Homelessness Multi-Disciplinary Team
Operational Document

1 Introduction

1.1 The Covid Pandemic has been challenging on many levels, but it has also provided opportunities to bring health, housing, and social care practitioners together to work with people who are homeless in the BCP Council area. Learning from the work of many professionals working across the system the time is right to develop a multidisciplinary team and Homeless Inclusion Centre, likely to be based at St Stephens.

1.2 St Stephens will be a location for people who are homeless in the BCP Council area to attend and access health, housing, social care and drug and alcohol advice support and treatment.

1.3 The multi-disciplinary team (MDT) will be made up of various professionals from several different employing organisations. The people involved are the people who can meet the multifarious and often complex needs of homeless clients.

2 Vision

2.1 The vision of Homeless Inclusion Multi-Disciplinary Team operating out of St Stephens is:

The Vision

Vision Statement

The Homeless Health Inclusion service will work to deliver a holistic, person centred service that aims to meet homeless peoples health housing and social care needs. The service will be inclusive and provided with compassion, understanding and all members of the Multi-Disciplinary Team will work consistently, honestly to develop trust with anyone who attends or has contact with the service.

Aims and Objectives

- Any homeless person coming into contact with Inclusion Health Service will receive a person centred response to their health, housing and social care needs
- The service will support people to access health, housing and social care support until such a time that they are settled in secure accommodation (including hostel or supported housing) and can access mainstream services.
- The service aims to support people toward settled accommodation away from a life on the streets.
- The service will help to break cycles of homelessness and hospital admissions by providing a responsive support service.

3 The purpose of the Inclusion Centre

3.1 The centre at St Stephens will provide a base for the MDT and provide a safe place for people who need the MDT's support to visit and access the help of one or more professionals working in the team.

3.2 The centre will have reception, tea and coffee making facilities, showers, lockers, washing facilities e.g. showers and washing machines. It will also have space for staff to work on laptops etc. The centre may also be able to provide access to Computer for the clients who attend the centre.

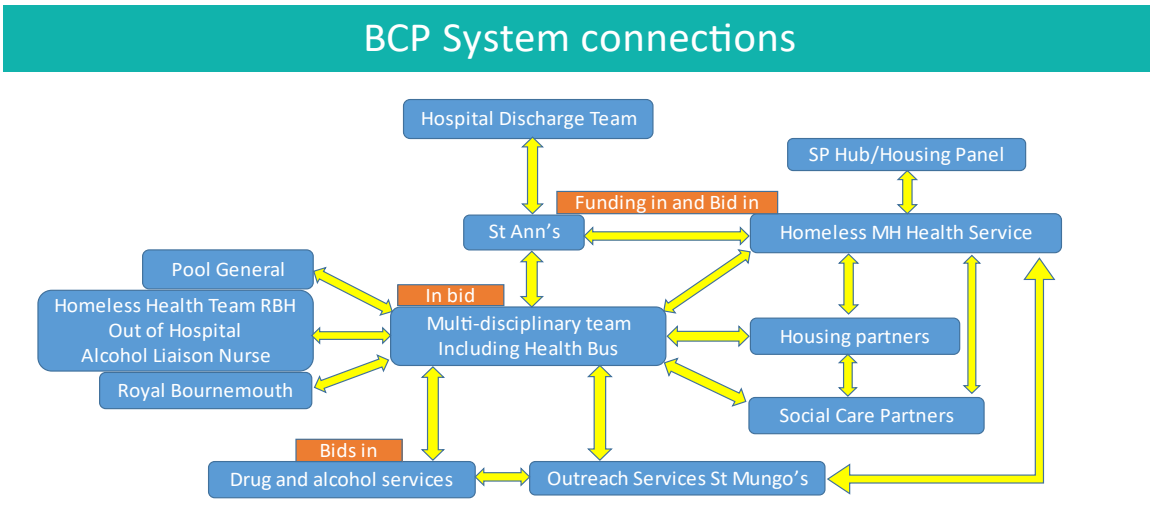
3.3 There will be clinic and meeting room space for the MDT to meet at least once a week and provide space for agreed sessions at the centre during the week.

3.4 The centre will have spaces where confidential conversations can happen privately and safely.

4 System approach including Out of Hospital, Mental Health, Drug and Alcohol Services and Housing options

4.1 The work with people who are homeless needs to happen across a system so that at whatever point the individual is at the response is right for them. So for example the first interaction might be on the street or in hospital and wherever that person is contacted is where their ongoing support starts.

4.2 There are several interfacing services that could feature in the support of the homeless individuals across BCP. The diagram below shows some of the key areas of interface and development with funding bids in place. Note that social work roles are being funded through RSI and Out of Hospital bids and to be included in future funding discussions:



4.3 As seen above there are several areas of work in development that might be touch points for people who are homeless. To ensure the most effective pathway using available funds in the most effective way possible way, all strategic partners will work together around a single plan for an individual regardless of where the person enters the system.

4.4 The pathway for any homeless client may have multiple entry points e.g. emergency department, psychiatric liaison, sec 136 under MH Act, housing department, street outreach and so on. Regardless of entry point the recording and care planning is the key central driver for all subsequent contacts.

4.5 For example someone in hospital being treated for an ulcer and infection, they will have a hospital treatment plan and discharge plan that should involve ongoing care/support perhaps in supported housing or perhaps via the Homeless Inclusion MDT. The shared care plan is crucial to ensure that the individual is supported consistently as this will enable all partners to support the individual based on a plan regardless of where or how the person is followed up.

5 Support available at the Inclusion Centre

5.1 The support available at the Inclusion Centre (IC) (St Stephen's) will have a strategic coordinator that is being funded in relation to the Out of Hospital developments. The MDT will also be likely to include:

- Housing advice
- Access to MH accommodation or other supported housing and floating support to support tenancy sustainment and other support concerns
- Access to GP and Nurse Practitioners
- Access to medical practitioner with special interest in MH and D&A including prescribing
- Mental Health support and treatment pathways
- Drug and alcohol advice support and treatment
- Hep C and other nurse specialists
- Access to out of hospital support where a person has been an inpatient in University Hospitals Dorset
- Street outreach support
- Social care assessments and support
- Potentially podiatry and dentistry

Other partners

- Dorset police vulnerability unit
- Faithworks
- Joint Response Vehicle
- Access Mental Health for crisis support

- As the centre is established there may be other partners such as CAB and Job Centre Plus Link Worker to Faithworks (Stay Safe & Sleep Safe & activity-based recovery programmes) and other similar organisations.
- CAB / Benefits support / No Recourse to Public Funds NRPF / immigration status advice

5.2 The table below is an example of sessional work into the IC. A weekly timetable based on sessions or chunks of time when different professionals can be available to clients. **The table below is an example only** and will be agreed by all partners based on what people know about busy times and type of needs that arise during a week etc. The final version (with changes as needed) will be agreed and signed off and included in the MOU that we develop as the MDT starts to take shape.

5.3 **Timetable of service availability hours of operation**

Open Monday to Friday 9am-5pm and it is proposed that sessions are either morning or afternoon and there is a query about the merit of some extended hours?

The timetable below is an example of how the service could operate and requires partners to comment on and suggest other options before we agree how the life of the MDT works.

It is likely that loose appointment slots will work so that for the client group there is flexibility within the service to support people to engage with health and other professionals working with the clients.

The key component in terms of managing access to the team members is the reception and welcome and triaging to understand what the person is attending for. It may be to test the waters in terms of engaging with health or other professionals or it might be for a scheduled appointment or group. The key is the welcome and the reception.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
9.00 - 12.30	GP, Nurse Drug and alcohol staff	GP, Charity, Housing	Nurse Practitioner Housing and Charity	MDT Meeting- all present in person or virtually.	GP and nurse
13.00- 17.00	Mental Health, Housing officer	Social worker Housing, Hep C nurse	GP and Mental Health and drug and alcohol	Charity and Mental Health, Drug and alcohol Nurse	Housing Charity

6 The MDT Approach and expectations

- Each member of the MDT will work within the bounds of their professional expertise and share the expertise with other members of the MDT to ensure continued learning and development of best practice.
- Any member of the team can be the lead case coordinator for an individual, the aim is best fit/match for the person and their bespoke needs. The lead case coordinator will be nominated at the weekly MDT meetings.
- Each team member agrees to attend either in person or virtually a team meeting once a week on an agreed day.
- Each team member will agree to be at the IC for their agreed sessions during the working week, Monday to Friday.
- The MDT will be chaired by a member of the MDT and the chair will operate on a rota basis so that all MDT members can share the responsibility.
- The MDT will have administrative support to ensure action notes re all client discussions are recorded and shared with the team members. All team members are responsible for ensuring their own agency databases are updated with all relevant information actions and risks.
- Discussions are always likely to include new homeless people and likely to discuss ongoing issues related to client being supported by the MDT especially if plans are not working in the way it was hoped or where a person's circumstances change.
- The MDT will decide about which service is best placed to take the client, for example drug and alcohol service or MH service. If taken on by drug and alcohol Service or Homeless Health Service, the service owns the responsibility for the case but will feed back to the MDT routinely or as requested when other issues arise. It is expected that even if a case is taken on by a specific service that partnership with MDT and information sharing will occur between the service and the MDT This approach will enable a shared care approach and support access to other support as needed.
- At some point clients will be closed to the MDT most likely because they move on, perhaps in to settled accommodation or away from the area. The MDT offer will not provide indefinite support, so the support or care plan needs to have actions and plan for exiting the service.
- Flexibility will be embedded into the MDT approach to ensure the best support for the client and care plans and exit plans tailored to the individual's needs.

7 Staff commitments to the MDT and to the system

7.1 In the first stage of developing the MDT and in relation to the system diagram (4.2) there are a lot of different partners and different employing organisations. Each practitioner who works at the IC as part of the MDT response is likely to be employed in one of the partners organisations with terms and conditions applicable to each organisation.

7.2 Each member of staff working into the MDT will be expected to fit into matrix management approach so, in relation to clients of the MDT the person will be accountable within the MDT for their work with that person. If there are, supervision, management or disciplinary or performance issues these will remain with the employing organisation.

7.3 Supervision in relation to MDT clients will happen within the context of the MDT, for example plans and decisions about an MDT client will be agreed in the MDT meetings. There will be joint reflective sessions for the team as it is established.

7.4 If a client It is subsequently taken on by a service due to their needs the worker will feed back to the MDT to update on progress. For example someone may be taken on by We are With You or a Community MH Team. This will depend on whether the person is still homeless or in TA/EA or whether they are stable in the nominated provision. As someone on a script would be within the prescribing service but they could be still rough sleeping.

7.4 Any individual case supervision required linked to MDT clients will be in line with professional standards so for example nurse practitioners will be supervised by people who are also medically trained e.g. nurses or GP. MH or Drug and alcohol staff will be accessing supervision from people of similar professional backgrounds.

7.5 It is expected that employing organisation will continue to provide the business-as-usual supervision where there are existing posts and where new roles are being trialled such as the social work roles supervision and line management will be under a temporary arrangement.

7.6 There will be a memorandum of understanding underpinning the partnership working arrangement including commitment to using the IC as a base on agreed days.

8 Commitments to staff working as part of the MDT approach

- Reflective practice approaches
- Good quality supervision that matches professional role within the context of MDT
- Respect for the professional expertise of each partner in the team
- Shared learning and development that enhances the partnership and the approaches working to working in homelessness
- Commitment from partners to provide shared training to upskill whole team

9 Criteria for MDT

9.1 The criteria for individuals to access the Inclusion Centre or MDT staff are:

- Homeless on the streets in the BCP council area; or
- Living in insecure accommodation such as B&B or hostel provided during the lockdown; or

- At imminent risk of homelessness; and
- In need of health, housing or social care advice and support

9.2 Non engagement will be an issue and people may exclude themselves if they are unable to engage. The purpose of the MDT and St Stephens and the Health Bus as the assertive outreach component of the MDT service is to target individuals where they have not engaged or where they have stopped engaging. If someone stops engaging there will be an agreed period of active and assertive outreach to try and engage the individual. The ambition of the MDT is to provide support for homeless people who may feel unable to access the care and support they need, and this may be by taking the service to them.

9.3 The Centre will not be an old-fashioned drop-in day centre, but it may be the service that enables engagement. This appears contradictory but it may be that the MDT agrees in a particular case that an individual can drop in because this is the only place of engagement. Case by case seems to be the best way forward and with MDT agreement, not just on adhoc basis. All MDT interactions will be based around a care plan and risk assessment.

Service Boundaries

9.4 The service is not available to securely housed individuals unless there is a threat of homelessness or risks that the individual although housed is not attending to their health concerns and have a history of homelessness.

9.4 If people return to St Stephens when they are housed, they will be actively encouraged, to access mainstream services. There will be support for that individual and advice and signposting to those local services. This will be the default position and any other option would be agreed through the MDT processes.

Consent

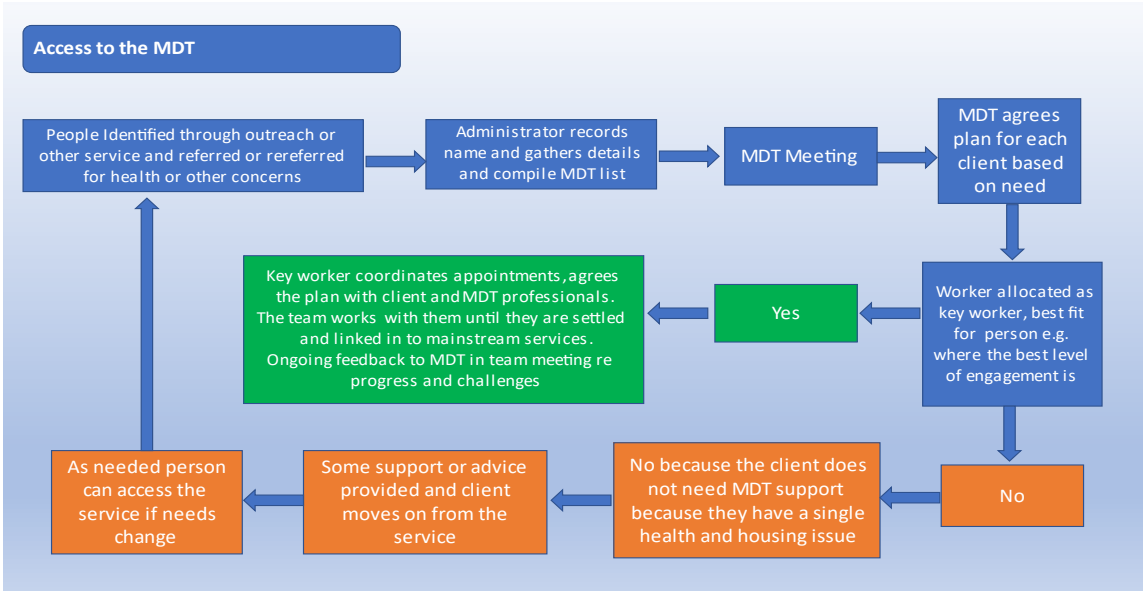
9.4 Consent in relation to accessing the MDT:

- Engagement with the MDT is taken as consent
- If a referral is needed to another service such as social care or CMHT then consent will be sought from client at that point.
- Consent should be specifically related to information sharing between MDT partners.
- Information will only be kept for the agreed amount of time and will be available for the MDT staff
- Records will be kept as prescribed by GDPR etc
- Teams will be the system used for MDT.

10 Pathway through the service

10.1 The diagram shows the pathway through the service it is likely that there will be a mix of people who access the MDT, and the MDT will provide ongoing support until

the person is settled. There will be other people whose needs are not so complex, and these people are likely to be offered advice, some support and treatment etc but they will not usually be managed by the full MDT approach.



11. Transfer Protocol

11.1 The point of the MDT and St Stephens is to provide support whilst a person is homeless. The aim of the service is to improve people's health and social circumstances including support in relation to finding the right accommodation for their needs. This will enable them to continue living with good health and improved life chances. The work of the MDT focus will be to move the person from street homelessness towards permanent accommodation.

11.2 Assuming the contact with the MDT and all the advice, support and treatment provided does the job, the individual may be ready to look at settled accommodation. The person may already be in temporary accommodation and waiting for permanent accommodation when they first engage with the DMT. The aim is to support the person towards appropriate accommodation for their health and social care needs and then engage them into mainstream health and social care services.

11.3 The approach may be different for each client. Circumstances may be different for each person and there will be some people in temporary accommodation waiting for permanent housing offer, others will be sleeping on the streets and avoid the idea and discussion about being in any settled housing.

11.4 Wherever possible the MDT will support the person from homelessness into accommodation and in to contact with mainstream health and social care services in the area they eventually are housed in.

11.5 As this will be the aim the following are key considerations:

- Support from the MDT for an agreed period as the person settles and this will be on case-by-case basis.
- Once in accommodation the MDT case coordinator will make sure they are linked into local GP, dentist, CMHT, drug and alcohol support and floating support etc. They will also close the case at an agreed time.
- It is the case coordinators responsibility to ensure full handover to mainstream services with their agreement.
- The MDT will have a person-centred approach and it might be the case that people will want to maintain some contact for a while whilst they are settling into their new setting and again this should be case by case and contact will ease off as people get settled.
- There will be a hand over protocol and agreed time for that handover. It will ensure that the person is settling and stable in their accommodation and engaged with mainstream health and social care services. This will enable people to adapt to the different support provided by mainstream services. The MDT approach will be assertive, and people seen frequently. The level and frequency of contact with mainstream services will be different and the person will be supported until confident with that level of contact.

12. Safeguarding

12.1 Homelessness and vulnerability and other complexities mean that the MDT will need to be fully signed up to working with Safeguarding and reporting etc.

12.2 Homelessness and vulnerability and other complexities mean that the MDT will need to be fully signed up to working with the Pan Dorset Safeguarding Policy and Procedures.

12.3 Safeguarding is everyone's business and the HIC MDT commit to raising Safeguarding Concerns with the relevant local authority when necessary, based on where the harm or abuse occurred.

12.4 The MDT are committed to safeguarding and will ensure risks are assessed and managed. Where it is necessary to alert partner agencies who have a statutory role, i.e. ASC, CSC, Police etc, these actions will be discussed and agreed by the MDT when it is safe to do so.

12.5 Emergency responses may be necessary, but any actions should be recorded within the MDT process. For example, it may be necessary to call upon the Police in an emergency, but the MDT will also consider if other subsequent actions need to be taken, e.g. referral to ASC etc.

13. Service evaluation and development

13.1 The MDT approach will be evaluated by NHSE in the South West. The CCG will fund the evaluation, and this will enable ongoing development and future commissioning to be based on an objective evaluation. To evaluate there will be a need for the

MDT to develop their key objectives and the following are suggestions to be discussed and agree as the MDT discussions progress:

- Fewer homeless people becoming acutely unwell requiring hospital admission
- Improved engagement with entrenched rough sleepers because of the MDT offer
- Reduction in the number of homeless individuals caught in a cycle of accommodation and homelessness
- Reduction in homeless individuals attending ED for primary care issues
- Increase in the number of homeless individuals engaging in primary care and Health & Social Care Provision

13.2 Assuming the evaluation shows that an MDT approach is the way forward with the client group and assuming homelessness in the BCP remains consistently an issue to be addressed. The future commissioning of the MDT will be decided on by the Integrated Care System and LA Commissioners. It could be the case that it works well without any need to commission it formally, it might be the case that something more formal will be needed to ensure continuity and consistency for this client group. Either way it should be based on level of need and the evaluation.

14. Memorandum of agreement between all services

14.1 Partners (employing or commissioning organisation)

- University Hospitals Dorset NHS Foundation Trust
- Dorset Health Care NHS University Foundation Trust
- BCP Council Housing
- BCP Council ASC
- Health Bus Charity
- We are with you
- St Mungos