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| Case Study Summary: **Respiratory Outreach Clinic** |
| Organisation/Place Team: **Nottingham University Hospitals and Framework Housing Association** |
| Project Aims:  **To increase early identification of respiratory issues in homeless community** |
| **How did you identify the need or group (i.e. what prompted this initiative)?**  Our overarching ambition was to address the shocking statistic that the median age of death of a rough sleeper in the UK is 44 compared to 86 for a housed person (source- ONS). Furthermore the commonest cause of death, after drug/alcohol, suicide and trauma is respiratory disease, for which there are no specific services nationally. |
| **How have you developed the offer?**  Patients who potentially need a respiratory review are identified by outreach teams from various service providers, including the Rough Sleeper Drug and Alcohol Treatment Team, the night before their appointment. They are encouraged to attend with an offer an £5 voucher to cover a meal or hot drink, and the service is coordinated by a clinical nurse specialist.  Patients are then seen by a nurse for a background drug and alcohol history and set of observations before seeing a respiratory consultant who performs a full respiratory history, examination and spirometry. Xrays, bloods and sputum culture are also available, and medicines can be prescribed from our clinic with the help of our pharmacist. Our manager captures data on an electronic record so patient data are kept on a live virtual ward. This improves communication across all the various care providers (primary, secondary, third sector) ensuring coordinated care. This helps address health inequalities and reduces hospital admissions with the ultimate aim of preventing premature deaths. |
| **What case studies / examples can you give that show people’s journeys?**  Firstly, at a system level we have prevented hospital admissions and ED attendances by providing treatment closer to the patients locality. Our service has reduced ambulance call outs and conveyances by having a senior clinician assess patients allowing more pragmatic and personalised treatment decisions.  Secondly, it has catalysed interaction between multiple independent services, encouraging better data sharing (all with the patient’s permission). For example, to access our service, each rough sleeper is firstly registered with a local GP by a social worker working in our clinic. Then, after the consultation a discharge summary is shared both with the GP, but also the referring care team (e.g. drug and alcohol team), improving communication and understanding of the individual respiratory problems, but also upskilling staff unfamiliar with respiratory disorders. Given the concern over communicable diseases such as TB and Covid this has led to much improved triage and better infection control processes. Co-location of social, mental and health services also encourages a whole person approach to each rough sleeper and reduces stigma which is often present around healthcare services.  Lastly, at an individual level we have made multiple diagnosis of emphysema, chest infection and one of potential TB. Most patients have been discharged back to their GP with a request for ongoing prescription, 3 have been referred onwards for further investigations within the hospital system and two have remained on our virtual ward follow up for repeat clinic appointments in the future. To date, over 7 clinics, we have seen 71 patients, 40% were rough sleeping and the remainder were “sofa surfers”; 90% had significant drug or alcohol exposures (or both) and 22% patients had 5 or more health comorbidities, 24% had at least 3 health conditions and 33% of patients suffered from mental health problems.  Individual patient feedback has been overwhelmingly positive. All the following quotes are from different rough sleepers:  “It was the first time I had seen them; they went above and beyond for me”; “The team were amazing, they really tried to help me”; “It was really good, I didn’t walk away not knowing, the doctor was 10 out of 10”; “It’s just the service we need, so many people take drugs and don’t look after their health”; “The inhaler has helped to ease my breathing, it’s made a difference”; “I have recommended it to other people”. |
| **What have you learnt?**  Integration of services with the patient at the centre is crucial, with care provided as close as geographically possible to the homeless, to improve attendance rates and reduce their concerns and potential stigma about hospital care |
| **What can everyone else learn?**  Integrating services is not easy but is rewarding when done properly, and does not need a major business case to secure large benefits. |