St George's Homelessness Inclusion Team

Six Month Evaluation Report

December 2023 – March 2024

Pathway
Homeless & Inclusion Health

NHS
St George's University Hospitals
NHS Foundation Trust

South West London Integrated Care System

Contents

Executive Summary

The St George's Homelessness Inclusion Team (HIT) provides a holistic, compassionate and multi-disciplinary service to respond to the complex needs of people experiencing homelessness and other inclusion health groups such as vulnerable migrants. HIT works collaboratively with the charity 'Pathway' as part of the Pathway Partnership Programme, which supports the NHS to meet the needs of inclusion health groups. Through Pathway the HIT is part of a national network of 19 'Pathway Teams' across the UK, nine of which are in the charity's Partnership support Programme.

As people experiencing homelessness and other inclusion health groups have dramatically worse health outcomes (starkly higher rates of morbidity and earlier mortality) than the general population and experience multiple barriers in accessing care, the need for services such as the HIT is acute. Additionally, levels of homelessness in the area of St George's Hospital (SGH) are high and rising, with 1614 rough sleepers identified in Wandsworth and surrounding boroughs in 2023/24 (up from 1468 in 22/23 and 1207 in 21/22).

Building on the previous impressive evaluation of this service, this report describes the nature of the service being delivered and the outstanding achievements of the HIT since it was relaunched in November 2023 following a service reconfiguration. The report covers the period December 2023 to May 2024, during which the team received **314** referrals, of which **257** (81%) were accepted onto the caseload (43 per month), a further **48** (15%) had supporting advice provided and just **14** (4%) were rejected. Since this period the caseload has continued to increase, with **106 referrals in July 2024 alone**. Thanks to their hard work and dedication, the team has achieved a wide range of positive outcomes for patients, other staff members/services and SGH, including;

Reducing discharges to the street and facilitating safe discharges

Housing data collected by the team shows a **60% reduction in rough sleeping**, comparing hospital admission to discharge, and the team completed a Duty to Refer (statutory homelessness referral to a Local Authority) for **93% of eligible patients**, helping SGH to **meet its statutory requirements under the Homelessness Reduction Act**. As a result of their compassionate, person-centered approach, **just 6.9% of patients seen by the team self-discharged** (compared to 14.4% reported in the previous evaluation), ensuring that these patients receive the care that they need, and enabling effective discharge planning, both of which reduce readmissions and reattendances to hospital. As a result of this work, the HIT have contributed to reducing rough sleeping in Wandsworth;

"*With people being released from prison and discharges from hospital to the street being two of the main causes of rough sleeping in Wandsworth, the HIT has had an*

incredibly positive impact on the levels of 'new flow' to the street. Since the introduction of the HIT, there has been a 44% reduction in 'new rough sleepers' in Wandsworth." - **Wandsworth Rough Sleeping Coordinator**

Improving hospital flow, reducing readmissions /reattendances, cost-savings

Through providing a holistic assessment of patients' needs, developing personalised care plans, securing appropriate discharge destinations, providing community follow-up, and linking patients in with a range of community services, the HIT intervention reduces preventable reattendances/readmissions to SGH. The team also has access to one 'step-down' bed, which allows patients who are medically fit, but needing further support, to be discharged safely, freeing up hospital capacity.

Case studies of ED frequent attenders seen by the HIT show large reductions in ED usage following the team's intervention, with estimates of **£5104** to **£10,208** in prevented ED costs per frequently attending patient per year. Multiplied by the estimated number of frequent ED attenders seen by the team each year (82), the HIT may prevent between **£418,528** - **£837,056** in ED costs per year. True cost-benefits for these cases are likely to be higher given that these estimates don't include avoided admissions.

The team's step-down bed was occupied for 233 nights over the past year, at a total cost of £28,470 per year. This represents 233 nights that a patient would have otherwise been in hospital, costing £136,771 (£587 per night). Subtracting the cost of the step-down bed gives an estimated **£108,301 in prevented costs per year.**

"The HIT are vital to the flow of patients in the hospital. They support in ensuring that beds are not occupied by people who could be supported by other services outside of the hospital." - ***SGH Staff Member***

Pathway's evidence base suggests that hospitals with a specialist homeless team based on Pathway's core model see **bed-days occupied by homeless patients fall by an average of 30%**[1].

Providing compassionate, holistic care to achieve positive outcomes for patients

Case studies presented in this report illustrate how the HIT has achieved extremely positive outcomes for patients. **60%** of patients without a GP were assisted to register with a GP they could access following discharge from hospital. Feedback collected from nine service users found that **100% thought the team was kind and caring at all times, made them feel completely safe and had been extremely helpful.**

"Before, I felt depressed, lonely and hopeless. Your service gave me some strength and belief that my voice will be heard." - ***Service User***

Being highly valued by other staff/services

Feedback collected from staff at St George's Hospital (SGH) and other external services was extremely positive. In particular, respondents highlighted how the HIT supports other services with complex cases, helps to coordinate safe discharges, brings services together to work collaboratively, and helps services to follow up with patients effectively. **100% of staff surveyed (38) said that the team was needed and should continue.**

"The team is amazing, and I can't think of a functional hospital without this team." - ***SGH Hospital Staff***

Driving improvements in collaborative working, education on homeless healthcare

By developing relationships with a range of services (such as outreach services, addictions services, GP practices and immigration services) the HIT has driven local improvements in collaborative working both within and outside of the hospital. The team also convenes regular multi-disciplinary (MDT) meetings to coordinate care for patients with complex needs. By ensuring patients are supported by a range of appropriate services, the HIT intervention reduces patients' reliance on SGH. The team also provides training sessions to groups of hospital staff, such as junior doctors and discharge teams, to help them effectively, safely and confidently support patients who are experiencing homelessness, or other inclusion health patients.

Supporting complex patients – NRPF / Safeguarding / Fleeing Violence

Almost **one in five (18%)** of all patients seen by the team had No Recourse to Public Funds or uncertain immigration status, and **30%** had safeguarding concerns. The team works closely with safeguarding teams and other services to support those fleeing or at threat of serious violence (i.e. gang, youth, criminal or sexual, exploitation and cuckooing) and domestic abuse. HIT recruited a team Violence Reduction Lead, which is the first role of its kind within the NHS, to support this work further. The HIT works closely with a range of organizations, including immigration legal advice provider Praxis (funded by Pathway), hospital safeguarding teams and third sector organizations, to support these extremely vulnerable patients.

"We work with the HIT to support extremely vulnerable migrants who need immigration advice. They have been extremely helpful in supporting patients to gather evidence for their immigration applications, helping them to attend important

appointments, and helping us to communicate with patients remotely when we are not able to come to the hospital to visit. them." - ***Praxis Case Worker***

"HIT are incredibly flexible and hardworking and always responsive to queries. HIT are always helpful when needed to liaise particularly around patients who are experiencing Domestic Abuse, and safeguarding concerns" - ***SGH Staff***

"Their ability to engage the over 25 serious violence cohort is great because this demographic often slips through the net with homeless services as they don't present like other rough sleepers" - ***SGH Staff***

Regional Winners – 2023 NHS Parliamentary Awards

St George's Accident and Emergency and Homelessness Inclusion Team was regional winners in the 2023 NHS Parliamentary Awards after being nominated by local MP Rosena Allin-Khan. The NHS Parliamentary Awards recognises the outstanding contribution of NHS staff, volunteers and other health and care sectors. HIT was also able to showcase their work and support for patients when NHS England Medical Director Professor Sir Stephen Powis visited the team in May 2023.

Challenges and Opportunities

Staffing and funding – given the high level of local need, the team's capacity is stretched with large caseloads. Increasing staff capacity within the team would allow it to support more patients and further reduce pressure on the hospital with more community engagement and follow-up. Long-term funding for the service would reduce staff turnover, increase knowledge retention and improve staff development.

Complex patient caseload – many of the patients seen by the team have extremely complex health, housing, care and immigration needs. Without specialist placements following hospital discharge it is extremely challenging to meet these patients' needs.

Step-down space – having access to a step-down bed has been extremely useful for the team, allowing them to safely discharge patients who need ongoing support. Increasing the number of step-down beds available to the team would be extremely beneficial for both patients and hospital flow/capacity.

Working across multiple boroughs – because the team works with patients who have local connections outside of Wandsworth, they need to work with multiple community partners and be familiar with multiple referral processes. The team has approached this by building strong relationships with community partners and sitting on the Homeless Health Southwest London Steering Group.

Introduction

The Homelessness Inclusion Team (HIT) started as a one-year pilot service within St George's University Hospital on 29th November 2021. They are now a well-established and well-respected service within the hospital, working hard to improve the health and wellbeing of people experiencing homelessness and other forms of social exclusion. They do this through multidisciplinary working, clinical advocacy and compassion.

The pilot project, funded by the Out of Hospitals Care Model fund, was extremely successful, as was highlighted in St George's Homelessness Inclusion Team nine-month evaluation report covering November 2021 – August 2022.[2] There was clear evidence of a high need for the service, and impressive outcomes were achieved. Following this, the team's funding has been continued by Southwest London ICS until the end of May 2025. However, without longer-term funding, it is challenging to attract and retain skilled and committed staff members, which is essential to delivering a high-quality service. By showing the value and positive outcomes achieved by the team, this report makes a strong case for the sustained long-term funding of this vital service.

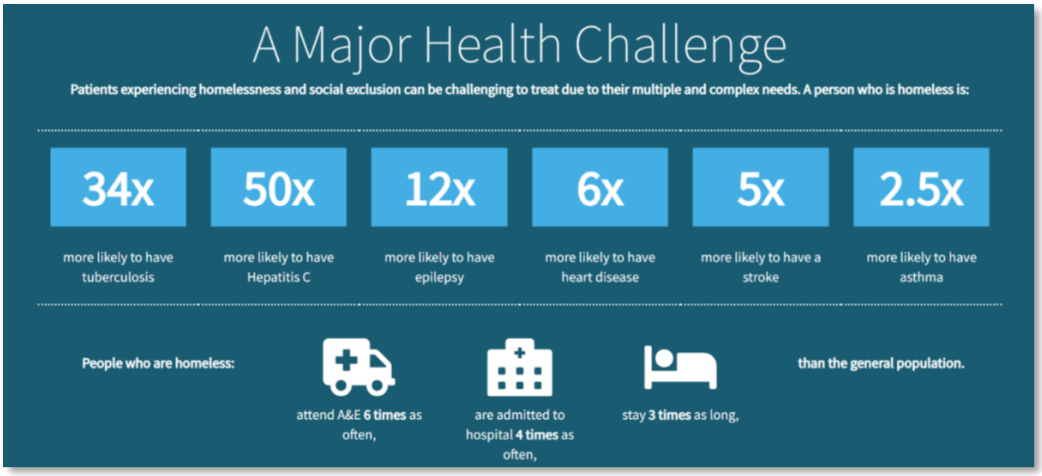
This report, to which HIT members have contributed significantly, outlines the nature of the service currently being delivered, how the service has developed, and what the outcomes have been over the past year. It also highlights key challenges and a vision for the future for the team.

Why is a specialist inclusion health service needed in St George's?

The health issues of people experiencing homelessness

People experiencing homelessness are known to suffer physical health problems at a greater frequency and intensity than the general population during their lifetimes, resulting in higher use of hospital services than the general population.

Figure 1: Health problems and secondary care usage patterns of people experiencing homelessness



Pathway Homeless & Inclusion Health

Many of these health problems are preventable. For example, in a study of 600 people experiencing homelessness that died in English hospitals between 2013 and 2017, the biggest killer was cardiovascular disease (30.1%), including strokes and heart attacks. 20.8% of the 600 deaths were caused by cancer. 16.9% were caused by respiratory disease (Aldridge et al, 2019).[3] Unfortunately however, tri-morbidity and complexity often make people experiencing homelessness more difficult to treat. 'Tri-morbidity' is the intersection of physical health, mental health and addictions conditions.

People experiencing homelessness often have high levels of mental health issues, alcohol and/or drug misuse as well as many physical health issues. For example, in a large survey of people experiencing homelessness from 2022, 82% of survey respondents reported some form of mental health issue.[4]

Such complexity can often be exacerbated by communication difficulties. Higher rates of brain injury, psychological trauma, mental ill health, autistic traits, language and literacy challenges, and prison and care histories, are all present in homeless populations making it more difficult for people to engage with services and process information.[5]

As a result of high morbidity and complexity, people experiencing homelessness die earlier. Aldridge et al (2018)[6] showed that all-cause standardised mortality ratios in people experiencing homelessness were 11.86 times higher in females, and 7.88 times higher in men, than in the general population. Similarly, recent ONS statistics show the mean age of death for people identified as homeless in 2020 to be a shocking 45.4 for men and 43.2 for women.[7]

Barriers to health care for inclusion health groups

Underpinning these health issues is the fact that people experiencing homelessness have poorer access to healthcare, despite having higher levels of need. The barriers to access for primary and secondary health care for inclusion health groups are considerable and include:

- Lack of ID or an address
- Language, literacy and cognitive issues
- Mental health and addictions
- Poverty e.g. having no phone credit
- Digital exclusion
- Practical issues e.g. 'Who will look after my dog?
- Lack of trust
- Embarrassment
- Immigration issues resulting in worries about NHS charging and/or deportation
- Addiction resulting in fear of drug and/or alcohol withdrawal
- Stigma

Patients without identification are frequently wrongly turned away from GP registration[8], even though NHSE guidance clearly states that ID and/or proof of address are not required for people to register with GPs.

High levels of homelessness in the St George's hospital area

St George's Hospital is based in the London Borough of Wandsworth. Levels of homelessness in Wandsworth and the surrounding boroughs are high, and the available data shows an increase in the number of rough sleepers and homelessness presentations to relevant local authorities from 21/22 to 23/24. Given the high levels of local homelessness and the health issues and barriers outlined above, there is a clear need for the HIT at St George's Hospital.

Numbers of people seen rough sleeping locally – CHAIN data[9]

The boroughs primarily served by the team have high levels of rough sleeping, as shown in the table below. The table also highlights a growing level of need in these boroughs, with the number of identified rough sleepers rising from 1207 in 21/22 to 1614 in 23/24.

Table 1: Number of rough sleepers per borough via CHAIN

	2021/22	2022/23	2023/24
Lambeth	438	623	681
Croydon	271	373	449
Wandsworth	264	173	172
Kingston	99	120	107
Richmond	61	86	100
Merton	45	63	77
Sutton	29	30	28
Total	**1207**	**1468**	**1614**

Numbers of people presenting to the Local Authority as homeless[10]

Levels of homelessness are also indicated by presentations on account of homelessness at the Local Authority. In Wandsworth alone, over 1,600 people were owed a prevention or relief duty by the Local Authority in 22/23. The levels of homelessness in the other boroughs served by the team are also high, and a projection for 23/24 shows an increase in the numbers of people being owed prevention or relief duties.

Table 2: Number of homelessness presentations owed prevention or relief duty – H-CLIC

	21/22	22/23	23/24 (projected*)
Lambeth	3222	3104	3552
Croydon	2429	*Data unavailable*	*Data unavailable*
Wandsworth	1463	1609	1673
Sutton	847	877	884
Merton	609	705	804
Richmond	389	583	597

Kingston	347	*Data unavailable*	288
Total	**9306**		
Total (minus Croydon)	**6877**	6878	**7799**

**projections based on data from Q1,Q2,Q3 of 23/24*

Pathway Partnership Programme

The Pathway charity helps the NHS to create and support specialist multidisciplinary hospital care coordination teams to support people experiencing homelessness and multiple exclusion whilst they are in hospital through its Pathway Partnership Programme. The St George's HIT is one of nine Pathway Partnership Programme teams around the UK.

Pathway Partnership Teams aim to improve the health and wellbeing of people experiencing homelessness and to support hospital, housing and Adult Social Care services in providing compassionate and holistic care for this patient group. Teams provide clinical advocacy, housing advice and support, bespoke care plans and high-quality care that supports safe and effective discharges from the hospital. Teams are multidisciplinary and include specialist GPs, nurses, allied health professionals, social workers, housing experts and care navigators. Service evaluation and research has shown multiple benefits of the Pathway model;

➢**Improves outcomes for homeless patients.** Better health and care outcomes are achieved during and after discharge and improved housing outcomes are achieved on discharge

➢**Improves capacity in busy hospitals.** A reduction in A&E attendances number of re-admissions and/or overall bed days has been demonstrated in most studies.

➢**Is cost effective.** This was demonstrated in one study using Quality Adjusted Life Years and has also been demonstrated by comparing the costs of the team to the reduction in secondary care activity for involved patients.

➢**Meets the statutory Duty to Refer requirements for hospitals under the Homelessness Reduction Act 2017.** Teams now ensure the Statutory 'Duty to Refer' which came in in 2018 is met.

➢**Is valued by hospital and community staff and improves integration.** Positive impacts on staff, partners and systems have been demonstrated in all studies

As a member of the Partnership Programme, St George's HIT receives a range of advice and support from the Pathway charity including;

- Regular support calls with the team to provide case and strategic advice
- Support with recruitment and interview processes for new team members
- Data analysis, service evaluation, quality improvement and reporting
- Reflective practice sessions for the HIT
- Membership to national inclusion health networks, masterclass sessions, support networks
- Legal advice via immigration advice services
- Training for new team members

To find out more about the Pathway Partnership Programme and how we work with the NHS, a more comprehensive review can be found here: The Pathway Partnership Programme Annual Report: 2022-23.

Service Description

The St George's Homelessness Inclusion Team (HIT) supports adult patients (18 or over) who are experiencing homelessness (e.g. rough sleeping, living in a night shelter, homeless hostel or fleeing violence) or vulnerably housed (e.g. sofa surfing or at risk of eviction) and have inclusion health needs (e.g. the most marginalised groups who struggle to engage or access health services such as vulnerable migrants, asylum seekers, prison leavers, experience of the care system, fleeing violence and those with substance misuse). It works with Inpatients, Emergency Department attendees, and people identified as being Emergency Department frequent attenders at St George's University Hospital. Core working hours are Monday – Friday, 9am – 5pm.

Staff structure and roles

The team currently has the following structure:

Hospital

- 0.5 WTE General Practitioner
- 2 FT Band 6 Housing Advisors
- 1 FT Band 6 Violence Reduction Lead
- 1 FT Band 4 Care Navigator
- 1 FT Band 6 Homeless Health Nurse
- 1 FT Band 6 Homeless Health Occupational therapist

Referrals

Referrals to the team can initially be made electronically on the hospital system, via email, phone, or face-to-face. Referrals can be made from within and outside the hospital (i.e. partner agencies can refer if they know a patient is in hospital), and patients can request to be referred to the team.

Team activities and interventions

- Holistic health assessments (including chronic disease, assessment of mental health, addictions, the physical sequelae of addictions, cognition / brain injuries, safeguarding and self-neglect, social care needs, the assessment of mental capacity, and housing, health and immigration law)
- Complex care planning and discharge liaison including supporting MDT meetings
- Support to understand and engage with medical treatment
- Trust building using trauma informed care approaches
- Prevent self-discharges
- Referrals (and support to link into) relevant services such as mental health and addictions services, homeless day centres, primary care services and social care.

- Housing and benefits support and advice, including the provision of skilled advocacy to Homeless Persons units/teams at Local Authorities
- Linking into legal and immigration support – Hodge Jones and Allen can provide legal advice for homeless patients during their stay in hospital, and the team will refer to independent immigration advice such as Praxis and South London Refugee Association
- Support to obtain birth certificates, passports etc with benefits and housing applications
- Liasing with police, probation and community safety teams
- Help with GP registration
- Fresh clothes, shoes, and other essentials whilst in hospital
- Personalisation fund to assist with items such as phones, headphones, TV credit, newspapers, food etc to support patients to feel more comfortable and stay in hospital
- Help to reconnect with loved ones
- Follow up in the community for up to six weeks
- Step Down Housing Support – one local bed obtained to support with discharge pressures and hospital flow when a patient may be medically fit but requires ongoing community/housing support to ensure a safe discharge.

Note that follow-up support is a central part of the support that the team offers for up to six weeks post discharge. When patients are given temporary accommodation by the council the team can visit to support this transition, settling a patient in (for example by supporting with buying household essentials like bedding) and supporting them to engage with the support in their new area and register with a new GP. In this way, the team are often used as a bridging service when other services don't yet have the ability to take on these patients and/or when floating support services don't exist.

The team have also developed an advice booklet called "The HIT List" with advice regarding local services providing housing, immigration, and social support, as well as day centres that can help with things such as clothes and food. This can be utilised when a patient presents outside of working hours to the ED and until HIT are able to contact them.

In addition, other key team roles are;

- Linking in with other Pathway Teams, community homeless nursing teams, GPs, outreach teams, hostel providers and the London Ambulance Service to develop care plans for frequent attenders to the ED.
- Providing education sessions, training and advice on homelessness and housing to hospital staff.
- Working on strategic issues around wider homelessness in the Southwest London Boroughs, supporting Hospital Discharge Policy with local boroughs, attending Southwest London Steering Groups, and inputting to Wandsworth homelessness needs assessments with Public Health and Healthwatch.

Figure 4: *Core objectives of the St George's Homelessness Inclusion Team*

Collaborative Partnerships

The team has worked hard to develop collaborative partnerships and is integrated well with a range of other community and health services. The team convenes weekly MDTs and invites hospital teams and outside agencies to develop multi-agency plans for patients who have complex needs.

Hospital partners

- Emergency Department
- Discharge Hub
- Mental Heath – Psych Liaison
- Addictions – Drug and Alcohol Team (DALT)
- Safeguarding
- Acute Medical Unit / Short Stay wards
- Trauma and Orthopaedics and Major Trauma Team
- Major Trauma Signposting Partnership
- Citizens Advice Bureau
- Major Trauma Psychology Team
- Chaplaincy
- Victim Support
- Redthread Youth Violence Team
- St Georges Hospital Charity

Community partners

- Addictions services such as Wandsworth Community Drug and Alcohol Service, Change Grow Live (Croydon), Via (Merton), RHEST (Pan London Substance Misuse Engagement Team)

- Homeless Outreach services – e.g. Spear, Kingston Churches, New Horizons
- Housing Teams and Rough Sleeper Leads – e.g. Wandsworth, Merton, Croydon, Sutton
- Hodge, Jones and Allen; and Praxis
- GP practices
- Immigration Advisors – South London Refugee Association, Eastern European Resource Centre
- St Mungo's MAPS Migrant Accommodation Pathways
- Homeless day centres – Faith in Action, South London Refugee Association, Southcroft Church, Spires
- Home Office Homelessness Escalation Teams
- Central London Community Healthcare NHS Trust Homeless Health Team
- Pathway
- HMP Wandsworth and the London Prison Group
- Women in Prison and DIVERT (Met Police Custody Intervention programme)
- DWP – Serious Violence and Exploitation Leads at various South London Job Centres
- MET Police (including BCU Gang units), Community Safety Teams and the National Probation Service
- Community Violence reduction programmes – e.g. Pathways 2 Progress, Carneys Community and Be Inspired

Supporting patients affected by serious violence

To address gaps in support to adults affected by serious violence, HIT recruited a Violence Reduction Lead into the teams which is the first role of its kind within the NHS, St Georges Hospital (SGH), and Pathway. This work aims to support those fleeing violence who are unsafe to return home. This can include gang, youth or sexual violence, exploitation, cuckooing, modern slavery, trafficking and domestic abuse. This is alongside supporting those patients leaving prison. This work links the hospital with the community network including local borough's community safety teams, community organisations, probation, police, and London prisons..

The HIT sit on several boards including the trusts Violence Prevention and Reduction Group, the Domestic Abuse Steering Group, Wandsworth Communities Against Violence Forum, Mayor of London's Violence Reduction Unit, Youth Practitioner Advisory Board and Responding Together to Knife Crime Forum. HIT have worked closely with Major Trauma teams to improve pathways for adults fleeing violence and fed into the Major Trauma Standard Operation Procedure for Violent Admissions. HIT fed into the consultations for the Knife Amnesty Bin, which was installed at SGH earlier this year, and have been working with the London Prison Group to establish better pathways for clients discharged between hospital and prison.

Ongoing work - HIT aims to support in setting up a Violence Reduction Board within the hospital to share best practice, is advocating for a Police Trauma team/Liaison Officer at St Georges Hospital, which exists in Royal London and Kings College Hospitals.

Step-Down Bed

The HIT secured an agreement with a local hotel to facilitate a single step-down bed on a block booking. This consists of a self-contained room with a double bed, bathroom and kitchenette. The team have used this to support hospital flow, safe discharges and prevent re-admissions. It has facilitated discharges when a patient is medically fit but may need more work to support them into accommodation (such as with housing or immigration) or also when they may need a safe space to recover (i.e. from a surgery to prevent wound infection/readmission). This step down is not staffed and so a risk assessment is made prior to patients being discharged here and only those with low/medium risks and with a discharge/move on plan in place. The team will then continue to work with the patient with daily contact required as part of the step-down agreement.

Looking to the future, a step-down facility with full-time support staff would be something the team would want to explore further. This is used across other Pathway teams and facilitates the discharge of more complex patients whilst relieving pressure on hospital staff.

Personalisation fund

One of the things that has been most valuable to the team has been the personalisation fund of £10,000 per year allocated to support patients directly. Being able to provide patients with items that support engagement and access, making their stay in hospital more comfortable (and therefore preventing self-discharge), has been vital. Of similar importance is assistance in accessing community support, help with attending assessments such as for housing, and support transitioning into any sort of new accommodation.

Using this fund, the team has a petty cash system in place that can be topped up weekly. The team also utilises the hospital ordering system to acquire stocks of phones so patients can be followed up in the community, and television packages for those patients with extended admissions to prevent self-discharge.

The petty cash fund is currently being used for:

- Toiletries – shower gel, shampoo, toothbrush, toothpaste, deodorant, combes / brushes, sanitary products, tissues
- Tea / coffees / snacks for whilst in hospital and outside
- Shoes / boots / trainers, underwear, socks, coats and other clothing

- Books, newspapers, puzzle books for whilst in hospital
- Phone credit
- Birth certificates online
- Transport for patients e.g. taxis, oyster cards, mainline train tickets
- Temporary accommodation individual items and welcome packs e.g. quilts and pillows, quilt covers, plates, cutlery, mugs and kettles.

Charitable Partnerships

The team has proactively engaged in partnerships with different charitable organisations to provide further support for patients, including;

St Georges Hospital Charity – supported with extending step-down bed allowing the vital support this provides to continue

Vodafone 'End Digitial Exclusion' Scheme – the team was awarded 300 SIM cards with unlimited calls and texts to provide to patients. This improves the team's ability to follow-up and stay in contact.

Comfort Cases – donated a range of personal items including duffel bags for patients who have experienced the care system, to support their transition out of hospital

Critical Support – supported clients with food packages, and furniture to support their move-ins to new accommodation

HSBC 'No Fixed Address Bank Account Scheme' - support patients without a home address to open a bank account, which is essential for them being able to claim benefits.

2023 NHS Parliamentary Awards

St George's Accident and Emergency and Homelessness Inclusion Team were regional winners in the 2023 NHS parliamentary Awards after being nominated by local MP Rosena Allin-Khan. The NHS Parliamentary Awards recognises the outstanding contribution of NHS staff, volunteers and other health and care sectors. For the past 6 years, it has given members of parliament the chance to showcase people working in their constituency in the healthcare profession. HIT were also able to showcase their work and support for patients when Professor Sir Stephen Powis NHS England Director visited the team in May 2023.

https://nhsparliamentaryawards.co.uk/shortlist/

Team Referral Data

The team collects referral data covering a range of information including patient demographics, immigration status, team activity and housing outcomes. The data presented below covers the period 01/12/2023 to 31/05/2024 (six months).

Key points

- The team has seen a high number of referrals, 314 (52 per month), over the six-month period. The team accepted 257 (81%) and provided advice for another 48 (15%). Just 14 (4%) referrals were rejected. The team received a further 106 referrals in July 2024 alone, highlighting the high demand for the service.
- Of accepted referrals 75% were male and 25% were female. The average age was 45 years (46 for males, 42 for females).
- 18% of all accepted referrals had No Recourse to Public Funds, and 30% had safeguarding concerns
- 70% of all accepted referrals had a local connection to Wandsworth, Merton, Croydon or Lambeth.
- The team completed a Duty to Refer for 93% of eligible and consenting patients, and registered 60% of patients who did not have a GP with a new GP they could access on discharge.
- Of the 218 accepted referrals for whom data was available, 53 (24%) were rough sleeping on assessment. Of these, 32 were discharged to suitable accommodation, a 60% reduction in rough sleeping.
- Of the 21 who returned to rough sleeping, 14 (67%) had No Recourse to Public Funds.
- Just 6.9% of accepted referrals self-discharged, improving on the rate of 14.4% identified at the previous evaluation. This is also far below the typical self-discharge rate of 15-20% identified for this population.

Referral Outcomes

Following an initial triage, referrals have three different outcomes;

Accepted

- **Brief intervention:** support provided including GP registration, referral to other services/signposting, and support with housing applications.
- **Holistic assessment and full intervention:** for more complex patients, often with long histories of homelessness and frequent attendance. Above support plus intensive case coordination across services, and community follow up.

Advice Only **-** The team does not physically see or contact the patient but provides advice to other relevant services including healthcare services, local authority and

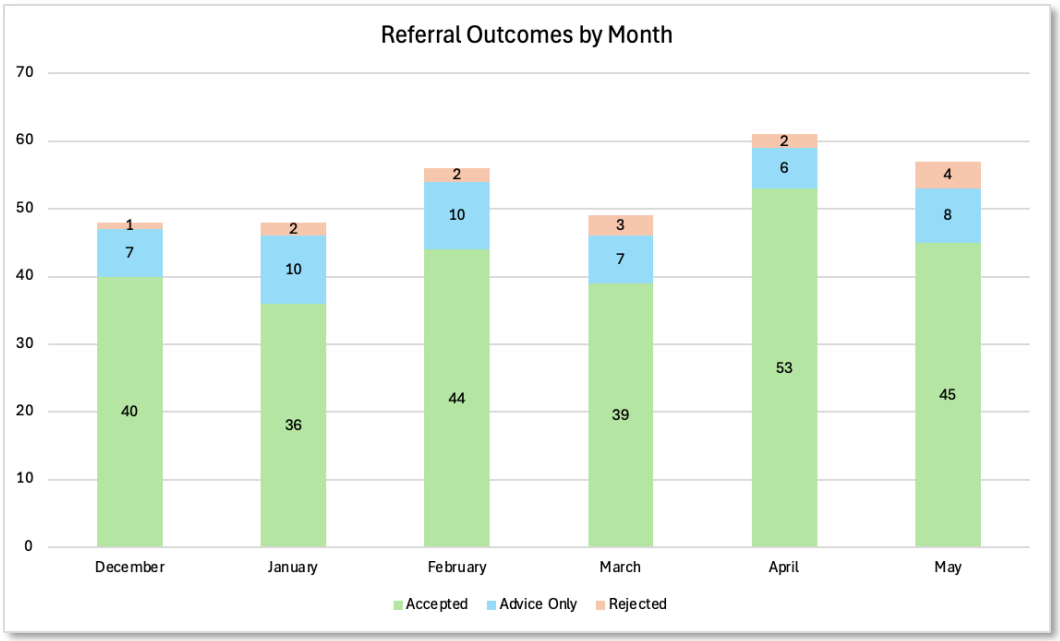
third sector. This is usually in cases where the patient presents to ED out of hours or over the weekend and has no contact details for the team to follow up with them directly.

Rejected **-** the patient does not meet the team's referral criteria.

Table 3: Referral Outcomes

	Total	%
Accepted	257	80.6%
Advice Only	48	15%
Rejected	14	4.4%
Total	319	

Chart 1: Referral Outcomes by Month



Of the 257 accepted referrals, 39 were still on the team's caseload and therefore had not had their data forms submitted. As such, further data is unavailable for these referrals. Data below is presented for 218 accepted referrals for whom forms were submitted.

Of the 218 accepted referrals, 133 received a full holistic assessment and were allocated to a team member for case management. A further 85 were seen by the team and received a brief intervention, including advice, signposting and referrals to other services.

Table 4: Referral Outcomes for Accepted Referrals

	Total	% (of 218)
Holistic assessment and case allocation	133	61%

Brief intervention only	85	39%

Demographics and Patient Information

Demographics

Demographic data collected is consistent with the previous service evaluation. There was a 3 to 1 male/female ratio, the most common age group was 36-45 (25% of accepted referrals) and the average age of accepted referrals was 45 years (male=46, female=42). The most common ethnicities of accepted referrals were White British (27%), White Other (17%) and Asian/British Asian – Other (11%). Overall, 18% of accepted referrals had No Recourse to Public Funds, and 30% had safeguarding concerns.

Chart 2: Age and Gender of accepted referrals

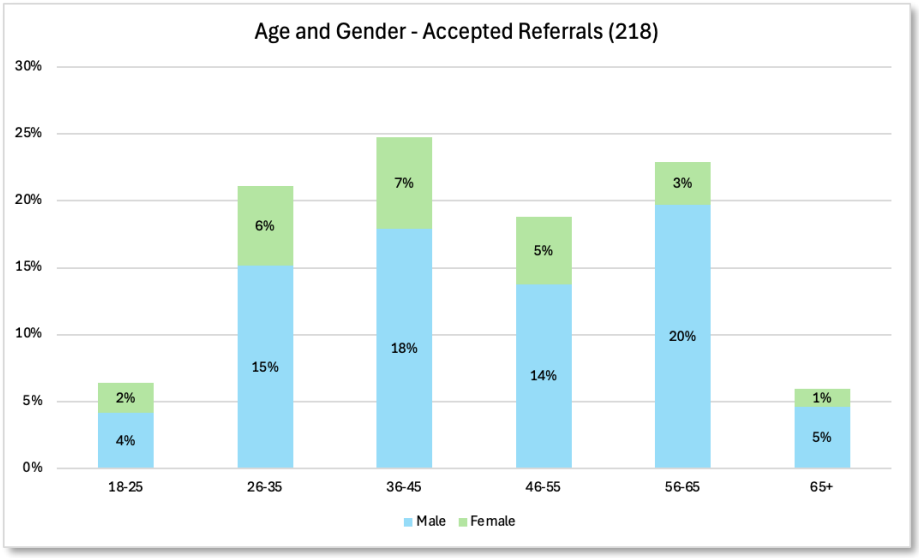
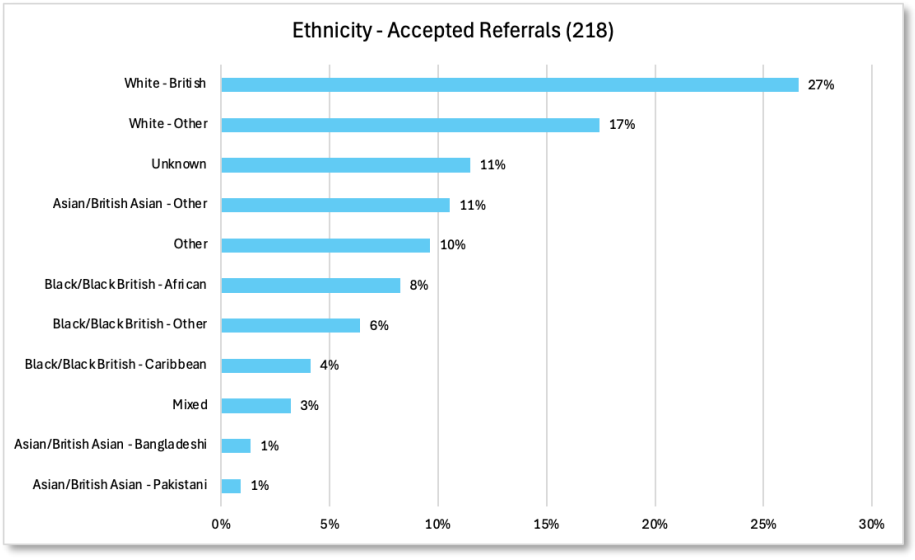


Chart 3: Ethnicity of accepted referrals



Pathway
Homeless & Inclusion Health

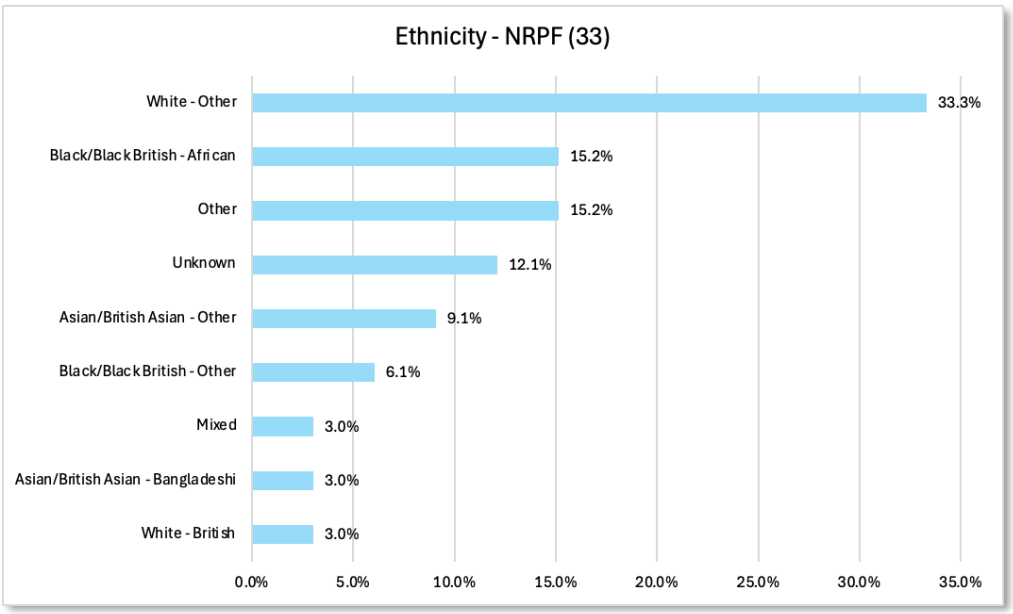
No Recourse to Public Funds

Of the 218 accepted referrals, 33 (15%) were confirmed as having No Recourse to Public Funds (NRPF). The team estimates that around half of patients with 'Unknown' status also have NRPF. Combined, this gives an estimated 18% of accepted referrals with NRPF.

Table 5: NRPF

	Total	%
NRPF	33	15%
Recourse	174	80%
Unknown	11	5%

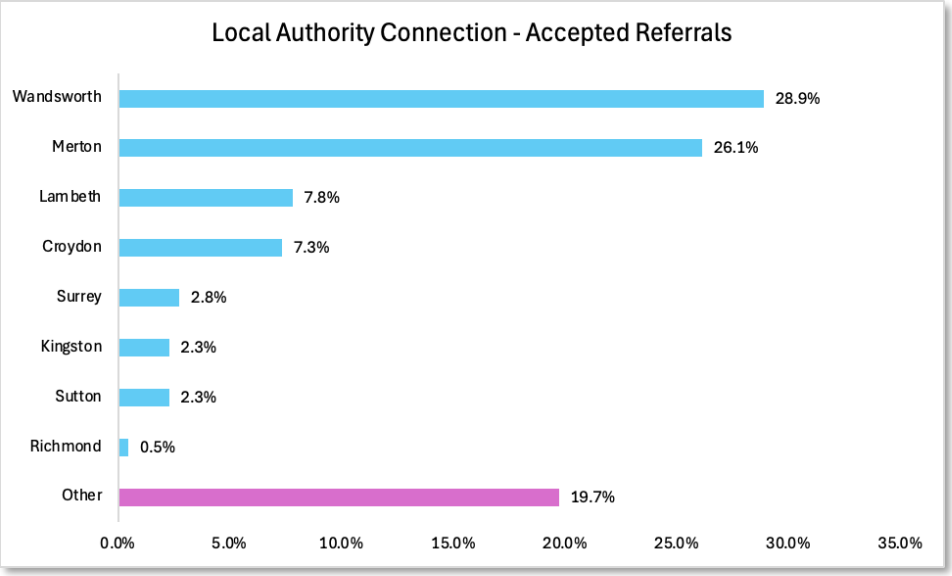
Chart 4: Ethnicity of patients with NRPF



Local Connection

Overall, 70% of the referrals accepted by the team had a local connection to the boroughs around St George's; Wandsworth, Merton, Lambeth, Croydon. Of the 'Other' group, 51% (22/43) had a local connection to another London borough, and 12% (5/43) had no local connection.

Chart 5: Local Connection of accepted referrals



Safeguarding and Mental Capacity concerns

Of the 218 accepted referrals, 66 (30%) were recorded as having either safeguarding or mental capacity concerns, or both.

Table 6: Safeguarding and Mental Capacity concerns

	Total	%
Safeguarding	35	16%
Mental Capacity	18	8%
Both	13	6%
None	152	70%

Activity and Outcomes

Duty to Refer

Hospitals have a statutory obligation, under the Homelessness Reduction Act, to refer patients experiencing or at risk of homelessness to the relevant local authority. By completing these applications, along with supporting clinical advocacy, the HIT is able to improve housing outcomes for patients and ensure that St George's Hospital is meeting its statutory obligations. For patients who received a full holistic intervention and consented to the referral, the team completed a referral in an impressive 93% of cases.

Table 7: Duty to Refer Outcomes – All Accepted Referrals

	Total	% (of 218)			Total	% (of 143)
Eligible	143	65.6%		**Referred**	116	81.1%
Not eligible	23	10.6%		**Not referred**	27	18.9%
Not applicable	52	23.9%				

Table 8: Duty to Refer Outcomes – Holistic Assessment Only

	Total	% (of 133)			Total	% (of 93)
Eligible	93	69.9%		**Referred**	86	92.5%
Not eligible	18	13.5%		**Not referred**	7	7.5%
Not applicable	22	16.5%				

GP Registration

People experiencing homelessness face many barriers to accessing and registering with a GP. GP access is essential, as it enables them to have their health needs met in the community and contributes to recovery following discharge from hospital. Of the 218 accepted referrals, 42 (19.3%) were not registered with a GP on assessment. Of the 42, 8 patients declined to be supported to register with a GP – of the remaining 34, 59% were assisted to register with a new GP they could access on hospital discharge.

Chart 6: GP Registration on assessment

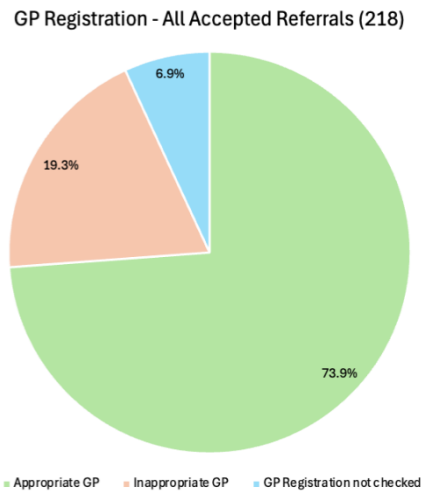
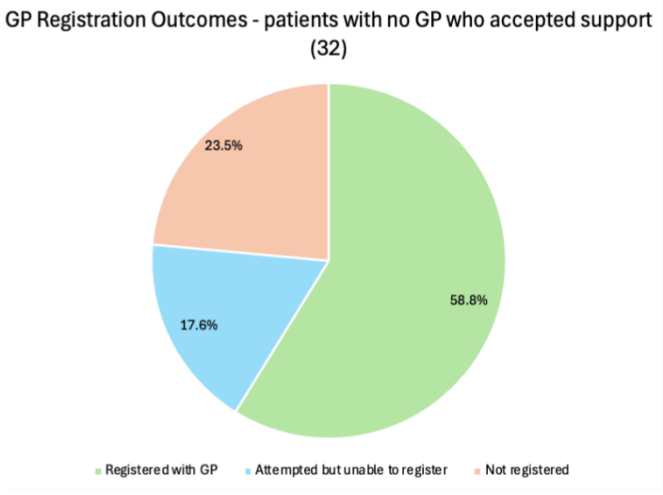


Chart 7: GP Registration outcomes

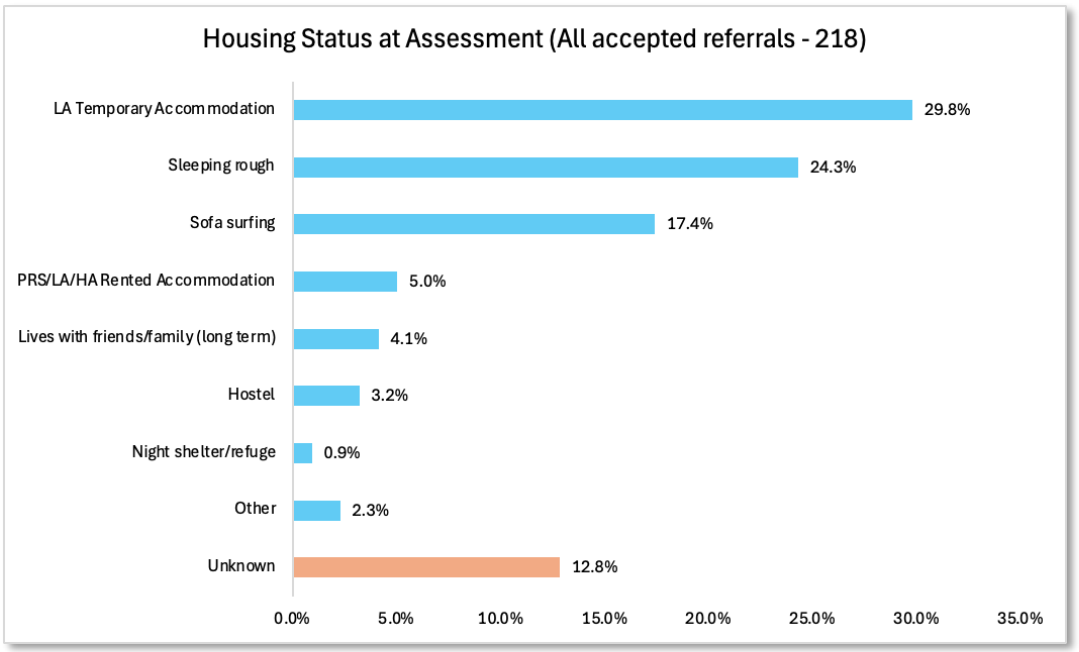


Similar outcomes were seen amongst the 133 patients who received a full holistic assessment – 32 (24%) of patients did not have a GP, and of those 59% were assisted to register with a new GP.

Housing Status and Outcomes

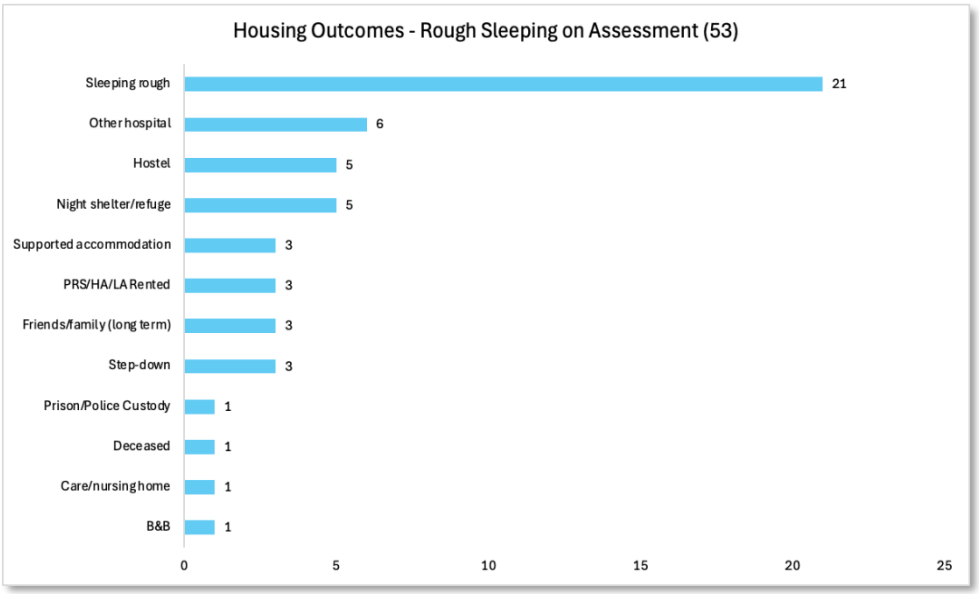
Overall, 42% of all accepted referrals were either sleeping rough or sofa surfing on assessment. Compared to the previous evaluation, the team saw a higher proportion of patients who were in temporary accommodation (29.8%) compared to just 8.1% previously). This may be due to the team seeing large numbers of people who are fleeing violence.

Chart 8: Housing status at assessment



Of the 53 patients who were rough sleeping on assessment, the team supported 32 into appropriate accommodation that they could access on discharge from hospital. This represents a 60% reduction in rough sleeping. Of the 21 patients who returned to rough sleeping, 14 (67%) had No Recourse to Public Funds. As these patients are not entitled to housing support, preventing returns to rough sleeping for this cohort is incredibly challenging.

Chart 9: Housing status at discharge, rough sleepers



Discharges from Hospital

Self-Discharges

A self-discharge is an instance in which a patient leaves the hospital (from either ED or an inpatient ward) before being medically cleared to do so. This may be before the patient has been seen, following an assessment, or during an inpatient stay.

Self-discharges can be seen as an indicator of hospital culture and quality of care. Previous research has shown that inclusion health patients self-discharge for several reasons including; experiencing negative attitudes from staff, being overwhelmed by busy hospital spaces, lack of appropriate support for withdrawals (such as opiate replacements), and other factors. Reducing self-discharges and ensuring patients access the healthcare they need is a key focus of Pathway Partnership Teams.

Table 9: Self-discharges by location

	Total	%
Overall	15/218	6.9%
ED Only	8/132	6.1%
Inpatients Only	7/86	8.1%

The overall self-discharge rate of 6.9% represents a significant achievement by the team. It is lower than the team's self-discharge rate seen at the previous evaluation (14.4%) and lower than self-discharge rates for this population identified in wider research (typically between 15-20%).

Delayed Discharges

Delayed discharges for inclusion health patients are typically caused by a lack of safe and appropriate discharge locations. The delayed discharge rate of 26.7% seen in the team's data is high, although fairly typical amongst Pathway Teams.

Table 10: Delayed discharges

	Total	%
Inpatients Only	23/86	26.7%

Length of Stay

Of the 218 accepted referrals, 86 (39.4%) were admitted as inpatients and had both admission and discharge date accurately recorded. Length of stay (LoS) data is presented below. The majority of patients (63%) stayed for two weeks or less, although 19% stayed for longer than six weeks. These are likely complex cases (severe brain injury, major trauma and social care needs) who require intensive clinical support in hospital, and specialist placements on dishcarge.

Table 11: Length of Stay

	Days	
Mean LoS	26	
Median LoS	10	
	Total patients	**% of patients**
1 week or less	31	37%
1-2 weeks	23	27%
2-3 weeks	6	7%
3-4 weeks	6	7%
4-5 weeks	2	2%
5-6 weeks	1	1%
Over 6 weeks	17	19%

Impact on Secondary Care Usage / Cost Savings

Frequent ED Attenders

Frequent ED attendances are an indicator that a person's health needs are not being met, either in hospital or in the community. Because of complex needs and poor access to services, people experiencing homelessness are over-reliant on ED, attending more frequently than the general population. By ensuring that health needs are assessed and addressed, and appropriate community support is in place following hospital discharge, Pathway teams have been found to reduce ED attendances for frequent attenders.

The HIT reviewed attendance data for three frequently attending patients that they had worked with during the previous six months. Following the HIT intervention, none of the patients had subsequently reattended SGH ED, over at least a four-month period. The costs associated with each of these three cases is outlined below'

The cost of an ED attendance was provided by St George's Hospital Finance Team

Frequent Attender 1 (see Case Study 2 below for details of the HIT intervention and outcomes)

- Prior to being referred to HIT, the patient had presented to St George's ED 24 times over the previous 9 months (2.6 per month)
- At a cost of £319 per ED attendance, the total ED cost for this patient over 9 months was £7656 = £10,208 per year
- Following the HIT intervention and securing accommodation, the patient had 0 ED attendances since this intervention
- **Estimated ED costs prevented: £10,208 per year**

Frequent Attender 2 (see Case Study 4 below for details of the HIT intervention and outcomes)

- Prior to being referred to HIT, the patient had presented to St George's ED 32 times over the previous 24 months (16 time per year)
- At a cost of £319 per ED attendance, the total ED cost for this patient over a year was £5104
- Following the HIT intervention and secured accommodation, the patient has had 0 ED attendances as of August 2024.
- **Estimated ED costs prevented: £5104 per year**

Frequent Attender 3

- Over the 2 years prior to HIT intervention, the patient had presented to St George's ED 24 times and Epsom and St Hellier's 18 times (21 attendances across both sites per year)
- At the cost of £319 per ED attendance, the total cost of this patient over a year was £6699

- Since HIT intervention in April/May, the patient has had 0 ED attendances as of August 2024.
- **Estimated ED costs prevented: £6699 per year**

Estimated annual ED costs prevented

Of the team's current caseload of 67, 11(16%) are 'frequent attenders' (>15 attendances in the past year). With the team accepting 257 referrals over 6 months, we can estimate an annual caseload of 514, with 82 (16%) being frequent attenders.

Potential ED costs prevented per year: (£5104*82) **£418,528 to** (£10,208*82) **£837,056**

Step-Down Bed

The HIT has one reserved step-down bed, which is used for patients who are medically fit for hospital discharge, but still need ongoing health support and have accommodation needs. Step-down beds free up hospital capacity by allowing medically fit patients to be safely discharged, rather than their discharge being delayed due to a lack of appropriate discharge location.

The team block books the bed at a cost of £78 per night. For the past year, this gives a total cost of £28,470. Over the past year, the step-down bed was occupied for 233 nights.

This equates to 233 nights in which patients would still have been occupying a hospital bed. At the cost of £589 per night[11] this gives a total cost of £136,771. Subtracting the cost of the step-down bed gives **estimated savings of £108,301**

Return on Investment

Combined, these examples show potential costs prevented of **£526,829 to £945,357 per year**. Given that the service as a whole costs £474,525 per year, this represents a significant return on investment. Given that these estimates do not account for prevented costs of readmissions or DNAs, true cost-benefits are likely to be even higher.

Case Studies

These case studies collected by the team illustrate the complexity of needs amongst people seen by the HIT, the activities and support delivered by the team, a multi-disciplinary approach in action, and the extremely positive outcomes achieved. The real names of patients have not been used.

Case Study 1

Background and Medical History

Aisha is a 27-year-old lady who presented to St Georges Hospital during her pregnancy. She was referred to HIT after the birth of her baby boy Henri. Aisha suffered a 4th degree tear during a forceps delivery and was admitted to the post-natal ward. She was made homeless in the late stages of her pregnancy and had been referred to maternity safeguarding at this time. She had worked throughout her pregnancy as an assistant manager but had to send her money abroad to her father for his cancer treatment. As a result, she had no money for accommodation and had been sofa surfing in unstable accommodation until this no longer became viable when she gave birth.

Upon being medically ready for discharge after a traumatic birth, Aisha had no housing options and would have been discharged to the street with her newborn baby. Aisha had attempted to gain help from the local authority previously, but had struggled to engage with the complex processes of the housing application and so her application had been declined.

HIT Interventions

HIT organised a referral to the council with detailed supporting information. The HIT was able to advocate to the council on Aisha's behalf and they then re-opened Aisha's case. After a review process the local authority provided Aisha with a studio flat which she has now moved into. The HIT supported Aisha to claim housing benefit and complete several applications, including council tax reduction, to make her transition into the community easier and therefore prevent breakdown of the placement. As Aisha had received a letter about rent arrears shortly after moving in, she was anxious she would lose her housing, especially after her recent traumatic experiences with the housing system and homelessness. To reduce Aisha's anxiety, we supported with advice around benefits and signposting to Citizens Advice Bureau.

Aisha's physical recovery after the birth was still ongoing, so since moving into her accommodation, the team have supported by visiting her and Henri at their home. During these visits she was able to discuss her health concerns and HIT supported her to engage with her GP to address them. The HIT also requested increased support from the health visitor team for Aisha and Henri. Aisha was also referred to Children's Social Services for further support.

During visits and through telephone communication, the HIT has been able to connect Aisha to local services such as charities for single mothers, apps that connect parents, and signposting to local baby groups. This has helped her begin to build a support network in a new area, making her feel less isolated and supporting her general wellbeing. She will be collecting baby items from a nearby charity that the HIT has signposted her to and, upon the HIT's request, her health visitor will be visiting more frequently, supported with a handover from the HIT including a detailed information about her medical history and social situation.

Aisha is feeling physically and mentally healthier every day, with multiple options to call on for support, ensuring she has the best start for her and Henri, so he can enjoy his early years feeling safe and secure.

Outcomes

- Liaised with and supported Maternity Safeguarding and Social Services.
- Provided emotional support during admission and in the community.
- Supported into Temporary Accommodation with the local authority.
- Supported to engage with a health visitor and GP in community.
- Supported to engage with local baby support and social groups.
- Signposted to charities to support with vital equipment for baby.
- Supported with benefits applications to prevent placement breakdown and re-admission.

Case Study 2

Background and Medical History

Rita is a 62-year-old lady who presented to St George's Hospital ED 24 times in the nine months prior to being referred to the HIT, as well as presenting twice to Croydon University Hospital. Rita had been rough sleeping with her husband Peter for several months over this period, sleeping outside in parks throughout cold and wet months with only a duvet. Rough sleeping had caused a marked deterioration in her management of chronic health conditions, leading to her multiple presentations. Her presentations included symptoms of chest pain, leg swelling and severe blisters on both feet associated with numbness. Her chronic health conditions include Type 2 diabetes, hypertension and possible heart failure. She required urgent referral to Cardiology and the Diabetic Foot Team as an outpatient. Rita and Peter struggled to access regular food and maintain their hygiene during this period leading to further deterioration of Rita's Type 2 diabetes and foot care.

The HIT completed a holistic assessment with Rita and discovered she had been evicted by an abusive landlord who did not provide adequate notice or allow them to make arrangements before leaving. Following this, they approached their local council for housing but were not supported after being deemed not in priority need for housing. This was despite Rita providing evidence of her medical conditions.

HIT Interventions

The HIT was able to advocate for Rita including collating detailed medical information and providing a medical letter to the council. After several weeks of advocating for the couple the local authority accepted the duty to house them as an emergency.

During the wait for the council to provide housing we provided ongoing support and closely observed Rita's health. This included daily calls for advice and emotional support which helped her and Peter gain a sense of control over their lives whilst waiting for housing support from the council support.

We signposted Rita and Peter to appropriate local homelessness services. They spoke highly of the day centre we referred them to and how it provided them with a sense of community. They would visit a service every day and have their clothes washed, have showers and eat a hot meal. Having their basic needs met was both a social intervention and a health intervention, as they were able to maintain nutrition, hygiene, and positive mental health while rough sleeping. During this period the HIT were able to support Rita to engage further with community case workers. Crucially, they felt they had a support system which led to reduced reliance on St George's services, including the ED, long term.

As a more direct community health intervention, Rita was referred to a community health nurse at a day centre called Southcroft Church, as well as being encouraged to seek support through her GP. She would see the nurse weekly to have her diabetes, blood pressure and feet monitored and treated. Rita also was supported to register with a new GP. This intervention resulted in a dramatic decline in Rita's presentations to St George's ED.

Rita and Peter have now been housed, Rita has stopped having to attend the ED, and Peter has been able to return to his job as a carer. The couple demonstrated great resilience through Rita's determination to maintain engagement with as many services as possible, and Peter's unwavering organisational and administrative capacities, necessary for the homeless application. The HIT also supported Rita and Peter to access independent immigration advice to support their housing. Rita and Peter shared that they are very happy with their experience with our team and are back to cooking nourishing homemade dishes for their family.

Outcomes

- Supported into Temporary Accommodation with the local authority.
- Supported to engage with sustainable local long-term housing options alongside local authority support.
- Supported to engage with community services and crucial nursing input.
- Supported to engage and access independent immigration advice
- Reduction in ED attendances – nil since supported into housing.
- Supported with GP registration.
- Supported to engage with vital hospital follow-up.

Case Study 3

Background and Medical History

Terry is a 73-year-old gentleman who presented to St George's Hospital ED with severe diarrhoea, reduced appetite, abdominal pain and acute kidney injury. He required admission for intravenous fluids and monitoring. Terry was referred to the HIT after he disclosed that he had been sofa surfing with a friend but could not return there on discharge so would be homeless. Terry also has a medical history of prostate cancer requiring a radical prostatectomy in 2020, Type 2 diabetes with diabetic retinopathy, hypertension, iron deficiency anaemia, cataracts, thyrotoxicosis and atrial fibrillation requiring blood thinners.

Terry had been living in the UK for the last 27 years and is originally from Jamaica. He disclosed to the HIT that he was not sure if he had immigration status to stay in the UK after struggling to understand the process of a previous asylum claim. He had therefore been wary of seeking regular help for his health in case this brought attention to his immigration status. It came to light he had been surviving on just £5 a month for years and relying on friends to help with food and a floor to sleep on.

HIT Intervention

The HIT was able to build trust and a relationship with Terry throughout several visits on the ward. Terry was then able to open up to the HIT about his immigration journey. After reviewing the paperwork and noting a previous asylum application, the HIT felt they could support him to re-engage with immigration services for a positive outcome. All of this vital and sensitive information was gathered during his four-day admission whilst Terry was in a place of safety. This was a crucial period to work intensively with someone who had avoided services for many years.

It was with this support and guidance from the HIT that Terry was able to engage again with the Home Office. The HIT was aware this process may take time, and so when Terry was medically fit the HIT were able to support hospital flow by placing Terry into the HIT Step Down Bed. This meant Terry was not discharged to the streets and enabled the HIT to support him further after discharge.

During this period, the HIT were also able to help Terry engage with his health. They supported him to engage with his inpatient medical team further and discuss his severe incontinence issues which he had struggled to talk about before. The HIT was also able to support him to review his medications and make further GP appointments on discharge to avoid readmission. They also supported Terry to engage with his hospital follow-up including an endoscopy. After supporting him to get a freedom pass this also meant he could then attend further health appointments with ophthalmology for his diabetic retinopathy at another Hospital, which he had also struggled to go to before due to financial constraints.

Terry was able to engage with the Home Office and it was confirmed he would have full status in the UK. Being able to build trust with the HIT enabled Terry to be supported and he was issued a biometric card. The HIT then supported Terry to make an application for the state pension meaning he would have access to funds for food and clothing after many years of just trying to survive.

Terry was then able to approach the Local Authority for the housing support that he was now eligible for. It took a lot of advocacy and several presentations to the Local Authority Housing team with a HIT member for Terry to be supported. The HIT also supported Terry with a detailed medical letter to housing services outlining his medical history and vulnerability. The HIT advocated and followed up the process of this housing application and provided everything that was required for Terry. This was an elderly man who did not understand the mechanics of the housing system, so the ongoing support was imperative. Without this Terry would have been rough sleeping which would have led to worsening health and readmission. During this period, the HIT also sought legal advice from its partners at Hodge Jones and Allen Solicitors, who provided a Letter of Action to the Local Authority. It was then that Terry was housed securely in his own accommodation. This property provided his first sense of freedom and security. This has allowed him to engage further with his health improving his wellbeing and his mental health.

Outcomes

- Supported to engage with health, vital hospital and GP follow up avoiding readmission.
- Supported into step-down accommodation, improving hospital flow and maintaining engagement and support.
- Supported to access help with immigration issues and ensure he had status in the UK.
- Supported with detailed Medical Letter.
- Supported into housing provided by the local authority and remains in this accommodation living independently.
- Supported to apply for state pension and freedom pass enabling him to be financially secure.

Case Study 4

Background and Medical History

Kevin is a 58-year-old man who prior to HIT support had presented to St George's Hospital ED 32 times in the past 24 months. His presentations included for symptoms of chest pain, shortness of breath, abdominal pain, vomiting and potential drug overdoses. Often, he would not wait for full investigation and treatment and struggled to engage with any follow up.

Kevin has a complex history of poly-substance misuse involving alcohol, crack and heroin. Kevin had been homeless for many years either rough sleeping or sofa surfing in unsafe situations such as squats with other drug users.

Kevin presented with numerous health symptoms, many of which could have been resulted in his death on the streets at any time. He reported feeling fatigued and tired of rough sleeping and needing help to access support and accommodation.

Kevin's medical history includes acute kidney failure, pancreatitis, gastroesophageal reflux, alcohol and drug dependence, as well as injuries via numerous assaults whilst being homeless including head injuries causing traumatic brain injuries.

HIT Interventions

As part of their work the HIT supported Kevin with a mobile phone, clothes and a travel card so contact could be maintained throughout its engagement and in the community. The HIT also requested a copy of his birth certificate to support his housing application as Kevin had no ID.

The HIT was able to do a holistic assessment of Kevin's health and housing needs. The team explored Kevin's substance misuse issues and the barriers he had faced in getting support for these. The HIT was able to refer Kevin to RHEST (Pan London Regional Homelessness Engagement and Support Team for Substance Misuse) and the local drug and alcohol team to support with his substance dependencies. The team also signposted Kevin to local day centres such as Southcroft Church to engage with the community nursing team.

A Duty to Refer was completed and sent to Wandsworth Council Rough Sleeping Team. The HIT and the Wandsworth Rough Sleeping Team then held an MDT to discuss Kevin's presentation and how multiple agencies could work together to provide support and accommodation.

Kevin struggled to engage with the initial support offered but the HIT was able to continue advocating for him during further ED attendances, building trust to the point that he was able to engage with Wandsworth Council. With continued liaison and support Kevin successfully attended the Council and was offered emergency accommodation. Kevin has not had any further attendances to ED since he was supported into accommodation.

Outcomes

- Supported into Temporary Accommodation
- Reduction in frequent attendances
- Community referrals into drug and alcohol support services

The personalisation budget was utilised to support with birth certificate for housing applications, clothing and hygiene products for comfort, and travel cards to support community engagement.

Patient Feedback

Feedback from patients supported by the team was collected via feedback forms, developed by Pathway in collaboration with Experts by Experience to make them as accessible as possible. Feedback was collected from nine patients, who all felt safe and cared for, felt that they were treated kindly, and found the team to be extremely helpful.

"You're like an angel without wings."

"What you are doing is great and much more funding is needed for work like yours."

"You honored your duty of care. With my situation everything seemed impossible. It is miraculous that I am still here and I am totally grateful."

"You helped a lot. You were brilliant and commendable. You are doing a brilliant job reaching out to the people that need it. Absolutely brilliant, straightforward. You couldn't have done any more for me and especially for my sick wife, helping her so much to find help for her health. I can't stop praising you as you could not have done more for me."

"Before, I felt depressed, lonely and hopeless. Your service gave me some strength and belief that my voice will be heard. You have been excellent for everything. You made me feel comfortable, reassured and well looked after."

"You are in constant contact with calls and texts. It feels like a friend. Even though you are helping so many people, it feels like you're giving 100% to me. With you I always keep in contact and tell the truth because it feels like you actually care."

Table 12: Did you feel safe and cared for by the team?

	Total	%
5 (I have felt completely safe and cared for)	8	89%
4	1	11%
3	0	
2	0	

1 (I have not felt safe and cared for at all)	0	

Table 13: Were you treated kindly by the team?

	Total	%
5 (I have been treated kindly at all times)	9	100%
4	0	
3	0	
2	0	
1 (I haven't been treated kindly at all)	0	

Table 14: Do you think that the team has helped you during your hospital visit?

	Total	%
5 (The team has been extremely helpful)	9	100%
4	0	
3	0	
2	0	
1 (The team has not helped me at all)	0	

Staff Feedback

Feedback on the HIT was collected from staff in a range of other services via a survey. These services included other hospital services, local authority housing services, rough sleeper outreach services and local homelessness charities. It is clear from the feedback that the HIT is a necessary and valuable resource at St George's, and for wider community services.

The responses show that other services and staff frequently refer patients to the HIT (Table 16) and frequently work collaboratively with them to resolve patients' issues (Table 17). This demonstrates the clear need for the service at the hospital, in the context of the high levels of homelessness and rough sleeping in the St George's area. Respondents felt that the team was easy to work with (100% extremely easy/easy), helpful (97% extremely helpful/helpful) and provides high quality care and support (100% excellent/good). 100% of respondents thought that the team was needed and should continue.

Comments left by respondents show the number of ways in which the HIT has supported patients and other services with challenging and complex issues, and driven local improvements;

- Supporting services to manage patients with complex needs, including NRPF, safeguarding issues and care needs
- Coordinating complex discharges, securing/providing community follow-up and support, supporting applications for appropriate accommodation
- Improving collaborative and multi-disciplinary working by liaising and linking different services
- Improving hospital flow by preventing avoidable reattendances/readmissions

Several respondents noted that, due to the level of need/demand, the HIT struggles with a large caseload and would benefit from having additional team members, such as an expanded community element.

"The team are extremely passionate about their work and getting the best outcomes for patients. They routinely go above and beyond in terms of following up patients after discharge and being involved in their care whilst here."

"The HIT are vital to the flow of patients in the hospital. They support in ensuring that beds are not occupied by people who could be supported by other services outside of the hospital."

"Since the introduction of the HIT, there has been a 44% reduction in 'new rough sleepers' in Wandsworth." - ***Wandsworth Rough Sleeping Coordinator***

"They are extremely responsive and helpful when we have queries regarding patients with whom they are working. They are an incredibly valuable service within the hospital, and it should not even be a question that they are needed and should continue!"

"The HIT provides an invaluable service at SGH and are able to support patients that no other team can. They have contributed hugely to reduced Length of Stay and place patients at the center of all their great work."

"I feel patients are in very safe, capable hands when referring to them. I think we would be lost without this team as it is essential for such a large number of patients we see."

"HIT are incredibly helpful regarding support of those fleeing violence over the age of 25 years old, as previously we very limited support/guidance for this due to resources. This also means we are able to expedite discharge for these patients, with their early intervention and referrals for housing support."

Table 15: Which type of service do you work at?

	Number of responses	% of responses
Other team/service at St George's Hospital	25	66%
Community healthcare service	2	5%
Local Authority housing service	3	8%
Other	8	21%

**Other includes; charities, legal advice services, civil servants*

Table 16: How often have you referred patients to the St George's HIT over the past 6 months?

	All the time	Often	Sometimes	Rarely	Never
Other St George's hospital services	12%	52%	28%	8%	
Community healthcare services		50%	50%		
Local Authority Housing services	33%		67%		
Other		13%	13%		75%
Overall	**11%**	**39%**	**29%**	**5%**	**16%**

Table 17: How often have you worked collaboratively with the St George's HIT to resolve issues for patients/clients?

	All the time	Often	Sometimes	Rarely	Never
Other St George's hospital services	26%	47%	24%	3%	
Community healthcare services		50%	50%		
Local Authority Housing services	33%	33%	33%		
Other	28%	48%	20%	4%	
Overall	**26%**	**47%**	**24%**	**3%**	

Table 18: How helpful have you found the St George's HIT

	Total	%
Extremely helpful	34	89%
Helpful	3	8%
Somewhat helpful	1	3%
Not so helpful		
Not helpful at all		

Table 19: How easy to work with have you found the St George's HIT?

	Total	%
Extremely easy	31	82%
Easy	7	18%
Neutral		
Difficult		
Very difficult		

Table 20: How would you rate the care and support provided by the St George's HIT to patients?

	Total	%
Excellent	32	84%
Good	6	16%
Okay		
Not so good		
Poor		

Table 21: Do you think the St George's HIT is needed and should continue?

	Total	%
Yes	38	100%
No		

Challenges and Opportunities

Despite the positive outcomes achieved, the HIT has faced a range of challenges. Managing these difficulties has generated learning and insights on the opportunities for service development. The key challenges and suggested solutions are highlighted below.

Staffing and Funding Instability

The HIT clearly demonstrates multiple improved outcomes for patients alongside financial savings. However, the team has struggled at times with staff capacity. This was evident in May 2023 when the team's funding was not confirmed as being extended until two weeks before it was due to end. This unfortunately meant the loss of some staff due to the uncertainty of their positions. Since then, the team has recruited into all positions, but this had meant a period of low staffing which impacted the services' capacity to take on new referrals. Improved certainty around funding would result in reduced staff turnover, leading to an increase in knowledge retention and available time for staff development.

The key areas where more staff would be welcome are:

- Administrative / data support
- Mental health practitioner (to deliver mental health interventions to these clients)
- Occupational Therapist
- Expert by Experience / Homeless Health Peer Advocate

Working with Multiple Boroughs

The team have a number of patients referred from multiple boroughs outside of Wandsworth. This means dealing with different referral processes, teams and application assessments from each borough's housing and social care departments. It also makes supporting patients on discharge challenging, requiring liaising with multiple community partners such as homelessness outreach teams, drug and alcohol teams, charitable organisations, day centres and GP surgeries.

It has proved challenging to learn about each borough's processes and build a network across them. To combat this, the HIT has worked to forge strong relationships with community partners, including facilitating shadowing opportunities in the hospital to aid collaboration between teams.

The team have close links with Wandsworth Local Authority including their housing and rough sleeping teams. They also sit on the Homeless Health Southwest London Steering Group where there is engagement with partners from across Merton, Sutton and Croydon. This has led to collaborating on the Homeless Hospital Discharge Policy for Wandsworth Housing, and there are currently talks with several other councils to

produce similar policy documents. The aim is to streamline the support and safe discharge of those experiencing homelessness.

No Recourse to Public Funds

No Recourse to Public Funds applies to those individuals who do not have eligibility for support from the housing or benefits systems, usually due to immigration issues. As in all the Pathway Partnership Teams, the challenge of meeting the needs of these people has been acute. Few options are available for people without recourse to public funds. The HIT have been building close links with immigration services, teams like St Mungo's Migrant Accommodation Pathway Service (MAPS) and Project 17, to further support these vulnerable patients. This includes support with applications to regularise their status or at times support for voluntary return to their home country. The HIT also helps to access appropriate community health and charitable support which those with NRPF are still entitled to, which in turn helps to reduce ED attendance.

Education

Education is a key focus of the HIT, and we have held education sessions with several teams across the hospital including discharge teams and junior doctors. The team would like to create the capacity to undertake more teaching as well as look to be part of induction sessions within the trust, improving referral processes and engagement, and empowering staff to feel confident in supporting those experiencing homelessness.

Complex patient caseload

One of the challenges the team has faced is the complexity of the patient group, both from a medical/health perspective but also their social care, housing and immigration needs. Many of the patients referred, especially those who have been rough sleeping for several years, have high levels of self-neglect, trauma, multiple mental health diagnoses, substance misuse needs, and chronic health conditions requiring social care support.

This group of patients require specialist placements that can meet all their needs and often social services struggle to find appropriate services. This is due to the number of nursing or residential placements declining referrals for those with substance misuse needs or adults under 65). Amongst this patient group the HIT have worked with patients in their 40s who have a history of rough sleeping and have presented with frailty levels of that usually seen in 80-year-olds.

The team continue to work with this patient group whilst awaiting social care support to engage with their health and substance misuse needs. This has in some cases then led to a reduction in their care needs or a change in their immigration status, which has in turn opened up further accommodation and discharge avenue

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