

Kings Health Partners Pathway Homeless Team



Pilot Project Report January – March 2014

Samantha Dorney-Smith, Interim Project Lead

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- The whole KHP Pathway team, these outcomes are the results of their collective dedication and application.

Foreword

This successful care coordination pilot has been a remarkable achievement and demonstrates the huge potential to improve health inequalities by focussed multi-agency working and integrated care. Above all it is a tribute to the team work and skills of the individuals brought together at short notice to deliver this pilot, building on the success of other Pathway teams around the country.

The scale and pace of this pilot is unprecedented, with more patients seen in the first 3 months than most Pathway teams will treat in a year. This would not have been possible without a number of supporting factors. Firstly Kings Health Partners Academic Health Science Centre supported by Guy's and St Thomas' Charity, gathered and presented the evidence to show that KHP is the lead provider of unscheduled secondary care to homeless people in London and supported the development of this team to respond to that need. Secondly KHP includes services with a long experience of work in this field, particularly the Health Inclusion Team and the START homeless mental health team, contributing a profound understanding of the issues to be tackled. Finally, Lambeth and Southwark Clinical Commissioning Groups supported by the South London Commissioning Support Unit responded to the evident need and despite a challenging financial situation funded the pilot and then extended the funding for the whole of the financial year.

Pathway is very proud to be associated with this team and looks forward to providing support and encouragement into the future.



Dr Nigel Hewett
Medical Director Pathway
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Executive summary

Following a Needs Assessment delivered in 2012, Lambeth and Southwark CCGs kindly commissioned an initial pilot of the 'Kings Health Partners Pathway Homeless Team'. The Pathway Homeless Team is affiliated to, and forms part of the Pathway network of 'Homeless Ward Rounds' in acute care settings nationally.

The pilot of the team ran from January – March 2014. The pilot team was multi-professional, and multi-agency, and involved 14 core staff. In addition to the team members directly funded by the CCGs, the team also benefited from working in close partnership with two hospital discharge projects funded by short-term Department of Health money. Therefore, 4 out of 5 of the involved Housing Support Workers were actually employed by St Mungo's Broadway and the Passage. The team also benefited from the input of a Groundswell Peer Advocate and Groundswell volunteers. This input was also made possible by short-term Department of Health funding.

The team received 431 referrals during this quarter. Although most of these referrals came from the A&E departments and medical admissions wards, referrals from outpatient departments were surprisingly frequent, and there were 8 referrals from the maternity department at Kings. Only 54.3% of clients seen at GSTT and 65.1% at Kings had a connection with one of the three surrounding boroughs, indicating a high level of transience in the population. At Kings, 29% of the population referred had no recourse to public funds, compared to an estimated 13% at GSTT.

An audit at GSTT showed an expected high prevalence of infectious disease (HIV 3%, Hep C 10%, TB 1.3%) in the cohort. Unsurprisingly 68.5% of those identified as homeless frequent attenders were alcohol dependent.

Although it is difficult to show improved outcomes at such an early stage, early results are promising. A total of 418 people were seen or case worked by the team during the pilot period (97% of those referred). Of those 30% overall had an improved housing status on discharge as a result of contact with the team, and 28 people were successfully reconnected, including to Spain, and the Philippines. This is a considerable achievement given the challenges of the client group, and represents some very real positive changes in people's lives.

At GSTT there was also a reduction in bed days in NFA and homeless hostel clients of 34% on Qtr 3 2013-2014 and 29% on Qtr 4 2012-2013. If an emergency bed day is costed at £260 a day, the total bed day saving equates to £94,380 saved, which is an excellent achievement for the pilot team.

At Kings the housing outcomes were better than at GSTT with 36% showing an improved housing status. However it was not possible to prove a reduction in bed days. This was because NFA and homeless hostel clients have made up only 37% of the population seen, with a very significant percentage being sofa surfers and people in other temporary accommodation (46%). Consequently we could not identify an equivalent 'before' group from hospital records to compare changes in duration of stay. Note that at GSTT, 77% of clients seen were NFA or from homeless hostels on referral.

For the team as a whole there have also been some major achievements with certain individuals across both sites. As a key example, one client who had been repeatedly attending 13 hospitals (including St. Thomas' and Guys), with an estimated 5 year cost of about £250,000 (508 A&E attendances, 59 admissions have so far been tracked), is now successfully accommodated as a result of contact with the team. The case studies in the report profile many other successes. Frequent attender work is a major area in which the team will continue to develop. Work on homeless frequent attenders started prior to pilot going live, and was shortlisted for a Nursing Times Emergency and Critical Care Nursing Award in November 2013.

Annual data at GSTT showed 4291 A&E attendances registered as NFA or to homeless addresses in 2013 – 2014. If this were only 77% of all 'homeless' attendances the estimated number of homeless attendances to A&E per year would be 5572. A conservative estimate of the number of A&E attendances registered as NFA or to homeless addresses at Kings in 2013 – 2014 is 596. If this were only 37% of all 'homeless' attendances, the estimated number of homeless attendances to A&E per year would be 1610. This demonstrates the ongoing high level of need at both sites.

135 staff (mostly A&E staff) were trained by the team during the quarter, as part of an ongoing training programme, and a resource booklet has been developed which is will shortly be available across both trusts. 71% of staff providing feedback thought the training was excellent or very good.

As a final outcome 50 feedback forms were received back during the quarter, representing 15.3% of the population seen. The average score from these forms was 4.87 (on a scale of 1-5 where 1 was poor, and 5 was excellent), which was obviously very positive. Two Focus Groups were run, and suggestions from the groups for service improvement have been taken on board.

The team has now come through the initial pilot phase, and has funding until March 2015. Lambeth and Southwark CCGs have kindly agreed to include the Department of Health posts in the funding award, so that the team can continue to capitalise of its success. The team has gained a lot of experience in the pilot phase, and will hopefully be able to continue to deliver on these early promising results. There are many innovative projects in development including the building of a pan-London network with other A&Es and discharge teams, and joint work with the London Ambulance service to put plans in place for hostel based frequent attenders.

In summary this has been a very successful pilot. A very real need has been evidenced for the team, and the considerable value that the team can add across a range quality and cost outcomes has been readily demonstrated. This team hit the ground running; and the dedication, hard work, and innovation of the team members cannot be understated. I wish the team all the best for the coming year, and am proud to have been a part of setting up this excellent service.

Samantha Dorney-Smith, Interim Project Lead, June 2014

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Introduction

The new Kings Health Partners Pathway Homeless Team has been operating across Guys and St Thomas' (GSTT) and Kings hospitals since January 6th 2014. The team has now completed the initial pilot phase (January - March 2014), and currently has funding until the end of March 2015. The plans are to extend the team into the South London and Maudsley (SLAM) hospitals from September 2014. The extension will be funded by the GSTT and SLAM charitable foundations.

The dual aims of the Pathway Homeless Team are to improve the quality of care for homeless patients, while also reducing potential delayed or premature discharges. There is an overarching aim to reduce future unscheduled admissions and A&E attendances.

The Pathway Homeless Team is affiliated to, and forms part of the Pathway network of 'Homeless Ward Rounds' in acute care settings nationally. Clinical practice within the teams is guided by the Pathway principles of practice. For further information see www.pathway.org.uk.

The team is multi-professional and multi-agency. The ongoing team at Kings and GSTT will be made up of 2 (part-time) GPs, 2 Registered Nurses, 1 Occupational Therapist, 1 Social Worker, 1 Business Manager, 4 Housing Workers, and a Groundswell Peer Advocate with support from Groundswell volunteers. The Housing Workers will continue to be seconded from St. Giles, the Passage, and Broadway. The Housing Workers and Groundswell Peer Advocate have honorary contracts in place.

The new SLAM service will add 2 Mental Health Practitioner posts, and further GP input. These posts will be recruited in September. The SLAM phase of the project will be formally evaluated.

This report covers the work of the pilot quarter. The early achievements of the project have been considerable, and this report presents those achievements, acknowledges some challenges, and makes recommendations for the development of the ongoing team.

Many thanks are owed to all the members of the pilot team and all the involved organisations for their enthusiasm, hard work, dedication and extremely cooperative partnership working.

Mission Statement

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

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

Service Summary

What the team provides as a service is briefly summarised below. The team:

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

Referral data

No of referrals

The table below presents referrals received from Monday 6th January to Monday 31st March (12 weeks). Although we did receive our highest number of referrals at both sites on the first week, this has not dropped significantly over time.

	GSTT	Kings	TOTAL
Total number of appropriate referrals	322	109	431
Inappropriate referrals (advice given)	17	4	21
Referrals in week 1	34	16	50
Referrals in week 12	31	10	41
Mean referrals per week	26.8	9.1	
Annual estimate of referrals	1288	436	1724

Source of referrals

Presented below are the top 10 referral originators for both sites. There were more A&E referrals from GSTT, but this is consistent with the known high number of A&E attendances from homeless patients at this hospital, and possibly the location of the team close to A&E.

Apart from this difference, the patterns of referral are similar between the two hospitals, with medical wards being the main referring wards. Note however that one of the maternity wards appears on the Kings data.

GSTT			Kings		
	Number	%		Number	%
A&E	131	41%	A&E	29	27%
Emergency Medical Unit	53	16%	Outpatient	17	16%
Outpatient	21	7%	Clinical Decision Unit	11	10%
Sarah Swift	21	7%	Lonsdale	6	6%
Victoria	13	4%	Oliver	6	6%
Albert	12	4%	David Marsden	5	5%
Hillyers	12	4%	Trundle	5	5%
William Gull	8	2%	William Gilliatt	4	5%
George Perkins	4	1%	AAU	3	3%
Urgent Care	4	1%	Annie Zunz	3	3%

Demographic data

We were unable to collect much detailed demographic data on our patients during the pilot phase. This will be possible when the team goes live with onto EMIS Web, a primary care patient record system. Demographics that will then be able to be collected include ethnicity, country of birth, first language, sexuality, registered disability, prison and care history. In the meantime we are able to present the following.

Patients on CHAIN

CHAIN is the street outreach database hosted by Broadway that records the bedded down contacts of street outreach teams. All Pathway Homeless Team staff members have access to CHAIN. At GSTT 48% of clients were found recorded on CHAIN, however at Kings this was less at 26%. From this we know that more patients at GSTT were traditional rough sleepers.

Age

Across both sites the mean age of those referred was 43.8 years. The oldest person referred was 87 years, the youngest 17 old, but most were between 25-55 years old.

Gender / Maternity cases

Women represented 24% of referrals at GSTT and 31% at Kings. This was skewed at Kings by the referral of 8 maternity cases, and 2 women with children 5 or under referred from A&E. 5 out of 8 of the maternity cases had no recourse. There were no referrals from maternity or for families at GSTT.

Eastern European Area Nationals

A manual search of data at both sites has revealed that EEA nationals formed approximately 12% of the referral population at GSTT, and 8% of the referral population at GSTT – rather less than expected.

Clients with No Recourse to Public Funds

A manual search of data at both sites has revealed that clients with NRPF (e.g. EEA nationals without recourse, failed asylum seekers and illegal migrants) formed around 13% of the referral population at GSTT, but 29% of the referral population at Kings. At Kings a further 5% were also current asylum seekers / refugees or trafficked. These figures underline the specific challenges experienced at Kings.

GP registration

Data analysis at GSTT revealed 42.5% of attendances were associated with no registered GP.

Housing status on referral (clients seen)

At Guys and St. Thomas' 77% of clients were NFA or lived in a homeless hostel on referral, however at Kings this made up only 37% of the population (see table below). 35% of the Kings population were sofa surfing, and 11% were in some form of temporary accommodation. This is significant because a) it underlines the two different populations, but also b) we are measuring our outcomes on those who are NFA or in known homeless hostels - so this may not now be appropriate at Kings.

Housing Status	GSTT		Kings	
No Fixed Abode	169	65%	20	24%
Homeless hostel	32	12%	11	13%
Sofa Surfing	25	10%	29	35%
Housed (threat of losing housing or unsuitable)	25	10%	12	14%
Other / unknown	5	2%	2	2%
Temporary accommodation (B&B or hotel)	6	2%	9	11%
Total	262	100%	83	100%

Borough link

The 'borough link' of clients 'seen or contacted' has been recorded, and is presented below. The borough link has been decided by a client's housing history and/or where they have been directed to on discharge.

54.3% at GSTT had a connection with one of the three surrounding boroughs. 65.1% at Kings had a connection with one of the three surrounding boroughs. This underlines that reconnection work is important.

Borough Link	GSTT	%	Kings	%
Westminster	53	20.2	1	1.2
Lambeth	45	17.2	20	24.1
Southwark	44	16.9	33	39.8
Lewisham	9	3.4	6	7.3
Other London	43	16.4	14	16.8
Other	64	24.4	9	10.8
Unknown	4	1.5	0	0
Total	262	100%	83	100%

Prevalence data (GSTT only)

A manual search of EPR was done at GSTT to try to establish prevalence data on our population. **It should be stressed that notes on EPR tend to be relatively poorly coded, and whilst some things (like HIV, TB) are likely to be accurately coded, most other things (like liver disease, intravenous drug use, mental health problems) will probably not be.** As such this should be seen as a work in progress, and would be expected to be far more accurate once the team goes on to EMIS.

217 sets of notes had adequate notes to be audited.

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

It is notable that alcohol dependence, substance misuse and mental health seem lower than expected.

However it is important to note that **on our most recent frequent attenders list 24 / 34 (68.5%) were known to be alcohol dependent** (with many of the others still unknown). A further 5 appeared to have their mental health condition as the main precipitating factor (14.7%).

Housing and Reconnection Outcomes

% referred clients seen

Overall, across both sites 97% of clients referred were either seen or contacted. Where clients have not been seen or contacted, this has generally either been because they have been referred overnight or over the weekend (some of these may be frequent attenders), and the team has been unable, or not had the capacity, to follow them up or contact them.

	GSTT	%	Kings	%
Total number of appropriate referrals	322		109	
Clients seen	242	76%	83	76%
Clients not seen, but casework done	69	21%	24	22%
Clients not seen	11	3%	2	2%
Total clients seen or case worked	311	97%	107	98%

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

	GSTT	%	Kings	%
Total clients seen by Housing Worker	110	42%	43	52%

The percentage of people that have had access to a housing worker has been a major contributor to the housing outcomes outlined below.

% improved housing status

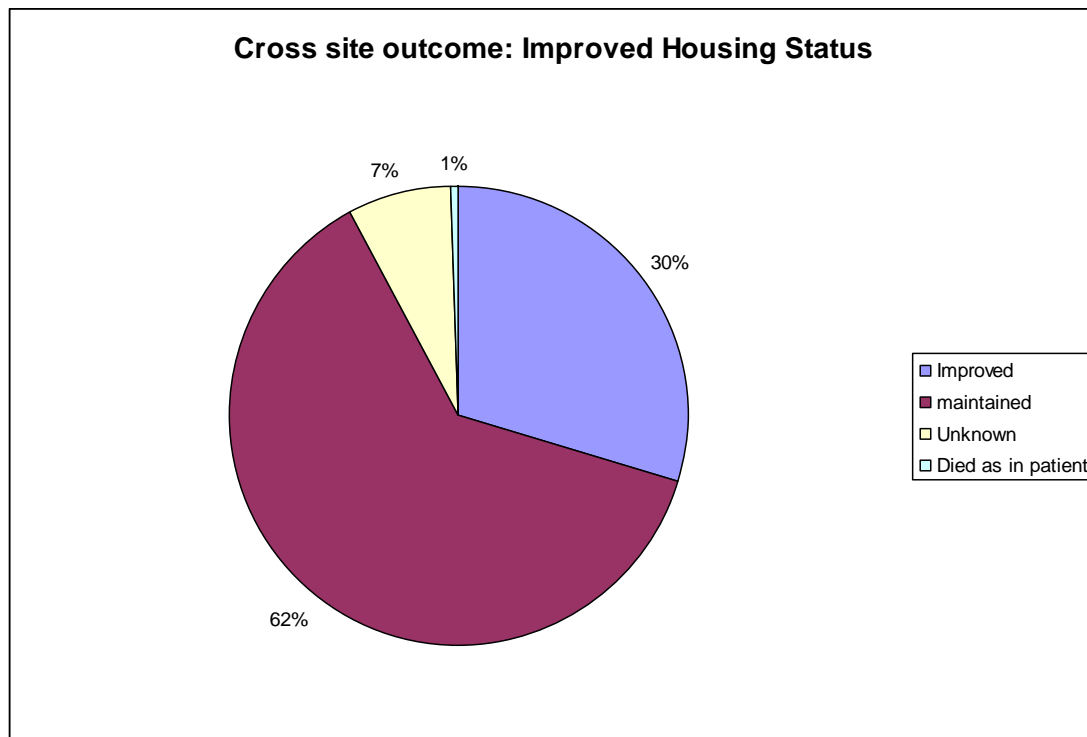
The next table shows improved housing status at both sites. This is measured on a simple housing ladder where the following categories are used:

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

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

Housing Status	GSTT	%	Kings	%
Improved	73	27.8	30	36.1
Maintained	167	63.7	48	57.8
Unknown (data incomplete)	20	7.7	5	6.1
Died as in patient	2	0.8	0	0
Total	262	100%	83	100%

Overall the % of clients that have improved their housing status as a result of contact with the team has been 30%. This is a major achievement given the nature of the client group.



Reconnections

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

	GSTT	%	Kings	%
Total clients reconnected	22	8.3	6	7.2

Secondary Care Usage Data

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

GSTT data

A&E attendances

4291 A&E attendances were found for 2013–2014. This is less than the 4923 found in the 2011 Needs Assessment; however the Guys Urgent Care Centre data is no longer included in the data, which probably explains the reduction.

Period	A&E attendances
Qtr 4 2012-2013	1068
Qtr 3 2013-2014	919
Qtr 4 2013-2014	1037

Since the team has been in post there has been a 12% increase in A&E attendances on Qtr 3 2013-2014, although a 3% decrease on Qtr 4 2012-2013.

Admissions

1055 admissions were found for 2013–2014. This is less than the 1378 found in the 2011 Needs Assessment. It is not know why this is.

Period	Bed days	Admissions	Average Length of Stay	Comments
Qtr 4 2012-2013	988	278	3.6	KA (housing worker) still in post
Qtr 3 2013-2014	1065	251	4.2	No intervention
Qtr 4 2013-2014	702	275	2.6	Pathway Team commences

There is a reduction in bed days of 34% on Qtr 3 2013-2014 and 29% Qtr 4 2012-2013. This benefit has been achieved by reducing the average duration of stay, which is likely to be a direct result of Pathway team care coordination.

Note that Kwasi Ansah, the previous hospital discharge coordinator was still in post in Quarter 2 2012-2013, and he will probably have had an effect on that quarter.

1065 bed days – 702 days = 363 bed days saved.

If an emergency bed day is costed at £260 a day this equates to £94,380 potentially saved.

Re-attendance and re-admission data

Presented below are the baseline re-attendance and re-admission rates for homeless patients at GSTT for the year 2013-2014. As can be seen the re-attendance rate for 'Other CCGs' is quite high. It is assumed that this is because this cohort is probably made up of transient people who are away from their own area, and therefore have no alternative route for accessing health care.

Readmission rates are highest for Lambeth and Southwark, so this is a target to work on. To put these result in context re-attendance rates in the general population tend to be around 6-7%.

CCG	7 day re-attendance rate	28 day readmission rate
Lambeth	15%	19%
Southwark	18%	23%
Westminster	18%	18%
Other CCG	30%	13%
Total	19%	18%

Costings

The table below presents charging data for homeless patients at GSTT for the year 2013-2014.

CCG	A&E attendance	Admission
Lambeth	£116	£1,322
Southwark	£120	£1,998
Westminster	£123	£2,115
Other CCG	£118	£1,020
Total	£118	£1,560

These average costs are what have been used to calculate costings in this report.

Workload estimate

Given we know that 77% of referrals at GSTT have come from NFA and homeless hostel clients the potential estimated number of relevant A&E attendances is 5572 and admissions is 1370.

Kings Data

Note that the search for this Kings data has not included a search for clients with GP registration with a specialist homeless primary care team (unlike the GSTT data)

A&E attendances and admissions

	Qtr 3 2013-2014		Qtr 4 2013-2014	
A&E attendances	149		196	
Admitted	20	13%	39	20%
Via LAS	60	40%	72	37%
No of attendees 3+ times	7		13	

This number of A&E attendances is essentially consistent with the 718 A&E attendances found in the 2011 Needs Assessment, but the number of admissions is considerably lower than the 240 admissions found in the previous Needs Assessment.

It is notable that the number of A&E attendances and admissions has gone up from Quarter 3 to Quarter 4, and the team do not seem to have had an effect on this cohort at Kings. However the fact that 63% of clients seen were not covered by this data, suggests that it would be an unreliable performance measure of the specific work delivered.

Workload estimate

If the Quarter 3 figures are used to estimate annual attendances this would give 596 A&E attendances and 80 admissions. However given that it is known that only 37% of referrals at Kings have come from NFA and homeless hostel clients, then the potential estimated population is number of relevant A&E attendances is 1610, and admissions is 216.

Frequent Attender Work

Individual Clients

Homeless client frequent attender work commenced in Quarter 4 2012-2013 at GSTT (prior to the start of the wider team), and is just commencing at Kings. Searches are done manually 3 monthly (at GSTT) and 1 monthly (at Kings) to identify candidates to casework.

The top 15 and 60 clients at GSTT for the year 2013-2014 have been costed below as an example of the population. A&E attendances have been costed at £118, and admissions at £1560 as per our costing information above. LAS calls are different to cost, but we have used a reference cost of £235 (Personal Social Services Research Unit, Unit Costs of Health and Social Care 2013).

2013-2014	A&E Visits	Per head	Via LAS	Admissions	Per head	Approximate Cost	Cost per person
Top 15	383	25.5	95 (25%)	69	5.5	£175,159	£11,677
Top 60	923	15.4	391 (42.4%)	209	4.4	£526,839	£8,780

In some ways these numbers and costs don't seem very much. However we know that our demographic of frequent attender generally attend a number of hospitals, so these costs do not adequately underline the benefits of frequent attender work. A case study of a patient frequent attending both GSTT and Kings which underlines this point is presented below. It must be stressed that although this person's case is extreme, it is not isolated case, and we have many similar (slightly less extreme) examples.

SC (AKA 9 different names, at least) – alcoholism, stroke, fits, hypertension, asthma

SC attended both sites in the first month of the project. She had a left sided weakness, and was obviously alcohol dependent. She was unkempt, and unsteady on her feet. It rapidly became clear there was a long history of various hospitals discharging her with no apparent plan, and/or SC discharging herself. Her level of mental capacity was unclear, as she did not engage in assessments. She did, however, express a desire to be cared for.

The team now knows that her pattern of homelessness and frequent attendance probably goes back to 2002, however we have tried to track her attendances for just 5 years 2009 – 2013. We have so far tracked 508 A&E attendances and 59 admissions across 9 hospitals. Complete data is still missing from 5 of these hospitals (particularly admissions data), and she is known to have been at least 13 hospitals. In our own data she has arrived at A&E via LAS 72% of the time.

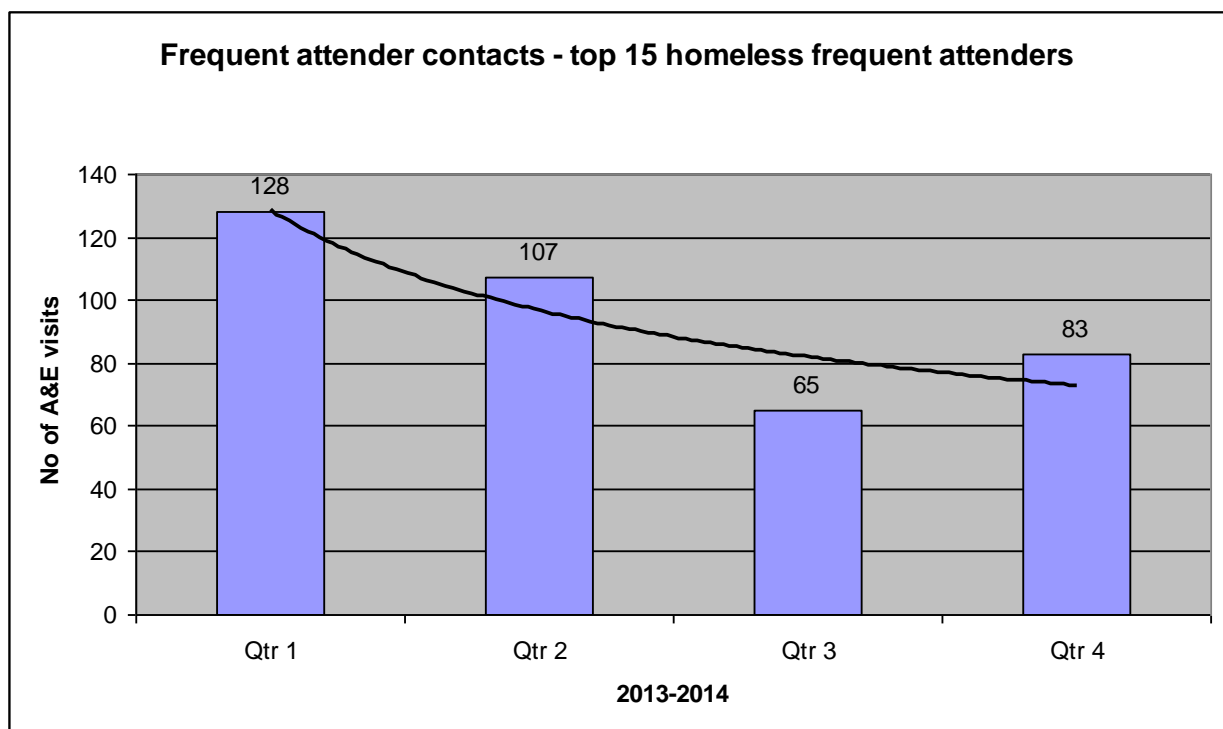
If you only cost the actual A&E attendances and admissions we know about this comes to £228,724 over the 5 years. If you estimate the missing data from other hospitals this is likely to increase this to at least £250,000, and may even double this sum.

SC was known to many others, and had absconded from a temporary B&B on the second occasion the team met her. The team created an e-mail group of involved people, and engaged in considerable discussion with Brent Social Services, where she was previously known. Her case was raised at a very high level, and they agreed to fund an appropriate nursing home placement without ever having assessed her.

An alert was put out to several A&Es from where she was eventually taken directly to the nursing home in Feb 2014. She still remains there, and has only attended A&E once since.

Frequent attender meeting

Since February 2013 there has been a monthly partnership meeting covering both sites to discuss the top frequent attenders for the last three months, and try to establish relevant links. The following chart represents the overall trend of attendance in the top 15 at GSTT since the meeting has been running. Although there has been a recent upturn in the number of visits, **there has been an overall downward trend, and 35% reduction in attendances from Quarter 1 to Quarter 4.**



Frequent Attendance from Homeless Hostels

We have also obtained aggregated data on homeless hostels so we know which hostels to develop relationships with. Several hostel managers already attend our frequent attenders meeting, and we are trying to target more. GSTT data is available for the whole year, and has been costed. **The estimated cost of the top 10 hostels for 2013-2014 of the GSTT attendances and admissions is £578,244.** It does need to be underlined here as well though, that clients based in hostels often attend multiple hospitals.

Interventions to reduce overall attendances from hostels so far have included:

- Analysis of attendance reasons / times in order to understand the problems
- Teaching to hostel staff
- Increased liaison with hostel staff
- Providing specific data so the hostels can lobby for in-reach services
- Lobbying for outreach services
- Specific A&E and LAS plans for targeted individuals
- LAS protocols put in place

From May 2014 we will be progressing this work by having a specific hostel based forum to share ideas.

Homeless hostel data for both GSTT and Kings is presented below:

Kings Homeless Hostel Data	Qtr 4 2013-2014 (This quarter)		Qtr 3 2013-2014 (Previous quarter)	
Barry House	24	12%	25	17%
Joe Richards	23	12%	8	5%
YMCA King Georges	18	9%	4	3%
Oasis Housing	8	4%	5	3%
Keyworth Street	7	4%	4	3%
Camberwell Foyer	7	4%	8	5%
YMCA - Knights Millennium Foyer	6	3%	3	2%
Acre Lane	5	3%	11	7%
Pagnell Street	4	2%	0	0%
Northcott House	4	2%	12	8%
Manor Place	4	2%	8	5%
Missionaries	4	2%	0	0%
Gateway	4	2%	4	3%
Graham House	4	2%	7	5%
TOTAL	115		99	

GSTT Homeless Hostel data 2013 -2014

	Borough	No of beds	A&E attendances	Attendance/ head	Admissions	Admission s /head	Bed days	Bed days / admission	LAS calls	% via LAS
Graham House	Lambeth	69	130	1.9	39	0.6	127	3.3	92	70.8
Hopkinson House	Westminster	36	119	3.3	33	0.9	126	3.8	82	68.9
Waterloo Project	Lambeth	19	110	5.8	13	0.7	40	3.1	63	57.3
Keyworth Street	Southwark	35	89	2.5	27	0.8	122	4.5	59	66.3
King George's	Westminster	68	84	1.2	19	0.3	32	1.7	51	60.7
Montfort House	Westminster	16	69	4.3	17	1.1	27	1.6	45	65.2
Robertson Street	Lambeth	42	80	1.9	40	1.0	283	7.1	39	48.8
Connection at St Martins (Nightshelter)	Westminster	40	72	1.8	15	0.4	47	3.1	26	36.1
Cardinal Hume Centre	Westminster	32	58	1.8	9	0.3	49	5.4	30	51.7
Manor Place	Southwark	34	47	1.4	16	0.5	94	5.9	25	53.2
Average				2.6						57.9
TOTAL			858		228		947		512	

(858 x £118 = £102,244) + (228 x £1,560 = £355,680) + (512 x £235 = £120,320)

Total = £578,244

GP Practices

Some targeted relationship building work has been done with GP practices, and further work is planned. The team GPs will be linking in with Lead GPs from the practices. The top 10 practices are identified below.

A&E attendances by GP practice			
THE DOCTOR HICKEY SURGERY	Westminster	918	242
PRINCESS STREET GROUP PRACTICE	Southwark	180	25
WATERLOO HEALTH CENTRE	Lambeth	189	23
MAWBEY GROUP PRACTICE	Lambeth	165	50
VICTORIA MEDICAL CENTRE	Westminster	89	8
DR CURRAN & PARTNERS (CLAPHAM MANOR)	Lambeth	89	37
GREAT CHAPEL STREET	Westminster	65	14
THE PEMBRIDGE VILLAS SURGERY	Westminster	55	11
MILLBANK MEDICAL CENTRE	Westminster	59	11
THE ECCLESBOURNE PRACTICE (excluded from total as likely to be one person)	E17	46	0
MANOR PLACE SURGERY	Southwark	39	13
HEALTH E1 (HOMELESS PRACTICE)	E1	37	15
BERMONDSEY AND LANDSDOWNE MEDICAL CENTRE	Southwark	36	17
		1921	466

Note that the Ecclestone Practice in Leyton E17 actually came in at number 9, and this will be investigated – it is likely to be one individual.

Case Studies

In the following pages 10 brief case studies are presented that profile four team successes, and four team challenges, and the case for respite care.

Case Studies – Successes

ST - 51 year old male. Ex IVDU, alcoholism, Hep C, leg ulcers, oesophageal varices, memory problems

Lived in Lambeth hostel for 4 years, prior to being reconnected to Bristol (where brother lived) in 2011. Returned to London for 'Crisis at Christmas' in 2013, and admitted to hospital (known frequent attender in Bristol). Said he wanted to stay in Lambeth. Had a history of abandoning multiple placements in Bristol in the two years prior, due to alcoholism, and fluctuating capacity.

Provided with TV, and daily 'befriending' type support by the team. Put back in contact with his sister, who he hadn't spoken to for 2 years. Considerable contact was made with Bristol services that knew him. As a result he decided to return to Bristol. The Social Worker managed the Ordinary Residence dispute that ensued, and the team represented him in Best Interest meetings.

He was finally escorted back to his own self contained flat in Bristol by one of our Housing Support Workers, and provided with 4 bags of shopping from the Food Bank, and basic kitchenware by our team. He was met at the door by the allocated Support Worker, with a Social Services appt due within 24 hrs.

6 weeks after his return, he was still in his flat with a daily support. He had made further contact with his family, had moderated his drinking (compared to previous levels), and had even given up smoking - preferring to continue with the cigarette replacements we had provided in hospital.

LA (AKA MW) – 55 year old female. Alcoholism, fits, ? mental health

Admitted to St. Thomas, seen, and then unfortunately self-discharged overnight. Known Camden client who had abandoned various hostels, and was sleeping on the buses. On CHAIN she was described as *'a highly chaotic street drinker with history of becoming aggressive... Self care can deteriorate to the point where she is doubly incontinent.'* The team were concerned that she was vulnerable, and decided to follow her up.

Initially Camden Social Services were contacted, but said that LA needed to reduce her drinking, before they could work with her. The local drug and alcohol services (CRI) also said they had discharged her from their care as she was not engaging in detox placements. She had also been found 'intentionally homeless' by housing although it was evident that a placement Social Care was required.

The team made contact with all interested parties (including the Spectrum Day Centre where she was well known), and ensured a network of contacts, and people to lobby Social Services. LA was admitted to the Royal Free once, and St. Mary's twice (including on a 136) over the next two months. Three further referrals were sent to Social Services by different teams as a result. A case conference was arranged mid-March and a suitable placement, Burleigh Road, was funded. LA was discharged successfully into the placement at the end of March.

SC - 47 year old man. Alcoholism, Hep C, pancreatitis, diabetes, asthma, ? bipolar

SC was a poor historian, but said he had lived in Liverpool, then Manchester, then Northampton. There were a few street contacts on CHAIN in Tower Hamlets, but not enough to gain him a local connection. The team arranged for a Neuropsychiatrist assessment, which showed him to have 'mild global impairment', but not enough to warrant Social Care.

In order to establish a local connection, the team accessed his GP registration and address history from the NHS Spine. This information was used to elicit more detail from SC. From this, the team contacted a number of involved providers around the UK to build up a picture of his address history and support needs. It was found that SC had actually been ASBO'd from Liverpool and Manchester for aggressive begging, and had last lived with a religious community in Northampton for about a year. There was a concern that he would be deemed intentionally homeless by Northampton council.

Our Housing Support Worker liaised with the local outreach team and Homeless Persons Unit in Northampton, prior to escorting him back to Northampton and presenting him at the HPU there. On presenting, the HPU agreed to provide temporary accommodation, whilst he was placed on the waiting list for an identified hostel. The worker bought him food for the weekend, and accompanied him to his temporary accommodation. The following week the team was called by the outreach team who confirmed that they had met with SC, and that he would be moving into the hostel accommodation in a few days.

CH – 29 year old man, Jamaican background. Alcoholism, cannabis, psychosis

CH was admitted to hospital after performing a self-circumcision whilst mentally unwell. When admitted he was illegally sub-letting his Grandma's council house with his partner and 6 month old baby. His partner had no recourse to public funds. Psychiatrists diagnosed the incident as a psychotic episode, and not secondary to drugs or alcohol. Surgical intervention was required for the self-circumcision. CH had had a long prior history of housing instability including being in foster care, and from 2009 - 2013 had been intermittently rough sleeping and sofa-surfing.

A number of considerations had to be taken into account when finding appropriate housing for CH, including concerns for his own mental health, and safeguarding concerns for the child. In fact CH did not want to return to his partner, clearly identifying relationship issues as one of the causes of his mental health deterioration.

A multi-disciplinary case conference was arranged to co-ordinate the discharge of the patient, and it was identified that CH needed to be safely housed in his own supported accommodation. Our Housing Support Worker then liaised with the Southwark re-enablement team, Housing Options, and the STEP (early onset psychosis) team, to house the patient safely, with appropriate community services. This process included e.g. supporting CH to attend several appointments, and do benefits claims. CH was housed appropriately, and continues to do well. His partner was referred to Social Services.

Case Studies – Challenges – 2 Maternity cases

VJ – 39 years old. Venezuelan born, Spanish passport, 29 weeks pregnant

VJ probably entered the UK in December 2013, and was accompanied by 15 year old daughter. She was admitted to the ante-natal ward with abdominal pains, after an alleged assault by her sister's partner. She had been sofa-surfing with her sister and sister's partner prior to admission, and was now unable to return there. She had not worked in the UK, and had no recourse to public funds. She had not had any prior antenatal care.

VJ was case worked extensively. It transpired she had previously referred herself twice to Social Services. Social Services were able to place her daughter in a foster placement, but VJ took her out after one night. VJ refused one women's refuge offer, (because it was too far away from her daughter), and two more wouldn't take her. She also refused all offers of reconnection. She was escorted to Housing Options as a last resort, but was already known there, and re-directed her to the Spanish embassy. Finally she told us that she no longer needed our support.

OA – 39 years old. Nigerian born, Irish passport, immediately post-partum

OA said she entered the UK from Ireland in September 2013, but only had evidence from March 2014. Initially she was accompanied by her 14 year old daughter, although she did later send her daughter home. She had had 17 pregnancies, and had 6 other children, living in Ireland with an aunt. She had had no antenatal care. There was an alleged history of domestic violence, and her husband was at home in marital home in Ireland, although there were no police reports. She claimed to be sofa surfing with various people, including someone she had met in McDonalds.

OA was refused by UK refuges, because she was deemed to be not at risk in UK. She was in receipt of basic benefits, but had no local connection to justify housing support. She was linked in with the St. Giles CAFE (Children and Families) project via our Housing Support Worker. They arranged for a refuge in Ireland, a guarantee of support around the domestic violence, and long term re-housing, however this was all refused. She claimed to be living on floor, without a cot or pram, but refused the St Giles home visit required to get her additional resources, and further support.

Concerns

These cases are very concerning, but rather representative of the overall maternity referrals. The underlying themes of both cases were:

- no antenatal care
- children out of school
- violence
- refusing reconnection
- went underground

The team presented these cases at a recent seminar 'New Challenges for Maternity: Deprivation, Debt and Migration' on May 1st 2014.

Case Studies – Challenges

JA – 73 year old Nigerian man with no recourse. Insulin Dependent Diabetes, Hypertension.

JA was a legal resident of UK from 1962 - 1976, and then went back to Nigeria. JA re-entered the country in 1999, and has remained here as an illegal migrant ever since. He has filed two legal claims for 'leave to remain' both of which have failed. The UKBA however, has no plans immediate plans to remove him (contact has been made with the UKBA caseowner). He is required to 'report' 6 monthly. JA says he stays in churches, ministries and on buses, so there are no bedded down CHAIN contacts for him. There are currently no accommodation options available to him.

JA is an insulin dependent diabetic. He was refused GP registration by 4 different practices, and another expressed reservations. The refusals have been on the basis of his homelessness, not his immigration status.

JA lost his previous GP after telling them he being evicted from the garage-like accommodation where he had been staying, and was now NFA in another area. Several weeks later he was admitted to Kings in ketoacidosis.

On discharge from hospital, the practice was contacted to see if they would re-register him, but they refused, saying they were unable to register NFA clients. The nearest homeless practice to the area he says he stays in (Merton) was then contacted, but they said they would need proof that he was NFA in Croydon (i.e. he would need to have been seen street sleeping in Croydon) to register him. He was then escorted him to a large practice in Lewisham (because he has outpatient appointments that he attends at Lewisham hospital) by a nurse, and his situation was explained face-to-face. He was again refused. During this time he was re-admitted for 5 days to Lewisham hospital.

JA was then seen at the Walk-In Centre in Croydon and given an interim prescription. However they then told him he would need to register with a homeless practice to get future prescriptions. He then took himself to a homeless practice in Westminster. The practice gave him a sandwich and cup of tea, and made some enquiries, and referred him on to the specialist asylum seeker and refugee GP service at the Pavilion practice in Brixton. He did not fit their criteria, but they agreed to book an appointment for him. He did not turn up. During this time attended Kings A&E seeking medication.

He has now been registered at a practice in Merton.

This case demonstrates both the accommodation, and GP registration challenges faced with this client group, and is particularly concerning considering his age and medical vulnerability.

BW – 61 year old Ghanaian man, full residency rights. Deteriorating neurological condition.

BW was in A&E 9 times, and admitted 3 times in a 6 month period. On two occasions previous to meeting the team he was directed to Housing Options by himself on discharge. Although he had family (including grown-up children) in the borough he was applying to, and wanted to stay there, he had split from his wife in that borough several years previously. Since then he had been sleeping at work in another borough, until having to leave work due to sickness, although he had no proof of this. **He was turned down for housing on both occasions, both due to a lack of proof of homelessness, and an unclear local connection, although he was not given a formal decision letter in either case.**

On the third occasion he was escorted to Housing Options by an experienced Housing Advocacy worker, who argued his case. Both boroughs felt it was not their responsibility; however he was eventually housed in temporary accommodation in the initial borough as a result of the direct advocacy.

He has returned to hospital since, but now has a care package in place in the temporary accommodation, and his hospital attendances have stopped. There is no doubt that he needed appropriate housing to stop the revolving door. This simple case demonstrates the value of having experienced housing workers based in hospitals, but does suggest housing and health would benefit from working more collaboratively together pan London.

Case Studies – the case for respite care

LG – 29 year old female, IVDU, alcoholism, DVTs, sepsis, renal failure

LG was brought in under the mental capacity act. She had languished in a doorway refusing to access healthcare for over a week. She has a long history of chaotic behaviour, and being multiply excluded from accommodation. When she was eventually brought in she was septic, which led to a multitude of systemic problems including renal failure.

Keeping LG in hospital was a major challenge for the team, but was achieved by interventions like turning the TV on, buying an electronic cigarette, visiting her daily, and intervening to ensure adequate Methadone treatment and pain control. The team formed a good relationship with LG, and did not have many difficulties with her. LG would also engage with physical therapies when the homeless team were present. In general the ward found her relatively easy to manage with our support, although did have to ban her long term street partner from the ward.

However because LG ended up with reduced mobility, and high support needs (and was additionally refusing substance misuse rehabilitation), realistic discharge options were essentially absent for LG. Two case conferences were held, and various options were considered, but none were deemed appropriate, as independent living seemed too much of a jump. LG eventually self-discharged in a wheelchair. It is unclear how long she will live without health services support.

PC – 40 year old male, IVDU, alcoholism, spinal cord injury

PC was brought into hospital having sustained a spinal injury secondary to injecting in his spine. He was rendered tetraplegic, with full use of his dominant arm, but limited use of his other arm. PC also has a long history of chaotic behaviour, and also has a long term partner who visited every day. PC took himself off the ward every day for long periods in his last three weeks on the ward. PC finds the ward environment difficult, after a long history of hostel dwelling and street homelessness.

PC discharge was delayed by over 3 weeks from when he was medically fit, due to the challenges of finding a wheelchair accessible placement. However 2 months after admission he was discharged into a temporary accommodation placement with support. This failed quite quickly, and he was re-admitted, due to some of the specific challenges of independent living. He was brought back to hospital, but due to lack of engagement in hospital this is likely to be a revolving door.

Both these clients remained in hospital longer than was necessary for their medical needs, and would have benefited from an environment where they could undergo continuing physical rehabilitation, in a place that could cater for, and manage their particular bespoke needs. In the current situation they are likely to become very expensive, recurrent re-admitters.

These, and many other clients that we have looked after, would have benefited from medical respite, and would have used less acute bed space as a result.

Teaching / Booklet

Teaching

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

The current training session can last between 30 min and 1 hour 30 minutes, and covers homeless statistics, basic housing law, mental capacity and personality disorder. Training has initially been focused on the A&E staff, but the training will be part of an ongoing program that will be developed and rolled out to other areas.

From January - March 112 people were trained at GSTT, and 23 people were trained at Kings. 84 completed feedback forms were received (62%). The totals feedback scores were as follows. **71% thought the training was excellent or very good.**

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

Learning Points

The main recurring theme in the feedback was the need for written information / handouts (see below). There was also a suggestion regarding the use of more case studies, and less Powerpoint slides (this has already been acted on). Some people felt learning about housing law was not relevant to them, but others really valued this. On balance we think we will keep this in.

Other Education

Other educational activities have included teaching GP trainees, supporting students, and having senior members of the Department of Health shadowing the team. Further education is planned including regular GP trainee education, and presenting to 2nd year medical students at Kings College Medical School.

Booklet

The team has compiled a booklet with general advice, and a summary of community homeless health and support services across Lambeth, Southwark and Lewisham. This is in the final stages of production, and will shortly have a 500 print run. If successful / well evaluated, we will edit / maintain this as part of the ongoing team's work.

Partner Report – St Giles Trust

Overall thoughts

We were very pleased to be asked to be part of this important project, and feel that St. Giles Trust has an important role to play in its development. The partnership has worked tremendously well with all the different partners.

We feel that the Pathway team is a much needed service, building a very necessary bridge between Health and Housing. If the service were now to go, this would have an impact on the hospital - it is clear that many clients currently present to hospital with housing difficulties and social concerns that can be dealt with effectively by a service like ours. It is a really good to have a joint team with a mix of housing and healthcare professionals, in order to speed appropriate housing applications.

Southwark links

Due to Tyrone Paul's length of time working in the housing industry, and in particular his long history of working in Southwark for St. Giles, we feel that the pre-existing relationships and trust built with Southwark Housing Options staff has enabled many patients to get housed who might not otherwise have been. Other relationships developed in his work at St. Giles have also have impacted very positively on the work of the team. This has included relationships with e.g. addictions services like Evolve and CDP, and the SPOT team.

Tyrone has also been involved in developing new relationships, and in particular has identified and built a relationship with a particular housing benefit funded hostel into which clients can now move into at a days' notice. This has been a major asset for the team. Tyrone negotiated the Service Level Agreement for this new relationship.

Development

We feel there is a need for more education to hospital staff regarding housing and other entitlements, and we would very much like to be part of this.

We are currently exploring whether the Pathway structure could accommodate other specialisms such as gang work with young victims of violence, and this might be very relevant at Kings.

Partner Report - St. Mungos Broadway

St Mungos Broadway Hospital to Home project works in both Lambeth and Hammersmith and Fulham in partnership with Groundswell. In Lambeth, the project has been integrated into the KHP Pathway Homeless Team. St. Mungos Broadway has brought value to the wider project through a) our direct experience of delivering housing services, b) our wide knowledge base accrued through providing a range of homeless services nationally, and, c) our specific relationships with local partner agencies and commissioners. The Housing Support Workers working on the team have benefited from continued specialist training, support and supervision that the St. Mungos Broadway management team have provided. It is felt that this would be lacking if the housing workers were employed in-house. In addition the Pathway Homeless Team leader has benefited from management support in resolving issues with housing departments, and difficult housing cases.

The three staff that have worked on the Pathway Homeless Team have all come with experience of working on the highly successful No Second Night Out project. The intensive casework approach operated by NSNO is directly applicable to the hospital setting because it emphasises:

- Urgent comprehensive assessment
- Sustained ongoing contact for a brief period
- An assertive, single-offer approach (emphasising the risks of continued homelessness, and managing expectations)
- An assertive advocacy approach with Housing Options teams (supported by training such that workers have a comprehensive knowledge of and practical experience of applying, the Housing Act)
- The importance of liaison, networking and building links
- The role of safe, facilitated reconnection

Overall the partnership has worked extremely well. The Housing Support Workers have been able to capitalise on the direct links with health staff to enable them to get the health information they require to win complex housing cases. In particular the Pathway Homeless Team GP's clinical assessment of 'vulnerability' with reference to legal definitions, has allowed the workers to approach local authorities and secure temporary accommodation, where this might not have been otherwise achieved for clients. Anecdotally, where Housing Worker colleagues in other hospitals have not been fully integrated into a clinical, multi-disciplinary team, there has been lower likelihood of success; mainly due to amount of time needed to communicate with all the relevant hospital teams.

During the pilot period 58 referrals were received for 51 clients. All were homeless (or about to become homeless). 24 were rough sleepers (41%), and 19 (33%) were sofa surfers. Of those that had had their cases completed at the end of March (31 clients), only 3 (9%) had returned to rough sleeping, although a further 4 had abandoned. All the others (77%) were safely placed in some sort of accommodation, and 19 HPU presentations were done during this time. It is felt the St Mungos Broadway contribution to the project has been extremely successful overall.

Partner Report – the Passage

The Passage Hospital Discharge project has now been in operation for 5 months, and supports St. Mary's and the Chelsea and Westminster hospitals, as well as St. Thomas'. Our workers link in across the three hospitals, and are supported by a Coordinator who oversees their roles. Our workers are also part the experienced and dedicated housing and outreach services that are delivered from our Westminster day centres, and this allows us to provide ongoing follow-up support.

We are very fortunate that Angela Blair's role has been incorporated into the Kings Hospital Pathway Team. The expertise and advice of the medical professionals on the team, and the sharing of ideas and knowledge between the housing professionals has been invaluable.

Across the project, we have had referrals for 109 clients to date, with 65 clients referred during this quarter. In many cases a brief intervention is all that is necessary to ensure safe discharge, however in other cases it has been much more complex.

In terms of outcomes, 75% of those accepted onto the project have had a comprehensive needs assessment, and 75% have had multi-agency discharge plans. 8 people have been reconnected nationally during the quarter. Overall a key objective of the project is to prevent discharge to the street. We are very pleased to report that 68% of clients were discharged to accommodation.

Case Study

SB is a frequent attendee at St Thomas', and Chelsea and Westminster Hospitals. SB had 35 A&E attendances and 27 admissions at St. Thomas' during April 2013 – March 2014. SB is 27, and has sickle cell disease, but appears to use his disease to gain admissions to hospital when he is not ill, but just wants somewhere to sleep. Initially Angela referred him into Passage House for interim care following a St Thomas' admission. Unfortunately, SB did not engage with the agreed plans, didn't pay his service charge, and didn't attend interviews that were arranged for him for move-on accommodation.

Following this Jill (our worker at Chelsea and Westminster) did intensive work with SB to support him to access other accommodation. Jill arranged for a thorough neurocognitive assessment to be carried out to see if cognitive deficits were the root of the non-engagement, but this turned out not to be true.

A case conference was arranged at the beginning of April, and a considered plan was developed. The plan aims to give a consistent message regarding engaging with our service, and states clearly that SB should only be admitted if genuinely unwell. The plan has now been shared across multiple hospitals.

This case study demonstrates the need for joined up thinking, and the value of the involvement of a project like the Passage's. The Passage team now has a list of 39 frequent attenders, many of whom are attending cross site.

Partner Report - Groundswell

Groundswell is a charity which enables homeless and vulnerable people to take more control of their lives, have a greater influence on services, and play a fuller role in the community. Our volunteers all have personal experience of homelessness, and are central to our project delivery – as peer advocates, peer educators and peer researchers. Groundswell currently has eight full-time and nine part-time staff and a pool of 40 Peer Advocates – 22 new advocates were trained last year. All of our volunteers and half of our staff team have personal experience of homelessness.

We deliver a range of innovative projects which put homeless people at the heart of solutions to homelessness: focusing on client involvement, peer research and health – with our largest project being the Homeless Health Peer Advocacy service - HHPA. HHPA works to address the health inequalities faced by homeless people by improving their access to healthcare - primarily through volunteers accompanying people to their health appointments. The one-to-one peer support enables people to make and attend health appointments. In addition to providing practical support, such as travel fares, reminders and accompaniment to appointments, peer advocates also focus on building the skills, confidence and knowledge to enable clients to continue to independently access health services. Our Peer Advocates have an impressive success rate at getting people to appointments, with only 12% of appointments booked with us ending up as DNAs.

Training for Peer Advocates lasts 6 weeks. Trainees attend 3 days a week, and are assessed against our Competency framework. Training covers:

- | | | |
|--------------------------|---------------------------------------|---------------------------------------|
| • Advocacy | • Mental Health Awareness | • Client Involvement |
| • Homeless Health | • Drug and Alcohol treatment pathways | • Evaluation & Monitoring |
| • Safeguarding | • First Aid | • Motivational Interviewing |
| • Equality and Diversity | • Reflective Listening | • Understanding Conflict |
| • Boundaries | • End of Life Care | • NHS Complaints |
| • Client Involvement | | • Drug and Alcohol treatment pathways |

Hospital to Home: We are currently working within the KHP Pathway Homeless Team, as part of the Hospital to Home project in partnership with St. Mungos Broadway. On the KHP Pathway Homeless Team one of our workers attends the team handover every Friday in order to be able to identify clients to work with. This worker then puts in relationship building work with clients whilst they are in-patients. This process has been beneficial for everyone, and has delivered good results.

In 2013-2014 Groundswell delivered 174 engagements in Lambeth, and 291 in Westminster. In our future work with the KHP Pathway Homeless Team we will also be working in Southwark, and have been offered the chance to have our work with the team economically evaluated by McKinsey.

Service user feedback

Feedback forms

A simple feedback form was created in-house for use with clients seen by the team. All clients are given a feedback form on first contact about the service they have received, however for a variety of reasons these are often not collected on discharge. Clients were asked to score the service on a 1 to 5 scale where 1 was poor and 5 was excellent.

50 were received back during the quarter, representing 15.3% of the population seen. **The average score from these forms was 4.87 which was obviously very positive.**

Focus groups

Two focus groups were held Wednesday 12th March 2014. One was held at St. Giles regarding the Kings service, the other was held at the Passage regarding the GSTT service. Participants were sourced from clients known to the team who had previously done service user involvement groups, or from clients that had expressed an interest in being further contacted on their feedback forms.

The focus groups were run by Stan Burridge the Service user Research Lead from Pathway, with two team members also engaging in the debate and taking notes. Clients were given a £20 Sainsbury's voucher for their involvement, and travel expenses. 7 participants attended the GSTT group and 6 participants attended the Kings group.

GSTT Themes

Approach of staff

In general participants said the team's approach was good. *'...every time I saw her she bent over backwards for me'*

Practical support

Participants felt the provision of practical assistance e.g. TVs was very useful.

Skilled advocacy

The benefit of skilled advocacy at the Home Persons Unit was noted. *'Ryan was very great... he quoted legislation' 'I've tried the council many times, but I get really depressed when I go there'*.

Providing accommodation

Where participants had been accommodated this was seen very positively. *'They got me temporary accommodation, it was great'*. However participants generally felt the team should have more access to temporary housing, and more power over housing authorities *'houses, that's the bottom line'*

Links with the Voluntary Sector

Links with voluntary sector agencies were seen as a positive and something that should be further developed. *'I've got no complaint if people work with other people like Gemma, its good'*.

Treatment by other hospital staff

Some negative attitudes from other staff were described. *'Don't tar us all with the same brush because we live in Graham house'*. One participant felt he had been 'kicked out' of hospital, when it was found he was homeless.

Feedback on primary care access

One person had difficulty accessing a mainstream GP service, but homeless health services were generally well accessed. It was noted that dentist and optician access in Lambeth had reduced (this is true). One person suggested that hostel outreach services made people lazy.

Main learning points

Privacy for discussions

Several participants noted that the team should have a private place where they can carry out discussions with service users. One person told how his assessment was carried out in a waiting room where other people were sitting.

What else should the team be doing?

Participants suggested in a variety of ways that the team should be politically active (including having someone in parliament!). There were also suggestions that the team should be ensuring equity across the board *'just to make sure people like us get the same treatment as everybody else'*, and improving communication across the hospital. Benefits advice was mentioned as a specific service that should be being provided.

Kings Themes

Approach of staff

In general the feedback was very good *'I met 3 of the team, they really tried their best...I think they really had concern that I had a place to stay, and for this I was really grateful.'* *'The Pathway team started talking to me about solutions and I calmed down.'* However one client said that he felt the team had not believed that he had nowhere to stay, and that he had been upset by this. *'I felt pressured that the Pathway thought I had a place to stay'*

Practical support

Practical support was felt to be of high value in encouraging people to stay in hospital *'Pathways, they came up and bought me a TV card...if it weren't for Pathways and staying in Hospital, I probably would have been back to where we were sleeping anyway...so Pathways saved my life that night.'* One client felt that *'I found the Pathway team to be of very limited help'*, although in fact, this client did access accommodation post discharge.

Providing accommodation

The provision of accommodation was felt to be the most important thing that could be provided, and where this hadn't been provided there was disappointment *'At the end, I felt like I was just abandoned, if they cannot give you accommodation they shouldn't just leave you... there should be follow up afterwards for e.g. a voucher'*. In general participants felt the team should have greater access to housing *'The team should get more power and status over housing.'*

Links with the Voluntary Sector

Linking in with other organisations was felt to be vital, and three participants felt this was an area in which the Kings team could improve *'The team should be more linked in.'*

Immigration issues

Immigration issues were acknowledged to be an issue with the support that could be provided to some clients. *'If I was British or European Union there would have been a lot more things they could have done for me'*

Treatment by other hospital staff

One participant again felt he had been stigmatised by other staff *'I've got a phobia about doctors, because they always think you're just there for valiums and DF's'*

Main learning points

Linking in

There was a strong feeling that links with other organisations – particularly for clients with no recourse to public funds, and addictions clients – could be improved.

Follow-up

There was a strong feeling that clients felt that follow-up was valuable, and would be desirable for everyone. *'The Pathway team visiting me, that made me happy, one worker visited me in Rehab.'*

What else should the team be doing?

Intermediate care was suggested as one thing a team like this should be providing *'I would put the patient in a place where they can take their medication properly, we need good health, good medication and a good environment.'*

KEY ACTION POINTS

The key action points they will be taken away from these two focus groups will be:

- To attempt to ensure all assessments take place in a private location
- To improve links with outside organisations for clients with no recourse to public funds and addictions (significant work has already commenced since the groups e.g. building links with the London Destitution Network, which is a network of services supporting no recourse clients)
- To provide follow up if and when possible

Partner feedback

Partner feedback has generally been very positive, and some comments are presented below.

'The team has been doing a great job, and we would definitely not have been able to provide the type of support these clients require.'

Hannah Sanchez, GSTT Discharge Team Manager

'We have had recent experiences of very poor discharges from London hospitals without Pathway teams.'

Rosa Ungpakorn, Specialist Nurse, Westminster Homeless Health Team

'When in hospital clients are fearful, taken from their perceived comfort zone (even on streets), and are forced to interact with people. This is a key moment for clients to make big decisions and if they return to their comfort zone the moment can be lost. ...I have found this team to be an excellent addition that has started to fill what was a gaping hole in the NHS provision of care for homeless people, which is to break the expensive and needless cycle of readmissions... I hope that the funding continues and that this model can be spread to other parts of the NHS.'

Eammon Egerton, Southwark Street Population Outreach Team Manager

'The Team should stay commissioned as there is a very important role to identify and support vulnerable people who turn to hospitals as their primary caregiver. Negotiating and liaising with services in Borough and across other Boroughs helps to put together a fuller picture, and hopefully negotiate a more appropriate support for the person.'

Dagnija O' Connoll, Community Mental Health Nurse, Westminster Joint Homelessness Team

'Overall the team are brilliant. They always respond to messages and have changed the attitude of some of the nurses on the ward, as when you call they appear to be more empathetic for the homeless which is great'

Serina Aboim, Community Nurse Specialist, Three Boroughs Health Inclusion Team

'the team are easy to contact for referrals, and are happy to follow patients up in the Maudsley AAU... In the past, this has been a barrier. They are very happy to work jointly with patients, and have clarified the legal, housing status of clients'

Paul Du Buf and Justin Stapleton – Alcohol Liaison Workers, Kings

Challenges - *External*

No Recourse to Public Funds

A number of clients the team deals with are no recourse clients who do not meet the threshold for NRPF Social Services teams, but do have medical needs. Many are well known to the UK Border Agency, but they have no options for them. It is very challenging knowing what to do with these clients, as the options are extremely limited. The team has made links with the No Recourse to Public Funds network, the London Destitution Network, and the Southwark Law Centre, and many staff members have been on training.

GP registration

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

'Handing Over'

This challenge has largely affected our Housing Workers. When clients are discharged they often have outstanding issues ongoing around e.g. their benefits, obtaining ID, and evidencing their housing claims. In many cases there are no services to hand over to, and when there are, these services often have long waiting lists, or they are overstretched. As a result these clients stay on our caseload for extended periods. Although the team justifies this work as re-attendance and re-admission prevention, it is obviously unsustainable in the long term. The team will be seeking to build close partnerships with Floating Support services to militate against this.

Housing departments / Housing Law

Housing departments are extremely stretched, and housing stock is extremely limited in many London areas. Consequently there have been some difficulties in convincing some housing departments that our housing workers are extremely knowledgeable, and would only present with clients if they were convinced they were owed a duty. However the managers and staff of our voluntary sector partner agencies have worked hard to build bridges, and help departments, understand the team. Overall things are improving across the board.

Other key issues for the team have been where clients have had to prove homelessness, if they have previously been e.g. sub-letting or living at work.

Communication

Although the team has developed considerable links with other partner agencies, these are built on individual relationships. What is really required is formal network through which, for example, alerts or plans for frequent attending clients could be filtered effectively up to all relevant partners (like all the other central London A&Es). This issue was taken to the London Health Commission in May 2014, but the team is also leading a pan London project looking at ways to develop links.

Challenges - *Internal*

Kings Health Partners

There are many challenges associated with running a team across 2 Trusts, and this is soon to become 3 Trusts. These issues fall into 3 main categories:

Contracting – enabling staff (including Bank staff, secondees, and voluntary sector workers) to work across more than one Trust

Operational – an example of this is budget management. It is challenging, for example, to buy furniture for one Trust when the budget is held by another. Space is also an operational problem.

IT – enabling a cross KHP team to communicate contemporaneously with itself has so far proved impossible (see below).

EMIS

From the beginning the intention had been that the team use EMIS Web as its clinical system in line with the Health Inclusion Team. This is being done so that a) the team can share information with itself across the Trusts, b) the team can share information and build a pathway with the GSTT Health Inclusion Team, GP practices (including homeless practices like the Dr. Hickey Practice) other relevant teams e.g. Westminster Homeless Health Team, and, c) so that the existing coding templates developed on the Health Inclusion Team can be used to easily deliver high quality demographic and prevalence data on the population.

However this has proved extremely difficult to deliver mainly due to technical issues and capacity, and the team still does not currently have a 'go live' date. This is a key governance issue and has been escalated appropriately.

Maintaining Clinical Skills

The clinician roles on this team require a high level of sophisticated clinical knowledge, however the staff are not able to practice their practical clinical skills in the role. This could be resolved by allowing clinicians regular 'back-to-the-floor' time, employing part-time staff (who could then work in clinical roles elsewhere), or enabling regular rotation for staff with other services.

Avoiding burnout

This team really is the 'hard cases' team, and the potential for burnout cannot be under-estimated. Monthly clinical supervision with an external facilitator who is a Psychologist will commence in June 2014, but there definitely needs to be some system of ensuring ongoing regular 1:1 clinical supervision for staff on an ongoing basis after the end of July.

Project and Future Opportunities

The team has a number of key initiatives ongoing that are aiming to improve care for this client group:

Pan London Data Sharing

In partnership with the wider Pathway team, the team has brought together a number of interested parties from A&Es, homeless health care providers and partnership agencies pan London to discuss ways of sharing alerts and key information on vulnerable and complex, transient clients. A business plan is being put together which includes solutions that involve people and/or IT. The London Ambulance Service and Coordinate my Care are likely to be key partners. Various funding opportunities for a pilot are being investigated.

London Ambulance Service Hostels Project

In partnership with the London Ambulance Service, the Health Inclusion Team and Great Chapel Street Medical Centre, the team is targeting hostels with high levels of frequent attendance, to look at ways of assisting clients to use better routes into appropriate healthcare. This will include teaching at hostels, LAS protocols for addresses and individuals, case conferences, and outreach to specific individuals.

Integration with the Health Inclusion Team

The team already has a strong partnership with the Health Inclusion Team. However over the following year we will be looking to build on this by having clear processes in place for ensuring the Health Inclusion Team staff get discharge notifications and test results for all their clients. From the Health Inclusion Team we are looking to ensure that the team get alerted when any of the Health Inclusion Team clients come to hospital, and ensure that we know what the outstanding needs of these clients so that we can maximise the benefit of these admissions. Obviously the installation of EMIS will assist with this.

When the project extends out into SLAM we will also be looking to partner similarly with relevant SLAM community service providers.

Partnership with St. Mungos Broadway Hospital Discharge project

The team already has a strong partnership with St. Mungos Broadway (via the Housing Workers), but we will also now be looking to maximise the benefit of their Hospital Discharge project, and create seamless and efficient routes into their designated hospital discharge beds.

Groundswell economic evaluation

We have been offered the chance to have the Groundswell input to the team economically evaluated by McKinsey. We will be working very closely with McKinsey to achieve this.

Partnership with 'Resolving Chaos'

The Big Lottery awarded Resolving Chaos £10 million over 8 years to work with the most chaotic clients across Lambeth, Southwark and Lewisham. They will be aiming to work with the 20 most chaotic clients in each borough. We are helping them select clients for targeting, and sharing data, and hopefully we will be able to work in close partnership together.

Homeless Frequent Attenders 'Befriending' bid / 'No First Night Out' bid

It has been noted that many of our highest homeless frequent attenders are lonely, and need befriending support. In partnership with Lambeth Local Authority we are looking to put in a joint bid for a befriending pilot to the 2014-2015 Department of Communities and Local Government Help for Single Homeless fund. We may also consider bidding for 'No First Night Out' money from the same fund to do a pilot of homeless outreach into A&E waiting rooms.

Data

Over the next year we will looking to introduce two specific initiatives that should generate better care, but also allocate NHS costs appropriately.

1. We will be looking to ensure that the correct GP is recorded on a client's hospital records, when the client is registered. Team members have access to the NHS Spine. Where GP registrations are recent and active, but there is no GP recorded on the hospital records, we will be seeking to edit this on hospital records. This will ensure that discharge letters go to the correct GP, but will also ensure that A&E attendances and admissions are charged to the correct Borough. Currently e.g. 54% of A&E attendances are charged to Lambeth CCG, although only around 17% of clients come from Lambeth. (This is because if a client is NFA, and has no GP registered the charges will default to Lambeth).
2. We will also be looking to ensure that a client's past medical history is coded fully on the GSTT and Kings EPR systems. Having an accurate past medical history recorded is obviously better for the client, and makes prevalence data searchable. However it also ensures that admissions are coded appropriately according to their complexity.

Training

The team will continue its training agenda to ensure that staff who see homeless clients when the team is not there will be adequately equipped to manage these clients.

Conclusion

This report has outlined a positive story of a very successful pilot projects. There are some challenges ahead, but there are many more opportunities for future developments and successes.

In conclusion, we feel that this pilot has fully demonstrated the aims and values of the Kings Health Partnership, and has been a resounding success for the Pathway charity. We look forward to demonstrating more successes in the coming year!