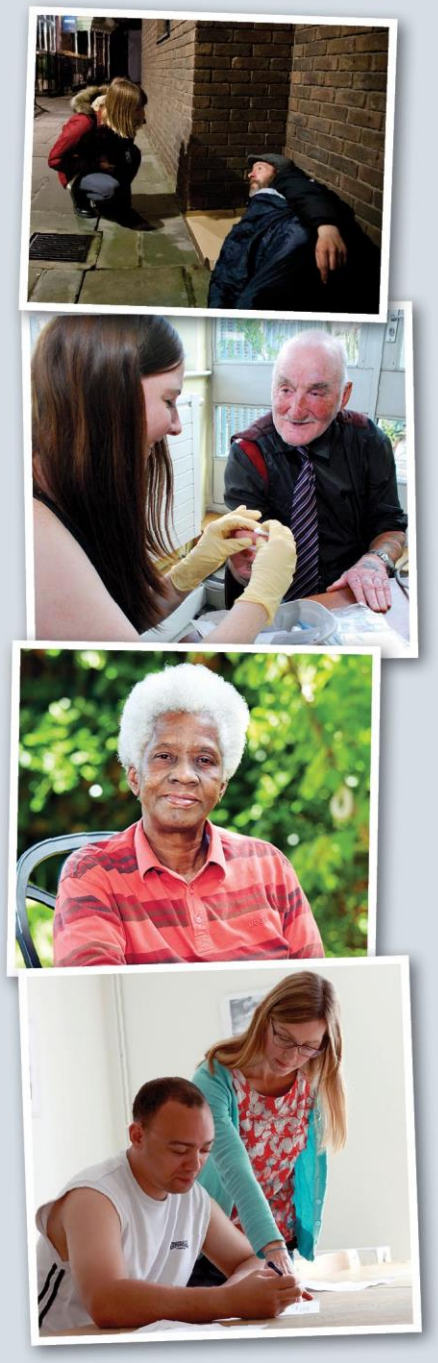
St Mungo's
Ending homelessness
Rebuilding lives

St Mungo's

Hounslow Outreach Service Report

April 2015 – April 2016



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About St Mungo's

St Mungo's vision is that everyone has a place to call home and can fulfil their hopes and ambitions.

As a homelessness charity and housing association our clients are at the heart of what we do.

We provide a bed and support to more than 2,500 people a night who are either homeless or at risk, and work to prevent homelessness.

We support men and women through more than 250 projects including emergency, hostel and supportive housing projects, advice services and specialist physical health, mental health, skills and work services.

We work across London and the south of England, as well as managing major homelessness sector partnership projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN).

We influence and campaign nationally to help people to rebuild their lives.

Contents

Introduction

This report covers the 2015-2016 financial year, and outlines the work carried out by the Hounslow Outreach Team, in co-ordination with the London Borough of Hounslow and Partners, to reduce the number of people living on and using the streets.

This report is a holistic look at the work carried out by the team with reference to the outputs agreed at tendering stage.

This is achieved through;

Prevention
This includes the use of St Mungo's referral and response system StreetLink and drop in services, such as the weekly drop in at the Civic Centre, fortnightly partnership meetings with iHear and a monthly drop in at the Olive Branch.

Assertive Street Work
Responding to referrals from StreetLink, local agencies and members of the public. We also conduct both early and late outreach shift to locate and verify rough sleepers and support them to engage with services.

Sustaining Recovery
We provide our clients with ongoing resettlement support once they have left the streets to ensure that they are able to sustain their tenancies.

Headline Statistics

	Q1	Q2	Q3	Q4
Referrals	95	99	95	98
Total Clients	112	111	86	70

The table below breaks down the categories of rough sleeping for new clients seen bedded down during the year, according to the Mayor's Rough Sleeping Group definitions;

Rough Sleeping Category	Q1	Q2	Q3	Q4
New RS with NSNO	23	21	16	18
New RS with a second night out but not living on the streets	18	19	16	2
New RS joining living on the streets population	2	0	1	0
Intermittent RS	22	32	25	22
LOS- Known	3	4	5	0
LOS- RS205+	3	3	2	2
Total	71	79	65	44

Demographics

The information in this section relates to clients bedded down during the twelve months covered in this report. Data is presented on the gender, age, nationality and immigration status of these clients.

Gender

	Q1	Q2	Q3	Q4	Total
Female	15	11	9	5	40
Male	97	100	77	65	309

Age

	Q1	Q2	Q3	Q4	Total
64-73	3	4	5	2	14
54-63	13	12	9	5	39
44-53	29	25	19	17	90
34-43	36	37	31	27	131
24-33	27	24	19	17	87
18-24	4	9	3	2	18
Under 18	0	0	0	0	0

Nationality

This year we have seen an increasing number of Polish rough sleepers move into the borough. These individuals, as EEA nationals, are entitled to reside in the UK for an initial period of three months without needing to exercise a Treaty right. After three months, the individual only has a right to reside in the UK if they are a qualified person exercising a treaty right. This means that after three months they should be working, or actively seeking work with a genuine possibility of securing employment.

Unfortunately for a large number of our clients this is no longer the case. Although some of them have previously been employed, the rough sleepers that we are seeing at the moment often have underlying substance misuse issues which are preventing them from accessing work. Where we don't believe the prospect of work to be a realistic one, we are working to engage these clients with reconnection services.

For those able to enter work, we support them to into ETE, offering English language classes and access to in-house training.

No Recourse To Public Funds

Out of the 387 referrals received over the past annum;

- 192 had recourse to public funds
- 117 had no recourse to public funds
- 78 chose not to provide us with this data

A breakdown of clients engaged with each quarter based on their immigration status and access to public funds is shown below. It is not fully representative of our client base as not all people encountered are willing to give us this information.

	Q1	**Q2**	**Q3**	**Q4**
UK National	64	52	25	12
EU National	37	40	46	33
Indefinite Leave to Remain	4	6	3	2
Asylum Seeker	1	1	2	3
Illegal Entrant	1	3	3	1

Incoming Referrals

Referrals are received from a wide range of services in Hounslow. We receive referrals from the SNT, iHear and Project 10, all of whom we work closely with. Health Professionals also refer into us and we are currently expanding these networks to take referrals directly from Hospital Discharge Teams.

We also receive a large percentage of our referrals through StreetLink, which allows individuals, their family and friends and members of the public to report the location of rough sleepers to us.

We have also started to receive referrals from other Homelessness Agencies, particularly those working in neighbouring boroughs, where they sometimes encounter individuals with a connection to Hounslow.

	Q1	Q2	Q3	Q4
Total referrals	95	99	95	98
Client verified rough sleeping	44	37	33	19
Client already in contact with service	9	6	5	11
Client located – newly engaging with service	25	22	11	10
Client located- taken to shelter/accommodation	14	3	3	5
Client not located	30	51	55	51
Duplicate referral	10	4	9	6

New Rough Sleepers

	Q1	Q2	Q3	Q4
People seen rough sleeping	136	143	91	51
People referred to NSNO Hub	48	52	43	23
Reasons for Non Attendance at Hub				
Alternative Identified	1	0	2	0
Were unable to refer as NSNO Hub full	35	30	23	10
Client refused Hub	1	2	2	0
Client refused to engage	4	9	5	6

The number of people recorded as 'seen rough sleeping' above, is not solely made up of new rough sleepers. Some of these individuals may have previously been seen by the Outreach Team and declined support or have been verified in other boroughs. As a result, not all of them will have been eligible for NSNO. The criteria for accessing NSNO changed in Q4, which may account for the steep drop in referrals.

All new clients are offered a referral to the Hub unless it is full, clients decline to engage, refuse the hub or alternatives are found.

A small percentage of verified rough sleepers chose not to engage with us. When this happens the team continue to visit the sleep site and attempt to build up these relationships, before once again offering assistance. If the client continues to refuse our services we will close the referral however, we always make it clear that we are able to reopen it if they decide that they need support.

A fair number of the rough sleepers the team encountered this year were unable to access the Hub as it was at capacity. In these cases the team offered to continue to work with individuals to find suitable accommodation.

NSNO

Since November 2014, NSNO had been piloting an extension to the criteria for the assessment hubs as a result of feedback but also because of the transition of NLOS into the portfolio of services.
Following a review of this the GLA agreed that the assessment hubs would revert back to only accepting new rough sleepers and that continued access for known rough sleepers would be given via the reconnection staging post. This change took effect in January 2016.

Although NSNO continues to take referrals for both new and known rough sleepers, the initial access routes into the service for referrals from outreach teams has change to the following:

- **Assessment Hubs**: New Rough sleepers only; those with just one bedded down contact.
- **Reconnection Staging Post Safe Seats**: Known rough sleepers seen bedded down more than once with no existing Single Service Offer on CHAIN and no clear local connection established.
- **Reconnection Staging Post Bed Spaces:** Known Rough Sleeper with a Single Service Offer requiring specialist support or intervention to facilitate reconnection.

Practically this has impacted on the number of rough sleepers the team can refer to NSNO; If the service is closed on the night of an outreach shift during which a new rough sleeper is verified, they lose the opportunity of being sent to the assessment hub as it is only available at the time the client is first seen bedded down.

This has meant that the team has needed to develop working relationships with other services in the borough that they can refer into. They have successfully housed clients through Clearing House and METRO (Multi-Agency Engagement Treatment and Reconnection Offer). They have also made successful referrals to the Supporting Independence Service, which aims to prevent crises by providing access to supported housing, and secured Discharge Beds for clients.

Despite these successes it has become increasingly difficult to house known rough sleepers. We are trying to identify other possible services in the borough that can provide our clients with emergency bed spaces.

Health

The Health interventions within the last 12 months are shown below.

This table shows the health vulnerabilities of the case managed clients. Clients may have one or more vulnerabilities or may have none.

Vulnerabilities	Number of Clients
Mental Health	125
Physical Health - TB	2
Physical Health – other	133
Drug Misuse	106
Alcohol Misuse	185
Learning Difficulties	16

The below gives a measure of case managed clients supported to engage. Those actively engaging are a percentage of those supported to engage.

	Q1		Q2		Q3		Q4	
	Supported to engage	Actively Engaging	Supported to engage	Actively Engaging	Supported to engage	Actively Engaging	Supported to engage	Actively Engaging
Drug Misuse	19	12	63	25	46	12	46	13
Alcohol Misuse	42	7	73	45	53	34	52	35
TB	0	0	0	0	0	0	2	2
Foot Clinic	0	0	0	0	0	0	0	0
Wound Clinic	0	0	0	0	1	0	1	1
Diabetes Care	0	0	0	0	0	0	0	0
Mental Health - Diagnosed	11	6	43	10	35	4	33	6
Mental Health - Undiagnosed	33	0	64	29	49	16	48	12
Chronic Long Term Condition	1	1	1	1	1	0	3	3
Dental	0	0	0	0	3	0	1	1
Other	0	0	5	5	5	5	0	0

The next table shows the individual health interventions carried out by the team in each quarter. There has not been a clear system on place for reporting these interventions so the numbers are no necessarily reflective of the number of interventions carried out by the team. However, it gives an indication of the type of work being done. This is an area we will improve upon going forwards.

Type of Contact	Q1	Q2	Q3	Q4	Total
Ambulance Called – Taken To A&E	0	0	1	0	1
Ambulance Called –Not Taken To A&E	0	1	0	1	2
Taken To A&E – No Ambulance Called	0	0	1	0	1
Supported To Hospital – Non Emergency	1	1	0	0	2
Medical Records/ Information Requested	1	0	1	1	3
MHT Visited Client	9	0	0	0	9
MHT Referral Assessment	0	0	1	0	1
Drug And Alcohol Assessment Completed	0	0	2	0	2
Non Residential Drug And Alcohol Service	0	1	6	0	7
Supported To The GP	9	9	13	16	47
Supported To The Dentist	0	0	2	1	3
Accompanied To The Opticians	1	0	1	0	2
Supported To Other Primary Healthcare Provider	1	0	1	1	3
Other Health Intervention	2	6	0	2	10
Total	30	19	30	23	102

Alcohol and Drug Interventions are a large area of work for the team. An allocated Outreach Worker attends fortnightly meetings with iHear to share information and to ensure that we are addressing clients' support needs in a unified manner.
One of the Outreach Workers identified that there were a number of Polish clients with alcohol misuse issues. They discussed this with them as a group and agreed that a Polish AA group would be beneficial. This was set up in April 2015 and has run successfully throughout the year. It is well attended by both rough sleepers and non-rough sleepers and goes some way towards bridging the gap between the homeless and the rest of the Polish community, as well as addressing their alcohol dependency issues.
The team have also developed a strong working relationship with Remar, a rehabilitation centre in Nottingham that offers assistance to disadvantaged people and individuals suffering from drug or alcoholic addiction. The team have successfully supported seven clients to engage in their residential programs this year.

Work with Mental Health Services has been a challenging area for the team this annum. Due the chaotic nature of our clients, sustained engagement with Adult Mental Health Services is often a struggle and a number of vulnerable clients have been left without access to services after failing to attend scheduled appointments. We are working hard to develop these relationships and provide advice and training around the best approach to working with the street homeless population.
During this financial year eight workshops have been facilitated by our Nurse; explaining StreetLink and the work of Hounslow Outreach, the Nurse's role and referral pathways and requesting clinicians keep in mind our client's homeless status; testing for known ailments suffered by rough sleepers and running consecutive tests as that patient may not present again for some time.

Another area identified as needing development this year has been around our relationship with Discharge Teams. They often seem either unaware of the support that the team can offer if they have a homeless client, or there is some ambiguity around the provisions that we can access.
We began to address this in the last quarter, facilitating three Informal Information and Introduction presentations with discharge teams at West Middlesex University Hospital. This is an area that we will continue to develop over the next financial year.

GP Registration

The Hounslow Service has established links with a number of local GP's to ease the process of registering clients and ensuring regular check-ups. We have a referral route with the Practice Heart of Hounslow and The Hounslow Family Practice.

Out of 379 clients case worked this annum

- 227 are registered
- 152 are either not registered or the client has declined to disclose

Nursing Input

- Training Sessions : 8 sessions delivered throughout the year
    - 2 x presentations to A&E staff
    - 3 x presentations to Discharge Teams
    - 2 x presentations to local GP's
    - 1x presentation to local mental health team
- 12x outreach session at Olive Branch drop in centre
- 12 x joint outreach shifts with Hounslow Outreach Team
- 5 x outreach sessions to Winter Night Shelter
- 12 x joint meetings with the Outreach Workers and SIS

The Nurse has taken on a key role in helping the Service Manager to develop links with primary and secondary health care providers in the borough. They work hard to publicise our service, delivering presentations and attending a number of different drop-ins to raise our profile. They have been developing referral pathways with A&E Teams, Discharge Teams, Local General Practices and Mental Health Services. They regularly liaise with other services including Social Services, Supporting Independence, iHear, Community Mental Health Teams, District Nurses, Occupational Therapists, Physiotherapists, Pharmacies, Sexual Health Clinics and TB services.

Additionally they carry a caseload of clients with more complex physical and mental health ailments as well as offering support and advice to the Outreach Workers whose clients often have more straightforward health concerns.

Over the last twelve months our Nurse has written several advocacy letters to GPs to smooth registration for outreach clients, this is often needed when the clients are based out of central Hounslow, where we do not have such close relationships with practitioners. They have referred clients to the Mental Health Assessment Teams and arranged psychiatric assessments for clients. They have also helped clients to obtain medical evidence needed to access accommodation and to sustain benefits claims when the Outreach Workers have been unable to do so.

Nurse Case Study

LC

LC has mental and physical health impairments and is drug dependent. LC has had a lot of support from organisations including St Mungo's, Groundswell, Each and iHear

She was supported into accommodation by our Outreach Team but there have been ongoing support needs around her health.

The Nurse initially got involved to make the necessary referrals for LC. There has been intensive liaison with District Nurses, iHear and Groundswell to facilitate regular appointments. LC is currently supported to two appointments each week.

Multiple referrals have been made to services including Social Services which resulted in LC's care package being increased.

An Occupational Therapy Assessments was arranged and carried out, this resulted in equipment such as a tray table and a perching stool being provided.

A referral was also made to a physiotherapist who awarded LC new crutches and a Wheelchair services which supported LC to obtain a more suitable chair, increasing her independence.

There is ongoing liaison with a local GP to monitor LC's health and provide interventions, despite poor engagement from LC. This includes provision of repeat prescriptions based on our Nurse's assessment and reporting.

Regular multi-agency meetings are held, due to the complexity of this case. The Nurse attends these to ensure that all parties are aware of LC's health support needs, what treatment is required and any concerns which arise.

Accommodation

Pre-Tenancy Work

The table below shows a breakdown of the pre- tenancy work done by the team over the last 12 months

	Q1	Q2	Q3	Q4	Total
Application sent to Clearing House	0	2	0	0	2
Application Sent to local authority	4	0	3	0	7
Application sent to other housing provider	3	3	4	0	10
Application made to PRS	2	2	1	0	5
Assessment for move-on	0	1	0	0	1
Handover to TST	1	0	0	0	1
Interview - client did not attend	0	0	1	0	1
Interview - offer agreed	1	1	0	0	2
Interview - offer withdrawn by provider	1	0	0	0	1
Result of application - successful	1	3	0	1	5
Result of application - unsuccessful	2	0	0	0	2
Signed Licence Agreement	1	1	0	0	2
Visit to accommodation provider	4	1	0	2	7
Total	20	14	9	3	46

Access to Accommodation and Assessment Centres

	Location	End of Q1	End of Q2	End of Q3	End of Q4	Total
Positive	Assessment Bed	0	0	0	0	**0**
	Temporary Accommodation	6	0	2	0	**8**
	Tenancy	13	3	0	2	**18**
	Supported Accommodation	0	2	1	0	**3**
	Treatment	0	0	2	5	**7**
	Living with Family/Friends	1	3	1	1	**6**
	Reconnected to Country of Origin	4	2	1	5	**12**
Neutral	Disappeared	1	1	2	1	**5**
	Hospital	0	0		0	**0**
	Remains on Streets in another borough	2	1	1	1	**5**
Negative	Detention	0	0	0	0	**0**
	Prison	0	0	2	0	**2**
	Squatting	0	0	0	0	**0**
	Deceased	0	0	0	1	**1**
	Total	**27**	**12**	**12**	**16**	**67**

The above table shows the location of clients whose cases were closed at the end of each quarter.

Currently there is a long waiting list for supported housing in the borough. We are working with local providers to try and ensure that our clients have prompt access to services. We have a good relationship with Clearing House and the Supporting Independence Service, both of which have housed a number of our clients this annum. We also receive notifications from Caridon of properties available for PRS.

There are a few long term chaotic clients living on the streets who have had numerous stays in Hounslow accommodation, this makes it more difficult to find somewhere to suitably house them in the borough. We are working to develop relationships with providers in other boroughs to try and identify other routes off of the streets for these individuals.

We have had a fair success referring clients with substance misuse support needs to Remar, a residential rehabilitation scheme in Nottingham, with seven attending their treatment centre this year.

Reconnections

The Outreach Team support reconnection through partnership with Hounslow agencies both statutory and voluntary and also agencies beyond Hounslow (including abroad), to facilitate assisted returns. This is particularly true on international reconnections, where we try to ensure that support services are involved before our client leaves the UK, in order to provide continuity in support.

Reconnections start with assertive work, giving a client a clear message as to what they are eligible for both inside and outside of the borough. It can be a long process as we try to facilitate voluntary reconnections, which means working closely with individuals to understand their concerns around returning home and try to find ways to mitigate them.

This year we have successfully reconnected eighteen clients – out of these six were inside the UK and twelve returned to their country of origin.

Education Training And Employment

The table below shows the number of clients supported to access education, training and employment over the last four quarters.

	Q1	Q2	Q3	Q4	Total
Attended Training Course	1	1	0	7	9
Attended Employability Skills Course	0	2	15	11	28
Engaged With Employment Agency	1	2	1	6	10
Attended ESOL Class	0	0	0	7	7
Entered Paid Employment	3	1	2	3	9
Entered Voluntary Employment	12	0	0	0	12
Engaged In Other Meaningful Use Of Time	0	3	2	6	11
Total	17	9	20	40	86

A number of clients identified that their English language skills were holding them back when it came to entering ETE. The team took this on board and recruited a volunteer who is now conducting weekly English Language classes that are aimed at improving individuals reading and writing skills.
A number of clients expressed an interest in completing the Construction Skills Certification Scheme. The necessary funding for this was sourced and the team ran revision sessions in the outreach office. Two clients have successfully passed their test this year.

Weekly drop in sessions are run by the Outreach Team at Project 10 and the Civic Centre - these are open to all potential clients and can be used as an opportunity to discuss ETE.

We have been using local services as well as using in-house provisions such as the Recovery College to promote work. Relationships have been established with The Upper Room in Acton who support clients to complete their CV's, offer interview support and help with job searches. Partnership working has also been established with a number of employment agencies in Hounslow; Direct Staff, Staff Line, Premier Work and Staffing Match. These agencies work with us to match clients to potential job opportunities.

General Outcomes For Clients

The table below gives an indication of the work carried out in each quarter. This refers to all work across all clients, those already engaged with the outreach team and those new to the service.

Event	Q1	Q2	Q3	Q4	Total
Supported into Accommodation	20	6	15	47	88
Engaged in case work / key working	23	24	5	10	62
Liaised with another Agency	58	43	22	18	141
Contact with Client – in accommodation, at the office or via phone/ email	144	129	62	71	406
Contact with Family/Friend	8	1	1	0	10
Overall Health Interventions	30	19	30	23	102
Homeless Persons Unit (HPU)	5	0	0	1	6
Immigration Advice/ Support	0	0	1	5	6
Institutional Stay	2	3	3	5	13
Supported to Access ETE	17	9	20	40	86
Support around Benefits	10	19	20	7	56
Offending/ Legal Support – contact with the police and court hearings	0	0	2	9	11
Pre-tenancy Work	20	14	9	3	46
Reconnection Advice/Support	9	2	5	11	27
Referral to Other Services	17	5	12	7	41
Street contact	152	173	100	61	486
Grand Total	515	447	307	318	1587

Client Case Studies

We continue to work with a very vulnerable and often chaotic client group. There is also a continuous flow of new people onto the streets of Hounslow. The following brief case histories illustrate some of the complexities faced.

EK

EK was verified by the outreach team in March 2015. She reported that she became street homeless 18 months prior to first contact, when she lost her job as a live-in nanny. EK had come to London on her own and did not feel that could return to her family in Poland, she did not want them to know that she had become street homeless.

Initially EK spent a few nights in the park by herself. She was then offered accommodation in a known encampment, sharing a caravan with a man who later became her partner.

When the team first met EK she was heavily pregnant. One of the other rough sleepers in her encampment knew of St Mungo's through a drop-in the team attends. He brought EK to see us hoping that we could help her to seek medical assistance. EK did not know where or to whom to turn to.
On the same day that EK presented, a Safeguarding Midwife and the Labour Ward Coordinator were contacted. An urgent appointment was also organised at the Maternity Triage.

At this point EK disclosed to staff that her partner had been violent towards her. EK was referred to an Independent Domestic Violence Advocacy Service and staff advocated for her to be allocated a Polish speaking worker. St Mungo`s then submitted a homelessness application and also requested an assessment under the National Assistance Act part 21 (1), (aa) as EK had no recourse to public funds and it was deemed unsafe for her to return to the encampment.
A referral was also made to Children's Social Care.

An Outreach worker attended Children's Social Care with EK. Where they were seen by a Duty Social Worker who advised that EK would not meet the threshold to enter the Children's Services caseload until her baby was born, at which point, if EK was willing to consider reconnection to Poland, it may be possible to house her and her new-born.

A member of the team accompanied EK to her scan, during which it was discovered that the baby's stomach was small and it was decided that induced labour was needed. EK agreed but was very anxious. During this time St Mungo`s was accompanying EK to all of her appointments, offering support, advocating for her and translating.

A short while later, EK gave a birth to healthy little baby girl. Due to concerns regarding living conditions and DV incidents, when the baby was born the case

was put under Child Protection under the category of neglect. EK was accommodated in a B&B whilst plans were made for her reconnection.

EK was not very forthcoming with information during the assessments with Social Services due to fear of the baby being taken away from her. St Mungo's continued to facilitate the relationship. EK seemed to bond well with the baby and during core meetings all of the professionals' feedback was positive.

Social Services conducted more detailed assessment regarding EK`s background, antenatal care, domestic violence incident, EK`s family relationship and her parents housing conditions, in order to proceed with reconnection.

During this time the Outreach Team made a referral to Homestart for a mother and baby kit and assisted in obtaining a birth certificate and passport for the baby as this was needed to facilitate reconnection.

Two months later, mother and her baby returned to EK`s country of origin. St Mungo`s contacted her a few weeks later to check how they were both settling in. EK reported that they were both happy and enjoying quality time with the family.

EK's ex still remains in the UK.

BG

In October 2015 BG was approached by the Hounslow Outreach Team and verified as a rough sleeper. BG told the team that she had become homeless in May after becoming the victim of domestic violence at the hands of her partner and her son and having to leave their home. BG had spent some time sleeping in the shed at the property, but after threats were continually made against her she decided to move to a local park and sleep in a tent with other rough sleepers. At this point BG lost her job.

Prior to the verification BG presented at the office, accompanied by one of our other clients, and explained her situation. During that appointment BG was referred to an Independent Domestic Violence Advocacy Service and assisted in applying for Job Seekers Allowance.

After verification BG was offered practical and emotional support. She was offered a place at NSNO and the team tried to link her in with iHear and a local GP practice. BG withdrew from the service, and despite saying that she was unhappy with her situation, would not accept our support. The team continued to visit the site and started to witness other members of the camp exploiting BG. She was the only one amongst them sustaining a successful benefits claim and they were using her money to support their addictions.

Her case was referred to Hounslow Social Services and a safeguarding alert was raised. However, when Social Services investigated it was decided that the client had capacity so they could not proceed further.

The team persisted and eventually, after some intensive work around engagement, BG accepted an offer of accommodation with Metro. She moved in November. Once BG was in a safe and secure environment, she was able to reflect back on her experiences and began to accept the support offered to her. She began to attend psychotherapy sessions to address her mental health issues, Polish AA meetings to address her alcohol dependency issues and ESOL classes to better her grasp of the language. The main goal was working towards reconnection with the view of accessing services in Poland. BG was also rebuilding her relationship with her son.
After two months BG secured job at local job agency and was employed part-time. Her confidence increased, she cut all contact with her old street friends and she sought advice on improving her health and image. She went to the doctors and got support to quit smoking. BG was very pleased with the quality of life that she had achieved.

Unfortunately, BG then began feeling unwell physically, she sought medical advice and after a number of tests she was diagnosed with lung cancer. Following this news, BG became depressed and relapsed. However, she was still being supported by Metro and the Outreach Team and slowly, her outlook is becoming more positive. BG is awaiting to undergo an operation. She has been sober since mid-January.

When asked about future plans, BG said that she would like to get better, which is her main goal now. But she is thinking beyond that, she said that once she is well enough she would like to go back to work as she liked the sense of achievement it gave her, the sense of being needed.

Long-Term Complex Need Clients – Update

The Rough Sleeper 205 initiative was set up by the Mayor's London Delivery Board in 2009 to support London's most entrenched rough sleepers. There are currently two 205 clients allocated to Hounslow on the GLA list.

DC

DC is an entrenched rough sleeper from the original 205 list. He was verified in Westminster in 2000. For the next decade and a half he was moved between hostels in Westminster. None of these provided DC with the environment that he required to address his support needs. By DC's own admission, he becomes anxious when he is surrounded by lots of people and found living in shared accommodation difficult. He couldn't cope with the often chaotic lifestyles of the other residents. He felt threatened and was frequently approached for money. He has said that his way of managing these situations was to abandon his accommodation and go back to the streets.

DC's engagement with Hounslow Outreach started in February 2015 when he was found by the team sleeping in a pedestrian subway off of the A4. He did not want to engage, saying that he was fine and did not need their help. However, the team continued to visit his sleep site, take an interest in how he was and remind him of their offer of help. Through this process, DC started to engage, attending the office to use the phone or have a cup of tea and a chat.

The team first attempted to move DC from the streets in the summer of 2015. They spoke to No Second Night Out who agreed to see DC and conduct an initial assessment with the view of potentially moving him into a room at their Low Needs Staging Post. The plan was to then set up a meeting with Westminster Outreach and Connections at St Martins as well as Hounslow Outreach and between us find longer-term adequate accommodation.

At first, DC agreed to this but on the day that he was due to be picked up and taken to the NSNO Hub, he was visibly anxious. His Outreach Worker asked what was wrong and DC broke down, saying that he would not be able to cope sleeping in the same space as so many other people. DC said that he couldn't accept the support and left. After this he went back to rough sleeping.

During this time the Outreach Team continue to maintain engagement, visiting his sleep site and supporting him to attend health and benefits appointments.

In November 2015 DC agreed to be referred to the Winter Shelter in Hounslow. He stayed there intermittently until a particularly cold spell in January 2016. When he began to stay more regularly.

He appeared to be enjoying his time at the shelter, getting on well with staff and residents and attending our office frequently. It became apparent that this might be an opportunity to re-address supporting DC off of the streets more permanently.

In mid-February, before the Winter Shelter closed for the year, the team started to discuss move-on options with DC. DC was willing to engage with the process, telling the team that he was tired of living on the streets.

DC's Outreach Worker discussed his case with the Local Authority and on their advice referred him to the SIS Team. DC was also supported to apply to the local housing register and his name was added. It was uncertain how long either of these routes to housing might take, so the team arranged with the Winter Shelter for DC's stay to be extended until he was housed.

Thanks to the Local Authority DC has been fast tracked and he has now signed a Tenancy Agreement with Hounslow Homes for a one bedroom flat in Feltham.

The support he receives from the team is ongoing during the settling in period; He has been referred to SIS for a floating Support Worker. He is still being supported to engage with Lakeside Mental Health Services. A grant application has been made to help DC furnish his flat. DC has also been supported to make his Housing Benefit claim.

Once DC is settled, the outreach Nurse will take over the case and provide further support and necessary referrals around DC's health needs until we are sure that DC can manage independently.

BM

BM was first encountered by Ealing Outreach Team in August 2013. He was located in the woods in Boston Manor Park. BM was willing to engage with the team and spoke about his current situation. He spoke coherently, telling workers that he has been rough sleeping since the 1990's.

BM did not want to give the team any of his details, but it was felt that he could benefit from regular interaction which might, over time, help him to engage with services.

BM continues to live in Boston Manor Park where he has built himself a sizeable camp. He is visited on a regular basis by the Outreach Team and a worker from the Personalised Budgets Team. He is now engaging well and accepts small items such as coffee and Irish newspapers but has refused any offers of help with accommodation. He is not in receipt of benefits and does not want to apply. He is not registered with a GP but again does not want support to access health services. The team have spoken to him about reconnection to Ireland but this has been rejected.

The Hounslow Outreach Nurse went to visit BM at his sleep site and conducted a brief health check in the third quarter of this year. BM seemed physically and mentally capable. However, when he was last visited in April 2016 his mobility seemed to be deteriorating. This is a concern as he often goes for long periods of time without encountering others and is unlikely to be able to summon

assistance for himself if he becomes unable to walk. He again refused services and is being monitored by the team.

There has also been a Famous Faces client allocated to Hounslow during this period.

JOD

JOD has been known to CHAIN since 2001 and in Hounslow since 2003. Over this time repeated attempts to house him have been made. The last accommodation secured for JOD was in 2010, however JOD left the hostel to return to his sleep site near the Chiswick Roundabout.

A lot of work was done to engage JOD during Q2 and Q3 however, despite frequent visits to his sleep site and two multi-agency case conferences no services were able to get JOD to engage.

A referral has been made to EASL, as there are concerns around JOD's mental health. TFL and Hounslow Highways have also been contacted as it is believed JOD is on their land.

JOD was last seen in the street count in November 2015 in the Chiswick area. The team have been advised not to approach JOD as he potentially poses a risk.

The team have worked with a number of other long term chaotic clients not belonging to a GLA list. All individuals have detailed recovery action plans, with multi-disciplinary team involvement, that aim to establish the best routes off the streets for each case.

Deaths Within The Rough Sleeper Population

There have been two deaths within the rough sleeping population in Hounslow over the last 12 months.

PDS

On March 15th 2016 PDS, was found deceased near Boston Road. He was near a known encampment and was possibly rough sleeping although there is no record of him on CHAIN and he was unknown to the Outreach Team. The team had previously raised concerns about the encampment in that area, which was vacated shortly after this death occurred.

VK

VK was an illegal entrant from Ukraine. He had been working with the service since November 2014.

The discharge team at West Middlesex Hospital called the outreach Nurse on March 9th 2016, the day before VK was due to be discharged. The hospital, knowing that he was street homeless, had agreed to discharge him and he wanted the teams support around housing options. The Nurse knew that the following day the team would not be available to support VK and arranged to get him discharged to the civic centre where the team would be based.

On March 10th VK arrived at the team's drop in session at the Civic Centre. He was in a taxi and had been accompanied by a Nurse from the West Middlesex Hospital, who advised the team that VK was stable and ready to be discharged. VK was visibly unwell. He was presenting as incoherent, and struggling to walk. His breathing seemed laboured. The team believed that the discharge was unsafe. They sought advice from a manager and called an ambulance which took VK back to hospital.

The Outreach Nurse phoned the ward to follow up and was told that VK had been diagnosed with terminal liver cancer before he was discharged. He wanted to be discharged home to die at his request. They believed he had somewhere to go but it fell through, they continued with the discharge.

The outreach Nurse began liaisons with Social Services as they were told that due to VK having no recourse to public funds, he would likely be discharged again.

The hospital then tried to arrange for VK to go to a hospice but VK was not registered with GP. They tried to register VK with a local practice but struggled as VK could not present in person. The Outreach Nurse stepped in and registered VK at The Hounslow Family Practice. Unfortunately the hospice by then had a waiting list and VK passed away before a bed became available.

This unfortunate situation highlighted a need to better our relationship with the Discharge Team. If they had a clearer understanding of the Outreach Teams role and their ability to access housing, there may have been more reluctance to discharge VK. Alternatively, we may have had more warning and been able to secure some temporary accommodation for him. This is now being developed so that as soon as the Discharge Team become aware that someone is homeless they inform the Outreach Nurse, who can in turn let the Outreach Workers know.

Furthermore, as a direct result of this situation it became apparent that the Hospital Discharge Team didn't know they could register a patient with a GP in their absence, the Outreach Nurse sent them the relevant guidelines and offered them some informal training.

Hotspots

We continue to work closely with Hounslow Central SNT, the Local Authority, Crime Reduction Officers, Immigration Services and local communities as part of Operation Kaleidoscope; providing the necessary support structure to rough sleepers in and around Hounslow, identifying hotspots and, where necessary, supporting statutory agencies to disperse them.

This year we have had a number of hotspots within the borough.

There is an abandoned caravan behind the Travelodge on Bath Road. At the beginning of Quarter One, it was being used as a sleep site by four or five people. The police were informed and they visited the site, removing the mattresses and making it uninhabitable.
Recently there have been reports of people sleeping there once again. The team have seen people drinking there during the day but have not encountered anybody bedded down there. The Safer Neighbourhood Team have been notified and they have also visited the site.

In November there were four tents housing six to seven people in Lampton Park. An Injunction was taken out by the council and the inhabitants were moved on. ICE were involved as there were a number of EU nationals not exercising their treaty rights. Two people were reconnected to Lithuania and one to Poland as a result.

In December there was an encampment of 10-12 people sleeping in the Montague Car Park. The majority of these were taken to Crisis over the Christmas period. They returned to their sleep site after New Year, until the first severe weather hit mid-January and they were housed in a Winter Shelter for two weeks. By the time that had ended the council had an injunction in place and they were moved on. The team are aware that a number of them are now rough sleeping in Richmond.

The allotments bordering Lampton Park have a thoroughfare of rough sleepers. These are closely monitored by the caretaker who makes the necessary referrals to the Outreach Team. Similarly Gunnersbury Park attracts a lot of rough sleepers. The Park Warden passes this intelligence on to the team who verify them and signpost them to services.

SWEP

Severe Weather Emergency Protocols were activated twice during this financial year once between January 14th- 28th and again between February 15th -17th.

On both occasions the support from The Shelter Project Hounslow was phenomenal. They provided us with 11 extra beds during the first SWEP, and an additional 7 on the second occasion. On both occasions they remained open for additional days to allow the team time to support their clients into alternative accommodation.

One of our clients was unable to be moved off of the streets during the cold spell. As he is a known drug user and the shelter does not take in people using substances in an uncontrolled way. There was no emergency accommodation in borough available and he refused to be taken to services in Harrow.

Although all of our clients needing support on these occasions were male, a similar problem may have been met had the team encountered female rough sleepers, as the shelter is only open to males.

Multi-Agency Working

The below table shows the referrals made each quarter to some of the key agencies that we liaise with.

Services referred to	Q1	Q2	Q3	Q4	Total
Counselling	0	0	0	1	1
Domestic Violence	1	1	4	0	6
Floating Support	0	1	0	0	1
Food Bank	5	2	3	2	12
London Reconnections Team	6	0	1	4	11
Social Services	1	1	4	0	6
Welfare Rights	2	0	0	0	2
Barka	2	0	0	0	2
Total	17	5	12	7	41

Over the past 12 months the team has worked hard to build and maintain relationships with local services.

We work closely with iHear, the local Substance Misuse Agency, to try and engage clients in the support services they offer. One of iHear's Outreach Worker's and one of our Outreach Team organised a Polish AA group in Hounslow. This is now running weekly on Thursdays at Hounslow Community Hall and is well attended. The same two workers have also facilitated a drop in at the No 10 Project. This now runs on a monthly basis.
We run a Housing Drop In with the SIS Team from iHear once a month.
The iHear Polish Outreach Worker participates in our shift rota on a regular basis and has also done joint day visits, to target particular clients, with one of the outreach staff.
Our Nurse and a case worker attend the iHear MDT meeting every two weeks.

We have a joint liaison meeting with the Police on approximately a monthly basis.

We now have a named contact with the Job Centre to fast track claims and to deal with benefit challenges. We have also supported clients to access The Upper Room and various Employment Agencies in the borough.

The Outreach Team attends The Olive Branch, a Saturday Drop in at the Trinity Church on a monthly basis.

We are currently developing relationships with Discharge Teams across the borough.

Staffing

Staff Changes

Eleanor Whittles, our Nurse, sadly left the team at the end of April 2016. The post is currently under recruitment.

Heather Benwell took over as the service Manager on April 4th 2016.

Added Value – students/volunteers

We had a Health Support Worker supporting the Outreach Nurse for the final quarter of this year.

We have a volunteer who runs weekly English Language classes for our clients.