. He had sought mental health support. After a difficult few days he tried to hand himself in his room with a rope tied over his curtain rail. Despite testing his weight first, the rail broke and instead they tried to tie a ligature to hang themself over a door frame. When this failed, they tried to do the same over a stairwell, where he was intercepted by a security guard.

Support needs

- Mental health needs
- Suicide attempts

Date of entering service

Unknow

Services/teams accessed

Oasis House

NHFT Homelessness Mental Health Practitioner

Outcome

Following the service user's suicide attempts the Homelessness MH Practitioner met with him. He was distressed and acutely suicidal. He was not safe to leave alone and his intention was to try to take his own life again. The Homelessness MH Practitioner spent all afternoon with him and he eventually agreed to a hospital admission. As there were no beds available, the Homelessness MH Practitioner worked with crisis services to create a plan to keep him safe with 1:1 support until a bed became available. They took the service user to the crisis bed themselves.

The service user engaged with support in hospital and his MH improved significantly. The Homelessness MH Practitioner has seen him several times since his discharge. He continues to engage with support, he is in touch with his young daughters and is hoping to move to independent accommodation soon.

Case study themes

- Mental health needs
- Suicide
- Cross-system working

Case study 2

Source: Homelessness Mental Health Practitioner

Background

The service user is a 20 year old female from the travelling community. She became homeless after moving from Wales to Northampton to live with her sister, a relationship that subsequently broke down. The service user has a history of psychotic episodes and has been admitted to hospital under a mental health section on three previous occasions.

Support needs

- Mental health needs (psychosis)

Date of entering service

Unknown

Services/teams accessed

- St John's
- Northamptonshire Healthcare NHS Foundation Trust (NHFT)
- UCAT
- CMHT

Outcome

Initially housed at St John's due to vulnerability.

St John's contacted the Homelessness Mental Health Practitioner because the service user was presenting with extreme paranoia and they were concerned for her mental well-being. Due to her mistrust of services, and fear of being hospitalised, she was refusing to engage in mental health assessments or support with generic services.

By visiting the service user at St John's in person over 2-3 occasions the Homelessness Mental Health Practitioner was able to gain their trust and assess her mental health needs then refer her to UCAT and subsequently CMHT and advise teams of her triggers which included mentioning the words 'mental health'.

With medication and support the service user's mental health improved and she was able to remain in the community.

Case study themes

- Mental health needs
- Support to remain in the community

Case study 3

Source: Homelessness Mental Health Practitioner

Background

The service user is a 24-year-old male and in April 2022 he was discovered by the outreach team sleeping rough in a wooded area on a housing estate after reports from neighbours that he was eating from their bins, trying the handles of their front doors, using the wooded area as a toilet and was creating rubbish that was attracting rats. Despite numerous visits from housing, police and other services he declined all support until the involvement of the NHFT Homelessness MH practitioner who was able to ascertain that until May 2021 he had been under the care of MH services, he had been admitted to hospital on several occasions but was receiving regular depot to manage his symptoms and when well, was able to hold down a full-time job. He then returned to his home country of Moldova in May 2021 until March 2022.

Support needs

- Mental health needs (acute psychosis)

Date of entering service

April 2021

Services/teams accessed

- Outreach team
- Housing
- Police
- NHFT Homelessness Mental Health Practitioner
- AMPH team

Outcome

The service user was sleeping in a soaking wet bed without a tent and surrounded by rubbish. He was unwashed and filthy. He appeared nervous and frightened and declined all offers of support. He was clearly unwell and needed urgent support so the Homelessness MH Practitioner contacted AMHP and eventually police were arranged to detain him under section 136. From there, an AMHP assessment concluded he was experiencing acute psychosis and was able to be admitted to hospital under section 2 to receive the urgent support he needed.

Case study themes

- Mental health needs
- Rough sleeping
- Declining support

Case study 4

Source: Northampton Children's Trust

RM had a Closure Order on his property on 8/7/21 due to being a nuisance neighbour and Keyways receiving several complaints about him. This was temporary, however led to a further closure and subsequent eviction in 2022. He then went to stay at his uncle's where he was not supposed to be staying. RM was referred to Keyways for homelessness and PA raised concerns about his vulnerability with housing, however he was not seen as being vulnerable enough for emergency housing despite this being challenged. Prior to him having to leave his flat PA did a referral to adults who felt he did not meet their criteria for support.

RM has since been in and out of prison for assault, threatening behaviour and breaking restraining orders. This has lead to him walking the streets and at times sitting in shop doorways. PA has raised concerns about his mental health which had deteriorated with him having psychotic episodes and displaying other concerning behaviours, some of which have got him arrested. However, assessments, have concluded he does have capacity and does not fit the criteria to be detained at Berrywood or anywhere else. This has lead to RM now thinking that he is to remain in prison for the rest of his life. RM has been referred to mental health, but not engaged. PA also contacted mental health in the prison, but he has not engaged there either.

RM is therefore unable to gain stable accommodation and move forward to try and get out of this situation. His homeless state has also led to him no longer receiving benefits.

Case study 5

Source: Lived experience research

R – woman, British, 41 yo

Overview of journey
Feb 2021 – domestic abuse leading to homelessness (sleeping in car, still working)
March 2021 – Reached out to council / 'never heard back from them'
March 2021 – **January 2023** – mix of rough sleeping and sofa-surfing in different locations ('at men's houses), development of depression and drug addiction, job loss.
February 2023 – UC worker contacted the council outreach team. Meeting with outreach team and organise verification.
January 2023 – Placed at HAARP, assessment and development of personal plan. Engagement with relevant services (health, drug misuse).
April 2023 – Moved to Richmond Fellowship support accommodation (women-only).

R homelessness journey started two years ago. She was a carer and her relationship turned abusive. She began to work at night to avoid her partner, eventually deciding to not return. She was sleeping in her car during the day. After a few months, the car broke and R went back to her ex-partner, who physically and violently abused her. At that time she decided to contact the council for the first time. She managed to meet with a council officer who *'dismissed her completely because I was working and he thought I didn't look very much homeless as I was clean and stuff'.* R mentioned that the council said that she was not vulnerable enough and not considered 'priorities needs' and that she never heard from them. It is unclear whether she formally made a homelessness application. She mentioned having tried to contact them in the three months following the initial meeting, but gave up after that. After a year of sofa surfing in a number of different locations ('*I slept in men's houses for as long as I could and for a year or so'*); R went into a depression, lost her job and developed an addiction to crack. It is her Universal Credit worker that contacted the outreach team 3 months ago *'my UC worker told me that my situation was not normal and that I should get help'*. She met with one of the outreach worker and quite quickly I got a room here [HAARP]. It was hard for them to verify me as I hide when I sleep rough. *'The system is stupid because the street is dangerous, especially for a woman. If they can find me then everyone can find me!.* R said that she then came to HAARP to get an assessment and that at the end of the meeting, she was offered a room. *'It was such a relief'.* R is very grateful and happy with the support she received at HAARP. She described having developed a personal plan with them highlighting the steps she needs to take. These include going for a blood test and to the doctor, getting S2S support and attending a training session.

'Having someone behind me to kick my ass a bit and giving a bit of support is so valuable. I had given up in so many areas. I got to a point where it was hard to turn up to appointment etc. I felt unworthy. Coming here helped a lot. They gave me all the support I needed' After 2,5 months at HAARP, R was offered a room in a shared female-only house provided by Richmond Fellowship. She has had an initial meeting with them, seems clear on her responsibilities and the support that she will get, and is looking forward to moving to the next stage of her recovery. She is hoping to continue to taking care of herself and to find a job in the next few months.

Case study 6

Source: Lived experience research

E – male, Easter European, 27 yo

Overview of journey
May 2022 – Lived in Leeds, loses his passport and lost his job
July 2022 – Moved to Northampton due to existing support system for eastern european community. He has a friend living here. He sublet a room for two months.
September 2022 – E cannot pay for his room and starts rough sleeping.
September – May 2023 – E is rough sleeping in Northampton while getting support from the Hope Centre and the outreach team in getting a new passport. Whilst rough sleeping, E develops epilepsy causing frequent seizure.

E. is Lithuanian and has been living in the UK for 4 years. He holds a pre-settled status but lost his passport almost a year ago which has led to his homelessness.

E. used to work in Leeds in warehousing. His passport expired and was lost. As a result, he lost his job. Not able to prove his identity and his rights, E. was not able to receive any financial support (E.g. UC). E. moved to Northampton two months after losing his passport following the advice of a friend. The rationale for moving to Northampton was the presence of a support system for the Easter European communities. E. subletted a room in a house for two months when he first arrived in Northampton, which he was unable to pay for longer. E. started sleeping rough in September 2022.

E. uses the services provided by the Hope Centre as well as International Lighthouse. E. does not speak English and finds it hard to navigate the system. He described how he was unable to access any financial or accommodation related support from the council or the job centre as he cannot prove his identity and rights. E. explained how the Hope Centre helped him in trying to get a new passport and that the request was underway. He said that he attended an appointment at the Lithuanian embassy with a member of the Hope Centre.

E. is in regular contact with the outreach team and accessed SWEP accommodation during the cold winter times.

As a result of living on the street, E developed epilepsy. He explained that he was not able to see a doctor without a passport. He described having been to A&E once and having received good treatment, despite the language barrier. He also described having been discharged to the street with no follow-up support / further check-ins.

E. said that he should receive his new passport next week. With this, he would then be able to access Universal Credit, register to a doctor and hopefully find a new job and get away from the street.

Case study 7

Source: Lived experience research

L – male, british, 42 yo

Overview of journey
End of March 2023 – Started rough sleeping after important financial issues, created as a result of drug addiction
Early April 2023 – After two weeks sleeping rough, discovered the Hope Centre. Accessed S2S health and mental health support.
Mid April 2023 – Placed at HAARP

L is 43 years old and originally from Worcester. He has been living in Northampton for 23 years. Until recently, he considered himself a *'functioning drug addict'*. He has been taking heroin for more than 20 years. He has been living on the street for short periods of time many times but described having always managed to *'sort himself out'* without support' until now. He also described having been financially independent all his life.

L had been sleeping rough for two weeks when someone in the street mentioned the Hope Centre, which he didn't know about. He said that during his time sleeping rough, he had no contact with the outreach team.

He described receiving great help and support since entering the Hope Centre for the first time. '*I went there and straight away a worker came to see me and spotted that I was new. He asked me about my situation and from that moment all the support was here and available to me. On a platter!'.* He mentioned accessing S2S and having had a mental health assessment and an assessment with HAARP within a day. He slept rough for two days after this until HAARP called to offer him a place. When asked how he was verified, L said that he never reached out or met with the outreach team. *'They must have verified me when I was sleeping'*

At the time of the interview, he had been at HAARP for three weeks: *'2,5 weeks in the big brother unit where they observe you, and a few days in the other unit where you are slightly more independent'*.

'*It feels like they care here [HAARP]. They don't want you to leave if they think you're gonna fall into pieces as soon as you leave. So they keep you until they feel you're ready. It's also very efficient. Within 48h of going to the Hope centre for the first time, I was in here [HAARP] and I enter rehabilitation as well. I got medication to start my addiction withdrawal and S2S as well.'*

L was very positive about the support he received. He was however unclear about what is next for him and what is available to him, as well the criteria that meant he was taken off the street so quickly. *'I don't know what is next, they are very good here but the future is a grey area and no one is really able to say clearly how the process works. I don't know how I got so lucky to have spent so little time sleeping rough.. All the other mates I met they have been sleeping there for weeks. It seems unfair but I am not gonna complain obviously. It's probably just luck. Or because I am chilled and I do what people tell me to do'*

Case study 8

Source: Lived experience research

J, male, British, 40yo

Overview of journey

- **Pre-November 2022 –** J lives in a small town in North Northamptonshire, he lost his job and went through a relationship breakdown.
- **November 2022-Now –** J moves into Northampton. He is sleeping rough, in a tent. He is coming to the Hope Centre every day for food and shower.

J has been sleeping in a tent for 5 months, in a park away from the town centre. '*I hear nothing but bad news about people sleeping in the town.*' He moved to Northampton from the small town where he grew up after a relationship breakdown and job loss which all happened very quickly. He wants to be able to start again in a place where everybody doesn't already know him – *'a clean break'*. His local connection is with North Northamptonshire.

J is aware of the Council Outreach team. His outreach worker was the first person he came into contact with since sleeping in the tent. He described them as *'helpful'*, they referred him to the Hope Centre and supported him with a Universal Credit application. He is now in regular contact with them.

J has made a homeless application but was told that he could not access support for three years because of his lack of connection. *'I am from the region but not the council area. My local council area is small and I want a clean break from that place and those people, that's why I stay here'*. J accepts that they won't help him until he's built up his connection, but explains that this also feels unfair because he sees the council help people who have come from other, further away places:

"the point is they don't send people back to Birmingham and London, they just help them here. But with me, they're refusing to help me […] if I'm 100 miles away or 20 miles away, what's the difference?"

J has also been told by other people that if he had a drug or alcohol problem then he would get the help: *"it makes you think I should just go out there and come back and say yeah I'm addicted to alcohol and drug then I know that I will then get the help. But I'm not like that, I'm truthful."*

J has a named outreach worker who he can go to with any immediate issues. He hasn't been to her with any issues but he knows and likes her. J comes to the Hope Centre every day *"I come here [hope centre] every day. It's like a lifeline to be honest, it makes a lot of difference this place does."*

J describes being refused accommodation during SWEP because he doesn't have a local connection and has been upset by this. J mentioned asking around why since then and that no one was able to come back with an answer why he wasn't accommodated during SWEP. No one came back to him with an answer. He describes how other people who came from Birmingham and other places outside Northampton were accommodated while he wasn't accommodated – to his understanding – because he doesn't have a local connection. This created tension and a lot of anxiety.

"they knew I was homeless, but they didn't come and see me or anything. No one came and check on me once during that bad weather. Not once […] they know you're there. They know I'm a person like anyone else."

"when it was minus 8 and everything they wouldn't even sweep me off the streets, which I thought was a little bit disgusting because [SWEP] is supposed to be for everyone isn't it. That's not the way that this council work it. There were loads of people here that were left on the streets during SWEP"

"I know I can't get helped being housed for 3 years, I accept that. That's ok, that's my problem. I've got to work around that. I think things should change a bit on that - but when it comes to being freezing cold and SWEP I think everybody should have the equal opportunities and that's not how the council works it"

"it does make you come down a bit mentally health wise when you see other people coming from out of town that have got no connection with Northampton whatsoever and they're getting SWEPT and I'm not, but I've been here since November."

J talked about the need to improve how information is communicated as well as transparency and consistency in how things work.

"Every time I asked something. You kind of get passed onto someone else and that person couldn't give you the answer that you wanted. Well someone must be able to know and explain to me how things work. That's all I want.'

Case study 9

Source: Lived experience research

M, 48, Woman, British

Overview of journey

- **March-April 2021 –** M is evicted from her private rented flat for non-payment and arrears. She had a crack addiction for a few years. M started rough sleeping.
- **May-December 2021** – M slept rough in Northampton.
- **January 2022 –** M contacted the council for the first time and within a week had a room at Oasis House. She accessed S2S shortly after moving in her room.
- **June 2022 –** M was given a 28 days eviction notice.
- **July 2023–** M was offered a place in NAASH supported housing accommodation (24h/7 staffed accommodation).

M was brought up in care. She first experienced rough sleeping after being evicted from her private rented flat for non-payment and arrears in 2020. She lived and slept rough in the street for a few weeks. Once she reached out to the council, she was offered a room at Oasis House within a week. She stayed at Oasis House for around 5 months before she was evicted for racial abuse. *'Apparently I called someone something and they said it was racist. '*

Oasis House gave her a 28 days eviction notice and during this time she was in touch with the council to find another solution. She was then referred to NAASH and got a room in a 24h/7 staffed supported accommodation. She described receiving a lot of support*: 'mental health, doctor appointment etc. Everything you want. The accommodation we are in is for vulnerable people'*. She also described the rules that she has to comply, including the 10pm curfew: *'the curfew... oh the curfew is terrible'*. She talked about the fact that she is not able to have any visitors coming and that the staff check and search her room regularly *'to see if we are hiding drugs or something'*. M described her addiction to crack as *'very difficult to get out of'* but it getting good support for it from NAASH and S2S

Case study 10

Source: Lived experience research

J, 45yo, Woman, British

Overview of journey

- 2019 – Moved to Northampton with her partner and five children. J was renting a house.
- 2020 – Domestic abuse and relationship breakdown. Children placed with other members of the family.
- June 2021 - J finds a new partner. They can't afford the house anymore and start sleeping rough, in a tent.
- September 2021 – J and her partner isolate in HARRP/Trinity House due to Covid-19
- November 2021 – J and her partner got a room in Oasis House and have been there since then. J's partner is waiting for detox.

J has five children. In 2019, she moved to a privately rented house in Northampton with her children and partner. A year later, she is victim of abuse from her partner and one of her children. The relationship with her partner ends and her children are placed with other members of the family. In 2021, Jane has a new partner but together they are not able to pay the rent. They start to sleep in a tent.

J described being approached by the outreach team multiple times, but that she was told repeatedly that the Council would not be able to help them both and consider them as a 'unit' as they could not prove a long-enough relationship. After a couple of months sleeping in a tent, they both got Covid-19 and as a result were offered a room in HARRP / Trinity House to isolate. *'They told us that we had the room for a week only and then that we would have to leave but in the end we were able to stay for much longer, something like 8 weeks'.* From HARRP/Trinity House, J and her partner then moved to Oasis House. They have been in Oasis House since then (1,5 y).

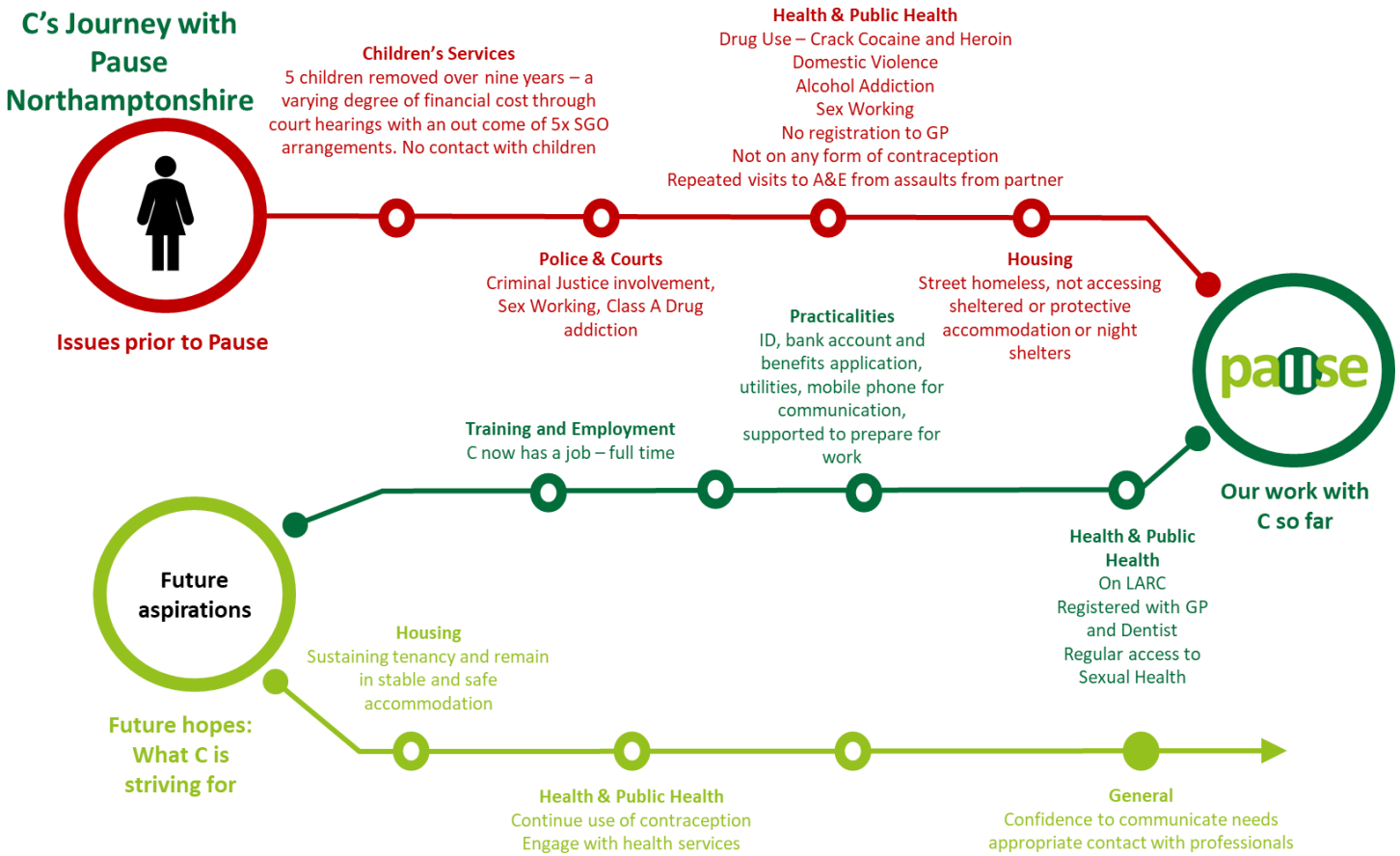
J's partner is waiting for a detox and has been waiting for more than 8 months. J's partner is seeing S2s but described a frustrating service. '*They are trying to help but they are so busy*'

J reflected on her and her partners' situation:

•'*We only got helped because we had Covid. It feels like they want you to stay in the street for at least 6 months before they help you. It's like the price to pay'.*

Case study 11

Source: Pause



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9. Recommendations

Recommendations

It is likely a number of recommendations will require dedicated business/ investment cases where appropriate

1.0 Improving access to and engagement with health and social care	
1.1 Specialist primary healthcare	1.1.1 To ensure routine access to primary care, the enhanced and targeted services for people experiencing homelessness should be reinstated at Maple Access. This might include dedicated GPs, drop-in clinics, in-reach and 'satellite clinics' in local settings etc. This should significantly reduce the need to attend a specific location at a specific time.
	1.1.2 The early work of special care dentistry to increase access to dental treatment for this cohort should be continued and expanded. This may include outreach services situated at convenient locations, flexible opening hours (early mornings or later into the evening) and collaboration with pre-existing services. Different modes of delivery will be required and should include a mix of "safety-net" services delivered at fixed sites, for example based at facilities for homeless people and outreach clinics (to include mobile dental clinics); and mainstreaming to local NHS primary dental care
1.2 Preventative health opportunities	1.2.1 Work towards an integrated health promotion approach with people experiencing homelessness. All patients attending drop-in clinics or engaging with the multidisciplinary outreach team should have their presenting problem addressed first, but also offered health screening and access to treatment to include: physical health assessment, screening for dental/oral problems, blood-borne viruses, smoking, drug and alcohol problems, TB screening, screening for mental health problems, diet and exercise etc. This approach will enable multiple services to be accessed simultaneously rather than multiple appointments at different sites.
1.3 Adult social care	1.3.1 To further advance the closer working between Adult Social Care and Housing Services, a specialist homelessness social worker role should be introduced within outreach; given the high numbers within this cohort and evidence of best practice. They should act as the Safeguarding Lead and ensure people experiencing homelessness are receiving assessments under the Care Act (2014) and the Mental Health Act (1983) and, for those assessed as having eligible needs (including Section 117 aftercare), care and support is provided
	1.3.2 Where eligible needs are identified, finding suitable providers and placements is extremely difficult for people experiencing multiple exclusion homelessness. Linked to the recommendations around the reshaping of the single homelessness pathway, more dedicated and specialist provision is required for this cohort
1.4 Enhanced mental health services	1.4.1 Ensure mental health services have working agreements and tailored eligibility criteria in place for people experiencing homelessness, the agencies that support them and the specialist mental health provision for this cohort. This should facilitate enhanced and easy access to treatment, including a willingness to work around relatively high rates of non-attendance at appointments. Complex trauma and personality disorders are significant drivers behind the poor mental health of homeless people, and the responses of mental health services and clinicians to this group should be designed with this in mind.
	1.4.2 Consider the use of appropriate mental health respite beds for those experiencing multiple exclusion homelessness and/ or with dual diagnosis

West Northamptonshire Council

Recommendations

1.0 Improving access to and engagement with health and social care (continued)	
1.5 Dual diagnosis	1.5.1 Alongside the integration of mental health and drug and alcohol services within the NHTT (see separate recommendation), ensure mental health services and substance misuse and alcohol services have multi-disciplinary dual diagnosis partnership working agreements, formal protocols and easy referral pathways in place for people experiencing homelessness. This should encourage a 'no wrong door' attitude and adhere to the following Inclusion Health Standard: "All mental health services should be ready to work with people with drug and/or alcohol problems in addition to mental health issues, and mental health services should foster good partnerships with drug and alcohol services to ensure effective joint working. Mental health treatment should still be offered even when the patient does not wish to engage with substance use treatment."
	1.5.2 Dedicated dual diagnosis workers within the NHTT could support the above recommendation, helping ensure initial assessments of mental health problems are provided within drug and alcohol services by staff with appropriate levels of training, to avoid inappropriate referrals. This would also provide easy access to psychology services within the MDT, facilitate 'joined-up clinics' etc.
1.6 Urgent care	1.6.1 All patients presenting to A&E should be questioned about housing status and all rough sleepers identified immediately on arrival to any department at the hospital ('Housing Status' and 'GP Status' asked as part of the triage process). Currently this is inconsistent and if there is no admission, housing officers might be unaware or not alerted of the visit. Better data recording should enable a case to made for a dedicated housing/ homelessness lead in A&E, if appropriate
1.7 Acute admissions	1.7.1 Make better use of periods of hospital admission for homeless patients. Currently some agencies may complete in-reach visits, conduct assessments etc. but much more could be done to use this time as an opportunity for a comprehensive and holistic assessment of a person's needs to enable appropriate personalised care planning that integrates health, social care and housing needs; and starts addressing the often complex and underlying issues that have led people to their situation.
1.8 Geography	1.8.1 There is significant centralisation of services for this cohort in Northampton town, increasing access issues for those in rural areas. Consider the use of and viability of increased outreach services to reach these localities
2.0 Intermediate care and transitions	
2.1 Physical health services	2.1.1 Develop intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care e.g. discharged from hospital (step-down care) or referred from the community who are at acute risk of deterioration and hospitalisation (step-up care). Pilot projects should be given adequate time (2-3 years minimum) to embed before being evaluated for outcomes and cost benefit.
2.2. Mental health services	2.2.1 As with physical health services, there should be intermediate care discharge accommodation available, so that those who no longer need psychiatric support can continue to recover within a therapeutic setting. These projects should take into account Psychologically Informed Environments guidance

Recommendations

3.0 Multidisciplinary and integrated service provision	
3.1 'One Stop Shop'	3.1.1 As well as the outreach and in-reach provision, upscale and coordinate provision for this cohort with co-location of all relevant services at an accessible location; with drop-ins, 'open-door' services etc. that people can self-refer to and access (even after any initial support ends), to reduce the risk of becoming homeless again because of unmet health, care and support needs. This would facilitate holistic assessments and wraparound support, as well as a number of other recommendations from this report e.g. opportunities for preventative health screening, providing wound care and simple dressings, dental treatment etc.; and could be linked to the Rapid Assessment Hub in the reshaped Single Homelessness Pathway
3.2 Multidisciplinary homelessness team	3.2.1 The NHTT could benefit from expansion in size to function as the locality's integrated and multidisciplinary homelessness team (e.g. additional Lead nurse, more recovery workers and lower caseloads/ more contact time is likely to be more cost effective); and in scope in the following opportunity areas: • Dedicated mental health social worker and/ or specialist homelessness social worker role; within outreach undertaking Care Act 2014, Mental Capacity and Adult Safeguarding assessments (acting as Safeguarding Lead) • Dual diagnosis workers • Mental Health and psychological professionals in addition to the current NHFT provision given the high prevalence of need e.g. MH nurses, MH practitioners, psychologists, psychiatrists • Pharmacists are part of local homelessness multidisciplinary teams in other locals areas, and/ or additional prescriber capacity dedicated to this cohort • Physical rehabilitation (such as occupational therapy and physiotherapy) The above should also allow the multidisciplinary team to provide and coordinate care across a range of settings (outreach, primary, secondary and emergency care, social care and housing services); ensuring continuity of care for as long as it is needed by the person, as well as supporting transitions in care such as prison, hospital and accommodation moves.

Recommendations

4.0 Data and intelligence	
4.1. Operational data	4.1.1 There is no cohesive form of information sharing and data collection at present (outside of the NHTT). A robust and easy to use digital system for recording and monitoring client data, including restricted access for partners, should be developed. This should help services collaborate with case tracking, contact tracing, community treatment and public health measures, e.g. for TB, HIV, hepatitis C. Ideally there should be a unified electronic record accessible wherever the person is seen
4.2 Strategic data	4.2.1 A limited range of data sources were identified which allowed analysis by accommodation status for health outcomes and risks, with a lack of consistency and completeness in identifying people experiencing homelessness in available data sources. Opportunities can be explored to improve recording and reporting of data and analysis; and support and encouragement for more 'screening' and recording of homelessness within routine NHS datasets. Housing status should be consistently recorded on clinical record systems and be a trigger to activating pathways and services for holistic intervention
5.0 The role of peers	
	5.1 Provide more volunteering opportunities or employ more people with lived experience of homelessness in designing, commissioning and delivering services. Expand the use of peer advocates or link workers to help people navigate the system and access support. Consider the development of a Peer advocacy service
6.0 Planning and commissioning	
6.1 Commissioning approach	6.1.1 Commissioning intentions should be clearly communicated and co-developed with the market. Policies, commissioning strategies, performance frameworks and funding streams should be designed so as to support the conditions to prompt and sustain innovation. Continue to develop and build a trusting and effective partnership between the council and support providers, recognising strengths and fostering shared support and solutions
6.2 Commissioning cycles	6.2.1 Acknowledging the regular uncertainty around funding, consideration should be given to longer commissioning cycles for services. This is especially important in a Housing-Led system with open-ended support. Funding levels need to be predictable and facilitated by longer term contracts, with a wider and longer-term view of 'cost effectiveness'. Providing longer term contracts allows providers to attract and retain staff at competitive rates of pay.
6.3 Joint commissioning	6.3.1 There is limited interaction between strategic commissioners across sectors, and joint commissioning for people experiencing homelessness. Utilise the local strategic governance forums to develop shared strategic priorities for funding and explore the significant opportunities for greater collaboration and commissioning outlined in this report e.g. Housing First. Commissioners across sectors should review and co-ordinate service specifications for retendering, and move towards alignment of commissioning cycles

Recommendations

7.0 Staff support and development	
7.1 Trauma-informed practice and psychologically informed environments	7.1.1 Although there are pockets of good practice within the current service system, there should be a coordinated, system-wide endeavour to create trauma-informed and psychologically informed environments (PIE), with the supporting culture shift and consistent understanding of what this means in practice and how to evidence it. Support and training should be available for health workers and non-health workers in understanding and working with people with mental health problems and histories of complex trauma.
7.2 System knowledge and awareness	7.2.1 Continue and invest in the pre-existing Multiple Exclusion Homelessness training (delivered jointly by the Street Services Team and Adult Social Care) to improve understanding of rough sleeping across the local service system, especially Multiple Exclusion Homelessness, amongst professionals and decision makers. This needs to be an ongoing requirement for new joiners
8.0 Governance	
8.1 Strategic and operational governance	8.1.1 Although homelessness and rough sleeping is a priority in multiple local strategies and plans, there needs to be strong local leadership and clarity on where the cross-sector strategic governance for the issue will sit. This should be supported by the recently established Housing Board at the Council. This could be incorporated into an existing forum, but will need the sufficient time and attention, or some areas have pre-empted potential statutory changes in this area; and established local "Homelessness Reduction Boards". These play a similar role to Health and Wellbeing Boards, and develop shared accountability for tackling homelessness and ending rough sleeping at a senior level with representatives from across the local service system.
	8.1.2 A number of these recommendations are intentionally "cross-system" in nature and will require the establishment of cross-sector communities of practice or an equivalent (e.g. the Housing Board's task and finish groups). This will help facilitate new initiatives, increase collaboration, reduce duplication, improve efficiency; and help pilot innovative practice. The Single Homelessness Forum has recently been refreshed and membership broadened, and should continue in its current form with a more enhanced scrutiny role of the local system and its collective performance.
8.2 Collective and shared vision	8.2.1 Agree a shared approach to communicating the suggested housing-led vision and shift in response to rough sleeping and single homelessness locally. This should emphasise things like not using the term “readiness” in relation to housing sustainment where possible, and developing a shared understanding of the reasons behind this. It may be that supported accommodation does help people become more ready, people themselves may say this too, but moving to a housing-led system asks us to question, not reinscribe, this thinking.

Recommendations

9.0 Single Homelessness Pathway *Sections 6 & 7 outline the full detail behind the proposed reshaping of the single homelessness pathway, based on adopting the Housing First/ housing-led principles*	
9.1 Strategic performance	9.1.1 Work towards an ability to quantify total homelessness demand, against total supply of settled homes to homeless groups on an annual basis. System level flow data is vital for system learning and improvements – and there is a need to develop metrics enabling total homeless journey time to be recorded for people in the pathway, record refusals, outcomes etc. This shared intelligence can also be used to inform upstream prevention approaches; and is reliant on a case management system (4.1).
	9.1.2 Develop targets for the provision and accessibility of affordable permanent housing stock for people experiencing homelessness. Targets (permanent mainstream housing) should be informed by evidence on the scale of homelessness (e.g. the modelling completed in Section 7) and included in strategic housing market assessments (SHMA) and other local strategies/ plans. All registered providers of mainstream social housing should set an annual guideline target for the minimum proportion of social lettings to homeless nominees; and report on their performance providing settled homes for homeless people. This should also include the adoption of housing led principles in their allocations and lettings processes
	9.1.3 To support the proposed changes to the pathway, there is a need for additional capacity and capability in strategic commissioning and contract monitoring/ oversight for single homelessness.
9.2 Customer journey	9.2.1 Ensure everyone receiving support related to homelessness has a clear and understood route into permanent housing as soon as possible – this should take into account their choices and needs and should be clearly articulated, with accessible steps for which they can take control (with support if needed)
	9.2.2 Review the role for rough sleeper 'verification' within a future housing-led system. If verification is deemed appropriate and necessary, review how it can be administered in partnership with as many partners as possible to ensure 'no wrong door' and taking into account the views and recommendations of people with lived experience of homelessness
9.3 Oversight of supported accommodation provision	9.3.1 The Council should pre-empt the forthcoming legal changes, with regards to managing and overseeing the quality of local supported accommodation. A framework of standards should be co-developed to inform a consistent understanding of 'quality'. This should align with the Housing First principles in order to focus the system on choice, control, rights and relationships. The ongoing dedicated work in this area should continue to provide a greater understanding and scrutiny of what non-commissioned services are providing.

West Northamptonshire Council

Annex A – Relevant practice/ service model examples

Acute Admissions | Pathway Model

The Pathway model trains NHS staff to help patients access the accommodation, care and support they need to recover and get life onto a better pathway after their stay in hospital. Pathway teams are led by specialist GPs who bring their experience caring for people experiencing homelessness in the community, as well as expertise in methadone prescribing, personality disorder, and chronic disease management. Nursing staff manage the team caseload and bring clinical experience in homelessness, addictions and/or mental health. Housing specialists bring their expertise to the service and help build links with voluntary sector services in the community. Some Pathway teams also include Care Navigators who have personal experience of homelessness, and larger teams also include occupational therapists, social workers and mental health practitioners. Pathway teams work with patients to create bespoke care plans for their support, including referrals to addiction services, ongoing treatment for health issues such as hepatitis C and tuberculosis, and community services offering social care. Coordinating input from housing departments, mental health and addictions services, social services, community and charity sector partners, teams provide empathetic, patient-centred, recovery-focused care.

Based in the hospital, Pathway teams: - Provide expert advice and clinical advocacy around homeless and inclusion health issues (such as substance misuse and substitute prescribing) for inpatients, improving care and treatment outcomes - Ensure patients with high support needs are able to engage with health and other services through holistic inpatient support and care, thereby reducing rates of early self-discharge - Help patients affected by homelessness find somewhere safe and appropriate to stay on discharge, taking into account their needs around health, care and general support - Support patients with financial issues, welfare entitlement and to access specialist legal help where possible - Help to replace lost ID documents - Ensure patients are registered with a GP for ongoing care - Refer and signpost to specialist community services to help with a variety of social, mental and physical health, and addictions issues - Reconnect patients to family and social support networks on discharge.

Intermediate Care | Bradford & Cornwall

Bradford Respite Intermediate Care Support Service (BRICSS) was established to address the complex medical and social care needs of people affected by homelessness being discharged from hospital and prevent the 'revolving door' of admissions. BRICSS developed as a partnership between Horton Housing Association and Bevan Healthcare (BHC). They provide a 14-bed unit for patients impacted by homelessness with continuing healthcare needs on hospital discharge, and aim for a 12-week placement in BRICSS. Patients are referred by a hospital-based Pathway Team. Medical aims and outcomes are set on a detailed management plan which supports timely move on to the correct accommodation. Clinical, social and housing practitioners provide integrated healthcare and social support. The BRICSS health team is composed of a GP, mental health / substance misuse nurse and physical health nurse. An evaluation indicated improved mental and physical health and a reduction in hospital admissions.

Cornwall Council, working in partnership with Harbour Housing and Stay at Home, have redesigned their out-of-hospital care services to increase the number of options available to patients affected by homelessness leaving hospital on Discharge to Assess Pathways. For those patients who do not have a home and require more than just a sign-posting service, Harbour Housing provides access to six self-contained units of accessible step-down accommodation. This comes with onsite practical support such as helping people to get to their hospital appointments, as well as holistic 'enrichment support' for improved health and wellbeing including counselling and a range of strengths-based activities. Where people have care and support needs including self-neglect and issues linked to drug and alcohol use, a specialist reablement service is provided for up to six weeks. The Stay at Home service provides CQC regulated activities into the step-down accommodation and into the community. Specialist reablement workers are trained in the use of trauma-informed approaches and can, for example, deliver naloxone to prevent drug-related deaths from overdose. Cornwall is one of 17 test sites that are up and running until March 2023 which are part of an evaluation of out-of-hospital care.

Commissioning Approaches | Plymouth Alliance

Plymouth is unusual compared to most councils, because the single homelessness service and the substance abuse service are contracted out to an 'alliance' of providers, including a number of voluntary sector providers, housing associations, health sector providers and the council itself. This includes the budget for temporary accommodation provision. In the Plymouth Alliance all providers have equal responsibility for all delivery. Plymouth City Council is both a commissioner and provider. Twenty five contracts spanning substance misuse and homelessness were aligned under the co-produced Alliance model. Partners share responsibility for achieving outcomes and are mutually supportive, making decisions based on the best outcome for the service user. The Alliance was awarded a single contract by Plymouth City Council for the provision of support for people who have needs in relation to homelessness and may also have support needs around substance misuse, mental health, offending and risk of exploitation. The Alliance Contract had a first year budget of £7.7m. The initial contract was for five years (from 2019) with a potential for extension to ten.

KEY CHANGES

- A no wrong door approach, where someone can present at multiple points into the system and still receive the same high quality, consistent offer
- A system of complex needs workers who deliver support wrapped around the person
- A reduction in duplication and inefficiency
- System decisions being made collectively about resources using a 'best for people using services' principle and the ability to respond flexibly to need.

SOME INITIAL RESULTS

- Alcohol outreach prototype has delivered 44% reduction in admissions and 33% reduction in bed days
- Many hostel residents are now in their own accommodation, which has reduced bed and breakfast spending by around £1/2 million.
- To respond with urgency to the Covid-19 Crisis the Alliance has made decisions according to two key principles – Is it legal? and Is it safe?
- Prevention of Covid-19 outbreaks among people supported by the Alliance
- Less than 10% no shows for drug addiction service

KEY LEARNING

- Change was based on an honest review of underperforming services
- There was real engagement at different levels with techniques like appreciative enquiry
- The alliance was born out of a process of collaboration – organisations working together (many for several years) before it was set-up
- There were parallel processes of systems leadership work with local organisations and the formal procurement
- Senior sponsorship of the project was crucial
- Officers and partners were able to draw on experience of other alliance contracts
- It's important to get the legal and procurement teams on board early
- It's important that partner organisation fully understand what they are signing up to in terms of jointly held financial risk
- It takes a lot of people resources – from commissioners and partners

Use of Peers | Groundswell Homeless Health Peer Advocacy (HHPA)

The Groundswell Homeless Health Peer Advocacy (HHPA) service supports people experiencing homelessness to address physical and mental health issues. The volunteer Peer Advocates delivering the service have all experienced homelessness themselves; in some areas Groundswell also have specialist Care Navigators or Case Workers – the majority began as volunteers. Everyone goes through a rigorous selection procedure (including DBS checks), attends a comprehensive training programme, and receives ongoing support and supervision to enable them to carry out the role safely.

A 2015 evaluation showed that HHPA improves client health through:

- Increasing access to preventative and early stage health services through the support of a peer to overcome the multiple, and interconnected, barriers they face;
- Increasing the confidence, knowledge and motivation of clients to both seek appropriate healthcare and manage their health proactively in the future; and
- Decreasing the numbers of scheduled appointments that are missed by clients, thereby ensuring treatment is received.
- Improved client health and changes in health related behaviour lead to cost savings for the NHS including:
- A 42 per cent reduction in unplanned care activity costs. Leading to an indicative saving of £2.43 for every £1 spent
- Between 50 and 70 per cent reduction in missed appointments bringing the number of appointments missed by homeless people supported by a Groundswell Peer Advocate down to the same as those missed by the general population and resulting in further cost savings;
- Potential future lifetime savings through better health leading to reduction in service use; and
  Possible efficiency savings of supporting clients to access those services which are already available to them.

Mental Health | Leicester

Leicester's NHS run Homeless Mental Health Service (HMHS) offers individualised mental health assessment and support, as well as access to mainstream NHS mental health services locally provided within Leicestershire Partnership NHS Trust. The service is staffed by two psychologists, a psychiatrist, three mental health practitioners, two dual qualified mental health nurses, a support worker and a dedicated clinical admin worker. An essential element is the mental health drop-in aspect of the service, and the accessibility and flexibility that provides. Pre-Covid-19, the service was based at the Dawn Centre, a council-run one-stop shop where anyone experiencing homelessness can walk in and access immediate support with benefits, housing advice and access to emergency accommodation, practical help, shower, change of clothes, access to a mental health assessment and GP appointment. The Dawn Centre hosts a YMCA day centre, a large council-run hostel, a specialist GP service, council staff specialising in housing and homelessness, outreach teams, and floating support. HMHS staff are part of the Multi-Agency Care Collaborative (MACC) which meets weekly to discuss and attempt to resolve difficulties which may be preventing service users with complex problems accessing services and support. MACC membership is multi-agency, and includes mental and physical health practitioners, staff working on housing, drugs and alcohol, sex workers, day centres and other voluntary sector staff.

Primary Healthcare | Brighton

Arch Health Care runs the Morley Street GP surgery and the homeless health engagement service for Brighton and Hove. The practice registers people sleeping rough, people in temporary supported accommodation, sofa surfers, gypsies, Roma and travellers. A full range of services are provided and the practice aims to meet QOF targets including COPD, asthma, and diabetes reviews. Accessibility is seen as very important, so efforts are made to make it as easy as possible for people to register with help to fill in forms, offering same day appointments and medication where possible, training for reception staff on mental health and substance misuse. In addition to the specialist GP service, the practice provides: in-reach to hospitals through Pathway teams and Pathway Plus; outreach to day centres through a nursing team which provides weekly clinics; and citywide leadership and integration through an annual conference, fortnightly complex case reviews involving social workers, housing staff and the voluntary sector.

West Northamptonshire Council

Adult Social Care | START

The START Homeless Outreach Teams are five multidisciplinary, integrated statutory community teams for people sleeping rough and hostel residents in Lambeth, Southwark and Croydon. They are funded by the local Clinical Commissioning Groups, NHS England and Office for Health Improvement and Disparities, and are composed of community psychiatric nurses, occupational therapists, social workers, with peer support from Groundswell, as well as three psychiatrists, two psychologists, a GP trainee and a nurse prescriber delivering opiate substitute therapy. START is based in South London and the Maudsley NHS Foundation Trust and integrated with Adult Social Care in two of the boroughs where it operates which enables the team to carry out Mental Health Act, Mental Capacity Act and Care Act assessments, and to lead on safeguarding procedures.

West Northamptonshire Council

Data | By Name List

Built for Zero (BFZ) is a model of ending homelessness that has achieved huge traction in the United States, Canada and Australia, by working within communities to realign systems and resources to end, rather than manage, homelessness. Understanding the problem of homelessness is central to BFZ, in which solutions at both the system and individual level are informed by quality real-time, person-specific data; common assessments; multi agency case management and prioritisation. These comprehensive data sets are held in the form of a By Name List (BNL) Information is collected directly from a person experiencing homelessness and shared, with consent, across all agencies and programmes. Data is updated at least monthly and allows local areas to monitor inflow (those entering homelessness, either newly identified or from housing) and outflow (people housed or leaving the area) at a system level, as well as use a common assessment approach to triage and prioritise support at an individual level. In the US BFZ movement alone, 80 communities operate a quality BNL, which is used to measure improvements and inform cycles of development. Community Solutions, the organisation behind BFZ in the US, have supported its export and adaptation in other countries.

Trauma-informed practice and psychologically informed environments | Plymouth

Plymouth has recently become a Trauma Informed City, with a number of overarching objectives:

- To review and reflect upon the emerging evidence regarding trauma informed approaches & Adverse Childhood Experiences, and continue to define an approach that envisions Plymouth as a Trauma Informed city.
- To promote the Trauma Informed Plymouth approach (Envisioning Plymouth as a Trauma Informed City), within city communities, agencies and partnership systems.
- To promote the Plymouth Trauma Lens as a consistent, universal and transformational narrative for a trauma informed city, that aspires to be courageously prevention focused.
- To work alongside & support communities, agencies, and partnership systems in becoming trauma aware and trauma responsive.
- To promote a system level response to the Trauma Informed approach and to support system change as a critical friend.
- To target three key service areas across the partnerships, namely school exclusions, criminal justice and mental health diagnosis.

Plymouth's Trauma-Informed Network is made up of more than 70 professionals, from a number of different agencies including; Devon and Cornwall Police, city schools, Barnardos, NSPCC, Harbour, Devon CCG and Plymouth City Council, all with insight of how trauma can affect people. The network will start to look at a system wide approach to tackling the effects of trauma by:

- preventing traumas occurring in the first place
- promoting protective factors for all children
- recognising the behaviours that may be the result of trauma and intervening appropriately
- helping adults who are already suffering adverse consequences.

Supported Accommodation Oversight | Hull & Birmingham

Hull City Council's 'Scores on the Doors' initiative, similar in principle to the Food Standard Agency's food hygiene rating, is a comprehensive rating system for supported housing providers in Hull. It is seeking to streamline how supported housing providers are assessed through the use of a comprehensive range of checks on: the quality of the support being delivered, the overall governance of the organisation, and the standard of the property. The development of 'Scores on the Doors' stemmed from several difficulties with existing supported housing review mechanisms and regulation in the sector. The system will look at three categories: support, how the organisation is governed and managed, and the quality of the property, thus giving a holistic view of how a provider is doing. Various activities which indicate any sort of action by the provider will be logged into an excel-based support tracker. From reviewing the support notes sent to them, Hull City Council staff will be able to log the quality of support that a resident is receiving over time by giving the interactions between support worker and resident a score from 1 – 8. These scores are plotted on a graph over time, with an average line in the middle representing a 'more than minimal' level of provision. The process for "Scores on the Doors" will be fully transparent and the scoring criteria will be shared with providers so that they can understand where they are performing well and where there may be room for improvement.

Birmingham have devised an 'Assessment Process Walkthrough' for new landlords as part of their pilot: 1. Check landlord. 2. Check ownership 3. Check for more than minimal care support or supervision. If the landlord provides the support, they are asked to provide evidence on: • What support is being given, in the form of support plans and/or needs assessments; • Staffing, including structure and nature of the role of each person, salaries and the percentage of time spent on support; • How support is funded; • Funds to cover the costs of employing support workers, which the council analyse. Housing Benefit should not be used to fund support, so rent levels may be reduced if Birmingham City Council thinks it is being used to pay support workers. If support is provided by someone else on behalf of the landlord, they are asked to provide evidence on: • What support is being given, in the form of support plans and/or needs assessments; • Service level agreements and contracts. 4. Checks on rent/eligible/service charges. The sector manager makes sure that all ineligible service charges (i.e. ones that relate to support) are removed, and that the lease charge corresponds with the rent that residents are being charged. 5. Other checks. As well as the above, Birmingham City Council checks: • Whether the housing is set up to cater for a specific group of people (e.g. those with issues relating to mental health or substance use); • How people are referred to the service; • Whether any information gathered from the resident confirms or contradicts information that the landlord has provided. If there are discrepancies, then Housing Benefit will be refused. 6. Housing Benefit authorisation.

Once all the above checks have been completed, the application is passed on to Birmingham City Council's Operations Manager to be authorised. Over the course of the pilot, Birmingham City Council have received 390 applications from new providers. While 62 of these were granted Housing Benefit, 211 were refused and another 117 had their rents restricted. This means that the gateway approach has likely resulted in savings to the public purse, and residents have benefitted from not being placed in poor provision.

Settled Supported Housing | Rowan Alba

Rowan Alba provide a service in Edinburgh ('Thorntree'), established in 2004. It provides support and accommodation for men age 50+ coming off the streets or having lived precariously in their own tenancy or the private rented sector.

All these men have addiction issues and some have alcohol related brain damage. Many have difficulty managing money and find it hard to live independently, being vulnerable to financial, emotional and physical abuse: they have histories of multiple and extreme disadvantage.

There are eight studio flats and four two-bed flats within a small building that also has a communal garden, canteen lounge and dining room. Residents have a full Scottish Secure Tenancy (SST) with Bield Housing Association which own the properties. Rowan Alba provide the housing support and care at home services for tenants. The service is funded through rent (housing benefit) and Edinburgh City Council homelessness revenue fund. HSCP Care at Home money now also contributes to costs because the service has been demonstrated to be keeping people out of hospital. Staff describe how when people came to the project they breathe a sigh of relief about having a roof over their head and then they can start to address their issues when they are ready. It isn't referred to as a project, but as a home for life. There is a three- or four-month period of adjustment, in which people realise that they are not going to be thrown out.

In this settled place, people start to recognise illnesses that have been undetected and with the wraparound support in place, they begin to work on their health. Men are also supported with money and paying their bills. There isn't a risk of losing their home because of any of these financial matters. Thorntree Street has accommodated 80 men since the project began with an average length of stay of seven to nine years. During that time there has been only one eviction, which was for a very serious assault. However, in the last year alone there have been eight non-Covid related deaths. Two people left voluntarily because they no longer had a problematic relationship with alcohol. "It's about them living their lives the way they want to".

Rapid Rehousing | Perth and Kinross Council

Over the past ten years, Perth and Kinross Council have been transforming their homeless services and improving outcomes for homeless households through service redesign and a range of new approaches. More recently they have introduced Home First, which supports homeless people to move directly to settled accommodation, where possible, and has built-in flexibility to respond to the multiple and complex needs of vulnerable customers. This new approach has significantly reduced the time homeless people wait for permanent housing and reduced reliance on the use of temporary accommodation. One of the many steps they took to achieve this was to carry out a full review of how they provide their homeless service and how they allocate housing. The Council is part of a common housing register with the two largest housing associations in the area, Caledonia and Hillcrest. These three landlords have had a common allocations policy since 2010. In 2016 the landlords reviewed their allocation policy, which placed a greater emphasis on Housing Options exploring all viable options to those in housing need. One change within the policy was to allow single people, from whom there was the highest demand in the homeless system, to opt for two bedroom properties as well as one, given insufficient supply of the latter. They also agreed a quota of lets to homeless households and to ensure best use of stock, the team adopted various approaches including the use of 'vacancy chains'. Through a combination of measures including enhanced access to the private rented sector, new build and 'buy-back' initiatives the Council were able to increase allocations to homeless households to 60 per cent which helped reduce the backlog of 'live' homeless cases. The impact on single people has been especially beneficial, allowing the Council to give more personalised and targeted focus to those with very specific housing needs, such as large families or people with medical requirements. It has drastically reduced stays in temporary accommodation and tenancy sustainment rates have remained high (over 90%) for previously homeless households. Perth and Kinross is now in a position where total allocations to homeless households are reducing, due to fewer homeless people waiting on every property shortlist. These positive outcomes have been achieved through many years of joint working between landlords, stakeholders, and a housing service wide approach to redesign. But it shows what can be done when all partners work together and the service has the confidence to make radical changes to how homeless services are delivered

Housing First | Camden

The London Borough of Camden's Housing First scheme is one of the longest running in England. Housing First was originally piloted in 2010 using innovations funding from the Council's former Supporting People Programme. Following a positive evaluation of the pilot, the decision was taken to commission an expanded service as part of the council's mainstream housing related support budget. The present scheme began in 2014 originally with 20 places and is delivered by St Mungo's. Successful Rough Sleeping Initiative bids enabled the scheme to grow to 30 places in 2017, 44 in 2018, and 50 in October 2020. The Council will be further expanding the scheme to 72 from January 2021 with revenue funding (but not capital funding for housing) from the London Mayor's Rough Sleepers' Accommodation Programme. Social housing provides around two thirds of current Housing First tenancies, which are accessed through Camden's own housing register, service level agreements with two partner housing associations and the pan-London Clearing House scheme. St Mungo's sources private rented tenancies. Tenancy sustainment is seen as a key indicator of the scheme's success, with 88 per cent of tenants housed since 2014 sustaining tenancies. Other positive outcomes include the majority of tenants' ongoing engagement with primary health care, mental health and substance abuse services. While the Council's Adult Pathway Commissioning Strategy has been developed in consultation with other statutory agencies, they are not closely involved in the commissioning process for the current Housing First service. Around 60 per cent of Housing First tenancies are located outside Camden, which makes multi-agency commissioning more challenging and highlights the case for a pan London approach. The service has been established broadly in line with the Housing First principles published by Homeless Link, and with a 1:5 support worker to client ratio. Camden Housing First is targeted at people with complex support needs who have been unable to move on through the Council's Adult Pathway. The evaluation of the original pilot scheme noted that a logical next step for the council would be to consider targeting chronically homeless people – including those sleeping rough – before they enter the Adult Pathway. Camden's service commissioner noted that there continues to be significant unmet demand for Housing First amongst those already within the Adult Pathway and that a preventative approach is not yet being considered. The council's annual review of service user data for those in the Adult Pathway found that 140 service users met the eligibility criteria for the Camden Housing First service. At the same time, few people fully move on from the service – three people have 'graduated' since 2014. The council remains committed to delivering Housing First, and the recent award under the RSAP will enable the council to significantly grow provision. In the longer term, the scope for further growth will depend on identifying additional sources of external funding in the face of pressure on the Council's reducing budgets.

Housing First | Scotland

In 2018 the Scottish Government published an Action Plan setting out the steps it would take to end homelessness in Scotland. The Ending Homelessness Action Plan commits to implementing rapid rehousing by default for all people experiencing homelessness, meaning that families, couples and single adults should be housed in settled, mainstream accommodation that meets their needs as quickly as possible rather than placed in temporary accommodation for long periods of time. Housing First is seen as one part of a wider spectrum of housing-led solutions to homelessness

Local authorities have been tasked with producing and implementing "Rapid Rehousing Transition Plans" to enable a move towards rapid rehousing and Housing First by default, with Government funding of £15 million to support this. Local authorities have produced 'gap analyses' setting out the scale of need for additional housing and support provision for people experiencing homelessness in their area, including the scale of need for Housing First. In parallel, there is a national commitment to increase the supply of social rented housing in Scotland, with a target of 35,000 new homes for social rent to be delivered between 2016/17 and 2020/21. For people experiencing homelessness and facing the most significant disadvantage, the ambition is to provide Housing First as the default response.

To help achieve this commitment the Government commits to scale up both Housing First and other specialist support options for those who need them, and to provide additional capacity to support local areas with this process. To drive the scaling up of Housing First, five Housing First pathfinders have been created to deliver 830 tenancies between 2018 and 2022. £6.5 million funding for this has been provided by Government, with a further £3.5 million raised by the social business Social Bite. Delivery oversight and funding of the programme is managed by the Corra Foundation and Homeless Network Scotland, and progress overseen by a governance group involving Scottish Government, Corra, Social Bite and Homeless Network Scotland. An advisory group involves a broader cross section of local government and third sector agencies. Multi agency partnerships are delivering services in each area, with fifteen agencies involved in delivering support across the five areas.

An independent evaluation process is underway, and there is a strong emphasis on transparency and shared learning. Learning from the pathfinders will inform the wider roll out of Housing First. The pathfinder process is addressing what a longer-term funding programme might look like, with the evaluation considering costs and the potential for savings across the homelessness and wider public sector. A year one evaluation report has shared learning and best practice from the pathfinders, highlighting the importance of collaborative partnership to deliver the systems change needed to scale up Housing First. This includes a collective approach to tackling risk, and sharing learning on what works. The tenancy sustainment outcomes of the Scottish Pathfinders have been comparable with the international evidence.

By September 2020:

- 327 tenancies had been started, of which 87 per cent were still being sustained (284 current tenancies).
- Of the 43 (13 per cent) of tenancies ended around half were not successfully sustained (eg they were abandoned), while around half were due to the death of a tenant or a longterm prison sentence.
- There have been no evictions from Housing First tenancies.
- Housing First schemes were operating in a number of areas before the pathfinders, and more services are planned as part of local authorities' Rapid Rehousing Transition Plans. Together it is anticipated that legacy and planned schemes will deliver 350 places in addition to the pathfinders by the end of 2020/21. There is a national ambition to grow provision to 3,650 tenancies a year over 10 years

West Northamptonshire Council

Annex B – Steering group membership/ stakeholders consulted

Stakeholder Engagement

A number of services within the Council were consulted and informed this needs assessment, alongside representatives from the following organisations

External members of project steering group (met three times in March, April and June 2023)

CGL/ Substance to Solution
Bridge
Hope Centre
Midland Heart
NAASH
Keystage Housing
Northampton Partnership Homes
Northamptonshire Healthcare NHS Foundation Trust
Maple Access
C2C Social Action
Pause
Northamptonshire Probation Delivery Unit
Homeless Link
Northamptonshire Children's Trust
Northampton General Hospital NHS Trust
International Lighthouse

Additional organisations consulted

DLUHC
King's College London & London School of Economics
NHFT Specialist Dental Services
Intervention Alliance
Northamptonshire ICB
DWP/ Jobcentre Plus

West Northamptonshire Council

Annex C – Cost Effectiveness

Housing-Led Unit Costs

Housing first	**9,683**
Housing support worker role £33.6 k p/a per caseload of 6	5,600
Team Leader role £44.7 k p/a per caseload of 24	1,864
Organisational overhead allowance charged at 15%	1,120
Health	600
Moved in costs	500
Long term congregate housing	**12,903**
Housing support worker role £33.6 k p/a per caseload of 4	8,400
Team Leader role £44.7 k p/a per caseload of 24	1,864
Organisational overhead allowance charged at 15%	1,540
Health	600
Moved in costs	500
Intensive floating support	**2,588**
Housing support worker role £27 k p/a per caseload of 12	2,250
Organisational overhead allowance charged at 15%	338
New tenancy/ basic floating support	**1,242**
Housing support worker role £27 k p/a per caseload of 25	1,080
Organisational overhead allowance charged at 15%	162