

Kings Health Partners Pathway Homeless Team



First year report – 2014



Executive summary

Following a Needs Assessment delivered in 2012, Lambeth and Southwark CCGs kindly commissioned an initial pilot of the 'Kings Health Partners Pathway Homeless Team' in the Guys and St Thomas' (GSTT) and Kings hospitals. The service commenced in January 2014, and following a 3 month pilot, received notice of ongoing funding. In February 2015, the team extended into the South London and Maudsley, following generous funding awarded by the Guys and St Thomas' and South London and Maudsley charities.

The Pathway Homeless Team is affiliated to, and forms part of the Pathway network of 'Homeless Ward Rounds' in acute care settings nationally. The team is multi-professional, and multi-agency. The clinical input currently comprises 2 part-time GPs, 2 nurses, an occupational therapist, a social worker, and 2 mental health practitioners. 6 further team members are seconded from 4 partnership agencies via Service Level Agreements - St Giles Trust, St Mungos Broadway, the Passage and Groundswell. Most of this input is concerned with housing advocacy and client engagement, with Groundswell also providing peer volunteers to attend health appointments in the community post hospital discharge.

This team is a glowing example of integrated care, working across 3 hospital trusts in both physical and mental health, and involving 4 partnership agencies. It is also shortly to be supported by an integrated clinical system (EMIS Web). A clear pathway of health care exists to the GSTT Health Inclusion Team (the outreach primary care service that works across Lambeth, Southwark and Lewisham), with other pathways to homeless health teams in Westminster. Relationships with housing departments and housing commissioners have been key to success, as has the team frequent attenders forum, which has successfully created active working partnerships with outreach services, hostel managers and the London Ambulance Service. On account of this the team was shortlisted for the Nursing Times Integrated Care award in 2014. The frequent attenders forum has been so successful that the model has been copied in other hospitals.

The team receives referrals for people who are homeless or vulnerably housed (which includes homeless hostel dwellers, those in temporary accommodation or sofa surfers, squatters and those at immediate threat of eviction). During 2014 the team received 1603 (GSTT 1086, Kings 517) referrals for 1414 individuals. 60% of clients at GSTT, and 45% of clients at Kings reported being rough sleepers. Only 47% of clients seen at GSTT and 63% at Kings had a 'local connection' with one of the three surrounding boroughs, indicating a high level of transience in the population. 17.4% of the referral population were confirmed to have no recourse to public funds. An audit at GSTT during the pilot phase showed an expected high prevalence of infectious disease (HIV 3%, Hep C 10%, TB 1.3%) in the cohort. Unsurprisingly 68.5% of those identified as homeless frequent attenders were alcohol dependent. 24% of clients seen had no GP on referral. 89% referrals were seen or had case work done by the team during the pilot period.

56% of clients referred to our service who were admitted, had an improved housing status on discharge. As part of this, over 100 people were successfully presented at homeless persons units by our housing workers. 51 people were successfully reconnected outside London and internationally, including to Australia, and the Philippines, and 65 people were reconnected to other London boroughs. Most of those reconnected also gained accommodation. Thus the team can claim a positive life change for 336 people, aside from the health gains the team achieves. This is a considerable achievement given the challenges of the client group. Where housing situations are not resolved, clients receive advice and signposting, and case work on many clients is ongoing.

Secondary care usage data extraction is still being analysed. However at GSTT from 2013 to 2014 there was a 9% reduction in A&E attendances, an 11% reduction in bed days in the measured cohort, and the average length of stay reduced from 3.2 to 2.6 days. Admissions increased 9% however, probably reflecting the fact that hospital staff are now more responsive to the needs of this client group, and recognise that they will have support with discharge planning. The team has also had many successes with frequent attenders. For example an analysis of 8 top frequent attending clients that were targeted, showed an average combined cost for these clients of £115,274 per year between 2011 and 2013. In 2014 this dropped to £11,576.

106 client feedback forms were received during the year, representing 8% of the population seen and 96% of responses were 'excellent' or 'very good'. Two Focus Groups were run, and suggestions from the groups for service improvement have been taken on board. A series of interviews is now in progress to get detailed feedback on the service, and a comprehensive service user involvement programme is planned. Three client comments are presented below:

'if it weren't for Pathway and staying in hospital, I would probably have been back to where we were sleeping anyway...so Pathway saved my life'

'You say you did your jobbut you also rebuilt my life'

'you did more for me in 48 hours than anyone else has done for me in 17 years'

Around 700 NHS staff or students were trained by the team during the year. The team has also compiled a booklet for staff with general advice, and a summary of community homeless health and support services across Westminster, Lambeth, Southwark and Lewisham. This has been well received, and is now available on-line.

Finally there are many innovative projects in progress including the building of a pan-London network with other A&Es and discharge teams, joint work with the London Ambulance service to put plans in place for hostel based frequent attenders, and developing a program of primary care in-reach (e.g. delivering vaccinations, brief intervention work, and smoking cessation advice whilst clients are in hospital).

The launch of the SLAM team service is also very exciting. This is the first time that a Pathway has delivered a service in a mental health trust, and the funding award has enabled a 3 year pilot of the service with an associated economic evaluation. The SLAM team went live on 23rd February 2015. Early results will be published ASAP.

In summary 2014 was very successful initial year. A very real need has been evidenced for the team, and the considerable value that the team can add across a range of quality outcomes has been readily demonstrated. The team is fully committed to compassionate, value based healthcare, and feels that that is upholds the mission and vision of the Kings Health Partnership.

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Introduction

In 2010 a Homeless Link report ⁽¹⁾ estimated that only 27% of homeless people admitted to hospital were receiving any help or support to resolve their housing situation. This situation was felt to be both unethical, and a huge missed opportunity for changing people's lives; but also held to be partially responsible for repeat A&E attendance and admission in some homeless people. In the same year a DH report ⁽²⁾ estimated that the annual cost for unscheduled care for homeless people was 8 times that for the housed population. Despite this, in 2011, a Crisis report ⁽³⁾ demonstrated that the average age of death for a homeless man was just 47 years old.

Set within this national context, a prospective Needs Assessment examining the need for a 'Pathway' homeless hospital discharge team was undertaken in 2012 ⁽⁴⁾. This needs assessment demonstrated that the Kings Health Partners were the lead providers of unscheduled secondary care to homeless people in London, and that there were clear health inclusion, quality and business objectives to be achieved. The Kings Health Partners Pathway Homeless Team commenced operation in Guys and St Thomas' (GSTT) and Kings hospitals in January 6th 2014, and will extend into the South London and Maudsley (SLAM) hospitals in February 2015. Considerable thanks are due to the Kings Health Partners Executive, Lambeth and Southwark CCGs and the GSTT and SLAM charities for their respective parts in funding the pilot and ongoing initiative. The project also benefited from early funding from the DH Homeless Hospital Discharge Fund.

The dual aims of the Pathway Homeless Team are to improve the quality of care for homeless patients, while also reducing potential delayed or premature discharges. There is also an overarching aim to reduce future unscheduled admissions and A&E attendances. Although the investment required for this team is considerable, this report demonstrates clearly that health inclusion and quality objectives are being met. This team is radically changing people's lives, and in some cases these are people with very entrenched and chaotic histories. This comes at a time when London has seen an increase in rough sleeping of 64% between 2010 and 2014 ⁽⁵⁾, and London hostel bed spaces reduced by 18% between 2012 and 2014 ⁽⁶⁾. Despite this team is addressing inappropriate patterns of secondary care usage, and potential cost savings are evident.

This report covers the work of the first year. A report on the initial pilot 3 months is also available. It is hoped that the innovative and ground-breaking nature of the integrated multi-agency and multi-disciplinary work is clearly evident in both reports. Many thanks are owed to all the members of the team for their enthusiasm, hard work, dedication and extremely cooperative partnership working - without whom the considerable success of the project would not have been possible.

1. Homeless Link (2010) The Health Needs of Homeless People – Findings of a National Audit
2. Department of Health (2010) Health Care for Single Homeless People
3. Crisis (2011) Homelessness: A Silent Killer
4. Hewett N., Dorney-Smith S. (2012) King's Health Partners and the Impact of Homelessness with proposed responses
5. St Mungos Broadway (2014) CHAIN Street to Home 2013-2014 Annual Report

Mission Statement

The Kings Health Partners Pathway Homeless Team Mission Statement was generated by the team, and is as follows:

- We aim to improve the health outcomes and the overall quality of health and social care experienced by homeless people.
- We aim to ensure that all homeless people have the best possible hospital experience, and achieve the best possible discharge outcomes.
- We aim to demonstrate that investment in quality, integrated care for homeless people is cost effective.
- We aim to reduce patterns of frequent attendance to hospital (where these have been deemed inappropriate), by meeting the needs of these clients in other ways.

Service Summary

The Kings Health Partners Homeless Team works across the Kings Health Partners with core teams based in GSTT, Kings and SLAM. The team comprises 2 part-time GPs, 2 nurses, an occupational therapist, a social worker, 2 mental health practitioners, 4.5 housing workers, 0.6 peer advocate, and a 0.6 'Integration Lead' post. Operational management is provided within the Trusts themselves by clinical managers with suitable expertise.

The team:

- Provides advice about homelessness, homeless health, and housing law
- Upskills secondary care staff by providing training / resources
- Spends time with patients, and provides practical assistance e.g. clothing, food, travel tickets, TV cards etc where possible
- Assists A&Es and in-patient teams to attempt to reduce the high rates of self-discharge, and re-attendance in this client group
- Provides skilled advocacy at Homeless Persons Units
- Uses existing links with homeless services across Westminster, Lambeth, Southwark, Lewisham and Croydon in order to meet client needs
- Works across primary and secondary boundaries to ensure health and social care needs are met in the community
- Safely reconnects people to their area of origin when this is relevant and appropriate
- Runs a homeless frequent attender forum
- Links in with other Pathway teams, and homeless hospital discharge projects, as well as community homeless health services, General Practices, outreach teams, hostel providers and the London Ambulance Service, in order to meet the needs of homeless frequent attenders
- Lobbies for political change when this is required

Referral data

No of referrals

The table below presents referrals received from Monday 6th January to Wednesday 31st December 2014.

	GSTT	Kings	TOTAL
Total number of appropriate referrals	1086	517	1603
Total number of individuals	934	480	1414

The number of referrals across the quarters dipped after the first quarter, but has steadily risen since quarter 1 at both sites. The larger rise at Kings can be attributed to active case finding.

	GSTT	Kings	Total
Q4 2013-2014	321	108	429
Q1 2014-2015	235	98	333
Q2 2014-2015	248	142	390
Q3 2014-2015	282	169	451
Total	1086	517	1603

Source of referrals

Presented below are the top 10 referral originators for both sites. Referrals come from a wide variety of locations across the Trusts and from the community. In the pilot phase at 7% of referrals at GSTT and 16% at Kings came from outpatients. Although this is rewarding and important work it is beyond the capacity of the current teams, and work with outpatients is unfortunately being gradually phased out.

GSTT			Kings		
	Number	%		Number	%
A&E	345	32%	A&E	196	38%
Emergency Medical Unit	185	17%	Clinical Decision Unit	49	9%
Sarah Swift	109	10%	Community	39	8%
Victoria	64	6%	R D Lawrence	21	4%
Albert	56	5%	Outpatients	19	4%
Outpatients	41	4%	Oliver	19	4%
Hillyers	37	4%	Katherine Monk	15	3%
William Gull	30	3%	David Marsden	14	3%
George Perkins	20	2%	Lonsdale	14	3%
Mark ward	18	2%	Trundle	11	2%

Demographic data

Patients on CHAIN

CHAIN is the street outreach database hosted by Broadway that records the bedded down contacts of street outreach teams, and thus 'verifies' people as rough sleepers. All Pathway Homeless Team staff members have access to CHAIN. At GSTT 50% of clients were found recorded on CHAIN, however at Kings this was less at 27%. From this we know that more patients at GSTT were traditional rough sleepers.

	GSTT - On CHAIN	Kings – On CHAIN
Q4 2013-2014	47%	26%
Q1 2014-2015	55%	33%
Q2 2014-2015	48%	28%
Q3 2014-2015	52%	21%
Average	50%	27%

More patients 'self-reported' being rough sleepers as can be seen below. This is not surprising – not all rough sleepers will be identified by outreach. The team makes referrals to outreach as necessary.

Housing status on referral (clients seen)

At Guys and St. Thomas' 60% of clients were NFA and 15% lived in a homeless hostel on referral, however at Kings this was only 45% and 13% respectively (see table below). Overall this means that the population being measured in our secondary care usage data set (all NFA clients, homeless hostel clients and clients registered at the two specialist homeless GP practices in Westminster) was representative of about 75% of referrals at GSTT, but only 58% at Kings. This means that alternative methods of data collection need to be examined, particularly at Kings, and this is currently underway.

	GSTT	Kings
No Fixed Abode	60%	45%
Homeless hostel	15%	13%
Sofa Surfing	11%	17%
Housed (including threat of eviction)	10%	18%
Other (e.g. temporary accommodation, B&B)	2%	3%
Unknown	2%	4%
Total	100%	100%

GP registration

27% of clients at GSTT and 16% at Kings of referrals had no registered GP at the point of referral during the year. This is broadly in line with national estimates of GP registration levels in homeless people.

Clients with No Recourse to Public Funds

We are often unable to establish fully whether clients have recourse to welfare benefits and housing, and establishing this is a core part of our work. However for the clients that have been definitely recorded as 'yes' or 'no' (see table below) we know that 17.4% of clients have no recourse. In reality this is more likely to be up at around 20-25%.

	GSTT			Kings		
	Yes	No	% no recourse	Yes	No	% no recourse
Q4 2013-2014	NR	NR		NR	NR	
Q1 2014-2015	156	33	17.5%	80	15	15.8%
Q2 2014-2015	177	36	16.9%	108	13	10.7%
Q3 2014-2015	184	44	19.2%	121	33	21.4%
Average	517	113	17.9%	309	61	16.4%

Borough link

The 'borough link' of clients 'seen or contacted' has been recorded, and is presented below. The borough link is mainly established by taking the client's housing history, and is essentially linked to their eligibility for housing (where they would have a case to obtain accommodation funded by the Local Authority). However in the case of clients with no recourse to public funds this may be the borough in which it is thought the client has strongest connections. It is important to note this does not translate to the CCG that is picking up health care costs, and this is discussed later.

47% at GSTT had a connection with one of the three surrounding boroughs (Westminster, Lambeth or Southwark). 63% at Kings had a connection with one of the three surrounding boroughs (Lambeth, Southwark or Lewisham). This underlines that reconnection is an important activity for the team.

GSTT	% of clients with a connection to Westminster, Lambeth or Southwark	KCH	% of clients with a connection to Lambeth, Southwark or Lewisham
Q4 2013-2014	47%	Q4 2013-2014	59%
Q1 2014-2015	47%	Q1 2014-2015	54%
Q2 2014-2015	46%	Q2 2014-2015	67%
Q3 2014-2015	48%	Q3 2014-2015	71%
Average	47%	Average	63%

Prevalence data (GSTT only)

This prevalence data has been brought forward from the pilot project report. No further searches have been done since. **It should be stressed that notes on EPR tend to be relatively poorly coded, and whilst some things (like HIV, TB) are likely to be accurately coded, most other things (like liver disease, intravenous drug use, mental health problems) will probably not be.**

When EMIS Web goes live in April 2015 the team should be able to produce much more robust and contemporaneous prevalence data.

217 sets of notes were audited for the period January to December 2014.

Condition	No	Prevalence
Mental health problems including DSH, severe mental illness, depression and anxiety	51	24%
Alcohol dependence	95	44%
Current or past substance misuse	37	17%
HIV	6	3%
Hep B	4	2%
Hep C	22	10%
TB	3	1.3%
Malignancy current or past	14	6%
Chronic illness including CVD, Respiratory, Gastro, Endocrine and Skin	88	41%
Liver disease/cirrhosis	15	7%

It is notable that alcohol dependence, substance misuse and mental health seemed lower than expected, and we expect this is related was related to inadequate documentation.

However it is important to note that **on our frequent attenders lists for during the same time period 24 / 34 (68.5%) were known to be alcohol dependent.** A further 5 appeared to have their mental health condition as the main precipitating factor (14.7%).

Housing and Reconnection Outcomes

% referred clients seen

Overall, across both sites 89% of clients referred were either seen or contacted. Where clients have not been seen or contacted, this has generally either been because they have been referred overnight or over the weekend (some of these may be frequent attenders), and the team was unable, or did not have the capacity, to follow them up or contact them.

GSTT	Referrals not seen	Referrals not seen, but had casework done	Referrals seen	Seen and/or casework done
Q4 2013-2014	16%	5%	79%	84%
Q1 2014-2015	8%	23%	69%	92%
Q2 2014-2015	8%	27%	66%	92%
Q3 2014-2015	4%	29%	67%	96%
Average	9%	21%	70%	91%

Kings	Referrals not seen	Referrals not seen but had casework done	Referrals seen	Seen and/or casework done
Q4 2013-2014	20%	6%	74%	80%
Q1 2014-2015	18%	5%	77%	82%
Q2 2014-2015	13%	32%	56%	87%
Q3 2014-2015	11%	47%	42%	89%
Average	16%	22%	62%	84%

% clients seen / contacted that were seen by a Housing Worker

The percentage of people that have had access to a housing worker has been a major contributor to the housing outcomes outlined below. The following table shows the percentage of admitted clients that saw a housing worker during the year.

	GSTT	Kings
Total clients seen by Housing Worker	48%	57%

% improved housing status

The next table shows improved housing status at both sites. This is measured on a simple housing ladder where the following categories are used:

- Rough sleeping
- Night shelter / NSNO / squat / sofa surfing
- Temp hostel / safe seat in permanent hostel
- Permanent hostel / temp accommodation from local authority
- Supported accommodation / permanent accommodation from local authority / private rent

Note that 'sofa surfing' can be difficult to rate. This can either be highly insecure, or actually relatively secure - so where this sits has been a judgement call on the part of the assessor.

The table below shows the total number and percentage of NFA or vulnerably housed patients (individuals, rather than referrals) that have been admitted, that have had an improved housing outcome as a direct result of contact with the team (A&E patients are omitted from this outcome, because A&E contacts are essentially brief intervention advice and signposting opportunities. This may result in reduced attendance, but is very unlikely to result in a client getting housed). 56% had an improved housing status on discharge overall.

Housing Status	GSTT	%	Kings	%	Total	%
Improved	199	55	91	56	290	56
Maintained	134	38	44	28	178	33
Unknown (data incomplete)	26	7	25	16	51	12

Reconnections

As was seen from the demographics many clients seen or contacted have not been from local boroughs, and thus reconnections are important. Several reconnections have been achieved using various pots of money including the Samaritan Fund. This has included successful reconnections to the Philippines, Spain, Bristol, Liverpool and Northampton. The later three were all escorted. Each of these reconnections represents an extremely valuable intervention. 116 clients were reconnected in total.

	GSTT	Kings	Total
Total clients reconnected national / international	42	9	51
Total clients reconnected in London	56	9	65
Total	98	18	116

Secondary Care Usage Data

Homelessness is not routinely recorded on hospital databases, so a proxy measure was needed to assess the impact of the Pathway team. The method piloted in other Pathway teams is to use NFA (no fixed abode) or known local hostel addresses, or registration with a specialist homeless primary care team, in order to identify a group of likely homeless patients. We then compare the activity data for these groups before and during the introduction of the team. This provides an objective measure of the impact of the Pathway team across the whole hospital, not just for those patients referred to the team.

At GSTT the team has been lucky enough to have the support of a data analyst (David Grant), who has assisted in the extraction and analysis of the data. At Kings the extraction has been done manually by the Kings operational manager, who has not had the capability to do detailed work on the data. As such the discussion around data trends below is based only on the GSTT data. It is hoped that the Kings team will get the support of a data analyst next year.

Data by quarter is presented in the tables on page 13 however this is a summary of the key trends.

GSTT

- A&E attendances saw a 9% decrease (4322 in 2013, 3936 in 2014)
- The % of clients attending by LAS saw a 5% decrease (57% in 2013, 54% in 2014)
- Admissions saw a 9% increase (1058 in 2013, 1158 in 2014)
- Bed days saw an 11% decrease (3339 in 2013, 2984 in 2014)
- Average length of stay decreased from 3.2 to 2.6 days
- Average re-admission and re-attendance rates increased

Kings

- A&E attendances saw a 12% decrease (773 in 2013, 677 in 2014)
- The % of clients attending by LAS saw a 20% decrease (44% in 2013, 35% in 2014)
- Admissions saw a 15% increase (103 in 2013, 118 in 2014)
- Length of stay was recently calculated to be 10.5 days (but this data was not available until recently). This is considerably longer than at GSTT, but is probably representative of a different demographic of patient at Kings. Kings sees less rough sleepers with the more brief admission type presentations (e.g. cellulitis, chest infections, fits, and head injuries)
- Re-admission and re-attendance rates, are not available

It is hard to draw conclusions from this data, because it is evident that not all of the attendances in these cohorts are being referred. At GSTT the number of referrals received (1086), represented only 28% of the number of attendances identified (3936).

In addition 25% of GSTT referrals were not actually in the cohort being measured anyway (because they were sofa surfers, from temporary accommodation or housed, and thus had an address that would not be picked up in the cohort). As such the actual number of referrals received from the identified cohort was only around 815 (or about 20% of the identified cohort). One of the reasons for this is that many frequent attenders only attend at night, and are thus not referred as such, but get picked up on the frequent attenders list. In addition, frequent attenders re-attending during the day, may often not get re-referred as such. However even taking this into account it appears that the teams are probably currently only seeing between a third to a half of the total number of individuals that are attending, and thus any inferences needed to be treated with caution.

Nethertheless the GSTT data has been examined in detail, to see what can be learnt, and this is an ongoing process. One key finding is that it has been interesting to note that in 2014 compared to 2013 there were actually *more attendances per person, but from less people* – although the overall number of attendances went down. This is surprising on a known background of the increasing numbers of rough sleepers in London generally – intuitively it might be expected that there would be more people. In addition it would be hoped that the frequent attenders forum would obviously reduce the number of attendances per person.

However the team are housing and reconnecting people, and are thus taking people out of the cohort, and this may explain the reduction in the number of individuals. It is then likely that the remaining individuals will tend to be more locally based, and probably be more inclined to re-attend at the same hospital if their experience of the hospital is good. Alongside this local outreach teams who have built up trust with the team will be more inclined to send clients back to hospital if they have concerns. The team would hope that over time this relationship building will result in case resolution for the more entrenched cases.

Analysis in October 2014 showed that although admissions had risen since April 2014, these appeared to have been exclusively in the cohort staying 0-1 days, mostly on EMU. Admissions staying greater than 1 day showed much reduced total bed days. The analysis suggested the number of patients staying over 7 days has considerably reduced. This explains why the average length of stay has reduced. It is felt the increase in admissions has been related to A&E staff being more inclined to admit frequent attending clients, because they perceive a way out for them through referral to the team.

Over the following months we will be looking at doing secondary care usage data analysis on the clients that teams have actually seen – probably via the use of ICD-10 coding for homelessness on the hospital system records. This should enable considerably better data analysis.

The team will also be measuring outpatient DNA rates in the cohort from next year.

Costs

A costing analysis of the total cost to Lambeth CCG for GSTT admissions (done in October 2014) for the financial year 2013/14 was £1.1million. After 2 quarters of 2014/15 the charge was £574k, which on a straight line projection would be £1.15million, which suggests no significant change. As such it unfortunately appears that any cost benefit from a reduced length of stay, is wiped out by the increased number of admissions.

However it was noted from data at that time that 37% of homeless admissions were being charged to Lambeth (although this only resulted in 32% of the cost). From 'local connection' data the team knows that 37% of referrals are not Lambeth 'residents' (it is thought to be only about 17%). The charges of a client registered as NFA with no GP will automatically default to Lambeth, hence this effect. As such, if the team were able to redirect charges, this is an area where the team could save money for Lambeth CCG particularly (the number of admissions charged to Southwark seems about to be about correct). This can be achieved by looking up the clients GP on the NHS Spine, confirming this with the client, and then editing the notes. This obviously has additional clinical benefits. The team started to do this from October 2014.

54% of A&E attendances were charged to Lambeth, an even higher percentage. It was however noted that the number charged to Southwark was lower than it should be, so some of the charging will just be reallocated to Southwark if the correct GP is added. It is suspected that clients who are admitted are more likely to have the right GP registered on their notes.

A calculation (based on the 17%) suggested that if costs were re-directed out of Lambeth for non-Lambeth clients there was a potential saving of around £400,000 to Lambeth and Southwark combined (although the majority of the benefit would rest with Lambeth CCG).

Data tables

Secondary care usage data tables are presented on the following page. The team produces quarterly reports on this data. If you are interested in receiving quarterly reports from the team please contact the operational leads.

Tabl1 1: GSTT secondary care usage comparative data by quarter

GSTT	2013					TOTAL	2014				
	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4		Qtr 1	Qtr 2	Qtr 3	TOTAL	
A&E total	1068	1339	996	919	4322	1037	999	1004	896	3936	
LAS total	592	770	571	516	2449	584	553	551	426	2114	
% via LAS total	55%	58%	57%	56%	57%	56%	55%	55%	48%	54%	
Admissions total	278	274	255	251	1058	275	279	308	296	1158	
% Admitted total	26%	20%	26%	27%	24%	27%	28%	31%	33%	29%	
Bed days total	988	712	574	1065	3339	702	582	714	986	2984	
LOS	3.6	2.6	2.3	4.2	3.2	2.6	2.1	2.3	3.3	2.6	
% Reattendance within 7 days		21%	21%	16%	19%	22%	25%	22%	20%	22%	
% Readmitted within 28 days		17%	17%	14%	19%	19%	18%	20%	25%	21%	

Table 2: Kings secondary care usage comparative data by quarter

Kings	2013					TOTAL	2014				
	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4		Qtr 1	Qtr 2	Qtr 3	TOTAL	
A&E	230	189	205	149	773	196	178	163	140	677	
LAS	96	90	93	60	339	72	68	55	46	241	
% via LAS	42%	48%	45%	40%	44%	37%	38%	34%	33%	35%	
Admissions	27	36	20	20	103	39	38	14	27	118	
% Admitted	12%	19%	10%	13%	13%	20%	21%	9%	19%	17%	

Case Studies

Secondary care usage data does not evidence the quality aspects of the team work, or achievements in terms of health outcomes. The team has a huge number of case studies that underline the impact that the team is having on individual lives that are available on request, and one such client is to be profiled in an upcoming issue of the GiST magazine (Guys and St Thomas' hospital magazine). However the case studies below have been selected to help illustrate the complexity of the work we undertake, and the clear need for a multi-disciplinary team approach. Some have had excellent resolutions, other cases have been more challenging, but all evidence the need for the team's intervention.

The team would encourage anyone with an interest in the way the team works to come and shadow for a day.

RF – 53 year old male, abdominal pain with bowel abscess leading to hemicolectomy and ileostomy. Type II Diabetic and ex-IVDU user on Subutex.

RF is a long term rough sleeper from Westminster who had refused to engage with homeless services for over 3 years, prior to meeting the team. Initially he was defensive and refused to engage, stating that living on the street was a 'lifestyle choice'. However after multiple attempts from one of our housing workers and the GP, he agreed to explore his options with the team. The GP worked with him to explain his health vulnerability, and he agreed to consider housing. Initially he was referred to the Westminster Hospital Discharge Network beds at the Harrow Road homeless hostel, but when they came to assess him he refused the placement saying he did not want to be placed in a 'homeless service'. The housing worker then discussed a Local Authority 'priority need' presentation with RF, but explained this might not be successful. He agreed to pursue this, stating he was 'ready to come inside'.

The GP wrote a supporting letter outlining his priority need status. A formal appointment could not be arranged with Westminster in advance of his initial proposed discharge date, but comprehensive information was sent to Housing Options in advance of a walk-in presentation. RF attended Westminster Council Housing Options with the housing worker, and spent the whole day completing the Part VII Homelessness application. The housing worker advocated strongly on the clients behalf around the five tests of homelessness legislation, and explained his personal circumstances and issues. RF was awarded a self-contained studio flat as temporary accommodation (TA) suitable for his physical health needs. Discharge was then delayed due to the clients worsening health, but he was discharged into this placement a week later. The Pathway team liaised with his GP around his continuing care in the community, and the maintenance of his prescriptions. RF was also re-engaged with floating support, who then went on to provide support to him on discharge, the first support of this kind he accepted for three years. It was confirmed three weeks later that Westminster accepted full statutory duty to permanently house RF.

This outcome was a major success for the team, and particularly the housing worker and GP. RF stated on that his reason for accepting the help of the team, was due to the approach taken by the team in treating him as an individual, and our emphasis on supporting him with his health issues.

LR – 78 year old female, undiagnosed mental illness, frail and vulnerable

LR had been NFA for 15 years, probably sleeping on buses, and in transport hubs, as she had never been picked by outreach teams rough sleeping. She may also have been supported by church members, because she had a strong Catholic faith and attended church frequently. She had multiple names and dates of birth, and repeated admissions had therefore gone un-noticed. She was often brought in by ambulance after being found wandering and incontinent, and had frequent attendances related to falls, minor head injuries and cellulitis. She had consistently refused to engage with services, and had been previously viewed not to have a mental illness, and to have capacity to make her own decisions.

When the team first met LR, her frailty and vulnerability was obvious. In the words of the team GP 'she is more unwell and vulnerable than most of the patients I look after in residential care'. In the preceding weeks before her admission on 14th February 2014, LR had been in hospital for 2 weeks out of 4. She was increasingly delusional and paranoid about her possessions during contact with the team, often accusing staff of stealing things. She often stuck her fingers in her ears if you tried to speak to her, demanded to speak to the Chief Executive, and made several attempts to leave.

The team then liaised with the Dagnija O'Connell from the Westminster Joint Homeless Team. Dagnija was at that time funded as the lone worker on a GLA project to gather information on female entrenched rough sleepers. Dagnija had gathered more detail about LR than other teams, including her confirmed date of birth and past history, but had not had the capacity to move things forward. The team then got in touch with LR's family, and did extensive work on her case – contacting all professionals that had been involved. LR had lived with her mother for 15 years in Lambeth, but had lost this council accommodation after her death, and her distress over this appeared to be a trigger for a chronic deterioration in her mental health.

The team involved liaison psychiatry, but they did not feel she had a severe and enduring mental illness, despite the evidence of her behaviour long term. The team then organised a best interests meeting, involving hospital and community staff. The family attended and agreed that residential care under guardianship would be most appropriate plan of action. The family described a long history of very difficult behaviour, but clearly cared for her and wanted to help. This was a key step as it enabled the team to use the family view to influence Consultants and admitting teams. The challenge of advocating for the patient and 'holding her' was felt by the whole team, but the team enabled her to stay long enough for appropriate assessments to take place.

A DoLs was requested, but at the DoLs assessment the external assessor then recommended that LR should be sectioned and admitted to the Maudsley under a Section 2 (as had been originally thought by the team). All our information gathering was sent to the admitting Consultant Psychiatrist at the Maudsley. He then worked well with our team, and developed a clear understanding of everyone's concerns, mostly importantly LR's. LR was admitted for a period of assessment. She did not try to leave, although she did appeal her section (this was declined). LR has subsequently been discharged from the Maudsley, and housed in residential care close to a church where she can maintain her faith. She and her family are now very happy.

JS – 37 year old man, intravenous drug user, admitted with high temperature and investigated for septic arthritis. He was diagnosed with a severe bacterial blood infection. He also had Hepatitis C, depression, and some mobility issues due to a previous ankle fracture.

JS was evicted from a Southwark homeless hostel earlier in 2014 due to his difficult behaviour. Following this he had been sleeping on a friend's sofa, until the flat had become uninhabitable due to an infestation. They subsequently both began sleeping rough in the stairwell of the block of flats, until JS contracted the infection which needed hospital treatment. JS was very unwell during his admission.

On contacting Southwark Housing Options the Pathway team housing worker was informed that JS would be found both 'intentionally homeless' for any temporary accommodation application, and in addition, due to his past bad behaviour in Southwark hostels, no further supported accommodation would be provided through the council's Re-enablement Team.

The Pathway GP then wrote a supporting letter to housing stating that drug use and homelessness had caused JS's severe infection, and underlining that his health problems made him more vulnerable than an average homeless person. She also outlined his urgent and evident need to engage with mental health and substance misuse services, in order to avoid relapse and further health deterioration. At the same time, she made these risks clear to JS, and encouraged his engagement with these services. The housing worker then supported JS to write an appeal letter expressing his contrition, and liaised with the manager of the Housing Re-enablement Team in order to obtain an assessment interview in which JS could advocate for himself.

An appointment was obtained on the day of his discharge, which the housing worker accompanied him to. JS signed a behavioural contract in order to be accepted back by the Re-enablement team, and understood the need for this in order to move forward. After some negotiation, he was placed in temporary accommodation with floating support. In addition, the team referred him to Groundswell, who have accompanied him to his outpatient hospital appointments and assisted him to register with a GP. The intervention probably led to a significant reduction in bed days, and a potential life saved.

MM – 44 year old man, alcohol dependent. Past diagnosis of bi-polar and learning disabilities on GP records.

MM lives in a Southwark homeless hostel, and is a frequent attender of A&E services, with 33 attendances in 2014. The majority of A&E attendances have related long term gastritis, abdominal pain and PR bleeding, and nearly all have involved LAS. MM often presents in acute pain exacerbated by a panic type presentation. Once seen in A&E MM is generally either referred back to his GP practice (which he refuses to attend), or self-discharges before medically recommended. Poor engagement with the GP is exacerbated by poor medication compliance. MM has been referred for outpatient investigations, but always DNAs them, even when offered an escort to accompany him. MM has mild cognitive impairment, anxiety and personality issues.

MM was visited at his hostel by a team member in an attempt to attempt to understand his issues, and discuss his reluctance to engage with the GP. MM stated that he felt the 'real doctors' were at the hospital, but was unable to explain his self-discharging behaviour. The team arranged for a community mental health team assessment, and this was undertaken, but the team did not feel that he had treatable mental health condition. A further attempt at outpatient endoscopy escorted by a Health Inclusion Team nurse failed. He also refused nurse support to attend substance misuse appointments, and Groundswell involvement. MM was re-engaged with his brother after 18 months without contact, which he was pleased with, but this did not change his views.

Following further discussion at the Frequent Attenders Meeting, the team then coordinated a planned inpatient admission in consultation with inpatient medical staff, hostel staff and the health inclusion team for upper and lower gastrointestinal endoscopies in November 2014. MM agreed to this, and did get admitted, but unfortunately the planned admission was unsuccessful as MM self-discharged before the endoscopies were completed. The team occupational therapist was then allocated to work with MM, in an attempt to understand and address his frequent issues.

MM has engaged with the OT and a holistic occupational therapy assessment and thorough analysis of MM is ongoing. In-depth analysis of his personal and environmental factors has revealed to the OT significant attachment difficulties, fragmented communication between services involved in his care, multiple missed substance misuse appointments, anxiety and uncertainty about his future, a problematic relationship with food, the integration of 'sick' role into his identity, and an externalised locus of control.

Occupational therapy intervention has so far has included advocating for a case conference, improving communication between key stakeholders, and engaging him Groundswell and CDAT (which he previously refused). Future occupational therapy intervention will focus on working with him to build an adaptive structure and timetable, linking him in with other community recourses and services including a 'Recovery College', and working towards another inpatient admission for his investigations (or getting him to attend these as an outpatient. Since the first outpatient session with the OT (end of November 2014), MM has attended A&E on one occasion only, which is significant as he attended on average 2.75 times a month prior to the intervention.

JK 44 year old M, Czech National

JK had 28 A&E attendances and 7 admissions at GSTT during 2013-2014, and was also known to the Chelsea and Westminster Hospital. He was alcohol dependent, and had been in ITU for a perforated duodenal ulcer. His health was deteriorating on the streets, due to his alcohol dependence. He had limited English, was not fit for work, was not exercising his treaty rights and was allegedly exploiting younger EU nationals. He had never worked, and had no eligibility for benefits or housing. After numerous engagements, many attempts to offer supported reconnection, and fact-finding from the Passage worker, he was eventually removed from the UK by UKBA in August 2014 after liaison with the Pathway team. Although this was quite a challenging route to take in terms of its' ethical implications, the Pathway team had, for example, the full support of the hospital safeguarding team. This was felt to be the best possible outcome.

WD 45 year old M, UK National

WD has been frequent attending a number of hospitals over a number of years. The total estimated cost for the last 3 years at STH is around £67,793 (101 attendances, 25 admissions, most attendances to GSTT come via LAS), and similar costs have been incurred at UCLH. Add to this his less consistent attendances at 3 other trusts, costs arising from this individual have probably total about 200K over 3 years. WD has alcohol issues, a personality disorder, possible learning difficulties and behavioural issues, as well physical health care issues e.g. leg ulcers. He has a history of aggressive behaviour when under the influence. He avoids primary medical services, instead going from hospital to hospital, and has a history of attention seeking behaviour (consistent with his untreated personality disorder). A multi-agency approach over a period of several months (with two case conferences and numerous assessments), finally resulted in WD being placed in the St Mungo's Broadway Hospital Discharge Network project at Harrow Road in Westminster at the beginning of January 2015. Considerable liaison from both the GSTT and UCLH Pathway teams, and Passage team was required to achieve this. Via this placement WD now has access to Psychology and Psychotherapy services if he engages with this, and daily nursing and health support worker input. This is felt to be his best option for starting down a recovery route, and it is hoped it will be successful.

SB 35 year old M, UK National

SB is a frequent attender across multiple hospitals. He has sickle cell trait, but comes to hospital seeking pain medication, as if in a sickle cell crisis. Cognitive assessments have demonstrated capacity, and mental health assessments show no definable mental illness. In 2013 / 2014 he attended GSTT 35 times, and was admitted 28 of these. SB has a history of arrears in Westminster, and is unwilling to set up a payment plan to address these. After months of casework from the Passage, SB was accepted into Romford YMCA which was a major achievement. Unfortunately, however, he was quickly evicted because of his behaviour. Alternatives are now being considered. In the meantime an admissions protocol has been set up with after liaison between the Pathway Team GP, the sickle cell team, and specialists from Chelsea and Westminster hospital, in an attempt to reduce his attendances. He is also known to be attending the Royal Free, Barts, Whittington and UCLH.

Frequent Attender Work

The Pathway Homeless Team's frequent attender work has built on a project initiated by A&E nurse Rachel Smith (who then became one of the KHP Homeless team staff members). The project largely grew out data obtained for the initial Needs Assessment for the Pathway team, but was later augmented by detailed data analysis on the demographics, patterns, and causes of frequent attendance in this group. High DNA rates for OPAs and low GP registration were noted in the group at the time.

Our regular frequent attender meetings provide a focus for the work, and involve statutory, charitable and voluntary organisations from across Westminster, Southwark and Lambeth e.g. specialist workers from GSTT and Kings e.g. psychiatric liaison and substance misuse workers, the Health Inclusion Team, Westminster Homeless Health Team, the START and Joint Homelessness Team (homeless community mental health teams), hostel managers, outreach teams, local GPs, day centre representatives, housing commissioners, and the London Ambulance Service. Driven by the desire to improve health outcomes and social outcomes for this group, engagement has been high and the network of contacts continues to grow. Searches identify rough sleepers and homeless hostel dwelling clients attending A&E over 5 times in 3 months, which are circulated prior to the meetings to allow the services involved to research the clients. An Information Sharing protocol, and the innovative creation of GSTT sponsored NHS.net accounts for charitable and voluntary sector staff, has enabled our wider multi-agency approach. Clients attending GSTT and Kings are discussed. NFA and hostel clients are discussed in separate meetings to maximise the benefit and relevance to specific stakeholders.

Informed care plans and alerts are produced on as many clients as possible. These documents are made rapidly accessible to A&E frontline staff, reducing the need for information gathering, duplication of testing, and unnecessary admissions in chaotic frequently attending clients. The team has also reached out to initiate pan-London communication with other Pathway teams, and other relevant health services, where clients have been transient and attending services outside our hospital catchment areas. On the back of the perceived success of the forum, other hospitals are now initiating similar forums, and our meeting protocols have been utilised by other teams to initiate similar projects. A shared problem-solving approach in the forum has also led to practice innovations e.g. the creation of hostel client information sheets for LAS crews, and the implementation of a doctor and nurse in-reach programme at a large Westminster Hostel, which has since reduced LAS call-outs and A&E attendances.

A stakeholder evaluation of the forum took place at St Thomas' in December 2014. Participants at the meeting were asked to feedback their comment on three areas – achievements, challenges and future needs. Comments were very positive, but changes will be made to reflect suggestions for improvement.

Table 3 overleaf presents some examples of frequent attender successes thus far. The average cost of the presentations of these 8 clients between 2011–2013 was £115,274 per year (costs started to drop in 2013, as some initial work reaped rewards), but in 2014 this dropped to £11,576.

Table 3: Examples of frequent attender successes

		2011		2012		2013		2014		Intervention
		A&E	Adms	A&E	Adms	A&E	Adms	A&E	Adms	
SC	STH	50	11	26	6	33	3	1	0	Pan-London frequent attender initially registered as NFA with no GP. Liasion with Brent Social Services. Placed in Nursing Home in Feb 2014.
30/10/1958	Kings	15	4	13	2	11	1	2	0	
GR	STH	59	9	58	8	62	4	19	4	Lambeth hostel client. Multi-agency case conferences. Has spent most of 2014 dry. Now has special case status at GP. Also pan-London attender.
11/10/1973	Kings	128	1	3	0	12	1	6	0	
SP	STH	41	6	58	8	27	6	1	0	Had assaulted A&E and LAS staff. Not exercising treaty rights. Liasion with Community Safety, UKBA. Placed in detention. Also pan-London attender.
17/03/1979	Kings	4	2	14	1	3	0	0	0	
PT	STH	18	13	14	8	15	5	0	0	Lambeth sofa surfer. After case discussed, assertively outreached and supported by HIT team. Sent back home to Sierra Leone via Choices in Mar 2014.
08/11/1973	Kings	17	2	28	2	36	5	0	0	
LR	STH	NK	NK	48	14	4	1	0	0	Went into christian detox supported by Southwark Outreach in March 2013 (first success of frequent attender forum). Has not returned to London.
28/03/1983	Kings	NK	NK	29	5	0	0	0	0	
FL	STH	4	3	2	1	27	10	1	1	Liasion with GP and Lambeth hospital promoted better service usage. Now placed in Graham House hostel supported by Lambeth outreach.
28/08/1947	Kings	NK	NK	NK	NK	NK	NK	NK	NK	
AP	STH	0	0	2	0	9	3	0	0	Housed by Southwark with support from a variety of agencies including ourselves. Now in Rosecourt House nursing home since Feb 2014.
26/03/1946	Kings	NK	NK	NK	NK	NK	NK	NK	NK	
RK	STH	NK	NK	NK	NK	12	4	1	0	Relocated from David Barker hostel to Aspinden Wood residential care after liasion with Southwark Social Services.
22/10/1956	Kings	1	0	21	3	4	1	1	0	
TOTALS		337	51	316	58	255	44	32	5	
COST		£39,766	£79,560	£37,288	£90,480	£30,090	£68,640	£3,776	£7,800	
			£119,326		£127,768		£98,730		£11,576	

Partnership Work - External partnerships

Housing Options

The pressure on Housing Options departments is widely recognised, with many London local authorities having over 20,000 people waiting on their housing lists. A recent report by Crisis (2014) ⁽⁷⁾ emphasised the challenges that homeless people face when approaching Housing Options departments alone. As such, the development of good working relationships with the homeless person's units at Lambeth and Southwark has been fundamental to our ability to improve the patient's journey through hospital and ensure safe and sustainable arrangements after discharge.

Through offering an on-site assessment by a housing worker, the homeless team have been able to identify the appropriate cohort who may require statutory assistance, which has taken a number of clients who are likely to be ineligible for statutory housing interventions out of the system by diverting them to the voluntary sector or other projects where appropriate.

Where statutory interventions appear as though they may be required, we have developed a joint approach to decision-making with Lambeth and Southwark housing departments, which ultimately aims to ensure that people are directed to the correct housing pathway. Relationship-building has been key, and is developing well, with an emerging partnership approach being taken by all. A hospital protocol was developed by Southwark, which has since been adopted by both boroughs, and a number of management meetings have reviewed and refined the protocol. Where there are potential delays to the discharge process, Southwark has agreed to attempt to offer telephone assessments where possible, and on-site assessments are being considered.

The following feedback was received from Akin Akinyebo, Pathway and Support Team Manager from Lambeth in March 2015:

'there has been significant improvement on hospital discharge within Lambeth. I appreciate your support, thank you very much. Please pass on my gratitude to your team.'

We hope to be able to use our experience with these boroughs to develop increasingly better relationships with Housing Options pan London.

The team only started logging the number of presentations to homeless persons units from July 2014 onwards. At GSTT, from July to December 2014 there were 34 attendances including 14 to Lambeth and 9 to Southwark. At Kings, there were 29 presentations to the Homeless Person's Units, including 7 to Lambeth and 12 to Southwark. All were offered temporary accommodation. In total there were thus 63 presentations during that 6 month period.

7. Crisis (2014) No One Turned Away

No Recourse to Public Funds

The KHP Pathway Homeless team members face regular complex challenges in the area of recourse to public funds (NRPF). Often a client's real situation takes time to establish due to the nature of the clients, and the need to build up trust. However if it is does transpire that a client has no recourse to welfare benefits and housing, case resolution is extremely challenging. Around 20% of the clients seen by the team have NRPF, which equates to about 18 clients per month. [N.B. The definition 'no recourse to public funds' (NRPF) is a condition imposed by the Home Office on a person subject to immigration control, giving them no entitlement to welfare benefits or public housing. It is important to note however that some EEA Nationals also develop this status by default because they have never worked in the UK, and even some returning UK nationals may find themselves in this situation if they have living outside of the UK.]

In response to this challenge the team has developed close relationships with the Thamesreach London Reconnection project (for EEA nationals) and the Refugee Action Choices reconnection service (for failed asylum seekers, visa overstayers and illegal migrants), in order to offer clients the choice to return home. In addition the team has developed relationships with the Overseas Offices in both trusts, and the UKBA. There have been a small number of successful reconnections in this group (11) during the year, each presenting a major success.

Ongoing training for the team in NRPF has been initiated. The most recent training provided by the NRPF Network, helped the team to gain expert knowledge regarding the legal framework surrounding entitlements of people with NRPF, and covered upcoming changes in legislation, including the Care Act, April 2015. The team has also received training from Praxis, and the Southwark Law Centre so staff gain a more general understanding of immigration issues, and Shelter around changes to benefits for EEA Nationals. The team has also formed links with the London Destitution Network, and is inputting into the DH working group on changes to secondary care charging. Finally team members regularly raise their concerns and stresses about managing the complexity of these cases at clinical supervision sessions.

An audit was undertaken of patients with immigration issues seen by the KHP Pathway Homeless team, with the purpose of informing the training needs of the team, and creating a protocol for the future. Within the audit the following patterns were noted:

- Visa overstayers were the biggest group
- All overstayers had family in the UK
- Most immigration patients had serious medical conditions, however none met current criteria for social care to take responsibility
- The average length of contact from the team was 3 weeks
- Histories generally changed a few times, and this was sometimes complicated by cognitive issues and mental health difficulties
- Several of these clients had criminal justice issues
- Some were hospital frequent attenders

The team has now developed its own NRPF protocol to inform management plans, and recognise this could be used to upskill ward staff as well.

Partnership Work – Internal Partnership Reports

St Giles Trust

In October 2013 St Giles Trust became a partner agency working with KHP Pathway Team, as part of the original funding bid to Lambeth and Southwark CCGs. The St Giles Trust housing worker is based at Kings College Hospital and works with homeless individuals and families who are either on a ward or present to A&E and have a housing issue. The full team includes a GP, a Band 7 Nurse, a Band 7 social worker and our Housing Advice Worker.

During the last year 108 clients that have been referred have had an improved housing status. The housing outcomes have achieved through local authority part VII homeless applications, accessing accommodation through local authority supported housing pathways, and providing pathways into the small number of direct access hostels. Our Housing Advice Worker secured a local agreement for a small number of our clients to directly access Grange Road. As St Giles operates within the Southwark borough, our housing worker has very successfully been able to build on pre-existing relationships.

The cohort of client's at Kings appears to differ somewhat to GSTT. There appear to be more sofa surfers, clients at threat of eviction, and immigration cases. Clients with high support needs related to serious health conditions such as cancer, HIV, neuropsychological problems and mobility issues are common. As such our housing workers knowledge of welfare benefits, as well as housing, has been key. Some clients have been linked to the wider St Giles service for ongoing support, or other agencies where this is appropriate.

Challenges

At Kings there is only one Housing Advice Worker who sometimes is quite thinly stretched, when having to provide outreach and carryout in house work in a timely way. This is evidenced by the fact that the worker has done 29 Housing Options presentations from July – December 2014, compared to 34 for 3 workers on the GSTT team. Late referrals to the service from the wards sometimes compounds this challenge. The team also receive a substantial amount of referrals for patients/clients with no recourse to public funds. However our worker has brokered several positive outcomes for clients with no recourse to public funds.

Successes

The service operates a multi-disciplinary approach, and has a wealth of knowledge, skills and expertise. The combined team members are able to provide tremendous support to each other, and this has led to many positive outcomes for clients. Discharge nurses at Kings have also been helpful in supporting the team and helping them to settle in.

Recommendations

We believe there is a need for follow up community provision, to ensure that clients are settled to prevent further re admissions, and ensure linkage with support services that could provide this. We also think there should be more ward visits and training to encourage staff to make referrals earlier.

Partner Report - St. Mungos Broadway

The St Mungo's Broadway Housing Liaison Workers have been funded through the KHP Pathway Homeless Team since 1st July 2014. Two Housing Liaison Workers are provided who mainly work on the GSTT side of the team. During these 6 months the two workers have been involved in 221 referrals at GSTT, which represents 42% of the total referrals to the team. 206 clients were worked with during this period, and 88 patients had an improved housing status on discharge (43%). The other 118 patients were given advice and / or signposted to relevant support services such as day centres, night shelters or legal advisory services. Many patients whom we have not been able to assist have had eligibility issues.

Of the 88 patients with improved housing outcomes, 26 were presented to local authorities, and of these 25 (96%) were awarded temporary accommodation under Part 7 of the Housing Act 1996 on the same day. This comes at a time when Crisis have recently demonstrated that when homeless people self-present at local authorities 57% are turned away with little or no assistance. The success of these presentations can be directly attributed to the advocacy role played by the workers who use their knowledge of homelessness legislation to maximise outcomes for the patient group. In all these cases the homeless team's GP has provided supporting letters for patients with a detailed clinical assessment of their 'vulnerability' with reference to legal definitions. This has provided a strong base from which to advocate for statutory entitlement. The partnership working within the KHP Pathway Team with the St Mungo's Broadway workers has enabled a sharing of expertise to maximise benefit to patients.

Key strengths St Mungo's Broadway brings to the KHP Pathway Homeless Team:

- Knowledge and experience of applying the Part VII of the 1996 Housing Act
- An assertive advocacy approach with Housing Options teams around statutory homeless duty
- Pre-existing management level relationships with many Housing Options departments (thus supporting and guiding KHP Pathway Homeless team management level decisions and negotiations)
- Knowledge and experience of working within local authority housing pathways for patients with support needs
- Relationships with a range of voluntary sector homeless services
- An urgent, intensive casework approach to problem-solving patient's housing and support needs, developed in No Second Night Out services
- Up-to-date knowledge on changes in legislation

Areas for ongoing development:

- We are taking a lead in developing better reporting mechanisms to capture housing worker outcomes for the whole KHP team
- We recognise the need for constant staff updating around clients with NRPF, and EEA National benefit changes and are contributing to this

It has been felt that St Mungo's Broadway has made a significant contribution to KHP Homeless Pathway Team in this first year, and we look forward to continued successful partnership working. Case studies are presented in the case study section.

Partner Report – the Passage

The Hospital Discharge Project began in November 2013, when the Passage, Connection at St Martin's and West London Mission received funding from the DH to work with homeless people in hospital. We began work with one Coordinator based at the Passage, and three Homeless Hospital Discharge Workers – one each based in St Thomas', St Mary's and Chelsea and Westminster hospitals. Our initial funding was for six months, but we were allowed to extend this over the full year.

Our work at St Thomas' coincided with the KHP Pathway Homeless team pilot project, and our St Thomas' project worker was incorporated into the team. We are grateful to the Pathway Team for including funding for our project worker, and a third of the Coordinator post into their bid for continuing funding, and we are now very pleased to be able to continue working together in 2015. We have also been very pleased to obtain continued funding for our work at St Mary's Hospital (through West London CCG) until September 2015, and Chelsea and Westminster Hospital (through Central London CCG) until April 2015. We have also recently appointed a 5th team member to work within the discharge teams in the Imperial Hospitals Partnership (St Mary's, Charing Cross and Hammersmith) funded by NHS winter pressures money. We believe our service is playing a large part in joining up the work of all these hospitals, for the benefit of some of our more transient clients.

In our first year we have worked with 229 clients. We are very proud to have prevented discharge to the street for 70% of these clients. We have also provided ongoing support to many of these clients through the Passage, and the support of our partner organisations has been invaluable in other cases. This support has included booking 28 clients into our Passage House Interim Care beds, and we have also linked many of our clients into the Groundswell Peer Advocacy scheme. Finally we have reconnected 25 clients (UK - 20, Ireland -1, EU - 3, Russia – 1).

More recently we have been delighted to be welcome 3 volunteers to Hospital Discharge team. One volunteer started in November 2014, and two more have completed training and will be joining us very soon. One of these volunteers is an ex-service user of this service, and two other ex-service users are now volunteering in another service. We also think this is a key outcome of our service.

There have been challenges, which have included the complexity of housing problems that are presenting, the high level of support needs in some clients (and the lack of appropriate placements to meet these needs), and the number of clients with no access to public funds. Team clinical supervision helps the team to deal with these issues. We also know many of our target frequent attenders only attend at night, and we are trialling night shifts as a response to this at St Mary's.

Overall we are extremely pleased with the way the team has progressed, and the success of our partnership working. Case studies of our work are presented in the case study section.

Partner Report - Groundswell

Groundswell provides a Peer Advocacy service to the KHP Pathway Homeless Team. Our paid project worker Olani Nemera currently works with homeless patients at GSTT identified at team case review meetings. Olani engages these clients in hospital, and then escorts them to follow-up health appointments after discharge, making recovery more likely, and re-attendance less likely. In addition Olani has a team of volunteers who help escort clients to appointments. Referrals are also accepted from the Three Boroughs Health Inclusion Team for hostel clients who have recently been discharged from KHP hospitals, and are deemed to be at risk of re-attendance or re-admission.

Groundswell's Homeless Health Peer Advocacy service works in partnership with a variety of services pan London. All volunteers and peer advocates have personal experience of homelessness, and their ability to successfully engage 'hard to reach' clients is key to the project's success. Volunteers are supported through our Volunteer Progression Programme with the aim of progressing to become peer advocates, and then case workers on the service, or getting paid work in other areas. This programme includes an extensive bespoke training programme, group supervision, and a cohesive, person-centred programme of coaching. Using the 'Supported Permitted Work' scheme we are able to support volunteers currently receiving ESA to become peer advocates. On this scheme they are able to both continue on benefits, and receive an additional £104 per week working in supported paid employment for 16 hours a week for a temporary period. To date 18 of the 44 volunteer graduates of the programme have moved into paid employment using this scheme.

Olani currently works 16 hours a week, making hospital visits 2 mornings a week. Olani does all initial engagements, and appointment work with more the complex cases, while the more straightforward work is handed over to the team of volunteers. (Olani did 26% of follow-up appointments last year). Here Olani describes his role:

'It is important to be patient with clients as some can be anxious and can find it hard to trust anyone... It is important to show clients that they have a future... You can share your experience and show there is a solution.'

'I went to talk to him and took my time to listen. I had to be patient with him... He was in a very difficult situation with a broken ankle and nowhere to go. He had many support needs, very complex needs...'

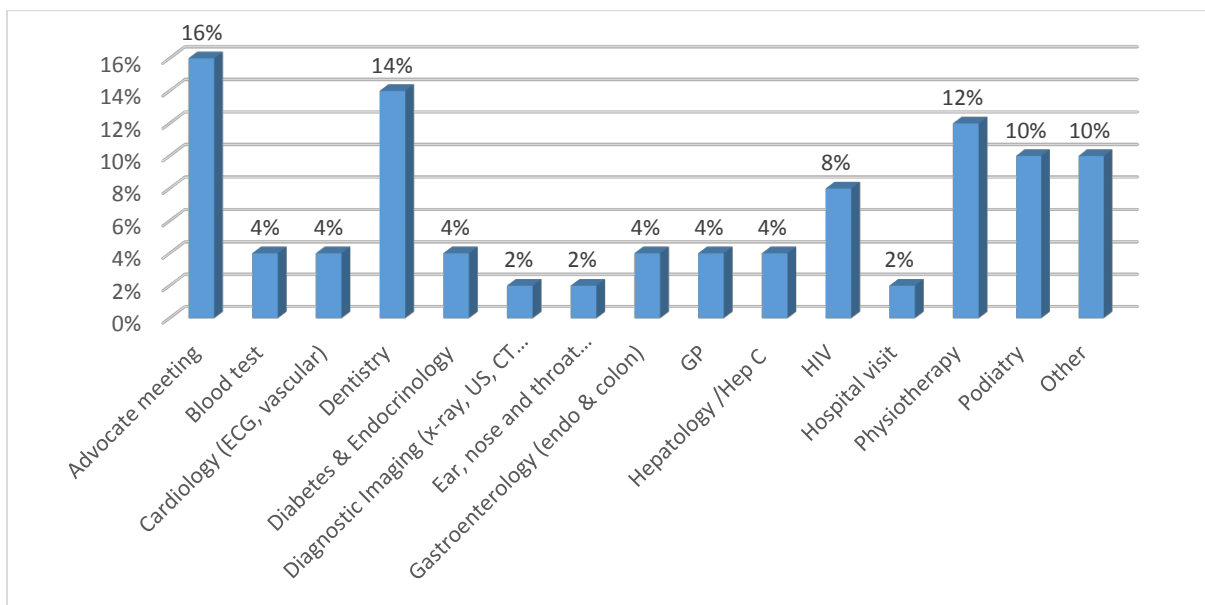
'It was reassuring for him that wherever he was going I would support him with his follow-up appointments and that he would not be left alone.'

This year Groundswell hopes to progress Olani to the role of Case Worker. He would then increase his hours from 16 to 22.5 hours per week. This would enable him to extend his work to the other KHP hospitals, and further develop Groundswell involvement e.g. assist in substance misuse work with clients. For this Groundswell are asking for an additional 5K per year (up from 30K in 2014-2015).

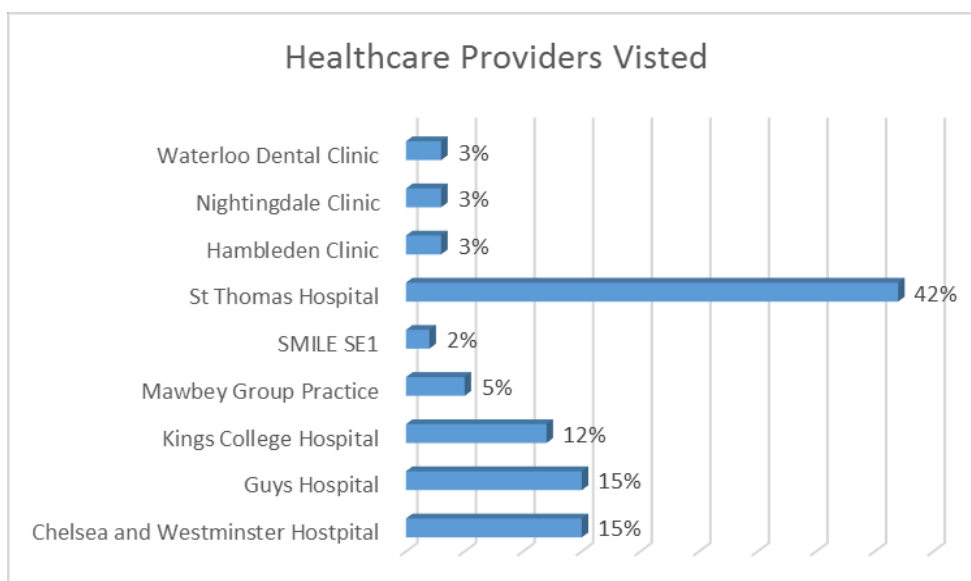
Data for 2014 (6 months July 1st – Dec 31st)

Activity area	Indicator	Total
Engagements in hospital	Number of initial engagement meetings	39
	Total hospital visits	97
	Average no. of visits per client	2.4
	Average length of visit	25mins
Engagements outside hospital	Number of appointments attended	78
Total number of engagements	Total for the period	175
	Average per month	29.2

Types of appointments attended



Health care providers visited for the appointments



Service User Involvement

Overview

Pathway is committed to involving homeless people in the design, evaluation and delivery of its services and a model of 'service user involvement' is currently being rolled out across the service at both St Thomas' and Kings College Hospitals. The aim of this is to maintain a focus on patient satisfaction, and ensure that our service is truly responding to the needs of homeless people in hospital.

Patient satisfaction has been measured in 3 ways:

- Patient Feedback Forms / Questionnaires
- Focus Groups
- In-depth interviews

Feedback forms

106 patient feedback forms were completed in 2014 (8% of the population seen). Overall there was a very high level of patient satisfaction reported via patient feedback forms. 96% of patients rated the Homeless Team as 'Very Good' or 'Excellent' (STH 100%, Kings 84%). Of the small number of patients who were less satisfied with the service, this included one patient who was deemed ineligible for housing and one who was unhappy that a copy of their assessment could not be provided without a written request.

Focus Groups and Interviews

2 focus groups and two in-depth interviews were held in 2014 (more interviews are planned in the next few months). In depth transcripts of both are available, however below is a selection of the considerable number of positive feedback received:

'every time I saw her she bent over backwards for me'

'no complaints . . .only admiration'

'You say you did your jobbut you also rebuilt my life'

'Olani took me outside in the fresh air . . .for the first time in 2 months. I really appreciate that – It's a big thing'

'they got me temporary accommodation . . . it was great'

'you did more for me in 48 hours than anyone else has done for me in 17 years'

'if it weren't for Pathway and staying in hospital, I would probably have been back to where we were sleeping anyway...so Pathway saved my life'

What are patients happy with?

Patients frequently expressed satisfaction with:

- Homeless Team providing smooth communication between hospital ward, outreach services, GPs and housing and hostel accommodation
- Homeless Team keeping patients fully informed of their discharge plans
- Homeless Team providing skilled advocacy and displaying excellent legal knowledge
- The friendly and practical approach of the Homeless Team, and the assistance given health and housing problems, as well as more practical things like clothing and transport

What changes would patients like to see?

Changes that patients would like to see were:

- Private rooms or spaces to be provided where homeless interviews can be carried out (due to the lack of private spaces on hospital wards and in A&E)
- Some patients said they will still not being treated with dignity by medical staff and other staff on the wards, and being 'judged' for being homeless, and that this needed to change.

Changes that patients would like to see that the team has little control over were:

- Some patients felt they would like to have continued input from the team following discharge from hospital
- Several patients felt that the team should have 'increased powers' to obtain housing for homeless people from local authorities or other sources

Service User involvement Plan for 2015-2016

- A further series of in-depth interviews are currently being carried out with patients who have received a service from the Homeless Team
- Service user experts from Pathway are involved in carrying out these interviews, and promoting the Pathway model of service user involvement
- Following on from the interviews, the team is planning a succession of focus groups on the theme of 'the hospital experience' for homeless people
- The team will also be continuing and developing our existing partnership with Groundswell, with the Groundswell Peer Advocate increasing his time commitment to the team from 2 half-days to 3 days per week.
- Long term future plans involve developing a team of volunteer 'peer navigators' to support homeless people in hospital

External Training and Team Development

External Training

Formal teaching sessions were carried out by the teams at both GSTT and Kings when the team went live. The sessions were planned and delivered by a collaboration of team members, including the Housing Support Workers and Groundswell advocates. The initiative has been led by our Social Worker in partnership with the Passage and Broadway leads.

134 people were trained in these initial sessions, and feedback forms were distributed. 84 completed feedback forms were received (62%). **71% thought the training was excellent or very good.** Feedback was further used to improve the teaching resources.

	Number	%
Excellent	13	15
Very good	47	56
Good	23	27
Average	1	1
Poor	0	0

This training session now forms the basis of many other internal and external requests for training. The current training session can last between 30 min and 1 hour 30 minutes, and covers homeless statistics, basic housing law, mental capacity and personality disorder. Training sessions delivered thus far are outlined below. The team would like to input into Trust induction training, deliver regular drop-in sessions for staff and develop a 'link nurse' program for the wards – these are all being investigated.

Training sessions delivered since the initial training during the pilot phase:

Target audience	When	No of attendees
FY2 induction teaching	August 2014	Delivered to all FY2s
A&E GP Registrar training	2 sessions delivered so far - one session each rotation	Will be delivered to all Registrars as part of a rolling program
Liver CPD training (by GP Zana Khan with Addictions Consultant Emily Finch)	October 2014	Attended by 27 multidisciplinary participants
Kings A&E nurse training	December 2014	Delivered to 11 staff
Medical Students Y 1 and 2 Kings	January 2015	Delivered to approx. 400 students

The GP at St. Thomas' is the education lead, and there is a plan in place to extend work with Kings Undergraduate Medical School to include as many medical students as possible, and offer medical student placements.

Other educational activities have included supporting students, and offering multiple shadowing opportunities, including having senior members of the Department of Health shadowing the team.

Booklet

The team has compiled a booklet with general advice, and a summary of community homeless health and support services across Westminster, Lambeth, Southwark and Lewisham. This has been well received, and will shortly have a second print run.

Team Development

Team development is essential to meet the needs of clients, and support staff in their challenging work in this specialist area. All staff have been asked about their training needs for 2015-2016, and have been encouraged to source training days that are relevant to them, and attend them wherever possible. Examples of bespoke training days that have been attended are Care Act training, immigration and housing training, and Pathway CPD days. The GSTT GP is also due to complete RCGP Level 1 Certificates in Substance Misuse, and Hepatitis B and C in March 2015.

However in addition the following training sessions have already been delivered to all team staff that have been able to attend (and in many cases opened up to other staff from our partnership agencies).

Pathway induction	December 2013, January 2015	Overview of current thinking in Inclusion Health, with basic overview on housing and immigration law
Kings Overseas Officer (to whole team)	July 2014	Overview of the services offered and working with the overseas team
Praxis legal advisory service	August 2014	Update on services available and how to refer/seek advice
Shelter EEA benefits training	August 2014	Update on benefits and entitlements for EEA nationals living in England
UKBA	November 2014	Update on from the UKBA on current services, processes for referral, contacts and collaborating with the homeless team
Southwark Law Centre Immigration Law level 1	December 2014	The background and case law underpinning immigration status and entitlements for overseas nationals
Louise Rabbitt, GSTT Safeguarding Lead - Mental Capacity training	December 2014	The work of safeguarding and the 2 step capacity assessment.
Southwark Law Centre Immigration Law level 2	January 2015	Case law underpinning housing entitlements for overseas nationals
NRPF Network - No recourse to Public Funds	January 2015	Update on definitions and entitlements for EEA and non EEA nationals in the context of the Care Act 2014
Hospital discharge network	January 2015	Training from Elin Jones who manages the St. Mungo's Broadway homeless hospital discharge beds covering referral criteria, assessment and onward planning.

Discussion

This section discusses some of the internal and external challenges that the team faces, and outlines any actions that are currently being taken to resolve these, and/or suggestions for future action.

Challenges - *External*

Relationships with Housing Departments

This issue was covered in the partnership section of the report. The challenge presented by the lack of Local Authority Housing stock is obviously considerable, but the team recognises that the way forward to address this issue locally is by developing close and robust partnerships with Local Authorities and other housing providers.

Pathway is also working closely with Crisis and Shelter to develop effective lobbying strategies to influence government and housing law with regard to the wider national issues.

No Recourse to Public Funds

The practical issues presented by clients with NRPF were partly covered in the partnership section of the report, but there are wider issues that require a lobbying response.

For example, the team bears witness to very challenging situations where EEA national substance misuse clients are not entitled to planned in-patient detoxification or rehabilitation, but are obviously deteriorating on our streets. There is also local evidence that many NRPF clients who are facing issues regarding access to primary care may be a public health risk – in one recent study at a Health Inclusion Team GP clinic for failed asylum seekers, routine testing showed 18% had a serious infectious disease ⁽⁸⁾.

The team is already involved in the DH monitoring group which seeks to raise any concerns about changes to secondary care charging, but Pathway will be looking for other effective lobbying routes to raise the profile of these issues.

8. Nyiri, P. (Nov 2012) A specialist clinic for destitute asylum seekers and refugees in London. British Journal of General Practice.

GP Registration

Our pilot report profiled a 73 year Nigerian Insulin Dependent Diabetic patient who had a hospital admission for ketoacidosis, but who had been turned away from 5 GP practices including 2 homeless practices. This was not on account of his immigration status, but on account of his homelessness. Many NFA patients are now being required to 'prove homelessness' in a local area in order to register at a GP practice.

This issue has been raised at national level in a variety of forums, and the team is now in possession of a clear guidance document which can be used to challenge individual practices when this type of issue arises. Pathway are considering partnering with Crisis to do a 'mystery shopper' exercise to profile this issue.

Lack of Floating Support

Many of our clients need ongoing support when they leave hospital with respect to e.g. their benefits, obtaining ID, and evidencing their housing claims. In many cases there are no services to hand over to, and when there are, these services often have long waiting lists, or they are overstretched. On a background of austerity it is somewhat unlikely that this will change in the immediate term.

The team will continue to raise the profile of this issue locally, and maximise the benefit of the support that Groundswell can offer out of hospital, and our Housing Workers can offer in hospital.

Pan London Frequent Attenders

The team deals with a large number of transient clients that present at a wide variety of locations pan London. Although the team has developed considerable links with other partner agencies, these are built on individual relationships, and a formal network to assist with alerting and information sharing is needed. This issue was raised at the London Health Commission hearings in 2014, and is now a key delivery point for the new Homeless Health Services Transformation Board (see opportunities section).

Challenges - *Internal*

Kings Health Partners

Working across 3 Trusts is challenging for both practitioners and managers. Examples of this are where staff need e.g. multiple e-mail addresses, and multiple IDs, and in some cases need to attend e.g. multiple inductions and system training sessions (even when the systems are the same e.g. EPR at GSTT and Kings). This has been particularly challenging for our honorary contract staff working via Service Level Agreements who need 3 separate honorary contracts in order to operate across the 3 Trusts. Managing staff across Trust boundaries can also be practically challenging e.g. when HR functions can only be accessed on-line via the intranet.

If KHP is to continue as an entity it would be beneficial to do a retrospective analysis of the practical issues faced by this team in order to inform future projects, and provide forward plans for resolving these issues and streamlining processes across the Trusts.

EMIS Web

Emis Web will finally go live for the team on the 1st April 2015, and this represents a major step forward. Not only will the team be able to communicate with itself cross site, and with the Health Inclusion Team, it will now be in a position to open sharing gateways with other GP practices across Lambeth, Southwark and Lewisham, and potentially across the homeless sector pan London.

However getting the system installed has been a major challenge, and the delivery of the go-live date is around 15 months late. There have been a number of issues involved, many of which were technical, and some which have rested with EMIS themselves. Nethertheless the challenge of getting 4 Trust IT departments (there are 2 in GSTT covering both acute and community), and the Commissioning Support Unit to work together effectively have been considerable. Again, a retrospective analysis would be beneficial.

Ward Based Conflict

Although the teams have generally been very welcomed across the Trusts (as is evidenced by the high number of referrals), occasional conflict with staff is experienced. This is largely due to high pressure on beds resulting in pressure to deliver potentially unsafe discharges. It has also occurred where acute teams have perhaps been less able to understand patterns of patient vulnerability, or concerns regarding clinical risk.

This has been discussed with Clinical Leads at both Trusts, and the team has the full support of senior management. In general the plan to resolve this is around training of staff – both at higher level e.g. in Clinical Effectiveness and Acute Medicine / Emergency Care Planning meetings, and more locally on key wards.

Maintaining Clinical Skills

The clinician roles on this team require a high level of sophisticated clinical knowledge, however the staff are not able to practice their practical clinical skills in the role. This issue is further dealt with in the opportunities section.

Avoiding burnout

This team really is the 'hard cases' team, and there is a huge potential for burnout. Monthly clinical supervision with an external facilitator who is a Psychologist commenced in July 2014, and all staff receive monthly 1:1s to mitigate against this. However this does need monitoring on an on-going basis.

Opportunities

This team has already shown itself to be a trail-blazer and national leader. It is a glowing example of integrated care, working across 3 hospital trusts in both physical and mental health, and involving 4 partnership agencies. Team members are involved in numerous forums and influential groups at national level, and the team is very well respected across the board. The team has shown a willingness to network, adapt, and evolve that has been unprecedented, and is constantly looking for ways to improve the service.

Aspirations for next year are considerable, and include:

Primary care 'in-reach'

The team is planning to start bringing primary care into the hospital. This has already started with the introduction of a 'primary care sticker' – essentially an aide memoir to hospital doctors to considering using the inpatient admission to do opportunistic primary care work. Our GPs have developed this, and will be working with in-patient doctors to role this innovation out.

However the intention is that this will progress to the delivery of primary care interventions by the team itself, where this is relevant and of benefit to patients. Examples of interventions that may eventually be undertaken by the team are e.g. smear tests, opportunistic vaccination, and specialist blood tests. Providing specialist wound care advice, or undertaking specialist bandaging on the wards could also be part of this development. This development will also enable clinical staff to maintain their clinical skills.

The team GPs and nurses will be undertaking an audit as soon as possible to look at which primary care interventions that should be priority.

Further integration with the Health Inclusion Team

The installation of EMIS Web is obviously a huge step forward in the process of bringing the Pathway and Health Inclusion Teams closer together, and regular management meetings are in progress to facilitate a 'one team' approach. The teams will be looking at ways to maximise the benefits of the integration for both patients and staff, and a joint away day planned for May 2015.

The Health Inclusion Team will become also more involved in our frequent attender forum over time, and may eventually take over the management of the hostel forum. The Health Inclusion Team will be very involved in the development of the primary care in-reach project - learning from the HIT team will inform the Pathway team approach.

Maximising the benefits of EMIS Web

With the installation of EMIS Web, the Pathway and Health Inclusion Teams will now be in a position to open sharing gateways with other GP practices across Lambeth, Southwark and Lewisham, but also potentially across the homeless sector pan

London. The team has already been approached by the Health E1 Homeless Medical Centre, Greenhouse Homeless Medical Centre, and Royal London Pathway teams who also use EMIS Web. This needs to be discussed with our respective Information Governance departments, but the technology involved in sharing is simple, and easy to operationalise. This is a very exciting development that will benefit patients and staff hugely.

Involvement in the Homeless Health Services Transformation Board

Following representation from the team to the London Health Commission, NHS England and the Office of London CCGs are together leading a programme to transform London's homeless health services. The programme's mandate derives from Recommendation 31 of the Better Health for London report, which states:

'Health and care commissioners should develop a pan-London, multi-agency approach to health care for the homeless and rough sleepers, with dedicated integrated care teams and commissioned across the capital by a single lead commissioner.'

There are 5 Expert Working groups covering the areas of Primary Care, Secondary Care, Data and Information Sharing, Mental Health and Intermediate care, and the KHP Pathway Homeless Team is well represented on the Board, and within the working groups.

The programme has 2 key objectives which should assist the KHP Pathway team to achieve it's objectives of linking in effectively with other services pan London.

1. Every homeless person receives care which reflects their greater need when compared with that of the general population, and is bespoke for those who are identified as high risk.
2. The systems which support clinicians and homeless people are linked up to reflect the transitory nature of the population and support improved outcomes across the system.

Overall the very existence of this work stream is a triumph of collective lobbying on behalf of the team, Pathway generally, voluntary sector partners (particularly St Mungos Broadway), and the London Network of Nurses and Midwives in Homelessness, and will hopefully help transform services for homeless people, whilst also making service provision more effective and joined up.

Developing Partnerships

The team is always looking for new partnerships or ways to develop our existing partnerships, however some key development areas for next year will be:

Groundswell Evaluation

We will be working with Groundswell on a project to effectively evaluate peer advocacy intervention with our clients. This is a formal evaluation being led by the Young Foundation. This will enable us to consider how we should develop the peer advocacy element of our teams.

'Resolving Chaos'

The Big Lottery awarded Resolving Chaos £10 million over 8 years to work with the most chaotic clients across Lambeth, Southwark and Lewisham. Resolving Chaos are working with selected clients in each borough, and the Pathway teams have helped select clients for targeting. Resolving Chaos have health economist input, and there has been discussion around how we might be to work together to evidence our collective and respective interventions.

GLA Rough Sleepers Group

In partnership with the London Ambulance Service, Health Inclusion Team and Great Chapel Street Medical Centre, the KHP Pathway team has been targeting hostels with high levels of frequent attendance, to look at ways of assisting clients to use better routes into appropriate healthcare. However it is felt that this approach could be rolled out more widely, and early discussions with the GLA have been undertaken.

Improving cost effectiveness

Over the next year we looking to ensure that the correct GP is recorded on a client's hospital records, when the client is registered. All team members have access to the NHS Spine. Where GP registrations are recent and active, but there is no GP recorded on the hospital records, or the wrong GP is recorded on the hospital records, we will be seeking to edit this on hospital records. This will ensure that discharge letters go to the correct GP, but will also ensure that A&E attendances and admissions are charged to the correct Borough.

Improving Secondary Care Usage Data Capture

As outlined in the secondary care usage data section the team will be looking to improve its data capture and analysis over the year. This will hopefully be achieved by coding all homeless patients seen by the team on the hospital systems using the ICD-10 homeless code, such that data analysis can be performed on the clients actually seen.

Outpatient DNAs will also be included in future data capture.

Training

The team will look towards developing a training strategy that will enable staff to better manage homeless clients when the team is unavailable, or at reduced capacity, and will also attempt to develop a better cultural understanding of homelessness and homeless health within inpatient teams.

KHP Pathway Homeless Team KPIs for 2015-2016

By way of conclusion to this report, it was felt that it might be useful to publish our proposed Key Performance Indicators for 2015-2016.

These have obviously been based on the learning from the first year, but may be subject to change as the project develops.

- 10% reduction in A&E attendance
- 10% reduction in bed days
- Reduction in absolute cost of attendances and admissions
- 1% reduction in annual average re-attendance and re-admission rates over the year at GSTT and Kings

- 80% of frequent attenders at both sites to have a multi-agency action plan that is available on the A&E systems
- 80% of admitted clients known not to be registered with a GP to be given assistance to register with a GP (unless this is refused – refusals to be documented)
- 95% of clients eligible for reconnection (either national or international) to be offered reconnection. (We will also report on the number of acceptances.)
- 95% of patients who are registered as 'no GP and NFA' on EPR and who have a GP on the Spine, to have their details changed appropriately.
- % of clients with an improved housing status on discharge to be reported (but no target attached)

- Report to be provided on nos of clients receiving practical assistance to include travel support, benefits assistance, ID assistance, referral to solicitor, and referral to solicitor. Number of escorts to housing or other appointments to be reported.

- Patient satisfaction measure to be reported.

End Note

Initiating and developing a multi-agency and multi-disciplinary service across 3 Trusts has not been without its difficulties, but every challenge has been met head on in a positive and constructive way. There are some continuing challenges ahead, but there are also considerable opportunities for future developments and successes, and the team has a real energy and appetite for this.

This service has fully upheld the aims and values of the Kings Health Partnership, and has been a resounding success for the Pathway charity. In addition the service has shown that it can actively deliver on the Public Health England vision to 'improve the health of the poorest fastest', and can meet the statutory duty conveyed on all NHS Trusts by the Health and Social Care Act 2012 to reduce health inequalities. This is a result of the collective dedication and application of the whole team.

In summary the KHP Pathway Homeless Team has had a very successful first year,

Samantha Dorney-Smith

Integration Lead, KHP Pathway Homeless Team

March 2015

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