

Brownlow Health Homeless Team Report 2024-2025



Introduction - Setting the Scene

The prevalence of homelessness is increasing. The latest Crisis Homelessness Monitor looking at 2023 found rough sleeping increased by 26% compared to the previous year. They estimated that the number of people experiencing core homelessness, the most acute forms, totalled 242,000 meaning **1 in 100 households in England are experiencing homelessness**.

The picture in Liverpool is just as stark. **In the last year, 890 unique individuals were seen rough sleeping equating to a total of 7,213 occasions of rough sleeping**. This represents a 19% increase on the previous year. The situation is exacerbated by a lack of move on options. Nearly 15,000 households are on a social housing waiting list in Liverpool with only one tenth, 1,500 properties becoming available annually.

Brownlow Health Homeless Team (BHHT) has observed a similar spike in the burden of homelessness. **As of the end of March, BHHT cared for 1,223 people experiencing homelessness (PEH)** an almost 100% increase from 2016 and notably a 55% increase from 2021 when current funding arrangements were made. Due to the nature of homelessness there is a significant flux in registrations. **In the last year 415 new patients experiencing homelessness registered** while 104 left the practice. This means the actual number of people cared for is higher than snapshot figures.

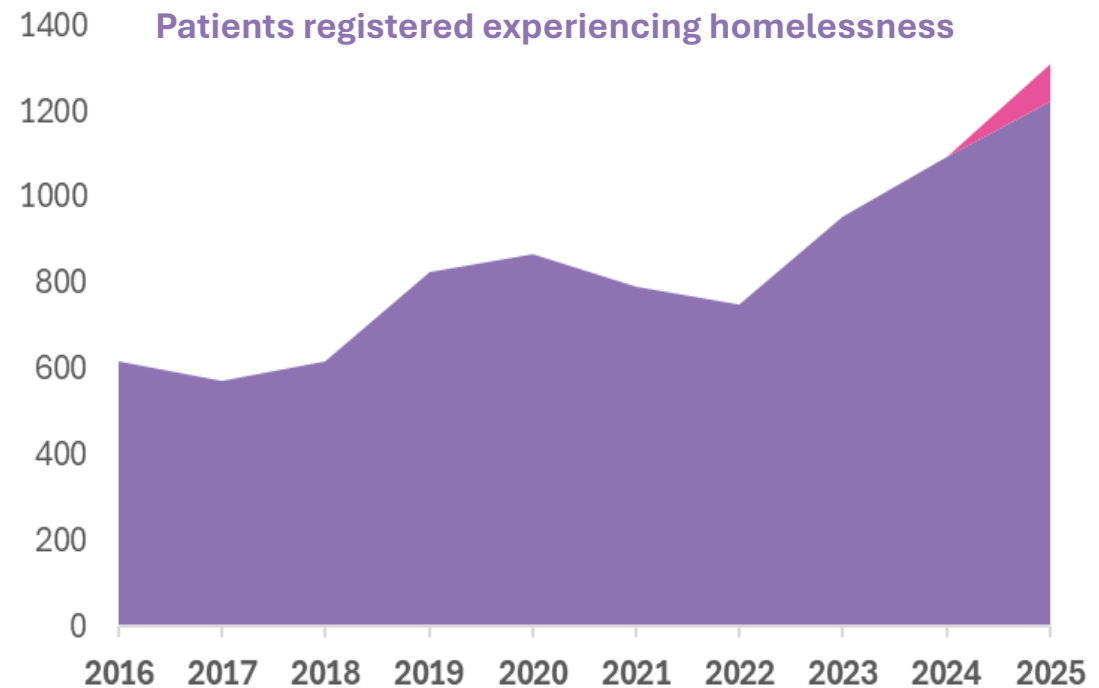
Research shows a cliff edge of increased morbidity and mortality for people experiencing extreme social exclusion. Pooled data shows mortality rates that are 8 times higher than the general population for men and 12 times higher for women resulting in an **average age of death of 46 and 42 for men and women experiencing homelessness respectively**. **People experiencing homelessness die 30 years before their housed counterparts**.

Along with increased mortality, people experiencing homelessness have significantly higher morbidity. Chronic disease is much more common and follows a similar cliff edge pattern. An audit found **63% of homeless individuals reported having a long-term illness, or disability, and 82% had a mental health diagnosis**. Despite high levels of illness, PEH commonly present late with advanced disease in a system which they mistrust, are

unaccustomed to, and which requires adherence to restrictive rules which are unrealistic and encourage further exclusion. Poor health is compounded by a high prevalence of mental illness and addiction often coined tri-morbidity.

Due to a disproportionate burden of morbidity and late initial presentation, PEH cost local healthcare systems more than their housed counterparts. **The annual cost of unscheduled care for PEH is eight times that of the housed population** and PEH are overrepresented amongst frequent attenders in Accident and Emergency (A&E) departments.

Despite rapidly increasing demand, BHHT continue to provide high class, innovative care for people experiencing homelessness in Liverpool. The team have provided a huge number encounters with patients to match increasing demand but continue to progress with new innovations and collaborations to provide for the needs of the population the team works alongside and serves.



Brownlow Health Homeless Team (BHHT) Structure

The work of BHHT and staffing roles are brought together from a number of sources of funding:

Core Funding

Brownlow Health is commissioned to provide enhanced primary care by Liverpool Place, part of Cheshire & Merseyside ICB. This funds the core team and their activities, related to provision of primary care for people experiencing homelessness.

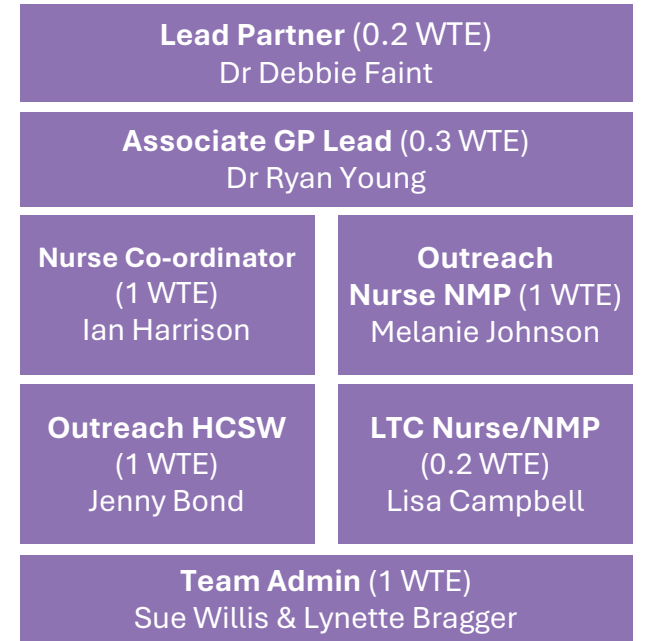
Additional Funding

BHHT receives additional funding to provide a Homeless Hospital In-Reach team funded jointly by Liverpool City Council and Liverpool Place, part of Cheshire & Merseyside ICB. Liverpool City Council Public Health Team fund two roles, Patient Mentor and Homelessness Worker and a Primary Care Alcohol Nurse.

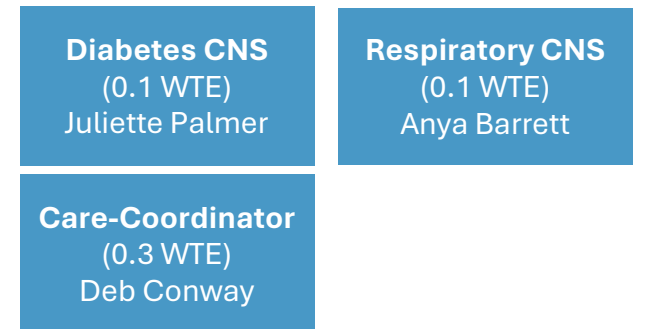
Brownlow Health Funded

Brownlow Health Practice & PCN fund additional roles as dedicated time for professionals to work with people experiencing homelessness. Additional specialist services provided by the team are provided without funding but do not include the addition of extra staff time.

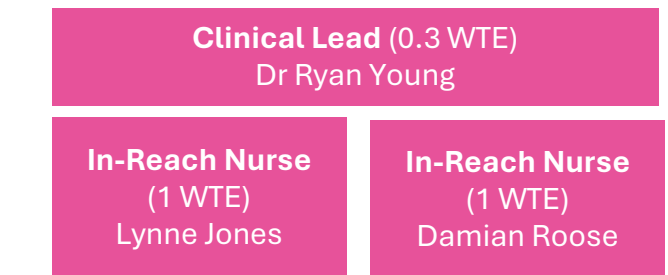
Core Funded Team



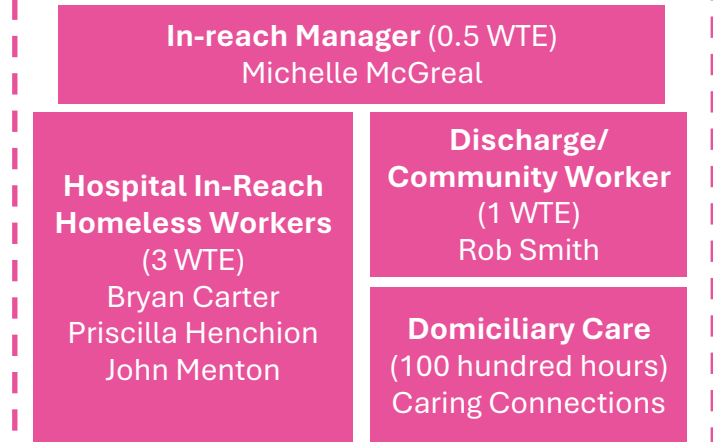
Brownlow Health Funded



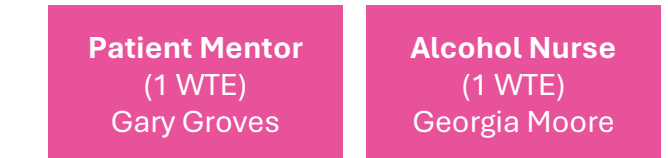
Hospital In-Reach (LA & ICB Funded)



Whitechapel Centre Employed



Public Health Funded



Brownlow Health Homeless Team Activities

- Core Funded Activities - Enhanced Primary Care - - -

Outreach

GP Outreach
1,211
visits/year

Nurse Outreach
785
visits/year

HAC

Four GPs
2,294
reviews/year

Three Nurses
2,054
reviews/year

Tissue Viability
266
reviews/year

Drug Service
280
reviews/year

General Practice

BHHT GP Appts
844
reviews/year

**BHHT GP Remote
Appts**
985
reviews/year

- Additional Funding - - -

Additional Funding: Hospital In-reach Team

Hospital In-Reach Team
1,329
referrals/year

**Hospital
Community Team**
40
referrals/year

Additional Funding: Public Health

Alcohol Nurse
cased load of:
128

Patient Mentor
783
reviews/year

- Brownlow Health Funded or Unfunded - - -

Hestia House
Residential Care

**Homeless
Hepatitis C Work**

Addictions Mgmt.
OST Prescribing

Transforming Choice
(Detox & Rehab)

**Homeless Palliative
Care MDT**

**Homeless Frailty
Service**

**Homeless Diabetes
Service**

**Homeless
Respiratory Service**

Core Funded Work

Enhanced Primary Care

Outreach

Homeless Access Clinic

Long-Term Conditions

Phlebotomy

Safeguarding

“This service has redefined what it means to provide inclusive, compassionate healthcare to those who are often overlooked by mainstream services.

The teams unique approach encourages access to quality healthcare by breaking down barriers that have long prevented individuals with multiple complex needs from receiving the help they need. Their tailored model not only addresses immediate health concerns but also empowers clients to manage chronic conditions and addictions. Due to this, our clients have experienced profound improvements in both their physical and mental wellbeing, and they now have renewed hope for the future.

This clinic is a shining example of how healthcare, when delivered with empathy and tailored to meet the unique needs of vulnerable populations, can drive real, positive change by breaking down barriers”

- Housing First Worker

Core-Team Work

Outreach

BHHT work primarily on an outreach basis, assertively assessing and managing people where they are, reducing barriers to access. The team visit people in temporary accommodation (hostels), on the streets, or in their own home if they have recently moved on from homelessness. This improves access, reduces risk of disengagement, builds trust with people and shifts the power balance inherent in healthcare settings. The team assess people through:

- **Regular clinics at Hostels:** Clinics are nurse led occurring weekly to monthly. Any resident can see the nurse, but individuals of concern will be identified for a more assertive approach to engagement.
- **Nurse case management at Hostels:** Patients of concern will be case managed by a member of the nursing team to actively monitor and manage health issues. The nursing team will liaise with BHHT doctors and other homeless and health services to co-ordinate an MDT response.
- **Long-Term Condition Management:** BHHT use an assertive outreach approach to review patients with chronic diseases. Review and management are in line with NICE guidance for conditions and in-line with QOF requirements.

In the last year:

794 nurse outreach reviews.

Average of 16 per week

1,217 GP outreach reviews.

Average of 24 per week

2,011 total outreach reviews.

Average of 40 per week.

Feedback

“weekly drop in clinics are always well attended and it helps early identification of serious health issues in our clients”

Hostel Manager

“Absolutely wonderful – always treated me with the utmost respect. The nurse is kind and patient and listens to what you say. They are top class”

Hostel Resident

“We feel very lucky to have the BHHT look after us. Many of our men have mobility and cognition difficulties, so due to that and often very poor mental health problems, cannot access walk in services”

Hostel Worker

- **GP Case Management:** Patients of concern will be case managed by a GP for physical health, mental health, or addiction management. These individuals usually struggle to engage with healthcare services and disease progression has reached a severe or critical phase.
- **Joint home visits:** BHHT will arrange joint home visits with the wider BHHT MDT such as, homeless palliative care or homeless diabetes teams or wider allied health professionals such as social workers. This will allow shared holistic plans to be formulated and to use the trust developed by BHHT to enhance engagement with other services.

Core-Team Work

Homeless Access Clinic (HAC)

BHHT provide a weekly open access clinic. The clinic is open to all and allows same day access, registration and treatment for any person. It is a one stop shop for a number of health issues and provides:

- Nurse assessment
- Long-term health monitoring and management
- Access to vaccines and health screening.
- Sexual health screening and contraception provision (including Depot, Coil and Implant).
- Assessment with a General Practitioner for physical health, mental health and addictions assessment and management.
- Specialist Skin Service
- Drug Addictions worker (NMP) – Brook Place (now CGL)
- Specialist Homelessness Advice & Support

All people who present to HAC are provided with food arranged by Gary Groves, our patient mentor who collects left over food from two Greggs stores and two Tesco stores the day before.

In the last year:

2105 nurse reviews.

Average of 41 per week

2346 GP reviews.

Average of 46 per week

4451 total clinical reviews.

Average of 87 per week

273 reviews by skin team & 286 by drug services

Feedback

“Everyone involved at the Brownlow Group Practice from the doctors and nurses, specialists support workers, and reception staff have done amazing work delivering the Homeless Access Clinic and providing the homeless community with the medical needs that they find often difficult to engage with by providing a safe and accessible place for people with the most multiple and complex needs”

Housing First Support Worker

“The persistent and consistent approach delivered with understanding, empathy, and compassion by everyone involved explains the comments and compliments I have received regarding the practices from my service users and proves to me how much they appreciate having the service provided”

Outreach Workert access walk in services

Periodically we have allied professionals within the clinic including:

- Podiatry
- Optician services
- Hepatitis C Team
- Homeless Mental Health Outreach Team (HOT)
- (Planned for next month) Physiotherapy clinic fortnightly.

The HAC is well known by all providers of homeless services across the city and people are often directed to the clinic to access healthcare services. The service is also well known to people experiencing homelessness and often people present who have heard from peers by word of mouth.

Core-Team Work

Long Term Condition Management

Management of chronic disease is central role to primary care to reduce ill-health and improve overall outcomes. There are currently 528 individuals (40%) of people registered experiencing homelessness who are on at least one chronic disease list as part of NHS Quality and Outcomes Framework (QOF). Patients may occur on more than one list, therefore, there are a total of 849 condition cases on any QOF list.

QOF lists are a useful way to monitor how we engage people in management of their chronic diseases. To the right is a list of QOF chronic disease conditions and the number of successful reviews completed. The percentage success considers those who have been excluded from the list. This may be due them being inappropriate, e.g. they are palliative or in prison, due to them refusing review, or due to at least three failed attempts to engage them. Only those conditions requiring a review as per QOF have been included. The numbers excluded is notably low given people experiencing homelessness can struggle to engage or trust healthcare services. Our exclusion rate of 11% is below the national average of 13%.

In the last year:

528 (40%) individuals have at least one chronic disease

849 chronic diseases in total (people having more than one).

BHHT achieved 100% of clinical QOF targets

QOF conditions are broken down into specific clinical requirements such as certain blood tests being required, or a blood pressure needing to be in a certain range, points are allocated for percentage success in each requirement.

In the last year BHHT achieved full QOF points across all clinical domains. In addition, full QOF points in public health domains except for cervical smears, achieving 62%, below the target of 80%.

- 121** Asthma reviews completed. **88% achieved**
- 9** Atrial Fibrillation reviews completed. **100% achieved**
- 18** Cancer reviews completed. **100% achieved**
- 16** Coronary Heart Disease reviews completed. **100% achieved**
- 130** COPD reviews completed. **95% achieved**
- 43** Diabetes reviews completed. **92% achieved.**
- 10** Learning Disability reviews completed. **100% achieved**
- 8** Heart Failure reviews completed. **100% achieved**
- 45** Hypertension reviews completed. **83% achieved**
- 146** Mental Health reviews completed. **83% achieved**
- 90** Pre-Diabetes reviews completed. **95% achieved**
- 14** Stroke reviews completed. **100% achieved**

Overall 634 reviews completed. 91% overall achievement rate.

Core-Team Work

Phlebotomy

BHHT carry out their own phlebotomy as this must be done on an assertive outreach basis or opportunistically when seeing patients. Further, people experiencing homelessness, often have difficult venous access and mainstream services are often inappropriate.

In the past year the team took bloods from 479 patients (40%) of patients experiencing homelessness. An individual may require more follow up blood tests or monitoring, therefore **in total phlebotomy was carried out by the team 637 times.**

Safeguarding

BHHT has an established safeguarding process independent of the main practice adult and child safeguarding teams. The whole BHHT meets monthly with the support of dedicated safeguarding care co-ordinators.

In the past year 98 patients have been open to our safeguarding team. There are 40 patients currently open to our safeguarding team.

A person's history and risks are discussed and a safeguarding plan is formulated. The safeguarding co-ordinators will monitor the plan over the following month and bring outcomes to the next meeting.

The co-ordinators will link in with social services and other statutory and non-statutory organisations to ensure effective communication.

Admin Support

Our team administrators, Sue Willis and Lynette Bragger along with our care coordinator Debi Conway provide vital organisational support to the team. In the last year we have opened up a dedicated phone line and e-mail to allow direct contact from homelessness providers to BHHT. The trio have also set up a system to monitor referrals to secondary care, chasing up appointment details and liaising with homelessness teams to reduce missed appointments.



Additional Funded Work

Hospital In-reach Service
Homelessness Worker &
Patient Mentor
Primary Care Alcohol Nurse

“Brownlow Homeless Health Team reach out to, value, and support many of the most vulnerable people in our city. They do it proactively with compassion and respect.

People who are homeless can face many obstacles to healthcare. This fabulous team works to overcome these. It saves lives and helps individuals build happier and healthier ones.

The whole team are highly appreciated by homeless patients and other services for always going the extra mile and meeting people where they are at right now in terms of their health needs and lives. They care for the whole person.

They are a beacon of hope in a challenging social context .

We would be lost without them ”

- Homelessness worker

Additionally Funded Teams

Hospital In-Reach

The hospital in-reach team is funded by Liverpool City Council and Cheshire & Merseyside ICB. The team is formed from a collaboration of:

- Brownlow Health: Lead GP (0.3 WTE) & 2x Full time Nurses
- Whitechapel Centre: Team Manager (0.5 WTE) & 4x Homeless Workers
- Caring Connections: 100 care hours per week in the community.

People experiencing homelessness or at risk of homelessness are referred to the team for support when they present to A&E or are admitted to a ward.

In the last year the team received 1,329 referrals.

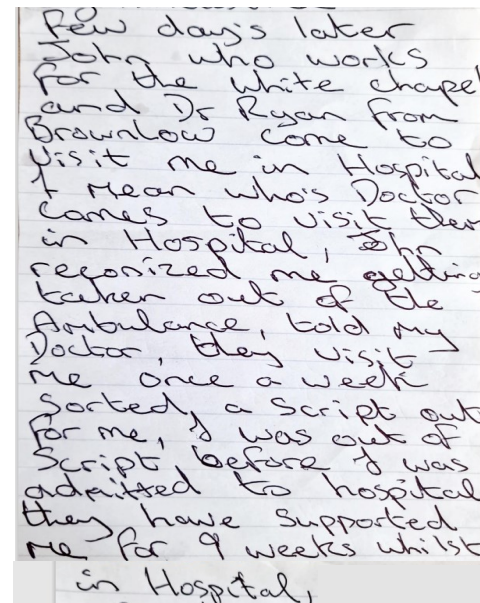
This has increased year on year as seen in the graph on the next page. The increase in referrals is due to increase need but also due to the efforts of the team to increase awareness of issues and their presence in departments of the hospital which commonly encounter people experiencing homelessness.

On review of attendances of people referred to the team over the last year:

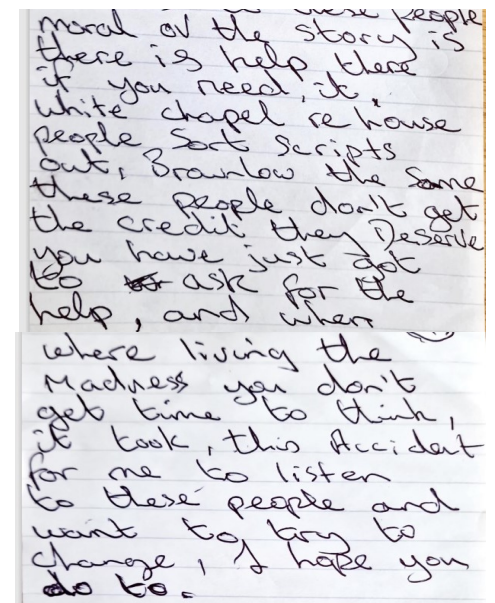
- 70% of referrals come from A&E with the remaining 30% coming from the wards or community providers
- 58% of people attend as walk-ins to hospital, 35% are brought by ambulance and 6% by police
- 30% presented primarily with a medical issue, 23% with an issue directly related to addictions (including overdose and detox), 23% presented primarily with a mental health issue while 15% presented due to an assault or recent musculoskeletal injury. Only 7% presented purely for a social issue.
- Only 39% of presentations lead to a hospital admission with 61% being dealt with in A&E or self-discharging before review.

Clinical input provided by the team includes:

- Assessment of clinical need to advise on appropriate placements and support in the community
- Liaison with the local authority to advocate for clinical and priority need
- Safeguarding assessments and support
- Liaison with social services to highlight care and support needs
- Cognitive & capacity assessments
- Advice on management of addictions management, including advice on Opiate Substitution Therapy prescribing
- Input of specialist clinical knowledge to clinical management plans e.g. diabetic care, palliative care
- Continuation of clinical care into the community



Few days later
John who works
for the white chapel
and Dr Ryan from
Brownlow come to
visit me in Hospital
I mean who's Doctor
comes to visit them
in Hospital, I
recognized me getting
taken out of the
Ambulance, told my
Doctor, they visit
me once a week
sorted a script out
for me, I was out of
script before I was
admitted to hospital
they have supported
me for 9 weeks whilst
in Hospital,



... new people
moral of the story is
there is help there
if you need it,
white chapel re house
people, sort scripts
out, Brownlow the same
these people don't get
the credit they deserve
you have just got
to ask for the
help, and when
where living the
Madness you don't
get time to think,
it took, this Accident
for me to listen
to these people and
want to try to
change, I hope you
do to.

Letter from patient cared for by Hospital In-Reach Team

Additionally Funded Teams

Hospital In-Reach

Providing concrete housing solutions directly from hospital has become increasingly challenging, due to lack of options within the saturated housing system and an increase in the number of referrals from A&E. Management of patients in A&E who are not admitted to hospital (61% of referrals) is challenging due to the short turn around time, lack of space, presentations out of working hours, and risk of self-discharge before review.

In the last year:

57% of people were provided with a direct accommodation solution

Within this group:

- 48% supported to a new accommodation solution such as B&B, temporary accommodation or friends and family
- 36% supported back to previous housing solutions.
- 10% supported through social care pathway
- 6% supported to detox, rehab, or mental health accommodation

29% of people were referred and supported to engage with an allied service or offered specialist housing advice

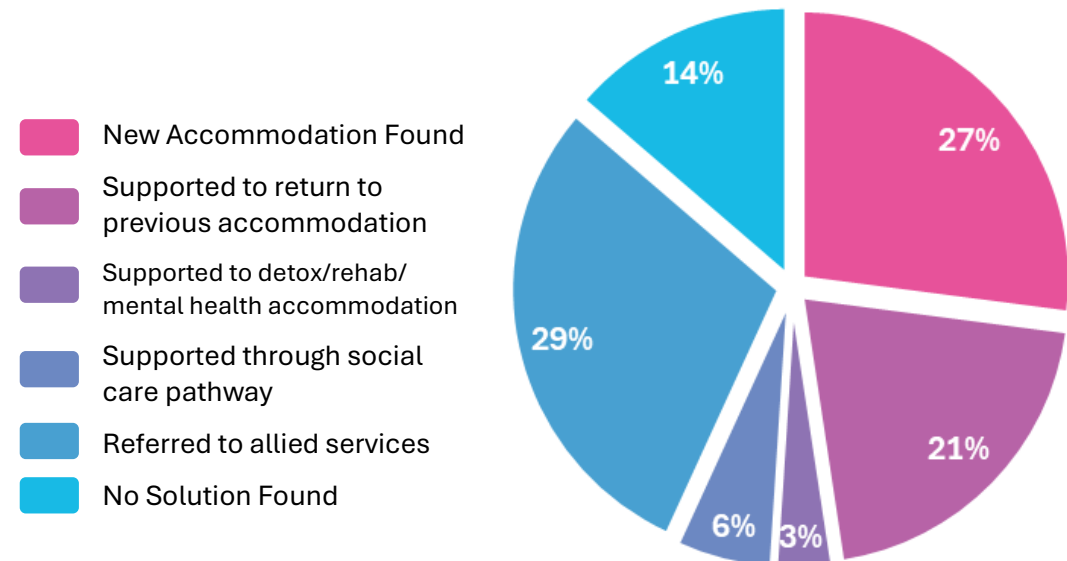
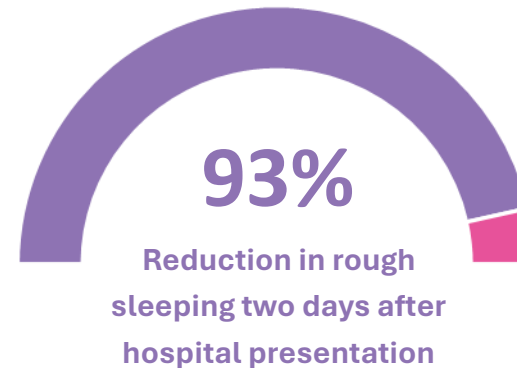
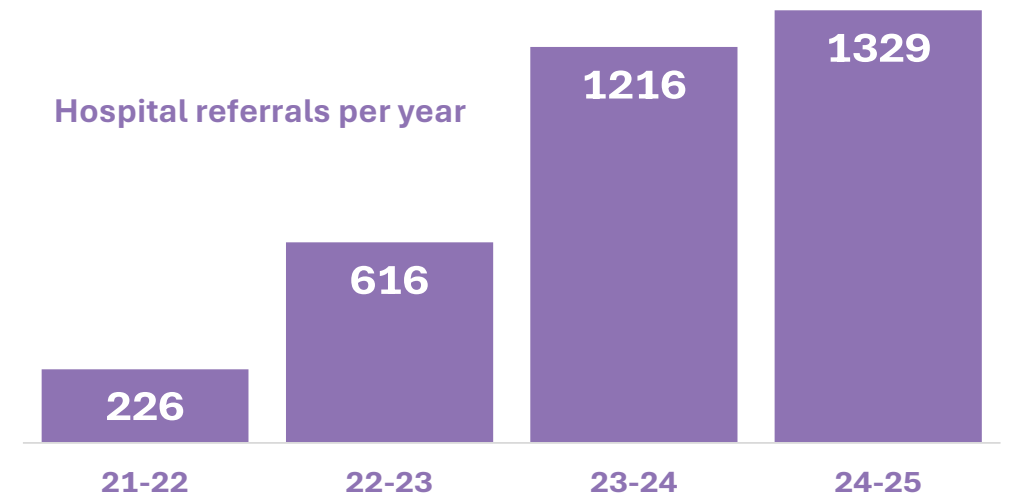
Within this group:

- 53% were referred to Whitechapel Services e.g. Assessment Centre or Night Assessment Hub
- 34% were supported to reconnect with their local authority
- 13% were provided housing or prevention advice,

For 14% of people the team were unable to provide a solution

Within this group:

- 80% self-discharged or were evicted before being seen or a solution was found
- 10% refused a provided solution offered
- 5% were taken into police custody
- 5% died while an inpatient in hospital



Additionally Funded Teams

Hospital In-Reach

Community Hospital Team

Due to need extending beyond hospital discharge, the team have extended their offer to include care into the community, establishing a community care team.

One hospital homelessness worker and one hospital in-reach nurse (Lynne Jones) from the hospital in-reach team form the community care team. This team supports individuals with their social, physical, mental, and addiction needs for up to 12 weeks after discharge.

The team liaise with allied services and actively manage clinical need with support from a GP in homeless health.

In addition, hospital prevention cases are accepted where clinical need or risk increases in the community. Initiating a rapid response and holistic offer prevents hospital admission for people who themselves wish to avoid admission at all costs. Over the last year the team have supported 40 people preventing admissions and re-admissions to hospital.

Feedback

“Lynne, I wanted to personally thank you for all your hard work and input with the patient. I felt for months I was fighting an uphill battle with this man, everybody I spoke to fobbed me off and told me he had capacity and there was nothing they could do....except you. You listened, you took the time to care for him the way nobody else would, so thank you. If only there were more people like you in this world”

-District Nurse

“I’m pretty sure you know this already but Lynne really is amazing She has shown such dedication in support ting the patient and not sure where we would be without her”

-Homelessness Manager

Case Study

Lyndsey, a 69-year-old female attended hospital after she became homeless fleeing domestic abuse from her long-term partner. She was referred to the Hospital In-Reach team who carried out a holistic assessment. Lyndsey has diagnoses of diabetes, poor eyesight, asthma, and arthritis. She was still weak from a triple heart bypass she had three months prior.

On discharge Lyndsey was placed in temporary hotel accommodation and referred to the Community Hospital Team for follow up support.

The Team supported Lyndsey to engage with an Independent Domestic Violence Advocate (IDVA) to maintain her safety, referred her for a social care assessment and claimed attendance allowance and pension credit to maximise her benefits.

Lynne Jones supported her to manage her medication, a recognised difficulty, organising a blister pack, providing inhaler education, and purchasing a fridge to store her insulin. Caring Connections (the team’s community care partner) provided an interim package of care, supporting her with shopping, medication prompts, and maintaining a habitual environment.

A social care *Your Needs Assessment* found Lyndsey to have eligible needs. She was referred to Extra Care Supported Accommodation, where she could enjoy the independence of her own flat, while receiving support from carers. In the interim Lyndsey was moved to Whitley House (a Whitechapel hostel) as it was felt she was experiencing isolation and loneliness in hotel.

Lyndsey was offered an extra care sheltered accommodation. The team supported her to sign and move into the property. In addition, she was referred to a Liverpool based support agency assisting her to access the local community, support with shopping, and encourage social engagement through activity sessions and organised trips.

Lyndsey was closed to the Hospital Community Team with all support and accommodation needs met. She had no further admissions to hospital.

Additionally Funded Teams

Homelessness Worker & Patient Mentor

This role is funded through public health monies which Brownlow Health pays to The Whitechapel Centre to employ a Homelessness Worker & Patient Mentor who is embedded in BHHT and on site five days.

Our Patient Mentor, Gary Groves, acts as a conduit between the team and The Whitechapel Centre ensuring holistic care for patients. He offers direct face to face support to patients throughout the week either in booked appointments or drop ins. His role includes:

- Supporting vulnerable patients to register.
- Liaising with homelessness services to identify individuals of concern and supporting them to engage with healthcare
- Supporting people at risk of homelessness, carrying out prevention work
- Supporting people experiencing homelessness, undertaking housing assessments, referring to the local authority and liaising with wider Whitechapel Centre teams.
- Supporting people to maximise benefits and complete application forms
- Providing pastoral and emotional support as a trusted member of support services
- Providing practical support including mobile phones, food, and clothing
- Supporting practice staff if experiencing challenging engagements with patients utilising de-escalation skills and working in a trauma & psychologically informed way.

In addition, Gary has developed links with local Gregg's bakeries and Tesco supermarkets to collect left over food weekly to provide food for our homeless access clinic. He provides food for 40-90 people per week who attend our drop-in clinic.

Gary was nominated for Extended Practice Team Member of the Year at 2024 General Practice Awards. He received a highly commended award from the organisers for his role at Brownlow Health.



Over the last year he has supported 783 individuals.

540 occasions of support for a person to engage around their physical health

520 occasions of support for a person to engage around their mental health

853 occasions of support for a person around housing or social issues

359 occasions of linking patients to other Whitechapel services for specialist housing or homelessness support.

Additionally Funded Teams

Homelessness Worker & Patient Mentor

Case Study

Sarah, a patient, attended the practice and confided in Gary that she was experiencing domestic abuse, including a threat to kill. The windows to her flat had been smashed and her front door kicked in by the perpetrator.

Gary made a referral to The Whitechapel Centre Domestic Abuse Service for specialist support and advice. He supported the patient to make a report to the police, contacted the landlord for repairs and target hardening measures, and provided a new mobile for safety and liaison with other services. Support was arranged for the patient to facilitate a safe return to her flat.

Gary arranged weekly follow up appointments enabling the patient to continue to engage with the clinic on a Thursday regarding her health & wellbeing and receive a methadone prescription. Through regular contact he ensured she felt listened to, strengthening trust and building her self-esteem.

Merseyside Police are still involved but the perpetrator no longer makes any contact with her.

Feedback

“Patients have built their trust up towards Gary and many will come to the reception desk asking to speak with him. He will always give as much time to the patients as they need and goes that extra mile to help them”

“He makes it his quest to get to know each patient that comes through the door so he can build a relationship that makes the patients feel at ease when they come into the clinic”



Additionally Funded Teams

Primary Care Alcohol Nurse

BHHT Alcohol Nurse role is funded through public health monies.

Georgia, our alcohol nurse works on an assertive outreach model to engage people where they are, reducing barriers to access. Primarily their focus is on people experiencing homelessness but also includes those who are housed who struggle to engage with mainstream alcohol services.

Georgia holds a caseload of patients, providing case management with regular repeat appointments.

Georgia works closely with allied services, meeting weekly with the hospital alcohol team, attending the Complex Lives MDT, and offering weekly drop-in clinics at a number of hostels in the city.

Over the last year she has also worked on fostering new partnerships and innovations:

- Established new links to a number of out of area rehabs to increase choice for individuals. These links have been successfully utilised where previous local options have been exhausted.
- Established new pathway into residential rehab for people experiencing homelessness focused on harm reduction and improving patient choice.
- Commenced a quality improvement project to use nalmefene (a medication used for binge drinking) for chronic high-level drinking as a harm reduction approach.
- Sitting on the nurse advisory panel for alcohol dependence in the Merseyside region.

Over the last year Georgia worked with **128 individuals**

118 people completed a full alcohol assessment

126 people provided harm reduction information and advice

76 worked through detox mapping, reviewing past treatments and planning future treatments

60 individuals have been referred to residential detox.

48 individuals attended & completed a residential detox

44 individuals have been referred to residential rehab

41 individuals attended and completed a residential rehabilitation program

31 individuals have received a course of intramuscular *pabrinex* injections (high dose vitamins) in the community. This is to reduce risks of brain injury and improve cognition

Feedback

“Georgia is a bundle of energy who comes in like a whirlwind and instantly gets the clients on side. She has been a godsend”

-Hostel Worker

“She has been fundamental in a number of clients going to rehab both locally and out of area – In the past year 12 clients have moved on to rehab. A number of clients have also been assisted to do in patient detoxes for health purposes”

-Hostel Manager

Brownlow Health funded & Unfunded Work

Addictions Management
Homeless Palliative Care Team
Homeless Diabetes Team
Homeless Respiratory Team
Homeless Frailty Team
Hestia House—Residential Care Home
Transforming Choice - Alcohol Rehab
Homeless Hepatitis C Work

“The team at Brownlow has made a significant difference in the support we provide to our homeless clients.

The teams visits ensure that clients receive consistent and compassionate care, and the support provided is invaluable.

Juliette’s expertise in diabetes management has been a game changer; she not only came to train our staff but also remains a constant source of support, always ready to answer our questions.

The work with methadone and buprenorphine prescribing has been essential in helping our clients manage their addiction and take steps toward recovery.

The HAC offers a vital opportunity for our clients to access medical attention, as many of our clients otherwise struggle to receive immediate support in a welcoming and compassionate environment.

The dedication to our clients is evident in the positive outcomes we’ve seen, and the hands-on approach is truly making a difference”

- Hostel Worker

Additional Specialist Services

Opiate Substitution Therapy (OST)

BHHT offer GP led OST prescribing for people experiencing homelessness or recently transitioned out of homelessness. The service is not commissioned but is offered to reduce barriers to engaging in addictions management.

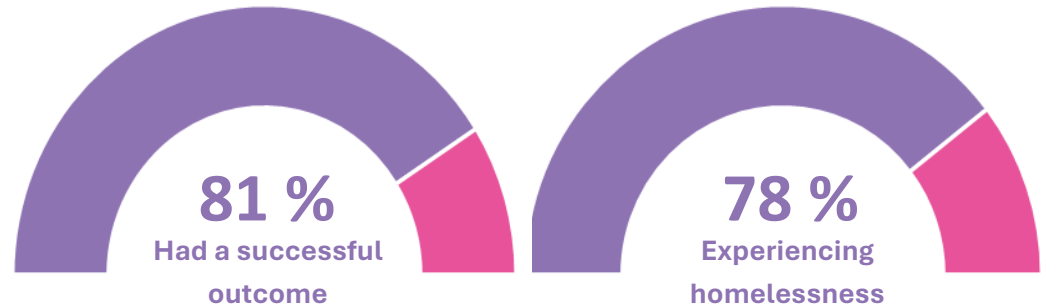
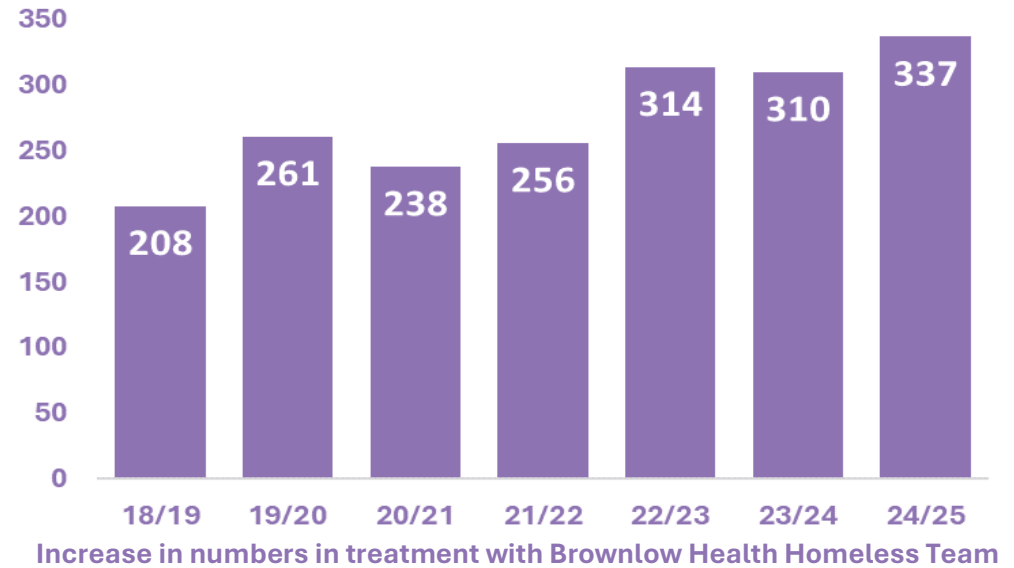
People are managed in the weekly Homeless Access Clinic (HAC), or by assertive outreach. The HAC is designed as a high tolerance, low threshold clinic where minimal expectations are placed on an individual to engage in OST treatment. Assertive outreach actively finds and holds people who struggle to engage in traditional healthcare models. Both models are designed to reduce barriers, aid engagement, and reduce harms.

In the last year BHHT provided OST treatment for 337 individuals, an increase from 310 in 23/24. A marked increase is noted for people who have only been in treatment with BHHT in that year period (i.e. not transferred from or to a commissioned provider), increasing from 181 in 23/24 to 264 in 24/25.

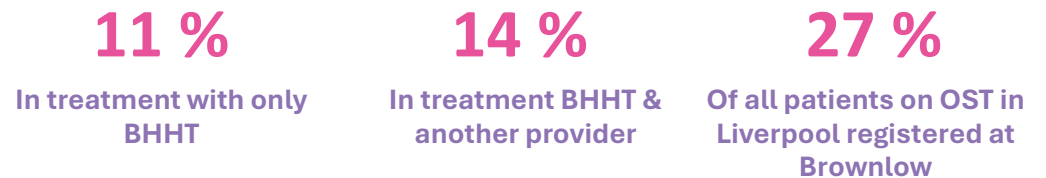
National monitoring data reports 2,130 people were in OST treatment in Liverpool last year. Those in treatment with BHHT are absent in this data. By adding patients who were only treated by BHHT we get a truer figure that 2,394 people received OST treatment. Based on this we can calculate that:

- 11% in OST treatment in Liverpool are in treatment only with BHHT.
- 14% in OST treatment in Liverpool are in treatment with BHHT at some point in the last year.
- 27% of people in OST treatment with any provider in Liverpool are registered and receive primary care from Brownlow Health.

In the last year, 81% of people in treatment with BHHT had a successful outcome (an increase from 79% in 23/24). A successful outcome is a person who has detoxed and remained abstinent, a person who remains in treatment at the end of the audit year period, a person who has been successfully transferred to a commissioned provider or a person who has a well-managed death with appropriate OST treatment.



Measuring all those in OST treatment in Liverpool:



Additional Specialist Services

Long-Acting Injectable Buprenorphine

BHHT offer Buvidal, a long acting injectable buprenorphine to manage opioid dependence in primary care.

Buvidal acts as a depot injection providing active treatment for a week or month period. The injection removes the need to attend a pharmacy daily and reduces the risk of people 'dropping out' of treatment.

In other areas, the use of Buvidal is focused on those who are stable in treatment. However, BHHT focus use for people who struggle to engage in traditional healthcare models and often drop out of treatment.

In the last year **41 people have been in treatment with BHHT on Buvidal, 85% had a successful outcome.**

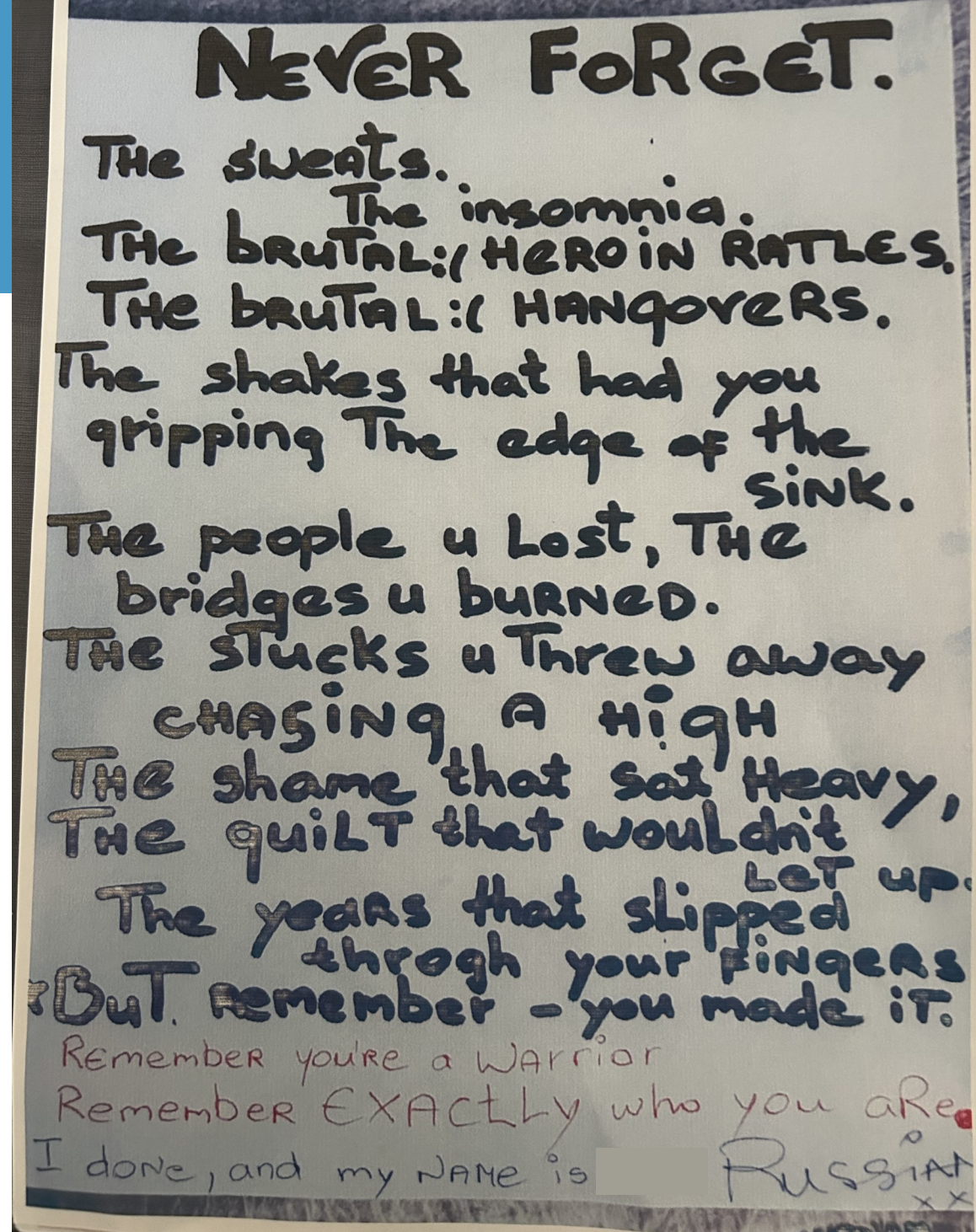
- 49%** remain in treatment
- 17%** have been transferred to a commissioned provider
- 15%** have been detoxed and remain abstinent
- 5%** were converted back to an alternate OST treatment
- 15%** fell out of treatment.

"I look up to the doctor, he makes me believe I can do better because of how much he helps me. I have been off Heroin now for nearly 2 years; everyone is proud of me"

-Patient

"I couldn't ask for better care for my siblings who have had problems with opioid addiction. Thanks to the doctor my sister is now free from the clutches of heroin and is no longer addicted to it. I can't thank you enough for what you've done for them both"

- Relative



Poem written by a patient commenced on Buvidal Treatment

Additional Specialist Services

Homeless Palliative Care Team

Liverpool Homeless Palliative Care MDT is provided jointly by BHHT and Marie Curie Hospice Liverpool with support from Palliative Care teams in the acute hospital trust. The service is not funded, rather offered as extensions of teams involved.

The team meet monthly to discuss patients who are approaching the end of their life. Outside of the monthly meeting the team will be in close contact, conducting individual or joint visits bringing together homeless and palliative specialisms, discussing advanced care planning and formulating bespoke end of life plans and providing education to staff and the wider MDT.

Over the last year the team have looked after 32 patients who are approaching the end of their life, ten of whom have died.

Of the 32 patients cared for

31 (97%) have recently experience homelessness

25 (78%) were currently homeless, the rest having recently moved into their own accommodation.

29 (91%) suffered from an active addiction to alcohol, heroin and/or crack cocaine.

19 (59%) were prescribed methadone by BHHT.

32 (100%) had a face to face palliative care review by a GP in BHHT.

21 (66%) had a face to face palliative care review by a Palliative Care Consultant.

14 (44%) had a face to face review by the palliative care therapies team.



The team have disseminated the work being carried out in Liverpool. Over the last year the team have provided teaching on Homeless Palliative Care to Palliative Care consultants and registrars, several hospices, and community nursing teams.

In January the work of the team was presented at Royal College of General Practitioners and Addictions Professionals: Managing Addictions in Primary Care Conference, winning first place for best presentation. The team also shared their work at a specialist conference in Manchester (artwork overleaf).

We are also supporting research in this area and have joined an advisory panel for a new national NIHR funded research project in Homeless Palliative Care.

In December, the Homeless Palliative Care Team were nominated and won the General Practice Team of the Year at the annual General Practice Awards.

Additional Specialist Services

Homeless Palliative Care Team

Case Study

Anne was admitted to hospital after a failed suicide attempt and found to have an ulcerating mass to her neck. She had not previously sought help as she was in a long-standing controlling domestic violence relationship, being unable to leave their shared house. From hospital she was placed in a domestic abuse refuge for women suffering addiction and registered with Brownlow Health.

Unfortunately, the neck mass was found to be malignant spread from a head and neck cancer which was non-curable. She was supported to engage with oncology by the Homeless palliative care team undergoing radiotherapy.

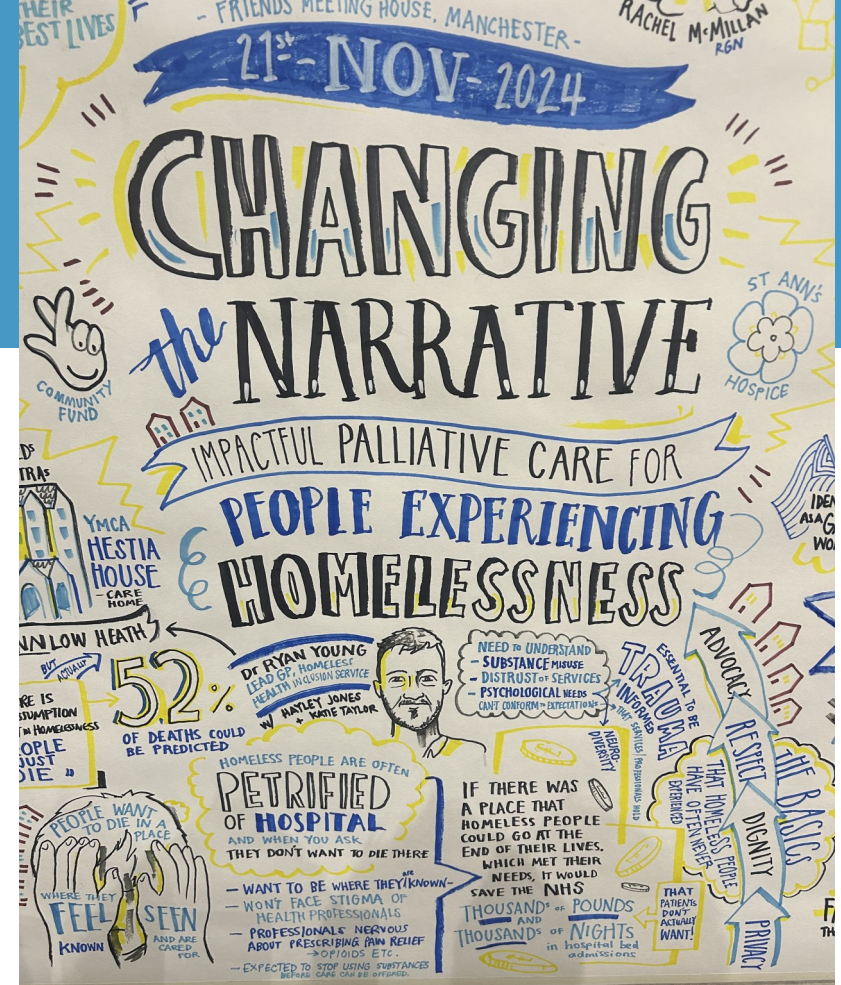
Anne suffered from addictions to alcohol, heroin, and crack cocaine. She was prescribed methadone by BHHT. The team also linked in with Royal Liverpool Hospitals alcohol team to provide a number of alcohol detoxes as per Anne's wishes, but ultimately she wished to continue drinking.

She was assessed by social services and funding was agreed for placement in Hestia House, a new residential care home for people experiencing homelessness.

Anne was anxious about how her pain would be managed due to her addictions. She was commenced and titrated on morphine to control her pain.

Anne was an active and independent woman with a quick wit. She was supported by the team to remain independent and enjoyed going out with staff shopping, for walks, and enjoyed supporting other residents with their needs. In the summer she attended a number of festivals held in the park, making positive memories with staff and other residents.

Anne struggled with side effects of palliative chemotherapy. Her wishes were discussed with her and she decided she did not wish further treatment or



admissions to hospital. She wished to be cared for and die at Hestia House as she felt this to be her home and a place of safety.

Due to the domestic violence relationship, Anne had become estranged from her family and desperately wanted to be reconnected with her son. The palliative care team made contact with her son and she was able to reconnect.

Over the next few weeks Anne's health declined, spending more time in bed and eating only small amounts. A syringe driver was commenced, managing her pain, agitation, and preventing withdrawal from opiates and alcohol. She passed away peacefully with her son present at her side in Hestia House.

Unfortunately, Anne had suffered multiple traumas throughout her life. However, the team were able to offer her comfort, peace, and choice at the end of her life and in death.

Additional Specialist Services

Homeless Diabetes Team

Experiencing homelessness creates huge challenges for an individual and their medical team to manage a diagnosis of diabetes. People are unable to manage their diet effectively or have regular meals, have competing priorities to managing their diabetes, have difficulty storing their medications, and can struggle to remember to take medication or eat food because of substances taken. As a result, people are at high risk of diabetic emergencies and death and tend to have poorly controlled diabetes.

The wider practice at Brownlow Health employs a full time Diabetes Clinical

There are currently **47 patients** registered who are experiencing homelessness and diagnosed with diabetes:

- **27 (57%) are diagnosed with type 2 diabetes.**
A form of diabetes influenced to a large degree by lifestyle which is initially managed by tablet medication.
- **11 (23%) are diagnosed with type 1 diabetes.**
A form of diabetes caused by the body attacking the pancreas which is always managed by insulin. There is a higher risk of diabetic emergencies.
- **9 (20%) are diagnosed with type 3c diabetes.**
A form of diabetes caused by damage to the pancreas, commonly in this population due to alcohol related pancreatitis. This form is unpredictable as the level of damage is not clear and usually requires insulin. Damage to the pancreas also damages the body's ability to absorb food.
- **19 (40%) are managed using insulin therapy,** which increases the risk of diabetic emergencies and requires regular monitoring of blood sugars.

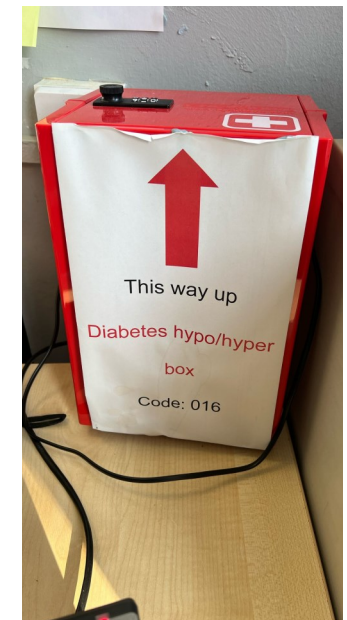
Nurse Specialist (CNS), Juliette, who has one session per week allocated to manage people experiencing homelessness. Juliette works within the BHHT:

- upskilling and offering advice to the clinical staff,
- undertaking assertive outreach into hostels or on to the streets, case managing complex cases
- providing education on diabetes to homelessness and hostel staff to support them to manage residents diagnosed with diabetes.

Collaboratively the team produce pragmatic and bespoke plans for diabetic patients, understanding individuals as a whole person with their own beliefs, behaviours and past. The team educate a person's wider support team and network and advocate on their behalf to statutory services.



Juliette Palmer - Diabetes CNS



Hypo Box in Hostel

Additional Specialist Services

Homeless Diabetes Team

NICE Guidance recommends completing nine key care processes each year to manage a person's diabetic health. The team have struggled to engage patients in diabetic eye screening with only 20% attending screening but are forming new links with eye screening services to set up a bespoke service in the new year. Excluding eye screening, 78% of patients had all of the remaining key care processes completed.

- 94% had a HbA1C (diabetes monitoring) blood test
- 87% had a Cholesterol blood test
- 96% had an eGFR (kidney monitoring) blood test
- 83% had a urine ACR (kidney monitoring) urine sample
- 93% had a BMI measurement (height & weight)
- 96% had a Blood Pressure Measurement
- 92% had a diabetic foot check
- 98% had their smoking status recorded and were offered cessation advice
- 20% had a diabetic eye screening test
- 92% had a diabetic holistic annual review.



Artwork from homeless diabetes research and education supported by BHHT

Juliette Palmer and Dr Ryan Young from BHHT were part of a national NIHR funded project exploring diabetes management for people experiencing homelessness. They were both involved in writing a new online education platform, a national survey of diabetes and homelessness specialists and speaking at a number of diabetes education days. They are also involved in writing research papers due to be published in the coming year regarding diabetes management in homeless health.

The team spoke at the Faculty of Homeless and Inclusion Health International Conference on diabetes management in Homeless Healthcare.

"Juliette is always available to visit or offer over the phone support and understands the complexities of our clientele. More recently we have seen an increase in the number of clients with diabetes, and staff were concerned that they didn't understand how to work with diabetes. Juliette came and delivered training to the team and helped improve our confidence"
-Hostel Manager

"Juliette's expertise in diabetes management has been a game changer; she not only came to train our staff but also remains a constant source of support, always ready to answer our questions"
-Hostel Worker

Additional Specialist Services

Hestia House

Hestia House is a 22 bedded CQC registered specialist residential care home, opened in 2023 that is specifically aimed at providing care for people who have experienced or are currently experiencing homelessness and have additional health and social care needs which are linked to homelessness. The service was established and is run by YMCA together. Traditional residential care homes are unequipped to manage the complex needs of people with a history of homelessness and often reject people who develop care and support needs at younger ages. The service meets care and support needs and offers a safe place to plan and deliver end of life care in the community.

The service has care and support staff on site 24 hours a day with a mix of knowledge and skills across homelessness and care work. The team work in a trauma and psychologically informed way to meet the needs of individuals.

Brownlow Health look after 20 of the people currently resident in Hestia House. As the care home is based outside of the practice area it does not receive any funding to provide care but care is offered as the team holds specialist knowledge and has long-standing relationships with people who are resident.

A GP from BHHT spends half a day a week at Hestia House reviewing patients face to face and co-ordinating care through an MDT with staff, a community matron, and the district nursing team. In addition, a nurse from BHHT attends fortnightly and a nurse from our hospital discharge team with knowledge of palliative care offers drop in sessions for staff and residents focused around palliative care needs. BHHT manages OST management for 13 residents offering holistic care for all of a patient's needs.

Hestia House is one of only a couple of care homes nationally providing specialist care for people experiencing homelessness. Brownlow Health and YMCA Together have presented the model of care at Hestia House at conferences to highlight best practice of care.



Additional Specialist Services

Case Study - Hestia House

Simon attended the HAC as his support worker was concerned about sudden weight loss. BHHT carried out a full medical review which found him to be severely malnourished (BMI 14) and bloods showed him to be in heart and kidney failure. An urgent home review was undertaken and end of life plans were put in place.

Simon lived in a shared flat with another patient. Both struggled with active addiction. Concerns were raised about his flatmates' ability to care for Simon due to his own health issues. Despite this Simon retained capacity and was adamant he did not wish to move.

Over the next week his health deteriorated, he was confined to his bed and unable to manage food. A syringe driver was commenced by the Homeless Palliative Care Team. From regular visits concerns grew that Simon was left alone for long periods without support and the accommodation was not safe for staff to visit.

On one visit BHHT managed to convince Simon to take up a bed at Hestia House, explaining the care and support on offer. The team called Hestia House who prepared a room immediately and he was transferred by a BHHT doctor that night.

Over the coming days Simon was very unsettled, disorientated, and demanding to go home. Staff worked with Simon to make him comfortable and feel safe and settled at Hestia. After a week Simon felt comfortable and was grateful he was transferred to Hestia House.

BHHT and Hestia staff planned for Simon's death in the coming days. However, he slowly managed more to eat, allowed staff to tend to his personal care, and provide him regular medication.

Four months later, Simon remains resident at Hestia House. While he is still very unwell, he has become more active, engaging in activities and his weight has very slowly started to increase. Without the combined working of Hestia House and Brownlow Health Simon would have died a difficult death four months prior. He now feels positive and grateful for each day he has.

Feedback

“The team see the whole person, they are strong advocates for our residents and are always kind and respectful- even in the most difficult circumstances- they never give up!

The team are responsive and their dynamic approach is essential for our residents.

The pathways supported by the homeless team means consistency of care and treatment- people do not have to share their story twice and feel they are cared for by a team that know and understand their difficulties.

Without the support from the homeless team, we would not have been able to grow Hestia into a home where people receive safe and effective care and treatment- they are very much part of our team.

A recent example of this was the care supported for a lady with terminal lung cancer. BHHT worked jointly with Hestia and Marie Curie, ensuring that she was able to return home to Hestia as her preferred place of dying after a long hospital stay. BHHT and Marie Curie provided education and support to the team but also to her family who were really struggling with accepting her needs and choices”

- Director of Specialist Services—YMCA Together

Additional Specialist Services

Homeless Respiratory Service

There is a significant burden of respiratory disease in populations experiencing homelessness.

120 per 1,000 patients under BHHT diagnosed with asthma.

Compared to 30 per 1,000 patients in practice population.

91 per 1,000 patients under BHHT diagnosed with COPD.

Compared to 7 per 1,000 patients in practice population.

A patient's respiratory health is primarily managed by the core homeless health nurses and GPs. In addition, the team can call on the expertise of Anya, the practice's respiratory clinical nurse specialist (CNS) employed by Brownlow Health.

The respiratory CNS has one dedicated session per week to specifically manage people experiencing homelessness. This can be through face to face appointments or on an outreach basis. Periodically Anya will also have a clinic within the Homeless Access Clinic to opportunistically review patients who drop in.

In the past year Anya reviewed 103 unique patients experiencing homelessness over a total of 149 appointments.

Owing to the work of our core homeless team and Anya, in the past year: **86% of people diagnosed with asthma and 94% of people diagnosed with COPD had an annual review of their respiratory conditions.** This includes assessment using validated scoring systems, optimisation of clinical management, patient education, inhaler technique discussions, and a holistic healthcare review.

Homeless Frailty Service

People experiencing homelessness suffer a high burden of frailty at a much younger. In a study of PEH 41.5% met criteria of frailty and 43.8% met criteria of pre-frailty. In a separate study people in a hostel setting with an average age of 56 were found to have frailty to a level expected for an 89 year old.

Brownlow Health have formed a frailty team, employing two advanced nurse practitioners, one occupational therapist, one nurse assistant and a pharmacist. Over the last year BHHT and Brownlow Frailty team have worked together to offer specialist Homeless Frailty Care.

In the last year the team reviewed 24 people experiencing homelessness. The average age was 56 with an average Rockwood score of 6.2, indicating significant impairment lying in between scores for moderate and severe frailty.

The majority (75%) were in emergency or temporary accommodation making long-term plans, such as accommodation modifications difficult.

95% were reviewed by the team Occupational Therapist

64% were reviewed by the team ANP

85% had a frailty focused medication review

74% were provided with a walking aid after review

69% were provided with other equipment after review

42% were referred to social services for assessment.

Additional Specialist Services

Transforming Choice - Alcohol Detox & Rehab

Transforming Choice is an alcohol detox and rehabilitation service in Liverpool. The service is unique in offering alcohol managed detox rather than a medical detox. The service has four intakes of residents per year who go through a 12-week course. At the end of 12 weeks individuals are supported into shared or independent accommodation with after-care in the community.

BHHT are clinical partners of Transforming Choice, assessing all potential residents, ensuring they are clinically suitable for the program, prescribing and administering intramuscular high dose vitamins during the detox period, and providing ongoing clinical support to staff and patients and clinical oversight.

Homeless Hepatitis C Work

BHHT have stepped up their work around hepatitis C over the last year. Managing hepatitis C has been difficult in primary care due to the large number of possible clinical codes used in house and by other services. The team have standardised and re-coded all those with a history of Hepatitis C to formulate searches for:

- People diagnosed with hepatitis C but untreated
- People currently in treatment
- People with resolved hepatitis C by treatment or self-clearing
- People at risk of hepatitis C.

The team have used these codes to target individuals to encourage engagement with treatment, maintain compliance, test those at the end of treatment, and screen those at risk. The team has also shared these lists with the local hepatitis teams using a collaborative approach to promote best care.

This has included:

- Hosting the hepatitis team at our Homeless Access Clinic
- Developing close communications to discuss patient care
- Co-ordinating the 'Liver Bus' visiting Brownlow practices, homeless services and hostels
- Running searches of the practice lists to identify people at risk of hepatitis C, sending text messages to offer screening and treatment.

Searches at the end year end show that:

167 venous blood samples were taken by BHHT to screen for hepatitis C.

39 patients have hepatitis C but have not yet engaged in treatment

43 patients are currently in treatment or awaiting a final blood test to check clearance of the virus

64 patients have engaged in treatment and achieved Sustained Virological Response (SVR), a blood test that confirms clearance of the virus.

45 patients have cleared the virus, but it is unclear if they received treatment.

Additional Achievements

Staff Development

Research

Teaching & Education

Awards

“Along with the excellent health care, and the teams willingness to provide flexible, useful interventions – that see beyond our SU’s addictions/behavioural challenges, what really stands out for me is how welcome & understood our service users are made to feel by the team.

For a group of people that often feel they don’t belong, feel unseen & unheard by society BHHT provide person centred care & advice in a way that ensures they feel welcome & valued .. this makes so much difference in their everyday lives”

-Homelessness Team Manager

Additional Achievements

Staff Development

Melanie Johnson, Homelessness Outreach Nurse has completed and passed her Non-Medical Prescribers qualification. She was supported and supervised by clinicians in BHHT. This will allow her to operate more independently when completing outreach improving patient care.

BHHT have recruited a new Clinical Fellow, Dr Stacey Allward, working one day a week as a GP in Inclusion Health focusing on women experiencing homelessness. Her day will be split between working at Women only hostels and in HAC.

Partners at Brownlow Health have funded a new monthly Clinical Supervision session for members of BHHT. This runs in work time for two hours and is provided by a clinical psychologist and a consultant in wellbeing.

Dr Rhiannon Osborne, a Foundation year 2 Doctor completed a four month placement with BHHT. She was able to learn about inclusion and homeless healthcare but also provided a great service to the team undertaking outreach visits, working on HAC and linking our homeless and migrant clinics. The team also offer a specialist placement for GP registrars.

Doctors in BHHT have supervised two District Nurses completing their Non-Medical Prescribers qualification. This strengthens ties between the two teams and increases knowledge of our patients needs.

BHHT have a new physiotherapist and clinical lecturer starting next month providing one clinical day a fortnight. This improves access for our excluded population to physiotherapy and is intended to lead the way to regular student physiotherapy placements with the team.

Teaching

BHHT host six monthly teaching days for homelessness and hostel workers. The last day provided education on respiratory homeless healthcare, infectious diseases and infection prevention, palliative care, and the work of our homeless hospital in-reach team.

BHHT gave two presentations at RCGP Addictions Conference on provision of OST in Primary Care for people experiencing homelessness and Palliative Care for People Suffering Addictions. The later presentation won the award for best verbal presentation.

BHHT gave three presentations at International Conference on Homeless & Inclusion Health. The presentations were on delivery of OST to hostels, Homeless Diabetes Care, and video highlighting the difficulties for women who are pregnant in the asylum system.

BHHT were involved in writing a new national e-learning course on Homeless Diabetes Care. The training will sit on the Fairhealth platform and is accessible to all health professionals. It has been CPD certified and is supported by Diabetes UK and Burdett Trust for Nursing.

BHHT host six medical students completing a health inequalities special education module. This allows students to experience homeless and inclusion health and learn more about pertinent and related topics.

BHHT has provided lectures as part of regular schedules to LJMU medical students, GP Registrars, Palliative Care Consultants & Registrars, Community Specialist Nursing Students & Community Matron Teams.

Additional Achievements

Research

BHHT are a co-applicant on an National Institute for Health and Care (NIHR) Research grant. The grant is currently at stage 2 of the process. The project aims to link multiple computer systems used by different professional bodies in the city to understand the needs of people experiencing homelessness and produce a cost-evaluation of BHHT work. We hope the system when developed will be able to provide real time feedback on new interventions across primary & secondary care, social services, and homelessness data sets.

BHHT were part of a NIHR funded research project exploring homeless diabetes care. The project looked at the experiences of health professionals and people with lived experience. The project also looked at what is already known about homeless diabetes care and what we can learn from safeguarding adult reviews of serious incidents. The team are in the process of submitting a number of papers for publication.

BHHT are on an advisory board for a new NIHR funded Homeless Palliative Care Research Project. The project is developing teaching resources to produce a number of communities of practice & centres of excellence across the country and evaluating their impact.

BHHT are involved in two Community Innovation Teams, funded to produce creative solutions including story-telling to address health inequalities. BHHT are involved in projects exploring high intensity use of A&E and uptake of vaccines in vulnerable migrant populations.

Awards

BHHT won the following awards at the National General Practice Awards in London:

- **Winner: GP Team of the Year:**
Liverpool Homeless Palliative Care Team
- **Highly Commended Extended Team Member of the Year:**
Gary Groves (Homelessness Support Worker & Patient Mentor)
- **Winner: Nursing Team of the Year:**
Brownlow Health including BHHT nursing Team

