Pathway homeless team at the Royal Sussex County Hospital, Brighton

Health and housing – a collaborative approach

St Martin in the Fields

Frontline Network Partner

OVERVIEW OF SESSION

- Video - Less? (journeystohealth.co.uk)
- Who are we and what patients we work with
- Why we exist
- Health consequences of homelessness
- What professionals we work with closely with
- What our patients discharge destinations look like
- Why a collaborative approach?
- Lets talk about money!
- Obstacles in keeping our patients safe
- Useful contacts
- Q and A

Who are we….

- **Christopher Sargeant** – GP for Arch and clinical lead for the team. Is also the medical director for the Pathway charity.
- **Katie Carter** – Housing and Team coordinator - works for Arch
- **Emily Greer** – Health inclusion in-reach nurse - Works for Sussex community NHS foundation trust (SCFT), also works in the community team for the homeless health inclusion team nurses.
- **Hannah Palmer** – In-reach nurse for the hospital team, Step-down nurse and practice nurse for Arch.
- **Simon Tanner** – A&E health engagement worker for rough sleepers - works for Justlife
- **Rachael James** – Weekend homeless team hospital worker - works for Justlife.

WHO DO WE WORK WITH…..

- **Those who would be homeless on discharge**
- **Patients who live in emergency accommodation**
- **Patients in medium and high support supported accommodation**
- **Those Sofa surfing**
- **Patients who are from the travelling community**

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Homelessness and health – why our team exists.

- Reduce no. of people discharged to the street
- Improve the experience of people experiencing homelessness and make healthcare more accessible to them
- Reduce stigma and healthcare exclusion
- Support wards where we can with collateral from the community and with complex patient care
- Reduce hospital readmissions
- Improve homeless health and reduce deaths related to homelessness.

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Homelessness and health

Health consequences of homelessness

- Poor physical health/chronic conditions
- Complex mental illness
- Drug and alcohol dependence

Tri-morbidity

Main reasons for admission:

- Trauma and orthopaedics
- Respiratory
- Infectious diseases
- Vascular
- Gastro

Homelessness health facts:

- 33x more likely to have tuberculosis
- 50x more likely to have Hep C
- 12x more likely to have epilepsy
- 6x more likely to have heart disease
- 5x more likely to have a stoke
- 2.5x more likely to have asthma
- Attend A&E 6x more often than the average population
- Admitted 4x as often and stay 3x as long

- Average age of death:
  46 years men
  42 years women

(Pathway UK, N.D)

Colleagues we work closely with:

Health

- Medical teams
- Surgical teams
- Mental health liaison team
- Hospital discharge management and all discharge staff
- Arch
- CGL (Ongoing prescribing)
- Community nursing teams (Mostly SCFT homeless team)
- Follow-up community health teams (for example Diabetes team)

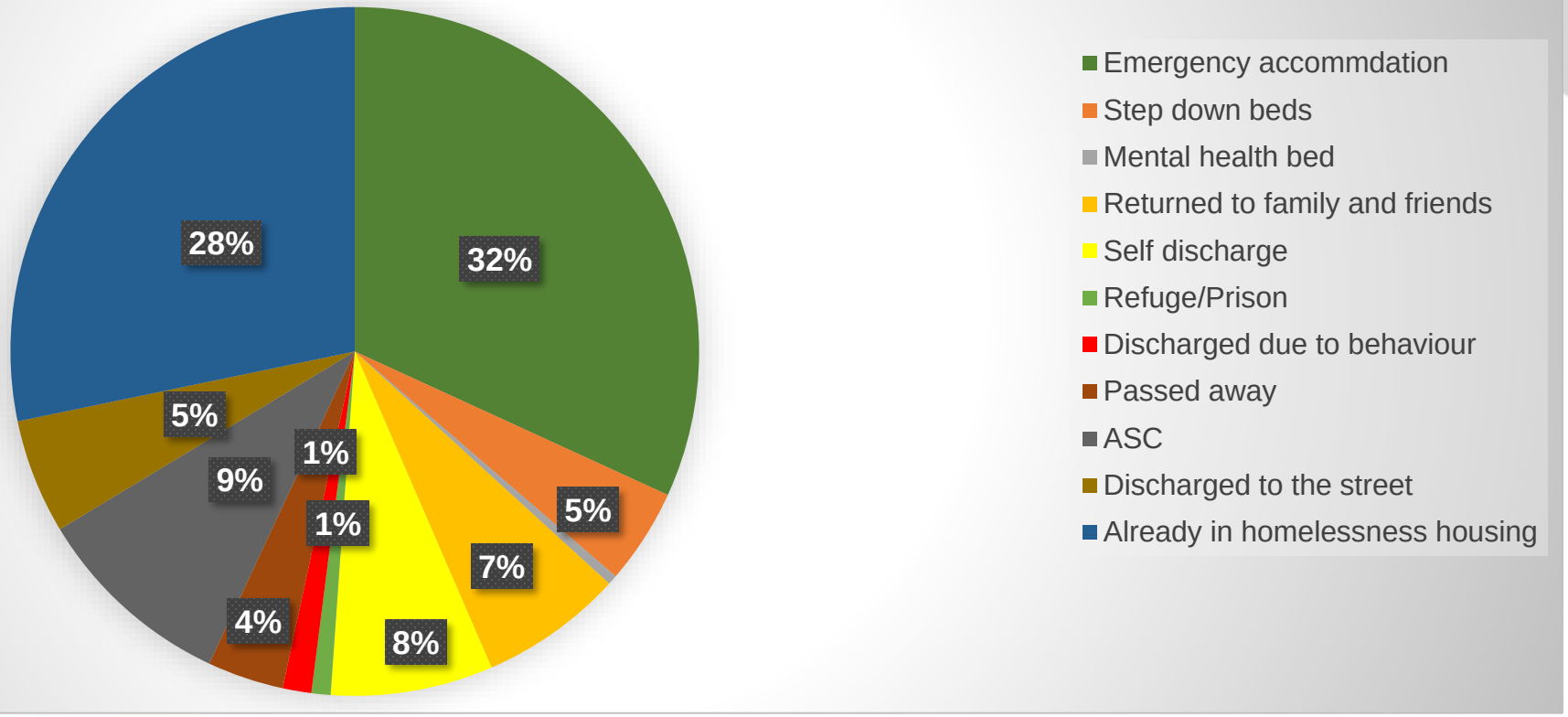
Social

- Housing authorities both in and out of area
- Social workers
- Changing futures team
- Hospital Safeguarding team
- Therapy teams (OT's and physios)
- Mental health homeless team and ATS

Community

- Justlife and other specialist community support workers, including those out of area (Turning tides etc)
- Step-down beds at St Pats and New Stiene mews
- CGL outreach, PHE and substance misuse services
- Supported accommodation providers
- Welfare officers (provided by BHCC)
- Victim Support (DV services)

Discharge destinations last 12 months



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Why a collaborative approach?

Over 90% of our inpatients require another specialist service (other than just medical attention), with the majority requiring more than one specialist service

Year on year homelessness deaths are increasing in England with Brighton being the 2nd worst after Belfast in 2022 despite the experienced services we have in the city (Museum of homelessness, 2022)

With limited housing pathways for more compound needs patients direct from the acute, we reply upon our colleagues to wrap around the support required to keep clients safe whilst suitable housing can be established. The result without this has real-life consequences, including serious health decline, safeguarding issues and even death.

What makes the difference:

Education

- We teach the year 4 medical students
- We do discharge training to all new nurses and HCA's coming into one of the main A&E wards (AAU)
- We take part in regularly ad-hoc training events including for consultants and senior staff

- The idea of this is to educate about homeless and health and complexities surrounding this

MDT'S and discharge planning meetings

- When appropriate we will set up and chair meetings (or always attend if invited by others) for more complex cases so that all teams can work together to make a discharge safe when perhaps things haven't previously been working.
- MAHHM (held by Arch) is held every two weeks and this often highlights those not coping and the communication at these meetings help to avoid hospital, or if the person does attend, we already know what the collateral is

Senior management understanding

- The acute setting is tough, an understanding from the senior management means we are able to do things as safe as possible, but we do have to appreciate the pressure on the acute.

Lets talk about money!

Case study:
Patient X
Was medically ready to leave hospital on **4th July** but due to issues with various discharge pathways, this patient didn't leave until **31st July.**
Hospital bed cost for 28 days: **£16,520 (Approx.)**
Nightly fee for emergency accommodation for 28 days: **£540.12 (Approx.)**

Obstacles in keeping our patients safe:

- Our patients are **not accepted at rehab** beds due to no address/sometimes complex histories, meaning they miss out on much required physical rehab and have to remain in the acute.
- **Patients being placed out of area** after a complex admission due to unsuitable/no housing stock in the city, meaning follow-up appointments and a putting POC in place is sometimes liogistically impossible from the acute setting. This means that the housing placement is totally unsuitable and puts some patients at serious risk.
- Due to the pressure on housing we have **substantial delays in patients being placed** once they are made medically ready
- There is currently **no service provision** that provides a more carehome-style environment that we are able to access from the acute for more complex cases involving, for example, people struggling with Alcohol brain injury (ABI)

USEFUL CONTACTS

- Hospital homeless team - tel: 07884195417
  email: Sxicb-bh.archpathway@nhs.net
- Justlife homeless in-reach for A&E rough sleepers
  07395 246 432
- Hospital drug & alcohol liaison ext. 67826
- Alcohol liaison nurse 07909 206 655
- Arch homeless GP practice, Brighton -
  tel: 01273 003 930
  email: Sxicb-bh.archhealthcare@nhs.net

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Thank you

Any Questions?

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References

Museum of homelessness (2022) ***Dying homeless project 2022*** [Online] Available from 2022 DRAFT Museum of Homelessness report of findings on homeless deaths in 2020 (squarespace.com) **[Accessed 27/09/2023]**

PATHWAY (N.D) ***A major health challenge*** [Online] Available from www.pathway.org.uk [Accessed 27/09/2022]

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