Brent Homeless Health Plan

GP Forum, 21 July 2023

Population Health Context

To reduce health inequalities for **People experiencing Homelessness in The London Borough of Brent**

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**

- 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

Mental health, dental health and foot health are often poor, along with high rates of respiratory disease

People who are rough sleeping are 17 times more likely to have been victims of violence and are 9 times more likely to take their own lives than the general population.

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
- having no fixed address leads to documents being lost
- appointments being missed

Poor mental health, substance and alcohol use compound these barriers.

Brent GP Registration Data indicates **2,460** people as homeless

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

- **One third** are female and **two thirds** male
- **61%** of single homeless people are from **BAME 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.

EMIS Data, May 2023

Tackling homelessness in Brent

Brent Homelessness Forum
- Collaboration with stakeholders

Out of Hospital Care Team
- Based at London North West and Imperial Hospitals
- MDT providing specific health interventions, social care, housing, advocacy and practical input so that patients are discharged in an improved situation, reducing hospital re-admittance and homelessness

Community Based Nursing Team
- Provision of a new community nursing team in Brent and Ealing for ongoing case management when patients are discharged from hospital

Population Health Management
- Dashboard pulling together activity and outputs to address health inequalities

Brent Health Matters and Find & Treat Team
- Outreach health checks
- Vaccinations / TB screening

Further Integration
- Podiatry
- Dentistry – Oral Health
- Community Pharmacy

Voluntary Sector
Crisis Skylight Brent, Ashford Place, St Mungo's, Groundswell
- Directly support people experiencing homelessness and work with partners to make services better

Brent Council / Public Health
Rough Sleepers Mental Health
Mental Health and Substance Misuse
Housing Needs
- Improve the mental health and wellbeing of inclusion health groups.
- Support integration and target rough sleepers through Outreach (TRSO)

Brent GP Practices
- Accept new registrations
- Accreditation as safe surgeries with Doctors of The World
- A MDT proactive health and wellbeing assessment to tackle health inequalities
- Vaccinations and Health Checks

Brent Local Scheme for GP Practices

LOCAL SCHEME

Tackling Health Inequalities by Supporting under-represented and disadvantaged people experiencing health challenges

a) Housebound *(physical or psychological illness)*

b) Homeless – *rough sleepers, those people living in accommodation which is not reasonable to continue to occupy, people living in hostels or supported accommodation, the hidden homeless i.e. people in 'squats' or 'sofa surfers'.*

c) Supported Living / Extra Care / Supported Care Services *(that are not covered under the Care Home DES)*

- We recognise that some of our patients are often not well-served by traditional models of healthcare and therefore adjustments to support these underserved groups to access healthcare would benefit them to achieve meaningfully improved outcomes and experience
- **Provide a personalised pro-active health review, support general wellbeing and offer of lifestyle and preventative interventions**

The review may include but not limited to:

- ✓ Utilise various roles in the PCN to support the individual e.g. medication review via a pharmacist, health and wellbeing coach, Mental Health Practitioner
- ✓ Provide a holistic assessment which may include a comprehensive Multi-Disciplinary Team (MDT) review to manage long term conditions
- ✓ Work in partnership with other system players to tackle the wider determinants of health inequalities – such as social care and the voluntary sector to prevent ill-health and manage long-term conditions e.g. Housing, Age UK, Crisis Skylight and Brent Health Matters Community Events
- ✓ Vaccinations / Immunisations (flu vaccine, covid vaccine, shingles, pneumococcal, MMR etc)
- ✓ Cancer screening (cervical cytology, bowel cancer screening and breast cancer screening)
- ✓ Referral to appropriate settings e.g. social prescriber
- ✓ Work with patients and carers to support self-care and self-management of complex and long-term conditions through shared decision-making
- ✓ Ensure that the specific vulnerabilities of these patient groups to Covid, Tuberculosis, Hepatitis B and C, HIV and substance misuse are recognised and onward referral for the screening is conducted

EMIS Homeless Template - enables doctors and health workers to create and maintain a detailed picture of a homeless person's health, capturing vital information including clinical history, mental health and addiction issues, as well as details on housing and financial status.

North West London / Brent Homeless Health Programme

- **2023/24 plan** – a snapshot:
  - Webinar – improve access, outcomes and experience for people experiencing homelessness and offered practical tips to support
  - Delivery of the local scheme for under-represented group
  - Create links between the partner agencies
  - Improve equity of access and experience for homeless patients in general practice
  - PCN DES Health Inequalities – work with the PCNs with a high prevalence of homeless people to consider a focus on homelessness
  - Homeless Health teams in acute and community trusts – remobilising after successful 3 year business case
  - BHM outreach health checks
  - Homeless Health dashboard, outcomes and community insights
  - Improving vaccination update in homeless patients

Top tips for GPs to support people with multiple disadvantage | Groundswell