North Middlesex University Hospital Homeless Discharge Team; Summary of Activity and Needs Assessment

Dr Helen Burnett & Maggie Doherty

A small "Pathway" team conducted 6 months of action research at North Middlesex Hospital to investigate the best way of improving health care for homeless people in the hospital. Their findings are helping to refine a definition of a range of services which might be recommended as appropriate to different levels of local need.

North Middlesex University Hospital Homeless Discharge Team; Summary of Activity and Needs Assessment

As an introduction to the work of the NMUH Homeless Discharge Team, it is worth considering the national picture of how homelessness impacts on health;

- The annual cost of unscheduled care for homeless patients is eight times that of the housed population 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 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.
- Homelessness is an independent risk factor for premature mortality 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.

Because of this, there have been several interventions aimed at improving health outcomes for the most vulnerable members of society;

- 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."
- 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.

The original Pathway service for homeless in-patients in the U.K. was developed in UCH as a response to the highly visible local problem of street homelessness. University College Hospital draws its patients from a broad area including Westminster and Camden, which are the 2 London boroughs with the largest street homeless populations. Westminster hosts over 2000 rough sleepers annually and Camden over 500.

The aim of the UCH model of care is to address all of the patients' health issues, whilst providing a place of safety, and respectful care. It is based on the widely accepted theory that street homeless individuals are uniquely vulnerable, in part because of their "trimorbidity". This is the co-existence of chronic physical health problems, mental health problems and substance misuse/ addiction. In addition these individuals are often very chaotic, may be entrenched in street homelessness and may have experienced traumatic life events such as growing up in care, abuse, domestic violence or service in the armed forces. Medical review by the Pathway team is intended to identify the possibly multiple medical and social problems, co-ordinate care and thus reduce rates of readmission. It is also hoped that the team's intervention can help with securing some sort of accommodation if possible. Due to spending constraints, and political factors, access to support for homeless people is

often impeded by local authorities, particularly for clients with no local connection. This can include access to services such as healthcare or addiction support, as well as access to housing. Liaising with local services can be very difficult and this is an area where specialist services in the hospital, with knowledge of the community, can be instrumental in securing a safe discharge for patients.

The scale and cost of homelessness is well documented within central London. Information for the outer London boroughs is much more difficult to access, and is likely to be incomplete.

Enfield

We have sourced the demographic information that follows from Enfield Borough Council sources.

- In the last 10 years the population of the borough has increased by 14.2% to 312,500.
- The Index of Multiple Deprivation places Enfield as the 64th most deprived local authority in England, and the 14th in London.
- 11% of working age adults claim benefits. This is the 6th highest of the London boroughs.
- The latest figures for households in emergency accommodation date from March 2013. At that time there were 2143 households in emergency accommodation. This is the 7th highest proportion out of the 326 English L.A.'s.
- Local housing stock is under greater pressure than most areas as there is competition from inner London boroughs to secure private rentals. Over 1000 households in the borough have been placed by other councils. This import of impoverished households is the highest level of any London borough.
- Access to secure tenancies is further exacerbated by rapidly rising house prices and reductions in benefit payments.
- Enfield has the 14th highest rate of acceptance of homelessness in London at 4.5/1000 households. In "A Summary of Enfield's Review of Homelessness January- June 2013" this relatively high rate of acceptances is noted and a key challenge is listed as "maintaining a low level of homelessness acceptances".

CHAIN reported identifying 63 rough sleepers in 2013. This is an increase of 39 since 2012.

Enfield has recently become the first borough nationally to implement an online portal for homelessness applications. The HPU will not accept homeless applications, except via the online process which requires the applicant to enter an email address.

Haringey

- The Index of Multiple Deprivation, last updated in Haringey council literature in 2010 reports Haringey as being 13 out of 326 English councils, and 4th most deprived of the London boroughs.
- 2880 households in the borough are housed in temporary accommodation.
- Homelessness acceptances are 6/1000 households, the 9th highest rate in London.

CHAIN reported identifying 85 rough sleepers in 2013. This is an increase of 42 since 2012.

Local Primary Care

- There is a shortage of local primary care service provision. Healthwatch Haringey has recently calculated that there is a deficit of 116,000 GP appointments per annum.
- Large numbers of the local GP surgeries are single handed. This is particularly the case in Enfield.
- There is no specialist homeless GP practice in either borough.
- QOF scores and patient satisfaction are below London and national averages for both boroughs.
- A+E activity at NMUH is the highest of any single site department in the country. However conversion of attendance to admission is markedly low at 8-9%, possibly reflecting inadequacies in local primary care.

We have 'phoned practices in both boroughs to invite them to agree to register our clients. None volunteered. We have visited one practice in each borough, identified locally as the most socially aware services. After making a presentation in support of improving healthcare for vulnerable groups, particularly the homeless, we invited further contact to arrange an agreement regarding patient registration. Neither practice chose to answer our requests.

Local Homeless Services

Pan London homeless services, such as Street Rescue and St Mungo's/Broadway, operate within the boroughs.
There are also numerous providers of social care that although not specifically directed at the homeless, nevertheless offer necessary services such as care for victims of domestic violence, Eastern European migrants and vulnerable migrants.
Edmonton hosts the Enfield Homeless Resource Centre, open Tuesday to Friday, offering advice, training and referrals. The equivalent service for Haringey is located in Hackney.
There are no open access hostels.
A Haringey winter night shelter has operated for 3 months per annum since 2009. In the winter of 2014/15 this is expected to be joined by another identical service in Enfield. Both will offer 12 places for individuals with low to medium level care needs.
Guiseppe Conlon Catholic Worker house in Haringey provides refuge for homeless vulnerable migrants.
Highway House, supported by a mission church, also in Haringey, provides accommodation for single homeless men.

NMUH Pathway Pilot July- December 2014

A GP and a CNS were recruited to provide a Homeless Discharge Team. The GP is contracted for 4 sessions per week, and the CNS is 0.5 WTE. Within these constraints we offer a service for full days on Tuesday, Wednesday and Friday, and morning cover on Thursday. Both team members have a background in healthcare for the homeless.
Induction, initial training and ongoing clinical supervision is provided by Pathway at UCH.
The service as currently provided costs £48k for 6 months

The NMUH Homeless Discharge Team has been taking referrals since 30/07/14. The following referral figures relate to the months of August and September 2014 only. Up until the end of September we had received 22 referrals, 15 of which were appropriate. (There have only been a further 6 referrals in October.) Those deemed to be inappropriate were generally for patients who were not in fact homeless. Thus we were assessing on average 2.4 patients per week and actually taking on the cases of 1.7 patients per week.

In addition, we have been approached to give advice on general housing matters. Having no expertise in housing policy, we have referred these requests to the appropriate services.

We have examined the records of those patients that we have contributed to the management of. At only 22 cases we recognise that this may not be a representative sample. However, with the data available we can summarise our client mix to date;

22 referrals for 21 patients with 1 patient having two admissions.

15 appropriate referrals.

Average age 45 (26-74).

6:1 M:F.

12/15 patients have chronic physical health problems.

3/15 patients have a mental health diagnosis.

6/15 patients have problems with substance misuse/ addiction.

In terms of conforming to the pattern of tri-morbidity:

0/3 forms of morbidity	13%
1/3 forms of morbidity	53% (90% accounted for by a chronic medical condition)
2/3 forms of morbidity	13%
3/3 forms of morbidity	20%

All patients identified as having a mental health problem or addiction issue were found to be connected to the appropriate community services prior to admission.

14 of the 15 patients already had a GP prior to admission.

5 of the 15 patients self-identified as rough sleepers. Of these only one had a CHAIN number or had been seen to be rough sleeping by an outreach team.

Conclusions

Our population of homeless patients here in NMUH appears to be very different to the population in central London that inspired the original Pathway team. We cannot infer population size from the work we have done to date, but the low numbers of referrals suggest that the local street homeless pool is relatively small. Also, from this very limited data set, and our observations whilst assessing patients, we would suggest that they are less unwell, less chaotic, less entrenched and less likely to be unknown to services than homeless in-patients in central London hospitals. Relatively few referrals were for rough sleepers. A more common scenario was the patient becoming homeless whilst admitted to hospital.

Trimorbidity is a relatively rare presentation and therefore there is less need for a co-ordinating specialist, medical service. During the time described we have not been required to make clinical contributions to care, but have instead been occupied with negotiating the labyrinthine complexities of homelessness strategy in Enfield, or supporting patients' attempts to prove eligibility for recourse to public funds.

Proposed Service Design

Whilst we do not have convincing evidence of a significant problem of street homelessness in the NMUH catchment area that is not to say that there is not a problem with homelessness in the two boroughs. There are a significant proportion of local households that are financially precarious and vulnerable to even small changes in income. There is a population of thousands that have been housed in Enfield and Haringey by other London councils as they cannot afford to house them in their home boroughs. These individuals are in temporary housing and therefore technically homeless. We suspect that there is a large, invisible accommodation crisis locally, and that it is likely to impact negatively on health.

In addition there is a lack of local services for homeless people. There are no primary care services with a remit to care for the vulnerable or excluded. Also, given local economic conditions, and the policy of Enfield council to reduce homelessness acceptances, we are finding that vulnerable patients are facing unprecedented barriers to exercising their statutory rights to make homeless declarations.

As previously described, the classic Pathway model is of clinical staff, working with or without trained peer support who act as patient advocates. However, this is a system that has been adapted in various ways to reflect local needs. For instance, in Chelsea and Westminster and St. Mary's hospitals there are no clinical team members; instead there is an expert housing advisor in each hospital seconded from the experts in homelessness at The Passage.

Our experience to date has allowed us to see how hospital spells are managed at NMUH. From this knowledge and the case mix data, it has been possible to develop a proposed model of homeless intervention for the trust. What has been apparent is the strength of the discharge team. This is a nurse led service of experienced practitioners who cover all of the hospital wards except those acute services associated with A+E. Thus they have knowledge of all impending discharges, and strong

relationships with the wards and community services. The acute units are covered by a multi-disciplinary admission avoidance team.

In our opinion, the ideal homeless service at NMUH would be a Housing/ homelessness advisor. We are in no doubt that the local community contains many vulnerable individuals and families who would benefit from housing advice and support. Prompt assessment and case management of in-patients by an expert in housing should reduce length of stay for homeless patients. In our experience presenting as homeless at NMUH is frequently associated with immigration difficulties. Thus the ideal candidate would be a housing worker with an interest in vulnerable migrants. However, it must be noted that only appropriately trained advisors can advise on matters of immigration status, and so this would be an informal aspect of the role.

Identification and assessment of in-patients will form the bulk of the advisors workload. However, there are other functions that could be covered by this role:

1. We have an unknown number of homeless patients presenting to A+E who are not admitted. We are working with the A+E Consultants to develop an education, census and signposting service within the department.
2. In collaboration with I.T. we are creating a template on the hospital EPR to record relevant information for a housing assessment. This will, in time, create a record of homeless in-patient characteristics, that should be useful in planning future service design.
3. It has been recognised that the patients attending the TB clinic have a markedly high level of homelessness. We have agreed a pathway for these patients to be assessed by the housing advisor, regardless of whether they are in or out-patients. We will also explore the possibility of making a similar arrangement with the HIV team.

All of these projects could be handed over to a non-clinical housing advisor once established. We do not believe that the work generated would be out-with the capacity of the post.

We would suggest that a full time Housing Advisor is recruited to join the Discharge Team. (An appropriately qualified Housing Advisor could be recruited for £23,000 p.a., if employed by the trust, or loaned from a specialist service for around £45,000 p.a.)They would be best deployed within the Discharge Team as it is hospital wide, and manages all discharges. However, strong links should be forged with the admission avoidance service also. By placing an advisor at the centre of the hospitals daily activity, we would hope that education of all staff in social issues would proceed organically, and that would allow the development of a culture of considering social factors when planning discharges. We would hope that it would also raise the level of consciousness generally in regards to the social determinants of health.

It would also be beneficial to aspire to involving clinical members of the discharge team in the homeless project, such as by attending appropriate training. In this way the housing advisor would be supported within the team, and complex discharges could be better facilitated by other team members. It is important that the profile and importance of the service is also maintained across the trust. Dr Sheinman, as the team's originator and champion, would be ideally placed to facilitate this.

We would recommend that the post holder be encouraged to maintain strong links with Pathway, with ongoing training and supervision.

Dr Helen Burnett

GP, Homeless Discharge Team NMUH

helenburnett@nhs.net

Maggie Doherty

CNS, Homeless Discharge Team NMUH

maggie.doherty@nhs.net

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

Charity Registration number: 1138741