Appendix 2a

Out of Hospital Care Model for people experiencing rough sleeping or at risk

Funding proposal for 21/22

Name of project	Birmingham Integrated Health and Homelessness OOHC Model

	Please provide details – indicates support for participation in the programme
Geography to be covered	Birmingham
Lead local authority (funding will be paid to on behalf of the partnership)	Birmingham City Council
Other local authority partner/s	
STP/ICS	Birmingham and Solihull Integrated Care System
CCG/s	NHS Birmingham and Solihull Clinical Commissioning Group
Secondary care provider partners	University Hospitals Birmingham NHS Trust Birmingham and Solihull Mental Health NHS Trust
Primary care provider partners	Homeless Primary Care Service
VCSE partners	Crisis Skylight Birmingham
Housing provider partners	Trident Reach Claremont Living
Other	Change Grow Live,

Please describe the governance structure/s that will provide direction and accountability, address barriers to effectiveness, receive and implement learning, from the proposed model?

Governance for the proposed model will be through the Better Care Fund and Birmingham Integrated Care Partnership (BICP) arrangements.

The model aligns with the existing BICP priority workstreams of Early Intervention and Neighbourhood Working. It is proposed that this work is closely aligned with the Early Intervention workstream given the linkages with system work on implementation, delivery and improvement of discharge to assess pathways that is being driven through this workstream. This will provide direction and accountability whilst helping to mainstream the model as the system approach to achieving better outcomes for the cohort. Links to the Neighbourhood Working workstream are important in respect of community based integrated working.

Issues and barriers emanating from the project will be addressed at a project level in the first instance and then escalated through the relevant BICP workstream for wider involvement of partners. This will enable appropriate identification of system level risks to delivery and relevant risk mitigation. Learning from the project will similarly feed directly into these workstreams to inform and shape business as usual planning.

Financial governance of the programme will be via the Better Care Fund; with reporting through to the BCF Programme Board and accountability to the BCF Commissioning Executive and ultimately the Health and Well-being Board. The project budget will be held within the Birmingham Better Care Fund to reflect and enable the integrated approach required to implement the model within the system.

.

All partners within the system recognise the need to address housing and homelessness challenges that impact on health and well-being outcomes.

Understanding the links between health and homelessness and addressing health inequality is a key strand of the Homelessness Prevention Strategy and Rough Sleeper Strategy Addendum. As such regular updates on this project will be reported to the Birmingham Homelessness Partnership Board.

Please confirm:	**Name/position/contact details**
The commitment of the locality and partners to programme participation up until March 2022, including participation in national learning and evaluation	Saba Rai Head of Service – Health and Homelessness Birmingham City Council Saba.rai@birmingham.gov.uk 07704539752
There is an expectation that learning will feed into your local commissioning processes for health care, social care and public health, as a means to secure sustainable outcomes	Birmingham Integrated Care Partnership. Better Care Fund Programme Board. Health and Wellbeing Board

Funding sources	**Total**
Total requested from DHSC to deliver OOHC model in 21/22	£600,000
Please indicate any other local funding that will be used eg, six-week NHS recovery funding, Better Care Fund etc. (not MHCLG £)	
Partners to this bid contribute additional resources to deliver the vision for homelessness prevention and supporting rough sleepers across Birmingham that will enhance the delivery of the out of hospital care model.	
Please indicate if 21/22	
MHCLG funding streams No further funding is required from MHCLG for this programme. We note that a range of MHCLG funding steams contribute to the delivery of the vision for homelessness prevention and supporting rough sleepers across Birmingham that will enhance the delivery of the out of hospital care model.	**No**
PHE substance misuse funding is required to deliver this?	**No**
PHE awarded a grant to public health to deliver a rough sleeper drug and alcohol treatment service in December 20. The grant value for 21/22 has not been confirmed.	
Total cost associated with the delivery of the OOHC model in 21/22	**£600,000**

Do you require expert support to assist in 21/22 delivery?
Yes

Yes, the LGA has been involved in the development of the funding bid and discussions are underway as to delivery support needs.

Will the proposal improve outcomes for:

General acute services Yes/~~No~~
Acute mental health services Yes/~~No~~
Other (please specify)

Please describe the target population who will benefit from the OOHC funding, and the gap/s you are seeking to fill through this funding

There is extensive work at a system level to improve out of hospital care for older people and to extend this to other vulnerable groups. This bid is therefore timely and offers an opportunity to enhance this work to meet the needs of rough sleepers and those at risk of rough sleeping.

The bid has been developed with multi agency collaboration to ensure it complements and enhances the utilisation of existing service provision, is strengths based and maximises the opportunity for helping rough sleepers break the cycle of repeated admission and readmission into hospital and ultimately, to support rough sleepers to maintain settled lives. The target population that will benefit from the funding will include rough sleepers and those at risk of rough sleeping who are:

- Admitted to hospitals across Birmingham
- Frequent users of urgent and emergency care
- At risk of re-admission
- Require a period of reablement / resettlement/ assessment before moving into accommodation.
- Require covid accommodation upon discharge
- Have complex co-occurring substance dependence, mental and physical health conditions

The LGA self-assessment tool assisted partners to identify gaps within our current out of hospital care model to support the development of this bid. Our system in relation to homelessness and rough sleeping is complex, fragmented with a wide array of commissioned and non-commissioned services and providers. Patient flow into and out of acute settings is through a range of pathways which are not clearly known or applied in relation to homelessness across all settings and there is limited clinical hospital specialist capacity to respond to the growing number of homeless individuals that present. We have a known community of frequent attenders who have a chequered history of engagement and frequently revolve between services.

The self-assessment enabled partners to articulate that we also have many components of the high Impact change model in place across Birmingham. This funding would look to address the gaps we have identified to bring the pieces of our local model together. These include: -

- End to end coordination, on-going support for people to get them linked with services
- A flexible 7-day service operating from each hospital
- Clear, consistent articulation of the Discharge to Assess (D2A) Pathway 0,1,2,3 for rough sleepers
- Consistent application and communication of pathways and processes
- Greater co-ordination between housing, mental health, substance misuse and primary care
- Harnessing the strength of peer lived experience
- Enhancing existing step up / step down and medical respite service provision

What impact do you hope to make through the OOHC funding?
(Programme objectives include: attendance/admissions avoidance; timely transfers of care from hospital; readmissions prevention; harm minimisation (including from Covid-19); improved health outcomes; reduction in rough sleeping, reduction in health inequalities/inequalities for specific populations, improved patient experience etc)

Our high-level programme objectives will be to:

- Support the reduction in rough sleeping across Birmingham
- Improve patient experience including person centred care
- Improve health and wellbeing outcomes
- Facilitate discharge co-ordination into appropriate housing pathways for individuals who are admitted into acute / non-acute / Enablement (EAB) settings and are clinically fit for discharge.
- Support timely transfers of care from hospital into supported accommodation settings.
- Prevent readmission into acute by ensuring patients have access to wrap around support to meet their individual needs.
- Reduce self discharge
- Minimise harm by ensuring supported discharge regardless of covid status.
- Deliver a 7-day integrated service

Please describe how the proposed interventions will be delivered to achieve the objectives for the population, including how these will work alongside existing services/accommodation (the overall model)

The overall aim of this proposal is to strengthen our specialist out of hospital care model for people who are homeless and at risk of rough sleeping in Birmingham.

The city's main objective to reduce rough sleeping is based on embedding comprehensive targeted prevention, relief and recovery from rough sleeping, adhering to the prevention pathway approach set out in our overall Birmingham Homelessness Prevention Strategy 2017+.

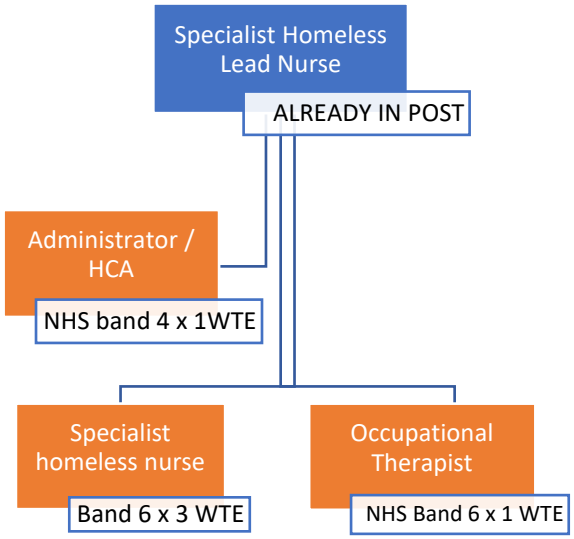
Utilising a combination of local, regional and national investment, key principle areas of action are focussed on the following 3 pathway areas or domains:

1. Preventing someone from rough sleeping in the first place - through prevention targeted at groups and circumstances
2. Crisis Relief through expanded outreach- providing quick safe and quality interventions to get someone from the streets and into integrated accommodation and support services designed to meet their needs in a holistic and coherent way.
3. Recovery - Keeping people from the streets through an improved coordinated system of support and integrated care.

The funding for the Birmingham Integrated Health and Homelessness OOHC Model will sit alongside other funding streams from MHCLG (Protect, NSAP, RSI, Housing Firs) PHE (Birmingham Rough Sleeper Drug and alcohol treatment model) and NHSE (Rough Sleeper Mental Health Team) to strengthen and further embed the integrated care and support to achieve the city's strategic aims.

We have followed the guidance set out in the HICM and the King's College Support Tool. The elements of the model we are looking to implement will boost our clinical specialist homeless nursing capacity as well as build our integrated multi agency team:

Clinically Led Specialist Homeless Team that is supported by an Integrated Specialist Homeless Team



Blue - signifies the existing model
Orange – signifies additional components of the model

1) Specialist Clinical In-reach for homeless Patients

Our self assessments have identified gaps in our current systems capacity for specialist homeless nursing and the need for greater involvement with homeless patients on wards to prevent self discharge and coordinate optimal patient centred treatment. There is a need for greater capacity on wards for the involvement of and supported handover to multi agency teams so that no patient falls between the gaps in processes and services or is discharged to the street. Our current service operates Monday-Friday 9-5.

Birmingham have four main acute sites that span 2 local authority boundaries.

- City Hospital in West Birmingham has a Homeless clinical Nurse (1 WTE) working as part of a multi-agency team (4 staff) across Sandwell and West Birmingham CCG boundaries.
- Heartlands and Good Hope hospitals have access to a Homeless Nurse (1 WTE).
- Queen Elizabeth Hospital currently has no specialist homeless nursing provision.

This is insufficient capacity for the numbers of homeless patients we are seeing. We are also aware of the need to increase specialist nurse presence on the wards of our acute hospitals to ensure more people who are homeless are identified as soon as possible after admission to enable effective and timely care planning and elective readmissions.

The Specialist homeless nursing team will:

- Provide specialist clinical nursing, advocacy and support across UHB, Good Hope and Heartlands Hospitals.
- Work across multiple acute sites operating a flexible 7-day service for up to 12 hours a day i.e. 8am – 8pm
- Ensure optimal patient care that supports transitions across health, housing and social care boundaries.
- Undertake case management of people with complex needs and ensure discharge into appropriate pathways
- Provide and facilitate hospital and community OT teams, to ensure the provision of therapeutic interventions, assessments, advice and support across homeless pathways from acute into step down / step up and move on.
- Co-produce and communicate effective integrated pathways and processes across agencies and sectors.
- Facilitate learning and development opportunities for partners to embed inclusion health good practice to drive up the quality of care.
- Work alongside existing primary care homeless service to operate a 'virtual ward round' that supports patients who are stepped down into our Homeless Medical respite transitions centre to prevent re-admission.
- Work in partnership with housing coordinators, social workers, accommodation providers, substance misuse and floating support workers to ensure care is wrapped around each patient from admission to resettlement.

To deliver the specialist clinical in-reach model we are looking to enhance the current nursing capacity with:

- **3 WTE x Specialist Homeless nurses (Band 6)**
- **1 x Band 6 WTE specialist homeless nurse (OT)**
- **1 WTE x HCA / Administrator (Band 4)**

To assist our specialist integrated homeless team they will have access to a resource envelope to engage rough sleepers in distraction activities and provide access to clothing, personal care items, communication devices whilst in hospital. In addition, the team will have a small resource to cascade their learning and share their specialist expertise so as to improve care co-ordination across the homeless discharge pathway.

2. Non-clinical Integrated multi agency team

a) Housing Co-ordination

With Year 1 OOHCM funding we have appointed two specialist (local authority) Housing Co-ordinators.
We wish to continue these posts in Year 2. The housing co-ordinators will work alongside the specialist homeless nurses and ward staff to provide expert advice on housing, benefits, duty to refer and will ensure appropriate access to local accommodation pathways. They will liaise closely with the Birmingham Housing Options service and its housing teams, as well as step down accommodation services, to provide a flexible 7-day housing co-ordination service that will facilitate timely discharge.

b) Substance misuse Hospital Link worker

An estimated 10% of rough sleepers are frequently admitted to hospital and evidence suggests that many homeless / rough sleepers discharge from hospital due to addiction. The Birmingham rough sleeper substance misuse service identified a gap for a hospital in-reach link worker to operate as a bridge between the integrated specialist homeless team and the rough sleeper substance misuse service. Local information from rough sleeper services suggests a hesitancy to remain in hospital due to perceived variation in approaches to substitute prescribing within hospital settings. This role will seek to ensure the needs of substance dependant patients are identified and will work with the specialist homeless team to advocate for appropriate substitute prescribing, utilise appropriate floating support and distraction activities and ensure needs are met on the day of discharge. The link worker will manage a small caseload of SU's who meet the revolving door criteria. Provide comprehensive assessments and recovery planning (using motivational interviewing techniques) and ensure effective hand over to community substance misuse teams.

c) Community step-down (short term floating support)

The self- assessments identified a gap in end-end co-ordination and continuity of support for homeless patients who were at heightened risk of self discharge, DNA appointments, self-neglect and falling between services. Alongside a team of peer advocates (funded though #HealthNow) the floating support workers will build relationships with homeless patients whilst in hospital settings, making sure they have access to clean clothes, toiletries, communication aides and distraction activities. They will seek to reduce isolation and boredom and connect the patient with peer navigators and in-hospital support services to maintain their engagement whilst undergoing treatment, assessments or awaiting discharge.

In addition to in-reach support, they will provide outreach to patients discharged into our pathways including the Adult transition centre and Summerhill to ensure continuity where trust has been gained. They will maintain support until other services are in place and working well (ideally for between 10 days and 6 weeks). They will 'walk' people to services for example ensuring GP registration and that people attend appointments to support their continued treatment, recovery and wellbeing.

The floating support workers are part of the integrated team and will ensure appropriate liaison with key services such as the vulnerable adults housing and wellbeing services is achieved and in place to prevent inappropriate re-admission to hospital. They will ensure care plans are co-ordinated between agencies and liaise with key workers as needed, to facilitate appropriate and timely handover of support. They will coordinate with the integrated team and key workers to escalate issues of concern that may heighten risk of readmission or risk to tenancy. It is anticipated that at least 1 of the floating support workers have lived experience of homelessness.

Through a personalisation fund, they will ensure people settle into their accommodation (including hotels where these are used) and that people have essential items such as shopping, heating and basic necessities met. The fund will be capped at an agreed limit per patient to ensure the maximum number of patients can benefit.

- **1 x WTE Substance misuse hospital link worker**
- **2 x WTE Housing co-ordinators (currently in post)**
- **6 x WTE floating support / resettlement support workers (across 5 sites**)

3. Residential Step-down (reablement/resettlement)

Summerhill House is a (generic) 40 bed D2A/Step-down unit providing safe accommodation for people from point of discharge. It includes a mixture of studio apartments and shared accommodation with fully furnished rooms. All rooms are disabled friendly, including a range of wet rooms and adapted kitchens. The provision of Summerhill House supports the ability to support a timely discharge of those who are medically fit and homeless.

Summerhill House provides reablement/ rehabilitation to homeless / rough sleeper patients many of whom self-neglect and lack executive capacity. The 2 x housing coordinators will receive referrals and co-ordinate step down transfer into Summerhill house. The in reach to hospital will ensure that referrals are appropriate.

While at Summerhill House the Housing Co-ordinators will support and work with the citizens to understand their long-term housing requirements and work to support homeless housing applications, bidding for properties and supporting their move on back into independent community living.

The additional investment in the integrated team will enable smooth transition from hospital and flexibility for boundary spanning across the discharge pathway to provide:

- Housing assessments, duty to refer, support to move on from Summerhill house – 2 x Housing co-ordinators
- Sessional input from the 1 x Occupational therapists.
- Continuity of care from the hospital nursing team following step down to prevent readmission.
- Substance misuse assessments and recovery planning 1 x substance misuse link worker
- Floating and peer advocacy support to reduce isolation, encourage participation in meaningful activities, build relationships.
- Continuation of floating support into move on accommodation for a time limited period.

4. <u>High Needs (Medical Respite) Residential Step-up/Step-down</u>

Research by King's College acknowledges that current step-down services do not work well for those patients described as 'chaotic, tri-morbid'. According to Dorney Smith, 'These patients have all been rough sleepers at some point, and are chronically, physically and/or mentally unwell with addiction problems (most have alcohol issues, many also have drug issues). They have often received or been offered every service available to them. They are usually already in a hostel or are still rough sleeping despite repeated attempts to engage them with support services. They are often frequent attenders, although they can also be non- engagers. They often leave prematurely or self-discharge and only 'block beds' later as they become more unwell. They need intense informed case management and may need end-of-life care.

Funded through the Next Steps Accommodation Programme and Birmingham city council and opening on 1st March 2020 is a new 11 bed step-up/step-down **Transition Centre** that is designed to test out new ways of working with this population. The service will provide intensive accommodation-based support to aid recovery and healing and support transition into independence. This accommodation will take the form of self-contained or shared units with on-site support provision for a single adult and childless couples over the age of 25 for a minimum of 6 months and up to 2 years, based upon assessed support needs and with achievable move-on options.

A range of services will provide support to residents within the transition centre. Mental health and substance misuse support into the transition centre is co-ordinated through arrangements with the CCG funded rough sleeper mental health service and PHE / RSI funded rough sleeper substance misuse service / rapid prescribers. The primary care homeless service will provide in reach to the service for patients registered with their service.

No additional resources are requested for this service as the increased investment in the integrated multi agency homeless team will enable the increased flexibility and capacity for boundary spanning the discharge pathway to provide:

- Sessional input from the 1 x Occupational therapists.
- Virtual ward round by the hospital clinical nursing team (continuity of care following step down).
- Effective handover to the primary care homeless, substance misuse and community health teams
- Participation in Multi-Disciplinary Team meetings (MDT)'s to prevent readmission
- Time limited floating and peer advocacy support (continuity of care following step down)

Timetable, risks and mitigation

Please provide a headline timetable for delivery that supports your funding request eg, it indicates when posts will be filled/accommodation needs will be met.

If you are seeking funding for posts in 21/22 and/or your proposal places new or different demands on the existing workforce, please describe how posts will be filled and/or the workforce will be supported in the available timeframe

The funding is seeking resources to recruit to new roles. Due to the limited timescales to develop the funding submission, further work will be undertaken to identify and mitigate risks to the recruitment to posts and impact on existing workforce.

Where possible, partners will be encouraged to consider internal recruitments / acting up and secondment arrangements due to the short-term nature of the funding and need to implement the model in year. An indicative timeline is added below but it must be noted, that partner recruitment processes will vary and impact these suggested timescales.

Delivery Timetable:

Date	Action
w/c 22 March	Funding Confirmed
w/c 22nd March	Key partners informed of bid
w/c 29th March	Role recruitment – prepare job descriptions
w/c 12th April	Jobs advertised by partners
w/c 17th May	Interviews take place
17th June – July 21	New staff in post (dependent upon notice periods and banding)
End July 21	Full complement of staff across the model.

If your funding request is reliant on access to accommodation, please describe how this will be made available in the 21/22 timeframe

N/A

Please describe any other identified risks and mitigations that you will put in place

Risks:

If confirmation of the successful award is delayed or the amount requested is reduced:

- This will impact timescales to recruit to posts and deliver the project and realise the outcomes within the financial year.
- Birmingham will not transform out of hospital care for rough sleepers at scale and pace.
- We will not deliver the level of person-centred care envisioned through this proposal.

Please send the completed template to RSHI-COVID@dhsc.gov.uk.

The deadline for template submissions is 4pm Monday 8th March 21.