Homeless health inclusion team (HHIT) and Pathway homeless team (Hospital) – a collaborative approach

Working together for better patient care

St Martin in the Fields

Frontline Network Partner

NHS Sussex Community NHS Foundation Trust

OVERVIEW OF SESSION

- Who are we and what patients we work with
- Why we exist
- Health consequences of homelessness
- Alcoholic related brain injury (ARBI) What do You think?
- Why a collaborative approach?
- Case study of Pathway and HHIT team working together for better patient care on discharge
- Our patients discharge destinations
- Obstacles in keeping our patients safe
- Useful contacts
- Q&A

Pathway homeless team - 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 for our healthbed and practice nurse for Arch.
- **Simon Tanner** – A&E health engagement worker for rough sleepers - works for Justlife
- **Gregg Lock** – In –reach nurse for the hospital team, step down nurse for our healthbed and practice nurse for Arch.
- **James Whatley** - 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.

WHO DO WE WORK WITH…..

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

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Homelessness and health – why our team exists.

- **Why we exist:**

- 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)

Sussex Community
NHS Foundation Trust

Introduction to SCFT's Homeless Health Inclusion Team

Presented by: Caterina Speight Clinical Service Manager and Clinical Nurse Lead

Excellent care at the heart of the community

The Homeless Health Inclusion Team

- We are a Multi-Disciplinary Team providing Health Care on Outreach and Hospital In-Reach to vulnerably housed patients struggling to engage with mainstream health services
- Nursing: Clinical Nurse Lead/Service Manager, In-Reach Nurse at the Hospital, Sister in Charge, Senior Grade Registered General Nurses and Health Care Assistant
- Therapies: Senior Physiotherapist and Occupational Therapy: Lead Senior Grade Occupational Therapist and OTA

Homeless and Vulnerably Housed

- Rough Sleeping,
- Supported Accommodations
- Emergency and Temporary Accommodations
- Sofa Surfing

Service history

- Homeless Project 2013
- Hub and spoke model in 2015
- In-reach role in 2016

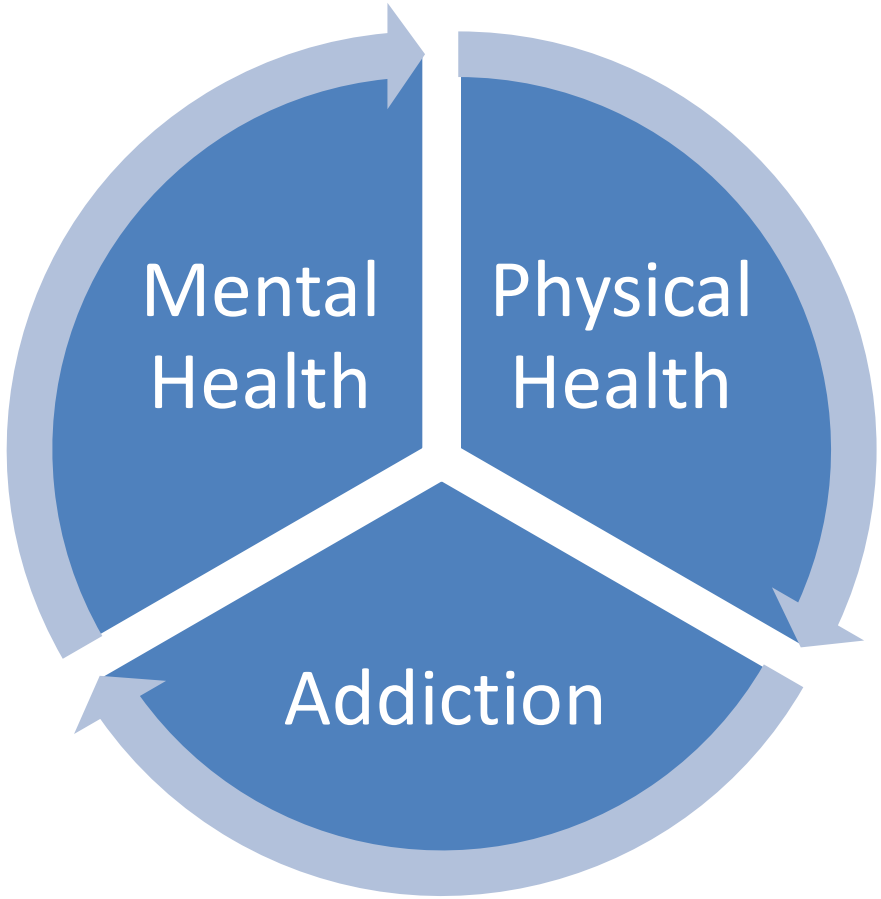
Multi-Agency Team Working (Integrated Community Teams)

Homeless Health Team: Breaking Down Barriers

Engaging and co-ordinating care

- ARCH healthcare and other local GP practices
- Referrals (and working alongside) Justlife
- Secondary Health care (hospitals)
- BHCC (housing, adult social care, welfare officers)
- Supported accommodation, Day Centres
- Other IPCT's, Responsive services,
- Community Diabetes, HIV, Heart failure, Respiratory Teams (within SCFT)
- CHC, Hospices
- Drug and alcohol teams
- Homeless Mental Health Team
- St Mungo's

Inclusion Health Nursing



Inclusion Health Therapies

Physiotherapy

- Difficulties with mobility: Falling/balance/stairs/
- walking aids
- Musculoskeletal issues
- Post operative rehabilitation
- Respiratory condition management
- Persistent pain

Occupational Therapy

- Meaningful Occupation
- Complex Case Mangement
- Anxiety Trauma Stabilisation
- Self harm
- Solution Focused therapies
- Group work

Integrated Working with the Pathway Team

Alcohol related brain injury – Nurse-led project

- Lead nurse within the Pathway homeless team and also the community HHIT team has set up a hospital MDT meeting every 6 weeks to do what we can with the resource we have. She has engaged all critical members of staff who acknowledge the increase in this patient cohort.
- This is going to involve, as a pilot, a Neurologist trying to engage and see a very small number patients to establish a diagnosis and how this may benefit them and those working with them.
- The lead nurse for Dementia at the trust completely advocates that this should be treated as a dementia. The reason that the brain injury has happened is irrelevant, the behaviours and cognitive deficits are often the same.

- Alcohol related brain injury (polleverywhere.com)

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

News statistics from the department of leveling up show that street homelessness in Brighton alone has risen by 27% and households placed into EA/TA rise of 9.7% from last year, (Emmaus,2024)

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.

Case study – HHIT team and Pathway team; **better together**

Patient X

- Male, 49 years old, History of alcohol dependence
- Originally in following a road traffic accident when the team first met him in hospital, and he was no longer able to stay with friends so we got him placed via the council into emergency accommodation on discharge from hospital
- Fast forward 8 months and patient came back in with a broken C6-C7 Fracture of the neck and broken collarbone. Due to complex collar care (Aspen), his old accommodation was not likely suitable, however, the OT team's at the hospital did not feel an access visit was required.
- Emily, the nurse from our team and a member of the community HHIT team, asked her colleagues Gemma (OT in HHIT) if she would do the access visit with her and the patient (the ward agreed).
- The assessment was extensive and the property was found to be wholly unsuitable as a discharge destination for multiple reasons, also, upon entering the room it was found to have been broken into and cuckooed.
- This assessment was passed to the hospital to explain that we would need to source new accommodation and it was then decided, with the agreement from the patient, that we would apply to our step-down beds at New Steine Mews. He was accepted and discharged there where he receives daily nurse check-up's if required up to 16 weeks – post-discharge, and also has access to a specialist support worker to help with a suitable move-on plan. Without this amazing joint-up working we would not have been able to achieve this outcome.

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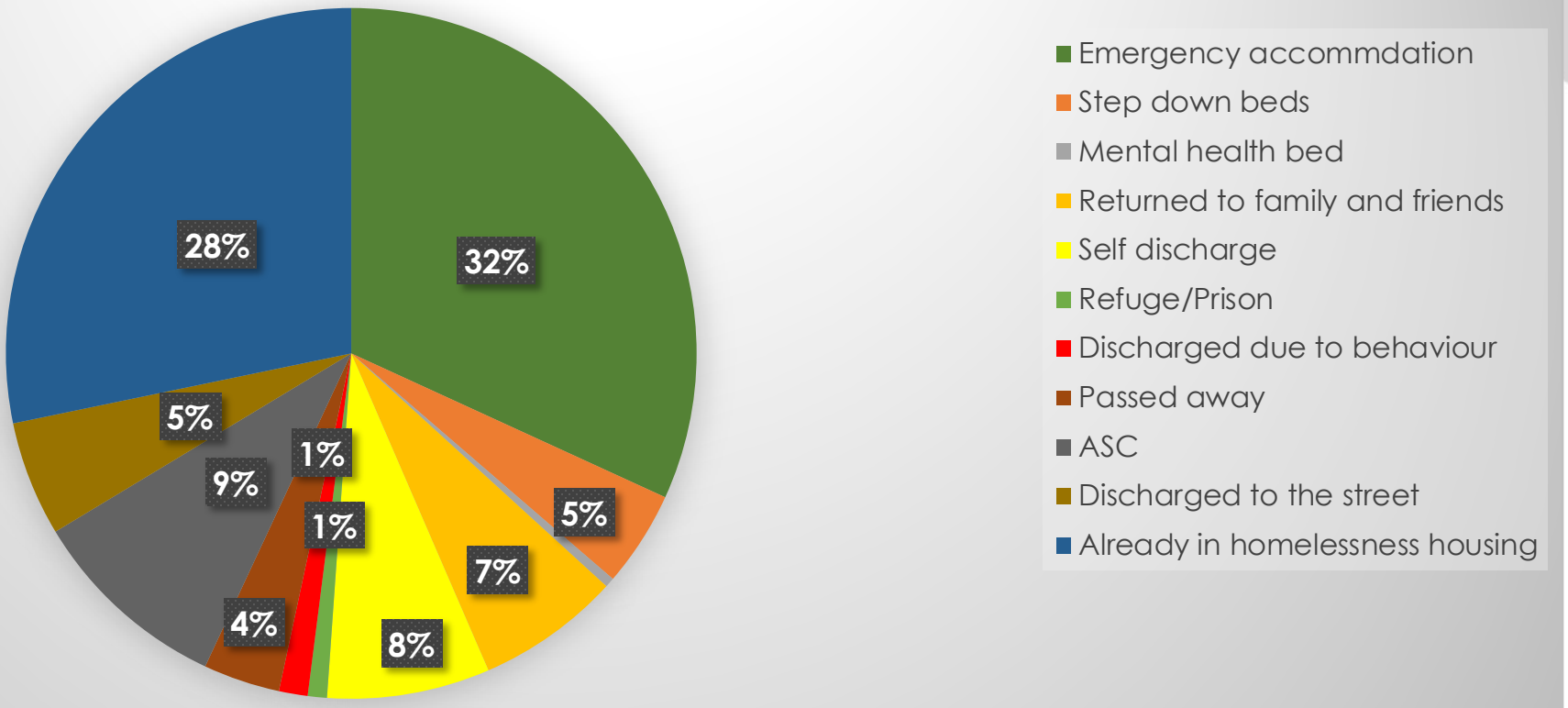
Discharge destinations last 12 months



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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 **T: 01273 731 900 EXT: 63060**
- 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

Emmaus (12/03/ 2024) ***Worrying statistics reveal street homelessness up by 27%*** *[Online]* Available from Worrying statistics reveal 27% rise in rough sleeping in Brighton (emmaus.org.uk) [Accessed 23/08/2024]

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

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