North West London Integrated Care System
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NHS
North West London

Homeless health plan for Brent (DRAFT)

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	Borough and Place-based Partnerships (PBPs)	ICB team
	Coordinating partner	Supporting Partner
Relevant Functions	- Embedding local data and insight from those with lived experience in planning- including PHM approaches with PCNs and INTs - Tackling local inequalities and ensuring equity of access (including primary care) - Local planning and design of service across partners- both understanding and meeting population health and wider needs - Developing any local offers for PEH- e.g. in-reach services - Identification of priority sites for health protection and resilience (Imms and MECC) - Local workforce support- CPD and overall health and wellbeing for front line staff	- Developing strategic plan for NWL ICB to build the overall Model of Care - Establishing standards that align to recent NICE guidelines e.g. hospital based care and step down - Supporting consistent and equitable delivery across ICB and ICS partners e.g. discharge protocol, GP IT coding - Leading strategic needs assessment for PEH and Inclusion groups - Leading with other ICBs and London/ National networks (e.g. Transformation Partners in Health and Care)- on single responses and joined up problem solving - Co-ordinating funding opportunities - Sharing best practice on what works and addressing variation across boroughs - Assessing and mitigating against inequalities- as part of a proportionate universalism approach to health inclusion groups
Service Transformation Area Responsibilities	- Developing local plans – borough PEH strategies / homeless health plans - Place based leadership across partners to bring together the model of care - Integrating services on the ground for PEH and Inclusion groups - Ensuring equity of access and outcomes- including prevention of avoidable admissions and shifting towards proactive, personalised and planned care	- Ensuring minimum standards are set at NWL level e.g. NICE guidelines - Driving change across NWL: consistency of offer, equity of access/ outcomes - 'Once for NWL' approaches that are pragmatic for a transient and mobile population rather then 8 times differently - Transformation at sector level (e.g. Out of Hospital Care Model) - Culture change and OD across Clinical workforce- both mind-set and CPD
Working together and engaging partners in our work	- Working closely with LA, Providers, VCS and lived experience to support integration and joint solutions - Working with ICB health inclusion leads- equity and funding opportunities - Involving people with lived experience on priorities and joint solutions Working with clinical networks, Place partners and ICB leads to understand health inclusion groups, identify barriers to access, and tackle structural inequities, exclusion and vulnerability	- Working closely with PBP to identify best practice, develop minimum standards, ensure consistent offer across NWL etc. - Coordinating with regional and national bodies
Decision Making Forums	- Local structures in Borough/ Place Based Partnerships – for decision making - Local homelessness fora- supporting joined up planning and delivery - NWL Homeless Health Steering Group- place based reps participating	- ICB Boards and Programmes e.g. Local Care Programme Executive, PHM HI Board, UEC, MH Programme Executive, ICB executive

Aims and Population Health Context

The scope of this plan is to reduce health inequalities for **People experiencing Rough Sleeping, or who have a history of rough sleeping or who at risk of rough sleeping in The London Borough of Brent**. As this group faces some of the most severest health inequalities.

What we know about PEH in NWL:

People experiencing homelessness have complex health needs. They are said to suffer from the **'tri morbidity'** of poor physical health, poor mental health and substance misuse. They also suffer considerably more from chronic diseases than those who have not experienced homelessness

- In 2020, the mean age of death for men was **45.9**, and for women **41.6**, with many of these deaths being from preventable causes.
- Rates of **drug and alcohol dependence are very high**. Mental health, dental health and foot health are often poor, along with high rates of respiratory disease
- The annual cost for unscheduled care for the homeless population is far higher than for the housed population. **A&E attendances** are **6x as high, admissions 4x as often** and **stays 3x longer** than the general population.
- The experience of homelessness itself acts as a barrier to accessing mainstream services; loss or theft of belongings, and having no fixed address leads to documents being lost, appointments being missed. Poor mental health, substance and alcohol use compound these barriers. Additionally, levels of autism, learning disability, ACE's and brain injury are higher amongst rough sleepers than the general population.

Local context

Brent Context (Homeless Health Dashboard)

The Homelessness Health dashboard gives some population insights specifically for Brent. These include:

- Patients coded with one of 14 ‘single homelessness’ snomed codes totals **2,469**

  (NB this appears to be a significant discrepancy from Local Authority numbers and may reflect historic figures)

  - Of GP registered patients **one third** are female and **two thirds** male
  - **61%** of single homeless people are from **BAME/ Global Majority groups**
  - **56%** of the population are aged between **40** and **64**
  - **15%** of the cohort have a frailty score indicating **severe or moderate frailty**, indicating clinical rather than chronological frailty, and a high level of vulnerability.

- The majority of homeless women in Brent are hidden from statistics and services and often ‘unverified’. This may include **sofa surfing, living in unsuitable housing such as squats.** It can be dangerous and is often traumatising.

Next steps

- Validate and triangulate the data with that from voluntary sector (Crisis Skylight) and Local Authority
- Place Based Partnership Governance – Case Management Arrangements at the local Complex Patient Management Group (CPMG) meetings

Health protection and resilience outreach

Covid Vaccination Programme

A flexible MECC model across clinics at Brent Civic Centre, local pharmacies and in-reach from Find & Treat and NWL Roving Teams.

NWL	Covid*	Flu
Brent	39%	12%
NWL Average	51%	10%

Clients have also been offered flu and pneumonia vaccinations and the opportunity to ask any questions about new variants, GP registration support, the vaccination programme (m-pox, diphtheria, Hep B etc) and how to protect themselves.

*% of patients who have had one or more covid vaccination- against all SNOMED coded individuals in GP IT records

Introduction

- Approached by Brent Homelessness Forum to discuss Health Support available to Homeless People and what more we can do to integrate Health and Social care
- On 2 Nov 2022, we presented the services available e.g. GP registration, outreach health checks through Brent Health Matters Team, Vaccinations, Find and Treat, NWL Roving
- Group discussions on:

What works well?

- Community outreach team at hospital – benefits of early referral and the hospital discharge team
- Groundswell offer around peer health advocacy
- SMART service
- Multiagency work and community outreach
- Information sharing and consent

What hasn't worked well / challenges?

- Language and cultural barriers
- Digital exclusion / Individuals not having a phone
- Lack of housing
- Mental Capacity Assessment when drug and alcohol also presenting
- GP registrations, Immigration Status
- Information sharing and obtaining consent
- Hospital discharge – linking with community based services e.g. substance misuse
- GPs to provide follow up information

What can we do to address these challenges?

- Ease of GP registration
- Flexible appointments
- Improved access to dentistry, podiatry etc
- Outreach health checks
- Contacting the GP surgery for information i.e. bypass numbers / emails etc
- Digital inclusion
- Making Every Contact Count

Brent HH Programme Workstreams

Workstream	Descriptive summary/ deliverable	When	Leads
Hospital Based Team	• OOHC Team – Exploring wider integration with Brent Voluntary services including Crisis Skylight with a focus on prevention and avoidance of hospital admissions. E.G. co-locating nursing and wider support in Crisis Skylight clinic room.		**Ali Bello** with initial support from GK
Primary, Community and Mental Health	• **Brent GP Surgeries** to attain 'Safe Surgeries' accreditation - Currently 39/51 – 76%. Aiming for 100% sign-up to the programme by Date to be agreed. • Scoping Complex Patient Management Group Multi-Disciplinary Meetings • Medicines Management support • With NWL Clinical Lead exploring Primary Care Model of Care		Brent Team (Versha / Anne A / Bharat)
	• **Community based nursing offer -** gap identified in Brent with no equivalent service to Inner NWL offer. Focus is physical health interventions e.g. wound care. • *Sustainability case addressing this need with decision expected February 23. Local planning subject to this.*		TBC
	Support with integration of **Rough Sleepers Mental Health Provision Service** (3 complex needs practitioners) in to the wider care and support network. **Mental Health and Substance Misuse.** Work with partners to scope joint work and further opportunities that would improve the mental health and wellbeing of inclusion health groups. Link with newly commissioned homeless mental health and Substance Misuse services.		Lucy Smith / Sarah Nyandoro
Learning and Development	• Brent team working with NWL Education Lead to **identify priorities** (e.g. trauma/ psychologically informed working, Inclusion Health key competencies) • Social Prescriber training and development		Anne McBrearty/ Brent lead TBC
Health Protection/Resilience	• Grace supporting development of local priority with Pauline Kane (Brent PH team)		Grace
Population Health Management	**Use dashboard** pulling together system activity/ outputs and sustainable insights, driving PHM approach and directly informing NWL/PBP work to tackle Health Inequalities. Any specific training for Brent's clinical workforce? (AMB)		TBC

Initial mapping of commissioned homeless health services in Brent

Out of hospital care teams. New team in Northwick Park and Ealing Hospitals.

- Annual estimate of people connected = **148**
- In addition, people connected in Inner Team (St Mary's Hospital) = **88**
- Total = **236**.

There is no specialist GP service within the borough, all practices accept new patient registrations and PCNs encouraged to consider this cohort as part of their PCN DES on Tackling Health Inequalities

Community based inclusion nursing and step down care: No service currently- see work streams and priorities.

Specialist **dentistry and oral health promotion** TBC

Specialist podiatry TBC

Rough Sleepers Mental health Provision Service (3 complex needs practitioners)

Health protection and resilience outreach Find and Treat roving team - TB, Blood Borne Virus (BBV) screening, broad immunisations, Covid19 testing and MECC offer at priority Brent sites alongside Brent 'local offer' and NWL roving teams

Liver scanning outreach - St Marys Liver and anti-viral unit – Outer London

Groundswell's homeless health peer advocacy supporting engagement for rough sleepers with complex needs in hostels/ supported accommodation and Ealing/ N Park hospitals. NB resource is 1 FTE across both Brent and Ealing whole patch.

- **WDP** is commissioned by Brent Council to provide Substance Misuse/ Alcohol services and support.
- Funded by the GLA, **Guy's and St Thomas' Hospital** are trialling a new initiative providing detox beds to rough sleepers with complex health needs
- *Data received from the Lead Commissioner of the Pan London Substance Misuse Programme indicate and 0 referrals have been made from Brent to the Rough Sleeping Drug and Alcohol Treatment Programme at St Thomas's Hospital.*

Homeless Health Partners – Named People

- Brent public health – Pauline Cane, Homelessness Lead Brent Public Health and Caroline Evans, Senior Public Health Strategist
- Housing Needs Team – Laurence Coaker, Head of Brent Housing Needs Group
- Voluntary Sector – Atara Fridler, Director of Crisis Skylight
- Supported accommodation providers and commissioner/s – Steve Davies St Mungo's
- Primary Care – Versha Varsani Head of Primary Care (Brent Borough), Dr Nigel De Kare-Silver, Dr Amanda Craig and Dr MC Patel
- Brent Health Matters – Francesca Caporiccio, Community Coordinator
- Integration / Community Services – Bharat Gami, Programme Delivery Manager (Brent Borough)
- Acute and emergency care – Ali Bello, Lead Nurse, Northwick Park Inclusion Health Team
- Mental health representation – Sarah Nyandoro, Head of Mental Health (Brent Borough) and CNWL - TBC
- Pharmacy – tbc ? Community Pharmacy / ICB Medicines Management / PCN Pharmacists ARRS ?
- Local healthcare providers: CLCH - TBC
- WDP - TBC
- Social Prescribing Services - TBC
- PTSE Support - TBC
- RAMHP Mental Health Service - TBC