HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 29 Brighton & Hove City Council

Subject:		**Update on Better Care Homeless Programme**
Date of Meeting:		**25 March 2015**
Report of:		**Alistair Hill, Consultant in Public Health**
Contact Officer:	**Name:**	**Alistair Hill** **Tel: 29-6560**
	Email:	**alistair.hill@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Overview and Scrutiny Committee conducted a review of hostels in 2014. The recommendations advised that

- Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Overview & Scrutiny Committee note the development of the Better Care programme to improve health outcomes of homeless people and develop an integrated health and care system.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Brighton and Hove Better Care Plan describes how services for our frail and vulnerable population will be improved to help them stay healthy and well, and will be more pro-active and preventative, and promote independence.

3.2 The plan draws on a wide range of experience and evidence of best practice both locally, nationally and internationally, and includes the views of local service users, their families and carers and local stakeholders. In Brighton & Hove a broad definition of 'frailty' has been adopted. As part of this broad approach improving health and care outcomes for homeless people has been identified as a priority.

3.3 Rough sleeper numbers fluctuate but the estimate in March 2014 was 132. The count is always lower and found 41 rough sleepers in November 2014.

3.4 There are approximately 400 homeless households in emergency accommodation, 370 single people in temporary accommodation, 500 single homeless people living in hostels and other supported accommodation, and an unknown number squatting and sofa surfing. Homelessness has increased by nearly 40% from 2010.

3.5 Nationally 13.5% of the general population attend A&E or an outpatient appointment compared to 39% of the Brighton & Hove homeless audit sample who attended A&E or an outpatient appointment (homeless health needs audit 2014). Over a 12 month period it is estimated only 7% of the general population will have an inpatient hospital stay compared to 25% of the homeless audit sample who had been admitted to hospital at least once in the last 6 months (homeless health needs audit 2014). Over 80% of homeless patients report having at least one physical health problem for 12 months or longer. Nationally, the average age of death in the homeless has been estimated as 47 years in men and 43 years in women.

3.6 The Joint Strategic Needs Assessment for 2014 and Brighton and Hove Homeless Health Audit highlighted the poor health and wellbeing outcomes in single homeless people locally[1]. There is a high prevalence of mental ill-health, drug and alcohol dependency and physical health need amongst the homeless. In addition there is high use of unplanned healthcare and low uptake of preventative services. Based on national and international evidence it is anticipated that a more integrated and flexible model of care, based around the needs of individuals rather than services of settings of care, will improve access to planned health and care, resulting in a reduced reliance on emergency and unplanned care, and better outcomes.

3.7 A Homeless Integrated Health and Care Board was established in 2014 with the vision " to improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential". Membership of the Board includes representatives from BHCC (adult social care, housing, public health), the CCG and NHS Trusts, a GP from Morley Street Homeless Healthcare, community and voluntary sector, Sussex Police and service user representation.

3.8 The Board is developing an integrated health and care model for the homeless population of the city by April 2016. A Multi Disciplinary Team (MDT) approach is being developed, led by primary care. This will work alongside service users to provide integrated, co-ordinated and personalised care. Key aspects include:

- Hosting specialist health and related services in a central hub, based around a specialist general practice
- Multi-disciplinary team providing outreach services in hostels and other settings, and inreach services to health services including hospital care.
- Care planning and case management.
- Involvement of service users in co-design of services

[1] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna-6.4.3-Rough-sleepers2.pdf

3.9 Whilst the integrated care model is being developed, care and support to homeless people has been strengthened. Progress has been made in co-ordinating care through establishing multi-disciplinary team meetings and trialling service delivery through pilot projects, including the Sussex Community Trust Hostels Collaborative Project and Pathway Plus projects.

3.10 The Collaborative Hostels pilot project was commissioned following the publication of a Homeless Health Audit conducted by Public Health and Housing in 2013, which highlighted the high level of health needs amongst the city's hostel population. The service is based on a proactive and in-reach model of care delivered by a multi-disciplinary team including nursing, occupational therapy and physiotherapy.

3.11 The team has been supporting service users in hostels with a high level of previously unmet complex health care need across a wide range of physical health and long term conditions. A total of 73 referrals were received in the first 6 months of 2014/15 and 81 residents have received a service. Overall a high level of engagement with health care has been achieved including high levels of registration with GPs.

3.12 The Pathway Plus project (originally funded by Department of Health in October 2013 to March 2014) is improving the care planning and co-ordination of care of homeless people admitted to hospital, and improving discharge care planning and follow up in the community. The project is delivered by a partnership involving Pathway, St Johns Ambulance and Justlife Foundation.

3.13 The project has worked with A&E and hospital wards to improve the identification of those who are homeless and admitted to hospital. For all those identified the team has provided comprehensive care and discharge planning.

3.14 Looking ahead for 2015/16 Better Care funding has been approved to enable the continuation of the pilot projects, and to strengthen MDT working.

3.15 A key priority is securing the links with mental health and substance misuse services. Additional resource has been secured to enable these links to be built over the next interim year, The mental health homeless team will be a key member of the Homeless Primary Care led MDT and will help to develop the psychological model of support and mental health clinical care pathways and standards for the homeless population.

3.16 The new Substance Misuse Services (SMS) contract will be implemented from April 2015 and an integrated model of service delivery is included within the contract. For Dual Diagnosis, four substance misuse dual diagnosis staff will be co-located with the mental health teams, to improve access to treatment and care and to ensure that care is delivered in partnership including: assessment and risk profiling, shared care planning and review. Links with the SMS services including the Dual Diagnosis workers and the Homeless model of care will be built in the next interim year. .

3.17 In 2015/16 a business case for the long term model for homeless care will be developed as part of the Better Care programme. This will be planned alongside the current and future Housing Related Support services commissioned by BHCC. There will also be an emphasis on health and wellbeing outcomes in the retendering process for these services.

3.18 Also in 2015, a pilot is running at New Steine Mews hostel regarding the use of Personal Health Budgets for homeless people, and delivery of health checks (commissioned by Public Health) is being piloted in hostels.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not applicable

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Service user engagement has been central to the development of the developing service model to improve care.

6. CONCLUSION

6.1 A programme of work is underway to support improving outcomes in homeless people including supporting them to stay healthy and well, providing more proactive and preventative services

6.2 The overall aim is to provide a health, care and support package to vulnerable homeless people in a way which extends beyond their accommodation to provide ongoing continuity and ensure information between services is shared to improve the outcomes for people. They will also have a named care coordinator who will be the lead professional and cases will be discussed at weekly MDTs. The work to improve the health and wellbeing of homeless people will be more effective with all agencies working together with a lead professional with improved coordination from Housing ASC, mental health and substance misuse services.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None specifically for this report. Financial implications are considered within the Better Care Programme.

Legal Implications:

7.2 None specifically for this report.

Equalities Implications:

7.3 None specifically for this report. An EIA for the developing model will be conducted later in 2015.

Sustainability Implications:

None specifically for this report.