Midlothian Integration Joint Board

Thursday, 22nd August 2024, 14:00-16:00

Public Health Update – Health Inclusion Team

Item number:	**5.9**

Executive summary

This report is to summarise the work of the Health Inclusion Team to date. It covers the last 4-year period and highlights some of the successes of the service.

The Health Inclusion Team (HIT) is a small nursing team, consisting of two part time nurses. They work with some of our most vulnerable populations in Midlothian such as those affected by homelessness, substance use, those in the justice system and unpaid carers. Due to the, sometimes, chaotic lifestyles of the individuals, the team operate a flexible engagement policy, which is essential to ensure continued supportive engagement.

The team have a target of seeing 145 people per year which was exceeded for 20/21 and 21/22, however for 22/23 this target was unmet, this was due to recruitment taking place during this reporting period and 23/24 we have again exceeded our target.

The Health Inclusion Team is unique to Midlothian and as such allows us to be responsive to local needs and challenges in the system. An example of this would be our work on frequent attenders at Accident and Emergency. A full report of this work will be presented at the senior management meeting before the end of the year.

Members are asked to:

- Note the work of the Health Inclusion Team and endorse the continued commitment to the prevention agenda.

Public Health Update – Health Inclusion Team

1 Purpose

1.1 This report sets out an update on the progress of the Health Inclusion Team

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Note the work of the Health Inclusion Team
- Continue to endorse commitment to Early intervention and Prevention

3 Background and main report

3.1 The Midlothian Health Inclusion Team is a small yet dynamic service that aims to improve the quality of life of people with one or more long-term health conditions and/or a significant difficulty in their lives. The service offers health assessments giving people the opportunity to have a strength based discussions about what matters to them. In practice, vulnerable adults (16+) are offered a discussion in a non-pressured environment to articulate what matters to them. Support, guidance, advocacy, health screening and signposting to other services/organisations are some of the interventions offered that builds on the person's social and human capital, resilience, self-management, and community integration thus addressing any identified unmet health and social needs. The team work with those most vulnerable to health inequalities. These mostly include populations affected by homelessness, substance use, justice, unpaid carers and poverty.

3.2 Service

The team is made up of 1WTE band 6 nurse split into 2 x 0.6WTE posts and an administrative support Band 3 0.26WTE in partnership with other services in Number 11.

While the service does offer booked appointment slots, the primary focuses is upon outreach, which is how most people engage. This is due to the nature of the clients the service is trying to engage and support. To help with engagement the service also operates a flexible Did Not Attend (DNA) policy where the team will continue to attempt engagement with clients far beyond the usual standard of three attempts.

The service outreach is across various local settings including all of Midlothian temporary accommodations, food banks, One Dalkeith, VOCAL (Carers support) and other community groups such as Penicuik Storehouse. The service is based at Number 11, with very good established links with groups/clinics taking place, for example the gender specific group work programmes (SPRING/Woman's Supper),

Community Payback team and also helping to run the sexual health clinic in Number 11.

Further, the team have implemented a pilot project with RIE Accident and Emergency (A&E) frequent attenders which early indication showed a reduction in attendance. A further report on this will be presented at SMT later in the year.

3.3 Monitoring and Evaluation

The Health Inclusion Team are fortunate enough to have the support of the LIST analysts whom provide monthly BOXI reports pulled from TRAK data.

Table 1: Key Performance Indicators for the Health Inclusion Team data January 2020 to April 2024.

measure	2020/21	2021/22 *	2022/23 *	2023/24
People in financial year (Number of people seen by HIT team)	153	162	143	180
New	59	104	77	62
Returning	94	58	66	118
Contact days	142	157	133	182
Total number of contacts (Number of contacts with clients – does not include attempted contacts)	566	517	435	561
Average contacts per day	4	3	3	3
Maximum contacts in a day	11	9	8	9
Total referrals (Referrals into HIT service)	109	100	133	206
Average wait (days) (Wait time till first appointment)	8	32	4	2
New referrals	109	98	111	30
Repeat referrals		1	20	130

* The HIT team were down one post between 1st December 2021 and January 28th 2022, due to absence. Then down a post due to vacancy from 16th April 2022 to 10th August 2022.

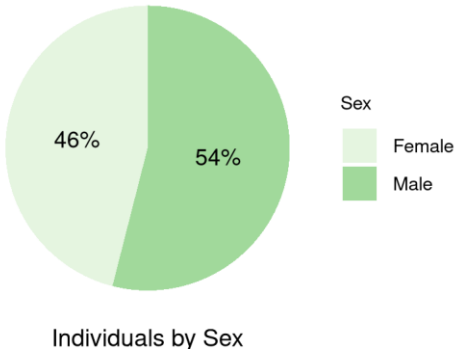
The above figures in table 1 show the service has engaged with a substantial amount of people over the last four years. In 20/2, 21/22 and 23/24 the team successfully met and exceeded the target of 145 people per year. The team did not meet this target in 22/23 due to vacancy and absence.

Average wait time is relatively small; the data shows that in 2022 it was higher due to absences and vacancy, so this escalated wait time for clients. Currently in 23/24, our wait time was on average 2 days, the team try to be as responsive a service as possible especially given the client groups we work with and often the urgency of need they have.

Figure 1: New and returning clients by financial year

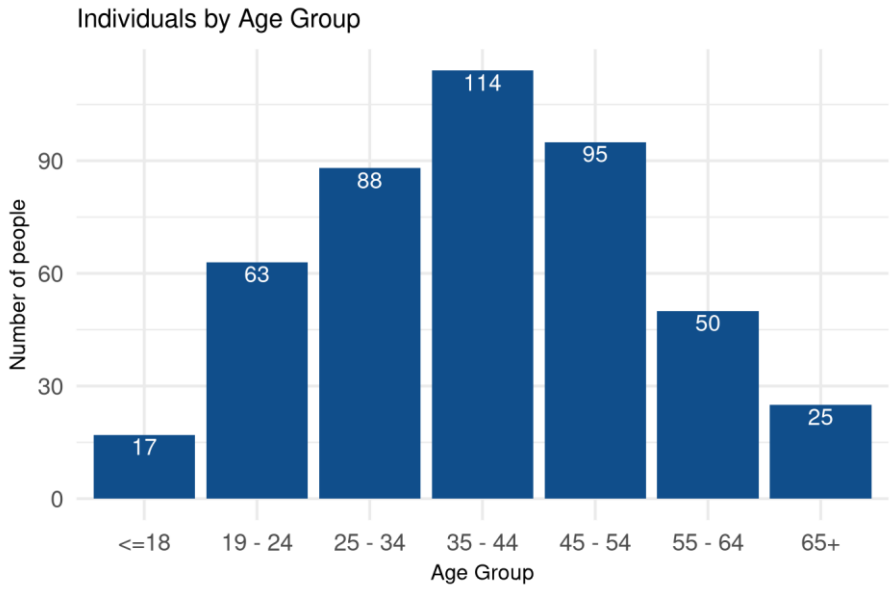
Figure 1 indicates that while the team continues to engage with new clients, the nature of the service means that clients often return to the service for support. This returning client base reflects a number of factors; chaotic lifestyle, complex needs, engagement with the services in No 11 (where HIT nurses are based) and therapeutic relationships with the HIT nurses. While often not seen as a positive outcome to have returning service users, the health inclusion team takes a different view and we feel this returning number demonstrates the trusting relationships that have been built with an often distrusting population.

Figure 2: Demographics of the service across the 4-year period



The split of people who have engaged with the service is slightly higher for men than women, this could reflect those within our temporary accommodation population as they tend to have more males living in the accommodations.

Figure 3: Individuals who have used the HIT service by age group



The age range is varied but on average out highest demographic tends to be the 35-44yrs old. This does tend to reflect the age in the temporary accommodations as well.

Table 2: Clients location during a HIT intervention

Patient_location	2020/21	2021/22	2022/23	2023/24	Total
Patients Home	93.1%	83.6%	77.0%	81.1%	84.1%
Other non NHS premises	2.3%	7.0%	12.9%	12.8%	8.5%
Other NHS Premises	4.6%	6.0%	6.7%	5.3%	5.6%
Midlothian Community Hospital	0.0%	3.5%	3.4%	0.2%	1.6%
Community Centre	0.0%	0.0%	0.0%	0.4%	0.1%
GP surgery	0.0%	0.0%	0.0%	0.2%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

The majority of our work is outreach as can be shown from the above table. Overall, in the past 4 years 84% of engagement has been in the clients' home, this is often the temporary accommodations, which shows the trusting relationship built within the accommodations and how effective the teams outreach approach is.

There are varieties of interventions the Health Inclusion Team can support with and these interventions are based on what the service user has expressed as their priority.

Table 3: Top 5 interventions people ask the Health Inclusion Team for help with.

Intervention	Total
Healthcare and lifestyle factors	2278
Advocacy and liaise	947
Referral to other	448
Assessment (initial/follow-up)	265
Substance use	130

As you will see the top intervention is often around healthcare and lifestyle, this includes diet/weight, smoking, physical activity and finance advice. The other highest is advocacy and liaising, this highlights the vulnerable nature of the populations the team work with and the trusting relationship they are able to build.

The team are aiming to collect feedback from our service users, specifically in the month of august using digital surveys. Feedback from this client group has proved challenging but that is something we are focusing on this year.

4 Policy Implications

4.1 The Health Inclusion Team works on health improvement to aid the following Health and Social Care policies:

- Reducing inequalities
- Committed to preventing and reducing alcohol and drugs harm
- Working to improve waiting times for patients
- Working to improve unplanned (unscheduled) healthcare

5 Directions

5.1 The Health Inclusion Team relates to all nine Directions, with an emphasis on Direction five: Health and social care services contribute to reducing health inequalities and Direction seven: People using health and social care services are safe from harm.

5.2 This report does not have an impact upon the ability of our service to deliver on the Directions and no revisions needed for existing directions.

6 Equalities Implications

6.1 The Health Inclusion Team work focuses on populations vulnerable to health inequalities, such as homelessness, poverty, the justice system, substance use and carers.

6.2 An Integrated Impact Assessment on the team was carried out in 2023.

7 Resource Implications

7.1 The team is made up of 1WTE band 6 nurse split into 2 x 0.6WTE posts administrative support Band 3 0.26WTE in partnership with other services in Number 11.

7.2 The outcome of this work and the reach of the service is vast in comparison to the resource input.

8 Risk

8.1 There is no active Partnership risk present at this time.

8.2 There is an acknowledged risk with this client group, risks include but not limited to poor physical and mental health, BBV, maladaptive coping mechanisms, suicide and trauma responses.

8.3 To mitigate these risks the team:

- Engage regularly with other teams
- Undertake training both mandatory and CPD
- Robust safe and well procedure
- Fully embedded with the working practices of No 11.

8.4 There is a risk that without the Health Inclusion Teams early intervention approach more people in vulnerable population groups could end up in crisis.

9 Involving people

9.1 The team continues to look at innovative ways to engage and gather feedback from people using the service. This will then shape future service design and delivery. This includes the use of JISC NHSL survey platform.

9.2 Partner organisations and those that represent service users were part of our Integrated Impact Assessment.

10 Background Papers

10.1 N/A

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Appendices:

Appendix One: HIIT Integrated Impact Assessment Report