Merida associates

# WELLcome Home

## Hospital Discharge Navigation Service

### Evaluation report

Merida Associates | November 2021

mind Birmingham

www.birminghammind.org

SHELTER

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

www.bsmhft.nhs.uk

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# Introduction

The WELLcome Home Navigation Service is provided through an innovative partnership between Birmingham Mind, an organisation that advocates for better mental health for all, and Shelter Birmingham, an organisation that campaigns for housing and homes for all.

Operating in the shared space of homelessness and mental health, WELLcome Home provides specialist support for those in crisis following a hospital admission. The service is delivered by two Navigation and Connections Discharge Coordinators (NCDC) roles and two peer mentor roles. It provides support to individuals and families experiencing housing issues while in hospital, to help them to be discharged safely to appropriate and accessible accommodation and to reconnect with their community after a stay as an in-patient.

Birmingham Mind (referred to as Mind) works with the Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT; also referred to as the Trust in this report) to support men who have been in-patients, to return to the community. Shelter Birmingham works with Birmingham Women's and Children's NHS Foundation Trust (BCH) to support to families of in-patient children to ensure that their homes can accommodate the needs of the child when discharged.

WELLcome Home aims to reduce hardships that are often exacerbated by a hospital admission by working closely with the multidisciplinary teams in both psychiatric and children's in-patient wards.

The service has been funded by the Big Lottery Community Fund Help through Crisis from June 2016 - June 2021. The Shelter NCDC strand of the work has now come to an end. The Birmingham Mind strand of theproject was successful in securing funding to continue.

*"Medical professionals are not trained up in the housing sector and therefore cannot be expected to understand rights, options, and law in regard to this. Therefore, with our service, this allows medical professionals to focus entirely on supporting the child towards being medically fit for discharge, while we take the pressure off and handle the housing needs that are the barrier to discharge. This overallhas led to earlier discharge than if a nurse was expected todo all the above without our service involvement."*

Staff member

### Evaluation approach

The approach to this evaluation was to:

- Undertake a literature review to explore the policy context for the work with a particular emphasis on the peer mentoring role.
- Undertake desktop research and review of the evaluation data, evaluation reports, case studies and other background information prepared by both Birmingham Mind and Shelter Birmingham.

- Capture the reflections and insights from people with experience of the service: clients, staff members and external partners.

Whilst it had been hoped that during the course of this evaluation COVID-19 restrictions would be lifted to allow face-to-face conversations and focus groups to be held, in the event this was not possible and all data gathering was carried out via MS Teams, Zoom or over the phone. It is likely that this proved to be a barrier for some people who had used the services to engage in the evaluation.

## Methodology

- An initial scoping meeting
- Separate introductory Zoom meetings with both the Shelter NCDC and peer mentor and the Mind NCDC and peer mentor
- Individual one-to-one Zoom/Teams calls with both peer mentors and both NCDCs
- Individual interviews with 2 key stakeholders from Birmingham and Solihull Mental Health NHS Foundation Trust
- A group interview with 3 key stakeholders from Birmingham Women's and Children's NHS Foundation Trust who work at Birmingham Children's Hospital
- An interview with 2 CLIC Sargent-funded paediatric social workerswho work at Birmingham Children's Hospital
- Individual interviews with key informants from Birmingham Mind (1) and Shelter Birmingham (4)
- Individual conversations with 6 people who had accessed support from the Shelter NCDC and peer mentor
- Individual conversations with 8 people who accessed support from the Mind NDC and peer mentor
- An extensive review of case studies prepared by WELLcome Home staff, reports and monitoring data.

All interviews were recorded, and contemporaneously key noted prior to being written up for analysis.

The data was analysed using a 4-stage process:

- Immersion – the process of organising the data into ideas and concepts to allow the evaluation team to become familiar with the collected data

*"There needs to be a medical reason to prioritise housing – for example, the impact of the cancer on the child or young person's mobility and so forth.*

*The family may be in poor or overcrowded housing, but a diagnosis does not entitle them to move up the housing list."*

Stakeholder

- Coding and indexing the data – the process of identifying commonalities and anomalies to ensure the reliability and validity of the data analysis
- Thematic summaries – the process of identifying and building themesand identifying emerging outcomes
- Analysis and interpretation – the process of understanding the data and using this to describe findings, draw conclusions and make recommendations

## The WELLcome Home partnership

The WELLcome Home service brought together the knowledge, skills, and experience of two well-established organisations with the intention of building on previous similar work in both organisations and the explicit intention of *"learning from each other at all levels[1]"*.

Mind brought their experience and knowledge of mental health and using asset-based community approaches in their work, combined with extensive partnership working with the NHS across many projects over several years and their learning from working with peer mentors and experts by experience. Mind provides the service to Birmingham and Solihull Mental Health NHS Foundation Trust supporting adults who are at the point of discharge on acute mental health wards.

Shelter brought their expertise in tackling homelessness and the learning from a 7-month one day a week pilot led by a Support Worker and an Advice, Support and Guidance Worker within Birmingham Children's Hospital. This pilot offered a drop-in service for families, where they were easily able to access support with housing issues that ranged from unlawful eviction to reporting disrepair. Shelter extendedthe work of the pilot with Birmingham Children's Hospital through WELLcome Home.

The partnership relationship was managed through a formal Memorandum of Understanding between the two organisations, with Mind being the lead partner.

*"The WELLcome Home Services navigate risk aversive assessment processes in partnership with community support and housing providers, to bring about solutions that greatly assist clinical decision-making processes."*

Mind Annual Report 2017

[1] Birmingham Mind Annual Report 2017

## WELLcome Home service model

The WELLcome Home service provides support to adult men in BSMHFT and the parents/carers of children in BCH who are clinically stable and ready to be medically discharged from hospital, but because of a range of factors, including the risk of crisis, are too vulnerable to be discharged safely.

Crisis situations include, for instance, access to suitable housing, financial hardship and the need to secure access to benefits, food, furniture and community support for people with complex needs. If these issues remain unresolved, people often stay longer inhospital, and take up hospital beds, for longer than they need to.

Recognising that hospital staff are not equipped to meet these non-medical needs, Mind and Shelter designed the Navigation and Connections Discharge Coordinator (NCDC) and peer mentor roles to address immediate barriers to discharge from hospital and provide tapered post-discharge support using holistic person-centred approaches. Within the wards covered by the project, they are usually the first point of contact for hospital staff wanting to access support for people ready to be discharged but unable to leave because of non-medical needs.

*"People shouldn't get stuck in systems longer than necessary… it's about being independent and being able to get on with their lives as quick as possible."*

*"… you may have had a diagnosis but that doesn't have to be the thing that defines your life …"*

*"It's usually housing/benefits stopping people being safely discharged."*

Staff members

### Birmingham Mind NCDC role

The Mind NCDC works closely with BSMHFT's Capacity Utilisation Clinician[2] who is usually the main gateway for patients to access the service. On occasion, clinicians will refer people into the service and the patients may talk to the worker on the ward to ask how they can access the service. Where people make a self-referral, the NCDC flags this at thenext Acute Wards Multi-Disciplinary Team weekly meeting (MDT) which includes consultants, matrons, psychologists, and other key clinicians andthe NCDC.

Being involved in the MDT meetings is essential to the NCDC role as all referrals are discussed at the MDT prior to being accepted. This is wherework with individuals is discussed, and care is planned. Moreover, the MDT is the place where risk and security issues are discussed to ensure understanding, assessing, and managing risk and complex needs.

[2] The Capacity Utilisation Clinician supports wards with discharge planning

It is through these MDT meetings and relationships with colleagues working for the Trust that the NCDC can advocate for a more person-centred approach by asking that the men who are the subject of MDT discussions have their voices heard as part of the support planning processes.

A short referral form is completed before either the NCDC or the peer mentor can start work with someone and a risk assessment is undertaken. Where someone has self-referred the MDT will, for example,let the NCDC know that medical staff are managing risks in the background and that this may not be the right time to start planning for discharge.

The service operates across 3 male wards (2 acute and a delayed discharge ward)[3] with the NCDC managing a caseload of around 30-35 people at any one time. The focus for the service is adult males as it is these people who are most likely to be homeless and most likely to experience more difficulties in finding accommodation once they leave hospital.

The demand for the service is high and the NCDC works with the MDT to prioritise who receives support from the Mind team.

The NCDC and the peer mentor work within mental health legislation as it relates to acute in-patient treatment, which means priority must be given to addressing people's physical and treatment needs first.

The people that get referred to the service generally have a range of complex needs and are experiencing several barriers to being discharged. This may include, for example, a previously transient lifestyle which means the men may not have any identification that proves who they are; others may have an unsettled immigration status and/or have no recourse to public funds; they may have experienced long or short-term homelessness prior to being in hospital, have a history of evictions and/or rent arrears or a forensic history of arson or violence. All of which means that potential landlords may see them as high-risk tenants and be reluctant to rent their properties to them.

The Trust supports people with their mental health needs and clinical teams are focused on clinical outcomes for people. Having nowhere

*"Hospital clinical teams are trained to treat health challenges that patients face at admission, but not necessarily environmental and social issues that can come to light once treatment has concluded. For example, a home may no longer be safe for a child to return to following an accident. The social and environmental crisis issues such as homelessness, debt or familial dynamics are inextricable from the patient, so a solution must always be found within the hospital setting before a successful discharge can be achieved."*

Mind Annual report 2017

[3] Acute wards support people who are experiencing an acute psychiatric crisis of such severity that it cannot be managed at home with the involvement and interventions of staff in the community.

to live, no support networks and no access to benefits are not reasons for people to be detained in hospital under the mental health act.

The NCDC works to remove many of these systemic barriers to discharge and recognises that much of their role is dealing with the unintended consequences of a poorly joined-up system that will prevent someone from being discharged from hospital.

Systemic challenges include for example:

- If someone is well and ready to move back into the community but came into the hospital after living on the streets or in temporary shelters and have no accommodation in place to return to, if discharged they become effectively homeless. At this point the hospital's duty of care prevents them from discharging that person.
- The local authority also has a duty of care to accommodate vulnerable adults, however when people present in need of accommodation, they need to be able to prove that they are homeless on that day, otherwise they are unlikely to be supported by the local authority. People who are in hospital are not homeless untilthey are discharged, which creates an impasse and people get 'stuck'occupying a bed space that they no longer clinically need.
- Many of the men who enter the acute mental health wards from the streets, or with no fixed abode, may not have the correct documentation (birth certificate, national insurance number and so forth) to be able to access 'gateway' benefits such as universal credit, without which there is no automatic right to housing benefit. Withouthousing benefit, finding somewhere to live is made much more difficult for someone who does not have a home to return to.

The NCDC role bridges these gaps and supports men to navigate the housing and benefits systems and risk averse assessment processes, through creative approaches to problem solving. They build relationshipswith housing providers and other agencies to dispel prejudices or myths about this client group and ensure that people can get access to the rightpaperwork to enable them to claim gateway benefits.

## Shelter NCDC role

The Shelter NCDC received referrals from both the Children with Medical Complexities Team[4] and the CLIC Sargent paediatric social work team at BCH.[5] Referrals were made following an initial assessment which explored a family's current living arrangements to make sure that the family had accommodation that was suitable to meet the needs of their child once discharged from hospital.

Initial assessments identified a range of issues for example overcrowding, untreated damp and mould, poor sanitary facilities, unsafe homes, draughty or poorly maintained properties needing extensive repairs, broken or faulty heating or no heating, combined with a housing provider/landlord (council, housing association or private sector) unwilling or unable to make the repairs.

Families may rent from a provider who is unable to give permission for home adaptions, such as a downstairs bathroom or make the changes needed to make the property accessible for the child because of the age or structure of the property.

*"…people go into a panic when they realise their house may not be suitable anymore"*

Staff member

It may be that the existing family home is not large enough or is without a room suitable to accommodate the discharged child's changed needs, for example requiring a wheelchair-accessible downstairs bathroom and bedroom.

Where the family is living in a home that is not suitable for the child to return to once well, the Shelter NCDC carries out a needs and risk assessment and then assists the family to get onto social housing waiting lists and Birmingham City Council's Housing Register and supports them to identify and bid for properties that meet their needs.

Bringing their specialist housing knowledge into the hospital, the NCDC took the strain off families by liaising with clinicians for letters to support housing applications and then carried out all the follow up and chasing work so that families did not have to. They assisted families to navigate their way through Birmingham City Council's and Housing Associations' bidding processes, informing and involving them as much as possible so

[4] The Children with Medical Complexities Team is a unique paediatric multi-disciplinary service, which supports the most medically complex children, from hospital to home https://bwc.nhs.uk/children-with-medical-complexities-team-/

[5] CLIC Sargent is a voluntary organisation within Birmingham Children's Hospital (and all the main children's cancer hospitals) that provides expert help for families with children who have cancer. They work closely with doctors, nurses and other NHS professionals as an integral part of the team caring for children with cancer. https://www.younglivesvscancer.org.uk/what-we-do/day-to-day-support/social-workers/

that parents learnt how to use the housing allocation systems. When suitable accommodation had been identified, the NCDC liaised with the housing provider to make sure that any repairs were completed before the family moved in and helped families to access grants to purchase, for instance, white goods, where needed.

Depending on the complexity of the support required, the NCDC either supported parents to submit benefits applications for housing benefit or carer's allowance or referred them on to the Citizens Advice Bureau for more technical help with Universal Credit and Disability Living Allowance claims.

The caseload was flexible and depended on the complexity of cases – however, during the life of the service all referrals were supported without creating a waiting list.

The service was only able to work with families in rented accommodation, families who owned their own homes (with or without a mortgage) were given information about disabled facilities grants. If they had a home with a mortgage and the property was unsuitable for the needs of their child, and parents are not able to access grants, then the service was unable to help them further.

**Peer mentoring**

The peer mentor role is an important element of the WELLcome Home service. In both organisations the peer mentor is an employed staff member who brings their own lived experience to the work that they do and shares those skills, knowledge, and experiences with the people they support.

Peer support schemes traditionally arose outside clinical mental health or other health services, often in the form of groups such as Alcoholics Anonymous and patient and service user civil rights movements in the 1970s. Academic Emma Watson[6] defines peer support within mental health services as "*social and emotional support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition, to bring about a desired social or personal change.*"

This can be applied to other services, where service users need emotional and social support to make change in their lives. Core principles of formal peer support include mutuality, emotional safety, and a non-directive

[6] https://pubmed.ncbi.nlm.nih.gov/29260930/ The mechanisms underpinning peer support: a literature review Dec 2019

approach, as well as a move away from 'helping' and towards 'learning together'. Watson also stresses its mix of functions and approaches, fromadvocacy, crisis support, training, supervising, volunteer roles and roles inthe statutory sector.

Peer support is a popular policy initiative in the UK (and worldwide); Watson states that peer support worker roles have been established in most NHS Trusts in the UK. Steve Gillard, in a 2019 Journal of Mental Health editorial, highlighted that Health Education England's Stepping Forward to 2020/21 mental health workforce plan included a proposed development of new peer worker roles as part of a cohort of non-traditionally qualified jobs alongside the clinical workforce.

The WELLcome Home peer mentors work with people on a one-to-one basis to provide emotional support, acting as both listening ear, role model and friendly 'guide,' with the ambition to use their experiences to help others cope in difficult circumstances and where appropriate, make positive changes to move forward with their lives.

*"…It's all about buildingclients' resilience … I empower them, to lookat and care for their sick child but also look at and resolve the issues that are there."*

Staff member

**Shelter peer mentor role**

The Shelter peer mentor worked alongside the NCDC to provide emotional support to parents, working with up to 12 cases at any one time (30 in total). People were referred into the service from the hospital teams and, where emotional support was indicated, the NCDC undertook a joint assessment with the peer mentor to identify support requirements and allocate tasks.

The peer mentor provided emotional and peer support focused solely on the housing issues the family were working through. All other forms of emotional support were provided by other teams in the hospital.

The peer mentor worked with *"what the client presents, and I draw on my own experience and often tell them just to take a deep breath…"* Much of the role involved being there for parents and supporting them through the day-to-day challenges of finding a new home at a time when their energies were focused on their sick child.

The peer mentor role was initially for 12 hours a week; however, this was increased to 22 hours per week in response to high numbers of families accessing the support.

Where a family needed to move house, the peer mentor worked with parents while the NCDC explored housing options; often encouraging families to think about widening their housing search into areas with

larger, more suitable properties and talking through with them how they would manage to maintain and build community and family connections if they did move to a different area. The peer mentor assessed a family's readiness to consider these difficult issues and returned to this conversation over a period of weeks to "*encourage people to face reality and make compromises.*" (peer mentor)

Many of the clients supported by the peer mentor were, at the time of referral, experiencing high levels of anxiety in relation to moving home to accommodate the needs of their sick child. The peer mentorhelped them with many of the 'mechanics' of moving – finding schools, dentists, GPs and so forth. By keeping in regular touch with clients, the peer mentor encouraged people to 'do things for themselves', to build their own skills and resilience, often sitting withthem while they made calls and decisions.

Drawing on their own experience of homelessness, the peer mentor helped parents get to grips with dealing with life outside hospital, reminding them, for example, about the importance of paying bills (especially rent) on time and supporting them to engage with any other children they may have about the proposed move. They helpedthem keep in contact with their families and community during a longhospital stay so that they had support in place when they left the hospital, to help them settle into their new home and surroundings.

*"Sometimes people just need to express emotion – people may need to cry for a time, and we'll spend time getting through that and then a conversation will open up and gradually the conversation will get closer to the heart of it and things may start to change. Maybesomebody will show much more interpersonal and emotional range – it's not just all about the troubles and problems they're having, they maybe talk about what they've seen on TV. Thelanguage becomes more positive, they start to more optimistically, hopefully, you see them speaking well of the relationships they have in their lives and then you start to see their behaviour change - they leave the house to do stuff and start connecting."*

Staff member

**Birmingham Mind peer mentor role**

With a lived experience of using secure forensic services and as an ongoing service user, the Mind peer mentor feels that developing his peer mentoring role has been a rewarding and reflective learning experience and something that has gone hand-in-hand with his own recovery journey.

Influenced by both Birmingham Mind's person-centred approaches to better mental health for all[7] and Carl Rogers' helpful relationships[8], the peer mentor works to form a relationship with the men referred to him. The NCDC provides contact information, some details about the person's recovery journey and a risk assessment.

Working part-time, 2 days a week, the peer mentor carries a caseload of between 4 and 10 people. The change in working practices during

[7] https://birminghammind.org/home/about-us/our-values/
[8] https://www.simplypsychology.org/carl-rogers.html

the COVID-19 pandemic meant that more men could be supported.[9] The primary task of the peer mentor is to form a relationship with the men that engage with the service, and through this relationship support people to "*move closer to what is happening to them"* as part of their recovery journey.

The peer mentor aims to encourage men to move away from thinking and feeling that 'they (for example the hospital, the clinicians, the system) are doing this to me and I'm helpless and have no agency or control over this' to understanding the situation they are in and exploring how they can be effective in the situation. The person may still not agree with the approach taken by clinical teams and services; however, they do move closer to understanding how they can work with, and therefore get more from, services because of this insight.

*"People often disagree with what's happening to them and I broke down for someone recently that this wasn't about them. We talked about the fact that the concerns were about the risk they present to themselves and others and while clinicians don't hold the absolute truth, they hold a portion of it, and you hold a portion of it.*"

The peer mentor wants to enable people to feel better able to be a more effective agent in their own lives as "*part of someone's recovery pathway is this connection to their experience and what recovery actually means*."

The starting point is to establish a relationship and build rapport with the person referred, one that is different to the transactional relationships people have with services and clinicians. He starts by activity listening to, acknowledging, and understanding people's stories, needs and goals.

The men want varying levels of engagement with the peer mentor and the peer mentor's experience led them to develop a continuum of support which can be typified as follows:

**Least engaged** are those men who distance themselves from their experiences in and out of hospital, and who feel that they do not need help, even though they may be experiencing challenges. This group of men are not connected to their experience and insist they do not need support. At this stage, the peer mentor "*respectfully wishes them well and leaves it at that."*

*"It's about forming a relationship and I've had conversations with people in the past wondering what makes a helping relationship helpful, how come speaking to someone is helping somebody – what's the magic that's happening there really.*

*I think it is that connection with somebody, in a small way a soulful experience with somebody that seems to do stuff for people on top of the practical elements of it.*

*There is something about how you connect to your experience and establish connections with what's happening …. People need supportconnecting with that ongoing experience and making sense of itand figuring out ways forward in ways that make sense to them."*

Staff member

[9] See page 31

**Some engagement** are those men who accept some peer-to-peer help to sort out accommodation and other practical aspects of life after hospital. The men in this group do not want to connect with the peer mentor or connect with their experience. In this situation the peer mentor builds a functional relationship with the person and some rapport to facilitate getting the practical tasks done and leaves it at that; aware that to force any further work or relationship building would be painful for that person.

**Short term intervention** of around 3 – 6 months that offers a mix of dealing with practical issues and builds sufficient rapport to develop relational and emotional support that helps people to connect to and make sense of their experience.

**Longer term intervention** of around 12-18 months. This is not necessarily intensive support for the whole time as, after the initial few months' work to make sure that accommodation and benefits are sorted, the ongoing relationship becomes more focused on connecting people with themselves, with their families and the community and helps them navigate community facilities.

The peer mentor creates time and space for people to express their emotions. Peer-to-peer conversations are often about sharing stories, talking about and expressing feelings and emotions and the Mind peer mentor helps to put things in context during those conversations.

For example, someone may spend a month or so talking with the peer mentor about their anxiety and about how difficult it is to leave the house, and after a few conversations there is a plan in place and they are leaving the house, going for a walk with the peer mentor and feeling less anxious each time it happens. People start to feel like they can be an effective agent in their own lives.

## Delivering benefits for systems and people

Underpinning the assumptions behind the design and delivery of the WELLcome Home service is the objective to reduce costs for the NHS by removing barriers to discharge.

The findings in this section are based on primary data gathered through interviews with stakeholders, conversations with people who have used both the Mind and Shelter services and data and case studies shared by both organisations.

This section of the report explores the difference the work has made to the people it has worked with and in the hospital trusts where the services are based.

*"It helped me where I didn't have to worry about someone's housing, I could concentrate on the more complex patients where there is other things for me to do – so that helps my workload"*

*"They built really good relationships with the team, it's not easy working on the wards, they were confident to work with different professionals Both personable, nice people, pleasant and smiley – that really helps."*

Stakeholder

### Benefits: Birmingham Mind service

The WELLcome Home project has influenced the wider mental health system in that Forward Thinking Birmingham[10] commissioned a similar service from Mind having heard about the emerging benefits of the service. This project has adapted the WELLcome Home service model to meet the needs of younger adults.

The project has also been able to influence ways of working within BSMHFT, including developing greater awareness of the barriers many patients face in the community. Mind has been able to build on its relationship with BSMHFT including 'expanding the scope of support offer by considering the development of new roles in co-production with Birmingham Mind.'

BSMHFT are clear that the service has delivered benefits to the Trust and have invested funding for the Mind team to continue to deliver an extended service for at least another 12 months, with the appointment of additional staff and peer mentors.

BSMHFT staff found that the service speeded up discharge processes and, as a result of this, men on the wards spend less time waiting for their discharge plans to be implemented and their frustration is reduced. Stakeholders feel that the service is likely to have "*contributed to increased bed capacity and because of this made significant savings into the hospital*". A further implication is that men waiting in A&E would be able to access a hospital bed more quickly.

[10] Birmingham's Mental Health Partnership for 0–25-year-olds

Interviewees commented that the staff had really good communication skills, both in the way they interacted with the men on the wards and those who entered the service, and in their relationships with staff teams.

The NCDC brings their specialist knowledge of housing and benefits into the Trust and this frees up staff time, particularly for complex cases meaning that staff can focus on other aspects of treatment and discharge planning.

In the wards supported by the NCDC, Trust staff can refer people with more challenging housing needs, such as those who want to live in a specific area of the city or who are long-term homeless with few of the skills needed to cope with living in rental accommodation without running into difficulties.

The Trust is aware that good discharge planning makes a huge difference in keeping people out of hospital for longer. Moreover, theTrust knows that unless barriers to discharge are removed as part of the discharge planning process, there is a significant risk of re-admission if service users do not have the support they need to live independently in the community.

Working with the Trust's MDTs, the service has been able to establish protocols whereby issues relating to the purchase of proof of identification documents, opening bank accounts, navigating habitual residency tests (HRT) for Universal Credit, and issues relating to service users with no recourse to public funds, are identified and managed.

Owing to the work of the service, ward staff's knowledge of housing and other issues has increased and their awareness of the services that are available in the wider community has been heightened.

Trust staff welcome the opportunity to be able to access the NCDC's insights and advice on housing, benefits and wider community services that are available on an ad hoc basis, and the team's flexibility and ability to work in partnership have been appreciated. Trust staff also know moreabout the services Birmingham Mind offers, for example floating support,and appreciate that the NCDC can fast track people into these services.

The fact that the service can operate in the hospital and in the community brings benefits to both patients and the Trust. Working with the Utilisation Capacity Clinician in the Trust to design housing pathways as part of discharge planning is welcomed, but the fact that the service can support people with follow up support and signposting after

*"The systemic issues that create hospital re-admissions from unresolved issues present challenges for professionals tasked with facilitating discharge. The WELLcome Home service has to take a sector wide grasp on issues such as GP registration dictating access to services and/ or medications, interconnected communications systems that capture risk management and housing allocation policies, staff wellbeing consideration for example mileage and travel to transferred clients."*

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discharge is particularly significant, as the Trust's role does not extend past the point at which people are discharged.

The service has connected discharged men to their community by helping them find support systems in the community and, for example, by helping them find out and be confident about transport links to other forms of support. This combined with the support to find and maintain a home, sorting out benefits entitlements and peer support reduces the stress and anxiety that people experience on discharge, reducing the likelihood of relapse and a return to hospital.

The men who participated in the evaluation could all identify how the support received from the project had helped them to stay well post discharge, and all spoke to their thanks and appreciation for the help and support they received. When asked what was different about working with the peer mentor, the men found it difficult to put this into words often saying, "*he had time for me,"" we talked", "I could be myself", "he knows what it's like"* and *"he listened."*

Service users talked about how their conversations with the peer mentor had helped build their confidence and their ability to connect with others, and some had insight into how this helped them to avoid becoming an in-patient again.

When asked what was important about the project, people told us that Birmingham Mind is an organisation that they trust, and often mentioned that it is one that puts people first and which understands the system.

When asked what was important about the peer mentor relationship, people felt that the fact the peer worker was open about, and able to share, the story of their personal journey through mental health services was of vital importance. One man said *"I asked why I should trust you, you're just being paid – he told me his story and by the end of it I trusted him". A*nother told us *"It helps because he's been through the same sort of experience, because I'm talking to someone who has been through the same experience, someone who hasn't doesn't understand*".

Service users felt that the peer mentor was good at making connections with people and gave examples of how they had connected with their community because of the time and support he gave. The peermentor often went with people to groups where they could meet new friends (pre-pandemic). He helped people de-code official letters and to understand how to deal with them.

*"If I didn't have* [names peer worker*] at that time I would probably have gone back into hospital."*

*"We talked about stuff I wouldn't talk about with a psychologist."*

*"If I didn't have Birmingham Mind's help, I probably would have got suicidal again."*

*"They take the time out, you can go to see them, they come to see you."*

*"I remember* [names peer mentor*] being there, and I was an absolute wreck, I couldn't walk into a room, the only person I needed was [names peer mentor], he walked beside me."*

Service users

One person described how, on being discharged from hospital, he knew that, given his history, clinicians were concerned that he would not cope in the community and that he would be back in hospital fairly quickly.

He started his relationship with the peer mentor while still in hospital he was fearful of leaving the safe and known hospital environment and concerned about how he would cope once back in the community. He found the connection with the peer mentor instrumental in helping him at a time when he felt *"lost and afraid."* Regular meetings helped him to open up about and address his fears and "*just knowing he was on the end of the phone helped with my nervousness."* Almost 2 years since discharge from hospital, he is living contentedly in his own flat.

**Demonstrating system savings**

A cost consequence analysis (CCA) is an approach used to carry out an economic evaluation of a service or initiative. It looks at the costs of delivering interventions and the consequences that have resulted from delivery to inform assessment of the value provided, financial and social. Unlike other forms of cost analysis, such as Social Return on Investment (SROI), it does not attempt to create an investment to savings ratio (for instance £1 invested creates £5 of cost savings).

*"The assumption is that in making decisions based on a CCA, different decision makers will place their own weights on the different benefits and on costs, implicitly if not explicitly. CCA is of particular interest in public health because the National Institute for Health and Clinical Excellence (NICE) in England permits the use of CCA for public health interventions, unlike other health care. CCA is often referred to as a disaggregated approach, because the benefits and costs are not combined into a single indicator such as net benefit or a cost-effectivenessratio.[11]"*

The approach taken for this evaluation was to use case studies of individual service users to set costs incurred by the programme in delivering support and interventions against potential costs that may have been incurred by the public sector if those men had not accessed the services.

Appendix 1 contains detailed case studies of 2 men supported by the service, and which are summarised below. The case studies were identified from a long list provided by the NCDC and peer mentor. Bothare indicative of the outcomes for many of the men supported by the service.

[11] Encyclopedia of Public Health pp 168-168 Cost-Consequence Analysis

**Case study summary: Baz**[12]

*About Baz*

In 2014 Baz was going through a difficult time. Evicted from the local authority-owned property that he had called home for 13 years because of a series of misunderstandings and miscommunication that led to his housing benefit being withdrawn. This meant that Baz was homeless and with nowhere else to go he started sleeping rough, mainly on the street. During this time, he withdrew from engaging with anyone. Even to the extent that he stopped responding to his 'legal name' and would only respond when addressed by his chosen alternative 'street' name. This made engagement with services and benefits claims almost impossible and without benefits he was unable to secure accommodation.

Baz was hospitalised 3 times between 2016-2017, where he was diagnosed as having bi-polar disorder. His most recent admission in 2017 came via the police who, following an arrest, identified he had mental health needs and he was admitted into hospital for an assessment.

*WELLcome Home service support*

While he was an in-patient, the NCDC worker helped Baz to work through his housing options. He was given information on all available vacancies and supported to complete applications and risk assessments, one organisation at a time, until he found a landlord willing to offer him a property.

The NCDC worked with the landlord before an initial meeting and attended the meeting with Baz, helping Baz to get all the paperwork signed and in order. This was particularly challenging as Baz still hadhigh levels of anxiety at the prospect of using his legal name and at that time still preferred to use his chosen alternative name.

The service supported him to move into a privately-owned property and facilitated his transition into the community as well as the legal challenges he faced when applying for benefits.

The NCDC helped Baz overcome another challenge that arose on his discharge day when the clinical team determined it would be necessary to place him on a Community Treatment Order to support him to comply with treatment in the future. Baz just wanted to put

*"She used to see me once a week and spend around an hour with me talking to me about how I'm feeling and what the meds are doing to me – always finding solutions which was difficult as I like to keep myself to myself. She's consistent and good at her job. Being consistent is important.*

*During my time in hospital I was confused, and when I first came out and knowing she was there was comforting and that she was available. I was able to feel vulnerable with her, that's not possible with the hospital staff as they're busy doing their job. It can feel like the staff are against me in the hospital as they don't always listen, and thesis listened to me I felt that [names NCDC] cared and the staff at the hospital didn't – it was their job. I could talk to her about anything it's helped me be more open – she talked to me about how it's all well, being quiet but you need to express yourself and make people understand."*

Conversation with 'Baz'

[12] Not his real name

the whole negative experience of ill health in the past and the NCDC helped him to understand that this was another step in his journey.

Post-discharge the service also supported Baz to attend housing and benefits appointments and to open a bank account in his legal name as well as finding out what was going on in his local community.

*Potential cost savings*

Since discharge, Baz has not been street homeless and has maintained his tenancy for over 4 years.

He received 131 hours of support from the WELLcome Home service costed as £15.15 per hour.

The total cost of the intervention in staff time was **£1,984.65**.

Potential costs saved can be estimated based on the following evidence:

- people who experience homelessness for three months or longer cost on average £4,298 per person to NHS services, £2,099 per person for mental health services and £11,991 per person in contact with the criminal justice system
- preventing homelessness for one year would result in a reduction in public expenditure of £9,266 per person[13]
- the potential cost to the public purse of rough sleeping estimated at £20,128.00 per annum [14]

The overall WELLcome Home intervention costs contrasted with potential health care costs:

- Residential psychiatric care at £842 per week (£3,268 per month)
- More intensive care provided in NHS mental health care clusters at £424 per day (£12,720 per 30-day month plus initial assessment costs of £311)
- Early intervention team costs at £2,782 for support provided in the community

[13] Pleace, N. & Culhane, D.P. (2016) *Better than Cure? Testing the case for EnhancingPrevention of Single Homelessness in England*. London: Crisis.
[14] Pleace, N. (2015) At what cost? An estimation of the financial costs of singlehomelessness in the UK. London: Crisis.

**Case study summary: Steven**[15]

*About Steven*

Following a complete breakdown, 70-year-old Steven was in hospital for 11 years. After such a long time in a ward environment, Steven was extremely frightened and concerned about leaving hospital. A previous discharge had not gone well for Steven and he voluntarily admitted himself back into hospital. He was fearful at the thought ofbeing out in the world and he found that the support from the peer mentor really helped him to cope with his transition from living on a ward to living in the community.

*WELLcome Home service support*

The peer mentor started to build a relationship with Steven while he was still living on a ward and just beginning the transition to being discharged into the community. Initially, the support involved escorting him on home visits to his flat and spending time with him there so that Steven started to feel more comfortable with his environment. The peer mentor and Steven would visit the shops together so that Steven became familiar with his local area.

These visits to the flat and shops gave the peer mentor and Steven time to start the process of getting to know each other. The focus for the peer mentor was on building an empathic relationship with Steven, one where both parties understood what their shared space contained psychologically and emotionally and then, from this shared conversation, they found the space to talk about building Steven's recovery journey.

Once he was discharged, the peer mentor visited Steven at his flat each week. These visits enabled the peer mentor to check in with himand for Steven to be able to express any concerns he may have and tohave support to undertake practical tasks, such as shopping.

*Potential cost savings*

Steven has not been re-admitted to hospital and has maintained his independent housing tenancy.

He received 60 hours of support from the WELLcome Home service costed at £15.15 per hour.

The total cost of the intervention in staff time was **£909.00**.

*"When I came out, I was very frightened and scared of the world, The peer mentor did a great job of keeping me going- he really helped me to sort my life out. Iwas nervous and frightened and didn't know where I was going and what I was doing.*

*He sat and talked to me – we met regularly … he helped me back into reality and facing the world again. …. Knowing that he was at the other end of a phone helped me to get back out into the world."*

*"It makes a huge difference that he's got experience of being in hospital – it's a different sort of conversation and he can bring things out into the open…. We talked and compromised – and I took small steps – he talked about moving forward and I wasn't so stuck or so depressed…. It's the one to one you can just talk and talk - it's really important that he's a peer and the talking is really important."*

Conversation with 'Steven'

[15] Not his real name

The overall WELLcome Home intervention costs contrasted with potential health care costs:

- Residential psychiatric care at £842 per week (£3,268 per month)
- More intensive care provided in NHS mental health care clusters at £424 per day (£12,720 per 30-day month plus initial assessment costs of £311)
- Early intervention team costs at £2,782 for support provided in the community
- Day care provision at £38 per day (£190 per week/£760 for 20 days support per month[16]

In terms of housing costs, Steven is living independently. This contrastswith estimates of the

- Cost of supported living accommodation at between £1,010 to £1,981 per week. The Local Housing Allowance figure in the West Midlands is approximately £256 per week[17]
- Eviction costs to a landlord are estimated by commercial legal services at between £1,300 (County Court) and £2,200 (High Court) per incident[18]. This however excludes the costs to local authorities and other providers in terms of re-housing and benefits adjustments.

[16] Source: Curtis, L. and Burns, A. (2020) Unit costs of health and social care 2020. University of Kent, Personal Social Services Research Unit

[17] Sources: Curtis, L. and Burns, A. (2020) Unit costs of health and social care 2020. University of Kent, Personal Social Services Research Unit and HM Government

[18] Source: https://www.nimblefins.co.uk/business-insurance/landlord-insurance-uk/average-cost-evict-tenant These figures are consistent with those provided in other related searches

**Benefits: Shelter service**

The Shelter NCDC developed a good relationship with the Housing Department's Registration and Allocations team at Birmingham City Council (BCC). This team governs the BCC Housing Register. Shelter was able to secure real change for clients who were ready to be discharged but did not have suitable accommodation. Applications forfamilies with an in-patient child at BCH, where housing is a barrier to discharge, are now processed within a week instead of 12 weeks via the standard system.

The WELLcome Home team also secured a bypass to a lengthy review process, which caused further delays to discharge as Shelter notes:[19]

*"Due to relationships built with BCC the team has been able to bypass the usual 'Suitability of Accommodation' Review Process if there is a medical reason for the property not being suitable for the client to accept (e.g., property not accessible for a wheelchair). Our families canresume bidding for a suitable property the next day."*

Previously, if families declined an offer their application would be reviewed, a process taking 8 weeks, and they would be unable to bid on other properties during that time. A negative review decision couldhave reduced their priority status level or even disqualified them fromthe housing register for a while. The bypass arrangement means that families at BCH will continue to benefit from a reduced timeframe for discharge in the future.

Moreover, pre-COVID the NCDC worked closely with BCH Occupational Therapists to make recommendations around necessary adaptions in the home. They visited potential properties to assess their suitability for the child and the adaptions they would need to be safely discharged.

In Year 3 of the project, the team secured the right for families to bid on unadapted, but adaptable, properties. Previously this had not been allowed, which Shelter identified as discrimination, as the likelihood of clients being able to secure an already adapted property was highly unlikely[20].

Both the Children with Medical Complexities team[21] and CLIC Sargent social workers agree they are more aware about the process of securing

*"People go into a panic when they realise their house may not be suitable anymore"*

Staff member

*I think everyone knows now about the importance of thinking about housing…you can't just think about it the day before the child goes home – which is a really big shift and people now understand their roles in it – that they have a part of play in it*

Stakeholder

[19] From Project Monitoring Report Year 4 2020 [edited]
[20] From Project Monitoring Report Year 4 2020 and Shelter Case Studies
[21] The Children with Medical Complexities team is a unique paediatric multi-disciplinary service, which supports the most medically complex children, from hospital to home.

rented accommodation for families who need rehousing to meet their child's needs as a result of working with the NCDC worker(s)[22]. BCH staff teams welcomed the expertise that the NCDC brought into the hospital and the additional capacity they provided. The paediatric social work team described being released from 'hours on the phone'sorting out housing, gaining time that could be spent providing emotional support to families. BCH teams reported that they had a clearer understanding of how the housing allocation system works, what information was needed and helpful to navigate it successfully, and what was not.

*"Making the right choice of housing is a weight on parents' shoulders, who have a child in hospital, and even though it can be changed to some degree, it depends how far the line they've got before they realise it is wrong."*

Stakeholder

For instance, both teams now understand what letters from the hospital need to include to support housing applications and noted that they *"had discovered that anything emotionally based in a letter made it harder for the housing department!".* They understand that letters need to be in simple language, stating the child's specific needs clearly and setting out the timescales to fit with medical discharge.

The NCDC designed a pro-forma letter that clinicians and other staff can use to save time and feedback from the hospital teams and families has shown that they received a much speedier response as a result.

Some of the families that participated in the evaluation were not always clear about the work that the NCDC undertook on their behalf 'behind the scenes' in securing suitable housing and accessing grants for adaptions and repairs. This demonstrates that the NCDC approach of taking some of the strain from parents while their child is in hospital worked well in practice. Other families expressed their gratitude and happiness to find themselves living in a home that met the needs of their sick child. Some commented that the support from the service had helped them move from hospital to a new home as easily and safely as possible.

Families all talked very movingly of the lived experience of caring for their sick child and the strain that placed on family life. Families were particularly anxious about the impact of COVID-19 on their child's health, and the implications of one or both parents being ill, and on plans to move.

One family talked about the council house where they were living with a child who was being treated for cancer. The mould growth was so extensive that their sick child developed a serious fungal infection. The

Our patients have multiple professionals involved in their care, both in hospital and out in the community.

[22] Staff changes meant that there was a change of personnel from the pilot and during the life of the service

other children in the household had severe asthma. The CLIC Sargentteam introduced them to the NCDC who helped them get rehomed.

When asked about the difference the service made, the parent commented *"Honestly it changed my life, they changed my life. All mychildren have asthma…. And they were having an asthma attack every 2 or 3 weeks especially in the winter ….in this house they are much bette*r."

One parent, whose child was diagnosed with childhood leukemia at 12 months, talked about how the family needed additional space that could be kept clean and away from the rest of the family. They were living with their in-laws in an overcrowded home and her child has a compromised immune system which means that she is particularly susceptible to infection. The family was working with the NCDC to find suitable permanent accommodation.

The peer mentor kept in regular contact, ringing them most weeks. However, as the parent commented *"she hasn't been able to play a role yet as I'm stuck waiting for somewhere to live*". She found the regular contact helpful as just having someone 'check -in' was important.

Before the family found out about service, they felt like they were not getting anywhere with the housing department. The family feel that the NCDC support helped them get closer to securing a suitable home. "*Before I got in touch with Shelter I was just sat there with no clue as to what was happening, no contact from the housing, and every time I did call housing, they'd just say it's a long list and it could be many years and I got more worried each time. As I got in touch with Shelter, they have helped me feel more at ease…she's been amazing and always calls me back and things."* COVID-19 slowed the whole process down, however, the family feel that they would not *"have got where we are without them*."

All the families who participated in the evaluation had worked with the peer mentor but found it difficult to articulate how the support had helped them as they moved out of hospital and into their home. Some of the families we spoke to did not understand that the peer mentor was there to offer emotional support around their housing issues and saw her as someone who kept in touch with them and passed messages onto the NCDC.

*"We were living somewhere that was very, very damp, the plaster was coming off the walls and we were struggling to find anywhere to live … to be very frank we didn't have much money so we couldn't afford anything else….my other children and my husband also started having to take an inhaler…. My landlordwasn't helpful…but after the help we've got somewhere else tolive and I'm very, very thankful we've got this place and everyone is better and since we've been here my son is so much better. The only thing that has changed is moving here our food is the same everything is the same and my son's eyes are better and even my other child is better."*

Service user

# Delivering outcomes

This section is structured against the project outcomes as agreed with the National Lottery.

Following changes in operational, management and leadership staff in the Shelter project team after the first 2 years of the service, a new service team worked with Shelter's internal evaluators to create a WELLcome Home theory of change (ToC) specific to the Shelter service. Itmapped how the activities delivered by the service would achieve the outcomes of the project. Thereafter a consultant from the National Lottery supported the development of a joint theory of change which mapped the change journey for both the Shelter and Birmingham Mind services (see Appendix 2).

In the months prior to February 2020, the Shelter team had been re-designing their data gathering tools for the project, including a refreshed evaluation plan to measure impacts against the ToC. The impact of COVID-19 meant that the tools were never fully implemented and some of the anticipated benefits of the service, for example, the cost savings in the number of bed days saved, were delayed and have not been realised.

As a result of the staff changes at Shelter, there was a lack of continuity in the use of data gathering and monitoring tools that were in place at the start of the project and data capture was less effective across the remaining life of the service.

This section uses statistics from years 1 - 3 of the Shelter data spreadsheet, analysed in more detail later, while Year 4 is taken from the Shelter team's WELLcome Home Project Outcomes Year 4 report.

**Outcome 1: people who have experienced hardship crisis are better able to improve their circumstances**

**Shelter**

Shelter collected client-reported outcome measures against the service outcomes, with data captured at the beginning of engagement with the service and again at the end. Start and finish data was compared to give an indication of the difference the service had made. The target was that80% of clients report an improvement to their wellbeing and independence.

Shelter gathered case studies and feedback from clients that show how the peer mentor contributed to improving the social opportunities for families supported. Over the life of the service, people were supported to

engage with social activities such as trips to Cadbury World, an Easter Fun Day and a visit to Birmingham Museum and Art Gallery.

As part of wellbeing support, peer mentors and NCDCs supported families experiencing domestic violence, and those who were bereaved during their engagement with the service.

The peer mentor also supported clients with mental health, including making links to other external services, benefits, grant applications and attending social events.

### *Building wellbeing*

Shelter's data shows that across years 1-4 of the service most peopleoverall reported that their emotional wellbeing had improved.

Table 1: improvements in emotional wellbeing across all measures

| Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|
| 82% (No. = 22 of 26) | 87% (No.= 12 of 14) | 100% (No.= 4 of 4) | 80% (No.= 4 of 5) |

### *Building independence*

To assess an increase in independence, in years 1-3 the Shelter team captured start and finish responses against 3 indicators measured on a scale of 1 to 10, with 10 being high:

1. confidence in managing at home
2. managing tenancy
3. managing finances.

Overall, the majority of those who reported noted an improvement in their independence across all measures

Table 2: improvement in independence across all measures

| Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|
| 86% Reported an average 3-point improvement in their scores (No. = 22 of 26) | 79% Reported an average 2-point improvement in their scores (No= 11 of 14) | 100% Reported an average 3-point improvement in their scores (No. =6 of 6) | 31% (7) clients' housing issues were dealt with and completed 36% (8) housing not completely sorted but moving in the right direction |

NB. figures for years 1, 2 and 3 formed from a composite of these 3 measures

## Birmingham Mind

Birmingham Mind received 186 referrals into the service during the 4 years covered by this report: with 89% of those people engaging with the service.

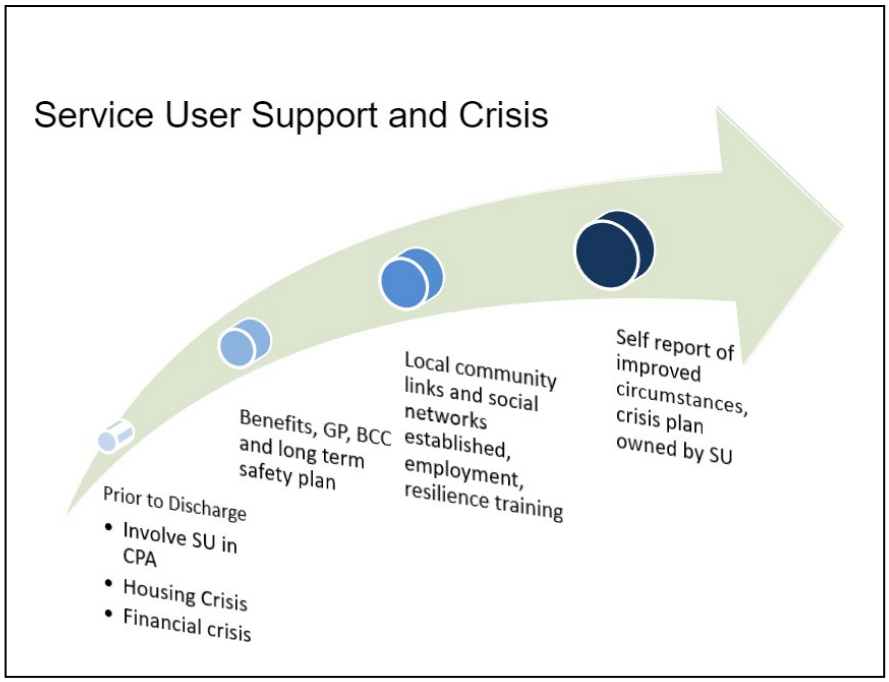
Referral pathways into the WELLcome Home Navigation Service were developed with staff teams in the three wards where the service was offered and Table 3 shows where referrals originated.

Table 3: source of referrals across all years

| Ward | Utilisation capacity clinician | Occupational therapist | Responsible Clinician | Ward Manager | Nursing teams | Self-referral |
|---|---|---|---|---|---|---|
| George | ■ | ■ | ■ | ■ | ■ | ■ |
| Endeavour[23] | ■ | ■ | | | ■ | ■ |
| Eden | ■ | ■ | | ■ | ■ | ■ |

Figure 1 shows what a service user might experience on their journey through the WELLcome Home service – taken from the WELLcome Home Service presentation. (Mind and Shelter)

Figure 1




[23] Endeavour is a delayed transfer of care (DTOC) unit specialising in overcoming challenges to discharge planning such as housing and financial hardship.

The service helps to facilitate faster discharge from hospital and patients are keen to engage. At the heart of the Mind WELLcome Home service is their person-centred approach. The people Mind works with often have very complex needs and long-term experience of housing insecurity, as well as mental ill health. Some want to live entirely independently, some want to live near their support networks, and others would prefer shared accommodation to help them develop their social skills. The service also provides practical help to overcome issues with the housing allocation system, by liaising across clinical and local authority teams.

Accessing the 'best' choice of housing is often not straightforward, and the support of the service can be vital to ensure account is properly taken of the men's wellbeing in the process. The service aims to give people agency over their lives; the peer mentor and NCDC work to help the men referred into the service understand that they can make decisions for themselves, and they can have a voice.

This approach helps people to work through their current crisis and to establish a firm base for life post-discharge. It centres the patient in helping them to be a part of directly determining and planning for improvements in their own lives, through advocacy by the NCDC and peer mentor and the relationships they have built with clinical staff.

*"…people get through it on their own agency as ultimately my job is to make them believe that this is their life and that they can make decisions and take some control. Because when you're sectioned you do lose some control and my job is to get them to think about the decisions, they can make for themselves..."*

Staff member

## Outcome 2: people who are at high risk of experiencing hardship crisis are better able to plan for the future

### Shelter

The Shelter team used the Resilience Scale measure to assess clients' reported sense of emotional wellbeing, physical health, management of their home/tenancy, finances, social networks and confidence, with improved resilience captured by a recorded improvement in all these areas.

Most of the clients reported an improvement in their independence and confidence across all measures.

Table 4: improvement in resilience across all measures

| Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|
| 88%<br>Reported an average 2-point improvement in their scores<br>(No. = 23 of 26) | 86%<br>Reported an average 3-point improvement in their scores<br>(No. = 12 of 14) | 100%<br>Reported an average 4-point improvement in their scores<br>(No. = 6 of 6) | 60%<br>Reported an improvement across all areas<br>(No.=3 of 5) |

Table 5: improvement in confidence across all measures

| Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|
| 85% Reported an average 3-point improvement in their scores (No. = 22 of 26) | 92% Reported an average 5-point improvement in their scores (No. = 13 of 14) | 100% Reported an average 8-point improvement in their scores (No. = 5 of 5) | 100% Reported an improvement across all areas (No.=unknown) |

Part of the support from Shelter was designed to help families to plan for the future. This included helping families to use planning and support tools to avoid future problems and, as part of the process, they agreed their support plan with the team. People were provided with self-help packs, support with budgeting, were signposted to local services and assisted to apply for grants for household essentials. The peer mentor encouraged families to make use of these tools.

Until December 2019, when funding for these additional services ended, families were also able to access courses, groups and events delivered through other Shelter services.

**Birmingham Mind**

The project supports service users during their current crisis and helps them plan for future. The service has evidence of helping service users tosecure appropriate accommodation, as a starting point to their post-discharge journey, and ensuring plans and support systems are in place if things go wrong.

Every service user has a person-centred crisis and housing support action plan developed prior to discharge, ensuring their needs are considered and met as far as possible. Mind reports that person-centred action plansare also shared with the BSMHFT partnership, where staff and clinicians find it useful in 'thinking holistically'.

Crucially, the Mind team looks to ensure that service users are placed in the right housing, rather than any housing, and in addition helps them to establish the right links into the local community for on-going support.

WELLcome Home service users with no fixed abode are given time to explore 3 options for accommodation by accessing housing referrals, assessments, and property viewings prior to agreeing a discharge date with the responsible clinician. A crisis plan post-hospital discharge covers

access to home treatment and establishing GP registration with HMO (house of multiple occupancy) providers.[24]

Post-discharge emotional and social support from the peer mentor also provides vital time and space for recovery for some service users, who might otherwise face repeated re-admission to hospital.

**Outcome 3: organisations are better able to support people to effectively tackle hardship through sharing learning and evidence**

**Shelter**

Shelter worked with a range of organisations who can identify vulnerability and hardship issues that can lead to crisis for the families it works with.

Shelter was represented on the Birmingham city-wide Disability Forum, which provides opportunities to share housing knowledge and expertise with other support organisations. Attendance at the Forum provided Shelter staff with insight as to where they could refer clients for further support to develop their independence and social skills.

Shelter had a key role in raising awareness among clinical staff and partners of the housing system and the ways in which it causes delays to discharge, as well as being able to help overcome those problems itself. The service was successful in building helpful relationships with housing teams in Birmingham City Council (BCC).

**Birmingham Mind**

The Mind team built excellent working relationships on the wards it covers and across BSMHFT, and as a result influenced the internal processes at the Trust. Hospital staff are now more aware of the challenges that need to be overcome when discharging men with a history of transient lifestyles back into the community. They better understand the difficulties men will face in accessing benefits and the risk of men wanting to stay within the hospital environment as it invariably feels safer than a community setting with no source of income.[25]

Good relationships with housing providers have been key in securing accommodation to support discharge and as the Mind NCDC notes.[26]

*"Sometimes people just need to express emotion – people may need to cry for a time, and we'll spend time getting through that and then a conversation will open up and gradually the convo will get closer to the heart of it and things may start to change. Maybe somebody will show much more interpersonal and emotional range – it's not just all about the troubles and problems they're having they maybe talk about what they've seen on TV. Thelanguage becomes more positive, they start to more optimistically, hopefully, you see them speaking well of the relationships they have in their lives and then you start to see their behaviour change - they leave the house to do stuff."*

Staff member

[24] Mind NCDC, Annual Report Sept 2019 – Sept 2020
[25] Mind NCDC, From HTC Annual Report Mind Sept 19 – Sept 20
[26] As above

*"The service cannot exist without (…) partnerships with registered social landlords/ Houses of Multiple occupancy landlords. (…) The relationships and partnership approach to working with landlords ensured that referrals and assessments were about more than simply identifying accommodation for the person because there are many variables that are nuanced with each and every case for example the level of support and presence available at each accommodation such as 24-hour onsite staffing and meal preparation."*

**Outcome 4: those experiencing, or who are at high risk of experiencing, hardship crisis, have a stronger, more collective, voice, to better shape a response to their issues**

**Shelter**

A goal of the service was to involve service users in feedback, evaluation and development of the service. Most of the service's involvement was with the parents / carers of the patients who are children (most under 18) and include children on life support systems and babies. Therefore, itwas not often appropriate to involve younger children, or those still veryill, in shaping the service.

Work on co-production and participation, a stated priority for year 4, wasdelayed due to COVID-19. Work had been done to develop a protocol forcontacting parents and carers and potentially speaking to children and young people, which the team had begun to take forward, however the Shelter team's approach to co-production and participation never fully came to fruition.

In the 2019 end of year report to the National Lottery, Shelter described the ways in which it advocated on behalf of families and children to ensure their housing needs were met. This included regular formalised meetings with Birmingham City Council (BCC) to discuss cases and raise any issues, barriers, or delays to securing housing.

**Birmingham Mind**

Some of the work around participation and co-production, including the development of service improvement forums within wards, was put on hold because of the COVID-19 pandemic. Prior to this, the service held service improvement meetings at the Birmingham Mind Beechcroft Hub for those people living in the community.

Mind has an additional set of complexities to consider when trying to organise meetings and facilitate in-patient participation on secure acute psychiatric wards, as they are not always suitable or appropriate settings to in which create productive engagement.

More generally, Birmingham Mind has a strong track record of co-production and has established ways for service users to become involved such as monthly open forums for each service; Joint Advisory groups made up of 50% staff and 50% service users; a central Improving Mind group that meets to carry out detailed work on Mind's policies, procedures, events; and service user representatives on the committees that form part of Mind's governance structure.

Mind also operates Mental Health and Wellbeing Hubs that offer 1:1 recovery support planning, recovery-focused activities and support to develop peer-led support networks and groups.

Birmingham Mind is continually developing paid opportunities for those with lived experience to become peer mentors/experts by experience across a range of its services, such as the WELLcome Home peer mentor role.

# The impact of COVID-19 on the WELLcome Home services

The impact of COVID-19 on the wider voluntary sector has been well documented by NCVO, The National Lottery's Community Fund and the Third Sector Research Centre amongst others and is not explored in this report. However, in common with the rest of the voluntary, health and social care sector, the rapid onset of the COVID-19 crisis and the uncertainty this created had an impact on both strands of the WELLcome Home project.

Following an initial period where all staff followed government guidance to stay home, expecting to return to 'usual work patterns' within a few weeks, both elements of the project began to explore how to adapt the service offer to working from home and remotely engaging with partners and clients.

All the staff talked of their rapid learning around the adaption to working from home and of the challenges of creating a space to work that was able to be private and confidential combined with home schooling while working in a complex environment and managing the demands from partners, families, and clients. All felt that they had made these adaptionswithin a very short space of time and were able to switch from face-to- face to remote support. All could see the benefits of retaining some of the adaptions post-COVID, such meetings being conducted via Zoom or Teams, however, all felt that work with clients is more meaningful and simpler when done face-to-face. There was, however, a general feeling that once remote working practices and systems were in place, clientsand staff found that subsequent lockdowns less challenging.

### Shelter

For the Shelter NCDC lockdown meant not being based in the hospital for the 2-3 days a week as they had been previously. This meant it was muchharder to stay in touch and communicate with the CMiC and CLIC Sargent teams and they had to adapt to using phone, emails and texts to share information and they joined BCH meetings on Zoom as often as possible.

It became clear that the full-service offer would need to be scaled back – which meant working with families on Zoom to complete housing applications and advising them on what to look out for during virtual property tours. The NCDC found it much harder to build rapport with families and to support the family to move from just focusing on getting a house to the wider support that the service could help them access.

Relationships with key contacts changed too and also moved to be maintained via Zoom and Teams calls.

The Shelter peer mentor found lockdown 1 especially difficult and reflected on the impacts for their own personal mental health and wellbeing and those of the families being supported. With some clients, the peer mentor moved from 1 visit or call per week or so, to 3 or 4 calls per week in order to help families to cope with the uncertainty about the process of finding new accommodation.

In those early weeks when the future looked and felt uncertain, some families did not want to even take their children into hospital for treatment because of their fears around infection with the virus and the impact that this would have on their child's health and the wider family's health and wellbeing. The peer mentor provided emotional support to families concerned about their income and keeping up with rent payments, and to others where people were still going out to work and were concerned about the risk of infection.

One family described their situation where their child required a course of chemotherapy that included time spent in hospital receiving the treatment and a rest period at home between rounds of treatment. The family just wanted to either stay at home or stay in hospital (both places they saw as being safe for them and their child) but were deeply concerned about the risk of infection when moving between the two.

Another parent talked about her concerns about her children attending school (once this was permitted again) and the risk of infection for her sick child.

A study conducted by Healthwatch England and The British Red Cross in 2020[27] into people's experience of hospital discharge during the early stages of the pandemic identified that a drive to find new beds within hospitals for acute COVID-19 cases led many patients to be concerned about the discharge processes and the lack of information and follow ups they received. However, reports from the Shelter WELLcome Home teamconversely indicated that children's discharge from BCH became slower, perhaps reflecting concerns of cross-infection, unmet housing needs and support requirements as identified by families and the team.

**Birmingham Mind**

Moving to all-remote working made some aspects of both staff roles more challenging, with communication being at the heart of most of them.

The multi-disciplinary team (MDT) meetings moved online, which is working well, and the NCDC is able to continue to work closely with the clinical teams, identify priorities on a weekly basis and share updates on actions taken during the week.

During the first lockdown, Birmingham Mind was commissioned to provide Birmingham's Mental Health Helpline which meant that the WELLcome Home team now have access to up-to-date information more easily. There is also a sense that, where providers continued operating, other services became a little more responsive since COVID-19, there is a sense that agencies are *"pulling together a little more."*

Communication with the men on the wards became more challenging, it can now take several days of ringing to be able to talk to someone. The only contact possible is via the ward phone, which means that a hospital staff member has to answer, find the person and then bring them to the phone for the Mind team to talk to them. This is made all the more challenging when a staff member answers who is not aware of the service and the team members have to explain and secure support to get the person they need during the call. Pre-COVID-19, an ID badge was all that was needed to gain access and, once on the ward, hospital staff could have relaxed conversations with the WELLcome Home team about the service.

27 https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20201026%20Peoples%20experiences%20of%20leaving%20hospital%20during%20COVID-19_0.pdf

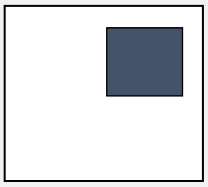
The team are leaving cases open a little longer so that people can access additional support if they need it to help with the impacts of the pandemic. The numbers of men wanting to access the service has risen during this time.

The peer mentor now carries out all his work with peers over the phone and finds that, because he is no longer travelling around the city for face-to-face meetings, he able to manage an increased workload. There are several men that the peer mentor is supporting where the relationship – even during the in-patient referral phase – has all been over the phone.

However, phone contact has proved frustrating at times, for example when people run out of credit or simply do not pick up and answer the phone. The peer mentor talked about the challenges of not being able todo anything practical to support people, and commented "..*some peers have taken backward steps during the pandemic lockdown. It is hard thatthey can't see the person is there physically, they needn't answer the phone whereas I turn up at their door and that's harder for them to ignore."*

Using an analogy of a square within a square, with the larger square being someone's life and the smaller square being their interaction with clinical and therapeutic services pre-pandemic, the peer mentor felt that he was often part of what the client saw as the smaller square with a weekly visit. He feels that for some of the people he supports he is now part of the larger square, with appropriate boundaries to maintain a professional relationship, as phone calls can mean more frequent contact and conversations.

Fig.2 Building relationships



# Learning points

Exploring what works is an important element of reflective and responsive service delivery and this section of the report explores what has worked well, what the partners have learnt from delivery and how this can inform the design and delivery of similar services in the future.

### *Partnership working with the NHS*

All organisations have their own organisational culture, which primarily relate to *"the way things are done around here*,[28]" and an important factor in any successful partnership working is cross-partner understanding of the systems, drivers, and constraints of all partners.

Moreover, partnership in this context relies on a number of factors:

- the willingness of partners to work together and to recognise the strengths and skills each partner brings to the table
- a shared agenda
- a willingness to overcome challenges
- opportunities to share outcomes and impact

It is not clear that initial conversations to discuss and agree how each element of the project would deliver in BSMHFT and BCH in relation to the above factors took place.

From stakeholder interviews, there was a general sense that the Birmingham Mind team understood how the NHS in general, and mental health services inparticular (both community and hospital-based), worked and this knowledge helped the NCDC to work within the ward and clinical team structures more easily. The Shelter team demonstrated less of an understanding about how the NHS more broadly functions, and the Birmingham Children's Hospital more specifically. Both teams were recognised as being experts in the housing and benefits fields and stakeholders appreciated the advice and knowledge being brought into clinical settings.

Effective communication is critical for the success of a partnership, and in each strand of the project building relationships with key stakeholders was essential. Where communication was ineffective or absent, some frustrations were inevitable. For example, with BSMHFT it was not alwayspossible for the multi-disciplinary team communication loop to work well. This meant that feedback from the NCDC to ward staff did not always filter through to the MDT. Nurses on the wards may have been updated

[28] Open University – web site accessed June 2021

but for various reasons may not have updated clinicians. The NCDC was not able, as an external provider, to directly update clinical records themselves (using RIO system) which meant that sometimes clinicians did not have the full picture.

### *Embed person-centred approaches to working with people*

Birmingham Mind has a strong organisational commitment to using meaningful person-centred approaches across all its services and both WELLcome Home team members have this ethos at the core of their day-to-day work. Person-centred approaches help empower people and give them the confidence to take control of their own lives. The WELLcome Home team understand that each person is responsible for their recovery, and therefore the relationship between team member and client is one of collaboration, mutuality, and partnership.

Shelter also advocates person-centred, strengths-based, or asset-based approaches that focus on recognising and developing an individual person's strengths. Such an approach means doing with, rather than doing for, building personal knowledge and skills that increase resilience.

### *Staff require support to deliver effectively*

The high-pressure, often fast-paced environment in which WELLcome Home teams delivered support to service users needs to be recognised by their employing organisations.

WELLcome Home teams worked with vulnerable adults and families coping with very ill children with complex needs, and the level of support people in those situations require can place considerable strain on staff. In addition, the teams worked within stretched hospital environments where there was a high demand for their services. This led to some teammembers feeling burnt out.

For example, the Shelter team found that Shelter's Employee Assistance Programme, offered as phone counselling, was not particularly beneficial when dealing with their own grief on hearing of the death of a child in a family that they had been working closely with for several months. Both team members (pre-COVID) were able to draw support from the CMiC team at BCH, however both had to find other avenues for day-to-day support to deal with other deaths and both acknowledged how difficult this aspect of their role was.

There needs to be an organisational awareness of the emotional impact of the roles. Employers can ensure that staff wellbeing policies are part ofthe day-to-day supervision and support provided to team members, and line managers need the skills and insight to recognise, discuss and address issues that may impact on staff wellbeing as they arise.

Leaders and managers need to be aware that when unavoidable changes in line management and support structures happen, staff may find it difficult to re-build productive working relationships with new managers so that they can provide the necessary emotional support. Staff recruitedinto similar roles to those in WELLcome Home should be made aware of the challenges they may experience and be encouraged to think about their own resilience and what support structures they mind find helpful from the start.

### *Peer mentoring is an essential element of the offer*

Peer mentoring has been a key part of the WELLcome Home services and both peer mentors bring the values of equal power relationships and reciprocal roles of helping and learning, rather than illness-focused approaches, to their work.[29]

Both peer mentors have independently created an approach to their work that is reflective of a review of research into peer-to-peer relationships carried out by academic Emma Watson[30]:

- The use of lived experience as service users or having similarly life experiences; peer mentors explicitly shared experiences and emotions with service users to build rapport, and implicitly drew on their own experiences of what did and did not work for them to inform and support service users
- So-called 'love labour' or emotional labour; highly emotionally engaged work, with strong emotional connections and emotional honesty as a crucial component, and a corresponding need for support to maintain the peer mentor's own wellbeing
- Occupying a liminal space; existing between two identities of 'service user' and 'mental health worker', as well as those 'included' in society and those 'stigmatised' or 'marginalised'
- Strengths-focused social and practical support; using social interests and practical tasks to draw out and build on a service user's strengths
- The 'helper' role; bringing benefits to the peer mentor, including feeling useful to others, reducing internal stigma, looking to others rather than oneself, and feeling looked up to.

[29] Gilliard 2019 https://www.tandfonline.com/doi/full/10.1080/09638237.2019.1608935
[30] https://pubmed.ncbi.nlm.nih.gov/29260930/

Both peer mentors experienced some challenges in their role. Clinicians and hospital teams often need more information about the benefits of peer mentoring and how support from a peer mentor can build agency and resilience – outcomes that are often intangible and hard to measure. The experiences of the men and families who accessed peer mentoring from WELLcome Home suggest that, whatever the challenges the 'system' faces in understanding the outcomes of peer support, beneficiaries know that it makes a significant difference to their lives.

This is especially evident from those men who have been supported by the Mind peer mentor – all of whom share a common (although generally differently articulated) view that the relationship with the peer mentor was important to them and brought tangible benefits. They appreciated alistening ear, sharing time and activities (pre-COVID-19) and conversations that not only fostered insights into their own illness but enabled them to make a connection with someone. From this connectionthey could connect to other, start to explore the world around them and develop their own social connections and networks. The phone connection with peer mentors in both strands of the project was particularly appreciated during the pandemic.

Peer support to families with a child in BCH generally stopped once the child was discharged to a safe and accessible home, with benefits and white goods in place and the case was closed.

### *Importance of clear data collection systems from the beginning*

Both Mind and Shelter are committed to demonstrating the impact and outcomes of their work, and both organisations are aware that data combined with testimonies from people who use the services are powerful tools for influencing commissioning, service design, funders, and policy makers. When sharing outcomes and impact with NHS partners evidence of the difference made is essential.

Good practice indicates that data gathering needs to be proportionate, understood by frontline staff, managers, and partners and ongoing across a project or service. Unless data is gathered routinely and consistently across the life of a project then organisations risk not being able to evidence the difference their work makes.

There is some early data captured on a spreadsheet by Shelter staff that indicates that bed blocking was reduced, and significant costs were saved, together with the evidence against Health through Crisis outcomes as seen on pp. 24-31, but the information was not captured consistently across the life of the service so it provides only partial evidence.

Changes in management and the Shelter delivery team meant that understanding of the sophisticated data collection and inputting processes that had been created were not effectively handed over and this opportunity was missed.

Shelter and Mind developed separate processes for data capture so it was not possible to compare or aggregate delivery against project outcomes information for both WELLcome Home services for the evaluation.

Mind captured monitoring data on the number of referrals and the types of support provided to families, housing and benefits etc. they kept action logs from multi-disciplinary team meetings that included progress updates to track the effectiveness of their interventions and they gathered many case study narratives of service users reflecting on their experience of the WELLcome Home service they had received and the difference it had made to them.

A shared methodology for data capture at the beginning of the project could have brought together the best elements of both monitoring and evaluation processes and enabled the establishment of a robust evidence base for this approach to supporting delayed discharge that would make it easier for services like this to be commissioned in Birmingham and elsewhere.

## Conclusion and recommendations

Qualitative evidence from both strands of the WELLcome Home services indicates they enabled speedier, safer, and more sustainable hospital discharge for both adult men from acute mental health wards at BSMHFT and children (by supporting their families) at BCH with ongoing medical and care needs. They also built service users' capability to engage with housing and benefits systems when in crisis and provided emotional and social support through difficult transition processes out of hospital.

Stakeholders recognised the success of the work and saw the benefits of working in collaboration with voluntary sector agencies that bring specialist skills and knowledge into the hospital environment. This is timely given the context of the current NHS transformation programme and the development of integrated care systems which bring the voluntary sector into commissioning and delivery partnerships with health, including mental health and social care.

The upskilling of hospital support teams, especially around navigating housing systems with patients and families, was welcomed, as was the negotiation of shorter routes through the property bidding process at Birmingham City Council and the creation of useful letter templates to support housing applications. The services reduced the non-clinical workload of hospital staff, freeing them up to provide more care, and achieved quicker and better outcomes for services users.

There were differences in the approach to peer mentoring in the two strands of the project and the evidence suggests that the model of in-patient and follow-up support in the community offered by the Mind team was more effective in enabling service users to successfully sustain tenancies and prevent re-admission into hospital. Families of children being discharged from BCH may have benefited from more ongoing support post-discharge as they acclimatised to supporting their child at home.

The project has showcased the benefits of people with lived experience being employed as professionals within teams and providing an important role in providing non-clinical support in hospitals and in the transition out of hospital, where people may be discharged into changed and unfamiliar circumstances to when they went in.

The cost consequence case studies indicate the cost effectiveness of this kind of work, where even interventions that extend over a fewmonths, cost less than the more expensive clinical and formal care responses that would be triggered if a discharge process was unsuccessful and service users rebounded back into statutory support.

## Recommendations

The recommendations are to inform future similar services based on learning from WELLcome Home.

- If delivering in partnership with another organisation, agree a shared theory of change, service outcomes, monitoring and evaluation processes and tools; and ensure staff are fully briefed and upskilled to implement them, before delivery commences
- Ensure that 'how to' guides for all aspects of delivery, including monitoring and impact data gathering systems, are produced and held within delivery organisations to ameliorate the impact of any staffing changes
- When delivering in a host / third party organisation such as a hospital:
    - confirm the delivery model with key stakeholders at the start, including referral processes / eligibility criteria
    - identify a named contact who will champion the service internally and facilitate access
    - agree what access you need to service users, team meetings and IT / record systems
    - agree success factors and how they will be measured
    - agree regular update and review processes to aid communication, build relationships and keep partners involved and up to date
    - foster a co-production relationship to encourage co-ownership of the service and support future commissioning.

# Appendix 1

## Cost Consequence case study: Baz[31]

In 2014 Baz found himself going through a really difficult time. He was evicted from the local authority owned property that he had called home for 13 years because of a series of misunderstandings and miscommunication that led to his housing benefit being withdrawn he found himself evicted, homeless and sleeping rough, mainly on the street. During this time Baz continued to withdraw, even to the extent that he stopped responding to his 'legal name' and would only respond when addressed by his chosen alternative name, which made engagement with services and making benefits claims almost impossible.

This also impacted on communications with health professionals because he did not believe in the treatments offered to the person that is his legal name. He reports having no mental ill-health prior to this and at the time found engagement with mental health services challenging.

He does however talk about going through a difficult time, which saw him hospitalised 3 times between 2016-2017, where he was diagnosed as having bi-polar disorder. His most recent admission in 2017 came via police following an arrest who identified he had mental health needs and he was admitted for an assessment.

*"If it hadn't have been for [names NCDC] guiding me through it I don't think I would have done it.*

*Birmingham Mind have helped me break down barriers and build the confidence to go for my dreams.*

*She was so friendly and accommodating and I was in a bit of a confused state so having someone on my side was important."*

### Access to WELLcome Home Service

Baz found out about the service while he was in hospital, when someone he knew on the ward recommended the NCDC service to him in March 2017.

The service supported him to move into a privately owned property and facilitated his transition into the community as well as the legal challenges he faced when applying for benefits.

The NCDC dealt with his most immediate need which was housing. This was complex process andmade more so by the fact that Baz didn't want to live in a hostel with up to 25 other people and he wanted to make a homeless application, however the process wasn't going well.

While he was still an inpatient the NCDC worker helped Baz to work through his housing options, and he was given information on all available vacancies and supported to complete relevant referrals and risk assessments one organization at a time until he found a landlord willing to offer a property.

[31] Not his real name

The NCDC worked with the landlord before the initial meeting and attended a meeting with Baz and the landlord and helped Baz to get all the paperwork signed and in order. This was particularlychallenging as Baz still had high levels of anxiety at the prospect of using his legal name and at thattime still preferred to use his 'chosen alternative name.

The NCDC helped Baz overcome another challenge that arose on his discharge day when the clinical team determined it would be necessary to place him on a Community Treatment Order to support him to comply with treatment in the future. Baz just wanted to put the whole negative experience of ill health in the past and the NCDC helped him to understand that this was another step in his journey.

Post discharge the service also supported Baz to attend housing and benefits appointments and to open a bank account in his legal name as well as finding out what was going on in his local community.

**Outcomes**

- He's still living in a house share with two other people, and has maintained his tenancy since 2017 (4 years to date)
- He reports that self-esteem and confidence have improved significantly
- He reports feeling much better about himself and feels able to cope with day to day living and to tackle any challenges that come his way
- He's not been admitted into hospital and hasn't any relapses since working with the service and while he may not totally accept the diagnosis, he now recognises that he needs to work with the people who can help.
- His claiming all the benefits he's entitled to including PIP[32], which he had been reluctant to do previously because the difficult associations he had with his legal name.
- He'd like to go to college and is considering being a peer mentor
- He's actively looking for a flat so that he can live on his own and hopes to find one over the next 12 months or so.

**What Baz says about the impact of the service**

Making the appointment to see the team was the first step, he feels much better about himself, and the challenges, and obstacles that may come his way. He can see things getting things done,and although he finds things difficult at times, he finds himself able to work through these and carry on moving forward**.**

Baz likes knowing where he's going to be sleeping and likes the area where he lives.

*She used to see me once a week and spend around an hour with me talking to me about how I'm feeling and what the meds are doing to me – always finding solutions which was difficult as I like to keep myself to myself. She's consistent and good at her job. Being consistent is important.*

*During my time in hospital I was confused, and when I first came out and knowing she was there was comforting and that she was available. I was able to feel vulnerable with her, that's not*

[32] PIP – Personal Independence Payments for people with a physical or mental health condition that affects daily living

*possible with the hospital staff as they're busy doing their job. It can feel like the staff are againstme in the hospital as they don't always listen, and thesis listened to me I felt that* [names NCDC] *cared and the staff at the hospital didn't – it was their job. I could talk to her about anything it's helped me be more open – she talked to me about how it's all well, being quiet but you need to express yourself and make people understand*

**Cost Calculations**

| Support Received | Face to face support (Hours) | Follow up support (Hours) | |
|---|---|---|---|
| In hospital support<br>NCDC - £15.15 p/h | 12 | 17 | |
| Community Support<br>NCDC - £15.15 p/h and additional Mind support service (also costed at £15.15 p/h) | 71 | 31 | |
| **Total** | 83 hours<br>£1,257.45 | 48 hours<br>£727.20 | **131 hours**<br>**£1,984.65** |

The total cost of the Birmingham Mind intervention is estimated at £1,984.65. Since then, Baz has not beenstreet homeless and has sustained his tenancy for over 4 years. This compares with:

- Evidence that people who experience homelessness for three months or longer cost on average £4,298 per person to NHS services, £2,099 per person for mental health services and £11,991 per person in contact with the criminal justice system.
- estimated that preventing homelessness for one year would result in a reduction in public expenditure of £9,266 per person.[33]

The overall intervention expenditure contrasts, in terms of potential health care costs with:

- the potential cost to the public purse of rough sleeping being estimated at Residential psychiatric care at £842 per week (£3,268 per month)
- More intensive care provided in NHS mental health care clusters at £424 per day (£12,720 per 30-day month plus initial assessment costs of £311)
    - Early intervention team costs at £2,782 for support provided in the community £20,128.00 per annum.[34]

[33] Pleace, N. & Culhane, D.P. (2016) *Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England*. London: Crisis.
[34] Pleace, N. (2015) At what cost? An estimation of the financial costs of single homelessness in the UK. London:

## Cost Consequence case study: Steven

Stephen who is 70 years old, was in hospital for 11 years following a complete breakdown.

After such a long time in a ward environment, Steven was extremely frightened and concerned about leaving hospital. He feared being out in the world and he found that the support from thepeer mentor really helped him to cope with his transition from living on a ward to living in the community.

A previous discharge hadn't gone well for Steven, and he voluntarily admitted himself back into hospital. This experience meant that he was very worried about leaving hospital and what could happen to him.

### Access to the WELLcome Home Service

The peer mentor started to build a relationship with Steven while he was still living on a ward, and just beginning the transition to living in the community. Initially the support involved escorting him on home visits to his flat, and spending time with him there so that Steven started to feel more comfortable with his environment and that he started to feel more at ease about living in the community.

The focus for the peer mentor being on building an empathic relationship with Steven. One where both parties tacitly understood what their shared space contained psychologically and emotionally and then from this shared conversation found the space to talk about building Steven's recovery journey.

*"He helped me look forward instead of getting lost in the past."*

*"Got me out of my shell and no one had done it before."*

*"I felt so much better about coming out of hospital knowing there was someone there in the background for me."*

The peer and Steven would visit the shops together so that Steven became familiar with his local area. These visits to the flat and shops gave the peer mentor and Steven time to have conversations and to start the process of getting to know each other.

Once discharged the peer visited Steven at his flat each week – these visits enabled the mentor to check in with him and for Steven to be able to express any concerns he may have, and for Steven to have support to undertake practical tasks such as shopping.

### Outcomes

- He has been living in the community for over 5 years
- His mental health has improved and continues to improve
- He is attending his regular outpatient appointments
- He is settled and maintaining his tenancy of a flat close to his son and daughter in law
- He looks forward to the future rather than dwelling on the past – and attributes this change to the work he undertook with the peer mentor.

## What Steven says about the impact of the service

Steven found having someone to talk to really important and comments that "*It's the one to one you can just talk and talk -it's really important that he's a peer and the talking is really important."*

He talks about how working with the peer mentor got him "*out of his shell*" in a way no-one had done before.

He commented that "*When I came out, I was very frightened and scared of the world, The peer mentor did a great job of keeping me going- he really helped me to sort my life out. I was nervousand frightened and didn't know where I was going and what I was doing.*

*He sat and talked to me – we met regularly … he helped me back into reality and facing the world again ..... Knowing that he was at the other end of a phone helped me to get back out into the world."*

Although neither Steven nor the peer mentor shared details of their experiences of secure forensic mental health services, they did find that knowing that each other had similar forensic history was an important element in building their working relationship.

Steven notes "*It makes a huge difference that he's got experience of being in hospital – it's a different sort of conversation and he can bring things out into the open… We talked and compromised – and I took small steps – he talked about moving forward and I wasn't so stuck or so depressed.... It's the one to one you can just talk and talk -it's really important that he's a peer and the talking is really important."*

## Cost Calculations

| Support Received | Face to face support (Hours) | Follow up support (Hours) | |
|---|---|---|---|
| **Peer mentor support both in hospital and in the community**<br><br>**£15.15 p/h** | 40 | 20 | 60 hours in total |
| **Total** | £606 | £303 | **£909** |

The total cost of the is, therefore, estimated at £909 in total.

Since the support from the project Steven has not been admitted to hospital and has maintained his independent housing tenancy.

The overall intervention expenditure contrasts, in terms of potential health care costs with;

- Residential psychiatric care at £842 per week (£3,268 per month)

- More intensive care provided in NHS mental health care clusters at £424 per day (£12,720 per 30 day month plus initial assessment costs of £311)
- Early intervention team costs at £2,782 for support provided in the community
- Day care provision at £38 per day (£190 per week/£760 for 20 days support per month.[35]

In terms of housing and accommodation costs, Steven is living independently. This contrasts withestimates of the

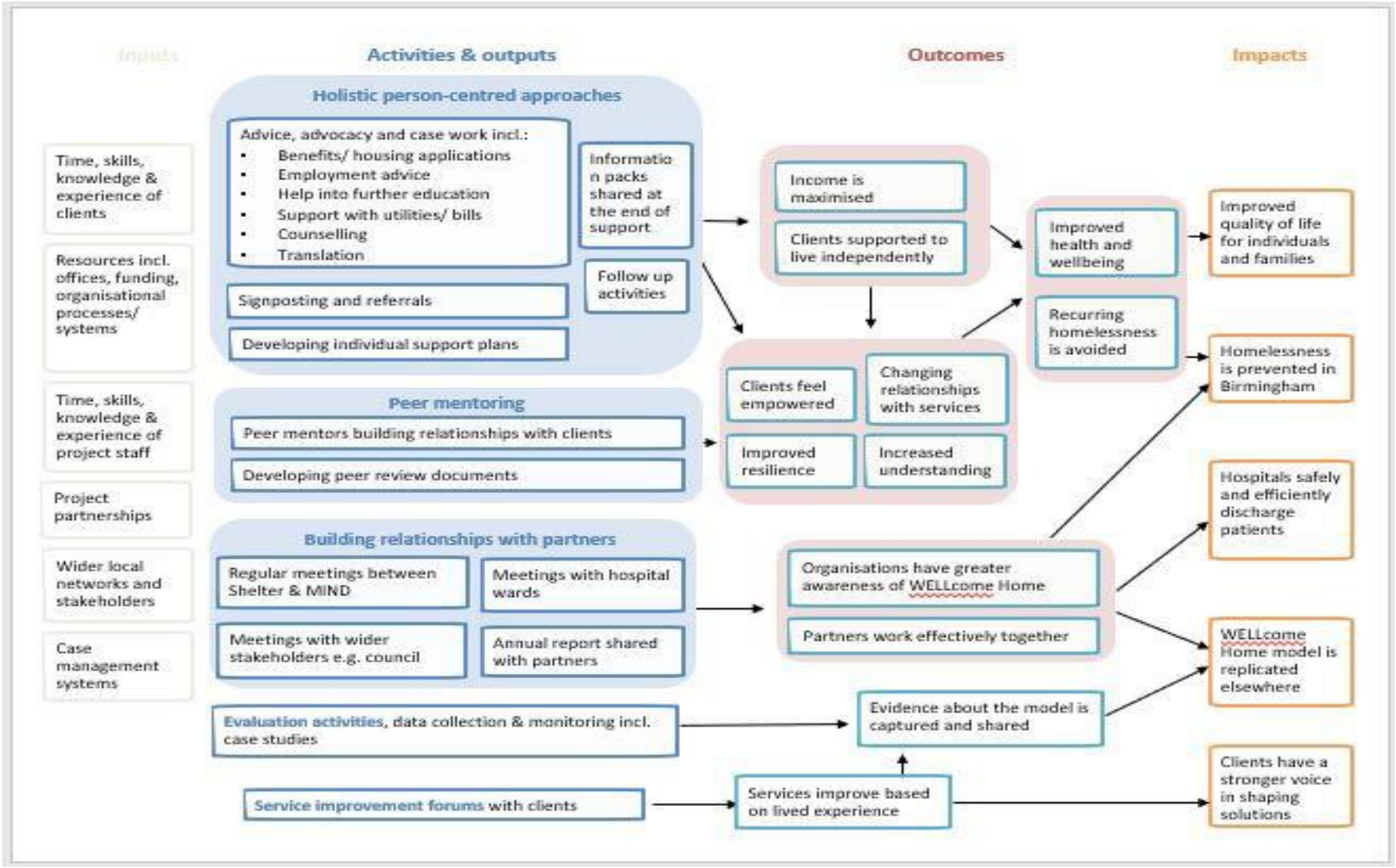
- Cost of supported living accommodation at between £1,010 to £1,981 per week. This contrastswith Local Housing Allowance figures in the West Midlands at approximately £256 per week[36]
- Eviction costs to a landlord are estimated by commercial legal services at between £1,300 (County Court) and £2,200 (High Court) per incident[37]. This, however, excludes the costs to Local Authorities and other advice providers in terms of re-housing and benefits adjustments.

[35] Source: Curtis, L. and Burns, A. (2020) Unit costs of health and social care 2020. University of Kent, Personal SocialServices Research Unit

[36] Sources: Curtis, L. and Burns, A. (2020) Unit costs of health and social care 2020. University of Kent, Personal Social Services Research Unit and HM Government

[37] Source: https://www.nimblefins.co.uk/business-insurance/landlord-insurance-uk/average-cost-evict-tenant These figures are consistent with those provided in other related searches

## Appendix 2: WELLcome Home theory of change



## Acknowledgements

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**Report prepared by**

Polly Goodwin and Karen Garry

Merida associates
www.merida.co.uk

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mind Birmingham
https://birminghammind.org/

SHELTER
https://england.shelter.org.uk/