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SERVICE REVIEW OF A CONSULTANCY PANEL TO INCREASE UNDERSTANDING OF BRAIN INJURY WITHIN THE HOMELESS POPULATION IN SHEFFIELD

CONSULTANCY PANEL: HOMELESS ASSESSMENT SUPPORT TEAM AND SHEFFIELD COMMUNITY BRAIN INJURY REHABILITATION TEAM

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ACRONYMS

CM	Case Management
DNA	Did Not Attend
EbE	Expert by Experience
HAST	Homeless Assessment and Support Team
HIHRG	Head Injury and Homelessness Research Group
HONOS	Health of the Nation Outcome Scales
LTNC	Long Term Neurological Conditions
NHS	National Health Service
ReQol	Recovering Quality of Life
SCBIRT	Sheffield Community Brain Injury Rehabilitation Team
SHSC	Sheffield Health and Social Care
SROI	Social Return on Investment

SUMMARY

- People who are homeless are more than twice as likely to have had a brain injury than someone in the general population. They are less likely than the general population to access specialist brain injury rehabilitation services.

- A collaboration between the Homeless Assessment and Support Team (HAST) and the Sheffield Community Brain Injury Rehabilitation Team (SCBIRT) aimed to increase the capacity of the homelessness team and enable the brain injury team to provide indirect support to clients not ready for their usual model of care.

- Six online consultancy clinics were held over a 12-month period at which a total of 13 clients were discussed using anonymised case notes.

- As a direct result of the consultancy clinics 2 referrals were made to SCBIRT to enable access to medical notes for funding applications to specialist inpatient services (1 successful, 1 pending at the time of writing) and 3 referrals to SCBIRT were averted. No referrals were made to SCBIRT for outpatient rehabilitation services.

- All panel members were extremely positive about the clinic and wanted it to continue. There were minimal and infrequent increases to some individual workloads but overall there was a reduction in referrals from HAST to SCBIRT. This is likely to represent a significant cost saving as well as reduction in lost clinical time through non-attendance for appointments. It also prevented potential disappointment and frustration for HAST clients who would otherwise have been referred to SCBIRT.

- Initially there were differing views about the appropriateness and benefits of having an expert by experience (EbE) on the panel. Governance requirements and timing issues meant that the clinic moved ahead without any EbE representation. At the end of the 12 month period it was felt by the majority that contextual information and insight provided by an EbE would have been a major benefit but this was accompanied by increased awareness of the need for SHSC to provide appropriate on-going support and supervision for EbEs due to the intense nature of the clinics and the distressing content of the case notes.

- SCBIRT's experience in co-production and the learning from this service evaluation make the consultancy clinic an ideal opportunity to take forward recruitment of EbEs for this more challenging type of work within a controlled and supportive environment.

- Current data collection tools and processes are not appropriate to capture the direct and indirect impact of the consultancy clinic with this client group. Appropriate evaluation methods do exist that could capture the cost effectiveness for SCBIRT and HAST as well as other community and emergency services whose over-use by some HAST clients may well be reduced as a result of the clinic. It would be valuable to explore implementing an appropriate evaluation to obtain more accurate data on the cost-effectiveness of the consultancy clinic.

"Colleagues shone light on a blind spot more or less in every panel meeting…It brought a very different dimension of knowledge".

INTRODUCTION

People who are homeless are more than twice as likely to have had a brain injury than someone in the general population. Among homeless communities the prevalence of brain injury is almost 50% and research in Leeds showed that in more than 90% of cases a traumatic brain injury was a precipitating factor to becoming homeless.[i] This is very much the case in Sheffield[ii] and was a key factor in the Homeless Assessment and Support Team (HAST) approaching the Sheffield Community Brain Injury Rehabilitation Team (SCBIRT) to find a way of collaborative working which would strengthen HAST's capacity to support clients affected by a brain injury. Both HAST and SCBIRT (one of the Long Term Neurological Conditions (LTNC) services) are part of Sheffield Health and Social Care (SHSC) NHS Trust. HAST can refer clients to SCBIRT although this has been problematic particularly due to the complex nature of clients' conditions and high levels of non-attendance.

SCBIRT has extensive experience of working collaboratively with experts by experience (often called 'lived experience') and has close links with the Head Injury and Homelessness Research Group (HIHRG) which is a small multi-disciplinary group led by a survivor of a traumatic brain injury. HIHRG has undertaken research on homelessness and brain injury in Sheffield and has provided training to professionals working in this area, including to the on-going Changing Futures project.[iii] HIHRG were therefore viewed as important partners particularly because they could provide a lived experience perspective of both brain injury and homelessness.

The co-production approach to this work in which HIHRG worked alongside HAST and SCBIRT from the outset in planning the consultancy panel fitted well with SHSC's strategy on co-production and increased partnership working. [iv]

METHODOLOGY

The consultancy panel consisted of members of HAST and SCBIRT. Case Management (CM) should also have been represented but they were only present at the first meeting due to absence and workload pressures. It was intended that an expert by experience (EbE) would also be on the panel but during the design process views differed about what they would contribute, and the need to go through a formal Trust recruitment process meant this would be difficult to achieve before the first panel meeting. Instead HIHRG led the evaluation.

Key departments in SHSC, including Quality Improvement and Clinical Effectiveness, and the Research Department were informed about the consultancy panel. The project was considered to be service evaluation as the patient outcome measures were already routinely collected.

The evaluation focussed on both process and outcome measures using qualitative and quantitative tools (Annex 1) immediately before the first clinic (baseline) and after the sixth (endline). Only a few people participated in the design of the study and the consultancy panels and to ensure confidentiality participants are referred to by their general rather than specific roles.

Six members of SHSC were interviewed at baseline (2 HAST, 2 SCBIRT, 1 CM, 1 LTNC management). At endline all except the CM representative were interviewed again and scored their experience of participation on a series of Likert scales (a type of rating scale often based on a 'completely agree/partially agree/partially disagree/completely disagree' response to questions).

RESULTS

Consultancy clinic process

The panel met six times on-line between December 2021 and October 2022, with most meetings held approximately every 8 weeks for 1.5 to 2 hours. Consultancy clinic meetings were held online which reduced travel time.

One or 2 clients were generally discussed at each meeting with a total of 13 HAST clients discussed either on single or multiple occasions.

The panel comprised:

- 2 brain injury specialists (a physiotherapist and occupational therapist)
- At least 2 frontline case workers and a manager from HAST

The mix of skills on the panel meant that discussions were limited to the meetings with no need for additional follow-up inputs other than for two specific referrals. Panel members felt that a representative of CM would have been valuable because of their gatekeeping role and strong links with a wide range of other clinical and pastoral services, including voluntary services.

During the first 6 months discussions focussed mainly on generic learning about brain injury including classification of minor, moderate and severe brain injury. An important initial aspect of discussion was also understanding better the ways each team worked. For SCBIRT this increased their understanding of the multiple complex challenges associated with HAST clients, and for HAST it explained why so many of their previous referrals to SCBIRT had been unsuccessful.

Participants felt the general structure and time commitment was appropriate and manageable, particularly as working relationships strengthened and new knowledge became embedded in HAST practice. It was felt that in future, however, the potential membership of the panel needs to be expanded with a pool of professionals participating either on a rotational basis, or as and when needed. Without this the long-term sustainability of the panel is doubtful.

Staff pressure and workload

The 4 front line workers, 2 from HAST and 2 from SCBIRT, who participated in both baseline and endline interviews said that participating in the consultancy clinic was an extremely positive experience which had led to either no, or a minimal, increase in either their workload or the pressure of work, particularly in the second half of the year. SCBIRT members provided supporting letters for funding for two HAST clients. This involved accessing and reviewing clinical notes to support HAST's application for the clients' admission to a specialist rehabilitation inpatient facility (Pinder House).[1] The time spent on this was 3 hours for one client and 5 hours for the other (the equivalent of an assessment and a supervision session, or two individual sessions with a client).

Although SCBIRT panel members said this additional work was manageable and ultimately saved time which would otherwise have been taken up by an outpatient referral, they described feeling concern and guilt about time lost from providing face-to-face care to SCBIRT clients. These conflicted emotions are likely to be compounded by the increasing number of cases referred to

[1] Pinder House is an NHS neuropsychiatric rehabilitation inpatient facility for men affected by acquired brain injuries and who have challenging behaviours.

SCBIRT from other services, and at an earlier stage in recovery, coupled with reduced resources within SCBIRT.

This was countered-balanced, however, by awareness that the clinic was an appropriate and constructive way for SCBIRT to provide specialist brain injury inputs for HAST clients while focusing their one-to-one work with clients who were able to benefit from the model of care provided by SCBIRT's outpatient rehabilitation services.

HAST panel members described how taking on new knowledge when they were already managing very heavy caseloads was challenging – one panel member reported "feeling quite floored sometimes" but the support provided within the panel prevented this being over-whelming and instead provided almost a breathing space within which to absorb and consider the new knowledge. As with SCBIRT, the HAST team described how participating in the clinic would lead to long-term gains particularly in time saved over seeking out appropriate sources of support for clients and applications. A clear example of this was the referrals to Pinder House. As a result of the support provided by SCBIRT, the HAST team said that they now knew how to do this and would feel confident about how to do this again in the future.

This improved understanding of potential sources of support for HAST clients was seen as a significant benefit from the clinic and one which potentially would have been greater if a Case Management representative had been able to attend the clinics.

Panel members were unanimous in reporting that any challenges associated with participating in the clinic were outweighed by the benefits. These included increased professional confidence, increased reassurance that clients were provided with appropriate care, and that newly acquired skills were transferable across wider caseloads.

Referrals

When the consultancy panel was being planned initially some concern was expressed that it might result in a substantial, and possibly unmanageable, increase in referrals from HAST to SCBIRT. This proved not to be the case, instead the consultancy panel led to a reduction in referrals.

It was estimated that without the clinic HAST would have referred 5 of the 13 clients discussed to SCBIRT (and other clients not discussed at the clinic might also have been referred). Instead 2 were referred, not for SCBIRT rehabilitation services but for the purpose of accessing medical notes to write supporting letters of funding to Pinder House. So, directly as a result of the clinic:

- 2 referrals were made for access to medical notes for funding applications (1 successful, 1 pending at the time of writing)
- 3 referrals were averted
- 0 referrals for SCBIRT outpatient rehabilitation services

This is a significant saving for SCBIRT as HAST referrals are characterised by multiple 'Did Not Attend' (DNA) missed appointments and are often not ready to engage with or benefit from rehabilitation services. This results in lost clinical time, reduced opportunities for other service users to access SCBIRT, and distress and disappointment to already vulnerable HAST clients.

Clients who are referred to SCBIRT but are not ready for outpatient rehabilitation are often then taken up by CM. It was originally intended to look at CM data from the clinic period and the preceding year to try to identify any changes. This was not possible but would be useful if the panel continues.

Client outcomes

It was originally assumed that having 8-week intervals between clinics would enable the HAST team to work with individual clients using the advice provided by SCBIRT panel members, and that changes in client capacity or well-being would be identified by pre- and post-clinic scores using routinely collected data.

In reality this was not possible or appropriate for reasons that are typical of HAST clients:

- other clients had to be prioritised for their own or others' safety
- clients disengaged from services
- clients' complex and multiple problems prevent linear progress over a short time period
- tools such as Health of the Nation Outcome Scales (HONOS) or Recovering Quality of Life (ReQoL) are not designed to identify or attribute change based on the sort of inputs provided by the consultancy clinic

Although it was hard to attribute changes to client outcomes during the relatively short period of the clinic evaluation, the panel did identify significant outcomes in terms of the way in which 3 clients' cases were taken forward for specialist care as a result of consultancy clinic. In one case the SCBIRT panel members identified that, contrary to the HAST team's original assumptions, a female client's behaviour was unlikely to be attributable to an existing brain injury. As a result the HAST team explored other potential causes which resulted in a focus on safeguarding issues.

In 2 cases clinic discussions resulted in HAST focussing on trying to access specialist inpatient rehabilitation at Pinder House. The SCBIRT members of the panel provided supporting letters for funding, as described in the 'Referrals' section above. Their specialist knowledge was described by HAST as significantly strengthening the submissions. In one case the application for funding was successful. The result of the other application is not yet known.

One of the main benefits of the clinic was that HAST staff said that they felt their new knowledge about brain injury was becoming embedded in their practice and that this, coupled with better understanding of other potential sources of support for clients, would improve the appropriateness of future referrals.

Expert by experience involvement

Widely contrasting views were expressed at the planning stage about whether an EbE should, or could, be included in the panel. The majority felt that an EbE would provide essential contextual information about living with a brain injury and/or housing insecurity. Concerns were, however, expressed about governance issues, confidentiality and whether the EbE's contribution would be appropriate within the clinic setting. SCBIRT is a leader within SHSC at co-production and ex-service users frequently work, on a voluntary basis, alongside clinicians to deliver services to SCBIRT clients. Co-production is also a SHSC strategic objective, however, the consultancy panel was a new EbE opportunity and recruitment for the position (in a paid or voluntary role) would not have been possible in time.

At endline the views expressed were more nuanced. Panel members still felt that the clinic would have been strengthened by the participation of an EbE and that their perspective could have helped inform the panel's decision-making process. A panel member said: *"We think about things from a very clinical rationale, and I think someone with lived experience can sometimes support you to think in a different way about the challenges that some of those clients might be facing".*

Despite feeling that the panel would be considerably strengthened by an EbE there was far greater recognition of the need to accompany this with formal supervision and support from within SHSC as is available to front line workers. Panel members described how distressing the information presented at the clinic could be and were concerned about its impact and the potential for this to inadvertently cause harm to someone who might have lived through something similar.

Along with the need for supervision and support there would be a need for appropriate induction to ensure shared expectations and understanding of how the panel works and decisions are reached. All panel members also felt that it could be challenging to recruit EbEs who are able to cope with the intense nature of the clinic and with the challenging and distressing situations discussed. However, by drawing on different networks such as homelessness and substance abuse, as well as existing brain injury and SHSC lived experience groups it seems likely that this would be possible. It is not a reason for failing to take this forward.

CONCLUSION

The consultancy panel was viewed by its members as an effective approach to working with a challenging client base who are typically hard to engage with and have multiple and complex health and social needs. Structuring the clinic consultation on anonymised client notes ruled out the challenge of DNAs. If an EbE had been on the panel this would have made governance issues easier.

At a time of extremely limited resources there is an opportunity cost for every action. In this case committing 2 staff for 2 hours every 8 weeks led to a reduction in referrals to SCBIRT. This is likely to have been a considerable financial saving. Changes within team-based working have implications for others besides the individuals concerned, however, and the implications of these changes and the trade-offs required need to be discussed beforehand to ensure a shared understanding of the purpose of the change.

Although HAST's clients are highly likely to have experienced a brain injury they seldom have enough stability in their lives to be referred to SCBIRT for rehabilitation services. The consultancy clinic had the double benefit of averting referrals of clients not ready for outpatient rehabilitation while increasing SCBIRT's reach, via HAST, to one of the client groups most affected by brain injury.

The Engagement and Experience team within SHSC is developing and supporting increasingly complex roles for people with lived experience and EbEs. Together with SCBIRT's long-standing experience of co-production with ex-service users the consultancy panel seems an ideal opportunity to facilitate EbE participation within a trauma informed practice perspective and to gain evidence-based understanding of the advantages and challenges of EbE participation in a consultancy panel.

The apparent reduction in referrals from HAST to SCBIRT suggests that the consultancy panel is potentially a highly cost-effective intervention – both directly to LTNC but also indirectly through reduced demands on other services such as A&E, emergency response and the police. As the clinic has been built into LTNC's service objectives for 2023 to prioritise working in partnership with other teams it seems a valuable opportunity to formally capture the investment of time and what it pays back. The Social Return on Investment (SROI) approach[v] [vi] would be an appropriate cost benefit evaluation methodology for this type of intervention which crosses over into different types of service provider and results in a range of health and social benefits.

ANNEX 1 DATA COLLECTION TOOLS

Type of measure	Question	Data source	Type of data	Respon-sibility	When
Process	Pre- clinic expectations	Key informant interview (KII)	Qualitative	HIHRG	Baseline
	HAST/SCBIRT/CM: Experience of participating	KII Likert scale	Qualitative Quantitative	HIHRG	Endline
	HAST/SCBIRT/CM: time staff spend on clinic liaison/organisation	KII	Qualitative	HIHRG	Endline
Outcome (for service providers)	HAST: Impact on case outcomes/management	Likert scale	Quantitative	HIHRG	Endline
	HAST: Extent information gained is used more widely	Likert scale	Quantitative	HIHRG	Endline
	HAST: Ease of goal setting process with clients	Likert scale	Quantitative	HIHRG	Endline
	HAST/SCBIRT/CM: Level of support/pressure on staff	Likert scale	Quantitative	HIHRG	Endline
	HAST/SCBIRT/CM: Change in appropriate referrals from HAST to SCBIRT/CM	SHSC data	Quantitative	HAST & CM	Baseline Endline
Outcome (for HAST service users)	Client improvement	ReQoL	Quantitative	HAST	Baseline Endline
		Canadian Occupational Performance Measure (COPM)	Quantitative	HAST	Baseline Endline
		HONOS	Quantitative	HAST	Baseline Endline
		Occupational Self Assessment (OSA)	Quantitative	HAST	Baseline Endline
Lessons learnt	Benefits	KII	Qualitative	HIHRG	Endline
	Challenges	KII	Qualitative	HIHRG	Endline
	Improvements	KII	Qualitative	HIHRG	Endline

[i] Oddy M et al The prevalence of traumatic brain injury in the homeless community in a UK city May 2012 Brain Injury 26(9):1058-64DOI:10.3109/02699052.2012.667595

[ii] Grant S et al (2016) Experiences of Homelessness and Brain Injury. Available from the Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/13718

[iii] https://changingfuturesheffield.info/

[iv] Sheffield Health and Social Care (2022) Quality Strategy 2022-2026

[v] Banke-Thomas AO et al (2015) Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review. BMC Public Health. 2015 Jun 24;15:582..

[vi] Kadel R et al (2022) Social Return on Investment (SROI) of mental health related interventions-A scoping review. Front Public Health. Dec 9;10:965148.