HOMELESSNESS FORUM

BRENT ROUGH SLEEPERS PILOT

Brent

NHS

OVERVIEW OF THE PILOT

This model will target rough sleepers who are isolated as a result of:

- Being estranged and/or uprooted from familiar surroundings who are experiencing high levels of distress by providing a reconnection service
- For those service users with no housing, health or social links

With the aim to re-establish links with family/support networks working closely with third sector reconnection services as well as foreign embassies to facilitate timely repatriation.

WHO WILL THIS PILOT SUPPORT?

- Anticipated target caseload for Brent is 60 clients for 2024/25, identified through the CHAIN data, Ashford Place, St Mungos, SMART Team and the Brent Westminster Drug Project 'New Beginnings' work with Rough Sleepers.
- These will be individuals who are rough sleeping and presenting with mental and physical health problems. The service will employ 3 full time Complex Needs Practitioners who will have a caseload of 15-20 people at any one time.
- The team will also liaise with Community Mental Health Hubs, St Mungo's Rough Sleeping Outreach Team, Brent Council's SMART Team, Brent Council's housing support practitioners, Voluntary Sector partners and other professionals as needed.

EXPECTED OUTCOMES

- Increased engagement of the homeless community with appropriate mental health services, including facilitating access to psychological interventions such as IAPT.
- Work with a caseload of 60 clients by 28th February 2025.
- Reduction of crisis and avoidable admission to mental health units.
- An improvement in mental health and wellbeing as measured by dialogue plus care planning.
- A reduction of avoidable A&E presentations, to be monitored via local A&E reporting framework.
- Improved access to and registration with GPs.
- Improved access to physical health services and physical health checks and screenings.
- Improved pathways into accessing accommodation, including supported accommodation and residential placements.
- Improved access to alcohol/substance services to be monitored via active referrals.
- A reduction in the number of people returning rough sleeping, to be monitored and reported against those who go on to access accommodation
- An increase in those sustaining stable long-term accommodation and an increase in those accessing tenancy sustainment support from St Mungo's.
- The use of continuous feedback via continuous evaluation of interventions and service user feedback.

THE TEAM

- Complex Needs Practitioner
- Physical Health Nurse
- Psychologist
- Team Manager
- OT
- Psychiatry support
- Left over money to be used for ad hoc speech and language therapy/peer support