

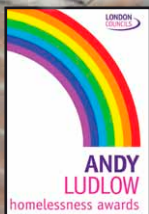
The London Pathway at University College London Hospitals

A Report on the first 12 months of service development

Dr Nigel Hewett, Medical Director London Pathway
Trudy Boyce, Senior Care Navigator Coordinator
Florence Cumberbatch, Homeless Healthcare Nurse Practitioner
Alex Bax, Chief Executive London Pathway
Stephanie Swan, Director of Finance, Project Management and HR
Professor Aidan Halligan Chair of Trustees

Winner of the Andy Ludlow Homelessness Awards 2010

Improvement programme supported by the Health Foundation



January 2011



London Pathway Ward Round Transforms Hospital Care for Homeless People

Opinions from people who use our service

"You were the only ones that felt my life was worth saving. I am now back with my family. A family I have not seen for ten years."

"I've never stayed in hospital as long as this (2 weeks) but I know you are really going to help me, I trust you, that's why I'm staying."

"Why do you want to help me? No one has wanted to help our kind before. You have saved me, thank you so much"

"With me being so ill I was grateful there was someone to speak on my behalf when sorting out my housing, you always went that extra mile."

"I very rarely talk to people about my situation but I can talk to you. You give the time and you don't judge so it is a relief to be able to unburden some of my problems without a feeling of shame."



Opinions from colleagues

"The change in the homeless service has been tangible, homeless patients are not waiting in hospital for any unnecessary length of time. The patients' views are sought and there is a joint solution to the issue. Having witnessed the open dialogue that occurs with the homeless people and the homeless team I am impressed with the empathy, trust and openness of the relationship. From the staff's point of view there is a full confidence that contacting the team will produce results and be in the interests of the patient. Staff spent a great deal of time previously to help the homeless, now that time is freed up and the homeless team's knowledge base in relation to other organisations is unique."

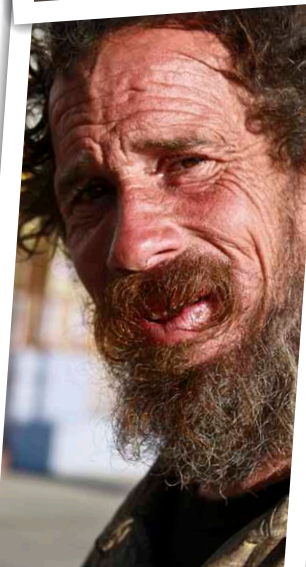
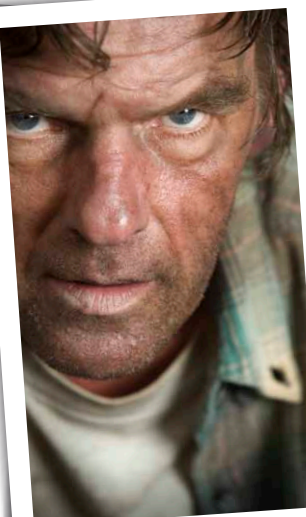
Denise Samphire. Senior Service Improvement Manager UCLH

"The joint working relationship between Camden Council's Housing Options Team and UCH has greatly improved the customer care experienced by homeless clients by providing them with a prompt and individually tailored service. Early notifications of a potential hospital discharge and our joint working protocols have enabled the Housing Options Team to quickly identify suitable accommodation preventing both delayed discharge and a return to the street."

Simon Rathborne. Housing Options and Opportunities Team Manager

"The homeless team provide the vital link between the hospital ward and community client support workers. This has supported completion of medical treatment, provided consistent medical management of opiate dependent clients and has ensured better communication with support services. Joint working and information sharing with the weekly meetings have helped support completion of treatment and reduce recurrent re-admissions. Additionally the homeless team have provided valuable support with complex substance misuse clients accessing hospital via A&E department and have ensured smooth admissions. The homeless team have been of enormous support in joint working with complex substance misuse clients at UCH, providing effective communication which has provided my service and hostels that I work with greater awareness of clients' medical management, discharge and follow up, which ensures accurate care co-ordination for the client and all staff involved."

Kate O'Brien Primary Care/Substance Misuse Nurse CRI/DAIS Camden South





London Pathway Wins Two Major Awards

Health Foundation Closing the Gap Award 2010

Against fierce national competition the London Pathway team won one of only 8 awards of £400,000 each, to develop our approach to homeless health care over the next two years.

This funding is awarded to test and demonstrate approaches to improving the quality of healthcare by transforming the dynamic between people who use services and those who provide them.

“The Health Foundation wants the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

Closing the Gap provides the opportunity for teams and organisations working in partnership to make demonstrable improvements in quality by tackling known gaps between best practice and routine delivery of care. In doing so, the scheme will build the knowledge and competencies of those who lead, manage and provide services to improve the quality of services for people who use them and to contribute to the creation of a systematic body of knowledge concerning healthcare quality.”

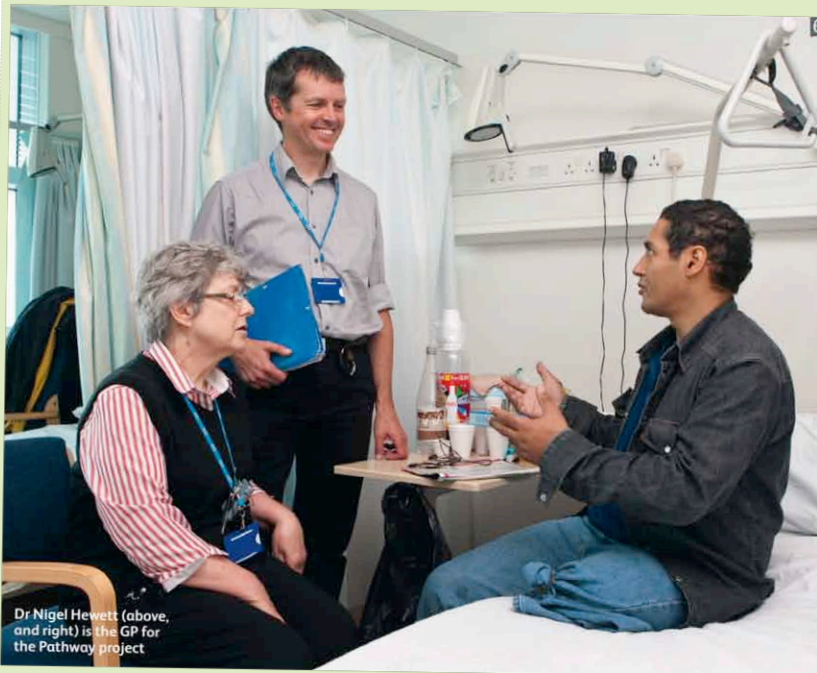
Andy Ludlow Homelessness Award 2010

The London Pathway team won the top prize of £25,000 in this prestigious award run by London Councils and sponsored by the 33 London borough councils, London Housing Foundation, Communities and Local Government, Shelter, and London Councils' Grants Committee.

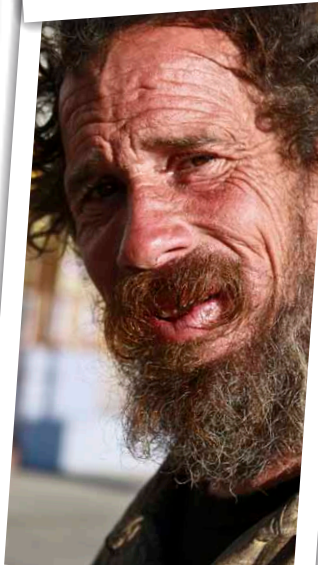
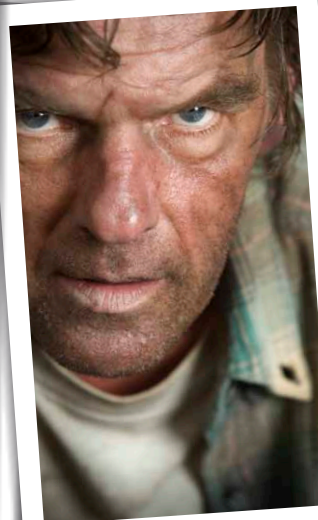
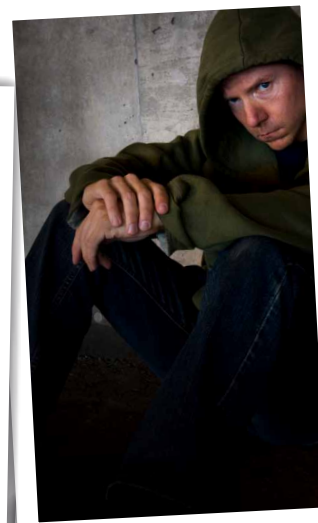
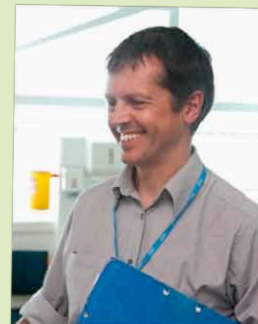
The prize money is awarded to organisations that demonstrate innovative and creative solutions for tackling homelessness in the capital, as well as recognising good practice.



Alternative Roots



Dr Nigel Hewett (above, and right) is the GP for the Pathway project



Patient Support

Hospital project wins London award for addressing the health needs of the homeless

A project that has brought together a doctor and nurses specialising in healthcare for the homeless and social care workers from other organisations, has won a top homelessness award.

The London Pathway project, based at University College Hospital in Camden, north London, took home the Andy Ludlow Homelessness Award trophy and a £25,000 prize.

The Pathway project was set up by professor Aidan Halligan after a homeless man died on the steps of the hospital after being treated repeatedly in A&E over a 12-month period. Realising that homelessness breeds particular and chronic health problems, Halligan set up a specialist team consisting of a GP, Dr Nigel Hewett, and two specialist nurses – Trudy Boyce and Florence Cumberbatch – all with considerable experience of working with

homeless people.

When a patient who is homeless is admitted, usually through A&E, Dr Hewett and a nurse visit them on the wards. Dr Hewett assesses their clinical needs while the nurse discusses plans for the patient's discharge, including liaison with social care, mental health, substance misuse and housing workers.

Lastly, one of a team of 'care navigators', who are either homeless or formerly homeless people with experience of the various services available, are introduced to befriend and support the patient – providing an important social network for homeless people that is often absent.

The chairman of the judging panel, Don Wood from the London Housing Federation, said the prizes went to the most original entries, and especially those whose systems could be

replicated elsewhere.

Dr Hewett, who set up a similar homeless healthcare project in Leicester and was awarded an OBE in 2006 for services to the homeless, said: "We're pleased for the recognition and hope that this will help us to spread the model elsewhere. We've already had interest from other hospital trusts."

Dr Hewett added that the model could be applied to patients with other kinds of acute, specialist needs. "Homeless patients visit hospital irregularly, their problems are advanced by the time that they do, and they often have complex combinations of physical and mental health problems," he said. "If it will work for homeless people, it will work for anyone."

"Homeless patients visit hospital irregularly, and they often have complex combinations of physical and mental health problems"

Running for just over a year, the scheme has decreased the number of emergency hospital

visits and increased the number of patients discharged into multi-agency care – with estimated savings to the hospital of around £300,000.

The Andy Ludlow award is open to all 33 London boroughs, and was named after a pioneering director of housing and social services for Haringey, who died of a brain haemorrhage at the age of 51. The award promotes the best and most original ways that the many agencies working with homeless people can work together.

Joint second place winners were the Cricklewood youth engagement scheme, set up and run by several young homeless people in an effort to try and reach youngsters involved in antisocial behaviour, and the Creating Positive Futures Work Programme, offering education and training to young people in Camden.

Joint third place winners on the night were the Brent Dual Diagnosis Project run by St Mungo's; Vision Housing which helps homeless ex-offenders find accommodation, training and employment; and the Broadening Horizons youth homelessness project run by the charity, Depaul UK.



Case History

(Names and some details have been changed to preserve confidentiality)

John, male 47

John's parents separated when he was a baby and his mother had drug and alcohol problems. He grew up in a variety of foster homes and local authority care homes and lost touch with his sister. He was often excluded from school and spent time in young offenders institutions and prison. For many years he struggled with injecting heroin dependency, this led to hepatitis C infection and damaged all of his peripheral veins. After prolonged methadone treatment from a community drugs team and a couple more periods of relative abstinence in prison he managed to stop using heroin but slipped into alcohol dependency. For the 2 years prior to his UCH admission he had stopped claiming benefits and was living in a squat without plumbing or heating. He was surviving by begging and keeping his alcohol withdrawal symptoms under control by drinking 3 litres of strong cider a day.

One day he collapsed in the street with abdominal pain and was brought to UCH. Abnormal blood tests were found and he was admitted to hospital where further tests revealed that he had Lymphoma – a cancer of the immune system.

Within 24 hours John went into alcohol withdrawal requiring detoxification treatment to control his symptoms. Feeling alone and desperate John was talking of taking his own discharge from hospital and returning to the streets. At this point the ward staff realised that the address he had given was a squat, and he was effectively homeless, the London Pathway team came to visit him the same morning. Our, non-judgemental befriending transformed John's experience of hospital and improved his relationship with the ward staff. A TV card and the purchase of some chocolate was the first step. A full history was taken, including specific housing, benefits and social history, details of past and current substance misuse and plans for discharge were explored with offers of help. It became clear that severe alcohol withdrawal was causing some paranoid thoughts that were affecting his behaviour. The medical team were approached to temporarily increase the dose of his detoxification medication and control his symptoms. John was then discussed at the London Pathway's weekly multi-agency team meeting. The alcohol team in-reach worker agreed to see him and offer support with continuing abstinence. The local street outreach team gave some background history, visited him on the ward for support and agreed to try and re-establish contact with his sister. The Local Authority housing options manager gave advice on a homelessness declaration and the GP homeless team lead wrote a detailed medical report to support his housing request.

Over subsequent days John was helped to re-establish a benefits claim and supported through the first round of chemotherapy. Regular attention from a Raki Healer on the ward helped with the side effects of treatment. After 3 weeks he was well enough to leave hospital, after a short period in temporary accommodation he moved into his own studio flat. During each admission for repeat chemotherapy he is visited by the London Pathway team who are also available for telephone support when he is outside the hospital. John remains abstinent from alcohol. He has re-established contact with his sister who has proved to be a good match for a bone marrow transplant, this offers a good prospect of cure for his lymphoma.

What is the London Pathway?

The London Pathway is a company limited by guarantee and a registered charity. Company No. 7210798. Charity registration 1138741.

Our charitable purpose is to improve the quality of healthcare for single homeless people and other multiply excluded groups in the United Kingdom

The London Pathway is a model of integrated healthcare for single homeless people and rough sleepers. It puts the patient at the centre of their own care pathway and works to transform health outcomes for one of the most vulnerable and deprived groups in our society. We believe that our model of healthcare developed for and with homeless people will also help other multiply excluded groups get better health services. We have established the London Pathway as a charity in order to share the model, train and support a new cohort of homeless healthcare nurse practitioners and care navigators, and to challenge the health service to deliver better quality healthcare to the most excluded.

The London Pathway is based on a set of fundamental values. In the London Pathway generosity, kindness, and compassion combine with a passionate commitment to professional quality to become the defining characteristics of health services for rough sleepers and single homeless people.

Our web site will give you more information about our board of trustees, our staff and our history at www.londonpathway.org.uk

The London Pathway's initial focus is to improve healthcare for homeless people admitted to hospital, although this has led us to develop a model that follows up patients long after they have been discharged.

London Pathway core services:

Acute hospital ward rounds

The London Pathway ward round is provided by an accredited London Pathway GP, supported by a specialist homeless healthcare nurse practitioner, visiting every homeless patient admitted to the hospital to co-ordinate all aspects of care and make plans with the patient for discharge.

Homeless healthcare nurse practitioners

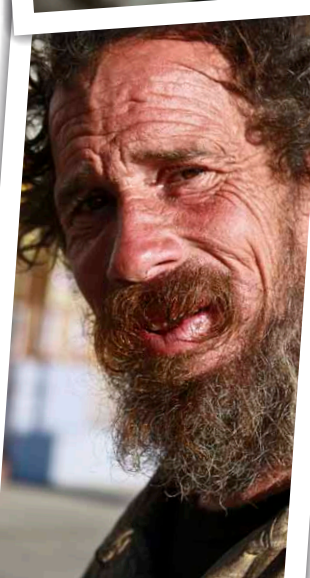
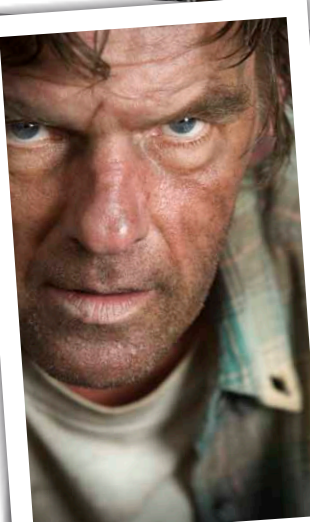
Work full time in the hospital supporting the ward round, liaising with medical staff across the hospital and with all other agencies involved, and providing daily support to homeless patients. They work with our patients to plan for life after hospital.


Care Navigators

With a personal experience of homelessness, Care Navigators befriend, support, challenge and mentor homeless patients in the hospital, helping them navigate the hospital environment, and supporting our homeless health nurse practitioners. They will help us follow-up patients post discharge.

Sanctuary

A necessary future development for the London Pathway approach is the provision of a community "Sanctuary" unit. Our analysis reveals a relatively small group of homeless people with complex needs and tri-morbidity (physical ill health with mental ill health and drug or alcohol misuse) who frequently need emergency hospital admission. Current models of community support are not meeting their needs and we propose





developing clinically orientated psychologically informed environments, modeled on homeless respite care units provided in the US. A Sanctuary will offer both a temporary home and access to 24 hour on-site primary care to optimize access to health care and minimize the need for further hospital admissions. Move on will be supported by the Care Navigator Team, following a “Housing First” approach – supportive case management in independent accommodation.

Needs assessment and start-up support

Before establishing a London Pathway service in a hospital it is important to understand current practice, assess local levels of need, and shape a service that will fit local circumstances. The London Pathway provides a bespoke development service to guide local health service staff to establish a service that meets our standards, and delivers the right outcomes for patients.

Accreditation, professional support and training

We are developing a set of clinical standards, a support network for homeless health specialists, and accreditation to ensure that new London Pathway services incorporate our value and ethos.

Case History

(Names and some details have been changed to preserve confidentiality)

Sue, female 33

Sue has a long standing heroin dependency with groin injecting and alcohol dependency. She was admitted with a chronic leg ulcer and a bleeding duodenal ulcer. At first she was reluctant to stay. She had a history of repeated admissions, premature self-discharge, poor engagement with support services and steadily deteriorating health.

The London Pathway team befriended her on the ward, following which she stayed long enough to see improvements in leg ulcer, stabilise on methadone and complete alcohol detoxification. During this time, she revealed a wish to return to her family in Scotland. The London Pathway team liaised with Scotscare and identified a means of funding the move home. A local drug treatment agency was identified and the current GP prescriber in London agreed to provide a script to facilitate the handover.

Sue stayed in London for 3 days after her hospital discharge in order to collect a benefits cheque; she remained in touch by telephone. At the last minute, funding for the return home was problematic because Sue needed to travel by train in order to take her dog with her. A medical letter was emailed to Scotscare confirming that her leg ulcer required her to have the leg room afforded by train travel. After arriving in Scotland further liaison was needed between the local pharmacy and the prescribing GP over the methadone script.

Sue settled back with her supportive family and her dog. She remains drug and alcohol free and has started visiting a dentist to get her smile restored.

The London Pathway is also a framework that can be adapted to the local situation of any Acute Trust

Objective 1 - Think Homelessness!

Check housing status for all patients on admission. If homeless, in a hostel, temporary or insecure housing, refer to the Homeless Healthcare Nurse Practitioner

Objective 2 - Homeless Team Coordinate Care

Patient seen by Homeless Healthcare Nurse Practitioner, visited by the Homeless Ward Round, needs assessed and Homeless Care Plan started

Objective 3 Care Plan Meeting

Complex needs cases referred to weekly Homeless Paper Ward Round for multi-agency Care Plan and Sanctuary assessment

Objective 4 Community Support

Care Navigator Team and service user plan community support and consider Sanctuary placement (ongoing medical needs, 2nd admission in 12 months, & complex case)

Objective 5 Sanctuary

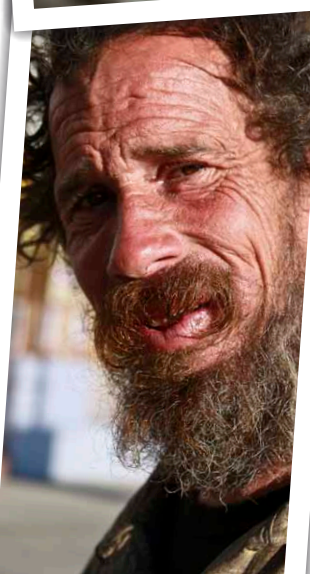
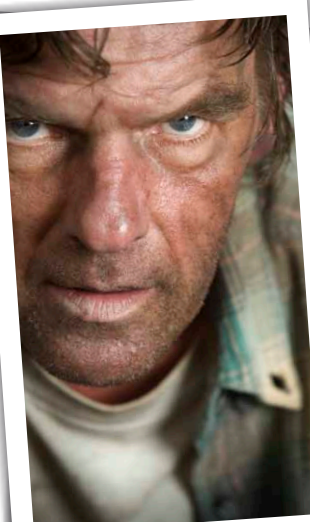
Tri-morbidity and complex needs treated in psychologically informed environment. Build relationships with Care Navigators aim for brief period of stabilisation, aiming for independent living for most people

Objective 6 Housing First

After stabilisation in Sanctuary, service user moves directly to independent permanent housing (private rented or housing association) with access to clinically led multi-agency Care Navigator support

Objective 7 Independence

Care Navigator Team and service user work towards independence - meaningful activities such as Streetscape, then work and paying taxes. For those with long-term care or support needs links made with local services.





Summary of findings in this report

- A hospital ward round and weekly collaborative meetings improves the quality of care for homeless people, support for hospital staff and multi-agency working
- A sustained impact on costs of re-admissions will require the introduction of post-discharge support by Care Navigators and development of a community residential unit – the Sanctuary
- Each unscheduled admission of a homeless patient to UCH costs on average £3,399
- During the first 12 months of this service there were 263 homeless patients admitted on 446 occasions at a total cost of £1,515,954
- 52% of the re-admissions occurred within 30 days of discharge – the cost of these re-admissions was £333,102 which will be at the expense of the hospital trust under new rules from April 2011
- Selecting all homeless patients admitted for a second time within a year would identify 96 patients as potential Sanctuary residents and Care Navigator clients. An average duration of stay of 16 weeks would require a 32-bed community unit.
- A community Sanctuary residential unit specialising in tri-morbidity would have the potential to both reduce the duration of current admissions and reduce the rate of re-admission and A&E attendance by homeless patients

Case History

(Names and some details have been changed to preserve confidentiality)

Dave, male 54

Admitted for surgical drainage of infected leg and hand, Dave was an alcohol dependent intravenous drug user on methadone, who had poor engagement with community services, and no local GP. He required repeated surgical drainage over several days. He had difficulty with pain control due to high opiate tolerance, and this caused friction with ward staff.

The London Pathway ward team befriended him and provided liaison with ward staff, pain team and drug treatment team to ensure adequate pain relief. An hostel key worker was invited into hospital to discuss a possible rehabilitation placement on discharge. Dave was supported with his benefits claim.

He became abstinent from drugs and alcohol on ward, but finally decided against rehab placement. Negotiation with the community drug team and GP ensured that he had methadone and stable opiate analgesia prescribed on discharge for daily collection to minimise risk. He stayed out of hospital for a year after discharge.

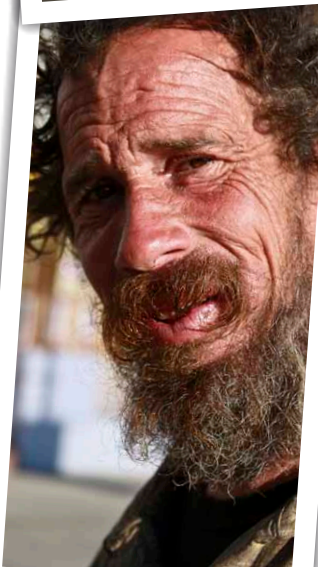
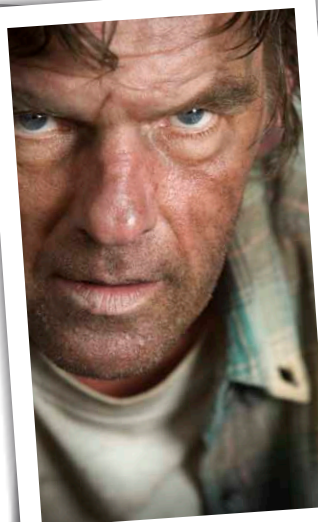
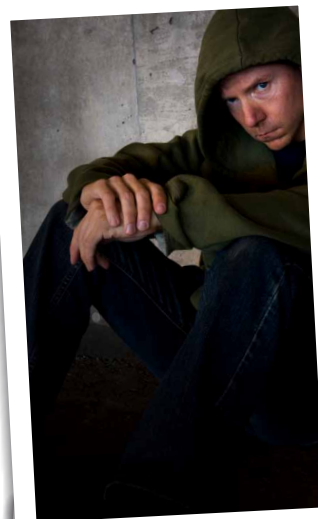
Background.

The London Pathway Homeless Team at UCH began a needs assessment in June 2009 and went live in October 2009. We now have a full year of data concerning patients referred to the team between 1st October 2009 and 30th September 2010.

Prior to setting up the service we audited UCH hospital records of homeless A&E attendances and admissions throughout 2008. This group of homeless people were identified by NFA (no fixed abode) in the address field, or with known hostel addresses in Camden, Islington and Westminster.

During the 2009 needs assessment period (June to December 2009) we gathered additional detailed data on homeless patients identified by ward staff and referred for assessment, this group included patients from a variety of boroughs, and people who gave an address on admission, but were unable to return there on discharge.

Despite the different sampling methods used consistent patterns of hospital attendance by homeless people can be identified.





Results from previous audits

2008 audit of patients from hostels in Camden, Islington and Westminster plus "NFA" A&E attendances and admissions.

A&E Data

- 559 patients recorded as NFA, or from hostels in Camden, Westminster and Islington attended casualty at UCH 1030 times during 2008.
- 46% of homeless patients A&E attendances are by ambulance
- A minority of patients are very frequent attenders and make high demands on the service. Average attendance is twice per year (85% of all individuals once or twice, with 71% of homeless patients attending only once). However 5% of patients attended more than 6 times. These 26 patients were responsible for 264 attendances during 2008. Therefore there is a core group of high-intensity users for whom the care they receive both in the community and in acute trusts is not resolving their health issues.
- Detailed analysis of the A&E records of these homeless frequent attenders showed all were NFA – so likely rough sleepers. 60% of attendances were judged to be appropriate – i.e. the sort of problem that should be managed in A&E. Most of the 40% of "inappropriate" attendances occurred in the early hours of the morning – making it likely that this small group are using A&E as a place of shelter through the worse of the night hours.
- Very frequent attendance at A&E by homeless patients appeared symptomatic of a complex situation of tri-morbidity, physical ill health with mental ill health and substance misuse in a context of lack of social support, poverty and chaotic lifestyles

Case History

(Names and some details have been changed to preserve confidentiality)

Jim, male 50

Jim was an emergency admission for treatment of a buttock abscess. He was a rough sleeper, with a recent prison stay. He is on methadone script and wants to avoid drug users so won't accept an hostel place. With the support of Camden housing department the London Pathway team managed to find a housing benefit funded private let that did not require a deposit. Jim was supported with the applications for housing and ESA benefits. After discharge he returned on several occasions to hospital for help with resettlement grant and support with housing benefit problems and negotiations with the landlord. He remains housed and avoiding drugs and alcohol 4 months after discharge.

Admissions data

- 185 homeless patients (defined as NFA plus hostels from local boroughs) were admitted a total of 220 times during 2008
- Analysis of the duration of stay compared to the “trim point”, showed that these patients stay on average one day per admission less than the duration expected for their condition
- 2009 needs assessment data showed 114 homeless admissions referred over a 5 month audit period, equivalent to 275 admissions during the year
- The principal physical conditions resulting in emergency admissions for the 114 patients studied during 2009 is as follows: -

Primary reason for admission	Number	Percentage
Alcoholic collapse or fit	20	17%
Korsakoff's, ataxia, alcoholic psychosis (neurological sequelae of alcohol)	7	6.5%
Trauma secondary to alcohol, head injuries, fractures	8	7%
Gastrointestinal consequences of alcohol (gastritis, duodenal, oesophageal varices, cirrhosis, pancreatitis)	16	14%
Sub-total all alcohol related	51	44%
Infection secondary to IVDU (septicaemia, abscess, ulcer, endocarditis)	18	16%
HIV (of which 2 also had TB)	9	8.5%
Sub-total all drug related	27	24%
Other/miscellaneous	15	13%
Falls/trauma unrelated to drink or drugs	8	7%
Malignant disease	5	4%
Suicide attempt	4	3.5%
Chronic Obstructive Pulmonary Disease (smoking related)	4	3.5%
Total	114	

This data confirms the widely published observation that complications of alcohol and drug abuse are the principal triggers for hospital admission. Substance misuse has complex links to poverty, childhood trauma, mental and physical ill health and can arise in response to the stress of homelessness, as well as being a cause of homelessness.





Outcomes data

The 2009 audit compared outcomes for 57 patients referred for housing advice during the needs assessment period June to August 2009, with 57 patients managed by the London Pathway team from October to December 2009. The provision of the London Pathway team was associated with the following changes: -

- Weekly multi-agency care planning meetings were implemented
- Average duration of unscheduled admissions for homeless patients reduced by 3.2 days per patient
- Appropriate durations of stay increased with double the number of patients staying 6-10 days
- Proportion of homeless patients discharged with multi-agency care plans increased 10 fold from 3.5% to 35%
- Where liaison psychiatry assessments carried out, proportion summarised in discharge letter increased from 33% to 75%
- Where methadone treatment plans necessary, information in discharge letter increased from 25% to 100%
- However, no change was seen in A&E attendances or hospital admissions over the next 6 months – this will require more intensive community support



New Cost Analysis Data

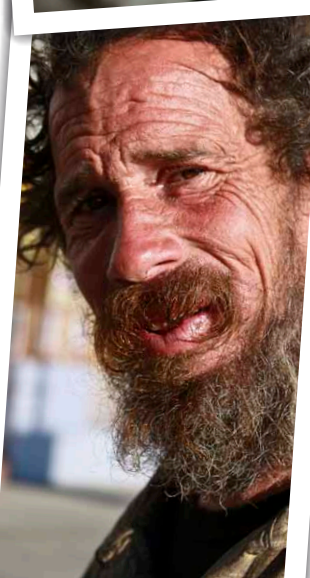
- Cost analysis of the 114 patients studied during 2009 established clear cost data for 103 patients (absent or incomplete data for 11 people) who were admitted 231 times during the year and attended A&E on 165 occasions. This data showed that each A&E attendance cost on average £83, each in-patient stay £3,026, and the 6 patients needing critical care cost £12066 per episode, giving a total secondary care cost of £785,148
- Annual secondary care costs were £7,623 per person (on average each person was admitted twice during the year) or £3,399 per admission, taking into account critical care and A&E costs.
- 6 month follow up of the 2009 audited group showed 75 readmissions from 114 patients. But 81% of these admissions related to just 17% (19 individuals) of the original patient group. In other words there is a relatively small group of homeless patients who are repeatedly admitted to hospital – a dedicated, health focussed community resource could change this pattern.
- Detailed analysis of these cases showed that nearly all would have benefited from better community support in the care navigator and Sanctuary model
- Two admissions in 6 months is a useful marker for very high future use of secondary care, and potential benefit from intensive community support.

Case History

(Names and some details have been changed to preserve confidentiality)

Peter, male 63

Peter is a very frequent attender at A&E for treatment of chronic obstructive pulmonary disease. He used to work as hospital porter, but has been sleeping rough for about 20 years. He attends hospital A&E in the night and then spends the next day dozing in the pharmacy queue, saying he is waiting for his inhaler prescription. He also sleeps on buses and the tube. The London Pathway befriended him in the hospital and built a relationship with him. They helped him apply for benefits and supported him in getting emergency accommodation in Westminster. His benefits cheques were delivered to the hospital and he was supported in applying for a post office account. He was accompanied to register with a GP and to keep appointments for neurology assessment of poor short term memory. The Social Services safeguarding procedure was triggered when it was discovered that housing benefit was being claimed in his name in another Borough. Peter revealed that he was driven out of a flat with threats of violence many years ago, and this is why he was still rough sleeping. He is now safely supported in residential care.





Data from full year audit 1st October 2009 to 31st September 2010

All patients referred and taken on by the homeless team were included in this audit. This includes rough sleepers, hostel dwellers, sofa surfers and those who lost their accommodation during the admission.

- 263 patients seen by the service in this 12 month period
- 10 people died during the year with an average age of 49.1 years (note: this is a small number and a selected group who were ill enough to be admitted to hospital, this will exclude those dying in the community of drug overdoses, suicide, trauma, who will tend to be younger)
- Total number of admissions 446, average of 1.7 per patient during the year and total cost of £1,515,954 (using average costs from 2009 audit)
- Total number of re-admissions during the year 189 (42% of all admissions) at a cost charged to PCT's of £642,411
- However 98 (52%) of the re-admissions occurred within 30 days of previous discharge and so will be charged to the acute trust under the new rules from April 2011. This would be a total cost to the trust of £333,102.
- 63% (167) of patients admitted only once.
- Targeting the 37% of patients admitted twice during the year would select 96 patients as potential Sanctuary residents & Care Navigator clients. An average duration of stay of 16 weeks in the Sanctuary would require 32 beds (at 100% occupancy).
- Can we identify those particularly sick homeless people who need better community support to reduce re-admissions? One third of patients are re-admitted and responsible for two thirds of the total admissions. Targeting these 96 people for intensive community support (care navigators and sanctuary) on their second admission will catch the 39 people (15% or roughly one sixth of homeless admitted group) who go on to be admitted 3 or more times and so are responsible for one third of all the admissions and two thirds of the re-admissions.
- A second admission in 12 months is therefore a useful marker for intensive support.



Critique – reflections on this evaluation and what we could do better

- The core purpose of our service is to improve the quality of health care for homeless people, starting with those admitted to hospital as an emergency
- The quality of patient experience is hard to measure objectively, we need to work more with the people who use our service to demonstrate the benefits
- Although our first evaluation showed potential savings by reducing duration of stay, this may be due to random variations between the before and after groups. Our experience suggests that we are often advocating for patients to stay in hospital to complete treatment. We are confident that we are improving the quality of care – but our hospital based interventions may be helping to identify unmet need – this is good for the patients, but may increase costs
- While concentrating on the ward round we have been slow to develop the Care Navigator programme. We have had some volunteers scoping the role, but funding has only recently been identified and full time Care Navigators will start working with us from early 2011.
- Our evaluation of the first 12 months of providing the service suggests that real potential for reducing secondary care demand lies with Care Navigator support and the provision of a network of “Sanctuaries” to provide dedicated residential tri-morbidity care for homeless people in the community.

Case History

(Names and some details have been changed to preserve confidentiality)

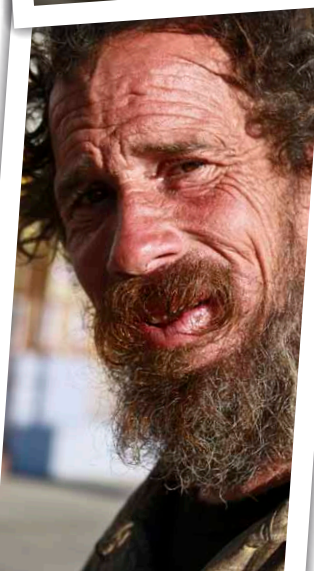
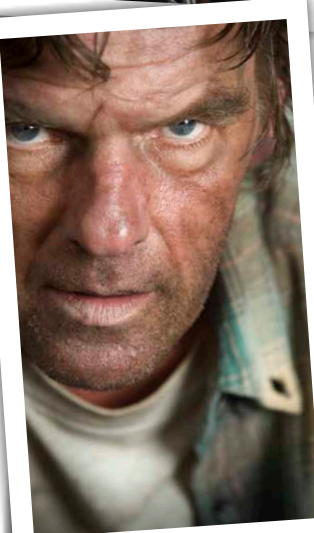
Jim, male 48.

Jim collapsed in A&E at UCH with alcohol withdrawal seizure and malnutrition. Paramedics had found him incontinent from urine and faeces in the ground floor common room of his hostel. He had been unable to climb the stairs to his room for two days.

Upon admission, it was discovered he also has alcoholic fatty degeneration of liver, cerebral atrophy and symptoms of cerebellar ataxia and peripheral neuropathy due to brain and nerve damage. And, he had scars of self-harm.

Since 1995, Jim has attended A&E at UCLH 155 times; has been admitted to hospital 11 times; and spent a total of 62 days as an in-patient. Usually, this has been related to self-harm or alcohol-related damage. He has been on the homeless circuit for the last seven years, with periods of rough sleeping. However, he has never been deemed to have support needs and medical care has been reactive. Any mental and physical health problems were considered alcohol-related.

Following assessments by an occupation therapist, physiotherapist, and a report from the London Pathway team it was finally agreed that he has long-term care needs. We found a placement for him in a residential unit.





Case History

(Names and some details have been changed to preserve confidentiality)

Eddy, male 40

Eddy has had prolonged treatment in intensive care for alcoholic cardiomyopathy, liver and renal failure. He accepts the need to stay off drugs and alcohol. The London Pathway team negotiated a placement at a "dry" hostel for patients recovering from dependency, and supported him on each subsequent planned admission for treatment of ascites. He remains off drink and drugs in the community, and has re-established a relationship with his father.



Case History

(Names and some details have been changed to preserve confidentiality)

Vince, male 59

A self employed electrician for 40 years, Vince has no family or savings and lived in B&B. Once out of work he rapidly became unable to pay for a room and took an overdose in despair. On ward he was discovered to be diabetic. The London Pathway team befriended him and supported him to approach Camden housing for help. They negotiated return to his B&B with backdated housing benefit to pay his arrears. After discharge there was a delay in getting his benefits. He returned to hospital for London Pathway team support in getting a crisis loan and was given a small cash support from the hospital Samaritan fund to buy food. With this support another overdose and admission were prevented.



Case History

(Names and some details have been changed to preserve confidentiality)

Bart, male 34

Bart is a security guard admitted with acute myeloid leukaemia. He had no savings and was on the minimum wage. He was staying with a friend, but could not return because his friend believed that he might “catch” the cancer. Bart had prolonged and repeated admissions for chemotherapy. There were difficult negotiations with the impoverished outer London borough, that was reluctant to accept a duty to house him. These prolonged negotiations were supported by medical reports. The London Pathway team finally helped to find a private let with housing benefit.

