NHS Standard Contract 2015-17

Homeless Peer Advocacy and Co-ordination

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Temp/perm registration – meds

Service Specification No.	<Insert>
Service	Homeless Peer Advocacy and Co-ordination
Commissioner	Central London, Hammersmith & Fulham and West London CCGs
Provider Lead	
Period	January 2017 – March 2018
Date of Review	<Insert>

1. Population Needs

1.1 National and London context and evidence base

National –

- Homelessness in the UK is rising. For example, the number of rough sleepers has increased by 27% in London and 31% in the rest of England, since autumn 2014 [DCLG February 2016]
- Recent research shows that homeless people are 8 times more likely to die than similarly aged people in the general population, due to increased death rates across the spectrum of disease categories. It is, therefore, to be expected that this highly co-morbid population will have substantially higher health care costs than other groups
- Homeless people, because of their chaotic lifestyles and range of complex needs, are less likely to be registered with a GP Practice. As a consequence, they are likely to attend A&E five times as much, stay three times as long and cost up to eight times as much as the general population
- High numbers receiving hospital treatment were discharged onto the streets without their underlying issues being addressed
- Homeless people typically present as multi-morbid with a 'tri-morbidity' of physical health, mental health and substance misuse issues. The combination of issues makes presenting complaints extremely hard to assess and treat. It also adds to the complexity of any long-term chronic management. Very often they are lost to follow-up or are unable to complete a course of treatment [Department of Health 2010]
- 1in 3 have latent TB, 1 in 5 has Hepatitis C and 1 in 100 has HIV
- A significant number are care leavers and an increasing number have a learning disability
- As a result of their multiple morbidities, homeless patients are often challenging to manage in primary care and are often unable to access primary care effectively. This has been addressed by the pan-London programme commissioning "My Right to Access" cards

London –

- London now accounts for more than a quarter of all people sleeping rough (26%)
- During 2014-15, 7,581 people spent at least one night sleeping on London's streets, equating to a 16% rise on the previous year and more than double the figure of 3,673 counted

in 2009-10
- London's statutory homelessness acceptances have gone up by 80% over the last 4 years

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1.2 Local context and evidence base

The local, tri-borough data from Homeless Link supports the national and London-wide trends, showing that the number of people sleeping rough has increased considerably in each borough in 2015-16. In each area, the majority of street homeless are comprised of male, 26-45 year olds, a large percentage of whom have alcohol and/or mental health conditions. They are primarily from the UK, as well as other Central and Eastern European countries.

Westminster has 36% of London's rough sleeping population, the most of any London borough and the highest in the UK

The Sustainability and Transformation Plan (STP), that sets out how North West London will deliver our shared ambition to enable people to live well and be well, specifically points to an intention to reduce homelessness in its 'Radically upgrading prevention and wellbeing' delivery area.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Locally defined outcomes

2.2.1 Standard, tri-borough peer advocacy service

a) Increased GP and dentist registration amongst the homeless population
b) A decrease in the number of 'Do Not Attends' at all appointments linked to this population group
c) An increase in the number of homeless people being able to understand and manage their health and wellbeing independently, through improved co-ordination and access to education and prevention
d) Service users with deteriorating conditions are recognised early and linked into primary care and other services
e) A reduction in homeless service users being admitted/ being re-admitted to hospital
f) High service user satisfaction with the service provided
g) Service users' interests and welfare is safeguarded
h) An increase in the number of opportunities provided to homeless service users that will enable them to become advocates for others and to progress into paid work

2.2.2 Central London CCG targeted peer advocacy service

a) A decrease in hospital attendance and activity for "hard-to-reach" homeless people
b) A decrease in hospital attendance and activity for frequent attenders living in homeless hostels

c) An increase in Patient Activation Measure (PAM) scores within the population

2.2.3 Central London CCG - ICN Support

a) Enable service users to access the right care, in the right place, at the right time
b) Potential service users are identified as early as possible after being admitted to hospital, their eligibility determined and a discharge process to the service begun
c) Service users with deteriorating conditions are recognised early as potential service users with a view to preventing a hospital admission
d) Service users have convenient access to high quality, holistic care
e) Service users are assessed and have a single care plan identified that is reviewed and amended regularly and takes account of their future well-being and ability to manage/ their move-on plan
f) Service users are discharged from hospital earlier than they would otherwise have been
g) There is a reduction in non-elective attendance and admission rates amongst homeless service users
h) Every opportunity is taken to link Service users in with other services, maximise engagement and address holistic needs
i) Service users leave the service fully recuperated and better connected with clinical and other services
j) Service User satisfaction with service provision is captured
k) Service users are discharged back to the streets where a viable move-on alternative is not identified

3. Scope

3.1 Aims and objectives:

3.1.1 Standard, tri-borough peer advocacy service

a) To support 240 contacts in Central London; 260 in H&F and 200 in West London to attend their primary care and hospital appointments
b) To promote health and well-being to the homeless population for 140 people in Central London, 180 in H&F and 120 in West London per year
c) To reduce health inequalities amongst the homeless population
d) To support and constantly promote early intervention and prevention
e) To support homeless people to access and engage with specialist and mainstream primary care health services, in order to address their health needs, thereby leading to a reduction in A&E attendance and unplanned acute admissions
f) To help address broader aspects of homelessness that may impact on the health of individuals
g) To ensure homelessness services provided by the CCGs are appropriate and acceptable to the patient group by providing feedback on where problems and gaps exist
h) To empower homeless clients to become peer advocates themselves and to provide a structured programme of support to advocates to enable them to take up long-term employment opportunities

3.1.2 Central London CCG targeted peer advocacy service

a) To proactively engage with individuals
b) To work with the specialist GP Practices, the Joint Homelessness Team and the Homeless Health Team (HHT) to engage with “hard-to-reach” homeless people and those who are high users of hospital services
c) To link closely with homeless hostel staff to engage with hostel clients who are high users of hospitals, with a view to bringing the patients to the practice instead of the hospital
d) Work towards ensuring that all targeted clients are on the caseload and being managed by the Practices, the Integrated Care Network for Homeless Health and that all

discharged ICN patients are on the standard peer advocacy caseload, where required

e) To actively work to reduce A&E attendance and NEL admissions amongst this population

3.1.3 Central London CCG - ICN Support

a) To proactively provide a support service to ICN patients and homeless hostels, with the following staff: The Project Manager (1WTE); supported permitted work project worker (0.8WTE). These will be further supported by the Tri-borough The Project Manager (0.1WTE); Admin (0.2WTE) and Director of Advocacy (0.05WTE)

b) To have a base in and work for the two dedicated homeless Practices to provide admin support to the ICN, including tracking patient stay data and outcomes, the management and oversight of hostel invoice processes, setting up MDT meetings and ICN staffing rotas

c) To contact hostel colleagues, at GP direction, to arrange and co-ordinate intermediate care beds for patients, ensuring that service users are taken to hostel beds and settled in

d) Act as the point of contact into the Practices for individual service users and hostel staff

e) To work with the GP Practices to provide an assessment of client needs, ensuring they are linked in fully to advocacy and peer support, during and after intervention, as needed

f) To liaise closely with hostel key workers to determine roles and responsibilities with regard linking service users with social services, housing teams and other appropriate services, as well as supporting access to benefits and also ensuring that reconnection options are fully explored

g) To interrogate clinical systems to proactively find potential appropriate service users

h) To oversee joint multi-disciplinary group meetings across the two homeless practices and one practice-based meeting for each of the two practices every month

i) To ensure that all parties contribute to a single, active care plan for each individual

j) Ensure that ICN actions are followed through and outcomes for service users are achieved

3.2 Service description/care pathway:

3.2.1 Standard, tri-borough peer advocacy service

The Provider shall offer a one-to-one engagement service for all street homeless people and homeless hostel-dwellers across the tri-borough CCG geography, to enable them to make, attend and get value from health appointments.

This includes:

- giving people practical support (such as help with travel fares, reminders and accompaniment to appointments)
- providing support in registering with a GP
- helping prepare people for appointments and, where appropriate, with understanding the content of the appointment
- explaining the roles of different professionals in the health service and enabling co-ordination of appointments
- helping individuals secure access to services
- safeguarding against individuals being disadvantaged or discriminated against because of their homelessness

In addition, peer advocates shall focus on building the skills, confidence and knowledge that will enable clients to access health services independently and appropriately.

The provider shall also work with people to put an increasing emphasis on maintaining wellbeing and preventative care, through offering health and well-being promotions, rather than the use of hospital care at points of crisis. These sessions shall be held across homeless hostels and day centres in the tri-borough and will be targeted around any identified health

needs established through feedback from service users, hostel staff and health audits. The provider shall build strong links with community health services (such as substance misuse, mental health, community physical health services) to help make these sessions focused and effective.

The Provider will support their volunteers' progress towards employment by providing a cohesive, person-centred programme of support and coaching that builds self-reliance and self-determination. This includes one-to-one management, group clinical supervision, access to an employment coach, full volunteer expenses, a progression bursary and an extensive bespoke training programme.

3.2.2 Central London CCG targeted peer advocacy service

The Provider shall employ an experienced advocate to work closely with Central London CCG's homeless Practices, Integrated Care Network for Homeless Health, Joint Homelessness Team and CLCH's Homeless Health Team (HHT) and attend multi-disciplinary team meetings, where appropriate. The advocate will work with specified individuals who will be either "hard-to-reach" or high intensity users of hospital services who are not in regular contact with the GP Practices but who have extensive numbers of non-elective admissions and A&E attendances.

Using CHAIN data, coordination with street outreach and hostels, as well as relationships with existing informal street networks, the Provider shall pro-actively seek out these individuals. They will then work to engage and build relationships with them, before offering accompaniment to appointments and linking them in with Central London's specialist homeless Practices and the Integrated Care Network for Homeless Health service (ICN). The ICN will seek to better manage the care for these patients, through providing fast-track care, putting in place a single care plan across organisations and utilising intermediate care beds, with a view to preventing hospital admissions and attendances.

The Provider shall also offer additional support and link the individuals in to other appropriate services, to resolve any non-health issues which may be acting as obstacles to accessing planned health services.

Once the targeted clients are identified and linked in with the ICN, the Provider shall continue to provide standard advocacy services to them, as needed.

In addition, the Provider shall be a point of contact for homeless hostel staff in the CCG area who have clients with urgent but non-emergency, health needs. The Provider shall undertake to visit the hostel with a view to ensuring the person attends a GP Practice or other primary care setting instead of A&E.

3.2.3 Central London CCG - ICN Support

The provider shall provide all necessary administration support to the ICN pathway – from supporting the clinical lead for each Practice to direct staffing resource, to managing MDTs, arranging beds for service users, liaising with hostel case workers, tracking all information relating to bed usage, patient outcomes and hostel invoices. The provider shall also take service users to the beds and provide advocacy services, as needed.

Staffing rotas

The provider shall help the two Practices ensure that weekly staffing timetables are compiled in line with MDT discussions and decisions made re: in/outreach and clinical support needed for service users in the hostel beds.

MDTs

Staff shall organise and oversee a joint Practice, monthly MDT meeting, rotating the venue between the two homeless GP Practices. In addition, it is expected that the Project Manager/Worker shall attend a monthly individual practice MDT meeting at the individual Practices. The service is expected to arrange, attend and oversee all administrative elements associated with the MDTs, such as room booking and issuing invitations and agendas. It is not

expected to chair the meetings.

Beds/Liaising with hostel workers
Staff shall act as the point of liaison for hostels, organising bed stays and taking service users to the beds and helping them settle in, as needed.

The Project Manager/Worker shall ensure that patient consent has been obtained, that clinical systems are updated and that a single care plan is in place for individual patients, with a clear line of primary care escalation identified and articulated to the hostels. They shall also liaise with hostel colleagues to arrange a division of activity relating to the support and move-on of each service user.

Tracking Information
All stays and patient outcomes will need to be tracked to enable the Practices and the CCG to monitor progress and return on investment.

Support
The Project Manager will need to build solid relationships with the various agencies associated with working with the homeless population in Westminster and will need to advocate on behalf of the service user.

The Project Manager/Worker will need to liaise with the JHT, Social Care and reconnection services, as required, and arrange benefits provision, as needed.

Provision
The service needs to be flexible and responsive, be able to cover any absences/annual leave and provide support to colleagues, as necessary. The service will need to be provided Monday to Friday 9am – 5pm.

3.3 Population covered

The standard service shall be available to all street homeless people across the tri-borough CCG geography.

The enhanced, targeted service shall be available to specified Central London CCG homeless people. It shall also be available to hostel-housed clients.

3.4 Any acceptance and exclusion criteria and thresholds

All street homeless and hostel dwellers within the three CCG geographical areas are accepted into the standard service. This includes those who are registered and those who are not but living in the area. Contacts shall be made in accordance with contractual agreements.

Homeless clients who do not live within the tri-borough and/or are not registered with a GP within the CCGs' geography, are excluded.

For the enhanced service in CL CCG, the acceptance criteria will be determined by the two homeless GP Practices, the Joint Homeless Team, the Homeless Health Team or the Integrated Care Network MDT. It will also include hostel-housed clients who have a health need that need encouragement and assistance to attend their GP Practice, rather than go to A&E.

3.5 Interdependence with other services/providers

The Peer advocates shall establish strong relationships with a range of stakeholders, including, but not limited to, those listed below:

a) GP practice staff: in particular, GPs, practice managers, practice nurses, practice counselors and primary care Out of Hospital Services

b) Homeless hostels and day centres
c) Community services, such as podiatry and cardio-respiratory
d) The Integrated Care Network (ICN) team and the Homeless Health Team (HHT) in Central London CCG
e) The homeless peripatetic nurse in Hammersmith & Fulham CCG
f) EASL
g) Secondary mental health services including ABT, Recovery, Older Adult and Home Treatment Teams and Emergency Duty Teams within Central & North West London NHS Foundation Trust (CNWL), the Tavistock and Portman NHS Foundation Trust (T&P), Camden & Islington NHS Foundation Trust (C&I), South London & Maudsley NHS Foundation Trust (SLaM), Joint Homeless Team
h) Relevant voluntary sector organisations
i) Psychological therapy services, e.g. CNWL IAPT service, GP practice counseling services, voluntary sector counseling services
j) City Council Social Services
k) City Council Homeless Outreach Services, day centres and hostels
l) City Council Housing Options Service
m) Job centres
n) Drug and Alcohol Services
o) Sexual health clinics
p) Local community pharmacies

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

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a) NICE Guidance Common Mental Illness (CG123)
b) NICE Guidance Anxiety: (CG113)
c) NICE Guidance Depression (CG90)
d) NICE Guidance Obsessive Compulsive Disorder (CG31)
e) NICE Guidance Post Traumatic Stress Disorder (CG 26)
f) Relevant NICE standards, e.g., on schizophrenia, medication
g) Psychosis: NICE Clinical guideline, (CG 178, 2014).
h) Bipolar Disorder: NICE Clinical guideline, (CG38, 2006).
i) Borderline Personality Disorder: NICE Clinical guideline, (CG78, 2009),
j) Anti-social Personality Disorder: NICE Clinical guideline, (CG77, 2009).
k) Schizophrenia Disorder: NICE Clinical guidance (CG82, 2009)
l) Care Quality Commission Regulations on Cooperating with other providers: Outcome 6 (CQC Quality and Safety Standards 2010)
m) Care Quality Commission Regulations on Safeguarding and Safety: Outcome 7(CQC Quality and Safety Standards 2010)
n) Working Together to Safeguard Children (2013)
o) Care Act 2014
p) NHS Constitution (in respect of complaints management)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

a) World Health Organisation: The Mental Health Context htttp://www.who.int/mental_health/policy/services/3_context_WEB_07.pdf
b) Information Governance Toolkit https://nww.igt.hscic.gov.uk/

4.3 Applicable local standards

As set out in Schedule 4

4.4 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

a) World Health Organisation: The Mental Health Context
htttp://www.who.int/mental_health/policy/services/3_context_WEB_07.pdf
b) Information Governance Toolkit https://nww.igt.hscic.gov.uk/

4.5 Applicable local standards

As set out in Schedule 4

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

Not applicable

6. Location of Provider Premises

The advocacy service will be provided from street, hostel and GP Practice settings so as to develop effective relationships with the street homeless population and close working relationships with homelessness workers. Clinical support and guidance will be provided by the GP Practices within each CCG area, as needed.