Department of Health & Social Care

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

Funding proposal for 21/22

Name of project	Nottingham and Nottinghamshire D2A Homelessness

	Please provide details – indicates support for participation in the programme
Geography to be covered	Nottingham City
Lead local authority (funding will be paid to on behalf of the partnership)	Nottingham City
Other local authority partner/s	
STP/ICS	Nottingham and Nottinghamshire
CCG/s	Nottingham and Nottinghamshire CCG
Secondary care provider partners	Nottingham University Hospital (NUH)
Primary care provider partners	GP Practices, CityCare Partnership (community outreach nursing)
VCSE partners	Framework, Emmanuel House
Housing provider partners	
Other	

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

Implementation group will be setup for the bid, which will report to the following:
Nottingham and Nottinghamshire D2A Homelessness Group
ICP Severe Multiple Disadvantage Programme Group, which reports through to the ICP Executive Team.
Nottingham City Council Executive Board
Nottingham City Council Cross Council Temporary Accommodation Group which reports to Chris Henning, Corporate Director, Development and Growth and Cllr Linda Woodings – Portfolio Holder for Housing, Planning and Heritage

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	Rachael Harding Homelessness Strategy and Partnership Manager Health – Naomi Robinson, Senior Joint Commissioning Manager Naomi.Robinson2@nhs.net
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	Rachael Harding Homelessness Strategy and Partnership Manager

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	Health – Naomi Robinson, Senior Joint Commissioning Manager Naomi.Robinson2@nhs.net

Funding sources	**Total**
Total requested from DHSC to deliver OOHC model in 21/22	£245,000
*Please indicate any other **local** funding that will be used eg, six-week NHS recovery funding, Better Care Fund etc. (not MHCLG £)*	
Please indicate if 21/22	
MHCLG funding is required to deliver this?	Yes/No
Sources: eg, NSAP, RSAP, Protect programme, Cold Weather Fund	£
A gap analysis has been completed to identify a cohort of people for whom, current accommodation pathways are not suitable. The measures put forward have been developed to complement existing funding and activity to support people sleeping rough (including that funded separately by Nottingham City Council, the voluntary sector and the Clinical Commissioning Group, and through funds awarded through NSAP, the Cold Weather Fund and Rough Sleeping Initiative.	The OOH programme delivery will form part of wider work to integrate rough sleeper support services and homeless outreach nurses. Particularly relevant are: Hospital Navigator Single Support Navigators
PHE substance misuse funding is required to deliver this?	£
Total cost associated with the delivery of the OOHC model in 21/22	£275,000

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

If yes, have you discussed this yet with the LGA's support team (Better Care Fund programme support)?
Yes, we've support with our local self assessment and in describing our specialist out of hospital model for homelessness

Will the proposal improve outcomes for:

General acute services Yes
Acute mental health services Potentially
Other (please specify)
Reduction in those experiencing rough sleeping

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

Over the last three months a partnership meeting of housing, health and specialist homeless provision have met to undertake a detailed analysis of the current hospital discharge process and its effectiveness for patients who are homeless.
Our system self-assessment has shown that the existing protocols and specialist homeless roles have achieved a partnership approach (i.e. duty to refer is completed by the hospital with education to ward staff and discharges are planned in a multi-disciplinary way, with the support of Hospital Navigator post (City only) and Homeless Health Team
However, the assessment showed that these processes are not always consistently followed and resource is not able to respond in a way that is time critical to the hospital Discharge to Assess (D2A) model. There is also not a mechanism to discharge directly to the rough sleeper pathway and a significant gap in housing options for people who are medically fit to leave hospital but have on-going health need.

There is not regular monitoring of data relating to homeless hospital discharge but a summary of a 3 month snapshot was provided by NUH and SFH to inform the review.

Key gaps and challenges

- Between 10-15 cases per month at NUH and 5-10 at SFH
- Delays in discharge range from 0-30 days with an average 5 days past medically fit
- Delays in identifying homeless patients at ward
- Frequent self-discharge and difficulty managing needs on ward
- The discharge timescales not suitable for short stays
- MDT urgent case review is typically held after medically fit stage
- Complex decision making in relation to agreeing housing priority need (differing thresholds) and discharge to asses clinical pathway
- Delays in accommodation being available (particularly rough sleeper beds)
- Very limited options for no recourse to public funds and those with no duty
- Individuals fall between priority need and rough sleeper shelters (they may be medically fit but have short term clinical needs that need to be met on discharge)
- Hospital ED do not consistently complete the duty to refer
- Patients are at high risk of readmission (some the same day as discharge)
- A need to consider whether a patient has an 'on-going health need' in the context of their wider complex needs/whether they are at risk of rough sleeping
- Difficulty discharging health cases (pathway 2 &3) to Edwin House and Assessment units

Three areas of focus:

1) Simplify access to accommodation routes directly from hospital for patient with no on-going health need (Discharge to Assess pathway 0)e.g. placement to rough sleeper accommodation and to units able to provide 24 hour nursing care if required
2) Put in place specific monitoring of homeless hospital discharges (agree indicators between partners e.g. delay between admission and flagging homelessness, readmission, length of stay)
3) Pilot step down accommodation primary for patients on Discharge to Assess pathway 1 for health stabilisation whilst longer term plans are put in place.

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)

Impact:

- Attendance/admissions avoidance through increased support to hospital ED teams
- Timely transfers of care from hospital, step down accommodation will enable patients with on-going health needs and wider social, housing needs to receive a through and considered assessment
- Reduction in rough sleeping (those returning to rough sleeping after hospital admission)
- Successful hospital stays/harm minimisation and support to maximise the benefit of hospital stay to create sustainable change for the individual
- Avoiding readmissions or ED attendance following a hospital stay
- Reduce the barriers for rough sleepers to receive treatment that would normally be offered in the community/at home by providing an alternative option.

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)

Pilot Step down accommodation proposal

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 Nottingham. The model will identify specialist homelessness roles to provide in-reach to the hospital and achieve vertical integration between our existing community based outreach nursing, Navigator support workers, housing assessment and the Integrated Discharge Team in the hospital.

The proposed model looks to fill in the specific gaps and issues with ensure effective hospital stays and safe and timely hospital discharge for patients who are homeless.

- Increased capacity to provide specialist homeless nursing, advice and education to hospital ward staff
- Increased capacity to case coordinate patients during their hospital stay, discharge planning and to follow up on discharge to ensure longer term health, care and support plans are in place
- Increased capacity to support ED front door with identification and completing duty to refer
- Simplified process to place patients with 24 hour nursing or care needs into suitable out of hospital beds (i.e. Edwin House and County Assessment Units)
- Need for increased accommodation availability to meet the needs of patients leaving hospital with a continued health need
- Need for increased housing assessment and advice resource to enable timely placement of patients to temporary accommodation (including rough sleeper beds)
- Need for accommodation option for people who have no priority housing duty or who have lost their temporary accommodation duty (particularly concerns around no recourse to public funds)

Proposal

To pilot an Integrated step down accommodation model for hospital discharge

This would support people who are homeless and require health stabilisation following a hospital admission. This would be a short stay 6-10 days in a self-contained unit of accommodation in order for health, social, housing, legal and wider needs to be assessed or stabilised.

The proposal is that this is housing managed but funded through either health or a joint funding arrangement. The accommodation would not be funded under the housing statutory duty or be classed as statutory temporary accommodation – however, patients placed there will need support and housing advice re-assessments during their 6-10 day stay.

Options for accommodation are currently limited to bed & breakfast/hotels in line with current temporary accommodation/ rough sleeper accommodation offer but learning from the pilot will need to be assessed alongside plans to develop wider temporary accommodation offer. We will also look to the outcomes of the pilot to indicate whether 'step up' accommodation would bring improved outcomes and system efficiency.

Accommodation resource:

15 units of accommodation across City and County (likely to be hotels at a cost of approximately £50 per

night).
Staffing:
The following additional resources would be needed in order to compliment existing Integrated Discharge Team process and integrate with community based models that are able to in-reach to provide specialist advice to support homeless patients:

- Specialist Hospital Homeless Nursing (1 WTE extra resource likely to be split 50/50 between current providers of in-reach form community based teams- would clearly identified to work in the hospital and prioritise hospital cases)
    - Provide specialist clinical nursing, advocacy and support across NUH sites, SFH and Bassetlaw hospitals
    - Participation in MDT's to prevent readmission
    - Ensure optimal patient care that supports transitions across health, housing and social care boundaries
    - Work across multiple acute sites operating, flexible hours with dedicated ward rounds and resource to IDT for all homeless pathway 1 cases
    - Undertake case management of people with complex needs and ensure discharge into appropriate pathways
    - Provide facilitation of boundary spanning MDT discharge planning between hospital, community teams, to ensure the provision of clinical, therapeutic interventions, assessments, advice and support across homeless pathways from acute into step down / step up and move on.

- Hospital Navigator Support Worker (1 WTE extra resource for City and 1 WTE extra resource for County)
    - Provide 1-1 holistic support to the individual, ensuring they have a personalised housing, health and support plan for hospital discharge and in the longer term
    - Ensure wellbeing needs are met and they are settled (access to food on discharge etc)
    - Provides 1-1 support, day to day planning and support
    - This role will include linking with a range of wider agencies to coordinate care such as substance misuse and immigration services
    - Provide a single point for information, MDT planning and coordination of packages of navigator and nursing to span hospital discharge and step down accommodation
    - Liaise with Housing Teams during the assessment process and to plan the individual's longer term accommodation options
    - Provide advice and support to Hospital ED teams in supporting homeless patients and improving the duty to refer process for those not admitted to wards

- Single System Insight/ Coordination (1 WTE – resource to be shared between City and County
    - Provide central point for monitoring data on discharges for homeless patients (learning and outcomes)
    - Follow up on the effective handover to the primary care homeless, substance misuse and community health teams
    - Virtual team meetings to pull together learning and establish outcomes monitoring the spans discharge, step down bed and long term care plans

Escalate issues with delays in assessment at step down bed

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.

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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

April - Funding Award confirmed
April- June – Advertise additional roles (nurse, coordinator and Navigator)
April-June- Delivery group meetings confirm partnership pathway and monitoring requirements (complete guidance HICM templates)
July- New roles commence
Sept- checkpoint review
Dec- review of delivery model and outcomes

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

The discharge protocol includes an urgent case review stage (MDT meeting), this will continue with housing, health and specialist homelessness teams agreeing a discharge plan for the individual, which includes discussion of available accommodation offers. If at this stage, the individual has no available options for temporary accommodation, the MDT will agree to utilise the OOH interim/step down accommodation funding for a period of one week to enable the individual to be discharged with support to stabilise health, to allow the housing assessment to be completed and advice provided about longer term accommodation options.

In the immediate term we will utilise hotel accommodation pending procurement of 'crashpad' flats and shared houses in Summer 2021.

Please describe any other identified risks and mitigations that you will put in place
The funding is short term and will be reliant on robust data monitoring and on-going case review, learning and discussion about longer term models (resource has been requested for a System Insight/Coordinator to support this).

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

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