Evaluation of the Rough Sleeping and Mental Health Programme in Oxleas NHS Foundation Trust and South West London and St George's Mental Health NHS Trust

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Health Innovation Network South London

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We also extend our sincere gratitude to the service users who generously shared their experiences of the programme. We also thank the stakeholders and outreach staff for their valuable insights, which greatly contributed to this evaluation.

About the Health Innovation Network South London

The Health Innovation Network (HIN) South London is the health innovation network for south London, one of 15 across England. We are the bodies uniquely established to connect NHS and academic organisations, local authorities, the third sector and industry, in order to increase the spread and adoption of innovation across large populations, at pace and scale."

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1. Executive Summary

1.1. Background

Oxleas NHS Foundation Trust (Oxleas) and South West London and St George's Mental Health Trust (SWLStG) jointly commissioned an evaluation to explore how their Rough Sleeping and Mental Health Programmes (RAMHP) have been implemented, delivered, and benefited service users during the period of July 2023 to June 2024.

RAMHP services comprise small teams of mental health professionals based within mental health trusts and provide flexible, reactive, and proactive support to people who are rough sleeping. RAMHP uses a proactive approach to supporting people sleeping rough, by taking the steps to meet people on the streets to assess and support their mental health. They work closely with other services to provide better integrated support and care for a population with often complex and unmet needs.

1.3. Key findings

This evaluation demonstrates that RAMHP in Oxleas and SWLStG has successfully engaged with rough sleepers. Evaluation insights revealed strong overall support for RAMHP's model of care and service delivery. Key factors contributing to its success include:

- **Addressing a critical need:** RAMHP fills a significant gap by providing essential assessments for rough sleepers, enabling them to access necessary support. Furthermore, it addresses a crucial deficiency in current service provision by offering direct referrals to mental health services, a function previously absent in outreach programmes working with this population.
- **Providing personalised care:** A flexible and holistic approach ensures services are tailored to each individual's unique needs. This approach recognises the complexity of challenges faced by rough sleepers and promotes a more effective pathway towards stability and wellbeing.
- **Improving service users' wellbeing:** The services demonstrate a positive impact on users' wellbeing, with significant improvements observed in most areas measured by the Health of the Nation Outcome Scores.
- **Comprehensive support:** The services provide comprehensive support, addressing a wide range of needs faced by rough sleepers. Beyond core services, RAMHP practitioners provide essential practical support with everyday needs. Their support extends to several activities such as organising and accompanying service users to healthcare appointments, housing services, etc.
- **Dedicated practitioners:** Working as part of a RAMHP team requires staff to be compassionate and passionate. Qualitative insights revealed how RAMHP practitioners adapt their schedules to meet rough sleepers needs. Recognising that a typical 9-to-5 working day does not align with the realities of rough sleeping, RAMHP staff go above and beyond to connect with individuals, conducting outreach at unconventional hours.
- **Strong partnerships:** RAMHP fosters collaborative working with outreach agencies and local authorities, facilitating valuable knowledge exchange. This integrated approach enhances overall service delivery and ensures individuals receive coordinated support. Joint shift working has proven highly beneficial for both partner organisations and RAMHP staff, resulting in enhanced assessments and increased engagement.

While participants recognised the value brought about by RAMHP services and its positive impact, they also highlighted operational and systemic challenges. They included:

- **Staff recruitment and retention**: Both RAMHP teams faced recruitment challenges, including periods of vacancy. Recruitment of staff was challenging as working for the services require people with a specific set of skills and outlook. In addition, the RAMHP pilot's short-term funding model, which resulted in fixed-term contracts, could make it more challenging to attract and retain qualified staff.
- **Team expertise**: Budget limitations restricted the RAMHP teams' size and expertise, preventing them from recruiting the full range of staff needed to optimally support service users (i.e. psychologist and physical health support).
- **Current referral criteria**: Some staff from RAMHP services and partner organisations understood that they are unable to refer or work with rough sleepers who are in emergency accommodation or those who are not actively rough sleeping but are in extremely unstable housing. However, there was some noted variability in the circumstances of people being referred into RAMHP (i.e. whether they were actively rough sleeping at the time of referral). Overall, the decision of RAMHP staff to accept or decline a referral could lead to some inconsistencies.
- **Wider implementation barriers**: Beyond operational barriers, participants identified broader systemic issues that hinder the provision of holistic support to rough sleepers such as lack of housing options, difficulties in completing mental health assessments with an extremely vulnerable population and navigating differences between boroughs.

Addressing some of these challenges will be crucial to further optimise service delivery and maximise positive outcomes for rough sleepers. However, given RAMHP's demonstrated effectiveness in addressing unmet needs, Oxleas and SWLStG's Mental Health Trusts should consider expanding and funding the programme, following the successful model in North and Central London.

The evaluation highlights key recommendations for enhancing service delivery. These recommendations address both practical, day-to-day improvements and higher-level, systemic changes that may require additional resources. They can be found in Section 9.

2. Background

This evaluation was jointly commissioned by Oxleas NHS Foundation Trust (hereafter, Oxleas) and South West London and St George's Mental Health Trust (hereafter, SWLStG). It explores how their Rough Sleeping and Mental Health Programmes (RAMHP) have been implemented and delivered, as well as their impact on their service users, since their inception in July 2023.

2.1. Homelessness in South London

People who sleep rough experience some of the most severe health inequalities and much poorer health than the general population. According to the UK Government, many have co-occurring mental ill health and substance misuse needs, physical health needs, and have experienced significant trauma in their lives.[1] Data from the UK homeless charity, Crisis, outlines that the average age of death for people experiencing homelessness is 47.[2]

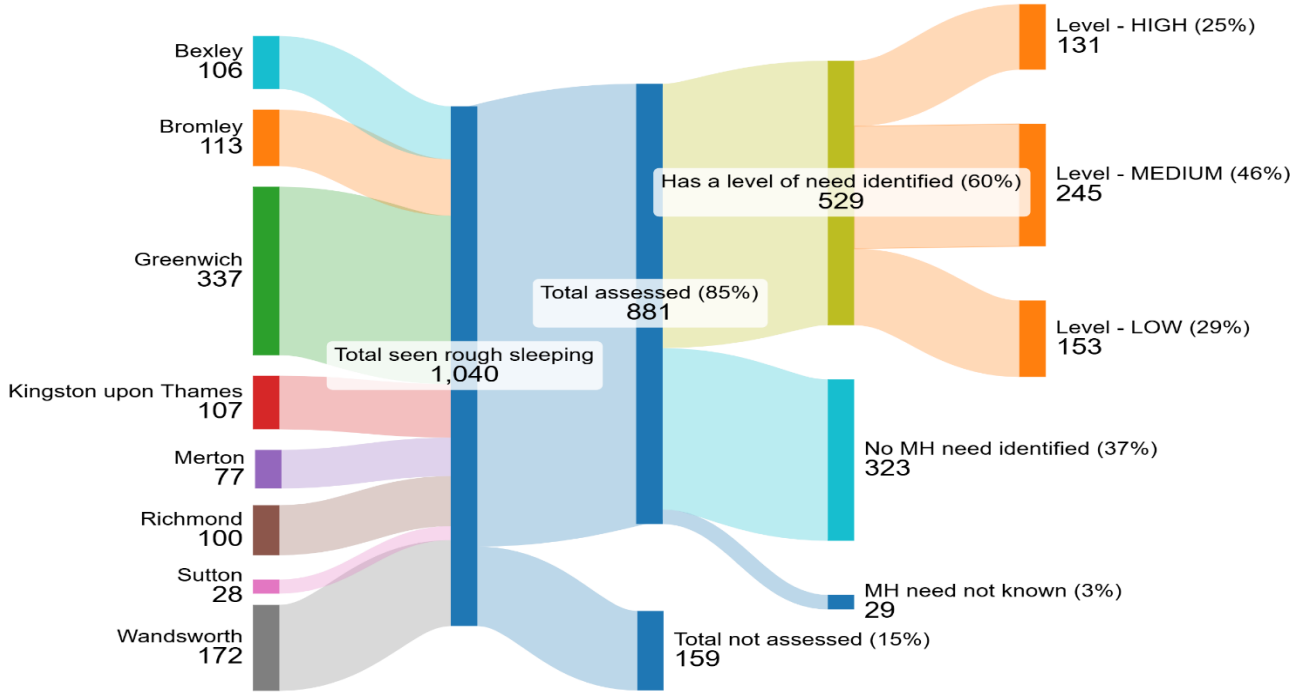

Figure 1: Mental health support needs of people seen rough sleeping in south London boroughs covered by Oxleas and SWLStG RAMHP 2023/24. SOURCE: CHAIN[3] See also Appendix 10.1

In South London boroughs covered by the RAMHP programme, the majority of rough sleepers (60%) who received a needs assessment in 2023/24 reported needing mental health support. Over two-thirds (71%) had a high or medium need for such support (Figure 1).

[1] Health matters: rough sleeping - GOV.UK
[2] crisis_homelessness_kills_es2012.pdf
[3] https://data.london.gov.uk/download/chain-reports/5ea89803-011e-44a2-9bec-a9463358ead6/CHAIN%20annual%20data%20tables%202023-24.ods

Despite the clear link between mental health and homelessness, many individuals in London have lacked access to essential specialist support.[4] Typically, mental health services provide care to people experiencing homelessness as patients within formal healthcare settings. This model creates barriers to access appropriate care. There is limited availability of dedicated homeless mental health teams offering more client-centred approaches, such as outreach.

2.2. About the Rough Sleeping and Mental Health Programme (RAMHP)

The Rough Sleeping and Mental Health Programme (RAMHP) was first launched in 2020 as a two-year pilot funded jointly by the Mayor of London and the then Ministry for Housing, Communities and Local Government. It was piloted in four mental health trusts in North and Central London (West London Trust, Central and West London, Northeast London Foundation Trust and East London Foundation Trust). Following the end of the pilot period, all four trust regions have continued this work, now funded through the health system.

RAMHP services comprise small teams of mental health professionals based within mental health trusts and provide flexible, reactive and proactive support to people who are rough sleeping. They also strive to develop close operational working links with other advocacy and support services in the non-profit sector with the core aim to enhance, fill gaps, build bridges between services, and help existing services work together more effectively.

An evaluation of the RAMHP pilot carried out by UCLPartners[5] found that the services were flexible and personalised, and over 70% of people who received support from RAMHP were not seen rough sleeping again within 12 months of discharge from the service.

2.2.1 RAMHP in South London

In 2023, the Greater London Authority (GLA) secured funding from the Ministry for Housing, Communities and Local Government to expand RAMHP to a further eight boroughs in South London, covered by two mental health trusts: Oxleas NHS Foundation Trust (Oxleas) and South West London and St George's Mental Health NHS Trust (SWLStG). They started delivery in July 2023 and are funded until March 2025.

As outlined in Figure 2, Oxleas covers three boroughs which include Bexley, Bromley and Greenwich. SWLStG covers five boroughs, which include Kingston, Richmond, Wandsworth, Sutton and Merton.

[4] Mayor's Rough Sleeping Services Briefing 2023-24
[5] https://www.london.gov.uk/sites/default/files/2023-10/UCLP%20Final%20RAMHP%20Pilot%20Evaluation%20-%20October%202022%283%29.pdf

Figure 2: Map of London boroughs covered by the Oxleas and SWLStG RAMHP services

While each RAMHP team has unique aspects, they all share core features: assertive outreach, navigation, advocacy, small caseloads, and trauma-informed care. Teams rely on partnerships with street outreach agencies for referrals and collaborate across boroughs to serve individuals experiencing homelessness, recognising their mobility.

2.2.2 Overview of the model of care

RAMHP uses a proactive approach to supporting people sleeping rough. This includes taking the steps to meet people on the streets to assess and support their mental health, instead of requesting they attend appointments in primary or secondary care settings. RAMHP teams include staff with a background in mental health and psychology, typically with qualifications in nursing, social work and occupational therapy.

To refer someone into the RAMHP service, the person being referred must be 'actively rough sleeping' defined by the Ministry of Housing as:

- People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments).
- People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" which are makeshift shelters often comprised of cardboard boxes).[6]

The person being referred should not already be accessing or under the care of secondary mental

[6] Health matters: rough sleeping - GOV.UK

health services and must be rough sleeping in a borough covered by the RAMHP teams. However, referrals can be made (at the discretion of each service), where a service user with significant mental health problems is at risk of eviction and consequent homelessness likely to be related to their mental health. There have also been examples when the teams have shared expertise with secondary mental health teams struggling to support service users under their care.

Day-to-day activities undertaken by RAMHP practitioners include:

- Conducting regular joint outreach shifts with homelessness outreach teams
- Meeting people sleeping rough and building relationships over time
- Assessing the mental health needs of people sleeping rough and discussing treatment and support options
- Attending multi-disciplinary and strategic meetings with partners
- Facilitating access into mental health services for people sleeping rough
- Supporting access to primary care (e.g. GP registration), and other health services (e.g. substance abuse services)
- Evaluating progress and being responsive to changing circumstances
- Delivering a range of treatment options
- Supporting homelessness and local authority colleagues to find the most appropriate accommodation options
- Continuing to provide support, discharging or making onward referrals as required

The discharge process from RAMHP services is based on guidelines that stipulate support ends four to six weeks after a service user has been allocated accommodation (temporary or permanent). However, in practice, discharge may be considered on a case-by-case basis.

3. Evaluation Approach

The evaluation aimed to understand how the Rough Sleeping and Mental Health Programme (RAMHP) has been implemented and delivered in Oxleas and SWLStG. In doing so, it sought to assess whether and how RAMHP has been effective in improving the wellbeing of the rough sleeping population in South London.

3.1. Evaluation Objectives

The evaluation sought to address the following:

Describe how RAMHP is implemented to better understand how the programme is working:

- How was the programme implemented overall by SWLStG and Oxleas?
- What were the essential features of both programme-level and service-level delivery that enabled success?
- What were the common challenges and/or obstacles faced by the local areas in delivering the programme and why did they occur?
- How partnership working between the RAMHP teams and other services occurred in practice?

Impact of RAMHP to understand if the programme had the desired impact:

- Were people with mental health needs who were sleeping rough able to access support and make positive changes to their lives?
- Were mental health teams (MHTs) and homelessness outreach agencies supported to make their services more appropriate and accessible?
- Did the programme result in cross-sectional learning and partnership collaboration?

Lessons and learnings to support sustainability of the service and inform improvements:

- Did the programme result in any wider changes to existing practices and/or any wider learning?

3.2. Evaluation Design

To gain a comprehensive understanding of RAMHP services in Oxleas and SWLStG, the evaluation employed a mixed-methods approach, integrating both primary and secondary data analysis.

3.2.1. Overview of data collection methods

Data collection involved a combination of qualitative and quantitative methods, as detailed in Table 1.

Table 1: Summary of data collection methods and analytical approach

Collection method	Description	Analysis
Service / clinical data	Three elements of quantitative data were extracted and received for evaluation: • Combined Homelessness and Information Network (CHAIN) data (see 3.2.3) • Quarterly key performance indicator reports from the Trusts to the Greater London Authority (GLA), from July 2023-June 2024 • Health of the Nation Outcome Scales (HoNOS) Scale (see 3.2.2)	All quantitative data was analysed in Excel using descriptive and inferential statistics.
Interviews and focus groups	Core RAMHP team staff and staff from partner organisations and outreach agencies were invited to complete individual interviews or focus groups. Service users were identified and recruited via RAMHP practitioners and interviewed by the evaluation team.	Interviews and focus groups were recorded and transcribed via Microsoft Teams. Themes were coded in Excel using a deductive approach based on the evaluation objectives.

Table 2: Sample size for quantitative and qualitative data by presents the sample size for data collected for each RAMHP service at Oxleas and SWLStG.

Table 2: Sample size for quantitative and qualitative data by pilot site

Oxleas	SWLStG
Quantitative data	**Quantitative data**
• 42 service users with CHAIN data • 25 service users with HoNOS scores at entry and discharge to the service • 103 service users overall with referrals	• 81 service users with CHAIN data • 59 Service users with HoNOS scores at entry and discharge to the service • 161 service users overall with referrals
Qualitative data	**Qualitative data**

• 3 service users participated in a 1:1 interview
• 6 staff from core RAMHP team
  ○ 4 participated in a focus group
  ○ 2 participated in 1:1 interview
• 10 staff from partner organisations (including Thames Reach, Via Org, local councils, and Bromley GP Alliance)
  ○ 6 participated in a focus group
  ○ 4 participated in a 1:1 interview
	• 2 service users participated in a 1:1 interview
	• 7 staff from core RAMHP team
	  ○ 4 participated in a focus group
	  ○ 3 participated in a 1:1 interview
	• 6 staff from partner organisations (including Spear London, Kingston Churches Action on Homelessness (KCAH), Encompass, and local councils)
	  ○ 2 participated in a focus group
	  ○ 4 participated in a 1:1 interview

3.2.2. The Health of the Nation Outcome Scales (HoNOS)

Health of the Nation Outcome Scales (HoNOS) are a set of 12 scales to measure the health and social functioning of people with severe mental illness, developed by the Royal College of Psychiatrists Research Unit. The scales are completed for service users on initial assessment and on discharge from the service with the intention of measuring change in response to interventions. Further details on

HoNOS and the analysis is given in section 6.1.1

3.2.3. Combined Homelessness and Information Network (CHAIN) Data

The CHAIN database[7] compiles and provides data about people seen rough sleeping by outreach teams and other agencies involved in supporting them. This includes demographic data and information on accommodation outcomes. It is funded by the Greater London Authority (GLA) and managed by Homeless Link. The majority of service users seen by the trusts working on the RAMHP project had a 'CHAIN ID' which was recorded by the teams. Anonymised aggregate data for service users referred to RAMHP teams between July 2023 and June 2024 was provided by Homeless Link.

3.2.4. Staff engagement

RAMHP staff were invited (via the team leads) to participate in the focus group facilitated by the evaluation team. Staff unable to attend the focus group were offered an individual interview to share their perspective on RAMHP (Table 2).

Staff from partner organisations were identified by the team leaders of each RAMHP team. Contact details were provided to evaluation staff who contacted the staff from partner organisation to invite them to a focus group or interview.

3.2.5. Service user engagement

Service user engagement was two-fold:

- **Expert by experience partner:** The evaluation team collaborated with a person with lived experience of rough sleeping who was recruited from SWLStG. This partner helped to co-design the service user-facing documentation, including the participant information sheet, consent form, and topic guide.
- **Interviews with RAMHP service users:** Five service users (three men and two women) participated in 30 to 45 minutes telephone interviews. Participants were recruited via the RAMHP teams at Oxleas (n=3) and SWLStG (n=2).

All service users were remunerated for their time.

3.3. How to read this report

This evaluation report is structured in four sections to provide a comprehensive understanding of RAMHP in Oxleas and SWLStG:

- Overview of RAMHP, providing a detailed description of RAMHP in both trusts, and service activity data
- Factors affecting the implementation of RAMHP
- Service and service users' outcomes, including an analysis of service user outcome data
- Lessons learnt to inform service improvement

Each section draws on both qualitative and quantitative data gathered across both trusts to address the key evaluation questions. It presents quantitative data by trust, highlighting individual differences. Qualitative findings identify common themes across both trusts.

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[7] CHAIN | Homeless Link

4. Overview of RAMHP services in Oxleas and SWLStG

This section provides a detailed look at how each Rough Sleeping and Mental Health Programme (RAMHP) team operates within their respective trust. In doing so, it explores how the service functions within both trusts, including the types of support offered, referral and discharge processes, team structures, and service activity data from July 2023 to June 2024.

4.1. How does RAMHP work

Qualitative insights revealed strong overall support for the RAMHP concept. Further analysis identified key themes related to (1) specialist support offered by RAMHP and (2) the tailored approach to the service user journey (i.e. service user identification, referral and discharge).

4.1.1. Support offered by RAMHP

RAMHP staff and stakeholders described a range of support offered by RAMHP:

- **RAMHP 'fills a gap' by providing key assessments for rough sleepers so they can access the support they need.**

"RAMHP's pathway and ability to get out and do assessment … it just seems a lot more robust [than Enabling Assessment Service London] ….It's nice to know they're really integrating themselves into the community and they're available where the rough sleepers are like. They meet them at their level." [Oxleas partner organisation]

The use of RiO (an electronic patient health record system for community, mental and child health providers) by RAHMP teams allows effective information exchange and collaboration among partner organisations. This facilitates collaboration by providing information and context to a rough sleeper's circumstances in multi-disciplinary meetings:

"I'd be chairing the forums every month and you know every month people would have issues where a Character Assessment was required for someone on the street or there was a Mental Health Act Assessment required for someone on the street and it's like, you know, the existing services weren't able to do that. So, every month people were asking me "When's the social worker starting?", or "When's the RAMHP team starting?". You know, they were the two sort of missing pieces to the puzzle." [SWLStG Partner Organisation]

- **RAMHP addresses a critical gap in service provision by offering direct referrals to mental health services,** a function previously lacking in outreach agencies working with rough sleepers:

"So for us…we literally had no access to mental health services. Obviously, it exists in itself, but … nobody really knew how to refer into Oxleas or work with Oxleas. It was very, you know, dead end. You try and find a way into it, but there just wasn't a way. So, this sort of provided that bridge between rough sleeping services and mental health services." [Oxleas Partner Organisation]

- **RAMHP also advocate in situations where a rough sleeper is not a service user of the service to improve access to support:**

"So, it is about making community mental health teams aware that they should keep cases open and that is where RAMHP are invaluable in challenging their colleagues to consider a different way of working." [SWLStG Partner Organisation]

"A lot of our clients, you know, if you refer them down the mainstream pathways, they're all getting rejected because they're all self-medicating and they say "I'm taking drugs ...to.. numb the voices in my head?" They're not gonna stop. And they're being declined mental health services, whereas the RAMHP team have got that much better understanding and they're trying to educate people at the same time. But it just it's going to take a long time to re-educate people and change the pathways that we are trying. [Oxleas Partner Organisation]

- **RAMHP can directly provide specialist support to service users.** For instance, SWLStG have an integrated substance misuse worker to support rough sleepers with a co-occurring disorder. This practitioner can conduct independent assessments, provide expert advice and share harm reduction strategies, and link in rough sleepers with local addiction services:

"There's a service user at the moment, we're just trying to help support get a medical detox and then go to rehab. So, we work quite closely with his drugs and alcohol worker and social services to get that funded for them. So yeah… there are definitely ties to a lot of different services." [SWLStG RAMHP]

- **RAMHP monitors rough sleepers, sometimes beyond their own caseload.** RAMHP teams provide (1) proactive outreach, by checking on those who they feel are particularly vulnerable even when they do not engage with the service, and (2) consistent support for rough sleepers who are referred and accepted into RAMHP, i.e. workers complete regular visits to meet with service users and look out for their wellbeing. This consistency is essential for building rapport and addressing their needs.
- **RAMHP works closely with a range of partner organisations, sharing information to ensure their service users receive the best possible support.** RAMHP practitioners attend Task and Target meetings and Rough Sleeping Forums where they share concerns about any identified rough sleepers, provide professional advice, address queries, plan engagement, and signpost to services:

"They sit on our Task and Target weekly meetings so we can discuss their individual cases with all the services available and they can plan outreach together." [Oxleas Partner Organisation]

- **RAMHP provides holistic support and practical assistance to service users.** Beyond core services, RAMHP practitioners offer hands-on support with everyday needs. Their support extends to several activities such as organising and accompanying service users to healthcare appointments, housing services and, for the Oxleas team, a mobile dental bus.

4.1.2. RAMHP service user journey: from identification to discharge

RAMHP is accessible through a range of pathways, including proactive identification by RAMHP practitioners during outreach shifts and referrals from partner agencies.

4.1.2.1. Identifying service users

Participants highlighted two main ways of identifying service users:

- **RAMHP teams conduct joint outreach shifts with partner organisations, specifically targeting rough sleepers who could benefit from support.** The RAMHP teams are flexible in their approach and can attend a late night or early morning shift to increase the chances of successful engagement with a rough sleeper on the street. There is evidence of this being particularly successful in Oxleas with 194 joint shifts completed between July 2023 and June 2024.

"They [RAMHP] join shifts most Fridays, and they visit service users together and this has just allowed us to have a much better holistic and person centred and trauma informed approach when working with service users." [Oxleas Partner Organisation]

- **RAMHP also encourages referrals from a network of partner organisations and outreach agencies,** providing multiple pathways for rough sleepers to access support.

4.1.2.2. Referring into RAMHP

Stakeholders, including RAMHP practitioners and partner organisations, praised the referral process for its straightforwardness and flexibility:

- **There are set criteria outlined to refer into RAMHP, but decisions can be made on a case-by-case basis to allow for a more flexible and service-user centred approach.** Typically, someone who is actively rough sleeping with a perceived mental health issue is suitable for a RAMHP referral. However, the discretion of RAMHP practitioners is applied in more complex cases. A referral to RAMHP requires the consent of the person being referred. Although, this is overridden in situations where RAMHP contributes to issuing a section 135[8] to ensure a person's safety.
- **The RAMHP referral process is simple to navigate.** Referrals can be done by completing a form or writing an email to the RAMHP teams. Information to provide includes where the person is sleeping rough, concerns around them, and any associated risk. While RAMHP staff appreciate the straightforward referral process, they noted that limited information sometimes requires additional fact-finding to gain a complete picture of the individual's needs:

"We have a lot of mystery around people coming in, so a lot of investigative work which is different .... usually in previous teams you have a clear background on people by the time they arrive at the service. Whereas a lot of the time, you don't have notes, you may not know their actual identity so there is a lot more uncertainty that you are working with". [SWLStG RAMHP]

"RAMHP] have made their referral process extremely easy to us. Honestly the only thing they request from us is an e-mail to their generic e-mail address and just a brief summary of what we're making. The referral is more than enough and that just activates everything very quickly". [Oxleas Partner Organisation]

[8] https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/#WhatIsSection136

- **A person does not need to have a bedded down contact recorded on Combined Homelessness and Information Network (CHAIN) to be referred into RAMHP.** It can take several weeks for outreach teams to find someone bedded down. Therefore, RAMHP services can take a referral without a person being 'verified' as rough sleeping by an outreach team. This allows them to work with people sleeping rough in a timely manner. However, staff reported that those who are 'verified' may 'stand a better chance' with accessing certain services e.g. local authority housing applications.

4.1.2.3. Duration of support and discharge from RAMHP

RAMHP offer a flexible point of discharge from the service to tailor and maximise the support provided. This was seen as a positive aspect of the RAMHP services.

- **However, the RAMHP discharge process (i.e. the timing and rationale for discharge) could benefit from greater clarity to ensure** a smoother experience for both stakeholders and service users. General guidelines suggest that the RAMHP team support service users for between 3-6 months, or 4-6 weeks post receiving accommodation. However, qualitative insights suggest timelines of continued support appear to vary:

"We want them to feel successfully settled and linked to other services. The reality is that it might take a while…" [Oxleas RAMHP]

4.2. RAMHP in Oxleas

4.2.1. Structure and staffing

An overview of the boroughs served, structure of the team and partner organisations RAMHP work with is outlined in Table 3: Breakdown of Oxleas RAMHP services, boroughs served, partner organisations. The Oxleas RAMHP team receive oversight and leadership from the Associate Director of Community Mental Health in Bromley. At the time of writing this report, the Oxleas team was also in the process of recruiting a full time Senior Social Worker.

Table 3: Breakdown of Oxleas RAMHP services, boroughs served, partner organisations

Oxleas NHS Foundation Trust		
Boroughs	Bexley Bromley Greenwich	
Partner organisations	Bexley Council Bromley Council Greenwich Council	Thames Reach Safer Spaces Viaorg (**Also** *WSUP (Woolwich Service Users Project); Greenwich Homeless Project; Bromley Homeless Health; Bexley Night Shelter; The Salvation Army, Bexley).*
RAMHP Team	1.0 WTE Senior Practitioner (Band 7) 1.0 WTE Senior Social Worker (Band 7) 2.4 WTE Clinical Practitioners (Band 6) 15 hours of admin support (Band 4)	

4.2.2. RAMHP Service users in Oxleas

The CHAIN dataset covers the period of July 2023 to June 2024, which includes data for **42 service users**. This represents the majority of RAMHP service users who had a CHAIN ID. A small number did not have a CHAIN ID and have not been included in the analysis.

While Oxleas assessed fewer individuals than SWLStG during the evaluation period (see section 4.3.2), this difference is primarily attributed to lower referral rates from two of the three boroughs they cover. This was largely due to staffing challenges within those boroughs, including a prolonged vacancy in the Rough Sleeping Coordinator role in one area. Referrals have increased since the evaluation period, with Oxleas reporting 45 new assessments completed in Quarter 2 of 2024/205.

4.2.2.1. Service user profile

Mental health needs: The majority of Oxleas service users with a CHAIN ID (76%) had a recorded mental health need within 12 months before starting the RAMHP service[9] (Table 4). This information comes from support needs assessments conducted by outreach staff, often before service users formally engage with RAMHP.

Table 4: Recording of mental health need - Oxleas

	No.	%
MH need not known/not recorded	10	24%
MH need recorded within 12 months prior to service start	32	76%
Total accessing service	42	

History of homelessness: There was a mix in duration service users had been rough sleeping (Table 5):

- The majority (43%) were first seen sleeping rough less than one month before starting with the service.
- The next largest group (38%) had first been seen rough sleeping over two years prior to the start of their engagement with RAMHP.

Table 5: Length of time before accessing RAMHP service users first seen rough sleeping - Oxleas

	No.	**%**
Not verified at service start	2	5%
Less than 1 month	18	43%
1-3 months	2	5%
4-6 months	1	2%
7-12 months	0	0%
1-2 years	3	7%
Over 2 years	16	38%
Grand Total	**42**	**100%**

[9] This analysis is based on the latest recorded assessment prior to a person's engagement with RAMHP and an assessment may not have been made. Where the MH need is not known or not recorded, this might be due to an assessment taking place and no MH need being identified OR that no assessment took place in that time period

Demographic characteristics of service users:

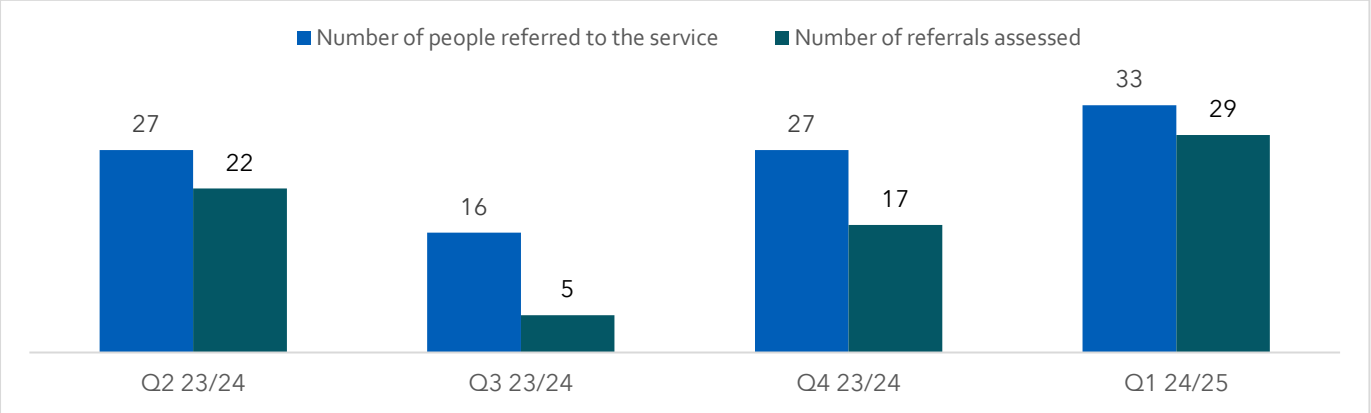
- The majority of service users were male (81%) which is representative of the proportion across the Greater London Authority (GLA) in 2023-24 (82%).[10]
- The ethnic breakdown of service users was predominantly White (79%), followed by Black (12%).
- The largest proportion of service users were aged between 36-45 (33%).

A detailed breakdown is provided in Appendix 10.2.

4.2.2.2. Referrals

Data on referrals was obtained from Key Performance Indicators (KPI) datasets submitted to the GLA quarterly. **Of the 103 referrals to the service during the evaluation period (July 2023 – June 2024), the team assessed 73 (71%)** (Figure 3: Number of referrals received and assessed per quarter, Oxleas, July 2023- June 2024

Figure 3: Number of referrals received and assessed per quarter, Oxleas, July 2023- June 2024



Referrals were sometimes found to be inappropriate. For instance, in Quarter 3 of 2023/2024, seven rough sleepers referred into RAMHP had moved into accommodation before an assessment could take place. Furthermore, some rough sleepers referred could not be located within the time period.

4.2.2.3. Period of care

Out of the 42 service users included in the analysis, 24 had a start and discharge date from the RAMHP service. Most service users (75%) were under the RAMHP team between one and six months, with a mean period of care was 86.7 days and median was 82.5 days. See Appendix 10.3.

4.3. RAMHP in SWLStG

4.3.1. Structure and staffing

An overview of the boroughs served, structure of the team, and partner organisations RAMHP work with is outlined in Table 6: Breakdown of SWLStG boroughs, partner organisations and RAMHP team. Although not directly employed by RAMHP, the SWLStG team receives additional support from a full-time Co-occurring Mental Health, Alcohol & Drugs (COHMAD) nurse. The team also includes a GP trainee, working 0.2 WTE, who is not funded by the GLA. The SWLStG RAMHP team also receives clinical and strategic oversight from the Clinical Manager for the Richmond Community Adult Services

[10] CHAIN Annual Report 2023-2024: https://data.london.gov.uk/dataset/timeline/chain-reports

and the Integrated Partnerships Manager for SWLStG Trust.

Table 6: Breakdown of SWLStG boroughs, partner organisations and RAMHP team

South West London and St George's Mental Health NHS Trust		
Boroughs	Kingston Richmond Wandsworth	Sutton Merton
Partner organisations	Kingston Council Richmond Council Wandsworth Council Sutton Council Merton Council	Kingston Churches Action on Homelessness (KCAH) Spear London Sutton Night Watch SPA
SWLStG RAMHP Team	1 x Team Lead (Band 7, 1 WTE) 2 x Senior Clinical Practitioner (Band 7, 2 WTE) 1 x Recovery Support Worker (Band 4, 1 WTE) Consultant Psychiatrist (0.2 WTE) Administrator (0.4 WTE)	

4.3.2. RAMHP service users in SWLStG

This section includes analysis of the **81 service users** in the CHAIN dataset from July 2023 to June 2024.

4.3.2.1. Service user profile

Mental health needs: Almost half (47%) of service users at SWLStG RAMHP had a mental health need recorded within 12 months of starting the service (Table 7). This information comes from support needs assessments conducted by outreach staff, often before service users formally engage with RAMHP.[11]

Table 7: Recording of mental health need - SWLStG

Recording of mental health need	No.	%
MH need not known/not recorded	43	53%
MH need recorded within 12 months prior to service start	38	47%
Total accessing service	81	

History of homelessness: The SWLStG RAMHP team supported individuals with a mixed history of rough sleeping (Table 8). However, the majority (47%) of their service users were first seen sleeping rough over two years prior to the start of their engagement with RAMHP. This suggests that longer-term rough sleepers are being supported by SWLStG.

Table 8: Length of time before accessing RAMHP service users first seen rough sleeping - SWLStG

	No.	%
Not verified at service start	7	9%
Less than 1 month	8	10%
1-3 months	8	10%

[11] This analysis is based on the latest recorded assessment prior to a person's engagement with RAMHP and an assessment may not have been made. Where the MH need is not known or not recorded, this might be due to an assessment taking place and no MH need being identified OR that no assessment took place in that time period

4-6 months	8	10%
7-12 months	7	9%
1-2 years	5	6%
Over 2 years	38	47%
Grand Total	**81**	**100%**

Demographic characteristics of service users:

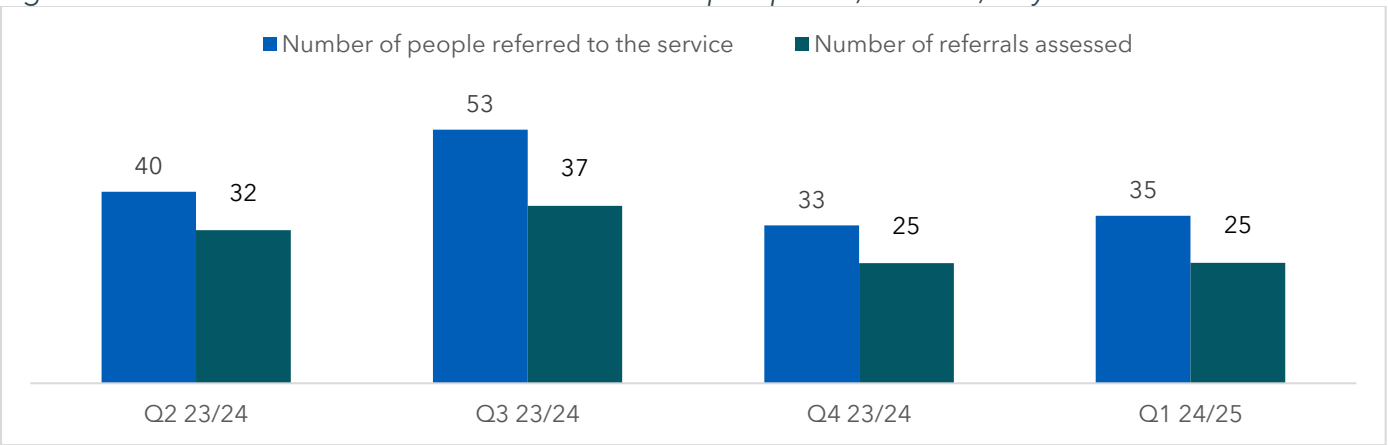
- The majority of service users were male (82%) which is broadly representative of the proportion across the GLA in 2023-24 (82%).
- The ethnic breakdown of service users was two thirds White (67%), followed by Asian (14%).
- The largest proportion of service users were aged between 46-55 (33%).

A detailed breakdown is provided in Appendix 10.2.

4.3.2.2. Referrals

Data on referrals was obtained from Key Performance Indicator datasets submitted to the GLA quarterly. **Of the 161 referrals to the service during the evaluation period (July 2023 – June 2024), the team assessed 119 (74%)** (Figure 4).

Figure 4: Number of referrals received and assessed per quarter, SWLStG, July 2023 - June 2024



Inappropriate referrals (particularly where a person was not deemed to be rough sleeping) and difficulties locating individuals were cited as reasons for assessments not being carried out.

4.2.2.3. Period of care

Out of the 81 service users included in the analysis, 69 had both a start and discharge date from the RAMHP service. The majority of service users (35%) were under the RAMHP team between one and three months. The mean period of care was 124.4 days and median was 88 days. See Appendix 10.3.

5. Factors affecting the implementation of RAMHP in Oxleas and SWLStG

This section explores the perspectives of Rough Sleeping and Mental Health Programme (RAMHP) staff and stakeholders. It highlights key themes across both services relating to the factors affecting the implementation of the RAMHP.

5.1. Key strengths of RAMHP and innovative approaches to supporting rough sleepers

RAMHP was perceived as effectively addressing an unmet need through its innovative and flexible approach. Staff particularly emphasised the positive impact of multi-agency collaboration and the dedication of its practitioners.

5.1.1. Addressing a growing unmet need

Participants highlighted how there is a clear rationale for the programme as:

- **RAMHP is critical in addressing the challenges of a growing rough sleeping population with varying needs.** Therefore, its implementation is vital to in providing necessary support:

"We're seeing more long-term rough sleepers on the streets. We're seeing more rough sleepers in general. Therefore, the need has increased as well." [Oxleas Partner Organisation]

"I've been crying out for a specialist mental health service to support this client group for a really long time." [SWLStG Partner Organisation]

- Linked to the above, **RAMHP supports people who would otherwise 'fall through the cracks'**. RAMHP directly engage marginalised individuals living on the streets, who are often overlooked by mainstream services, especially with regards to mental health:

"The service is filling the gap (..) The average age of premature death for this population is 44 years. That is unfair. What more could we do to provide a support and address some of the concerns? (…) Unless we work collectively. What has been working well for us is that we're filling this gap in terms of providing much needed services for this population that's forgotten." [Oxleas RAMHP]

"It's been quite eye opening and concerning where in some cases, if it hadnt of been for our involvement, some of these people would ahve been 'ping-ponging' around different councils". [SWLStG Partner Organisation]

- **Before the implementation of RAMHP, staff from partner organisations described a lack of mental health support for rough sleepers**, and difficulties in referring this population into mental health care pathways. Rough sleepers with substance misuse issues faced significant challenges in accessing mental health support due to the fragmented approach to care provision:

"So basically, 99% of our service users got zero mental health input." [Oxleas Partner Organisation]

5.1.2. An innovative and flexible approach to providing support to rough sleepers

There was an agreement among most participants that through personalised care, proactive identification of service users, and its integration within the NHS, RAMHP provides a truly innovative approach to supporting rough sleepers:

- **RAMHP teams go out to meet rough sleepers.** RAMHP's outreach component makes it an engaging and responsive service that is able to better support rough sleepers, ensuring they are not left to try and navigate services alone.
- **As part of the NHS, RAMHP practitioners can navigate services more effectively and streamline access to care for rough sleepers.** Staff from partner organisations valued RAMHP staff being employed by the NHS, as they felt that this allowed for better response from other NHS staff and services, alongside increased efficiency in dealing with referrals and requests.
- **RAMHP offers a flexible approach to delivering care:**
    - **RAMHP practitioners demonstrate a deep commitment to supporting rough sleepers, even when engagement is challenging.** They understand the nature of rough sleeping, including that people will not always attend every appointment and might struggle to engage. Accordingly, they do not apply rules such as closing a case after a specified number of failed attempts to attend appointments. This adaptable approach ensures that rough sleepers continue to receive support, even when facing challenges that might lead to discharge from other services. Data from quarterly Key Performance Indicators showed that on average, 70% (SWLStG) and 75% (Oxleas) of service users had more than three contacts, suggesting successful engagement with this approach.
    - **RAMHP practitioners adapt their schedules to meet rough sleepers needs.** Recognising that a typical 9-to-5 working day does not align with the realities of rough sleeping, RAMHP staff go above and beyond to connect with individuals. They conduct outreach at unconventional hours, sometimes as early as 5am or late into the night, to meet people where they are.

5.1.3. Multi-Agency Collaboration and Information Sharing

Although located within the NHS, RAMHP is delivered in partnership with outreach agencies and other services (as outlined in Table 3 and 6). Participants strongly emphasised the value of partnership working and its crucial role in enabling RAMHP to provide holistic support and meet the complex needs of rough sleepers. More specifically, participants identified the following success factors:

- **RAMHP's simple and flexible referral process makes it easy for partner organisations to connect their service users with essential mental health support.** Contrasting to other referral processes, partner organisations noted that RAMHP's was *'extremely easy'* to follow.
- **Joint shift working has proven very valuable to partner organisations staff, who highlighted:**
    - The combined expertise of outreach workers and mental health experts facilitates the assessment of rough sleepers' mental health status.
    - The presence of a mental health specialist can increase a rough sleeper's willingness to engage with services, and more generally help build rapport.
- **RAMHP staff can connect rough sleepers with various services via multi-agency networking**. RAMHP work with outreach services to identify and support rough sleepers, and work to bridge the gap between NHS, local authority, and partner organisations.

- **Partner organisation staff highlighted the benefit of having RAMHP staff being able to access mental health data via RiO** (as highlighted in section 3.4.1). This access enabled informed decision-making and improved care co-ordination. Accessing this data prior to RAMHP was a 'lengthy process':

"Having access to RAMHP to check if a person is known by checking RiO or the database if someone has come from outside of London is very useful." [SWLStG Partner Organisation]

- **Both RAMHP teams and partner organisations found significant value in information and knowledge exchange.** RAMHP teams benefited from increased awareness of critical areas like housing policy while partner organisations gained deeper insights into mental health issues relevant to rough sleepers, and NHS mental health service delivery.
- Linked to the above, **RAMHP practitioners expressed a strong appreciation for the expertise of outreach workers.** Outreach agency staff also praised RAMHP staff for listening to their views, acknowledging their own expertise and skills gained through their direct experience working with rough sleepers.

5.1.4. Dedicated staff with mental health expertise

Stakeholders recognised the strong partnerships forged by RAMHP practitioners and their respect for outreach workers' input. They also identified specific skills contributing to positive outcomes for rough sleepers:

- **RAMHP teams have a good understanding of the challenges faced by rough sleepers.** This includes an understanding of how some may be using substances to manage symptoms of an undiagnosed mental health problem. In these situations, mental health services typically do not get involved, but RAMHP would.

"A lot of our service users, you know, if you refer them down the mainstream pathways, they're all getting rejected because they're all self-medicating." [Oxleas Partner Organisation]

- **There was a consistent view that RAMHP staff go 'above and beyond' to ensure that service users have access to support and receive a 'wrap around' service:**

"So, they're really good at working with the other services. For example, we've got like one really vulnerable service user who [A RAMHP Practitioner] will arrange doctor's appointments, and physically go and find that service user and take them to the appointment." [Oxleas Partner Organisation]

"The people I work with are amazing. Like genuinely the staff are so good at what they do. Really compassionate and caring and knowledgeable." [SWLStG RAMHP]

- **RAMHP staff were described as compassionate, communicative and caring about the rough sleepers that they serve.** Successful stories of RAMHP engagement highlighted their ability to meet rough sleepers 'at their level' and provide sensitive support.
- **Successful implementation of RAMHP is associated with supportive and compassionate leadership**. Oxleas staff emphasised feeling supported and empowered to advocate for service users and provide them with the best support available. This observation was echoed by partner organisations working with the team.
- **Staff appreciate opportunities for professional training and development.** In addition to providing expertise in mental health, RAMHP staff are expected to work successfully alongside partner organisations to navigate support for service users. Oxleas RAMHP staff shared how they were provided with training opportunities. SWLStG RAMHP staff felt they would benefit from receiving training in areas such as housing law to equip them with the knowledge required to advocate for their clients and appeal decisions.

5.2. Implementation challenges

While participants recognised the value brought about by RAMHP services and its positive impact, they also highlighted operational and systemic challenges. Addressing these challenges was considered crucial to further optimising service delivery and maximise positive outcomes for rough sleepers.

5.2.1. Operational challenges

Participants identified two key operational challenges as impacting the delivery of RAMHP: staffing and inconsistent referral processes.

5.2.1.1. Staff recruitment and retention

Both RAMHP teams have experienced staff shortages and turnover:

- **RAMHP teams faced recruitment challenges, including periods of vacancy.** Recruitment of staff was challenging as working for RAMHP requires someone with a specific set of skills and outlook. RAMHP staff acknowledged the importance of having a complete team in place to be able to deliver a 'hands on' service. This was echoed by staff from partner organisations and highlighted that RAMHP teams were able to be most responsive when the service was fully staffed. Retention was identified as important for continuity of support, so that rough sleepers can build trust and a good rapport with longer serving RAMHP workers.
- **The RAMHP pilot's short-term funding model, which resulted in fixed-term contracts, could make it more challenging to attract and retain qualified staff.**
- **Budget limitations restricted the RAMHP teams' size and expertise, preventing them from recruiting the full range of staff needed to optimally support service users**. This lack of specific expertise within the teams was identified as a potential barrier to providing comprehensive support to service users. Both RAMHP teams highlighted the added benefit of additional team members with specific expertise to enhance service delivery and outcomes:
    - They discussed the positive impact a psychologist could add to the team (either as a core member of the team or on a sessional basis), to help provide better support to service users with experience of trauma.
    - While SWLStG have a part-time consultant psychiatrist in post who engages with rough sleepers weekly, Oxleas does not have this clinical expertise and believe it is a key gap within the service, especially to support with mental health diagnosis:

"We haven't had a psychiatrist in the team which has brought some challenges because at times there has been a need."[Oxleas RAMHP]

    - The absence of physical health expertise within RAMHP teams was also identified as a barrier to providing holistic support to rough sleepers. RAMHP staff noted how opportunities to address physical health needs may be missed if individuals disengage or face difficulties attending appointments. At the time of writing this report, the Oxleas team have plans to collaborate with a nurse to accompany RAMHP practitioners on outreach shifts to provide such expertise (including delivering services such as skin scraping to check for scabies or provide wound care):

"Say RAMHP might not realise how severe a wound or an infection might clinically be, and then it would be me working alongside them. Going this guy's going to get sepsis if he does not get treatment, I'm really concerned." [Oxleas Partner Organisation]

5.2.1.2. Referral processes

Current referral criteria do not address rough sleepers in emergency accommodation or those who are not actively rough sleeping but are in extremely unstable housing. However, some staff and stakeholders noted variability in the circumstances of people being referred into RAMHP (i.e. whether they were actively rough sleeping at the time of referral):

- **Stakeholders and RAMHP staff reported some inconsistencies in referral processes.** While the nature of RAMHP is to be a responsive and flexible service, interpretation on what constitutes an appropriate referral can lead to inconsistencies in processes, especially in complex cases. The apparent lack of consistency appeared to be a more prominent issue in SWLStG; for instance, there was an account from a partner organisation questioning whether RAMHP would accept the referral of a rough sleeper riding the bus at night without a known sleep site. Conversely, there was another account of a referral being accepted for someone who was in a precarious housing situation but not actively rough sleeping.
- **Staff from some partner organisations believe the RAMHP offer should be extended to rough sleepers in emergency accommodation or in more complex unsafe housing situations.** One example shared highlighted the case of a vulnerable woman experiencing homelessness who would stay with men posing a risk to her safety to avoid sleeping on the streets.

5.2.2. Wider system barriers to implementation

Participants identified broader systemic issues that hinder the provision of holistic support to rough sleepers. These challenges, some of which extend beyond the direct control of RAMHP teams, are grouped into four core themes: 1) Challenges faced in facilitating access to the most appropriate support, 2) Ability to provide continuity of care, 3) Navigating differences between boroughs, and 4) Misunderstanding around RAMHP's remit.

5.2.2.1. Facilitating access to the most appropriate support

- **Challenges around applying section 135** If RAMHP staff believe a rough sleeper poses a risk to their own safety, they can apply for a section 135 which allows police to take them to a place of safety. Although distressing for both staff and service users, it was deemed necessary in some cases to help a rough sleeper access appropriate support. However, one staff member from a partner organisation noted the challenges around the practical implementation of a section135. They described a situation whereby police could visit an identified sleep site to issue a section 135, but if the person was not within a specified vicinity, it could not go ahead, and the application would have to be re-submitted. Additionally, the mental capacity of some rough sleepers could in some instances change hour-by-hour, further complicating the process. Another challenge mentioned was around noted inconsistencies in how Section 135 warrants are applied across boroughs (see 5.2.2.4).
- **Completing mental health assessments can be challenging.** RAMHP workers conduct outreach shifts to engage with and assess rough sleepers. However, the nature of rough sleeping means that a person may not be at their expected sleep site during a visit, or they may be intoxicated, or in a situation that is deemed unsafe for the RAMHP worker to be in and therefore unable to make an assessment.

- **Lack of housing options creates a challenge to accessing accommodation.** Stakeholders and RAMHP staff highlighted a lack of appropriate housing options in all boroughs covered by the RAMHP teams. Some boroughs do not include hostels and there were accounts of rough sleepers having to move out of their local area to receive temporary or permanent accommodation.

5.2.2.2. Ability to provide continuity of care

- **RAMHP support typically ends once a service user has moved into temporary or permanent accommodation.** In line with guidelines, service users are usually discharged from RAMHP within 4-6 weeks of this transition. However, participants highlighted how critical and challenging this time was for service users, where they must become accustomed to living on their own, navigate bills and benefits, as well as orient themselves to new surroundings. In interviews, service users emphasised a wish to continue receiving support from RAMHP workers for longer than is currently offered. For them, gaining housing does not solve all issues they faced and can create new obstacles (as described above). However, a key goal of RAMHP highlighted by staff, is to facilitate the transition of rough sleepers into mainstream mental health services. They underscored the importance of this transition, explaining that it enables individuals to access ongoing, comprehensive care within established systems.

  "Some people want more, it's not always that's the right answer. So, part of the function of the team is to try and get people integrated into mainstream services and not for people to feel disadvantaged or isolated because of their rough sleeping (…) So we need better pathways for people to access health and social care and whatever other services for people, and it shouldn't be the RAMHP team that's filling that gap. They should be supporting clients into those pathways." [Oxleas RAMHP]

- **Service users who move out of a borough covered by a RAHMP team are no longer able to receive their support.** Due to service users sometimes being housed in a different area of London, RAMHP workers must navigate these challenges and ensure comprehensive handovers take place. This is key to build trust and reduce the burden on the service user to repeat their story and relive any experienced trauma.

5.2.2.3. Misunderstanding of RAMHP's remit

- **Expectations of partner organisation staff around the role of RAMHP and its actual remit did not always align.** A couple of staff members from partner organisations highlighted instances where they suspected a rough sleeper had autism and would have liked a confirmed diagnosis, to access appropriate support the person. RAMHP are unable to offer a confirmed diagnosis, but they can carry out screening for Attention Deficit Hyperactive Disorder (ADHD) or autism, when indicated. This allows them to advocate to local authorities to provide tailored support, in addition to referring service users for full assessment. The teams can also address any mental health symptoms linked to autism. However, challenges around getting an Autism diagnosis highlights wider issues with regards to a lack of provisions nationally.

5.2.2.4. Navigating differences between boroughs

- **Each borough differs in available services and resources to support rough sleepers.** Some local authorities were more challenging to engage and work with than others. Participants reported how boroughs can vary in their approach to rough sleepers and understanding of mental health. Processes can differ between boroughs, for example, issuing of Section 135 warrants (see 5.2.2.1) and housing priority can depend on differences in local authorities and

magistrates. There is also variation in rough sleeping populations between boroughs. These differences pose a challenge to RAMHP workers navigating the best support for rough sleepers:

"RAMHP [in SWLStG] covers 5 boroughs and the boroughs are all very different from each other...Then the makeup of the population is different. The space itself is different. And then who that attracts is different." [SWLStG RAMHP]

6. Outcomes of the RAMHP programme in Oxleas and SWLStG

This section uses qualitative and quantitative analysis to explore the impact of the Rough Sleeping and Mental Health Programmes (RAMHP) in Oxleas and SWLStG on the lives of rough sleepers and how RAMHP has fostered collaboration and improved service delivery among partner organisations, leading to more holistic and accessible support.

6.1. Impact on RAMHP service users

Overall, quantitative and qualitative data analysis suggests that **service users' outcomes have improved**.

6.1.1. HoNOS

HoNOS (Health of the Nation Outcome Scales) are a set of tools used by mental health professionals to assess and measure a person's mental health and social functioning. They can help track progress over time and ensure that treatment is effectively improving their overall health.

There are 12 scales in the HoNOS system, each looking at different areas:

1. Overactive, aggressive or disruptive behaviour
2. Non-accidental self-injury
3. Problem-drinking or drug taking
4. Cognitive problems
5. Physical illness or disability or disability problems
6. Problems associated with hallucinations & delusions
7. Problems with depressed mood
8. Other mental and behavioural problems
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

Each scale is scored with the following classification:

0	No problem
1	Minor problem requiring no formal action
2	Mild problem but definitely present
3	Problem of moderate severity
4	Severe to very severe problem

Oxleas and SWLGsT RAMHP services record HoNOS scores at initial assessment and discharge. The changes in pre- and post-intervention scores can be measured in two ways: statistical change in HoNOS profiles (described here) and categorical change (this can be found Appendix 0).

The change in mean average HoNOS scores[12] was used to calculate the Cohen's d effect size, in order to determine any clinically significant improvement. Table 9: HoNOS Effect Size (Cohen's d) describes the clinical significance of a given effect size. [13]

Table 9: HoNOS Effect Size (Cohen's d)

Effect Size (Cohen's *d*)	**Interpretation**	
-0.8 or lower	Improvement of critical clinical importance	**Clinically significant improvement**
-0.5 to -0.8	Improvement of moderate clinical significance	
-0.2 to -0.5	Small or clinically negligible improvement	
-0.2 to 0.2	No change	
0.2 to 0.5	Small or clinically negligible deterioration	
0.5 to 0.8	Deterioration of moderate clinical significance	**Clinically significant deterioration**
0.8 or higher	Deterioration of critical clinical importance	

6.1.1.1. Oxleas – HoNOS statistical profile change

In Oxleas, 25 service users had both initial and discharge HoNOS assessments for the period of July 2023 – June 2024 (Table 10: HoNOS statistical profile change by domain - Oxleas).

The highest areas of need by mean score were in domains 11 (Problems with living conditions) and 12 (Problems with occupation and activities).

[12] The initial and discharge scores for service users are only included where the score on initial assessment was 2 or above. This is because if initial scores of 0 or 1 are included it is more likely that the discharge score will also be 0 or 1 and it will overall dilute the average change result seen. Furthermore, treatment plans are likely to have been created to target the areas of need.

[13] For each trust, the mean scores on initial and discharge assessments for each domain is set out in a table, alongside the total number of service users included (where the initial score was >1) and the Effect size (Cohen's d). A more detailed breakdown of this analysis, including the standard deviation, is presented in Appendix 10.4

Table 10: HoNOS statistical profile change by domain - Oxleas

OXLEAS	INITIAL SCORE		DISCHARGE SCORE		Effect Size (Cohen's d)
DOMAIN	**Mean**	**Number**	**Mean**	**Number**	
1. Overactive, aggressive or disruptive behaviour	2.8	12	0.8	12	-2.18
2. Non-accidental self-injury	2.4	7	0.7	7	-1.96
3. Problem-drinking or drug taking	3.0	18	2.8	18	-0.26
4. Cognitive problems	2.4	5	1.2	5	-1.39
5. Physical illness or disability or disability problems	2.5	11	2.0	11	-0.60
6. Problems associated with hallucinations and delusions	2.7	12	1.0	12	-1.81
7. Problems with depressed mood	2.8	16	2.0	16	-0.90
8. Other mental and behavioural problems	3.2	21	1.9	21	-1.08
9. Problems with relationships	3.0	21	1.8	21	-1.18
10. Problems with activities of daily living	2.8	13	1.0	13	-1.66
11. Problems with living conditions	3.7	24	1.3	24	-2.37
12. Problems with occupation and activities	3.6	21	1.6	21	-2.33

Improvement of critical clinical importance were seen in most domains at discharge from Oxleas, with the largest changes in domains of highest need (i.e. 11 Problems with living conditions and 12 Problems with occupation and activities) (Figure 5).

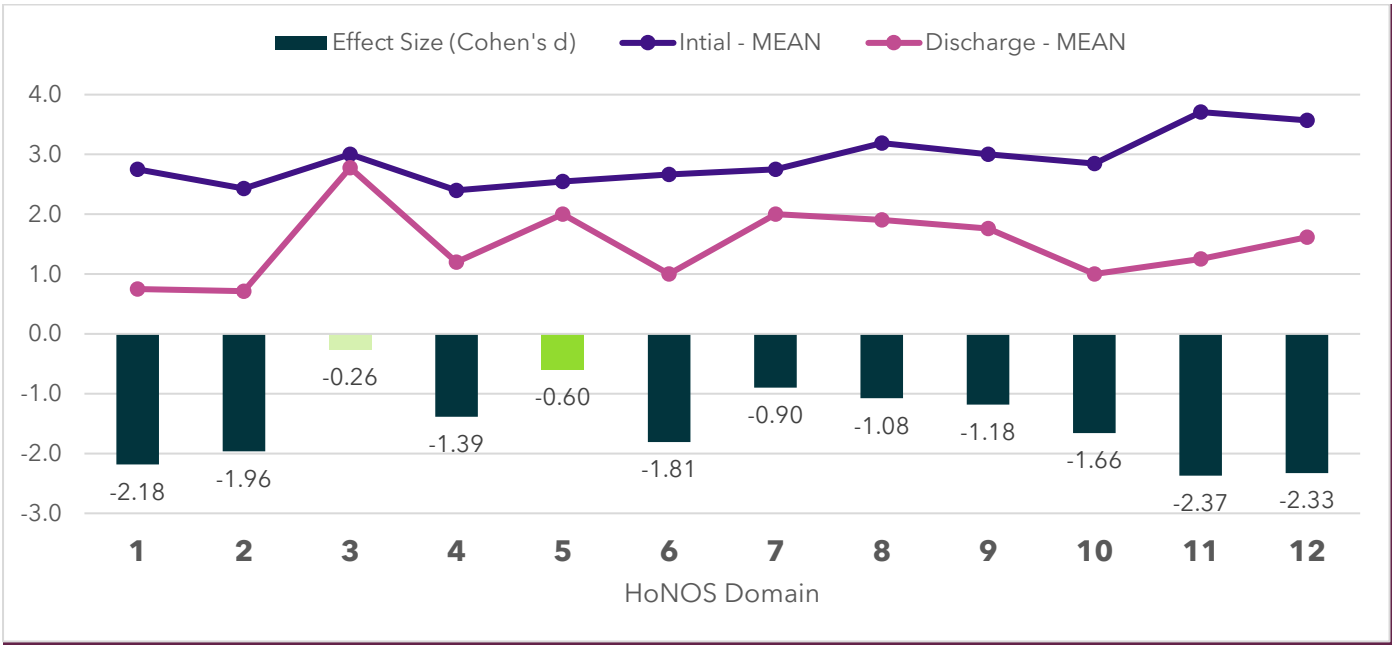


Figure 5: Oxleas – HoNOS profile change

6.1.1.2. SWLStG – HoNOS statistical profile change

In SWLStG, 59 service users had both initial and discharge HoNOS assessments for the period of July 2023 – June 2024 (including one service user with two instances of care under the RAMHP team).

The highest areas of need by mean score were in domain 3 (Problem drinking or drug taking) and domain 11 (Problems with living conditions) (Table 11: HoNOS statistical profile change by domain - SWLStG).

Table 11: HoNOS statistical profile change by domain - SWLStG

SWLStG	INITIAL SCORE		DISCHARGE SCORE		Effect Size (Cohen's d)
DOMAIN	**Mean**	**Number**	**Mean**	**Number**	
1. Overactive, aggressive, or disruptive behaviour	2.3	19	0.8	19	-1.55
2. Non-accidental self-injury	2.3	12	0.4	12	-2.64
3. Problem-drinking or drug taking	3.1	30	2.1	30	-0.81
4. Cognitive problems	2.5	11	1.1	11	-1.45
5. Physical illness or disability or disability problems	2.7	18	1.6	18	-0.87
6. Problems associated with hallucinations & delusions	2.7	24	1.7	24	-0.87
7. Problems with depressed mood	2.4	34	1.3	34	-1.50
8. Other mental and behavioural problems	2.8	46	1.6	46	-1.18
9. Problems with relationships	2.5	43	1.5	43	-1.14
10. Problems with activities of daily living	2.6	37	1.5	37	-1.25
11. Problems with living conditions	3.5	56	2.0	56	-1.18
12. Problems with occupation and activities	2.8	41	1.8	41	-0.89

Improvement of critical clinical importance were seen in all domains at discharge from SWLStG, with the largest changes in domains 2 (Non-accidental self-injury), 1 (Overactive, aggressive or disruptive behaviour) and 7 (Problems with depressed mood) (Figure 6:SWLStG -HoNOS profile change). A clinically significant change was seen in domain 3 (Problem drinking or drug taking) – it is worthy of noting that an integrated substance misuse worker present in SWLStG.

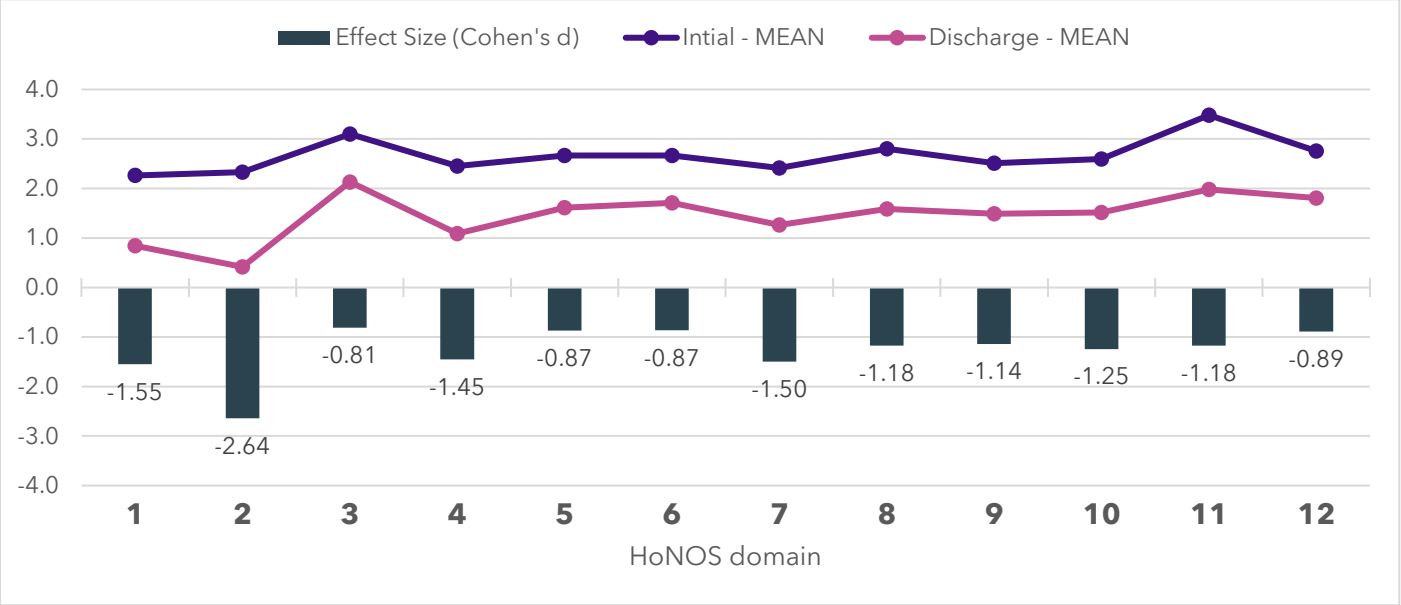


Figure 6:SWLStG -HoNOS profile change

6.1.2. GP Registration

A key performance indicator for RAMHP services is service user registration with a GP on discharge from the service. Both RAMHP services saw the majority of service users registered with a GP on discharge:

92% in Oxleas and 81% in SWLStG[14].

6.2. Staff and stakeholder perspective on RAMHP's impact on service users

Whilst there was a recognition that it can be challenging to demonstrate impact overall, staff and stakeholders reported that RAMHP has had a very positive effect on service users. RAMHP teams engage with rough sleepers through respectful and dignified outreach, persistent support, advocating for them and creating life changing moments. RAMHP practitioners build trust with individuals to take small but important steps towards positive change, with something as simple as having a conversation.

6.2.1. RAMHP provides service users with respect and dignity

- **Respect and dignity are at the core of RAMHP's approach to the rough sleepers they work with.** The considerate approach of RAMHP increases chances of engagement and makes people feel heard. Taking time to build trust, through simple acts like going for a coffee, can lead to profound positive changes. Staff from partner organisations spoke about how becoming a rough sleeper can have a dehumanising effect and that support from RAMHP brings a 'glint of humanity' back to their lives:

"The one comment that stuck out with me from a service user was 'They treated me like I was a normal person…they didn't look at me as though I was crazy. And that's the first time that I felt as though I, you know, I could or want to open up to someone that was from a mental health team." [Oxleas Partner Organisation]

6.2.2. RAMHP staff are persistent in their efforts to engage

- **RAMHP practitioners are persistent in their attempts to engage with rough sleepers.** An example was given of the Oxleas RAMHP team 'refusing to give up' on a rough sleeper who had a suspected mental health condition by regularly checking in on them over a 10-month period.

6.2.3. RAMHP staff advocate for their service users

- **RAMHP help service users be heard.** RAMHP staff represent service users in professional meetings and advocate for them and their capabilities. Examples include placing a service user with autism in suitable accommodation and providing a shorter assessment time for someone with suspected Attention Deficit Hyperactive Disorder (ADHD) to receive a housing assessment.
- **Rough sleepers receive help beyond mental health support, extending to assistance with daily life.** RAMHP staff can help service users to understand their own mental health condition better. They can also help get people 'back on their feet', organising prescriptions, applying for benefits, and accessing education and employment.

6.2.4. Support from RAMHP can be life changing

[14] Some early data recording issues means this figure is likely to be higher

- **RAMHP can save lives.** There were accounts where input from RAMHP contributed to the increased safety of rough sleepers, for example via the issue of a section 135 which helped make the potential difference between life or death:

"It's amazing to see the transformation that someone's gone from being at like one of the lowest points of their life to really starting to pick back up again. So, you know, one of my clients is just like constantly singing RAMHP's praises like you saved my life. Like you guys have, like, really, completely turned everything around." [SWLStG RAMHP]

"Recently [the RAMHP team] probably saved someone's life in Greenwich (…) I saw him and flagged him loads of times on other services. He's now in hospital on 15 minute watch for heart attacks and under section and so on. If RAMHP hadn't been able to get involved (…), he'd still be out on the streets. And they were the ones that managed to get him in. So it is so important I can't even begin to tell you." [Oxleas Partner Organisation]

- **Initial accommodation outcome data is also encouraging.** For service users verified by CHAIN and with a discharge date from the service, only around a quarter of service users (25% at Oxleas and 28% at SWLStG) were subsequently seen sleeping rough within six months of discharge. These findings are similar to the UCLP RAMHP evaluation accommodation outcomes in north London which looked at a longer time frame.

6.2.5. RAMHP service users case studies

Interviews were undertaken with service users who had received support from the Oxleas and SWLStG RAMHP teams. Five service users' stories are presented (N.B. names have been changed to maintain anonymity).

Oxleas: Case Study 1

Ryan experienced repeated bouts of homelessness throughout his adult life. His most recent episode, lasting three years, was triggered by a relationship breakdown and eviction. Ryan, who struggles with anxiety and depression found himself rough sleeping. During that time, he met his current partner, Abbie. They faced harsh conditions, including living in a tent in the woods during winter.

"Last winter it was so cold, it was unbearable. At some points I had her lying on me so she wouldn't touch the floor. It has been a whirlwind."

A local charity shop manager noticed their situation and contacted an outreach agency, which connected them with RAMHP. The RAMHP service provided vital support for Ryan and Abbie, offering a lifeline during a challenging time.

"The ball was rolling… they did so much for us. They got in touch with the council."

The RAMHP team provided the couple with emotional support. Ryan found a safe space to talk with his RAMHP support workers, who provided consistent encouragement and understanding.

"I was phoning the [RAMHP worker] to talk about anything and she was always on the phone…. [the RAMHP worker] has helped so much. We opened up to her."

The RAMHP team encouraged Ryan and Abbie to seek treatment for drug addiction, and they have now been drug-free for several months, aided by the medication, Buvidal. They also helped Ryan with his Personal Independence Payment (PIP) application.

Ryan and Abbie are now in secure accommodation. This is the first time they have had their own place. Despite this progress, they are both worried about maintaining their tenancy. Although not under Oxleas RAMHP team's care anymore, they feel they could reach out to them if needed:

"I feel if I needed help … the [RAMHP workers] wouldn't never say 'nah I can't help you now' because they know what we are like."

Oxleas: Case Study 2

Hope, a 44-year-old woman with a history of mental health issues, experienced a severe mental health crisis that led to her eviction and homelessness. Overwhelmed, she found herself sleeping rough in Greenwich, without a support network and reluctant to burden her family.

"Everything that could possibly go wrong, went wrong, I had a bad mental break... and an illegal eviction on top of it. I wasn't in the right mental space."

A brief encounter with StreetLink offered no immediate solution, leaving her to seek refuge in Lewisham hospital overnight.

A few days later, she was found by Thames Reach staff, sleeping in Greenwich in front of a pub between two chairs. Thames Reach referred her to Oxleas RAMHP straight away.

"At that point, I had kind of given up, I was tired. But then I got that support... it was so helpful because I had been on my own for so long. When I met [RAMHP support worker], she was amazing. She didn't cut me off; she understood I hadn't had positive human interaction in a very long time."

The RAMHP team, in collaboration with Thames Reach, provided immediate support, addressing her basic needs and establishing a trusting relationship. Critically, they facilitated access to healthcare, including a new GP who was impressed by the detailed notes provided by her RAMHP key worker.

This comprehensive approach led to a diagnosis of post-traumatic stress disorder, depression, anxiety, attention deficit hyperactivity disorder, and obsessive-compulsive disorder. With a clearer understanding of her conditions, Hope began receiving targeted mental health support.

"They really made sure I got the care I needed. All the things I asked for with my last GP, they made sure I got. It was thanks to the RAMHP staff. My experience, the human side of it, has been phenomenal."

Hope noted how a [RAMHP worker] went above and beyond, equipping her with practical information on accessing food and navigating essential services. Working with Thames Reach and the council, they also secured her placement in supported living and ensured a smooth transition with continued contact and support.

"I didn't feel abandoned when I was discharged (…) My [RAMHP] worker sent me a great email and told me I could contact her if I needed to, which I have done. I still check in with them."

SWLStG: Case Study 1

Sarah was made homeless after being evicted from her rented accommodation due to being unable to afford the significant rent increase. Working as a care assistant, she was also struggling to find regular shifts. The high rental costs post-COVID meant that she was unable to find any other affordable accommodation and so ended up sleeping in her car. Shortly after this, someone crashed into her car. Following this accident, she was no longer able to sleep in her car and also sustained a spinal injury. Sarah had approached her local council whilst sleeping in her car but was told she was not high priority for housing.

She decided to turn to her GP, as her mental health was impacted by these challenging series of events. It was through her GP that Sarah was introduced to a RAMHP worker.

The RAMHP worker played a role in helping Sarah to access temporary accommodation. They also regularly met Sarah to provide support, taking them for coffee and a chat, and visiting them at their new home. In addition, the RAMHP worker helped Sarah to access medication for her mental health. Since working with RAMHP, she is receiving in-person counselling and physiotherapy. The RAMHP worker advocated for Sarah to access support from the local council and to receive benefits. Sarah really appreciated the support provided by the RAMHP worker, saying:

"*She stood up for me… It was marvellous." […] "She's always positive…she gave me that encouragement".*

Sarah just wishes that the RAMHP team could have worked with her longer, to check-in on how she is doing and help her navigate this new phase of her life:

"I wish she could stay longer".

Despite being in temporary accommodation, she does not know when she will be able to access permanent accommodation and injuries from her car accident mean that she is not in good enough health to work. Some days she struggles to get out of bed. Having extended support would help her manage these challenges.

SWLStG: Case Study 2

Ali started rough sleeping and regularly going without showers or food after a series of difficult events. This included losing his business, a relationship breakdown and an accident that caused neck and back injuries. He was in a situation where he did not know what to do.

His mental and physical health were in a poor state. It was a really difficult time in his life, where he felt like he had *'absolutely nothing'*.

After around seven months of rough sleeping, he approached a charitable organisation in the local area. They supported him to access food, clothes, benefits and introduced him to a RAMHP worker. They helped him to access housing and get medication for his mental and physical health. The RAMHP worker regularly met with Ali, visiting him at his accommodation on several occasions, sometimes accompanied by the RAMHP psychiatrist consultant. The RAMHP worker also helped Ali to apply for a 'Freedom pass' to facilitate free travel across London. Ali is very grateful for the support he received from the RAMHP worker:

"[They] did a lot… they can really do the job!".

For Ali, life has gotten better since being introduced to RAMHP. The support received has resulted in an improvement in his mental and physical health.

The RAMHP worker no longer supports Ali, but they are due to receive support from a case nurse. When asked about his thoughts on the RAMHP service, Ali said:

"The RAMHP service is a very good service…it is urgently needed for rough sleepers".

6.2.6. Challenge in measuring the impact of RAMHP on service users

Despite stakeholder and RAMHP staff accounts of positive impact on service users, participants reflected on the difficulties of demonstrating measurable impact for rough sleepers:

- **RAMHP impacts on rough sleepers in ways that cannot always be measured.** It is worth considering what could have happened to a rough sleeper had they not been supported by RAMHP:

"It is difficult to show outcomes, but we can say without RAMHP, these people will have deteriorated." [SWLStG Partner Organisation]

"I'm sure they track all their interactions, but yeah, I think unfortunately (…) it's sometimes hard to track the best part of RAMHP because actually we're not always going to have outcomes for those that are under RAMHP (…) I think the fact that people are still on the street is not necessarily a negative thing because it takes time." [Oxleas Partner Organisation]

- **Staff spoke about how it can be very difficult for someone rough sleeping to open-up to professionals**. Any engagement, no matter how small should be acknowledged as a positive impact:

"I think with RAMHP it's very personal and for us, you know, we might have had a service user that we couldn't engage for years and then suddenly they're talking weekly to this member of staff for me, that's a success. Just getting somebody talking, which you can't monitor. They might write in their case notes." [Oxleas Partner Organisation]

6.3. Impact of RAMHP on partner organisations and wider system

As discussed in Section 5, participants noted that partner organisations have benefited from RAMHP's expertise, gaining valuable mental health knowledge and access to additional support resources for the people they serve. Stakeholders from partner organisations noted that:

- **Overall, staff from partner organisations value the contribution made by RAMHP.** They felt the ability to provide outreach through mental health practitioners had been crucial in connecting with and supporting the most vulnerable rough sleepers. They also praised RAMHP staff's ability to access and interact with other NHS services as 'critical' and 'amazing'. This stands in contrast to their previous experiences with mental health services that felt like 'hitting a brick wall':

"Not having it [RAMHP] to having it has been a game changer… It would be a massive step back [if this wasn't funded again]." [SWLStG Partner Organisation]

"They [RAMHP] are amazing. Please don't get rid of them. Please make sure we keep them." [Oxleas Partner Organisation]

- **Outreach staff reported increased confidence and improved mental health knowledge as a direct result of working with RAMHP, better equipping them to assist rough sleepers** (as noted in Section 5). Working alongside RAMHP practitioners, outreach staff reported having developed their understanding of mental health conditions, their presentations and the influence of stressful factors.

- **RAMHP teams fostered strong collaborative relationships with a diverse range of organisations.** Beyond working with outreach and partner organisations, RAMHP staff proactively coordinated care for service users by reaching out to various NHS partners. Demonstrating their commitment to comprehensive care, the Oxleas team proactively established relationships with GP services and, as a result, provide joint drop-in sessions at homeless shelters and successfully advocated for the provision of a mobile dental service to meet the needs of this vulnerable population:

"I think it's helped us to understand how important it is to establish relationships with other services. Not that we didn't know that, but I just think you know, they've set up a foundation for us now." [Oxleas Partner Organisation]

Participants also described the positive impact of the RAMHP service which extended beyond its service users and partner organisations, to wider benefits to the NHS:

- **Although not easily quantifiable, there was a perceived reduction in burden on the NHS and partner organisations.** Qualitative evidence from the evaluation suggests that RAMHP's approach can contribute to a more efficient and sustainable support system for rough sleepers. In addition, the improvement of service users' HoNOS scores (i.e. problems with living conditions; problems with occupation and activities; problem-drinking or drug taking) suggests that engagement with RAMHP has wider positive impacts on health and social outcomes and associated resources.

7. Limitations

This evaluation successfully collected quantitative and qualitative data across both services. However, there were some limitations.

Quantitative data

- Due to comparatively short timeframes, full data sets were not available. For example, HoNOS data was only available for service users with an initial and discharge assessment. At the time of writing the report, a large number of service users had not been discharged or had changed situation (such as entering prison) meaning a discharge assessment may not have been possible.
- Although the majority of service users were verified on CHAIN, a small number were not and were therefore not captured as part of the demographics, mental health needs pre-assessment and accommodation outcomes.
- CHAIN data itself has limitations. For example, the number of assessments of rough sleepers recorded is, in part, affected by the number of outreach workers available on the streets.
- Both CHAIN and KPI data was only available in aggregate format. It is therefore not possible to interrogate at an individual level. Data across the various datasets was also not linked.
- As this programme was a pilot, benchmarking has not been possible.

Qualitative data

- The evaluation team were provided with a list of partner organisations to contact for interviews and focus groups. This list may not be exhaustive of the organisations impacted by RAMHP.
- All staff from partner organisations, listed by the RAMHP teams were contacted to invite to interviews or focus groups. However, at SWLStG, not all staff responded to this invite and therefore did not participate in the qualitative element of the evaluation. Their experiences are therefore not reflected in this evaluation.
- The evaluation team spoke to five service users, recruited via each RAMHP team. Whilst these service users shared compelling stories, we understand that these people were willing to talk about their experience, all of which were positive. We did not engage with any service user who had a different experience or failed to engage to understand barriers to accessing RAMHP support.

Timeframe limitations

- This evaluation spans the timeframe July 2023 – June 2024 and therefore only provides a snapshot of RAMHP's impact during their pilot and not longer-term impact or impact on service users yet to be discharged.

8. Conclusion

This evaluation demonstrates that the Rough Sleeping and Mental Health Programme (RAMHP) in Oxleas and SWLStG has successfully engaged an historically underserved population. Key factors contributing to this success include a flexible and holistic approach to care, tailoring services to individual needs and providing comprehensive support, dedicated practitioners, and strong partnerships with outreach agencies and local authorities.

Analysis of Health of Nation Outcome Scales (HoNOS) scores and qualitative insights demonstrated positive outcomes for service users. Furthermore, RAMHP has fostered valuable knowledge exchange between its teams and partner organisations, enhancing overall service delivery.

To maximise sustainability and impact, further investment should consider prioritising specialised expertise (i.e. embedding specialists in the team, such as psychiatrists and physical health practitioners) and expanding eligibility (i.e. widening referral criteria to include homeless individuals at risk, beyond those actively rough sleeping). This will enable RAMHP to reach a broader population and provide even more comprehensive support.

The findings in this evaluation echo those for other RAMHP services in London[15], which suggest that this is an effective model for supporting rough sleepers with mental health needs.

[15] https://www.london.gov.uk/sites/default/files/2023-10/UCLP%20Final%20RAMHP%20Pilot%20Evaluation%20-%20October%202022%283%29.pdf

9. Lessons learnt and recommendations

The insights and lessons learnt from the evaluation highlight key recommendations for enhancing the Rough Sleeping and Mental Health Programme (RAMHP) in Oxleas and South West London and St George's (SWLStG).

9.1. There is a case for continuing the RAMHP services

RAMHP received overwhelmingly positive feedback, despite some operational challenges. The services address a growing unmet need among rough sleepers by delivering improved support and care. There is a case for the continuation and further development of the services.

- **Staff and partner organisations support the continuation of RAMHP.** Discontinuing the service would limit access to effective mental health support for rough sleepers. Staff '*do not want to lose this service*' and '*can't imagine going back to no mental health outreach*'.

- **Evaluation findings, including qualitative insights and HoNOS data analysis, demonstrate the RAMHP model is effective in engaging rough sleepers and delivering positive outcomes**. The outreach component of RAMHP, alongside a determination 'not to give up' on rough sleepers, contributes to effective engagement with some of the most marginalised and vulnerable people.

- **Funding should be strategically allocated to RAMHP to optimise its impact and reach, specifically by increasing access to its services**. This includes reviewing the roles and expertise required within the services to provide wrap-around-care.

- **The RAMHP services recognise the value of KPIs in guiding their work**. However, the current KPIs may not fully capture the nuanced nature of RAMHP's impact and would benefit from a review. This process should involve staff feedback and consider both qualitative and quantitative measures to ensure a comprehensive and meaningful assessment of the programme (see related recommendations in 7.5).

Recommendations:

- **Commissioners and providers should explore funding options** to ensure long-term sustainability of RAMHP at Oxleas and SWLStG.
- **Funding should consider what additional roles and/or expertise** RAHMP teams need to provide a wraparound service that can support a wider range of rough sleepers.
- To ensure a more nuanced and comprehensive understanding of RAMHP's impact and benefits, the **KPIs used to measure its success should be re-evaluated and refined.**

9.2. RAMHP is better equipped to meet the needs of its service users with a diverse and complete team

- **Recruiting and retaining a skilled and compassionate workforce is essential to effectively support rough sleepers.** Staff continuity is key to building trust and engaging service users who have traditionally faced barriers to accessing services. The evaluation found examples of strong recruitment and staff support practices. Therefore, some of the recommendations below aim to build upon these existing strengths and further enhance these positive practices.

- **RAMHP functions most effectively when teams comprise a mix of skills and expertise.** Additional expertise in psychology, psychiatry, physical health and social work would further benefit its service users.

Recommendations:

- RAMHP recruitment processes should carry on prioritising staff with the values and qualities essential for working with rough sleepers by:
    a. **Clearly articulating the essential attributes of compassion, empathy, and dedication in job descriptions.**
- **Developing/ refining interview questions to effectively assess candidates' alignment with RAMHP's values and their capacity for compassionate care.** The RAMHP staffing structure (and professional mix) should be reviewed to build on the existing multiple disciplinary teams by including mental health practitioners. A consultant psychologist or psychiatrist (e.g. who are able diagnose and prescribe) would improve the service offer and provide better wrap-around-care. Physical health expertise (e.g. a nurse practitioner) would also allow for outreach to include support such as wound care.
- Strategies to improve staff retention should be prioritised through emphasizing/ carrying on the following:
    a. **Cultivating a supportive and respectful team environment with clear processes**. This includes continuing to incorporate reflective practices to help staff process challenging cases and promote wellbeing.
    b. **Enhance existing support and supervision structures.** Ensure staff have consistent access to mentorship and readily available guidance when needed. Explore opportunities to expand these resources based on staff feedback and needs.
    c. **Expand opportunities for professional development.** Continue to support staff in pursuing further training in areas of interest, such as housing and safeguarding.

9.3. Develop an approach to raise awareness of RAMHP processes

- **Despite outlined referral criteria, additional information would be useful to help make decisions on more complex or less clear-cut cases.** In addition, allowing greater flexibility in referral criteria would enable RAMHP teams to reach and support more rough sleepers with diverse needs. This information could be incorporated into Standard Operating Procedures (SOPs) to help staff navigate complex situations (i.e. when a person might not be activity rough

sleeping but is at risk of homelessness or putting themselves in a dangerous situation to avoid sleeping rough).

- **The remit of RAMHP has, at times, been misinterpreted,** with partner organisations not being clear about distinctions between the boundaries of their own and RAMHPs responsibilities when supporting rough sleepers.

Recommendations:

- **RAHMP should develop and implement strategies to ensure clear communication of its referral processes, roles, and responsibilities to both core staff and partner organisations.** This will help avoid potential confusion, increase appropriate referrals and promote successful working relationships.
- As part of the reviewing funding options for RAMHP, **the services should consider formally extending referral criteria to increase their reach and remit** (and to include any changes with their SOPs).

9.4. Collaboration between RAMHP teams and partner organisations are crucial to providing comprehensive support to rough sleepers

- **Staff discussed the benefits of learning from other RAMHP teams.** There is a Community of Practice of all RAMHP teams in London. Staff are encouraged to attend such meetings as they are an opportunity to share experiences and learn from one another.
- **Open communication and a 'feedback loop' would be beneficial to monitor and support service users e.g., with housing applications.**
- **Good practice should be shared within trusts that cover multiple boroughs**. Oxleas share best practice and learning across all three boroughs. They emphasised the importance of not working in silo. In addition, working across 3 boroughs allows greater flexibility in terms of service access and being able to refer clients to different mental health services.

Recommendations:

1. **Oxleas and SWLStG teams should consider engaging with more established RAMHP teams.** This knowledge exchange should focus on understanding key strategies for service development, funding applications, and stakeholder engagement.

2. **Oxleas and SWLStG teams should consider setting up local forums** comprising a range of stakeholders including NHS and Local Authority commissioners to showcase their work.

9.5. Enhancing data collection and analysis for service improvement

- While the impact of RAMHP on rough sleepers extends beyond readily measurable outcomes, this evaluation found that data collection methods need improvement to fully capture the impact of RAMHP on rough sleepers.

Recommendations:

The routine collection and analysis of high-quality data is crucial for understanding RAMHP's effectiveness, maximising impact and supporting continued service improvement. To achieve this, the following should be considered:

- **Review and refinement of Key Performance Indicators (KPIs),** to better understand service activity (i.e. number of contacts per service user, etc). As part of this, the Oxleas and SWLStG teams should consider collaborating with other RAMHP services to share best practices in data collection and analysis to inform service planning and resource allocation.
- **Streamline data collection:** Develop user-friendly templates to facilitate efficient data collection at the service user level.
- **Carry on consistently recording referral sources:** This data is key illuminate referral patterns, inform targeted advertising strategies, and help raise awareness to increase service uptake.
- **Enhance data accessibility,** to allow RAMHP staff to query the CHAIN database on an individual level for improved case management and contribute to wider data analysis for programme evaluation.

10. Appendices

10.1. Total seen rough sleeping broken down by assessed for mental health need and level (2023/24)

	Total seen rough sleeping	Total assessed	% Assessed	A need recorded	% with a need	High	Medium	Low	No need	Not known
OXLEAS	**556**	**450**	**81%**	**305**	**68%**	**75**	**146**	**84**	**135**	**10**
Bexley	106	97	92%	72	74%	25	32	15	24	1
Bromley	113	81	72%	47	58%	13	19	15	32	2
Greenwich	337	272	81%	186	68%	37	95	54	79	7
SWLStG	**484**	**431**	**89%**	**224**	**52%**	**56**	**99**	**69**	**188**	**19**
Kingston upon Thames	107	96	90%	27	28%	8	13	6	67	2
Merton	77	65	84%	40	62%	11	16	13	22	3
Richmond	100	99	99%	67	68%	19	25	23	26	6
Sutton	28	25	89%	15	60%	5	7	3	9	1
Wandsworth	172	146	85%	75	51%	13	38	24	64	7
Grand Total	**1040**	**881**	**85%**	**529**	**60%**	**131**	**245**	**153**	**323**	**29**
GLA Total	**11993**	**8982**	**75%**	**4267**	**48%**	**1052**	**1882**	**1333**	**4433**	**274**

Source: Combined Homelessness and Information Network (CHAIN), downloaded from: https://data.london.gov.uk/dataset/chain-reports

10.2. Demographics breakdown – service users at each Trust

	OXLEAS		SWLStG		Total	
GENDER	**#**	**%**	**#**	**%**	**#**	**%**
Female	8	19%	8	10%	16	13%
Male	34	81%	72	89%	106	86%
Not known	0	0%	1	1%	1	1%
TOTAL	**42**	**100%**	**81**	**100%**	**123**	**100%**
ETHNICITY	**#**	**%**	**#**	**%**		
ASIAN	1	2%	11	14%	12	10%
BLACK	5	12%	10	12%	15	12%
MIXED	2	5%	0	0%	2	2%
OTHER	1	2%	4	5%	5	4%
WHITE	33	79%	54	67%	87	71%
Refused	0	0%	2	2%	2	2%
TOTAL	**42**	**100%**	**81**	**100%**	**123**	**100%**
AGE GROUP	**#**	**%**	**#**	**%**		
18 - 25	1	2%	3	4%	4	3%
26 - 35	5	12%	13	16%	18	15%
36 - 45	14	33%	20	25%	34	28%
46 - 55	12	29%	27	33%	39	32%
Over 55	10	24%	18	22%	28	23%
TOTAL	**42**	**100%**	**81**	**100%**	**123**	**100%**

10.3. Period of care

	Oxleas		SWLStG	
	#	**%**	**#**	**%**
Under 1 month	3	13%	11	16%
1 - 3 months	9	38%	24	35%
3 - 6 months	9	38%	15	22%
6 - 12 months	3	13%	16	23%
Grand Total	**24**	**100%**	**69**	**100%**

MEAN	**86.7**	**124.4**
MEDIAN	**82.5**	**88**

10.4. HoNOS Statistical Profile change tables

Note: The scores are taken where the initial assessment in each domain was 2 or above. Please see PowerPoint Presentation from Healthy London Partnership on how HoNOS is analysed and for the equation for calculating Cohen's d.

	Initial Assessment			Discharge Assessment			
OXLEAS	**Mean**	**StdDev**	**Count**	**Mean**	**StdDev**	**Count**	**Effect Size (Cohen's d)**
1. Overactive, aggressive, disruptive or agitated behaviour	2.8	0.5	12	0.8	1.2	12	-2.18
2. Non-accidental self-injury	2.4	0.8	7	0.7	1.0	7	-1.96
3. Problem-drinking or drug taking	3.0	0.8	18	2.8	0.9	18	-0.26
4. Cognitive problems	2.4	0.5	5	1.2	1.1	5	-1.39
5. Physical illness or disability or disability problems	2.5	0.7	11	2.0	1.1	11	-0.60
6. Problems associated with hallucinations and delusions	2.7	0.8	12	1.0	1.0	12	-1.81
7. Problems with depressed mood	2.8	0.6	16	2.0	1.0	16	-0.90
8. Other mental and behavioural problems	3.2	0.7	21	1.9	1.5	21	-1.08
9. Problems with relationships	3.0	0.8	21	1.8	1.2	21	-1.18
10. Problems with activities of daily living	2.8	0.9	13	1.0	1.3	13	-1.66
11. Problems with living conditions	3.7	0.5	24	1.3	1.4	24	-2.37
12. Problems with occupation and activities	3.6	0.6	21	1.6	1.0	21	-2.33
Grand Total	**3.0**	**0.8**	**181**	**1.6**	**1.3**	**181**	-1.35

	Initial Assessment			Discharge Assessment			
SWLSGT	**Mean**	**StdDev**	**Count**	**Mean**	**StdDev**	**Count**	**Effect Size (Cohen's d)**
1. Overactive, aggressive, disruptive or agitated behaviour	2.3	0.6	19	0.8	1.2	19	-1.55
2. Non-accidental self-injury	2.3	0.5	12	0.4	0.9	12	-2.64
3. Problem-drinking or drug taking	3.1	0.8	30	2.1	1.5	30	-0.81
4. Cognitive problems	2.5	0.7	11	1.1	1.1	11	-1.45
5. Physical illness or disability or disability problems	2.7	0.8	18	1.6	1.5	18	-0.87
6. Problems associated with hallucinations and delusions	2.7	0.7	24	1.7	1.4	24	-0.87
7. Problems with depressed mood	2.4	0.6	34	1.3	0.9	34	-1.50
8. Other mental and behavioural problems	2.8	0.7	46	1.6	1.3	46	-1.18
9. Problems with relationships	2.5	0.7	43	1.5	1.1	43	-1.14
10. Problems with activities of daily living	2.6	0.6	37	1.5	1.1	37	-1.25
11. Problems with living conditions	3.5	0.7	56	2.0	1.7	56	-1.18
12. Problems with occupation and activities	2.8	0.9	41	1.8	1.2	41	-0.89
Grand Total	**2.8**	**0.8**	**372**	**1.6**	**1.3**	**372**	**-1.09**

10.5. HoNOS Categorical Change

An alternative method of measuring HoNOS scores is by categorical change. This method converts all of the scores into 'High' or 'Low' as follows:

0	No problem	Low severity (L)
1	Minor problem requiring no formal action	
2	Mild problem but definitely present	
3	Problem of moderate severity	High Severity (H)
4	Severe to very severe problem	

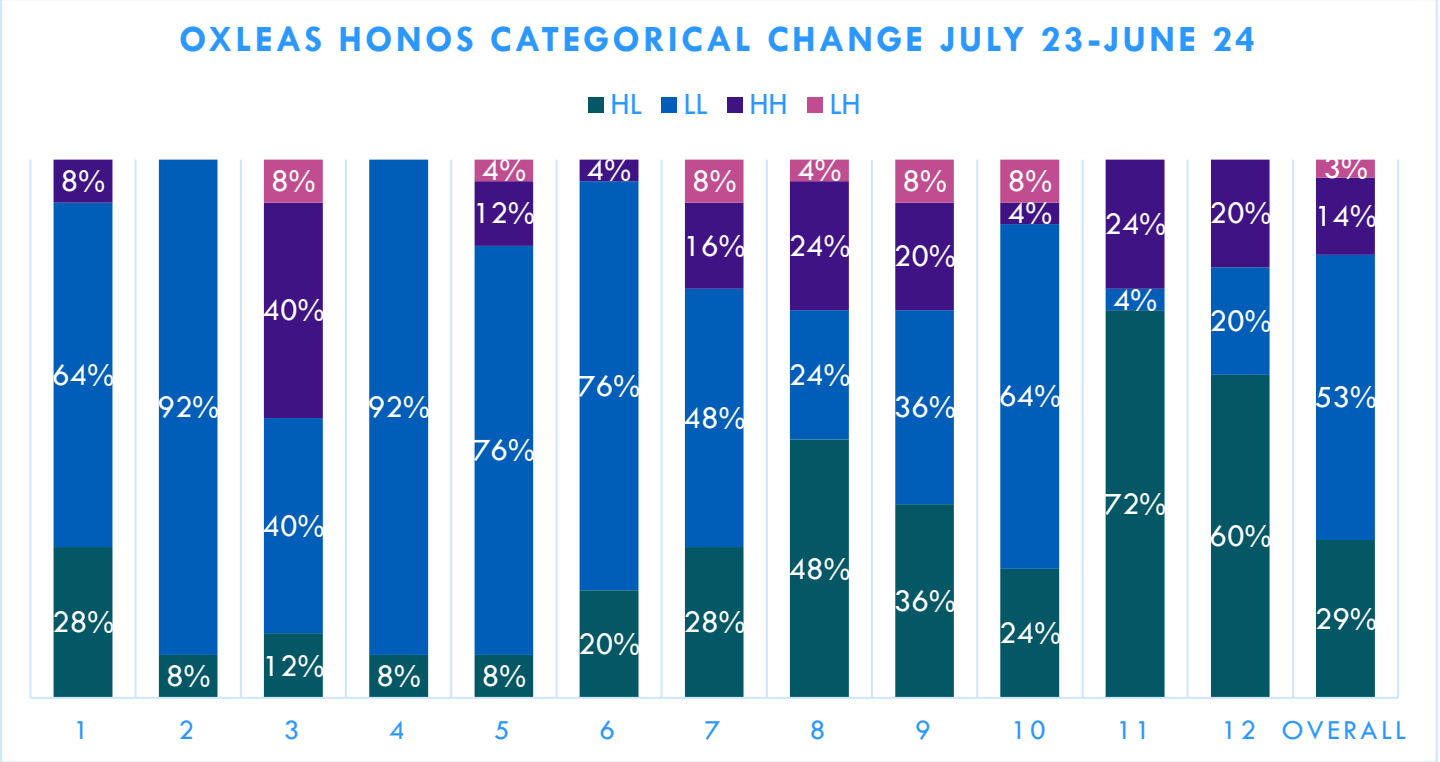
Converted initial and discharge scores are brought together to show either:

HL	High severity to Low severity	Improvement
LL	Low severity to Low severity	No change
HH	High severity to High severity	No change
LH	Low severity to High severity	Deterioration

Oxleas: HoNOS Categorical Change

In Oxleas, as with statistical profile change, there were very high rates of improvement in domains 11 and 12 (72% and 60% of cases went from high to low severity respectively) as shown in the statistical profile above. Almost half (48%) of cases went from high to low severity in domain 8 (Other mental and behavioural problems). In six domains, there were a few cases of a deterioration.

Oxleas/Domain	HL	LL	HH	LH
1. Overactive, aggressive, disruptive or agitated behaviour	28%	64%	8%	0%
2. Non-accidental self-injury	8%	92%	0%	0%
3. Problem-drinking or drug taking	12%	40%	40%	8%
4. Cognitive problems	8%	92%	0%	0%
5. Physical illness or disability or disability problems	8%	76%	12%	4%
6. Problems associated with hallucinations and delusions	20%	76%	4%	0%
7. Problems with depressed mood	28%	48%	16%	8%
8. Other mental and behavioural problems	48%	24%	24%	4%
9. Problems with relationships	36%	36%	20%	8%
10. Problems with activities of daily living	24%	64%	4%	8%
11. Problems with living conditions	72%	4%	24%	0%
12. Problems with occupation and activities	60%	20%	20%	0%

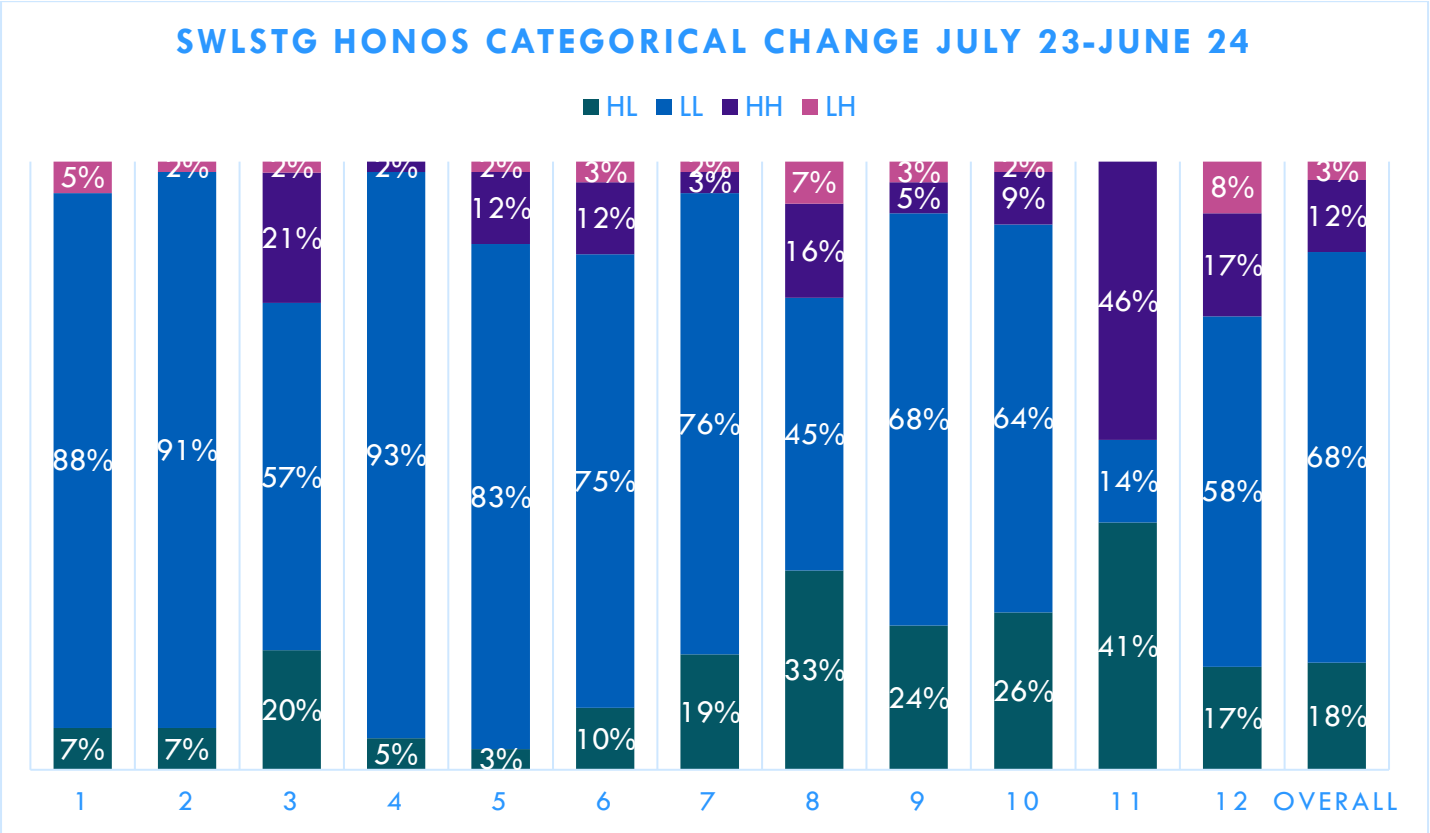


Overall for Oxleas HoNOS scores, strongly significant improvements were found in a number of domains.

SWLStG: HoNOS Categorical Change

In SWLStG, there were high rates of improvement in domains 11 and 8 (41% and 33% of cases went from high to low severity respectively). However almost half (46%) of cases in domain 11 (problems with living conditions) remained unchanged by being High severity on both initial and discharge scores. There were a few cases of a deterioration but a very low rate.

SWLStG/Domain	HL	LL	HH	LH
1. Overactive, aggressive, disruptive or agitated behaviour	7%	88%	0%	5%
2. Non-accidental self-injury	7%	91%	0%	2%
3. Problem-drinking or drug taking	20%	57%	21%	2%
4. Cognitive problems	5%	93%	2%	0%
5. Physical illness or disability or disability problems	3%	83%	12%	2%
6. Problems associated with hallucinations and delusions	10%	75%	12%	3%
7. Problems with depressed mood	19%	76%	3%	2%
8. Other mental and behavioural problems	33%	45%	16%	7%
9. Problems with relationships	24%	68%	5%	3%
10. Problems with activities of daily living	26%	64%	9%	2%
11. Problems with living conditions	41%	14%	46%	0%
12. Problems with occupation and activities	17%	58%	17%	8%



10.6. Accommodation outcomes

CHAIN data from July 2023 to June 2024 show that:

- 42% of RAMHP service users with recorded discharge dates under Oxleas transitioned into temporary accommodation, and 17% into long-term accommodation.
- 18% of RAMHP service users with recorded discharge dates under Oxleas transitioned into temporary accommodation, and 1% into long-term accommodation.

Accommodation outcomes of people discharged from RAMHP South London July 2023 - June 2024[16]

	Oxleas		SWLStG	
Accommodation type	No.	%	No.	%
Hubs, shelters and emergency accommodation	**1**	**4%**	**1**	**1%**
Long-term accommodation	**4**	**17%**	**1**	**1%**
Temporary accommodation	**10**	**42%**	**12**	**18%**
Total with outcome	**15**	**63%**	**14**	**21%**
Total without outcome	9	38%	54	79%
Total with discharge date	24	100%	68	100%

[16] This data is based on latest outcome recorded for each client between the service start date and two weeks after the service discharge date.

The table below shows subsequent rough sleeping of people accessing RAMHP South London during the evaluation time period:

- A quarter (n=6) of Oxleas RAMHP service users were seen subsequently rough sleeping within 6 months
- Just over a quarter (n=19) of SWLGST RAMHP service users were seen subsequently rough sleeping within 6 months

Subsequent rough sleeping of people accessing RAMHP South London July 2023 - June 2024[17]

Seen rough sleeping subsequent to discharge from service	Oxleas		SWLStG	
	No.	%	No.	%
Seen within 3 months	4	17%	17	25%
Seen within 6 months	6	25%	19	28%
Seen within 12 months	6	25%	19	28%
Total with discharge date	**24**		**68**	

[17] People who were discharged from the service after October 2023 will not yet have had a full 12 months within which to be seen rough sleeping. The period categories in the table are cumulative (i.e. someone seen within 12 months will by definition also be included in the figures for 3 and 6 months)