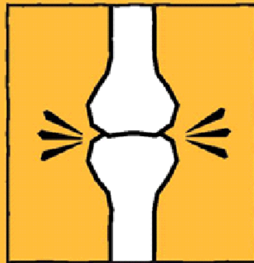
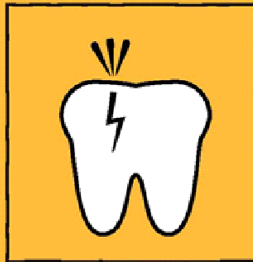
Groundswell

Out of homelessness

Stress?



Strains?



Aches?

Pains?

Need to see a doctor or dentist? Let a Health Peer Advocate help.

Great Chapel Street
Medical Centre

Integrated Care Network

David Woodley, ICN project lead, Groundswell

Dr Natalie Miller, GP lead for ICN at Great Chapel Street Medical Centre

Context

- **Patients with 'no fixed abode' attending A&E departments has nearly trebled since 2010/11.**

- **Homeless patients are 7 x more likely to attend A&E than housed patients**

- **Recorded admissions from emergency departments to hospital wards have also rocketed, from 3,378 in 2010/11 to 5,029 in 2017/18.**

- **Each visit to A&E is estimated to cost the NHS around £148, and one day spent in a hospital bed around £400 – meaning these figures alone represent a bill to the NHS of more than £4.7m.**

- **Source. BMA freedom of information report.**

ICN

- **The Integrated Care Network, (ICN)**
  - CCG commissioned collaborative project
  - Groundswell, Great Chapel Street Medical Centre and Dr Hickey Surgery
- **Aim**
  - To reduce A&E attendances and non-elective admissions to hospital
- **The ICN caseload + beds**:
  - Max. 30 patients on caseload from both specialist homeless GP practices
  - 4 beds
- Assisting patients to **navigate the health services** and empower them to ultimately navigate those services

Background

- 2016
  - Step up/step down
  - Bed-focussed project
  - 11 respite beds across numerous hostels in Westminster.
  - Maximum 6 week stay in the bed
  - 2 ‘mental health beds’ managed by the JHT
  - 9 ‘physical health beds’ managed by the homeless GP practices.

Evolution

- Need to prove cost-saving for NHS
- Commissioning of service addressing social determinants of health
- Step down - difficult to demonstrate cost saving to CCG
- Duplication of MH funding due to block contract funding

- NRPF – difficulty with concept of funding accommodation
- Cost saving across other public sectors evident but not captured

Current model

- Contract held by Groundswell since 2018
- Health component contracts held by both GP surgeries who manage and oversee the clinical aspects
- Care navigation role as project lead
- 4 beds across 2 hostels
- Tighter ‘criteria’ for use of beds
- Introduction of a ‘caseload’ of patients
- High intensity users – evolving focus for caseload

Criteria for beds

- Health problem that could:
  - Lead to admission in next 4 weeks
  - Improve significantly in 6 weeks
- Recourse to public funds
- No specific mental health component
- Not step down

Criteria for caseload

- ICN Caseload:
- Referral to the Integrated Care Network is based on medical need and the complexity of that need
- Patients must be registered or plan to register with either Great Chapel Street Medical Centre or Dr Hickey Surgery
- **Clients do not require recourse to public funds to be on the ICN caseload**

Referral pathway

Referral

- Referral from Health professionals
- Referrals from Homeless services.
- David.woodley@nhs.net
- Groundswell website for referral form.

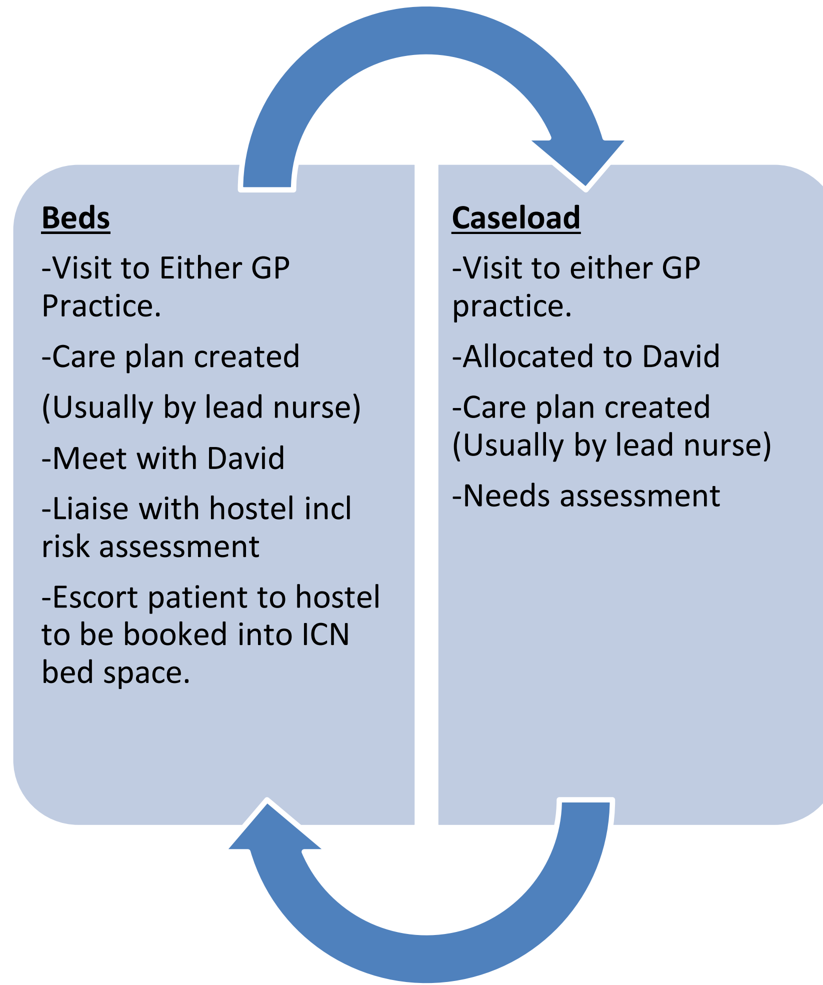
ICN Caseload

- Decisions on whether a patient is accepted on to the ICN caseload will be made by a **clinician** from either of the two GP surgeries.
- Clients can be in accommodation or rough sleeping.
- **Clients do not require recourse to public funds.**

ICN Beds

- The ICN respite beds work in conjunction with the caseload. Providing respite to reduce the risk of hospital admission.
- Client must be street homeless / not currently in accommodation
- **Have recourse to public funds.**

Practicalities



Overview of what ‘gets done’ during a bed stay and caseload

- Liaison with support services
- Care Navigation through primary and secondary care, using Groundswell HHPA to accompany to appointments
- Assess social needs
- Signpost to services
- Regular telephone and text contact with patient.
- Link up between support services
- Intensive case-managed healthcare led by ICN Lead nurse

Outcomes measured

- Money – cost savings to CCG – £61,000 in 9 months
- QOL – EQ5D
- Frequency of attendance to A&E and NEL admissions (data collected by CCG)
- Social Outcomes
- ‘Soft’ outcomes of improved relationship and partnership working across services / development of SLAs with hostels etc

Challenges

- Engagement can sometimes lead to *increased* use of healthcare
- NRPF – massive gap in provision
- Proving a negative – intervening before a secondary care attendance
- Difficulties with terminating bed stay
- Risk assessments
- Long-term changes in health service use and cost-savings not recognised

Strengths

- Collaborative working
- Case management
- Short-term intensive personalised multidisciplinary care – gold standard
- Inter-sector trust and relationships
- Well-received by patients who have been through the pathway

Testimonials

- *“I thought I was going to die before I came into GCS and you put me in the bed”*
- *“Thankfully [due]to the help and support from ICN and Groundswell I can honestly say [they] saved my life. I would not be writing this letter today if I did not receive this support. I am eternally grateful”*
- *“We’ve never felt ready to think about our health before but because of this bed and Dave, we’re ready now”*

Case 1 (bed)

Mr AK – 52yr

- 4 x recent A&E (multiple A&E since 2013) plus NEL admissions for IVabx
- Cellulitis and infected ulcer
- PMH brain injury, MH problems, substance misuse

- Rough sleeping and not attending primary care

ICN bed

- Antibiotics
- Elevation of legs
- Daily dressings
- Weaning off addictive prescription medication (DHC / pregab)
- MH support – counsellor / MHCP / psychiatrist
- Preventative medicine – BBV screen and vaccination
- Support to access housing and benefit assistance
- Care navigation to all medical appointments at GP and TVN

Outcome

- £4852 cost saving for CCG with a 4 week bedstay
- Temporary accommodation
- No further A&E attendances or NEL admissions
- Improvement in health
- Improvement in EQ5D
- Mainstream registration locally with local TVN input

Case 2 (caseload)

Mr ED 53yrs

- Temporary accommodation in Westminster following extended hospital admission
- Crohn's disease / sepsis / stoma / malnutrition / dehydration / renal failure
- Multiple readmissions to hospital after discharge
- Struggling to manage his own care in the community
- Difficulties adhering to prescribed medication and attending hospital appointments

ICN caseload

- Complexities of his care and support needs and high risk of NEL admission
- Social services referral for care needs
- Prompting regularly re his medication and arranging delivery of new dossett box
- Co-ordinating frequent hospital appointments and arranging a peer advocate

Outcome

- ED remains on the ICN caseload
- Weekly reviews and home visits
- Text reminders to see GP
- No A&E visits or unplanned admissions to hospital since.
- His health has vastly improved and he is managing his health conditions more independently

Questions / future considerations

- What other data can we collect?
- What other outcomes could we measure?
- CCG would like to collect data for the caseload patients - what might this look like?
- Collaborative funding?
- Cost savings if NRPF needs met?

Thank You.

Groundswell

Out of homelessness

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Great Chapel Street
Medical Centre