St Georges Homelessness Inclusion Team

9-month evaluation report summary - Nov 2021 – Aug 2022

People experiencing homelessness have an excess mortality rate 7.9 times (men) and 11.9 times (women) compared to the general population (Aldridge et al, 2018). They also have worse access to health and social care. South West London has high levels of homelessness. For example, 1207 rough sleepers were identified in the boroughs surrounding St Georges between 2021-2022 (Chain, 2021).

The Pathway charity has developed a national model of complex care coordination to meet the health, housing and social care needs of people experiencing homelessness when they attend or are admitted to hospital. The St George's pilot of a Pathway model team commenced on 29th Nov 2021. This report outlines how the pilot developed over the first 9 months and summarises headline outcomes. The current team comprises a part time GP, full time nurse, two housing workers, a care navigator, and since April 2022, and a part time community nurse.

246 patients were accepted by the team in the first 9 months of the project and supported with health assessments and care coordination. 75% were male, 25% were female. 40.2% were White British, 38.2% Other (including White Other), and 12.2% Black or Asian. 16.3% were known or suspected to have No Recourse to Public funds. 60% of accepted referrals had

a local connection to either Wandsworth, Merton or Croydon, although over 20% had a local connection to boroughs outside South West London.

50 (20.3%) patients were rough sleeping at the point of acceptance. Others were sofa surfing, being evicted, or already in a homeless hostel or temporary accommodation. Rough sleeping was reduced from 32% to 7.5% of patients on discharge by the team - a 77% decrease. This represents 39 individuals that were prevented from returning to rough sleeping. Rough sleeping, insecure housing and sofa surfing situations collectively were deceased by 55%. The percentage of patients with Temporary Accommodation placements on discharge increased from less than 1 in 10 on admission, to 1 in 3 on discharge. 14.4% of accepted referrals involved self-discharges (some were referred after the self-discharge). This is very much in line with national rates of self-discharge in inclusion health groups, but reducing self-discharge is an area for focus for future years.

During the 9 months, 95 patients had a Duty to Refer completed, 28 people were newly registered with GPs, and 30 people had address details updated. These all represent improvements in care. Case studies also demonstrate the excellent health and wellbeing impacts of the team.

A proactive care planning audit was undertaken to robustly examine opportunities to improve care. A key positive aspect was that the audit revealed a high level of engagement with patient GPs - audit notes revealed the GP had been identified in 90% of patients and contacted in 94% of these cases. Areas identified in which the team could improve care in the future including supporting mental health needs during admission, and addictions needs post discharge. A 'returned to rough sleeping audit' has also revealed ways that the team can work with the hospital to improve care e.g. around the identification of safeguarding issues, mental capacity assessments and presentations out of hours.

Feedback from patients has been extremely positive. In a set of 20 feedback interviews randomly undertaken with patients who had agreed to be contacted after discharge, team members were universally talked about as kind, helpful and knowledgeable. Patients that rated the team all gave the team a 10/10 or in two cases an 11/10 (!), and all thought that the team should continue.

Quotes included:

'If they hadn't helped me, I'd be on the streets. I had no chance to survive without them.'

'I thought they were outstanding. They went above and beyond the call of duty. They were fantastic, they pushed and pushed. Without them I wouldn't be where I am (a rehab centre).'

'all the advice that the homeless team gave me really worked – as a result I have now had 3 months of treatment and I am in a move-on house for 2 years'

Feedback has also been good from both hospital and community partners:

'Having the Homeless Inclusion Team now has been a great help. They are an excellent team with experience and knowledge that can support discharge coordinators.'
– Discharge Coordinator

'You and your team have been incredible so please extend our thanks to them in addition others already mentioned' – Drug and Alcohol service

In addition, the St George's team has been recognised pan-London as a centre of excellence; it was chosen as the main team to feature in the London Homelessness Awards application, which the Pathway Partnership Programme collectively won in Oct 2022.

A survey of hospital staff not working in the Pathway team was undertaken. 13 random surveys were filled in by staff, mostly from A&E. 61% said they saw someone experiencing homelessness at least weekly, 77% said they had cared for someone that was discharged to the street. Only 61.5% were aware of the statutory Duty to Refer. This may be because only 23% had had training in inclusion health, while 92% said they thought such training would be beneficial. Sadly only 23% said they thought that the health care at St Georges provided to people experiencing homelessness was good, and nobody thought it was excellent. 46.1% though it was poor or very poor. Obviously, this means that hospital staff feel there are opportunities for improvement. The team has had limited capacity to provide teaching to hospital staff this year but would like to do more next year. Where teaching has been undertaken e.g., to GPs in the community with the support of an Expert by Experience – this was received very well, and 62.5% of attendees rated the session as excellent.

Positive secondary care impacts were noted in a data extract looking at the attendance and admission patterns of patients seen by the team. Following first referral to Homelessness Inclusion Team, patients who frequently attended Emergency Department (10+ attendances in the prior year) showed a collective decrease of -65.9% in their Emergency Department attendance rates, and patients who were frequently admitted (4+ admissions in the prior year) showed a collective decrease of -61.2% in their inpatient admission rates. Patients who had been frequently admitted also showed a significant increase in length of stay - this represents care completion and will have contributed to the reduction in attendances and admissions. As a worked case study example, the team achieved a potential cost saving for one frequently attending and admitted patient of £17,585.

Finally, the team has reviewed the challenges it experienced in the last year, to understand what can be learned and what the future team should look like. Plans have been made e.g. to improve data recording, increase teaching time and produce an advice booklet for patients and staff. However, recommendations have also been made regarding the need for increased staffing levels to improve overall capacity and increase the skill mix in the multidisciplinary team. It is important to note that the team has already been proactive in developing solutions

e.g., by developing and bringing in a new triage process, and initiating its own clinical supervision.

Overall, the report reveals a reflective team, with highly skilled staff, that is delivering extremely positive outcomes for many patients, and probable cost reductions to the system. It is hoped that this report will support any future business plan for the team.

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References:

- Aldridge R et al. (2018) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance misuse disorders in high-income countries: a systematic review and meta-analysis. The Lancet. Vol 391. January 20. pp. 241-250
- Chain (2022) CHAIN ANNUAL REPORT GREATER LONDON APRIL 2021 - MARCH 2022 https://data.london.gov.uk/dataset/chain-reports