Facilitating safe and effective discharge for homeless patients

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- Who we are - Pathway Approach
- Challenges of working with homeless patients
- Interventions for a safe discharge
- Examples of good practice

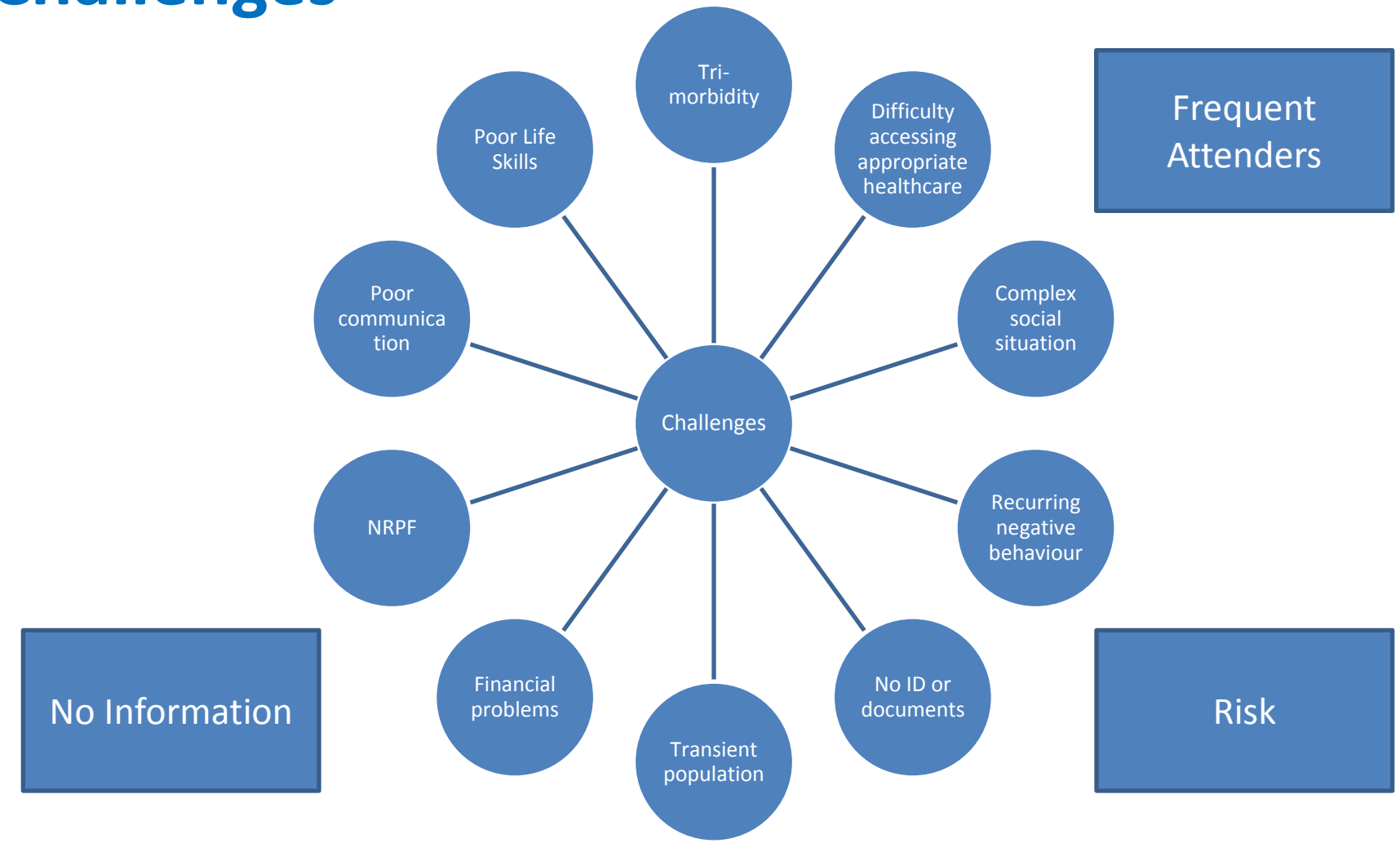
Who we are – Pathway Approach

- KHP Pathway Homeless Team – 3 NHS Trusts in South London – KCH / GSTT / SLaM
- Pathway Approach - Homeless 'Ward Round' – integrated pathway for homeless patients
- Pathway teams help support inpatient clinical teams around homeless **health and housing** issues
- Support collaborative care across health, housing, social and voluntary sector, increasing safe discharge

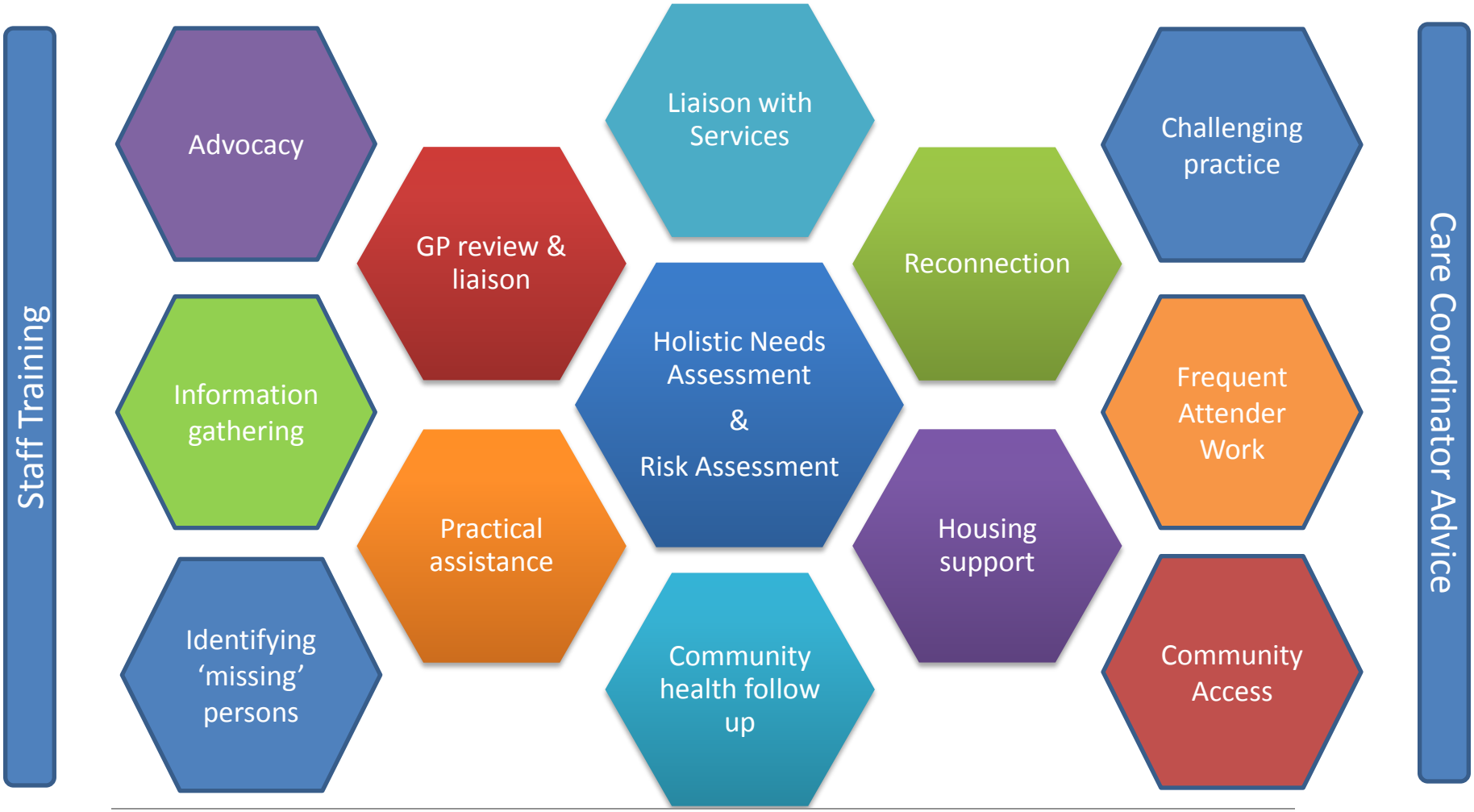
Who's in the team in SLaM?

- 2 x Advanced Mental Health Practitioners (full-time)
- 1 x Housing Worker (3 days a week) – Rotational post
- 1 x GP (3 sessions per week)

Challenges


Tri-morbidity
Poor Life Skills
Difficulty accessing appropriate healthcare
Frequent Attenders
Poor communication
Complex social situation
Challenges
NRPF
Recurring negative behaviour
No Information
Financial problems
No ID or documents
Risk
Transient population

Interventions



Interventions

Liaison with Services

- GP surgeries
- Hostels/shelters
- Southwark Law Centre
- Other Pathway Teams
- LA Housing Departments
- Home office/immigration services
- Partner Homelessness charities
- Police

Housing Support

- Advice
- Support letters/reports
- Housing history
- No Recourse Advice
- Part 7 homeless application
- Referral to supported accommodation
- Attending appointments

Interventions

Reconnection

- Local (London boroughs)
- National
- International

Community Health Follow up

- Handover to CMHT
- Health Inclusion Team
- Addiction services
- GP registration support
- Discharge letter to GP

Interventions

Practical Assistance

- Food
- Transport
- Clothing
- 'Starter pack'

Challenging Practice

- Understanding link between health and homelessness
- Advocacy for client group
- Challenging negative attitudes

Interventions

Community Access

- Reintegration/orientation to community
- Confidence building / empowerment
- Life skills – eg. money/tenancy management

Identifying 'Missing' persons

- Enables transfer of care to correct hospital / community
- Using variety of resources to identify

DN – Complex – Tri morbidity

DN – 41yr old Male, admitted following release from prison, homeless, suicidal (overdose)

- Entrenched Rough Sleeper (205 client)
- Poly-substance misuse
- Offending history
- Physical health issues

Challenge to Discharge

- Local Connection
- Lack of appropriate housing options
- Disconnected professional support network

Intervention

- Multi-agency collaboration
- Extensive info gathering and housing history
- Advocacy and 2 to1 community support

Outcome

- Housed in temporary B&B accommodation on the day (discharged from hospital)
- Longer-term success unclear

CH – UK reconnection

CH - 32yr old Female with diagnosis of BPAD admitted under Section 3.

- Suspended from university and university halls due to MH
- Unable to return to family home

Challenge to Discharge

- Local housing connection – Outer London borough
- Section 117 (MHA) duty with Outer London borough services
- GP in different borough
- Student status – may not be eligible for housing/benefits
- HC changing mind about location on discharge

Intervention

- Rapport building/advocacy/advice – patient centred care planning
- Liaison with multiple services
- Team GP review / support letter
- Housing presentation and GP registration

Outcome

- Reconnection for housing and health

II – EU national reconnection

II - 35yr old Bulgarian male, admitted under Section 2 – risk to self

- Been in UK 6 months – accommodation through work (construction)

Challenge to Discharge

- Unclear if entitled to housing assistance/benefits in UK
- Wanted to return to Bulgaria but no ID or possessions
- No English spoken
- Lack of collateral history

Intervention

- Located ID and possessions with help interpreter (and Google maps!)
- Liaised with employer and escorted to place of work
- Ticket bought
- Liaison with family

Outcome

- Returned to family home in Bulgaria – Before Christmas

TD – missing person

TD - 50yr old Female Admitted via A&E on Section 2 – paranoid, UTI, evidence of neglect

- Identity unknown - false name and DoB and address given
- Transferred between 3 wards (acute and MH) over 10 days – still identity unknown

Challenge to Discharge

- Unknown person
- No collateral history
- Vulnerable but unable to advise without information

Intervention

- Thorough notes review – checked CHAIN, GP Spine with names and addresses given
- Internet search alias name found in notes – matched a Missing Person Report

Outcome

- Ward liaised with police – confirmed address, family contact
- Correct GP spine record matched
- Transferred back to local hospital – had been AWOL

Multi-agency and Multidisciplinary

Guy's and St Thomas' NHS
NHS Foundation Trust

St Mungo's
Ending homelessness
Rebuilding lives

South London and Maudsley NHS
NHS Foundation Trust

THE PASSAGE
to ending homelessness

King's College Hospital NHS
NHS Foundation Trust

Southwark
Law Centre

groundswell
inclusive solutions to homelessness

St GILES TRUST

pathway
Healthcare for homeless people

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