



Homeless health needs assessment for Barts and the London NHS Trust

June 2011

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Barts and The London 
NHS Trust

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Health
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**Closing
the Gap**

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Pathway works with NHS partners to improve health services for homeless people

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The Most Revd and Rt. Hon. Dr Rowan Williams, Archbishop of Canterbury;
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Ken Livingstone, former Mayor of London

Pathway Needs Assessment at The Royal London Hospital

Executive Summary

Barts and The London NHS Trust commissioned this needs assessment in collaboration with a charity called Pathway. The aim was to explore the impact of homelessness and multiple deprivation on our Trust and to develop a locally applicable approach to improving health care for homeless people.

The needs assessment has confirmed considerable potential and enthusiasm for improving collaborative care for homeless people. Funding for a pilot project has been found through an NIHR research grant and it is proposed that the project should commence in the Autumn of 2011.

Introduction

Pathway is a new charity formed to transform the quality of healthcare for homeless people and other socially excluded groups. It works in partnership with NHS organisations to develop, test, evaluate and support new integrated models of care.

The Marmot review¹ highlights the fundamental unfairness and injustice inherent in the increasing inequalities of our society, and the economic and social consequences that impact on the rich as well as the poor. He proposes a system of "proportionate universalism" – helping all sections of society "but with a scale and intensity that is proportionate to the level of disadvantage". For the homeless population this raises the possibility of improving outcomes by targeted investment, with the very real prospect of reducing unscheduled expenditure in secondary care. Marmot encourages us in the words of Pablo Neruda to "rise up with me against the organisation of misery". Working with homeless people to improve the health of their peers gives health professionals the opportunity to re-ignite the passion and vocation that took them into the caring professions, and offers the prospect of improving health care systems for the benefit of us all.

Background

Statistics

Half of England's rough sleepers are in London² and over a third of No Fixed Abode (NFA) hospital admissions occur in the NHS London area⁴. But homelessness is a national issue - there are significant concentrations of homeless people in most large cities and many coastal towns and the problem can be hidden and easily ignored in rural areas. There are similar trends for single young homeless people, and for homeless families.

There were 47,093 people using Supporting People funded hostel places in England during 2009/10 and rough sleeping in London increased by 30% over the 5 years to 2009/10³.

Outcomes are poor; for example the average age of death of a homeless person is between 40 and 42 years⁴, and a homeless drug user admitted to hospital is seven times more likely to die over the next five years than a housed drug user

admitted with the same medical problem⁵. Homeless children and young people are likely to enter such a cycle without early intervention.

The root causes of homelessness are both complex and multi-factorial. Simply providing adequate housing is of course a fundamental first step, but is not enough. Many people who go on to be homeless will have suffered significant emotional and/or physical trauma in childhood, will have suffered from poor familial relationships, and poverty in its many manifestations is an ever present factor. Other factors implicated in homelessness include the general lack of sufficient affordable housing, unemployment, mental ill health, physical ill health, low educational attainment and substance misuse. These factors operate at both individual and societal levels.

Definitions

Homelessness is often the end point and consequence of multiple disadvantage. We have tried to avoid narrow definitions of homelessness, but while obviously including rough sleepers this needs assessment also includes hostel dwellers and the insecurely housed.

Economic modelling

Research by Professor Barry McCormick⁴, DH Chief Analyst has shown that homeless people attend A&E six times as often as the housed population, are admitted four times as often and stay three times as long – because they are three times as sick. This results in secondary care costs that are eight times higher than average, largely consisting of unscheduled emergency admissions. The Nuffield Trust recently reported an overall increase of 11.8% in emergency admissions in England over the past five years at a cost of £330 million per year⁶. Professor McCormick's analysis produces a conservative estimate of £85 million spent each year on secondary care for NFA patients, most resulting from emergency admissions. In fact this is likely to be a considerable underestimate, as many homeless people will give a hostel or "care of" address and not be revealed by this type of analysis.

Homelessness is a health care issue

There is a growing understanding, supported by international research⁷, that chronic homelessness is an associated but probably non-causative marker for tri-morbidity, complex health needs and premature death.

Tri-morbidity is the combination of physical ill health with mental ill health and drug or alcohol misuse. This complexity is often associated with advanced illness at presentation, in the context of a person lacking social support who often feels ambivalent both about accessing care and their own self worth.

Simply housing long-term homeless people (although an essential first step) does not, of itself, resolve the underlying problems. When homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequences of drug and alcohol dependence⁷.

Care coordination and integrated care

The Kings Fund is preparing a report called "avoiding the gaps" which addresses the issue of care coordination within secondary care and between secondary care and the community. The model of care developed by Pathway can be seen as a care coordination approach, which has the potential to encourage models of integrated care. Professor McCormick's paper highlights the potential for developing such a new model of health care delivery for homeless patients, based on the highly successful service provided in Boston USA⁸. This model is of a fully integrated primary and secondary health care service including specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

The Pathway Charity

Pathway is a company limited by guarantee and a registered charity. Company number 7210798. Charity registration number 1138741. Our charitable purpose is to improve the quality of healthcare for single homeless people and other multiply excluded groups in the United Kingdom.

Pathway is a model of integrated healthcare for single homeless people. 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 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.

Pathway is based on a set of fundamental values. We believe generosity, kindness, and compassion combined with a passionate commitment to professional quality should be 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 Pathway core services

Hospital Ward Rounds

The Pathway ward round is provided by an accredited Pathway GP, supported by a specialist homeless health 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. The GP and nurse coordinate a weekly "paper ward round" care planning meeting that includes front line members of statutory and voluntary sector organisations such as social services, housing options, street outreach, drug and alcohol services, liaison psychiatry, hostel key workers, discharge coordinators and clinical teams.

Homeless health nurse practitioners

Work full time in the hospital supporting the ward round, liaising with medical, nursing and allied professionals across the hospital and with community agencies, while 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 and support patients post discharge.

Sanctuary

A necessary future development for the 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 hospital admission. Such patients have a disproportionate effect on the number of unscheduled re-admissions within 28 days, and unplanned A&E re-attendance within 7 days. Current models of community support are not meeting their needs and we propose developing clinically orientated psychologically informed environments, modelled 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 optimise access to health care and minimise the need for further unplanned hospital attendances. 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

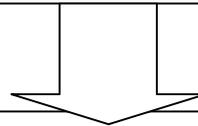
Before establishing a Pathway service in a hospital it is important to understand current practice, assess local levels of need, and shape a service that will fit local circumstances. Pathway provides a bespoke development service to support local health service staff to establish a service that meets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

Accreditation, professional support and training

In collaboration with the Faculty for Homeless Health⁹ we have developed a set of clinical standards. A support network for homeless health specialists combined with accreditation will ensure that new Pathway services will incorporate our values and ethos.

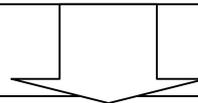
Objective 1 - Think Homelessness!

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



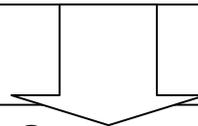
Objective 2 - Homeless Team Coordinate Care

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

HHP refers to Care Navigator Team & assesses need for Sanctuary Placement (ongoing medical needs, second admission in 12 months, and complex case).

Findings from the London Pathway pilot at University College Hospital

The UCH needs assessment began in June 2009 and the service went live in October 2009. The UCH data is provided in order to allow comparison with data from Barts and the London Trust.

UCH A&E data

UCH data from 2008 showed 559 patients (recorded as NFA, or with local hostel addresses) attending on 1030 occasions. 46% of these attendances were by ambulance. Of those arriving by ambulance 19% were admitted, but 28% left without treatment. 71% of patients attended only once, but 5% of patients attended more than 6 times in the year, with an average of 10 attendances per person. This suggests a core group of high intensity users who could benefit from a targeted intervention.

UCH Admission data

Needs assessment estimates of 220 admissions (185 individuals) for 2008 and 275 admissions for 2009 were rather less than the actual experience of 446 admissions (263 individuals) during the first 12 months of running the service. This is because patients referred included residents of homeless hostels from other Boroughs, and people who gave an old address on admission, but were actually of no fixed abode. 52% (98n) of the re-admissions occurred within 28 days of discharge.

UCH Costs Data

On average each unscheduled admission (including A&E costs) for a homeless person cost £3399. The total expenditure on unscheduled admissions for homeless patients in the first 12 months (to September 2010) was £1,515,954, of which £333,102 was on re-admissions within 28 days.

Statistical analysis of 2010 Royal London admissions and A&E attendances for homeless patients

Approach for isolation of homeless patient cohort

For this analysis a homeless patient:

- Has no fixed abode (or variants) recorded on the Barts and The London NHS Trust main Patient administration system or
- is registered to the GP practice Health E1, Homeless Medical Centre (F84733) or
- has one of the following hostels as the recorded address on the Barts and The London NHS Trust main Patient administration system.
 - The Aldgate Hostel. 7 Dock St, London, E1 8LL
 - Booth House. 153-175 Whitechapel Road London, E1 1DN
 - Daniel Gilbert House. 1-5 Code Street London, E1 5ER
 - The Hopetown Hostel. 60 Old Montague Street, London, E1 5NG
 - Edward Gibbons House. 1, Edward Gibbons House, Parmiter St, London, E2 9NG
 - Hackney Road Hostel. 296-302 Hackney Road ,London, E2 7SJ
 - Dellow Centre, 82 Wentworth Street, London, E1 7SA
 - Queen Victoria Seamens Rest. 121-131 East India Dock Rd, London, E14 6DF
 - The Whitechapel Mission. 212 Whitechapel Rd, London, E1 1BJ

Admissions to Royal London Hospital

During 2010, 660 homeless patients were admitted on 955 occasions, 524 (79.4%) were admitted only once 78 (11.8%) were admitted twice and 58 (8.8%) more than twice. Of the 295 repeat admissions, 150 were within 28 days of the previous admission. The average number of admissions per patient was 1.45.

The following table shows admissions by admission method group and separately identifies those that had re admissions within 28 days.

Admission Method	Count of 2010 admissions at the Royal London Hospital		
	No subsequent admission or next admission in more than 28 days	Had subsequent attendance in less than 28 days	Total
Emergency (via A&E)	569	108	677
Emergency (not A&E)	172	32	204
Elective	50	9	59
Maternity	6	0	6
Birth	5	1	6
Transfer	3	0	3
Total	805	150	955

A&E Attendances

During 2010 1729 patients were seen on 2931 occasions, 1369 (79.2%) attended only once 158 (9.1%) attended twice and 202 (11.7%) more than twice. Of the 1,201 repeat attendances 494 were within 7 days of a previous attendance.

The following table shows attendances by disposal method description and separately identifies those that had re attendances within 7 days

Disposal Method	Count of 2010 A&E attendances at the Royal London Accident and Emergency Department		
	No subsequent attendance or next attendance in more than 7 days	Had subsequent attendance in less than 7 days	Total
Admitted to hospital bed/became a LODGED PATIENT of the same Health Care Provider	832	99	931
Died in Department	21		21
Discharged - did not require any follow up treatment	502	105	607
Discharged - follow up treatment to be provided by General Practitioner	526	125	651
Left Department before being treated	209	95	304
Left Department having refused treatment	21	9	30
Referred to A&E Clinic	11	4	15
Referred to Fracture Clinic	55	4	59
Referred to other health care professional	33	8	41
Referred to other Out-Patient Clinic	52	11	63
Transferred to other Health Care Provider	170	33	203
Other	3	1	4
Unknown	1		1
Total	2436	494	2930

Cost calculations.

The contract monitoring team have allowed the data analyst access to the live charging tables in their databases and he has isolated the income relating to the homeless patient cohort himself.

For the 2,230 A&E attendances he found 2,205 in the charging database with a total commissioner liability of £314,959.02

For the 955 hospital spells he found 913 with income of £1,853,554.80 before excess bed day (stays greater than the trim point) charges. Of these spells 33 had stays beyond the trim point triggering extra income of £130,501.24.

So about £2.3 million pounds of expenditure on this client group in 2010.

Commentary on statistics

In terms of admissions Barts and the London seems to have more than twice the volume of patients compared to UCH, but a greater proportion of homeless patients admitted only once (79.2% cf 63%). 150 patients (cf 98 at UCH) were re-admitted within 28 days.

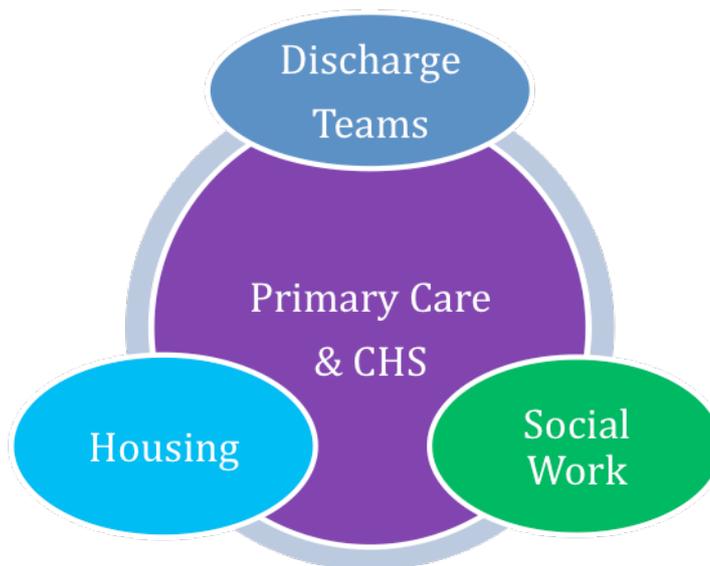
A&E attendances are about three times that of UCH, both in terms of numbers of individuals and numbers of attendances. Similar proportion attending only once (79.2% cf 71%).

Services consulted in and around The London Hospital



Key points of feedback received from Stakeholder meetings & liaison:

- Identified need to improve early identification of patients admitted to the RLH who do not have secure housing to be discharged to (including updating hospital records).
- **Tower Hamlets Housing Options & Support Team** has identified a need for statistics on how many admissions to RLH are from patients with connections to other boroughs. This information will be key to effective commissioning & planning around housing provision.
- It has become apparent during this needs assessment that the care of homeless patients would benefit from strengthening the relationships, communication & joint working between the following:



- Some **hostel managers** have expressed the desire to improve liaison & joint working between healthcare professionals (in both primary & secondary care) & hostel staff in order to improve care & provide a seamless service. The Aldgate Hostel is currently in the process of setting up a regular liaison meeting with Health E1-Homeless Medical Centre to discuss people of concern.
- **The discharge team (sister & co-ordinators)** at their weekly complex discharge meeting expressed great positivity about working collaboratively with the Homeless Team. Their roles already seemed to have a great deal of common ground.
- Senior Directors & Managers in **Community Health Services (CHS)** have expressed & shown a great willingness to engage & work with the Homeless Team. They are currently recruiting a **CHS discharge co-ordinator** for the wards at RLH. This will create potential for an exciting opportunity to improve care planning around the discharge of complex homeless patients & work jointly with the Homeless Team.

- **CHS** managers have fed back the piloting of an innovative **virtual ward round of patients identified in primary care as high risk**. These patients will be case managed by the community matron & district nurse. If the pilot proves successful & is rolled out across Tower Hamlets this approach could fit in perfectly with the Homeless Team's work by improving the care of complex homeless patients & reducing or preventing hospital admissions.
- **Housing & Outreach teams** have identified a training need for relevant hospital staff around housing pathways & eligibility & also around rough sleeper assessment applications.
- **Tower Hamlets Housing Options & Support Team** has given commitment to send a senior member of staff to the weekly Homeless Team Multiagency Meeting at RLH.
- **Primary care** has identified the need to improve the quality of discharge summaries. Particularly points of concern are that discharge summaries often do not mention when methadone has been prescribed, daily quantity nor when last dispensed and also that discharge summaries are frequently not issued if a patient self discharges from hospital
- Current positive examples of productive joint working between secondary & primary care around homeless patients were highlighted during the needs assessment. These include **Alcohol Liaison Nurses, Fast Response Team, Epilepsy Nurse Specialists & Blood Born Virus Team/Hepatology** all having close working relationships & excellent communication with **Health E1-Homeless Medical Centre**
- Allied health professionals from **Therapies at BLT** identified lack of access for homeless people to **Intermediate Care**, particularly inpatient rehabilitation. The current difficulty seems to be that patients will not be accepted unless they have an address to be discharged to.
- **Mental health** has identified that current commissioning & funding arrangements for psychiatric inpatients do not seem to work satisfactorily or fairly for homeless people who have strong links to other boroughs but who have long complex psychiatric admissions in Tower Hamlets. Similar admissions for medical or surgical problems are billed to the borough of origin but in mental health it comes from a block Tower Hamlets contract. In areas like Tower Hamlets with a large homeless population this has significant impact on mental health budgets.
- **Tower Hamlets Housing Options & Support Team** feel that there is a group of mental health patients who are difficult to manage in the community but who need to be housed in supported (mental health) housing otherwise they just end up being re-admitted or worse. They have had cases of people being discharged from psychiatric admissions at Mile End with no notice to housing services so have to be placed in B&Bs

without staff who are appropriately trained. Crisis House apparently does not accept homeless patients without an address to be discharged to.

Opportunities at Barts & the London Trust to implement the Pathway approach:

- Funding for a pilot project has been obtained by means of a National Institute for Health Research, Research for Patient Benefit grant. The research lead is Professor Graham Foster and Pathway supported the research application.
- The pilot funding will allow for a full time band 7 nurse to be seconded for the duration of the pilot, supported by 4 weekly GP sessions provided by Health E1-Homeless Medical Centre. Outcomes and patient satisfaction will be evaluated and published.
- There is already an established discharge team that meet weekly to discuss complex cases with input from the Clinical Lead for Patient Flow, Occupational Therapy, Homeless Social Worker from the Fast Response Team, Community Liaison Nurse & Social Work Liaison. CHS is also establishing a discharge co-ordinator role. Joint working with these posts would feed well into the Homeless Team’s role of improving the care of homeless people admitted to RLH.
- Housing & outreach services have voiced commitment to joint working.
- Therapies at BLT have voiced commitment to joint working.
- CHS have voiced commitment to joint working.
- While yet to be finalised it is likely that the Homeless Team nurse could sit under the discharge team at RLH & possibly line managed by the Clinical Lead for Patient Flow
- The weekly multi-agency meeting will ideally include representatives from the following (as appropriate & relevant):

BLT HOSPITAL TEAMS	EXTERNAL AGENCIES
Social work (homeless & generic)	Tower Hamlets Housing Options & Support Team
Liaison psychiatry	Tower Hamlets Street Outreach Support Team
Discharge Team (CHS, medical, surgical)	Health E1-Homeless Medical Centre
Acute medical & surgical teams	Hostel staff
TB Team	Drug & Alcohol Outreach Team
	Drug & Alcohol Services (CDT, ISIS , SAU, THCAT)
+ ANY FRONT LINE AGENCY & HOSPITAL STAFF ARE ALWAYS WELCOME TO ATTEND!	

Feedback from launch seminar Thursday 9th June 2011

The meeting was introduced by Stephen O'Brien Chairman of Barts and the London NHS Trust, and Chaired by Toby Lewis Chief Operating Officer. 60-70 participants attended from a wide range of hospital and community health services, the voluntary sector, housing, social services and public health. The meeting included presentations on the Pathway model, the headline findings of this needs assessment and an explanation of the research protocol associated with NIHR funding for a 12 month pilot scheme.

Participants were asked to raise concerns and offer potential solutions. These are summarised as follows: -

Issues	Solutions/positive outcomes
Relationship with police and enforcement agencies	Case by case & mediated via other partner agencies (e.g. street teams), relationship management
Equity with other patient cohorts	Discussion with commissioners, improved patient pathways for all- re-specification
Improved patient involvement in service planning	
Resource implications if more care shifted into the community	Community services join BLT in July 2011
Difficulties of consent	
Extended Length of stay	Identify other discharge options, benefit of lead time reduction
Include Mile End?	
Commitment of other Local Authorities?	Tower Hamlets housing options fully committed and ready to help with data collection
Access to rehab. If NFA	Discuss with commissioners
Is re-admission the right metric?	
Psychiatric input & impact on length of stay	Under review
	Teaching/sharing of learning from MDT

Participants were also asked "what will success look like?" With the following responses: -

- Prompt referral of appropriate patients to homeless team becomes routine
- Nobody involved with care of homeless patients in Tower Hamlets feels isolated, unsupported or uncertain how to contact or engage colleagues in other disciplines whose help they need to arrange care
- Reduction in length of stay for homeless people admitted to RLH
- Improved patient satisfaction and ability to self care on discharge
- Reduction in the number of homeless people admitted to RLH
- A permanent cost neutral (at least) homeless team at RLH
- Shift of care into the community
- Better planned discharges
- Be as good as the epilepsy team!
- Appropriate length of stay
- Appropriate number of admissions
- Effective health interventions, especially for mental health and drug & alcohol cases
- Palliative care links – St Josephs
- Health input and experience feeding into hostel development and commissioning
- Improved re-connections
- Every discharge a safe discharge
- Healthier population
- Increased proportion of elective to non-elective admissions

Finally participants were asked to "sign up" to the following agenda: -

- ◆ Are you willing to commit to contribute to providing improved, compassionate and caring health care and improved quality of life for homeless people in Tower Hamlets?
- ◆ Are you willing to "think homelessness" and make it your business to find out whether your patient has a secure address to be discharged to?
- ◆ Are you willing to contact the homeless team promptly once you identify a homeless patient?
- ◆ Are you prepared to work with the homeless team to try to meet the needs of your homeless patient and contribute to their care plan?

- ◆ Are you willing to commit your organisation and an appropriate member of your team to attend the weekly Homeless MDT when appropriate?
- ◆ Are you willing to review the minutes of the weekly MDT if you have not attended or make sure an appropriate member of your team has done so to ensure that your team can contribute when needed?
- ◆ Are you prepared to work together and communicate with colleagues to improve the care homeless people receive while in the RLH and after discharge?
- ◆ Are you willing to review and change policies, procedures and practices that exclude homeless people so that we can ensure that they have equal access to the same services that housed people do?

References

1. The Marmot Review. Fair Society, Health Lives. Strategic review of health inequalities in England post-2010. London: The Marmot Review; 2010.
2. See <http://www.communities.gov.uk/publications/corporate/statistics/roughsleeping2009>
3. Jones A. and Pleace N. A Review of Single Homelessness in the UK 2000 to 2010. Crisis 2011. Available at www.crisis.org.uk
4. DH Office of the Chief Analyst. Healthcare for Single Homeless People. Department of Health. 22 March 2010
5. Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. International Journal of Epidemiology 2009; 38:877–883
6. See http://www.nuffieldtrust.org.uk/publications/Trends_in_emergency_admissions_BRIEFING
7. O’Connell JJ. *Premature Mortality in Homeless Populations: A Review of the Literature*, 19 pages. Nashville: National Health Care for the Homeless Council, Inc., 2005.

8. O'Connell et al. The Boston Healthcare for the Homeless Program: A Public Health Framework. American Journal of Public Health August 2010; Vol 100 No 8:1400-1408

9. Faculty information at <http://www.collegeofmedicine.org.uk/faculties/faculty-care-homeless-people>



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