

# Homeless Health Webinar

## Showcasing the Brighton & Hove approach

### Questions, Answers and Next Steps 09/07/2020

#### Contracting:

**Q: How does the CCG contract with the Arch practice? Are there any additional services/finance included?**

**A:** Arch CIC operate a GP surgery near Brighton Pier and have a list size of around 1,400. This is operated under an APMS contract, which is due to expire late 2021.

Brighton and Hove has had a service aimed at providing GP services to the homeless and rough sleeper community for over 10 years. The service has been operated by Arch since 2016.

Arch CIC also works with Brighton and Sussex University Trust around discharge and the local authority linking with housing need to provide an integrated service for the homeless and rough sleepers

During Covid19, Arch CIC have been additionally contracted to provide triage and outreach services to a number of hotels and other sites being used to house the homeless. This has also allowed this group to be register with GPs to ensure ongoing medical provision as well as allowing Arch to work with other health services to give support to this population group. Ongoing health care is part of the package when housing officers work on re-housing options.

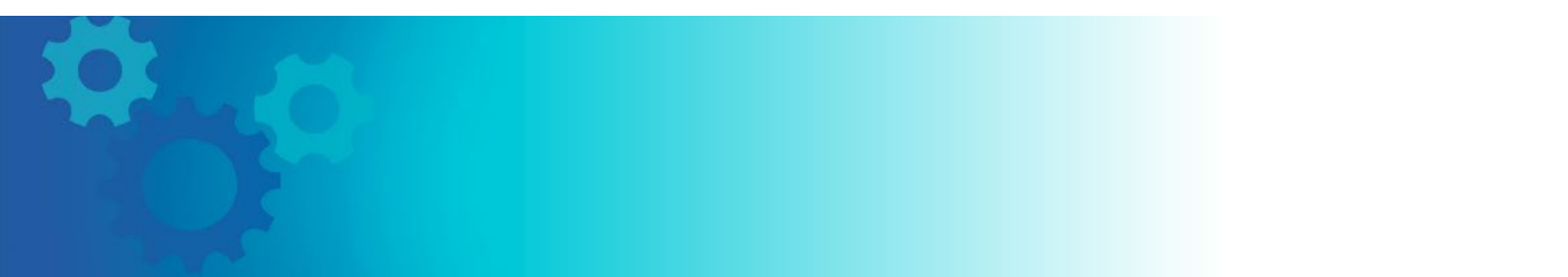
(Thanks to Steve Sollitt for the response. To discuss further please contact Steve at [steve.sollitt@nhs.net](mailto:steve.sollitt@nhs.net))

#### Data & Impact Evaluation:

**Q: Where did you (Brighton & Hove team) start with the data picture and how did you get buy in to get partners to collect and share?**

**A:** Brighton & Hove (Thanks to Emily Ashmore for this) - We commission Real Systems to provide a client database which enables journey tracking, referrals into supported housing and acts as a casework system. We contract all of our services to use the system and we have non-commissioned providers (including Arch and the Homeless Nursing Team) as users. The system is easy to use and helpful so buy in was pretty easy to secure.

Debbie Kennedy: I have contacted providers of [CHAIN in London](#), to get more information about that system and how they got buy-in from partners in London.



**Q: Are you able to share the savings on taking this approach on health please?**

**A: The Arch Practice** (Thanks to Tim Worthley for this) - savings can be difficult to demonstrate as we have existed as a homeless surgery in different formats for approximately 20 years. We can demonstrate reductions in admission etc. through our hospital in-reach and health engagement work - the following link may be of interest: [https://www.pathway.org.uk/wp-content/uploads/BJHCM\\_2017\\_23\\_8\\_367-371homeless\\_patients.pdf](https://www.pathway.org.uk/wp-content/uploads/BJHCM_2017_23_8_367-371homeless_patients.pdf)

**Bevan Health Care CIC** (Thanks to Lucy Baker for this) - This is evidence presented by Gina Rowlands (Clinical Lead and Director) in a presentation of the impact of accessible and specialist primary care, intermediate care and hospital discharge provided by Bevan Healthcare which evidences the cost savings.

If you want to know more the people to contact are:

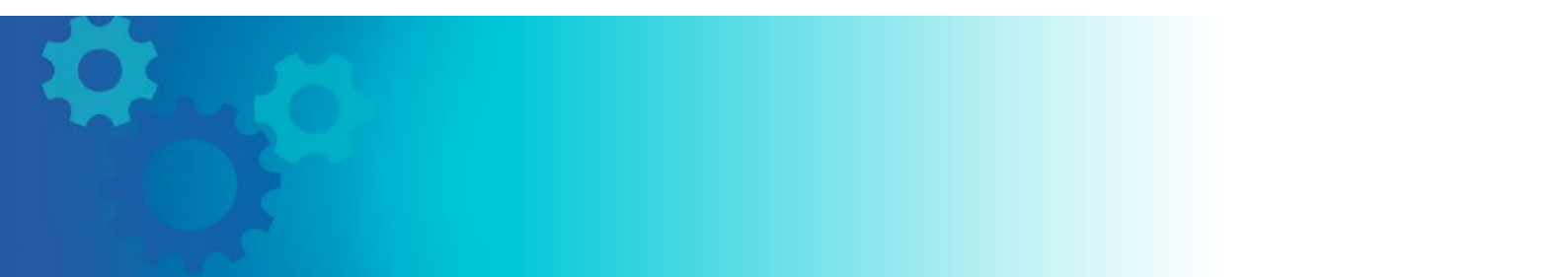
**Gina Rowlands:** Gina.rowlands@bradford.nhs.uk or

**Helen Phelan:** Helen.Phelan@bthft.nhs.uk

- SMT: average 65% increase seen in the uptake of primary care services in the three months after first engagement with street medicine
- Pathway: 62% reduction in total in-patient and A&E costs - estimated £2.4 million saving in secondary care since the commencement of the service in 2013
- Intermediate care facility: yielding £2 to £4 return on £1 spent
- Good multi-disciplinary communication
- Effective resettlement to sustainable accommodation
- Safer medication management

Pathway is the hospital discharge service for people who are homeless. Helen set up this service. Research by Michelle Cornes shows that all 4 elements of the service that Bevan Healthcare CIC provides is needed:

- GP service
- Hospital discharge
- Intermediate care
- Health outreach (Bevan has a mobile health bus).



## Opportunities for Primary Care Networks:

**Q: Are there longer-term implications/roles for PCNs through this work?**

**A:** There are opportunities for PCN to deliver services at scale for the population of their member practices and use multi-disciplinary teams to target services to the specific needs of the street homeless and rough sleepers. PCNs can also augment existing outreach teams by deploying a few clinical and non-clinical staff to support existing services.

As described by Brighton & Hove colleagues, the outreach multi-disciplinary team approach works well for this population group. Having a service at PCN-level (or across several PCNs) could have the benefits of retaining a local service thus creating a sustainable relationship with the local street homeless and rough sleepers whilst developing or contributing to a bespoke service that is best adapted to their needs.

Social prescribing link worker roles can be key in supporting the homeless population. They can also offer the opportunity to recruit someone with lived experience who may have unique insight into the practical complexities that living on the street may bring. The national Inclusion Health team is developing a role profile to support PCNs interested in recruiting to such a role.

**Q: Would you please be able to share the Link to the recorded session, so this can be shared with other colleagues unable to attend and also share the PP/Slides?**

**A:** The recording, slides and Q&A are available at: <https://wessexsenate.nhs.uk/rough-sleeping-webinar/>

## Next Steps – future events

**27 July 2020 11.00 -12.30** – Addressing inequalities in mental health and learning disability

**TBC** – Introduction to the MHCLG prospectus and expectations of local areas in response

