Greater Manchester Joint Commissioning Board

Date: 20 July 2021

Subject: Homelessness and Health Implementation Update

Report of: Dr Ruth Bromley, Clinical Chair, Manchester Health and Care Commissioning

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PURPOSE OF REPORT:

This report provides an update on continuing work on homeless healthcare and sets out our plans for implementation. It considers the capacity and resource required to ensure delivery and continued influence around this priority area of work into 2022.

KEY ISSUES TO BE DISCUSSED:

Implementation has started on priority workstreams set out in the Homelessness and Health Group implementation plan. The paper provides an update on this progress and sets out where the previously agreed investment from JCB will be aligned to this work. It also looks to confirm ongoing clinical leadership into the programme post March 2022, to support the two year commitment to this work.

RECOMMENDATIONS:

The Greater Manchester Joint Commissioning Board is asked to:

- Note the progress against the delivery plan for this year.
- Note the intention for investment to be aligned to defined elements of the implementation plan and to establish the required clinical leadership.

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1.0 CONTEXT AND BACKGROUND

1.1. Since June 2019, GM Joint Commissioning Board (JCB) and GM Health and Social Care Partnership have made significant investment into rough sleeper programme 'A Bed Every Night' (ABEN), ensuring that throughout the year a bed is available for anyone who wants one. This has formalised a more collaborative relationship between homelessness and health, acknowledging the impact rough sleeping and homelessness has on both physical and mental health and the risk to life of sleeping on the street.

1.2. Extensive discussions through JCB meetings concluded that homeless healthcare is, and should remain, a priority of JCB and our GM system tackling the areas of the biggest health inequalities and a two year programme of investment has been agreed to support this, to March 2023. It has been a long-term ambition of the GM Homelessness and Health Group that any health system investment into homelessness should allow us to support the improvements and reorganisation in the health system that we want to for homeless and inclusion health groups.

1.3. In acknowledgement of this, investment to March 2023 looks to divide the committed funding as outlined in the table below, to begin the transition away from solely funding accommodation, with an identified proportion utilised to support delivery of the GM Homelessness and Health Group ambitions.

1.4. This investment is crucial to us being able to progress key areas of activity, detailed further in this paper. To ensure this momentum is maintained we also need to ensure the right capacity and resource is in place to drive this forward. We also want to ensure that our ambitions are fully recognised by the system, confirm appropriate leadership for the programme and have homelessness and inclusion health secured in the future architecture of the GM Integrated Care System, so we are able to connect this work into the wider focus on health inequalities.

2.0 HOMELESSNESS AND HEALTH ACTIVITY

2.1. The GM Homelessness and Health Group has positioned its work to date on establishing how we create sustainable transformation and deliver system change to reduce health inequalities in our homeless population. Working in this way shifts expectations away from commissioning and provision of a whole system of specialist services for our homeless population, and instead considers how we make existing services more inclusive and build towards a health system, which re-affirms the fundamental rights of homeless people in their access to and interactions with health care.

2.2. The Homelessness and Inclusion Health proposition and associated workplan speak to this aim and confirm where we need to focus to influence inclusive delivery within mainstream services and embed principles of Inclusion Health into services and commissioning practice.

2.3. To support operationalisation of these aims, we have agreed a further detailed implementation plan for this year (21/22), which drills down into the areas we think warrant some immediate attention (Appendix 1). The investment from JCB for 21/22 £100,000 will be utilised to resource elements of this one-year plan, bringing in the right type of capacity where this is the most appropriate route for delivery.

2.4. We have already started to interrogate barriers in key services areas we want to improve. These are the areas we feel we can have most impact and have agreed initial areas of focus for this year as Primary Care, Secondary Care and a Trauma Responsive workforce. We also know there is more to do on collaboration between mental health and substance misuse services and are working proactively with the two GM Mental Health Providers on an appropriate response to this.

2.5. Delivery of activity to support the priorities outlined in the plan is already underway:

- Four pilot models of out of hospital care established, with funding from DHSC, to test 'housing-led' discharge that supports with recovery after a hospital episode, based on research by Kings College London. The pilots cover a range of interventions such as dedicated nursing capacity for continuity of care, step down accommodation with support, mental health discharge coordination and housing options presence in a discharge team. Local and national evaluation of these models will provide the knowledge to develop GM wide delivery and commissioning guidance and to influence change within the system, such as the development of a GM D2A Standard.

- Embarking on a programme of work to identify and empower homeless champions in Primary Care Networks. We have used national best practice and the Faculty of Inclusion Health standards as the framework to describe what good looks like in experiences with General Practice. Engagement is planned with Primary Care Providers and Leads to inform how this can be embedded.

- Aligning our work with that of the Trauma Responsive GM programme and proactively engaging with the workstreams established through this programme to share learning, ensure our work on homelessness is visible and that we are able to use any opportunities arising from this to have a more comprehensive trauma informed response for our homeless population. We are proactively identifying and engaging with parts of the system that would most benefit from testing out trauma responsive approaches.

- Ensuring ongoing connectivity to wider homelessness work through GMCA and localities, supporting workstreams on Homeless Families and engaging with development and implementation of the Homelessness Prevention Strategy.

2.6 There are specific elements of this plan that will be supported by the JCB investment and bring forward deliverable products:

- We will utilise the Trauma Responsive GM workforce development framework to buy in specific training targeting at the frontline health and homelessness workforce.

- We will work with GMHSCP Primary Care Transformation Team and VCSE partners to invest in the development and scope of the PCN Homeless Champions offer.

- As part of this, we will also invest in our specialist homelessness GP practices to create a workforce development offer which is aligned to the PCN Homeless Champions.

2.7 Alongside the themed activity captured in the implementation plan, we are continuing to support any activity in relation to Covid-19 and homelessness including the roll out of the vaccination programme to people experiencing homelessness.

2.8 We also want to take a more proactive role in marshalling the health and care system to play a role in our plans and implement change within localities. We intend to reinvigorate the network of locality Homeless Health Leads to do this.

3.0 LEADERSHIP AND GOVERNANCE

3.1. Going forward, there is a need to consider how we need to resource this activity long term in a way that demonstrates our commitment to the agenda, so we are able to maintain momentum, the high profile of the work and confirm the right leadership in this space. Activity to date in support of the work programme has been resourced and supported through capacity from GMHSCP, Joint Commissioning Team and volunteered clinical leadership but something more formal is needed so that we are able to influence in the right places to bring about change.

3.2. Clinical leadership is currently provided through Manchester and Stockport CCG Clinical Chairs voluntary time. From April 2022, the transition to a GM ICS means these roles will no longer be in place and there is a need to confirm ongoing clinical leadership into the programme. To do this we will develop a role specification for a clinical lead for homelessness for the period April 2022 – March 2023 with an investment of two sessions per week

to support the programme. Recruitment to this post will give much needed formal and dedicated capacity to the programme. A proportion of the Year 2 £400,000 funding will be utilised to support this.

3.3. Ensuring the right connectivity into the wider homelessness governance and health system governance is crucial to embedding these ambitions in wider strategies and plans and ensuring recognition of the work and connecting it into other areas which it should be connected to.

3.4. The group has well established links into the GM homelessness governance through the GM Homelessness Programme Board, other operational groups and relationships with GMCA. We are seeking to replicate this relationship on a more formal basis within GMHSCP, for homeless healthcare to have a clear route into current governance at the highest level and to establish closer links with the GM Population Health Board. It will also be important to secure a place for this agenda in the future architecture of the GM ICS as it emerges and suggest this is through representation on the appropriate Boards and formalised reporting into any structures around health inequalities and inclusion.

4.0 RECOMMENDATIONS

4.1. The Greater Manchester Joint Commissioning Board is asked to:

- Note the progress against the delivery plan for this year.
- Note the intention for investment to be aligned to defined elements of the implementation plan and to establish the required clinical leadership.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Appendix 1.

GM Homelessness and Health Group - 2021/22 Implementation Plan

This Implementation Plan confirms the activity the GM Homelessness and Health Group will oversee and support during 2021/22, reflecting the longer-term ambitions set out in the 'Commissioning for Inclusion – Homeless Healthcare' paper and overarching workplan. The activity outlined here has been informed by the Group, setting priorities for this year and supported by the Faculty of Inclusion Health.

Theme – Commissioning for Inclusion Plan	Actions	Timescales	Stakeholders / Partners
Primary Care To continue our locality-based discussions, data-gathering and creation of agreed standards, principles & with colleagues providing frontline care Inclusion health commissioning standards as a guiding framework.	• Reinvigorate previous work on GP registration for people experiencing homelessness, informed by the Faculty for Inclusion Health standards. - Scope PCN Homelessness Champions offer - Engagement with Providers on implementation - Comms and marketing materials • Explore with primary care options for appropriately coding patients who are homeless • Engagement with Primary Care Networks on use of Additional Roles Reimbursement Scheme (ARRS) posts and the value of care co-ordination • Explore opportunity for contract variation through the DES to allow for a focus on homeless and inclusion health groups	Q1 – Q2	Primary Care Transformation Team GP Providers Communications and Engagement Team
Trauma responsive workforce Building on progress	• Work alongside the Trauma Responsive GM programme and their comprehensive training package to develop the understanding and skills of front-line health and care colleagues in delivering services and supporting clients with	Q1	Trauma Responsive GM MHCC

already made in this area, put education and learning opportunities at the centre of empowering our cross-sector homelessness colleagues To role model and insist upon a Psychologically-informed approach that extends to everyone working within homeless healthcare	complex needs in a trauma responsive way. • Roll out training activity to front line health and care staff with a particular focus where we believe barriers to accessing services regularly present themselves. • Share examples and impact of utilising ACE scores as a viable index of need in risk stratification for treatment.	Q3 – Q4 Q1 – Q4	
Secondary Care Work with the Faculty of Inclusion Health, & local experts, utilising international evidence, to design a clinical model for specialist healthcare, drawing in holistic, pan-sector discharge planning. Scoping out the development of step-down 'respite' beds for people who are homeless and needing time to recover after acute hospital admission, before onward	• DHSC 'accommodation-led' hospital discharge pilot to understand the effectiveness of interventions to support hospital discharge for people experiencing homelessness (Salford, Manchester, Bolton, Oldham) including Covid-19 positive discharge accommodation (Covid Care). • Evaluation of Covid Care and 'accommodation-led' discharge pilots. Outcomes to be shared with senior commissioners and system leaders. • Development of guidance and standards to support commissioning of specialist healthcare and accommodation that supports effective discharge. • Explore A&E interactions, presentations and access to support in that setting. Formally share existing best practice models in GM.	Q1 – Q4 Q1 – Q4 Q3 – Q4	Providers and commissioners of secondary care Urgent and Emergency Care DHSC and LGA

transfer to accommodation			
Mental Health Engagement with providers and stakeholders in the mental health and homelessness systems. Commitment to describe and perpetuate what we do well and to the honest interrogation & eradication of barriers. Inclusion Health commissioning standards as a guiding framework across mental health and substance misuse.	• Adopt our work around mental health as an overarching strategic aim to influence commissioning and service delivery. • Formal sharing of Faculty of Inclusion Health guidance with mental health providers to understand best practice, gaps and actions required in relation to these standards. • Engage with and challenge the Provider Collaborative on its response to mental health and substance misuse for inclusion health groups. • Explore opportunities presented through shifting in commissioning infrastructure and practice to embed inclusion health principles into core standards for Mental Health and also substance misuse services.	Q1 Q2 – Q3 Q1 – Q4	GMMH Pennine MH Trust GM Provider Collaborative GMCA - GM Substance Misuse Lead / Substance Misuse Review / Public Sector Reform
National and Regional lobbying	• Championing the potential to utilise socio-economic vulnerability and homelessness as a risk factor in prioritisation for treatment. • Regionally – prioritisation within elective care (Cath Briggs) • Nationally – to scope opportunities across all NHS treatment (Ruth Bromley)	Q3 – Q4	NHSE /NHSE NW