



KING'S HEALTH PARTNERS

Pioneering better health for all

Pathway Needs Assessment
King's Health Partners

King's Health Partners and the Impact of Homelessness

With Proposed Responses

Authors

Nigel Hewett
Medical Director, Pathway

Sam Dorney-Smith
Joint Service Lead, Health Inclusion Team

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South London and Maudsley 
NHS Foundation Trust

Guy's and St Thomas' 
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NHS Foundation Trust

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Pathway was established as a charity in 2010. Our purpose is to transform health services and health outcomes for homeless people by working in and with the NHS. Pathway does this by developing and supporting new service models, setting standards for good quality healthcare, and giving voice to homeless people as patients. Pathway currently has specialist homeless health teams in four NHS hospital trusts and four new teams are due to launch this year. Pathway also hosts and supports the Faculty for Homeless and Inclusion Health.

For an electronic copy of this publication and for more information about Pathway visit our web site at www.pathway.org.uk

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Pathway
5th Floor East,
250 Euston Road
London, NW1 2PG

Charity number: 1138741

Contents

Foreword by Sir Robert Lechler, Executive Director, King's Health Partners

5	Executive Summary
9	Introduction
11	King's Health Partners Academic Health Sciences Centre
12	Guy's and St Thomas' NHS Foundation Trust
18	King's College Hospital NHS Foundation Trust
21	South London and Maudsley NHS Foundation Trust
24	Lambeth Borough/Community Consultation
26	Southwark Borough/Community Consultation
27	Westminster Borough/Community Consultation
28	Inner North West London Data
30	Homelessness Service User Perspective
32	Proposed Intervention
34	Cost benefit calculations for each Trust
35	References

Appendix 1 Methodology

Appendix 2 Costing Calculation Assumptions

Appendix 3 Questionnaire

Appendix 4 Summary: Medical Respite Centre Proposal

Foreword



We are delighted to be working with Pathway Charity in this exciting and innovative initiative to improve the health of our homeless population and thank Guy's and St Thomas' Charity and our commissioners for supporting these plans.

King's Health Partners includes one of the largest providers of unplanned secondary care to homeless patients in London and spans community physical and mental health services across several boroughs. Consequently our partnership faces considerable challenges in meeting the needs of this vulnerable population.

Despite these challenges, the structure and scale of our organisation also provides us with a unique opportunity: to make the most of our collaboration by co-ordinating care across our community and secondary networks; and improve the care we offer to homeless people, who we know have a higher rate of serious health problems and difficulty accessing healthcare.

Our staff are already working to improve health for homeless patients, by ensuring they have access to the appropriate care in other areas of our hospitals and in the community. Indeed a project involving A&E nurses in St Thomas' Hospital with colleagues from King's College and South London and Maudsley (SLaM) hospitals was shortlisted for an industry award earlier this year having halved the number of A&E attendances for this group of patients.

This initiative will build on this existing work and make sustainable changes to how care is delivered. Working with Pathway we plan to develop a single service to provide care coordination for homeless patients across King's Health Partners with one multi-agency, multi-professional team providing patient-centred, integrated care across physical and mental health providers, drug and alcohol services, hospital and community care - fulfilling an overarching goal of King's Health Partners, to bring together mental and physical healthcare.

There is strong evidence from a systematic review of randomised controlled trials that an individualised discharge plan for inpatients is more effective than routine discharge care. Re-admission to hospital is reduced by 15% for patients provided with individualised discharge planning. Our Pathway approach will introduce GP and nurse led care coordination for homeless patients in hospital, combining integrated care with discharge planning, and reducing length of stay by 30%.

Our care co-ordination teams working across Guy's and St Thomas' Hospital, King's College Hospital and SLaM have a long history of providing specialist care for homeless people. I believe that combined with Pathway's impressive track record of delivering results, together we will ensure that homeless patients are discharged back into the most appropriate housing and social support structures, reduce length of stay and re-admission, and associated costs. Most importantly, we will improve outcomes for these patients.

Professor Sir Robert Lechler
Executive Director, King's Health Partners

Executive Summary

National Context

- The annual cost of unscheduled care for homeless patients is eight times that of the housed population^[1] and homeless patients are overrepresented amongst frequent attenders in A&E.
- Despite this expenditure, the average age of death for homeless patients is just 47 years^[2] and they have a reduced quality of life caused by multi-morbidity.
- Prevalence of multi-morbidity increases with deprivation and has an onset 10-15 years earlier in deprived groups than in the most affluent groups.^[3]
- Homelessness is an independent risk factor for premature mortality^[4] and is associated with extremes of deprivation and multi-morbidity. The annual cost of health inequalities to the NHS is estimated by the Institute of Health Equity to be £5.5 billion.
- The Marmot Review states – “To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.”^[5]
- The vision of Public Health England expressed through the Outcomes Framework is “to improve the health of the poorest fastest.”
- The Health and Social Care Act 2012 imposes for the first time a statutory duty on all health care providers to “have regard to the need to reduce health inequalities” by means of the services which they provide. Commissioners are further required to reduce health inequalities in access, outcomes and by means of improved integration.

Challenges

- The combination of physical ill health with mental ill health and drug or alcohol misuse (tri-morbidity) is often central to the challenge of managing homeless patients in an acute hospital setting.^[6]
- Existing community services in health, housing and social care defend their budgets by rigidly restricting access to a defined “local” population – this renders care coordination particularly challenging for homeless people, who often have weak or no ties to any locality and lack documentary proof of any entitlements. Hospital teams lack the knowledge and networks to coordinate care effectively.

Local context - the size of the homelessness challenge to King's Health Partners

- Guy's and St Thomas' Hospital is one of the largest providers of unplanned secondary care to homeless patients in London. There are good links with the Three Boroughs Homelessness Team, and a regular meeting has just been set up to attempt to manage the challenge of the homeless frequent attenders. Data analysis for the calendar year 2011 (with homelessness defined as No Fixed Abode, a known hostel address, or registration with a specialist homeless GP practice) revealed that there were 4,923 A&E attendances by 2,234 patients. Admissions data revealed 1,379 admissions for 1,044 patients, total bed days 3,757 and average duration of stay 2.72 days. Total GSTT associated secondary care costs £5,623,810.
- King's College Hospital also has smaller numbers of homeless patients (annually 240 admissions of 214 patients and 862 bed days, with an average duration of 3.59 days stay), with A&E seeing 718 attendances annually, many more patients settled in local hostels, good links to the Three Boroughs Team and support from a full time social worker based in King's A&E. Total King's associated secondary care costs £947,089.
- SLAM has smaller numbers of homeless patients (148 admissions annually) but much greater cumulative bed days – 6,858 days annually with an average duration of 46 days stay. SLAM benefits from the particular skills of the Homeless Outreach Team (START), but this just provides assessment of current rough sleepers in the community. There is a focus of activity

around patients admitted to the Acute Admissions Unit (AAU) for short alcohol detoxification, with other patients evenly spread across the Maudsley, Lambeth and Lewisham hospital sites and a small number of patients at the Bethlem Hospital. The particular challenge is care coordination and discharge planning for patients who cannot be allocated to a Community Mental Health Team (CMHT) because they are homeless with no clear local connection. The total cost of SLAM homeless admissions is £2,670,553 annually. This is before consideration of the costs of private hospital beds which are required if all available NHS acute beds are blocked.

Grand total of King's Health Partners related annual secondary care costs for homeless patients = £9,241,452

[fig1] Comparison data from previous Pathway needs assessments

Hospital* (Total beds according to Dr Foster Health)	Number of homeless patients admitted during (year)	Total annual number of homeless admissions	Number (%) of patients admitted more than once	Total number (%) of homeless re-admissions	Number (%) of re-admissions occurring within 28 days
UCH (846)	488 (2010)	680	102 (21%)	294 (43%)	153 (52%)
RL (728)	650 (2010)	955	136 (21%)	295 (31%)	150 (51%)
BSUH (496)	237 (2010)	430	81 (34%)	274 (64%)	123 (45%)
RF (622)	218 (2010)	288	56 (26%)	92 (32%)	27 (29%)
GSTT (858+270)	1044 (2011)	1379	168 (16%)	503 (36%)	181 (36%)
KCH (830)	214 (2011)	240	13 (6%)	26 (11%)	14 (54%)

(* UCH = University College Hospital | RL = Royal London Hospital | BSUH = Brighton and Sussex University Hospital | RF = Royal Free Hospital, London | GSTT = Guy's and St Thomas's | KCH = King's College Hospital).

Since collecting this data University College Hospital, Royal London, Brighton and Sussex University Hospital and Royal Free Hospitals have all introduced Pathway care and coordination teams for their homeless patients.

Opportunities for King's Health Partners

- GP and nurse led Pathway care coordination for admitted homeless patients improves quality of care and is cost effective, reducing annual bed days by 30 %^[6]
- King's Health Partners (KHP) includes centres of excellence in the management of medical and surgical emergencies, community and inpatient mental health care and treatment for drug and alcohol dependency, with a liaison psychiatry team linking St Thomas' and King's.
- KHP particularly benefits from the specialist expertise of the START team, which provides community mental health services for rough sleepers in Lambeth and Southwark. The Three Boroughs Team also provides nurse led primary care and specialist intermediate care for rough sleepers and hostel dwellers in the same area. These two teams have a 20 year history of joint working.
- KHP is a single organisation with an overview of homeless health care encompassing both vertical integration between community and secondary care and horizontal integration between physical health care, mental health and drug and alcohol misuse.

What is lacking is a KHP Pathway service for homeless patients to enhance integration through care coordination between the many centres of excellent practice across KHP.

Recommendations for hospital based care coordination

- ***A single Pathway service to provide care coordination across King's Health Partners. The service will be multi-agency and multi-professional, working as a team to ensure patient-centred and integrated care coordination.***

- ***This Flagship service will clearly demonstrate that all members of KHP are addressing their new statutory duties concerning health inequalities. It will show the benefits of sharing expertise across KHP and model patient-centred care, bridging divides between physical health care, mental health care, clinical academic groups, drug and alcohol services, hospital and the community.***

- ***The team will include:***

 - Six Homeless Health Practitioners, consisting of two general nurses and four Mental Health Practitioners;
 - Ten GP sessions per week, provided by two GP's contracted for 52 weeks per year from a local practice or urgent care centre provider in collaboration with the Three Boroughs Team;
 - A full time social worker employed by KHP;
 - A full time housing specialist contracted from a third sector provider with local knowledge and support;
 - A half time, band 4 secretary for administrative support;
 - Specialist legal support from the King's in-house legal team as necessary.
- ***Shared medical records will be essential to link the team members. This is best provided by EMIS web – a mobile GP system which can be linked to the Three Boroughs Team records.***

- ***Every team member will require: an initial induction; training from Pathway Charity in the Pathway methodology; on-going access to networking meetings; training updates; and psychological support through facilitated reflective practice. Evaluation of the intervention's outcomes will also be essential.***

- ***Pathway Nurse Homeless Health Practitioners (HHP) anchor the service at each site and coordinate care around two weekly multi-agency meetings: Guy's and St Thomas' "Lambeth Axis", linked to the Lambeth Hospital in collaboration with Lambeth housing and social care; and King's and Maudsley hospital's "Southwark Axis", in collaboration with Southwark housing and social care.***

- ***Lambeth Axis Pathway Nurse Homeless Health Practitioners will include one band 8a clinical lead, and one band 7 nurse based with the Guy's and St Thomas' discharge liaison team, providing care coordination support to A&E and Emergency Medical Unit (EMU) and for homeless admitted patients on any ward. In addition two band 7 Mental Health Practitioners (ideally including mental health trained occupational therapist and dual diagnosis worker) would be employed. Both would work between the Guy's and St Thomas' team and the Lambeth Hospital. At the Lambeth Hospital, the Pathway***

Team will work in close coordination with the Lambeth Hospital Social Work Team, targeting homeless patients that do not come under the remit of the Lambeth team and providing support to homeless patients at Lewisham hospital.

- *Southwark Axis nurse Homeless Health Practitioners will be two band 7 Mental Health Practitioners (ideally including mental health trained occupational therapist and dual diagnosis worker). They will be based with the King's Discharge Liaison Team, providing care coordination mainly for homeless patients at the Maudsley site and facilitating multiagency working for complex homeless patients at the King's site. When necessary, advice and support can also be given for homeless patients at the Bethlem Hospital.*

- *The total cost of a KHP wide Pathway service is estimated to be £675,480. This represents 7% of the current expenditure on homeless patients across KHP.*

- *Peer support from Care Navigators is a key component of the Pathway approach, but this component can attract external funding and is best introduced once hospital teams are established.*

- *It is noted that the existing King's A&E based social worker will be a key contributor and link person for the King's component of the scheme. It is recommended that provision of an equivalent post in Guy's and St Thomas' A&E, while not a part of the Pathway service, would be a significant support.*

Recommendations for Medical Respite – enhanced community care

- *Additional savings and improved care could be realised by providing a KHP medical respite unit in the community. Step-down convalescent care has the potential to further reduce duration of stay and re-admissions, in addition to the benefits of care coordination in hospital. A detailed specification has been drawn up by Pathway, and a potential site identified in Lambeth. The Three Boroughs Team has experience of providing such a service and has published data on cost benefit.^[7]*

- *Medical Respite is briefly described and financially modelled in Appendix 4 of this report. There is considerable enthusiasm for the concept in the hospitals and the community. However, a Pathway KHP hospital team is the first and necessary step; Medical Respite would then provide additional benefit and would require separate funding. A more detailed paper on this theme is available on request.*

Introduction

Emergency admissions in England

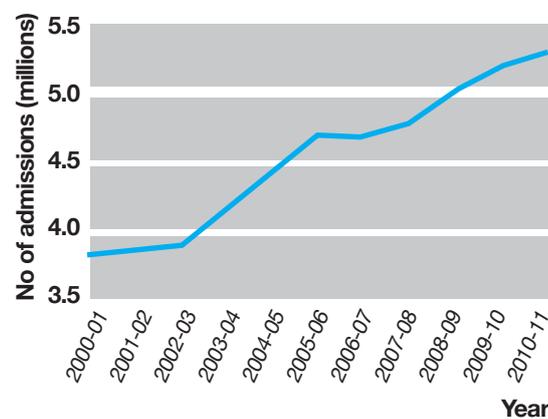
A recent King's Fund paper^[10] summarises the research evidence about avoiding hospital admissions. Emergency admissions represent around 65% of hospital bed days in England and this figure has been rising steadily for many years. Avoiding emergency hospital admissions is a major concern for the NHS, not only because of the high and rising unit costs of emergency admission compared with other forms of care, but also because of the disruption it causes to elective health care.

People from lower socio-economic groups are at higher risk of avoidable emergency admissions. In the UK, admission rates are significantly correlated with measures of social deprivation. Socio-demographic variables explain around 45% of the variation in emergency admissions between GP practices, with deprivation more strongly linked to emergency than to elective admission. Practices serving the most deprived populations have emergency admission rates that are around 60–90% higher than those serving the least deprived populations. Higher levels of morbidity in a population are associated with higher levels of emergency admission. Admission rates are also correlated with chronic illness. Higher levels of recorded morbidity and chronic disease in patients registered with GP practices have also been shown to be associated with higher rates of emergency admission from those practices.

Department of Health research has shown that homeless patients are admitted to hospital four times as often as the housed population, stay three times as long (because of more serious and complex conditions) and cost eight times as much each year.^[1]

[fig2] Emergency admissions to NHS hospitals in England, 2000-11.

Roland M, Abel G BMJ 2012; 345:bmj.e6017



Rough sleeping has risen steadily since 2008. In London 2011/12, 5,678 people were seen sleeping rough, an increase of 43 % on the previous year.^[8] Nearly half of these were contacted in Westminster. Across England 50,000 households were accepted as homeless, an increase of 14% on the previous year.

Emergency admissions are expensive and disruptive.

A major driver of emergency admissions is social deprivation.

Homeless people represent the extremes of poverty and social deprivation in England.

National Policy Context

The 2012 Health and Social Care Act introduces new duties for the Secretary of State for Health, "In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service" (Section 1C of the NHS Act 2006, as amended by the 2012 Act). The phrase "health service" incorporates both the NHS and public health. This duty will also impact on the Department of Health in terms of its role to establish NHS and public health systems, the National Commissioning Board (NCB), Foundation Trusts and Clinical Commissioning Groups (CCGs).

The NCB and CCGs will have a particular duty to reduce inequalities with respect to access to services, outcomes and integration of service delivery.

The first and key measure of the NHS outcomes framework is "Preventing people from dying prematurely". Recent research by Crisis^[2] shows that the average age of death for homeless people is just 47 years.

The Public Health Outcomes Framework provides additional context:

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

Outcome 1: Increased healthy life expectancy, taking account of the health quality as well as the length of life.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities, through greater improvements in more disadvantaged communities.

The National Inclusion Health Board (NIHB) has been set up to hold the DH to account in meeting its health inequalities duties. In 2012, the NIHB commissioned Homeless Link and St Mungos to provide guidance on hospital discharge for homeless people.^[9] This guidance highlighted the Pathway approach as an exemplar of integrated and cost effective care.

Pathway and evidence based responses to homelessness in secondary care

Integrating primary and secondary care can be effective in reducing admissions. There is strong evidence from a systematic review of randomised controlled trials that an individualised discharge plan for a hospital inpatient is more effective than routine discharge care that was not tailored to the individual. Re-admissions to hospital were significantly reduced by around 15% for patients allocated to structured individualised discharge planning.^[10]

The Pathway approach introduces GP and nurse led care coordination for homeless patients admitted as an emergency, thus combining integrated care with discharge planning. This approach is primarily intended to improve the quality of care, but it has the additional beneficial effect of reducing bed days associated with admissions of homeless patients by 30%.^[6]

Pathway is a registered charity which trains and supports clinical teams in secondary care. Teams are now active in University College Hospital, Royal London, Royal Free, and Brighton and Sussex University Hospital. More information is available at www.pathway.org.uk

King's Health Partners

An Academic Health Sciences Centre (AHSC) is an organisation which delivers healthcare to patients and undertakes health-related science and research. It usually has a well developed role in teaching and education as well. This type of organisation is fairly common among the leading hospitals and universities around the world.

King's Health Partners is one of England's five AHSCs, bringing together a world-leading research-led university – King's College London – and three successful NHS Foundation Trusts: Guy's and St Thomas', King's College Hospital, and South London and Maudsley.

Their aim is to create a centre where world-class research, teaching and clinical practice are brought together for the benefit of patients. They want to make sure that the lessons from research are used more swiftly, effectively and systematically to improve healthcare services for people with physical and mental health problems. This is about providing a world-class service.

At the same time as competing on the international stage, their focus remains on providing local people with the very best that the NHS has to offer. King's Health Partners brings real and lasting benefits to the communities of south London. Local people would continue to benefit from access to world-leading healthcare experts and clinical services which are underpinned by the latest research knowledge.

Guy's and St Thomas' NHS Foundation Trust

Dedication to provide high quality, personal care for all their patients is at the heart of everything that Guy's and St Thomas' does. They provide a full range of services for local residents as well as specialist services for patients from further afield. Their care takes place in two of London's best known teaching hospitals, Guy's Hospital and St Thomas' Hospital, where the Evelina Children's Hospital is also located. They also provide community care in health centres for residents of Lambeth and Southwark, and are part of the King's Health Partners (one of only five Academic Health Sciences Centres in the UK). As such, they are pioneers in health research, and provide high quality teaching and education.

“This should be the number one focus for health care for London – addressing homelessness and alcohol dependency would be a major contribution to health care, because of huge expenditure and poor outcomes.”

Dr Richard Leach Clinical Director Acute Medicine Guy's and St Thomas'

Guy's and St Thomas' Homelessness Statistics

Definitions used to identify a group of homeless patients from existing hospital records for the calendar year 2011 are shown in Appendix 1, and data sources for cost calculations are shown in Appendix 2. We are grateful for the support of Guy's and St Thomas' staff in providing data for this study. Analysis of A&E attendances was carried out with the assistance of Rachel Smith, Senior Staff Nurse in A&E, who performs a 'Homeless Link Nurse' role for the department. A&E and admissions data were collated with the assistance of David Grant, Data Analyst, Health Informatics GSTT.

Guy's and St Thomas' is the largest provider of unplanned secondary care to homeless patients in London

Accident & Emergency Data

Data analysis for the calendar year 2011 revealed 4,923 A&E attendances by 2,234 homeless patients.

Local Authority data for A&E attendances during 2011

Homeless patients were identified by No Fixed Abode (NFA) in the address field, by known hostel addresses from the local Boroughs, or by registration with a specialist homeless GP in those boroughs. Westminster is the only local borough which fully registers patients with specialist homeless practices – other areas provide enhanced access to mainstream practices with nursing support, so this method cannot be used as a marker for homelessness as the practices also register non-homeless patients. This method can only provide an underestimate of the actual numbers of homeless people attending A&E as it does not include those who use an old or “care of” address or hostel dwellers from other boroughs.

[fig3] Local Authority data for A&E attendances during 2011

Hostel Postcode Local Authority	Number of patients seen	Total number of attendances	Patients seen only once	Patients re-attending within 7 days
NO FIXED ABODE	1626	3308 (67%)	1004	1158 (35%)
WESTMINSTER:				
Hostel	197	552	102	206
Homeless GP	121	305	57	91
S/TOTAL	318	857 (17%)	159	297 (35%)
SOUTHWARK	237	401 (8%)	86	130 (32%)
LAMBETH	122	345 (7%)	53	102 (35%)
LEWISHAM	4	12	2	5 (42%)
TOTAL	2234	4923 (100%)	1304	1692 (34%)

For those homeless patients attending A&E, the largest category is No Fixed Abode (NFA) accounting for 67% of those attending. The next largest category is patients with a hostel address or homeless GP registration in Westminster (17%). This group exceeds the combined numbers from Southwark, Lambeth and Lewisham.

It is, of course, very likely that many of the NFA patients are also sleeping rough in Westminster, since Westminster has the greatest number of rough sleepers in London. 34% of all the homeless A&E attendances were re-attendances within seven days, which adversely affect performance targets.

PCT Data for homeless patients attending A&E during 2011

There is a significant difference between data on the area a homeless patient has come from, and the PCT that receives the bill for that care. Payment for secondary care depends on where the patient is registered with a GP, or if unidentifiable, the patient's address. If the patient has neither a GP nor an address and is considered to be No Fixed Abode, then they are given the postcode ZZ99 3VZ and the costs default to the host PCT – in this case Lambeth. If no information is recorded at all then postcode ZZ99 is used, and the costs for these patients are absorbed by the Trust. So although only 7% of the homeless patients were residents in Lambeth, 39% of the patients were billed to Lambeth by default.

[fig4] PCT Data for homeless patients attending A&E during 2011

PCT Billed for all homeless A&E attendances	Number	Percentage of all homeless A&E costs
Lambeth	1921	39%
Westminster	996	20%
Southwark	490	10%
Lewisham	52	1%
Other Inner London	202	4%
Other Greater London	138	3%
Other England	174	3.5%
Trust Absorbed	950	19.5%
Total	4923	100%

Cost calculations (see Appendix 2):
 $4,923 \times \pounds 108 = \pounds 531,684$, LAS calls $4923 \times 0.5 \times \pounds 225 = \pounds 553,837$

Total annual GSTT homelessness related A&E costs for 2011, including ambulance costs = £1,085,521

Outcomes for homeless patients attending A&E

Further analysis of a sample of NFA patients attending A&E found that 43.3% were discharged "home", 25.6% were admitted, and 17.9% left the department without completing treatment.

Of those discharged for GP follow up, 72% had no GP recorded, or had a GP registered outside of London. Of those given outpatient appointments 70% did not attend, and of those given fracture clinic appointments only 43% attended their initial appointment, with only half again attending follow-up.

[fig5] Condition data

Presenting Complaint*	Hostel%	NFA%
Drunk, OD/poisoning	18.5%	26.6%
Limb Problem	16.5%	16.6%
Mental Health	7.3%	5.9%
Abdominal Pain	5.5%	
Falls	4.5%	2.7%
Fits	4.0%	6.5%
Collapse	4.1%	5.4%
Assault	3.9%	4.8%
Head Injury	3.7%	3.2%
SOB	3.5%	
Wounds	3.5%	1.7%
Chest Pain	2.4%	
Abdo pain/chest pain/SOB	10.4%	8.1%

*Condition data ('unwell' was the top condition, but these patients have been removed)

Cost calculations (see Appendix 2):

$4,923 \times £108 = £531,684$, LAS calls $4923 \times 0.5 \times £225 = £553,837$

Admissions data

Admissions data for the calendar year 2011 revealed there had been 1,379 admissions for 1,044 homeless patients, and a total of 3,757 bed days with average duration of 2.72 days stay. This is the highest level of homeless activity so far found in any London hospital using the same Pathway needs assessment methodology, and mirrors the proportions found by a separate data collection from Inner North West London (INWL) PCT Cluster, reported elsewhere in this report.

Local Authority data for homeless patient admissions during 2011

Likely local authority of origin is derived from known hostel addresses or specialist GP registration.

[fig6] Local Authority data for A&E attendances during 2011

Hostel Postcode Local Authority	Patients Admitted	Episodes of admission (% of total)	Admitted only once	Re-admission within 28 days
NO FIXED ABODE (NFA)	748	901 (65%)	664	88
WESTMINSTER:				
Hostel	108	177	81	38
Homeless GP	53	89	34	22
S/TOTAL	161	266 (19%)	115	60
SOUTHWARK	68	92 (7%)	53	10
LAMBETH	66	118 (9%)	44	22
LEWISHAM	1	2	0	1
TOTAL	1044	1379	878	181

Similar proportions are shown for these admitted patients, as was found for those attending A&E. The largest group is NFA with 65% of admissions, then Westminster with 19%; more than Southwark, Lambeth and Lewisham combined. It is likely that many of the NFA patients admitted are sleeping rough in the Westminster area.

PCT Data for homeless patient admissions during 2011

At the time of gathering this data, Primary Care Trusts (PCTs) commissioned and paid for secondary care. From April 2013, this is the responsibility of Clinical Commissioning Groups (CCGs).

As discussed for A&E data, which PCT pays for secondary care depends on where the patient is registered with a GP. If a registered GP cannot be identified then it will depend on the patient's address. If the patient has neither GP nor address and the patient is considered to be No Fixed Abode, then they are given the postcode ZZ99 3VZ and the costs default to the host PCT – in this case Lambeth. If no information is recorded at all then postcode ZZ99 is used, and the costs for these patients are absorbed by the Trust.

Analysis of PCTs actually billed for homeless admissions provides the following breakdown:

[fig7] PCT Data for homeless patients admissions during 2011

PCT Billed for homeless admissions	Number	Percentage of all admission costs
Lambeth	785	57%
Westminster	216	17%
Southwark	103	-
Lewisham	9	1%
Other Inner London	57	4%
Other Greater London	42	3%
Other England	76	5%
Trust Absorbed	91	7%
Total	1379	100%

So although only 9% of the homeless patients admitted had an address or GP in Lambeth, Lambeth PCT paid for 57% of the homeless admissions because they absorb the NFA costs. Cost calculations (see appendix 2): admissions 1,379 x £3291 = £4,538,289. PCT Data for homeless patients attending A&E during 2011

Total annual GSTT associated secondary care costs, A&E and admissions = £5,623,810

Staff members / groups consulted within Guy's & St Thomas' Hospital

Sir Ron Kerr, CEO

Kwasi Ansah, Former homeless patient coordinator at St Thomas'

Ian Abbs, Medical Director

Amanda Williams, Manager, Community Early Interventions and Specialist Teams

Sam Dorney-Smith, Three Boroughs Team

Beth Christian, Consultant in Emergency Medicine

Discharge Coordination Team: Jane Chester, Manager; Kit; Emma; Lisa; and Julie. Katherine Henderson, Consultant in Emergency Medicine

Victor Cooke, Consultant in Emergency Medicine

Laura Hunter, Consultant in Emergency Medicine

Dylan Jenkins, Transformation Consultant St Thomas'

Andrew Hodgkiss and Sean Cross, Liaison Psychiatry

Rachel Smith, A&E Homelessness Link Nurse

Heidi Jensen, Head of Nursing; and colleagues Darlene Romero, Susan Wood, Sarah Murray and Lee Patient (at Matrons meeting)

Richard Leach, Clinical Director Acute Medicine

Elizabeth McAndrew, General Manager, Acute Medicine

Shantelle Quashie, PCT funded Alcohol Worker (A&E and in-patients)

Morning Ward Round, EMU Team

Victoria Hastings, Service Manager

Rebecca Schiff, Consultant in Elderly Medicine

Perspective from Guy's and St Thomas' Staff

There is an almost universal recognition of the major impact homeless patients have on Guy's and St Thomas', accompanied by a great enthusiasm to embrace proposals that improve care coordination for this patient group.

The Accident and Emergency Department is planning many changes, including a re-build, but this provides opportunities to ensure that dedicated homeless service provision is built into new ways of working. There is an opportunity for joint working across London, to address a common and rotating population of frequent attenders, many of whom are homeless. Some of these patients are not being well served by "overmedicalising" their problems, with frequent investigations and exposure to iatrogenic risk, which would be better addressed away from A&E. The emergency medical unit has a particularly brisk turn around, which requires a prompt, on-site response for homeless patients. There is an impression of three distinct groups of homeless patients using A&E: rough sleepers or NFA registering for treatment; temporarily housed patients from hostels registering for treatment; and un-registered homeless people, using the waiting room for shelter. A bi-monthly, A&E frequent-attenders meeting has recently been set up with representatives from Westminster, Lambeth and Southwark. There is clear recognition of a need for daily liaison with community services and for a commitment to work together.

Discharge team nurses have particular areas of responsibility: A&E and EMU, elderly care, stroke and neuro, medical, palliative, orthopaedic, and oncology. A three year pilot of a housing worker employed by Lambeth Borough to work with the discharge team has recently ended. He saw about 250 patients a year including chaotic hostel dwellers and rough sleepers from all areas. There is an impression that homeless patients are staying longer since this post was

discontinued, and an acknowledgement that a lot of useful contacts and knowledge has gone with the post holder.

Liaison psychiatry bridges Guy's and St Thomas' and King's, providing about 2,500 assessments and arranging 400 admissions each year, of which around 17% are homeless. There is probably a lower threshold for psychiatric admissions of homeless patients because there is no home treatment or community mental health team option. Guy's and St Thomas' is particularly challenged by patients coming from a wide range of areas (unlike King's which deals with a more local Lambeth/Southwark population) and those presenting with end stage alcoholic liver disease.

Homelessness and alcohol dependency should be the number one focus for health care in London; there is huge expenditure with poor outcomes, and it is estimated that homeless/alcohol dependent/complex patients represent about 20% of unscheduled admissions. Brief interventions are undoubtedly worthwhile, but the elephant in the room is seriously dependent drinkers.

Recommendations for Guy's and St Thomas'

- ***A Pathway service that can link A&E, EMU and the inpatient wards could provide multi-agency care coordination with a Lambeth focus.***
-

King's College Hospital NHS Foundation Trust

King's is one of the country's leading NHS Foundation Trusts. They are a provider of local services, a centre for specialist care and a world-class teaching hospital. They are one of four partners in the Academic Health Sciences Centre, King's Health Partners that collaborates to produce world-class research, driving their vision to become the best medical research campus in Europe.

King's Statistics

Definitions used to identify a group of homeless patients from existing hospital records are shown in Appendix 1, and data sources for cost calculations are shown in Appendix 2. We are grateful for the support of King's staff in providing data for this study. Analysis of A&E attendances was carried out with the assistance of Gulgun Daldeniya, Data Analyst, Business Information Trauma. Emergency and Acute Medicine and admission data were collated by Arlene Sibanda, Senior Information Analyst, Business Intelligence.

Accident and Emergency Data

For the calendar year 2011 there were 718 attendances of 435 patients at King's A&E. A total of 306 patients attended only once during the year, and only 37 (5%) patients returned within seven days of the first attendance.

PCT Data for homeless A&E attendances:

Southwark 46%

No PCT identified 32%

Lambeth 19%

Lewisham 3%

Cost calculation: A&E $718 \times \pounds 108 = \pounds 77,544$, LAS $718 \times 0.5 \times \pounds 225 = \pounds 80,775$

Total annual cost for homeless patients attending A&E = $\pounds 158,319$

Admissions Data

During 2011 there were 240 admissions of 214 patients, occupying 862 bed days (average duration 3.59 days).

PCT data on these 240 admissions:

133 (55%) Southwark

30 (13%) Lambeth

20 (8%) overseas visitors

17 (7%) other London

16 (7%) elsewhere UK

15 (6%) Westminster

9 (4%) Lewisham

Cost calculation for admissions (see appendix 2) $240 \times \pounds 3,291 = \pounds 789,840$

Total King's associated secondary care costs (A&E plus admissions) = $\pounds 948,159$

Staff members / groups consulted within King's College Hospital

Tim Smart, CEO

Mike Marrinan, Medical Director

Sue Bowler, Divisional Manager Trauma, Emergency and Acute Medicine

Karl Mason, Senior Social Worker, Accident and Emergency Department

King's consultant meeting: Oscar Gibbs, Srivastava Vivek, Cheeroth Salim, Saxena Akash, and Zohra Khattak

Acute Medicine Consultants; Vanessa Sweeney, Head of Nursing for Acute Medicine

King's Discharge Team: Rose O Keefe, Gerry Maycock, Jane Mitchel-Reilly, and Diane Nelson

Meredith Jacobs, Head of Legal Services

Perspective from King's Staff

The view of King's staff is that there is not a great demand or need for a full Homeless Ward Round Team for King's; the issue is not as pressing as that facing other hospitals and generally homeless patients are appropriately managed. The reasons given for this state of affairs are covered by three categories: community factors, previous services/innovations; and hospital factors, which are discussed further below. However, it is important to note that housing and social care providers in Lambeth and Southwark did feel that there was scope for improving the coordination of care.

Community factors

Southwark has only one homeless drop in centre (compared to three in Lambeth). St Gile's closed its Camberwell drop in centre in 2005 and this seems to have contributed to a reduction in street activity. This is part of a political drive - "no new services in Camberwell". Street activity generally seems to cluster in the north of the borough where there is less social housing and greater proximity to central London homeless clusters. There is of course a debate about whether such changes in local services can reduce homelessness overall, or merely displace it to other areas.

Previous services/innovations

Between 2002 and 2004 there was a St Gile's employed housing worker in A&E, funded by the King's Fund. During the second year the service expanded to cover admitted patients. A total of 135 patients were seen over the two years, with referrals not exceeding 2-3 per week. The general view was that staff teams learned a lot from this service, which contributed to improved patient care but was not considered necessary for continuation beyond the pilot period. Certainly the numbers of patients seen were considerably fewer than those usually referred to Pathway teams in hospitals of a similar size.

Hospital factors

There is a Redthread service in A&E and trauma wards working with gang members and young victims of violence.

This innovative service brings youth workers alongside hospital staff to exploit the "teachable moment", find a safe route out of trouble, and may dissuade some young people from paths to homelessness.

Full time social worker in A&E

This unusual and innovative service is a hospital funded post, so is able to address practical issues of concern to any patient attending A&E. In contrast, most hospital based social work teams are funded by the local borough, so are only able to see patients who are clearly "ordinarily resident" in that borough and who have care needs sufficient to require social services

intervention. Consequently, hospital social work teams generally do not get involved in issues of benefits, housing or any situation where there is not a statutory duty to intervene.

Onsite, hospital employed legal team

Again, this is not a service which is routinely available in Acute Trusts as legal advice is commonly purchased, when needed, from local solicitors. This hospital team is perceived to be easily accessible, ready to get involved and can also advise in disputes over which health, social care or housing department should take responsibility for a patient.

Discharge team

Generally, discharge team referrals are made early in admissions by a variety of staff (physios, Occupational Therapists, doctors etc – not just nurses). The discharge team have a very close relationship with the overseas team; there is proper case management/ownership with daily board review meetings, i.e. in house delays have clear focus, clear estimated discharge dates to work to, and a centralised team which shares expertise.

Despite all this good work, some potential areas for improvement were recognised. Generally relationships with local housing departments were not ideal. About 3-4 patients were discharged to Housing Options per week, often these would have a local connection but the “priority need” may be tenuous. It may be that some patients are concealing their homeless status because there is no specific service offered.

Recommendations for King's College Hospital

- ***King's has a number of strengths which could support a KHP Pathway service for homeless people; specifically the expertise of the discharge team, in house legal team and an A&E social worker.***

- ***Within King's there is potential for improving the quality of information provided to support patients discharged to housing options, and the discharge team may wish to call upon a specialist team for support with specific, complex and unusual cases.***

- ***A Southwark focused Pathway team could bridge and share expertise between King's and Maudsley Hospitals to improve care planning and collaboration with community services.***

South London and Maudsley NHS Foundation Trust (SLAM)

SLAM provide the widest range of NHS mental health services in the UK. They also provide substance misuse services for people who are addicted to drugs and/or alcohol. They work closely with the Institute of Psychiatry, King's College London, and are part of King's Health Partners Academic Health Sciences Centre.

SLAM has 4,800 staff and serves a local population of 1.1 million people. They have over 100 sites and provide support to around 39,000 people in the community. There are currently 68 inpatient wards across four main hospital sites, providing inpatient care for over 5,000 people each year.

SLAM Statistics

In 2011, there were 148 admissions of 114 homeless patients, resulting in 6,858 admitted days and up to six admissions per patient in the year. A total of 53 admissions (about 36%) were under a section of the Mental Health Act. The average duration of stay was 46.3 days.

PCT attribution for these admissions:

Lambeth 45 (30%)

Lewisham 30 (20%)

Southwark 23 (15%)

Croydon 15 (10%)

Other England 15 (10%)

Unknown and no GP 8 (6%) (host PCT of admitting ward –Southwark 4, Bromley 1, Lambeth 3)

Other Greater London 7 (5%)

Overseas visitors 5 (4%)

Homeless patients admissions grouped by the hospital from which they were discharged:

Maudsley 53 (36%) (of which 15 were AAU admissions for alcohol detoxification)

Lambeth Hospital 38 (26%)

Lewisham Hospital 30 (20%)

Bethlem Hospital 18 (12%)

Oak adolescent unit 5 (3%) (2 patients)

Ruskin Unit (Guy's site) 4 (3%)

A conservative estimate of the costs of these admissions can be obtained by multiplying the number of admitted bed days (6,858) by the average mental Health Care Resource Group (HRG) excess bed day payment (£326) and applying the Market Forces Factor (MFF) for SLAM (1.1945), resulting in a cost of £2,670,553 annually. This is before consideration of the costs of private hospital beds, which are required if all available NHS acute beds are blocked.

Interesting triangulation of our data is provided by a recent paper published by Tulloch et al^[11] looking at length of stay for all SLAM admissions during 2008 and 2009. This identified 16% of admissions as associated with homelessness and 15% with residential mobility. Length of stay was 99% longer for those showing residential

mobility and 45% longer for homelessness. Interestingly, homelessness and residential mobility were greater predictors of length of stay than the admitting diagnosis.

Staff members / groups Consulted within SLAM

Gus Heafield, Acting CEO

Martin Baggaley, Executive Medical Director and Head of Clinical Governance, SLAM

Zoe Read, Executive Director, Strategy and Business Development

Emily Finch, Clinical Director, Addictions CAG

Acute Assessment Unit Maudsley: Julie Winnington, Prof Colin Drummond, Jenny Bearn, Grace Makoni, Robert Hill and Tessa Garwood

Hugh Jones, Consultant Psychiatrist, Maudsley

START Team: Jane Williamson, Clinical Service Lead; Phil Timms, Consultant; Paul Emerson

Emma Williamson, psychologist employed by START for psychologically informed environment project at St Lukes Hostel

Alison Beck, Head of Psychology, SLAM Trust

Kathy Taylor, Consultant Clinical Psychologist, SLAM

Lambeth Hospital discharge meeting: Maria Nery, Luther King Ward Sister; Polly Ragoobar, Nelson Ward Sister; Fay O'Connell, Lambeth Discharge Coordinator;

Desron Baptiste, Early Onset Discharge Coordinator; Edith Kafor, Social Worker, Triage ward; Sandra McCook, Social Worker; Rita Degraft, Tony Hillis Ward Sister

Lambeth Triage Team: Lee Smith, SW practitioner manager; Ruth Tilley, SW; Sandra McCook, Community Care Officer

Maudsley bed management meeting: Jane Williamson, Ann Witham, Hugh Jones, Mike Egan, Paddy Quinn

Natalie Warman, Assistant Director of Nursing, SLAM

Hilary Williams, Lead Occupational Therapist, SLAM

David Blazey, Grants Project Manager, Maudsley Charity

Perspective from SLAM staff

SLAM becoming part of KHP resulted in Clinical Academic Groups (CAGs). However, this resulted in a need to concentrate on diagnostic groups rather than geographical areas, which has not made engagement any easier for patients with a mixture of psychotic episodes, personality issues and drug and alcohol misuse. Another significant, recent change is the reduction of the START Homeless Outreach Team. Now, the team only provides engagement and assessment for homeless patients with severe mental illness with a view to referring on to mainstream services, so cannot provide care coordination or take on the role of a Community Mental Health Team (CMHT).

At the Maudsley site, 5-10 patients out of 75 inpatients are homeless at any one time. Spread across the wards, on average this equates to 2-3 per ward. If the patient is not connected to Southwark, it is more problematic to coordinate discharge. Bed blocking can be a problem, and there are plans to introduce a triage ward in 2013. Whilst concern was expressed about discharging homeless patients, there is no systematic approach to tackle this. Concerns were both that some homeless patients were too briskly discharged to avoid bed blocking, and others stayed much too long because discharge planning and assertive advocacy with housing and social care were no-one's particular responsibility. Out of area clients and those who do not need CMHT follow up, are particularly challenging. A historical and ongoing issue is the lack of any social services input to the Maudsley site. The Pathway approach has interesting synergies with ACTAD (assertive community treatment for alcohol dependence). ACTAD is a Medical Research Council (MRC) study; it provided a focus on assertive engagement, help to get services, and produced promising results for those failed by the motivational approach.

Southwark drug services work closely with Southwark SORT (Street Outreach Team), and report that of early dropouts from drug treatment, about half are homeless. Medical admissions of homeless patients tend to be to St Thomas', which can make coordination a problem.

Lambeth Hospital: A report on capacity with regard to mentally ill rough sleepers is being prepared following the case of patient MK who died on the streets in December 2010 after a psychiatric admission. Many patients appear to become homeless on or after admission, perhaps because landlords take the opportunity to evict. A Lambeth Supported Needs Assessment and Placement (SNAP) representative visits Lambeth hospital weekly to coordinate discharges, but when patients have physical health needs these are often not well articulated (potential role for GP- an in-house trial of a GP assessing patients on the McKenzie unit found 41% had physical health care needs requiring onward referral for specialist assessment). The particular challenge is non-Lambeth patients. Lambeth triage team has been set up within the past year (a new social work team whose primary responsibility is to Lambeth patients without a care coordinator) with a view to planning for discharge. Patients who are not Lambeth residents do not come under their remit. Also, Lambeth patients placed at Maudsley hospital prove a challenge to manage remotely.

Recommendations for SLAM

- ***The general view is that there is a real prospect to improve care coordination for currently underserved patients, particularly those without a clear connection to the host borough, by providing hospital in-reach. This will combine the skills and experience of the START Rough Sleepers Mental Health Team and the Three Boroughs Primary Care Team as part of a Pathway care coordination service for homeless people. Specific skills offered by occupational therapists and dual diagnosis workers in a mental health setting would bring additional benefits to the wider team.***
-

Lambeth Borough: Community Consultation

Consultation in Lambeth

Public documents reviewed:

- Lambeth review of homelessness 2007/8 to 2011/12
- Supported Accommodation Commissioning Plan: Rough Sleepers and Single Homeless September 2010
- Lambeth homelessness strategy 2012-2017
- Serious case review into death of rough sleeper MK in December 2010, published June 2012
- Combined Homelessness and Information Network (CHAIN) Annual Report for Lambeth April 2011 to March 2012
- 3 Boroughs Health Inclusion Team Annual Report 2011/12
- Review of the needs assessment of clients served by the Three Boroughs Primary Health Care Team

Individuals consulted:

Akin Akinyebo, Specialist Housing Services Manager, Housing Options and Advice

Elizabeth Clowes, Assistant Director, Commissioning Social Inclusion Adult Community Services, London Borough of Lambeth

Jenny Alexander, Aurora (Social enterprise training and supporting peer mentors)

Adrian Mclachlan, Chair, Lambeth Clinical Commissioning Collaborative Board and co-Chair Lambeth and Soutwark Integrated Care Programme

Emma Stanton, Beacon UK

Will Norman, Lambeth SORT Team

Carolyn Dwyer, Divisional Director for public realm

Sue Foster, Assistant Director, Planning and Regeneration

Rachel Sharpe, Divisional Director, Housing

Neil Wightman, Head of Housing Needs

Homeless frequent attenders meeting: Ash More, Lambeth Public Health; Steve Jones, LAS Waterloo Station Manager; Clive Palmer, LAS Frequent Attenders Officer; Stuart Bakewell, Area Manager, St. Mungo's; Tony Waters, Manager, Graham House; Bill Tidman, Area Manager, Thamesreach; Dan Ware, Manager, Lambeth, Assessment Centre.

Perspective from Lambeth

During the year up to March 2012, 504 verified Lambeth rough sleepers were contacted by services, which was an 18% increase on the previous year. Of the rough sleepers, 50% were of UK nationality and 23% Central or East Europeans; 62% reported alcohol problems, 43% drugs, and 48% mental health problems. Only 14% had neither alcohol, drug, nor mental health support needs.

Homeless acceptances in Lambeth increased by 27% over the five years leading up to 2011/12 and by 13% over the year 2011/12, in line with a 14% national increase. Re-commissioning of services produced the new Lambeth Assessment Centre (LAC). This is responsible for assessing rough sleepers and vulnerable single adults who may require access to Lambeth's Vulnerable Adult Accommodation Pathway including: people with complex and multiple needs, vulnerable offenders, victims of domestic violence mental health problems and those dependent on substances. Access to LAC is through the street outreach team and the Council's Support Needs Assessment and Placement Team (SNAP). The Serious Case Review

of the MK case should result, amongst other changes, in a named lead for rough sleepers in each Mental Health Trust.

There is a general enthusiasm for improving coordination with King's, Guy's and St Thomas' and SLAM. The London Borough of Lambeth has good relationships with Lambeth triage ward, with a SNAP representative attending weekly bed management meetings, but lack a similar relationship with the other hospitals in KHP and would very much value establishing such a relationship. The potential to improve care coordination for homeless patients with complex needs during an unscheduled admission is widely recognised. The A&E frequent attender meeting is already identifying individuals who are not currently known to community services and making referrals, for example, to the Lambeth SORT team. The Lambeth street outreach team is keen to work in a more coordinated way with KHP hospitals. A collaborative multi-agency approach is very much in keeping with other initiatives in Lambeth, such as the Integrated Care Programme for older people.

Southwark Borough: Community Consultation

Consultation in Southwark

Public documents reviewed:

- Southwark rough sleepers action plan 2010/11
- Southwark homelessness action plan 2011/12
- CHAIN Annual Report for Southwark April 2011 to March 2012
- Three Boroughs Health Inclusion Team Annual Report 2011/12

Individuals consulted:

Natty St. Louis, Southwark Rough Sleeper Street Population Coordinator

Olive Green, Physical Disability No Recourse to Public Funds Case Manager

Evan Jones, St Gile's

Eammon Egerton, SPOT Team Manager

Bournemouth Road Southwark Housing Options: Marie Samuel, Manager; King'sley Ogbonda, Re-ablement Team Manager; Zona Vernon; John Idehen, & Thomas Trenton –team members; and Pauline Edwards, Housing Options.

Perspective from Southwark

A total of 641 verified Southwark rough sleepers were contacted by services during the year to March 2012, which is a 40% increase on the previous year. Findings show the following: 31% were of UK nationality and 47% Central or East Europeans; 57% reported alcohol problems, 39% drugs, and 46% mental health problems; and only 16% had neither alcohol, drug nor mental health support needs.

Statistics confirm the view of front line services, that the key challenges amongst rough sleepers in Southwark are mainly in two groups: Central and East Europeans who are “not exercising their treaty rights” - that is, not working, seeking work or entitled to benefits; and undocumented migrants, mainly illegal immigrants and “overstayers” – people who have stayed after their visa has expired and so have no access to benefits, housing or social care. There are separate mental health and physical health no recourse to public funds case managers in Southwark. To be eligible for this, clients need to be in the process of a new asylum application or appeal, and have community care act assessment with identifiable care needs identified before they will be taken on (mainly under S21 1948 National Assistance Act).

Southwark housing main hospital referrals come from Maudsley and King's. In the past there was a team member with responsibility for hospital discharge cases. The worker would attend ward rounds and bed blocking meetings and work with a counterpart at Maudsley to help with getting ID, evidence of residency etc and preparing a housing application. Now the team only has capacity to visit existing clients of the team if admitted to hospital. There are now clear communication problems with the hospitals, shown by clients turning up with medical letters saying they need supported accommodation, but without the necessary evidence of health and support needs. There is general enthusiasm for improving links with hospitals in Southwark and a clear view that there is room for improvement.

Westminster Borough: Community Consultation

Consultation in Westminster

Public documents reviewed:

- CHAIN annual report for Westminster 2011 to 2012
- Westminster homelessness strategy update 2008-2010
- Westminster's Joint Strategic Needs Assessment Homeless Health Needs Assessment October 2010.
- Westminster Housing Strategy 2007-2012

Individuals consulted:

Maxine Radcliffe, Practice Nurse, Great Chapel Street Surgery

Alex Wilkins, GP, Mary Hickey Practice and St Thomas' A&E minors unit

Philip Reid, GP, Great Chapel Street Medical Centre

Pat Baugh, Homeless Health Team

Steve Davis, King Georges Hostel

Audrey Barnett, Hopkinson House

Helena Doyle, Hopkinson House

Perspective from Westminster

A total of 2,974 verified rough sleepers were contacted by services in Westminster in the year to March 2012, an increase of 23.4% on the previous year. Most of the increase was a result of people who were new to rough sleeping. Findings show the following: 52% were of UK nationality and 34% Central or East European; 45% reported alcohol problems, 32% drugs, and 47% mental health problems; and only 23% had neither alcohol, drug nor mental health support needs.

The Westminster joint strategic needs homeless health needs assessment recommended routine monitoring of homeless patients' use of A&E and unscheduled admissions at St Thomas', with stronger working links between hospital discharge teams and homelessness services.

It is reported to be very difficult to get information on patients who have been admitted, with very little proactive collaboration with primary care.

The general understanding is that KHP services are largely commissioned by Lambeth and Southwark PCTs, but St Thomas' particularly receives a number of patients who are based in Westminster, even if they are not accepted as having a local connection to that borough. Hostels with many frequent hospital attenders are very much in favour of better links and support.

Inner North West London (INWL) Rough Sleepers Hospital Data Analysis^[12]

From the perspective of KHP, this data needs to be interpreted with caution, because they do not include information on rough sleepers who are not registered with a GP, and they also exclude those registered with a GP outside of the INWL area. So, for example, rough sleepers registered with GPs in Lambeth and Southwark will not be included. However, they do provide some triangulation with data from KHP activity analysis. It was found that rough sleepers accessed A&E seven times more frequently than the general population, they were also admitted more frequently and experienced more co-morbidity. Secondary care costs were five times more than for the general population. Interestingly they were also four times more likely to attend outpatient appointments (despite high Did Not Attend rates), suggesting that the issue is not just about inadequate access to planned care. One in five rough sleepers had three or more diseases.

Inner North West London Primary Care Trust Cluster includes Kensington and Chelsea, Hammersmith and Fulham, and Westminster. Researchers for INWL have access to hospital activity data for rough sleepers who are registered with GPs in these PCTs. Rough sleepers were identified from the Combined Homelessness and Information Network (CHAIN) database. Only those who had been seen rough sleeping on at least three occasions, in two separate quarters, were included between January 2010 and December 2011. Rough sleeping data was analysed from Westminster, Lambeth, City of London, Kensington and Chelsea, Hammersmith and Fulham, Hackney, Tower Hamlets, Camden and Southwark. Of the 3,450 frequent rough sleepers identified by this method, 933 (27%) were registered with GPs in INWL PCTs. NHS activity data was studied for the period January 2010 to June 2012.

[fig8] Summary of NHS activity for rough sleepers in INWL with matched NHS data

Type of activity	Patients	Episodes
A&E	450	3,272
Outpatient	435	4,413
Inpatient	294	802

Comparing this activity with the rest of INWL patients suggests seven times the rate of A&E attendances, four times the number of outpatient departments attendances and four and a half times the inpatient activity.

[fig9] A&E attendance for rough sleepers from INWL

Hospital	Attendances	Patients	Attendances per patient
Guy's and St Thomas'	1,010	310	3.3
Imperial	965	343	2.8
Chelsea and Westminster	332	159	2.1
UCLH	280	128	2.2
King's College Hospital	82	19	4.3
Royal Free Hampstead	54	20	2.7

[fig10] Hospital Admissions, top six providers for INWL rough sleepers*

Provider	Number of Attendances
Guy's and St Thomas'	223
Imperial (St Mary's only)	178
UCLH	109
Chelsea and Westminster	103
Hammersmith	76
King's College Hospital	9

*Note, the final publication shows 260 admissions for Imperial, but this includes Charing Cross and Hammersmith hospitals, which are part of the same Trust (personal communication).

Summary

The analysis of this sub-set of rough sleepers shows Guy's and St Thomas' as the most frequent provider of unscheduled care to homeless patients registered with INWL PCT Cluster, and confirms high use of secondary care by rough sleepers.

Homeless Service User Consultation

We are grateful to Stan Burrige, our peer researcher, for this consultation which was carried out over two sessions at the Passage Day Centre in Westminster during drop-in sessions provided for rough sleepers in December 2012. Each person was interviewed using a simple questionnaire to gather basic information and open questions about contact with health care services.

The questionnaire is included as Appendix 3.

A total of 29 interviews were completed. All the interviewees had personal experience of rough sleeping.

- 28% were female, 72% male in keeping with other surveys.
- Age groups: 16-25, 1; 26-45, 13; 46-59, 13; 60 plus, 2.
- Current housing status: rough sleeping, 19; hostel, 8; sofa surfer, 1; independent living, 1.
- 19 (66%) were registered with a GP and all but one said the practice was easy to get to.
- Of those 19 registered with a GP 8 had consulted within the last week and another 8 within the last month.
- Of those 10 not registered, 4 had still consulted a GP within the last week, but 6 had not seen a GP for over a year.
- 14 people had attended A&E on more than 22 occasions. Only two of this group were not registered with a GP. Two people reported attending A&E "many times", both were also GP registered.
- 13 of the >22 A&E attendances were at St Thomas', the rest at 8 different departments. Half of the attendances were by ambulance.

Patients were asked to describe their experience of A&E, most of which were positive:

"Not good. Lots of tests, needles and was given no food or drink"

"It was ok"

"Pretty good, they were very quick"

"Depending on the hospital"

"Quickly dealt with, care was good"

"Brilliant, fabulous"

"The last time poor treatment"

"Very good"

"Good, they were lovely"

"Treated well once admitted"

"Referred to King's College for jaw, very good treatment there"

"In and out, given pills and discharged"

"Good"

Some time was spent explaining the role of a Pathway team and asking whether or not they felt that this would make a difference to the way they were treated. Most of those who answered this said it would be a good idea:

“All hospitals should do that, it would save time”

“Yes, it would mean I could be honest about being homeless”

“Yes, it would be better if they understood (homelessness)”

One person said that ***“it might end up segregating people”***.

A total of 7 patients had been admitted 13 times in the past year, 9 admissions at St Thomas' and the remainder at 4 other hospitals.

When asked to describe their experience of being in hospital the following replies were given:

“Good, no complaints”

“It was ok”

“Not good”

“Very bad, discharge nurse was very rude”

“Very good”

“Good”

Only three patients felt that being homeless had affected the way that they were treated and that homeless people were discharged more quickly, offering the following quotes:

“They seem to discharge homeless people quicker”

“When they realised I was homeless, I was quickly discharged”

“I was treated badly, told to leave when I had no-where to go; the discharge nurse roughly removed the red tag and inpatient tag, and was very rude”

The final question asked if the respondent felt a Pathway team might have improved the treatment they received as an inpatient:

“Yes, then can be honest, might get some help with housing or a drug worker”

“Yes someone to advise you”

“Yes”

“It would be good. The bad treatment would not happen with someone who knows you. Already at St. Thomas' there's a nurse who understands better”

“Good treatment, poor follow up”

“Yes, if they understood it would always be better”

The last person produced a Pathway card from his stay at UCH.

Proposed Intervention

Recommendations for hospital based care coordination

- ***A single Pathway service to provide care coordination across King's Health Partners. The service will be multi-agency and multi-professional, working as a team to ensure patient centred and integrated care coordination. The staffing numbers are based on the current experience of services in place at University College Hospital, the Royal Free, The Royal London, and Brighton and Sussex University Hospital, which were then related to likely patient numbers across KHP and the additional challenge of piloting the service in A&E and across mental health services.***

- ***This Flagship service will clearly demonstrate that all members of KHP are addressing their new statutory duties concerning health inequalities, show the benefits of sharing expertise across KHP, and model patient centred care which bridges divides between physical health care, mental health care, clinical academic groups, drug and alcohol services, hospital and community.***

- ***The team will include: ten GP sessions per week, provided by two GPs contracted for 52 weeks per year from a local practice or urgent care centre provider in collaboration with the Three Boroughs Team; six Homeless Health Practitioners, consisting of two general nurses and four Mental Health Practitioners; a full time social worker employed by KHP; a full time housing specialist contracted from a 3rd sector provider with local knowledge and support; a half time band 4 secretary for administrative support; and specialist legal support from the King's in-house legal team as necessary. Team leadership will be provided by a band 8a nurse based with the Guy's and Thomas' Team.***

- ***Shared medical records will be essential to link the team members. This is best provided by EMIS web – a mobile GP system which can be linked to the Three Boroughs Team records.***

- ***Every team member will require an initial induction and training from Pathway Charity in the Pathway methodology, on-going access to networking meetings, training updates and psychological support through facilitated reflective practice. Evaluation of the outcomes of the intervention will also be essential.***

- ***Pathway Nurse Homeless Health Practitioners anchor the service at each site and coordinate care around two weekly multi-agency meetings: the "Lambeth Axis" – Guy's and St Thomas' linked to the Lambeth Hospital in collaboration with Lambeth housing and social care, and the "Southwark Axis" - King's and Maudsley hospitals in collaboration with Southwark housing and social care.***

- ***Lambeth Axis Pathway nurse Homeless Health Practitioners will include one band 8a clinical lead and one band 7 nurse based with the Guy's and St Thomas' Discharge Liaison Team, providing care coordination support to A&E and EMU and for homeless admitted patients on any ward. In addition two band 7 Mental Health Practitioners (ideally Occupational Therapists with mental health***

experience) will work between the Guy's and St Thomas' team and the Lambeth Hospital. At the Lambeth Hospital, the Pathway team will work in close coordination with the Lambeth Hospital Social Work Team, targeting those homeless patients that do not come under the remit of the Lambeth team and providing support to homeless patients at Lewisham hospital.

- *Southwark Axis nurse Homeless Health Practitioners will be two band 7 Mental Health Practitioners (ideally one OT with mental health experience and one Mental Health Practitioner with dual diagnosis experience). They will be based with the King's discharge liaison team and provide care coordination mainly for homeless patients at the Maudsley site and facilitate multiagency working for complex homeless patients at the King's site. When necessary advice and support can also be given for homeless patients at the Bethlem Hospital.*
 - *The total cost of a KHP wide Pathway service is estimated to be £675,480 which represents 7% of the current expenditure on homeless patients across KHP.*
 - *Peer support from Care Navigators is a key component of the Pathway approach, but this component can attract external funding and is best introduced once hospital teams are established.*
 - *It is noted that the existing King's A&E based social worker will be a key contributor and link person for the King's component of the scheme, and it is recommended that provision of an equivalent post in GSTT A&E, while not a part of the Pathway service, would be significant support to this service.*
-

Cost benefit estimates for King's Health Partners

- **Total annual revenue costs of the proposed service are estimated as £675,480.**

- **The Pathway intervention has shown a 30% reduction in annual bed days for homeless patient admissions.**

- **Admissions of homeless patients to KHP during 2011 (excluding A&E expenditure) cost a total of £7,998,682 (GSTT £4538,289, KCH £789,840, SLAM £2670,553).**

- **A 30% reduction would save £2,399,604, net £1,724,124.**

- **Even a conservative estimate of 10% reduction in bed days would result in savings of £799,868 or £124,388 after costs.**

- **In addition the service is structured to provide support to A&E with managing homeless frequent attenders and admissions to EMU. There is no published data on a Pathway intervention in A&E, but there is considerable scope for the same care coordination model to show benefits in addition to those estimated for admissions.**

Recommendations for Medical Respite – enhanced community care

- **Additional savings and improved care could be realised by providing a KHP medical respite unit in the community. Step-down convalescent care has the potential to further reduce duration of stay and re-admissions, in addition to the benefits of care coordination in hospital. A detailed specification has been drawn up by Pathway, and a potential site identified in Lambeth. The Three Boroughs Team has experience of providing such a service and has published data on cost benefit.**

- **Medical Respite is described and financially modelled in Appendix 4 to this report. There is considerable enthusiasm for the concept in the hospitals and the community. However, a Pathway KHP hospital team is the first and necessary step, Medical Respite would then provide additional benefit and require separate funding.**

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Appendix 1

Methodology for identifying a group of homeless patients from existing hospital records

There is no universally applied method of recording homelessness for patients seen in A&E or admitted to hospital, so we have devised a method of identifying a significant part of the homeless population from data already available on the hospital database.

A search is prepared identifying those with No Fixed Abode (NFA) in the address field; or with the address and postcode of known hostels in the boroughs adjacent to the hospital; or registration with a specialist homeless GP practice in those boroughs. This is only effective for practices that solely register homeless patients, so cannot be used for those that see homeless patients in addition to mainstream patients. We clean the data to remove children and maternity cases (these will receive a statutory response from social services), and also remove patients with addresses marked as “unknown” (these cases are usually people brought in unconscious or unable to give an address, and not necessarily homeless).

This method cannot identify hidden homeless (e.g. sofa surfers sleeping with different friends each night), nor those who give an old address. Interestingly though, in the hospitals which have introduced Pathway services, we have found that the number of referrals received by the team in practice do approximate to the number predicted by this method.

Appendix 2

Costing calculation assumptions

Average cost of an A&E attendance - £108. Department of Health (2012) NHS Reference Costs 2011-2012

London Ambulance Service (LAS) Cost per incident 2009-2010 - £225. DH (2011) Transforming NHS Ambulance Services. National Audit Office. 'The cost per call across ambulance services varies between £144 and £216, and the cost per incident varies between £176 and £251'

Percentage of arrivals that arrive by LAS – 50%. Lane, R (2005) The Road to Recovery. A feasibility study into Homeless Intermediate Care. Analysis of A&E data showed 51% of homeless clients had arrived at A&E by LAS.

Average cost of a non-elective admission - £1436 (not accounting for excess bed days). DH (2012) NHS Reference Costs 2011-2012

London Pathway. Average cost of a homeless unscheduled admission (from UCLH audit of actual homeless admissions referred to the Pathway team) - £3,399. Pathway Medical Respite Centre Prospectus, May 2012.

Consideration of how to cost homeless admissions – DH NFA figures show 3x duration of stay because more unwell. National average cost £1436 (so could suggest $3 \times 1436 = £4,308$), but Pathway UCH figure £3399 (includes some hostel patients as well as NFA so used as best estimate. Figure included A&E cost but not ambulance, so reduced by £108 for this exercise to £3291.

Questionnaire (page 2)

Question 2: Is the surgery easy to get to?

Yes	
No	

Question 3: (if registered.)When did you last see your GP?

Within the past 7 days	
Within the past month	
Within the past 3 months	
More than 3 months ago	

Question 4: (if un-registered.)When did you last see any GP?

Within the past 7 days	
Within the past month	
Within the past 6 months	
Within the past year	
Over one year ago	

YOU AND HEALTH part two A&E

Question 5: Have you attended an A&E department in the past year?

Yes		If yes, how many times?	
No			

St. Thomas's	
UCH	
Kings	
St. Mary's	
Royal London	
Other (please state)	

Question 6: Which hospital's A&E did you attend?

Question 7: How did you get there?

Ambulance	
Public transport	
Walking	
With someone else	

Question 8: Is this the nearest hospital to where you live?

Yes	
No	

Questionnaire (page 3)

Question 9: How would you describe your experience of A&E?

--

Question 10: Do you feel your status of 'homeless' affected the way you were treated by A&E?

Yes	
No	

Question 11: If yes, how do you feel your status of 'homeless' affected the way you were treated by A&E?

--

Question 12: Have you ever been refused treatment by an A&E department?

Yes	
No	

Question 13: Do you think a PATHWAY team at A&E might have improved your treatment?

Yes	
No	

YOU AND HEALTH part three Hospital admissions

Question 14: Have you been admitted into hospital in the past year?

Yes		If yes, how many times?	
No			

Question 15: Which hospital were you admitted to?

St. Thomas's	
UCH	
Kings	
St. Mary's	
Royal London	
Other (please state)	

Question 16: Is this the nearest hospital to where you live?

Yes	
No	

Question 17: How would you describe your experience of being in hospital?

--

Questionnaire (page 4)

Question 18: Do you feel your status of 'homeless' affected the way you were treated as an inpatient?

Yes	
No	

Question 19: If yes, How do you feel that your status of 'homeless' affected the way you were treated as an inpatient?

--

Question 20: On leaving where were you discharged to?

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Question 21: Did you receive any follow up care after leaving hospital for example out-patients appointments?

--

Question 22: Do you think a PATHWAY team at might have improved your treatment as an in-patient?

Yes	
No	

Appendix 4

Pathway Medical Respite Centre

(2 page Executive Summary)

Pathway Medical Respite Centre

Executive Summary

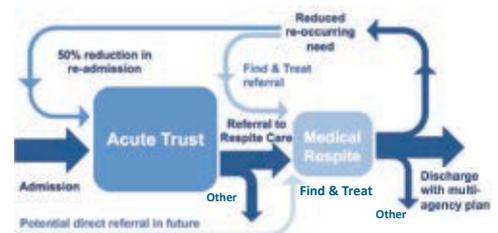
- **Current healthcare arrangements for the homeless are inappropriate; services often fail to meet the health needs of a very vulnerable group; costs are high and outcomes are poor.**
- **Compared to the general population, homeless people have complex health needs; use A&E to access healthcare; are more frequently admitted to hospital; remain for longer; and have high rates of re-admission.**
- **Current arrangements are expensive and result in very poor health outcomes. The failure to deal with the patients' health problems leads to a cycle of admission/discharge/readmission, with some patients attending as many as 30 times per annum.**
- **For the currently homeless, average age of death is 47 for men and 43 for women; suicide rates are very high; tri-morbidity is the norm (tri-morbidity is an entrenched combination of mental illness, substance abuse and physical ill health).**
- **Secondary care costs are 8 times higher than for the non-homeless; because of the severity of health need and cyclical re-admissions.**

Pathway, a new charity formed to transform health services for homeless people, has been developing *new models of care*. The first element is a specialist hospital team, initially introduced at UCLH, working with all admitted homeless patients. This team improves healthcare quality while homeless people are in hospital, and develops or refreshes patients' long term care plans. This approach is now being rolled out in other hospitals, based on Pathway's proven approach.

Pathway hospital teams work closely with London's specialist TB outreach "Find & Treat" team.

Working with other homelessness agencies, Pathway's close monitoring and evaluation of homeless patients in the acute setting has identified the critical need for a new, more cost effective facility, providing intermediate, convalescent care after a hospital admission for a clinically defined sub-group of homeless patients.

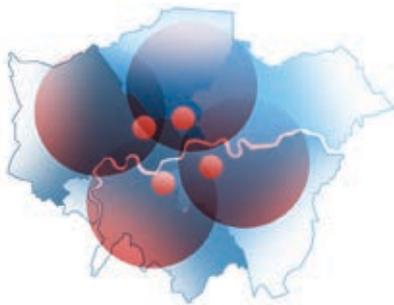
The proposal is to commission a specialist residential service, offering patients a short-term supportive community, providing both medical and other services. The service would be medically led, offer patients a psychologically informed environment with a parallel focus on convalescence/recovery, and planning for move-on. Most patients will stay around 14 days for convalescence, but stays of up to 6 months are anticipated for some cases, including palliative care.



This service would help shift the focus from acute care alone, creating a more integrated, multi-agency health and social care service for some of the sickest homeless patients.



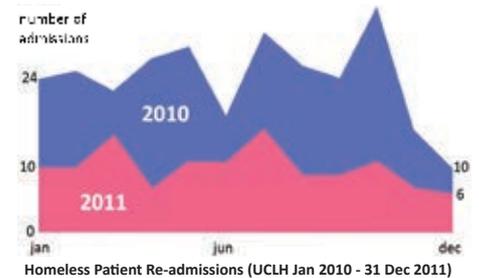
- To deliver four medical respite centres for London will require the capital's health service to commit **£30 million over 5 years** (or less than 0.0024% of total annual spending on the NHS in London)
- This feasibility study shows how this investment would actually save the health service money, avoiding **nearly £45 million** of expensive hospital care over the same period



2015 - Cross-London cover through 4 centres

- Access to a medical respite centre would have **saved £682,000 per annum** on beds at one hospital alone, on top of the **£400,000 already saved** through better case management from the Pathway hospital teams
- We estimate that in **inner London alone around 1,000 patients a year would benefit** from a stay in medical respite care following an acute admission
- For an NHS investment of **£1.5 million per annum** per centre, London could significantly improve health outcomes for this relatively small, but highly vulnerable group, at the same time as significantly saving costs of acute care
- Pathway's medical respite centre will deliver **better outcomes for patients and save the NHS money**

- Pathway's hospital teams have shown a focus on homeless patients generates significant reduction in bed days (**1,000 bed days per annum saved at ULCH**)
- The medical costs generated by homeless people is significant in London hospitals; **a safe, medically-led intermediate health and social care facility would improve results and reduce costs**
- In 2009 the **cost of each homeless patient** admission at UCLH was **£3399**. Pathway estimates that in inner London alone over 5,000 homeless people are admitted to hospital as an emergency each year





Healthcare for homeless people

Pathway
5th Floor East
250 Euston Road
London NW1 2PG

tel: 0203 447 2420
email: info@pathway.org.uk
web: <http://www.pathway.org.uk>