Exploring health and mortality amongst Tenancy Sustainment Team clients

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Funded by GLA

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br research
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pathway
Healthcare for homeless people

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- The aims of the GLA funded TST health & mortality research
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The Clearing House & TST teams

- A lasting legacy of the 1991 Rough Sleepers Initiative
- 40 Housing Associations
- 1700 tenancies supported by TST team (commissioned by GLA)
- Support consists of support worker, visiting between weekly and monthly
  - St Mungo's TST North
  - Thames Reach TST South

  - Referrals from homelessness services (hostels, outreach etc)
  - History of rough sleeping history + a support need
  - Waiting list and allocations
- Tenancies are reviewed after two year period

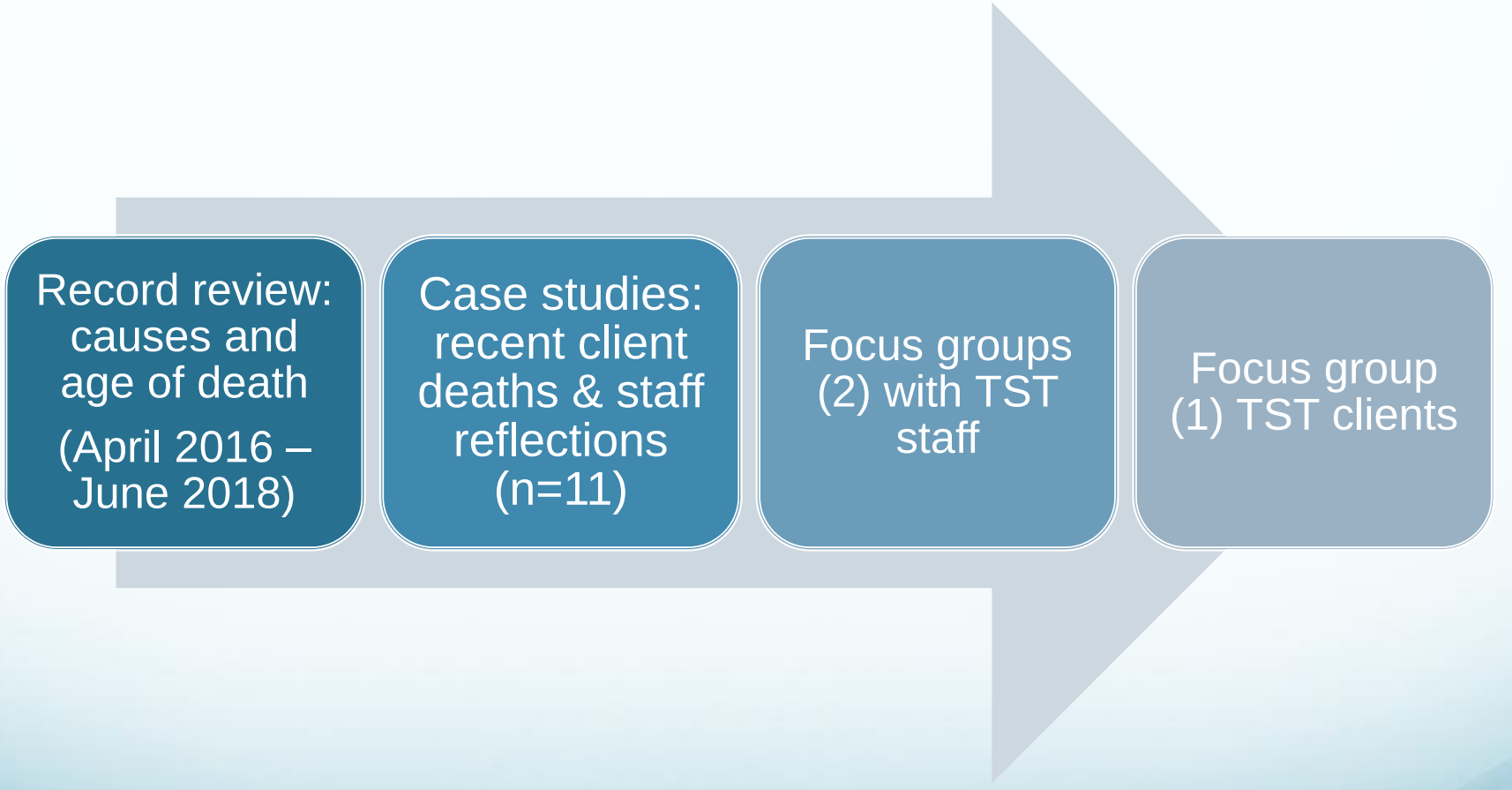
Study objectives

Due to concern over deaths in TST projects, GLA commissioned work to:

1. Better understand mortality and morbidity in the TST cohort

2. Provide practical recommendations for the TST teams and commissioners in order to improve their services

Methods


Record review: causes and age of death
(April 2016 – June 2018)
Case studies: recent client deaths & staff reflections (n=11)
Focus groups (2) with TST staff
Focus group (1) TST clients

Findings

Cause of death (April 2016 – August 2018)

as determined by project records

55 deaths aged between 30-72 (average age of death: 52 years)

Primary cause of death	Number
Cancer	11
Cardio vascular	6
Respiratory	2
Gastro /liver	4
Toxicity / Drug overdose	4
Cause of death unclear: heavy drug and/or alcohol use	12
Cause of death unclear: uncertain if related to substance misuse	8
Cause of death unclear: no significant current use of drugs or alcohol	8

Limitations of coding:

Many had multiple morbidity

‘Cause of death unclear’ contains cardiomyopathy, heart failure, cirrhosis, liver & kidney failure, breathing difficulties etc

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Substance misuse in clients who died

Substance-related support need	Number of clients N (%)
Current alcohol	16 (29)
Current drugs	5 (9)
Current both	9 (16)
Past alcohol	3 (5)
Past both	3 (5)
Not a known problem for client	10 (18)
Data not available	9 (9)
Total	55

54%

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Case studies

Case studies: key findings (a)
characteristics of population

2 female, 9 male

Average age of death 56

8 cases client in very poor health, 2 unexpected deaths, 1 unable to say

Strong link between complex health problems and drug and alcohol dependency

- 8 of the 11
  - 3 drug & alcohol
  - 5 alcohol dependency

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Case studies: key findings (b)

Impact of substance use

- Those who died youngest were using drugs/ had used drugs in the past (40s)
- Those using alcohol but not drugs died in their 40s, 50s and 60s
- The 3 people who were not drug or alcohol dependent were older (70, 71 and 61)
- Ill health acted as motivator for reducing or abstaining (or the intention to) for some

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Case studies: key findings (c)

Some indicators of poor health determined by staff:

- Poor mental health and social isolation
- Weight loss and poor nutrition
- Cirrhosis
- Mobility problems, breathing problems
- Recurrent abscesses, chronic pain
- Diabetes, poor foot health
- Non engagement (e.g. cases closed with substance misuse)

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Focus groups

TST staff focus group
Challenges for staff

- High case loads (up to 50)
- Perception of increasing number of clients with high support needs (including older clients)
- Difficulties engaging with people who were heavy users of substances
- Practical difficulties of access / finding clients / language barriers

'*More than 50% [of my] clients… have quite serious health issues, and it's ongoing health issues… [Facilitator: How many of your clients would you say are in really good health?] A small handful to be honest. About 10% if that*

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TST staff focus group *working with other agencies*

- Often felt like 'working in isolation': not adequately supported by health and social care professionals
  - Difficulty getting access to GP's (less an issue with specialist practices)
  - Often challenging getting social services POC
- Blocked from accessing information: health professionals not understanding support worker's role
- Lack of flexibility of services

'We're social workers, cleaners, advisors, we're just everything… We either do it or there's no one else to do it.'

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"[When my client was discharged from hospital], he was still unable to comply with his medication and that went on for a couple of months while I was going back and forth, writing… letters to his GP … and contacting social services. Finally, he had a care package put in place. If I'd given up after my first and second attempt...I don't think he would have survived another two, three months."

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“I took a client for an assessment at a Community Mental Health Team last week… they were talking about referring him to Substance Misuse Service and I said ‘he’s talking about suicide and killing others and he doesn’t drink every day, he’s not dependent, can you please give him support for his mental health and we can worry about that afterwards.”

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TST staff Focus group: 3
Palliative care

- Most deaths feel ‘sudden’ or ‘unexpected’ - but often not surprising on reflection
- TST staff feel burden of responsibility for very sick clients
- Dual diagnosis: barrier to getting the right help for some of those most in need
- Positive experiences of cancer support
- Less positive regarding other illnesses such as liver disease. Sense of stigma
- Deaths can have huge impact on staff

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“Where I had [someone] with cancer, there was a lot of support from other teams, with alcohol when it’s liver failure, when people are bleeding from certain passages … you get less support and I don’t know why that is.”

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“ have a client that I walked in on, and I was told that if I’d not walked in at that time, probably an hour later he would have been gone [dead]. I had to call the ambulance. He had epilepsy, he had drunk one litre of vodka and he had … hit his head on the floor...”

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‘*He improved, then there was silence and he stopped engaging with appropriate services, then the next thing I heard was `he’s gone’.. And the impact of that on myself as well was really heavy, I took it personally, I underestimated how it will affect me.’.*

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Clients: Focus Group
Key findings

- Recognition of negative impact on health of rough sleeping
- Moving into accommodation gives opportunity to address health problems
- TST support was very helpful and important
- Poor engagement with health services often a result of lack of motivation, feeling stigmatized or lack of flexibility of services
- Positive cycle of feeling better resulting in taking control of health and wellbeing
- Ongoing problem of social isolation
- The ‘drop off’ of support as needs reduced (often a challenge for clients with increased risk of isolation and relapse)

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“I’ve reduced my intake of alcohol greatly on my own, alcohol and drugs… But since I’ve had my property, as much as I’m happy with the property, it’s the isolation and the loneliness. …sometimes there are set backs, that’s where you need extra support.”

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What TST staff said they needed:

- An improved flexible and timely multidisciplinary response to those with complex health and care needs
- In reach – such as Nursing / OT support to the team
- More time to spend with clients with high needs (smaller case loads)
- Flexibility in determining priorities
- Meaningful activities to alleviate isolation

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What TST clients said they needed:

Flexible, continuous support to help maintain any health gains and prevent deterioration

Peer support: *'There is a therapeutic value of people that have been through the same sort of stuff that we can all relate to and we have our common bond'*

Support for getting into Education, Training and Employment to combat isolation and promote sense of purpose

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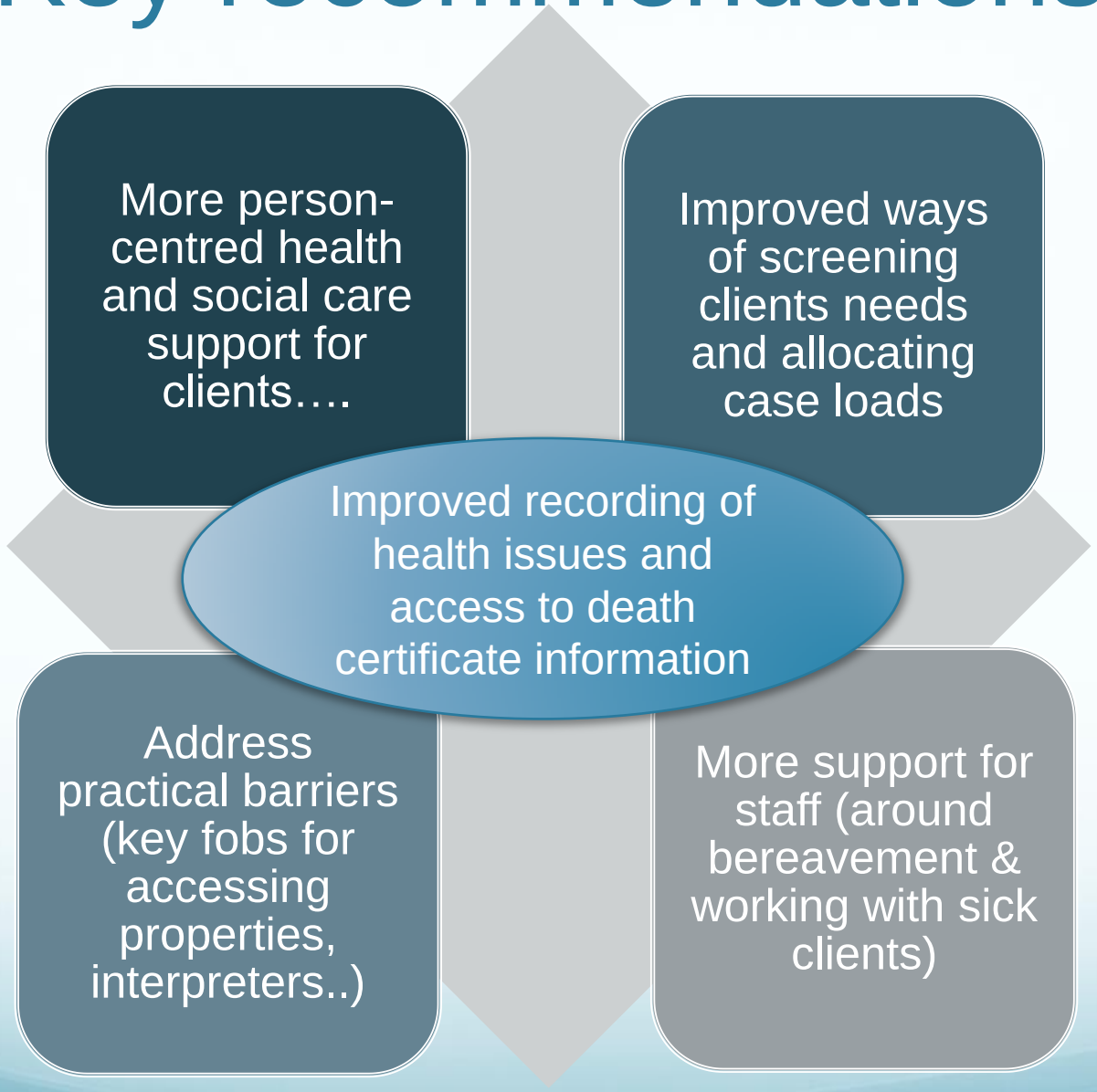
Key recommendations:



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Improving the Management of Long-term Conditions (LTCs)

Wider implications of this work….

NHS Long Term Plan

- NHS Long Term Plan (2019) supports the development of Integrated Care Systems (ICSs).
- By 2021, ICSs to cover all of the country.
- Still searching for the Holy Grail? What's different about integration this time around?
- Embedding the 'Chronic Care Model' in Neighbourhood Teams

'Supporting patients to **'self-manage**' their health and wellbeing, and to become **'active partners**' in personalised care and support planning will improve clinical outcomes, reduce unscheduled care costs and lead to better value for money (Dept. of Health, 2012

Operating models for coordinated care put multidisciplinary working at the heart of the system. Members of the Strategic Partnership can help develop and implement this new care model.

What?

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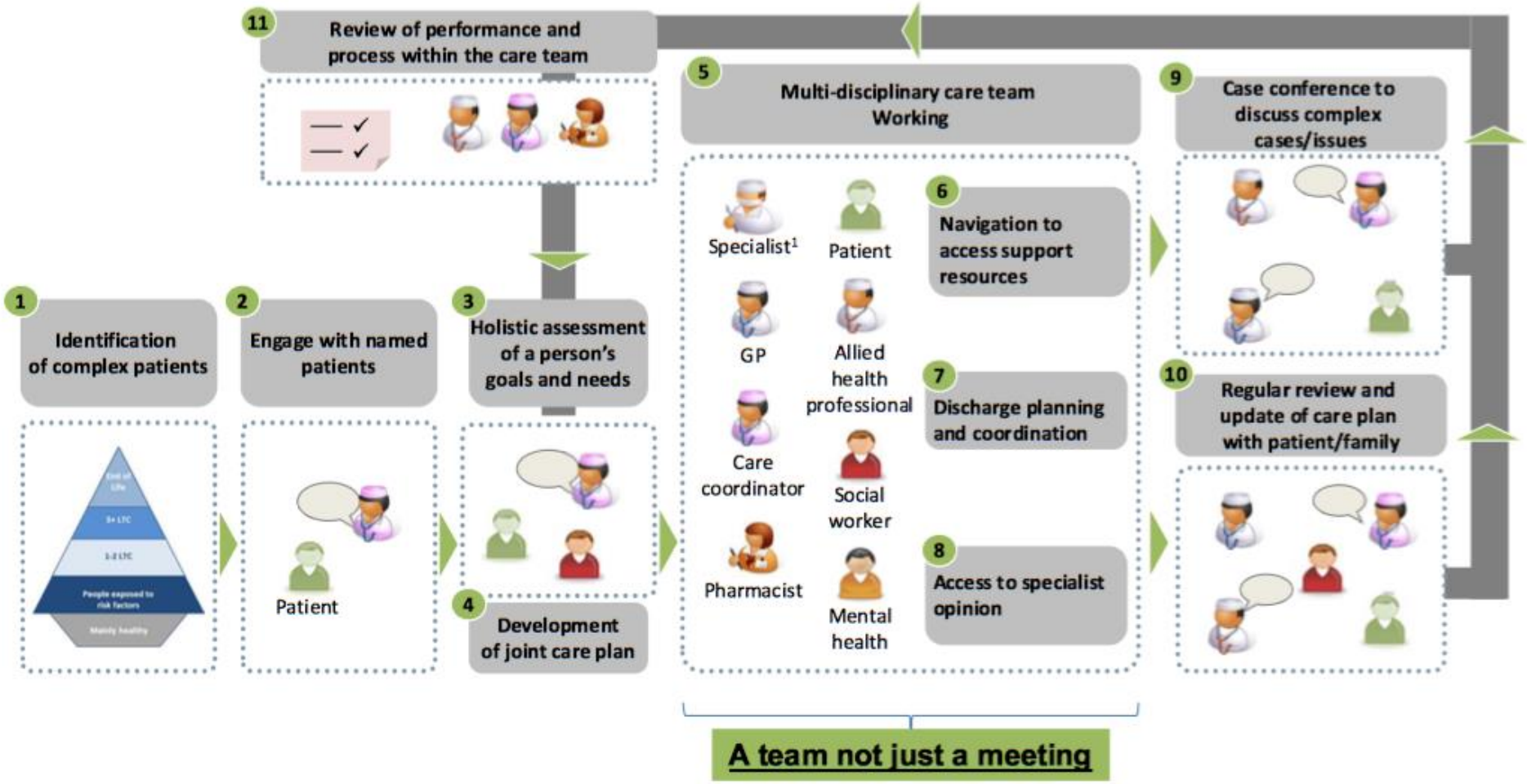

Source: Adapted from Carter, Chalouhi, Richardson – What it takes to make integrated care work (McKinsey Health Int[illegible] 2014)

NHS Southwark Clinical Commissioning Group

Southwark Council

Fragmentation means that services often don't take a holistic view of a person's needs and this can lead to poor care, poor outcomes and avoidable medical interventions

Why?

Michael's story is an illustrative account, showing how a holistic, whole person approach which considers health, social and economic needs could make a real difference.

Michael is 62. He moved to Southwark ten years ago for work, but has recently been made redundant. He lives alone in rented accommodation. Since losing his job Michael sees fewer people. He worries about his rent, and growing debt.

Michael has insulin-dependent diabetes, hypertension and depression. He knows he should eat better and exercise more, but it feels hard; going to a gym is another expense and it's quick and easy to eat take-away food. Michael feels things are out of control, and his only real comfort is alcohol.

The police have taken Michael to A&E four times in the past six months, after he collapsed in the street following particularly heavy drinking. His diabetes is a problem; he has called an ambulance twice in the past month and been admitted into hospital with hypoglycaemia because he hadn't eaten enough.

In hospital Michael met other people with diabetes. One person had had a heart attack related to diabetes. She had also had an amputation last year as her leg ulcers refused to heal. She told Michael that she wished someone had helped her before it was too late. When Michael was discharged he was very worried; he didn't want to have a heart attack or end up needing an amputation but he didn't know what to do.

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We want to develop local care so that it is more integrated, coordinated and so that it is financially sustainable now and for the future

What?

- GPs, nurses, social workers and hospital consultants will collect and use information to identify people like Michael early and arrange the best support for them. Integrated teams will understand all of his needs and capabilities.
- The team will have the time to understand Michael, what is important to him and his goals. Michael's mental and emotional needs will be considered equal to his physical health needs, and his care team will include psychologists and psychiatrists.
- The team will use techniques like proactive care planning to help Michael start to take control of his life. Michael will feel like he is working with an expert care team, rather than just being treated by them or being told what to do

- Michael will be able to meet other people who are experiencing similar things in peer-support groups. He will be able to access education and self-management support to feel more confident and live well with his conditions. Michael will feel reassured that he can contact a care team member quickly, if he needs to.
- Michael will find it easier to access social activities and groups, and feel more connected and able to make friends. He will get practical advice on issues like housing, debt-management, benefits, and employment.
- Living a healthier life will be simpler. Michael will know where the local parks are, and that they're safe. He will be able to access free gyms and swims, and cycling and walking will be easier because the roads will be safe and well lit.

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Future Research

- Chronic Care Model designed for **‘all pathways and conditions’** – yet to be tested in inclusion health.
- What will be the implementation challenges?
- How can we stratify risk? What does comprehensive assessment look like?
- How can we turn ‘self neglect’ into ‘self care’?
- What are the workforce implications (e.g. moving beyond tenancy sustainment to health and wellbeing coaching?)

Practical Action

- **National Level** – Make sure housing and the housing workforce is included in the development of ICS (Memorandum of Understanding)
- **At a Pan London level,** Clinical Commissioning Groups (CCGs) and Greater London Authority (GLA) to connect around local ICS development
- **Front line practice** - Integration is about relationships, finds ways to build them. E.g set up a community of practice – become a member of the neighbourhood team.

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