Improving outcomes for homeless inpatients in mental health

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Abstract

Purpose – *The purpose of this paper is to describe the delivery of the first clinically led, inter-professional Pathway Homeless team in a mental health trust, within the King's Health Partners hospitals in South London. The Kings Health Partners Pathway Homeless teams have been operating since January 2014 at Guy's and St Thomas' (GStT) and Kings College Hospital and expanded to the South London and Maudsley in 2015 as a charitable pilot, now continuing with short-term funding.*

Design/methodology/approach – *This paper outlines how the team delivered its key aim of improving health and housing outcomes for inpatients. It details the service development and integration within a mental health trust incorporating the experience of its sister teams at Kings and GStT. It goes on to show how the service works across multiple hospital sites and is embedded within the Trust's management structures.*

Findings – *Innovations including the transitional arrangements for patients' post-discharge are described. In the first three years of operation the team saw 237 patients. Improved housing status was achieved in 74 per cent of patients with reduced use of unscheduled care after discharge. Early analysis suggests a statistically significant reduction in bed days and reduced use of unscheduled care.*

Originality/value – *The paper suggests that this model serves as an example of person centred, value-based health that is focused on improving care and outcomes for homeless inpatients in mental health settings, with the potential to be rolled-out nationally to other mental health Trusts.*

Keywords *Inclusion, Health, Homeless, Pathway, Mental, Excluded*

Paper type *Research paper*

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Introduction

Homeless and excluded groups experience extreme health inequity, high morbidity and premature mortality (Aldridge *et al.*, 2017). Mental illness in people experiencing homelessness is common (Stergiopoulos *et al.*, 2017) and it is a key reason for attendance at emergency departments and admission to psychiatric wards (O'Neill *et al.*, 2007). In England 80 per cent of homeless people report some form of mental health issue and 45 per cent have been diagnosed with a mental health problem, with depression and severe mental illness like schizophrenia being particularly pronounced (Homeless Link, 2014; Aldridge *et al.*, 2017). Mental illness is thought to affect most people involved the homelessness, drug treatment and criminal justice systems (Bramley *et al.*, 2015, p. 6). Welfare cuts, proof of entitlement, a local connection (LC) (Dobie *et al.*, 2014) and the need for ID (Homeless Link, 2017) are exacerbating pre-existing difficulties in accessing community support such as housing and healthcare (Dobie *et al.*, 2014).

Homelessness is characterised by complex needs (Fazel *et al.*, 2014) described as "tri-morbidity" – the combination of physical illness, mental illness and addictions (Homeless Link, 2014; Stringfellow *et al.*, 2015). Yet uptake of preventative and scheduled healthcare by homeless people is low (Luchenski *et al.*, 2017). Contacts with services are often ineffective because the focus tends to be on addressing one problem as opposed to adopting an holistic approach aimed at addressing complex health and social needs (Bauer *et al.*, 2013; Salize, Werner and Jacke, 2013; Bramley *et al.*, 2015; Davies and Mary, 2016).

Secondary care and homelessness

In the UK and Internationally, health systems have identified the importance of integrated care for people experiencing homelessness with mental health needs (Fraino, 2015; Stergiopoulos *et al.*, 2017; Cornes *et al.*, 2018). Despite this increased awareness there remains a lack of dedicated service provision for people who are homeless in psychiatric inpatient and community mental health settings (Bauer *et al.*, 2013). Moreover, multi-disciplinary care planning, reablement, integrated working and relationship building have been identified as important components in secondary care provision for homeless patients (Cornes *et al.*, 2018).

Pathway performed a randomised parallel arm-trial in two inner-city hospitals in order to compare standard care (from a hospital-based clinical team) with enhanced care with input from specialist homeless teams. Although length of stay did not differ between the groups, patients experiencing enhanced care recorded improved quality of life scores. The group benefiting from enhanced care was also found to be less likely to be discharged on to the street following a period of hospitalisation (Hewett *et al.*, 2016). To date, this service delivery model has not been replicated in a mental health setting in the UK. Internationally, however, intensive inpatient psychiatric support for homeless people has been shown to improve engagement, reduce relapse (Killaspy *et al.*, 2004; Pearson, 2010) and improve tenancy sustainment. The deployment of multi-disciplinary care has been found to be effective in improving, residential stability and reducing admissions to psychiatric hospitals (Stergiopoulos *et al.*, 2015).

Method

This paper reviews existing literature to understand how the role of specialist inpatient homeless teams has become established in secondary care settings. It also draws on the personal experiences and observations of the team working in a specialist in-reach homeless hospital team in a mental health setting at the South London and Maudsley (SLaM) Foundation Trust in South London. This approach is complemented by the inclusion of routine clinical and demographic data (e.g. each episode of care and includes demographics at admission, interventions and outcomes at discharge) collected by the Pathway team at SLaM and early findings from the evaluation.

The Pathway approach to multi-disciplinary care for homeless in patients

In 2009 the Pathway Charity implemented a model of GP and nurse-led homeless hospital ward rounds at University College Hospital, London, based on a similar service run by consultants Boston, USA (www.bhchp.org/). Key tasks include reviewing clinical and discharge goals, assisting with care planning, explaining medical findings, communicating with multiple hospital-based teams and community service providers, so as to facilitate a safe discharge (Hewett *et al.*, 2012). The Pathway model has since grown and spread across acute care settings in the UK and internationally to Perth, Western Australia. As noted earlier, however, the Pathway approach has not as yet been applied in a mental health setting (www.pathway.org.uk/teams/).

Following an urban multicentred needs assessment in South East London (Hewett and Dorney-Smith, 2013), the Kings Health Partners (KHP) Pathway Homeless Team service commenced at Guy's and St Thomas' (GStT) and Kings College Hospital (KCH) in January 2014. The service was expanded to SLaM in February 2015. The service aims to improve health and housing outcomes for homeless people admitted to hospital, improve quality of care and reduce delayed or premature discharges from hospital (Dorney-Smith *et al.*, 2016). The needs assessment sought to establish the cost of attendances and admissions, while also actively involving patients and stakeholders in shaping solutions. It demonstrated that homeless psychiatric admissions cost almost £2.7m annually across four boroughs (Hewett and Dorney-Smith, 2013). Additionally, a study at SLaM identified the need for housing was a cause for delayed discharged and that homelessness was independently associated with a 45 per cent increase in length of stay (Tulloch *et al.*, 2012).

Lambeth and Southwark Clinical Commissioning Groups (CCGs) funded the KHP Pathway Teams at GStT and KCH from 2014, whilst the team at SLaM was funded by the GStT and

Maudsley (SLaM) charities as part of a three-year pilot. The inter-professional team includes GPs, general nurses, mental health practitioners (MHP), occupational therapists and a social worker employed by the hospital trusts. The housing workers and peer advocate are seconded from the voluntary sector (St Mungos, St Giles Trust, the Passage and Groundswell). The SLaM team is comprised of two full-time Band, seven MHP, a sessional GP, a housing worker from one of the partner voluntary organisations, three days a week and a business manager one day a week. The team is overseen by an operational manager and has senior clinical management from a clinical director. The service evaluation is supported by clinical academics from the Institute of Psychiatry and Kings College London. The teams work together to improve outcomes and experience of homeless and vulnerably housed people across the three hospital trusts.

Service attributes

Overview

The SLaM NHS Foundation Trust is a large secondary mental healthcare provider with responsibility for secondary mental healthcare support to four South London boroughs (Croydon, Lambeth, Lewisham and Southwark) along with tertiary mental health services to a wider population. There are four hospital sites providing inpatient provision for each borough and some national services. The catchment population served by the Trust is over 2m people, mostly resident in inner-city areas.

The aims of the service are to improve health and housing outcomes for homeless people admitted to hospital, improve quality of care while reducing delayed or premature discharges from hospital. The key outcomes are to reduce unscheduled admissions and support access to scheduled care and community services. The team provides expert review and support around housing and health issues by assertively advocating for patients through partnerships and links with GPs, community health services, social services, housing departments, hostels, outreach teams and a wide range of community and voluntary sector services. Within the trust the team works closely with bed management, ward managers and the welfare team. The team developed a forum with other homeless services at the Trust including Psychology in Hostels and the START team (a rough sleepers' mental health outreach service) and works collaboratively with the Health Inclusion Team – a community nurse-led homeless service based in Lambeth, Southwark and Lewisham.

Service development

The needs assessment in 2012 estimated that there are around 150 admissions of homeless people a year across all four SLaM sites. To effectively plan the service design and delivery, the team were appointed before the service launch. They undertook a simple survey of SLaM wards and found that across the 12 responses 22 per cent of patients ($n = 46$) patients were assessed as having had an episode of homelessness that month, and in 13 per cent cases this was perceived to be a current cause of delayed discharge. In the previous five months the place of safety (emergency psychiatric ward) identified 84 patients without a LC to the hospital's four boroughs. Staff identified chaotic lifestyles and lack of suitable placements as key to discharge delays.

This snapshot identified more patients than the needs assessment. Due to limited resources, it was agreed that the team would see patients admitted to Lambeth and Southwark psychiatric wards (Lambeth Hospital and Maudsley Hospital) who were not in contact with a Community Mental Health Team (CMHT). In practice, patients have been seen with and without a LC to all four SLaM boroughs (Southwark 25 per cent, Lambeth, 24 per cent, Lewisham 9 per cent and Croydon 7 per cent). Patients linked to CMHTs are supported with advice and signposting. The team had the benefit of the experience of the Pathway Teams at GStT and Kings before going live, so were able to make the decision to incorporate a housing worker into the service to address some of the issues raised in the audit. Going forward, NHS funding has been identified to support a whole-time housing worker. This will enable the team to work in partnership with inpatients linked to a CMHT. It is perhaps worth noting here that the team have come to attribute the underestimation of homeless admissions to the fact that patients are typically admitted to SLaM primarily based on GP registration, which is usually linked to a historic address.

Routine data collection would consider these patients as housed. This is an important learning point for other Mental Health Trusts, considering a Pathway Homeless Team.

KHP pathway homeless team at SLaM receives referrals for admitted patients in Lambeth and Southwark who are homeless or vulnerably housed and without a care co-ordinator. This is irrespective of their right to statutory entitlements, nationality or LC.

Referral criteria:

- admitted to a SLaM inpatient ward;
- 18+;
- patients living in homeless hostels, B&B, sofa surfers or who have nowhere to go on discharge;
- patients with any mental health diagnosis;
- patients without a care co-ordinator, including those with no local housing connection and no recourse to public funds (NRPF); and
- homeless frequent attenders, e.g., to A&E, acute wards or place of safety and/or patients who are having both physical health and mental health admissions.

The team accepts referrals for patients who meet the criteria but will offer advice to care co-ordinators or wards for patients who do not.

Having a care co-ordinator linked to a CMHT was the main reason why patients were not accepted to the caseload. The team reviews patients' notes and offers advice, information and signposting to support care-coordinators. Patients referred from wards outside of Lambeth and Southwark were offered the same advice service.

Service model

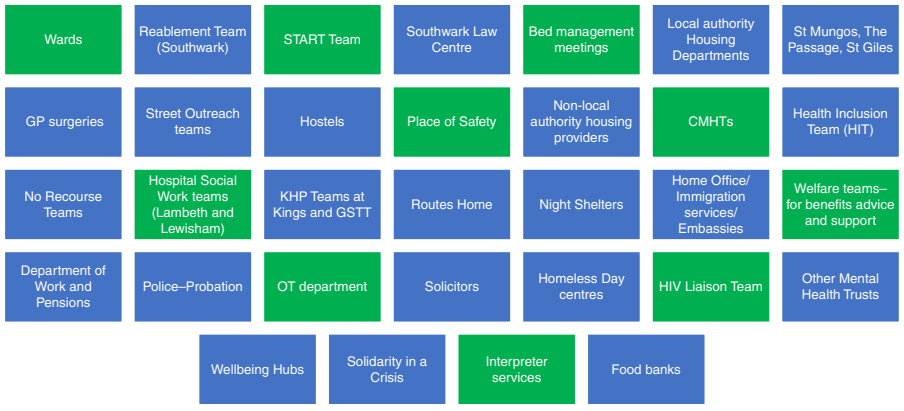
At referral, the team reviews the hospital records and routinely checks several databases including:

- NHS Spine – to see if clients are registered with a GP, and to review housing history associated with GP registration. Next of kin details are also sometimes available.
- CHAIN – rough sleepers' database for London which includes details of sleep sites, key workers and service contacts.
- EMIS Web – a primary care record system also used by the Health Inclusion Team and which is now used by other Pathway Teams and healthcare providers across London, with work almost complete to develop data sharing.
- Local care record – records, test results and documents from local hospitals and practices in some areas. It can help confirm medical history and medication.

The team works closely with a wide variety of services across the Trust and in the wider community. An audit of patients found that on the average the team liaised with five services per patient, though for very complex patients the figure was substantially higher at 11 services. Communication and case planning therefore underpin the work of the team and on average the team attends six multi-disciplinary ward round meetings a week.

In 2015, the KHP teams successfully applied for charitable funding for a three-year specialist legal advice project. The funding enabled Southwark Law Centre to provide rapid advice by e-mail or phone in housing, immigration and welfare law. The law centre attends a clinical meeting at each site once a quarter in order to provide updates on relevant case law and statute specifically relating to housing, welfare and immigration. This service has proved to be an invaluable resource to the KHP team, primarily as a means for furthering legal knowledge and understanding, but also importantly for individual patients who have benefited from access to legal advice. The Law Centre has also taken on specific cases (Figure 1).

Figure 1 Internal and external services the team works with



Notes: Internal SLaM services are green and external services are blue

Specialist team roles

The Pathway model allows the team to use both their specialist expertise and more generic skills. Holistic assessments are undertaken by any member of the team and reviewed as part of a daily team meeting. Cases are discussed weekly between the whole team at the case review meeting. Depending on the specific circumstances a plan will be outlined and communicated with the patient and the ward. For example, patients who are rough sleeping before admission may be supported to make homelessness or supported accommodation application whereas those who are at risk of eviction would need support from the local authority to maintain their accommodation or be housed somewhere more suitable. Referrals are made for Care Act assessments, where patients have care needs or require mental health supported accommodation. Those without entitlement to statutory services will be supported to access private rental accommodation, night shelters or legal support.

All patients are supported to register with a GP and apply for welfare benefits (if eligible). Appropriate follow up is arranged before discharge. Patients are also supported to access necessities such as a mobile phone, foodbank vouchers and subsistence until benefits are established.

Team members have had training to develop in specialist expertise in NRPF, Mental Capacity Act, Mental Health Act, safeguarding, welfare benefits, modern day slavery and trafficking, along with key clinical content such as substance misuse (see Figure 2).

Mental health practitioner (MHP)

The MHPs have experience of working with a wide variety of mental health conditions, thus providing the team with valuable knowledge and insight into the needs of people experiencing mental health problems. The MHPs jointly run the service which ensures continuity of care from inpatient to community services. They screen all referrals and allocate cases to the appropriate team member. Part of the assessment process involves, assessing patients' health and social care needs, communicate plans and making recommendations to the admitting teams. They also take the lead on working with ward staff to plan for safe discharge. This process includes formulating care plans and risk assessments around the functional impact of homelessness and advocating around impact of mental health on homelessness. The MHPs independently contribute to supporting medical letters and reports around homeless and health issues. They also provide mental health support and advocacy for patients at housing appointments when required, communicating the risks and needs of complex clients with other services. MHPs also lead on delivering training to wards and other professional groups, offer student placements, and present at external conferences and events.

Figure 2 Interventions of the KHP Pathway Homeless team

Housing worker

The housing worker role is a rotational post across all KHP teams. It provides an opportunity for the housing worker to develop expertise through working in different healthcare settings and with patients with differing primary health needs. The housing worker is experienced in providing housing advice and advocacy, using knowledge of housing law and regulation, to identify all possible housing options. They will support clients to make homeless presentations to the council, present evidence collected by the team and advocate in respect of homelessness legislation. The housing worker is also able to provide rapid housing advice and signposting when patients have a brief admission.

GP

This is the first time a GP has been employed in a senior (consultant grade) role within SLaM. Patients with severe and enduring mental illness are at a significantly increased risk of developing physical health problems, in part this is attributable to the medication a patient might receive. The GP supports patients to be screened and treated for health problems before handing over to community teams at the point of discharge. The GP works closely with consultants to understand the role of the team and to promote shared working. The GP is also responsible for writing clinical letters of support for patients both for statutory homelessness applications and for supported accommodation routes and writes GP to GP discharge summaries to improve handover of patient care and follow up needs. The GP has coordinated the service evaluation and communicates findings and outputs to the operational management and steering committees within the trust, and outwardly through Pathway and at local and national meetings and conferences.

Business manager

The business manager supports the team with collecting, recording and analysing data and producing quarterly reports. The business manager oversees payments and liaison with the partner organisations and maintains overall administration and management support.

Clinical academics

During the pilot phase, the charity grants included funding for a research evaluation in collaboration with a clinical academic and a health economist. This included a data analysis and an economic analysis. Following pilot funding, the team received short-term CCG funding.

Outcomes and patient demographics

The pilot service ran from December 2014 to December 2017 and received 465 referrals of which 237 met the team's criteria.

Data analysis showed that 34 per cent were admitted voluntarily, 27 per cent under section 2 and 14 per cent under section 3 of the Mental Health Act. Severe mental illness was diagnosed in 77 per cent of patients seen (psychosis 54 per cent, schizophrenia 12 per cent and bi-polar 11 per cent). Emotionally unstable personality disorder was reported or diagnosed in 19 per cent of patients. Tri-morbidity was evidenced with a quarter of patients reporting a past medical history. A total of 24 per cent reported harmful or problematic drinking, 17 per cent reported alcohol dependence and 13 per cent drug dependence. Also, suicidality or self-harm affected 38 per cent of the patients. In total, 5 per cent of patients seen were HIV positive and 2 per cent Hepatitis C positive, which is considerably higher than the local prevalence. Chronic illnesses (diabetes, asthma, COPD and Epilepsy) affect 14 per cent of patients. Of note, a quarter of patients had a history of violent behaviour towards others (Table I).

A total of 175 patients (74 per cent) seen by the service had an improved housing status on discharge. Patients were support to access emergency (e.g. night shelters) and supported (e.g. hostels) accommodation, private rental properties while others were successfully reconnected. A further 25 (11 per cent) had their housing status maintained largely by preventing loss of accommodation. It is not possible for the team to improve housing status in all instances; indeed, some patients will return to rough sleeping or self-discharge or abscond from the ward. A total of 57 patients (24 per cent) presented to housing departments and 67 patients (28 per cent) were referred for supported accommodation. Where housing solutions were not found, patients received advice, signposting and case work to identify key workers and services that could support them. In total, 133 patients (56 per cent) were seen by a housing worker and 95 letters were written by the GP to support housing applications. The average length of stay was 33 days.

These outcomes include the 24 per cent of patients who had NRPF. The team saw an increase in reported rough sleeping from 24 per cent of patients seen in the first year to 48 per cent seen in the second year. This is likely to reflect the on-going increase in rough sleeping in England (Ministry of Housing, Communities and Local Government, 2017).

Reconnection

Reconnection in the context of the team's work is defined as outside of SLaMs four boroughs. LC is established by taking a patient's housing history and identifying their eligibility for housing, funded by the local authority.

There are several reasons why it is important to accurately identify LC and thus avoid submitting homelessness applications to arbitrarily selected local authorities (LA):

1. The team has developed positive relationships with the nearest LA and depend on them for assistance for a large proportion of the caseload. Additionally, many people experiencing homelessness come to London from elsewhere.

Table I Housing status at admission of patients referred to the service

Housing status	*Number*	*Percentage*
Rough sleepers	85	35.9
Sofa surfing	54	22.8
Living with family	29	12.2
Private rental accommodation	26	11
Living in a homeless hostel	9	3.8
Housed	5	2.1
Temporary accommodation	6	2.5
Other (night shelter, squats)	7	2.9
Unknown (discharged or transferred before assessment)	16	6.8

2. Certain services are provided on a discretionary basis which means that LA have no legal duty to provide them. Therefore, hostel and supported housing pathways usually only accept people with a very clear LC.
3. LA have a "power" to refer to another local authority for discharge of full duty (permanent offer of accommodation) once the patient has received a positive decision for permanent housing. It is more sensible to approach the local authority where the client is likely to receive this full duty for housing and offer a supported transition from hospital than a potentially unsupported one.

It is worth acknowledging that individually, patients have a right to approach any local authority they want in an emergency. In such emergencies the Pathway Homeless Team may not be able to identify a LC, so may consider approaching the nearest local authority for assistance. Similarly, where patients are fleeing violence, we are more likely to support the patient's choice even if there is no documentary evidence of violence (although the team endeavour to help them obtain such evidence wherever possible).

A total of 157 patients (66 per cent) seen by the team, had a LC to one of the SLaM's four boroughs. Given that admission is based on registration with a local GP, patients are usually admitted either because they are NFA (with no GP) or due to historic GP registration. This indicates a high level of transience as well as the importance of identifying patients who can be reconnected outside of the SLaM boroughs, where they may have an entitlement to access housing.

Reconnection is a challenging work and involves the whole team; from the point of identifying the patient's most likely borough of LC through to working with the patient to make applications to housing departments and support services and registering patients with a local GP. Due to the need for a local GP and address, it can be challenging to organise CMHT follow up outside of SLaM boroughs, but the team achieves this by arranging GP registration and working with admitting teams to ensure follow up is arranged before discharge. A total of 61 (30 per cent) patients were offered reconnection outside Local and London Boroughs and 12 per cent of patients have a LC outside the UK. In total, 50 (21 per cent) were successfully reconnected. Those who declined reconnection are supported to access services such as night shelters, private rental accommodation or to stay with friends and family members. This underscores the fact that reconnection is an important activity for the team.

Evaluation findings

Statistical analysis

Dr Alex Tulloch worked closely with the team to develop a "logic model" which links the operation of a service to activities, outputs and outcomes. It showed that the Pathway intervention should impact bed days, readmission to hospital and use of services after discharge. SLaM benefits from computerised anonymised data on all admissions, allowing identification of a homeless control group who did not receive Pathway input. Mathematical modelling provided comparison of: bed days and rate of readmission. Early analysis shows that the intervention reduced bed days but not readmission rates.

Service use inventory

Professor Paul McCrone worked closely with the team to develop an acceptable version of Client Service Receipt Inventory to measure acute and community service use at admission, 3 and 6 m intervals. Unit costs of services were then attached.

Early analysis shows that unscheduled care was reduced, and community mental health was increased in the intervention group.

Cost savings

Early analysis shows that patients experiencing the Pathway intervention receive better care and outcomes at no additional cost and possibly a reduced cost to the NHS.

Operational development

Working with local authorities and voluntary sector

It is important to note that LA are experiencing increasing homelessness applications against the backdrop of funding cuts and a chronic shortage of affordable social housing. The team has therefore sought to enhance its relationship with housing teams and housing provision through working collaboratively with LA and the voluntary sector. This is exampled by:

- raising awareness of the impact and vulnerability of patients experiencing the full spectrum of mental health problems including suicidality, depression, anxiety and personality disorder, in addition to psychosis;
- raising awareness of the needs and risks of young people with mental health problems, particularly in the context of family and relationship breakdown;
- working with colleagues from the Southwark Law Centre to clarify the responsibilities and interaction between the Care Act, LC and section 117 aftercare of the Mental Health Act;
- referring to and collaborating with voluntary sector housing services;
- highlighting the overlap and inter-relationships between physical health, mental health and substance misuse problems; and
- developing hospital discharge protocols with local boroughs.

Patient and staff feedback

Each year the KHP Teams undertake a cross site series of structured interviews with patients from all three teams. Patients described how the Homeless Team had kept them fully informed about their care and had maintained good communication with between ward staff and other agencies involved. Most patients rated the KHP Pathway Teams as good or excellent.

Direct feedback from patients seen by the Pathway Homeless Team at SLaM:

> […] inspired by your kindness I am this Christmas holiday volunteering with Crisis. (Patient)

> I feel happy inside and I've never felt like that before. (Patient)

Integration within the trust

As the team became firmly embedded within the Trust, it quickly became clear that ward and community teams needed support in managing the onward care and discharge planning of homeless patients. They articulated the challenge in managing homeless patients, so were able to see the impact of team's expertise and skills, and a change in approach away from discharging to the streets. Consultants described meaningful and positive outcomes for homeless patients within rapid timeframes. The team facilitates care through regular communication both within the team and by regularly reviewing patients on wards and in wards rounds. Stigma and poor discharges were challenged directly with those involved. Direct feedback from staff articulated the added value of the service and improved care and outcomes for patients:

> I've noticed a real change in the culture towards homelessness, most notably in the ending of the practice of discharging to the street. (Nurse on acute psychiatric ward)

> Through successfully tackling the complex issues […] I have absolutely no doubt that this Team have paid for themselves many times over. (Consultant Psychiatrist)

Case 1: role of the GP and reconnection:

Patient: 35-year-old female from an EEA country, arrived in the UK following relationship breakdown, previously living with family in home country.

Medical problems: relapse of Bi-Polar affective disorder after lapsing from treatment, diagnosed with type 2 diabetes following routine blood screening on ward.

Other problems: not entitled to statutory service in UK, children and family support in home country, admitted to SLaM because she was using a local address.

Activities initiated by the Pathway Homeless Team: she was assessed by a MHP and supported to consider options, lack of entitlements in UK and away family support. MHP liaised with the family and supported the ward to do the same.

Activities initiated by the GP: the GP noted that tests results and requested repeat blood tests to confirm the diagnosis. GP met the patient on several occasions and provided advice and leaflets. GP discussed the case with the diabetes team and agreed to manage the patient on the ward with oral medication. GP supported the patient to start treatment.

Overall achievement: patient's mental health improved, and she received a supported repatriation, re-engagement with her family and follow up arranged with local specialist teams.

Case 2: role of the MHP and housing worker in dual diagnosis

Patient: 34-year-old woman, history of dual diagnosis and Post Traumatic Stress Disorder. Admitted with a paracetamol overdose and self-harm. She was not referred to the Homeless Team as she gave a historic address but was recognised by the Pathway team housing worker who saw her during a recent admission to Kings.

Medical history: crack addiction and recently terminated pregnancy.

Other problems: sex working, vulnerable and homeless for several years, residing in crack houses and fled temporary accommodation. History of childhood trauma and domestic violence as an adult; children living with their father who raised safeguarding concerns. Patient wanted to go to rehab.

Activities initiated by the Pathway Team: a safeguarding alert was raised by MHP. The housing worker secured temporary accommodation through the local authority and follow up was arranged with the substance misuse and mental health teams. A multiagency safeguarding meeting was organised by MHP and a referral to rehab. KHP Pathway Teams were aware of the case and the plan if the patient presented.

Following a period of loss of contact with services and further admissions, the patient was placed in an all-female rehab outside of London. She remained there for four months and contacted her children's father until she left the rehab and lost contact with services again.

The patient maintained phone contact with the MHP and through this, she was accepted at a local hostel. Over time, her care was handed over to the Health Inclusion Team nurse and the hostel staff, who supported her to register with a GP, engage with substance misuse services and specialist services for sex workers.

Overall achievement: patient has been in the hostel for 18 months. She has attended A&E twice but was not admitted. She is engaging with health services and although she remains sex working and using drugs, she has maintained accommodation, which has reduced the risks to her safety.

Community mental health follow up

The period around discharge from hospital has been recognised as higher risk due to transitioning between accommodation and services (Windfuhr and Kapur, 2011). Best practice guidance recommends a community follow up within a week of discharge (NICE, 2016). From early in the service it became clear that lack of address was a barrier to linking patients with CMHTs for "seven days" or other community follow up, particularly in a first or new presentation.

Once LC is confirmed the team ensure that patients have as many aspects of follow up in place before discharge from the service. Once this is recognised the team will work closely with wards and CMHTs to develop closer working relationship, enabling appointments, referrals and care co-ordinators to be allocated before discharge, or as soon afterwards if this is not possible.

Transitional support

The team identified a need to work with some patients for a period post-discharge to support a smoother transition into their new accommodation status. The team recognised that transition

from hospital to unfamiliar accommodation is challenging and that this can both cause anxiety and increase the risk of accommodation breakdown and return to homelessness. Transitional support needs include:

- supporting someone to maintain their accommodation;
- setting up benefits payments;
- supporting on-going housing applications; and
- engagement in meaningful activity or support to engage with new CMHTs.

Transitional support is planned with the patient at the time of discharge from hospital depending on patient need, other community support already in place, location of new accommodation and type of accommodation – e.g., temporary unsupported or B&B. Support may be over the phone or face-to-face depending on patient need and team resources. On average the team works with patients for ten days post-discharge. Patients are discharged from the caseload once longer-term support is in place, or there is no longer a need for the support. This work is similar to a "critical time intervention" model which could be tried more formally in mental health settings (de Vet *et al.*, 2017).

Meaningful activity after discharge

Prior to or at the time of discharge, the team will provide information and signposting to patients to orientate them to the local area and available services – e.g., public libraries, community mental health services, returning to work, volunteering and peer support.

Discussion

Previous evidence supports the role and value of specialist homeless health teams in secondary care in improving health and housing outcomes in homeless inpatients (Dorney-Smith *et al.*, 2016; Hewett *et al.*, 2016; Blackburn *et al.*, 2017). The KHP Pathway Homeless Team at SLaM supports the role of these services in mental health trusts and confirms that they offer effective person-centred care. While there is frequently a desire to focus on the economic benefits of new models of care, the work of the Pathway Homeless Team is underpinned by values of equity, social justice and parity of care for homeless and excluded groups.

In previous service evaluations, there was an immediate but ultimately unsustainable reduction in bed days, probably due to rapid resolution of less complex cases (Dorney-Smith *et al.*, 2016) and this was in the absence of a statistical evaluation of the service. The robust research evaluation at SLaM demonstrates improved housing status and altered use of healthcare services after discharge, with a statistically significant reduction in bed days. The analysis accounts for the variation in complexity and other confounding factors that limit previous evidence.

The benefits of consistent positive outcomes for patients are reflected in positive relationships within the Hospital Trust. This resulted in earlier identification of homelessness issues and referral to the service, with an improved understanding of the importance of safe and effective discharge arrangements for complex patients. This is particularly relevant given the increasing numbers of rough sleepers in England (Ministry of Housing, Communities and Local Government, 2017).

This paper is limited by the service model and evaluation components. By way of illustration it took a full year to establish the remit of the evaluation and programme of work. The evaluation did consider measuring health-related quality of life, but limited time of the clinical academics and limited academic experience of the GP to complete the evaluation resulted in a narrower focus on bed days and service use. This focus was privileged on the basis that it was more likely to lead to on-going NHS funding. However, it is vitally important for organisations who want to implement inpatient homeless teams to learn lessons from this team. As such, Pathway homeless teams are complex service interventions. So, we would argue that applying flexible use of the MRC

framework for complex interventions can offer a more structured and a theoretically-informed approach to developing the service and associated evaluation (Craig *et al.*, 2008).

Future research in this area should include qualitative interviews with patients and staff exploring the barriers and facilitators to caring effectively for homeless and excluded groups. Interviews with patients and an assessment of long-term outcomes and quality of life measures would also be valuable.

In April 2018, the Homelessness Reduction Act came into effect in England and from October 2018 Public Bodies, including NHS Trusts, will have a duty to refer anyone who is homeless or at risk of homelessness. The impact of this on NHS Trusts remains to be seen, though there is reason to believe that NHS Trusts with a Pathway Homeless Team are likely to be particularly well placed to respond to this agenda.

The use of evidence to support service development and delivery is essential. Clinical teams working with researchers in leading the design and delivery of services seems to be a robust model for quality and efficiency in healthcare. Whilst the NHS continues to experience financial challenges, these constraints should not affect the implementation of best practice and value-based healthcare (Porter, 2010) nor should it stand in the way of improving health of the poorest fastest (Marmot and Bell, 2012). Providing person-centred care which enables individuals to address their health, social and housing needs together, gives the patient the best opportunity to break the cycle of homeless.

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Further reading

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