HEALTH & WELLBEING BOARD	Agenda Item 23 Brighton & Hove City Council

Subject:		**Integrated health, social care and housing support for "homeless" people**		
Date of Meeting:		**11 September 2013**		
Report of:		**Geraldine Hoban, Chief Operating Officer, Brighton and Hove Clinical Commissioning Group**		
Contact Officer:	**Name:**	**Geraldine Hoban**	**Tel:**	**574863**
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Key Decision:	**No**			
Ward(s) affected:		**All**		

FOR GENERAL RELEASE.

1. SUMMARY AND POLICY CONTEXT:

1.1 Brighton and Hove has a significant and growing number of people who could be called "homeless" ie living in temporary accommodation, hostels, squats, on friend's sofas or sleeping rough.

1.2 Despite a good range of services existing in the City, our models of care and service delivery too often do not meet the needs of this very vulnerable community as evidence by their poorer health outcomes and use of emergency/crisis services.

1.3 A recent call by the Department of Health to explore innovative ways of delivering better outcomes for people through more integrated health and social care led to an expression of interest being submitted by partners in the City. The submission proposes the delivery of integrated health, social care and housing advice to this group of "homeless" people through a co-located multi-disciplinary team (MDT).

1.4 The Health and Wellbeing Board was informed of the intention to bid at its meeting in June and members agreed that this was a worthwhile project.

1.5 The Department of Health has since informed the CCG as the lead organisation that the proposal was not successful. Whilst feedback on the bid was very positive, they did not feel that the pilot would have the broader population impact required of the national pioneer sites.

1.6 There is, however, from earlier discussions with partner agencies, a real willingness to implement a local integrated service along the lines of the model proposed.

1.7 It is therefore recommended that despite not achieving national pioneer status the City proceed with a programme to deliver an integrated service and set up the necessary governance arrangements to oversee implementation.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Board –

2.1.1 Note the detailed expression of interest in becoming a national pioneer site for integrating health, social care and housing support and the Department of Health's response;

2.1.2 Endorse the intention of partner agencies to implement the integrated model described in Appendix 1;

2.1.3 Approve the setting up of a multi-agency Programme Board to oversee implementation of the integrated care model;

2.1.4 Provide oversight of the Programme Board on an ongoing basis.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 There is an increasing national push for greater integration between health and social care as a way of driving more person centred and efficient services.

3.2 Health and Wellbeing Boards will increasingly be mandated to provide the oversight for local integration and pooled budgets.

3.3 The Department of Health, in collaboration with other partners such as the Association of Directors of Adult Social Care, NICE, Public Health England etc has called on local areas to submit an expression of interest should they wish to pilot innovation in integrated care. The national programme will provide tailored support to pioneer sites in return for disseminating and promoting lessons learned for wider adoption across the country.

3.4 Locally key partners were very keen to put themselves forward as a pioneer site. Stakeholder meetings were held with key partners across the City including the range of healthcare providers, social services, housing and third sector. The resulting proposal focuses on the development of an integrated, co-located primary care led multi-disciplinary team to provide health, social care and housing support to homeless people.

3.5 An expression of interest was submitted to the Department of Health on 28th July, a copy of which is attached at Appendix 1 to this paper.

3.6 Communication was received from the Department of Health in August providing feedback on the bid but concluding that it had not been successful. It was considered to be "a good collaborative bid, which aligns with local strategies and population priorities. The application demonstrated positive health and wellbeing board support and examples of integrated responses to need". However, "Whilst there was a clear plan, the Panel considered that there was little evidence or detail around cost benefits and were unsure whether there is sufficient population for desired impact at the scale required to be a national pioneer". The full response from the Department of Health is attached as Appendix 2.

3.7 However, despite not being awarded pioneer status, partner agencies in the City are keen to implement an integrated service along the lines of the model proposed. This is clearly a very needy population who could be better served by working in a more integrated way.

3.8 The cost of the service would be met within existing resources – ie a re-engineering of the model of delivery rather than investment in a new service. Some element of pump priming may be needed to initiate the new service and small amounts of non-recurrent funding will be sought to enable this.

3.9 The CCG will provide the project management resource required to support implementation.

3.10 In order to oversee the implementation of this model it is suggested that a Programme Board be established comprised of key partner agencies. Each organisation would be accountable through its own governance arrangements but the programme of implementation would be overseen by the Health and Wellbeing Board.

3.11 This Programme Board would align with current and emerging strategic planning groups around integration of health, housing and social care but would focus specifically on the implementation of the integrated MDT.

4. CONSULTATION COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 A range of stakeholder organisations were involved in formulating the expression of interest.

4.2 Greater community engagement and service user involvement in particular will be a key part of phase I of the project.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The integrated service is expected to reconfigure existing resource within a new model of delivery. Evidence from elsewhere would suggest that a more integrated service delivers efficiencies in other parts of the health or social care system but this has not been quantified locally as yet. This will be a key part of phase 1 of the Programme and reflected in both the Council and Health budget strategies and medium term plans.

Finance Officer Consulted: *Anne Silley* *Date: 02/09/13*

Legal Implications:

5.2 The recommendations at paragraph 2 above are consistent with the Health & Wellbeing Board's terms of reference, under which it may promote integration and joint working in health and social care issues across Brighton & Hove in order to improve the health and wellbeing of the city's population.

Lawyer Consulted: *Oliver Dixon* *Date: 30/08/13*

Equalities Implications:

5.3 An EIA has not been carried out on the expression of interest given the tight timescale for submission but will be a key part of the programme as it progresses.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 This initiative is aimed at better supporting vulnerable 'homeless' people, a group which is over-represented both as the perpetrators of crime & disorder and as the victims of crime. The initiative should therefore help reduce crime & disorder, although no precise targets/outcome measures have been identified at this stage.

Risk and Opportunity Management Implications:

5.6 Although the group of vulnerable 'homeless' people is still relatively small (albeit growing rapidly), it has a disproportionate and statistically significant impact upon demands for health and care services; on crime, anti-social behaviour and noise nuisance; on housing-associated problems etc. There is therefore both a significant risk in not better targeting support for this group of people, and potential benefits to be accrued from doing so, across a wide range of services. Detailed risk/opportunity assessment and mitigation would be undertaken by the Programme Board.

Public Health Implications:

5.7 The 2012 JSNA evidenced that the single homeless population have poor health outcomes (including mental ill-health, drug & alcohol dependency, physical health problems) and make disproportionate use of high cost unplanned healthcare. National evidence from different sources shows that, of deaths that occur in hostels or while registered with homelessness services, the average age at death is low (about 40-44 years). Patients registered with Brighton Homeless Healthcare had high A&E attendance rates, emergency admission and readmission rates and low rates of planned inpatient admissions. Additional evidence will be provided by the Homeless Link Health Audit which is being

conducted in hostels and other settings as part of the JSNA programme (as approved by the Health and Wellbeing Board). More effective commissioning and service provision has the potential to improve outcomes and reduce costs.

Corporate / Citywide Implications:

5.8 "Tackling Inequality" is one of the Council's key priorities, and the group of vulnerable 'homeless' people are amongst the most disadvantaged in the city. Therefore, any actions which improve outcomes for this client will help deliver the corporate objective.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Given the failure of the pioneer bid, partners could have abandoned plans to better integrate services for this client group. However it is clear that there is a pressing need to work more closely to support vulnerable 'homeless' people, hence the recommendations within this report.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 Brighton and Hove has a large and growing number of "homeless" people with extremely poor health outcomes.

7.2.1 Despite a significant amount of resource directed at our homeless community and some examples of excellent practice we do not have a strategic or fully joined up approach to the planning or delivery of services to our most vulnerable community.

7.2.2 Establishing a co-located MDT which integrates the whole range of health, social care and housing support will help develop a more comprehensive and joined up service for homeless people in the City.

7.2.3 Establishing a Programme Board to implement the model, overseen by the Health and Wellbeing Board will strengthen the mechanism for delivery and accountability for this key programme of work.

SUPPORTING DOCUMENTATION

Appendices:

1. Submission of Interest in Being a Pioneer Site for Integrated Health, Social Care and Housing Support in Brighton and Hove.

2. Response from the DH regarding Brighton and Hove's Expression of Interest in being a Pioneer Site for Integration

Documents in Members' Rooms

None

Background Documents

None

Appendix 1:

Integrating Health, Social Care and Housing Support for Homeless People in Brighton & Hove

Expression of Interest to be a Pioneer Site

June 2013

A Collaborative Submission by:

Brighton and Hove Clinical Commissioning Group, the City Council, Community and Voluntary Sector Forum, Brighton & Sussex University Hospitals Trust, Sussex Community Trust, Sussex Partnership Foundation Trust and Morley Street Homeless Practice

1. INTRODUCTION

Brighton and Hove CCG, in partnership with the City Council, Public Health, the Third Sector, Primary Care, Community Healthcare, Mental Health and Substance Misuse Services and Secondary Healthcare providers are keen to pioneer a person centred model of health, social care and housing support to homeless people in the City. This expression of interest has been endorsed by our Health and Wellbeing Board at its meeting on 12th June 2013.

We have chosen this cohort of individuals as they are some of our most vulnerable individuals, often with a combination of physical ill-health with mental illness and substance misuse (drug and alcohol), complex health needs and premature death. The City is seeing a year on year rise in homelessness. Homeless people are more likely to use A&E, spend time in hospital and to be heavy users of mental health and substance misuse services. Despite some beacons of good local practice and innovation there has never been a strong enough focus on a multi-agency personalised joined up approach in the City. We are aware that some of our current services can operate within rigid boundaries – geographical, cultural, organisational, systemic and legal frameworks – and therefore prevent homeless people from accessing the healthcare and support they require.

We would use the opportunity of becoming a Pioneer site (and the support it would offer) as a lever to engage stakeholders and homeless people in this programme of work. We would establish an overarching strategic board for Health, Social Care and Housing and other partners including the Police, Probation Services and Third Sector in the City to oversee the pilot, establish a multidisciplinary integrated support team co-located with city centre homeless services, develop integrated pathways into and out of other key service areas, and identify and trial a range of integrated solutions to key priority areas. We would embed evidence based best practice and personalisation in all areas of service delivery and share the learning locally and nationally.

2. DEFINITION OF HOMELESSNESS

For the purpose of this proposal we have defined homelessness as:

- People in temporary accommodation;
- Hostel occupants;
- Hidden homeless i.e. people in ‘squats’ or ‘sofa surfers’; and
- Rough sleepers.

3. HOMELESSNESS IN OUR CITY

Brighton and Hove is a city with a population of about 275,000 living in 121, 540 households. Located between the South Downs and the sea, about 53 miles from London, the City is renowned as a “party” town with a vibrant arts and leisure scene. The City has significant pockets of deprivation and high levels of mental health/substance misuse needs compared to other areas in the South East.

The City has a challenging picture regarding housing stock with:

- Low levels of home ownership or social housing;
- 9th highest private rented sector in England;
- One of the largest stocks of houses in Multiple Occupancy in England;
- Steady increase in average rental costs – well above the Housing Benefit Local Housing Allowance;

The combination of high levels of need, pressure on accommodation and the impact of the economic downturn/welfare reform has meant our City is witnessing an increasing level of homelessness, well above the national level.

Since 2003/04 the most common reason for homelessness in the city is due to eviction by parents, family or friends (32.3% in 2009/10). Together with loss of private accommodation (31.8%) it accounts for almost two thirds of homelessness in the city in 2009/10. A further 25 households were accepted due to domestic violence (6.8% of all homelessness acceptances).

In Brighton and Hove more than half of all homelessness acceptances involve families with children, or a member of the household who is pregnant, although homelessness acceptances in these groups are lower than the national average. Homelessness in Brighton and Hove during 2009/10 due to physical disability is over two times higher than the England average and due to mental illness is over three times higher (BHCC Housing Statistical Bulletin, 2009/10).36 A large proportion of homeless young people are not in education, employment or training and care leavers are over-represented.

There has been a sharp increase in the number of recorded rough sleepers in the City. In November 2011 the official rough sleeper street count was 37, up from 14 the previous year. This is an increase of more than 160% compared with a national increase of 23%. CRI – an organisation who provide services to this group locally, worked with 732 rough sleepers (sleeping on the streets or in insecure temporary accommodation) in 2011/12 – an increase of 24% on the previous year.

Current monitoring data suggests that rough sleepers in Brighton and Hove are 90-95% male, predominantly aged between 30 and 45 years and 20% are non-British nationals, with those who are from other countries mainly being from Eastern Europe.

The growing number of homeless in our City is a challenge for the health and wellbeing of a very vulnerable group of people, as well as placing an unprecedented pressure on health, housing support services and other statutory partners.

4. THE NEEDS OF HOMELESS PEOPLE

We know from local and national evidence that homeless people have significantly worse health than the general public, for example:

- 80% of homeless people have one or more physical health need. For over half, this represents a chronic health problem.

- 70% of homeless people have at least one mental health problem[1].
- Depression and anxiety are five times as common as with the general population.
- Mortality rates for coronary heart disease are 12 times greater for patients registered with our homeless practice compared to the 2nd highest rate.
- Rough sleepers experience TB at 200 times that of the known rate among the general population.[2]
- A third of rough sleepers have attempted suicide.
- The average age of death of a homeless person is estimated to be 43-47[3]
- A&E attendances are five times higher in our homeless population than the local average. 40% of homeless people will have used A&E in the past six months, and nearly a third will have been admitted to hospital as an inpatient.[4]
- Hospital readmission rates (at 28 days after discharge) are twice as high as the local average.
- When rough sleepers attend hospital, they average seven A&E attendances per patient, nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases.
- Planned in-patient admissions are a third lower than the local average.
- Rough sleepers face a number of attitudinal and structural barriers to accessing healthcare. These include discrimination by health professionals, difficulty in registering with a GP, a lack of knowledge of services, a lack of continuity of care, and cost. Fear of stigmatisation and health as a low priority are also significant barriers.

5. CURRENT SERVICE PROVISION

There is a significant amount of support available to homeless people in the City and some excellent examples of innovative practice.

- A General Practice dedicated to homeless people exists in the city. This has been established for over 10 years and has a list size of approximately 1000. This practice offers all the services a normal GP surgery would, and was set up to address the particular health concerns faced by homeless persons. It works closely with the services mentioned below, but is currently unable to offer outreach.
- Integrated Primary Care Teams (district nursing, specialist nursing and therapy support) working around clusters of GP Practices are beginning to provide in-reach to hostels providing follow up care after hospital discharge; palliative care; monitoring of complex multiple chronic conditions and providing ongoing support. This is a rapidly increasingly complex caseload which requires specialist expertise and knowledge from case managers and advanced practitioners.

[1] Homeless Link, The Health and Wellbeing of people who are homeless: findings from a national audit,(2010) www.homeless.org.uk/health-needs-audit

[2] See Inclusion Health: Evidence Pack (March 2010) www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf

[3] Crisis, Homelessness: a silent killer (2011). This study looks at the mortality of single homeless people which includes those sleeping rough, in hostels and in other hidden homeless situations. This should not be confused with life expectancy figures.

[4] Homeless Link, The Health and Wellbeing of people who are homeless

- A year long randomised clinical trial has been undertaken by the Pathway based at our local acute hospital – Brighton and Sussex University Hospital Trust (BSUH). The trial investigates the effects of a specific GP led homeless team within the hospital on outcomes for patient including levels of satisfaction, length of hospital stay and re-admission rates. One benefit of the trial has been the instigation of a weekly patient centred MDT attended by primary, secondary and community healthcare professionals, social workers, housing workers, hotel managers, third sector organisation, street outreach workers and medical students and the ability to work across providers and follow patients back to the community.
- A mental Health Homeless Team provided by Sussex Partnership Foundation Trust (SPFT) who works specifically with service users who are street homeless and in temporary accommodation. This is a multi-disciplinary team in conjunction with the City Council; the team works closely with other statutory and community and voluntary sector providers across the City to meet the needs of this challenging and hard to engage client group.
- A member of SPFT staff is seconded to the Council's Temporary Accommodation and Allocations Team in order to source appropriate placements within residential, temporary and supported accommodation for service users known to adult mental health services. This role is also key in facilitating timely and safe discharges from acute in-patient settings.
- Psychiatric liaison services are provided within BSUH 24 hours a day. This service works closely with all acute medical in-patient services particularly those in the integrated hospital discharge team and A&E.
- SPFT provide an integrated substance misuse service in Brighton and Hove in partnership with Crime Reduction Initiative (CRI). This is an assessment, treatment and care coordination service. Both drug and alcohol services are provided to the BSUH A&E department as part of this service. Interventions including counselling, prescribing, harm minimisation, group work, rehabilitation with a substantial focus on recovery, peer and user involvement.
- Substance misuse services have lead nurses and recovery mentors allocated to each of the hostels in the City.
- There is a variety of innovative Third sector support services provided for homeless people in the city. The Community and Voluntary Sector Forum (CVSF) the local umbrella body for the third sector, has over 350 community groups and voluntary organisations within its membership. A number of their members provide support services to homeless people. Some of the services include:
- Brighton Housing Trust: First Base Day Centre which offers a range of services to support people who are sleeping rough or insecurely housed in the city to get off the streets, and start realising their aspirations through work, learning and leisure and find a place the can call home. Some of the services include a healthy lifestyles project, promotional and awareness of sexual health, a CV and employment service, heritage and cultural activities, and a catering social enterprise company: www.bht.org.uk/services/first-base-day-centre
- Clocktower Sanctuary: which provides a drop-in and referral centre for homeless young people aged 16 to 25. The sanctuary offers a friendly space, food and drink, access to computers and the internet, signposting to housing, health, education, employment and social services, as well as practical and emotional support to help young people get their lives back on track: www.theclocktowersanctuary.org.uk

- Friends First Trust: Provides supported housing and move-on housing to single homeless people: www.friendsfirst.org.uk
- Brighton Soup Run: Volunteers serve hot soup, bread, and tea to anyone who needs it seven days a week on Marine Drive in Brighton and by the Peace Statue on the Brighton/Hove border. It provides a lifeline to homeless and vulnerable people across Brighton and Hove.
- St Johns Ambulance Homeless service: Works to improve access to primary health care services for homeless and vulnerable people across Sussex. Delivers practical training for professionals and homeless people, and works from primary health care units in the community, Brighton and Hastings: www.sussex.sja.org.uk
- Sussex Nightstop: Arranges temporary accommodation on a night by night basis for young people at risk of homelessness, in the homes of trained volunteers: www.sussexnightstop.org.uk
- A range of supported housing for vulnerable single homeless men and women provided by organisations such as Brighton YMCA, www.brightonymca.co.uk Southdowns Housing www.southdownhousing.org etc
- A report into the role and contribution of churches in the city, written in 2011, identified that there were 12 outreach projects, 9 drop-ins, and 2 supported housing schemes run by churches, most that are not part of the CVSF membership.
- Housing services in the City commission a range of assertive outreach support, recovery mentors, relocation work; 'No Second Night Out' pilots; alcohol nurse; severe weather emergency responses and have demonstrated positive outcomes for clients such as increasing contact with GPs, helping clients to access detox support, hostels and private rented sector accommodation and hospital and residential care, reducing antisocial behaviour and helping clients to reconnect with family.

As Phase I of the Pilot we would look to conduct a thorough mapping exercise to both quantify and cost the level of support in existence across the City and to better understand the strengths and gaps in current service provision and identify opportunities for further integration/streamlining service models.

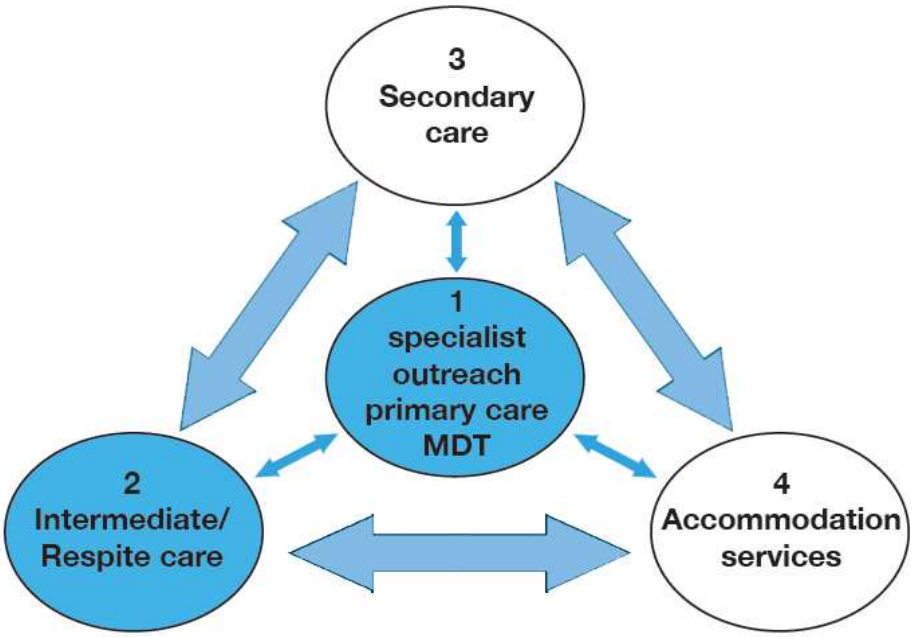
6. PROPOSED MODEL OF CARE

Our aim is to provide a high quality primary care focused model of support for homeless people in the City, shifting the focus from crisis management to preventative, proactive care, service co-ordination and case management. This will not only provide a better quality intervention and health outcome for the person concerned but these models have been shown to be cost effective to the health economy including reducing hospital admissions and in-patient stays[5]. Additionally, targeted health interventions for homeless people have been shown to reduce the amount of time that people are homeless.

The integrated model of care we are proposing therefore is evidence based and the one recommended by the Faculty of Homeless Health[6].

[5] St Mungos (2010), Homelessness, it makes you sick: www.mungos.org/campaigns/momelessness_it-makes-you-sick/
[6] The Faculty for Homeless Health - Pathway (2011) Standards for Commissioners and service providers. www.londonpathway.org.uk/uploads/homess health standards.pdf

Figure 1 - Integrated approach to commissioning of homeless health services.



Our model will offer a single point of access with a common assessment framework. Care will be integrated horizontally through the establishment of a co-located primary care led MDT with patient centred care planning at the heart of the model and continuity of care across service provision, namely: primary care, community nursing and therapy services, mental health, substance misuse and alcohol services, social services, learning disability services, third sector and housing support. We would ensure vertical integration with secondary care through clear integrated pathways of care and a model of in-reach and strengthen our Intermediate /Respite Care in order to avert unnecessary secondary care admission, prevent inappropriate hospital discharge and emergency re-admission and organise onward care and resettlement.

Peer support will be integral to the model of care we are proposing. There are currently some excellent examples of homeless peer support in the City including Care navigators at BSUH, and CRI peer mentoring with rough sleepers. The Pathway approach includes peer care navigators (who have personal experience of homelessness) working as an integral part of the team who support patients on the wards and then continue to support them after discharge from hospital.

The integrated service will work in a psychologically informed way by ensuring appropriate training and development for all staff working in the MDT and across integrated pathways to respond effectively to people with psychological needs and longstanding emotional problems. Working with SPFT we will ensure that there is appropriate training for staff in the MDT and across pathways of care which address issues such as dual diagnosis, harm minimisation and motivational interviewing. Integrating physical and mental health needs across all areas of service provision is a priority for the CCG and we would use the learning from this pilot and share good practice across other services.

We would also want to ensure sexual violence, assault and exploitation is explicitly addressed as part of this Pilot as we know that these issues impact heavily on those who are insecurely

housed or homeless, and further reduces their access to health services. We would link to local projects doing work on this issue, such as work with young people: http://www.sussexcentralymca.org.uk/information_advice_support/_wise_project; the local rape crisis centre: Survivors Network http://www.survivorsnetwork.org.uk and local support groups for domestic violence: www.riseuk.org.uk

The City has signed the Armed Forces Covenant and we will ensure the needs of veterans are explicitly addressed in this Pilot. A liaison post for homeless ex-military personnel is currently being commissioned in conjunction with the Ministry of Defence and will be a key link for the MDT.

We are keen to explore the opportunities for greater personalisation and increased choice within this Pilot. The initial mapping exercise will enable us to quantify more clearly current service provision and finances. A key focus of the programme will be to explore the options for pooled funding and piloting personalised budgets.

All partner agencies are committed to co-locating staff within a newly established MDT and working within a whole system governance framework. We have a history of successful integrating of service provision in the City which we can draw on including multidisciplinary Hospital Rapid Discharge Team at the front door of A&E comprising Social Workers, Therapy and Nursing staff, Integrated Primary Care Teams (nursing, therapy, and social workers) configured around clusters of GP Practices and integrated health and social care services in adult mental health, dementia services and substance misuse.

7. ENGAGEMENT WITH SERVICE USERS

Our ethos is to fully engage service users at all levels during this Pilot.

Lead by service users, we will create a series of meaningful statements about care against which we will monitor the quality and impact of our Integrated Pilot.

Whilst we will ensure service users are part of the overarching governance as well as the operational management of the Pilot, we would also like, as part of the support from the national programme to look at more innovative and meaningful ways in which we can fully embed service users in planning, delivery and evaluation.

8. EXPECTED OUTCOMES

We would work closely with our partner agencies in the City wide Strategic Board to refine the expected outcomes from the Pilot. Some initial areas of thinking include:

- Reduction in the numbers of rough sleepers.
- Reduction in the breakdowns in temporary accommodation
- Reduced length of stay in acute beds – mental health and hospital.
- Reduced emergency admissions for people classed as homeless.
- Reduced emergency re-admissions for people classed as homeless.

- Improved user satisfaction with service provision.
- Increased number of homeless people registered with a GP.
- Increased number of homeless people registered with a long-term condition, receiving case management and regular reviews.
- Improved measures of social re-ablement such as education and training/back to work etc.

9. IDENTIFYING FINANCIAL EFFICIENCES FOR RE-INVESTMENT

National and international evidence suggests that more proactive and integrated services for homeless people can reduce their use of urgent care services.
There were in excess of 200 emergency admissions of homeless people to our local hospital over the 12 month duration of the project. Whilst data from our local research project is not available until later in the year, other Pathway sites have demonstrated a 30% reduction in length of stay for this cohort of patients and significant reduction in re-admissions. We will look to fully estimate the impact of our integrated approach on urgent care as well as other services drawing on the evidence from elsewhere once the service and financial mapping exercise has been completed.

10. PLAN FOR DELIVERING THE INTEGRATED VISION

In pulling together this expression of interest we have obtained the full sign up of partner agencies in reconfiguring existing resource within an integrated model of care.

In order to deliver the integrated vision we envisage the Pilot having three distinct phases.

Phase I where we will establish the governance arrangements and engage further and in more detail with the wider stakeholder group including Ambulance services, Third Sector Providers, Sussex Police, Community Safety Team, Probation Services, Academic organisations etc to map current services, describe barriers to access and identify good practice and innovation already in existence. During this phase we will actively engage with homeless people and will to work closely with them to inform service redesign. We will develop a narrative with homeless service users as per National Voices which sets the direction and vision for the MDT.

Phase II will see the establishment of the co-located MDT, development of the single assessment framework and integrating pathways of care with other key service providers.

Phase III will involve the piloting of innovate practices such as personal health budgets, peer support mechanisms and other areas as defined on a rolling basis.

We will look to embed evaluation and reflective practice at all levels of project delivery. Our intention is to continually evaluate our approach and the outcomes of pilots rolling out the integration concept to other parts of the local system. We will share the learning as to what

has worked and what has not worked locally and nationally via relevant learning networks, websites, conferences etc.

We are linked into the National Pathway and the Faculty for Homeless and Inclusion Health are interested in highlighting and sharing any learning that comes out of the Pioneer Site.

Futurehealth Brighton is a social enterprise run by local GPs who are looking at innovation and integration of services from the perspective of primary care. They have expressed an interest in working with us through the different phases of the project. They would also be able to offer links with Brighton's Community and University Partnership Program and other academic institutions that have expertise in evaluation, as this is a key theme of the integration vision.

Phase I	July – Dec 2013	Initiate City Wide Strategic Planning Board to oversee implementation of Pilot. Recruit senior project management resource to oversee programme of work. Map current service provision and expenditure across all partner agencies. Conduct stakeholder engagement to further understand strengths and weaknesses of current configuration. Develop specification and project plan for implementation of the MDT. Agree and embed structures for patient engagement Secure location for hosting MDT.
Phase II	Jan-Dec 2014	Establish MDT and co-locate staff. Define and roll out case management processes. Develop and roll out common assessment framework Continue to identify good practice, identify gaps and feed into rolling Programme Plan.
Phase III	Jan 2015 onwards	Roll out of pilot projects such as personal budgets; peer support mechanisms, models of palliative care etc Ongoing review and reflective learning to be built into operational model and governance structures.

11. Summary and Conclusion

Brighton and Hove is a city with a large and growing number of homeless people who have extremely poor health outcomes. Despite a significant amount of resource directed at our homeless population and some excellent examples of innovation in the City – particularly in relation to third sector provision, primary care support and local research – we do not have a strategic or joined up approach to supporting our most vulnerable community.

Our proposal is to establish a primary care led MDT integrating the whole range of health, social care and housing support to homeless people building on the good practice which currently

exists in pockets across the City and develop seamless pathways of care into and out of other key services.

We aim to test a variety of innovative pilots such as peer support mechanisms, service user engagement, models of palliative care and personal budgets for homeless people in the city.

A senior City-wide Partnership Board would be established to oversee the Pilot and ensure a more joined up approach to the strategic planning and operational delivery of services for this client group.

Our links to national organisations and academic institutions will help us to evaluate the impact of our model and disseminate the learning/good practice on a wide scale.

The following evidence has been considered in pulling this bid together.

Innovation/ evidence	Brief description
Personalisation Guidance for the Homeless sector (2012) Pilots (4 parts of the country)	• Early stages of development within the homelessness sector. • Homelessness services are embracing the new approach in a variety of innovative ways within existing services such as reviewing current delivery, while some have been funded directly to carry out individual budget pilots • The majority of pilots within the homelessness sector have focused on responses to outreach in specific relation to the target of ending rough sleeping by 2012. • The pilots have being extremely successful in re-housing entrenched rough sleepers across the country, and learning from these pilots will be vital for how the sector approaches personalisation in the future. • Implementing personalisation can take many forms, for example looking at areas of the project where choice is limited to clients such as shift patterns and key workers, meals and activities. http://homeless.org.uk/sites/default/files/How%20to%20personalise%20your%20service%20-%20Final.pdf **http://www.jrf.org.uk/sites/files/jrf/supporting-rough-sleepers-summary.pdf**
Integrated care pilots	A pilot offering integrated care for homeless people with the aim of reducing mortality and morbidity, and reducing acute secondary healthcare usage among its clients. Using a band 7 nurse, care coordinator and GP (once a week) reductions seen in secondary care usage. http://www.mungos.org/services/recovery_from_homelessness/homeless_intermediate_care_pilot_project/
Single point of access and assessment to	Multiple exclusion homelessness. Access to assessment is the key to accessing the resources that allow for outcome based and individualised responses. More importantly, access to a shared or common assessment framework is vital if we are to prevent a 'retrench to silos' where each service sector evolves its own approach to personalisation meaning that people end up with multiple budgets, one for health, one for care and one for housing support http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/2011/cornesetal2011homelessnesssummary.pdf
Improving hospital admissions and discharge. E.g. Pathways	Hospitals, local authority housing teams and voluntary sector organisations should work together to agree a clear process from admission through to discharge to ensure homeless patients are discharged with somewhere to go and with support in place for their on-going care. This process should start on admission to hospital. Pathway at BSUH (2011) http://homeless.org.uk/sites/default/files/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf http://www.londonpathway.org.uk/uploads/Pathway_draft_BSUH_Homeless_needs_assessment.pdf
The	The psychologically informed environment (PIE) can be created in a service such

psychologically informed environment (PIE)	as a hostel or day centre where the social environment makes people feel emotionally safe. A PIE is an approach rather than a place, its an 'enabling environment'. PIEs can be developed within existing commissioned services, wherever appropriate training and development enables staff to respond effectively to people with psychological needs and longstanding emotional problems.http://www.southampton.ac.uk/assets/imported/transforms/peripheralblock/UsefulDownloads_Download/A6FD3BB1EB2A449987C12DFF91EF3F73/Good%20practice%20guide%20%20%20Psychologically%20informed%20services%20for%20homeless%20people%20.pdf
Role for adult social care for the homeless	Specialist homeless post in Adult social care resulted in • Improved communication between ASC and hostel staff • Better understanding of role and remit of ASC for hostel staff • Continuity resulting in a more joined up way of working and better outcomes for clients • Proactive working leading to early interventions for clients • http://homeless.org.uk/ASC-specialist-social-work-post-hostel-residents
Peer support for homeless toolkit and Promoting Access to Health Services (PATHS) project	Toolkit- Peer support for homeless this includes peer health education, Peer health promotion, peer health advocacy, peer involvement in commissioning. The PATHS project provides volunteers who can go with patients to their appointments, helping them to remember the time and day, find the their way there and back, and to feel confident enough to deal with new health staff http://homeless.org.uk/sites/default/files/HomelessHealth_PeerActivityToolkit_0.pdf http://www.oxhop.org.uk/getinvolved/paths.html
Pathways - Standard for commissioners and service providers- Faculty of homeless health.	– Integrated approach to commissioning homeless health and services – Horizontal - patient centred care planning and continuity of care across service provision – Vertical integration- Compassion, communication and continuity of care between primary, secondary and community care. – Standards for commissioners – Outcome measures http://www.londonpathway.org.uk/uploads/homeless_health_standards.pdf
Service user involvement, engagement and empowerment	Person centred coordinated care where by the individuals needs are fully assessed and are given timely readily understood information and are supported to make informed choices and to be actively involved in their care planning to help them to reach their goals and desired outcomes. They will have coordinated MDT care that will support them in making decisions about their care and the personal health/social care budgets available to them to obtain their goals. Ensuring a smooth transition into other services once outcomes have been realised. http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf **Using the Narrative developed for us by National Voices will be developed for homeless people.**

2: Appendix 2 - Response from DH on Expression of Interest

From: Pioneers [mailto:pioneers@dh.gsi.gov.uk]
Sent: 09 August 2013 16:31
To: Hoban Geraldine (NHS BRIGHTON AND HOVE CCG)
Subject: Expression of interest to become a Pioneer

By email
Geraldine Hoban

9 August 2013

Expression of interest to become a Pioneer – 006-South Brighton

Dear Colleague,

Thank you for expressing an interest in becoming a pioneer in health and social care integration.

Over 100 expressions of interest were received, clearly indicating a very high level of commitment to service improvement, meeting the challenge of designing coordinated services around the needs of patients and service users. Many of the expressions of interest were of a high quality.

Unfortunately your application has not been shortlisted for further consideration, but we would like to ensure you benefit from the wider programme of support we are putting in place. We were impressed with the range of ambitious plans and initiatives already underway and are therefore very keen for you to remain involved and to be part of a network of support, sharing the learning taking place in your area.

The Panel's decision is final, but in order to help you further refine your plans for integrated care and support, the Panel has provided the following feedback on your application:

The Panel considered that this was a good collaborative bid, which aligns with local strategies and population priorities. The application demonstrated positive health and wellbeing board support and examples of integrated responses to need. Whilst there was a clear plan, the Panel considered that there was little evidence or detail around cost benefits and were unsure whether there is sufficient population for desired impact at the scale required to be a national pioneer.

Through reviewing the applications we have a clearer picture of what localities need from the Integrated Care and Support Collaborative in order to enable and empower integration locally. Over the coming months, we will develop the support programme that localities need. The pioneers, when selected, will be a key part of that programme, sharing the lessons from their experiences for wider adoption.

Your details have been passed to NHS Improving Quality (NHSIQ), which is hosting the Integration Care and Support Exchange (ICASE) and will be developing a range of approaches to ensure that the learning from Pioneers is widely shared and further developed. As an area that has expressed interest in this programme of work, NHS IQ will keep you informed of these learning and development opportunities, which we encourage you to engage with over the coming months. As a first step, based on the feedback we have received from local areas, and recognising the need for pace, we have commissioned the production of a toolkit to support business planning and delivery locally. Please let us know if you would be willing to contribute to developing this.

The expectation is that all localities will make progress in planning and delivering better integrated care and support over the coming years, irrespective of whether they are a part of the pioneers programme, supported in particular by the recently announced Integration Transformation Fund that will be shared between the NHS and local authorities. We encourage you to share the proposals within your pioneer application with local partners, as local planning in relation to this Fund gets underway. Further details on the Integration Transformation Fund will be published shortly.

The national partners thank you for sharing through your application, a description of your work to take forward integrated care and support. This information is very valuable to us as we continue the on-going process of ensuring that policy at national level supports innovation locally. As a result, colleagues may be in touch in the coming weeks to discuss elements of your application in more detail.

Yours Sincerely,

The Integrated Care and Support Pioneer Team
Part of the National Integrated Care and Support Collaboration
2N15 Quarry House, Quarry Hill, Leeds, LS2 7UE