NHS
North Central London
Integrated Care Board

Healthy London Partnership

Establishing Effective Healthcare Provision and Pathways for People who are Homelessness or at Risk of Homelessness

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Healthy London Partnership

Presentation overview

1. Engaging with the hidden homeless population to ensure their access to healthcare
2. Providing targeted interventions for people who are homeless with complex needs including substance and alcohol use issues and mental health concerns
3. Developing robust pathways to reduce avoidable admissions and prevent patients at risk of homelessness being discharged without suitable accommodation
4. Working in partnership with councils and housing associations to provide effective wrap-around care

Homelessness in London

Homelessness in London

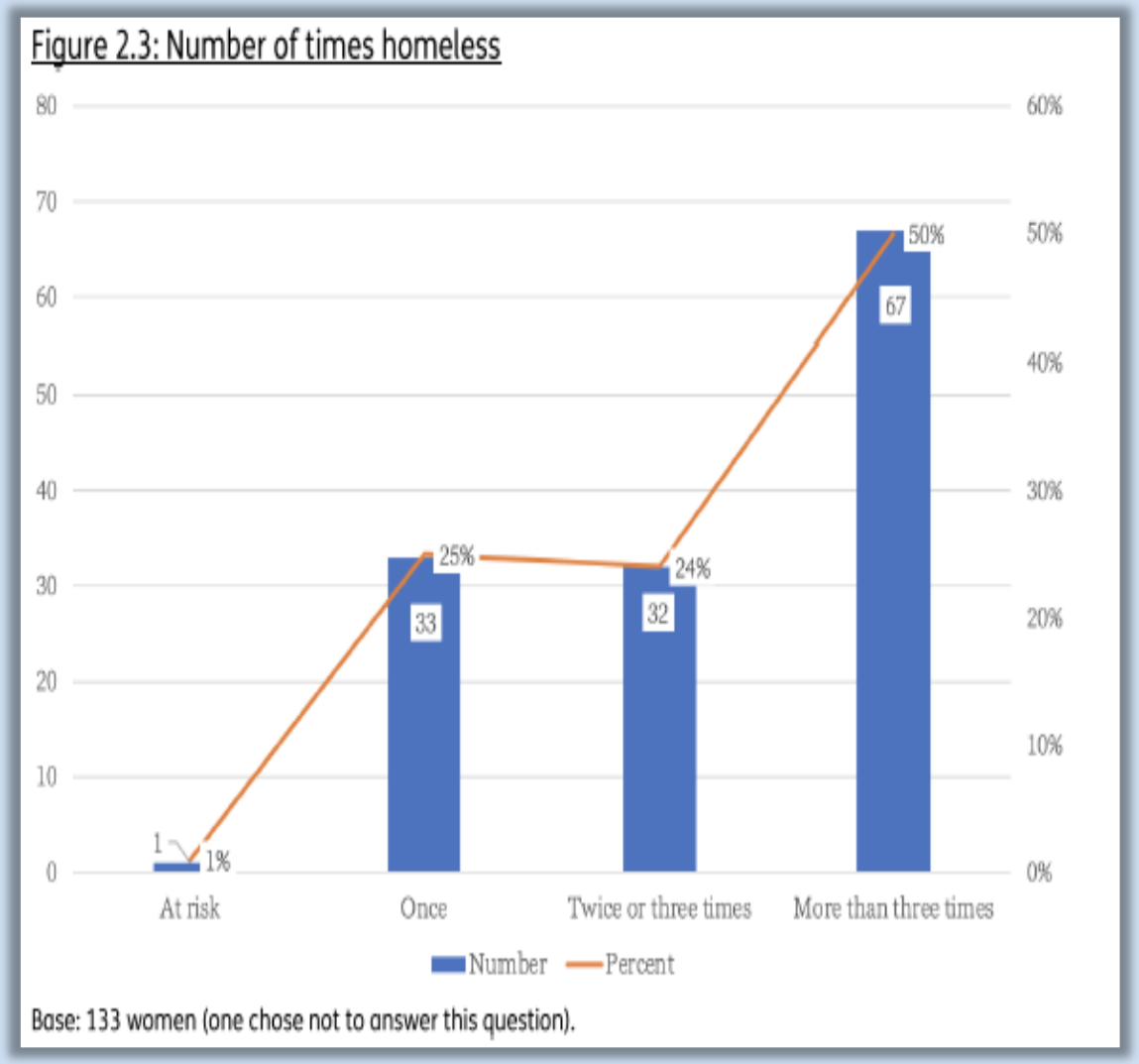
- April 2021 - March 2022 around **8,000 people recorded as sleeping rough** in London
- Rough sleeping is the most visible form of homelessness, yet an additional **150,000 homeless Londoners – including 75,000 children –** live in temporary accommodation arranged by their local borough
- Estimated that there is **13x more hidden homeless people** in London than those recorded as rough sleeping

1

Engaging with the hidden homeless population to ensure their access to healthcare

Trapped & Hidden - Women and homelessness

- Women's experiences of homelessness, and the traumas they face – are vastly different from men's
- Women's trauma is often rooted in gender-based violence and abuse
- Hidden homeless because they have different patterns of rough sleeping
  - Often intermittently sleeping on the streets
  - Significant risk of exploitation - Exchanging sex for accommodation
  - They move around, so don't stay in same place
  - Reluctant access mixed accommodation
- Missed by homeless services



https://www.shp.org.uk/news/out-of-sight-out-of-mind-flic-and-the-university-of-york-launch-research-into-womens-hidden-homelessness
https://www.mungos.org/we-must-not-let-the-health-needs-of-women-experiencing-homelessness-be-forgotten/

Trapped and hidden

Trauma and abuse can impact women's attitudes and experiences when dealing with support and mental health services.

- It can leave women trapped in a cycle of homelessness and poor health as their problems are aggravated
- Women recovering from domestic abuse struggle to feel comfortable in services which are mostly male-dominated
- In 2019, only 10% of accommodation services in England provided women-only accommodation

"Women experiencing homelessness are living in a state of survival, often without access to services and in high-risk environments where they are frequently subjected to violence and abuse".
The University of York.

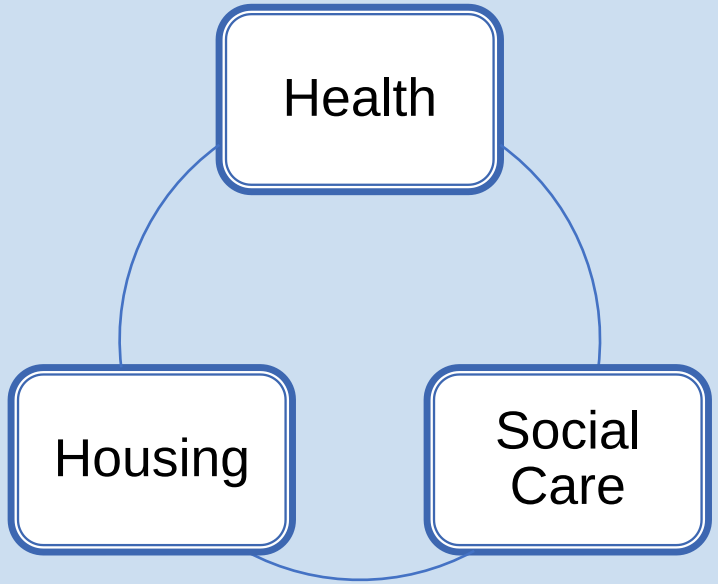
https://www.shp.org.uk/news/out-of-sight-out-of-mind-flic-and-the-university-of-york-launch-research-into-womens-hidden-homelessness
https://www.homeless.org.uk/sites/default/files/site-attachments/Single%20Homelessness%20Support%20in%20England%20-%20Annual%20Review%202019.pdf

Improving access to healthcare

A women's strategy is a necessity, not an afterthought

- Ensuring services recognise and understand women's needs
- Creating strategy and adapting systems to support these needs
- The intersection of domestic abuse and homelessness needs to be acknowledged and fully recognised

How would an integrated health, housing and social care offer specifically for women look like in your local area, and what's needed for this to be developed?



Each aspect is intrinsically linked to the overall success and reduction of recurrent homelessness

Children experiencing homelessness

- Although recorded under Statutory Homeless and housed in temporary accommodation, often the fact that they are homeless is hidden from the wider system and not fully understood by health care services

Children experiencing homelessness may be affected by a variety of health challenges because of:

- Difficulty in accessing regular health care - Frequent moves between accommodation results in either moving out of area from their GP surgery or disengagement with their GP as lost communication with change of address;
- Delayed presentations - Fear of seeking help due to questioning by health services that could lead to social service referrals
- Missed/delayed childhood immunisations
- Increased use of A&E for primary care interventions;

Effects of poor housing on children

- Asthma and breathing difficulties,
- Hives and allergic reactions to infestations
- Delayed walking and crawling –poor muscle tone and core strength.
- Flat head syndrome
- Delayed speech
- Poor nutrition –under/overweight –no cooking facilities
- Fear of unfamiliar, noisy dirty homes
- Delayed potty trainings
- Not ‘school ready’

Cycle of trauma

"Professionals may label a child as "hyperactive," "oppositional," "shy," or "spacey," when these behaviours may be fight, flight, or freeze responses to ongoing stress."

(Bassuk,2010)

- Involves a threat to physical or emotional well-being.
- Results in intense feelings of fear and lack of control
- Leaves people feeling helpless.

Improving access to healthcare

Increased health service understanding of the needs of children and families who are homeless

- Community Link Worker
- Training for professionals in GP surgeries and ED
- GPs with specialist interest
- Specialist Health Visitors

“We need to listen, learn and act. Children are our future and it is our duty to provide them with the best start in life.”

Champions Project

2

Providing targeted interventions for people experiencing homelessness with complex needs including substance and alcohol use issues and mental health concerns

Homelessness is a health issue – complex need and tri-morbidity

Substances use disorder

- 39% drug-related issues
- 27% alcohol-related issues

Physical health problems

- 73% a physical health problem, 41% long term
- Hepatitis C 50x more likely
- TB 34x more likely
- COPD 10x more likely
- Heart problem 5x more likely

Homelessness causes premature death

The average age of death for homeless **men** is **46 years**, and for **women it was 41 years**

Mental health problems

- 80% experiencing mental health problem, 45% diagnosed
- High rate of ‘personality disorder’ / complex trauma and psychotic illness

Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2018to2020

Beijer, U et al (2012) Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. The Lancet Infectious Diseases; 12:11, 859–870

Homeless Link: the unhealthy state of homelessness, health audit 2014

Dan Lewer et al. BMJ Open 2019;9:e025192

Services addressing MH and Rough Sleeping in London

START Team:
Homeless Outreach (START) is a small multi-disciplinary assessment team for street homeless people in Lambeth, Southwark and Croydon. Our role is to engage and assess homeless people with severe mental health problems and to refer them on to local mainstream services

FOCUS Homeless MH team:

Assertive outreach service to homeless people and people in hostels, aged 18 years and over.
Offer assessment, triage, signposting (if appropriate) and treatment.
The team will advocate on their client's behalf and support them with social and practical issues. They assist with health, social wellbeing and physical health issues on the way to recovery and resettlement to more permanent accommodation and linking to services appropriate to the individual's needs.

CENTRAL LONDON HOMELESS HEALTH SERVICE:

Open access, outreach service which takes primary care into non-NHS settings.
Provided on the street, in daycentres, hostels and specialist GP practices, the service makes the NHS available to people who otherwise have difficulty gaining access to care.
Our team consists of nurses and counsellors, with additional input from the Trust's dentistry team as well as the podiatry team who provide walk-in clinics Monday to Friday.
The aim of this crucial service is to relieve suffering, provide public health screening, offer help and support with rehousing, return patient's to mainstream services and remove the need to use accident and emergency for primary care.

Pan London Co-Occurring Conditions Programme: Aims & Objectives

- **Funding**: DLUHC Rough Sleeper Drug & Alcohol Treatment Grant: Funded April ‘22 – March ’24
- **Integration & Collaboration**: Working in partnership with each London ICB region to drive change in regional and pan-London strategy, service design and delivery to **improve the integration of support for people experiencing co-occurring conditions of homelessness, mental health, and substance use issues**

Protocols	Integration	Access	Treatment
• Establish protocols for integrated care between homelessness, mental health, learning disability and substance use services across London	• Coordination, communication and joint-working between homelessness, mental health, learning disability and substance use provision across London	• Improve access to substance use treatment for people experiencing homeless in London	• Improve treatment completion rates and access to general healthcare and GP registration

Stakeholder consultations: Emergent themes

Integration

Lack of integration of mental health with substance use/homelessness provision

Access

The need for flexible & accessible service models (bearing in mind stretched resources)

Trauma

The need for consistent trauma informed/sensitive approaches to enable engagement & retention in treatment/support (esp. at assessment stage)

Staffing

Widespread challenges recruiting staff & high levels of fatigue across all sectors

Shared learning

The need to share good practice & build capacity of the sector to work effectively with people with co-occurring conditions

Co-production

The expertise of people with lived experience is critical for effective service design – but rarely resourced

What will programme success look like?

The programme aims to act as a catalyst, conduit & facilitator for change – but leadership & action has to be owned & driven forwards pan-London, within each ICB & at place

Protocols: Sub-regional & pan-London protocols & joint working agreements between mental health, homelessness & substance use services

Service Models: Development of more accessible, flexible & engaging substance use & mental health service models, building on existing good practice (via Test & Learn sites)

Learning: A programme of shared learning to disseminate good practice & create pan-London networks

Co-production: Embedding co-productive approaches into substance use and mental health commissioning

Challenging stigma & discrimination: The development of awareness raising resources

Workforce development: the creation of learning resources to build the capacity of the sector to meet the needs of people with co-occurring conditions

3

Developing robust pathways to reduce avoidable admissions and prevent patients at risk of homelessness being discharged without suitable accommodation

What's needed?

Targeted healthcare, housing and social care for people experiencing homelessness directly improves health outcomes, reduces risk of early mortality and leads to health system benefit. Helps support people who are rough sleeping to move towards stable accommodation which in turn generates system benefits.

- **HOSPITAL DISCHARGE IS CRUCIAL TO BREAKING THE CYCLE OF HOMELESSNESS**; a decisive intervention at the point of discharge allows people experiencing homelessness to change their lives in a positive way and is an effective route into accommodation [1]
- **PEER ADVOCACY - Groundswell's peer advocacy delivered a 42 per cent reduction in unplanned care activity costs** through increased access to preventative health services, increased motivation and confidence to manage healthcare and reduced number of missed appointments. Leading to an **indicative saving of £2.43 for every £1 spent** [2]
- **INTERMEDIATE CARE SERVICES -** NICE Guidance recommends the provision of **intermediate care services** with intensive, multidisciplinary team support through **transitions between settings** [3]
- **SPECIALIST, FLEXIBLE AND EASY ACCESS PRIMARY CARE** - Groundswell peer-led conversations and evaluation (91 participants across 24 London boroughs) highlighted the need for **specialist, flexible and easy access primary care for people experiencing homelessness** [1] **Appropriate services within the community that address health conditions and reduce admission**

1. Healthy London Partnership and Groundswell, More than a statistic, October 2016 More than a statistic - Healthy London Partnership
2. The Young Foundation, Oak Foundation, Groundswell, Saving Lives, Saving Money, 2015, Saving Lives, Saving Money | Groundswell
3. NICE Guidance NG 214, Integrated health and social care for people experiencing homelessness, NG 214, March 2022

Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit

Aim

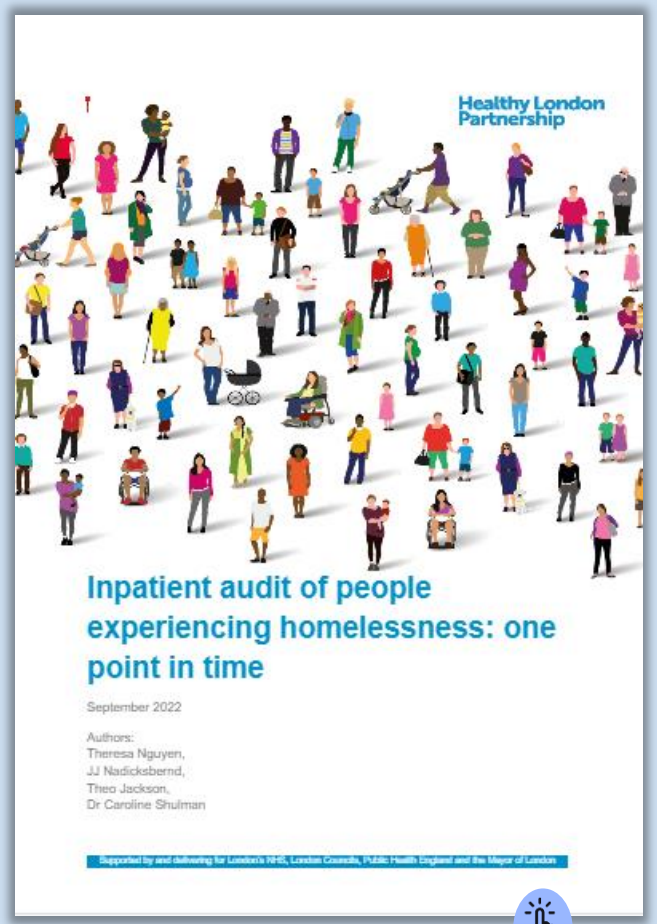
To help inform commissioning decisions by understanding:
current hospital caseload
challenges / barriers to safe discharge from hospital
gaps in provision (such as intermediate care / high level care / community support)

Methodology

A one point in time, one week in February 2022, a snapshot of hospitals' inpatient homeless population

Participants

19 hospital teams across London
15 acute hospitals
3 mental health hospitals
1 community (step-down unit) hospital
Note: A&E were not included in this audit.



Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit - Healthy London Partnership

Key findings

Detailed findings for 104 out of 150 patients (86 acute and 18 mental health)

- **92% UNABLE TO RETURN TO PREVIOUS LIVING SITUATION -** As it was unsuitable for their health and care needs
- **44%DELAYED DISCHARGES** due to lack of appropriate accommodation or awaiting assessments

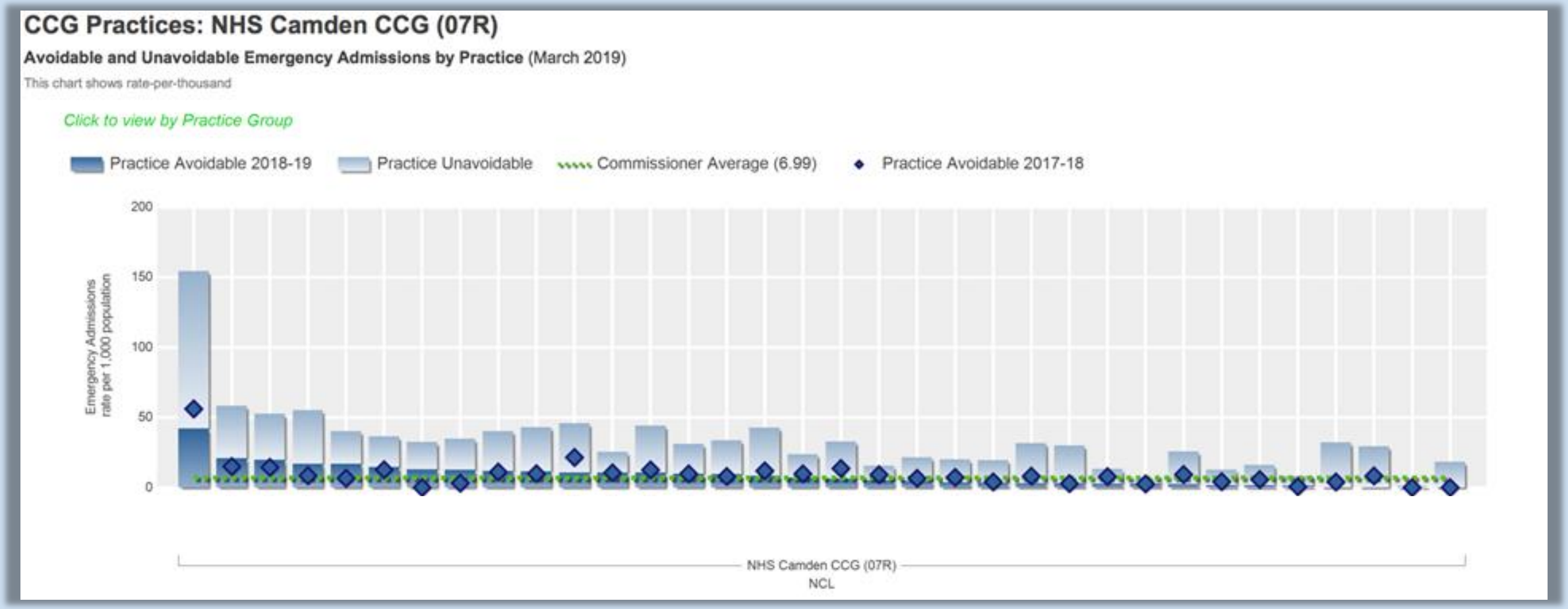
- **ONLY 1 PERSON REQUIRED ACCOMMODATION ALONE** following their hospital stay.
- **45% REQUIRED INTERMEDIATE CARE -** for rehabilitation or while awaiting further assessment and support (e.g. immigration, social care)

PEOPLE HAD VERY COMPLEX NEEDS

- **64%** had **3 or more** different clinical issues (17% had **between 5-8**)
- **55%** reported to have care needs

- **37.5% HIGH LEVEL NEEDS** - **requiring 24/7 nursing e.g., rehab/care-home** setting
- **16.4% HAD PHYSICAL, MENTAL AND SUBSTANCE USE ISSUES** requiring **accommodation with 24-hour non-clinical staffing and clinical in-reach**
- **37.5% had lower level needs** that could be supported in **accommodation with community in-reach** from services such as adult social care, community mental health team, immigration, floating support, peer advocates, etc.

Snapshot of Avoidable and Unavoidable Admissions



Avoidable Admissions - Physical Health Conditions
Soft tissue/cellulitis/wound care

- Hospital coding is not consistent – however, the general understanding of the wide range of soft tissue/wound care related problems has been broadly categorised as Cellulitis of other parts of limb.

Avoidable Emergency Admissions by Primary Diagnosis (March 2019)
This table shows top ten diagnoses for AVOIDABLE EMERGENCY admission

Primary Diagnosis	Avoidable Emergency Admissions	Occupied Bed Days	Cost Mar 2019
Lobar pneumonia, unspecified	28	213	£112,611
Urinary tract infection, site not specified	20	107	£81,710
Chronic obstructive pulmonary disease with acute lower respiratory infection	11	62	£24,332
Cellulitis of other parts of limb	9	58	£50,085
Congestive heart failure	9	97	£50,040
Chronic obstructive pulmonary disease with acute exacerbation, unspecified	7	29	£13,153
Asthma, unspecified	6	15	£7,626
Acute tonsillitis, unspecified	5	12	£4,505
Tubulo-interstitial nephritis, not specified as acute or chronic	4	14	£6,237
Acute upper respiratory infection, unspecified	3	9	£2,851
Other (Diagnoses)	69	324	£153,760
Total	**174**	**940**	**£506,910**

March 2019

- 9 avoidable admissions
- 58 bed days
- **COST: £50,085**

The Cost of Wound Care on the NHS

For people experiencing homelessness, leg care – particularly wound care, is a huge issue. Injecting in the lower limbs can lead to leg ulcerations, wound and skin infections, abscesses and pseudoaneurysm

- **£8.3 billion** – annual NHS cost of which: £2.7 billion on healed wounds and £5.6 billion on unhealed wounds

Of these overall costs, there is no indication on costs related to wound care management for those facing homelessness

Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013 - PubMed (nih.gov)

Misunderstood and Overlooked webinar: Addressing leg ulceration as a physical health need for people experiencing homelessness | Single Homeless Project (shp.org.uk)

Case Study

Background
- 54-year-old male
- History of injecting in the lower limb
- History of multiple admissions related to leg conditions
- Chronic leg ulceration 2 years *cost implications
- Co-morbidities: active smoker, asthma, COPD, Atrial Fibrillation

Presenting Complaints / Diagnosis
- CEAP Classification Venous Disease:
- Right C6 active ulcer - Left C4 venous eczema

Patient implications
- Reduced mobility impacting on falls
- Reduced sleep
- Pain
- Varied experience in the past with lower limb care

Healthcare Costs (Resources)
- Dressings cost (2 years)
- Nursing time (2 years)
- GP appointments
- Recurrent A&E attendance and admissions due to cellulitis and leg swelling (2 years)

Costs to patient
- Reduced mobility
- Stigma
- Malodour

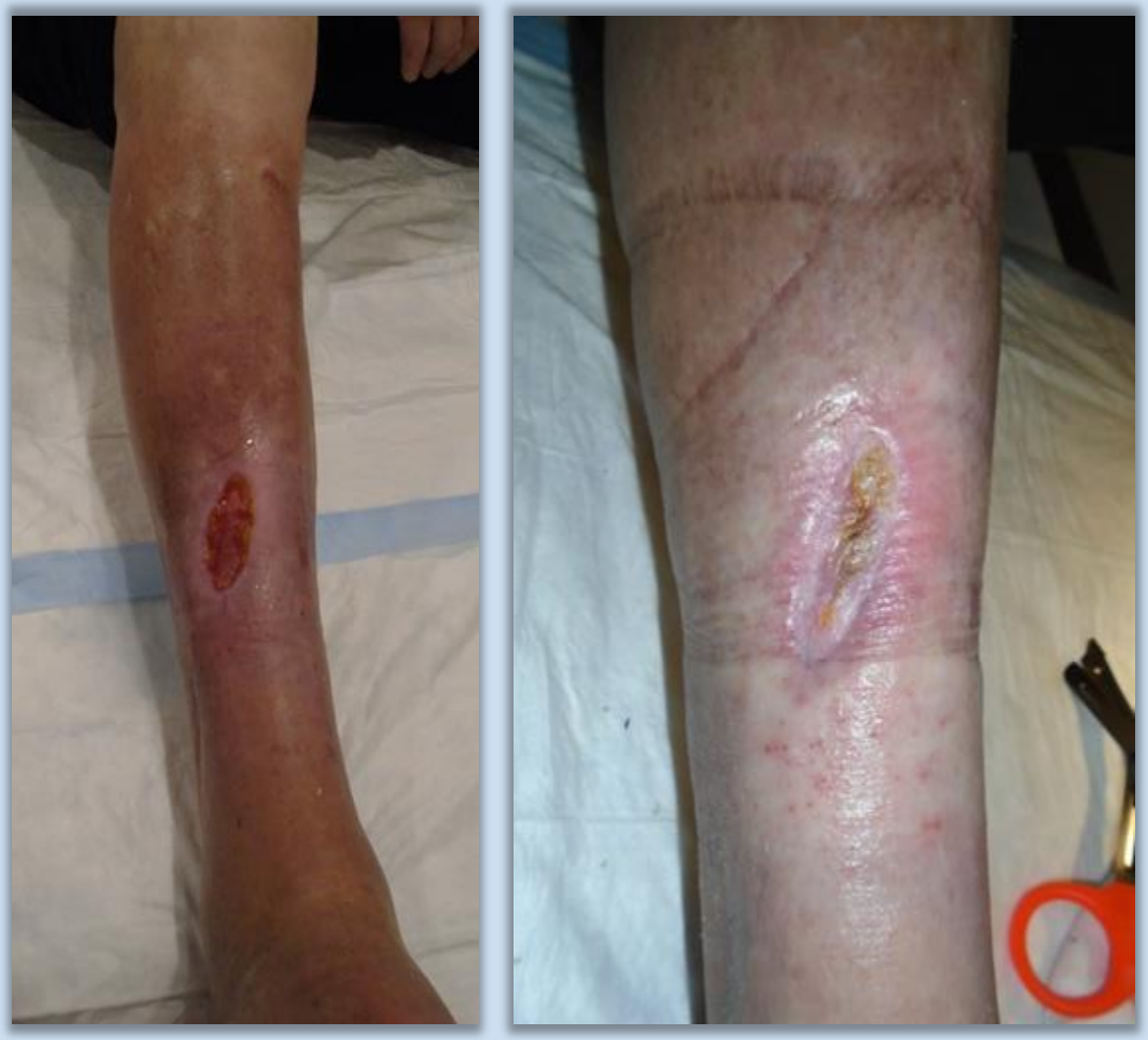
Case Study: Treatment

Treatment

- Full assessment including Doppler of the lower limb, nurse-led no requirement to see a vascular surgeon at this point.
- Important: During the nurse-led Doppler assessment patient was found to have arrhythmia which at the time was thought to be AF (atrial fibrillation) – he was referred to cardiology and AF was confirmed.
- **Commenced reduced compression to the affected leg**
- **Skin care**
- **5 months of consistent engagement and compression**

Results

- Healed wounds
- Skin condition improved
- Swelling reduced
- Compression hosiery * for lifelong wear to prevent reoccurrence



(left): before treatment; (right): after treatment

Tissue Viability Wound Care Pilot Project 2019

- Clinic – one specialist TV nurse 2 days a week for 8 months
- 113 patient reviews were completed (31 of these were new patients)
- No A&E/hospital admissions other than 1 amputee query DVT
- No antibiotic prescription
- No recurrent cellulitis admission
- All patients engaged with care, came to appointments and were committed.
- The success of the clinic was based on the clinical skills of the nurse and the relationship & trust of the patient

4

Working in partnership with councils and housing associations to provide effective wrap-around care

Guidance from the Fuller report

'At a system level, ICSs, particularly through their local authority members, have the opportunity to shape and co-coordinate cross-sector efforts to support people to stay well, by working with the voluntary sector, local business and education providers to provide a more consistent offer for socially excluded and most disadvantaged groups, for homeless and inclusion health services. For example, we heard clearly the benefit of system-level (and in some instances regional) co-ordination, and co-design of services for inclusion health groups will be essential to ensure equity of access and address the needs of people for whom traditional models may work less well.

... A real measure of success for this and other ICS strategies will be weather ICSs have meaningfully improved outcomes and experience for these groups which are often not well served by traditional models' (Pages 16-17)

[NHS England » Next steps for integrating primary care: Fuller Stocktake report](#).

NCL vision for people experiencing homelessness

Working together across the system and in partnership with people experiencing homelessness focusing on individual's strengths, interests and potential to enable their transition into a sustained recovery from homelessness.

Infrastructure/Enablers
- Data & evidence
- Contract management
- Info Sharing Agreements
- IT Systems
- Joint Commissioning

Governance
Borough Health & Wellbeing Board
Borough Partnerships
Rough Sleeping Strategic Board/MEAM Strate Board
ICS Population Health and Inequalities Committee

VALUES embedded through training

- psychologically informed
- gender informed
- trauma informed
- strengths-based
- co-produced
- accessible and inclusive services

Healthcare

Mainstream services: GP registration and access, dentistry, optometry community health, mental health

Specialist and targeted support
Specialist GP and LCS, joined up support - mental health, substance use, physical health, health peer advocacy, children's services, safeguarding

Out of Hospital Care
Dedicated Intermediate Care, move on coordination and system coordination, End of Life Care, NHS 111

Drug & Alcohol

- Ongoing stabilisation
- Substitute prescribing
- Care planning / Detox support / Dual diagnosis support

Prevention

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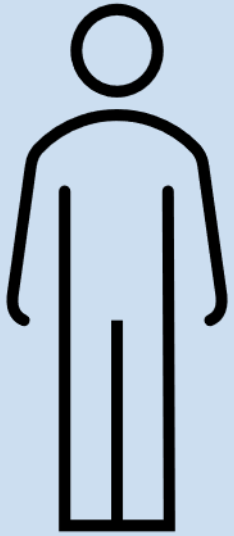

Social Care

- Safeguarding for vulnerable groups (including DV and modern slavery)
- Dedicated social workers and care act assessments where appropriate

Benefits, legal and other specialist advice

- Benefits support
- NRPF
- immigration support
- Other legal advice

Income, employment, education

- Range of education, employment and training opportunities in each borough
- Benefits and immigration support, legal advice

Accommodation
Supported Housing, Social Letting Quotas
Night Shelters with support from Housing First

Floating / peer / keyworker support to connect up the system of health, care, housing and other support including engagement in social connections and meaningful activities

- Interdependencies
- Violence against women and girls
- Adult and child Safeguarding
- COVID-19 response
- Staff health and wellbeing

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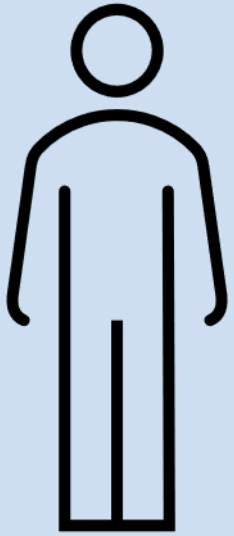

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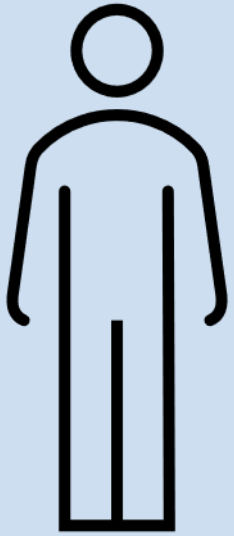

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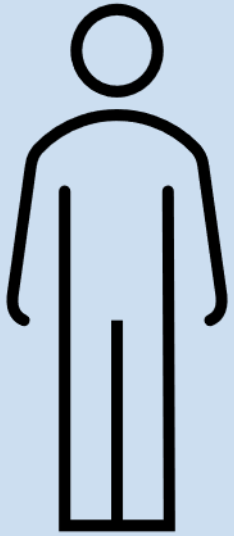

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- Benefits and immigration support, legal advice

Accommodation
Supported Housing, Social Letting Quotas
Night Shelters with support from Housing First

Floating / peer / keyworker support to connect up the system of health, care, housing and other support including engagement in social connections and meaningful activities

- Interdependencies
- Violence against women and girls
- Adult and child Safeguarding
- COVID-19 response
- Staff health and wellbeing

NCL vision for people experiencing homelessness

Working together across the system and in partnership with people experiencing homelessness focusing on individual's strengths, interests and potential to enable their transition into a sustained recovery from homelessness.

Infrastructure/Enablers
- Data & evidence
- Contract management
- Info Sharing Agreements
- IT Systems
- Joint Commissioning

Governance
Borough Health & Wellbeing Board
Borough Partnerships
Rough Sleeping Strategic Board/MEAM Strategic Board
ICS Population Health and Inequalities Committee

VALUES embedded through training

- psychologically informed
- gender informed
- trauma informed
- strengths-based
- co-produced
- accessible and inclusive services

Healthcare

Mainstream services: GP registration and access, dentistry, optometry community health, mental health

Specialist and targeted support
Specialist GP and LCS, joined up support - mental health, substance misuse, physical health, health peer advocacy, children's services, safeguarding

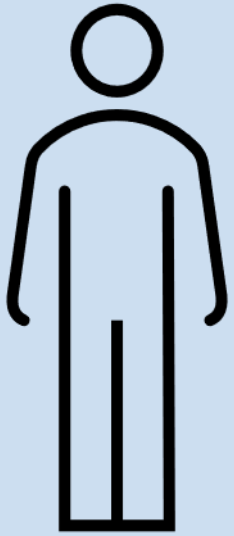
Out of Hospital Care
Dedicated Intermediate Care, move on coordination and system coordination, End of Life Care, NHS 111

Drug & Alcohol

- Ongoing stabilisation
- Substitute prescribing
- Care planning / Detox support / Dual diagnosis support

Prevention

- BBV testing
- Sexual health
- Smoking cessation
- Immunisation and vaccination
- Cancer screening
- Nutrition



Social Care

- Safeguarding for vulnerable groups (including DV and modern slavery)
- Dedicated social workers and care act assessments where appropriate

Benefits, legal and other specialist advice

- Benefits support
- NRPF
- immigration support
- Other legal advice

Income, employment, education

- Range of education, employment and training opportunities in each borough
- Benefits and immigration support, legal advice

Accommodation
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NHS
North Central London
Integrated Care Board

Healthy London Partnership

THANK YOU

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Appendix

Londonwide Homeless Health Primary Care Steering Group

Established in December 2021

Brings together all London ICS homeless commissioning leads, London Councils, Frontline clinical and non clinical teams, including GPs and practice nurses, secondary care teams, people with lived experience, Public Health, research groups, charity organisations working with people who are homeless

Sub group 1 - Registration, access, content and quality of health care provision

Sub group 2 – Training for both clinical and non clinical primary care staff

Sub group 3 - Coordination between mental health, primary care and drug and alcohol services

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NHS South West London

NHS North Central London Integrated Care Board

SAFE SURGERIES

North West London Integrated Care System

NHS North East London

NHS South East London

UCL

homeless link

Healthy London Partnership

Groundswell Out of homelessness

NHS Digital

Public Health England

NHS England

Queen Mary University of London

LONDON COUNCILS

pathway Healthcare for homeless people

SUPPORTED BY MAYOR OF LONDON

Londonwide LMCs The professional voice of London general practice

Doctors of the World UK

Camden Adult Pathway Partnership

Service description

- The Camden Adult Pathway Partnership (CAPP) team is delivered by University College London Hospitals NHS Foundation Trust and provides innovative in-reach nurse-led health interventions to over 600 vulnerable homeless people living across 15 supported housing services in Camden. The CAPP nurses carry out health assessments, health checks, make referrals, and provide advice and support.
- At the heart of CAPP is an ethos of building relationships and partnership working that provides well-coordinated, client-centred wraparound care supporting homeless people to feel better and improve their health. CAPP co-ordinates support for the individual in a way that is flexible, friendly and trauma-informed.
- We are recruiting an additional nurse and a social worker via RSI funding. We will also commence cervical screening on site at hostels from January 2023, as part of our work to improve access to cancer screening.

Service data (taken from 6 monthly data Jan-June 2022)

- 179 people (a third of the total clients) were seen with an average number of 2.7 appointments per person, demonstrating improved and sustained engagement with health services
- Over 70 clinics run, with over 480 appointments attended
- 26% of clients were female, in line with hostel population demographics
- 20% of people supported have tri-morbidity of physical health, mental health and problematic drug and/or alcohol use
- Most common presenting issues/conditions were: mental health (80), dentistry (73), poor nutrition (72), drug and alcohol use (62), opticians (55), MSK (52).

The aim is to reduce health inequalities for the homeless population, including increased access to mainstream services, improving patient experience and positive outcomes.

Expected outcomes include:

- Increased registration and engagement with primary care
- Reduced mortality from preventable causes
- Improved health and quality of life
- Increased confidence in ability to self-manage health conditions
- Increased access to early mental health support for BAME patients
- Reduced unplanned urgent and emergency service use (e.g., A&E attendance)
- A more coordinated and integrated health and care support offer for homeless clients

Evidence of effectiveness

- 117 out of 179 clients (65%) previously had poor engagement with primary care (unregistered, unknown or not having seen a GP in last 12 months) and were supported by CAPP to re-engage
- 93% (27) of BAME patients with a mental health need engaged in early intervention support
- 86% of hostel staff agreed that CAPP empowered them to better support the health needs of their service users
- Positive patient reported outcomes:
  - Average satisfaction score of 9.7 out of 10
  - 90% feel more confident and positive talking to other health professionals
  - 80% feel their health and wellbeing has improved
  - 68% of patients more active and confident managing their own health

Case study

Context of health issues

Our client presented to us with the following health concerns:

- Wound on his hand
- Chronic gastric issues
- Drinking up to 30 units of alcohol and smoking 20 cigarettes a day
- Needed flu vaccine, dental appointment and eye test
- Described poor engagement with primary care / health services

CAPP involvement

- Through health screening, CAPP identified both a wound infection and urine infection. CAPP coordinated with GP and pharmacy to prescribe antibiotics.
- CAPP referred client to Groundswell to support with attending numerous gastroenterology appointments we had arranged – including endoscopy and tropical medicine
- CAPP identified high cholesterol and low vitamin D from blood tests and gave advice and support to address this
- CAPP referred client to ICAS and encouraged him to attend community alcohol rehab which was hugely successful
- CAPP referred client to smoking cessation team

Outcomes

- Client has given up alcohol and smoking
- Received flu vaccine, dental care and optician appointment
- Healthier lifestyle, including gym membership
- Cholesterol halved, triglyceride levels 8 times lower, vitamin D doubled
- Cause of gastric problems identified and addressed, leading to reduced A&E admission (client attended A&E twice within the 3 months preceding CAPP intervention)
- Client's self-reported health rating improved from 5/10 to 9/10 within 3 months

Feedback from key system partners (GPs, other health services, drug and alcohol services, peer support etc.)

- *"Since the CAPP team has been introduced there is a bigger focus on physical health for this client group from all services/ partners."*
- *"Working with CAPP has been a refreshing and positive experience. We would like to see more initiatives like this."*
- *"The MDT model is a much needed example of good integrated work"*

Olallo House and Mildmay Mission

A place to recover, receive rehabilitation, plan and move on from homelessness following a period of hospital admission

Expected outcomes

- A safe place for the person to engage with health and social care services, for rehabilitation and recovery.
- To place from where to engage with employment agencies, private rented, review/educate on medication
- A place to support integration with services and move on from homelessness to break the pattern of re-admission / attendance at hospitals

Service Data

Olallo

17 clients referred and accepted 01.02.22 TO 16.08.22
10 clients had No Recourse to Public Funds (NRPF)
13 have been discharged, 12 moved on from homelessness and 1 self discharged (went missing). They had a combined total of 721 days with a mean average of LOS of 55 days.

Mildmay Mission (complex D2A P2 beds)

12 people admitted over the period 21/22 with a total of 277 bed days

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Evidence of effectiveness

- The National OOHCM pilot P2 bed average LOS is 105 days. NCL OOCHM D2A P2 mean average of 55 days in Olallo and Mildmay Mission 23 days
- Snapshot audit from Acute discharge delays showed that a person had mean average of 21 days in discharge delay during November and February. 17 Patients could have resulted in at least 357 acute bed days being saved costing **£247,101.12** had they been pulled out as soon as no longer meeting criteria to reside
- Prevention of discharge to the streets
- Immigration status change in 2 cases - both now moved on to secure accommodation
- Care Act Assessments carried out for 2 cases – both eligible
- OOHCM P2 bed weekly discharge planning meetings

Next steps:

Patient experience using EQ45D.
Building stronger strengthens based approach to move on by OOHCM colleagues
Recruitment to LBC MOC should increase flow and pull out of Olallo

Patient feedback:
Case 1: “I cannot say enough good things about the staff, kind, interested and knowledgeable not only have they made my stay an absolute pleasure and a life saver they also assisted me with paperwork. Little I could think of would improve it. A minor point perhaps blinds in the bathroom
Case 2 “I think the team it’s the best they treated me with a lot of respect they are so kind and welcome. I think I am so lucky to be here. Thank you”

Peer Advocacy (Camden and Islington)

Service description

Groundswell Homeless Peer Advocacy supporting rough sleepers & people in Camden and Islington's Adult Hostel Pathway to access health services

Service data

Appointments Supported	20-21	21-22	22-23 (Q1)
Camden	322	332	70
Islington	145	400	109

Expected outcomes

Improved and sustained engagement with primary, community and planned secondary heath services to improve health outcomes and reduce reliance on emergency services

Evidence of effectiveness

	% Booked Appointments Attended	% Clients Registered with a GP
Camden	71%	97%
Islington	77%	98%

"I've observed the work undertaken by Groundswell change lives, and in many instances, save lives. The peer's role model at every step ensuring that clients gain the skills and confidence to themselves become more empowered and informed with greater control over their own wellbeing." Service Manager

Case study

BB was originally referred to Groundswell following a request from his keyworker to support him to attend health appointments related to diabetes and a heart condition. A problem drinker BB was not attending his appointments at the time and his alcohol use was exacerbating a general deterioration in his physical health. There were numerous ambulance call outs for BB prior to Groundswell becoming involved. Our initial appointments with him were to help him attend GP appointments but during this time he suffered a heart attack. Groundswell maintained the support following BB's heart attack and to date we have been requested to support him to 21 appointments, 17 of which he has attended. Groundswell has been able to maintain the relationship with BB despite the fact he has moved hostels in the borough. He has gradually became more independent in relation to his health appointments and now attends some without accompaniment

Move on Coordinators and System Coordinator

Service description

Move on Coordinators (MOC) - There are 5 NCL OOHCM MOC, one employed by each local authority. They provide time critical housing support intervention to discharge teams and to the client whether they are housing eligible or not (those with NRPF). The support is in the main provided in the community setting including partnership working with outreach teams, VCS, immigration and housing colleagues to secure safe accommodation for discharge, legal advice for immigration status and welfare and benefit support.

System coordinator - There is one system co-ordinator employed by NCL ICB overseeing the OOHCM who has the collective view of barriers to discharge, seeking change opportunities for improvement across NCL and driving those changes

Single point for escalation of complex discharge cases and coordinating move on support across NCL and wider as required. Leads on the co-ordination of complex step up cases

Expected Outcomes

- Avoid discharge to streets is the a key principle, decrease discharge delay and re-attendance/admission to hospital.
- To support discharge from hospital, including attendance at client discharge planning meetings, guidance and support on housing application paperwork (if appropriate).
- To provide direct and indirect education and awareness raising of homelessness DTR, Homeless Reduction Act, NRPF.
- To decrease the reported confusion in housing process and decrease delays with DTRs

Service data

System Co-ordinator has lead on 3 complex step up cases since February 2022, an example presented in Case study NC and 49 NCL complex escalation support case unblocking since October 2022. 63% were male.
Formed part of the task and finish group for the creation of the London Housing Directory (went live in March 2022), the NRPF and discharge webinar (delivered by NRPF Network in early summer 2022) and the NCL housing discharge workshop (November 2022), set up Homeless Personal Health Budget digital process (with NCL PHB lead), working on UCLP for homeless and driven discussions on safeguarding; a pan London discharge and homeless group is being set up.

MOC have supported 262 cases between October 2021 and June 2022, with a 62% increase in caseload between Q4 21/22 and Q1 22/23. 69% were male, majority white male. There was no discharge to the street cases.

Evidence of effectiveness

Housing services report receiving DTR from hospitals in a more timely fashion at least 1 week in advance (sometimes 3 weeks) prior to client being ready for discharge this could indicate an increased communication between housing and health and social care teams.
The impact is less temporary accommodation being used.
Clients self management in accommodation with integration into community including VCS befriending services, English classes
Head of system coordination is “the anchor point”
Next steps

- Review Housing Assessment structure support process e.g. direct sharing of DTR to increase referral numbers
- Ongoing integration with Transfer of Care Hubs and building up local connection opportunities
- Recruitment to the LBC MOC (vacant since February 2022)
- Understand impact of Housing directory (scoping underway)
- Understand discharge teams views and impact of OOHCM (scoping underway)

NC step up case study and CA Case studies follows demonstrating move on coordinator and system co-ordination leadership