NOTTINGHAM TRENT UNIVERSITY

opportunity NOTTINGHAM

Believing in people. Inspiring change.

Keeping *Everyone In*

Rough sleepers and the Coronavirus emergency in Nottingham

Authors:
Karan Kaur and Grant Everitt, Opportunity Nottingham
Graham Bowpitt, Nottingham Trent University
Mandy Clarkson, NHS Nottingham and Nottinghamshire CCG

January 2021

www.opportunitynottingham.co.uk
0115 850 4128
@OppNottingham
Search for Opportunity Nottingham

COMMUNITY FUND

Opportunity Nottingham is made possible by funding from the National Lottery Community Fund.

Preface

Before the Covid-19 pandemic, the suggestion that with almost no notice more than 100 rough sleepers in Nottingham would be found accommodation in 4-star hotels in the city, and that this scheme would be largely successful, would have likely been considered hopeless fantasy. Covid-19, however, has changed many things and one has been to show the unthinkable can work. Key to the success described in this report was the quality of the hotels, but also the partnership that came together almost overnight. Opportunity Nottingham was pleased to be part of this partnership as one of the agencies delivering support to *Everyone In* guests in the hotels. Opportunity Nottingham is about delivering new solutions and making systemic changes to support people experiencing severe and multiple disadvantage (SMD). *Everyone In* fitted this agenda very well. It is a new solution involving overnight changes to the system and almost everyone accommodated as part of *Everyone In* in Nottingham were experiencing other disadvantages in addition to homelessness. This is why we were pleased to be asked to carry out this evaluation and take the chance to view *Everyone In*, through the lens of multiple disadvantage.

> “…the unthinkable can work”

The evaluation has also enabled us to feed learning about SMD into the Nottingham Integrated Care Partnership (ICP). It is most welcome that the ICP has supporting people who face multiple disadvantages to live longer and healthier lives, as one of its priorities. As Opportunity Nottingham looks towards its own legacy priorities, we will support further initiatives the ICP is developing under the multiple disadvantage priority. This includes evaluating the wraparound Multi-Disciplinary Team (MDT) meetings that are now taking place for people experiencing SMD.

Acknowledgements

We would like to thank everyone who provided the data and other information on the basis of which this report has been compiled, including those who made themselves available for interview. In particular, we would like to thank staff from Framework’s Street Outreach Team and the Emmanuel House Support Centre who provided data on guests and their outcomes. We would also like to thank all the health care and other staff who provided support to guests at the hotels for their valuable insights into the experience.

Executive Summary

In the light of the global coronavirus emergency, like all local authorities in England, Nottingham City Council and its partners responded to Government instructions at the end of March 2020 by commissioning two hotels to accommodate everyone sleeping rough in the City or at risk of doing so. This is a report of the experiences of those who were guests and of those who supported them during the first three months of the lockdown, in the hope that lessons can be learnt about more effective provision for homeless and vulnerable people in the months and years ahead. Evidence for the report was derived from data on guests recorded by support staff at the two hotels, a survey conducted with frontline service providers and interviews with a range of stakeholders, including support staff and one guest. The following summary gives a flavour of the guests and the outcomes that were achieved.

- There were 168 guests, of whom 119 were men (71%) and 49 were women (29%).
- Of those willing to state their ethnicity, 60% were White British and 24% White European.
- Nearly all guests (96%) had needs other than homelessness, with over a third having at least three of the needs associated with severe and multiple disadvantage (SMD), of which mental ill-health and substance misuse were the most common.
- The most common reasons for homelessness were relationship issues (30%), having no recourse to public funds (18%), eviction from previous accommodation (18%) and prison release (13%). Of the women guests, 37% were fleeing domestic abuse.
- Placing what would normally be dispersed rough sleepers in fixed safe locations made ‘in reach’ possible for other support services, facilitating access to guests for the Homeless Health Team (56%), the Health Shop (23%), Nottingham Recovery Network (11%) and GP registration (9%).
- 47% of guests were considered to have mental health issues. Toward the end of the *Everyone In* period, a community mental health nurse was brought in to provide specialist in-reach. However, this came too late to have much impact.
- Service providers reported a range of other benefits, such as guests having basic needs met and better nutrition, greater service flexibility, better collaboration between services, and improved health outcomes. Personalised, multi-disciplinary, holistic care planning became possible.
- A high proportion of guests (41%) were supported to move into secure accommodation (a tenancy or supported accommodation) and this varied little between those with fewer than three SMD needs (43%) and those with three or more (38%).
- Hotel life did not suit all guests, with more than a quarter excluded for reasons mainly related to anti-social behaviour or drug-related incidences. This proportion included more than a third of women guests. Another small proportion (7%) left of their own accord.

Recommendations

- Nottingham City Council and its partners should seek to secure funding for establishing a permanent source of emergency accommodation for all rough sleepers in the City.
- This accommodation should be self-contained for each resident and accessible 24 hours a day, with opportunities for recreation and support staff on site. The accommodation should take a gendered approach and include women only spaces.
- A multi-disciplinary team (MDT) representing all support services relevant to the full range of complex needs typically experienced by rough sleepers should be commissioned by the City Council and its statutory sector partners to cover housing, health, social care, probation and substance misuse.
- All rough sleepers and other adults with severe and multiple disadvantage should be routinely referred to the MDT for assessment and regular consideration at MDT meetings for a coordinated, planned response to complex needs.
- MDT members should work collaboratively towards the permanent resettlement and improved well-being of all beneficiaries who are referred to it.
- The City Council should expand the availability of housing under the Housing First scheme for the permanent accommodation of rough sleepers.

NOTTINGHAM TRENT UNIVERSITY

opportunity NOTTINGHAM
Believing in people. Inspiring change.

Contents

Introduction: getting '*Everyone In*'

On the 23rd March 2020, the UK went into lockdown due to the Covid-19 pandemic. Lockdown meant that people could only leave their homes for work, essential shopping and once a day for exercise. Given the risks posed by the rough sleeping population, the Government issued a directive on 26th March initiating a nationwide scheme called *Everyone In*[1] which essentially meant that those who were rough sleeping were to be provided with hotel accommodation, in order for them to comply with the lockdown rules and to be safe during the pandemic. Nationally, this resulted in 15,000 people who were either sleeping rough or staying in communal shelters being accommodated in self-contained emergency accommodation, typically hotels, B&Bs or hostels[2]. In Nottingham, the City Council led a hastily convened partnership across the public, private and voluntary sectors to provide support for 168 people who were rough sleeping or at risk of rough sleeping over the next three months.

> "...those sleeping rough were to be provided with hotel accommodation"

The two hotels commissioned for this purpose were supported by staff from the Emmanuel House Support Centre and Framework Housing Association. The hotel scheme was only funded for a short period, and there was uncertainty about how long it would be sustained. Particularly, there was concern about how much funding for the scheme would be received from Central Government. Consequently, support staff had a very limited time to work with people and the main focus was to help individuals secure alternative accommodation. Rough sleeper guests at the hotels also had access to health and substance misuse services, along with food provided by voluntary groups.

The aims of this report are

- To evaluate the impact of the scheme on the lives of guests;
- To review the experience of operating the scheme by service providers;
- To learn lessons in working with rough sleepers more effectively.

The research period covers the first three months of the operation of the hotels. Two hotels provided accommodation, here referred to as hotel A and hotel B. Due to the high demand for the accommodation, there were often waiting lists, and the 168 people began their residence at different times. It would be misleading to suggest that all current rough sleepers were thereby accommodated, either at the outset, or during the three months of this research. Nationally, around 90% of rough sleepers were accommodated initially, but reported rough sleeping numbers soon increased thereafter.[3] Figure 1, based on figures submitted by the Street Outreach Team (SOT), compares numbers in the hotels in Nottingham with those still on the streets on particular nights in each of the three months.

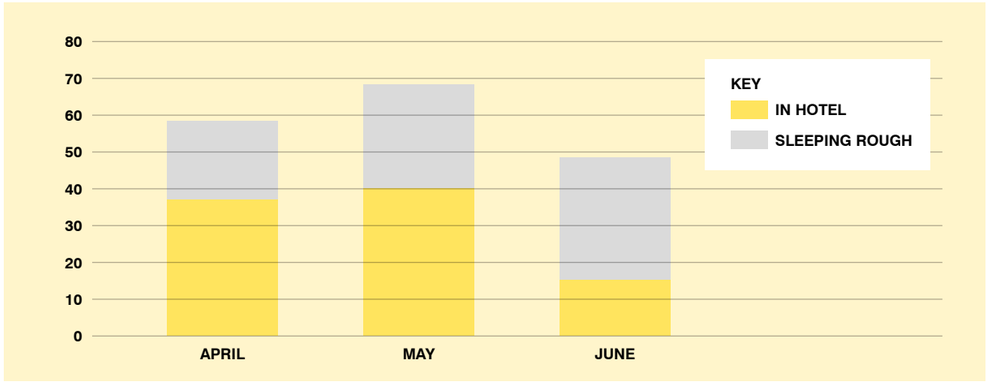
The 168 people were referred via two pathways, the "Everyone in" (EI) scheme or through "priority need" (PN) via the City Council's Housing Aid service. People referred through EI were made up of people who were found rough sleeping during this period, whereas those who were referred

[1] Ministry of Housing, Communities and Local Government (2020), *Coronavirus (COVID-19): letter from Minister Hall to local authorities on plans to protect rough sleepers*, On-line: MHCLG. https://www.gov.uk/government/publications/letter-from-minister-hall-to-local-authorities

[2] Ministry of Housing, Communities and Local Government (2020), *Coronavirus (COVID-19) emergency accommodation survey: May 2020,* On-line: MHCLG. https://www.gov.uk/government/statistics/coronavirus-covid-19-rough-sleeper-accommodation-survey-data-may-2020

[3] Fitzpatrick, S., Watt, B. and Sims, R. (2020), *Homelessness Monitor England 2020: COVID-19 Crisis Response Briefing, London: Crisis, On-line:* https://www.crisis.org.uk/media/242907/homelessness_monitor_england_2020_covid19_crisis_response_briefing.pdf

Figure 1: Monthly one-night head counts of hotel guests and rough sleepers, April-June 2020



through PN were at risk of rough sleeping. From the end of March to the end of June, 115 people were accommodated through the EI scheme, whilst 53 guests were accommodated through Housing Aid as PN. EI guests were those sleeping rough or residing in Nottingham's Night Shelter, run by Emmanuel House but obliged to close at the start of the scheme for public health reasons. PN guests were those deemed by Housing Aid to be at risk of sleeping rough and vulnerable due to high support needs, and they were located in Hotel B.

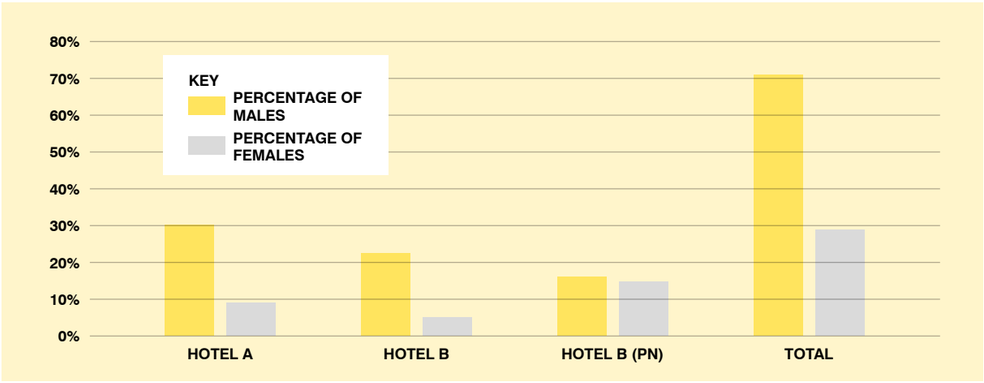
How the report was compiled

The research involved a triangulation of methods in order to capture rich data on the experiences of those involved in the hotels, both guests and service providers. An on-line survey was conducted in order to gather information about the guests. The survey captured key demographics, reasons for homelessness, additional needs, the destination of guests and the agencies with whom individuals worked during their residence. As Emmanuel House and the Street Outreach Team were primarily responsible for supporting the guests, surveys were completed by a staff member from Emmanuel House and through gathering information from the Street Outreach database. Another survey was conducted with key stakeholders which included a GP, the Homeless Health Team, NHS Mental Health, Nottingham Recovery Network, Street Outreach, the Health Shop and the Nottingham Hepatology service. This was to gather information on how the hotels had impacted on these services. In addition to this, four interviews were conducted with workers who had direct involvement in either establishing the hotel scheme or working directly in the hotels and there was one interview with a hotel guest. The list of questions for the surveys and interviews can be found in the Appendices. Data in this report comes from the support staff surveys, unless otherwise specified.

The guests and their characteristics

The following section charts some of the key characteristics of the 168 guests. Looking first at **gender**, 119 (71%) identified as men and 49 (29%) as women, making this a predominantly male population, but not as much so as Nottingham's rough sleeping population more generally. Figure 2 shows how guests were distributed between the two hotels by gender, showing that the PN group was more balanced in terms of gender.

Figure 2: Gender of guests at each of the hotels



The hotels were mixed and did not have separate areas for women. Interviewee 1 noted that *"We also recognise we need a gendered approach - there is a lack of female only provision"* within the hotels, so, when planning future provision, the Council recognises that it needs to cater to the needs of women. Lack of gender segregation in emergency hotel provision has been highlighted as an issue in the response to the crisis nationally.[4] However, Interviewee 2, a male hotel guest, stated that he felt quite safe when comparing the accommodation to a communal shelter, showing the benefits of the privacy and security of having their own room.

The more equal proportions of men and women found in the PN group may be due to the fact that, whilst women may be less likely to sleep rough, they may be more likely to be at risk of homelessness from issues such as fleeing domestic violence, which accounted for 61.5% of the women who came via PN (see Table 1 below). This would award them a 'priority need' status in a Housing Aid assessment. By contrast, guests who came through the EI route were made up of 80% men and 20% women, which nevertheless represents 4% more women than national data on rough sleeping would suggest[5] and possibly reflects a trend towards increased rough sleeping amongst women.

Table 1 shows how the 168 guests were distributed between different **ethnic groups**. There is an under-representation of every ethnic minority group except for 'Black/ African /Caribbean/Black UK', where the percentage is slightly higher than the Nottingham 2011 census population[6] would suggest. Moreover, those who come from 'other white backgrounds' (21%) are over-represented compared with the Nottingham 2011 census when they only amounted to 5.1% of the population. This may be due to this group being mainly migrants and therefore more at risk of having 'no recourse to public funds', thereby making accommodation extremely difficult if they do not meet the criteria to obtain DWP benefits.

Table 1: The distribution of guests by ethnic group

ETHNICITY	COUNT	PERCENTAGE
White British	91	54%
White Irish	1	1%
Other White background	35	21%
Mixed ethnic background	4	2%
Asian/Indian/Pakistani	4	2%
Other Asian	2	1%
Black/African/Caribbean/Black UK	13	8%
Other	2	1%
Unknown/not stated	16	10%

[4] Making Every Adult Matter (MEAM, 2020), *Flexible response during the Coronavirus crisis: Rapid evidence gathering.* On-line: http://meam.org.uk/2020/06/11/flexible-responses-during-the-coronavirus-crisis/

[5] Homeless Link (2020), *2019 Rough sleeping snapshot statistics.* On-line, https://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20analysis%20of%20rough%20sleeping%20statistics%20for%20England%202019.pdf

[6] Nottingham Insight (2019), *Population.* On-line, https://nottinghaminsight.org.uk/population/

The guests and multiple disadvantage

Homelessness was by no means the only need that guests had. All but 4% had needs associated with severe and multiple disadvantage, including mental ill-health, substance misuse and offending experience, both as perpetrators and victims, especially domestic abuse. Figure 3 shows the proportion of guests in each hotel who had each of a list of additional needs.

Figure 3: Proportion of guests with additional needs in each hotel (%)

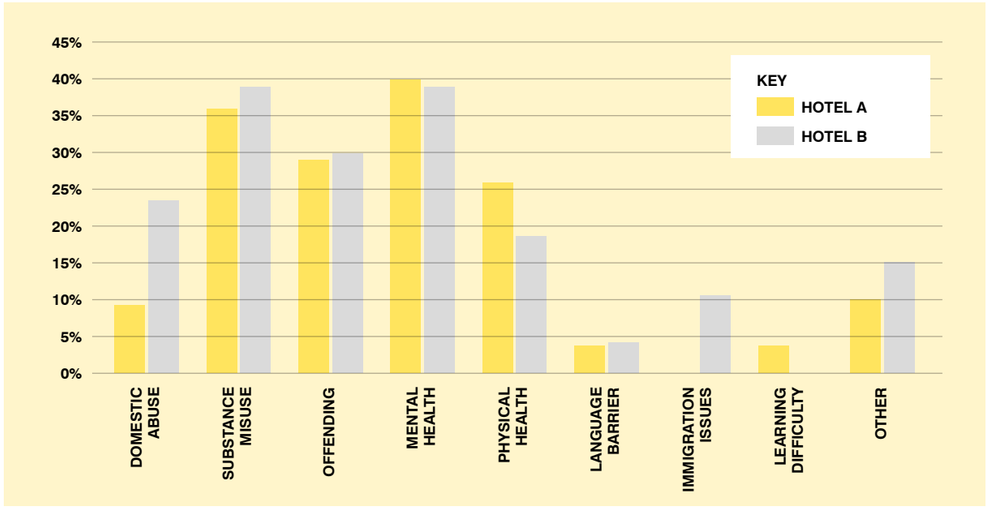
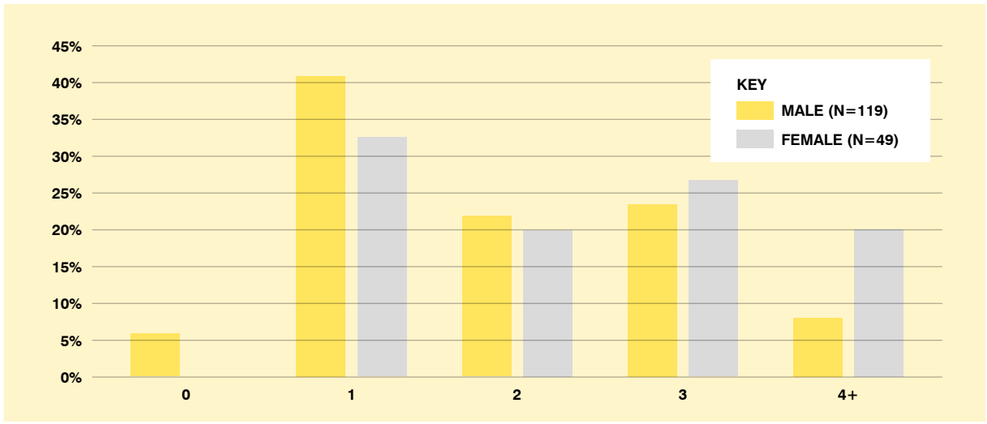


Figure 4 shows how guests varied according to the number of additional needs they had. What it shows is that women were more disadvantaged than men, if we take number of additional needs as our yardstick.

Figure 4: The number of additional needs of men and women



Among the PN group, women guests were more likely than men to be victims of domestic abuse and to have issues with their mental health and substance misuse, whereas men were more likely to be migrants.

More light is shed on the needs of guests if we examine their reasons for homelessness. Table 2 gives the distribution of reasons between men and women and PN and EI guests. The columns add up to more than 100% as some guests had more than one reason for their homelessness.

Table 2: Reasons for homelessness by gender between PN and EI groups (%)

	MALE (PN)	FEMALE (PN)	MALE (EI)	FEMALE (EI)
Relationship breakdown	33.3	11.5	15.2	13.0
No recourse to public funding	0	0	29.3	13.0
Domestic abuse	11.1	61.5	0	8.7
Rent arrears	3.7	0	0	4.3
Eviction	11.1	7.7	7.6	26.1
Hostel Exclusion	3.7	3.8	6.5	13.0
Homeless upon prison release	14.8	11.5	13.0	13.0
Local connection issues	0	0	5.4	0
Overcrowded housing	14.8	0	0	0
Financial issues	0	0	12.0	4.3
Unsuitable housing	0	0	8.70	0
Other	29.6	15.4	38.0	26.1

The main reason for homelessness among men in the PN group was relationship breakdown, followed by 'other' reasons, mainly an inability to continue sofa surfing. We have already noted the prominence of domestic abuse as the main reason for homelessness among PN women. This shows that, overall, homelessness in the PN group had more to do with relationships than any other issues.

The reasons for entering the hotels through the EI scheme were starkly different from those who had entered through PN. The women in this cohort tended to become homeless following eviction or issues such as long-term rough sleeping, substance misuse or having 'no recourse to public funds'. Moreover, although 15.2% of the male EI cohort were homeless due to relationship breakdown, the most common issue for their homelessness was having 'no recourse to public funds'. Whilst male guests were more likely to have slept rough, the scheme highlights that although female guests may not have rough slept, their needs tend to be just as high as those of men, so it is important to provide support to women who are at risk of rough sleeping as they may have other needs which are just as important to address.

> "...male guests are more likely to have slept rough"

The prominence of 'no recourse to public funds' among the main reason for homelessness among EI men could help to explain why 'white other' people were over-represented in this cohort. The Local Government Association[7] has called upon the Government to provide support to those who

have 'no recourse to public funds', as Covid-19 has made it difficult to safeguard these people nationwide. Three interviewees mentioned that working with people who had 'no recourse to public funds' could be difficult. Although, there may have been fewer needs arising from severe and multiple disadvantage, their circumstances were complicated by the lack of resources. Interviewee 3 stated that

> *"People with absolutely no recourse to public funds have a harder time, but people who are able to start taking the small steps like getting the right paperwork, getting the right documents, and then they can start looking for work. But once you are able to get some public funds, some benefits, you can start looking at taking the next steps after that. Some are not entitled to benefits and therefore have to start working immediately and go straight into the workforce. I guess everyone's situation is different. Some people need to take trips to embassies to get documents like a passport before they can get maybe – Some people are struggling to get a bank account; some people are struggling to get settled status. So, it depends what position they're in at that point in time, but there have been many who have managed to make all of those steps and put themselves into a position where they are entitled to benefits or able to get themselves a bank account or get themselves a job and start earning and saving up for a deposit on a flat."*

This shows that for people who have 'no recourse to public funds', there is more than one trajectory. It may be easier for some to get access to benefits or work, depending on whether they can secure the relevant documents. However, in a significant number of cases, a lot of work between many agencies needs to be undertaken in order to achieve positive outcomes. The hotels have made this work easier to facilitate as there were different agencies working within the hotels and even agencies who were not working within the hotels had easier access to the guests as they had a fixed abode.

[7] Local Government Association (2020), *Councils call for suspension of No Recourse to Public Funds during COVID-19 crisis.* On-line, https://www.local.gov.uk/councils-call-suspension-no-recourse-public-funds-during-covid-19-crisis

The help they received

The agencies involved with developing and facilitating the hotel scheme identified that people's additional needs also needed to be addressed. With 96% of guests having needs additional to homelessness, statutory and voluntary services believed that it would be beneficial to work together in order to help guests achieve positive outcomes. The EI scheme allowed organisations to provide an in-reach service within the hotels in order to help them to engage with residents.

Figure 5 gives the distribution of services accessed by gender. Approximately 56% in total accessed support from the Homeless Health Team for reasons such as having Covid-19 symptoms or needing support with GP registrations and deep vein thrombosis. In a small number of cases the Homeless Health Team has also helped guests with their mental health through sending mental health referrals to specialist services and signposting guests to their GP. A mental health nurse did commence in-reach sessions at Hotel A but only in the last weeks of the scheme and so was only able to engage with a small number of guests.

Similar proportions of men and women accessed the Homeless Health Team, were supported with GP registrations or accessed the Health Shop. Regarding the Nottingham Recovery Network (NRN), women were more than twice as likely to attend, possibly due to a greater likelihood of them having issues with substance misuse to begin with. Aside from these four support services, guests worked with a wider range of agencies, such as housing agencies, Jobcentre Plus, social services, Prostitute Outreach Workers (POW) and mental health services.

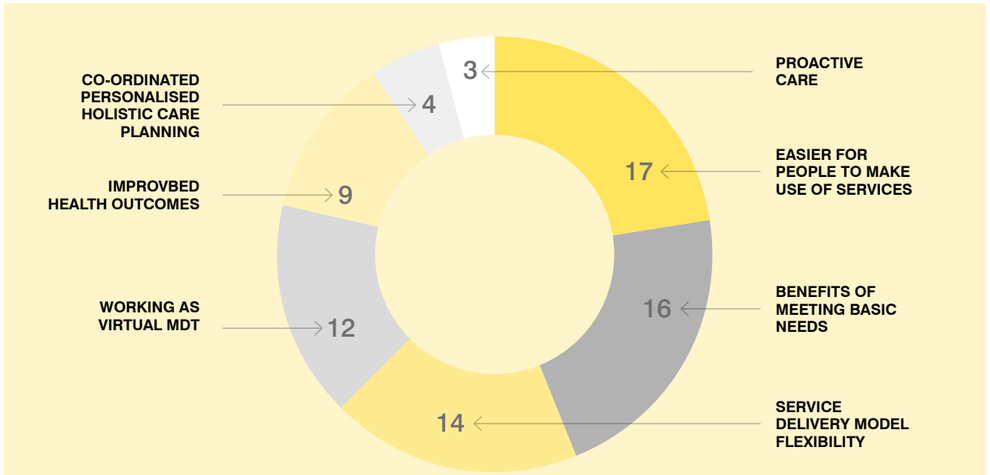
Figure 5: Distribution of services received by gender

For those with 'no recourse to public funds', ongoing support was received from places such as the Refugee Forum and Nottingham Law Centre, in order to help with applying for settled status or providing the necessary evidence in order for guests to access benefits. The coronavirus lockdown helped agencies to work more collaboratively with each other, in order to achieve the best outcomes for guests. However, a small proportion with immigration issues were quite difficult to support, as lockdown meant that some embassies were closed. Consequently, guests had to wait until lockdown measures were alleviated in order to continue their application for settled status. This has been a nationwide issue.[8]

Key stakeholders who either operated within the hotels or worked closely with those involved in the hotels have seen their services improve for people who have rough slept. Figure 6 presents a summary of the outcomes most commonly mentioned by stakeholders.

[8] Crisis (2020), *Homelessness Monitor England 2020: COVID-19 Crisis Response Briefing*. On-line, https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/homelessness-monitor/england/homelessness-monitor-england-2020-covid-19-crisis-response-briefing/

Figure 6: Frequency of outcomes mentioned by stakeholders (Stakeholder survey)



The most commonly mentioned area of improvement was making services easier to access and to enable services to meet the basic needs of their service users. In the past, the Health Shop has struggled to engage with people who were from Eastern Europe or who were seeking asylum/ refugee status. However, the in-reach service and the joint working with Emmanuel House's Wellbeing Team within the hotels led to a significant increase in engagement with the Health Shop and all guests in Hotel B and all but 8 residents in Hotel A were given sexual health screening tests, according to the stakeholder survey.

Furthermore, the coronavirus lockdown had impacted GP services significantly. Prior to the lockdown, GPs had established outreach services for the homeless population which were no longer operating during this time. The hotel scheme made it easier to treat people who were rough sleepers and in some cases the GP saw their patients' health improve from being housed in the hotel which had helped to improve nutrition. In some cases, the hotel scheme led to guests receiving lifesaving interventions. An example of this can be seen in the case study provided by the hepatology service.

Case Study - Hepatology

SP was a rough sleeper for more than 10 years. He thinks he may have been tested for Hepatitis going to prison but doesn't recall being given the results. He would often busk to earn money for his substance misuse and was not accessing drug treatment. He then received accommodation as part of the 'Everyone in' campaign during the COVID 19 pandemic. Where he tested positive for Hepatitis c antibodies on an oral mouth swab, DBS tested which confirmed active virus (needs treatment). If he hadn't been tested as part of this initiative he would have unlikely been tested anywhere else (wasn't registered with a GP) and would not have known about his diagnosis which is detrimental to his liver health and also potentially spreading the virus to anyone he's using drugs with. The virus may not have been discovered until he developed decompensated liver disease. Now he is housed we can offer treatment via our homecare pathway. Treating someone who is street homeless is very difficult as they have no means to store medication safely. Curing his hepatitis c will prevent him developing liver cirrhosis and the need for liver transplantation. Not only is this gentleman, now accessing treatment for his Hepatitis C he is also engaging with drug treatment and has a methadone script.

Before moving on, mention should also be made of the informal support that contributed to the *Everyone In* scheme. This included the welcoming hotel staff (see next section) and the concierge/security service. It also included the city charities that delivered three good quality and nutritionally well-balanced meals a day. Whilst nutritional food is available to rough sleepers on the streets, often from the same charities, having it delivered to each person's room meant a rather greater level of take up. This point was appreciated by the homeless nursing team who observed, when combined with access to high quality hygiene facilities, the positive difference this has made to health…

> *"Team have witnessed improved outcomes due to environmental changes. Hotel has provided washing facilities which has increased hygiene of residents. As well as access to meals. Both improved hygiene and nutrition are felt to have improved wound healing rates"*

Psychologically informed environments

Whilst the hotels were an instant reaction to the Covid-19 pandemic, it was found by the interviewees that the environment generated in the hotels nevertheless showed elements of being psychologically informed. The hotels which were provided for those who were homeless were of high quality, having a rating of 4 stars. Moreover, the hotel staff did not have previous experience of working with this cohort. However, the way in which they interacted with their guests was perceived positively. Interviewee 2 who was a guest at hotel B stated

> *"And the staff there were absolutely amazing… If you were a bit upset or you needed some help, they would always be there. They would come and check on you to make sure you're all right. And when they didn't see you for a bit, they would come up to your room to see if you were all right and just have a little chat with you. It was really nice".*

Interviewee 4 also stated that *"The staff at Hotel A treated the people we placed as valued customers – and treated them same as all the other guests".* Both statements show that the hotel staff exhibited a high standard of customer service and that they were often supportive to the guests. The positive relationships which were built between the staff and guests is one of the most important components of psychologically informed environments[9]. Furthermore, giving *Everyone In* guests the same treatment as other guests helps to reduce the feelings of 'otherness' and increases a sense of belonging, which can help to increase wellbeing[10]. Interviewee 4 pointed to past experiences of housing rough sleepers in lower quality accommodation, where there were quite a few instances of the hotel being damaged. However, as Hotels A and B were of high quality, there were far fewer instances of this, with guests often remarking on the high quality of the hotel. These interviews show that when homeless people are normalised and treated in the same way as any other guests without preconception or stigma, then behaviour is also normalised. When it came to moving on from the hotel, there were in some instances difficulties experienced by guests in accepting alternative accommodation, as they felt that the quality was poor in comparison to the hotel.

> "…hotel staff exhibited a high standard of customer service"

There were worries that guests would suffer from social isolation due to rules stating that they must stay in their hotel rooms. However, interviewee 5 stated that there was an established rough sleeper community, where guests tended to know one another from the streets, and so they would often speak to each other and sometimes sneak into each other's rooms, which was sometimes overlooked. Furthermore, interviewee 3 stated that there was access to TVs and one of the hotels was situated in an area close to a park, which helped guests' wellbeing.

Through the testimonies of workers who have been in this area for a considerable length of time, there was an agreement amongst them that the high-quality provision of the hotels had a positive impact on guests. Feedback from the stakeholder survey showed that

> *"Some very long-standing rough sleepers took up the offer of the hotel and subsequently it's made them realise the benefits of being indoors. In some cases, we have been "amazed" certain people have come indoors. They had forgotten about this because they had been outside for so long it had become normal. Now they have realised they don't want to return to outside. The fact the hotel was good quality has been important. Traditionally hotels used as homeless accommodation are at the very low end of the market and these have problems. There is no doubt using a quality hotel had a psychological benefit as well as physical. People have felt cared for and also a sense of refuge from their usual world. That combined with the psychological impact of the pandemic has motivated some people to reduce/end drug use and take up accommodation".*

The way in which the hotel staff worked with the guests despite lack of experience can be seen as good practice and something which may need further investigation. However, as hotel staff did not have experience with this clientele, and there were paying guests in the hotel whose needs had to be served, there were occasional clashes of interest. The hotels were not always suited to rough sleepers with the most complex issues, as staff sometimes struggled to support people with higher levels of need. This led to a significant number of exclusions, which is explained more in the 'exclusions' section of the report.

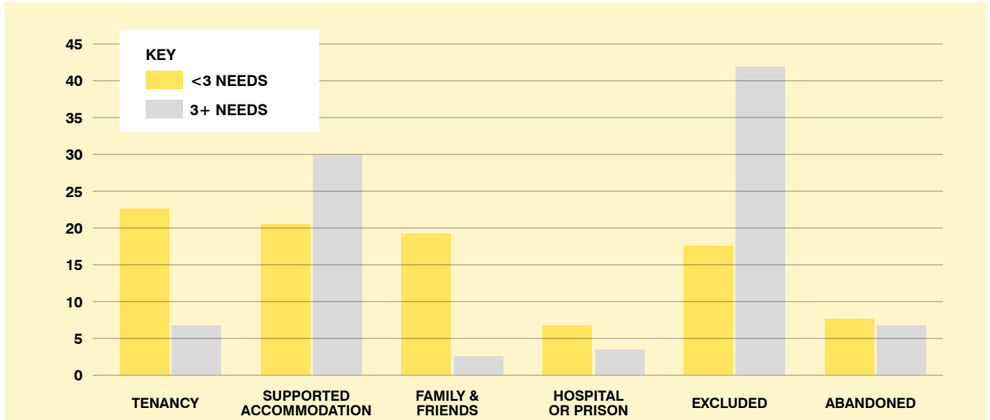
[9] Keats, H., Maguire, N., Johnson, R. and Cockersell, P. (2012) *Psychologically informed services for homeless people (Good Practice Guide),* Southampton: Communities and Local Government. Available at: https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf

[10] Sargent J., Williams A., Hagerty B., Lynch-Sauer J. and Hoyle K. (2002), 'Sense of belonging as a buffer against depressive symptoms', *Journal of the American Psychiatric Nurses Association,* Vol 8. Issue 4, pp. 120-129, Available at: https://www.sciencedirect.com/science/article/abs/pii/S1078390302000083

Outcomes for guests

The *Everyone In* scheme generated accommodation outcomes in proportions far in excess of what is normally achieved among rough sleepers, including those with high support needs. Overall, the scheme has seen 54% of guests moving into secure permanent accommodation, other temporary accommodation or with family or friends. Whilst this is just over half of the guests receiving a 'positive' move-on, at the time of writing ongoing work is still taking place to help current or former guests access accommodation. Interviewee 5 stated that *"people who were in the hotel were being prioritised for move-on accommodation from the Council"*, thereby allowing guests to be fast-tracked into accommodation, speeding up the process of move-on. Figure 7 distinguishes accommodation outcomes for the 60 guests with high support needs (three or more SMD needs) from those achieved for the 108 guests with low support needs (fewer than three). It does show guests with fewer support needs were more likely to be able to move on to a tenancy. So, of the guests with less than three additional needs were more likely to be housed in their own tenancy or supported accommodation. By contrast, for those with three or more needs, the proportion moving to a tenancy was lower. Moreover, guests with higher support needs were more likely to be excluded.

Figure 7: Accommodation outcomes for guests by number of support needs (%)



Even so, very few people returned to street homelessness. Even those evicted from the hotels were found alternative accommodation in most cases within a small time period, as Interviewee 5 pointed out

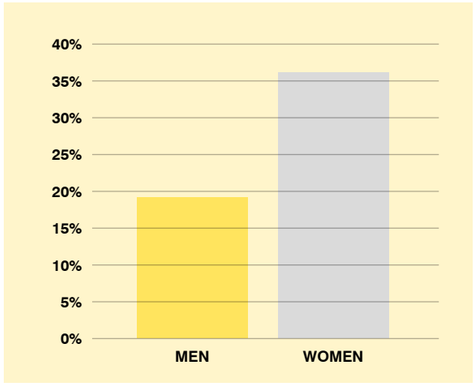
> *"Some of the more entrenched rough sleepers were asked to leave the hotel, however even though they were there for a short period of time, after a few days after they were evicted, alternative accommodation was managed to be secured."*

It is clear therefore that without the *Everyone In* scheme it would have been extremely difficult to accommodate people during lockdown, especially those with 'no recourse to public funds' and those who were previously accommodated in the winter night shelter, where social distancing was almost impossible. This shows that much has been achieved within the three-month period that was studied, as during this time the majority of guests were moved on from the hotel. It should be noted though that guests with higher support needs were less likely to be moved on to a tenancy and, though their immediate homelessness had usually ended, they were more likely to remain in short term housing options or be excluded. The next section looks specially at this latter group.

Guests who abandoned or were excluded

Whilst the hotel scheme was received positively by all those involved, it proved to have some limitations. In total, 26% of guests were excluded from the hotels. Exclusions most often arose from incidents relating to substances (46%). When we compare the needs of excluded guests with the rest, the data shows that twice the proportion of 'excluded' guests had issues with substance misuse and offending. Furthermore, 16% more 'excluded' guests had issues with their mental health than those who were not excluded. Interviewee 5 stated that whilst the mental health in-reach service was useful, it perhaps came too late as the guests who would benefit most from the scheme would be those who were evicted early on. The issue with mental ill-health and evictions was supported by interviewee 3 who complained that *"A service user with mental health problems completely ruined a fire alarm and damaged the wiring. They're expensive to repair"*. It appears that the hotel scheme's effectiveness decreased for guests with higher support needs. For these guests, simply being housed was not enough to help alleviate their issues and secure accommodation. This was further illustrated by gender comparisons. Figure 8 shows a far higher proportion of women excluded than men.

Figure 8: Proportions of excluded guests by gender (%)

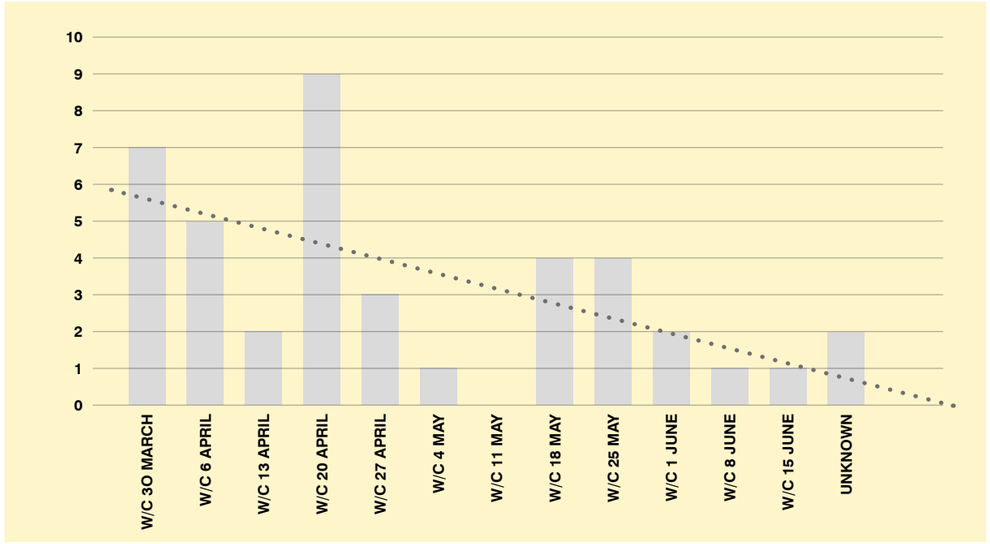


As we have seen above, women tended to have a higher level of needs than men, and the hotel scheme saw 36.7% of its female guests being evicted compared with 19.3% of men. In addition to mental health, substance misuse was also prominent among those who were excluded, a pattern which was also reflected in gender differences, as women guests tended to have significantly higher mental health and substance misuse issues than men.

Whilst there was a high exclusion rate, most exclusions took place within the first month of

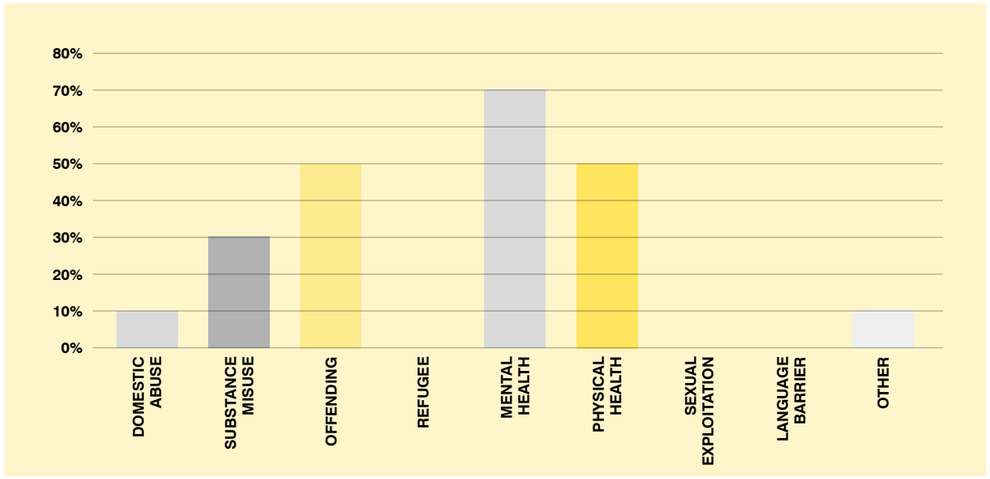
the hotels operating, as Figure 9 illustrates. Interviewee 5 stated that *"it was initially a bit of a shock for the hotel as they were not trained to work with people who have complex needs",* so the reason for the earlier exclusions could have to some extent been attributed to the hotels adjusting to the new clientele as well as introducing and evolving the in-reach support provided to make it better fit the guests and their new environment.

Figure 9: Exclusions per week



There was a small proportion of guests (7%) who left the hotels of their own accord. Figure 10 shows the support needs of those who abandoned. For instance, a majority had issues with their mental health.

Figure 10: Support needs of guests who left voluntarily (% abandonments)



The main reason for leaving voluntarily was a reluctance to accept an alternative accommodation offer. Interviewee 4 stated *"you can see where people are being asked to move out of a really nice hotel and into a hostel – you can see why some people may have an issue with that".* This was an unintended consequence of the hotel scheme; the quality of the move-on option was seen as inferior to the hotel, discouraging guests from taking up the offer and leading them to leave the hotel with no viable move-on accommodation.

> "...the hotel scheme was not a one size fits all project"

From developing the hotel scheme, interviewee 1 mentioned that *"we recognise the need for a range of options. Hotels didn't work for everyone"* and that other interventions are needed in order to help people at risk of homelessness. One guest who left the hotel believed that they would not be able to cope with managing their own tenancy and decided to sleep rough. A small minority did not feel safe in the hotel surrounded by other people, so they decided to abandon for that reason. This shows that the hotel scheme was not a one size fits all project as there was a significant number of people who were excluded and a small minority who decided that the hotel was not suited to their needs.

Everyone In through the lens of multiple disadvantage: a case study

The higher rates of exclusion and abandonment among guests with multiple needs shows that the hotel scheme can struggle to accommodate those who are experiencing an array of issues. To work effectively with this group of people, long term support will need to be provided in order to help them to achieve a fulfilled life[11]. Moreover, interviewee 1 stated that *"I was aware the hotels might be difficult for people with high levels of complex needs – but there was such short notice, there weren't enough beds in the complex needs services".* Therefore, there was an acknowledgement that *Everyone In* did not work for many people experiencing severe multiple disadvantage. Having said that, it would be wrong to write it off as completely unsuitable for people experiencing SMD. The scheme did have some success working with people who experience multiple disadvantage as exhibited by the case study below.

Case Study - Millie

Millie is a 40-year-old woman has been through the homelessness cycle for many years. In the last six years, she has spent a significant time street homeless. Alongside homelessness, she regularly misuses substances and has issues with her mental health, which has led to suicidal ideation and on occasions has attempted to take her own life.

During the first few weeks of the UK lockdown, Millie was evicted from her accommodation due to issues with her behaviour. This led to her rough sleeping, which initially made it hard for workers to engage with her as her location was unknown. During her time rough sleeping she was physically assaulted by her partner which led to his arrest. Millie was then accommodated in a hotel which did not have a supported element to the service. Millie felt unsafe at the hotel she was staying in and when she went food shopping she was verbally abused by members of the public. However, she was motivated to try and reduce her substance misuse and so decided to self-detox, which led to a hospital admission due to seizures. Upon her hospital discharge, she returned to the unsupported hotel which was a concern for her workers involved.

[11] Bowpitt, G., De Motte, C., Legister, C., Spours, J., Walsh, R., Everitt, G. and Kaur, K., (2018), *Multiple Needs: Meeting the Challenge,* Nottingham: Opportunity Nottingham. Available at http://www.opportunitynottingham.co.uk/uploadedfiles/documents/37-1542795128-opportunity_nottingham_year_four_report_2.pdf

Millie was eventually accommodated at a hotel where she would receive support from different agencies. Being accommodated at the hotel has given Millie some more stability in her life. She has received support from the Homeless Health Team to access treatment for her physical health and she is in a safe place away from her abusive partner. Millie is still motivated in reducing her substance misuse and is hoping to enter residential rehab. This would have been difficult to achieve rough sleeping or in the hotel with no support. As whilst she was rough sleeping it was extremely difficult to get hold of Millie and at the other hotel, other residents were trying to pressure her into taking drugs and she felt alone and scared. Being accommodated at the supported hotel, workers have managed to help complete all the paperwork for a rehab application and there has been an increase in engagement with her Substance Misuse worker. Millie has also been able to access a mental health assessment at a convenient time for her at the hotel and her substance misuse has further reduced.

Historically, Millie would often find herself getting evicted, thus losing her housing duty. Therefore, a case conference meeting was held between Framework, Housing Aid and Opportunity Nottingham to discuss Millie's housing and the most effective way to support her going forward. They have agreed to ensure that Millie's transition into rehab goes as smoothly as possible. She has been offered accommodation at a service where she feels comfortable staying at and if her partner was to find her location before she enters rehab plans have been put in place to find accommodation in a refuge for a limited time, to ensure that her partner does not hinder her progress. She is also receiving intensive support from Opportunity Nottingham who will be supporting her with food shopping and keeping her engaged in activities in order to help keep her progress on track.

Staying at the supported hotel has been extremely progressive for Millie. It has allowed all agencies around Millie to work more collaboratively together in order to achieve the best possible outcome for Millie. Furthermore, Millie can have some troubles with attending appointments therefore the flexibility of the mental health assessment appointment means that she can get quicker access to an assessment and it has been easier to rearrange the appointment, which is very beneficial to Millie.

Conclusions and recommendations

During these unprecedented times, the *Everyone In* scheme has proven to be effective, but it is not without flaws, reflecting experience nationally[12]. This final section summarises the successes and reservations encountered in operating the emergency response in Nottingham, and makes some tentative recommendations based on what has been learnt.

Successes

- 168 people who were sleeping rough or at risk of doing so were accommodated in hotels between the end of March and the end of June 2020.
- The self-contained nature of the hotel rooms effectively prevented the spread of Covid-19 in the homeless population.
- The high quality of the 4-star accommodation, along with fear of Covid-19, accommodated long-term rough sleepers who had long eluded helping services.
- The suspension of regulatory barriers to accommodation meant that, for instance, migrants with 'no recourse to public funds' were included.
- Extending the response to beneficiaries deemed high priority and at risk of rough sleeping by the City's Housing Aid service enabled vulnerable groups such as women fleeing domestic violence to be included and to see the hotels as places of safety.
- Locating a hitherto elusive population in a fixed location facilitated more effective access to a range of other support services for the 96% of guests who had needs in addition to homelessness, including 56% accessing the Homeless Health Team.
- Support services for guests with mental and physical health issues and drug and alcohol problems reported being able to work more collaboratively, with greater flexibility.
- Contrary to initial fears, the atmosphere at the hotels reflected features of Psychologically Informed Environments, with high quality support staff from Framework and Emmanuel House, good relations between guests and hotel staff, and little damage to property.
- Fears of isolation and boredom during lockdown were offset by opportunities for social interaction and the well-appointed nature of the hotel rooms, which all had TVs, for instance.
- Positive outcomes were achieved for a high proportion of guests, including 41% moving on to more secure accommodation, and health improvements arising from guaranteed shelter and regular meals.

[12] See, for instance: Fitzpatrick, S., Watt, B. and Sims, R. (2020), Homelessness Monitor England 2020: COVID-19 Crisis Response Briefing, London: Crisis, On-line: https://www.crisis.org.uk/media/242907/homelessness_monitor_england_2020_covid19_crisis_response_briefing.pdf; Making Every Adult Matter (MEAM, 2020), Flexible response during the Coronavirus crisis: Rapid evidence gathering. On-line: http://meam.org.uk/2020/06/11/flexible-responses-during-the-coronavirus-crisis/

Reservations

- The emergency response was by no means comprehensive in removing all rough sleepers from the streets of Nottingham during the 3-month period.
- The hotel experience did not suit everyone: 26% had to be excluded, mainly for reasons connected with substance misuse and anti-social behaviour; and 7% left of their own volition. The exclusion rate was higher for those with higher levels of multiple disadvantage.

Recommendations

- Nottingham City Council and its partners should seek to secure funding for establishing a permanent source of emergency accommodation for all rough sleepers in the City.
- This accommodation should be self-contained for each resident and accessible 24 hours a day, with opportunities for recreation and support staff on site. The accommodation should take a gendered approach and include women only spaces
- A multi-disciplinary team (MDT) representing all support services relevant to the full range of complex needs typically experienced by rough sleepers should be commissioned by the City Council and its statutory sector partners to cover housing, health, social care, probation and substance misuse.
- All rough sleepers and other adults with severe and multiple disadvantage should be routinely referred to the MDT for assessment and regular consideration at MDT meetings for a coordinated, planned response to complex needs.
- MDT members should work collaboratively towards the permanent resettlement and improved well-being of all beneficiaries who are referred to it.
- The City Council should expand the availability of housing under the Housing First scheme for the permanent accommodation of rough sleepers.

Appendix 1: Interview Schedule

Hotel provision for rough sleepers in Nottingham in response to *Everyone In*

1) How did you feel about the offer of hotel accommodation for homeless people?

a) Explore feelings of surprise, delight, anxiety, willingness to accept.
b) For guests: tell us how and when you encountered the offer. What was it like being offered a room in a hotel?
c) For staff: tell us about your involvement. What sense do you get of how guests felt about the offer?

2) How did it compare with Night Shelter or any other emergency accommodation you have experienced?

a) What were the differences? Was the experience better or worse?

3) How was life in the hotel managed? Were there any particular challenges in relation to, e.g.

a) Maintaining public health expectations with respect to social distance, washing etc.
b) Security and personal safety
c) Relating to hotel staff
d) Social isolation and meeting friends
e) Needing to go out
f) Keeping occupied
g) Keeping hotel rules
h) Getting food
i) Access to health care and medication
j) Access to drugs and alcohol
k) Managing mental health

4) Did your wellbeing improve or get worse?

a) Ask guests separately and get a general impression from staff.

5) What was your experience of other services while in the hotel?

a) How did it affect willingness to engage?
b) Ask about the accessibility of GP, mental health, substance misuse, probation, DWP, housing etc.
c) How did being in the hotel affect ease of access?
d) Did services behave differently in relation to, e.g., flexibility, responsiveness.

6) What support was available for move-on and what were the results?

a) For guests: tell us how and when you moved out of the hotel. What were your feelings? Were there any barriers to overcome? Has move-on worked for you?
b) For staff: how easy has it been to secure move-on for hotel guests? How does it compare with moving people on from the Night Shelter?

7) What thoughts do you have about how the benefits of the hotel experience can be maintained in future services?

a) Talk about the proposed wrap-around service.

Appendix 2: Hotel Survey collection

1) Name of resident

2) Date of birth

3) Ethnicity

4) Gender

5) What are the reasons for homelessness:

Relationship breakdown	No recourse to public funding	Domestic abuse	Rent arrears
Eviction	Hostel Exclusion	Homeless upon prison release	Local connection issues
Overcrowded housing	Financial issues	Unsuitable housing	Other (please state)...

6) What are the residents areas of need in addition to homelessness:

Domestic abuse	Substance Misuse	Offending	Refugee
Mental Health	Physical Health	Sexual exploitation	Language barrier
Other (please state)...			

7) Date of accommodation at hotel

8)

a) Was the resident supported to access one of the following services:

NRN	Homeless Health Team	GP registration	The Health Shop

b) If you responded yes to any of the services in q.8a what have been the outcomes of engagement?

9)

a) Has the resident been supported to access any other services (e.g. benefits, domestic abuse, social care), if so which agencies?

b) If you responded yes to any of the services in q.9a what have been the outcomes of engagement?

10) Does the resident engage with mental health services? If yes, did they engage with the services before being accommodated at the hotel?

11) Do you believe the resident could benefit from mental health support, if they do not already access any mental health services?

12) Date the resident left the hotel

13) Reason for leaving the hotel

Social housing tenancy	Private housing tenancy (Own)	Private (shared)	Care home
Family/friends	Hostel accommodation	Supported accommodation	Hospital
Prison	Other temporary accommodation	Evicted	Unknown
Other (please state)...			

Key stakeholder questions

1) How has service provision changed during Covid-19 response?
2) What benefits did the hotel accommodation (and lockdown) bring to delivery of your service?
3) How has the Covid-19/hotel accommodation changed the ability to engage rough sleepers?
4) Has service provision during Covid-19 enabled collaborative service delivery with wider healthcare and support services? How has this been of benefit?
5) Could any of these changes have been made prior to Covid-19?
6) Did use of technology change during this time and what impact did it have on individual and your service delivery?
7) What insight have you gained into the impact of the hotel environment on the wellbeing of individuals?

Specific Key stakeholder questions

GP questions:

1) How many have registered with a GP Practice who were not previously? (Number of people)
2) How many have received a GP medical assessment? (physical or remote)
3) How many people were assessed for Covid -19? (Number of people)
4) Are now receiving treatment for a long-term condition e.g. diabetes, respiratory illness, mental illness (Number of people and type of treatment)
5) How many of those already registered, have received GP assessment who had not engaged with GP services for over 1 year?

Homeless Health Team questions:

1) How many had a nursing assessment?
2) For how many was this a first contact with the service?
3) How many were identified as needing mental health assessment?
4) How many were identified as having a mental health need?
5) Have received wound care check or advice (total number)

6) Have received tissue viability specialist treatment (total number)
7) Have received wound care that prevented attendance / admissions to A&E
8) Have received other nursing input that prevent attendance/admission to A&E
9) How many have registered with a GP Practice who were not previously? (number of people in hotel and not)

NHT Mental Health questions:

1) How many were identified as needing a MH assessment
2) How many received MH assessment at the hotel?
3) How many achieved partial engagement e.g. some contact with MH provision
4) How many have received a mental health diagnosis (previously not known)?
5) How many received a MH intervention?
6) How many have now have an active care plan?
7) How many were already known to secondary care Mental Health Services?

Nottingham Recovery Network questions:

1) How many have received a substance misuse assessment?
2) For how many was this a first contact with the service?
3) How many have commenced substance misuse treatment (broken down by treatment modality)
4) How many have received harm reduction advice (broken down by modality)
5) How many reported an improvement in substance misuse?
6) How many entered detox?
7) How many received Opiate Substitute Treatment?

Street Outreach questions:

1) How many service users were identified as having 'additional' needs and what were they? E.g. health, substance misuse
2) How many service users did you support to access wraparound services? E.g. nursing, benefits, domestic abuse services
3) How many have a care plan, who did not previously?
4) How many identified as needing a social care assessment
5) Have accessed employment schemes?
6) Have made positive steps to move into employment?
7) How many residents were evicted or left the hotel accommodation of their own accord without move on plans, what was the reason for this?
8) How many were newly identified safeguarding risk e.g. victims of modern slavery?

NOTTINGHAM TRENT UNIVERSITY

opportunity NOTTINGHAM

Believing in people. Inspiring change.

www.opportunitynottingham.co.uk
0115 850 4128
@OppNottingham
Search for Opportunity Nottingham

COMMUNITY FUND

Opportunity Nottingham is made possible by funding from the National Lottery Community Fund.